An tÚdarás Árachas Sláinte
The Health Insurance Authority

Report on a public consultation on the community rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme

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## Introduction

On 4th January 2021, the Health Insurance Authority and the Department of Health published a consultation paper on the community rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme.

The consultation sought to gain the views of the public and all interested parties on the core principles underpinning the Risk Equalisation Scheme and the changes being proposed to the scheme from 2022 for a 5 year period.

The new Risk Equalisation Scheme must be notified to the European Commission for appraisal under State Aid regulations and this public consultation was an important step in informing and influencing changes to the Risk Equalisation Scheme and the notification process to the European Commission.

There were four specific questions put forward in the consultation paper:

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

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

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

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

In total, 20 submissions were received in response to the consultation. These included a mix of members of the public, insurance companies and other interested parties.

The purpose of this paper is to consider and summarise the submissions received with the focus being on the answers provided to the four specific questions asked. We note that the submissions contained much wider comments and views on the overall private health insurance market in Ireland which have been read but which may not be fully addressed in this paper. This paper attempts to provide responses, either directly or indirectly, to all topics raised in the submissions. Individual comments or questions from each submission may not be separately identified.

The recommendation made to the Department of Health by the Health Insurance Authority in relation to the new Risk Equalisation Scheme from 2022, which takes into consideration the submissions received under the consultation, are set out in a separate report titled "Recommendation to the Department of Health on proposed changes to be incorporated into the Risk Equalisation Scheme".

## Background

### *The Health Insurance Authority*

The Health Insurance Authority ("Authority") is a statutory regulator for the Irish private health insurance market. It was established in 2001 under the Health Insurance Act 1994.

The principal functions of the Authority, as set out in the Health Insurance Act 1994 (as amended), are as follows:

- To monitor the health insurance market and to advise the Minister (either at his or her request or on its own initiative) on matters relating to health insurance;
- To monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts;
- To carry out certain functions in relation to health insurance stamp duty and risk equalisation credits and in relation to the risk equalisation scheme;
- To take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
- To maintain "The Register of Health Benefits Undertakings" ("the Register") and "The Register of Health Insurance Contracts".

### *The private health insurance market*

The Irish private health insurance system is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefits. These principles aim to ensure that private health insurance does not cost more for those who need it most. The system is unfunded, meaning that there is no fund build up over the lifetime of an insured person to cover their expected increased claims cost as they get older and less healthy. Instead, the money contributed by insured people is pooled by each insurer and the cost of claims in any given year taken from the pool.

It is in this context that the concept of community rating must be understood. It means that the level of risk that a particular consumer poses to an insurer does not affect the premium paid. In other words, everybody is charged the same premium for a particular plan, irrespective of age, gender and the current or likely future state of their health with some limited exceptions as set out in legislation.

### *The Risk Equalisation Scheme*

For the private health insurance market in Ireland, community rating is supported by the Risk Equalisation Scheme ("RES"). In a community rated market, risk equalisation is required to balance the higher costs of insuring older and less healthy members against the lower costs of insuring younger and healthier members.

It is widely recognised that in a community rated market without a robust RES, insurers with lower risk profiles will tend to be more profitable, all else being equal. As a result, in the absence of a robust RES, insurers will be incentivised to do the following:

- Design products so that they are not attractive to older and less healthy customers (risk selection); and
- Segment their customer base by age / health status so that older and less healthy people pay more for insurance (market segmentation).

On the other hand, both consumers and efficient insurers would benefit from a properly functioning competitive market with a robust risk equalisation system.

The existing RES uses two measures to reallocate costs between insurers with the aim of equalising risk:

- Age related health credits (ARHC) which vary by age, gender and level of cover. Importantly, this is a prospective measure based on the characteristics of the insurer's policyholders.

- Hospital utilisation credits (HUC) payable in respect of some health services. This is a retrospective measure based on actual utilisation.

Credits are paid from the RES to insurers based on these factors and the credits are funded by a stamp duty payable by insurers that varies between adults and children and by level of cover. Currently the credits are designed to allocate approximately 80% of all credits to be based upon the prospective measure with the remainder being HUC payments. Risk equalisation credits and Stamp Duties are calculated using estimates of the expected market position over the period they will apply. However, payments to and from the Risk Equalisation Fund are based on actual underlying business mix and hospitalisation experiences of the different insurers.

### *Proposed changes*

The current RES has been operating since 2016. The Department of Health are proposing to introduce a new RES to commence from 2022 for a period of 5 years. As required by European law, the new scheme will be notified to the European Commission for appraisal under State Aid regulations.

The proposal put forward in the public consultation document was that the existing RES would be amended to include a High Cost Claims Pool. The existing elements of the RES, ARHC and HUC, would also remain. It has been proposed that the High Cost Claims Pool (HCCP) will initially be set at 40% quota share and €50,000 threshold. This means insurers will be paid credits equal to 40% of the cost of claims that are in excess of €50,000 in respect of a specified period of cover.

In developing the proposal for the new Risk Equalisation Scheme, the Department of Health together with the Authority have had regard to the following aims:

- The Principal Objective under the Health Insurance Act, 1994 (see Appendix)
- Avoiding over-compensation being made to a registered undertaking
- Fair and open competition in the health insurance market
- Avoiding the Fund sustaining surpluses or deficits from year to year
- Maintaining the sustainability of the market
- Maintaining the stability of the market which relies on younger cohorts continuing to purchase PHI. This is important to maintain the intergenerational solidarity that underpins the principal of community rating. This may be better achieved by a lower cost of PMI, including lower levels of stamp duty.

### *High Cost Claims Pool*

The concept of a high-cost claims pool exists in several risk equalisation schemes in different countries and is typically designed as a risk sharing pool for high-cost, low-incidence claims. A HCCP usually operate in conjunction with other features of risk equalisation schemes.

The major benefit of a HCCP is that it can provide compensation to the insurers who have claims from the most high cost/high risk individuals. This can reduce insurers' incentives to avoid insuring such individuals. The main disadvantage of a HCCP is that if claims above a certain level are covered by the pool, then there is also a risk that insurers would be less likely to challenge and efficiently manage high-cost claims.

