Vhi Insurance DAC

Submission to the Health Insurance Authority's public consultation on community rated health insurance market in Ireland and proposed changes to Risk Equalisation Scheme

5th February 2021

SUBMISSION CONTENTS

EXECUTIVE SUMMARY

Vhi welcomes most of the incremental improvements for the proposed RES ('**RES 2022**') and especially the high cost claimants pool ('**HCCP**') which will (1) reduce claims distortions from high cost claimant outliers and (2) improve the efficient allocation of risk specific health credits to sicker[1] customers across the market which will improve support for the Principle Objective and the interests of all customers.

The private health insurance ('**PHI**') market plays a significant role within the Irish healthcare system and it operates on the principles of community rating, open enrolment, lifetime cover and minimum benefits. These legal principles are designed to ensure that all customers can access appropriate benefits at affordable prices and irrespective of their age or medical history. Promoting and strengthening the system of community rating is the principal objective of government private health insurance policy. Risk equalisation is an essential component of all international community rated markets and supports community rating by reducing the distortions from risk selection incentives and risk imbalances between insurers.

Risk selection incentives (or the predictable losses associated with older and sicker customers) adversely affect competition, consumers and health-care systems. Incremental improvements in risk equalisation will reduce risk selection activities and increase competition based on health care quality, innovation, better health outcomes and efficiency. Previous risk equalisation schemes have incorporated a series of progressive incremental improvements designed to improve the operation of community rating within the Irish health insurance market and the proposed RES 2022 includes the addition of a HCCP to address the large risk selection incentives and losses associated with sicker customers of all ages.

In our submission Vhi Insurance DAC ('**Vhi**') presents the following evidence in support of HCCP - (1) reduces predictable risk selection incentives and plan proliferation, (2) reduces claims volatility from expensive claims outliers[2], (3) increases support for community rating, (4) improves the operation of sophisticated measures of health status such as DRGs and (5) increases incentives for competition based on efficiency, innovation and provision of health care services. This evidence is available from academic literature, precedents from international RES schemes and internal Vhi projections. Vhi's commitment to the PHI market is unchanged and Vhi expects that HCCP will improve competition based on healthcare, efficiencies and will reduce plan proliferation and benefit all customers in the market.

The Authority lists seven new policy aims and these are outlined in the Consultation Paper. Previously there were four aims and the expansion to seven aims seeks to achieve multiple objectives and where one in particular contradicts support for the Principle Objective. Vhi is of the view that those aims

[1] 'Sicker' customers are defined as customers with either chronic illnesses or condition who require ongoing, and often lifelong, expensive healthcare services for their illness or conditions, e.g. cancer, heart disease

[2] Buchner F et al (including Dirk Goepffarth representing the German health insurance regulator) acknowledged this function of the HCCP and in the context of the removal of the HCCP from the German RES in 2009 commented that - *"for rather small sickness funds the abolishment of the high-cost pool can produce a high financial burden, especially if they cover many high-cost cases."*

which best support the Principal Objective, i.e. promoting and strengthening community rating, are prioritised in any assessment of policy aims for RES 2022.

Other factors which should be considered in the context of this consultation include (1) changes to treatment locations due to Covid-19, (2) international precedents for quota share of 80%, (3) prospective scheme efficiency incentives includes scheme volatility, (4) healthcare competition helps control medical inflation, (4) measure of scheme RES effectiveness needs to include the net benefits from all credits, (5) over-compensation measure should reflect the business risks and level of profits earned within the Irish health insurance market, (6) reducing insurer risk imbalances will reduce future insurer Net Financial Impacts[3] ('**NFI**s') from RES 2022 and will increase the scope for further support to the Principle Objective and (7) better RES will reduce super-normal profits and higher resulting premiums paid by customers.

[3] Definition used by the Authority to describe insurer net contributions to the RES Fund or insurer net receipts from the RES Fund

1. INTRODUCTION

1.1 Vhi Insurance DAC ('**Vhi**') is pleased to comment on the public consultation in relation to the community-rated health insurance market in Ireland and proposed changes to the risk equalisation scheme. Each of the questions is dealt with in a separate chapter within this submission.

2. QUESTION 1

"Given that Ireland has a voluntary community rated market for health insurance, do you agree with the principle and overall substance of the Risk Equalisation Scheme?"

