An tÚdarás Árachas Sláinte
The Health Insurance Authority

Risk Equalisation Scheme 2022

Recommendation to the Department of Health on proposed changes to be incorporated into the Risk Equalisation Scheme

11 June 2021

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Executive Summary

The Authority are recommending that the Risk Equalisation Scheme (RES) is changed for contracts commencing from 1 April 2022 to include an allowance for a High Cost Claims Pool (HCCP). The form of other risk equalisation credits, i.e. age related credits and hospital utilisation credits, which exist under the existing RES, should remain.

For the first year of the inclusion of the HCCP (2022/23), the Authority is recommending that the HCCP credits are based on a 40% quota share on claims in excess of €50,000.

The Authority are recommending that initially the introduction of the HCCP should facilitate a redistribution of other credits as opposed to an increase in credits, all else being equal. One of the objectives of introducing the HCCP is to increase the proportion of risk equalisation credits associated with health status. For this reason, the Authority is proposing that the element of credits paid in respect of age related credits is reduced by an amount corresponding to the value of the HCCP. This would mean, all else being equal, there would be little to no change in stamp duty purely as a result of the introduction of a HCCP.

The Authority are making this recommendation having considered:-

- Analysis carried out based on HCCP data received from the three registered undertakings[1]
- Submissions made under the public consultation on "Community-rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme" which was published on 4th January 2021
- Previous analysis and work completed in January 2020 on a HCCP and its impact on effectiveness[2]
- The Principal Objective of the Health Insurance Act,1994
- The current state of the private health insurance market and concerns over participation, sustainability and stability in response to the current and future economic outlook as a fall out from Covid-19 and Brexit
- Expert advice from its actuarial advisors KPMG (see separate report dated May 2021)
- The most recent RES calibration as outlined in the "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits" dated September 2020.

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

- The recommendation increases the effectiveness of the RES from 30.3% to 47.7% based on the Authority's defined measure of effectiveness

- The recommendation is allocating more credits based on actual health status across all ages and is sharing risk for low incidence high cost claims. This is contributing to more targeted distribution of health related credits. This should serve to decrease insurers incentives to segment and risk select, and encourage insurers to compete on efficiencies. The initial calibration will capture very high cost high risk claims but it is at such a level that insurers should still retain a sufficient level of exposure to such claims and as such will still be encouraged to manage those claims efficiently. It is also at such a level that it is not

[1] Irish Life Health, Laya Healthcare & Vhi Insurance DAC
[2] RES Effectiveness: Impact Assessment of the Introduction of a HCCP and changes to other measures

compensating for benefit richness or inefficient claims practices.

- The proposal is a redistribution of credits from lives who are over 65 to high risk lives of all ages and thereby should not have an adverse impact on younger participants and new entrants to the PMI market and therefore contribute to intergenerational solidarity which is essential to the sustainability of the market. The offsetting impact is a marginal increase in the expected net claims costs for those aged over 65 but this is marginal and the Authority considers it is not likely to have an adverse impact on the sustainability of the market.

- The projected impacts for the different insured lives are marginal and thus should not adversely impact competition at an aggregate level, and also serve to support stability and sustainability of the market. This results in a marginal impact on the expected net financial impacts on each of the insurers which means that in the short term they are not materially impacted and there is also no projected overcompensation based on the proposed calibration.

- The recommendation is that the inclusion of a HCCP will be on a phased basis. The expected position in the first 12 months is that HCCP credits will represent approximately 7% of total projected credits and is not likely to have a material impact on any one insurer. The Authority considers that it is therefore unlikely to alter insurer behaviour and as such should support market stability.

- The recommendations are consistent with approaches and practices used in the existing RES and this should also contribute to stability and ease of implementation for insurers.

The Authority is proposing that the HCCP parameters are kept under annual review throughout the 5 year term of the new RES. The Authority is recommending that the element of credits distributed in respect of health status i.e. HCCP and hospital utilisation credits, are increased on a phased gradual basis over the term of the RES, subject to monitoring insurer behaviour in response to the HCCP, market dynamics and achievement of the aims set out under the principal objective.

1. Background

The Risk Equalisation Scheme ("RES") for the private health insurance market in Ireland supports community rating, which is the principal objective of the Health Insurance Acts, 1994 – 2020, ("the Act"). In a community rated market, in general, all lives pay the same for the same policy regardless of age or health status. Discounts are applied to children and young adults. Risk equalisation is used to redistribute funds between lower and higher risk lives with the aim of making insurers less concerned about the risk profile of their underlying customers. This helps to ensure that, in a community rated market, health insurance is affordable to all irrespective of risk profile. In order for the RES to be effective, to the approach to risk equalisation must strike an appropriate balance between compensating insurers with higher levels of risk, maintaining the sustainability of the market, having fair and open competition in the market and promoting efficiency so as to reduce overall claims costs.

The existing RES uses two measures to share and redistribute risk:

- Age related health credits (ARHC) which vary by age, gender and level of cover. Importantly, this is a prospective measure based on the characteristics of the insurer's policyholders.
- Hospital utilisation credits (HUC) payable in respect of some health services. This is a retrospective measure based on actual utilisation.

Risk equalisation credits are paid to insurers per insured life based on these factors. The credits are funded by a stamp duty that varies between adults and children and by level of cover. Risk equalisation credits and stamp duties are calculated on an annual basis, using estimates of the expected market position over the period they will apply. However, payments to and from the Risk Equalisation Fund ("REF") are based on actual number of people (by age/sex/level of cover) with health insurance and hospitalisation experiences of the different insurers.

The RES is an allowable State Aid that required approval from the European Commission. When the 2013-2015 RES was introduced, the Minister for Health committed to implementing in the future a more refined health status measure than hospital utilisation credits ("HUC") to equalise risk in respect of the higher costs of insuring less healthy patients of all ages. This commitment was made in the context of a Universal Health Insurance ("UHI") system being introduced and mandatory Diagnosis Related Groups ("DRG") reporting by private hospitals being introduced. This commitment was re-iterated by the Minister for Health when the 2016-2020 RES was approved by the European Commission.

In 2014 the Department of Health ("DoH") and the Authority commenced work on the development of a more refined health status measure using DRGs to be implemented in a timely and phased manner, based on expanding the use of the Hospital Inpatient Enquiry ("HIPE") system to encompass full coverage of all public and private hospital treatment. When the Government decided not to proceed with Universal Health Insurance, the plan to expand the HIPE system into private hospitals did not proceed.

A working group made up of the insurers, Dept. of Health officials, private hospitals, the Healthcare Pricing Office (HPO), HIA and other relevant bodies was set up to examine alternatives. While all agreed that a health status credit, most likely through the use of Diagnosis Related Groups (DRG) credits should ultimately be incorporated into the RES, the Department of Health considered that it would take some time to implement and as such incorporating a High Cost Claims Pool ("HCCP") into the RES was viewed as a pragmatic alternative. Since then, the introduction of a HCCP has been examined and explored by the Department of Health and the Authority and formed the basis of the proposal put forward in the January 2021 public consultation of the inclusion of a HCCP. The

introduction of a HCCP does not preclude the introduction of DRGs or other health status credits. For now, for the purposes of RES 2022, the focus is on the introduction of a HCCP.

2. Risk Equalisation Scheme 2022

The RES is due to be refreshed from 2022. The major development of the RES for the years 2022-2026 is the inclusion of a HCCP within the existing RES framework.

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

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

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

Aims of the 2022 Risk Equalisation Scheme

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 (Appendix A)
- 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 Risk Equalisation Fund sustaining surpluses or deficits from year to year
- Maintaining the stability of the market which relies on younger cohorts continuing to purchase private health insurance. This is important to maintain the intergenerational solidarity that underpins the principal of community rating.

Authority Objectives in Recommending The High Cost Claims Pool

The overall aim of the RES is to facilitate affordable access to health insurance for all irrespective of perceived risk or health status and to consider the aims and objectives outlined above.

In making its recommendation the Authority, in focusing on the aims of the Act, has considered a number of key objectives that the revised RES should aim to achieve. In order for the RES to be effective, the Authority is of the view that it needs to strike an appropriate balance between compensating insurers with higher levels of risk, maintaining the sustainability of the market, having fair and open competition in the market and promoting efficiency so as to reduce overall claims

costs and lead to better outcomes for consumers. These objectives are discussed in detail below. In evaluating alternative choices, the Authority is mindful that all of the objectives cannot be achieved to the same extent and as such an appropriate balance must be struck.

The Authority has focused on the following objectives:

- The revisions to the RES, in particular the introduction of the HCCP should Improve the overall effectiveness of the RES based on the Authority's defined measure of effectiveness.
- Reduce incentives for risk selection so that insurers are indifferent (or at least less incentivised) to target less risky and more profitable customers; More targeted distribution of health related credits and an improvement in the effectiveness of the RES should reduce the incentives for risk selection so that insurers are indifferent between sicker and heathier customers.
- Sustainability of the market: In making its recommendations, the Authority is focused on the sustainability of the market and in doing so affordability across all age groups must be considered being mindful of the importance of younger consumers entering the market to contribute to intergenerational solidarity. A less effective RES leads to insurers risk selecting and targeting higher priced products to sicker customers they perceive to have higher risks, which can make products targeted at sicker customers (who might also be older) more expensive. The Authority is aware that achieving this objective across all customers is challenging.
- Promote fair and open competition between insurers, such that insurers compete on the basis of efficient operation and quality of service, rather than on the basis of risk selection. Fair and open competition in turn supports sustainability of the health insurance market. While competition is driven by the business decisions of the insurers, and the decision to enter or exit the market, the Authority contributes to achieving this objective by setting RES Credits so that the net recipient is not over-compensated, as a result of the net credits received.
- Stability of the market; The Authority considers stability of the market an important objective and in its deliberations has been mindful of any policy decisions on the impact on market stability.
- Consistency with other aspects of the RES: One of the objectives of the Authority in assessing different policy options is to ensure consistency of decision making across different aspects of the RES. This is to ensure that introducing new credits, such as the HCCP, does not increase the incentives for risk selection;
- Ease of implementation – one of the criteria in selecting between options is the ability of the insurers to implement the proposed approach. While the Authority recognises that the introduction of a HCCP will place an additional reporting burden on insurers given the data required to track and monitor claims, the Authority is conscious that this burden should not be excessive. This objective is supported by meeting the other objective of consistency with other aspects of the RES. This should minimise the number of changes to internal systems that the insurers will need to undertake when implementing the HCCP reporting requirements.

Analysis

A high cost claims pool is defined by two parameters:

- The value of claims at which point the risks are shared (the Threshold);
- The percentage of claims covered by the HCCP, above the Threshold (called the Quota Share)

Once it has been decided that a HCCP should be included, a decision must be made as to the scale of these two parameters and how the HCCP will interact with the other elements of the RES.

The Authority has previously carried out in depth analysis and made recommendations to the DoH[3] in January 2020 regarding the inclusion of a HCCP and the quota share and threshold that should apply. In that report it recommended that a HCCP should be included and it should have a threshold of €50,000 and a quota share of 40%. This selection was made based on the previous analysis carried out by the Authority and as documented in the January 2020 report from the Authority to the DoH on the incorporation of a HCCP and its impact on effectiveness.

Since then:

- the Authority has collected more detailed high cost claims data from the three open market insurers (Irish Life Health, Laya Healthcare, Vhi Healthcare) relating to contracts incepted from 1 January 2016[4] to 31 December 2019 and with claims paid up to 30 June 2020;
- the Authority has carried out its latest RES calibration which recommended risk equalisation credits for contracts commencing from 1 April 2021 ("2021 RES");
- the DoH, together with the Authority, carried out a public consultation[5] in January 2021 on "Community rated health insurance market in Ireland and proposed changes to the Risk Equalisation Scheme" which set out the proposal to introduce of a HCCP with a quota share of 40% and threshold of €50,000 and
- the Authority sought external expert advice from its actuarial advisors KPMG.
- The Authority has continued to monitor the market and claims data and notes that COVID-19 has and continues to impact the health of individuals, the economy, the provision of health services and in turn the private health insurance market.

The Authority has refreshed its previous analysis and recommendation to take into consideration the most up to date information it has available to it and the current state of the private health insurance market. This updated analysis has used the updated HCCP data from the insurers and the 2021 RES as its benchmark.

[3] "Impact Assessment of the Introduction of a HCCP and changes to other measures"

[4] One insurer was not in a position to provide the level of data requested prior to 2017 due to changes in IT systems

[5] https://www.hia.ie/publication/previous-public-consultation-papers

3. HCCP Data

The initial step for any assessment of how to incorporate high-cost claims into the RES is to examine the historic levels and patterns of high cost claims, as the best predictor of likely future high-cost claims.

The Authority received detailed monthly claims data from the three registered undertakings to assist in its HCCP analysis. The data was provided in respect of total claims paid up to 30 June 2020, which were above €10,000 for individual contracts written between 2016 and 2019. The data was provided by the insurers on a voluntary best endeavours' basis, it is not audited and the Authority has not carried out extensive validation and verification of the data. The Authority has relied upon the accuracy of the data provided and relied upon the insures to have carried out adequate data verification and validation before providing the data to the Authority. The description of the data and summary of the data is set out in Appendix B.

