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 2021 to 30 June 2022, including advice on Risk Equalisation Credits

30 September 2022

Contents

1. Executive Summary

This report sets out the Authority's recommendation on Risk Equalisation Credits and the associated level of stamp duty for contracts commencing in the period 1 April 2023 to 31 March 2024.

The report also includes an analysis of the health insurance market information (Information Returns) received by the Authority in respect of the period 1 January 2022 to 30 June 2022, which influenced the recommendations.

The key components of the recommendation are as follows:

- An increase in stamp Duty for Advanced products from to €438 from €406 in the 2022/2023 RES. The primary reason for this is a reduction in the surplus available to off-set claims costs – reduced from €100m in 2022/2023 to €55m in 2023/2024.
- No change in the level of HUC credits or in the parameters (threshold and cost share) for the high cost claims pool ("HCCP"). As this will be the first year that the full impact of the HCCP will be experienced, the amount of the overall fund covered by the HCCP will increase from 6.5% to 11.4%. This means that the proportion of credits going to health status will increase to 34.1% (from 30.0%) and the amount of credits applying to age status will decrease to 65.9% (from 70.0%).
- The reduction in the proportion of the Risk Equalisation Fund ("REF") going to age credits leads to a reduction in age credits for those over 65 years.
- Allocating more credits based on actual health status across all ages results in a more targeted distribution of health-related credits. This increases the effectiveness of the RES from 43.6% to 50.4% based on the Authority's defined measure of effectiveness[1].
- A reduction in the Non-Advanced level of stamp duty relative to the Advanced level of stamp duty from 30% to 25%, reflecting the fact that those with Non-Advanced health insurance plans have seen a sharper reduction in claims, compared to those with Advanced plans. This reflects the reduced level of usage of public hospitals by those with private health insurance. The Authority expects that consumers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurer's product pricing.

In developing these recommendations, the Authority examined recent trends in the health insurance sector and consulted with the health insurance companies. The recommendations are based on the Authority's best estimates of how many people will have health insurance and what will be the type and cost of claims that they make on those health insurance plans. The key assumptions underlying these recommendations were:

- The population with health insurance will continue to increase in line with the growth observed over the last two years. Estimated number of people with health insurance will increase to 2.378m by October 2023;
- Overall level of health insurance claims has not yet returned to the level observed before the COVID-19 pandemic;
- Expected inflation in relation to private hospital and consultant costs was estimated at 5% per annum, while the Authority assumed no increase in public hospital charges for 2023/2024;
- The recently observed trend of increased numbers of day procedures and reduction in proportion of over-night claims will continue; and

[1] "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

- There will be a continuing movement in health insurance claims away from private care in public hospitals towards care in private hospitals.

The Authority considers that the recommendation strikes an appropriate balance between its objectives. The recommendation has been set so as 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. These recommendations have been developed in the context of continuing uncertainty arising from the COVID-19 disruptions to health services, that have a direct impact on those with health insurance accessing a range of in-patient and out-patient services.

2. Background and Recommendations

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 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 2023/2024 Risk Equalisation Scheme ("RES") calibration, i.e. for health insurance contracts entered into in the period 1 April 2023 to 31 March 2024.

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 2022.

2.1. Recommendation

Stamp Duty

The Authority is recommending that the stamp duties that would need to be paid by the insurers on health insurance contracts that are entered into between 1 April 2023 and 31 March 2024, in order to support the Risk Equalisation Credits, are as follows:

Table 2.1 Stamp duty recommendation for contracts incepted 1 April 2023 – 31 March 2024

Age Band	**Stamp Duties from 1 April 2023 to 31 March 2024**		**Stamp Duties from 1 April 2022 to 31 March 2023**		**Change**	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17and under	€36	€146	€41	€135	(€4)	€11
18 and over	€109	€438	€122	€406	(€12)	€32

The recommendation is to utilise the €55m surplus expected to exist in the REF (when the credits and Stamp Duty on all contracts that commence in advance of 1 April 2023 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 €55m.

[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

The increase in Advanced stamp duty is principally driven by a reduction in the estimated surplus from €100m (applied to 2022/2023 stamp duty) to €55m (available to be applied to the 2023/2024 stamp duty). The surplus has built up in the REF over recent years, due to the fact that claims on the REF have been below the income from stamp duty.

The estimated €100m surplus that was credited to the 2022/2023 stamp duty was driven by the effects of COVID-19. As a result of COVID-19 imposed restrictions on access to public and private hospitals, lower risk equalisation credits were paid out of the REF.

In last year's report the Authority noted that if the surplus in the REF was not applied to the 2022/2023 stamp duty, Advanced stamp duties for adults would have been set at €475, as opposed to €406, and the Non-Advanced adult stamp duty would have been €142, as opposed to €122. With a smaller surplus available for the 2023/2024 stamp duty (as the gap between expected and actual credits paid to date was reduced), the stamp duty would increase in 2023/2024, all other things being equal.

The Authority notes that if the surplus in the REF was not applied to the 2023/2024 stamp duty, Advanced stamp duties for adults would be €474, as opposed to €438, and the Non-Advanced adult stamp duty would be €118, as opposed to €109.

Risk Equalisation Credits

The Authority proposes that the following Risk Equalisation Credits should apply for health insurance policies that are entered into between 1 April 2023 and 31 March 2024.

Table 2.2 Risk Equalisation Credits for contracts incepted 1 April 2023 – 31 March 2024

Age Related Health Credits (ARHC)								
Age / gender / level of cover credits from 1 April 2023 – 31 March 2024					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	€950	€525	€25	€50	€0	€25
70-74	€525	€400	€1,550	€1,075	€25	€50	(€25)	€0
75-79	€775	€575	€2,300	€1,650	€0	€0	(€75)	(€50)
80-84	€900	€625	€2,725	€1,950	(€50)	(€25)	(€250)	(€175)
85+	€1,000	€700	€3,000	€2,050	(€150)	(€75)	(€550)	(€375)

Hospital Utilisation Credit (HUC)			
Night	Day	Night	Day
€125	€75	No change	No change

Hight Cost Claims Pool (HCCP)	
Quota Share 40%	No change
Threshold €50,000	No change
Rolling HCCP (Cross Over Period Allowance)	Included

The Age Related Health Credits ("ARHC") 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 ARHC for Non-Advanced cover contracts are based on the average claim costs for Non-Advanced contracts (which generally limit coverage to private care in public hospitals). 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 140.0% (2022/2023: 137.7%) of the average net claims cost across all lives. This increase is due to the

increased amount of the overall RES which is attributable to health status (hospital utilisation credits ("HUC") and high-cost claims) rather than to age status.

The Authority is not recommending any change in the level of day or night HUC.

The Authority is recommending that the HCCP credits for 2023/2024 continue to be based on a 40% quota share on claims in excess of €50,000. These are the parameters agreed to by the Authority and the European Commission in the RES notification and used last year in the 2022/2023 RES calibration. While the Authority's proposed parameters in respect of the HCCP are unchanged, we note as this is the second year of HCCP being included in the RES, cross-over periods have been included in the calibration, i.e. rolling quarters in a 12-month period are used commencing from 1 April 2023 determined by the date the claim is incurred. The estimated size of the credits to be distributed in respect of the HCCP for 2023/2024 RES calibration is €101.2m or 11.7% of the overall credits (compared to €55.4m or 6.5% in 2022/2023). The increase in HCCP credits is largely driven by the allowance for cross-over periods in this year's calibration. This is in line with expectations guided in last year's report.

The table below sets out the split of total RES credits paid out by different age cohorts for the 2023/2024 and 2022/2023 RES calibrations.

Table 2.3 Split of total RES credits paid by age cohort

Age Cohort	Age Credit	HUC	HCCP	Total Credits
Recommended 2023/2024 Calibration				
0-17	0.0 (0.0%)	8.8 (72.9%)	3.3 (27.1%)	12.0 (100.0%)
18-29	0.0 (0.0%)	8.2 (76.9%)	2.5 (23.1%)	10.7 (100.0%)
30-39	0.0 (0.0%)	13.9 (78.8%)	3.7 (21.2%)	17.6 (100.0%)
40-49	0.0 (0.0%)	18.5 (72.2%)	7.1 (27.8%)	25.6 (100.0%)
50-54	0.0 (0.0%)	11.0 (69.5%)	4.9 (30.5%)	15.9 (100.0%)
55-59	0.0 (0.0%)	13.4 (63.6%)	7.7 (36.4%)	21.1 (100.0%)
60-64	0.0 (0.0%)	17.0 (62.8%)	10.0 (37.2%)	27.0 (100.0%)
65-69	88.3 (72.2%)	20.8 (17.0%)	13.2 (10.8%)	122.2 (100.0%)
70-74	132.9 (77.3%)	23.6 (13.7%)	15.4 (9.0%)	171.9 (100.0%)
75-79	162.9 (80.2%)	26.1 (12.8%)	14.2 (7.0%)	203.1 (100.0%)
80-84	113.3 (77.8%)	20.6 (14.1%)	11.7 (8.0%)	145.6 (100.0%)
85+	90.4 (75.6%)	20.8 (17.4%)	8.4 (7.0%)	119.5 (100.0%)
Total	**587.7 (65.9%)**	**202.7 (22.7%)**	**102.1 (11.4%)**	**892.5 (100.0%)**
2022/2023 Calibration				
0-17	0.0 (0.0%)	8.8 (83.5%)	1.7 (16.5%)	10.5 (100.0%)
18-29	0.0 (0.0%)	7.8 (85.2%)	1.4 (14.8%)	9.2 (100.0%)
30-39	0.0 (0.0%)	13.4 (85.9%)	2.2 (14.1%)	15.6 (100.0%)
40-49	0.0 (0.0%)	18.0 (81.3%)	4.1 (18.7%)	22.1 (100.0%)
50-54	0.0 (0.0%)	10.4 (79.3%)	2.7 (20.7%)	13.1 (100.0%)
55-59	0.0 (0.0%)	13.2 (75.6%)	4.2 (24.4%)	17.4 (100.0%)
60-64	0.0 (0.0%)	16.8 (75.3%)	5.5 (24.7%)	22.3 (100.0%)
65-69	83.9 (75.2%)	20.6 (18.4%)	7.2 (6.4%)	111.7 (100.0%)
70-74	131.5 (80.4%)	23.8 (14.5%)	8.2 (5.0%)	163.5 (100.0%)
75-79	158.2 (82.6%)	25.5 (13.3%)	7.7 (4.0%)	191.4 (100.0%)
80-84	118.0 (81.6%)	20.6 (14.3%)	5.9 (4.1%)	144.5 (100.0%)
85+	98.4 (79.9%)	20.3 (16.5%)	4.5 (3.6%)	123.1 (100.0%)
Total	**590.0 (70.0%)**	**199.0 (23.5%)**	**55.4 (6.5%)**	**844.1 (100.0%)**

Across all age bands, the age credits have decreased as the percentage of the overall scheme covered by the ARHC decreases as the level of HCCP increases. These reductions have been offset somewhat

by an increase in the level of HCCP credits distributed for the ages in receipt of ARHC, although some of the reduction in ARHC is distributed to younger lives in the form of HCCP credits which results in a more targeted distribution of credits.

Setting credits and stamp duty to avoid risk selection and market segmentation are key in terms of maintaining market stability. The recommendation has been set so as 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.

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

2.2. 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 2023 to 31 March 2024, 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]	[redacted]	[redacted]	588
HUC €m	[redacted]	[redacted]	[redacted]	203
HCCP €m	[redacted]	[redacted]	[redacted]	102
Stamp Duty €m	[redacted]	[redacted]	[redacted]	(838)
Net Financial Impact* €m	[redacted]	[redacted]	[redacted]	55
Net Financial Impact per Insured Life €	[redacted]	[redacted]	[redacted]	

[redacted]

2.3. Key Assumptions and Basis of Calculation

The development of the RES recommendation for 2023/2024 is based on a number of key assumptions regarding the market for health insurance, the cost of consultants and hospital care, as well as assumptions around usage of health care services.

The primary assumptions underpinning the 2022 and recommended 2023 RES calibrations are shown in Table 2.5 below. An overview of the rationale for these assumptions is set out in the remainder of this section with further detail provided in Section 4.

Table 2.5 Assumptions underpinning Recommended 2023 calibration vs 2022 calibration

	2022 RES Calibration	Recommended 2023 Calibration
Claims Adjustment		
Base Data	31 December 2019	31 December 2019
Claims Mix		
Public	24%	17%
Private	54%	60%
Consultant	22%	23%
Inflation		
Public	3%	0%
Private	3%	5%
Consultant	3%	5%
Number of years of inflation	3.25 years	2.25 years *
Hospital Utilisation Rates		
Overnights	64.5%	60.0%
Day	35.5%	40.0%
Hospital Utilisation Credits		
Overnights	€125	€125
Day	€75	€75
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	40%	40%
Rolling Claims	No	Yes
Insured Population Data		
Base Data	30 June 2021	30 June 2022
Growth rate	3%	3%
Other		
REF Surplus	€100m	€55m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	30%	25%
NCC	137.7%	140.0%

** The mid-point of incurred claims for contracts entered into in the period 01/04/23 – 31/03/2024 is 01/04/24. Under normal circumstances, claims would be inflated for a period of 4.25 years (from 31/12/19 to 01/04/24). Thus, the projection period of 2.25 years effectively assumes 0% inflation for private and consultant for the two years to 31/12/2021 and 5% for the 2.25 years from 01/01/2022 to 01/04/2024.*

2.3.1. Rolling HCCP Claims

The Authority, in its recommendation on the inclusion of a HCCP into the RES stated that its aim was to ensure that the HCCP and hence credits related to health status, would cover a higher proportion of the REF claims over time.