2.1 The private health insurance ('**PHI**') market insures c.46% of the population and pays for c.30% of total spending on acute private hospitals. As such the PHI market plays a significant role within the Irish healthcare system. The PHI market operates based on the principles of community rating, open enrolment, lifetime cover and minimum benefits and these principles are designed such that all customers can access appropriate benefits at affordable prices and irrespective of their age or medical history. Promoting and strengthening the system of community rating is the Principal Objective of government policy that also includes other objectives such as fair and open competition, avoiding over-compensation and maintaining market sustainability.

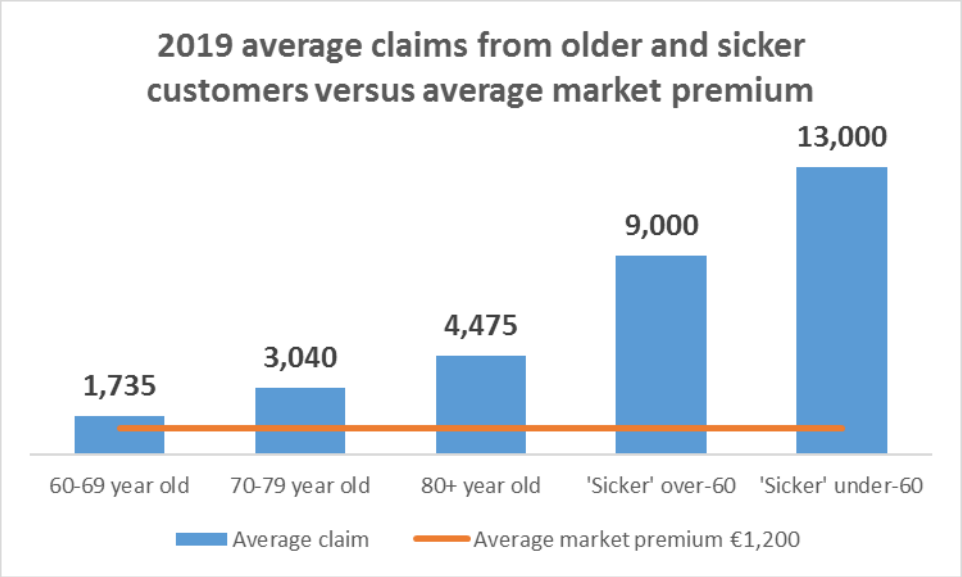
2.2 Risk equalisation is a further regulation which operates as an essential support for a stable and efficient community rated market. The purpose of risk equalisation is to reduce the competitive disadvantages for insurers and customers associated with the predictable higher costs and losses associated with older and sicker[4] customers. Risk equalisation is an essential component of all international community rated markets and supports community rating by reducing the distortions from risk selection incentives and risk imbalances between insurers to ensure a level playing field in the market to the wider benefit of consumers' welfare[5].

2.3 The following chart shows the predictable higher claims of older and sicker customers and the predictable losses (or risk selection incentives) when compared to the average premium in the market of €1,200. These risk selection incentives affect (1) competition in the market where the higher costs of older and sicker customers are not shared fairly

[4] 'Sicker' customers are defined as customers with either chronic illnesses or condition who require ongoing, and often lifelong, expensive healthcare services for their illness or conditions, e.g. cancer, heart disease, COPD, psychiatric illnesses etc. Sicker customers are also persistently high cost claimants over many years and will remain significantly unprofitable for conceivably most of their lives. Insured persons with chronic illnesses are not buying health insurance per se but are instead buying a funding plan to pay for their ongoing health-care requirements. Vhi has estimated the extent of sicker customers across the market based on its own DRG coding of discharges and an estimate of sicker customers within Laya and Irish Life Health.

[5] Van de Ven W. et al (2007) - *"good risk adjustment is an essential pre-condition for reaping the benefits of a competitive health insurance market. Without good risk adjustment the disadvantages of a competitive insurance market may outweigh its advantages."*
Judgment of the Court of First Instance in case T-289/03, British United Provident Association Ltd (BUPA) and Others v Commission of the European Communities – "*"the essential purpose of the open enrolment and community rating obligations is to spread those burdens fairly over the entire Irish PMI market, so that any PMI insurer bears only the burdens linked with the average market risk profile. If those burdens were not equalised, the functioning of the community rating aimed at an equal allocation of risks between PMI insurers to enable the cross-subsidy of premiums between the generations would be impeded."*

across all insurers operating in the market and (2) consumer interests where insurer priorities and activities are influenced by the scale of predictable profits from younger and healthier customers and predictable losses from older and sicker customers.