The 2019 high cost claims data was the least developed, in that many of the underlying costs may not yet have been settled by the insurers. The level of claims from contracts issued in 2019, which were incurred in 2020, may also have been distorted due to Covid -19. The Authority, therefore, decided to exclude, from its analysis, claims from contracts issued in 2019. Instead, it used claims data arising from contracts sold in 2018 for purposes of the analysis. To carry out the analysis, the fully developed claims data was required, i.e., reflecting all of the claims associated with a particular contract period. This required an estimation to be made of the ultimate cost of claims when all claims relating to a particular contract have been fully settled. The Authority considers that the 2018 contract data was the most recent, non-distorted claims data which was close to being fully developed. Claims data from older periods (2016/2017[6]) was used to help with determination of development factors for the 2018 contracts.

Based on the raw claims data arising from contracts sold in 2018, there were 4,209 claims which exceeded €50,000. The data also indicated that the size of the claim does not vary significantly by age. In fact, marginally higher average claims tend to occur at younger ages. At the same time, we note that there are fewer occurrences of high cost claims at younger ages. The 2018 data indicates that 50% of the 4,209 high cost claims which exceeded €50,000 were in respect of those aged over 70 – these individuals represented 11% of the insured population as at 1 January 2019. [redacted]

The tables below summarise the raw claims data arising from contracts sold in 2018 as provided by each of the three registered undertakings in respect of claims greater than €50,000:

Table 3.1 Raw High Cost Claims Data for claims over €50,000 by Insurer and by Age Group, 2018

€m	[redacted]	Market	Market Average
0-17		€11.3	€81,453
18-29		€6.8	€69,085
30-39		€11.4	€76,362
40-49		€21.7	€76,492
50-54		€16.2	€84,144
55-59		€25.2	€80,829

[6] [redacted]

60-64	[redacted]	€32.2	€80,282
65-69		€44.3	€81,507
70-74		€51.4	€78,949
75-79		€47.2	€79,725
80-84		€37.9	€76,387
85+		€26.4	€75,138
Total		€332.0 (100%)	€78,868
Average claim			
Data from Information returns received by the Authority in respect of calendar year 2018 relating to all claims[7]			
Market share (by count)	[redacted]		
Market Share (by 2018 premium income)			
2018 Total Claims			

The raw data arising from contracts sold in 2018 was adjusted in the analysis to allow for full development of claims, to estimate the total value of the likely high-cost claim. The 2018 claims data was also inflated to 1 April 2022. This was done so that the analysis of the high-cost claims data would be consistent with the time frames and claims data underpinning the 2021 RES. 1 April 2022 is the average exposure point for claims from contracts written in the period 1 April 2021 – 31 March 2022 when the HCCP credits would apply if they had been introduced in RES 2021. Appendix C shows the assumptions and methodology used.

This adjusted claims data was used for the analysis carried out and discussed in this report. In subsequent sections of this report, any data referred to will mean the adjusted data unless specified otherwise. A summary of the adjusted data is outlined below.

Table 3.2 Raw 2018 claims data for claims over €50,000 by Insurer and by Age Group, inflated and developed

€m	[redacted]	**Market**	**Market Average**
0-17		€14.9	€88,075
18-29		€9.7	€74,141
30-39		€16.3	€80,080
40-49		€31.2	€80,005
50-54		€21.9	€88,774
55-59		€33.9	€86,345
60-64		€43.9	€85,319
65-69		€61.0	€85,726
70-74		€70.2	€84,018
75-79		€65.4	€84,006
80-84		€51.2	€82,374
85+		€37.7	€79,122
Total		€457.4 (100%)	€83,586

[7] Report to the Minister for Health on Evaluation and Analysis of Information Returns for July to December 2018

If the HCCP is implemented, the Authority will require data from insurers in relation to their past claims' history for insured lives with high cost claims on a bi-annual basis as part of the Information returns to permit an annual review of the HCCP parameters as part of the annual review of the risk equalisation credits and stamp duties to be recommended to the Minister of Health. The requirements relating to information returns are as per the Health Insurance Act 1994 (Information Returns) Regulations 2009.

4. Approach to carrying out analysis

In developing these recommendations, the Authority began by considering whether the proposed approach outlined in the consultation, namely an inclusion of a HCCP with a quota share of 40% and a threshold of €50,000, remains appropriate.

In doing this assessment, the Authority has compared the 2021 RES calibration as is with a calibration that includes a HCCP. The 2021 RES, which recommended risk equalisation credits for contracts commencing from 1 April 2021 ("2021 RES"), is the most recent RES calibration and as such this has been used as the benchmark for all of the analysis carried out to inform the recommendation being made.

The analysis looks at the impact on the 2021 RES if a HCCP was in place at the most recent calibration and examines how it would impact the recommended stamp duties and credits for contracts commencing in the period 1 April 2021 to 31 March 2022.[8]

Set out below are the key metrics from the 2021 RES in respect of contracts that are renewed or entered into on or after 1 April 2021 but before 31 March 2022. The information in Table 4.1 and Table 4.2 has been taken from the "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits"[9]. It should be noted that there is no one correct measure of "effectiveness" but the measure the Authority has used is described fully in the report "Risk Equalisation Scheme Effectiveness Impact: Assessment of the Introduction of a HCCP and changes to other measures" (dated January 2020).

Table 4.1 Stamp Duty and risk equalisation credits for contracts incepted from 1 April 2021 to 31 March 2025

	Adult Stamp duty (advanced/non advanced)	**Claims Cost Ceiling**	**Utilisation credits (overnight/day)**	**Effectiveness[10] (all ages)**	**Projected Age Credit Fund**	**Projected HUC Fund**
RES 2021	€449/€157	133.5%	€125/€75	30.3%	€605m (75%)	€200m (25%)

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 2021 to 31 March 2022 are as follows:

Table 4.2 Net Financial Impacts by Insurer

€m	**Irish Life Health**	**Laya Healthcare**	**Vhi Healthcare**
Age related health credits (ARHC)	[redacted]		

[8] The actual stamp duty and risk equalisation credits for contracts commencing from 1 April 2022 cannot be determined at this time and will not be known until the calibration for 2022 RES is carried out later in 2021.
[9] www.hia.ie/sites/default/files/Report%20to%20the%20Minister%20for%20Health%20on%20Risk%20Equalisation%20Credits.pdf
[10] "Effectiveness" is defined in the previous report and is a "R-squared weighted average variance" measure which considers the change in the square of the deviations (before and after the RES) of the average claims for each insurer to market average claims at each age band relative to the market average claim weighted by claims costs before application of the RES

Hospital Utilisation Credit (HUC)		[redacted]	
Stamp duty			
Net Financial Impact			

Note: The estimated surplus in the REF is €43m which is why sum of credits does not equal sum of stamp duties

The above key metrics and measurables have been considered as part of the analysis.

Submissions under the public consultation have also been considered in the Authority's deliberations and references to such submissions are made throughout the document however a more detailed separate report has been prepared on the submissions received via the public consultation.

There are a number of key parameters which the Authority has considered in reaching its recommendation and many of the items are interlinked. Each area had to be considered but ultimately it is the combined impact of each of these decisions which has contributed to the recommendation**s** being made.

5. Interaction with other credits

The existing RES redistributes funds from the Risk Equalisation Fund ("REF") on the basis of age related health credits (ARHC) which vary by age, gender and level of cover and hospital utilisation credits (HUC) based on hospital utilisation.

The introduction of a HCCP to the existing RES requires the Authority to assess how the HCCP will interact with these existing credits. In establishing how the level of credits from the HCCP will be calculated, there were two options considered by the Authority:

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

This was also raised in the public consultation with one submission mentioning that there could be significant overlap with existing credits for some high-cost claims and depending on the age/gender of the claimant there could be significant difference in credits received, for a comparable level of health related risks. Another submission proposed that ARHC should be reduced to facilitate the introduction of a HCCP with a view to allowing stamp duty to remain unaffected.

To give some idea of scale, based on the HCCP data received, claims which exceeded €50k in respect of contracts incepted in 2018 were €332 m (raw unadjusted data) and approximately €6 m was received in ARHC and €26 m in HUC for those same claims. HUC credits are received irrespective of age and increase with the length of stay but ARHC are given in respect of those aged 65 and over and is a fixed amount per contract irrespective of the size of the claim. Therefore, for high cost claims we can see credits in respect of HUC are much more material relative to AHRC.

ARHC

The aim of the ARHC is to share risk for those assumed to be sicker, where age is assumed to be an indicator of health status in the absence of other health indicators. The ARHC is a prospective measure of risk and serves to address affordability for those who are assumed to have higher risk i.e., those over age 65. The ARHC also serves to reduce incentives for insurers to risk select against these age cohorts who are expected to have higher claims if insurers are compensated adequately for the risks they face.

The HCCP data provided as outlined in table 3.1 indicates that age does not have a material impact on the scale of high-cost claims. In fact, the data implies that the market average claim, of those categorised as high-cost, decreased for those aged over 80. This suggests that in the case of high cost claims, age is not an indicator of the size of the claim. If the HCCP credit is not adjusted to take into account ARHC received in respect of the life then, all else being equal, more credits will be received for a life who is over age 65 than one under 65. This is despite that life being of no higher risk in terms of the scale of a high cost claim.

An example of how a HCCP is administered where age credits exist in another jurisdiction is included in Appendix D.

HUC

The aim of the HUC payments is to use actual hospitalisation as a measure of risk irrespective of age. Long periods of hospitalisation can be associated with high-cost claims which is evident in the HCCP data provided. For the 2018 claims data exceeding €50,000, the average length of hospitalisation is 70 treatment days (this includes day case and overnight stays), compared to an average treatment

day of 1.05 for calendar year 2018 in respect of the entire insured population at that time, as per the 2019 RES report. However, it should be noted that the average treatment day is across the entire insured population and not just those who incurred claims.

For a high cost claim, some of the HUC payments are received in respect of hospitalisations before the claims become eligible for HCCP, and some are in respect of hospitalisations after the HCCP threshold is reached. Since some of the additional claims' costs are already compensated through HUC payments, the provision of HCCP credits without a deduction for HUC credits received in respect of the same claim could result in an element of double counting.

In theory, as age is not considered to be a determining factor in relation to the scale of high cost claims (as evidenced in Section 3), the Authority has considered whether or not an allowance for ARHC should be made when determining the overall level of compensation. In other words, should the HCCP credit be calculated and then the full ARHC deducted from this amount, subject to a minimum of zero. This approach to setting the HCCP credit would reduce the level of HCCP credit allocated. However, we can see in Section 3 that the frequency of high cost claims for older lives is higher. This means that deducting the ARHC from the credits due under the HCCP could potentially lead to further market segmentation, if it caused insurers to risk select away from older lives. Such an approach would conflict with the principal objective of the Act. Older lives would receive less from the HCCP, relative to younger lives, but are more likely to have a high-cost claim. Hence, insurers could be incentivised to charge more for products that are attractive to this cohort, design products in such way to make them less attractive or alter marketing/advertising strategies all with the aim of reducing attractiveness to this cohort.

The options considered by the Authority are illustrated below by way of example:

Age	**18**	**80**
Claim Amount (A)	100,000	100,000
Threshold (B)	50,000	50,000
Quota Share (C)	40%	40%
No Credit Offset		
HCCP Credit (D) = Max((A-B) * C,0)	20,000	20,000
HUC Received (E)	10,000	10,000
ARHC (F)*	0	3,150
Total Credits Received (D+E+F)	**30,000**	**33,150**
Credit Offset		
Adjusted Threshold (G) = B+E+F	60,000	63,150
HCCP Credit (H) = Max((A-G) * C,0)	16,000	14,740
HUC Received (E)	10,000	10,000
Age Related Health Credit (F)*	0	3,150
Total RE Credits Received (H+E+F)	**26,000**	**27,890**
No HCCP		
Total credits received (E+F)	**10,000**	**13,150**

**** For the purposes of the above analysis, ARHC has been assumed to remain constant in line with the ARHC calculated assuming no HCCP as a simplification. The actual ARHC will differ in practice due to the size of the HCCP pot.***

Under the first option – No Credit Offset – the HCCP credit is calculated as the difference between the claim amount minus the Threshold (€100,000 – 50,000) multiplied by the Quota Share (40%), which equals a HCCP Credit of €20,000. Neither the HUC nor the ARHC are taken into account when estimating the HCCP credits. Both the 18 year old and the 80 year old would receive a HUC of €10,000 on the assumption that the claim involved 100 night hospital stay. In addition, the 80 year

old would receive an ARHC of €3,150, for a total credit of €33,150, compared to €30,000 for the 18 year old.

Under the Credit Offset approach, the Threshold is increased by the amount of credits already received by an individual insured life, e.g., from HUC and ARHC. Under this option, for the 18 year old, the HCCP credit is calculated as the adjusted Threshold (€100,000 – (€50,000 + €10,000)) times the Quota Share, which equals a HCCP credit of €16,000. For the 80 year old, the HCCP credit is calculated at €14,740, because the adjusted Threshold also includes the ARHC of €3,150. The total credits received for the 18 year old are €26,000 (€16,000(HCCP) + €10,000 (HUC)). The 80 year old receives a total of €27,890 (€14,740 (HCCP) + €10,000 (HUC) + €3,150(ARHC)).

We can see that the approach allowing for the offsetting of ARHC and HUC reduces the magnitude of the HCCP credit received, for a given threshold level and quota share. This approach does reduce the variation in total credits received from all categories (HCCP, HUC, ARHC) by age for high cost claimants, albeit the older life still receives a marginally higher credit overall.

Based on the analysis carried out, allowing for offsetting of ARHC and HUC as outlined above lowers the magnitude of the HCCP credits by c€20 m or 27%, for the proposed Threshold and Quota Share levels. See Appendix E for full details.

