An tÚdarás Árachas Sláinte
The Health Insurance Authority

Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2020 to 30 June 2021, including advice on Risk Equalisation Credits.

October 2021

Contents

1. Overview

The Minister for Health ("the Minister") has requested that the Health Insurance Authority ("the Authority") provide a Report to the Minister under Section 7E of the Health Insurance Act 1994.

In preparing such a Report the Authority is required to include:

- Such matters concerning the carrying on of health insurance business that the Authority considers ought to be brought to the attention of the Minister; and
- The Authority's conclusions in relation to what Risk Equalisation Credits and Stamp Duty would be appropriate having had regard to the criteria set out in Section 7E(1)(b) of the Act.

Section 7E(1)(b) requires the Authority to have regard to the following objectives:

- The Principal Objective (community rating);
- Avoiding over-compensation being made to a registered undertaking;
- Maintaining the sustainability of the health insurance market;
- Fair and open competition in the health insurance market; and
- Avoiding the Risk Equalisation Fund ("REF") sustaining surpluses or deficits from year to year.

The purpose of this report is to recommend an appropriate level of stamp duty for the 2022/2023 Risk Equalisation Scheme ("RES") calibration, i.e. for policies renewing in the period 1 April 2022 to 31 March 2023. The RES is due to be renewed from April 2022, as at the date of preparing this report, the notification process with the EU Commission was still ongoing. The recommendation has been prepared on the assumption that RES 2022 is implemented in accordance with proposals put forward to the EU Commission i.e. the inclusion of a High Cost Claimants Pool ("HCCP").[1]

The Authority has also included a recommendation based on the existing RES i.e. no inclusion of a HCCP. In the event that a HCCP is not implemented by 1 April 2022, this is the recommendation of the Authority for credits applicable for contracts commencing in the period 1 April 2022 to 31 March 2023.

The report also contains an evaluation and analysis of the Information Returns[2] received by the Authority from undertakings for the 6-month period commencing on 1 January 2021.

[1] Recommendation to the Department of Health in proposed changes to be incorporated into the RES, June 2021

[2] Under the Health Insurance Act 1994 (Information Returns) Regulations 2009, Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2011 and Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2013

2. Executive Summary

The primary objective of this report is to set out the Authority's recommendation on Risk Equalisation Credits and the associated level of stamp duty for contracts commencing in the period 1 April 2022 to 31 March 2023.

An analysis of Information Returns Information Returns received by the Authority in respect of the period 1 January 2021 to 30 June 2021 has also been included.

Recommendation

The Authority is proposing a material reduction in stamp duty for health insurance contracts from April 2022 to March 2023. As a result of lower claims activity by consumers of private health insurance, due to COVID-19, an estimated surplus of €100m has built up in the Risk Equalisation Fund ("REF"). The Authority is proposing a return of this €100m to consumers via a reduction in stamp duty for contracts commencing or renewing in the period 1 April 2022 to 31 March 2023.

This reduction is a once off reduction as a result of COVID-19 imposed restrictions on access to public and private hospitals, which resulted in lower risk equalisation credits being paid out of the REF.

The Authority does not have a role in setting premiums charged by the health insurers. However, a reduction in stamp duty reduces the costs incurred by insurers and the Authority considers that it is important that customers can benefit from this reduction via a corresponding reduction in premiums charged by the health insurers.

The Authority notes that if the surplus in the REF was not applied to the 2022/2023 stamp duty, advanced stamp duties for adults would be €475, as opposed to €406, and the non advanced adult stamp duty would be €142, as opposed to €122. Comparable levels of stamp duty are likely required next year, assuming the level of claims are in line with forecast levels.

The Authority is recommending that the stamp duties that would need to be paid by the insurers on policies that are renewed or entered into between 1 April 2022 and 31 March 2023, in order to meet the cost to the REF of the recommended Risk Equalisation Credits, are as follows:

Table 2.1 Stamp duty recommendation for contracts incepted 1 April 2022 – 31 March 2023

Age Band	**Stamp Duties from 1 April 2022 to 31 March 2023**		**Stamp Duties from 1 April 2021 to 31 March 2022**		***Change***	
	Non-Advanced	**Advanced**	**Non-Advanced**	**Advanced**	***Non-Advanced***	***Advanced***
17and under	€41	€135	€52	€150	*(€12)*	*(€14)*
18 and over	€122	€406	€157	€449	*(€35)*	*(€43)*

The Authority proposes that the following Risk Equalisation Credits should apply for health insurance policies that are renewed or entered into between 1 April 2022 and 31 March 2023.

Table 2.2 Risk Equalisation Credits for contracts incepted 1 April 2022 – 31 March 2023

Age Related Health Credits (ARHC)								
Age / gender / level of cover credits from 1 April 2022 – 31 March 2023					***Change from current credits***			
	Non-Advanced		**Advanced**		Non-Advanced		Advanced	
	Male	**Female**	**Male**	**Female**	Male	Female	Male	Female
64 and under	€0	€0	€0	€0	*€0*	*€0*	*€0*	*€0*
65-69	€325	€150	€950	€500	*(€25)*	*(€50)*	*(€75)*	*(€50)*
70-74	€500	€350	€1,575	€1,075	*(€50)*	*(€50)*	*(€100)*	*(€75)*
75-79	€775	€575	€2,375	€1,700	*(€50)*	*(€50)*	*(€125)*	*(€100)*
80-84	€950	€650	€2,975	€2,125	*(€75)*	*(€50)*	*(€175)*	*(€125)*
85+	€1,150	€775	€3,550	€2,425	*(€100)*	*(€50)*	*(€200)*	*(€125)*
Hospital Utilisation Credit (HUC)								
Night		**Day**			*Night*		*Day*	
€125		€75			*No change*		*No change*	
Hight Cost Claims Pool (HCCP)								
Quota Share 40%					*First year of this credit*			
Threshold €50,000					*First year of this credit*			

The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 137.7% of the average net claims cost across all lives. This increase in the claims cost ceiling from 133.5% to 137.7% is to facilitate the introduction of the HCCP.

The above recommendation assumes the new RES, incorporating a HCCP, is approved by the EU Commission and is implemented into law prior to 1 April 2022, based on the proposals made by the Authority to Department of Health in June 2021.

Alternative Recommendation

In the event that a HCCP is not implemented by April 2022, there will be no credits payable in respect of a HCCP. The ARHC as outlined above would change as follows:

Table 2.3 Age related health credits for contracts incepted 1 April 2022 – 31 March 2023 assuming no HCCP

Age / gender / level of cover credits from 1 April 2022 – no HCCP					***Change from current credits***			
	Non-Advanced		**Advanced**		***Non-Advanced***		***Advanced***	
	Male	**Female**	**Male**	**Female**	***Male***	***Female***	***Male***	***Female***
64 and under	€0	€0	€0	€0	*€0*	*€0*	*€0*	*€0*
65-69	€350	€200	€1,075	€600	*€0*	*€0*	*€50*	*€50*
70-74	€550	€400	€1,725	€1,200	*€0*	*€0*	*€50*	*€50*
75-79	€825	€600	€2,550	€1,825	*€0*	*(€25)*	*€50*	*€25*
80-84	€1,025	€700	€3,175	€2,275	*€0*	*€0*	*€25*	*€25*
85+	€1,225	€825	€3,775	€2,575	*(€25)*	*€0*	*€25*	*€25*

The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 133.5% of the average net claims cost across all lives i.e. no change to the existing claims cost ceiling.

The stamp duty recommendation as outlined in Table 2.1 would still apply and the HUC rates of €125 for overnight hospital stays and €75 for day case treatments would also continue to apply.

Projected financial impact of the recommendation

The Authority estimated that the projected net financial impacts on each of the insurers for a 12-month period, based on the credits and stamp duty applying for policies commencing in the period 1 April 2022 to 31 March 2023, would be as follows:

Table 2.4 Projected Financial Impacts for recommendation with a HCCP

Recommendation	Irish Life Health	Laya Health Care	Vhi Healthcare	Market
ARHC €m	[redacted]			590
HUC €m				199
HCCP €m				55
Stamp Duty €m				(745)
[redacted]				[redacted]
Net Financial Impact* €m				*100*
Net Financial Impact per Insured Life €				

Table 2.5 Projected Financial Impacts for recommendation without a HCCP

Recommendation	Irish Life Health	Laya Health Care	Vhi Healthcare	Market
ARHC €m	[redacted]			645
HUC €m				199
HCCP €m	-	-	-	-
Stamp Duty €m	[redacted]			(745)
[redacted]				[redacted]
Net Financial Impact €m	[redacted]			*100*
Net Financial Impact per Insured Life €				

*[redacted] [redacted]

The recommendation is to utilise the €100m surplus expected to exist in the REF(when the credits and Stamp Duty on all contracts that commence in advance of 1 April 2022 are fully earned) to reduce the level of stamp duty. This means that overall, the level of credits to be paid will exceed the stamp duty receipts, by a magnitude of €100m.

Key Assumptions and Basis of Calculation

The key assumptions for the 2022/2023 RES Calibration are as follows :

Base Year - The information returns for the period January 2020 - July 2021 show that the claims in this period have been heavily distorted due to COVID-19. The impacts of COVID-19 and more recently the Cyber-attack on the HSE is continuing to impact the provision of healthcare and as such is continuing to have an impact on the claims being experienced by health insurers. The full effects will only become clear in subsequent market and claims data, when all claims are fully settled. For this reason, the Authority did not consider that claims covering this period would be a suitable basis for underpinning the calibration of RES 2022/2023. The data for January - December 2019 has therefore been used as our starting point to determine average claims and average utilisation per insured life as the most recent non distorted data available to the Authority.

Insured Population: The insured population has remained resilient since early 2020 and increased over the last 12 months by 47k or 2.2%. The Authority has also taken the view that the insured population will continue to grow by the same scale as experienced in the last 12 months. Population data underpinning the RES calibration is 1 July 2021 data projected to 1 October 2022 (mid-point of relevant contracts) and assumes that the insured population will increase by 58k over 1.25 years

Utilisation: Hospital utilisation has been slower to recover than expected due to subsequent waves of COVID-19 and this was more evident in public hospitals which are still not operating at full capacity. Although there are signs of increased utilisation, the anticipated surge in demand for hospital services did not materialise to the degree expected in the second half of 2020 or first half of 2021. Total days and nights paid in the first 6 months of 2021 are still more than 20% lower than in the same period in 2019 indicating utilisation has not fully been restored. Based on this, the Authority has assumed a 0% p.a. increase in utilisation in 2022/2023, relative to 2019. This change has a very small impact on stamp duty (€2) and age related health credits.

Claims Inflation: The Authority have reduced the claims inflation assumption from 4% p.a. to 3% p.a. This assumption is the extent to which we think average claims per insured person will increase and is not the expected change in the unit cost of medical treatments. Increases in the insured population by healthier lives will contribute to a drop in the average claim per person. The change in this assumption is to some extent based on the emergence of inflation being lower than 4% in 2017 to 2019 and also taking into consideration that there is not expected to be any increase in public bed night charge for private patients over the relevant period and as such it is expected 70-75% of claims will be subject to inflation.

REF Surplus: The expected surplus within the REF when all claims have been settled in respect of contracts incepted up to 31 March 2022 is €100m. This €100m of surplus will be applied to contracts commencing in the period 1 April 2022 to 31 March 2023. If there was no surplus within the REF the adult Advanced stamp duty would be closer to €470 compared to the recommended rate of €406.

Other assumptions:

- The level of non advanced stamp duty should be 30% of Advanced stamp duty level (reduced from 35% as per last year's calibration)
- Claims Cost Ceiling 133.5% unchanged from 2021/2022 RES Calibration assuming no HCCP
- Bed Night HUC/ Day Case HUC €125/€75 (unchanged from 2021/2022 RES Calibration)

The rationale for these assumptions is provided in more detail in Section 4.

We have also considered some sensitivities around these assumptions when setting our recommendation – see Appendix 3.

Conclusions

The Authority acknowledges that COVID-19 continues to bring a degree of uncertainty to the calibration of the RES and that there is a range of potentially acceptable options for the stamp duty and Risk Equalisation Credits that could be considered as reasonable. It is necessary to strike a balance between the level of stamp duty paid by all policyholders and the level of compensation paid to insurers in respect of older and/or sicker lives. In considering this balance, the Authority has had regard to all its objectives.

The recommendation has been set as so to strike a balance between sustaining community rating by keeping health insurance affordable for older less healthy consumers and maintaining the

sustainability of the market by keeping younger healthier consumers in the market while maintaining the effectiveness of the RES.

The Authority considers that the recommendation strikes an appropriate balance between its objectives:

- The recommendation increases the effectiveness[3] of the RES from 30.3% to 43.6% based on the Authority's defined measure of effectiveness and assuming a HCCP is implemented;
- The recommendation is allocating more credits based on actual health status across all ages and is sharing risk for low incidence high cost claims at all ages. This is contributing to more targeted distribution of health-related credits. This should serve to decrease insurers incentives to segment and risk select, and encourage insurers to compete on efficiencies;
- The projected net claims cost at all ages is lower than those projected last year at all ages, with the greatest reductions at younger ages (assuming a HCCP is introduced) which should contribute to competition, support stability and sustainability of the market; and
- The lower stamp duty and the reduction in the Non-Advanced relative to the Advanced should serve to address concerns about affordability and stability of the market at the current uncertain time. The Authority is of the view that it is only fair that consumers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurer's product pricing.

Further details on the recommendation are included in Section 7, 8 and Appendix 2 of the report.

[3] "R-squared weighted average variance" measure which considers the change in the square of the deviations (before and after the RES) of the average claims for each insurer to market average claims at each age band relative to the market average claim weighted by claims costs before application of the RES

3. Background

The recommendations contained within the report have been developed with due regard to the principal objectives as set out in Section 1A of the Health Insurance Act (see Appendix 4).

Aims of the RES

The principal objective of the Authority is to ensure, in the interests of the common good, that access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by income tax or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the respective age range and general health status of the members of any particular generation (or part thereof).

The Authority, in developing its recommendations regarding risk equalisation credits and stamp duties, must have regard to, and strike an appropriate balance between, the following objectives as per Section 7E(1)(b) of the Act:

- The Principal Objective (community rating);
- Avoiding over-compensation being made to a registered undertaking;
- Maintaining the sustainability of the health insurance market;
- Fair and open competition in the health insurance market;
- Avoiding the REF sustaining surpluses or deficits from year to year; and
- Maintaining the stability of the market which relies on younger cohorts continuing to purchase private health insurance. This is important to maintain the intergenerational solidarity that underpins the principal of community rating.

RES Calibration

It has been assumed that the RES calibration for health insurance policies that are renewed or entered into on or after 1 April 2022 will distribute risk equalisation credits in three ways:

1. Age related health credits (ARHC): these apply from age 65 onwards and vary by age, level of cover and sex
2. Hospital utilisation credits (HUC): a fixed amount for each night/day that an insured person spends in private hospital accommodation
3. High Cost Claims Pool credit (HCCP): an amount determined as a percentage (quota share) of claims in excess of a defined amount (Threshold)

At the time of writing this report, the inclusion of a HCCP has not yet been approved by the European Commission and as such the Authority have looked at calibrations with and without the inclusion of a HCCP. For the first year of the inclusion of the HCCP (2022/2023), the Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000.

Data informing calibration

Half-yearly information returns for the period July to December 2020 and January to June 2021 periods were received from Irish Life Health DAC (trading as Irish Life Health), Great Lakes Reinsurance UK Ltd (formerly trading as GloHealth), Elips Insurances Ltd (trading as Laya Healthcare), Swiss Re Portfolio Partners (former Quinn Insurance Ltd business) and Vhi Insurance DAC (trading as Vhi Healthcare)). The returns were accompanied by independent accountants' reports and analyses of the differences between total claims paid and returned benefits.

The information returns received by the Authority include data on "returned benefits[4]". These benefits exclude certain benefit payments. The main exclusions from returned benefits are:

- Benefits relating to services not involving a hospital stay; and
- Benefits relating to services otherwise excluded from the definition of "Returned Health Services".