2.4 Within the academic literature there are many examples of the negative effects of risk selection incentives on competition, consumers and health-care systems, including[6] -

- Drawbacks for society as a whole including (1) reduced access to high quality health care for the chronically ill, (2) efficient insurers losing market share to inefficient insurers, (3) resources used for selection seen as social welfare losses, (4) bankruptcy of an insurer with a disproportionate share of older and sicker customers and (5) super-normal profits for insurers who do not bear their fair share of the higher costs of older and sicker customers.
- Risk selection by insurers may lead to efficiency problems and fairness issues including (1) customers on inappropriate plans and (2) differences in plan premiums which reflect not only variation in quality and efficiency but also risk selection profits and losses.
- Higher premiums for older and sicker customers who subsidies lower premiums for younger and healthier customers.
- Lower insurer response to the preferences of older and sicker customers which restricts the benefits of competition to younger and healthier customers where insurers do not seek to acquire a reputation for excellence in chronic illnesses.

2.5 Competition in the Irish market is largely defined by risk selection profits for younger and healthier customers and many of the negative effects listed above exist in the Irish market. While the RES was instituted to tackle this issue, it only partially succeeded

[6] Van de Ven W et al (1999), Chapter 17, Handbook of Health Economics, "Risk adjustment in competitive health insurance markets"

because the design of its features only allows it to be partially effective. Incremental improvements in risk equalisation will further reduce risk selection activities and increase competition based on health care quality, innovation, better health outcomes and efficiency.

2.6 Previous risk equalisation schemes have incorporated a series of progressive improvements designed to improve the operation of community rating within the Irish health insurance market. The current RES, ('**RES 2016**'), is substantially the same scheme as RES 2013 but where the hospital utilisation credit ('**HUC**') was expanded to include daycase admissions. Similarly the proposed RES ('**RES 2022**') is substantively the same as RES 2016 but with the proposed addition of a high cost claimants pool ('**HCCP**') to address the large risk selection incentives and losses associated with sicker customers of all ages.

2.7 Longer term it is widely acknowledged that health credits based on diagnosis related codes[7] ('**DRG's**') will substantively address the losses from sicker customers. In the short to medium term there is a real requirement to make an incremental improvement in health credits and provide further support to sicker customers and Vhi supports the proposal to introduce a high cost claimants pool.

High cost claimants pool ('HCCP')

2.8 There is consensus in academic literature that even the most sophisticated risk-equalisation model may not be able to accurately predict the extremely high expenses of individuals who are persistently high-cost patients and thus some permanent form of risk sharing may be necessary to avoid risk selection against under-priced high-cost patients. This consensus can be observed in research by prominent health-care economists and academics.[8]

2.9 There is also consensus internationally on the use of HCCP within developing and sophisticated risk equalisation schemes. There are many international precedents for the introduction of HCCP in advance of more sophisticated measures of customer health and, latterly, the retention of HCCP to improve the operation of sophisticated measures

[7] Diagnosis Related Groups (DRGs) are the classification of patient discharges into homogenous groups based on patients diagnosis which are expected to have similar resource usage and clinical patterns of care. DRGs are used with the Irish public health-care system to allocate budgets and understand patient activity within the public health-care system.

[8] Van de Ven W. et al (2011), Health Affairs 34, No.10 (2015) 1713-20, "Risk selection threatens quality of care for certain patients: lessons from Europe's health insurance exchanges"[8] – (excerpt) *"Even the best risk-adjustment model that is feasible in practice may not be able to accurately predict extremely high expenses of individuals who persistently fall in the 2-4 percent of patients with the highest expenses, including patients with a rare disease. Thus, some permanent form of risk sharing may be necessary to avoid risk selection against under-priced high cost patients."*

of customer health, including Germany, Netherlands, Czech Republic and United States ACA and Medicare Part D. Australia also operates a HCCP for sicker customers.

2.10 The HCCP acts as a simple reinsurance 'excess of loss' pool for individual insured customers whose total claims exceeds the claims excess parameter. It is the international norm that total claims of an individual customer over a 12 month period (either incurred over a policy year or paid over four calendar quarters) are considered for inclusion within the HCCP[9]. One of the main advantages of the HCCP is that total claims are readily available for all customers in the Irish market. It is the standard practice internationally to set the share ratio parameter at c.80% to promote risk sharing for the very highest cost customers whilst preserving sufficient incentives for claims efficiency. It is also standard practice internationally to either (1) maintain a fixed claims excess parameter or (2) flex the claims excess parameter in line with claims inflation. **Vhi is recommending that the Health Insurance Authority ('the Authority') reviews the standards and best practices associated with the HCCP within the German, Dutch, Czech, Australian and US markets.**

2.11 The two main HCCP parameters are the 'claims excess' and the 'quota share' and these two parameters act together to define the level of risk sharing and incentives for efficiency within the market. Vhi notes that the Authority is proposing a 40% quota share and a claims excess of €50,000. The choice of 40% quota share does not have any precedent either internationally or within academic literature. **Vhi would like to understand why the Authority is recommending a quota share of 40% and why it is more advantageous than the international standard parameter of 80%**, which figure is accepted internationally as providing the optimum combination of risk sharing for the very sickest and expensive customers whilst preserving incentives for efficiency.

