IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann

Submission to the Health Information Authority on Risk Equalisation in the Irish Private Health Insurance Market

August 2010

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Private Health Insurance (PHI) markets are inefficient markets and require Government intervention to address market failures. In an open PHI market, insurance companies would tailor packages and prices to attract healthier low-risk individuals while high-risk individuals would be priced out of the market.

The Irish PHI regulatory system is based on the key principles of community rating, lifetime cover, open enrolment and minimum benefit. Community rating requires a health insurer to charge the same rate of premium for a given level of benefits irrespective of age, sex or health status. For community rating to work risk must be shared between insurance companies. Risk equalisation is a mechanism used to redistribute resources to insurers to more accurately reflect the risk status of enrolees. Risk equalisation is an imprecise art and all methods have their pros and cons. Even with the tightest risk equalisation scheme in place, for-profit insurance companies will always have the incentive to try to select low-risk clients.

PHI does not offer satisfactory protection for poor people or high risk individuals and little research has been done into the real effects of PHI on quality of care and efficiency. PHI cannot be a substitute for an adequately funded public universal health care system and any policy that would leave healthcare decisions to market forces would raise serious alarm bells with IMO members.

The interaction between PHI policy and the Irish public health systems is complex. The Irish healthcare system faces a number of issues and challenges including access to services, future sustainability and inequity. Policies promoting private hospital care and PHI to increase access and provide extra funding for healthcare have at the same time contributed to a multi-tiered health system. Healthcare is becoming increasingly unaffordable for lower income groups in Ireland who are neither covered by a Medical Card nor PHI.

The public system also subsidises the private system. Purchasers of PHI receive a tax rebate yet often rely on the public system for urgent and complex care. If this tax rebate continues the question arises as to whether there should be some form of risk equalisation between the public and private funding system.

IMO members are calling for a Universal Health Care system whereby all residents in Ireland should be entitled to medically necessary healthcare regardless of ability to pay and based on the following principles:

- *Universality - access to adequate healthcare for all*
- *Services that are free at the point of access*
- *Equity of access*
- *Solidarity*
- *Transparency*
- *Quality of care and value for money*
- *Choice and mobility*
- *Clinical autonomy*
- *Efficiency*
- *Affordability*

- *Sustainability*[1]

Even with an adequately funded universal healthcare system the IMO recognises that there will always be a demand for PHI. In funding healthcare privately the same principles should apply. However PHI should remain voluntary and people should not feel compelled nor be able to purchase PHI to side-step waiting lists.

Complex PHI regulation requires the use of public resources. Particularly in the current economic climate careful consideration should be given to the cost of risk equalisation and whether the resources required would be better spent on public health services.

Consideration of Different Risk Factors

In the consultation document the HIA considers the risk factors that could be included in a new risk equalisation scheme and categorises these under three headings:

- **Underlying risk factors** such as age, gender, disability status, address, occupation status, occupation, welfare support, mortality, living alone or maternity.
- **Diagnosis related risk factors** such as Diagnostic Related Groups or Chronic Illness
- **Resource usage factors** such as claims expenditure, hospital bed utilisation, or pharmaceutical cost groups.

Underlying Risk Factors

Q4.1 What are your views on using underlying risk factors in a risk equalisation scheme?
Q4.2 What underlying risk factors should be used?
Q4.3 What data should be collected from undertakings in respect of underlying risk factors?
Q4.4 Should underlying risk factors be fully or partially equalised?
Q4.5 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?
Q4.6 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?
Q4.7 Would a risk equalisation system based on underlying risk factors (in addition to age and gender) be sufficiently effective in supporting community rating?

The IMO supports the concept of community rating in voluntary PHI whereby the cost of a particular level of cover is same for all insured lives, regardless of their risk status. The principle objective of community rating is solidarity between enrolees irrespective of age,

[1] See IMO position paper on Universal Health Coverage – April 2010

sex or health status. While age and gender are easily identifiable variables, establishing a proxy for health status can be more problematic.

As mentioned above PHI does not offer satisfactory protection for poorer people and therefore low income groups must be adequately protected by the public health care system. Voluntary PHI is generally unaffordable for lower income groups and therefore it is unnecessary to include a measure of socio-economic status in the risk equalisation scheme.

Diagnosis Related Risk Factors

Q4.8 What are your views on using diagnosis related risk factors in a risk equalisation scheme?
Q4.9 What diagnosis related factors should be used?
Q 4.10 What data should be collected from undertakings in respect of diagnosis related factors?
Q4.11 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?
Q4.12 Do issues arise for private and public hospitals?
Q4.13 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?
Q4.14 Should the differences in costs between different diagnosis risk factors be fully or partially equalised?
Q4.15 Would a risk equalisation system based on diagnosis related risk factors be sufficiently effective in supporting community rating in the best interests of consumers?

The IMO does not advise the use of diagnosis related risk factors, such as Chronic Illness or Diagnostic Related Groups (DRGs), in the risk equalisation scheme as the adverse incentives created do not justify the cost.

While payment for patients with specific more expensive chronic diseases can encourage screening for these diseases, the use of chronic illness in a risk equalisation scheme creates incentives for insurance companies to over report illnesses in return for greater compensation. Therefore standardised definitions of disease and consistent levels of treatment are required across insurance companies. The cost of collecting and verifying the data would be considerable.

Using a hospital based system of Diagnostic Related Groups (DRGs) such as the Hospital Inpatient Enquiry (HIPE) system does not support changes in delivery models – and can incentivise more costly hospital treatment when more effective treatment may be available in primary care or in community care. As highlighted in the consultation document the incentive exists for insurers to upgrade to more complex DRGs in return for greater compensation.

