Compliance with Health Insurance Acts, 1994 to 2016

This document lists issues that arise for an insurer in complying with the Health Insurance Acts 1994 - 2016. The document is not a comprehensive description of the legislative requirements and is written in simplified language. The actual legislation should be examined to determine the exact measures an insurer must adopt to comply with the legislation. This document does not deal with the legislative environment for holding an authorisation from the Central Bank of Ireland to transact non life insurance business in Ireland.

Prohibition on carrying on of Health Insurance Business unless registered with HIA

Section 16 of the Health Insurance Act, 1994 prohibits any person other than a registered undertaking from carrying on health insurance business. Health insurance contracts are contracts where one of the purposes involves the reimbursement or discharge in whole or in part of charges in respect of hospital inpatient services or relevant health services (outpatient services).

The detail of what is involved in being on the Register of Health Insurance Undertakings is set out in Sections 14 and 15 of the Health Insurance Act, 1994 and in SI 80 of 1996, SI 72 of 2009 and SI 335 of 2005. It involves holding an authorisation (within the meaning of the EC (Non Life Insurance) Framework Regulations 1994) for the time being in force to carry on non-life insurance business and complying with the provisions of the Health Insurance Act 1994.

Community Rating:

Section 7 of the Health Insurance Act 1994 (as implemented by Section 5 of the 2001 Act and Section 2 of the Health Insurance (Amendment Act 2014) prohibits non community rated health insurance contracts. This means that insurers must charge all consumers, with certain limited exceptions, the same net premium for a given level of cover regardless of age, sex and other risk factors. The exceptions are:

- Children: the premium charged in respect of children (under 18) must be waived or reduced by the health insurer. Such a premium may not be more than 50% of the standard premium.
- Young Adults: Insurers may apply a sliding scale of premiums for young adults in the age range of 18 -25 that vary from 50% of the adult rate at ages 18 -20 to 100% of the adult rate at age 26.
- If you first buy health insurance at age 35 or over, an age at entry loading may apply to your premium. The loading is 2% of the gross premium for every year of age higher than age 34. Allowance is given for previous periods of cover as an adult, periods of unemployment since 2008 of up to 3 years and for people whose principal residence was outside the State on 1 May 2015 who takes out a health insurance policy within 9 months of their principal residence being in the State. (S.I. No 312 of 2014)
- Members of group schemes: the premium in respect of members of group schemes may be reduced, but may not be less than 90% of the standard premium.

Section 2(1) of the Health Insurance (Amendment) Act 2013 Act makes it clear that community rating applies to the gross premium less any risk equalisation credits and excludes any tax relief.

Open Enrolment

Insurers must accept all applicants for insurance cover, regardless of their risk status. The rules are set out in Section 8 of the Health Insurance Act, 2001.

Waiting Periods

Statutory Instrument No 79 of 2015 sets outs the maximum waiting periods an insurer may apply. A summary of these regulations is as follows:

The maximum waiting period for claims from accidents and injury is Nil.

The maximum waiting period in respect of maternity benefits is 52 weeks.

The maximum waiting period that a health insurer may impose in respect of other conditions that did not exist at the time that the insured person started insurance is 26 weeks.

The maximum waiting period that a health insurer may impose in respect of conditions that existed at the time that the insured person started the policy is 5 years. The definition of a pre-existing condition is an ailment, illness or condition where the signs or symptoms existed at any time in the period of 6 months prior to the policy commencing.

For upgrades in cover or switches between insurer, the maximum waiting period that an insurer can impose in respect of the additional benefits is 2 years.

If a gap in cover does not exceed 13 weeks, periods of cover are added together.

No waiting periods apply to chidren added to a policy within 13 weeks of their date of birth or adoption.

Minimum Benefits

There are minimum benefits that must be provided by all health insurance contracts except those that solely cover public hospital daily in patient charges or solely relevant health services (out-patient services). These are set out in the Minimum Benefit Regulations of 1996 (SI 83 of 1996), (SI 333 of 2005), (SI 612 of 2014) and (S.I 96 of 2015). The minimum benefits include:

- Public hospital daily in-patient charges of €75 a night for up to 10 nights.
- The cost of a multi occupancy room in a publicly funded hospital where the patient elects to be to be treated privately
- For in patient and day patient services in a private hospital, the lesser of (a) €171 for each in-patient day or (b) 60% of the charge made by the hospital less €51 for each day in a single room.
- Monetary amounts for special procedures
- Monetary amounts for consultant fees

Lifetime Cover

Under Section 9 of the Health Insurance Act 1994 as amended by Health Insurance (Amendment) Act 2016, an insurer may not refuse to insure anyone for health insurance except as set out in that Section.

