Review of Measures to Reduce Costs in the Private Health Insurance Market 2013

Independent Report to the Minister for Health and Health Insurance Council

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ACKNOWLEDGMENTS

I would like to acknowledge the support and co-operation I received from all participants in this review – the health insurers, the Health Insurance Authority, and the Department of Health.

Pat McLoughlin
November 2013.

FOREWORD

There are currently 2,047,020 people insured with inpatient health insurance plans, or 44.6% of the population. This is a reduction of 61,797 over the previous 12 months (September 2012 – September 2013). The market peaked in 2008 with 2,297,000 people insured at that time.

In 2012, Irish private health insurers paid claims totalling almost €2 billion. Between 2004 and 2008, there was an increase of 6.7% in the average claim per insured person. Between 2008 and 2012, there was an increase of 12.6% per insured person.

An increase in claims paid by private health insurers inevitably leads to an increase in premiums, which have also been increasing steadily over the past ten years, in particular since 2008. In 2008 the average premium paid by each insured person was €728.80. In 2012 this had risen to €1047.47, representing a 44% increase in the 2008 to 2012 period.

CHAPTER 1 Introduction and Terms of Reference

1.1 Context

It has been recognised for some time that the rising cost of private health insurance (PHI) needs to be addressed. It is evident from the data available on the private health insurance market over recent years that the combination of a number of factors – reduction in numbers holding PHI, the age of those holding PHI, increases in claims costs, increases in premiums and the overall state of the economy - are having a serious impact on the PHI market, its costs and its sustainability.

Voluntary private health insurance has played a part in the Irish health care system since the establishment by the State of the Voluntary Health Insurance Board in 1957. The VHI was established to provide health insurance cover for hospital costs to the 15% of the population who were at that time not eligible for public hospital services. Following the opening of the market to competition in response to provisions under EU law concerning non-life insurance business, there are now four companies active in the Irish market – State owned VHI, Aviva Health Insurance, Glohealth and Laya Healthcare. The main legislative provisions governing the Irish private health insurance market are set out in the Health Insurance Acts 1994 – 2012 and regulations made thereunder.

Private health insurance in Ireland is supplementary and complementary to the public health system. Undoubtedly, holders of PHI in Ireland have high expectations of what their health insurance will provide, including access to the latest medical technology and innovations.

Irish consumers generally continue to believe that health insurance is a highly valued commodity and hold a strong desire to have health insurance cover. This is illustrated in a survey of consumer attitudes to private health insurance commissioned by the Health Insurance Authority, published in May 2012. Consumers view health insurance as a means to access healthcare services more quickly and consider health insurance a necessity rather than a luxury. The overall satisfaction level with PHI cover was 86% of current holders, based on the sample surveyed. The survey also confirms that many people are under strain to keep their health insurance cover due to affordability and tolerance for price increases has reduced sharply. Affordability, the impact of price rises, employment issues and the general economic environment are all affecting consumer sentiment and attitudes towards health insurance.

It is in this context that the current Review of Measures to Reduce Costs in the Private Health Insurance Market has been conducted.

1.2 Establishment, Membership and Terms of Reference of the Review Group

The Consultative Forum on Health Insurance was set up in late 2011 by the Minister for Health with the private health insurance companies to tackle issues of mutual concern. The Forum was established against a background of rising claims costs at a time of general deflation and private and public sector pay reductions.

Since its establishment the Consultative Forum has been acutely conscious of the need to respect Irish and EU competition law in its deliberations; this has also been the case for this review.

On 27 June 2013, I was appointed by the Minister for Health to Chair a Review Group under the auspices of the Consultative Forum, to work with the insurance companies and the Department of Health to effect real cost reductions in the private health insurance market. The Minister recognises that private health insurance costs are unsustainable at present, and wants insurers to address the base costs of their claims. The Minister asked the Review Group to identify effective cost management strategies that all insurers can adopt, thereby ensuring the long-term sustainability of the private health insurance market.

Membership of the Review Group is comprised of representatives of the four commercial health insurers – Aviva Health Insurance, Glohealth, Laya Healthcare and VHI Healthcare, the Department of Health and the Health Insurance Authority. The Secretariat is provided by the Department of Health.

The following Terms of Reference were agreed by the Group, under which the Independent Chair would report:

The Minister for Health and the four commercial private health insurers have agreed to a process to effect real cost reduction/cost management in the Irish private health insurance market to ensure its long term sustainability.

The Review Group will be chaired by Mr. Pat McLoughlin. The Review Group will also comprise representatives from the Department of Health and the HIA and will be mindful of the need to respect competition law in its deliberations. All parties will be represented by two persons. As appropriate, the Chairman may meet other stakeholders for their input in order to complete the review.

The purpose/objective of the Review Group is to consider/identify effective industry-wide cost reduction/cost management strategies for the private health insurance market (scope to include but not limited to public hospitals, private hospitals and consultants). It is envisaged that this will be a two stage process as follows:

Phase 1 – Review Group/Chair to produce a high-level analysis of measures identified to reduce/manage private health insurance costs to include proposals or recommendations on the following broad themes:

- Understanding the drivers of significant increase in claims in recent years
- Utilisation Management
- Clinical audit - provision of treatment in an appropriate medical setting to appropriate care standards, to include clarification or common understanding of day case & side room/care pathways/interaction with HSE National Clinical Programmes
- Efficiency improvements in length of stay, admission processes, discharge management and claims processing, including fraud and maladministration
- Provider reviews – public and private
- Clarification on classification of consultants
- Measures to promote participation of younger members in the PHI market
- Standard Plan for PHI (will be further progressed through the deliberations of the existing CFHI Subgroup)

- Effective commercial management of proprietary drugs/utilisation of generic drugs
- Agreement to set targets for cost reduction/management.

Phase 1 is to be completed by end October, with the Independent Chair to report simultaneously to the Minister for Health and the Health Insurance Council.

Phase 2 – Following Stage 1, the Review Group will undertake a detailed evaluation to further develop its Stage 1 high level analysis and to include proposals/recommendations on the following:

- Audit of the volume of procedures
- An examination of the base cost of claims - to include agreement on the benchmark costs of a comprehensive range of procedures
- Further development of clinical audit and interaction with HSE Clinical Programmes
- Measures to introduce procedure-based payments in public hospitals and clarity on what is chargeable, including negotiation of rates and rewards for efficiency and outcomes
- Measures to curb year-on year increases in claims through wider/more targeted use of claims management tools
- Consideration of possible ways to lessen the impact of medical technology /innovation on PHI costs, i.e. through cost effectiveness analysis. This will include the development of initiatives to manage procurement
- Legislative measures that might be required to address cost reductions
- Agreement on measures to promote participation of younger members in the market, e.g. discounts on premiums for 23-29yr olds ; introduction of LCR (will be further progressed through the deliberations of the existing CFHI Subgroup)
- Industry approach to private A&Es
- Industry approach to private psychiatry
- Ways to clarify certain processes and structures which influence charges to private health insurers, e.g. consultant classifications, consultant charges for private patients, determination of public/private patient status at admission, completeness of claims information from public hospitals
- Further efficiency improvements in relation to length of stay, admission & discharge procedures and claims processing
- Increased utilisation of appropriate Primary Care settings.

