



An tÚdarás Árachas Sláinte
The Health Insurance Authority

Report to the Minister for Health on an evaluation and analysis of returns for 1 July 2011 to 30 June 2012 including advice on risk equalisation credits.

16 November 2012

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Introduction

Requested Report

The Department of Health (“the Department” requested that the Health Insurance Authority provide a Report to the Minister “in anticipation of the enactment of the Health Insurance (Amendment) Bill 2012”. The Department requested that the Report include an evaluation and analysis of Returns for the period 1 July 2011 to 30 June 2012 and the Authority’s conclusions in relation to what credits and stamp duty would be appropriate assuming that the Health Insurance (Amendment) Bill 2012 is enacted as initiated (apart from proposed amendments included in a document circulated at the Health Insurance Consultative Forum on 14 November 2012). The Department requested that the Authority’s conclusions would have regard to the criteria set out in the Bill including the proposed amended section 7E of the Bill, which would provide for Reports to include the following:

- (i) An evaluation and analysis in respect of information returns relating to the period 1 July 2011 to 30 June 2012
- (ii) such matters concerning the carrying on of health insurance business and developments in relation to health insurance generally that the Authority considers ought to be brought to the attention of the Minister (including information in relation to the profitability of any registered undertaking or former registered undertaking where the operation of the proposed relevant financial provisions would be expected to result in a positive cumulative net financial impact on the undertaking)
- (iii) subject to subsection (1A), the amounts of the risk equalisation credits that the Authority considers, after having regard to such evaluation and analysis, would need to be afforded, under the proposed Risk Equalisation Scheme, to persons insured by registered undertakings (other than restricted membership undertakings) having regard to the principal objective (in so far as the principal objective relates to relevant contracts), the aim of avoiding overcompensation being made to a registered undertaking or former registered undertaking under the operation of the relevant financial provisions (other than section 470B of the Taxes Consolidation Act 1997), the aim of maintaining the sustainability of the health insurance market and the aim of having fair and open competition in the health insurance market, and”, and
- (iv) if the amounts referred to in subparagraph (iii) were given effect by a statutory provision, the amount of the stamp duty that the Authority considers, after having regard to the aim of avoiding the Fund sustaining surpluses or deficits from year to year (as calculated using approved accounting standards) and would need to be paid, pursuant to section 125A of the Stamp Duties Consolidation Act 1999, by registered undertakings (other than restricted membership undertakings) in respect of the persons insured by them in order to meet the cost to the Fund of the total of the amounts referred to in subparagraph (iii).

This Report has been agreed by the Members of the Authority.

Date of Commencement of Credits

The analysis and projections in this Report are based on applying the credits and stamp duty to all new / renewing contracts in 2013. On 14 November 2012, the Department of Health informed the Authority that it is now proposed that these credits and stamp duty are to apply for the period 31 March 2013 to 31 December 2013, with 2012 credits and stamp duty applying up to that date. This change does not affect the Authority's conclusions regarding credits. However, due to ageing, it does have a small impact on stamp duty. It would also impact on the projected net financial impact figures.

It was not possible to revise all of the calculations in the Report to reflect the proposed change within the time available. Instead all of the calculations are carried out on the basis of the credits / stamp duty applying for all of 2013, but an adjustment is applied to the stamp duty for the Recommendation in the Summary and Conclusions Section and in Section F.

Section A – Summary and Conclusions

Evaluation and Analysis of Data Received

The evaluation and analysis of returns and of the other data received by the Authority for the twelve months ending 30 June 2012 shows that, after the application of tax credits and the stamp duty for policies renewing in 2012, the net claims cost for older people continues to be significantly higher than the net claims cost for younger people.

The approach adopted for contracts renewing in 2012 was to calculate the tax credit for each age group over the age of 60 to be the greater of the amount necessary to compensate for 65% of the higher claims cost of the age group (based on market claims data) and the amount necessary so that the net claims cost for the age group does not exceed 150% of the market average claims cost (again based on market data).