The RES recommendation for 2023/2024 has been updated to allow for rolling HCCP claims (over a 12-month period). This will increase the HCCP credits, absent any change in the parameters, due to more claims reaching and exceeding the threshold value. This is in line with the aim of gradually increasing the HCCP pot. The increase in proportion of total credits allocated to HCCP credits (2022/2023 Calibration: 6.5% vs 2023/2024 Calibration: 11.7%) is in line with expectations guided in last year's report. The Authority is not recommending any changes to the threshold or quota share applicable to the HCCP credits for 2023/2024.

2.3.2. Assumptions Used to Forecast Claims for 2023/2024

The Authority uses claims and returned benefits data observed in the market to estimate the likely level of claims for the relevant RES period 2023/2024. The assumptions used are outlined below and were developed based on the Authority's knowledge and understanding of the health insurance market and feedback from the health insurance companies.

Claims Inflation

In previous years, the authority has assumed that all components of the claims increased in cost at the same rate. A single inflation assumption of 3% applied for the 2022/2023 calibration. In reality, the different components of overall claims (public, private hospital and consultants) are subject to different inflation pressures. The Authority have now introduced a separate inflation assumption for each of public/private/consultant element of returned benefits.

The Authority has assumed a 0% inflation for public hospital costs, as there is no indication that the HSE charge for privately insured patients will change for the period of the 2023/2024 RES.

The Authority notes that the cost of claims in private hospitals are also more exposed to inflationary increases. In 2019, the average annual inflation in returned benefits for private hospital and consultant treatment was 5%. Therefore, the Authority proposes claims inflation rates of 5% for private and 5% for consultant to be used for the 2023 calibration. This is consistent with information provided by the health insurers to the Authority in April 2022. The Authority also examined the impact of a high inflation and lower inflation scenarios, which are described in more detail in Appendix 3.

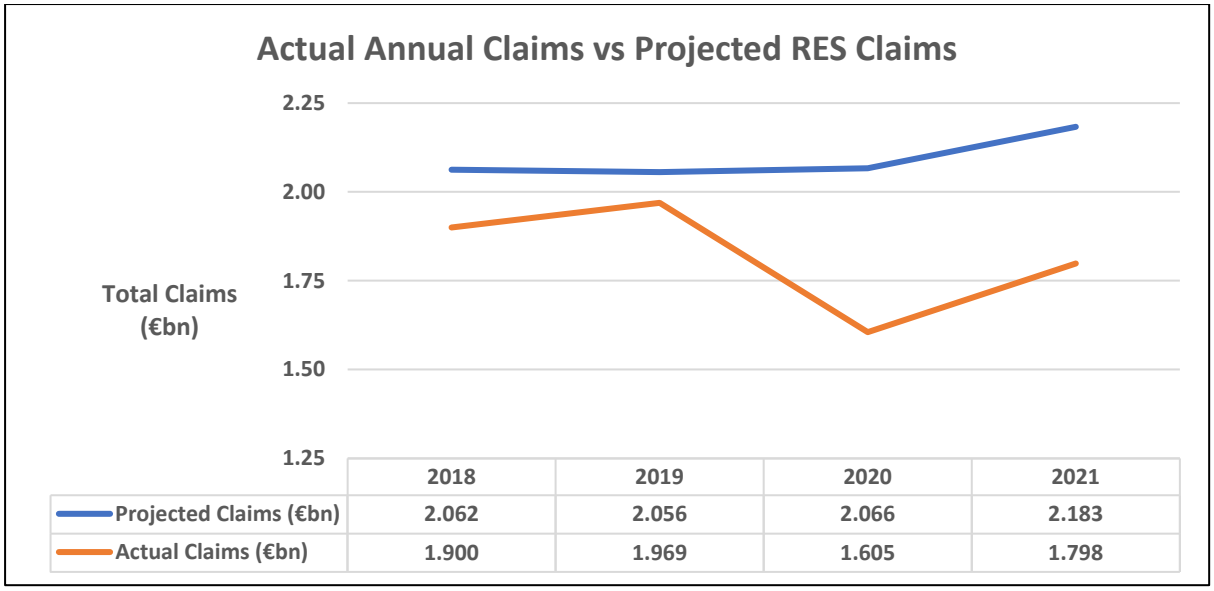
Base Year Data

Prior to 2020/2021, the Authority usually used the most recent 12 months of claims information in order to estimate the claims for the next contract period. Since 2020 the claims data has been significantly distorted by changing pattern of access to healthcare due to COVID-19's impact on health services, the Authority views the most recent 12 months of claims (2021/22) as an unsuitable basis for projecting claims for the 2023/2024 contract period.

In addition to the ongoing disruption to health services as a result of COVID-19, the claims data received in respect of 2021 was also impacted by the May 2021 cyber-attack on the HSE, which affected the use of public hospitals and the timing of claims being submitted to the insurers. The latter event caused a back log in settlement of claims which at December 2021 may not have been fully settled. Disruption to health services in some settings is also continuing into 2022. The Authority, therefore, considers that the claims data covering the period 1 January 2019 – 31 December 2019 is a more reliable basis and proposes to use it for the starting point for projecting claims for the 2023/2024 RES period. This claims data represents the most recent stable/non distorted data set. This was also the basis for claims projections when calibrating the 2022 RES.

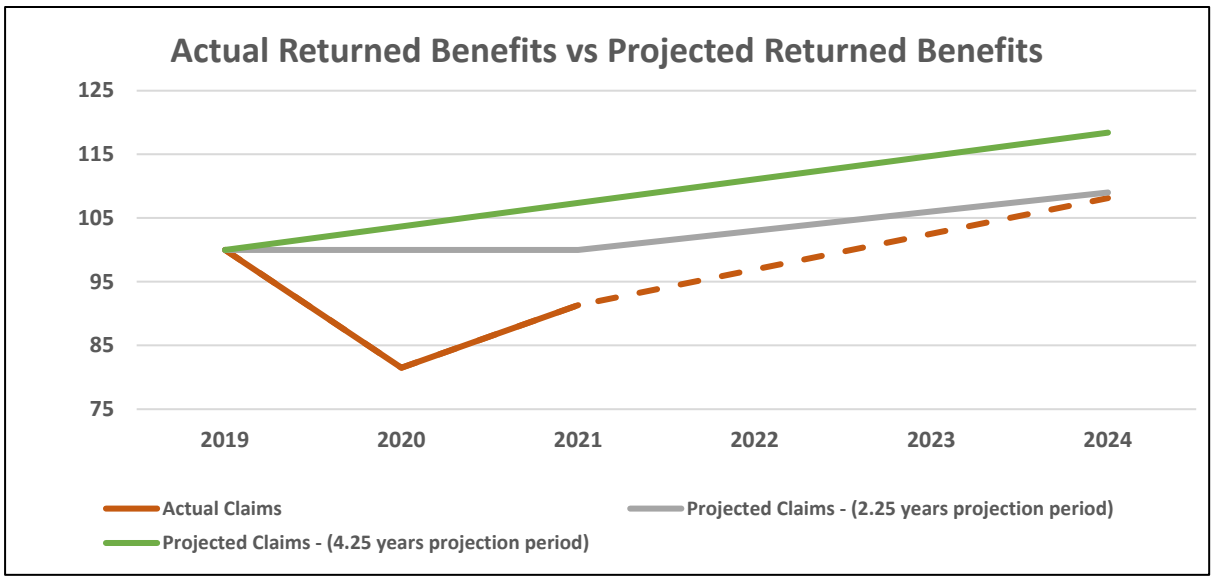
Starting with the 2019 claims data, the Authority needed to make some assumptions regarding how the 2019 claims would have changed over time to reflect a non-distorted mix of claims for 2022/2023. This level of claims is then subject to an assumed inflation rate to estimate the 2023/2024 claims levels.

The chart below shows that actual claims have historically been below those predicted in the RES calibration. This difference notably diverged over the last two years, when the impact of COVID-19 reduced the level of access to health services, and hence claims, compared to what the Authority had forecast.



For the 2022/2023 RES, the Authority had forecast that the claims would grow at an annual rate of inflation each year from the 2019 base, i.e. for a period of 3.25 years. Following the same approach would have involved growing the claims for a period of 4.25 years for 2023/2024.

Under normal circumstances, claims of 4.25 years of inflation would be applied (from 31/12/19 to 01/04/24 which is the mid-point of incurred claims) to generate the expected level of claims for the 2023/24 RES estimates. The Authority proposes a reduction in the projection period i.e. instead of projecting claims for 4.25 years, the Authority proposes a reduction in the number of years of inflation applied to 2.25 years. On the basis that claims levels have still not fully recovered to 2019 levels (as set out in the graph below) despite a growing insured population and taking on board that there has been no significant increase in supply other than private hospitals working longer hours as they tried to deal with the back log created by COVID-19. This is equivalent to assuming 0% inflation for private and consultant for the two years to 31/12/2021 and 5% for the 2.25 years from 01/01/2022 to 01/04/2024.



Claims Mix

The mix between public, private and consultant costs has an impact on the overall cost of claims in any year. In recent years, we have observed a reduction in the level of claims in public hospitals, and relative increase in claims in private hospitals. More specifically, in 2021 and early 2022, there has been a divergence in how public and private hospitals have responded to the unwinding of COVID-19 operating restrictions. 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. The Authority have, therefore, adjusted the claims mix (i.e. the proportion of returned benefits attributable to public, private and consultant) implied in the 2019 claims data (i.e. 24%, 54% and 22%) to be in line with the mix observed in the 2021 claims data (i.e. 17%, 60% and 23%) as set out in Table 4.14.

2.3.3. Insured Population Data

The insured population has remained resilient since early 2020 and increased over the last 12 months by 67,603 or 3.0%. While the economic outlook remains uncertain. The Authority has assumed that the insured population will continue to grow by the same scale as experienced in the 12 months to 1 July 2022. Consistent with the methodology used for the 2022/2023 Calibration, the population data is assumed to grow at an annualised rate of 3% per annum. It is therefore projected 1.25 years to 1 October 2023 (the mid-point of relevant contracts) as set out in Table 2.6.

Table 2.6 Change in insured population

(Members 000s)	1-Jul-20	1-Jul-21	1-Jul-22	Projected 1-Oct-23
Population	2,179	2,226	2,294	2,378
Difference		2.1%	3.0%	3.7%

2.3.4. Estimated Claims Value used for RES Calibration 2023/24

The cumulative impact of the assumptions used to forecast claims, and the population growth assumptions results in the projected returned benefits for the 2023/24 RES calibration period as set out below:

€ m	Public Hospitals	Private Hospitals	Consultant	Total
2019 Total	471	1,071	428	1,969
2020 Total	398	852	356	1,605
2021 Total	310	1072	416	1,798
Estimate for 2022*				1,978
2023/24 Estimate	407	1,307	527	2,241
Percentage Change	(13.4%)	22.0%	23.1%	13.8%
Rate of Annualised Growth**	(6.3%)	9.3%	9.7%	5.9%

**Estimate for Claims in 2022 is based on actual claims for the first half of 2022 multiplied by 2.*

***Assumed rate of annualised growth over the period 31 December 2021 to 1 April 2024.*

As can be seen in the above table, the total value of returned benefits are assumed to increase by 5.9% p.a. in aggregate (over the period 31 December 2021 to 1 April 2024). This accounts for the fact that the numbers of people with health insurance is forecast to increase, the population with health insurance is assumed to age (with higher claims for older age cohorts), and the cost of individual claims is assumed to increase in line with the inflation assumptions discussed above. This can be considered as a 6.3% p.a. reduction in public hospital claims, compared to the value of public hospital claims,

offset by 9.3% p.a. and 9.7% p.a. increases in private hospital and consultant claims (annualised growth over the 2.25 years of inflation).

Within this estimate, we have assumed that there are no capacity constraints in any hospital (public and private) and that at all age cohorts are able to access healthcare at utilisation rates consistent with those experienced in 2019, as outlined in Section 2.3.5. below.

2.3.5 Hospital Utilisation Rates

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 2021 or first half of 2022. Total days and nights paid in the first 6 months of 2022 are still more than 6% lower than in the same period in 2019. Although this suggest an increase in utilisation compared to the same period last year which was more than 20% down on 2019, it also highlights utilisation has not fully been restored. Based on this, the Authority has assumed overall utilisation levels assumed in the 2023/2024 Calibration are consistent with those observed in 2019 data.

The 2019 data showed that 64.5% of hospital utilisation related to overnight stays, while the remaining 35.5% related to day case procedures. However, more recent data suggests an increased shift towards day case procedures in hospitals. Thus, the Authority proposes adjusting the utilisation split to assume that 60% of the projected hospital utilisation to relate to overnight stays, with the remaining 40% projected hospital utilisation to relate to day case procedures. As day case procedures are expected to result in lower claims than overnight stays, the assumption change implicitly assumes additional claims inflation above that outlined in Section 2.3.2 above.

2.3.6. REF Surplus

Based on the claims made to date to the REF for contracts incepted over the 2021/2022 and 2022/2023 periods, the Authority continues to see a surplus build up in the REF, due to claims being lower than estimated.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €55m (2022/2023 Calibration: €100m) in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2023 are fully earned. Although the REF surplus is lower than for the €100m for the 2022/2023 RES, the Authority estimate that the REF will likely continue 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 the population with health insurance exceeding the Authority's forecast for the 2022/2023 timeframe.