Outlined below are some of the Authority's views on the two options considered:

	Pros	**Cons**
No Credit Offset	▪ Reduced net claims costs for younger lives if stamp duty unchanged due to HCCP allocation. Could help with market sustainability and affordability issues. ▪ Maximises the level of HCCP being distributed for any given level of Excess / Quota Share. ▪ Higher level of effectiveness compared to offsetting other RE credits as claims costs across the market are higher on average in respect of older lives.	▪ High cost claim amounts do not show signs of materially varying by age. Thus, an 18 year old could be expected to have similar costs to that of an 80 year old for treatment of the same high cost claim condition. The intention of the RES is to equalise for risk differences. The inclusion of ARHC would result in the 80 year old receiving a higher level of RE credits for the same underlying risk. ▪ Largest increase in net claims cost for older lives if stamp duty unchanged as ARHC reduced. ▪ As HUC payments already paid, there is an element of double counting if no offset for HUC is taken into account.
Credit Offset	▪ Avoids double counting for HUC payments . ▪ High costs claims can have similar risk characteristics across different ages so questionable as to whether an older life should also benefit from	▪ Serves to increase the level of claimant excess and therefore reduces the magnitude of HCCP credits being distributed for any given level of Excess / Quota Share. ▪ Calibration of model more complex due to iterative nature of ARHC

	ARHC if underlying risks / claims costs are similar. ▪ Australian system includes an allowance to offset for age credits as already allocated elsewhere which links in with above point.	calculation as returned benefits net of ARHC allocated to HCCP credits would be an input into the calculation of the ARHC.

The Authority is recommending that an adjustment should be made to allow for ARHC and HUC payments that will have already been received by an insurer in respect of a high cost claim when determining the level of HCCP credits to be made. The ARHC and the HUC payments received in respect of an insured life will increase the threshold at which the HCCP credit will begin to apply.

6. Definition of A Claim to be included in the HCCP

a) Time Based or Event Based

In determining how a claim can be included in the HCCP, the first issue addressed by the Authority was the approach to defining the claim. Two options were considered – time based or episode of care based.

The Authority is of the opinion that the HCCP should include all claims incurred by an insured life over a period of time. Inclusion in the HCCP should not be based on an individual episode of care. The reason for adopting this approach was primarily ease of administration and consistency with other aspects of the RES. When a customer incurs a claim, it is not obvious to the insurer what is the underlying reason for an episode of care to take place. Therefore, the insurers would not be in a position to easily identify separate claims based on different episodes of care. In addition, it is likely that episodes of care may be related to each other, particularly for those that have significant medical needs, which will comprise many of the claims within the HCCP.

b) Time period for claims to be Included in the HCCP

Once the decision was made to base the definition of a claim on the timeframe in which the episodes of care took place , it is then necessary for the Authority to identify the appropriate time period for claims to be included in the HCCP.

The RES is currently calibrated annually and the recommended credits each year are in respect of contracts commencing from 1 April to 31 March of the following year. Generally, insurance contracts are one year in duration, with customers renewing the contract at the end of the period, or switching to a different product or different insurer. The Authority has considered the time period which should apply for high-cost claims and has considered the following two options:

- A contract year approach, where eligibility for HCCP credits is based on claims occurring between the start and end date of a contract year, applicable for each insured customer;
- A rolling 4 quarter approach, where the value of the claim is assessed based on the most recent four quarters of claims based on treatment date by an individual customer and settled by the insurer, even if this crosses a contract renewal period. This would apply where a customer has renewed with the same insurer.

The Authority is conscious that if a period of treatment crosses a contract renewal period, a claim may fail to satisfy the high cost claims threshold if it is based on contract years. For example, if a policy had a high cost claim of €100,000 and the costs incurred in respect of this claim was equally split between contract periods, i.e. €50,000 incurred in the contract period before policy renewal and €50,000 incurred in the contract period after policy renewal but all within 12 months, then under that HCCP calibration the insurer would not receive any HCCP credits. If, however the claim started and ended within a contract period, i.e., just before the policy renewal then the claim would be included in the HCCP, and the insurer would receive HCCP credits.

Approach	Pros	Cons
No Allowance for Cross Over Periods	▪ It would lower the high cost claims and the credits payable and therefore less of an impact on net claims cost ceiling or stamp duty	▪ High cost claims which span adjacent contract years would not be treated consistently and are likely to receive lower HCCP credits.

	▪ Less complex to calibrate and administer. ▪ It is consistent with other credits, as ARHC and HUC are based on contract years	▪ Lower level of effectiveness as some high cost claims will receive reduced (or no) HCCP credits. ▪ Less targeted allocation of resources towards sicker lives.
Include Allowance for Cross Over Periods	▪ An assessment of the high cost claim over a rolling period would be more equitable and would ensure that high cost claims which span adjacent contract years would be treated consistently. ▪ Reduce incentives for the insurers to defer treatments to times when they are likely to receive higher HCCP credits which may not be in the best interests of patients. ▪ Higher level of RES effectiveness as some high cost claims will receive HCCP credits that they might otherwise not receive.	▪ More complex for the Authority to calibrate and administer. ▪ Further reduction in ARHC for a given quota share and threshold (as the increased allocation to HCCP reduces the allocation to ARHC) which would increase the net claims cost for older lives all else being equal.

The HCCP data provided by the insurers, used to analyse the financial impacts of different policy options, was based on contract years and as such is appropriate for use for analysing the HCCP credits likely to be payable in respect of a contract year.

To calculate the total expected level of HCCP credits, including the magnitude of claims that cross a contract period, the Authority requested KPMG to estimate the potential impact of allowing for a cross over period. They estimated the additional HCCP claims incurred for full adjacent contract periods based on 12 months exposure in each period. This has been done as the data provided to the Authority was provided on a claims paid/settled basis as opposed to claims based on treatment dates (incurred basis). Based on the data available, KPMG estimated that applying the crossover approach would add approximately €40 million to the total level of HCCP credits. It should be noted that this is an estimate to gauge the potential scale of allowing for cross over periods and this is likely to be a conservative estimate based on the approach and data used. To determine the actual calibration for RES 2022, more data would be required from the insurers to permit a more accurate assessment of the impact of cross over periods. It is the intention of the Authority to request data on a treatment date/incurred basis to allow for refinement to this estimate.

The Authority notes that the impact of allowing for cross over periods will only have an impact after the first 12 months of the inclusion of a HCCP. This is because, upon introduction, the inclusion of claims into the HCCP will be forward looking. The HCCP credits will not include claims that occurred before the introduction of the HCCP, and the impact of the cross over claims will only be observed after a full 4 quarters have elapsed. The rolling approach applies where a customer has renewed with the same insurer. If a customer changes insurer at the end of a contract period, then the value of the claim for HCCP Threshold purposes resets to zero. The Authority is mindful of ensuring that its decisions do not have a negative impact on competition, such as switching between insurers. The Authority does not consider that this approach would do that.

The table below illustrates how a rolling quarterly approach would work.

	Q1 Year 1	Q2 Year 1	Q3 Year 1	Q4 Year 1	Q1 Year 2	Q2 Year 2
Claim Amount	0	40,000	50,000	20,000	10,000	10,000
Cumulative claims (4 quarters)	0	40,000	90,000	110,000	120,000	90,000
HUC received	0	2,000	3,000	950	500	500
Cumulative HUC received (4 quarters)	0	2,000	5,000	5,950	6,450	4,950
ARHC received	2,950	0	0	0	2,950	-
Cumulative ARHC received (4 quarters)	2,950	2,950	2,950	2,950	2,950	2,950
Cumulative Credits received (4 quarters)	2,950	4,950	7,950	8,900	9,400	7,900
Threshold	50,000	50,000	50,000	50,000	50,000	50,000
Adjusted Threshold	52,950	54,950	57,950	58,900	59,400	57,900
HCCP Credit (max ((40%x (Claim – Adjusted Threshold),0)	0	0	12,820	20,440	24,240	12,840
HCCP Credit received in preceding 3 quarters	0	0	0	12,820	20,440	24,240
Final HCCP Credit	0	0	12,820	7,620	3,800	0

The above assumes the individual is with the same insurer for the entire period and the claim amounts included in each quarter relate to hospitalisations/treatment in that quarter. When it comes to actually claiming HCCP credits from the REF, this can only be done once the claim has been paid by the insurer and a claim submitted to the Authority.

The Authority is recommending that claims are included in the HCCP based on claims incurred(i.e. claims relating to treatment dates) over a rolling 4 quarter period basis in a 12 month period.

c) Definition of Claim – Paid vs Incurred

A further issue addressed by the Authority is whether or not the claims included in the HCCP are on the basis of claims paid vs claims that have incurred but not yet settled. For the purposes of the HCCP, the Authority considers that claims paid and claims settled by the insurers are identical.

In assessing the basis for including a claim in the HCCP, the Authority assessed whether or not such claims should be included in the HCCP when they were incurred by the customer or when they were paid by the insurers. To be consistent with the approach used for payments related to HUC, the Authority concluded that to be included in the HCCP, the claim must have been paid by the insurer before a claim from the RES could be made.

However, for the purpose of submitting a HCCP claim, to accommodate the time period for a claim (4 consecutive quarters), each insurer must indicate the time period of the treatment to which the claim relates. This will facilitate the calculation of whether or not the claim meets the Threshold level.

7. Eligible Claims

Introducing a HCCP requires the Authority to consider what claims are eligible for HCCP purposes.

The Authority has considered the following options:

- Eligible claims should be based on "Returned Benefits"[11] which is consistent with the existing RES calibration
- Eligible claims should be based on "Claims"[12]

The determination of risk equalisation credits and stamp duties is currently based on Returned Benefits as defined in the Act. Returned benefits typically exclude services not involving a hospital admission, such as outpatient services and services relating to preventative health services, infertility, dental or cosmetic services. In 2019, Returned Benefits represented 88% of total Claims as per data provided by the insurers to the Authority.

Based on the HCCP data provided by the insurers, this percentage of returned benefits to total claims is much higher for claims that are above €30,000. The table below illustrates the ratio of Returned benefits to Claims in respect of claims arising from contracts incepted in 2018 for various thresholds. This is because a high-cost claim is generally associated with treatment in a hospital setting.

Threshold	**€50,000**	**€45,000**	**€40,000**	**€35,000**	**€30,000**
Developed Claims above Threshold (uninflated)					
Total Developed Claims	€341.8m	€391.5m	€451.6m	€519.5m	€602.1m
Total Developed Returned Benefits	€335.6m	€384.7m	€442.7m	€509.4m	€590.5m
Ratio	98.2%	98.2%	98.0%	98.1%	98.1%

Based on the data outlined above, the decision would not appear to have a material impact on the calibration of the HCCP and the subsequent level of credits. In assessing whether or not the HCCP credits should cover "Claims" for an insured life, or "Returned benefits", the Authority has considered a number of other factors. First, the Authority considers that it is important that the approach is consistent with how ARHC and HUC are calibrated. The Authority does not want its approach to claims vs returned benefits for claims that fall into the High-Cost claim category to incentivise or disincentivise treatment in a particular setting over what is best for the consumer. The Authority would also not like to impose an unreasonable administrative burden on the insurers for what could potentially have little impact.

The Authority are minded to base HCCP credits on Returned benefits for consistency with the existing RES calibration.

Under the public consultation a number of items were raised that would impact the definition of eligible claims for HCCP purposes and which have also been considered by the Authority:

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

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

Drugs

Cover for drugs which are not approved by the HSE or appropriate regulatory body are not covered by all insurers. Some of the responses to the consultation proposed that these drugs which are potentially very expensive should not be included in the HCCP as it causes distortions within the RES and can distort competition between insurers.

The HCCP data provided by insurers did not contain sufficient data to permit an analysis of the scale and impact of unapproved drugs on high cost claims data and HCCP credits to be payable.

The Authority would like to clarify that there is a difference between what benefits an insurer may choose to offer to their customers and what claims costs should be reasonably shared across all customers via the risk equalisation scheme. Consumers that do not bear the full premium cost of their insured risk are more likely to purchase larger amounts of insurance, e.g., more benefit rich policies. These additional costs are then spread across all other customers, via the Risk Equalisation Scheme and higher stamp duty levels. The overall objective of the RES is to share reasonable claims costs via the RES and the stamp duty. For this reason, the ARHC are based on claims associated with a Level 2 plan, as this has been deemed as a reasonable level of cover by the Authority, for risk equalisation purposes.

The Authority takes on board the submissions made on this point but are also conscious that excluding such drugs for the HCCP could have adverse impacts for consumers. A possible course of action could be to limit the amount of high cost claims to the equivalent cost of approved drugs. But the Authority must also consider any practical and administrative limitations.

The Authority is proposing that the cost of unapproved drugs is excluded from the HCCP and that the cost of the equivalent approved drug can be included instead.

Ancillary costs

One of the responses to the consultation suggested that the definition of a claim for HCCP purposes should be broadened to include ancillary costs which can be associated with managing high cost claims such as legal costs. It is the view of the Authority that the definition of a claim for HCCP purposes should be consistent with the existing RES. Risk equalisation is a process that aims to address differences in insurers' claim costs that arise due to variations in the health status of their members. It is not designed to address differences in administration expenses or costs of running a business which are not prescribed health services as per the Act and as such should not be included in the RES.

Cause of high cost claim

it was suggested that a potential vulnerability with the proposed HCCP is that it does not distinguish between unpredictable high cost claims and more predictable high cost claims. The Authority is of the view that the HCCP should not distinguish between recurring chronic high cost claims and one off claims at the current time and that such a level of refinement could be addressed with the introduction of DRGs.

Approach	**Pros**	**Cons**
Claims	▪ Highest level of allocation so targets the costs associated with high cost claims regardless of setting.	▪ Not aligned to current RES which is calibrated off returned benefits.