A HCCP would increase the element of risk sharing based on health status or actual claims experience, similar to hospital utilisation credits. This contrasts with risk indicators/predictors such as age and sex which can lead to older healthy lives being overcompensated. The purpose of a HCCP is to share risk for low incidence and high cost claims at all ages.

The exact parameters of a High Cost Claims Pool will influence the effectiveness of the Risk Equalisation Scheme. A careful balance has to be struck when calibrating the High Cost Claims Pool taking into consideration all of the aims listed above.

In the consultation, it was proposed that a High Cost Claims Pool would be introduced in a gradual and phased manner with a view to maintaining market stability and to provide the opportunity to monitor market reaction and adjust the High Cost Claims Pool appropriately over time.

## Response to Consultation

The consultation was published in three national newspapers on 4th January 2021 with an initial deadline of 1st February 2021 which then got extended to 8th February 2021 on request.

By 8th February 2021, the Authority received 20 responses.

Of the 20 responses:

- 9 were from members of the public
- 7 from representative bodies/experts in a related subject matter
- 3 from open market insurers
- 1 from a restricted membership undertaking

The full list of respondents is listed in Appendix A and details of each submission will be published on www.hia.ie .

The Authority wishes to thank all those who contributed to the process.

The consultation asked for responses to four specific questions. Some of the submissions did not answer all/any of the questions and some went beyond the scope of the consultation and the questions posed.

We have attempted to group the responses under the four questions asked.

**Question 1**

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

Of the 20 responses, 10 confirmed that they agreed with the principle and overall substance of the Risk Equalisation Scheme ("RES"); 4 stated that they did not agree with the principle and/or the substance of the RES, and 6 did not address this question directly.

Of the 4 that disagreed with the principles and substance of the RES, various reasons were provided. One respondent, a member of the public, said they considered the cost of health insurance too expensive with annual price hikes and as such the RES is ineffective. Another member of the public had similar views, health insurance is too expensive and too complicated. In particular he raised the issue of minimum benefits and disagrees with benefits such as maternity being included in all products.

Another respondent disagreed with the RES on the grounds that it was inadequate. The submission claimed that the RES does not compensate insurers with higher risk profiles adequately. A consequence of the inadequacy is market segmentation with insurers being incentivised to risk select. It also stated that the insurers are making profits which are higher than normal.

Irish Life Health, an open market insurer, while supporting community rating and agreeing that an appropriate Risk Equalisation Scheme is necessary to support a community rated health insurance market, expressed an opinion that the existing RES is not adequate and a comprehensive review of the entire scheme is required.

*Authority response*

Having reviewed the responses, the Authority remains convinced that a risk equalisation scheme is required to support a community rated health insurance market in Ireland.

In a community rated market without robust risk equalisation, insurers will design products to attract customers with lower risk profiles, which will tend to be more profitable, other things being equal. Also, while insurers would be expected to benefit from the profitable custom of healthier consumers, insurers with products that attract less healthy consumers would be at a financial disadvantage by incurring claims costs that are higher than the community rated premium. As a result, in the absence of a robust risk equalisation system, insurers will be incentivised to design products so that they are not attractive to less healthy consumers, who are usually older. On the other hand, both consumers and efficient insurers would benefit from a properly functioning competitive market. Consumers would benefit from price and product competition. Insurers that design, sell and administer products in a cost effective manner that are attractive to the market would be profitable. This would not be the case in a community rated health insurance market which does not have a robust risk equalisation system.

Impact on consumers

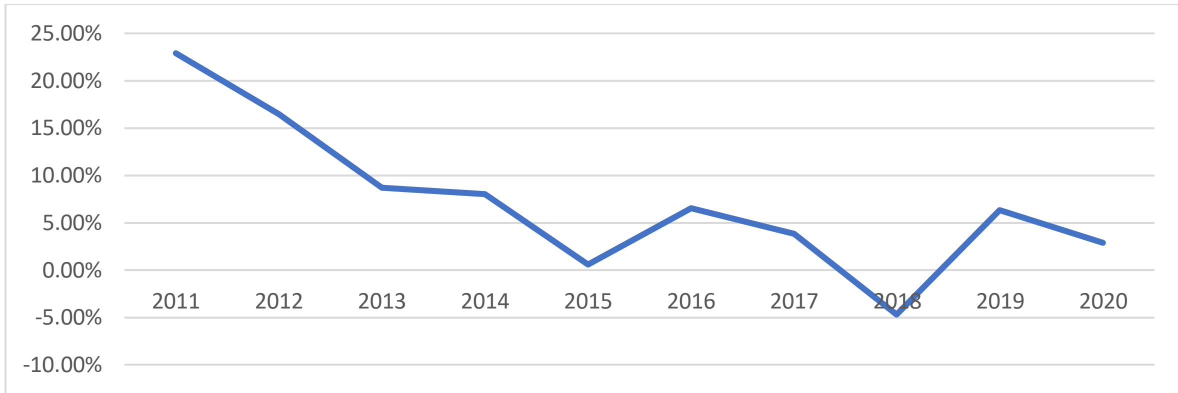
In a community rated market without a robust risk equalisation system, risk selection and segmentation become critical to the commercial success or failure of health insurance providers. In order to compete in such a market, insurers will try to focus their commercial activity on designing

and selling products that improve their risk profiles rather than, for example, on improving their efficiency. As younger and healthier consumers are more likely to be profitable, insurers would actively seek them out as customers and these customers would benefit, in the short to medium term. As less healthy consumers, who tend to be older, are not as profitable, insurers may make their products less attractive to them. Insurers may market themselves in a manner so that older and less healthy consumers are less likely to be aware of new more competitive plans aimed at younger healthier consumers. For example, insurers may do this by limiting benefits that might be valued by this group. Despite the requirements to adhere to community rating and open enrolment, insurers would be able to adopt a range of commercial practices to assist them in risk selection and risk segmentation in the absence of a robust risk equalisation system. The result would be that older and less healthy people would increasingly pay more for health insurance than younger and healthier consumers. This is contrary to the principal objective of the Minister and the Authority under the Health Insurance Acts.

