Society of Actuaries in Ireland

Consultation on community-rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme

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Response to Health Insurance Authority

February 2021

Preface

The Society of Actuaries in Ireland ("Society") is the professional body representing the actuarial profession in Ireland.

The Society welcomes the opportunity to submit this response to the consultation on community-rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme.

In preparing this response, our focus has been on the public interest and the responses do not purport to reflect the views of the health insurance industry.

We would be happy to respond to any questions on this response. Please contact Philip Shier, Head of Actuarial Practice, at philip.shier@actuaries.ie.

General Comments

The Society agrees with the principle of a risk equalisation scheme (RES) to support voluntary community rating for private health insurance. The Society notes that RES is a well-established practice in many developed countries to support their community rated health insurance systems.

The Society notes the seven aims of the Department of Health ("Department") in the review of the RES, and is supportive of these aims. However, it is likely that any proposed amendment to the RES will meet some of the aims and not others and indeed may run counter to some of the aims.

The Society is, overall, in favour of the introduction of a High Cost Claims Pool (HCCP) system into the proposed new RES. In our response to question 3, we have identified a number of issues with the proposal to introduce a HCCP which might create risks or vulnerabilities to the RES. It is likely that most of these have already been recognised by the Department but the detail in the consultation paper is insufficient for us to determine this. It would be helpful if the HIA were to publish evidence supporting the proposal based on the data available to it, or references to overseas jurisdictions (such as Australia, Germany and Holland) where such an approach has been adopted.

Responses to Numbered Questions

(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?

The Society agrees with the principle of an RES to support voluntary community rating for private health insurance. The Society notes that RES is a well-established practice in many developed countries to support their community rated health insurance systems.

The Society agrees the overall substance of the current RES is supportive of the current community rated market. The Society is, overall, in favour of the introduction of a HCCP system into the proposed new RES.

However, the Society does have reservations over the long-term use of the HCCP as a risk based measure in the RES. The Society believes a more targeted risk-based measure such as Diagnostic Related Groups (DRGs) would be preferable for long-term use, and this is discussed further in Question 4.

(2) Would the changes proposed affect your involvement in the private health insurance market?

The Society is not involved in the private health insurance market and accordingly has no response to this question.

(3) Are there risks or vulnerabilities that do not feature and should be included, and why

The Society has identified a number of issues associated with the HCCP proposal as outlined in the consultation document proposal which may create risks and vulnerabilities for the RES and these are discussed below. The Society has also included a number of practical implementation challenges as part of its response to this question. Notwithstanding the list of issues outlined below, it is important to note that, as previously stated, the Society is overall in favour of the proposal to introduce an HCCP.

Department's First Aim for the New RES

The consultation document states the following is the Department's first aim for the new RES:

"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".

The Society notes the Principal Objective of the Health Insurance Act is focussed on insured lives, not insurers. Accordingly, it appears an aim of the RES should not be to transfer funds between insurers but to transfer funds between insured lives. It also follows that any aims or measure of effectiveness introduced to assess the RES should consider the effectiveness of transfers to and from insured lives and not insurers.

Extent of Correlation between large claims and health status

The document notes that, while less than 1% of the 2016 insured population made claims in excess of €50,000, they made up c.16% of total claims by value in that year. That does demonstrate large claims are commercially material when viewed in aggregate. However, it does not demonstrate whether large claims are meaningfully correlated with underlying health status (as a proxy for lower and higher levels of risk).

Whilst it is logical that larger claims would be broadly associated with poor health status, the Society notes that large claims can arise that have weak to no correlation with health status, for instance:

- Serious road and workplace accidents.
- Neurodegenerative diseases that strike otherwise healthy young and middle aged people – e.g. early onset dementia (inc. Alzheimer's and Parkinson's), the primary progressive form of multiple sclerosis and ALS.
- The impact of Covid-19 which can cause extended hospitalisation periods in reasonably healthy middle aged people. There is also the disturbing emerging issue of 'long Covid' that appears to significantly impact even young and previously healthy lives.