Review of Market Developments

In the last year, insurers have continued to adopt strategies to segment and select profitable business through differential pricing to targeted groups. This undermines community rating and the principal objective. These strategies have included the maintenance of a large number of plans offering similar benefits but with significant differences in pricing, with lower cost plans being marketed to lower risk groups. Three out of the four open membership insurers also maintain lower cost products with reduced orthopaedic and ophthalmic benefits in private hospitals (for products that cover private hospitals). Few older people are insured on these plans.

In respect of products that mainly cover public hospitals, there is less difference in price between long established products and newer products, although products offering limited maternity cover are significantly lower cost.

Proposed Legislative Changes

It is proposed that, from 31 March 2013, risk equalisation credits will vary by age, gender and level of cover. It is also proposed that a new credit will be introduced, which will be payable in respect of each night spent in a private hospital or in a designated private / semi-private bed in a public hospital.

Date of introduction of credits based on Level of Cover, Gender and bed utilisation

This report was prepared on the basis that the new structure of credits would commence on 1 January 2013. On 14 November, the Department of Health stated that it is proposed that the new credits will apply for policies commencing in the period 31 March 2013 to

31 December 2013 and that the 2012 rates of stamp duty and credits will apply for the period 1 January 2013 to 30 March 2013.

Changes in the periods for which rates apply impact on the calculations in the following ways:

- Due to ageing consumers will, on average, be slightly older over the period 1 January 2013 to 30 March 2013 than over the calendar year 2012, which means that the Risk Equalisation Fund would be projected to make a small loss in respect of the period 1 January 2013 to 30 March 2013 if 2012 rates are applied for this period.
- Likewise, due to ageing, consumers will, on average, be slightly older over the period 31 March 2013 to 31 December 2013 than over the calendar year 2013.
- Due to inflation, average claim rates are likely to be higher over the period 31 March 2013 to 31 December than over the full year 2013

It is considered that the inflationary impact referred to above is small in the context of the assumptions and within the margin of rounding.

The combination of the two ageing effects is more significant and could be addressed by adding less than €5 to the adult stamp duty rates. This adjustment has been included in the recommended stamp duty rates included in the Conclusion section.

Calculation of Risk Equalisation Credits and Levy

The evaluation and analysis of returns received and the review of market developments indicate that it is appropriate to increase total credits payable in respect of older and less healthy people with products that provide substantial cover for private hospitals; this leads to a concomitant increase in the stamp duty for these products. Likewise there is evidence in the data received and in market behaviour that the stamp duty and credits payable in respect of contracts that mainly provide cover for public hospitals should be reduced.

The proposed legislation also provides for credits payable in respect of hospital utilisation. This could be used to provide credits in respect of less healthy people. However, the Authority recognises that such credits, if set too high, could lead to perverse incentives to use hospital services. In this context, the Authority's conclusions provide for this credit to be initially set at €100 per night.

In respect of age and gender credits the Authority's conclusions provide for credits to be payable so that the net claim cost for any age / gender group should not exceed 140% of the average claim cost for the level of cover (net of credits and stamp duty), weighted by the market age / gender distribution. In calculating the credits, credits for "non-advanced" contracts are based on returned benefits for products that primarily provide cover for public hospitals (Level 1 contracts) while the credits for "advanced" contracts

are based on returned benefits for contracts that provide cover for semi private rooms (but not private rooms) in most private hospitals (Level 2 contracts).

In regard to the level of credits, the Authority considered, whether a higher level of credits could be warranted in order to support the Principal Objective. Such a case could be made. However, the conclusions in this Report already provide for a significant increase in credits and in the stamp duty payable for “advanced” contracts and the Authority would be concerned that to apply further increases at this stage could give rise to risks in the context of the sustainability of the market, particularly in the context of the current challenging market conditions.

In deciding on the level of credits, which will apply in respect of the whole market, the Authority has had regard to the claims rates within insurers as well as the market claims rates.

Conclusion

The Authority proposes that the following credits should apply for health insurance policies that are renewed or entered into on or after 31 March 2013. The credits applicable in 2012 are shown for comparison.