The insurers also provided HCCP data as per a HCCP data request sent by the Authority for the period January 2017 – December 2020. The data was provided by the insurers on a voluntary best endeavours' basis, it is not audited and the Authority has not carried out extensive validation and verification of the data. The Authority has relied upon the accuracy of the data provided and relied upon the insurers to have carried out adequate data verification and validation before providing the data to the Authority.

The Authority requested insurers to provide a summary of their views on the outlook for the health insurance market. Information provided by insurers included projections of population, claims and accounts as well as notes on their assumptions and responses to the Authority's questions.

In June 2021, the Authority reached out to the insurers with a number of questions around future impacts of COVID-19 and some more general themes impacting the 2022 RES calibration. Each insurer submitted a paper and projections on insured lives and claims over the period 2021 – 2023 with detail on their views/ observations. We have summarized some of the main themes below. The views were varied in terms of responses but covered the following areas:

- Expected future claims levels, claims mix and claims inflation, future market membership and ageing, hospital utilisation levels;
- Move to treatment outside hospital settings;
- Level of stamp duty and approach for Non-Advanced contracts;
- Age credits and HUC;
- Level of claims cost ceiling;
- Extension of young adult discounts;
- Overcompensation assessment;
- Capacity and other issues arising as a result of COVID-19;
- Views around the timing of implementation of a HCCP;
- Sustainability of the market, competition, structure and size of the market and segmentation; and
- Affordability of Health Insurance.

The Authority has considered the views of the insurers and the points raised when setting credits and stamp duty for policies commencing in the period from 1 April 2022 to 31 March 2023 and the assumptions impacting the recommendation set out in this report.

Data errors

See Appendix 6 for the list of errors and issues with data included in the information returns. These errors are currently being addressed but the corrections are not reflected in the data outlined above.

[4] Health Insurance Act 1994 (Information Returns) Regulations 2009 as amended.

Note

The underlying figures in the various tables contained in this report are calculated to many decimal places. In the presentation of our results there may be reconciliation differences due to the effect of rounding.

Throughout the report we have used the following terms interchangeably:

- 'Age Credits' and 'Risk Equalisation Premium Credits'
- 'Stamp Duty' and 'Levy'
- 'Claims Cost', 'Average Returned Benefits' and 'Average Claims'

Throughout this document we refer to Irish Life Health DAC , Elips Insurance Limited and Vhi Insurance DAC by their trading / brand names (Irish Life Health, Laya Healthcare and Vhi Healthcare).

The remainder of this report is laid out as follows:

Section 4 outlines the assumptions used to determine the recommendation for Risk Equalisation Credits and stamp duty for contracts commencing in the period 1 April 2022 to 31 March 2023 and the data informing those assumptions.

Section 5 sets out market developments over the last 12 months.

Section 6 sets out overcompensation considerations as this forms one of the objectives in making our recommendation as is required under Section 7E(1)(b)

Section 7 sets out the recommendation in respect of Risk Equalisation Credits and Stamp Duty

Section 8 highlights the projected impacts of the recommendation and the key metrics considered when making the recommendation

Appendices include analyses of the information returns received and supporting documentation

4. Assumptions

In this section we set out the key assumptions used in the calibration of the RES, and the data analysis that influenced the assumptions.

Membership and Population Forecasts

Membership

Table 4.1 sets out the membership details and market shares of insurers. The data excludes members serving initial waiting periods.

Table 4.1 Insured population by insurer

Insurer	1-Jul-20		1-Jan-21		1-Jul-21	
	Members 000s	Market Share (%)	Members 000s	Market Share (%)	Members 000s	Market Share (%)
Irish Life Health	461	21.2%	466	21.2%	471	21.2%
Laya Healthcare	597	27.4%	611	27.8%	623	28.0%
Vhi Healthcare	1,121	51.4%	1,124	51.1%	1,132	50.9%
Total	2,179		2,200		2,226	

The overall insured population increased by 46,833 lives over the 12 months to 1 July 2021 (1 July 2019 to 1 July 2020: 48,114). Each of the insurers has experienced an increase in the number of insured lives but Irish Life Health's market share remains unchanged over the year with Laya Healthcare seeing a small increase in market share of 0.2% and Vhi Healthcare a corresponding decrease.

As of end June 2021, 46.7% of the Irish population are estimated to have private health insurance (including restricted undertakings), which is 0.3% higher than the percentages observed at end June 2020.

Gender profile of insurers' members

The gender distributions of the memberships of the three insurers for the period January to July 2021 are set out in Table 4.2. The proportions in each gender for each insurer have remained relatively static for some time.

Table 4.2 Gender distribution of insured population

Gender	Irish Life Health	Laya Healthcare	Vhi Healthcare	Market
Male		[redacted]		49%
Female				51%

Age Profile of Insurers Members

The age distribution (average for the period January to June 2021) of each insurer's membership is shown in Table 4.3. The figures shown in brackets are the corresponding averages for the period January to June 2020.

Table 4.3 Age profile of insured members

Age group	Irish Life Health	Laya Healthcare	Vhi Healthcare	Market
0-17	[redacted]			22.6% (22.9%)
18-29				11.9% (11.6%)
30-39				12.9% (13.1%)
40-49				16.1% (16.0%)
50-54				7.1% (7.1%)
55-59				6.6% (6.7%)
60-64				6.0% (6.0%)
65-69				5.4% (5.4%)
70-74				4.6% (4.6%)
75-79				3.4% (3.2%)
80-84				2.1% (2.0%)
85+				1.5% (1.4%)
Under 65				83.1% (83.4%)
Over 65				16.9% (16.6%)

[redacted]

At a market level there has been an ageing of the population with the proportion of the insured population over 65 increasing from 16.6% to 16.9% over the last 12 months.

Level of cover by the insured population

In analysing the information returns, we have split the products into the following levels of cover.

- Level 1 products provide cover mainly in public hospitals[5];
- Level 2 products provide substantial cover in private hospitals but this cover is mainly provided for semi-private accommodation[6];
- Higher levels of cover relate to products that provide cover for private rooms in private hospitals.

The proportion of each insurer's membership in each market segment on 1 July 2021 is shown in the Tables 4.4 and 4.5 (1 July 2020 figures are shown in brackets).

Table 4.4 Proportion of each insurers' population with each level of cover

	Level 1 Products	Level 2 Products	Higher Cover Products
Irish Life Health	[redacted]		
Laya Healthcare			
Vhi Healthcare			
Total	9% (9%)	76% (76%)	16% (16%)

[5] A contract considered to be "Level 1" may or may not fall within the legal definition of a Non-Advanced contract.

[6] Level 2 contracts and Higher contracts would all be "Advanced" contracts.

The proportion of Irish Life Health customers with Level 2 cover products increased during the year and the proportion of Laya Healthcare customers with higher cover products has also increased.

Table 4.5 Proportion of each insurer's population with Non-Advanced/Advanced level

	Non-Advanced	Advanced
Irish Life Health	[redacted]	[redacted]
Laya Healthcare		
Vhi Healthcare		
Total	8% (8%)	92% (92%)

Non-Advanced products cannot provide more than 66% of the full cost for hospital charges in a private hospital. The concept of Non-Advanced contracts commenced on 1 January 2013 and the first contracts were categorised as Non-Advanced on 31 March 2013. As at 1 July 2021, there were 34 products (Irish Life Health: 22, Laya Healthcare 10 and Vhi Healthcare: 2) being marketed classified as Non-Advanced with 176,401 members insured.

Review of membership projections in the Authority's 2020 recommendation

In last year's RES we projected the population at 30 June 2019 forward to 01 October 2021 (to allow for the natural ageing of the insured lives) and then reduced by it by 6.5% to allow for an expected market shrinkage. We assumed that all lapses would occur under age 60. However, this did not materialise and the population over the period 1 July 2020 to 1 July 2021 increased as outlined below.

Table 4.6 Change in insured Population

Change in insured lives by age			
Insured Membership	**1-Jul-20**	**1-Jul-21**	**Net Diff**
Aged 17 and under	503,584	506,766	3,182
Aged 18 to age 29	254,026	266,835	12,809
Aged 30 to age 39	288,633	289,494	861
Aged 40 to age 49	348,305	356,756	8,451
Aged 50 to age 54	153,137	156,222	3,085
Aged 55 to age 59	144,381	146,503	2,122
Aged 60 to age 64	130,385	133,019	2,634
Aged 65 to age 69	115,849	118,441	2,592
Aged 70 to age 74	98,737	100,709	1,972
Aged 75 to age 79	68,938	73,804	4,866
Aged 80 to age 84	43,255	45,376	2,121
Aged 85 and over	30,172	32,310	2,138
Total	**2,179,402**	**2,226,235**	**46,833**

If we project using last year's assumption to 1 July 2021, we can see the assumption was understated by 134,695 lives at 1 July 2021. See table 4.7 below.

Table 4.7 Actual vs Expected population growth to 1 July 2021

Difference Actual vs Assumption as at 1 July 2021			
Insured Membership	**Assumed Population 1 July 2021**	**Actual Population 1 July 2021**	**Net Diff**
Aged 17 and under	465,895	506,766	40,871
Aged 18 to age 29	239,954	266,835	26,881
Aged 30 to age 39	260,906	289,494	28,588
Aged 40 to age 49	330,247	356,756	26,509
Aged 50 to age 54	146,813	156,222	9,409
Aged 55 to age 59	143,413	146,503	3,090
Aged 60 to age 64	132,180	133,019	839
Aged 65 to age 69	117,753	118,441	688

Aged 70 to age 74	103,330	100,709	-2,621
Aged 75 to age 79	72,322	73,804	1,482
Aged 80 to age 84	45,986	45,376	-610
Aged 85 and over	32,741	32,310	-431
Total	2,091,540	2,226,235	134,695

Projected population for RES 2022/2023

The insurers have mixed views on the outlook for participation in the health insurance market. Some believe the population will continue to grow, but at a slower pace than previous years. Others have taken the view there will be a reduction in the short to medium term but then it will recover back to existing levels. There was also an expression of concern with affordability for younger lives and the importance to market sustainability.

Unemployment Rate

In last year's report, the Authority considered the impact on market membership based on unemployment rates, and forecast a reduction in participation given previous evidence of strong correlation between unemployment and private health insurance take up

As per the latest live resister figures published by the CSO, levels of unemployment have fallen by 25% over the year from 244k to 184k.

	Live Register Total	Seasonally Adjusted	Pandemic Unemployment Payment (PUP)	Temporary Wage Subsidy Scheme (TWSS)	Employment Wage Subsidy Scheme (EWSS)	Total [1]
July 2020	244,562	225,500	276,069	459,990	22,486	951,605
June 2021	175,281	171,700	228,322	-	352,846	728,748
July 2021	184,213	169,500	163,327	-	n/a	n/a
Change in month	-	-2,200	- 64,995	-	n/a	n/a
Change in year	-60,349	-	-112,742	-	n/a	n/a

[1] Estimated total number of persons (excluding overlaps) on the Live Register or benefitting from the PUP, the TWSS or the EWSS

If we look at the figures for July 2019 (pre pandemic) we can see that there are fewer lives unemployed now than there were then.

	Live Register Total	Seasonally Adjusted	Pandemic Unemployment Payment	Temporary COVID-19 Wage Subsidy Scheme	Total (Excluding overlaps)
July 2019	206,396	189,600	-	-	
June 2020	220,871	213,700	438,933	392,336	1,010,695
July 2020	244,562	226,600	274,578	447,639	922,696

The summer forecast for Ireland carried out by the European Commission[7], shows that GDP in Ireland grew by 7% in the first quarter of 2021 and the projection for the year is 7.2% and 5.1% in 2022. This compares to GDP growth of 5.6% in 2019.

[7] https://ec.europa.eu/economy_finance/forecasts/2021/summer/ecfin_forecast_summer_2021_ie_en.pdf

Having considered the views of the insurers, the current unemployment figures relative to last year and the forecast for Ireland carried out by the European Commission, the Authority has taken the view that the insured population will continue to grow. In our projections the base population is the 1 July 2021 population, and this is projected for 1.25 years to 1 October 2022 (mid-point of the contracts from 1 April 2022 to 31 March 2023). The membership is assumed to increase in line with the change in the market membership in the period 1 July 2020 to 1 July 2021 (46,833) until 1 October 2022. The projections assume an increase in the number of insured lives of 58,541 over 1.25 years i.e. 1.25 x 46,833. This is consistent with the methodology used in past RES calibrations with the exception being the approach used last year.

Additionally, while the total market size is a critical factor in balancing the financial impact of credits and stamp duty, the forecast age profile and product mix is also important. The Authority has assumed that the changes in age profile and product mix over the 12 months to July 2021 in Table 4.8 will continue at the same pace until 1 October 2022 for the market as a whole.

Table 4.8 Projected Population for contracts incepted between 1 April 2022 and 31 March 2023

	Actual Population as at 1 July 2021		Projected population as at 1 October 2022		Change	
Age	**Population**	**Age Distribution**	**Population**	**Age Distribution**	**Population**	**Age Distribution**
0-17	506,766	22.8%	510,744	22.4%	3,978	-0.4%
18-29	266,835	12.0%	282,846	12.4%	16,011	0.4%
30-39	289,494	13.0%	290,570	12.7%	1,076	-0.3%
40-49	356,756	16.0%	367,320	16.1%	10,564	0.1%
50-54	156,222	7.0%	160,078	7.0%	3,856	-0.0%
55-59	146,503	6.6%	149,156	6.5%	2,653	-0.1%
60-64	133,019	6.0%	136,312	6.0%	3,293	-0.0%
65-69	118,441	5.3%	121,681	5.3%	3,240	0.0%
70-74	100,709	4.5%	103,174	4.5%	2,465	-0.0%
75-79	73,804	3.3%	79,887	3.5%	6,083	0.2%
80-84	45,376	2.0%	48,027	2.1%	2,651	0.1%
85+	32,310	1.5%	34,983	1.5%	2,673	0.1%
Total	2,226,235		2,284,776		58,541	

Base Year Data

COVID-19 continues to distort the insurers information returns received to 30 June 2021. As such, the Authority have taken the view that it is not appropriate to base claims projections on data from July 2020 – July 2021. Thus, the data used for claims projections is the January to December 2019 claims data as this is the most recent non distorted claims data available to the Authority.

The Authority has taken the view that for RES 2022/2023 (i.e. in respect of policies renewing in the period 1 April 2022 to 31 March 2023) claims experience will revert to "normal" (pre-COVID) levels as indicated by the average claims implied by the 2019 data.

The Authority believe a reasonable method for projecting the average returned benefit per insured person for renewals from 1 April 2022 is to project the average returned benefits derived from the 2019 data to the mid-point of the claims expected to occur in respect of contracts incepted between 1 April 2022 and 31 March 2023. Ageing of the market is allowed for in the population projections.

Claims

A key assumption in the development of the RES recommendation is the assumption regarding changes in the level of claims year on year.

The total claims payments made by the open market insurers in 2019, 2020 and the first half of 2021 are set out in Table 4.9. It is noted that these figures exclude claim payments by restricted membership insurers.

Table 4.9 Claims paid by insurer

€ m	Irish Life Health	Laya Healthcare	Vhi Healthcare	Total
First Half 2019		[redacted]		1,113
Second Half 2019				1,135
2019 Total				**2,248**
First Half 2020				970
Second Half 2020				906
2020 Total				**1,876**
First Half 2021				1,026

The total claims paid in the first half of 2021 were €56m (6%) higher than the first half of 2020. This is a very different story to 12 months ago whereby claims paid in the first half of 2020 were €143m lower than the first half of 2019. The reduction in claims compared to 2019 and previous periods can be considered to be attributable to COVID-19, primarily due to the nationalisation of the Private Hospitals from April – June 2020, the cancellation of non-essential surgical procedures in both private and public hospital settings and reduced capacity. Despite the increase in claims relative to the second half of 2020, claims in the first half of 2021 are still much lower than pre-COVID levels (€87m lower than the first half of 2019). It is also worth noting when considering this analysis that the above data is on a claims paid basis and as such will reflect settlement delays. For that reason the impacts of COVID-19 will continue to be evident in future information returns.