Phase 2 is to be completed within six months, with the Chair to report simultaneously to the Minister for Health and the Health Insurance Council.

Secretariat to the Review Group will be provided by the Department of Health.

1.3 Legislative Provisions for Private Health Insurance

The legislative provisions for the Irish private health insurance market are set out in the Health Insurance Acts, 1994 - 2012 and regulations made thereunder. The Health Insurance Acts legislate for the four principles of private health insurance in Ireland –

- Community Rating, supported by Risk Equalisation
- Open Enrolment
- Lifetime Cover
- Minimum Benefit.

Community Rating: Community rating is a fundamental cornerstone of the Irish health insurance market. Under community rating, everybody is charged the same premium for a particular health insurance plan, irrespective of age, gender and the current or likely future state of their health. Community rating therefore means that the level of risk that a particular consumer poses to an insurer does not directly affect the premium paid.

Risk Equalisation: Community-rated health insurance systems across the world use risk equalisation as a mechanism to distribute fairly some of the differences that arise in insurers' costs due to the differing health status of all their customers. A company with a worse than average risk profile (and therefore higher claims costs) will be a net beneficiary from the scheme while a company with a greater proportion of younger and healthier people will be a net contributor to the scheme but, of course, benefit considerably from having much lower claims costs. The new Risk Equalisation Scheme which took effect from January 2013 is an essential support to community rating, providing a cost subsidy from the young to the old, and the healthy to the less healthy.

Open Enrolment and Lifetime Cover: Under open enrolment, private health insurers must accept all applicants for insurance cover, subject to prescribed waiting periods, regardless of their age, sex or risk status.

Lifetime Cover guarantees all customers of private health insurers the right to renew their policies, irrespective of factors such as age, sex, claims history or risk status.

Minimum Benefits: The Health Insurance Act 1994 made provision for the Minister to issue regulations specifying the minimum level of cover that every in-patient health insurance contract must include. This is to protect consumers, in a complex market with a large range of products, from being sold policies that do not provide a sufficiently comprehensive level of cover.

1.4 Review Objectives

The objective of the Review is to consider/identify effective industry-wide cost reduction/cost management strategies for the private health insurance market. The scope of the review includes, but is not limited to, public hospitals, private hospitals and consultants.

1.5 Approach and Methodology

It was agreed by the Group that the Review would involve two stages: Phase 1 of the Review would involve an initial identification of the key priority areas to be examined by the Group, to be addressed at both industry and individual level, with a view to achieving early outcomes. On completion of Phase 1 of the Review it was agreed the Chair would report to the Minister and the Health Insurance Council, following which and subject to Ministerial approval, the Review would move to Phase 2 by undertaking a detailed evaluation, further developing its Stage 1 high-level analysis.

Following the inaugural meeting of the Review Group, the Chair met bi-laterally with the representatives from the insurance companies, and requested submissions from them to identify the key priority areas on which the Group would focus. A follow-up questionnaire was then issued to insurers, which informed the written submissions subsequently provided to the Chair. These submissions contained the health insurers' views, comments and proposed strategies and approaches to progress the issues identified.

The Chair then had further bi-lateral meetings with the insurers and was at all times cognisant of the need to respect competition law and to act entirely within the spirit as well as the provisions of this legislation. The Chair was also conscious of commercial sensitivities involved for the private health insurers.

The issues to be addressed at both industry and individual level were discussed and agreed at subsequent Review Group meetings.

Submission of Claims Cost data to the Health Insurance Authority

The Review Group agreed that the HIA would develop a data template for circulation to the private health insurers in order to capture data to aid an examination of the drivers behind the increase in claims costs since 2008.

The claims cost data and information provided by the private health insurers will be used to aid analysis of the main providers and procedures, as well as changes in unit costs and utilisation levels. Detailed aggregate sector data for the years 2007-2012 will be compiled. All data to be provided by each insurer is confidential and commercially sensitive.

Following discussions and final agreement of definitions of terms with the private health insurers, the HIA circulated the agreed template to the private health insurers in early November 2013. The insurers will provide returns by early December 2013, to allow sufficient time for any system testing and compatibility issues.

Data will be collected by the HIA on the top 30 procedures from each insurer using the template, and a comparison and evaluation of the data received will be used to examine the drivers behind the increases. All data will be aggregated; insurers will not be identifiable separately. Data will be submitted on surgical procedures. For non-surgical/non-diagnostic procedures (medical cases), it was agreed a separate template will be used to capture this information and a "trend analysis" will be undertaken.

A detailed analysis of both sets of results will be included in the Phase 2 report.

Chapter 2 Identification of Key Priority Areas

Overview of Private Health Insurance Market

2.1 Introduction

The context of this review arises from major changes in private health insurance coverage, a rise in premiums, significant increases in the cost of claims, changes in the age structure of those covered by PHI and increases in the supply of private beds in private hospitals and consultant manpower over the past number of years.

Findings

The evidence of the changes outlined above is as follows:

Health Insurance Coverage

- The percentage of the population covered by PHI has dropped from 50.9% in December 2008 to 44.6% in September 2013. This is a drop of 250,093.

- The actual population with cover is 2.05 million which is similar to the population covered in 2005.

Increases in Premiums

Premiums have been increasing steadily over the past ten years and in particular since 2007. The percentages shown are calculated by dividing the total premium paid in the market in each year and the average number of people (including children) and then calculating the change compared to the previous year's average premium.

Average Premium Paid and Percentage Increase

2007 – 2012

Year	Average Premium	% Increase
2007	€671.39	10.5%
2008	€728.80	8.6%
2009	€811.49	11.3%
2010	€871.28	7.4%
2011	€934.55	7.3%
2012	€1,047.71	12.1%

Increases in Costs of Claims

There has been a major increase in the cost of claims since 2004 and particularly since 2008.

- The average cost of claims paid per insured person increased by 6.7% per annum between 2004 and 2008.
- The average cost of claims paid per insured person increased by 12.6% per annum between 2008 and 2012.
- The total claims paid in 2012 was €1,856m compared to €1,704m in 2011 – an increase of 9%.
- The average claim paid per insured person in 2012 was €911, compared to €797 in 2011, an increase of 14%.