Impact on the market

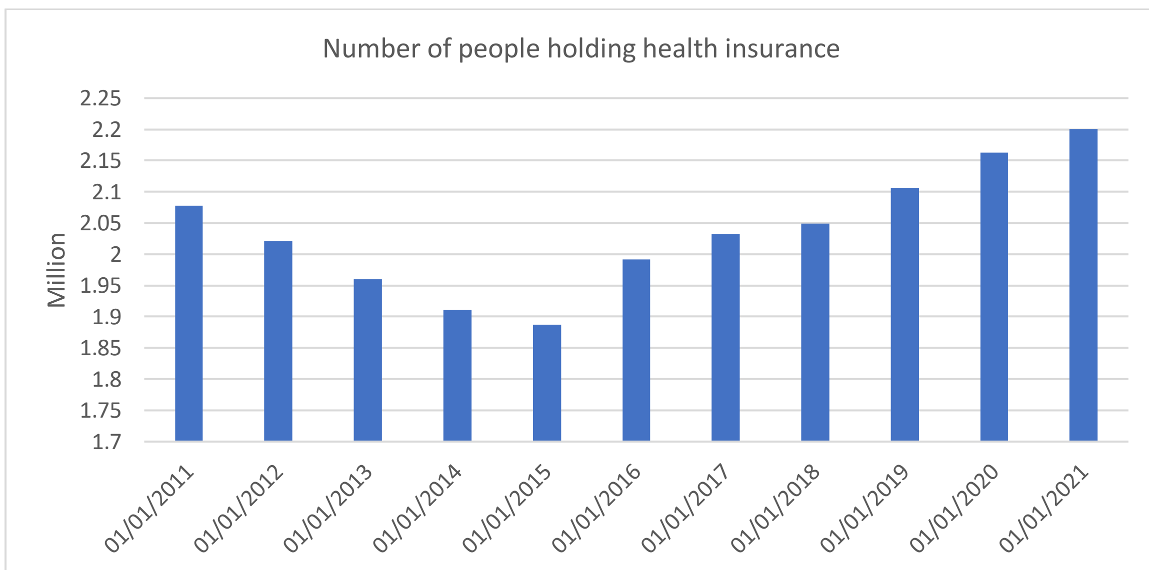
The Authority is concerned that a systemic issue might arise for the market if the long term viability of insurers with less favourable risk profiles was negatively impacted by risk selection, absent a risk equalisation scheme. If an insurer left the market, there would be consequences for both competition and the stability of the health insurance market as a whole. Regardless of its level of efficiency, an insurer with a less favourable risk profile at a product level would be obliged to either have higher premiums than the market or incur significant losses. If its premiums were higher, than the market it is more likely to lose younger rather than older customers (as younger customers have a greater propensity to switch / or let their insurance coverage lapse if they perceive coverage to be too expensive), on the basis that their better health status means they have a lower need for health insurance. A worsening risk profile might oblige an insurer to increase premiums further, resulting in a worsening cycle. It is important to note that, because competition is distorted via risk selection, an insurer would incur such difficulties regardless of its level of efficiency or the attractiveness of its products; such difficulties would result directly from its risk profile in the absence of a robust risk equalisation system.

The Authority considers that the Irish health insurance market, which does include a Risk Equalisation Scheme, demonstrates a reasonable level of competition. The chart below shows a history of premium inflation as measured by the consumer price index. This measures changes in the price of “insurance connected with health”. We can see that this has fallen from highs of close to 23% in 2011, which could be taken as indicating the existence of competition in the market.




Furthermore, the market share of the largest insurer was 58.6% in December 2012 but in December 2020 was 51%. This demonstrates that the market is becoming more competitive over time.

The market is also continuing to grow with 2.2m holding health insurance contracts as at 1 January 2021.




Over the years refinements have been made to the risk equalisation schemes always with a view to improving its efficiency and adequacy and consequently to promote competition and disincentivise market segmentation. Establishing an effective risk equalisation scheme is challenging and in a market which has over 300 contracts available from just three insurers it is apparent there is still a significant level of market segmentation. The effectiveness of a risk equalisation scheme needs to be monitored and requires regular updates. The intention of the proposal to include a High Cost Claims Pool (HCCP), set out in the public consultation, is to add a further refinement with a few to further enhancing the effectiveness.

In response to the issue raised with regard to minimum benefits, the Authority notes that under the Minimum Benefit Regulations (S.I. No 83/1996), all insurance products that provide cover for inpatient hospital treatment must provide a certain minimum level of benefits. It is considered necessary to regulate the minimum level of benefits because of the complex and specialist nature of private health insurance products, which without regulation, could result in consumers being provided with products that do not provide a sufficiently comprehensive level of cover. Based on the principles of open enrolment and community rating, insurers are required to offer products

without discriminating on the basis of sex, age or health status.  For that reason, insurers are required to offer products that cover the same set of minimum benefits to all customers.

The Authority keeps the scope of minimum benefits under review to ensure that they remain appropriate.

**Question 2**

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

The proposed change as outlined in the public consultation was the introduction of a high cost claims pool (HCCP). In the consultation, it was proposed that the HCCP would be introduced with an initial quota share of 40% and a threshold of €50,000. The Threshold reflects the level above which claims can be included in the HCCP, and the quota share represents the share of the claim above the threshold that will be covered by the HCCP.

Of the 20 responses, 9 stated that the introduction of a HCCP would not impact their involvement in the Risk Equalisation Scheme, 9 did not comment and 2 responses specifically stated that the proposed change would impact their involvement in the RES. One of the two who stated that it would have an impact was a member of the public and no reason or further detail was included as to why it would impact their involvement. The other was from Irish Life Health who stated that, based on their understanding of how the HCCP would be implemented, its introduction would likely lead them to review their plans for innovation. The introduction of a HCCP would also change how they would approach and invest in the market. Irish Life Health acknowledge that the HCCP, in theory, may increase the effectiveness of the RES, based on the current measure of effectiveness. However, their view is that, based on the information available to them, it is likely to increase the cost of health insurance for those who can least afford it. Irish Life Health were also of the opinion that the HCCP will share inefficiencies across the market and increase claims cost to the detriment of customers and cause further instability within the market. They also state that they believe it will result in further overcompensation of the net beneficiary of the RES.