[redacted]

Based on the above and due to reporting delays, the Authority is of the view that the information returns in HY2 2021 and HY1 2022 will continue to contain some level of distortion, as a result of COVID-19 and the Cyber-attack on the HSE. It is expected that the impacts will reduce over time assuming claims revert to pre-COVID-19 levels in the short to medium term.

Insurers provide details of claim payments that fall within the definition of "returned benefits" in information returns. The benefits included in information returns (described as "returned benefits") as a percentage of total claims paid for the second half of 2020 and for the first half of 2021 are set out in Table 4.10.

Table 4.10 Returned benefits as a percentage of total claims

Insurer	Returned Benefits July – Dec 2020	Returned Benefits Jan – June 2021
Irish Life Health	[redacted]	
Laya Healthcare		
Vhi Healthcare		
Total	87%	85%

The benefits excluded from Returned Benefits are primarily claims in respect of outpatient benefits. As we can see the proportion of total returned benefits included in total claims is reducing. As the data outlined in the table is impacted by COVID-19, we cannot yet determine if this is a temporary or short-term trend.

Table 4.11 splits out the returned benefit payments between those attributable to public hospitals, private hospitals, and to hospital consultants. The total returned benefits paid were €870m in the first half of 2021 compared to €758m in the second half of 2020. The increase of €112m is made up of increases in the payments to Private Hospitals (€96m) and Consultants (€38m) and is slightly offset by the reduction in Public Hospitals (-€21m). This is indicative of public hospital capacity being slower to recover and is also influenced by longer payment delays in public hospitals.

Table 4.11 Returned Benefits broken down by service provider

		Irish Life Health €m's	Laya Healthcare €m's	Vhi Healthcare €m's	Total €m's
First Half 2019	Public Hospital	[redacted]	[redacted]	[redacted]	234 (24%)
	Private Hospital				526 (54%)
	Consultant				214 (22%)
	Sub Total				*974*
Second Half 2019	Public Hospital				237 (24%)
	Private Hospital				544 (55%)
	Consultant				214 (21%)
	Sub Total				*995*
2019 Total					**1969**
First Half 2020	Public Hospital				224 (26%)
	Private Hospital				431 (51%)
	Consultant				191 (23%)
	Sub Total				*847*
Second Half 2020	Public Hospital				173 (23%)
	Private Hospital				421 (55%)
	Consultant				164 (22%)
	Sub Total				*758*
2020 Total					**1605**
First Half 2021	Public Hospital				152 (17%)
	Private Hospital				517 (59%)
	Consultant				202 (23%)
	Sub Total				*870*

We can also see from the above table the level of claims in HY1 2021 is still behind the claims in the same period in 2019 for each of the insurers and as such demonstrates that claims have not yet fully bounced back to pre-COVID levels. This is also evident in the chart below which shows a history of claims from 2017.

Chart 4.1: Historic levels of claims distribution by insurer

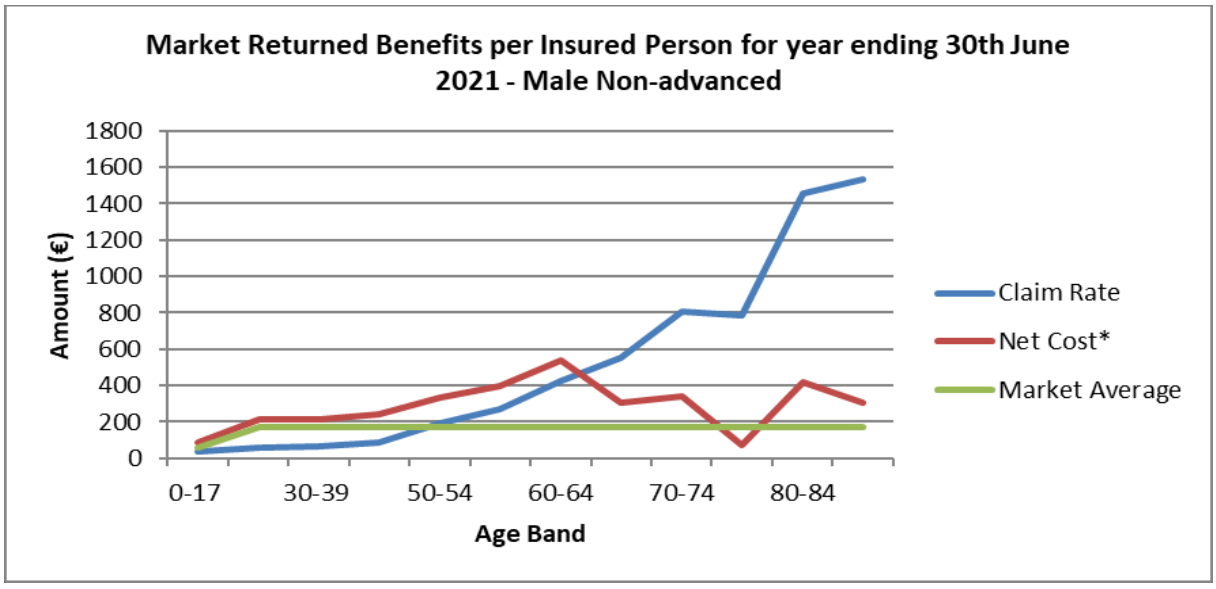
[redacted]

Average claim per member

The information returns provide returned benefit for each age, gender and product for each insurer for the second half of 2020 and the first half of 2021. The average returned benefit per insured person (i.e. the claim rate) for each age group and for the market is calculated from these returns. It should be noted that these figures are distorted by the reduction in returned benefits as a result of COVID-19.

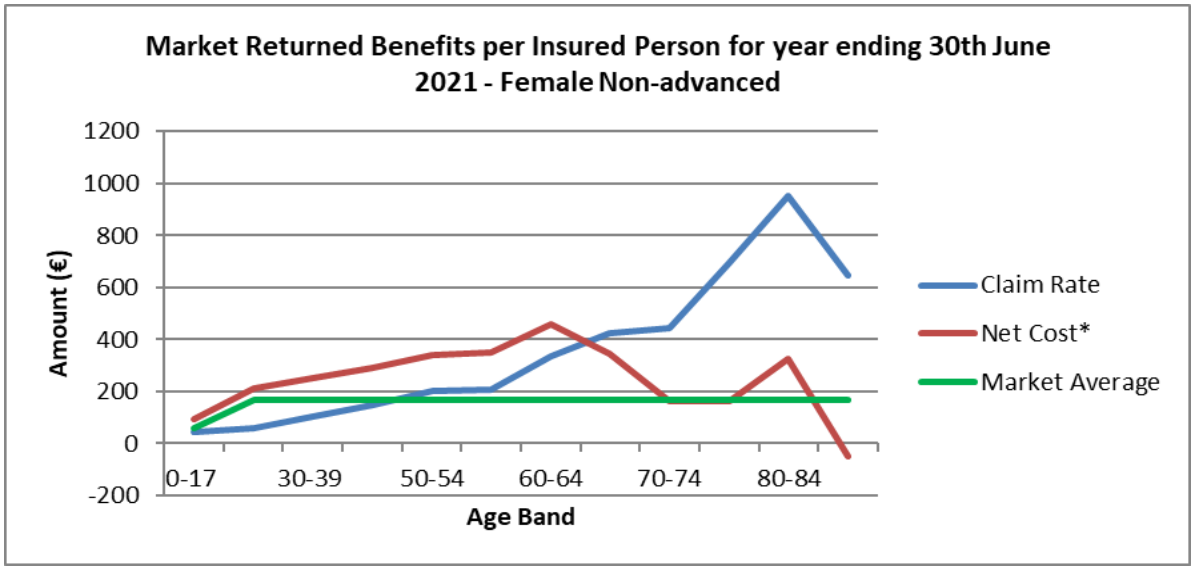
Charts 4.2 to 4.5 set out the average returned benefit by age, the market average returned benefits, and the corresponding net cost after application of the risk equalisation credits and stamp duties for the different age cohorts. This allows us to analyse the impact the credits and stamp duty have on the claim rates for the 12 months ending June 2021 for these different cohorts. It should be noted that the analysis uses credits and stamp duties based on those applicable for policies that were renewed or entered into between 1 April 2021 and 31 March 2022, while the market returned benefits are those settled during the year ending 30 June 2021 and as such could relate to contracts incepted over various periods. We can see from the charts below that the average net claims cost has fallen and is below the market average line at older ages for all products. This is an impact of COVID-19 and reporting lags could also be contributing to this. The average returned benefits for the period are much lower than expected when the risk equalisation credits were set, which lowers the average net claims cost giving the effects seen in the graphs below.

Chart 4.2



** Net Cost is defined as average returned benefit for July 2020 – June 2021 plus stamp duty less age and hospital utilisation credit for renewals from 1 April 2021 onwards. The same definition on Net Cost is applied to Charts 4.3 – 4.5 below.*

Chart 4.3



Application of Advanced Credits and Stamp Duty to Level 2 Products

Chart 4.4

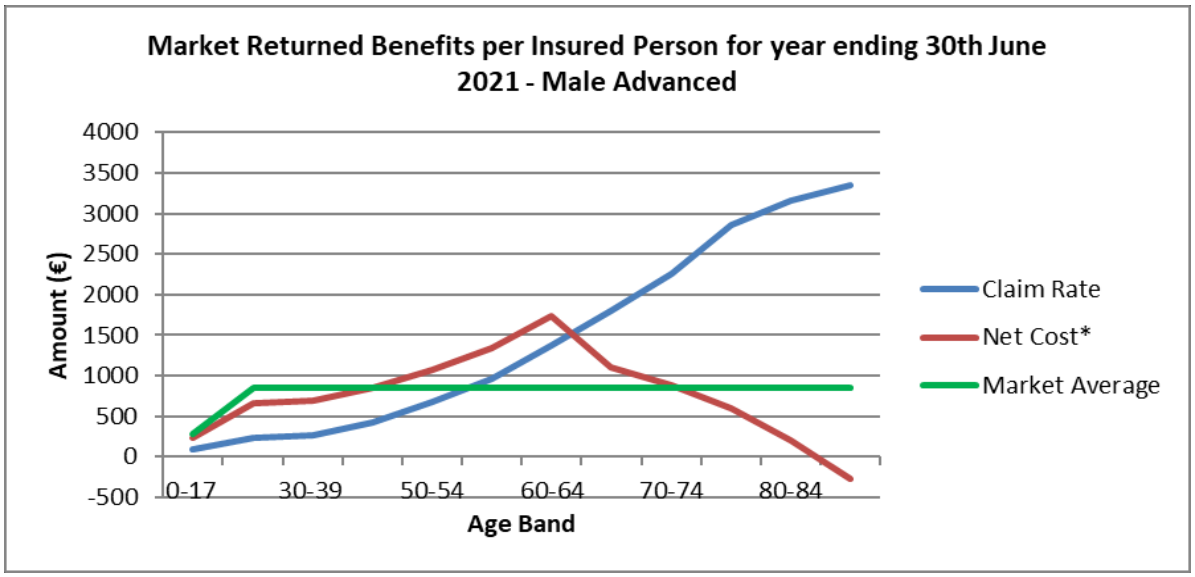
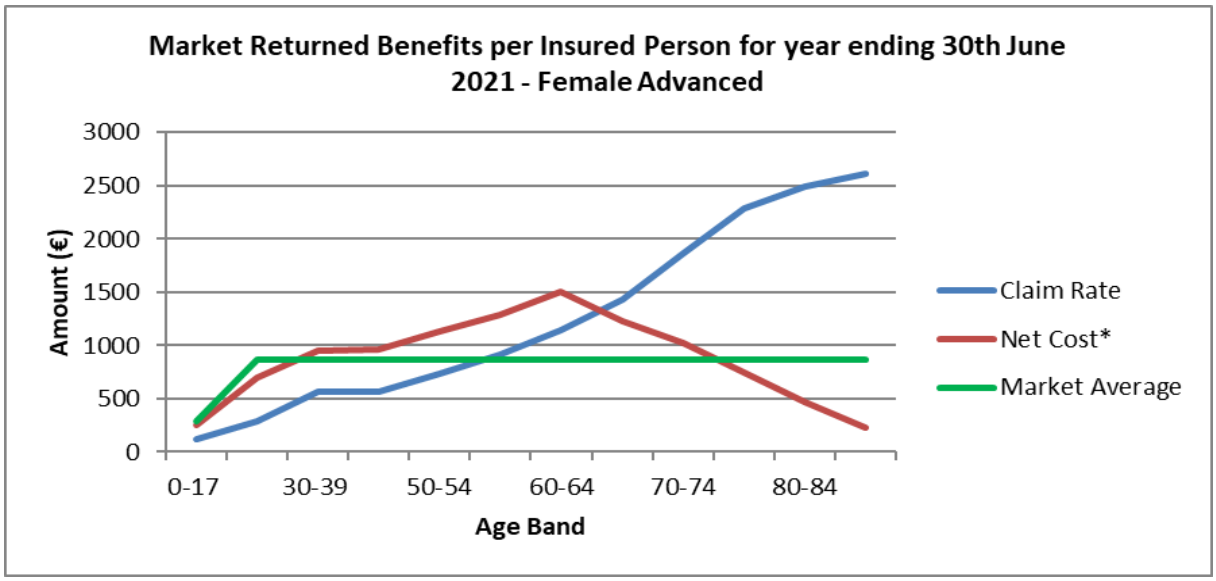


Chart 4.5



This analysis excludes the impact of refunds/benefit payments that the insurers made to consumers in response to their lower than anticipated claims during 2020.

The 60-64 age group is an outlier for both males and females with higher net costs at that age group compared to lives in the adjacent age groupings. This is due to no age credits applying to the 60-64 age group.

Average returned benefits by age

Last year the Authority decided that a reasonable method for projecting the average returned benefit per insured person for renewals from 1 April 2021 was to project the 2019 claims information with a claims inflation rate of 4% p.a. over the term of the projection applied per age band. It was also assumed that there would be selection effects of the assumed reduction in population under age 60 and thus average claims costs were expected to increase.

Due to the distortions caused by COVID-19 over 2020 we have compared the average returned benefits in the 12 months to 30 June 2021 to the average returned benefits for the 12 months to 30 June 2019 (as it has no COVID-19 distortions). The figures for June 2019 vs June 2018 are included in brackets.

Table 4.12 Comparison of average returned benefits at June 2021 and June 2019

Age Group	Irish Life Health	Lava Healthcare	Vhi Healthcare	Market
0-17	[redacted]			-39.1% (-3.4%)
18-29				-11.3% (-2.9%)
30-39				-16.7% (2.3%)
40-49				-15.1% (1.5%)
50-54				-12.6% (0.2%)
55-59				-14.2% (0.9%)
60-64				-14.3% (1.3%)
65-69				-19.7% (3.1%)
70-74				-22.3% (1.1%)
75-79				-25.4% (0.6%)
80-85				-30.8% (1.0%)
85+				-36.0% (-4.1%)
All Ages				-20.3% (1.5%)

We can clearly see the impact of COVID-19 on average claims across all ages. As noted previously the average returned benefits in the 12 month period to 30 June 2021 will have been impacted by the nationalisation of private hospitals in Q2 2020 due to reporting delays, which is a key driver in the reduction over that 12 month period. In Appendix 1 tables we have included a yearly history of the change in average returned benefits in tables A1.3 and A1.4.

Claims inflation

In setting the claims inflation assumption for 2022/2023, the Authority must consider the average claims across the market.

Historical claims data has showed that average returned benefits at all ages has been falling in recent years, ignoring 2020 and 2021. Whilst the change in average returned benefits from year to year has been volatile and not consistent across all ages (due in part to the relatively low numbers of claims involved for some age cohorts), in 2017 to 2019 there was no evidence of average claims inflation of 4% at any age. Whilst the cost per individual claim may be going up, the growth in the insured population over the past number of years is working to lower the actual average claim across all insured lives not just those making claims.