	▪ Difference between Returned Benefits and Claims is relatively small	
Returned Benefits	▪ Aligned to current RES which is calibrated off returned benefits.	▪ Some treatments associated with high cost claims are not in hospital settings and excluding them may reduce the effectiveness of the HCCP at compensating those claims. ▪ May increase the administrative burden on insurers to track Returned Benefits on a per claim basis, which differs from the approach used for ARHC and HUC
Limit Cost of Drugs	▪ Transparency over drugs to be used (or costs allocated) based on HSE approved list. ▪ Consistency of approach: Reduces competitive advantage if one provider covers newer drugs and markets their products on that basis.	▪ May be difficult to determine appropriate cost of equivalent approved drugs if unapproved drugs are used. ▪ Limiting payments to approved drugs (i.e., no payment in respect of unapproved drugs) means that in the first instance, cost of these drugs would be covered solely from premium income rather than claims from RES. This could result in insurers limiting treatment options that insurance plans will cover.

The Authority is recommending that HCCP credits should be awarded based on Returned Benefits . For the purposes of the HCCP, Returned benefits should not include the costs of drugs not approved by the HSE. Should a "Returned Benefits" basis prove particularly challenging for the Insurers from an administrative perspective the Authority would accept a Claims based approach for the first RES cycle. This is to give the insurers sufficient time to update their systems. The same approach must be followed by all undertakings.

The Authority is recommending that only the costs of drugs on the HSE approved list should be included in the HCCP credits.

8. Cap on claims

The Authority has considered whether or not a cap should be placed on the level of claims which are eligible for HCCP credits. The reasoning for a cap would be to ensure that insurers are incentivised to continue to manage very high claims as efficiently as possible. This would limit the amount of claims that are shared across all customers via the HCCP. A number of submissions in the consultation proposed that a cap should be considered and suggested various alternatives as to how a cap could be implemented.

The Authority have considered two options

- Include a cap on eligible claims for HCCP purposes
- Exclude a cap on eligible claims for HCCP purposes

The introduction of a cap on the level of eligible claims would reduce the impact of the HCCP on the overall RES. It would limit the size of a claim that would be covered by the HCCP to a maximum level, on the basis that claims costs above this level should not be shared across all health insurance customers. Setting a cap could alter the potential for very large claims emerging as the insurers would not receive compensation as a result of claims that exceeded the cap. As such, insurers should be more incentivised to manage and monitor the claims cost such that claims would not exceed a certain level. If this was the case, this in turn would mean that the level of total claims would in theory be lower as a result.

We expect a high degree of variability and volatility with high-cost claims. A disadvantage to the introduction of a cap is that the existence of a cap is unlikely to mitigate these very large claims emerging. It could also potentially encourage adverse behaviour by insurers to limit the scope of treatments covered by insurance, which may impact on the level of treatment provided to a patient.

Based on the HCCP data provided the majority of high-cost claims (80% by count and 66% by amount) are below €100,000 as outlined below. Therefore, the introduction of a cap above €100,000 would be unlikely to have a material impact on the magnitude of the HCCP credits paid out and would impact only a very small number of claims. In contrast, setting a cap too low could serve to be in contradiction of the purpose of the HCCP.

Table 8.1 Profile of claims data

Threshold	**Count**	**Percentage of Total Count**	Claims	**Percentage of Total Claims**
€50k	5,472	100%	443,844	100.00%
€100k	1,076	19.66%	150,292	33.86%
€150k	304	5.56%	58,311	13.14%
€200k	84	1.54%	21,207	4.78%
€250k	29	0.53%	9,213	2.08%
€300k	11	0.20%	4,316	0.97%
€350k	6	0.11%	2,710	0.61%
€400k	3	0.05%	1,556	0.35%
€450k	3	0.05%	1,556	0.35%
€500k	2	0.04%	1,075	0.24%

Based on the initial calibration of the HCCP being proposed, the Authority considers that insurers, to date have been incentivised to manage claims efficiently, and with the introduction of a HCCP will

still be incentivised to manage claims as efficiently as possible. Since very high claims occur relatively infrequently, they are not likely to have a significant impact on the overall size of the risk equalisation fund based on the initial HCCP parameters. Therefore, the Authority does not see the benefit to including a cap on claims to be included in the HCCP at this point in time.

However, over time if the calibration was to change and a higher quota share introduced, this recommendation would require further consideration as to the appropriateness of the cap.

The Authority is recommending no cap is introduced based on the proposed initial calibration but is recommending the inclusion of a mechanism to give the ability to review this position as part of the annual RES calibration.

9. Proportion of credits to be allocated based on HCCP

One of the objectives of introducing the HCCP is to increase the effectiveness of the RES. This is done by increasing the proportion of the RES credits based on health status. This permits a more targeted distribution of credits based on health status regardless of age, gender or level of cover. It should also serve to reduce market segmentation and risk selection by reducing insurers incentives to avoid insuring such risks, via targeting health insurance products towards healthier lives. This is in line with the principal objective of the Act which is to set credits such that "the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the healthier 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".

In considering the various parameters of the RES, the Authority has given consideration to the need to maintain fair and open competition in the market, by ensuring that Authority decisions do not lead to inefficient exit from the market (i.e. market sustainability). The Authority considers that this objective is best achieved by managing changes in the scale of potential HCCP credits relative to the total credits being paid to insurers. As indicated in previous reports, the Authority believes that the HCCP should be introduced in a phased and gradual manner so as to maintain stability in the market and to allow observation of the response of the market to its introduction. This will allow the Authority to facilitate the evolution of the HCCP in response to the market. If HCCP threshold is set too high, there is the risk that the HCCP will equalise risk for only the sickest individuals and may not be sufficient to improve the effectiveness of the RES. Conversely if the threshold is too low then the HCCP will equalise risk for more individuals but it may result in a significant increase in the cost of risk equalisation, which may impact the affordability of health insurance and thus the sustainability of the market.

The Authority believes the appropriate approach is to start with a level of credits for the HCCP which are sufficiently large to warrant their inclusion in the RES, whilst being sufficiently small to allow a phased, controlled introduction of the HCCP. This will allow the Authority to monitor and observe its impact and increase the level of credits slowly and gradually if there are no adverse changes to market dynamics and claims management.

The Authority is of the view that target HCCP credits representing approximately 10% of total credits is a reasonable starting point in year one. HCCP credits of this scale increase the effectiveness measure of the RES by a notable amount (see appendix F), increases the allocation of credits to health status whilst still encouraging efficient claims management and would not cause a significant disruption or shock to the market and should not impact sustainability at this level.

The calibration proposed, with a threshold of €50,000 and a quota share of 40%, falls within this range, based on the RES 2021 calibration. This recommendation is consistent with the analysis presented in "HIA Report on High Cost Claims Pool", April 2019 prepared for the Department of Health. In that report, the HIA proposed that the parameters for the HCCP should be set at a level that would generate approximately 10% of the overall RES (or half the current cost of HUC).

10. Threshold and Quota share

The threshold is defined as the value of claims at which point the risks are shared. The quota share is the percentage of claims, above the threshold, that would be covered by the HCCP.

The proposal that was consulted on by the Authority and the DoH in the public consultation is to introduce a HCCP with a threshold of €50,000 and quota share of 40% as was recommended by the Authority in its previous analysis and report. The rationale for that threshold and quota share was set out in that report, and based on claims data that was available to the Authority at that time. In that report, the Authority noted that the proposed threshold and quota share increased the effectiveness of the RES by a notable amount whilst keeping projected average claims costs at a reasonable level and was considered to strike an appropriate balance between market stability and sustainability.

Since that report, the Authority carried out updated analysis to inform its recommendations on the calibration of the HCCP. This updated analysis took into account more up to date claims data provided by the insurers as well as the impact of the various policy decisions outlined in the previous sections.

The Authority has considered two approaches in its analysis:

A. the introduction of a HCCP is implemented as a redistribution of existing credits i.e., the scale of risk equalisation credits do not increase and thus stamp duty does not increase; or
B. the introduction of a HCCP is implemented as an additional credit i.e. scale of risk equalisation credits does increase and thus stamp duty increases.

This analysis was done, assuming the HCCP had been introduced in RES 2021 i.e., for contracts commencing between 1 April 2021 and 31 March 2022. It was based on the historic 2018 claims, full developed and inflated to 1 April 2022 (which is the average exposure point for claims from contracts written in the period 1 April 2021 – 31 March 2022). The analysis has also been done on the basis that the HCCP will provide compensation in respect of cumulative claims costs that exceed the high cost claims threshold, and as such may be representative of multiple claims that in isolation do not meet the definition of a high cost claim on a standalone basis.

To inform its recommendation in this regard, the Authority examined a number of scenarios that combined different levels of threshold and quota share and assessed the impact of these combinations on the overall effectiveness of the RES. For example, a 30% quota share with a threshold in the range €40- €50 k leads to projected HCCP credits close to 10% as outlined in Appendix F and have similar levels of effectiveness as a 40% quota share and €50,000 threshold, albeit marginally lower.

In deciding between alternative scenarios, the Authority examined how the range of scenarios delivered on its key objectives, as outlined in Section 2. The Authority focused on the scenarios that led to the greatest increase in effectiveness, whilst balancing the other objectives of sustainability, fair and open competition and stability.

Based on this analysis (shown in Appendix F), the Authority is recommending that the first year of introduction of the HCCP should comprise a 40% quota share and €50,000 threshold. It is at the upper limit of the scale of credits which the Authority is targeting and it increases effectiveness by a notable amount. The quota share is at a level which will still encourage efficient claims management by the insurers, which contributes to the objective of promoting fair and open competition. By

starting at this level, the objective of market sustainability is achieved, and there is sufficient scope to increase the quota share in the future to further achieve the objective of increasing the proportion of credits associated with health status, and thereby increasing the effectiveness of the RES. The threshold is considered to be at an appropriate level which captures a notable number of claims whilst not being so low that it could lead to increases in the cost of risk equalisation which may affect the sustainability of the market. The Authority therefore did not find sufficient justification to depart from the quota share and threshold consulted on.

RES 2021

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 currently 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 133.5% 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; 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 analysis outlined below considers a HCCP with a quote share of 40% and threshold of €50,000.

Option A

If the HCCP is introduced so as to not in itself increase the level of distribution of risk equalisation credits, but with the aim of more targeted distribution of credits to sicker lives with very high claims, then in theory the introduction of the HCCP should not influence the level of stamp duty. This would mean that either ARHC or HUC would need to be reduced to accommodate this. The approach taken under this option is that HUC would remain unchanged and ARHC would reduce which means the net claims cost ceiling increases. The rationale for leaving the HUC unchanged is that the objective of the HCCP is to increase the amount of the fund attributable to health status. To reduce the HUC to incorporate the HCCP would contradict this objective.

As the HCCP would be distributed to all lives (while ARHC is distributed to lives age 65 and older) the net claims cost for older lives would increase, as the reduction in the ARHC would be greater than the corresponding increase in the HCCP, for this age group. Depending on the response of insurers to the changes in the mix of RES credits, this could make health insurance less affordable for older consumers.

Option B

If the HCCP is introduced so as to increase the level of credits distributed by the RES, option b, then all else being equal, the stamp duty would have to increase to facilitate this. The approach taken is that the net claims cost ceiling has been maintained at its existing level with the introduction of the HCCP, HUC credits have remained unchanged (for the same reason as stated above) and therefore stamp duty has been increased. The ARHC are not completely unchanged under this option due to second order effects. This is because the stamp duty collected to fund the HCCP is redistributed through HCCP payments to all lives that experience a high-cost claim. Overall, the net claims cost across the market as a whole is unaffected as the additional stamp duty collected is redistributed as HCCP credits. However, as some of the HCCP is distributed to older lives the level of ARHC reduces. This is because the level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 133.5% of the average net claims cost across all lives. As these lives are expected to be in receipt of HCCP credits, the expectation is that less ARHC will be required so that the net claims cost for these lives does not exceed the claims cost ceiling of 133.5% of the average net claims cost across all lives.

Both options are viable but lead to the conflicting objectives in terms of affordability and market sustainability.

The key metrics based on a quota share of 40% and threshold of €50,000 are outlined below for both options. The table below shows the comparison between RES 2021 with and without a HCCP under options A and B.