General product rules

Under Section 7AB of the Health Insurance Act, 1994, as inserted by Health Insurance (Amendment) Act 2012, a registered undertaking shall submit a sample of each new or revised contract to the Health Insurance Authority not later than 30 days before first offering such a product. Section 11E(2) and Section 11E(3) of the Act require the Authority to determine whether each inpatient product provides for Non Advanced Cover or Advanced Cover. The definition of what constitutes Non Advanced Cover and Advanced Cover is set out in Section 11E(4) of the Act. A contract that provides health insurance cover of not more than 66% of the full cost for hospitals charges in a private hospital (or minimum benefits if greater) is a Non Advanced Cover contract. All other contracts are Advanced Cover contracts.

A change in Benefits payable under a contract can only be made on 1 April of a year if the change switches the contract from/to Advanced Cover/Non Advanced Cover.

An undertaking will maintain all offers for not less than 60 days on the same terms and conditions and the product has to be for a period of 12 months unless there is good and sufficient reason for a different term.

Prohibition of Inducements

Section 11 of the Health Insurance Act, 1994 prohibits health insurers from making inducements to a person to terminate or not to effect or renew a health insurance contract with that undertaking.

Information returns

A registered undertaking selling inpatient products (excluding restricted undertakings) shall make information returns half yearly. The format of the returns is set out in S.I No 294 of 2009 as amended by SI No 690 of 2011, SI No 522 of 2013 and SI No 608 of 2015.. These undertakings shall also provide profit & loss accounts and balance sheets in respect of its health insurance business annually.

Levy on insurers

Section 17 of the Health Insurance Act, 1994 and SI 255 of 2001 set out the rules that apply in relation to health insurers making levy returns to the Health Insurance Authority. These Regulations were amended in 2010 by SI No 539 of 2010 which reduced the levy payable to the Authority from 1 January 2011 from 0.14% to 0.12% of premium income. The levy was reduced in SI No. 528 of 2014 to 0.01% of premium income in 2015 and 2016 reverting to 0.09% of premium income from 2017 onwards

Support to community rating

The 2013 Risk Equalisation System involves open membership insurers receiving higher premiums for insuring older persons in in-patient health insurance plans.

Credits equal to the amount of the additional premium are payable to the insurer by the Risk Equalisation Fund (REF). As a result all adults with that level of in-patient cover pay the same net amount but insurers receive higher gross premiums in respect of insuring older persons to partly compensate for the expected higher levels of claims.

A payment is also made to insurers by the REF in respect of each night that a customer spends in private or semi private accommodation.

Credits are funded by a stamp duty payable by open membership insurers for each person that they insure in inpatient health insurance plans.

The health credits and the community rating health insurance levy are administered by the health insurance companies and the Risk Equalisation Fund. Community rating health insurance levy payments for renewals from 1 January 2013 are paid by insurers to the Revenue Commissioners who in turn transfer the money to the Risk Equalisation Fund. Risk Equalisation Credits are paid out of the REF to the insurers by The Health Insurance Authority. Any surpluses or deficits in the Fund are carried forward and allowed for in setting future stamp duty amounts.

The Health Insurance Acts sets out the process around Risk Equalisation Credits:

- The amounts of the Risk Equalisation Credits are specified in the Health Insurance Acts.
- The Authority evaluates and analyses claims, population and other data included in half yearly information returns.
- Once a year the Authority issues a report to the Minister for Health on its evaluation and analysis of these returns, if requested to do so by the Minister for Health. This report includes recommendations on the amounts of the risk equalisation credits and the amounts of the community rating stamp duties. The recommendations have regard to the principal objective of the Health Insurance Act 1994, the aim of avoiding overcompensation, the aim of maintaining the sustainability of the health insurance market and the aim of having fair and open competition.
- If the Minister for Health proposes to change the Risk Equalisation Credits he does so by proposing to the Oireachtas amendments to the Health Insurance Acts,.
- The Minister for Health may, having regard to the Authority's Report, the principal objective, the aim of avoiding overcompensation, the aim of maintaining the sustainability of the health insurance market and the aim of having fair and open competition, make recommendations to the Minister for Finance on the amounts of the community rating stamp duty, which are provided for in the Stamp Duties Consolidation Acts.
- The amounts of the Risk Equalisation Credits and the Stamp Duties become law if enacted by the Oireachtas.

The following Credits and Stamp Duties apply for policies commencing from 1 March 2016 – 31 March 2017 are set out in the Health Insurance (Amendment) Act 2015:

Age range	Non-advanced cover		Advanced cover	
	Male	**Female**	**Male**	**Female**
60-64	€0	€0	€0	€0
65-69	€575	€375	€1,125	€800
70-74	€900	€675	€1,800	€1,300
75-79	€1,175	€850	€2,550	€1,900
80-84	€1,550	€1,100	€3,375	€2,375
85+	€1,775	€1,250	€4,150	€2,775

A hospital utilisation payment is paid in respect on each admission to private or semi-private accommodation by an insured person, is as shown below:

Overnight	€90.00
Day-Case	€30.00

Community Rating Stamp Duty	Non-advanced cover		Advanced cover	
Under 18	€67		€134	
Over 18	€202		€403	