The table below shows the percentage change in the average returned benefit per insured person for all levels of cover in a 12 month period relative to the previous 12 months. E.g. for 2018 the data shown is the percentage change in average returns benefits per insured person from the 12 month period ending in June 2017 to the twelve month period ending in June 2018.

Table 4.13 Change in average returned benefits relative to prior 12 months

Age Group	2015	2016	2017	2018	2019	2020
0-17	4%	21%	-11%	-18%	-3%	-13%
18-29	3%	-1%	-5%	-5%	-3%	-8%
30-39	-3%	4%	-4%	-8%	2%	-8%
40-49	-2%	0%	-2%	-1%	2%	-9%
50-54	-1%	1%	-4%	1%	0%	-13%
55-59	3%	5%	-7%	-1%	1%	-8%
60-64	0%	7%	-5%	-1%	1%	-6%
65-69	5%	2%	-4%	-4%	3%	-8%
70-74	4%	9%	-7%	-4%	1%	-8%
75-79	8%	7%	-6%	-2%	1%	-9%
80-85	18%	2%	-2%	-9%	1%	-9%
85+	21%	4%	0%	-7%	-4%	-9%
All Ages	7%	5%	-3%	-3%	2%	-8%

The change in average returned benefit seen in 2020 and 2021 is distorted by impacts of COVID-19 but 2017,2018 and 2019 experience, whilst fluctuating, does not support a claims assumption of 4% p.a. at any age cohort.

Insurers were asked for their views on the outlook for claims inflation and the responses varied. All three expect higher claims inflation in the short term during the remainder of 2021 and into 2022 but from 2022 into 2023 the responses ranged from 3% to 8%, with varying responses for private, consultant and public hospital related claims.

The overall level of claims is impacted by several factors. One is the mix of over-night and day cases. As the sector transitions from over-night to day cases for some procedures, the level of claims declines. Another driver is the mix between procedures in public and private hospitals. Public hospital

charge is set by the HSE/Dept of Health. Claims in public hospitals account for approximately 25% of total claims, based on 2019 data. At the point of drafting this report, there was no indication of any change in this charge for 2022/2023. Assuming no change in the daily rate charged for private patients in public hospitals, this leaves an estimated 75% of claims which may be subject to inflation.

The Authority feels that there is insufficient evidence to support 4% p.a. average claims inflation and proposes a reduction to 3% p.a.

The method for projecting the average returned benefit per insured person for renewals from 1 April 2022 is to project an increase of 3% p.a. over the term of the projection to the actual age specific market claims cost per insured person determined for the 12 months to end December 2019.

This assumption does not include the impact of changing demographics which is provided for in the population projections, and which is expected to contribute a further 1% p.a. to claims inflation over the period.

Utilisation

Information returns include separate details of the number of hospital inpatient days and day case admissions (hospital days) paid for by insurers in respect of their private patients' admissions. The total number of nights/ days in the last two years paid by the open membership undertakings is set out in Table 4.14. We note there are distortions in the below information caused by data issues as noted in Appendix 6. We have not been provided with revised returns for prior periods which would impact the information presented below. The impacts of COVID-19 is also evident in the data below for 2020 and 2021.

Table 4.14. Total number of hospital days

000's	Overnight	Day case	Total
First Half 2018	572	306	878
Second Half 2018	564	308	872
First Half 2019	538	292	830
Second Half 2019	546	311	856
First Half 2020	489	237	726
Second Half 2020	356	231	587
First Half 2021	373	269	643

The data shows that the total hospital days have increased in the first half of 2021 by 9.6% compared to the second half of 2020 which indicates some signs of recovery in utilisation. It also shows that days have increased by more than nights indicating day procedures have bounced back faster than nights but some of this could be impacted by timing of payments with day cases typically being settled faster. We can also see that despite the bounce back relative to the second half of 2020, hospital days are still behind levels seen in 2019, with total hospital days being 77% of those in the same period in 2019.

Table 4.15 shows the split by insurer for the January to June 2021 time period.

Table 4.15 Total number of nights/days by insurer

000's	Overnight	Day case	Total
Irish Life Health	[redacted]		
Laya Healthcare			
Vhi Healthcare			
Total	**373**	**269**	**643**

The proportion of days to total hospital days is quite varied between insurers, [redacted]

[redacted]

[redacted] [redacted] [redacted] . We note some of this information is likely be impacted by the data issues as noted in Appendix 6. This compares to days representing on average 35% of total hospital days during 2018 and 2019. The above splits could be a short-term impact due to day services being able to increase capacity and turnover faster than night services, in response to COVID restrictions.

Bed night inflation

Similar, to average returned benefits, we have not used the data in respect of January 2020 –June 2021 when setting base hospital utilisation rate. This is due to distortions in the data, due to the impact of COVID, as evident in Table 4.14.

In order to project utilisation rates for 2022/2023, the average overnight stays and day case days per insured person for the 12 months from January 2019 to end December 2019 were calculated for each age group/gender/level of cover/insurer. We then apply an assumption regarding growth in utilisation for the 2022/2023 period i.e. bed night inflation.

There has been a downward trend in the total level of hospital days (days and nights) claimed over the last number of years, ignoring 2020 and 2021. This is made up by a decrease in overnight stays at the majority of ages which has been marginally mitigated by increasing day cases for some ages but an overall impact of falling days. Table 4.16 shows a 5 year history of the change e.g. for 2016 the data shown is the percentage change in days/nights in the 12 month period ending in December 2016 relative to the twelve month period ending in June 2015. It shows in the period 2017-2018 hospital days have been falling.

Table 4.16 Percentage change in Hospital Days

Market	2016	2017	2018	2019	2020
Nights	5%	-10%	-6%	-5%	-22%
Days	8%	-2%	-3%	-2%	-22%
Nights & Days	6%	-7%	-5%	-4%	-22%

The historical change in average nights/days by insured person (i.e. utilisation factor) at each age is outlined below. Whilst the Authority notes that there have been historical data issues from the insurers in submitting this information which will have an impact on the analysis, the Authority does not consider that it would change the overall trends emerging. The datashows that at the majority of ages during the period 2017-2019 the utilisation factors have been decreasing. E.g. for 2018 the data shown is the percentage change in average day case days per insured person from the 12 month period ending in December 2017 to the twelve month period ending in December 2018.

Table 4.17 Change in average day case days per insured person

Age Group	2016	2017	2018	2019	2020
0-17	2%	-18%	-12%	-9%	-35%
18-29	3%	-8%	-7%	-14%	-13%
30-39	2%	-7%	-10%	-7%	-26%
40-49	1%	-2%	-8%	-7%	-24%
50-54	0%	-4%	-6%	-9%	-24%
55-59	1%	-4%	-7%	-5%	-23%
60-64	6%	-5%	-8%	-2%	-25%
65-69	3%	-6%	-5%	-5%	-26%
70-74	6%	-6%	-5%	-4%	-24%
75-79	5%	0%	-3%	-1%	-24%
80-85	3%	3%	-2%	1%	-26%

85+	8%	3%	2%	2%	-26%
All Ages	4%	-2%	-4%	-3%	-25%

Table 4.18 Change in average night case days per insured person

Age Group	2016	2017	2018	2019	2020
0-17	9%	-28%	-19%	-10%	-23%
18-29	-5%	-13%	-14%	-6%	-16%
30-39	4%	-17%	-7%	-7%	-17%
40-49	-2%	-13%	-3%	-8%	-21%
50-54	0%	-13%	-9%	-9%	-23%
55-59	-1%	-17%	-7%	-6%	-28%
60-64	2%	-10%	-13%	0%	-26%
65-69	0%	-12%	-10%	-2%	-27%
70-74	1%	-16%	-9%	-6%	-24%
75-79	4%	-12%	-8%	-12%	-27%
80-85	-3%	-7%	-14%	-8%	-27%
85+	-3%	-4%	-7%	-17%	-27%
All Ages	-1%	-9%	-9%	-11%	-26%

There is also a physical limit to capacity and supply of beds. The Authority is not aware of any increase in available hospital capacity coming on board in the period which is under consideration. As a result, the Authority consider 0% p.a. an appropriate assumption in aggregate. The Authority has taken the position that utilisation by age band will not be more than the rates implied by the 2019 data. The Authority will keep this assumption under review.

The Authority are recommending, therefore, that the bed night inflation (the assumed increase in hospital utilisation) assumption is reduced from 1% p.a. to 0% p.a.

High Cost Claims

The HCCP data provided by the three open market insurers was provided during 2021 to support the calibration of the HCCP both on an incurred basis (timing of provision of health services) and on a claims paid basis. The data was prepared by the insurers on a best endeavours basis and has not been subject to external review or audit. As the process is not fully embedded in the insurers' processes it is possible that further refinements may be made which may impact on the results of the analysis prepared. If the HCCP is implemented, the Authority will require data from insurers in relation to their past claims' history for insured lives with high cost claims on a bi-annual basis with their information returns.

The proposed calibration is a HCCP with a 40% Quota Share and €50,000 claims excess. We have set out the total amounts claims expected to be included in the HCCP (before allowing for quota share and claims excess and before allowing for inflation) for this calibration below:

Table 4.19 HCCP data showing number of claims exceeding €50,000

No. of claims exceeding €50,000 – Raw Data				
Age Group	**Irish Life health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
0-17	[redacted]			136
18-29				101
30-39				151
40-49				289
50-54				198
55-59				319
60-64				411

65-69	[redacted]			553
70-74				661
75-79				604
80-85				512
85+				354
All Ages				4,289

Table 4.20 HCCP data showing value of claims exceeding €50,000

Total claims exceeding €50,000 – Raw Data				
Age Band	**Irish Life health €m**	**Laya Healthcare €m**	**Vhi Healthcare €m**	**Market €m**
0-17	[redacted]			€11
18-29				€7
30-39				€12
40-49				€22
50-54				€17
55-59				€26
60-64				€33
65-69				€45
70-74				€53
75-79				€48
80-84				€39
85+				€27
Total				€340

We note cross-over periods will not apply for the first year of the calibration and as such have not been included in our calculations. No allowance has been made for rolling claims. Full detail of the HCCP proposal is included in Appendix 5.

Financial Position of the Risk Equalisation Fund

In the Risk Equalisation Scheme, the Authority recommends the amounts of stamp duty having considered the aims set out in Section 7E(1)(b) one of which is to have regard to the aim of avoiding the REF sustaining surpluses or deficits from year to year.

Table 4.21 Projected Surplus in REF

€m	**Retained Revenue Reserves 31/12/2020**	**Projected Surplus/deficit at end of claim period**
01/01/2013 – 31/03/2019 Contracts	48.2	50.0
01/04/2019- 31/03/2020 Contracts	31.8	34.6
01/04/2020 - 31/03/2021 Contracts	7.7	3.0
01/04/2021 – 31/03/2022 Contracts	0.0	13.4
Investment Income Less expenses	(1.9)	(1.8)
Other	0.3	0.8
Total	**86.1**	**100.0**

When setting credits in last year's report the Authority assumed an initial surplus of €43m which was expected to be exhausted due to the expectation that expected allocated credits would exceed expected stamp duty receipts by €43m. This estimation and indeed the risk equalisation credits and stamp duties assumed that capacity would revert to normal levels when the credits would apply and that there would be a shrinkage in the insured population i.e. lower stamp duty would be collected. However, over the last 12 months hospital usage and claims have continued to be impacted by COIVD-

19 and the insured population has increased, both of which has contributed to a larger than expected surplus within the REF.

In aggregate, the Authority has assumed that there will be a surplus of circa €100m in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2022 are fully earned.

Summary of Key Assumptions

	1 April 2022 to 31 March 2023	**1 April 2021 to March 2022**
Base Claims data	2019 data	2019 data
Claims inflation p.a.	3.0%	4.0%
Bed night inflation p.a.	0.0%	1.0%
Participation at mid-point of projection period (1 Oct 2022/1 Oct 2021)	€2.285 m	€2.103 m
REF surplus	€100 m	€43 m

Our recommendation based on the above assumptions is outlined in Section 7 and some sensitivities to the assumptions are included in Appendix 3.

5. Market Developments

COVID-19 Impact

COVID-19 continued to disrupt the usage of health insurance / hospitalisation services into the first half of 2021. The disruption since March 2020 is reflected in the Information Returns from insurers for January – July 2020, July – December 2020 and January – July 2021 although the full effects of COVID-19 and the cyber-attack on the HSE in May 2021 will only become clear in subsequent Information Returns. The future impact on the private health insurance market and any long term impacts it may have on the usage and provision of health care as well as any potential adverse economic effects is uncertain at this time.

Analysis of the Information Returns shows that the reduction in claims due to COVID-19 varies by the age of the policyholder (see table A1.3 and A1.4 in Appendix 1), although claims across all ages and insurers have reduced significantly when compared to pre-COVID levels. In monetary terms, the reduction has been much larger for older lives, as their normal expected claims costs are higher.

All three insurers have made some form of refund to policyholders in response to their period of reduced claims activity in 2020. [redacted]

Product Developments

The number of inpatient plans on sale in the market by the three open membership insurers has increased marginally in the last year with 312[8] inpatient private health insurance plans on the Product Register on 31 July 2021 (excluding restricted undertakings). This is an increase of 6 plans since 31 July 2020. Of the 312 plans available at 31 July 2021, Irish Life Health provide 122 plans, Laya Healthcare 105 plans and Vhi Healthcare 85 plans.

Segmentation/ Competition

The claims arising in respect of older age groups are typically higher and more frequent than for younger age groups. Insurers therefore remain incentivised to use various marketing and other strategies to segment the market. Product developments and special offers have reflected these incentives. Newer products offering better value than existing comparable products are marketed to newer and younger customers. Product developments have tended to concentrate on providing cover attractive to younger healthier customers but less attractive to older, less healthy customers. All insurers have products with reduced orthopaedic benefits in private hospitals, with approximately 65% of the market insured under these plans.

This segmentation, as well as a greater reluctance amongst older people to change product / insurer and the fact that older people are likely to have products with higher benefits, has resulted in a situation where older people, on average, pay significantly higher premiums than younger people.

Table 5.1 Average returned benefits and average net claims

	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €	Total Market €m's
Average Returned Benefit per insured person (June 2020 - June 2021)					
18-64	[redacted]			585	581
Over 65's				2,166	565

[8] This counts each of Irish Life Health's core plans as one plan, rather than counting each permutation of cover linked to a core plan as one plan.

Average Net Claim per insured person (June 2020 - June 2021)					
18-64	[redacted]			988	919
Over 65's				816	643
Average Gross of Tax Relief Premiums per insured person (June 2020 - June 2021)					
18-64	[redacted]			1,586	1,549
Over 65's				2,069	1,764
Average Difference per insured person (June 2020 - June 2021)					
18-64	[redacted]			598	629
Over 65's				1,253	1,121
	Irish Life Health €	**Laya Healthcare €**	**Vhi Healthcare €**	**Weighted Market Average €**	**Total Market €m's**
Average Returned per insured person (June 2019 – June 2020)					
18-64	[redacted]			627	609
Over 65's				2,647	669
Average Net Claim per insured person (June 2019 – June 2020)					
18-64	[redacted]			1,028	999
Over 65's				1,084	274
Average Gross of Tax Relief Premiums per insured person (June 2019 – June 2020)					
18-64	[redacted]			1,551	1,528
Over 65's				2,012	508
Average Difference per insured person (June 2019 – June 2020)					
18-64	[redacted]			523	530
Over 65's				928	235

Table 5.2 Differences in Average returned benefits and average net claims

	Irish Life Health €	**Laya Healthcare €**	**Vhi Healthcare €**	**Weighted Market Average €**	**Total Market €m's**
Average Returned Benefit per insured person (Difference)					
18-64	[redacted]			(42)	(28)
Over 65's				(480)	(104)
Average Net Claim per insured person (Difference)					
18-64	[redacted]			(40)	(18)
Over 65's				(268)	(61)
Average Gross of Tax Relief Premiums per insured person (Difference)					
18-64	[redacted]			35	71
Over 65's				57	31
Average Difference per insured person (Difference)					
18-64	[redacted]			75	88
Over 65's				325	91

It should be noted that the average returned benefits in the 12 month period to 30 June 2021 will have had a greater exposure to the impacts of COVID-19 and the nationalisation of private hospitals due to the fact that returned benefits are based on settled claims and the impact of settlement delays. This has resulted in lower returned benefits in the 12 months to 30 June 2021 compared to the previous 12 month period.