Table 10.1 Metrics illustrating impact of a HCCP based on RES 2021

	Adult Stamp duty (advanced/ non advanced)	**Claims Cost Ceiling**	**Hospital Utilisation credits (overnight/ day)**	**Effectiveness[13] (all ages)**	**Projected Age Credit Fund**	**Projected HUC Fund**	**Projected HCCP fund**
RES 2021[14]	€449/€157	133.5%	€125/€75	30.3%	€606m (75%)	€200m (25%)	-
RES 2021 with a HCCP							
Option A	€449/€157	140.3%	€125/€75	47.7%	€515 (63%)	€200 m (25%)	€93m (12%)
Option B	€474/€157	133.5%	€125/€75	48.0%	€554 m (65%)	€200 m (24%)	€93m (11%)
Projected net financial impacts for a 12 month period based on the credits and stamp duty above for policies commencing in the period 1 April 2021 to 31 March 2022							
RES 2021 (no HCCP)							
€m	Irish Life Health		Laya Healthcare		Vhi Healthcare		
Age related health credits (ARHC)		[redacted]					
Hospital Utilisation Credit (HUC)							

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

[14] Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits

Stamp duty		[redacted]	
Net Financial Impact			
Option A: RES 2021 with a HCCP, total credits remain unchanged			
€m	Irish Life Health	Laya Healthcare	Vhi Healthcare
Age related health credits (ARHC)		[redacted]	
Hospital Utilisation Credit (HUC)			
High Cost Claims Pool (HCCP)			
Stamp duty			
Net Financial Impact			
Impact of HCCP			
Option B: RES 2021 with a HCCP, total credits increase			
€m	Irish Life Health	Laya Healthcare	Vhi Healthcare
Age related health credits (ARHC)		[redacted]	
Hospital Utilisation Credit (HUC)			
High Cost Claims Pool (HCCP)			
Stamp duty			
Net Financial Impact			
Impact of HCCP			

Please note the figures above:-

- illustrate the projected position had a HCCP been introduced when the calibration of RES 2021 was being carried out and assumes a HCCP would have applied to contracts commencing in the period 1 April 2021 to 31 March 2022
- assumes ARHC and HUC are offset from HCCP credits in the manner illustrated in section 5
- assumes there are no changes to the HUC rates
- assumes claims for HCCP purposes are based on "returned benefits" with no exclusions
- assumes no cap is imposed on claims eligible for HCCP credits
- assumes rolling quarters in a 12 month period

The analysis demonstrates that for both options:

- the introduction of a HCCP increases the effectiveness by a notable amount from 30.3% to 47.7%/48.0%.
- the HCCP increases the allocation of credits based on actual health from 25% to 37% thereby meeting the Authority's aim of more targeted distribution of credits based on underlying health risks
- HCCP credits are estimated to represent 12% of total risk equalisation credits which is within the range outlined in Section 9. Note that this falls to 7% if we ignore crossover periods, which will apply in the first year of introduction of the HCCP. The impact of crossovers has been included above as it represents a long term view.

Option A is projected to have the least financial impact on each of the insurers, with the expected change to the net financial impacts being in the range -€5m to +€6m. This relatively small impact indicates that the introduction of a HCCP at this level, with no change in stamp duty, is not likely to alter insurer behaviour significantly. It should ensure that insurers are still incentivised to manage

high cost claims efficiently, should maintain market stability and should not in itself have an adverse impact on competition or overcompensation.

[redacted]

RES 2021 set credits and stamp duty such that the projected net claims cost for age groups 65 and over did not exceed the claims cost ceiling of 133.5% of the market average net claims cost.
The introduction of a HCCP impacts the age related health credits under both options despite the net claims cost ceiling remaining unchanged under Option B (this due to second order impacts described earlier). The table outlined below illustrate the change to the age related health credits under both options.

Table 10.2 Illustration of impact of a HCCP on age related health credits

Age	Male Non-Advanced	Female Non-Advanced	Male Advanced	Female Advanced
RES 2021				
0-64	€0	€0	€0	€0
65-69	€350	€200	€1,025	€550
70-74	€550	€400	€1,675	€1,150
75-79	€825	€625	€2,500	€1,800
80-84	€1,025	€700	€3,150	€2,250
85+	€1,250	€825	€3,750	€2,550
Option A: RES 2021 with a HCCP, total credits and stamp duty remain unchanged				
0-64	€0	€0	€0	€0
65-69	€275	€125	€825	€375
70-74	€450	€325	€1,425	€950
75-79	€725	€525	€2,200	€1,550
80-84	€900	€600	€2,800	€1,950
85+	€1,100	€725	€3,325	€2,250
Impact of Option A				
0-64	***€0***	***€0***	***€0***	***€0***
65-69	***(€75)***	***(€75)***	***(€200)***	***(€175)***
70-74	***(€100)***	***(€75)***	***(€250)***	***(€200)***
75-79	***(€100)***	***(€100)***	***(€300)***	***(€250)***
80-84	***(€125)***	***(€100)***	***(€350)***	***(€300)***
85+	***(€150)***	***(€100)***	***(€425)***	***(€300)***
Option B: RES 2021 with a HCCP, total credits increase				
0-64	€0	€0	€0	€0
65-69	€325	€175	€925	€475
70-74	€500	€350	€1,525	€1,050
75-79	€775	€550	€2,325	€1,650
80-84	€925	€625	€2,900	€2,075
85+	€1,125	€775	€3,450	€2,375
Impact of Option B				
0-64	**€0**	**€0**	**€0**	**€0**
65-69	**(€25)**	**(€25)**	**(€100)**	**(€75)**
70-74	**(€50)**	**(€50)**	**(€150)**	**(€100)**
75-79	**(€50)**	**(€75)**	**(€175)**	**(€150)**
80-84	**(€100)**	**(€75)**	**(€250)**	**(€175)**
85+	**(€125)**	**(€50)**	**(€300)**	**(€175)**

The analysis shows that the age related health credits decrease more significantly under option A due to the increase in the net claims cost ceiling from 133.5% to 140.3%. However, it is important to look at the overall impact of all credits because although the age credits are reducing, these cohorts will be receiving credits in respect of HCCP and HUC. The impact on the distribution of credits at all ages can be seen in the table below which shows the projected impact of the introduction of a HCCP on net claims after the RES by age band. 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 all credits from the RES.

Table 10.3 Projected net claims cost by age band

Net Claims Cost After RES €	**RES 2021**	***Option A***	**Impact of Option A**	**Option B**	**Impact of Option B**
0-17	320	314	(6)	321	1
18-29	721	712	(9)	735	14
30-39	930	916	(14)	939	9
40-49	1,023	1,003	(20)	1,025	2
50-54	1,227	1,197	(30)	1,220	(7)
55-59	1,531	1,483	(48)	1,506	(25)
60-65	1,910	1,842	(68)	1,866	(44)
65-70	1,688	1,765	77	1,691	3
70-75	1,697	1,780	83	1,706	9
75-80	1,698	1,790	92	1,704	6
80-85	1,700	1,798	98	1,710	10
85+	1,672	1,782	110	1,683	9

Under option A we can see that the expected net claims cost for those under age 65 decrease as a result of the HCCP because more credits are being targeted across all ages. The expected net claims cost for those over age 65 increases accordingly as the total amount credits being distributed are unchanged. Under option B the net claims cost for under 50s is expected to increase as a result of increasing stamp duty albeit this is dampened by the allocation of HCCP credit and there is little to no change to the net claims costs for the over 65s. Maintaining the claims cost ceiling impacts the level of ARHC due to second order effects. This is because the stamp duty collected to fund the HCCP is redistributed through HCCP payments to all lives that experience a high-cost claim. Overall, the net claims cost across the market as a whole is unaffected as the additional stamp duty collected is redistributed as HCCP credits. However, as some of the HCCP is distributed to older lives the level of ARHC reduces. This is because the level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 133.5% of the average net claims cost across all lives. As these lives are expected to be in receipt of HCCP credits, the expectation is that less ARHC will be required so that the net claims cost for these lives does not exceed the claims cost ceiling of 133.5% of the average net claims cost across all lives.

Set out below are pros and cons of both options:

Approach	Pros	Cons
Option A	▪ Stamp duty unchanged. ▪ Reduction in net claims costs for younger lives as they are in receipt of HCCP credits. ▪ Significant increase in the level of effectiveness of 17.4% due to the inclusion of the HCCP (see Section 11 – Projected Effectiveness).	▪ Results in an increase in net claims cost for ages in receipt of ARHC as allocation to ARHC reduced and a portion of the HCCP credits are allocated to younger lives. ▪ Lower allocation of resources towards ARHC which impacts on affordability for older lives.

	▪ Increase in allocation of resources towards lives with largest claims (see Section 10 – Projected Net Financial Impact).	
Option B	▪ Maintains the claims cost ceiling which helps with market segmentation issues. ▪ Further increase in the level of effectiveness although increase limited to 0.3%.	▪ Stamp duty increases as other elements of the RES calibration are unchanged. Limited to increase of €9 in stamp duty for non-advanced contracts (i.e. 35% of the stamp duty change for advanced contracts) based on €50k / 40% calibration. ▪ Increase in net claims costs for younger lives although impact softened due to HCCP allocation. ▪ Additional cost could be viewed negatively by the market and capacity to absorb dependent on economic conditions prevailing.

Having considered all of the analysis the Authority believes that the initial introduction of a HCCP should not in itself serve to increase stamp duty or increase the total level of risk equalisation credits. Rather, the introduction of the HCCP should initially aim to redistribute existing credits based on health status, irrespective of age as per Option A. In effect that means reducing credits which are payable based entirely on age and redistributing them to very sick lives across all ages.

The analysis in table 10.1 illustrates that option B, i.e. maintaining the net claims cost ceiling at 133.5% by increasing stamp duty, does not alter the effectiveness measure materially (47.7% to 48.0%) relative to the position which sees no change in stamp duty, option A. The expected net financial impacts of the RES for each insurer under option B leads to larger changes compared to option A, with the two net contributors seeing a greater fall and the net beneficiary seeing a larger increase. Option A is less likely to cause market disruption and to distort competition and permits a gradual introduction of a HCCP.

Option A sees an increase in the net claims costs after the RES for over age 65 whilst option B sees no material change for this age cohort as illustrated in table 10.3. But Option A sees a decrease in the net claims cost for under 65s in all age cohorts whilst option B sees an increase for those under age 50. The Authority considers that the increase in net claims cost for the over 65s is not likely to impact their involvement in the market and that the reduction in net claims cost at younger ages helps to address sustainability and affordability.

The Authority is of the view that a balance has to be struck between the various aims as outlined in Section 2. The Authority considers on balance, that the level of HCCP credits being recommended in this report, and implementation by way of redistribution of credits all else being equal, strikes an appropriate balance between improving effectiveness and maintaining stability and sustainability whilst being mindful of competition and overcompensation. It should also act to reduce incentives for risk selection and segmentation of high risks. Risk equalisation is a process that aims to address differences in insurers' claim costs that arise due to variations in the health status of their members. Risk equalisation involves payments to or from insurers related to the risk profile of their

membership. The approach of redistribution of credits as illustrated by option A is in response to more information being available on the risk profile of these insurers and allows more targeted distribution of credits.

A number of respondents to the consultation addressed the impact of the introduction of the HCCP on the level of stamp duty and affordability of the RES. Several of the submissions expressed concern over the HCCP increasing the cost of health insurance for those who can least afford it. One submission proposed that there should be no change to stamp duty. In contrast, another insurer, in their submission, believes changes to stamp duty has no impact on affordability.

One respondent to the public consultation considered that a quota share of 80% and threshold of €40,000 was a more appropriate calibration.

The Authority considered a wide range of calibrations outlined in Appendix F including this one. In examining this threshold/quota share combination, the Authority has concluded that it would lead to a HCCP contribution to the overall RES that fell outside of the range the Authority has considered a suitable starting point(30%). As such, it would not be in line with the aims of a controlled phased introduction with a view to maintaining market stability. The Authority is also mindful of the current market environment, and the importance of maintaining stability, a concern that was expressed by several insurers in their submissions.

The recommended levels of HCCP credits, therefore meets the Authority's intention of introducing the HCCP in a gradual incremental non disruptive manner whilst considering the aims and objectives of the RES as per Section 7E(1)(b) of the Act.

The Authority is recommending a quota share of 40% and a threshold of €50,000 for the year one calibration and is recommending that the initial introduction of a HCCP should be done on the basis of redistribution of ARHC credits.

11. Progression of RES from 2022

The Authority has also considered the progression of RES 2022 over its 5 year term.

The Authority is proposing that the HCCP is introduced in a phased incremental manner. This will allow the Authority to monitor the reaction by the insurers with regards to market segmentation, risk selection, competition and any changes to claims efficiency and hence to maintain market stability.

A challenge in a risk equalisation scheme is to achieve net payments to and from the risk equalisation fund, on an annual basis, that reflect differences in risk profile, but which do not also reflect other differences between insurers which should not be equalised – e.g. difference in claims payment philosophies, efficiency and benefit richness offered by different insurers across different products. This can be challenging in a market which has over 300 products.

The Authority believes that directing more credits based on health status and actual claims experience, rather than risk predictors, helps in sharing payments based on underlying risk. However, we need to be cognisant of the impact of such a decision on the market. We recognise the importance of ARHC as a tool to help meet the principal objectives of the RES where age is a proxy for health status. Any material changes to ARHC could potentially have a significant impact on the net claims cost of older lives which in turn could impact on the price of insurance products that are more frequently purchased by older lives, the willingness of older customers to purchase those products, and hence the stability of the market and community rating itself.

- An increase in the level of HCCP credits is likely to manifest itself in increased net claims costs for older lives all else being equal, on the basis that HCCP credits will be spread across all age groups. This is because the claims cost ceiling increases in order to maintain stamp duty. This consequently reduces the level of ARHC, which act to reduce the net claims costs for those lives.
- Equally, maintaining the claims cost ceiling at levels prior to the introduction of the HCCP is likely to lead to considerable increases in the level of stamp duty required, which in turn could equally disrupt the market and lead to potential market exits at younger ages.

Over the term of the next RES, the Authority is proposing that the allocation of credits based on health status should be increased. This increase should be implemented gradually and only if such increases contribute to the achievement of the Principal objective. The extent of any such increase will be considered each year as part of the annual calibration with consideration given to numerous factors. These factors include market participation by age cohort, claims inflation, market segmentation and competition. Any recommendation should continue to encourage efficient claims management for high cost claims and disincentivise market segmentation and thereby encouraging insurers to compete in terms of efficiency, product innovation and consumer outcomes. Impact on community rating and affordable access to health insurance for all, healthy and sick, young and old must be at the forefront.

The analysis outlined below illustrates the impact on RES 2021 if the level of credits based on health status i.e. HUC and HCCP, represented 50% of total credits.