The Authority has therefore recommended that this estimated surplus of €55m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2023 to 31 March 2024.

2.3.7. Ratio of Non-Advanced to Advanced Stamp Duty

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. Non-Advanced products do not provide more than 66% of the full cost for hospital charges in a private hospital. As a result, Non-Advanced policy holders are more likely to avail of public hospitals when using their health insurance. As at 1 July 2022, 8% of the market held a Non-Advanced contract which was unchanged from the previous year. The ratio of Non-Advanced claims to Advanced claims for 2021/2022 was 29% for over 65 and 21% for all ages and has fallen to 24% for over 65 and 17% for all ages. This is largely driven by the nature of these products which would be largely used in public

hospitals which have been impacted more severely by COVID-19. The Authority is therefore proposing to set the Stamp Duty for Non-Advanced contracts at 25% (2022/2023 Calibration: 30%) of the stamp duty relating to Advanced contracts. This means that the contribution of the Non-Advanced products to the REF better reflects the claims that holders of these products make on the fund.

2.3.8. Net Claims Cost Ceiling

The calibration of the RES 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.

As part of the work on the HCCP recommendation to the Department of Health (June 2021), the Authority recommended that the HCCP would be introduced in such a way as to reallocate credits from age credits to HCCP. As such, the HCCP should not cause an increase in stamp duty all else being equal. This means that the increase in the HCCP in this RES calibration due to the rolling dynamic will reduce the amount of credits allocated to age credits and thus will necessitate an increase the net claims cost ceiling.

In the 2022/2023 Calibration the net claims cost ceiling was 137.7%, which resulted in an estimated 70.0% of credits being in respect of age and, 23.5% in respect of HUC and 6.5% in respect of HCCP.

For the 2023/2024 Calibration, the Authority proposes a net claims cost ceiling of 140.0%, which results in an estimated 65.9% of credits being in respect of age and, 22.7% in respect of HUC and 11.4% in respect of HCCP.

We have also considered some scenarios with alternative assumptions when setting our recommendation – see Appendix 3.

3. Methodology for Developing Recommendations

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 implies that all age cohorts can 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 entered into on or after 1 April 2023 will distribute risk equalisation credits in three ways:

1. ARHC: these apply from age 65 onwards and vary by age, level of cover and sex;
2. HUC: a fixed amount for each night/day that an insured person spends in private hospital accommodation; and
3. HCCP: an amount determined as a percentage (quota share) of claims in excess of a defined amount (Threshold). 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 2021 and January to June 2022 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. Other historic information returns (as previously provided to the Authority by the insurers) have also been used in arriving at the recommended calibration.

The information returns received by the Authority include data on "returned benefits[3]". 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 2021. The data was provided by the insurers on a voluntary best endeavours' basis[4], 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.

Consultation with Insurers

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 and claims as well as responses to the Authority's questions regarding the RES calibration. 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;
- Use of 2019 claims data as the base data for projections;
- Move to treatment outside hospital settings;
- Level of stamp duty and approach for Non-Advanced contracts;
- ARHC and HUC;
- Level of claims cost ceiling;
- Overcompensation assessment;
- Capacity and other issues arising as a result of COVID-19;
- Views around the parameters used for 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 2023 to 31 March 2024 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.

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.

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

[4] The 2023 Information Returns will include

Throughout the report we have used the following terms interchangeably:

- ‘Age Credits’ and ‘Risk Equalisation Premium Credits’‘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 2023 to 31 March 2024 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.

4.1. Summary of Key Assumptions

Whilst each individual assumption must be justifiable and within the range of reasonableness, it is the combined impact of the assumptions which will impact the recommendations to be made in relation to stamp duties and risk equalisation credits. In making the recommendation, as per Section 7 of the Health Insurance Act, the Authority must have regard to the principal objective, the aim of avoiding overcompensation, maintaining the sustainability of the health insurance market and having fair and open competition in the market.

Set out below are details of the assumptions underpinning the 2022 and recommended 2023 RES calibrations. An overview of the rationale for these assumptions is set out in the remainder of this section.

Table 4.1 Assumptions underpinning Recommended 2023 calibration vs 2022 calibration

	2022 RES Calibration	Recommended 2023 Calibration
Claims Adjustment		
Base Data	31 December 2019	31 December 2019
Claims Mix		
Public	24%	17%
Private	54%	60%
Consultant	22%	23%
Inflation		
Public	3%	0%
Private	3%	5%
Consultant	3%	5%
Number of years of inflation	3.25 years	2.25 years *
Hospital Utilisation Rates		
Overnights	64.5%	60.0%
Day	35.5%	40.0%
Hospital Utilisation Credits		
Overnights	€125	€125
Day	€75	€75
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	40%	40%
Rolling Claims	No	Yes
Insured Population Data		
Base Data	30 June 2021	30 June 2022
Growth rate	3%	3%
Other		
REF Surplus	€100m	€55m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	30%	25%
NCC	137.7%	140.0%

** The mid-point of incurred claims for contracts entered into in the period 01/04/23 – 31/03/2024 is 01/04/24. Under normal circumstances, claims would be inflated for a period of 4.25 years (from 31/12/19 to 01/04/24). Thus, the projection period of 2.25 years effectively assumes 0% inflation for private and consultant for the two years to 31/12/2021 and 5% for the 2.25 years from 01/01/2022 to 01/04/2024.*

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

4.2. High Cost Claims

The HCCP data provided by the three open market insurers was provided during 2022 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.

The calibration for the HCCP is a 40% Quota Share with a €50,000 claims excess. We have set out how the HCCP credits for the 2023 recommendation have been calculated.

Table 4.2 HCCP Credits for 2023/2024 RES calibration

HCCP Credits		
Quota Share	*(a)*	40%
Threshold	*(b)*	€50,000
High-Cost Claims in respect of policies incepted in 2018		€333,602,538
Projected High-Cost Claims in respect of policies incepted in 2018 allowing for projected claims inflation	*(c)*	€433,125,970
Rolling HCCP Claims (average based on historical experience)	*(d)*	€110,260,189
HCCP Claims	*(e) = (c) + (d)*	€543,386,159
Projected HCCP Policy Count	*(f)*	4,913
Threshold	*(g) = (f) * (b)*	€245,650,000
Credit Offsets		
ARHC	*(h)*	€5,298,575
HUC	*(i)*	€37,262,032
Final HCCP Credits	***(a) * ((e) – [(g)+(h)+(i)])***	**€102,070,221**

- Claims data is based on policies incepted between 1 January 2018 and 31 December 2018. These claims and policy counts are then developed based on information received from the insurers up to 31 December 2021. This results in total projected developed claims of €433.1m and projected policy count of 4,913;
- Rolling HCCP claims are calculated to reflect claims which occur and overlap the policy renewal date which are likely to receive lower credits in aggregate when compared to claims that do not occur near the policy renewal date as the claim would be allocated to two contract periods. For example, if a policy had a high cost claim of €100,000 and this claim was equally split between contract periods, then under the proposed HCCP calibration the insurer would not receive any HCCP credits. However, if the claim occurred just before the renewal date, then the insurer would receive HCCP credits. Total rolling HCCP claims are €110.3m. This figure is based on the average impact that rolling claims would have on the HCCP based on high-cost claims data arising in the

periods 2017-2018, 2018-2019 and 2019-2020. More recent data was available but ignored due to the impact of COVID-19;

- The threshold for the first €50,000 of the claims to be excluded from the HCCP is €245.7m;
- HCCP credits are offset by ARHC of €5.3m and HUC of €37.3m; and
- Final credits are then calculated as the Quota Share x (HCCP Claim – (Threshold + HUC + ARHC)) resulting in the final HCCP credits of €102.1m

Further details of the HCCP proposal are included in Appendix 5.

Rolling HCCP Claims

The Authority stated as part of the RES notification and work on the HCCP proposal that its aim was to phase the introduction of the HCCP over time, to account for a higher share of the overall REF.

The RES calibration has been updated to allow for rolling HCCP claims which will result in an increase in HCCP credits. This is in line with the aim of gradually increasing the HCCP pot. The increase in proportion of total credits allocated to HCCP credits (2022/2023 Calibration: 6.5% vs 2023/2024 Calibration: 11.7%) is in line with expectations guided in last year's report.

4.3. Membership and Population Forecasts

Membership

Table 4.3 sets out the membership details and market shares of the open market insurers. The data excludes members serving initial waiting periods.

Table 4.3 Insured population by insurer

Insurer	**1-Jul-21**		**1-Jan-22**		**1-Jul-22**	
	Members 000s	**Market Share (%)**	**Members 000s**	**Market Share (%)**	**Members 000s**	**Market Share (%)**
Irish Life Health	471	21.2%	474	20.9%	485	21.2%
Laya Healthcare	623	28.0%	645	28.5%	658	28.7%
Vhi Healthcare	1,132	50.9%	1,144	50.6%	1,151	50.2%
Total	**2,226**		**2,263**		**2,294**	

The overall insured population increased by 67,603 lives over the 12 months to 1 July 2022 (1 July 2020 to 1 July 2021: 46,833). 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 0.7% and Vhi Healthcare a corresponding decrease.

As of end June 2022, 46.4% of the Irish population are estimated to have private health insurance (including restricted undertakings), which is 0.3% lower than the percentages observed at end June 2021. This was due to the change in the CSO estimate of the overall size of the population in Ireland.

Gender profile of insurers' members

The gender distributions of the memberships of the three insurers for the period January to July 2022 are set out in Table 4.4. The proportions in each gender for each insurer have remained relatively static for some time.

Table 4.4 Gender distribution of insured population

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

Age Profile of Insurers Members

The age distribution (average for the period January to June 2022) of each insurer's membership is shown in Table 4.5. The figures shown in brackets are the corresponding averages for the period January to June 2021.

Table 4.5 Age profile of insured members

Age group	Irish Life Health	Laya Healthcare	Vhi Healthcare	Market
0-17	[redacted]	[redacted]	[redacted]	22.3% (22.6%)
18-29	[redacted]	[redacted]	[redacted]	12.3% (11.9%)
30-39	[redacted]	[redacted]	[redacted]	12.8% (12.9%)
40-49	[redacted]	[redacted]	[redacted]	16.0% (16.1%)
50-54	[redacted]	[redacted]	[redacted]	7.1% (7.1%)
55-59	[redacted]	[redacted]	[redacted]	6.6% (6.6%)
60-64	[redacted]	[redacted]	[redacted]	6.0% (6.0%)
65-69	[redacted]	[redacted]	[redacted]	5.4% (5.4%)
70-74	[redacted]	[redacted]	[redacted]	4.5% (4.6%)
75-79	[redacted]	[redacted]	[redacted]	3.5% (3.4%)
80-84	[redacted]	[redacted]	[redacted]	2.1% (2.1%)
85+	[redacted]	[redacted]	[redacted]	1.6% (1.5%)
Under 65	[redacted]	[redacted]	[redacted]	82.9% (83.1%)
Over 65	[redacted]	[redacted]	[redacted]	17.1% (16.9%)

[redacted]

[redacted]

At a market level there has been an ageing of the population with the proportion of the insured population over 65 increasing from 16.9% to 17.1% 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];

[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.

- 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 2022 is shown in the Tables 4.6 and 47 (1 July 2021 figures are shown in brackets).

Table 4.6 Proportion of each insurers' population with each level of cover

	Level 1 Products	Level 2 Products	Higher Cover Products
Irish Life Health	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]
Total	8% (9%)	76% (76%)	16% (16%)

[redacted]

Non-Advanced products cannot provide more than 66% of the full cost for hospital charges in a private hospital. As at 1 July 2022, there were 35 products (Irish Life Health: 22, Laya Healthcare 11 and Vhi Healthcare: 2) being marketed classified as Non-Advanced with 169,568 members insured.

Table 4.7 Proportion of each insurer's population with Non-Advanced/Advanced level

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

Actual vs Expected Population Forecasts

Table 4.8 shows that the insured population has continued to increase (the average increase over the last 4 years is 2.5% p.a.) and the market has remained resilient despite the economic and health impacts of COVID-19. This was also evident in the consumer survey carried out by the Authority which demonstrated that the attitudes to health insurance were not impacted by COVID-19[7].

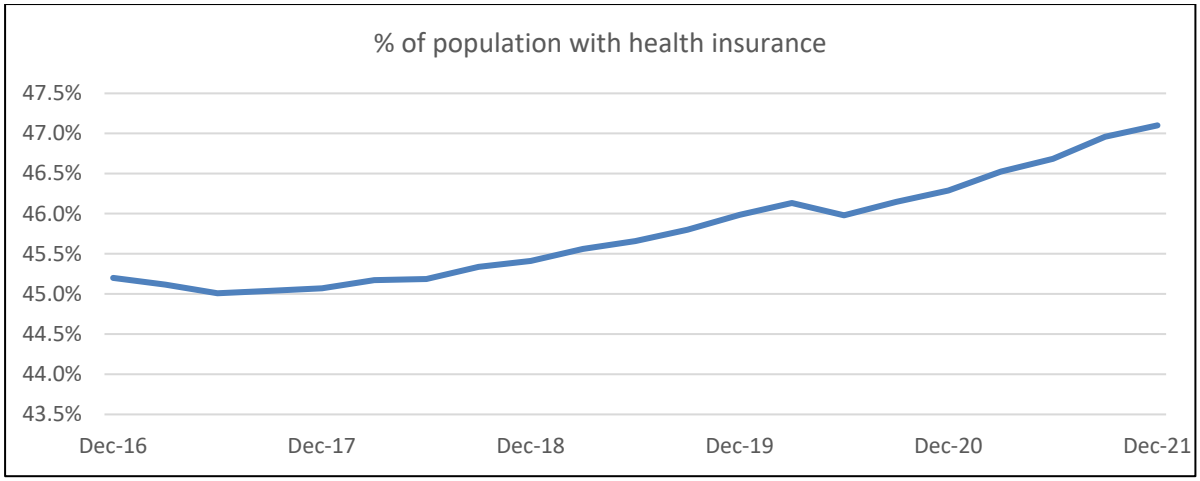
Table 4.8 Insured population

Insurer	1-Jan-18	1-Jan-19	1-Jan-20	1-Jan-21	1-Jan - 22
Members 000's	2,049	2,107	2,163	2,200	2,263
% increase year on year		2.8%	2.7%	1.7%	2.8%

The percentage of the Irish population estimated to have private health insurance (including restricted undertakings) also continues to increase. Chart 4.1 shows the increase in those holding private health insurance over the 5 years to 31 December 2021.