Age Bands	Age-related tax credits applied in 2012	Recommended hospital bed utilisation credits for 2013	Recommended age / gender credits for 2013			
			Non-advanced		Advanced	
			Men	Women	Men	Women
59 and under	€ NIL	€100				
60-64	€600	€100	€175	€125	€400	€275
65-69	€975	€100	€450	€250	€1,025	€725
70-74	€1,400	€100	€750	€475	€1,625	€1,075
75-79	€2,025	€100	€1,250	€700	€2,275	€1,700
80-84	€2,400	€100	€1,600	€1,300	€3,150	€2,125
85 and above	€2,700	€100	€1,600	€1,300	€3,150	€2,125

The Authority considers that the stamp duties that would need to be paid by the insurers of policies that are renewed or entered into between 31 March 2013 and 31 December 2013 in order to meet the cost to the Risk Equalisation Fund of the risk equalisation credits are as follows:

Age Bands	Stamp duty applied in 2012	Recommended stamp duties for 2013	
		Non-advanced	Advanced
17 and under	€ 95	€ 63	€120
18 and over	€285	€190	€360

Allowing for the impact of Budget 2013

The December Budget may make some changes to how private patients are charged for utilising public hospitals. As the Authority is not aware of what measures may be applied and how they will interact with the Health Insurance (Amendment) Bill 2012, the figures in this Report have not allowed for any such changes or for the impact on credits, bed usage or stamp duties.

The Authority considers that each additional €10m charged to insurers by public hospitals for policies renewing in 2013 will increase average claims costs, age credits and stamp duty for Non-Advanced Cover contracts by approximately 1.1% and for Advanced Cover contracts by approximately 0.6%. This assumes that total charges and total utilisation of “designated” beds increase at the same rate.

The figures in the above paragraph do not allow for second order effects that increased charges in respect of public hospitals may have on, the market profile (in terms of age gender and health status) or on the split between non advanced and advanced contracts, product design or market activity.

Net Financial Impacts

The calculations of net financial impact are based on credits and stamp duty applying for the whole of 2013 and are also based on the stamp duty before the application of the adjustment to reflect the impact of postponing the commencement date of the credits, although, the impacts of these two factors will largely cancel each other out in terms of their effects on the Net Financial Impacts.

	Aviva €m	Laya €m	Vhi €m	Fund €m
Credits				524
Stamp Duty				524
Net benefit				-

These figures are an estimate of the credits and stamp duties that would be payable to / by each insurer in respect of policies commencing in 2013 and are based on the projected memberships described in Section E of this report. In particular, this means that there is

no figure shown for GloHealth as there was no projection of its membership. This is because it did not start trading until 1 July 2012 and, therefore, no data in relation to its experience or membership has been received.

In practice, GloHealth would pay stamp duties and receive credits in respect of its policies that commence or renew in 2013. On the assumption that the entry of GloHealth into the market does not change materially the overall market size or the membership profile, the impact would be to reduce the stamp duties and credits payable/receivable by those insurers who lose members to GloHealth, with a corresponding increase in the amounts for GloHealth.

The net financial impact on the Risk Equalisation Fund is sensitive to mid-policy year cancellations / rewrites where a full year's stamp duty arises but only a proportion of the tax credit applies. It is also sensitive to the rate of ageing of the insured population, which in turn is impacted by the rate of growth / decline in the market. The Authority has assumed that the number insured will continue to decline at the same rate as it declined over the past 12 months and that the decline will occur in the same age groups. Accordingly, the Authority estimates that the market will decline by a further approximately 90,000 between 1 July 2012 and 1 January 2014. However, due to current economic circumstances, there is considerable uncertainty in relation to this assumption.

The extent to which the Risk Equalisation Fund is cost neutral for 2013 renewals will depend on how closely the assumptions made in this report are borne out in practice. If 50,000 people with non-advanced contracts more than projected left the health insurance market by the end of 2013, there would be a negative impact on the Fund of approximately €9m.

Similarly if 50,000 younger members with advanced cover contracts more than projected were to downgrade their contracts to non-advanced Cover this would result in a loss to the Fund of approximately €9m. There is particular uncertainty in relation to how the market split between advanced and non-advanced contracts may develop. This is because the changes in stamp duties and potential budgetary measures are likely to significantly impact on relative incentives between these sectors of the market and it is not possible to predict with confidence how insurers and consumers may react to these substantial changes.