Laya Healthcare confirmed that they are committed to the private health insurance market and although the introduction of a HCCP is likely to have an adverse impact on Laya Healthcare, they accept that it would increase the effectiveness of the RES.

Vhi also stated that they remain committed to the market and that no proposed changes would affect that commitment.

*Authority response*

The principal objective of the Authority in performing its functions under the Health Insurance Act, 1994 ("the Act") 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).

In making its recommendation to the Department of Health on the inclusion of a HCCP in the RES from 2022, the Authority acknowledges the importance of maintaining stability in the market. The recommendations are set out in a separate report titled "Recommendation to the Department of Health on proposed changes to be incorporated into the Risk Equalisation Scheme" referred to hereafter as the "Recommendation report". The report is published on the Authority website alongside this response to consultation. A report from the Authority's external expert advisors, KPMG, which was considered in the recommendations made by the Authority has also been published.

One of the key objectives, therefore, of any change in the RES, including the introduction of a HCCP, is that it should be done in a gradual manner with the aim of maintaining market stability. To this end, it has recommended that HCCP credits should represent approximately 10% of the overall value of credits in the first year that it is introduced. This is considered in Section 9 and 10 of the Recommendation report.

Another objective in relation to the recommendation of risk equalisation credits and stamp duties for the RES is to avoid overcompensation. This objective has been considered as part of the overall recommendation to the Department of Health. The Authority is required to carry out an overcompensation assessment according to section 7F of the Health Insurance Acts. The overcompensation assessment is required to be performed in each of the three years 2019 to 2021 for the appropriate time periods ending in the previous December. A separate overcompensation assessment report is prepared each year for the Minister.

This overcompensation assessment will continue as part of the new RES. The credits payable as part of the HCCP will be treated in the same manner as other credits payable to the insurers. In this way, the Authority will be in a position to assess the impact of all RES credits on the net-beneficiary insurer, and assess whether any over-compensation has taken place.

The provision in Section 7F(2)(b) that the Minister may prescribe Regulations with regard to the preparation of the financial statements referred to in Section 7F(1) has been law since Section 7F was first enacted in the Health Insurance (Miscellaneous Provisions) Act 2009. The Authority have also just completed draft regulations under Section 7F(2)(b) of the Health Insurance Act, the regulations are intended to facilitate an effective and fair overcompensation assessment as set out in the Health Insurance Acts (the Acts). The regulations are currently under consideration by the Department of Health and subject to this would be published by the Department of Health as secondary legislation.

Full detail of the recommendations made by the Authority and the considerations and objectives underpinning those recommendations are set out in Recommendation report.

## Question 3

### *Are there risks or vulnerabilities that do not feature and should be included, and why*

The answers, where provided, were varied and covered a large number of topics and themes. We have extracted and summarised the common themes.

### Transparency

A number of responses stated that more information and detail was required in relation to the implementation of a HCCP, the rationale underpinning the proposed HCCP parameters, the impact on the other RES components and how the calibration will change over the term of the RES.

*Authority Response*

The Authority has set out its recommendations in relation to the inclusion of a HCCP in the RES and the progression of the RES over its 5 year term in its report to the Department of Health. This report sets out the options considered by the Authority, the data upon which the analysis has been conducted and the rationale underpinning the recommendations. It also includes analysis on the projected impacts on key metrics such as net claims cost after RES, impact on other credits of the RES and impact on stamp duty.

### Sustainability and Affordability

Irish Life Health stated in their response that the risk to the future sustainability of the health insurance market appeared not to have been considered in the review of the RES. They highlighted the need to attract sufficient young lives with the goal of intergenerational support and that should not mean persons on cheaper plans subsidising consumers who chose to pay for more expensive plans. They consider that there is a risk to that health insurance becomes unaffordable for younger/healthier lives and that the RES exacerbates the affordability challenge by not adequately managing the size of the subsidy from lower risk customers to higher risk customers.

Vhi also mentioned long term affordability as a risk to the future sustainability of the market, they identified medical inflation as being the long term risk to affordability.

Vhi also stated that there is the risk that credits are not adequately sharing risks among insurers and as such insurers do not bear their fair share of the health risks to support community rating. This is resulting in “super normal” profits by insurers which are not returned to customers or spent on healthcare needs and as such is impacting affordability and competition.

Laya Healthcare also expressed their views on the risk to affordability and that this must be considered. They proposed no change to stamp duty as one way to address this risk.

Laya Healthcare also believes there is a risk that an insurer is disproportionately compensated by the RES leading to unfair competitive advantage.

*Authority response*

The principal objective of the Authority in performing their functions under the Act 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 subsidy which is in operation in the health insurance market is not fundamentally one from lower-benefit plans to higher-benefit plans in terms of which plans pay the highest proportion of stamp duty, but one of the low-risk portion of the market paying for the credits which the high-risk portion of the market accrues. In calculating the levels of risk equalisation credit that will apply for the following year, the Authority bases the credits that will apply for advanced cover plans (92% of market are in advanced plans) on the Level 2 products. Level 2 products provide substantial cover in private hospitals but this cover is mainly provided for semi-private accommodation. At 31 December 2020, 76% of consumers with health insurance held level 2 products, with 9% holding lower levels of cover and 15% holding higher levels of cover. By setting the credits based on the claims covered in the Level 2 products, the Authority considers that the Stamp Duty and credits will not include the higher hospital accommodation costs which may be covered by high-benefit plans. In general, the Authority would note that a market level the greatest driver of increased claims costs is age, not the specific plan purchased.

The high cost claims pool data provided by the insurers showed that the size of the claim for claims over €50,000 does not vary significantly by age but the frequency of occurrence increases with age. This suggests that high cost claims are not linked to "benefit richness" or level of cover. Including a HCCP, therefore, does not create cross subsidisation whereby lower benefit plans subsidise higher level plans as suggested by Irish Life Health.