Table 11.1 Illustration of increased allocation of HCCP credits

	Current RES Calibration	Proposed HCCP Calibration (50k/40%)	€35k/60% HCCP Calibration (maintain stamp duty)	€35k/60% HCCP Calibration (change stamp duty)
Advanced Contracts	449	449	449	507
Claims Cost Ceiling	133.5%	140.3%	150.7%	133.5%
Projected Net Claims Cost After RES by Age Group				
0-17	320	314	307	325
18-29	721	712	696	751
30-39	930	916	896	949
40-49	1,023	1,003	975	1,029
50-54	1,227	1,197	1,156	1,210
55-59	1,531	1,483	1,420	1,475
60-64	1,910	1,842	1,752	1,807
65-70	1,688	1,765	1,910	1,688
70-74	1,697	1,780	1,925	1,713
75-80	1,698	1,790	1,937	1,723
80-84	1,700	1,798	1,941	1,727
85+	1,672	1,782	1,928	1,713
Total Projected RES Flows				
Stamp Duty	764m	764m	764m	862m
ARHC	606m (75%)	515m (64%)	387m (48%)	490m (54%)
HUC	200m (25%)	200m (25%)	200m (25%)	200m (22%)
HCCP	0m (0%)	93m (12%)	215m (27%)	215m (24%)
Effectiveness				
All Ages	30.3%	47.7%	60.9%	61.7%
Projected Net Financial Impact				
[redacted]				

The above demonstrates that increasing the level of credits in respect of HCCP increases the effectiveness of the RES. But an increase in effectiveness must be balanced with the other objectives of the RES. Absent any change in the commercial strategies of the insurers, with regard to product design and target customers, an increase in the proportion of credits going to the HCCP could have unintended consequences and impact competition , affordability and sustainability. The above is an example of a way in which the credits could be introduced. In reality there are a number of ways in which health status credits could be increased, increasing HUC and HCCP together, the HCCP could be increased by increasing the quota share, reducing the threshold or a combination of both.

The Authority is recommending that any changes made to the parameters of the HCCP (primarily the threshold value and the quota share) over the term of the RES are done on a phased basis and carefully managed over time. The Authority is proposing that credits in respect of health status i.e. HCCP plus HUC, would not exceed 50% of overall credits by 2026. The Authority notes that this is an indication of direction of travel but that it is not possible to guarantee in advance how the level of credits will progress due to the element of judgement and reaction to market dynamics and claims experience that are required each year.

12. Recommendation

The Authority is recommending the inclusion of a HCCP in the risk equalisation scheme for the period 2022 – 2026 to commence for contracts entered into from 1 April 2022.

The Authority is recommending that the introduction of a HCCP should initially be done on the basis of a redistribution of credits from ARHC to allow more targeted allocation of credits towards health status. The Authority considers that the recommendation being made is in keeping with the principal objective of the Health Insurance Acts and strikes an appropriate balance between the aims set out in Section 7E(1) of the Act. The Authority is of the view that the recommendation increases the effectiveness of the RES, is not likely to disrupt the market and is mindful of the need to promote sustainability and competition. It is a recommendation for a suitable starting point for the introduction of a HCCP.

Within the existing RES, the flexibility exists to alter the balance between ARHC and HUC, on an annual basis, as long as the claims cost ceiling does not fall below 125%. Whilst the RES has been calibrated to a claims cost ceiling of 130% for a number of years, the most recent RES was calibrated to a claims cost ceiling of 133.5% with the expected HUC representing c25% of total expected credits compared to 20% in previous years. The Authority is recommending that this flexibility is retained for the RES for 2022 to 2026.

In making this recommendation the Authority has considered the analysis contained in this report, professional advice from its advisors and submissions from the public consultation. It should be noted that this recommendation is on the basis that these are the credits and stamp duties that would have applied for contracts commencing from 1 April 2021 to 31 March 2022 if a HCCP had been in place at the most recent calibration in 2020, applicable for health insurance contracts entered into from April 2021 to March 2022.

In year one of the new RES, for contracts commencing from 1 April 2022, the Authority is recommending a calibration based on the below:

Approach	HCCP is to be introduced as a redistribution of credits
Target HCCP pot	Year one approximately 10% of overall credits
Quota Share	40%
Threshold	€50,000
HCCP Claim	Returned benefits as per Health Insurance Acts but excluding drugs not approved by the HSE for use in public hospitals
Calculation of high cost claim credit	40% x (HCCP Claim – (Threshold + HUC + ARHC))
Time period	Rolling quarters in a 12 month period commencing from 1 April 2022 determined by date claim is incurred
Cap on HCCP claim	No cap initially but to be kept under view
Claims cost ceiling	Floor of 125% (no change)
HUC & ARHC	Continued inclusion with no change to structure

RES 2022 credits and stamp duties

For contracts from April 2022 onwards, the Authority would use the approach outlined in these recommendations, in combination with updated claims data and market analysis to set the credit and stamp duty on an annual basis.

At the time of the actual calibration of RES 2022, the Authority in making its recommendation to the Minister, will use the levers it has at its disposal to balance the conflicting requirements of the RES, in particular the achievement of the principal objective versus the need to promote sustainability and competition, and the need to avoid over-compensation.

In recommending the credits and stamp duties in respect of new contracts entered into in the period 1 April 2022 – 31 March 2023, the Authority will consider the most up to date data available to it, the market circumstances at that time, the estimated surplus within the Risk Equalisation Fund ("REF") and the parameters of the approved RES 2022.

Based on all of the above the Authority will make its recommendation to the Minister with regard to risk equalisation credits and stamp duties for contracts commencing from 1 April 2022.

Projected Impact on key metrics assuming the HCCP was introduced for RES 2021 i.e. for contracts commencing from 1 April 2021

	Adult Stamp duty (advanced/ non advanced)	Claims Cost Ceiling	Utilisation credits (overnight/ day)	Effectiveness[15] (all ages)	Projected Age Credit Fund	Projected HUC Fund	Projected HCCP fund
RES 2021	€449/€157	133.5%	€125/€75	30.3%	€605m (75%)	€200m (25%)	-
With HCCP	€449/€157	140.3%	€125/€75	47.7%	€515 (63%)	€200 m (25%)	€93m (12%)

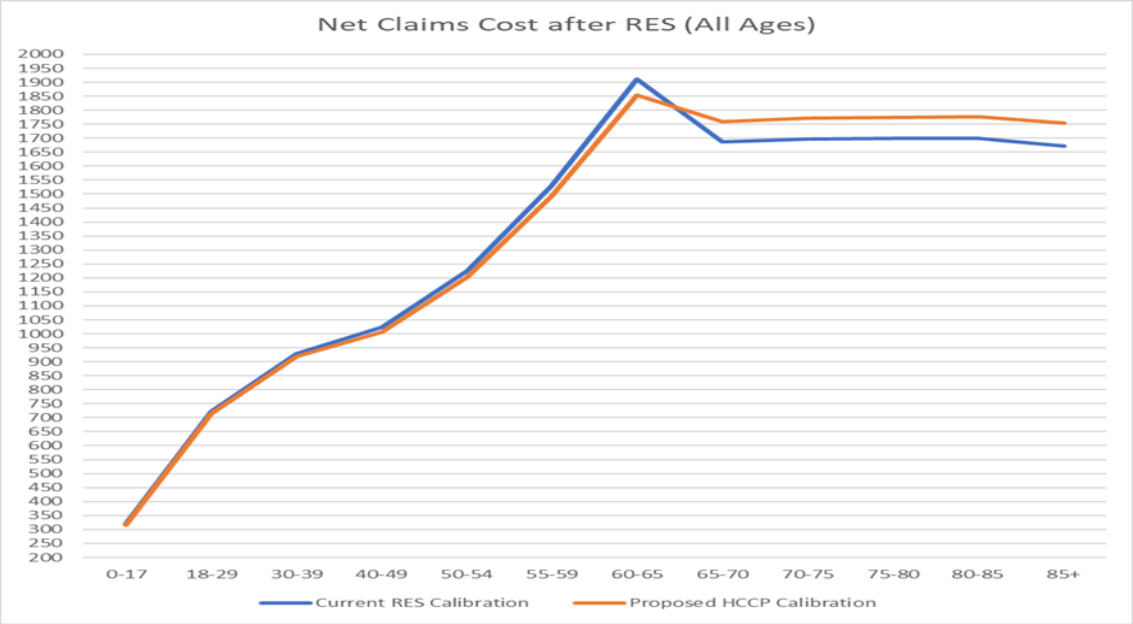
Projected net financial impacts for a 12 month period based on the credits and stamp duty above for policies commencing in the period 1 April 2021 to 31 March 2022

RES 2021 (no HCCP)			
€m	Irish Life Health	Laya Healthcare	Vhi Healthcare
Age related health credits (ARHC)			
Hospital Utilisation Credit (HUC)			
Stamp duty			
Net Financial Impact			

RES 2021 (HCCP)			
€m	Irish Life Health	Laya Healthcare	Vhi Healthcare
Age related health credits (ARHC)			
Hospital Utilisation Credit (HUC)			

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

High Cost Claims Pool (HCCP)		[redacted]	
Stamp duty			
Net Financial Impact			
Impact of HCCP			



It should be noted that the illustrated metrics outlined above allow for the recommended rolling four quarters approach. The additional claims from this approach will not impact during the first year of the HCCP. Thus, the figures presented above are representative of a longer-term view of the impact of inclusion of the HCCP in the RES and are overstated for year one.

Example for an 80 year old male on an advanced contract

Annual Premium	Q1 Year 1	Q2 Year 1	Q3 Year 1	Q4 Year 1	Q1 Year 2	Q2 Year 2
Claim Amount	0	40,000	50,000	20,000	10,000	10,000
Cumulative claims (4 quarters)	0	40,000	90,000	110,000	120,000	90,000
HUC received	0	2,000	3,000	950	500	500
Cumulative HUC received (4 quarters)	0	2,000	5,000	5,950	6,450	4,950
ARHC received	2,950	0	0	0	2,950	-
Cumulative ARHC received (4 quarters)	2,950	2,950	2,950	2,950	2,950	2,950
Cumulative Credits received (4 quarters)	2,950	4,950	7,950	8,900	9,400	7,900
Threshold	50,000	50,000	50,000	50,000	50,000	50,000
Adjusted Threshold	52,950	54,950	57,950	58,900	59,400	57,900
HCCP Credit (max ((40%x (Claim – Adjusted Threshold),0)	0	0	12,820	20,440	24,240	12,840
HCCP Credit received in preceding 3 quarters	0	0	0	12,820	20,440	24,240
Final HCCP Credit	0	0	12,820	7,620	3,800	0

13. Administrative considerations

The implementation of a new RES and the inclusion of a HCCP will require administrative changes for the Authority and the insurers in terms of data collection under Information returns (section 7D of the Act) and in terms of claiming and processing payments from the Risk Equalisation Fund(section 41C and 11F of the Act).

Information Returns

The Authority are proposing that the following data is collected from insurers which is similar to the data which they have provided to date. Data on claims which exceed €10,000 should be included.

We suggest that the information returns contain the following information as a minimum:

- Data split into contract periods
    - Member No. / Identifier
    - Sex
    - Age at contract inception
    - Product Level (1, 2, 3+)
    - Advanced/ Non-Advanced flag
- The total claims paid for an insured life for each contract period split by year of payment of the claim.
- All claim payments are included i.e. it includes outpatient claims
- Returned Benefit claim payment breakdown by public, private, consultant
- Total Cell Claim Value split by month
- Total number of overnight stays split by month

For each insured life with high cost claims the required information should be the total claim amount paid by the insurer for that member within a contract period. If the total claim amount paid to end of the period is less than €10,000, then no data should be included in respect of that insured life. For the avoidance of doubt, we have suggested that the HCCP will provide compensation in respect of cumulative claims costs that exceed the high cost claims threshold, and as such may be representative of multiple claims that in isolation do not meet the definition of a high cost claim on a standalone basis.

Consistent with the information returns we recommend that the information provided to the Authority to calibrate the HCCP should be accompanied by an independent accountant's report stating that the returns are in line with the regulations as is currently the case under Health Insurance Act 1994 (Information Returns) Regulations, 2009 [S.I. No. 294 of 2009].

Data for payments

Currently, the insurers must complete forms as provided by the Authority to make claims for risk equalisation credits from the Risk Equalisation Fund.

New forms will have to be prepared by the Authority to capture sufficient data on HCCP so that the Authority is satisfied that the amount being claimed is payable. The Authority is currently minded to apply a quarterly claims process in respect of HCCP to allow sufficient time for such large claims to accumulate. The Authority is currently working through this to find the most efficient way to implement for all relevant stakeholders. The Authority will reach out to the insurers when it has a suitable working draft for discussion and to ensure any administrative hurdles can be managed early.

Included in Appendix G is the most up to date draft of the information that the Authority is considering collecting.

Auditing Procedures

If a HCCP is implemented this could give rise to some potentially large claims in respect of a single insured person albeit the volume of claims will be relatively low.

The Authority would intend to select a random sample each quarter for which it would require full backup and evidence of the amount being claimed from the REF. The Authority would propose doing this for at least the first 12 months of operation of the HCCP. The Authority is also minded to request full back up of claims over a certain amount.

The annual inspections which are carried out by the Authority in respect of the payments from the REF would also be extended to incorporate HCCP credits.