The "Difference" rows in the above table do not represent profit for different age groups with different insurers. This is because *inter alia* the average premium, average claim and Risk Equalisation Credits do not relate to precisely the same time period, there is no allowance for expenses and there is no allowance for claims not included in returns to the Authority. The average premium figures do not allow for any COVID-19 related refunds/benefit payments. However, the table does provide an

indication of the relative level of profitability for different age groups and shows that, profitability is significantly higher for older lives this year when compared to last year.

This could be indicative of reduced claims as a result of COVID-19 as the age credits would have assumed a higher level of average claims for older lives. The same could be said of younger lives as the average level of profitability has increased. However, the impact is more pronounced for older lives because age credits are received for them. If average claims were to reduce on a sustained basis going forward that age credits should also reduce, as the net claims cost for older lives is calibrated to target 133.5% of the market net claims costs in line with the claims cost ceiling. However, the insurers' view is that whilst throughput is currently lower that normal levels of usage will resume from 2023. Notwithstanding, age credits are a substantial portion of the total credits distributed and thus, in the event of reduced hospitalisation and claims levels, may not be as effective at targeting credits as other more health related measures might do, e.g. DRGs, HCCP or HUC to a lesser extent, which supports the argument for the introduction of a HCCP. Furthermore, a reduction in claims in respect of older lives may make them more attractive to the insurers if viewed as potentially more profitable.

6. Overcompensation

Accounts of the net beneficiary

Profitability of Registered Undertakings

Section 7E(1)(b)(iii)(I) of the Health Insurance Acts requires that credits are set with a view to avoiding overcompensation for a net beneficiary of the RES:

> *"the amounts of the risk equalisation credits that the Authority considers, after having regard to such evaluation and analysis, would need to be afforded, under the Risk Equalisation Scheme, to persons insured by registered undertakings (other than restricted membership undertakings) having regard to the principal objective (in so far as the principal objective relates to relevant contracts), the aim of avoiding overcompensation being made to a registered undertaking or former registered undertaking…."*

The Authority carried out an assessment of whether overcompensation has occurred in the three-year period 2018 – 2020 using actual insurer's certified financial statements. The Authority determined that one registered undertaking (insurer), Vhi Insurance DAC, was a net beneficiary of the RES. The Authority also determined that Vhi Insurance DAC had not made a profit which was in excess of the reasonable profit in respect of the above mentioned relevant period according to the provisions of the Health Insurance Acts.

Vhi Insurance DAC have provided financial data setting out their expected profitability over the period 2021 – 2023, as set out below, to enable the Authority to understand whether the credits proposed for the RES calibration in respect of contracts entered into in the period 1 April 2022 – 31 March 2023 are calibrated such that they would avoid overcompensation occurring.

€m	2020	2021	2022	2023
Open Market Size				
Vhi (excl. Plan P)				
Market Share				
Income				
Claims				
Return of Value				
Net RES				
Reinsurance				
Admin				
UW Profit				
Investments				
PAT				
Sales				
Return				
3 yr ROS				

Vhi Insurance DAC have noted in their projections that they expect moderate increases in stamp duty. They have assumed ARHC decrease and HUC and HCCP credits increase and they have also assumed young adult rates are extended to 35 in 2022. For the 2022/23 RES calibration the Authority proposes significant reductions in the levels of stamp duty largely as a result of the expected surplus within the REF, which isn't reflected in Vhi Insurance DAC's projections. The Authority is of the view that the 2022/23 RES calibration once enacted should be factored into the insurers' pricing basis and as such the premium levels reflected in the financial projections provided to the Authority will change to reflect the latest RES calibration. As such, the Authority would not expect overcompensation to occur on the assumption that experience follows the assumptions underpinning the RES calibration and assuming Vhi Insurance DAC reduces their premiums based on the calibration presented to them.

In relation to overcompensation, the Authority, at the request of the Department of Health, has prepared a pre-draft of Regulations concerning the annual financial statements that insurers are required to furnish to the Authority for the purpose of the overcompensation assessment as regards the RES as per Section 7F(1) of the Health Insurance Acts. The insurers have been consulted with on these draft regulations and work is ongoing in relation to this. Section 7F(2)(b) of the Health Insurance Acts states: "The Minister may prescribe the bases for the calculation of costs, premia and other relevant financial data that are to be included in a statement of profit and loss or balance sheet to be furnished to the Authority pursuant to subsection (1)." This has not been allowed for in any considerations relating to overcompensation within this report.

7. Recommendation on Risk Equalisation Credits and Stamp Duty

The Authority acknowledges that there is a range of potentially acceptable options for the stamp duty and Risk Equalisation Credits that could apply for contracts commencing in the period 1 April 2022 to 31 March 2023. The lingering effects of COVID-19 bring a greater degree of uncertainty regarding likely usage levels of private health services, associated level of claims, and insured population. In developing these recommendations, the Authority has struck a balance between the level of stamp duty paid by all policyholders and the level of compensation paid to insurers in respect of older and/or sicker lives. In considering this balance, the Authority has had regard to all of the objectives set out in Section 7E(1)(b) and in particular this year the objectives of market sustainability and fair and open competition.

The recommendation calculates credits by gender, product level and age such that for each age group over 65, the net cost should not be more than a specified percentage, the net claims cost ceiling, of the average net cost across all groups. A Hospital Utilisation Credit is applied for overnight inpatient stays and for day stays.

HCCP Parameters

For the first year of the inclusion of the HCCP (2022/2023), the Authority is recommending that the HCCP credits are based on a ***40% quota share*** on claims in ***excess of €50,000***. We note the impact of rolling quarters will not apply for the first year of the calibration and as such have not been included in our calculations. The estimated size of the credits to be distributed in respect of the HCCP for 2022/23 is €55m or 6% of the overall credits.

Full detail of this proposal is included in Appendix 5. As noted, at the time of writing this report, the inclusion of a HCCP in the RES has not yet been approved by the European Commission and as such the Authority have put forward recommendations with and without the inclusion of a HCCP.

Hospital Utilisation Credits

The Authority is not recommending any change in the level of day or night hospital utilisation credits. The level of these credits will remain as:

Table 7.1 HUC rates

	Hospital Utilisation Credit for contracts commencing 1 April 2022 to 31 March 2023
Overnight	€125
Days	€75

HUC currently is the only credit paid related to the actual health status of an individual policy holder as measured by usage of health services. With the introduction of the HCCP, there will be in increase in the overall level of credits paid associated with health status. For this reason, the Authority did not see a rationale to increase the level of HUC paid.

Ratio of Non-Advanced to Advanced Stamp Duty

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. The Authority is proposing to set the Stamp Duty for Non-Advanced contracts at ***30%*** of the stamp duty relating to Advanced contracts.

Non-advanced products tend to cover access to public hospitals. The impact of COVID and the HSE cyber-attack has fallen predominantly on access to services in public hospitals, disproportionately affecting those with non-advanced products. It is not certain that the number of cases treated in public hospitals return to 2019 levels, even by 2022. With the likely lower level of claims associated with

non-advanced products, therefore, the Authority considered it appropriate to lower the ratio of stamp duty for non-advanced products from 35% to 30%.

Application of €100m of REF Surplus to 2022/23 Stamp Duty

After careful consideration, the Authority is of the view that there is likely to be a ***surplus of circa €100m*** in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2022 are fully earned. The Authority has estimated that the REF is likely to be positively impacted due to lower levels of hospitalisations as a result of COVID-19 together with an increase in expected levels of stamp duty receipts due to resilience experienced in the market relative to expectations.

This is an exceptionally large surplus relative to prior years and is a consequence of two factors. First, claims and hospitalisations were lower than projected when the risk equalisation credits and stamp duties which applied during 2020 and 2021 were set. Second, the population with health insurance was higher than projected which generated additional stamp duty without a corresponding increase in claims. Under Section 7E(1) of the Health Insurance Act 1994, the Authority must have regard to this surplus and credits and stamp duties must be set with the "*aim of avoiding the Fund sustaining surpluses or deficits from year to year*". The RES is designed to be self-funding, and any surplus/deficit arising impacts the RES in future periods.

The Authority has therefore recommended that this estimated surplus of €100m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2022 to 31 March 2023.

The Authority acknowledges that similar reductions will not be facilitated in later years and as such there could be an increase in stamp duty next year assuming all else is equal and that the surplus is fully extinguished in line with expectations. The Authority considers that such increases can be managed by both the Authority in their future recommendations and the insurers in their product pricing. The health insurance market has proven itself to be resilient over the past two years.

Stamp Duty

The Authority is recommending that the stamp duties that would need to be paid by the insurers on policies that are renewed or entered into between 1 April 2022 and 31 March 2023, in order to meet the cost to the Risk Equalisation Fund ("REF") of the recommended Risk Equalisation Credits, are as follows:

Table 7.2 Stamp Duty recommendation for contracts incepted 1 April 2022 – 31 March 2023

Age Band	**Stamp Duties from 1 April 2022 to 31 March 2023**		**Stamp Duties from 1 April 2021 to 31 March 2022**		***Change***	
	Non-Advanced	**Advanced**	**Non-Advanced**	**Advanced**	***Non-Advanced***	***Advanced***
17and under	€41	€135	€52	€150	*(€12)*	*(€14)*
18 and over	€122	€406	€157	€449	*(€35)*	*(€43)*

The fall in stamp duty relative to last year is largely due to the expected REF surplus of €100m.

Age Related Health Credits

The Age Related Health Credits for Advanced ("ARHC") cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). The ARHC for Non-Advanced cover contracts are based on the average claim costs for Non-Advanced contracts. Adjusted claims costs for Non-

Advanced contracts aged over 65 are calculated by applying the average ratio of Non-Advanced claims cost to Level 2 claims cost for all ages over age 65 combined. The average claims costs are based on claims arising in the Jan 2019 – Dec 2019 time period since the claims arising in January 2020 - July 2021 are distorted as a result of COVID-19.

The recommendation as outlined below is based on the assumptions outlined in Section 4 of the report.

The Authority proposes that the following Risk Equalisation Credits should apply for health insurance policies that are renewed or entered into between 1 April 2022 and 31 March 2023.

Table 7.3 Risk Equalisation Credits for contracts incepted 1 April 2022 – 31 March 2023

Age Related Health Credits (ARHC)								
Age / gender / level of cover credits from 1 April 2022 – 31 March 2023					***Change from current credits***			
	Non-Advanced		**Advanced**		***Non-Advanced***		***Advanced***	
	Male	**Female**	**Male**	**Female**	***Male***	***Female***	***Male***	***Female***
64 and under	€0	€0	€0	€0	*€0*	*€0*	*€0*	*€0*
65-69	€325	€150	€950	€500	*(€25)*	*(€50)*	*(€75)*	*(€50)*
70-74	€500	€350	€1,575	€1,075	*(€50)*	*(€50)*	*(€100)*	*(€75)*
75-79	€775	€575	€2,375	€1,700	*(€50)*	*(€50)*	*(€125)*	*(€100)*
80-84	€950	€650	€2,975	€2,125	*(€75)*	*(€50)*	*(€175)*	*(€125)*
85+	€1,150	€775	€3,550	€2,425	*(€100)*	*(€50)*	*(€200)*	*(€125)*
Hospital Utilisation Credit (HUC)								
Night		**Day**			*Night*		*Day*	
€125		€75			*No change*		*No change*	
Hight Cost Claims Pool (HCCP)								
Quota Share 40%					*First year of this credit*			
Threshold €50,000					*First year of this credit*			

The above recommendation assumes the new RES incorporating a HCCP is approved by the EU Commission and is implemented into law prior to 1 April 2022. The Authority's proposed calibration in respect of the HCCP, which is currently the subject of consideration by the EU Commission, is set out in Appendix 5 and is unchanged from the proposals made to Department of Health in June 2021. We note cross-over periods will not apply for the first year of the calibration and as such have not been included in our calculations.

Alternative Recommendation

In the event that a HCCP is not implemented by April 2022 there will be no credits payable in respect of a HCCP. The ARHC as outlined above would change as follows:

Table 7.5 Age related health credits for contracts incepted 1 April 2022 – 31 March 2023 assuming no HCCP

Age / gender / level of cover credits from 1 April 2022 - 31 March 2023					***Change from current credits***			
	Non-Advanced		**Advanced**		***Non-Advanced***		***Advanced***	
	Male	**Female**	**Male**	**Female**	***Male***	***Female***	***Male***	***Female***
64 and under	€0	€0	€0	€0	*€0*	*€0*	*€0*	*€0*
65-69	€350	€200	€1,075	€600	*€0*	*€0*	*€50*	*€50*
70-74	€550	€400	€1,725	€1,200	*€0*	*€0*	*€50*	*€50*
75-79	€825	€600	€2,550	€1,825	*€0*	*(€25)*	*€50*	*€25*
80-84	€1,025	€700	€3,175	€2,275	*€0*	*€0*	*€25*	*€25*

85+	€1,225	€825	€3,775	€2,575	*(€25)*	*€0*	*€25*	*€25*

The stamp duty recommendation as outlined in Table 7.2 would still apply and the HUC rates of €125/€75 would also continue to apply.

Sensitivities

In coming to the recommendation, the Authority have looked at a number of sensitivities on the recommendation for the 2022/2023 RES. Detail of the impact of the sensitivities versus the recommendation are included in Appendix 3.

Rationale for the Recommendations

The principal aims of the Authority in terms of avoiding risk selection and market segmentation are key in terms of maintaining market stability. There is a balance between an increased effectiveness percentage and the levers available to calibrate the RES.

The recommendation has been set as so to strike a balance between sustaining community rating by keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger healthier consumers in the market while maintaining the effectiveness of the RES.

The Authority considers that the recommendation strikes an appropriate balance between its objectives:

- The recommendation increases the effectiveness[9] of the RES from 30.3% to 43.6% (30.9% if no HCCP) based on the Authority's defined measure of effectiveness and assuming a HCCP is implemented. We note that the effectiveness of the recommendation is increased significantly by the inclusion of the HCCP. The inclusion of a HCCP in the RES acts as a measure to help reduce the risk of risk selection. This is because the HCCP provides a level of compensation for the largest claims / highest risks and thus should help to reduce incentives for insurers to target less risky and more profitable customers;
- The recommendation is allocating more credits based on actual health status across all ages and is sharing risk for low incidence high cost claims. This is contributing to more targeted distribution of health-related credits. This should serve to decrease insurers incentives to segment and risk select, and encourage insurers to compete on efficiencies;
- The projected net claims cost at all ages is lower than those projected last year at all ages, with the greatest reductions at younger ages (assuming a HCCP is introduced) which should contribute to competition, support stability and sustainability of the market; and
- The lower stamp duty and the reduction in the Non-advanced relative to the Advanced should serve to address concerns about affordability and stability of the market at the current uncertain time. The Authority is of the view that it is only fair that consumers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurer's product pricing.

[9] "R-squared weighted average variance" measure which considers the change in the square of the deviations (before and after the RES) of the average claims for each insurer to market average claims at each age band relative to the market average claim weighted by claims costs before application of the RES

8. Projected impact of recommendation

Set out below are details of the expected impact of the inclusion of the recommended calibration (with and without a HCCP) relative to the projected impacts of the RES calibration for contracts commencing in the period 1 April 2021 to 31 March 2022.

Impact on stamp duty

The table below reconciles the change in stamp duty relative to the stamp duty recommended last year. The fall in stamp duty is largely driven by the change in REF surplus as outlined below.