Age Structure of the Market

The age structure and trends within the structure have a major bearing on premiums, cost of claims and utilisation of cover. The data shown gives the age breakdown of people who have inpatient cover with the four open membership insurers at 1/1/2013. The table excludes people insured with restricted membership undertakings and people serving initial waiting periods.

Age Group	Estimate of % of population with P.H.I. with open market insurers at 1/1/2013
0-17	41%
18-29	31%
30-39	41%
40-49	47%
50-59	51%
60-69	52%
70-79	48%
80+	35%

- In 2003, 13.3% of the insured population was aged over 60.
- In 2009, 15.9% of the insured population was aged over 60 (a rate of increase of 0.4% per annum).
- In 2012, 19% of the insured population was aged over 60 in the second half of 2012 (a rate of increase of 1% per annum since 2009).
- In 2008 there were 2.21 private health insurance customers aged 18-39 for every one customer aged over 60.
- By the end of 2012 there were 1.54 private health insurance customers aged 18-39 for every one customer aged over 60.

Private Beds

- The number of beds in private hospitals increased from 2,695 in 2008 to approximately 3,200 in 2011, an increase of 18.7%.

Public Consultants

- There has been an increase in public consultants from 1,947 in 2005 to 2,593 in 2012, an increase of 33%.

Summary

On the available evidence to date, it is likely that unless rising health insurance costs are tackled robustly, the following trends will continue:

- The percentage of the population covered will continue to drop because of the general economic outlook in the medium term.

- Premiums will continue to increase because of a range of factors including the need to control substantially rising claims costs and volumes, the reduction in income tax relief, bed charges at full economic cost for private patients in public hospitals, and the new charges for private patients who occupy public beds.

- Trends in increasing utilisation are likely to continue leading to an increase in the cost of claims.

- The age structure of the market will continue to cause a decrease in the patients in the 18-39 age category compared to the over 60 group.

These trends will occur in a situation where there is unlikely to be any significant increase in private beds and consultant manpower.

Conclusion

A continuation of all of these trends will pose a serious challenge to the sustainability of a community rated private health insurance market. The recommendations in this report are being put forward in this context.

2.2 Overall objective

The Chair met with insurers at bilateral meetings to identify the main issues from the insurers' perspective with a view to identifying the key issues on which the Chair would report and make recommendations. Once key priority areas were identified and agreed, insurers were asked to identify practical measures and devise strategies to reduce/manage private health insurance costs with a particular focus on the priority areas.

2.3 Overview of issues

These are the key priority areas identified by the insurers:

Settings:	The importance of ensuring care is delivered in an appropriate setting (e.g. whether day ward or side room procedure), and the need for approved procedures for each setting, was identified as a key issue.
Malpractice/fraud issue:	Aim to agree an industry approach as soon as possible.
Admission Procedures and Processes:	This would include A&E admissions, determination of public or private admission, processes and controls, classification of consultants etc.
Utilisation Management/Issues:	Examine scope for developing strategies at industry level to address over-utilisation and ensure evidence-based care is practised.
Efficiency of Payment Mechanisms:	There is a need to agree to implementation of an e-claims process, to consider relevant issues and identify what is needed to progress this.
High Cost Drugs:	Industry and provider acceptance to use drugs approved by the pharma economic unit and examine the potential for national procurement.
Psychiatry Days/Issues:	The area of psychiatry, such as benefits, length of stay, accuracy of diagnosis, care setting etc. needs consideration.

The issues, findings, and recommendations in relation to these key priority areas are discussed in Chapters 3 to 11.

Chapter 3 Controlling Costs in Private Health Insurance

Introduction

The Minister for Health has placed a major emphasis on the need to control costs in the private health insurance market in Ireland. The Health Insurance Authority has examined the issue and has identified the following relevant facts:

Findings

- Between 2004 and 2008, the average cost of claims paid per insured person increased by 6.7% per annum. During this period the Consumer Price Index grew by on average 3.9 percentage points.

- Between 2008 and 2012, this increase was 12.6% per annum. During this period, the Consumer Price Index fell by an average of 0.3%.

- The total claims paid increased from €1,704 million in 2011 to €1,856 million in 2012, an increase of 9%.

- The average claim paid per insured person increased from €797 in 2011 to €911 in 2012, an increase of 14%.

- The 14% increase in the market average prescribed benefit paid per insured person in 2012 reflects an increase in the average number of treatment days per insured person of 10% and an increase in the average cost per treatment day of 4%.

- Between 2004 and 2008, the average number of treatment days per insured person fell by 12%.

- Between 2008 and 2012 the average number of treatment days per insured person increased by 45%.

- The increase in the average claim per member of 61% between 2008 and 2012 largely results from increased usage of hospital services, with the utilisation measures increasing by 45% and the cost per utilisation increasing by 11%.

Submissions/Research

The rise in cost in the Private Health Insurance market is not an Irish phenomenon and the costs of healthcare tend to rise faster than general price inflation. The following are examples of what has been introduced in some countries as a means of controlling costs:

- The Netherlands introduced a policy of limiting expenditure growth in hospitals to 2.5% between 2012 and 2015.

- The Netherlands has also introduced lump sum agreements specifying the number of treatments paid for each year.

- In 2012 pricing for hospital products was extended to 70% of hospital expenditure in the Netherlands.

- The introduction of "Preferred Drug Formularies" in the Netherlands reduced the price of generic medicine.

- Germany and France are examples of countries which have introduced Diagnosis Related Group (DRG) reimbursement. (This is a scheme that provides a means of relating the type of patients a hospital treats with the costs incurred by the hospital).

- There has been a significant rise in "exclusionary" and "restricted" policies in Australia in recent years.

- In Australia, insurers must submit premium increases to Government for approval.

- In 2000, Lifetime Community Rating was introduced in Australia which led to a lower average age and reduced claims per person.

Conclusion

It is not clear what precise issues are giving rise to the growth in claims in Ireland, particularly in the last 5 years. Submissions have identified the following as potential contributors:

- An increase in the ageing of the population
- Higher use of insurance by membership
- Increased bed capacity in the private health hospital service
- Cost of high cost drugs and implants
- Shift of activity from public hospitals to High Tech Hospitals
- Increased claims for depression and psychiatric disorders
- Increased public bed charges for private patients.

While individual insurers have made submissions detailing some information on the contributions of the above, there is a need for data from all insurers which will help understand the issues leading to the growth in claims. During Phase I considerable agreement was reached with insurers on how such an exercise should be carried out.