Appendix A – 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 B – HCCP data collected

The Authority received detailed monthly claims data from the three open market insurers to help support the calibration of the HCCP and enable further analysis and refinement to be performed. This data included the following:

- Member number
- Age
- Gender
- Level of Cover (level 1, 2,3+)
- Total Claim paid in respect of a specified contract period
- Returned Benefits
- Number of Bed Nights
- Number of Day Cases Nights
- Total ARHC received

The above data was provided in respect of total claims above €10,000 for individual contracts written between 2016 and 2019. The data was provided by contract year, with a further sub split within contract years to understand how the claims data aligns to the RES calibration, e.g. claims in respect of 2019 contracts were split between policies that incepted 1 January 2019 – 31 March 2019 and 1 April 2019 – 31 December 2019. For each cohort, information in respect of claims paid up to 30 June 2020 was provided.

Summary of data collected

No. of claims exceeding €10,000 – Raw Data				
Age Band	**Irish Life health**	**Laya Healthcare**	**VHI Healthcare**	**Market**
0-17	[redacted]			1,122
18-29				1,106
30-39				1,993
40-49				3,856
50-54				2,806
55-59				3,977
60-64				5,195
65-69				6,551
70-74				7,477
75-79				6,607
80-84				4,857
85+				3,791
Total				**49,338 (100%)**

Total claims exceeding €10,000 – Raw Data				
Age Band	**Irish Life health €m**	**Laya Healthcare €m**	**VHI Healthcare €m**	**Market €m**
0-17	[redacted]			€30.7
18-29				€28.1
30-39				€47.6
40-49				€92.1
50-54				€66.0
55-59				€95.3
60-64				€123.7
65-69				€162.1
70-74				€186.2
75-79				€168.2
80-84				€126.4
85+				€97.9
Total				**€1,224.3 (100%)**

No. of claims exceeding €50,000 – Raw Data				
Age Band	**Irish Life health**	**Laya Healthcare**	**VHI Healthcare**	**Market**
0-17	[redacted]			139
18-29				98
30-39				149
40-49				284
50-54				192
55-59				312
60-64				401
65-69				544
70-74				651
75-79				592
80-84				496
85+				351
Total				**4,209 (100%)**

Total claims exceeding €50,000 – Raw Data		
Age Band	[redacted]	**Market €m**
0-17		€11.3
18-29		€6.8
30-39		€11.4
40-49		€21.7
50-54		€16.2
55-59		€25.2
60-64		€32.2
65-69		€44.3
70-74		€51.4
75-79		€47.2
80-84		€37.9
85+		€26.4
Total		**€332.0 (100%)**

Appendix C – Data modification for calibration purposes

The insurer claims data provided to the Authority has been used to estimate the ultimate claims expected to be incurred in respect of each sub-contract year.

It has been assumed that the claims data in respect of contracts written in the period 1 January 2016 – 29 February 2016 are fully developed this has been used this as a basis for estimating the ultimate claims amounts in respect of the other sub-contract years using non-life actuarial techniques. Similar analysis in respect of overnight stays and day-case HUC claims was also carried out.

For purposes of the calibration claims data arising from contracts entered into during 2018 has been used. This data was assumed to be 98% developed. The claims data in respect of contracts entered into in 2018 was further developed to allow for any additional claims experience that might emerge (but not yet paid out by the insurers) based on experience observed in the claims data in respect of contracts entered into in 2016 and 2017.

Additionally, consistent with the expected level of claims inflation underpinning the current RES calibration, claims inflation of 4% p.a. for a period of 3.25 years has been applied to allow for the expected increase in the cost of the claims emerging from 2018 contracts to when the claims would be paid from the current RES calibration, had the HCCP been introduced. The 3.25 years reflects the time from 31 December 2018 (which is the average exposure point for claims in respect of contracts written in 2018) up to 1 April 2022 (which is the average exposure point for claims from contracts written in the period 1 April 2021 – 31 March 2022) when the HCCP credits would apply.

For the avoidance of doubt, the allowance for claims inflation of 4% p.a. for a period of 3.25 years serves two purposes.

- To allow for claims which are likely to exceed the claims threshold due to inflationary effects expected in the future. For example, claims of €44,016 in 2018 prices would have inflated to €50,000 in real terms for the purposes of the 2020 RES calibration. The adjustment ensures that such claims are considered when determining the level of the HCCP pot.
- By carrying out this calibration exercise, as if claims had occurred in respect of contracts entered into in the period 1 April 2021 – 31 March 2022, the conclusions are expected to be representative of the likely level of claims cost when the HCCP is operational.

The summary adjusted data is outlined below.

No. of claims exceeding €50,000 – Raw Data Inflated and Developed				
Age Band	Irish Life health	Laya Healthcare	VHI Healthcare	Market
0-17	[redacted]			169
18-29				131
30-39				203
40-49				390
50-54				247
55-59				393
60-64				514
65-69				712
70-74				836
75-79				779
80-84				621
85+				477
Total				**5,472 (100%)**

Total claims exceeding €50,000 – Raw Data Inflated and Developed		
Age Band	[redacted]	Market €m
0-17		**€14.9**
18-29		**€9.7**
30-39		**€16.3**
40-49		**€31.2**
50-54		**€21.9**
55-59		**€33.9**
60-64		**€43.9**
65-69		**€61.0**
70-74		**€70.2**
75-79		**€65.4**
80-84		**€51.2**
85+		**€37.7**
Total		**€457.4 (100%)**

Appendix D – Australian risk equalisation system

How the HCCP in Australia works[16]

The Australian RES system includes a HCCP which is firstly age dependent and subsequently subject to an upper limit.

Age	% of benefits included in aged based pool (ABP)
0-54	0%
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78%
85+	82%

The amount to be notionally allocated to the HCCP is to be calculated in accordance with the formula m(R-T) - H, where:

- m is 82%;
- R is the total gross benefit for the current and the preceding 3 quarters less the amount notionally allocated to the ABP in the current and preceding 3 quarters;
- T is the designated threshold which is $50,000;
- H is the sum of the amounts notionally allocated to the HCCP in the preceding 3 quarters.

Examples of how the HCCP in Australia works

Example 1 of ABP calculation:

For example, Mr X, a 59-year-old insured person whose birthday is on 24 January is admitted to hospital on January 19. Mr X is discharged from the hospital on 29 January. Mr X's gross benefit is $10,000. In this case, as half the time in which Mr X was receiving treatment was spent while he was 59 years old and the other half while he was 60 years old, the amount to be notionally allocated to the ABP will use the rates in both the 55-59 and the 60-64 age cohorts. Therefore, the amount notionally allocated to the ABP will be: 0.5*$10,000*15%+0.5*$10,000*42.5% which equals $2,875.

Example 2 of ABP & HCCP calculation:

Mr X is 63 and has a gross benefit of $100,000. In this case, the amount that will be notionally allocated to the ABP is $42,500 (42.5% * $100,000). Assuming that Mr X has not made a previous claim in the preceding 3 quarters, Mr X will be above the $50,000 threshold. That is, $57,500 (the amount not notionally allocated to ABP in the current quarter with no other claims in the preceding 3 quarters) exceeds the designated threshold of $50,000. Here, the amount that will be notionally allocated to the HCCP is $6,150 (82% * ($57,500 - $50,000) - 0). As there are no gross benefits in the preceding 3 quarters, the only amount that was not allocated to the ABP is the amount in the current quarter (i.e. $100,000 - $42,500 = $57,500) and the amount notionally allocated to the HCCP in the preceding 3 quarters is zero.

[16] **The details are sourced from: https://www.legislation.gov.au/Details/F2015L01051**

Example 3 of ABP & HCCP calculation:

Assuming that, in the next quarter, Mr X has another gross benefit of $100,000 and is still 63, the amount to be notionally allocated to the ABP will be the same as in the previous example. That is, the amount allocated to the ABP will be $42,500. The calculation of the total amount not notionally allocated to the ABP will need to account for the previous claim amount in Example 2 for the purposes of calculating whether the total amount not allocated to the ABP exceeds the designated threshold. In this case, the total residual amount will be $115,000 ($57,500 (amount not allocated in the ABP in the previous quarter) + $57,500 (amount not allocated in the ABP in the current quarter). The result is that the total amount not allocated to the ABP in the current quarter and in the preceding 3 quarters of $115,000 exceeds the designated threshold of $50,000.

The amount to be notionally allocated to the HCCP in this case will be $47,150, which represents 82% of the difference between the sum of the total amount not allocated to the ABP in the current and in the preceding 3 quarters ($57,500 + $57,500) and the threshold ($50,000), minus the sum of the amount notionally allocated to the HCCP in the preceding 3 quarters (in this case, as there was only one amount in the previous quarter, the sum is $6,150).

Using the formulae above for illustration we get:

M * (R-T) – H = 82% * ($115,000 - $50,000) - $6,150 = $47,150

Appendix E – Impact of offsetting ARHC and HUC

No HUC/ARHC offset

	Exclusion of Cross Over periods	Inclusion of Cross Over periods
Approach	▪ 2018 HCCP claims data in excess of threshold developed to maturity. ▪ Inflation applied to claims data (which increases the level of applicable claims)	▪ 2018 HCCP claims data in excess of threshold developed to maturity. ▪ Inflation applied to claims data (which increases the level of applicable claims) ▪ Allowance for cross-over of policies between cohort years *(as ILH have not provided 2016 data, the periods looked at are 2017-2018 and 2018-2019)*
Threshold	€50k excess	€50k excess
Quota Share	40%	40%
Inflation Allowance	4%	4%
Inflation Period	3.25 years	3.25 years
Number of Lives	5,472	5,472
Final HCCP Pot	€73.5m	€113.1m
Detailed Description	1. Total Claims + Inflation at 4% for period of 3.25 years = €457.4[17]m 2. Reduce this amount by the total excess (€50k*developed claim count) = €457.4m - €50k*5,472 = €183.8m 3. Apply the quota share (40%) = €183.8*40% = €73.5m	1. Total HCCP Pot excluding cross over periods of €73.5m (see previous column) 2. Additional HCCP cross over claims of €99.0m (allowing for inflation). Apply the quota share (40%) = €99.0*40% = €39.6m[18]
Final HCCP Pot (6% Inflation	€86.1m	€128.2m
Final HCCP Pot (10% Inflation	€115.9m	€163.4m

[17] The €457.4m represents the €443.8m total claims over €50k adjusted for expected future claims development as set out in Appendix C

[18] The additional claims used for the purposes of the analysis are based on the average claims emerging from 2018 claims in respect of 2017 contracts and from 2019 claims in respect of 2018 contracts and have been increased to allow for expected inflation when the HCCP would apply. The €39.6m in respect of cross over periods reflects any potential credit offsets due to the additional HUC and ARHC that would be payable in respect of these claims. More specifically, this has been calculated as the difference between the combined total HCCP of two adjacent contract periods (assuming one claimant excess applies) less the sum of the HCCP of the individual adjacent contract periods (assuming two claims excesses apply). For the purposes of the calculation of the combined total HCCP, the claimant excess includes the total level of HUC over the two contract periods with one claims threshold and one ARHC applying. For the purposes of the sum of the HCCP of the individual adjacent contract periods two claims thresholds and two ARHC are applied (i.e. one per contract period). An average of the 2017-2018 and 2018-2019 cross over period calculations, adjusted for expected claims inflation for when the HCCP would apply, has been included in the final HCCP calculation.

Partial offsetting of HUC and ARHC

	Exclusion of Cross Over periods	Inclusion of Cross Over periods
Approach	▪ 2018 HCCP claims data in excess of threshold developed to maturity. ▪ Inflation applied to claims data (which increases the level of applicable claims) ▪ Calculate Adjusted Excess as Threshold + HUC + ARHC received to date for cohort year ▪ Quota Share applied to Claim *less* Adjusted Excess	▪ 2018 HCCP claims data in excess of threshold developed to maturity. ▪ Inflation applied to claims data (which increases the level of applicable claims) ▪ Calculate Adjusted Excess as Threshold + HUC + ARHC received to date for cohort year ▪ Allowance for cross-over of policies between cohort years *(as ILH have not provided 2016 data, the periods looked at are 2017-2018 and 2018-2019)* ▪ Quota Share applied to Claim *less* Adjusted Excess
Threshold	€50k excess	€50k excess
Quota Share	40%	40%
Inflation Allowance	4%	4%
Inflation Period	3.25 years	3.25 years
Number of lives	5,472	5,472
Number of Nights	313,525	313,525
Number of Days	45,369	46,199
HCCP Pot (No Offset)	€73.5m	€113.1m
HUC	€42.6m	€42.6m
HUC Offset (HUC * Quota Share)	€17.0m	€17.0m
Age Credits	€6.6m	€6.6m
Age Credit Offset	€2.7m	€2.7m
Final HCCP Pot	€53.8m	€93.4m
Detailed Description	1. Option 1 HCCP Pot = €73.5m 2. Increase Excess by HUC of €42.6m. Apply the quota share (40%) = €42.6% = €17.0m 3. Increase Excess by Age Credits of €6.6m. Apply the quota share (40%) = €6.6*40% = €2.7m 4. HCCP Pot = €73.5m - €17.0m - €2.7m = €53.8m	1. Total HCCP Pot Last Step of €53.8m 2. Additional HCCP cross over claims of €99.0m (allowing for inflation). Apply the quota share (40%) = €99.0*40% = €39.6m[19]
Final HCCP Pot (6% Inflation	€64.6m	€106.7m
Final HCCP Pot (10% Inflation	€90.8m	€138.3m

[19] The €39.6m in respect of cross over periods does not reflect any potential credit offsets due to the additional HUC that would be payable in respect of these claims.