Chart 4.1 Insured population by insurer

[7]https://www.hia.ie/sites/default/files/Health%20Insurance%20Authority%20Kantar%20Report%202021%20Jan%202022%20Final.pdf



If we project using last year's assumption to 1 July 2022, we can see the assumption was understated by 20,770 lives at 1 July 2022, showing that the insured population has grown more than expected. See table 4.9 below. Most of the growth has taken place in the younger cohorts, which is consistent with the growth in the level of employment in the economy.

Table 4.9 Actual vs Expected population growth to 1 July 2022

Difference Actual vs Assumption as at 1 July 2021			
Insured Membership	**Assumed Population 1 July 2022**	**Actual Population 1 July 2022**	**Net Diff**
Aged 17 and under	509,948	516,816	6,868
Aged 18 to age 29	279,644	283,577	3,933
Aged 30 to age 39	290,355	297,097	6,742
Aged 40 to age 49	365,207	365,326	119
Aged 50 to age 54	159,307	161,967	2,660
Aged 55 to age 59	148,625	149,095	470
Aged 60 to age 64	135,653	135,478	(175)
Aged 65 to age 69	121,033	121,337	304
Aged 70 to age 74	102,681	102,413	(268)
Aged 75 to age 79	78,670	78,618	(52)
Aged 80 to age 84	47,497	47,401	(96)
Aged 85 and over	34,448	34,713	265
Total	**2,273,068**	**2,293,838**	**20,770**

Economic Outlook

The economic outlook is also a consideration given previous evidence of strong correlation between unemployment and private health insurance take up. We also know from the last recession there can be a delay between economic shocks and consumers dropping their health insurance.

The spring forecast for Ireland carried out by the European Commission[8], projects GDP growth of 5.4% in 2022 and 4.4% in 2023. Despite the war in Ukraine and high inflation, net exports are projected to remain resilient and an important source of growth. Inflation is rising and expected to remain high, albeit moderating in 2023. The fiscal outlook is set to further improve, with the budget balance set to reach a surplus of 0.4% of GDP in 2023 supported by a rapidly recovering labour market, a gradual reduction of large household savings through consumption and a relatively benign financial situation in the corporate sector. They forecast a continuation of high inflation in 2022 of 4.6% but falling to 2.5% in 2023.

[8] https://ec.europa.eu/economy_finance/forecasts/2022/spring/ecfin_forecast_spring_2022_ie_en.pdf

The Central Bank quarterly forecasts[9] have projected GDP growth of 4.3% in 2023 and falling to 3.9% in 2024. Their inflation forecasts, as measured by HICP is similar to the European Commission for 2022 at 6.5% and a fall to 2.8% in 2023 and a further fall to 2.1% in 2024.

However, the war in Ukraine does create an element of uncertainty and the longer the war continues the greater the degree of uncertainty.

The impact of high inflation on the cost of claims and in turn premiums combined with a potential drop in disposable income must be considered when projecting the insured population and indeed future claims. But it is also worth bearing in mind that the social profile of people with health insurance continues to be largely people from the white collar/ professional socio-economic group (ABC1s) who may be able to withstand impacts of what is expected to be short to medium term high inflation.

Views of insurers

Projected population for RES 2023/2024

Having considered the views of the insurers, the economic outlook and the forecasts for Ireland carried out by the European Commission and the Central Bank, the Authority has taken the view that the insured population will continue to grow over the next projection period. In our projections the base population is the 1 July 2022 population, and this is projected for 1.25 years to 1 October 2023 (mid-point of the contracts from 1 April 2023 to 31 March 2024). The membership is assumed to increase in line with the change in the market membership in the period 1 July 2021 to 1 July 2022 (67,603) until 1 October 2022. The projections assume an increase in the number of insured lives of 84,504 over 1.25 years i.e. 1.25 x 67,603. This is consistent with the methodology used in past RES calibrations with the exception being the approach used last year.

Table 4.10 Change in insured Population

Change in insured lives by age			
Insured Membership	**1-Jul-21**	**1-Jul-22**	**Net Diff**
Aged 17 and under	506,766	516,816	10,050
Aged 18 to age 29	266,835	283,577	16,742
Aged 30 to age 39	289,494	297,097	7,603
Aged 40 to age 49	356,756	365,326	8,570
Aged 50 to age 54	156,222	161,967	5,745
Aged 55 to age 59	146,503	149,095	2,592

[9] https://www.centralbank.ie/news/article/quarterly-bulletin-2022-2-economic-growth-set-to-continue-but-slower-higher-inflation-expected-6-Apr-2022#:~:text=Exports%20are%20forecast%20to%20grow,substantially%20over%20the%20coming%20months.

Aged 60 to age 64	133,019	135,478	2,459
Aged 65 to age 69	118,441	121,337	2,896
Aged 70 to age 74	100,709	102,413	1,704
Aged 75 to age 79	73,804	78,618	4,814
Aged 80 to age 84	45,376	47,401	2,025
Aged 85 and over	32,310	34,713	2,403
Total	**2,226,235**	**2,293,838**	**67,603**

Additionally, while the total market size is not a critical factor in balancing the financial impact of credits and Stamp Duty, the forecast age profile and product mix is important. The Authority has assumed that the changes in age profile and product mix over the 12 months to July 2022 in Table 4.11 will continue at the same pace until 1 October 2023 for the market as a whole.

The Authority notes that this forecast does not take account of the impact of any RMUs terminating their coverage and their members transitioning to one of the open market insurers. This may impact both the total level of insured population, and the age distribution.

Table 4.11 Projected Population for contracts incepted between 1 April 2023 and 31 March 2024

	Actual Population as at 1 July 2022		Projected population as at 1 October 2023		Change	
Age	Population	Age Distribution	Population	Age Distribution	Population	Age Distribution
0-17	516,816	22.5%	529,379	22.3%	12,563	-0.3%
18-29	283,577	12.4%	304,505	12.8%	20,928	0.4%
30-39	297,097	13.0%	306,601	12.9%	9,504	-0.1%
40-49	365,326	15.9%	376,039	15.8%	10,713	-0.1%
50-54	161,967	7.1%	169,148	7.1%	7,181	0.1%
55-59	149,095	6.5%	152,335	6.4%	3,240	-0.1%
60-64	135,478	5.9%	138,552	5.8%	3,074	-0.1%
65-69	121,337	5.3%	124,957	5.3%	3,620	0.0%
70-74	102,413	4.5%	104,543	4.4%	2,130	-0.1%
75-79	78,618	3.4%	84,636	3.6%	6,018	0.1%
80-84	47,401	2.1%	49,932	2.1%	2,531	0.0%
85+	34,713	1.5%	37,717	1.6%	3,004	0.1%
Total	**2,293,838**		**2,378,342**		**84,504**	

4.4. Claims Data

Historical Claims Experience

The total claims payments made by the open market insurers in 2019, 2020, 2021 and the first half of 2022 are set out in Table 4.12. It is noted that these figures exclude claim payments by restricted membership insurers.

Table 4.12 Claims paid by insurer

€ m	Irish Life Health	Laya Healthcare	Vhi Healthcare	Total
First Half 2019	[redacted]	[redacted]	[redacted]	1,113
Second Half 2019	[redacted]	[redacted]	[redacted]	1,135
2019 Total	[redacted]	[redacted]	[redacted]	**2,248**
First Half 2020	[redacted]	[redacted]	[redacted]	970
Second Half 2020	[redacted]	[redacted]	[redacted]	906
2020 Total	[redacted]	[redacted]	[redacted]	**1,876**
First Half 2021	[redacted]	[redacted]	[redacted]	1,026
Second Half 2021	[redacted]	[redacted]	[redacted]	1,097
2021 Total	[redacted]	[redacted]	[redacted]	**2,122**
First Half 2022	[redacted]	[redacted]	[redacted]	1,187

The total claims paid in the first half of 2022 were €161m (16%) higher than the first half of 2021. This is a very different story to 24 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 recent increase in claims in the first half of 2022, claims are only marginally higher than pre-COVID levels, but are lower per insured person, given the 7% increase in the number of people insured.

Based on the above and due to reporting delays, the Authority is of the view that the information returns since 2019 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 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 from the second half of 2020 to the first half of 2022 are set out in Table 4.13.

Table 4.13 Returned benefits as a percentage of total claims

Insurer	Returned Benefits July – Dec 2020	Returned Benefits Jan – June 2021	Returned Benefits July – Dec 2021	Returned Benefits Jan – June 2022
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
Total	87%	85%	85%	83%

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 4.14 splits out the returned benefit payments between those attributable to public hospitals, private hospitals, and to hospital consultants. The total returned benefits paid were €989m in the first half of 2022 compared to €928m in the second half of 2021. The increase of €61m is made up of increases in the payments to Public Hospitals (€52m) and Consultants (€17m) and is slightly offset by the reduction in Private Hospitals (-€9m). This is indicative of public hospital capacity recovering following the impacts of COVID-19 although they are still €23m lower than the claims observed in the first half of 2019.

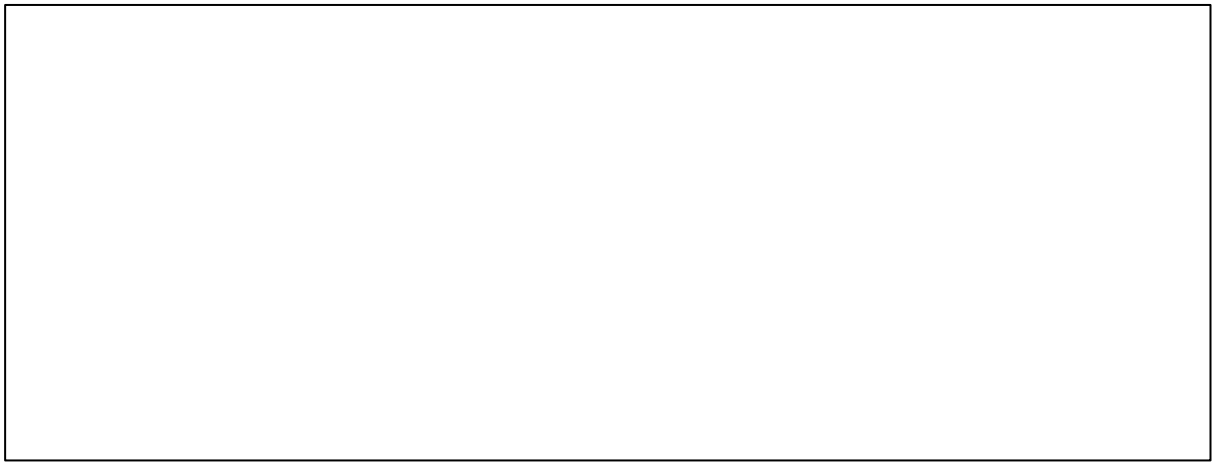
Table 4.14 Returned Benefits broken down by service provider

		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	[redacted]	[redacted]	[redacted]	526 (54%)
	Consultant	[redacted]	[redacted]	[redacted]	214 (22%)
	Sub Total	[redacted]	[redacted]	[redacted]	*974*
Second Half 2019	Public Hospital	[redacted]	[redacted]	[redacted]	237 (24%)
	Private Hospital	[redacted]	[redacted]	[redacted]	544 (55%)
	Consultant	[redacted]	[redacted]	[redacted]	214 (21%)
	Sub Total	[redacted]	[redacted]	[redacted]	*995*
2019 Total		[redacted]	[redacted]	[redacted]	**1969**
First Half 2020	Public Hospital	[redacted]	[redacted]	[redacted]	224 (26%)
	Private Hospital	[redacted]	[redacted]	[redacted]	431 (51%)
	Consultant	[redacted]	[redacted]	[redacted]	191 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	*847*
Second Half 2020	Public Hospital	[redacted]	[redacted]	[redacted]	173 (23%)
	Private Hospital	[redacted]	[redacted]	[redacted]	421 (55%)
	Consultant	[redacted]	[redacted]	[redacted]	164 (22%)
	Sub Total	[redacted]	[redacted]	[redacted]	*758*
2020 Total		[redacted]	[redacted]	[redacted]	**1605**
First Half 2021	Public Hospital	[redacted]	[redacted]	[redacted]	152 (17%)
	Private Hospital	[redacted]	[redacted]	[redacted]	517 (59%)
	Consultant	[redacted]	[redacted]	[redacted]	202 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	*870*
Second Half 2021	Public Hospital	[redacted]	[redacted]	[redacted]	158 (17%)
	Private Hospital	[redacted]	[redacted]	[redacted]	556 (60%)
	Consultant	[redacted]	[redacted]	[redacted]	214 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	*928*
2021 Total		[redacted]	[redacted]	[redacted]	**1798**
First Half 2022	Public Hospital	[redacted]	[redacted]	[redacted]	211 (21%)
	Private Hospital	[redacted]	[redacted]	[redacted]	547 (55%)
	Consultant	[redacted]	[redacted]	[redacted]	231 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	*989*

Claims Inflation

We can see from Chart 4.2 (which shows a history of claims since 2017) that while the level of claims in HY1 2022 is slightly ahead of the claims in the same period in 2019 for each of the insurers. While this demonstrates that claims have returned back to pre-COVID levels, the expectations around future inflation relative to 2019 need to be tempered.