The projections for individual insurers are sensitive to developments in each insurer's age profile, which can be influenced by product or pricing strategy or by developments in one particular insurer and it is not possible to predict many of these factors. As such, projections of the net financial impact on individual insurers are subject to considerable uncertainty and should be viewed as indicative only.

Sustainability of the market

There is a conflict between the maintenance of the Principal Objective (community rating) and the sustainability of the health insurance market. The recommendation of the Authority has taken account of these conflicting objectives along with the evaluation and analysis of returns, avoiding overcompensation and the maintenance of fair and open competition in the market.

In the year from 1 July 2011 to 1 July 2012 the number of people aged 18 -29 with private health insurance fell from 267,720 to 241,221 a reduction of 10%. This trend has been evident for a number of years and reflects, in part, a decision by some in this age group to opt out of private health insurance. This trend is threatening to undermine the intergenerational solidarity that supports community rating. Measures that could help to mitigate this risk are:

- Lifetime Community rating could be introduced allowing insurers to charge people over the age of 30 taking out health insurance for the first time a loading based on the age at which they take out private health insurance.
- At present insurers are allowed offer full time dependent students between the age of 18 and 23 discounted premiums. Insurers normally give the discounts to those aged 18-21. To incentivise young adults to take out private health insurance in their own right, insurers could be allowed the option of charging adults aged 18-29 discounted adult rates. As an example, a permitted discount of 15% of the adult rate applicable to people of the age 18-29 not in receipt of a student discount would not impact on the Authority's recommendations in this Report.

Other Regulatory Measures

This Report is focused on supporting community rating by enhancing the risk equalisation system. While this is critical in order to support community rating and address the market strategies of segmentation and selection referred to herein, other regulatory measures are also necessary to support a community rated market, including strong minimum benefit and open enrolment regulations. Such measures may also include further rules relating to the products that may be provided, information and notice requirements and measures to encourage younger people to purchase health insurance.

Section B. Evaluation and Analysis of Returns and other Data Requested

Information Returns

Half-yearly returns for the July to December 2011 and January to June 2012 periods were received from Aviva Health Insurance Ireland Ltd (trading as Aviva Health), the Voluntary Health Insurance Board (trading as Vhi Healthcare) and Quinn Insurance Ltd (under administration). In addition, a return for the period January to June 2012 was received from Elips Insurances Ltd (trading as Laya Healthcare). The returns were accompanied by independent accountants' reports and analyses of the differences between total claims paid and prescribed benefits.

Quinn Insurance Ltd (under administration) has ceased writing new business with effect from 1 May 2012. At their renewal dates, Quinn's customers are being invited to renew contracts with Laya Healthcare. In the analysis for this report, combined numbers for Quinn and Laya have been given as these are more comparable with those for other insurers. However, separate figures for Quinn and Laya have also been given where relevant. Both Quinn and Laya policies are now administered and marketed by Laya Healthcare Ltd.

Returns were not required or received from BUPA Insurance Ltd as it was not a registered undertaking during the periods even though it is still settling a small amount of claims incurred in previous periods. Returns were not applicable for Great Lakes UK Ltd (using the brand GloHealth) as it started selling health insurance policies on 1 July 2012.

This Report is, to a significant extent, based on the information returns received under the Health Insurance Act 1994 (Information Returns) Regulations 2009, as amended, for the two 6-month periods commencing on 1 July 2011 and on 1 January 2012. Where appropriate, account has also been taken of data submitted for earlier periods.

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

- Benefits relating to services provided other than by a hospital or a hospital consultant.
- Benefits relating to services otherwise excluded from the definition of "Returned Health Services", such as outpatient benefits.

The prescribed benefits are the same as the returned benefits except that they further exclude any amount of benefit exceeding the maximum prescribed benefit levels set out in the Regulations.

Membership Profile

Market Size

The following table sets out membership details and market shares of insurers. The data is taken from returns for the first half of 2011, the second half of 2011 and the first half of 2012.