The Authority has considered the potential impact of the inclusion of a HCCP on the stability of the market, affordability and sustainability. This is addressed in detail in the Recommendation report. In summary, the recommendation is that the inclusion of a HCCP would not increase the overall level of credits but rather redistribute credit based on health status. From a long term perspective, the Authority will continue to monitor the market and the effectiveness of the RES as the market evolves. The Authority considers that any changes should be incremental with a view to maintaining market stability and avoiding shocks.

### Health status

The submission from the Society of Actuaries and from Dr Conor Keegan mentioned the risk that not all large claims are associated with poor health status/chronic conditions and asked if the HCCP will be differentiating between such claims as is done in some other international schemes.

*Authority Response*

The Authority has considered what claims should be eligible for HCCP purposes and considered the following two options

- Eligible claims should be based on "Returned Benefits"[1] which is consistent with the existing RES calibration
- Eligible claims should be based on "Claims"[2]

The determination of risk equalisation credits and stamp duties is currently based on Returned Benefits as defined in the Act. Returned benefits typically exclude services not involving a hospital admission, such as outpatient services and services relating to preventative health services, infertility, dental or cosmetic services.

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[1] The rules for which benefits should be included in the information returns are set out in the Health Insurance Act 1994 (Information Returns) Regulations 2009 as amended.

[2] "Claims" as defined in the Health Insurance Act 1994 (information Returns) Regulations 2009

As part of the above assessment of options it was also considered if there should be any other exclusions or refinements made to the definition of eligible claims and one such consideration was should a distinction be made between predictable (chronic illness) and non-predictable (following a serious accident) high cost claims. The aim of the introduction of a HCCP is to compensate for costs of health services, while a DRG based scheme would be prospective in terms of differentiating between chronic and non-predictable claim. We note that high cost claims occur as a result of non-predictable claims as well as chronic illnesses. The Authority is of the view that the HCCP should not distinguish between recurring chronic high cost claims and one off claims at the current time. Such a level of refinement could be addressed with the introduction of DRGs.

The Authority also considered the treatment of ancillary costs and drugs which are not approved by the HSE and/or relevant regulatory bodies in its analysis of definition of eligible claims. Both of these specific items were also raised in submissions to the consultation and fall under the consideration of the definition of eligible claims.

The Authority has recommended that initially eligible claims for HCCP purposes should be based on Returned Benefits. This definition is consistent with the existing RES and based on the HCCP data provided by the three insurers Returned Benefits represent c98% of total claims in respect of high cost claims in excess of €50,000.

Section 7 of the Recommendation Report for further information on the rationale underpinning the recommendation on the definition of eligible claims for HCCP purposes.

### Overcompensation

A common response was in relation to the risk of overcompensation of the net beneficiary of the RES. The suggestion commonly included was that there should be more transparency with regard to the overcompensation test. This comment was made by all three open market insurers.

Irish Life Health believes that the introduction of a HCCP heightens the risk of over compensation and that the current overcompensation test is not fit for purpose.

Laya Healthcare stated that a greater of level of transparency, regulatory oversight and independent verification should be introduced to mitigate the risk of overcompensation from the RES.

Vhi recommended that the benchmark of comparable insurers is published to improve market transparency.

*Authority Response*

Annually, the Authority assess whether or not the RES credits it is recommending are likely to give rise to a return on sales in excess of the benchmark of 4.4% (the overcompensation test) every year. This is done in the context of the Authority's annual recommendation to the Minister in relation to risk equalisation credits and stamp duties. One of the aims of the RES as outlined in Section 7E(1)(b) of the Act is to avoid overcompensation.

The credits paid in respect of the HCCP will be treated in the same manner as the HUC and ARHC in terms of assessing overcompensation. The recommendation being made in respect of the HCCP to be included in the first year of the RES is projected to have relatively small impact on the net flows of the RES for each insurer and is not expected to increase the likelihood of the net recipient of the RES being overcompensated. Please refer to Section 10 of the Recommendation Report.

Each year this will be considered as part of the recommendation to the Minister on the risk equalisation credits and stamp duties for the year ahead.

The Authority is required to carry out an overcompensation assessment according to section 7F of the Health Insurance Acts. The overcompensation assessment is required to be performed in each of the three years 2019 to 2021 for the appropriate time periods ending in the previous December. A separate overcompensation assessment report is prepared each year for the Minister. The overcompensation test itself is also currently under review and the draft regulations have been shared with the three open market insurers for discussion and in the interests of transparency.

A review on the benchmark for reasonable profit as it currently stands as a return on sales, gross of reinsurance and excluding investment income, not exceeding 4.4%in a three year period is also being conducted and each of the insurer's views have been sought on this.

The retrospective overcompensation assessment will take into consideration all risk equalisation credits including those in respect of the HCCP.

## Administration

Dr Conor Keegan asked the question whether or not the increased data requirements to implement the HCCP would pose any data protection issues for the insurers or indeed any resourcing issues for the Authority.

*Authority response*

In its recommendation the Authority has considered the administrative burden and challenges that a HCCP may bring for the open market insurers and the Authority itself.

The Authority intends to have an open discussion with the insurers with regards to how the existing administrative processes will need to be adapted to accommodate a HCCP. This would include the processes for making claims for credits from the Risk Equalisation Fund and in terms of reporting twice yearly as part of the information return process. The objective is to agree a common approach across all three open market insurers, to facilitate the administration of the scheme.

The Authority is confident that the changes in the administration of the RES by the inclusion of the HCCP will not have a negative impact on the operation of the RES.

## Conflicting interests

Two responses, Ruth Barrington and Irish Life Health, commented that a risk/vulnerability of the RES is the conflict associated with the role of the Minister of Health. Irish Life Health considered that the Minister is conflicted due to its role as ultimate regulator of the of the health insurance market, the state ownership of Vhi and controller of the largest hospital network for the provision of private health serves in the State. Ruth Barrington stated that the Minister and Department of Health had other potentially conflicting interests in the health insurance market.