Chart 4.2: Historic levels of claims distribution by insurer



In previous years, the authority has assumed that all components of the claims increased in cost at the same rate. A single inflation assumption of 3% applied for the 2022/2023 calibration. In reality, the different components of overall claims (public, private hospital and consultants) are subject to different inflation pressures.

Looking at historical returned benefits, as set out in Table 4.14, the proportion of returned benefits attributable to care in private hospitals has been increasing over the last five years. The cost of claims in private hospitals are also more exposed to inflationary increases which could contribute to the increase, while the reimbursement rate paid for public hospital claims has not changed since 2014. Claims in public hospitals account for approximately 17% of total claims based on 2021 data, reducing from 25% based on 2019 data. Assuming no change in the daily rate charged for private patients in public hospitals, this leaves an estimated 75% to 85% of claims which may be subject to inflation. In 2019, the average annual inflation in returned benefits for private hospital and consultant treatment was 5%. Therefore, the Authority proposes claims inflation rates of 0% for public, 5% for private and 5% for consultant to be used for the 2023 calibration.

The inflation assumptions used allow for claims inflation in respect of the average returned benefits for each age/ gender/ level of cover cohort. The inflation assumptions do 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. Ageing of the insured population is allowed for implicitly in the population projections.

Base Year Data

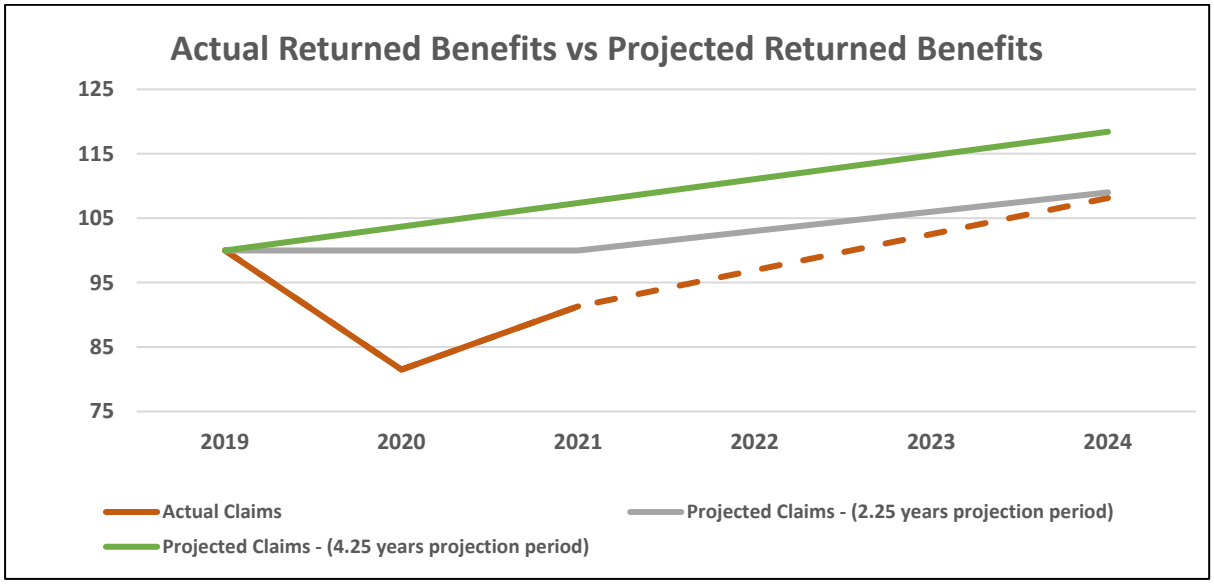
The Authority has taken the view that for RES 2023/2024 (i.e. in respect of policies entered into in the period 1 April 2023 to 31 March 2024) claims experience will not fully revert to “normal” (pre-COVID) levels as indicated by the average claims implied by the 2019 data.

Prior to 2020/2021, the Authority usually used the most recent 12 months of claims information in order to estimate the claims for the next contract period. Because data since 2020 has been significantly distorted by changing pattern of claims due to COVID-19’s impact on health services, the Authority views the most recent 12 months of claims as an unsuitable basis for projecting claims for the 2023/2024 contract period.

The claims data received in respect of 2021 continues to be impacted by the ongoing disruption to health services as a result of COVID-19. The May 2021 cyber-attack on the HSE also affected the use of public hospitals and the timing of claims being submitted to the insurers. The latter event caused a

back log in settlement of claims which at December 2021 may not have been fully settled. Disruption to health services in some settings is also continuing into 2022. The Authority, therefore, considers that the claims data covering the period 1 January 2019 – 31 December 2019 is a more reliable basis for projections for the 2023/2024 period, and proposes to use it for the starting point for projecting claims for the 2023/2024 RES period. This claims data represents the most recent stable/non distorted data set. This was also the basis for claims projections when calibrating the 2022 RES.

Two of the three insurers were in agreement that 2019 data is a reasonable data set to use as the base data for 2023/2024 claims, given COVID-19 continues exerting volatility and uncertainty in claims data for 2020 and 2021. One insurer did state that they believe 2021 claims data is a suitable starting point. However, the monthly REF claims and bi-annual returns received by the HIA for this period continues to show volatility in the pattern of claims, and, as such, the Authority believes it is too volatile to use for projections relating to 2023/2024.



Claims Mix

In terms of the mix of claims between public, private and consultant the views of the insurers varied.

[redacted]

The insurers all noted that capacity constraints in the system will be a significant driver of claims costs. They expect a high demand for healthcare services over the projection period but note there is no extra supply. Capacity in the private hospitals may also be impacted adversely by any future agreements between the State and private hospitals with negotiations on this believed to be ongoing.

In light of the observed data and the views of the insurers, the Authority have adjusted the claims mix (i.e. the proportion of returned benefits attributable to public, private and consultant) implied in the 2019 claims data (i.e. 24%, 54% and 22%) to be in line with the mix observed in the 2021 claims data

(i.e. 17%, 60% and 23%) as set out in the table above. The Authority will continue to monitor this assumption and review as part of the 2024/2025 RES calibration.

Forecast Claims Levels (Returned Benefits) by Source

The cumulative impact of the assumed claims adjustments results in the projected returned benefits as set out below:

Table 4.15 Projected Returned Benefits by Source

€ m	Public Hospitals	Private Hospitals	Consultant	Total
2019 Total	471	1,071	428	1,969
Estimated 2023/24	407	1,307	527	2,241
Percentage Change	(13.4%)	22.0%	23.1%	13.8%
Rate of Annualised Growth*	(6.3%)	9.3%	9.7%	5.9%

** Assumed rate of annualised growth over the period 31 December 2021 to 1 April 2024.*

As can be seen in the above table, returned benefits are assumed to increase by 5.9% p.a. in aggregate. This can be considered as a 6.3% p.a. reduction in public hospital claims offset by 9.3% p.a. and 9.7% p.a. increases in private hospital and consultant claims. This is driven by the combined effect of changes to the assumed claims mix, different inflation rates and ageing of the population.

4.5. Hospital Utilisation Rates

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 three years paid by the open membership undertakings is set out in Table 4.16. 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 are also evident in the data below for 2020 and 2021.

Table 4.16 Total number of hospital days

000's	Overnight	Day case	Total
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
Second Half 2021	403	313	716
First Half 2022	459	320	779

Table 4.17 shows the split by insurer for the January to June 2022 time period.

Table 4.17 Total number of nights/days by insurer

000's	Overnight	Day case	Total
Irish Life Health	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]
Total	**459**	**320**	**779**

The proportion of days to total hospital days is quite varied between insurers, [redacted] 41% for the market as a whole. 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-19.

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 2021 or first half of 2022. Total days and nights paid in the first 6 months of 2022 are still more than 6% lower than in the same period in 2019, even though population with health insurance has increased by 7% during the same time period. Although this suggest an increase in utilisation compared to the same period last year which was more than 20% down on 2019, it also highlights utilisation has not fully been restored. Based on this, the Authority has assumed overall utilisation levels assumed in the 2023/2024 Calibration are consistent with those observed in 2019 data, and thus the projections do not include an allowance for increased utilisation per member.

The 2019 data showed that 64.5% of hospital utilisation related to overnight stays, while the remaining 35.5% related to day case procedures. However, more recent data suggests an increased shift towards day case procedures in hospitals. Thus, the Authority proposes adjusting the utilisation split to assume that 60% of the projected hospital utilisation to relate to overnight stays, with the remaining 40% projected hospital utilisation to relate to day case procedures. As day case procedures are expected to result in lower claims than overnight stays, the assumption change implicitly assumes additional claims inflation above that outlined in Section 4.4 above.

4.6. 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 4.18 Projected Surplus in REF

€m	**Projected Surplus/deficit at end of claim period**
01/01/2013 – 31/03/2019 Contracts	52.5
01/04/2019 – 31/03/2020 Contracts	39.2
01/04/2020 – 31/03/2021 Contracts	12.4
01/04/2021 – 31/03/2022 Contracts	51.7
01/04/2022 – 31/03/2022 Contracts	(100.0)
Other incl. Investment Income Less expenses	(0.8)
Total	**55.0**

When setting credits in last year's report the Authority assumed an initial surplus of €100m which was expected to be exhausted due to the expectation that expected allocated credits would exceed expected stamp duty receipts by €100m.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €55m (2022/2023 Calibration: €100m) in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2023 are fully earned. Although the REF surplus is lower than for the €100m used in the current calibration, the Authority estimate that the REF will likely continue 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 actual number of people with health insurance being above the projected levels.

The Authority has therefore recommended that this estimated surplus of €55m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2023 to 31 March 2024.

4.7. Ratio of Non-Advanced to Advanced Stamp Duty

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. Non-Advanced products do not provide more than 66% of the full cost for hospital charges in a private hospital and as a result, Non-Advanced policy holders are more likely to avail of public hospitals when using their health insurance.

As at 1 July 2022, 8% of the market held a Non-Advanced contract which was unchanged from the previous year. The ratio of Non-Advanced claims to Advanced claims last year was at 29% for over 65 and 21% for all ages and has fallen to 24% for over 65 and 17% for all ages. This is largely driven by the nature of these products which would be largely used in public hospitals which have been impacted more severely by COVID-19.

The Authority is therefore proposing to set the Stamp Duty for Non-Advanced contracts at 25% (2022/2023 Calibration: 30%) of the stamp duty relating to Advanced contracts, so that the contribution to the REF from those with Non-Advanced products better reflects their level of claims on the fund. Stamp duty paid on Non-Advanced products should not be subsidising the level of claims from Advanced products. With this reduction passed onto consumers via premium levels, the price of Non-Advanced products should reasonably reflect the claims costs of those with that type of product.

4.8. Net Claims Cost Ceiling

The calibration of the RES 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 ("NCC") ceiling, of the average net cost across all groups. The impact of the net claims cost ceiling on the ARHC could be considered as follows:

- The average returned benefit amount is calculated for the market as a whole for each cohort where age credits are applied (i.e., Advanced / Non-Advanced and male / female). Level 2 average claims are used in the calibration for Advanced cover contracts;
- In theory, if there was no surplus then the NCC across the market as a whole before and after RES would be the same, i.e. stamp duty collected would equal credits paid out. Thus, the average claim before and after RES is impacted by the level of surplus in the REF;
- When calculating the NCC or average claim after RES (by age and level of cover), the formula is as follows:

  Average Claim before RES + Stamp Duty (to cover all credits) – ARHC Credits – HUC Credit – HCCP Credit = Average Claim After RES = NCC

- The ARHC 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 140% of the average net claims cost for Level 2 contracts.

As part of the work on the HCCP recommendation to the Department of Health last June, the Authority recommended that the HCCP would be introduced in such a way as to reallocate credits and as such should not cause an increase in stamp duty all else being equal. This means that the increase in the HCCP in this RES calibration due to the rolling dynamic will reduce the amount of credits allocated to age credits and thus will increase the net claims cost ceiling for older age cohorts, as the reduction in age credits is only partly offset by HCCP claims.

In the 2022/2023 Calibration the net claims cost ceiling was 137.7%, which resulted in an estimated 70.0% of credits being in respect of age and, 23.5% in respect of HUC and 6.5% in respect of HCCP.

For the 2023/2024 Calibration, the Authority proposes a net claims cost ceiling of 140.0%, which results in an estimated 65.9% of credits being in respect of age and, 22.7% in respect of HUC and 11.4% in respect of HCCP.

The principal aims of the Authority in terms of avoiding risk selection and market segmentation are key in terms of maintaining market stability. Keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger healthier consumers in the market. A more targeted allocation of credits based on health status rather than age helps to reduce market segmentation and reduce incentives for insurers. The overall effectiveness of the RES has increased from 43.6% in 2022/2023 to 50.4% in the 2023/2024 calibration largely driven by the higher allocation of credits based on health status through HCCP rather than ARHC.