Appendix F – Scenario analysis of different calibrations

Impact of Calibration Approach on Key HCCP Metrics (including allowance for Cross Over Periods)

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	HCCP Pot (€ million)												
0	0.0m												
30,000		126.1	168.1	210.1	252.2	294.2	336.2	126.1	168.1	210.1	252.2	294.2	336.2
35,000		107.5	143.4	179.2	215.1	250.9	286.8	107.5	143.4	179.2	215.1	250.9	286.8
40,000		92.4	123.2	154.0	184.8	215.6	246.4	92.4	123.2	154.0	184.8	215.6	246.4
45,000		80.0	106.7	133.3	160.0	186.7	213.4	80.0	106.7	133.3	160.0	186.7	213.4
50,000		70.1	93.4	116.8	140.1	163.5	186.8	70.1	93.4	116.8	140.1	163.5	186.8
	HCCP Pot as % of RE Credits												
0	0.0%												
30,000		15.7%	20.8%	26.2%	31.7%	36.9%	42.0%	14.6%	19.0%	23.2%	27.3%	31.2%	34.9%
35,000		13.3%	17.8%	22.3%	26.8%	31.3%	36.0%	12.6%	16.4%	20.2%	23.8%	27.2%	30.6%
40,000		11.5%	15.2%	19.1%	22.9%	26.8%	30.9%	10.9%	14.2%	17.6%	20.8%	23.8%	26.9%
45,000		9.9%	13.2%	16.5%	19.8%	23.2%	26.6%	9.5%	12.5%	15.4%	18.2%	21.0%	23.6%
50,000		8.7%	11.5%	14.5%	17.4%	20.3%	23.2%	8.4%	11.0%	13.6%	16.1%	18.6%	21.0%
	Stamp Duty €												
0	449												
30,000		449	449	449	449	449	449	484	495	507	518	530	541
35,000		449	449	449	449	449	449	478	488	498	507	517	527
40,000		449	449	449	449	449	449	474	482	490	498	506	514
45,000		449	449	449	449	449	449	471	478	485	492	499	506
50,000		449	449	449	449	449	449	468	474	480	486	492	498

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/ Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	Effectiveness (over 65)												
0	31.6%												
30,000		51.3%	56.2%	60.4%	64.1%	67.3%	69.9%	52.2%	57.2%	61.5%	65.3%	68.5%	71.1%
35,000		50.9%	55.6%	59.7%	63.5%	66.7%	69.3%	51.7%	56.4%	60.7%	64.5%	67.8%	70.5%
40,000		50.2%	54.7%	58.8%	62.5%	65.7%	68.5%	50.6%	55.4%	59.6%	63.4%	66.7%	69.5%
45,000		48.3%	52.3%	56.2%	59.7%	62.8%	65.5%	48.8%	53.1%	57.0%	60.4%	63.6%	66.5%
50,000		46.7%	50.6%	53.9%	57.2%	60.2%	63.0%	47.2%	51.0%	54.6%	57.9%	61.1%	63.9%
	Effectiveness (all)												
0	30.3%												
30,000		48.6%	53.5%	57.8%	61.7%	65.1%	68.0%	49.3%	54.3%	58.6%	62.6%	66.0%	68.8%
35,000		48.1%	52.9%	57.0%	60.9%	64.3%	67.2%	48.7%	53.4%	57.8%	61.7%	65.1%	68.0%
40,000		47.2%	51.7%	55.8%	59.6%	63.0%	65.9%	47.5%	52.3%	56.5%	60.2%	63.7%	66.6%
45,000		45.3%	49.3%	53.2%	56.8%	59.9%	62.8%	45.7%	49.9%	53.9%	57.3%	60.6%	63.5%
50,000		43.8%	47.7%	51.1%	54.5%	57.5%	60.4%	44.2%	48.0%	51.7%	55.0%	58.2%	61.1%
	Claims Cost Ceiling												
0	133.5%												
30,000		143.1%	146.4%	150.5%	154.6%	158.7%	162.8%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
35,000		141.6%	144.3%	147.3%	150.7%	154.2%	157.7%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
40,000		140.3%	142.6%	144.8%	147.6%	150.5%	153.4%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
45,000		139.4%	141.3%	143.3%	145.2%	147.8%	150.3%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
50,000		138.6%	140.3%	142.0%	143.7%	145.6%	147.9%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/ Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	Net Financial Impact												

Impact of Calibration Approach on Key HCCP Metrics (excluding allowance for Cross Over Periods)

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	HCCP Pot (€ million)												
0	0.0m												
30,000		82.3	109.8	137.2	164.7	192.1	219.6	82.3	109.8	137.2	164.7	192.1	219.6
35,000		67.7	90.3	112.9	135.5	158.1	180.7	67.7	90.3	112.9	135.5	158.1	180.7
40,000		56.3	75.0	93.8	112.5	131.3	150.1	56.3	75.0	93.8	112.5	131.3	150.1
45,000		47.3	63.0	78.8	94.5	110.3	126.0	47.3	63.0	78.8	94.5	110.3	126.0
50,000		40.4	53.8	67.3	80.7	94.2m	107.6	40.4	53.8	67.3	80.7	94.2	107.6
	HCCP Pot as % of RE Credits												
0	0.0%												
30,000		10.2%	13.6%	17.0%	20.4%	23.9%	27.5%	9.8%	12.8%	15.8%	18.6%	21.4%	24.2%
35,000		8.4%	11.2%	14.0%	16.8%	19.6%	22.4%	8.1%	10.6%	13.1%	15.6%	18.0%	20.3%
40,000		7.0%	9.3%	11.6%	14.0%	16.2%	18.6%	6.7%	8.9%	11.0%	13.1%	15.2%	17.1%
45,000		5.9%	7.8%	9.7%	11.7%	13.7%	15.6%	5.7%	7.5%	9.3%	11.1%	12.9%	14.6%
50,000		5.0%	6.7%	8.3%	10.0%	11.7%	13.4%	4.9%	6.5%	8.0%	9.6%	11.1%	12.6%
	Stamp Duty €												
0	449												
30,000		449	449	449	449	449	449	472	480	487	495	503	510
35,000		449	449	449	449	449	449	468	474	480	486	493	499
40,000		449	449	449	449	449	449	465	470	475	480	485	490
45,000		449	449	449	449	449	449	462	466	470	475	479	483
50,000		449	449	449	449	449	449	460	464	467	471	474	478

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/ Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	Effectiveness (over 65)												
0	31.6%												
30,000		45.7%	49.3%	52.4%	55.6%	58.5%	61.0%	46.3%	50.1%	53.3%	56.7%	59.5%	62.2%
35,000		45.1%	48.4%	51.5%	54.4%	57.2%	59.7%	45.5%	48.9%	52.2%	55.2%	58.1%	60.6%
40,000		44.2%	47.1%	50.1%	53.0%	55.6%	58.1%	44.6%	47.6%	50.7%	53.6%	56.2%	58.9%
45,000		42.7%	45.2%	47.9%	50.3%	52.8%	54.9%	43.0%	45.7%	48.4%	50.9%	53.4%	55.7%
50,000		41.4%	43.8%	46.2%	48.4%	50.4%	52.4%	41.8%	44.3%	46.6%	48.8%	50.9%	53.1%
	Effectiveness (all)												
0	30.3%												
30,000		43.0%	46.6%	49.8%	53.0%	55.9%	58.6%	43.4%	47.1%	50.5%	53.8%	56.7%	59.5%
35,000		42.3%	45.6%	48.8%	51.7%	54.5%	57.1%	42.5%	46.0%	49.2%	52.3%	55.2%	57.8%
40,000		41.2%	44.2%	47.2%	50.0%	52.7%	55.2%	41.5%	44.6%	47.6%	50.5%	53.2%	55.8%
45,000		39.8%	42.3%	45.0%	47.4%	49.9%	52.1%	40.0%	42.6%	45.4%	47.9%	50.3%	52.6%
50,000		38.6%	41.0%	43.4%	45.5%	47.6%	49.7%	38.9%	41.3%	43.6%	45.9%	48.0%	50.2%
	Claims Cost Ceiling												
0	133.5%												
30,000		139.8%	142.0%	144.1%	146.3%	149.0%	151.7%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
35,000		138.6%	140.4%	142.1%	143.8%	145.5%	147.7%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
40,000		137.7%	139.1%	140.5%	141.9%	143.3%	144.7%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
45,000		137.0%	138.2%	139.3%	140.5%	141.7%	142.9%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%
50,000		136.5%	137.5%	138.5%	139.5%	140.5%	141.5%	133.5%	133.5%	133.5%	133.5%	133.5%	133.5%

	Maintain Stamp Duty (HUC / Age Credit Offset)							Change Stamp Duty (HUC / Age Credit Offset)					
Excess/ Quota Share	0%	30%	40%	50%	60%	70%	80%	30%	40%	50%	60%	70%	80%
	Net Financial Impact												

Appendix G – Administration data collection

Current working draft of administration form for processing HCCP credits from the REF

In order to receive payment for their high cost claims, insurers will need to provide details to the Authority. Outlined below is an initial template for claims which have been paid in respect of hospitalisation/medical treatment occurring in a particular quarter. The corresponding information in respect of the previous 3 quarters should also be provided to enable the Authority to identify if any errors / adjustments to incurred paid claims previously notified to the Authority have arisen, although we would expect that the insurers should highlight and report these to the Authority. The information from the previous three quarters is required to allow for HCCP to be paid based on a rolling 12 month period. For the avoidance of doubt, the schedule of paid claims to be provided by insurers should be based on the date of the provision of health services and not based on the timing of the payment of the claim, although the claim payments should only be included where claims are paid and settled.

Member Details	
Member Number	
Contract Period	
Age attained at the start of the policy year	
Gender	
Product at the start of the policy year	
Level 1,2 or 3+	
Advanced "Y" or "N"	
Quarterly Claim Details (Current quarter)	
Period of Claim (Quarter / Month)	
Total Claim	
Total Returned Benefit	
Annual Risk Equalisation Premium Credit	
HUC credit received	
Quarterly Claim Details (1st prior quarter)	
Period of Claim (Quarter / Month)	
Total Claim	
Total Returned Benefit	
Annual Risk Equalisation Premium Credit	
HUC credit received	
HCCP Credit Received	
Quarterly Claim Details (2nd prior quarter)	
Period of Claim (Quarter / Month)	
Total Claim	
Total Returned Benefit	
Annual Risk Equalisation Premium Credit	
HUC credit received	
HCCP Credit Received	
Quarterly Claim Details (3rd prior quarter)	
Period of Claim (Quarter / Month)	
Total Claim	
Total Returned Benefit	
Annual Risk Equalisation Premium Credit	
HUC credit received	
HCCP Credit Received	

Appendix H: Calibration of the RES

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

Calibration Calculation Approach

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

    - High cost claims pool credits.
- The stamp duty calculation is performed separately for each component part in the above order.
- Age Related Health Credits:
    - The age credits for Advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). These credits apply from ages 65 and over. Claims inflation of 4% per annum is assumed over the term of the projection allowing for some pickup in public hospital claims.
    - The age credits for Advanced cover products are calculated to be the amount necessary so that the net claims cost for no age group from age 65 and over exceeds 133.5% of the average net claims cost for Level 2 contracts.
    - The average net claims costs are adjusted to allow for HUC and HCCP. In simple terms the stamp duty in respect of HUC and HCCP is added to the net claims costs while the credits expected to be received are deducted. Thus the claims cost ceiling applies to the adjusted Level 2 net claims cost amount.
    - When a HCCP is included, the projected average returned benefit reduces as average HCCP for the cohort of lives has been removed from the average returned benefit and as such the Claims Cost Ceiling is applied to a lower amount. The amount of HCCP depends on the level of the quota share and claims excess.
    - The calculated age credits are rounded to the nearest €25.
    - The age credits for Non-Advanced contracts are based on the average claim costs for Non-Advanced products. Adjusted claim costs for Non-Advanced contracts aged 65 and over are calculated by applying the average ratio of Non-Advanced claims costs to Level 2 claims costs for all ages 65 and over combined. The age credits for Non-Advanced contracts are calculated using the same methods as advanced contracts although the results are smoothed due to lack of claims data at older ages.
- Hospital Utilisation Credits:
    - A hospital utilisation credit of €125 would be made for each night that an insured person spends in a hospital. Inflation of 1% per annum in hospital admissions is assumed for all age groups.
    - 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 35% of the rate applying for Advanced contracts.
- The Stamp duty levels incorporate any anticipated surplus or deficit in the Risk Equalisation Fund when all payments into/out of the Risk Equalisation Fund have been made in respect of contracts that commence prior to the start of the period.

Glossary

2021 RES	Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, include advice on Risk Equalisation Credits", September 2020
Act	Health Insurance Acts 1994 to 2020
ARHC	Age Related Health Credits
DoH	Department of Health
DRG	Diagnosis Related Groups
HCCP	High Cost Claims Pool
HIA	Health Insurance Authority
HUC	Hospital Utilisation Credit
Claims Cost Ceiling	The age related credit for an age group is determined such that the average claims cost for that age group after allowing for the impact of the expected utilisation credits, age related credits and the stamp duty required to fund these, would be at most a fixed percentage of the market average claims costs across all age groups.
NFI	Net Financial Impact
Quota share	The percentage of claim which is compensated
RES	Risk Equalisation Scheme
REF	Risk Equalisation Fund
The Authority	Health Insurance Authority (statutory regulator of Irish PMI market)
Threshold	The portion of claims above this amount are eligible for risk sharing within the HCCP
UHI	Universal Health Insurance

References

HIA “Report to the Minister for Health on Evaluation and Analysis of Information Returns for July to December 2018”, May 2019

HIA Report to Department of Health, “Report on Hight Cost Claims Pool”, April 2019

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

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

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