Table 8.1 Reconciliation of change in stamp duty

Reasons for Change of Advanced cover Adult Stamp Duty from 2021 enacted to 2022 recommended	Non-Advanced Stamp Duty	Advanced Stamp Duty	Effectiveness All Ages	Average Net Claims Cost (Market)
2021 enacted Stamp Duty	**€157**	**€449**	**30.3%**	**€1,044**
Impact of removing assumed market contraction and selection effects	(€2)	(€6)	1.8%	(€68)
Impact of using 2021 population data	€5	€15	(1.2%)	€32
Impact of updating surplus to €100m	(€14)	(€39)	0.1%	(€24)
Impact of reducing Non-Advanced % to 30%	(€20)	€2	(0.2%)	€0
Impact of reducing Bed Night Inflation to 0% p.a.	(€1)	(€2)	(0.7%)	€0
Impact of reducing Claims Inflation to 3% p.a.	(€4)	(€13)	0.7%	(€32)
2022 Recommended Stamp Duty No HCCP	**€122**	**€406**	**30.9%**	**€952**
Change from 2021 to 2022 Recommended	(€35)	(€43)	0.6%	(€93)
2022 Recommended Stamp Duty with HCCP	**€122**	**€406**	**43.6%**	**€951**
Impact to recommendation of including a HCCP	€0	€0	12.8%	(€1)

Impact on projected net claims cost

The net claims cost is the claims cost an insurer incurs in respect of an insured life after payment of stamp duty and receipt of risk equalisation credits. For an insurer the average net claims cost for a given age, gender and level of cover is influenced by the following:

- The average claims cost which tends to increase with age as on average older lives incur higher costs than younger lives;
- ARHC which serves to significantly reduce the net claims cost for those over 65 (who typically have larger claims). The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 137.7% (or 133.5% if no HCCP) of the average net claims cost across all lives
- HUC reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience episodes of hospitalisation and acts as a proxy for health status;
- HCCP reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience claims above a defined amount (threshold) and acts as a proxy for health status; and

- Stamp duty increases the net claims cost for all lives, stamp duty is collected from insurers to fund the distribution of credits. The level of ARHC (influenced by the claims cost ceiling) is a key driver of the level of stamp duty.

Outlined below is the impact of the recommendation on the projected net claims cost of insured lives by age. This is one of the metrics which is considered by the Authority when making its recommendation to ensure the recommendation will not cause instability in the market, and also to gauge projected impact on the market. Set out in the table below are details of the change in net claims cost (and impact) by age for the recommended 2022/2023 RES with and without a HCCP. A graphical representation of the net claims cost by all ages and ages over 55 is included in the charts that follow. We can see that the net claims cost at all ages has fallen under both recommendations.

Table 8.2 Projected net claims cost by age

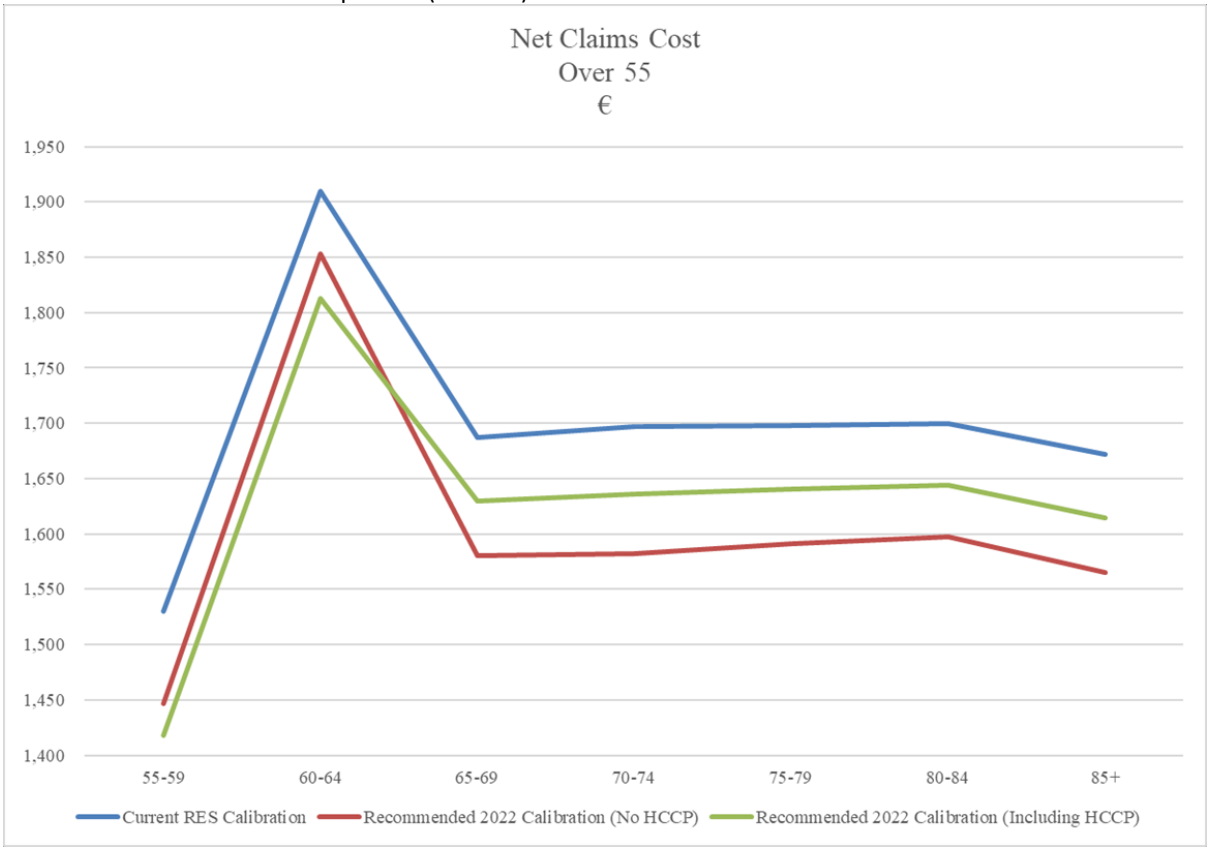
Net Claims Cost After RES	Current RES Calibration	Recommended 2022 Calibration (No HCCP)	Impact of Recommended Calibration (No HCCP)	Recommended 2022 Calibration (Including HCCP)	Impact of Recommended Calibration (Including HCCP)
0-17	320	287	*(32)*	284	*(36)*
18-29	721	641	*(80)*	636	*(85)*
30-39	929	827	*(102)*	820	*(110)*
40-49	1,023	930	*(93)*	918	*(105)*
50-54	1,226	1,137	*(89)*	1,120	*(106)*
55-59	1,531	1,447	*(84)*	1,418	*(112)*
60-64	1,910	1,853	*(57)*	1,813	*(97)*
65-69	1,687	1,580	*(107)*	1,630	*(57)*
70-74	1,697	1,582	*(115)*	1,636	*(61)*
75-79	1,698	1,591	*(106)*	1,641	*(57)*
80-84	1,700	1,598	*(102)*	1,644	*(55)*
85+	1,672	1,565	*(106)*	1,615	*(57)*

Table 8.3 Reconciliation of change in projected net claims cost

Impact on Market Average Net Claims Cost of moving from 2021/22 Calibration to the 2022/23 Recommendation								
Age	2021 RES Calibration	Impact of removing population reduction and selection effects	Impact of updating to use 2021 population	Impact of updating surplus to €100m	Impact of reducing Non-Advanced Stamp Duty to 30%	Impact of reducing bed night inflation to 0%	Impact of reducing claims inflation to 3%	2022/23 RES Calibration Recommendation No HCCP
0-17	320	*(19)*	*9*	*(13)*	*0*	*(0)*	*(10)*	287
18-29	721	*(35)*	*15*	*(36)*	*(0)*	*(1)*	*(22)*	641
30-39	929	*(57)*	*20*	*(36)*	*(1)*	*(0)*	*(28)*	827
40-49	1,023	*(52)*	*27*	*(36)*	*(0)*	*(0)*	*(31)*	930
50-54	1,226	*(48)*	*34*	*(37)*	*0*	*0*	*(39)*	1,137
55-59	1,531	*(35)*	*37*	*(37)*	*0*	*1*	*(49)*	1,447
60-64	1,910	*(6)*	*47*	*(37)*	*1*	*2*	*(63)*	1,853
65-69	1,687	*(102)*	*37*	*10*	*2*	*4*	*(57)*	1,580
70-74	1,697	*(103)*	*38*	*11*	*1*	*(7)*	*(54)*	1,582
75-79	1,698	*(105)*	*57*	*(14)*	*2*	*8*	*(55)*	1,591
80-84	1,700	*(105)*	*42*	*11*	*(9)*	*(2)*	*(40)*	1,598
85+	1,672	*(105)*	*50*	*(5)*	*2*	*7*	*(56)*	1,565

Chart 8.1: Net Claims Cost Comparison (All Ages)

Chart 8.2: Net Claims Cost Comparison (Over 55)



Impact on effectiveness

The Authority has a defined measure of effectiveness and in making its recommendations this is one of a number of metrics which is considered. Outlined below is the change in this effectiveness measure under both recommendations and shows a material increase in effectiveness with the introduction of a HCCP and a smaller increase with the alternative recommendation.

Table 8.4 Change in effectiveness

	Over Age 65	All Ages
2021 RES Calibration	**31.6%**	**30.3%**
Recommended 2022 Calibration (No HCCP)	**32.9%**	**30.9%**
Impact of Recommended 2022 Calibration (No HCCP)	*1.3%*	*0.6%*
Recommended 2022 Calibration (Including HCCP)	**46.2%**	**43.6%**
Impact of Recommended 2022 Calibration (Including HCCP)	*14.5%*	*13.3%%*

Impact on projected net financial impact of the RES for each insurer

The projected net financial impacts for each insurer, for a 12-month period, based on the credits and stamp duty applying for policies commencing in the period 1 April 2022 to 31 March 2023 are outlined below for each recommendation. This is another metric which has been considered as part of the analysis. Note that the projected financial impacts shown from last year are included for comparison, but we now know that some key assumptions underpinning those projections are not likely to materialise i.e. fall in population and selection effects on claims.

Table 8.5 Projected Net Financial Impacts by insurer

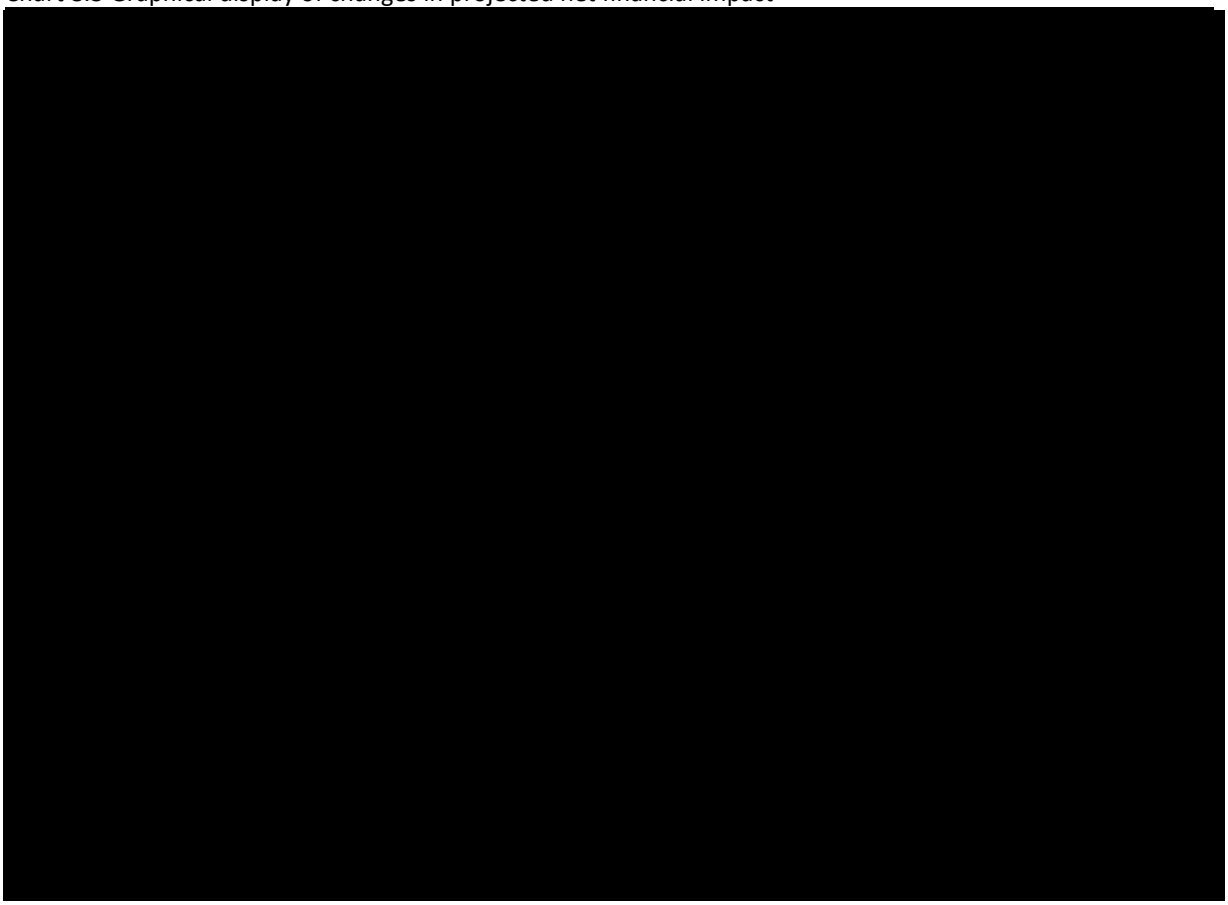
Projected RES Flows								
From 1 April 2021								
€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**				
Age Credits	[redacted]			605				
HUC				200				
HCCP				-				
Stamp Duty				(763)				
NFI				*43*				
From 1 April 2022 (no HCCP)					**Change from 1 April 2021 Credits**			
€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
Age Credits	[redacted]			645	[redacted]			*40*
HUC				199				*(1)*
HCCP	-	-	-	-	-	-	-	-
Stamp Duty	[redacted]			(745)	[redacted]			*18*
NFI				*100*				*57*
From 1 April 2022 (including HCCP)					**Change from 1 April 2021 Credits**			
€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
Age Credits	[redacted]			590	[redacted]			*(15)*

HUC	[redacted]	199	[redacted]	*(1)*
HCCP*		55		*55*
Stamp Duty		(745)		*18*
NFI		*100*		*57*

**Does not include impact of rolling quarters, the impact of which is estimated to be increase the HCCP proportion of credits from 6% to c. 11% of the overall credit pot.*

The projections for individual insurers are based on historic patterns of insurer's age profile and market share by age group. The actual net financial impacts will be influenced by their product and pricing strategy or by developments in one particular insurer. The net financial impact on the REF is sensitive to the rate of ageing of the insured population, which in turn is impacted by the rate of growth / decline in the market. It follows that the extent to which the REF is cost neutral will depend on how closely the assumptions made in this report are borne out in practice.

Chart 8.3 Graphical display of changes in projected net financial impact



Appendix 1: Further analysis of Information Returns

The information returns for H1 2021 have been distorted as a result of COVID-19 and the HSE cyber-attack and thus the information presented below may not give a true indication of any trends in experience. The figures in relation to 2020 also contain distortions due to COVID-19. H2 2019 and previous do not contain such distortions and are likely to give a better understanding of the experience emerging before the distortions of COVID-19 impacted.

Risk Profiles

The three insurers have different product mixes and conduct their business differently. This makes risk profile comparison complex. In order to compare risk profiles, we looked at the following measures:

- Average Claim per insured person;
- Average Treatment Days per insured person; and
- An index based on the Age/Sex Risk Profile of each insurer; complementary to this index, we also gauge the significance of variations in treatment days not captured by the Age/Sex Risk Profile Index by calculating a Hospital Utilisation Risk Profile Index.

In each case the Authority will note the disadvantages of the index being used. Also, where appropriate, when calculating indices, the Authority will treat each insured child as 1/3rd of an insured adult to reflect the fact that they are not charged a full premium.