5. Market Developments

Key market developments:

- The number of people with health insurance continues to increase (01/07/2022: 2.378m vs 01/07/2021: 2.226m). Growth has exceeded our forecasts from last year, particularly for the younger age cohorts;
- The average adult premium across the market is €1,410 for 01/07/22 which is a reduction of c. 3% since the 01/01/22;
- All insurers put through price reductions on their plans, in response to the stamp duty reductions that came into force on 1st April 2022.
- The number of inpatient plans on sale in the market by the three open membership insurers has increased marginally in the last year with 32410 inpatient private health insurance plans on the Product Register on 1st July 2022 (excluding restricted undertakings). The number of new products introduced so far in 2022 are 6 and number of plans retired are 3.
- [redacted]Total claims paid out by insurers in 2021 are below estimates (both the Authority's and the insurers). Table 5.1 below shows the total claims payments for the insurers for the last three years. [redacted]

Table 5.1 Total Claims Payments by Insurer

€m	Irish Life Health	Laya Healthcare	Vhi Healthcare	Total
2019 Total	[redacted]	[redacted]	[redacted]	2,248
2020 Total	[redacted]	[redacted]	[redacted]	1,876
2021 Total	[redacted]	[redacted]	[redacted]	2,122

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.

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.

Average Returned Benefit & Average Net Claims Cost

Table 5.2 below sets out the average net claims and average premiums for June 2021 – June 2022 for lives aged 64 and under and lives aged 65 and over.

[redacted]

Table 5.2 Average returned benefits and average net claims: June 2021 – June 2022

	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
Average Net Claims Cost per insured person (June 2021 - June 2022)				
18-64	[redacted]	[redacted]	[redacted]	997
Over 65's	[redacted]	[redacted]	[redacted]	1,168
Average Gross of Tax Relief Premiums per insured person				
18-64	[redacted]	[redacted]	[redacted]	1,534
65 and above	[redacted]	[redacted]	[redacted]	1,997
Average Difference per insured person				
18-64	[redacted]	[redacted]	[redacted]	537
65 and above	[redacted]	[redacted]	[redacted]	830

The "Difference" column in the above table does 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 above table does provide an indication of the relative level of profitability (before expenses and claims not included in returns are allowed for) for different age groups and shows that, profitability appears to be significantly higher for older lives when compared to younger lives.

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, however the impact is more pronounced for older lives because age credits are received for them.

If we compare to the corresponding analysis performed in the September 2019 Report, as set out in Table 5.3 below, we can see that the relative level of profitability (before expenses and claims not included in returns are allowed for) was lower for older lives, noting that the analysis is not directly comparable due to different age groupings used. This suggests that age credits within the past 12 months were too high relative to the level of claims being paid.

Table 5.3 Average returned benefits and average net claims: June 2018 – June 2019

	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
Average Net Claim per insured person (June 2018 - June 2019)				
18-59	[redacted]	[redacted]	[redacted]	1,043
60 and above	[redacted]	[redacted]	[redacted]	1,534
Average Gross of Tax Relief Premiums per insured person				
18-59	[redacted]	[redacted]	[redacted]	1,454
60 and above	[redacted]	[redacted]	[redacted]	1,815
Average Difference per insured person				
18-59	[redacted]	[redacted]	[redacted]	411
60 and above	[redacted]	[redacted]	[redacted]	281

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 2019 – 2021 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.

The Health Insurance Act 1994 (Preparation of Financial Statements) Regulations 2022 [S.I. No. 146 of 2022] came into effect on 30 March 2022, which impact on how profitability and expenses are recognised by insurers in the financial statements furnished to the Authority. These Regulations apply to financial statements furnished to the Authority pursuant to section 7F(1) of the Act of 1994 in respect of the calendar year 2022 and for every year thereafter. Additionally, Section 7F of the Health Insurance (Amendment) Act 2021 updated the threshold for the level of reasonable profit from 4.4% p.a. to 6% although this is to be transitioned in on a phased basis with a threshold of 4.9% applying to the assessment in respect of the three-year period 2020 – 2022. The Authority has not been furnished with updated projections which allow for the impact of these Regulations. As such the impact of these Regulations 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 2023 to 31 March 2024. 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.

Stamp Duty

The Authority is recommending that the stamp duties that would need to be paid by the insurers on policies that are entered into between 1 April 2023 and 31 March 2024, in order to meet the cost to the REF of the recommended Risk Equalisation Credits, are as follows:

Table 8.1 Stamp duty recommendation for contracts incepted 1 April 2023 – 31 March 2024

Age Band	**Stamp Duties from 1 April 2023 to 31 March 2024**		**Stamp Duties from 1 April 2022 to 31 March 2023**		**Change**	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17and under	€36	€146	€41	€135	(€4)	€11
18 and over	€109	€438	€122	€406	(€12)	€32

The increase in stamp duty is principally driven by a reduction in the estimated surplus from €100m to €55m built up in the REF.

The estimated €100m surplus arising for the purposes of the calculation of stamp duty in respect of contracts entered into in the period 1 April 2022 to 31 March 2023 was driven by the effects of COVID-19. More specifically, it arose 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.

In last year's report the Authority noted 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. Thus, the reduction in the estimated surplus is a key contributor to the increase in stamp duty in the period. The Authority notes that if the surplus in the REF was not applied to the 2023/2024 stamp duty, Advanced stamp duties for adults would be €474, as opposed to €438, and the Non-Advanced adult stamp duty would be €118, as opposed to €109.

If there was no surplus within the REF the adult Advanced stamp duty would be closer to €474 compared to the recommended rate of €438.

Risk Equalisation Credits

The Authority proposes that the following Risk Equalisation Credits should apply for health insurance policies that are entered into between 1 April 2023 and 31 March 2024.

Table 8.2 Risk Equalisation Credits for contracts incepted 1 April 2023 – 31 March 2024

Age Related Health Credits (ARHC)								
Age / gender / level of cover credits from 1 April 2023 – 31 March 2024					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	€950	€525	€25	€50	€0	€25
70-74	€525	€400	€1,550	€1,075	€25	€50	(€25)	€0
75-79	€775	€575	€2,300	€1,650	€0	€0	(€75)	(€50)
80-84	€900	€625	€2,725	€1,950	(€50)	(€25)	(€250)	(€175)
85+	€1,000	€700	€3,000	€2,050	(€150)	(€75)	(€550)	(€375)
Hospital Utilisation Credit (HUC)								
Night		Day			Night		Day	
€125		€75			No change		No change	
Hight Cost Claims Pool (HCCP)								
Quota Share 40%					No change			
Threshold €50,000					No change			
Rolling HCCP (Cross Over Period Allowance)					Included			

The ARHC 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 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 (adjusted for inflation) since the claims arising after this period have been distorted as a result of COVID-19. 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 140.0% (2022/2023: 137.7%) of the average net claims cost across all lives.

The Authority is not recommending any change in the level of day or night HUC.

The Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000 which are the parameters agreed to by Authority and the European Commission in the RES notification and used last year in the 2022/2023 RES calibration. While the Authority's proposed calibration in respect of the HCCP is unchanged, we note as this is the second year of HCCP being included in the RES, cross-over periods have been included in the calibration, i.e. rolling quarters in a 12-month period are used commencing from 1 April 2023 determined by the date the claim is incurred. The estimated size of the credits to be distributed in respect of the HCCP for 2023/2024 RES calibration is €101.2m or 11.7% of the overall credits (2022/2023 Calibration: €55.4m or 6.5%). The increase in HCCP credits is largely driven by the allowance for cross-over periods in this year's calibration. This is in line with expectations guided in last year's report.

Full detail of this proposal is included in Appendix 5.

Alternative Recommendations Considered

In coming to the recommendation, the Authority have looked at a number of alternatives to the recommendation for the 2023/2024 RES. Detail of the alternative recommendations 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 of the RES from 43.6% to 50.4% based on the Authority's defined measure of effectiveness[11]. We note that the effectiveness of the recommendation is increased significantly by the inclusion of rolling quarters in the assumed claims. The 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;
- Stamp Duty for Advanced products has increased compared to the current calibration (2022/2023 calibration: €406 vs 2023/2024 calibration: €438). This is driven by the reduction in the RES surplus (2022/2023 calibration: €100m vs 2023/2024 calibration: €55m). The RES surplus of €100m used in the 2022 calibration was driven by lower than expected claims and hospitalisations due to COVID-19. Also, the population with health insurance was higher than allowed for in the 2022 calibration which generated additional stamp duty without a corresponding increase in allocated credits; and
- The reduction in the Non-Advanced relative to the Advanced from 30% to 25% should serve to address concerns about affordability and stability of the market. 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.

[11] "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

Impact on Key Metrics

The table below reconciles the change in stamp duty (and other key metrics) between last years and this year's recommendations. The increase in stamp duty is largely driven by the change in REF surplus as outlined below. Further detail on the movement of other key metrics, including details of the financial impact on each of the insurers, is included in Appendix 3.

Table 9.1 Reconciliation of change in stamp duty

	Stamp Duty				Credits Allocated				
	Stamp Duty (Rolling HCCP)	Diff	Effectiveness (all)	Diff	Age Related	HUC	HCCP	Total Credits	Diff
2022 Calibration	**€406**		**43.6%**		**€590.0m (70.0%)**	**€199.0m (23.5%)**	**€55.4m (6.5%)**	**€844.1m**	
Rolling HCCP Claims	*€417*	*€11*	*52.6%*	*9.0%*	*€565.9m (65.3%)*	*€199.0m (23.0%)*	*€101.2m (11.7%)*	*€866.1m*	*22.0m*
Claims Adjustment	*€413*	*(€4)*	*50.5%*	*-2.1%*	*€556.0m (64.9%)*	*€199.0m (23.2%)*	*€101.2m (11.8%)*	*€856.2m*	*(9.9m)*
Hospital Utilisation Rates	*€412*	*(€1)*	*50.4%*	*-0.1%*	*€559.1m (65.3%)*	*€194.9m (22.8%)*	*€102.1m (11.9%)*	*€856.1m*	*(0.1m)*
Insured Population Data	*€414*	*€1*	*50.7%*	*0.3%*	*€590.6m (66.0%)*	*€202.7m (22.6%)*	*€102.1m (11.4%)*	*€895.3m*	*39.2m*
Other *Ratio of Non-Adv Stamp Duty to Adv Stamp Duty*	*€415*	*€2*	*50.5%*	*-0.1%*	*€590.4m (66.0%)*	*€202.7m (22.6%)*	*€102.1m (11.4%)*	*€895.2m*	*(0.1m)*
RES Surplus	*€445*	*€30*	*50.5%*	*0.0%*	*€601.4m (66.4%)*	*€202.7m (22.4%)*	*€102.1m (11.3%)*	*€906.1m*	*10.9m*
Net Claims Cost Ceiling	*€438*	*(€7)*	*50.4%*	*-0.1%*	*€587.7m (65.9%)*	*€202.7m (22.7%)*	*€102.1m (11.4%)*	*€892.5m*	*(13.6m)*
2023 Recommendation	**€438**		**50.4%**		**€587.7m (65.9%)**	**€202.7m (22.7%)**	**€102.1m (11.4%)**	**€892.5m**	

The change in stamp duty is primarily driven by the change to the REF surplus, all else being equal.

The Authority has a defined measure of effectiveness and in making its recommendations this is one of a number of metrics which is considered. The proposed changes to the RES calibration result in a material increase in effectiveness primarily driven by the changes to the HCCP to include an allowance for rolling claims.

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 140.0% (2022/2023: 137.7%) of the average net claims cost across all lives;

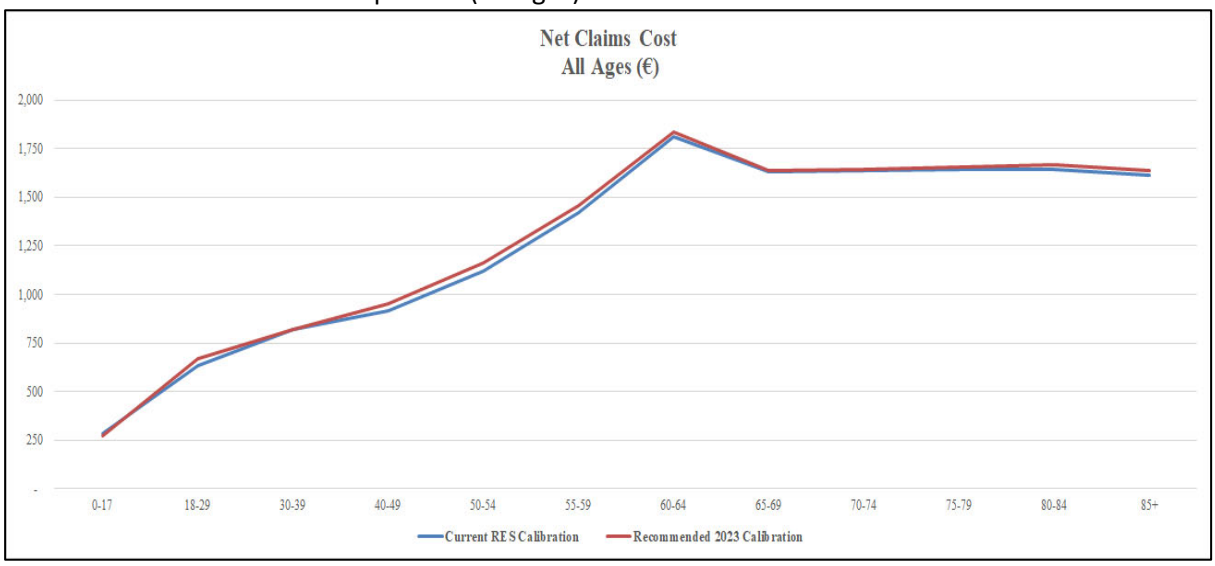
- HUC reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience episodes of hospitalisation and acts as a proxy for health status;
- HCCP reduces the net claims cost for less healthy people of all ages through compensatory payments for members 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.