2.12 Whilst the Authority states that the introduction of HCCP is a progressive improvement and will improve RES effectiveness it has not published its supporting evidence. The disclosure of such evidence would assist with our understanding of the rationale and allow Vhi to make informed comments on this point. Vhi wishes to make reference to the following evidence in support of introducing HCCP to RES 2022.

- Academic literature demonstrates evidence that HCCP risk sharing (1) reduces predictable risk selection incentives, (2) reduces claims volatility from expensive claims outliers[10], (3) increases support for community rating, (4) improves the operation of sophisticated measures of health such as DRGs and (5) increases

[9] Full claims from a customer over a year is required to accurately measure claims outliers over the claims period.

[10] Buchner F et al (including Dirk Goepffarth representing the German health insurance regulator) acknowledged this function of the HCCP and in the context of the removal of the HCCP from the German RES in 2009 commented that - *"for rather small sickness funds the abolishment of the high-cost pool can produce a high financial burden, especially if they cover many high-cost cases."*

incentives for competition based on efficiency, innovation and provision of health care services.

- International precedents of long term use of HCCP within developing and sophisticated risk equalisation schemes.
- Vhi internal projections demonstrate evidence that (1) HCCP is risk specific where high cost claimant status is predictive of future high cost claimant status, (2) reduction in risk selection incentives for sicker customers, (3) reduction in risk selection incentives associated with specific chronic illnesses, (4) reduction in claims volatility from expensive claims outliers and (5) increased support for community rating and market stability.

Updated Department of Health Aims[11]

2.13 It is worth noting that the Public Consultation document offers no guidance on the relative priority of the aims. Support for the Principal Objective is the legally binding priority and some of the wide ranging aims may interfere with support for the Principal Objective. **Vhi is recommending that guidance on the prioritisation of the aims is published to improve the transparency of the operation of these aims whilst making them subservient to the Principle Objective.**[12]

Aim 1 - Improve the overall effectiveness of the Scheme in terms of distributing funds from insurers with lower levels of risk to those with higher levels of risk

2.14 This aim relates to distributing funds between insurers and does not fully reflect the Principal Objective which is set out in legislation and focuses on the individual customer and not insurers. The Principal Objective is intended to reduce the selection incentives for insurer's to target one customer over another and the focus on insurers in this aim arguably distracts from the core intention of the Principal Objective. This aim may prioritise results less directly linked to the Principal Objective. For example, if all insurers in the Irish PMI market have the same risk profile and, as such, there would be no insurer NFIs (or Net Financial Impacts[13]) arising from risk equalisation. This aim would become redundant in effect whereas underlying customer risk selection incentives would remain and this aim could interfere with support for the Principal Objective and reduction of risk selection incentives.

[11] Previous aims provided support for the Principal Objective, fair and open competition, market sustainability and avoiding over-compensation.

[12] The EU Court of First Instance ('CFI') made a judgement in the Bupa case, concerning the Irish PHI RES, which acknowledges the principle that not all community rating regulatory aims carry equal significance and some aims are more important than others. As an example the CFI confirmed that the objectives of RES and the interests involved must take priority over the need to facilitate access to the market.

[13] The Authority's terminology for net contribution net receipts to and from the RES Fund by Laya, Irish Life Health and Vhi.

Aim 2 – Reduce the incentives for risk selection so that insurers are indifferent (or at least less incentivised) to target less risk and more profitable customers

2.15 The Principal Objective as set out in the legislation is focused on the individual customer and this aim would appear to be the highest priority aim as it is uniquely focussed on achieving the Principal Objective.