Overall impact relative to HUC

As a retrospective measure, it is very plausible the proposed HCCP will more accurately equalise claims between individuals when compared to the existing Hospital Utilisation Credits (HUCs). It is not clear, however, whether at an aggregate level it will result in significantly different transfers between insurers in the market. It would be instructive to understand if the HIA has analysed the impact on transfers between insurers of the proposed HCCP as compared to just a continuation of the HUC. Note that if there are significant differences in transfers (even when based on the same level of levy), this will impact on the equilibrium of competition in the market.

Does Proposed HCCP Supports the Department's Second Aim for the New RES?

The consultation document states the following is the Department's second aim for the new RES:

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

The proposed HCCP is a retrospective measure (like HUCs). All the practical and theoretical evidence points towards prospective measures (such as age credits) being the most effective policy initiative as regards blunting incentives for insurers to target less risky and more profitable customers. Practice and theory point towards retrospective measures being relatively much less effective in this regard. In addition, the Society notes the following quote from the consultation document relating to the proposed HCCP, that the introduction of the HCCP *"… increases the element of risk sharing based on actual claims experience similar to hospital utilisation credits as opposed to risk indicators/predictors such as age and sex… "*. This reinforces the impression the intention is to retrospectively rebalance claims rather than modifying market participants' incentives or behaviours.

The consultation paper refers to some health insurance products placing relatively high excess payments on orthopaedic care such as joint replacements. It argues such product design features can discourage older customers from purchasing them. However, the current cost of both knee and hip replacement procedures are significantly below the proposed claims excess of €50,000 so the proposed HCCP is unlikely to have an impact on this example of market segmentation.

Many large claims in Ireland above the proposed €50,000 HCCP excess arise from long stays in public hospitals and private psychiatric hospitals. Both these sources of claims are underpinned by current Minimum Benefit Regulations. Accordingly, it is unlikely participants could – in response to risk selection incentives - lower their exposure to such claims through product design or marketing strategies.

The next two sections below discuss ways in which the proposed HCCP could increase market inefficiencies by creating undesirable incentives for participants, which might offset any reductions in incentives for risk selection generated by the proposed HCCP.

Discouraging Claims Cost Efficiency

It is certainly a risk with a HCCP (or an excess of loss reinsurance treaty) that setting the quota share element too close to 100% could adversely affect the incentives for market participants to prudently manage high cost claims.

In that context, the Society welcomes the proposed relatively modest initial 40% quota share element and the stated intention to gradually increase it over a phased period, allowing the opportunity to monitor ongoing market reaction. This seems a pragmatic and sensible risk mitigation approach. The Society notes the international application of HCCPs indicates a quota share higher than 80% starts to create real concerns about counter-productive behaviours.

The Society believes the it would improve the functioning of the market if the Department outlined the length of the intended phase-in period and what the ultimate HCCP structure may look like, assuming no materially adverse market reaction is observed during that period.

The Society also believes consideration could be given to creating a second excess layer with a starting point appreciably above the proposed €50,000 level for the first excess layer and with a lower quota share percentage. As an example, the first excess layer could be between €50,000 and €150,000 with the proposed initial 40% quota share. In this example, the second excess layer would be above €150,000 and could be set (say) 15% lower at an initial 25% quota share. This 15% differential would be maintained as the HCCP moves through its phase-in period. The intent here would be to ensure market participants retain a clear incentive to effectively manage the largest of claims.

Reduced Incentives to Manage Large Claims

The Society notes the current RES structure only includes claims arising from medical care in Irish hospitals. It does not cover the following ancillary costs where:

- The eligibility of an individual large claim is being contested and has entered the court system. This can result in substantial legal costs that are directly attributable to the claim.
- Reports are commissioned from external medical experts specifically relating to the eligibility or efficacy of a proposed medical procedure.

These ancillary costs are not common, but they do occur in practice. In particular, they can materially augment the cost of existing claims.

Also, critically, many of these ancillary costs are optional – in that if a market participant agrees to pay a large claim in question in full at an early stage then these ancillary costs will not arise. The proposed HCCP (after completion of its proposed phase-in period) could well create an unintended incentive for market participants to quickly admit large claims where there are reasonable grounds for disputation.

Additionally, due to this issue the proposed HCCP should not be regarded as a cost efficient substitute for 'excess of loss' reinsurance cover market participants may choose to put in place.