The projected net claims cost of insured lives by age 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 2023/2024 RES calibration. A graphical representation of the net claims cost by all ages is included in Chart 9.1. We can see that the net claims cost has fallen for the age group 0-17 and increased for all other age groups under the 2023 recommendation.

Table 9.2 Projected net claims cost by age

Net Claims Cost After RES	Current 2022 RES Calibration	Recommended 2023 Calibration	Impact of Recommended Calibration
0-17	284	272	*(12)*
18-29	636	668	*31*
30-39	820	821	*1*
40-49	918	951	*32*
50-54	1,120	1,162	*42*
55-59	1,418	1,459	*41*
60-64	1,813	1,837	*25*
65-69	1,630	1,640	*10*
70-74	1,636	1,640	*4*
75-79	1,641	1,654	*13*
80-84	1,644	1,668	*24*
85+	1,615	1,639	*24*

Chart 9.1: Net Claims Cost Comparison (All Ages)



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 2023 to 31 March 2024 are outlined in table 9.3 below.

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.

Table 9.3 Projected Net Financial Impacts by insurer

Projected RES Flows								
From 1 April 2022								
€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**				
Age Credits	[redacted]	[redacted]	[redacted]	590				
HUC	[redacted]	[redacted]	[redacted]	199				
HCCP	[redacted]	[redacted]	[redacted]	55				
Stamp Duty	[redacted]	[redacted]	[redacted]	(745)				
NFI	[redacted]	[redacted]	[redacted]	100				
From 1 April 2023					**Change from 1 April 2022 Credits**			
€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**	**Market**
Age Credits	[redacted]	[redacted]	[redacted]	588	[redacted]	[redacted]	[redacted]	(2)
HUC	[redacted]	[redacted]	[redacted]	203	[redacted]	[redacted]	[redacted]	4
HCCP	[redacted]	[redacted]	[redacted]	102	[redacted]	[redacted]	[redacted]	47
Stamp Duty	[redacted]	[redacted]	[redacted]	(838)	[redacted]	[redacted]	[redacted]	(93)
NFI	[redacted]	[redacted]	[redacted]	55	[redacted]	[redacted]	[redacted]	(45)

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.

Appendix 1: Further analysis of Information Returns

The information returns for 2020, 2021 and H1 2022 have been somewhat distorted as a result of COVID-19 and more recently the HSE cyber-attack, and thus the information presented below may not give a true indication of long-term trends in experience. Information returns in respect of 2019 and before do not contain such distortions.

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 A1.1 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**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	**548**	**461**	**409**	**464**	**488**	**512**
% change vs July-Dec 2019		**(16%)**	**(25%)**	**(15%)**	**(11%)**	**(7%)**

Due to the impact of COVID-19, the market returned benefit per insured from Jan-June 2022 is €512 which remains lower than the July-Dec 2019 period of €548. This metric has been trending upwards since July-Dec 2020 as the impacts of COVID-19 are reducing although it still remains distorted.

Comparing the first half of 2022 with the second half of 2019 shows a 7% reduction in the market average returned benefit. [redacted]

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**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	100%	100%	100%	100%	100%	100%

[redacted]

Average Returned Benefits per Insured Person for the 12 months to the end of June 2022 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. The corresponding market figures the 12 months to the end of June 2019 are shown in brackets to help illustrate the current levels of claims arising relative to those observed pre-COVID. As can be seen average claims levels are still below pre-pandemic levels across all levels of cover for both genders.

Table A1.3: Male Non-Advanced

Age Group	**Irish Life Health €**	**Laya Healthcare €**	**Vhi Healthcare €**	**Weighted Market Average €**
0-17	[redacted]	[redacted]	[redacted]	41 (108)
18-29	[redacted]	[redacted]	[redacted]	66 (87)
30-39	[redacted]	[redacted]	[redacted]	87 (95)
40-49	[redacted]	[redacted]	[redacted]	130 (163)
50-54	[redacted]	[redacted]	[redacted]	195 (247)
55-59	[redacted]	[redacted]	[redacted]	324 (314)
60-64	[redacted]	[redacted]	[redacted]	438 (571)
65-69	[redacted]	[redacted]	[redacted]	721 (803)
70-74	[redacted]	[redacted]	[redacted]	793 (1,057)
75-79	[redacted]	[redacted]	[redacted]	1,134 (1,248)
80-84	[redacted]	[redacted]	[redacted]	1,313 (1,379)
85+	[redacted]	[redacted]	[redacted]	1,589 (2,729)
All Ages	[redacted]	[redacted]	[redacted]	**206 (250)**

Table A1.4: Male Level 1

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	43 (111)
18-29	[redacted]	[redacted]	[redacted]	74 (90)
30-39	[redacted]	[redacted]	[redacted]	94 (100)
40-49	[redacted]	[redacted]	[redacted]	136 (168)
50-54	[redacted]	[redacted]	[redacted]	209 (263)
55-59	[redacted]	[redacted]	[redacted]	335 (363)
60-64	[redacted]	[redacted]	[redacted]	484 (626)
65-69	[redacted]	[redacted]	[redacted]	812 (954)
70-74	[redacted]	[redacted]	[redacted]	1,093 (1,125)
75-79	[redacted]	[redacted]	[redacted]	1,387 (1,718)
80-84	[redacted]	[redacted]	[redacted]	2,020 (2,196)
85+	[redacted]	[redacted]	[redacted]	1,944 (3,242)
All Ages	[redacted]	[redacted]	[redacted]	**272 (329)**

Table A1.5: Male Level 2

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	108 (174)
18-29	[redacted]	[redacted]	[redacted]	263 (282)
30-39	[redacted]	[redacted]	[redacted]	288 (309)
40-49	[redacted]	[redacted]	[redacted]	462 (486)
50-54	[redacted]	[redacted]	[redacted]	721 (772)
55-59	[redacted]	[redacted]	[redacted]	1,034 (1,114)
60-64	[redacted]	[redacted]	[redacted]	1,471 (1,589)
65-69	[redacted]	[redacted]	[redacted]	1,970 (2,231)
70-74	[redacted]	[redacted]	[redacted]	2,568 (2,921)
75-79	[redacted]	[redacted]	[redacted]	3,302 (3,730)
80-84	[redacted]	[redacted]	[redacted]	3,676 (4,461)
85+	[redacted]	[redacted]	[redacted]	4,010 (5,493)
All Ages	[redacted]	[redacted]	[redacted]	**951 (1,068)**

Table A1.6: Male Level 2+

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	112 (183)
18-29	[redacted]	[redacted]	[redacted]	260 (274)
30-39	[redacted]	[redacted]	[redacted]	288 (309)
40-49	[redacted]	[redacted]	[redacted]	470 (492)
50-54	[redacted]	[redacted]	[redacted]	752 (793)
55-59	[redacted]	[redacted]	[redacted]	1,082 (1,132)
60-64	[redacted]	[redacted]	[redacted]	1,526 (1,658)
65-69	[redacted]	[redacted]	[redacted]	2,091 (2,333)
70-74	[redacted]	[redacted]	[redacted]	2,750 (3,053)
75-79	[redacted]	[redacted]	[redacted]	3,575 (4,011)
80-84	[redacted]	[redacted]	[redacted]	4,077 (4,919)
85+	[redacted]	[redacted]	[redacted]	4,762 (6,041)
All Ages	[redacted]	[redacted]	[redacted]	**1,063 (1,173)**

Table A1.7: Female Non-Advanced

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	44 (93)
18-29	[redacted]	[redacted]	[redacted]	48 (89)
30-39	[redacted]	[redacted]	[redacted]	124 (170)
40-49	[redacted]	[redacted]	[redacted]	158 (197)
50-54	[redacted]	[redacted]	[redacted]	260 (259)
55-59	[redacted]	[redacted]	[redacted]	296 (352)
60-64	[redacted]	[redacted]	[redacted]	379 (424)
65-69	[redacted]	[redacted]	[redacted]	563 (634)
70-74	[redacted]	[redacted]	[redacted]	583 (765)
75-79	[redacted]	[redacted]	[redacted]	810 (1,091)
80-84	[redacted]	[redacted]	[redacted]	924 (1,472)
85+	[redacted]	[redacted]	[redacted]	1,288 (1,693)
All Ages	[redacted]	[redacted]	[redacted]	**202 (253)**

Table A1.8: Female Level 1

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	50 (93)
18-29	[redacted]	[redacted]	[redacted]	54 (95)
30-39	[redacted]	[redacted]	[redacted]	142 (183)
40-49	[redacted]	[redacted]	[redacted]	168 (208)
50-54	[redacted]	[redacted]	[redacted]	276 (276)
55-59	[redacted]	[redacted]	[redacted]	311 (372)
60-64	[redacted]	[redacted]	[redacted]	392 (456)
65-69	[redacted]	[redacted]	[redacted]	661 (704)
70-74	[redacted]	[redacted]	[redacted]	826 (1,030)
75-79	[redacted]	[redacted]	[redacted]	1,095 (1,307)
80-84	[redacted]	[redacted]	[redacted]	1,326 (1,786)
85+	[redacted]	[redacted]	[redacted]	1,718 (2,493)
All Ages	[redacted]	[redacted]	[redacted]	**262 (321)**

Table A.9: Female Level 2

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	114 (166)
18-29	[redacted]	[redacted]	[redacted]	306 (308)
30-39	[redacted]	[redacted]	[redacted]	618 (689)
40-49	[redacted]	[redacted]	[redacted]	636 (687)
50-54	[redacted]	[redacted]	[redacted]	852 (853)
55-59	[redacted]	[redacted]	[redacted]	1,033 (1,074)
60-64	[redacted]	[redacted]	[redacted]	1,260 (1,341)
65-69	[redacted]	[redacted]	[redacted]	1,644 (1,789)
70-74	[redacted]	[redacted]	[redacted]	2,137 (2,400)
75-79	[redacted]	[redacted]	[redacted]	2,687 (3,063)
80-84	[redacted]	[redacted]	[redacted]	3,070 (3,667)
85+	[redacted]	[redacted]	[redacted]	3,059 (4,205)
All Ages	[redacted]	[redacted]	[redacted]	**981 (1,089)**

Table A1.10: Female Level 2+

Age Group	Irish Life Health €	Laya Healthcare €	Vhi Healthcare €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	118 (173)
18-29	[redacted]	[redacted]	[redacted]	310 (311)
30-39	[redacted]	[redacted]	[redacted]	632 (696)
40-49	[redacted]	[redacted]	[redacted]	655 (696)
50-54	[redacted]	[redacted]	[redacted]	876 (892)
55-59	[redacted]	[redacted]	[redacted]	1,083 (1,121)
60-64	[redacted]	[redacted]	[redacted]	1,346 (1,410)
65-69	[redacted]	[redacted]	[redacted]	1,711 (1,895)
70-74	[redacted]	[redacted]	[redacted]	2,277 (2,574)
75-79	[redacted]	[redacted]	[redacted]	2,958 (3,370)
80-84	[redacted]	[redacted]	[redacted]	3,386 (3,986)
85+	[redacted]	[redacted]	[redacted]	3,413 (4,687)
All Ages	[redacted]	[redacted]	[redacted]	**1,081 (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 A1.11 and A1.12 below.

We note the figures below are impacted by the CCV data issues set out in Appendix 6.

Table A1.11 Average Returned Benefit per Treatment Day

Average Returned Benefits per Treatment day (€)				
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
Market	1,292	1,354	1,296	1,269

Average returned benefits per treatment day have reduced across the market as a whole over the past 12 months by 6.2% (i.e. reduction between Jan-June 2021 and Jan-June 2022). [redacted]

Table A1.12 Average Returned Benefit per Treatment Day relative to market

Average Returned Benefits per Treatment day as a % of the Market Average				
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]
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 A1.13 and A1.14 below. Again, each insured child counts as 1/3rd when counting the number of insured persons in order to allow for the fact that children are not charged a full premium.

We note again the figures below are impacted by the data issues set out in Appendix 6.

Table A1.13 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**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	0.472	0.395	0.317	0.343	0.376	0.403

Table A.14 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**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	100%	100%	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 to 0.403 in the 6-month period to June 2022, a fall of 15%.

[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 A1.15 Age/Sex Risk Profile Index

Age/Sex Risk Profile Index						
Insurer	**July-Dec 2019**	**Jan-June 2020**	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	100%	100%	100%	100%	100%	100%

[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. [redacted].