Aim 3 – Encourage younger healthier lives into the market by keeping stamp duties at acceptable levels for younger policyholders

2.16 Levy does not increase costs across the market as a whole and plan levy payments also fund the receipt of credits by the plan. For example the levy has increased by €449 since 2009 and yet market numbers have not fallen and the cheapest adult price for a plan with private hospital benefits remains competitive at €729[14]. As another example, there have been two large decreases in the non-advanced stamp duty, -12% in 2018 and -11% in 2020, but the non-advanced market size decreased from 195,000 at 1/7/2017 to 184,000 at 1/7/2019. **Vhi would like to see evidence which supports the link between levy and market sustainability and that such evidence is published.**

2.17 This aim makes a direct link between market sustainability and lower levy. Vhi believes this aim is an over-simplification and does not accurately reflect the complexity of insurer pricing. It ignores the many other important influences on plan prices including claims, medical inflation, operating expenses, profit margins, net RES payments/receipts to/from RES Fund, changes in reserves, reinsurance and solvency capital requirements. This aim also implicitly accepts that sufficient support may not be offered to the Principle Objective and that an acceptable consequence of keeping stamp duties at acceptable levels for younger customers could be lower levy, lower credits and higher plan prices for older customers.

Aim 4 – Promote efficiency in the market by compensating for risk differences and not structural or expense differences

2.18 Vhi strongly supports the development of a robust RES which prioritises prospective credits based on sophisticated measures of health risk. This robust RES model would (1) minimise the stamp duty required to fund risk specific credits, (2) avoid any compensation other than for predictable selection incentives and risk differences and (3) reduce risk based distortions of competition in the market and ensure insurers can earn a sustainable return.

[14] Laya Precision 600 Connect

Aim 5 – Avoid over-compensation within the market place

2.19 Vhi supports an over-compensation measure and test, which is set in an objective and transparent manner, and reflects as closely as possible the levels of return and business risk existing in the Irish market. Otherwise this test may (1) distort competition between Vhi, as the net recipient, and other insurers and (2) discourage new entrants into the market. RES 2022 will continue to operate multiple safeguards against over-compensation[15] and even with the addition of HCCP it is expected that RES 2022 will remain only partially effective with a corresponding low level of over-compensation risk.

Aim 6 – Fair and open competition in the health insurance market

2.20 The understood purpose of the community rated market is that all insurers should bear their fair share of the higher costs of older and sicker customers[16]. It is not clear how this aim will be interpreted and implemented in future and **Vhi is recommending that the Authority publishes its evaluation framework for fair and open competition to improve market transparency**.

Aim 7 – Maintain stability in the market such that there are no sharp shocks that could disrupt and potentially destabilise the market

2.21 The Irish PMI market differs from most European health insurance markets in that participation is voluntary. It is not a compulsory system of social insurance and limited tax relief support is received from the Government. As such Vhi continues to support the Authority's actions to promote market stability where 'sharp shocks' can arise from a range of sources including government actions, provider/supply side, claims, risk imbalances, changes to levy structure, legislative framework, legal cases etc. However any concern in relation to 'sharp shocks' must be based on a reasonable expectation of instability so as not to interfere with support for the Principal Objective.

[15] RES 2016 contained this safeguards against over-compensation, including (1) HIA, as part of annual report to Minister, carries out a prospective assessment of over-compensation based on insurer business forecasts, (2) HIA, as part of annual report to Minister, carries out a retrospective assessment of over-compensation based rolling prior 3 years and 4.4% ROS measure, (3) 125% net claims cost threshold limits scheme effectiveness, (4) luxury benefits claims adjustment removes any 'luxury' prices and RES only equalises claims/risk based on 'plan B' benefits, (5) non-advanced/advanced considered separately to avoid any competition distortions at a product level and (6) excluded claims from RES continue to ensure that RES only deals with hospital claims.

[16] Judgment of the Court of First Instance in case T-289/03, British United Provident Association Ltd (BUPA) and Others v Commission of the European Communities – "*"the essential purpose of the open enrolment and community rating obligations is to spread those burdens fairly over the entire Irish PMI market, so that any PMI insurer bears only the burdens linked with the average market risk profile. If those burdens were not equalised, the functioning of the community rating aimed at an equal allocation of risks between PMI insurers to enable the cross-subsidy of premiums between the generations would be impeded."*

3. QUESTION 2

"Would the changes proposed affect your involvement in the private health insurance market?"

3.1 Vhi remains committed to the Irish PHI market, including its customers and other stakeholders, and no proposed changes included within RES 2022 will affect this commitment.

3.2 Vhi does anticipate that the addition of HCCP to RES 2022 will reduce risk selection incentives and change behaviours in the market by reducing competition based on risk selection (and plan proliferation) and increasing healthcare based competition including healthcare innovation, efficiencies and better health outcomes. Any such changes in market behaviour will benefit all customers in the market.