*Authority Response*

The role of the Authority and the Minister for Health are defined in legislation in the Health Insurance Acts, 1994. The Authority is established and operates as an independent statutory regulator and its functions are defined in the relevant legislation. The Authority is independent of the Department of Health in the exercise of its functions and part of its role is to support the Minister.

The principal functions of the Authority as provided for in the Health Insurance Acts include the following:

- To monitor the health insurance market and to advise the Minister for Health (either at his or her request or on its own initiative) on matters relating to health insurance;
- To monitor the operation of the Health Insurance Acts ("the Acts") and, where appropriate, to issue enforcement notices to enforce compliance with the Acts or take prosecutions;
- To carry out certain functions in relation to health insurance stamp duty and risk equalisation credits and in relation to the risk equalisation scheme;
- To take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
- To maintain "The Register of Health Benefits Undertakings" and "The Register of Health Insurance Contracts".

The Authority is audited by the Comptroller and Auditor General and subject to the requirements thereof. The Authority is also subject to the corporate governance procedures of the "Code of Practice for the Governance of State Bodies" issued by the Department of Finance.

The role of the Department of Health and the Minister in ultimately setting risk equalisation credits and stamp duties under the RES and any potential for conflicts of interest is a matter for the Minister.

## Timing

Laya Healthcare raised concerns over the timing of changes to the RES on the grounds that it could destabilise an already volatile market, during the current ongoing pandemic. They suggested that it would be better to introduce the HCCP at a time when economy has recovered and employment levels return to pre-pandemic levels.

*Authority response*

The new RES and introduction of a HCCP was due to be effective from April 2021 but was postponed until 2022 at the request of the Department of Health in recognition of the uncertainty that existed in the market as a result of COVID-19. One of the key drivers of the postponement was to ensure that there was a reasonable degree of market stability before changes to the RES was introduced. The Department of Health and the Authority are of the view that the implementation of the new RES and indeed improvements in its effectiveness by the inclusion of a HCCP should now proceed. Based on figures at 31 March 2021, participation in the private health insurance market has not been adversely impacted so far by economic impacts of COVID-19. Indeed, increasing numbers of people have taken out health insurance compared to the previous 12 months.

Market stability has been a key consideration in the Authority's recommendation on the calibration of RES 2022. This has been one of the key objectives of the Authority's recommendations with regard and it is also aware of ensuring insurers are appropriately informed to allow sufficient time to factor into their pricing and policies.

**Question 4**

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

There were a number of topics raised in response to this question, common topics and themes have been summarised below.

## Interaction with other risk equalisation credits

Laya Healthcare believe that age related health credits should be reduced to fund the introduction of the HCCP allowing stamp duty to remain unaffected and in their opinion improving the competitive balance in the market. Irish Life Health state that unless changes are made to the age related credits and/or hospital utilisation credits, there could be a significant overlap with existing credits for some high cost claims which depending on the nature of the high cost claims and the age/gender of the claimant could lead to a significant difference in the credits received by an insurer.

*Authority response*

The existing RES redistributes funds from the Risk Equalisation Fund ("REF") on the basis of age related health credits (ARHC) which vary by age, gender and level of cover and hospital utilisation credits (HUC) based on hospital utilisation.
The introduction of a HCCP to the existing RES required the Authority to assess how the HCCP will interact with these existing credits. The Authority considered two options:

- Adjusting the level of HCCP credits to take into account ARHC and HUC associated with the life in the specified period; or
- Make no adjustment to the level of HCCP credits for ARHC and HUC paid from the REF.

Taking on board the outcome of the analysis, the aims and objectives of the RES, the Authority have recommended an adjustment to the level of HCCP credits for ARHC and HUC already received in respect of an insured life. The recommendation is for a partial offsetting of credits and reduces the variation in credits by age for high cost claimants, albeit a life over 65 would still receive a marginally higher credit. It should be noted that based on the high cost claims data received by the insurers, the size of a high cost claim does not vary significantly by age but the frequency of occurrence does increase by age.

Section 5 of the Recommendation report sets out the analysis carried out, the pros and cons of both options and the recommendation of the Authority.

## Cap on claims

A number of submissions commented that consideration should be given to placing a cap on the level of claims which are eligible for HCCP credits. The reasoning for a cap would be to ensure that insurers are incentivised to continue to manage very high claims as efficiently as possible. This would limit the amount of claims that are shared across all customers via the HCCP.

*Authority response*

The Authority gave consideration to this proposal but based on the HCCP data provided to it by the insurers, did not determine any justification for a cap at the current time. However, the Authority is recommending that it reserves the right to introduce a cap at a future date if so required. Section 8 of the Recommendation report provides more detail on this recommendation.

## Diagnostic Related Groups

All three of the insurers and other representative bodies in their submissions highlight the crucial need for a move to implement Diagnostic Related Groups (DRGs) in the near future.

The Department of Health and the Authority are supportive of DRGs and recognise the merits of the incorporation of DRGs within the RES as a means to increase its effectiveness.

Whilst it had been the hope that DRGs would have formed part of the new RES, it was recognised that it will take time to implement and a HCCP was put forward as an interim step to improve effectiveness and increase the element of RES credits attributable to actual health status.

The Authority will continue to support the Department of health towards the goal of implementation of DRGs as a component of the RES.

## Stamp duty as a % of premium

Irish Life Health's view is that the current flat rate stamp duty is socially regressive, inequitable and poses a significant risk to the sustainability of the market by making entry plans expensive and discouraging younger and healthier customers from taking out health insurance. Their view is that stamp duty should be set as a % of premium.

*Authority Response*

Each insurer pays a stamp duty in respect of each insured person to the Risk Equalisation Scheme. The stamp duty is then paid back to the insurers in the form of risk equalisation credits depending on the age profile and level of claims that they experience. In this way, the community rated market is enabled and each consumer pays the same premium for their health insurance policy.