Table A1.16 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	July-Dec 2021	Jan-June 2022
Irish Life Health	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laya Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Vhi Healthcare	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

[redacted]

Chart A1.1

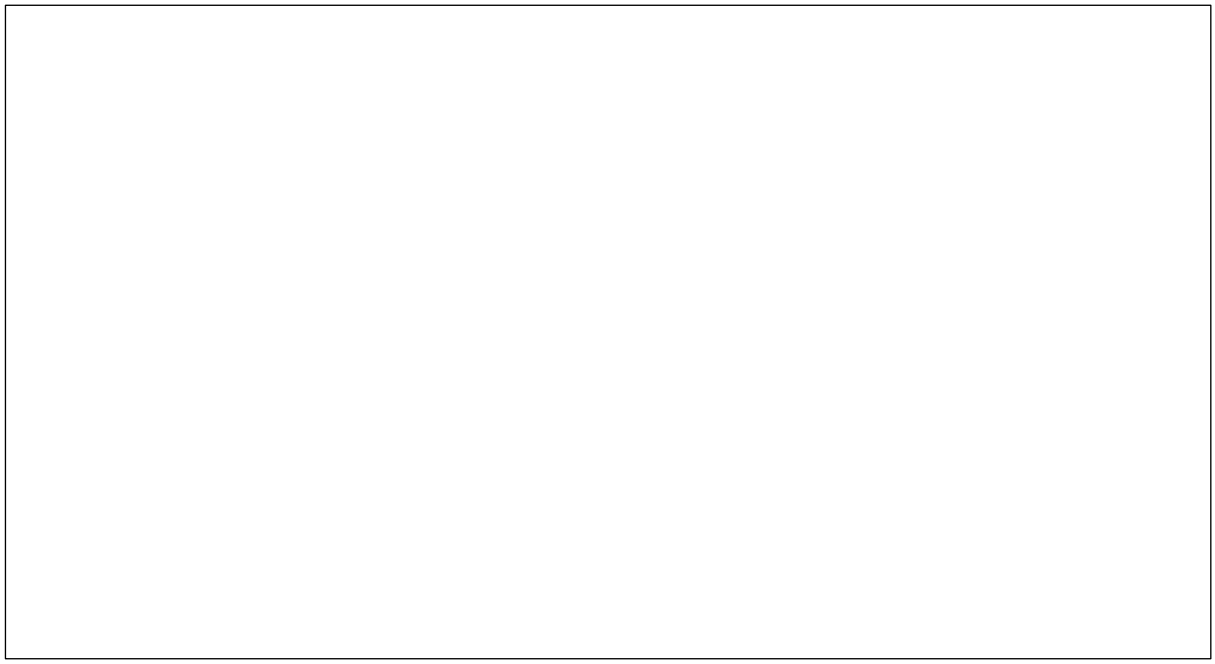
The corresponding in-patient and day case averages are shown in Charts A1.2 and A1.3 respectively.

[redacted]

Chart A1.2

[redacted]

Chart A1.3



Appendix 2: Risk Equalisation Credits and Stamp Duty from 1 April 2023

Table A2.1 below show the projected membership as at 1 October 2023 (the time the average policy incepted between 1 April 2023 and 31 March 2024). Tables A2.2 to A2.3 show the projected returned benefits, hospital nights and day case admissions as at 1 April 2024 (the midpoint of the average policy incepted between 1 April 2023 and 31 March 2024). 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 2023

Projected Membership as at 1 October 2023				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	13,051	12,264	260,031	244,032
18-29	14,805	15,904	137,103	136,693
30-39	16,166	16,076	128,411	145,948
40-49	17,873	16,943	161,762	179,460
50-54	6,554	6,471	75,438	80,686
55-59	5,276	5,045	67,327	74,688
60-64	3,827	3,898	62,004	68,823
65-69	2,846	2,798	56,680	62,633
70-74	1,810	1,767	47,849	53,117
75-79	1,047	1,056	38,916	43,616
80-84	415	484	21,906	27,127
85+	216	363	14,491	22,646
Total	**83,885**	**83,068**	**1,071,918**	**1,139,471**

Table A2.2 Projected Average Returned Benefit at 1 April 2024 (€)

Projected Average Returned Benefit at 1 April 2024 (€)				
Age Group	**Non-Advanced**		**Advanced**	
	Male	Female	Male	Female
0-17	79	72	155	146
18-29	75	75	302	326
30-39	90	144	337	650
40-49	134	179	530	732
50-54	222	225	827	897
55-59	254	316	1,206	1,178
60-64	452	341	1,740	1,482
65-69	802	654	2,387	1,945
70-74	1,020	850	3,035	2,530
75-79	1,301	1,072	3,870	3,191
80-84	1,486	1,201	4,423	3,573
85+	1,624	1,269	4,831	3,775
All Ages	**202**	**208**	**989**	**1,006**

Table A2.3 Projected Total Bed Nights at 1 April 2024

Projected Total Bed Nights at 1 April 2024				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	964	891	29,253	27,315
18-29	588	648	20,505	27,165
30-39	807	1,799	18,709	62,888
40-49	1,536	1,743	33,490	55,455
50-54	999	772	23,758	27,366
55-59	927	1,132	30,779	34,737
60-64	1,318	773	43,229	44,119
65-69	1,497	1,326	57,505	53,365
70-74	1,527	1,011	65,411	65,940
75-79	997	844	77,981	77,783
80-84	648	757	63,973	69,662
85+	395	633	65,159	82,516
Total	**12,202**	**12,329**	**529,751**	**628,309**

Table A2.4 Projected Total Day Case Admissions at 1 April 2024

Projected Total Day Case Admissions at 1 April 2024				
Age Group	**Non-Advanced**		**Advanced**	
	Male	**Female**	**Male**	**Female**
0-17	298	183	12,182	8,584
18-29	465	557	12,794	15,599
30-39	768	964	17,590	27,463
40-49	1,369	1,881	34,409	56,309
50-54	693	958	23,942	33,903
55-59	702	862	28,330	37,481
60-64	682	695	35,566	41,319
65-69	648	579	43,398	44,663
70-74	510	416	45,927	46,531
75-79	348	275	44,443	43,509
80-84	121	140	26,189	26,447
85+	46	55	15,428	17,772
Total	**6,651**	**7,566**	**340,199**	**399,581**

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 140.0% 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 0%, 5% and 5% per annum for public hospital, private hospital and consultant respectively. 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 25% of the stamp duty relating to Advanced contracts. The REF is projected to have a surplus of €55m when the contracts written prior to 1 April 2023 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.

In our projections we have projected the population at 1 July 2022 forward to 1 October 2023 (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.

The Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000 based on rolling claims over a 12-month period.

[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 2022 would continue through to 1 October 2023.

Table A2.5a – Recommended Stamp Duty and Credits

Age	Stamp Duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€m)	Total Credits (€m)	Total HCCP (€ms)	Total Stamp Duty (€m)
	Non-Adv	Adv	Non-Advanced		Advanced					
			Men	Women	Men	Women				
0-17	36	146	0	0	0	0	9	0	3	12
18-29	109	438	0	0	0	0	8	0	2	11
30-39	109	438	0	0	0	0	14	0	4	18
40-49	109	438	0	0	0	0	19	0	7	26
50-54	109	438	0	0	0	0	11	0	5	16
55-59	109	438	0	0	0	0	13	0	8	21
60-64	109	438	0	0	0	0	17	0	10	27
65-69	109	438	350	200	950	525	21	88	13	122
70-74	109	438	525	400	1,550	1,075	24	133	15	172
75-79	109	438	775	575	2,300	1,650	26	163	14	203
80-84	109	438	900	625	2,725	1,950	21	113	12	146
85+	109	438	1,000	700	3,000	2,050	21	90	8	120
Total							**203**	**588**	**102**	**838**

Table A2.5b – Projected Net Financial Impact by Insurer

€m	Irish Life Health	Laya Healthcare	VHI Healthcare	Total
Age Related Health Credits	[redacted]	[redacted]	[redacted]	588
Hospital Bed Utilisation Credit	[redacted]	[redacted]	[redacted]	203
HCCP	[redacted]	[redacted]	[redacted]	102
Stamp Duty	[redacted]	[redacted]	[redacted]	(838)
Total	[redacted]	[redacted]	[redacted]	55

Appendix 3: Analysis of Movement & Sensitivity Analysis on Credits and Stamp Duty from 1 April 2023 for Recommended Methodology

The table below reconciles the change in stamp duty and other key metrics from the current 2022 RES calibration to the recommended 2023 RES calibration.

	2022 RES Calibration	Rolling HCCP Claims	Claims Adjustment	Hospital Utilisation Rates	Insured Population Data	Ratio of Non-Adv Stamp Duty to Adv Stamp Duty	Other RES Surplus	Net Claims Cost Ceiling	Recommended 2023 Calibration
Stamp Duty									
Advanced	**€406**	€417	€413	€412	€414	€415	€445	€438	**€438**
Non-Advanced	**€122**	€125	€124	€124	€124	€104	€111	€109	**€109**
CCC	**137.7%**	137.7%	137.7%	137.7%	137.7%	137.7%	137.7%	140.0%	**140.0%**
Projected RES Flows									
Stamp Duty	**€744.6m**	€764.6m	€757.0m	€756.1m	€794.4m	€794.6m	€851.2m	€837.5m	**€837.5m**
Total Credits	***€844.1m***	€866.1m	€856.2m	€856.1m	€895.3m	€895.2m	€906.1m	€892.5m	**€892.5m**
ARHC	***€590.0m (70.0%)***	*€565.9m (65.3%)*	*€556.0m (64.9%)*	*€559.1m (65.3%)*	*€590.6m (66.0%)*	*€590.4m (66.0%)*	*€601.4m (66.4%)*	*€587.7m (65.9%)*	***€587.7m (65.9%)***
HUC	***€199.0m (23.5%)***	*€199.0m (23.0%)*	*€199.0m (23.2%)*	*€194.9m (22.8%)*	*€202.7m (22.6%)*	*€202.7m (22.6%)*	*€202.7m (22.4%)*	*€202.7m (22.7%)*	***€202.7m (22.7%)***
HCCP	***€55.4m (6.5%)***	*€101.2m (11.7%)*	*€101.2m (11.8%)*	*€102.1m (11.9%)*	*€102.1m (11.4%)*	*€102.1m (11.4%)*	*€102.1m (11.3%)*	*€102.1m (11.4%)*	***€102.1m (11.4%)***
Effectiveness									
All Ages	**43.6%**	52.6%	50.5%	50.4%	50.7%	50.5%	50.5%	50.4%	**50.4%**
Over 65	**46.2%**	55.3%	53.8%	53.6%	53.7%	53.6%	53.7%	53.6%	**53.6%**
Total Projected NFI €m									
[redacted]									
[redacted]									
[redacted]									
Total	**€100m**	€102m	€99m	€100m	€101m	€101m	€55m	€55m	**€55m**

Below is a summary of the alternatives considered for setting credits and Stamp Duty from 1 April 2023 with HCCP.

Alternative Recommendations

	2022 RES Calibration	Recommended 2023 Calibration	Alternative Recommendations		
			High Inflation Scenario [1]	10% Reduction in Private Hospital Claims	Low Inflation Scenario [2]
Stamp Duty					
Advanced	€406	€438	€469	€409	€424
Non-Advanced	€122	€109	€117	€102	€106
CCC	137.7%	140.0%	140.0%	140.0%	140.0%
Projected RES Flows					
Stamp Duty	€745m	€838m	€897m	€782m	€811m
Total Credits	*€844m*	€892m	€951m	€836m	€865m
ARHC	*€590m (70%)*	*€588m (66%)*	*€646m (68%)*	*€547m (65%)*	*€561m (65%)*
HUC	*€199m (24%)*	*€203m (23%)*	*€203m (21%)*	*€186m (22%)*	*€203m (23%)*
HCCP	*€55m (7%)*	*€102m (11%)*	*€102m (11%)*	*€103m (12%)*	*€102m (12%)*
Effectiveness					
All Ages	43.6%	50.4%	47.4%	52.2%	51.7%
Over 65	46.2%	53.6%	50.6%	55.3%	54.8%
Total Projected NFI €m					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	€100m	€55m	€54m	€55m	€54m

[1] High inflation scenario assumes claims inflation rates of 0.0% for public hospitals, 9.7% for private hospitals and 9.7% for consultant over the 2.25-year projection period

[2] Low inflation scenario assumes claims inflation rates of 3.0% for public hospitals, 3.0% for private hospitals and 3.0% for consultant over the 2.25-year projection period

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: HCCP Calibration

The Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000 which are the parameters agreed to by Authority and the European Commission in the RES notification and used last year in the 2022/2023 RES calibration:

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 2023 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

Appendix 6: Data errors

[redacted]

Appendix 7: RES recommendation for contracts incepted 1 April 2022 to 31 March 2023

Table A7.1 Risk Equalisation Credits

Age Bands	Utilisation credits (overnight / day case) from 1 April 2022	Age / gender / level of cover credits from 1 April 2022			
		Non-Advanced		Advanced	
		Men	Women	Men	Women
64 and under	€125 / €75	€0	€0	€0	€0
65-69	€125 / €75	€325	€150	€950	€500
70-74	€125 / €75	€500	€350	€1,575	€1,075
75-79	€125 / €75	€775	€575	€2,375	€1,700
80-84	€125 / €75	€950	€650	€2,975	€2,125
85 and above	€125 / €75	€1,150	€775	€3,550	€2,425

Table A7.2 Stamp Duty

Age Bands	Stamp Duties from 1 April 2022 to 31 March 2023	
	Non-Advanced	Advanced
17 and under	€41	€135
18 and over	€122	€406

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 set so that no age group has a projected net of RES claims cost which exceeds 140.0% 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 over the term of the projection is calibrated by element of returned benefit (public: 0% p.a., private: 5% p.a., consultant: 5% p.a.).
    - 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 140.0% 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 25% of the rate applying for Advanced contracts.
- The stamp duty levels incorporate any anticipated surplus or deficit in the REF when all payments into/out of the REF have been made in respect of contracts that commence prior to the start of the period.