Benefit per Insured Person

Comparing risk profiles by comparing the average returned benefit per insured person of each insurer is not completely reliable. It does not allow for the fact that insurers may conduct business in different ways and have different age profiles or that one insurer may sell more of a product that provides less benefits or provides a different level of cover (for example, by applying different excesses, exclusions or waiting periods).

Counting each child as 1/3rd and each adult as 1, the average returned benefit per insured person for each insurer is outlined in Table A.1 below.

Table A1.1 Average returned benefit per insured person €

Average Returned Benefits per Insured Person (€)				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	**548**	**461**	**409**	**464**
% change vs July-Dec 2019		**(16%)**	**(25%)**	**(15%)**

Due to the impact of COVID-19, the market returned benefit per insured from Jan-June 2021, remains lower than the July-Dec 2019 period at €464, which is a slight increase from the average benefit over the 6 months previous July-Dec 2020 however these periods are all heavily distorted as a result of COVID-19.

Comparing the first half of 2021 with the second half of 2019 shows a 15% reduction in the market average returned benefit. The corresponding change in the average claims cost for all three insurers are reduction of 8% and 13% for Irish Life Health and Laya Healthcare with a 18% fall in Vhi Healthcare's average returned benefit.

The average returned benefit per insured person as a percentage of the market average for each insurer is set out in Table A1.2 below.

Table A1.2 Average Returned Benefits per insured person

Average Returned Benefits per Insured Person as a % of the Market Average				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	100%	100%	100%	100%

[redacted]

Table A1.3 Change in Average Returned Benefits per insured person

	Change in Average Returned Benefits 12 months to June 2018 V 12 months to June 2019				Change in Average Returned Benefits 12 months to June 2019 V 12 months to June 2020			
Age Group	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
0-17	[redacted]			-3%	[redacted]			-13%
18-29				-3%				-8%
30-39				2%				-8%
40-49				2%				-9%
50-54				0%				-13%
55-59				1%				-8%
60-64				1%				-6%
65-69				3%				-8%
70-74				1%				-8%
75-79				1%				-9%
80-84				1%				-9%
85+				-4%				-9%
All Ages				2%				-8%

Table A1.4 Average Returned Benefits per insured person

	Change in Average Returned Benefits 12 months to June 2020 Vs 12 months to June 2021			
Age Group	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
0-17	[redacted]			-30%
18-29				-4%
30-39				-10%
40-49				-7%
50-54				1%
55-59				-6%
60-64				-8%
65-69				-12%
70-74				-16%
75-79				-18%
80-84				-24%
85+				-30%
All Ages				-13%

We note the above tables demonstrate the reduction in average returned benefit as a result of the distortions from COVID-19. We have shown early periods for comparison.

Average Returned Benefits per Insured Person for the 12 months to the end of June 2021 broken down by age group and level of cover are shown in the following tables. Figures for older ages, in particular for Non-Advanced contracts, are particularly prone to random fluctuation. Note, these figures are likely to be distorted by COVID-19 and the corresponding market figures the 12 months to the end of June 2019 are shown in brackets to help illustrate this.

Table A1.5: Male Non-Advanced

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17				37 (108)
18-29				59 (87)
30-39				66 (95)
40-49				90 (163)
50-54				193 (247)
55-59				267 (314)
60-64				423 (571)
65-69				551 (803)
70-74				809 (1,057)
75-79				782 (1,248)
80-84				1,455 (1,379)
85+				1,536 (2,729)
All Ages				**173 (250)**

Table A1.6: Male Level 1

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17				39 (111)
18-29				61 (90)
30-39				79 (100)
40-49				100 (168)
50-54				208 (263)
55-59				284 (363)
60-64				472 (626)
65-69				667 (954)
70-74				1,009 (1,125)
75-79				1,185 (1,718)
80-84				1,430 (2,196)
85+				1,879 (3,242)
All Ages				**233 (329)**

Table A1.7: Male Level 2

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			92 (174)
18-29				239 (282)
30-39				267 309)
40-49				428 (486)
50-54				678 (772)
55-59				963 (1,114)
60-64				1,368 (1.589)
65-69				1,794 (2,231)
70-74				2,262 (2,921)
75-79				2,860 (3,730)
80-84				3,165 (4,461)
85+				3,354 (5,493)
All Ages				**850 (1,068)**

Table A1.8: Male Level 2+

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			97 (183)
18-29				235 (274)
30-39				263 (309)
40-49				431 (492)
50-54				702 (793)
55-59				998 (1,132)
60-64				1,409 (1,658)
65-69				1,888 (2,333)
70-74				2,391 (3,053)
75-79				3,012 (4,011)
80-84				3,409 (4,919)
85+				3,971 (6,041)
All Ages				**935 (1,173)**

Table A1.9: Female Non-Advanced

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			44 (93)
18-29				58 (89)
30-39				105 (170)
40-49				146 (197)
50-54				200 (259)
55-59				208 (353)
60-64				336 (424)
65-69				426 (634)
70-74				442 (765)
75-79				696 (1,091)
80-84				953 (1,472)
85+				646 (1,693)
All Ages				**169 (253)**

Table A1.10: Female Level 1

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			46 (93)
18-29				62 (95)
30-39				112 (183)
40-49				154 (208)
50-54				201 (276)
55-59				224 (372)
60-64				384 (456)
65-69				504 (704)
70-74				645 (1,030)
75-79				947 (1,307)
80-84				1,199 (1,786)
85+				1,266 (2,493)
All Ages				**218 (321)**

Table A.11: Female Level 2

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			117 (166)
18-29				284 (308)
30-39				560 (689)
40-49				564 (687)
50-54				739 (853)
55-59				909 (1,074)
60-64				1,141 (1,341)
65-69				1,438 (1,789)
70-74				1,868 (2,400)
75-79				2,283 (3,063)
80-84				2,490 (3,667)
85+				2,610 (4,205)
All Ages				**861 (1,089)**

Table A1.12: Female Level 2+

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]			123 (173)
18-29				284 (311)
30-39				574 (696)
40-49				578 (696)
50-54				767 (892)
55-59				936 (1,121)
60-64				1,209 (1,410)
65-69				1,503 (1,895)
70-74				1,982 (2,574)
75-79				2,481 (3,370)
80-84				2,756 (3,986)
85+				2,933 (4.687)
All Ages				**943 (1,195)**

Average returned benefit per treatment day

The differences in the average returned benefit per member is partly due to differences in the average benefit per treatment day for each insurer and partly to differences in the average number of treatment days per insured person for each insurer. The average returned benefit per treatment day varies between insurers as set out in Tables A.13 and A.14 below.

We again note the Laya Healthcare 2020 and 2021 figures are impacted by the CCV issue and so we would expect the Laya Healthcare figures to be marginally higher for 2021 and 2020 and lower for 2019.

Table A1.13 Average Returned Benefit per Treatment Day

Average Returned Benefits per Treatment day (€)				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	1,162	1,166	1,292	1,354

Average returned benefits per treatment day have increased across the market as a whole over the past 12 months. [redacted]

Table A1.14 Average Returned Benefit per Treatment Day relative to market

Average Returned Benefits per Treatment day as a % of the Market Average				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	100%	100%	100%	100%

[redacted]

Average number of treatment days per insured person

Another approach for comparing risk profiles is to compare the average number of treatment days per Insured Person. However, it does not separate out all differences in the way insurers conduct business or all differences in the level of cover.

The reliability of the average treatment days per member also relies on the assumption that the "value" (in terms of the underlying healthcare cost) of each treatment day is the same for each insurer. In practice, it is possible that this assumption may not be borne out. For example, where the cost of treatment days varies by age of the patient or the treatment and insurers' memberships have different age or treatment profiles, a comparison of the number of treatment days per member would not fully capture the differences in the risk profiles of the insurers.

The average number of treatment days per member for each insurer is set out in Tables A1.15 and A.16 below. Again, each insured child counts as 1/3 when counting the number of insured persons in order to allow for the fact that children are not charged a full premium.

[redacted]

Table A1.15 Average treatment day per insured person

Average Treatment day per Insured Person				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	0.472	0.395	0.317	0.343

Table A.16 Average Treatment day per Insured Person as a % of the Market Average

Average Treatment day per Insured Person as a % of the Market Average				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	100%	100%	100%	100%

The average treatment days per insured person was relatively stable in periods before December 2019. Due to the impact of COVID-19, the average treatment days per insured person has reduced from 0.472 in the six months ending December 2019 to 0.343, a fall of 27%.

[redacted]

Age/Sex Risk Profile Index

Another approach is to compare the risk profiles based on the age/sex profile of each insurer. We do this by applying a "risk weighting" to each member of the insured population. This weighting will be based on the age/sex of the insured person. We can then compare the average weighting for each insurer. We refer to this average weighting as the Age/Sex Risk Profile Index.

The difficulty with this approach lies in finding an appropriate weight for each age/sex combination. One weight that may be considered appropriate is the market average number of treatment days for each age/sex group. Thus, each insurer is using the same weights.

The use of the number of treatment days as the basis for setting the risk weights is not without its disadvantages. As already mentioned, the number of treatment days will not provide a pure measure of risk, since it could include an element of efficiency and other factors. Also, as noted earlier, it does not take account of differences in the value of treatment days.

Table A1.17 Age/Sex Risk Profile Index

Age/Sex Risk Profile Index				
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**
Irish Life Health	[redacted]			
Laya Healthcare				
Vhi Healthcare				
Market	100%	100%	100%	100%

Table A1.17 [redacted]

Hospital Utilisation Risk Profile Index

Of course, the Age/Sex Risk Profile Index ignores differences in risk profiles due to other factors, i.e. it ignores whether insurers' risk profiles vary within age/sex bands. It therefore ignores differences in

hospital utilisation within age /gender cells. In order to gauge the significance of variations of risk profile within age/sex bands we calculate an overall index of the hospital utilisation risk profile (ignoring the effect of differences in the age/sex distributions of the memberships). We call this index the Hospital Utilisation Risk Profile Index.

The Hospital Utilisation Risk Profile Index is calculated by estimating the average number of treatment days that each insurer would have if they all had the same standard age/sex profile and their own level of treatment days for each age/sex group. The standard age/sex profile that we use is the profile for the market as a whole.

As we aim to ignore the effect of the age and sex profile with this index, there is no need to adjust for the number of children. Table A1.18 shows the relative values of the Hospital Utilisation Risk Profile Index over time for Irish Life Health and Laya Healthcare relative to Vhi Healthcare's.

Table A1.18 Hospital Utilisation Risk Profile Index

Hospital Utilisation Risk Profile Index (Percentage of Vhi Healthcare's Index)				
Insurer	July-Dec 2019	Jan-June 2020	July-Dec 2020	Jan-June 2021
Irish Life Health				
Laya Healthcare				
Vhi Healthcare				

Chart A1.1

Chart A1.2

As Chart A1.3 shows,

Chart A1.3

Appendix 2: Risk Equalisation Credits and Stamp Duty from 1 April 2022

Table A2.1 below show the projected membership as at 1 October 2022 (the time the average policy incepted between 1 April 2022 and 31 March 2023). Tables A2.2 to A2.3 show the projected returned benefits, hospital nights and day case admissions as at 1 April 2023 (the midpoint of the average policy incepted between 1 April 2022 and 31 March 2023). This data was used in the calculation of the stamp duty and Risk Equalisation Credits in the scenarios shown below.

Table A2.1 Projected Membership as at 1 October 2022

Projected Membership as at 1 October 2022				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	14,683	13,934	248,274	233,852
18-29	14,385	15,179	126,946	126,336
30-39	17,590	18,270	118,291	136,420
40-49	19,347	18,646	156,453	172,874
50-54	6,930	6,763	70,514	75,872
55-59	5,576	5,364	65,328	72,888
60-64	4,087	4,122	60,794	67,308
65-69	2,782	2,735	55,272	60,892
70-74	1,929	1,888	47,151	52,207
75-79	909	894	36,783	41,301
80-84	463	518	20,844	26,203
85+	212	391	13,190	21,190
Total	**88,892**	**88,703**	**1,019,839**	**1,087,343**

Table A2.2 Projected Average Returned Benefit at 1 April 2023 (€)

Projected Average Returned Benefit at 1 April 2023 (€)				
Age Group	**Non-Advanced**		**Advanced**	
	Male	Female	Male	Female
0-17	108	99	184	174
18-29	85	88	299	292
30-39	107	184	337	502
40-49	164	218	528	602
50-54	270	276	831	820
55-59	314	397	1,224	1,150
60-64	570	414	1,801	1,587
65-69	833	670	2,478	2,158
70-74	1,072	887	3,191	2,832
75-79	1,375	1,126	4,092	3,645
80-84	1,633	1,309	4,859	4,264
85+	1,885	1,443	5,609	4,744
All Ages	**232**	**244**	**1,047**	**1,071**

Table A2.3 Projected Total Bed Nights at 1 April 2023

Projected Total Bed Nights at 1 April 2023				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	1,143	1,062	29,373	27,541
18-29	601	652	20,000	26,418
30-39	920	2,157	18,175	61,883
40-49	1,749	2,025	34,122	56,251
50-54	1,114	853	23,395	27,134
55-59	1,033	1,255	31,469	35,683
60-64	1,476	866	44,603	45,393
65-69	1,553	1,369	59,141	54,926
70-74	1,716	1,146	68,158	68,755
75-79	914	759	78,062	78,157
80-84	757	832	64,390	71,239
85+	411	671	62,730	81,473
Total	13,387	13,646	533,615	634,853

Table A2.4 Projected Total Day Case Admissions at 1 April 2023

Projected Total Day Case Admissions at 1 April 2023				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	305	189	10,566	7,476
18-29	407	480	10,781	13,136
30-39	762	992	14,742	23,343
40-49	1,349	1,884	30,287	49,373
50-54	671	913	20,386	29,058
55-59	672	837	25,014	33,275
60-64	662	672	31,698	36,716
65-69	581	516	38,545	39,610
70-74	495	409	41,323	41,807
75-79	275	211	38,475	37,666
80-84	121	138	22,800	23,330
85+	41	52	12,784	15,137
Total	6,341	7,293	297,402	349,927

Recommendation

The recommendation calculates credits by gender, product level and age such that for each age group over 65, the net cost should not be more than 137.7% (or 133.5% with no HCCP) of the average net cost across all groups. A Hospital Utilisation Credit of €125 is applied for overnight inpatient stays and €75 is applied for day stays. Claims inflation is assumed to be 3% per annum and bed night inflation is assumed to be 0% per annum.

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. The stamp duty for Non-Advanced contracts is set at 30% of the stamp duty relating to Advanced contracts. The REF is projected to have a surplus of €100m when the contracts written prior to 1 April 2022 have fully earned credits and stamp duty.

The Age Risk Equalisation Premium Credits for Advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). The Age Risk Equalisation Premium Credits for Non-Advanced cover contracts are based on the average claim costs for Non-Advanced contracts. Adjusted claims costs for Non-Advanced contracts aged over 65 are calculated by applying the average ratio of Non-Advanced claims cost to Level 2 claims cost for all ages over age 65 combined. The average claims costs are based on claims arising in the Jan 2019 – Dec 2019 time period since the claims arising in January 2020 – July 2021 are distorted as a result of COVID-19 and the HSE cyber-attack.

In our projections we have projected the population at 1 July 2021 forward to 1 October 2022 (to allow for the natural ageing of the insured lives), we have not allowed for any market shrinkage, this is a key judgement for the population projection.

We have included our recommendation with and without a HCCP (and sensitivities also). For the first year of the inclusion of the HCCP (2022/23), the Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000. We note cross-over periods will not apply for year 1 of the calibration and as such have not been included in our calculations. No allowance has been made for rolling claims.

Recommendation No HCCP

[redacted] These figures are based on the projected membership of the Report which assumes that the changes in market membership by insurer in the year to end June 2021 would continue through to 1 October 2022.