Stamp duty is a fixed flat amount which varies by age, adult or child, and by level of cover, advanced or non-advanced. As at 31 December 2020, 92% of the insured population are in advanced products and as such the applicable stamp duty is currently €449 for an adult or €157 for a child.

In a report prepared in January 2020 by the Authority for the Department of Health (which was shared with each of the insurers), stamp duty as a % of premium was examined. This analysis showed that stamp duty as a % of premium decreased the effectiveness of the RES by a considerable amount. This was not unexpected as if the total level of stamp duty collected remains unchanged and younger people typically have lower premiums due to the products they select, the amount of stamp duty payable by older lives increases which in turn increase the net claims cost for older ages.

We know from the insurer market and claims data reported to the Authority that those over age 65 typically pay on average c30% more for their insurance plans than under 65s due to their product choices. An approach whereby the credits paid from the RES are funded by a stamp duty charged as a percentage of premium would place a higher financial burden on those paying higher premiums. This would result in older and less healthy people funding a higher proportion of the credits. This would be a fundamental dilution of the purpose and effectiveness of the scheme.

It should also be noted that there is no price control in health insurance. The Health Insurance Acts permit insurers to vary the premiums of health insurance plans once they provide at least 30 days' notice to the Authority

The Authority have not at this time recommended the introduction of a stamp duty as a percentage of premium.

### Effectiveness measure

Two submissions stated their views on what an appropriate measure of effectiveness should be given the aim of the introduction of a HCCP is to improve the effectiveness of the RES.

*Authority Response*

In January 2020 the Authority prepared a report to the Department of Health on the introduction of the HCCP and its impact on effectiveness.[3] Within this report the Authority defined their measure of effectiveness[4] which would be used as a means to measure if various refinements of the RES increased or decreased the existing effectiveness of the RES. There are various ways in which effectiveness could be defined and measured but the Authority have continued to use this measure in their latest Recommendation report. It should be noted that the impact on effectiveness is just one of many metrics used in assessing the various options with regard to the HCCP and its incorporation into the RES.

[3] RES Effectiveness: Impact Assessment of the Introduction of a HCCP and changes to other measures

[4] "Effectiveness" is defined in the previous report and is a "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

## Other

Within the submissions received some topics were raised which the Authority consider to be outside of the scope of the current review of the RES but which are valid and note worthy items which should be considered and explored further for potential inclusion in future work programmes and reviews to be carried out by the Authority.

A summary of those topics and comments/suggestions made are outlined below.

### Returned Benefit definition

Adjust claims to recognise the Covid inspired changes in private healthcare delivery and, where necessary, medical services required by customers to non-hospital settings.

### Minimum benefit review

Review the benefits included under minimum benefit legislation

### Product proliferation and design

The vast number and complexity of plans in the market is confusing to consumers and makes it difficult to choose and understand the level of cover being provided. The number of plans should be reduced. The practice of introducing co-payments for commonly required procedures such as orthopaedic and ophthalmic procedures and indeed marketing points to market segmentation and risk selection.

### Flexibility of the RES

The RES should be able to react and adjust to unforeseen circumstances such as COVID-19.

### Standardised plan

The RES should be based on a standardised plan with standardised costs.

### Luxury benefits

Luxury' benefits are typically defined as the higher prices of private room accommodation within acute hospitals. The treatment of 'luxury' benefits within RES 2016 is now outdated and inappropriate.

## Appendix A – Submissions received

Alliance of Retirement Public Servants
AON (Health Care Advisors for large multinationals)
Dr Conor Keegan
ESB Staff Medical Provident Fund
Irish Life Health
Irish Society of Physicians in Geriatric Medicine
Laya Healthcare
Retired Civil and Public Servants Association
Ruth Barrington, *Former Assistant Secretary, Department of Health Chief Executive, Health Research Board Director, Voluntary Health Insurance Board*
Society of Actuaries in Ireland
Vhi Insurance Dac

9 members of the public also responded

## Appendix B – 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 health services 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.

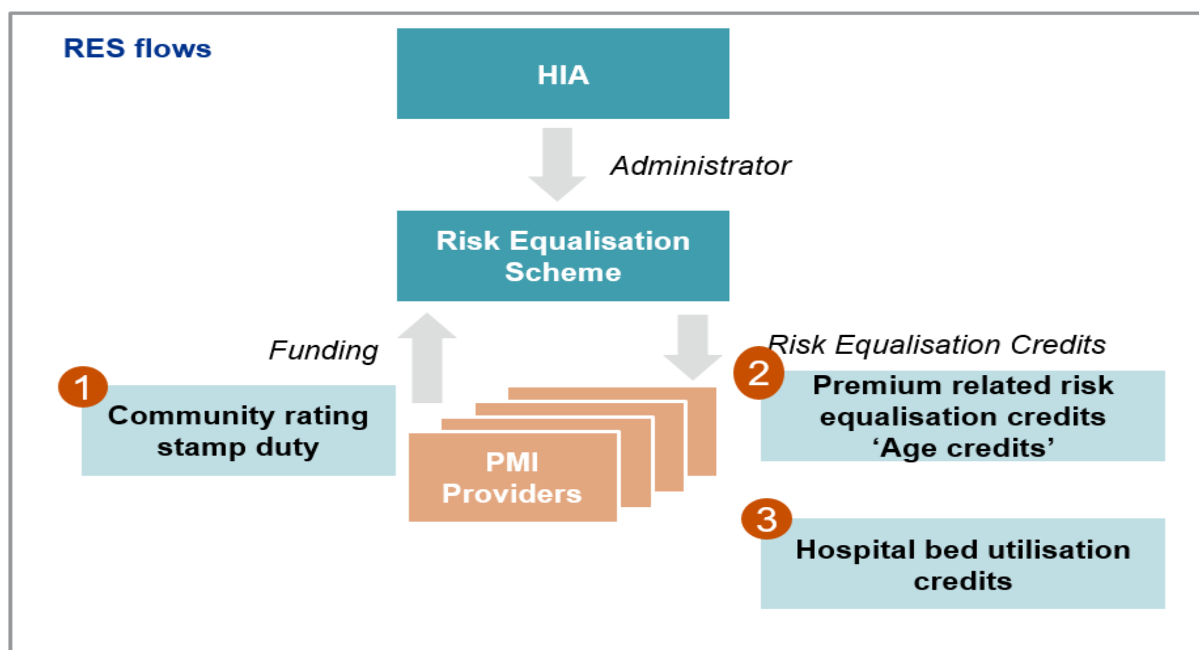
3) Nothing in this section shall affect the operation of section 7(5) or 7A.