Recommendations

There is a need to understand in some detail the drivers behind rising costs in the private health insurance industry. As part of Phase 1 it was agreed that all insurers would provide data to help us understand the issues leading to the growth in claims.

- The template agreed at the Forum and issued to insurers by the HIA in respect of surgical cases should be completed within 6 weeks to enable their independent validation.

- In future, the HIA should collect and analyse data in a similar format to the template now agreed, on a regular basis.

- The insurers and the HIA should agree a mechanism for comparing medical cases early in Phase 2 to enable a similar exercise be carried out.

- The issues identified in the medical and surgical review should form the basis of decisions needed at an individual insurer level and industry level where appropriate for the Phase 2 Report.

Chapter 4 Care Settings and Use of Resources

Introduction

One of the main drivers of the cost of private health insurance is the setting where care is provided and the length of time required to treat a patient in that particular setting.

Submissions

Insurers cited the following as indicators of waste and the potential for reduction in costs:

- Echocardiography and Pulmonary Function Tests are out-patient in nature and should be reimbursed accordingly.
- Due to advances in processes and technology a number of procedures should have their reimbursement rates by insurers reduced e.g. cataracts.
- Some patients are being admitted as an inpatient to hospital when a day patient or side room admission is more appropriate.
- Patients are being treated on a day basis where a side room treatment is more appropriate.
- The admission of patients the night before a surgery is leading to inappropriate overnight stays in public hospitals.
- A clear definition of day case and side room procedures needs to be developed.
- 75% of patients should be admitted on the day of their procedure in public hospitals as per the HSE guidelines.
- The basket of Day-care Procedures already developed as a collaborative initiative between the HSE's Quality and Clinical Care Directorate and the Royal College of Surgeons in Ireland should be agreed across the industry.

Findings

- The public hospitals are reimbursed on a per diem basis while private hospitals have negotiated fixed price rates for surgical and diagnostic procedures.
- A case based charging system using Diagnosis Related Groups (DRG) would set a fixed, pre-established payment for each case or patient episode according to the DRG of the patient. This approach is in line with that proposed in the Money Follows the Patient policy paper and the Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals.

- Implementation of this system would help to drive cost efficiency because fixed payments encourage hospitals to eliminate unnecessary services, to reduce lengths of stay and to develop a competitive advantage in areas in which they are high performers. It would also incentivise hospitals to move towards treating particular conditions on a day case or outpatient basis as opposed to an inpatient basis.

- The approach would also deliver greater alignment between the way that public and private hospitals are reimbursed.

Recommendations

- In order to ensure that patients are treated at the lowest possible cost consistent with quality, insurers should use existing information on the appropriate treatment locations for individual procedures. For example, the Irish casemix system already has a specific list of procedures that are coded as day cases, and the British Association of Day Surgery (BADS) has a list of procedures that should normally be targeted for day surgery, and for other settings such as side-room-type procedures. The HSE/RCSI basket is also useful in this regard. Insurers should use information of this kind to query cases claimed as an in-patient which might have been carried out on a day basis or as a side room procedure.

- The Minister should pursue implementation of a case based charging system using Diagnosis Related Groups (DRGs) for private patients in public hospitals.

- The Department and the HSE, with appropriate input from the private health insurers, should develop plans as early as possible in 2014 for the implementation of a case based charging system using DRGs for private patients in public hospitals.

Chapter 5 Age structure of the Market

Introduction

The Irish private health insurance market is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefits. It aims to ensure that private health insurance does not cost more for those who need it most. The level of risk that a particular consumer poses to the insurer does not affect the premium paid. Open enrolment and lifetime cover means that, except in very limited circumstances, insurers must accept all applicants for health insurance and all consumers are guaranteed the right to renew their policies regardless of their age or health status.

The market requires a sizeable cohort of younger members, who are generally healthier, to offset the high cost of members who are in the older age brackets, especially those 70 years or over. Data from insurers indicates that the average cost of claims in the 70+ age group is 10 times that of the 18-29 age group and 7 times that of the 30-39 age group. The retention of high numbers and attraction of new members in these age brackets is critical to the sustainability of a community rated system.

Findings

The changes in the age structure of the market indicate the following:

Net change in insurance market from 1/1/2012 to 1/1/2013

Age Group	Market
0-17	-15,564
18-29	-26,295
30-39	-19,745
40-49	-6,361
50-59	-3,105
60-64	-565
65-69	4,184
70-74	2,394
75-79	1,891
80-84	1,351
85+	1,000
Total	**-60,815**

- In 2012, the insured population of those aged under 60 decreased by 71,000 while it increased for ages over 60 by 10,000.

- In 2011, the insured population for ages under 60 decreased by 68,000 while it increased for ages over 60 by 10,000.

- The increases at the older ages reflect the ageing demographic of the insured population and the lower propensity of older people to cancel cover.

- The proportion of the insured population in the older age groups has increased markedly as is evidenced:

  2003 : 13.3% of insured over 60 years
  2009 : 15.9% of insured over 60 years
  2012 : 19.0% of insured over 60 years

- It is estimated that the percentage of the population who have insurance with open market insurers in the 18-29 category is 31% compared to the overall average of 43% for the total market.

Conclusion

The fact that the Irish population is falling in the 15-29 age group and the impact of the ageing of the population are already challenges facing healthcare costs. The trends in the private insurance markets are ever more concerning, as, if the present trends continue, the cost of claims will have to be met by a reduced number of members who will increasingly be in the middle and older age groups. These consume much greater healthcare resources themselves. It is difficult to predict the tipping point at which affordability determines that more people in the younger age categories leave the private health insurance market and the market fails to attract younger and healthier members.

The *Household Budget Survey 2009-2010* published by the Central Statistics Office shows the challenges facing households:

- There was a real decrease of approximately 4% in the volume of average household consumption over the five year period up to 2010.

- The proportion of total household expenditure that related to expenditure on food dropped from 18.1% in 2004-2005 to 16.2% in 2009-2010.

- The proportion of total household expenditure that related to housing increased from 12% to 18.2%.

- In 1980 medical related expenditure (e.g. expenditure on doctors, dentists, medicines and health insurance) accounted for 1.8% of total household expenditure as against 4.6% thirty years later.

Recommendations

- The Minister for Health should consider introducing measures to encourage younger members into the market and discourage by means of a financial penalty, people who take out health insurance for the first time after age 30. This would be in line with the principles of *lifetime community rating.*

- Health insurers should prove their commitment to retaining and attracting persons in the 18-29 age group by discounting premiums for full time students up to age of 23, which is allowed at present under health insurance legislation.