Table A2.5a – Recommendation no HCCP

Age	Stamp Duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€m)	Total Credits (€m)	Total Stamp Duty (€m)
	Non Adv	Adv	Non-Advanced		Advanced				
			Men	Women	Men	Women			
0-17	41	135	0	0	0	0	9	0	66
18-29	122	406	0	0	0	0	8	0	106
30-39	122	406	0	0	0	0	13	0	108
40-49	122	406	0	0	0	0	18	0	138
50-54	122	406	0	0	0	0	10	0	61
55-59	122	406	0	0	0	0	13	0	57
60-64	122	406	0	0	0	0	17	0	53
65-69	122	406	350	200	1075	600	21	97	48
70-74	122	406	550	400	1725	1200	24	146	41
75-79	122	406	825	600	2550	1825	25	170	32
80-84	122	406	1025	700	3175	2275	21	127	19
85+	122	406	1225	825	3775	2575	20	105	14
Surplus									100
Total							**199**	**645**	**845**
Projected Deficit									**0.0**

Table A2.5b – Recommendation no HCCP

€m	Irish Life Health	Laya Healthcare	VHI Healthcare	Total
Age Related Health Credits		[redacted]		645
Hospital Bed Utilisation Credit				199
Stamp Duty				(745)
Total				100

<u>Recommendation including HCCP</u>

[redacted] These figures are based on the projected membership of the Report which assumes that the changes in market membership by insurer in the year to end June 2021 would continue through to 1 October 2022.

Table A2.6a – Recommendation including HCCP

Age	Stamp Duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€m)	Total Credits (€m)	Total HCCP (€ms)	Total Stamp Duty (€m)
			Non-Advanced		Advanced					
	Non Adv	Adv	Men	Women	Men	Women				
0-17	41	135	0	0	0	0	9	0.0	2	67
18-29	122	406	0	0	0	0	8	0.0	1	107
30-39	122	406	0	0	0	0	13	0.0	2	108
40-49	122	406	0	0	0	0	18	0.0	4	139
50-54	122	406	0	0	0	0	10	0.0	3	61
55-59	122	406	0	0	0	0	13	0.0	4	58
60-64	122	406	0	0	0	0	17	0.0	5	53
65-69	122	406	325	150	950	500	21	84	7	48
70-74	122	406	500	350	1575	1075	24	132	8	41
75-79	122	406	775	575	2375	1700	25	158	8	32
80-84	122	406	950	650	2975	2125	21	118	6	19
85+	122	406	1150	775	3550	2425	20	98	4	14
Surplus										100
Total							**199**	**590**	**55**	**845**
Projected Deficit										**0.0**

Table A2.6b – Recommendation including HCCP

€m	Irish Life Health	Laya Healthcare	VHI Healthcare	Total
Age Related Health Credits	[redacted]			590
Hospital Bed Utilisation Credit				199
HCCP				55
Stamp Duty				(745)
Total				100

Appendix 3: Sensitivity Analysis on Credits and Stamp Duty from 1 April 2022 for Recommended Methodology

Below is a summary of sensitivities performed on the recommended methodology for setting credits and Stamp Duty from 1 April 2022 with and without a HCCP, note scenario 1 is the current 2021/22 RES and scenario 2 is the recommendation for the 2022/23 RES. All other sensitivities are based on the 2022/23 calibration with the following changes:

<table>
<tr><th>Scenario</th><th>Sensitivity</th></tr>
<tr><td>1</td><td>2021/2022 Recommendation</td></tr>
<tr><td>2</td><td>2022/2023 Recommendation</td></tr>
<tr><td>3</td><td>Increase claims inflation to 4% p.a.</td></tr>
<tr><td>4</td><td>Reduce claims inflation to 2% p.a.</td></tr>
<tr><td>5</td><td>Surplus reduced by €10m to €90m</td></tr>
<tr><td>6</td><td>Increase Claims cost ceiling to 135%</td></tr>
<tr><td>7</td><td>Marginal population reduction at ages under 60, with selection effects
<table>
<tr><th>Age</th><th>Reduction</th></tr>
<tr><td>0-17</td><td>3.5%</td></tr>
<tr><td>18-29</td><td>3%</td></tr>
<tr><td>30-39</td><td>2.5%</td></tr>
<tr><td>40-49</td><td>2</td></tr>
<tr><td>50-54</td><td>1%</td></tr>
<tr><td>55-59</td><td>0.5%</td></tr>
</table></td></tr>
<tr><td>8</td><td>Claims reduce by 10%</td></tr>
</table>

Sensitivities No HCCP

Net Claims Cost (All Ages)

Stamp Duty €	2021/2022 RES	2022/2023 RES	Claims inflation 4%	Claims inflation 2%	Surplus reduced by €10 m	NCC 135%	Population reduction	Claims are 10% lower
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Advanced	449	406	419	393	413	401	407	358
Non-Advanced	157	122	126	118	124	120	122	107
CCC	133.5%	133.5%	133.5%	133.5%	133.5%	135.0%	133.5%	133.5%

Total Projected RES flows €m								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Stamp Duty	763m	745	769	721	757	736	735	657
ARHC	605m (75%)	645m (76%)	668m (77%)	621m (76%)	650m (77%)	637m (76%)	635m (76%)	579m (76%)
HUC	200m (25%)	199m (24%)	199m (23%)	199m (24%)	199m (23%)	199m (24%)	199m (24%)	179m (24%)

Effectiveness								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
All Ages	30.3%	30.9%	30.2%	31.6%	30.9%	30.8%	30.7%	31.7%
Over 65	31.6%	32.9%	32.2%	33.7%	33.0%	32.9%	32.8%	33.8%

Total Projected NFI €m								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
[redacted]								
Total	42	100	99	99	91	100	99	101

Sensitivities with HCCP

Stamp Duty €	2021/2022 RES	2022/2023 RES	Claims inflation 4%	Claims inflation 2%	Surplus reduced by €10 m	NCC 135%	Population reduction	Claims are 10% lower
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Advanced	449	406	419	393	413	401	407	358
Non-Advanced	157	122	126	118	124	120	122	107
CCC	133.5%	137.7%	137.5%	138.0%	137.7%	139.2%	137.7%	138.2%

Total Projected RES flows €m								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Stamp Duty	763	745	769	721	757	736	735	657
ARHC	605m (75%)	590m (71%)	614m (71%)	566m (69%)	592m (70%)	583m (70%)	582m (70%)	522m (69%)
HUC	200m (25%)	199m (23%)	199m (23%)	199m (24%)	199m (24%)	199m (24%)	199m (24%)	179m (24%)
HCCP	0m (0%)	55m (6%)	55m (6%)	55m (7%)	55m (7%)	55m (7%)	55m (7%)	55m (7%)

Effectiveness								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
All Ages	30.3%	43.6%	42.6%	44.5%	43.6%	43.5%	43.5%	45.4%
Over 65	31.6%	46.2%	45.2%	47.1%	46.1%	46.1%	46.0%	48.0%

Total Projected NFI €m								
Scenario	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Irish Life Health	[redacted]							
Laya Healthcare								
Vhi Healthcare								
Total	42	100	100	99	89	101	102	100

Appendix 4: Principal Objective

1A. Principal objective of Minister and Authority in performing respective functions under Act.

1. The principal objective of this Act is to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of with no differentiation made between them (whether effected by risk equalisation credits or Stamp Duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the health risk status, age or sex of, or frequency of provision of health services to, any such consumers or any class of such consumers, and taking into particular account for the purposes of that objective –
    a. the fact that the health needs of consumers of health services increase as they become less healthy, including as they approach and enter old age,
    b. the desirability of ensuring, in the interests of societal and intergenerational solidarity, and regardless of the health risk status or age of, or frequency of provision of health services to, any particular generation (or part thereof), that the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the more healthy and the less healthy, including between the young and the old, and, without prejudice to the generality of that objective, in particular that the less healthy, including the old, have access to health insurance cover by means of risk equalisation credits,
    c. the manner in which the health insurance market operates in respect of health insurance contracts, both in relation to individual registered undertakings and across the market, and
    d. the importance of discouraging registered undertakings from engaging in practices, or offering health insurance contracts, whether by segmentation of the health insurance market (by whatever means) or otherwise, which have as their object or effect the favouring of the coverage by the undertakings of the health insurance risk of the more healthy, including the young, over the coverage of the health insurance risk of the less healthy, including the old.
2. A registered undertaking shall not engage in a practice or effect an agreement (including a health insurance contract), which has as its object or effect (whether in whole or in part) the avoidance of the achievement of the principal objective.
3. Nothing in this section shall affect the operation of section 7(5) or 7A.

Appendix 5: Proposed HCCP Calibration

As per the June 2021 HCCP Report, based on the analysis performed the following calibration for the purposes of introducing a HCCP into the RES for contracts entered into from 1 April 2022 was proposed:

Approach	HCCP is to be introduced as a redistribution of credits
Quota Share	40%
Threshold	€50,000
HCCP Claim	Returned benefits as per Health Insurance Acts but excluding drugs not approved by the HSE for use in public hospitals
Calculation of high cost claim credit	40% x (HCCP Claim – (Threshold + HUC + ARHC))
Time period	Rolling quarters* in a 12 month period commencing from 1 April 2022 determined by date claim is incurred
Cap on HCCP claim	No cap initially but to be kept under view
HUC & ARHC	Continued inclusion with no change to structure

* The additional claims arising from a rolling four quarters approach will not have an impact until after the first 12 months of the HCCP.

Appendix 6: Data errors

Appendix 7: RES recommendation for contracts incepted 1 April 2021 to 31 March 2022

Risk Equalisation Credits

Age Bands	Utilisation credits (overnight / day case) from 1 April 2021	Age / gender / level of cover credits from 1 April 2021			
		Non-Advanced		Advanced	
		Men	Women	Men	Women
64 and under	€125 / €75	€0	€0	€0	€0
65-69	€125 / €75	€350	€200	€1,025	€550
70-74	€125 / €75	€550	€400	€1,675	€1,150
75-79	€125 / €75	€825	€625	€2,500	€1,800
80-84	€125 / €75	€1,025	€700	€3,150	€2,250
85 and above	€125 / €75	€1,250	€825	€3,750	€2,550

Stamp Duty

Age Bands	Stamp Duties from 1 April 2021 to 31 March 2022	
	Non-Advanced	Advanced
17 and under	€52	€150
18 and over	€157	€449

Appendix 8: Calibration of RES

- In determining the recommended level of credits for each category, the HIA takes into account the information returns made to it by insurers. The HIA analyses and evaluates the market, on the basis of all information returns and, if necessary, on the basis of other information it considers relevant to those purposes, e.g. future expectations of claims and bed utilisation inflation.
- The recommended credits make allowance for expected market position when the credits are expected to apply, i.e. number insured, average claims and overnight and day hospitalisation rates split by age and between advanced and non-advanced levels of cover.
- Risk equalisation credits are paid in respect of individuals who are insured through relevant health insurance contracts within Ireland (As defined in Section 125A(1) of the Irish Stamp Duties Consolidation Act 1999, Section 11E of the Health Insurance Act 1994 and specified in regulations under Section 11E.) and who meet the specified age and gender criteria. 5-year age bands are currently used for determining credits.
- For the purposes of the RES, insurance products are categorised into products providing non-advanced cover and all other products. Non-advanced means a contract which provides health insurance cover for not more than 66% of the full cost for hospital charges in a private hospital, or not more than the prescribed minimum payments within the meanings of the Health Insurance Act 1994 (Minimum benefit) or Regulations 1996 whichever is greater. Contracts providing higher coverage are considered to be advanced contracts.
- Lower age related credits and stamp duties apply in respect of individuals who do not have advanced cover. The inclusion of a product differentiation in setting the levels of credits and stamp duties is designed to ensure that the support is proportionate and does not involve people with lower levels of benefit subsidising to a disproportionate degree people with higher levels of cover than those that they have chosen for themselves.
- As risk equalisation credits are currently set so that no age group has a projected net of RES claims cost which exceeds 133.5% of average by level of cover, the RES will not be 100% effective, particularly at the older ages. This reflects competing aims of maintaining the sustainability of the market and stability of the market which relies on younger members to maintain the intergenerational solidarity that underpins the principal of community rating.
- The method to calculate the RES credits has been approved by the EU Commission in SA.41702 (paragraph 83) as sufficiently clear and defined in advance. Also, the Commission points out, that the RES is not 100% effective in equalising the differences in risk profiles of insurers' portfolios, which reduces the likelihood of overcompensation (paragraph 111). Hence, the overcompensation report does not reassess the appropriateness of the level of RES credits, but is only looking at the resulting profits at the level of a net beneficiary, which may not exceed a return on sales, gross of reinsurance and excluding investment income of 4.4% p.a., calculated on a rolling three year basis (see SA.41702, paragraphs 41 -47, 106 – 113, 121).
- The applicable rates of Risk Equalisation Credits and Community Rating Stamp Duty are set out in law.

Calibration Calculation Approach

- Data contained within the information returns provided by the insurers is used to determine average returned benefits and hospital utilisation rates (day case and overnight) by age group and by level of cover. These figures are increased to allow for inflationary effects in terms of increased claims costs and increased in hospital admissions from the date of the information returns to the date when the credits will apply on average.
- Stamp duty can be split into the following component parts:
    - Age related health credits;

    - Hospital utilisation credits; and
    - High cost claims pool credits.
- The stamp duty calculation is performed separately for each component part in the above order.
- Age Related Health Credits:
    - The age credits for Advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). These credits apply from ages 65 and over. Claims inflation of 3% per annum is assumed over the term of the projection allowing for some pickup in public hospital claims.
    - The age credits for Advanced cover products are calculated to be the amount necessary so that the net claims cost for no age group from age 65 and over exceeds 133.5% of the average net claims cost for Level 2 contracts.
    - The average net claims costs are adjusted to allow for HUC and HCCP. In simple terms the stamp duty in respect of HUC and HCCP is added to the net claims costs while the credits expected to be received are deducted. Thus the claims cost ceiling applies to the adjusted Level 2 net claims cost amount.
    - When a HCCP is included, the projected average returned benefit reduces as average HCCP for the cohort of lives has been removed from the average returned benefit and as such the Claims Cost Ceiling is applied to a lower amount. The amount of HCCP depends on the level of the quota share and claims excess.
    - The calculated age credits are rounded to the nearest €25.
    - The age credits for Non-Advanced contracts are based on the average claim costs for Non-Advanced products. Adjusted claim costs for Non-Advanced contracts aged 65 and over are calculated by applying the average ratio of Non-Advanced claims costs to Level 2 claims costs for all ages 65 and over combined. The age credits for Non-Advanced contracts are calculated using the same methods as advanced contracts although the results are smoothed due to lack of claims data at older ages.
- Hospital Utilisation Credits:
    - A hospital utilisation credit of €125 would be made for each night that an insured person spends in a hospital.
    - A hospital utilisation credit of €75 would be made in respect of each day case admission.
    - The total number of lives is used to derive the stamp duty required in respect of HUC.
- High Cost Claim Pool Credits:
    - Total HCCP (which depends on the level of the quota share and claims excess) is paid out in credits.
    - The claims excess is defined as the HCCP Threshold plus (Total ARHC for contract year) plus (HUC received in claim quarter and previous 3 quarters).
    - The total number of lives is used to derive the stamp duty required in respect of HCCP.
- The stamp duty for Non-Advanced reflects the lower credits paid in respect of these contracts, and, accordingly, be set at 30% of the rate applying for Advanced contracts.
- The stamp duty levels incorporate any anticipated surplus or deficit in the Risk Equalisation Fund when all payments into/out of the Risk Equalisation Fund have been made in respect of contracts that commence prior to the start of the period.

Appendix 9: Relevant Documentation

This report should be read alongside the following documents:

- "Risk Equalisation Scheme 2022: Recommendation to the Department of Health on proposed changes to be incorporated into the Risk Equalisation Scheme" dated 11 June 2021
- "Draft Paper for Department of Health proposing how a High Cost Claims Pool might work" (dated February 2019); and
- "HIA Report on High Cost Claims Pool" (dated April 2019) and "Risk Equalisation Scheme Effectiveness Impact: Assessment of the Introduction of a HCCP and changes to other measures" (dated January 2020).