3.3 Any reduction in risk selection incentives, from an incrementally improving RES 2022, will not reduce (1) any potential profit opportunity from the Irish market and (2) potential new entrants into the market. Instead it will only change the necessary strategic capabilities required to succeed in the Irish PMI market including a greater focus on chronic disease management programmes, integrated care and health care strategic relationships.

3.4 The ESRI 'Hippocrates' healthcare demand model is projecting increased private healthcare demand out to 2030 which will in turn increase demand for private healthcare services and health insurance. This increased demand for health insurance will support the future market and profitability and also insurer participation.

4. QUESTION 3

"Are there risks or vulnerabilities that do not feature and should be included, and why."

Impact of Covid-19 on evolution of healthcare delivery

4.1 Covid-19 has accelerated changes in the delivery of private healthcare with hospitals attempting to restore activity levels by improving efficiencies and expanding opening hours on weekdays and weekends. Some daycase activity is anticipated to move from hospital daycase wards to outpatient ambulatory centres. This change of treatment location to a lower cost setting will benefit all customers with claims efficiencies and lower costs. However the definition of Returned Benefits currently disregards any acute hospital activity transferring to outpatient locations and the loss of HUC credits will act as a disincentive to these reforms. **Vhi is recommending that the Authority review its definition of Returned Benefit claims to recognise the Covid inspired changes in private healthcare delivery and, where necessary, medical services required by customers should matter more than the treatment location**.

Regulatory incentives for efficiency

4.2 Risk equalisation can either function in a prospective or retrospective manner. A prospective system of risk equalisation is generally accepted as superior as it (1) reduces predictable risk selection incentives, (2) creates incentives for efficiencies where the insurer has certainty over premium and must manage claims costs appropriately. As such, prospective RES systems have been adopted by all sophisticated international health insurance markets. In contrast a retrospective system of risk equalisation is generally superior at reducing risk selection incentives but at the expense of premium certainty and efficiency incentives where actual claims costs are equalised at the end of the equalisation period. One unavoidable characteristic of prospective RES systems is volatility, where for example the Authority has to model claims, bed utilisation, customers, plan benefits, treatment locations, medical inflation and Fund surpluses for the Irish prospective RES and actual outcomes may differ from projections. It is emphasised that volatility should not be a problem within any insurance market where management of volatility is a core competence. Any actions to introduce controls on volatility could undermine incentives for efficiency and the benefits to customers from prospective RES systems.

Inefficient parameters reducing benefits of HCCP

4.3 The Authority has proposed HCCP parameters of (1) share ratio of 40% and (2) claims excess of €50,000. These parameters are interrelated but ultimately the share ratio is the most important parameter as it sets the level of trade-off between reducing risk selection incentives and promoting claims efficiencies. A claims share of 80% is accepted internationally as providing the optimum combination of risk sharing for the very sickest and expensive customer whilst preserving incentives for efficiency. The Authority's choice of 40% quota share does not have any precedent either internationally or within academic literature and **Vhi would like to understand this fully and suggests that the Authority publishes its evidence of why a quota share of 40% is preferable**.

4.4 The HCCP, with the Authority's proposed parameters, will still constitute an improvement but it will not be focused on the very highest cost claims outliers and the very sickest customers. Instead it will spread its focus more widely over higher cost claimants and, in comparison to a HCCP with a share ratio of 80%, it will have (1) lower reductions in claims volatility from the most extreme claims outliers, (2) lower reductions in risk selection incentives, (3) lower reductions in risk selection incentives from specific chronic illness and (4) less risk specific HCCP credits which will weaken the matching between health credits and sicker customers and ultimately weaken support for the Principal Objective and lower RES effectiveness.

Medical inflation and long term affordability

4.5 The long term threat to PHI affordability is not ageing per se but rather medical inflation which is currently increasing plan prices by 4% p.a. and contributing the majority of announced plan price increases. Medical inflation generally exceeds earnings growth and will continue to do so into the future. Irish private medical inflation of 4% is low by European standards and as the number of older insured customers increases then the risk of medical inflation of 5% or 6% (reflecting an increasing incidence of chronic illness within an ageing insured population) also increases. Over a ten year outlook this risk of increasing medical inflation could have serious implications for PHI affordability. Introducing and expanding the HCCP will increase competition based on healthcare and claims efficiencies and will increase controls on medical inflation such that all customers will benefit from improved long term affordability.