Note:
Ireland and Australia share quite similar healthcare systems. Both countries offer universal public coverage in addition to supplementary voluntary health insurance cover which is subscribed to by similar high proportions of the respective populations. A combination of "carrot and stick" measures introduced in Australia in 1999/2000 appears to have led to a major once-off increase in members with little cost to the Government.

Chapter 6 Clinical Audit and Utilisation Management

Introduction

The Health Service Executive, in 2013, has produced "a Practical Guide to Clinical Audit" which was developed following a review by experts in the field of clinical audit in Ireland and in the UK. The document describes Clinical Audit as a "tool which can be used to discover how well clinical care is being provided and to learn if there are opportunities for improvement".

The document outlines the many reasons to undertake clinical audit:

- "Clinical audit offers a way to assess and improve patient care, to uphold professional standards and 'do the right thing'.
- Through clinical audit, healthcare staff may identify and measure areas of risk within their service.
- Regular audit activity helps to create a culture of quality improvement in the clinical setting.
- Clinical audit is educational for the participants. It involves being up to date with evidence based good practice.
- It offers an opportunity for increased job satisfaction.
- It is increasingly seen as an essential component of professional practice.
- It can improve the quality and effectiveness of Healthcare."

Milliman Review

The Department of Health on the 25/2/2011 published a redacted version of a report on VHI's claims costs carried out by its actuarial advisors Milliman. Some of the key findings of the Milliman report included:

- The need to introduce "utilisation management" which can ensure that members receive the right treatment, at the right time in the right facility.
- Lacks the infrastructure to determine whether it is paying for treatments which have a proven medical value, or whether treatments are taking place in the most appropriate setting from the point of new of the cost or quality of care.
- In practice, through utilisation management, VHI could exercise more control over claims costs by agreeing parameters within which consultants would have the freedom to operate.

- Building a stronger utilisation management function will naturally result in increased administrative costs, but the potential benefits in terms of reduced claim costs are significant.

Milliman point out that "In the U.S and other first world settings utilisation management can reduce inpatient hospital admissions by as much as 10% and total inpatient hospital bed days by as much as 30%. For example, it is well documented that utilisation for high-tech diagnostic imaging (CAT scan, MRIs and PET scans) can reduce utilisation by up to 20%."

Submissions

Insurers in their submissions outlined the following actions:

- A pre-authorisation process is being used increasingly
- Call backs are being made to members to ensure treatment billed was received and accommodation charged was occupied
- Clinical audits of specific cases
- Hospital specific utilisation reviews
- National and international panels who advise on best medical practice and clinical appropriateness
- Trend analysis and comparison with the practice of consultants peers
- The majority view amongst insurers supported:
  - National procurement of drugs
  - Having a defined list of drugs that should be covered within the industry
  - High cost drugs should only be covered where the National Centre for Pharmacoeconomics (NCPE) has approved the drugs following cost effectiveness services.

Conclusions

International evidence supports the need for investment in clinical audit and utilisation reviews. Insurers have indicated that they are finding that the investment is also paying a return in Ireland. Insurers have agreed that there is scope to bring current practice in line with best practice internationally. Insurers have supplied details of their current arrangements for determining the appropriateness of claims.

Evidence produced suggests that attention to clinical audit on the part of the insurers is a relatively recent development. While the level of activity on clinical audit has been

increasing, an independent evaluation of the extent of clinical audit being carried out by each insurer would be beneficial as part of Phase 2.

Recommendations

- The current clinical audit and utilisation arrangements should be assessed in Phase 2 to determine if they are in line with the robustness of international practice.

- The extent of clinical audit being carried out by each insurer should be independently evaluated in Phase 2 of this work.

- The potential for national procurement of drugs, a national drug formulary and adherence to NCPE outcome assessments should be assessed in Phase 2.

Chapter 7 Industry approach to Private Psychiatry

Introduction

While the cost of psychiatric care is small relative to the overall reimbursement levels for medical and surgical services, the PHI industry raised this issue with me because of a number of concerns they had as regards cost.

Among the concerns they identified were:

- The lack of clinical guidelines
- The absence of a primary/community based infrastructure in the mental health sector
- The majority of existing facilities are based in Dublin with clinics based in the cities of Cork and Galway
- Too great a reliance on an in-patient model of care
- Longer lengths of stay in private psychiatry centres than in public hospitals.

Findings

My findings are based, to date, on submissions from insurers and published data. I propose to offer an opportunity to owners of independent/private and private charitable centres to receive their submissions or meet with them to get their perspective on how the system could be reformed. International practice indicates a higher use of pre-authorisation and continuing authorisation than is practised in Ireland. However such systems are bureaucratic and costly for insurers and providers.

Guidelines for treatment for psychiatric conditions
Insurers could have implemented guidelines themselves to support the medical necessity for inpatient treatment but have not done so at this stage. It is important that any guidelines that are developed at an industry level carry credibility and weight and are used to support a new way of providing a comprehensive integrated Mental Health Service.

Accreditation
A better approach to a restructuring of the model of care and a way to control future escalating costs may be better served by a system of accreditation.

Lengths of Stay
The HRB Statistics Series 20 *Activities of Irish Psychiatric Units and Hospitals 2012* provides data which supports the contention that independent/private and private charitable centres have longer lengths of stay compared to general hospital psychiatric units. Their 2012 report outlines the following:

- Over one-third of all discharges from both general hospital psychiatric units (56%) and from psychiatric hospitals (54%) occurred within two months of admission, compared with 23% from independent/private and private charitable centres.

- Average length of stay for all discharges was longest in psychiatric hospitals at 309.2 days (median 12 days), followed by 47.2 days (median 31 days) in

- When discharges of one year or more were excluded, independent/private and private charitable centres had the longest average length of stay at 36.3 days (median 31 days) followed by psychiatric hospitals, at 25.6 days (median 11 days) and general psychiatric unit, at 21.3 days (median 11 days).

The model of reimbursement has meant that private providers have not met the best international practice of an integrated private mental health service and insurers in the main cover an in-patient model of care with the exception of some day- hospital/day centres.

International Benefit models

Submissions to me have pointed out that benefit models internationally are based on the overall system in that country, e.g.:

- In South Africa, a managed care approach is used.
- In Germany, benefit is paid for each specific input in the patient's care.
- In Australia, in a system similar to Ireland, private insurers reimburse for psychiatry on a per diem basis. The rates vary based on different treatment programmes and include a tiered rate which reduces the amount paid to facilities at a certain point during the admission. It is stated that this system succeeded in driving down the average length of stay in Australia from 28 days to 19 days.

While international comparisons in an area such as this need to be treated with caution, the length of stay in the selected countries are:

Ireland:	36.3 days
Germany:	22.0 days
Australia:	19.0 days
South Africa:	15.0 days

My conclusions to date are that:

- Private patients are poorly served by the model of care which lacks a comprehensive and integrated approach by insurers and providers.