Currently private patients in public hospitals are charged average per diem rates while private hospital charges reflect more accurately the level of treatment. This creates an incentive for patients requiring complex costly care to be treated in public hospitals while patients requiring less expensive care are pushed towards private hospitals. Using a DRG system in the risk equalisation scheme while the charging system remains different between hospitals would further enhance these incentives.

While the IMO does not recommend the use of DRG in the risk equalisation scheme, the IMO does support some monitoring of case-mix in both public and private hospitals, to identify "cherry picking" and risk avoidance by insurance companies, especially in relation to services for the elderly.

Resource Usage Factors Q4.18 to Q4.22

Q4.18 What are your views on using resource usage related risk factors in a risk equalisation scheme?
Q4.19 What resource usage factors should be used?
Q4.20 What data should be collected from undertakings in respect of resource usage factors?
Q4.21 Should the differences in costs between different resource usage risk factors be fully or partially equalised?
Q4.22 Would a risk equalisation system based on resource usage related risk factors be sufficiently effective in supporting community rating?

The IMO supports the principle of efficiency in healthcare financing whether public or private and considers that money should follow the patient. Therefore the IMO recommends that equalisation payments are made on the basis of actual payout.

Using claims expenditure in the risk equalisation model has a number of key advantages:

- the information is readily available and easily verifiable in the audited accounts of insurance companies. It is therefore less expensive method of risk equalisation and can be implemented immediately.
- is more flexible and allows for:
    - changes in the delivery of healthcare – that is from secondary to primary or community care
    - advances in technology and treatment and any consequential changes in the cost of treatment
    - and imminent changes in the payment system – the steering group are due to make recommendations on costs and charges associated with private and semi-private treatment services in public hospitals later this year.

To use claims expenditure in risk equalisation, individual payout data for all enrolees would be analysed in order to allow division into Finance-based risk categories (FBRC). Risk equalisation would then be based on the average payout per category (FRBC). Since we know that the age, sex and diagnosis influence costs, it would not be necessary to include age and gender in the scheme.

Critics say that using claims expenditure does not encourage insurers to control costs and therefore claims expenditure should only be partially equalised. The IMO believe that measures used to control costs must be evidence-based.

The IMO does not recommend other resource utilisation factors such as hospital bed utilisation or pharmaceutical cost groups as again they create perverse incentives for insurance companies. Hospital bed utilisation like DRGs can incentivise hospitalisation when more effective treatment may be available in primary care or in community care or lead longer hospital stays. Pharmaceutical cost groups can lead to an over-reliance on

drug therapy where non-pharmaceutical treatments may be more appropriate or can lead to over-use of more expensive drugs.

Q4.23 This consultation paper has suggested some possible measures of health status (underlying risk factors DRGs, hospital utilisation etc) that could be used in addition to age and gender. Are there other measures that might be adopted?
Q4.24 Is it necessary to use more than one health status measure in a risk equalisation system, in order to ensure that it is effective in supporting community rating?

The more complex the risk equalisation formula, the more costly it will be to collect and verify the data. Whether public resources are better spent elsewhere should be carefully considered.

Benefits to be included

Q 5.1 To what extent should costs incurred in providing primary care, preventative treatment / care and care in the community be included in the system?
Q 5.2 How should the limits be set so as to exclude what may be regarded as luxury benefits? How should these limits be updated / kept under review?
Q 5.3 Should fixed price procedures be subject to different limits than other forms of treatment? How should fixed price procedures be defined?

Limiting risk equalisation payments to just hospital services creates incentives for patients to be treated in a hospital setting rather than a more appropriate primary or community-based setting is contrary to best practice and national policy.

All medically necessary care including hospital services, GP services, community care, prescription drugs and evidence-based preventive care should be included in the minimum benefits regulations. The application of risk equalisation must ensure some degree of social equity. It is not appropriate that subscribers to low cost plans of their insurers should be levied to support high cost insurers. Therefore equalisation should be at the statutory minimum level.

The IMO is making a separate submission to the HIA regarding Minimum Benefit regulations in the Irish PHI market.

Transition Arrangements

Q6.1 What are the views of stakeholders in relation to this approach?
Q6.2 What type of data would be necessary under this approach in order to assess the extent to which differences in claim costs for each age group between insurers arise from health status differences or from other causes?
Q6.3 Would it be possible to adapt this kind of approach when designing a robust system? How would this be done?

The HIA's proposal to continue with the tax-based loss compensation system in the interim would not be necessary as a risk equalisation scheme based on actual payout could be immediately implementable.

Q7.1 Should the system include special provisions for new entrants? How should these provisions be framed?
Q7.2 Should the risk equalisation transfers take into account the amount of lifetime community rating loadings that an insurer receives and if so, how should the transfers incorporate these loadings?
Q7.3 How should the new risk equalisation scheme take account of changes in minimum benefit regulations?
Q7.4 Should the risk equalisation calculations of the Health Insurance Authority be published?

In the interests of efficiency and transparency the risk equalisations system should not be overly complicated and calculations should be published.

IMO Motions related to PHI
The IMO supports the concept of community rating in voluntary healthcare insurance (General Motion 15a, 1992).

That the IMO urges the proposed health Insurance Act incorporate provisions including the monitoring of case-mix in both public and private hospitals, to identify "cherry picking" and risk avoidance by insurance companies, especially in relation to services for the elderly (General Motions 25, 1994).

The IMO believes that community rating requires that if a subscription is equally levied benefit too should be equally available and internal rationing of services, including the marginalisation of needs of the elderly, are not compatible with plans claiming community rating (General Motion 32, 1994).

The IMO urges the Minister for Health to ensure that any equalisation payments from health insurance companies be on the basis of actual payout (General Motion 33, 1994).