## Appendix C – Risk Equalisation

Risk equalisation aims to reduce or eliminate expected differences in insurers' claims costs that arise due to variations in known risk factors of the insurers' customers, for instance age of insured in health insurance. On average, in a community rated market without a RES, older and unhealthy consumers tend to be unprofitable.

*Risk Equalisation Fund*

- The REF, administered by the HIA, provides insurers with risk equalisation credits. Risk equalisation credits vary with customers' age, gender, level of cover and hospital utilisation.
- Risk equalisation credits and Stamp Duties are calculated using estimates of the expected market position over the period they will apply. However, payments to and from the REF are based on actual underlying business mix and hospitalisation experiences of the different insurers.
- The RES is designed and calibrated with the aim of avoiding overcompensation. In order for the RES to be effective it needs to strike an appropriate balance between compensating insurers with higher levels of risk, maintaining the sustainability of the market, having fair and open competition in the market and promoting efficiency so as to reduce overall claims costs. An insurer is considered to be overcompensated by the RES if over a three year period it makes a surplus that exceeds a "reasonable profit". To date overcompensation payments back into the Risk REF have not occurred.
- According to the EU-Commission's Decision (SA.41702), all insurers (except RMUs) in the Irish PMI market are SGEI providers and will receive credits from the 2016 RES, and thus could potentially be net beneficiaries of the scheme.



*Community rating stamp duty ('Stamp Duty')*

- The system is funded by the community rating stamp duty, which is payable by open membership undertakings to the Revenue Commissioners who pass the money to the REF. The stamp duty is payable for each person insured on a contract to which the RES applies. There are four rates of stamp duty, with different rates for adults and for children (persons under the age of 18 are generally one third of the adult rate) and different rates for advanced contracts and for non-advanced contracts.

- The risk equalisation credits and the stamp duty are administered by the health insurance companies and the REF. Risk equalisation credits are paid out of the REF to the insurers. Any projected surpluses or deficits in the REF are carried forward and allowed for in setting future stamp duty amounts.

*Premium related risk equalisation credits ('Age credits')*

- Premium related risk equalisation credits, as follows:

    - Age and gender:
      credits varying in 5 year age bands up to age 85 and for age 85 and above;

    - Different credits for each gender (at higher ages average claims costs for males significantly exceed those for females).

    - Level of cover: credits for advanced contracts are higher than those for non-advanced contracts due to higher expected claims levels.

*Hospital bed utilisation credits*

Fixed amounts for each overnight stay in hospital, as well as for all day-case admissions to hospitals. In this way, the cost of claims arising for those who spend nights / in hospitals is reduced, reducing the cost to the insurer of insuring less healthy people. The same HBUC applies across all age / gender and level of cover groups. It is set at a level to avoid incentive for hospitalisation.

## Appendix D – Age related credits

The following age-related credits will apply from 1 April 2021:

| Age Bands | Age / gender / level of cover credits from 1 April 2021 | | | |
|---|---|---|---|---|
| | Non-advanced | | Advanced | |
| | Men | Women | Men | Women |
| | | | | |
| 64 and under | €0 | €0 | €0 | €0 |
| 65-69 | €350 | €200 | €1,025 | €550 |
| 70-74 | €550 | €400 | €1,675 | €1150 |
| 75-79 | €825 | €625 | €2,500 | €1,800 |
| 80-84 | €1,025 | €700 | €3,150 | €2,250 |
| 85 and above | €1,250 | €825 | €3,750 | €2,550 |

The hospital utilisation credit amounts from 1 April 2021 will be €125 for an overnight hospital stay and €75 for a day case admission.

The stamp duty on health insurance contracts that will apply from 1 April 2021 are as follows:

| Age Bands | Stamp duties from 1 April 2020 to 31 March 2021 | |
|---|---|---|
| | Non-advanced | Advanced |
| 17 and under | €52 | €150 |
| 18 and over | €157 | €449 |

## Appendix E - Glossary

| | |
|---|---|
| Act | Health Insurance Acts 1994 to 2020 |
| ARHC | Age Related Health Credits |
| Claims Cost Ceiling | The age related credit for an age group is determined such that the average claims cost for that age group after allowing for the impact of the expected utilisation credits, age related credits and the stamp duty required to fund these, would be at most a fixed percentage of the market average claims costs across all age groups. |
| DoH | Department of Health |
| DRG | Diagnosis Related Groups |
| HCCP | High Cost Claims Pool |
| HIA | Health Insurance Authority |
| HUC | Hospital Utilisation Credit |
| Irish Life/ILH | Irish Life Health |
| Laya | Laya Healthcare |
| NFI | Net Financial Impact |
| Quota share | The percentage of claim which is compensated |
| RES | Risk Equalisation Scheme |
| REF | Risk Equalisation Fund |
| Stamp Duty | Community rating stamp duty: contributions to RES by PMI providers payable for each person insured on a contract to which the RES applies. |
| The Authority | Health Insurance Authority (statutory regulator of Irish PMI market) |
| Threshold | The portion of claims above this amount are eligible for risk sharing within the HCCP |
| UHI | Universal Health Insurance |
| Vhi | Vhi Insurance Dac |

## Appendix F - References

*HIA Report to Department of Health, "Report on Hight Cost Claims Pool", April 2019*

"RES Effectiveness: Impact Assessment of the Introduction of a HCCP and changes to other measure" January 2020 report from HIA to Department of Health

*RES 2021 report: "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, include advice on Risk Equalisation Credits", September 2020*

*KPMG report to the Authority: "Report on final proposed calibrations of the HCCP", 12 May 2021*