High cost claimants pool will not have the complexity and advantages of a commercially available reinsurance contract

4.6 The HCCP shares many of the important features of an excess of loss reinsurance contact but it will not contain all of the complexity of these private and bespoke commercial contracts. However HCCP does offer certain advantages over a commercially available reinsurance contract as (1) HCCP is more efficient as reinsurance fees would have to be passed onto high-risk older and sicker customers and reducing support for community rating and (2) traditional reinsurance would not reduce selection incentives as insurers could still gain competitive advantage by avoiding bad risks and keeping reinsurance premiums low.

Measure of RES effectiveness

4.7 The public consultation document mentions that HCCP will improve RES effectiveness and Vhi is presuming that the Authority is using a standard measure of RES effectiveness which measures the net benefits from all types of credits in reducing claims variation around the average claim in the market.

4.8 Any measure of RES effectiveness which only seeks to measure reductions in claims variation within age cohorts is only suitable to measure the relative net benefits of health credits. This limited measure of RES effectiveness will not be comprehensive and will not measure the combined impacts of changes in age and health credits and could lead to inappropriate decisions and recommendations which may result in unintended lower support for the Principal Objective. For example the latest Authority's recommendation to the Minister was partly justified by an increase in the measure of RES effectiveness even though the scheme was offering less support to older customers as a whole and by extension to community rating (where the net claims cost ceiling increased from 130% to 133.5%[17]).

Measure of over-compensation

4.9 The over-compensation measure and test should be set in an objective and transparent manner and the benchmark of comparable insurers should reflect as closely as possible the business risks and levels of profits earned in the Irish PHI market. Otherwise this test will not be sufficiently transparent with consequences for distortions of competition and new entrants into the market. **Vhi is recommending that the benchmark of comparable insurers is published to improve market transparency**.

[17] And where the HUC rate and average claim in the market remained unchanged between the alternative choices of 130% and 133.5% net claims cost ceiling.

Future additional support for community rating will have less implications for insurer Net Financial Impacts ('NFI's')

4.10 Fair and open competition is supported when risk specific credits are allocated to insurers to offset risk imbalances and ensure that the higher costs of older and sicker customers are fairly borne by all insurers. HCCP is a more risk specific health credit than either HUC or age credits. As such, it will more efficiently allocate health credits to sicker customers and, as such, support the Principle Objective and fair and open competition. Vhi's NFI (or Net Financial Impact[18]) has been approved by the EU Commission as compatible with the internal market and in large part because the scheme is risk specific and NFIs are linked to (1) risk specific credits for older and sicker customers and (2) insurer risk imbalances versus the average risk in the market. However the EU Commission and the Authority continue to remain interested in the level of Vhi NFIs. Over the lifetime of RES 2022 it is expected that risk imbalances between insurers will continue to fall and mainly due to mortality in Vhi's oldest customers. As risk imbalances between insurers continue to fall then insurer NFIs should also decline. This natural decline in NFIs will improve the conditions to offer further support to the Principle Objective and fair and open competition which will benefit all consumers in the market where competition will increasingly prioritise healthcare innovation and efficiencies.

Super-normal profits

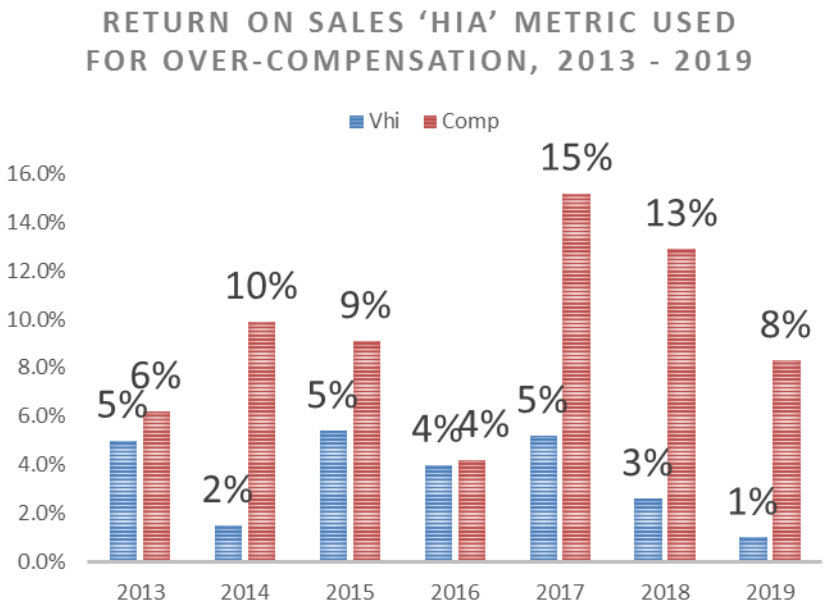
4.11 Insurers who do not bear their fair share of the health risks to support community rating are consistently earning super-normal profits and well in excess of the capped level of profits earned by Vhi[19] (as the net beneficiary of the RES Fund). If an improved health credit is not introduced into RES 2022 then PMI customers will continue to be dis-advantaged as these super-normal profits, funded by higher premiums, are removed from the market and not returned to customers or spent on their healthcare needs.