- Insurers need to demonstrate that they will reimburse providers who re-structure their service offering.

- Providers need to benchmark their performance against best national and international practice as regards admission rates and lengths of stay and restructure their service offering to include Mental Health Teams, day hospitals, day centres and outpatient clinics.

Recommendations

- The Minister for Health should use his existing powers under legislation to authorise the Mental Health Commission to establish and maintain a system of accreditation of comprehensive mental health services in line with the principles of a Vision for Change. Such a system should be developed in partnership with the various stakeholders and should be self-funded. Insurers could then fund accredited providers on the basis of an integrated model of care.

- Health Insurers and providers should engage in negotiations to put in place a service model with minimum benefits which is in line with international best practice.

- While restructuring of the service offering will take time, I plan to report on the progress made by the insurers and providers at the completion of Phase 2 of this exercise.

Chapter 8 Fraud, Waste and Abuse

Introduction

There is limited information available on the extent of fraud, waste and abuse in the private healthcare insurance industry in Ireland. In the United States, the following definitions are used to describe the issues:

- Fraud: Obtaining or attempting to obtain healthcare services or payment by dishonest means, with knowledge, willingness or intent.

- Waste: Unnecessary healthcare costs due to inefficient or ineffective providers/insurer practices, systems or controls.

- Abuse: Providing healthcare services that are inconsistent with good medical financial and business practices (example: unnecessary testing).

Submissions/research

As a result of submissions and research, the following points were made in a national and international context:

- In the United States, the National Health Care Antifraud Association (an organisation of about 100 private insurers and public agencies) estimates that upwards of 3% of their healthcare spend is lost annually to fraud, waste and abuse.

- The White House has stated that $4.1 billion was recovered in 2011 arising from tougher screening procedures, stronger penalties and new technology.

- The total value of recoveries in the United States over the last three years was $10.7 billion.

- The European Healthcare Fraud and Corruption Network (EHFCN) conservatively estimated that approximately €45 billion is lost annually to fraud and error alone within the E.U.

- Significant amounts are being recovered by health insurers arising from audits.

- Insurers who have provided additional resources in this area are reporting significant return on investment.

- An industry approach has been developed in many countries with good international co-operation in preventing fraudulent billing and claiming.

Findings:

While the majority of healthcare providers are honest and well-intentioned, there is evidence of abuse in the system. Health insurers reported the following anomalies which had been identified:

- Claims being made for semi-private accommodation when the patient had been on a trolley.
- Inappropriate invoicing for non-designated beds.
- Consultant up-coding of procedures.
- Inappropriate lengths of stay.
- Private fees for patients treated in a public facility.
- Inappropriate invoicing for certain specified drugs, tests and prostheses.
- Consultants claiming benefit when they were not present or had not personally performed the procedures.
- Cross speciality referrals when they are not strictly clinically necessary.

Industry professional representatives have been very supportive of removing inappropriate behaviour where it has been identified. There was a large degree of common ground by insurers as to the issues that they were dealing with.

Recommendations

- There is a need for the health insurers to acknowledge publicly that fraud/ malpractice exists and to publish data on the extent of monies recovered from hospitals and consultants.
- Private health insurers should adopt a co-ordinated industry approach to the identification and tackling of fraud, waste and abuse within the healthcare market.
- The industry should engage with the Data Protection Commissioner to ensure that all its actions are within their legislative competence.
- The industry should develop a plan over the next three months which will be reported on in Phase 2, which builds on national experience of other insurance and financial providers who have addressed this issue. This has been achieved through a co-ordinated approach in conjunction with law enforcement. The international experience of other countries which have such a co-ordinated approach should also be evaluated.

- The industry should fund a whistle-blower initiative which has an online anonymous reporting facility, hotline facilities and actively promote the initiative within the customers of the industry and public and private providers.

Chapter 9 Chronic Disease Management

Introduction

The HSE point out that the care of people with chronic illness consumes between 70-80% of all health care spending. In its Chronic Illness Framework the HSE notes that people with chronic illness are far more likely to:

- Attend their GP - 80% of GP consultations relate to chronic illness.
- Present at an Emergency Department - 66% of patients admitted through Emergency Departments have exacerbations of their chronic illness.
- Be admitted as an inpatient.
- Use more inpatient bed days than those without a chronic illness – 60% of hospital bed days are accounted for by people with a chronic illness. In addition, a small proportion of patients (5%) who have a chronic illness use 40% of inpatient bed days.
- Suffer increasing morbidity, have compromised quality of life and die prematurely.

The Framework states that "it has been shown that chronic illness can be better managed in a well-developed multidisciplinary primary care setting, provided the necessary supports are put in place for patients and their carers".

Findings

Private health insurers fund care on an episodic basis and while some initiatives have been tried by insurers, there has been no system-wide initiative to fund chronic diseases other than by acute care reimbursement. Insurers have indicated their acceptance of the long term benefits of integrated care models. However, an individual insurer who invests in such models runs the risk of investing significant resources up front and then finding that the patients concerned have moved to another insurer who benefits from their reduced use of services including in-patient care.

Conclusion

The public and private healthcare system would benefit from an enhanced implementation of chronic care programmes. The CEOs of the private health insurers have, in direct discussions, agreed to participate positively at CEO level in initiatives to examine how to incentivise more integrated care models for dealing with chronic disease.

The Department of Health published a Policy Framework for the Management of Chronic Disease, *Tackling Chronic Disease* in 2008. As part of the HSE's National Plan for 2014, it is proposed to update this, with particular reference to the work since 2008 on the development of Clinical Care Programmes.

Recommendations

- As part of the commitment to develop and update the existing Chronic Disease Management Framework, the Department of Health and the HSE should engage closely with private health insurers to develop an integrated model of care for treatment and management of chronic disease. The updated Framework should in particular consider how best insurers could play a role in incentivising patients towards prevention and management of chronic disease.

- Insurers who commit to such programmes should be incentivised through the risk equalisation scheme which can recognise the upfront costs of such programmes.

Chapter 10 Claims Processing

Introduction

There is a largely paper-based claims processing system in operation in the private health insurance market. Claim forms are completed by hospitals and consultants and sent to the health insurers. Progress has been made in the submission of e-images directly from the hospitals but this falls short of electronic claims submission and payment. A streamlined claims submission process is more beneficial to the provider as it will reduce processing costs, cut debtor days and improve cash flow. The benefits to the insurers include a faster understanding of their exposure to claims in a given time period and the ability to examine the claims in a timely manner from an audit perspective. It is difficult to understand how a streamlined system that benefits insurers, public and private providers and patients has taken so long to implement.