The Society suggest that the Department should give consideration to broadening the definition of what can be included in the cost of a claim (to the extent that such broader costs are legitimately required for the specific management of the claim) for the specific purposes of the proposed HCCP.

Use of 2016 Claims Data

The Society notes the consultation document makes use of 2016 industry claims data to justify the selection of €50,000 as the initial threshold.

The Society recommends that the Department should satisfy itself that €50,000 remains an appropriate initial excess for a HCCP starting in 2022.

Allowing for Future Inflation

The consultation document doesn't state whether there will be a policy to index the excess for the effects of future inflation. As is well known, there is a long established trend of medical related inflation being higher than general inflation, and with an aging population, a static €50,000 excess will have the gradual impact of converting the proposed HCCP from a (limited) form of 'excess of loss' reinsurance cover to that more resembling a form of 'quota share' reinsurance over the long term. That would very much be at odds with the stated aims of the HCCP.

Catering for Fluctuating Claim Estimates

The final value of some claims may occasionally take a substantial period of time to be finalised. This is relatively more likely in the case of large claims. For instance, the eligibility of a proposed highly expensive medical procedure could be contested and take some time to work its way through the legal system.

In these circumstances, the market participant will initially have to apply an individual claim estimate. Inevitably, the eventual finalised claim amount will differ from this initial claim estimate.

The Society believes the Department should give consideration to ensuring the HCCP methodology is capable of handling subsequent legitimate adjustments to an initial claim estimation for which it has already paid initial compensation to the market participant.

Impact on RES Stamp Duties

The consultation document states the following is the Department's third aim for the new RES:

"Encourage younger and healthier lives into the market by keeping stamp duties at acceptable levels for younger policyholders".

On a purely standalone basis, stamp duties would have to be increased to facilitate the introduction of a HCCP. The Society does note the final paragraph of section 4 of the consultation document could perhaps be interpreted as implying stamp duties will be kept constant and the HCCP's staged introduction will be funded by taking an increasing element of those stamp duties. However, the intent of the wording in that paragraph is ambiguous.

The Society notes the current monetary nature of stamp duties (as opposed, for instance, to being applied as percentages of premiums) means increases in stamp duties have the most impact on moderately priced plans (excluding non-advanced plans). Such moderately priced plans play important roles in terms of attracting younger lives into the market – as directly noted in the third aim - and as a workable solution for older lives with moderate means.

Participants exiting or entering the market

Under current legislation, a participant who decides to exit the Irish health insurance market will also quickly drop out of the RES. That is acceptable for the current structure of stamp duties, age-related credits and hospital utilisation credits. However, the HCCP may represent a more complicated situation in terms of quickly dropping out of the RES. The Society recommends that the Department should give careful consideration as to how an 'exiting' participant from the health insurance market is handled by the HCCP, given that it could be several years after a participant exits the market before all its HCCP related claims are fully finalised.

Conversely, the introduction of a HCCP could facilitate the entry of new participants to the market.

(4) Do you have additional suggestions for refinement of the Risk Equalisation Scheme in Ireland?

A RES consultation paper from the HIA in June 2010 discussed in some detail the case for introducing a Diagnostic Related Groups (DRG) classification system into Ireland's RES system. Subsequent to that, the HIA produced a detailed report in August 2014 on incorporating DRGs into the RES. This report set out a five year timeline for the introduction of DRGs but as yet there has been no proposal to introduce a DRG system into the RES.

There is ample international evidence that – despite the administrative overhead that goes with it – a well-crafted DRG system can appreciably enhance the effectiveness of a RES system (in particular, it offers significant support for the Department's first RES aim). In addition, the international evidence points towards a DRG system offering appreciably more utility than a HCCP system. Indeed, international experience suggests HCCP is often just a transitory interim fix on the journey towards introducing a DRG system.

As it stands, it will now be 2027 at the earliest before such a DRG system could be introduced into Ireland's RES and even 2027 will be a challenging timeline to meet for its introduction.

The Society notes the accumulated impact of Ireland's gradually aging demographics is likely to be much more keenly felt in this coming decade. Ireland's RES system will need the support of ambitious reforms – such as DRGs – so it remains fit for purpose for these future, more challenging times.

The Society would be happy to offer any advice and assistance it can to the Department and the HIA in formulating and introducing an effective DRG system into Ireland's RES.

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