4.12 **This chart shows the level of profits earning by Vhi and its competitors in the market. The measure of profit shown is the Authority's measure of profit that it uses to assess over-compensation in the market (i.e. Return on Sales gross of reinsurance and interest costs)[20]. This chart shows that insurers who are not bearing their fair share of the higher costs of older and sicker customers across the market are earning significantly higher profits than Vhi over a long period of time.**

[18] The Authority's terminology for net contribution net receipts to and from the RES Fund by Laya, Irish Life Health and Vhi.

[19] Where profits are compared based on the Authority's measure of profit, or return on sales gross of reinsurance and interest costs and based on published data from the Authority's report to the Minister.

[20] Financial inputs for the Authority's measure of profit across the market is sourced from the Authority's annual reports to the Minister.


RETURN ON SALES 'HIA' METRIC USED FOR OVER-COMPENSATION, 2013 - 2019
Vhi
Comp
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
5%
6%
2%
10%
5%
9%
4%
4%
5%
15%
3%
13%
1%
8%
2013
2014
2015
2016
2017
2018
2019

5. QUESTION 4

"Do you have additional suggestions for refinement of the Risk Equalisation Scheme in Ireland?"

High cost claimants pool parameters

5.1 A claims share of 80% is accepted internationally as providing the optimum combination of risk sharing for the very sickest and expensive customer whilst preserving incentives for efficiency. Vhi projections also confirm that implementing a claims share of 80% and an appropriately higher claims excess will focus the HCCP on the very highest cost claimants and with the following benefits – (1) highest reduction in claims volatility from the most extreme claims outliers, (2) highest reduction in risk selection incentives, (3) highest reduction in risk selection incentives from specific chronic illness and (4) more risk specific HCCP credits.

HCCP will not be sufficient to eliminate selection incentives for sicker customers and a patient diagnosis related health credit is still required

5.2 International and European RES schemes include more sophisticated measures of health status which are typically based on (1) DRG coded patient diagnoses or (2) drug prescriptions. As PHI does not cover drug prescriptions then the only likely measurement candidate is DRG coded patient diagnoses. DRGs were originally expected within RES 2016 and will not now feature within RES 2022. Measures to introduce DRGs into a future RES will be required to start immediately as the introduction timescale is at least 5 years and where, for example, it took substantially longer to introduce DRGs into the German RES.

5.3 In the interim, procedure codes could be introduced as an interim DRG credit where procedures uniquely define surgical DRG codes which are 60% of all DRG codes. Procedure codes have the advantage that the information is currently available and highly standardised across insurers[21].

[21] All insurers reimburse professional fees for medical and surgical procedures based on a standard list of procedure codes which applies to all accredited and approved medical professionals. The vast majority of these professionals are consultant physicians. These procedure codes are very similar across all 3 Irish health insurers and are an essential input component for the classification of the majority of DRGs.

Chronic disease management programmes

5.4 Both Germany and Czech Republic RES introduced health credits based on participation in chronic disease management programmes. The main objectives of these programmes were to stabilise the chronic illnesses of enrolled customers and reduce hospital admissions. A secondary objective of these programmes was to create registries of customers with chronic illness in advance of DRGs or other measures of customer health diagnosis.

Amendment of 'luxury' benefits claims adjustment methodology

5.5 'Luxury' benefits are typically defined as the higher prices of private room accommodation within acute hospitals. The treatment of 'luxury' benefits within RES 2016 is now outdated and inappropriate. It is introducing significant and ongoing distortions into the RES methodology with negative implications for the recognition of health status risk and for the support of the Principle Objective. Health status is not uniform across plan categories and sicker insured persons, with higher admission rates and longer lengths of stay, 'self-select' and typically purchase higher cover plans. The HIA's current 'luxury' benefits methodology is inappropriate and excessive and overestimates 'luxury' benefit prices where, as a consequence, a significant portion of eligible higher cover plan utilisation is included within the HUC credit but the associated claims are disregarded from the age credit.