Submissions

In submissions I have received and perspectives given by key parties in the process, the following, often contradictory, views have been offered:

- Private providers appreciate the importance of cash flow and certainty of payment and submit invoices in a timely manner and normally within about 30 days.

- Insurers state they welcome the submission of claims as early as possible for an understanding of their claims exposure, their reimbursement exposure and cash flow management.

- Insurers have supplied data stating that the average delays between discharge and receipt of claim is between double and treble the time by public hospitals as compared to private hospitals.

- Providers argue that while insurers state that they wish to process claims received quickly, in reality they query and pend claims as a means of delaying payment. Public providers argue that the extent of pended/delayed claims has been rising in recent months.

- Public providers claim they have difficulty managing the claims process and have difficulty in many cases in getting the treating consultant to sign the claim form.

- Consultants state that they also wish to be reimbursed as early as possible but that public hospitals do not have the same focus on billing as private hospitals do, and that this affects their ability to sign completed claim forms.

- Insurers deny any tardiness in payment and stress the importance, in particular, in getting a dedicated person in each provider (hospital) to follow up on legitimate queries.

Findings

- Both insurers and providers offer evidence of delays in submitting and processing claims. Improved speed in claims processing is important for both insurers and providers and therefore electronic claiming quickly needs to become the standard practice for all.

- Speedy processing of claims helps -

  Patients, where a query will be easier to deal with if the discharge was recent.

  Private Providers as cash flow and certainty of payment is critical for their business.

  Health Insurers as they need to know their claims exposure as early as possible.

  Public Providers as they need to manage the process of debtor management as per best practice.

- Health insurers have already agreed to adopt an industry approach to the introduction of electronic claiming with providers. The objective of the industry group on E-claiming is to define the standard for electronic Direct Pay Claiming in Ireland, to drive the transition to and govern the operation of electronic claiming under this standard.

- Health insurers, providers and Ireland itself in its business processing have been slow by international standards in targeting the benefits of e-invoicing and e-payments.

- Twenty one public hospitals are currently implementing a health insurance management system which involves submitting scanned images of claims, with twelve more due to go live in 2014. This is a welcome step towards full electronic claiming.

Recommendations

- Public hospitals should have as part of the National Service Plan requirements for 2014 debtor management performance at least equivalent to that in operation in the private hospitals.

- A report on performance against this target should be provided by the end of Phase 2 by the HSE.

- There should be a roll-out plan agreed between health insurers and public providers to mandate all public hospitals and consultants with admitting rights therein to switch to electronic claiming no later than the end of 2015.

- Health insurers should seek to agree written 'terms of trade' with HSE hospitals and voluntary hospitals regarding how they interact in relation to claims and payment arrangements. There should be a specific agreement on the timescale for submission of completed claims by hospitals, and for final processing by insurers (i.e. clarification of queries, payment of claims or rejection).

- All hospitals should submit agreed final claims to insurers within the timeframes agreed in the 'terms of trade'. Failure to respect agreed timeframes would mean that the insurer would pay a specified proportion (e.g. 90% or 95%) of the value of the claim. Conversely, should insurers fail to settle claims within an agreed time frame, they could be required to pay the provider, public or private, an additional specified percentage (e.g. 5% or 10%) of the value of the claim. This situation should be monitored by the HIA to ensure it is working effectively and fairly. The implications of implementing this recommendation at an operational level will be considered under Phase 2 of this process.

- While the issue arises only in a relatively small number of cases, it should be open to the HSE to suspend the admitting rights of consultants who repeatedly fail to complete and sign claim forms for private insurance within a reasonable period of time.

Chapter 11 Admission and Discharge Procedures and Processes

Introduction

A number of issues were raised which it was stated would result in greater clarity regarding eligibility, identification of category of consultant and definitions of a public/private case.

Findings

Evidence was provided of a lack of clarity in relation to a number of issues which should be dealt with by way of direct talks between the Department of Health, the HSE and insurers. The following recommendations should provide clarity on issues identified.

Recommendations

- The HSE should introduce standard procedures for public hospitals, following consultation with the industry, which ensures that it is clear that a patient has exercised their choice as to whether they wish to be treated as a public or private patient.

- Public hospitals should take responsibility for ensuring that consultants are adhering to their contract type.

- Health insurers should have access to the contract type of each consultant and where it is claimed that there is a separate side agreement in place, this information should be brought to the attention of the office of the Director of Acute Services in the HSE who can determine the issue.

- Patients on discharge should be provided with the opportunity to confirm the details of the treatment received and the names of the treating consultants. This would provide clarity to the hospitals, consultants, insurers, and patients on issues that subsequently can delay claims.

CHAPTER 12 Summary of Recommendations

1. Controlling Costs in Private Health Insurance (Chapter 3)

Recommendations

There is a need to understand in some detail the drivers behind rising costs in the private health insurance industry. As part of Phase 1 it was agreed that all insurers would provide data to help us understand the issues leading to the growth in claims.

- The template agreed at the Forum and issued to insurers by the HIA in respect of surgical cases should be completed within 6 weeks to enable their independent validation.
- In future, the HIA should collect and analyse data in a similar format to the template now agreed, on a regular basis.
- The insurers and the HIA should agree a mechanism for comparing medical cases early in Phase 2 to enable a similar exercise be carried out.
- The issues identified in the medical and surgical review should form the basis of decisions needed at an individual insurer level and industry level where appropriate for the Phase 2 Report.

2. Care Settings and resources (Chapter 4)

One of the main drivers of the cost of private health insurance is the setting where care is provided and the length of time required to treat a patient in that particular setting.

Recommendations

- In order to ensure that patients are treated at the lowest possible cost consistent with quality, insurers should use existing information on the appropriate treatment locations for individual procedures. For example, the Irish casemix system already has a specific list of procedures that are coded as day cases, and the British Association of Day Surgery (BADS) has a list of procedures that should normally be targeted for day surgery and for other settings such as side-room-type procedures. The HSE/RCSI basket is also useful in this regard. Insurers should use information of this kind to query cases claimed as an in-patient which might have been carried out on a day basis.
- The Minister should pursue implementation of a case based charging system using Diagnosis Related Groups (DRGs) for private patients in public hospitals.

- The Department and the HSE, with appropriate input from the private health insurers, should develop plans as early as possible in 2014 for the implementation of a case based charging system using DRGs for private patients in public hospitals.

3. Age Structure (Chapter 5)

Recommendations

- The Minister for Health should consider introducing measures to encourage younger members into the market and discourage by means of a financial penalty, people who take out health insurance for the first time after age 30. This would be in line with the principles of *lifetime community rating.*

- Health insurers should prove their commitment to retaining and attracting persons in the 18-29 age group by discounting premiums for full time students up to age of 23, which is allowed at present under health insurance legislation.

Note:
Ireland and Australia share quite similar healthcare systems. Both countries offer universal public coverage in addition to supplementary voluntary health insurance cover which is subscribed to by similar high proportions of the respective populations. A combination of "carrot and stick" measures introduced in Australia in 1999/2000 appears to have led to a major once-off increase in members with little cost to the Government.

4. Clinical Audit and Utilisation Management (Chapter 6)

Recommendations

- The current clinical audit and utilisation arrangements should be assessed in Phase 2 to determine if they are in line with the robustness of international practice.

- The extent of clinical audit being carried out by each insurer should be independently evaluated in Phase 2 of this work.

- The potential for national procurement of drugs, a national drug formulary and adherence to NCPE outcome assessments should be assessed in Phase 2.

5. Industry Approach to Private Psychiatry (Chapter 7)

Recommendations

- The Minister for Health should use his existing powers under legislation to authorise the Mental Health Commission to establish and maintain a system of accreditation of comprehensive mental health services in line with the principles of a Vision for Change. Such a system should be developed in partnership with the various stakeholders and should be self-funded. Insurers could then fund accredited providers on the basis of an integrated model of care.

- Health Insurers and providers should engage in negotiations to put in place a service model with minimum benefits which is in line with international best practice.

- While restructuring of the service offering will take time, I plan to report on the progress made by the insurers and providers at the completion of Phase 2 of this exercise.

6. Fraud, Waste and Abuse (Chapter 8)

Recommendations

- There is a need for the health insurers to publicly acknowledge that fraud/malpractice exists and to publish data on the extent of monies recovered from hospitals and consultants.

- Private health insurers should adopt a co-ordinated industry approach to the identification and tackling of fraud, waste and abuse within the healthcare market.

- The industry should engage with the Data Protection Commissioner to ensure all its actions are within their legislative competence.

- The industry should develop a plan over the next six months which will be reported on in Phase 2, which builds on national experience of other insurance and financial providers who have addressed this issue. This has been achieved through a co-ordinated approach in conjunction with law enforcement. The international experience of other countries which have such a co-ordinated approach should also be evaluated.

- The industry should fund a whistle-blower initiative which has an online anonymous reporting facility, hotline facilities and actively promote the initiative within the customers of the industry and public and private providers.

7. Chronic Disease Management (Chapter 9)

Recommendations

- As part of the commitment to develop and update the existing Chronic Disease Management Framework, the Department of Health and the HSE should engage closely with private health insurers to develop an integrated model of care for treatment and management of chronic disease. The updated Framework should in particular consider how best insurers could play a role in incentivising patients towards prevention and management of chronic disease.

- Insurers who commit to such programmes should be incentivised through the risk equalisation scheme which can recognise the upfront costs of such programmes.

8. Claims Processing (Chapter 10)

Recommendations

- Public hospitals should have as part of the National Service Plan requirements for 2014 debtor management performance at least equivalent to that in operation in the private hospitals.

- A report on performance against this target should be provided by the end of Phase 2 by the HSE.

- There should be a roll-out plan agreed between health insurers and public providers to mandate all public hospitals and consultants with admitting rights therein to switch to electronic claiming no later than the end of 2015.

- Health insurers should seek to agree written 'terms of trade' with HSE hospitals and voluntary hospitals regarding how they interact in relation to claims and payment arrangements. There should be a specific agreement on the timescale for submission of completed claims by hospitals, and for final processing by insurers (i.e. clarification of queries, payment of claims or rejection).

- All hospitals should submit agreed final claims to insurers within the timeframes agreed in the 'terms of trade'. Failure to respect agreed time frames would mean that the insurer would pay a specified proportion (e.g. 90% or 95%) of the value of the claim. Conversely, should insurers fail to settle claims within an agreed time frame, they could be required to pay the provider, public or private, an additional specified percentage (e.g. 5% or 10%) of the value of the claim. This situation should be monitored by the HIA to ensure it is working effectively and fairly. The implications of implementing this recommendation at an operational level will be considered under Phase 2 of this process.

- While the issue arises only in a relatively small number of cases, it should be open to the HSE to suspend the admitting rights of consultants who repeatedly fail to complete and sign claim forms for private insurance within a reasonable period of time.

9. Admission and Discharge Procedures and Processes (Chapter 11)

Recommendations

- The HSE should introduce standard procedures for public hospitals, following consultation with the industry, which ensures that it is clear that a patient has exercised their choice as to whether they wish to be treated as a public or private patient.

- Public hospitals should take responsibility for ensuring that consultants are adhering to their contract type.

- Health insurers should have access to the contract type of each consultant and where it is claimed that there is a separate side agreement in place, this information should be brought to the attention of the office of the Director of Acute Services in the HSE who can determine the issue.

- Patients on discharge should be provided with the opportunity to confirm the details of the treatment received and the names of the treating consultants. This would provide clarity to the hospitals, consultants, insurers, and patients on issues that subsequently can delay claims.

Chapter 13 Conclusions and Next Steps

Almost €2bn was paid in claims by Irish private health insurers in 2012. Of this total, 93% relates to hospital stays coming within the definition of prescribed health services and is paid: to private hospitals 46%, public hospitals 27% and hospital consultants 20%. The remaining 7% relates mainly to outpatient benefits, or to benefits (including hospital benefits) that do not come within the definition of prescribed health services. It is evident from data available on the private health insurance market over recent years that the combination of a number of factors - reduction in numbers holding PHI, the age of those holding PHI, increases in claim costs, increases in premiums and the overall state of the economy - are having a serious impact on the PHI market and its sustainability.

This report draws attention to the potential for insurers to invest in better integrated care which in the short term would require investment, but would benefit in the long term in the costs of managing chronic diseases. It also recommends that consideration be given to initiatives to attract younger members into the market. The study being carried out on claims cost will provide the evidence necessary to determine why and where costs are rising and will inform the recommendations in Phase 2.

This report concentrates on a number of areas where decisions can be taken in advance of Phase 2. It was originally expected that Phase 2 would take 6 months to complete, however the Minister has now requested that Phase 2 be completed within 3 months. The four principles of community rating, open enrolment, lifetime cover and minimum benefit have, to date, served the market well. It is in the interests of public and private providers, private health insurers and the public, of all groups, that there is a sustainable market for health insurance in Ireland. The lack of a sustainable market based on community rating would lead to a risk rated model of insurance. When this model is applied to health insurance, the inevitable result is that older people and less healthy people have to pay substantially more for the same cover.