Insurer	01-Jul-11		01-Jan-12		01-Jul-12	
	Members 000s	Market share (%)	Members 000s	Market share (%)	Members 000s	Market share (%)
Aviva Health	363	17.8	376	18.6	367	18.5
Vhi Healthcare	1,231	60.2	1,202	59.5	1,179	59.4
Quinn	450	22.0	443	21.9	363	18.3
Laya	-	-	-	-	75	3.8
Quinn/ Laya combined	450	22.0	443	21.9	438	22.1
Total	2,044		2,021		1,985	

Overall, the total number of insured persons fell by about 60,000 in the 12 months ended June 2012. Most of this decline can be attributed to Vhi Healthcare, whose membership decreased by 52,000 over the same period. Membership changes were relatively small for Aviva Health and for Quinn/Laya combined. It is also apparent that the sharp growth in Aviva Health's membership, which grew by 100,000 in the year ended June 2011, has come to an end.

As of end June 2012, 46.3% of the Irish population are estimated to have had private health insurance compared to 48% in June 2011.

Vhi Healthcare's market share has consistently fallen since the market was opened to competition although the rate of decline has reduced in the year to June 2012. The fall in market share has mainly been in the younger age groups.

Gender profile of insurers' members

The gender distributions of the memberships of the three insurers for the period January to June, 2012 are set out in the table below. The proportions in each gender for each insurer have remained relatively static for some time.

Gender	Aviva Health	Vhi Healthcare	Quinn Healthcare	Laya	Quinn and Laya combined
Male	48%	48%	49%	48%	49%
Female	52%	52%	51%	52%	51%

Age Profile of Insurers Members

The age distribution (average for the period January to June, 2012) of each insurer's membership is shown in the following table. The figures shown in brackets are the corresponding averages for the period January to June 2011.

Age Group	Aviva Health	Vhi Healthcare	Quinn/Laya combined	Market
0-17				24.2% (24.1%)
18-29				12.3% (13.3%)
30-39				16.2% (16.7%)
40-49				15.3% (15.2%)
50-54				7.0% (6.9%)
55-59				6.5% (6.3%)
60-64				5.8% (5.6%)
65-69				4.8% (4.4%)
70-74				3.3% (3.1%)
75-79				2.3% (2.2%)
80+				2.3% (2.1%)

Vhi Healthcare continues to have a much greater proportion of members in the age groups 70-74 and older compared to the other insurers, but the difference is reducing.



Over the past year, for each insurer and for the market, the percentage of insured persons in the older age groups has increased.

Claims Profile

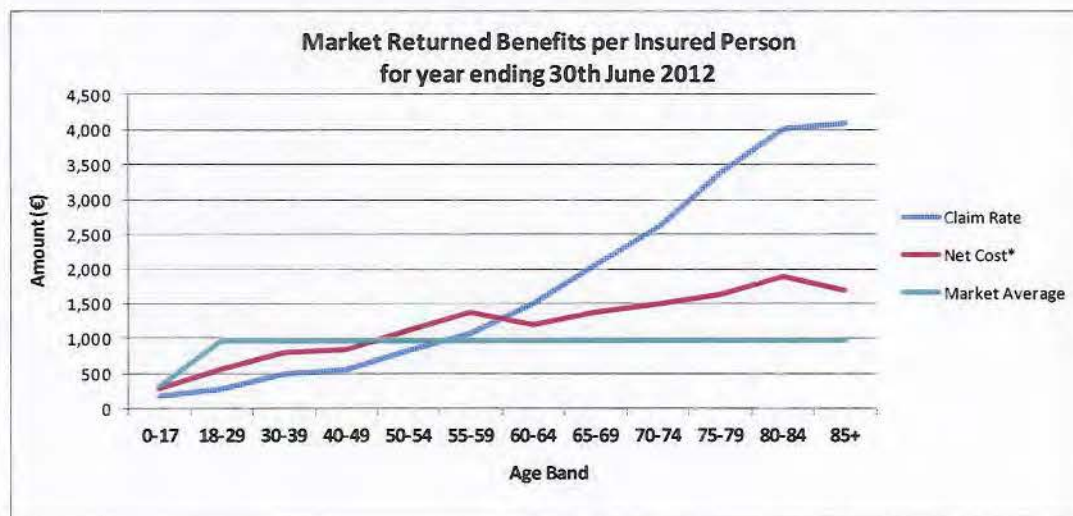
Proportion of claims included in returns:

The benefits included in information returns (described as “returned benefits” and “prescribed benefits”) as a percentage of total benefits paid for the second half of 2011 and for the first half of 2012 are set out in the table below

Insurer	July-Dec 2011		Jan-June 2012	
	Returned benefits	Prescribed benefits	Returned benefits	Prescribed benefits
Aviva Health				
Vhi Healthcare				
Quinn				
Laya				
Quinn and Laya combined				

Average claim per member

The information returns provide the returned benefit for each age and gender for each insurer for the second half of 2011 and the first half of 2012. The average returned benefit per insured person (i.e. the claim rate) for each age group and for the market is calculated from these returns and increases with age group.




* Net Cost is defined as average returned benefit plus stamp duty less age related tax credit for 2012 renewals.

The preceding chart shows the impact the 2012 age related tax credits and stamp duty would have on claim rates for the 12 months ending June 2012 for the market as a whole.

It should be noted that the 2012 age related tax credits apply for the policy year from the renewal date in 2012 while the market returned benefits are for the year ending June 2012. The net cost is lower than the market average claim rate for all age groups up to age 55-59 and higher than the market average claim rate for all age groups from age 60-64 and above. After application of the 2012 age related tax credits and stamp duty, the net costs for older age groups remain significantly higher than for younger age groups (e.g. the net cost for those aged 80-84 is 3.3 times that for age group 18-29). This means that insurers continue to have a significant incentive to attract younger customers and avoid older customers.

The following chart shows the average net cost (i.e. returned benefit adjusted for stamp duty and age related tax credit) per insured person by age range for each insurer for the twelve months to end June 2012.



Further analysis of the information returns for July to December 2011 and January to June 2012 is in Appendix 1.

Results by level of cover

Note on Terminology

In analysing returns, the Authority split data into levels of cover.

- Level 1 products provide cover mainly in public hospitals,
- Level 2 products provide substantial cover in private hospitals but this cover is mainly provided for semi-private accommodation
- Higher levels of cover relate to products that provide cover for private accommodation in private hospitals.

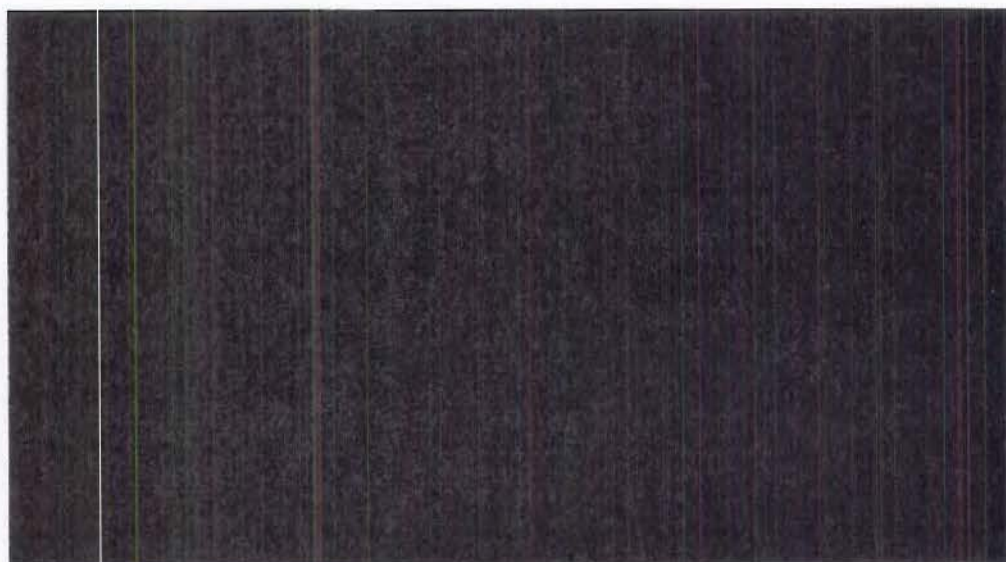
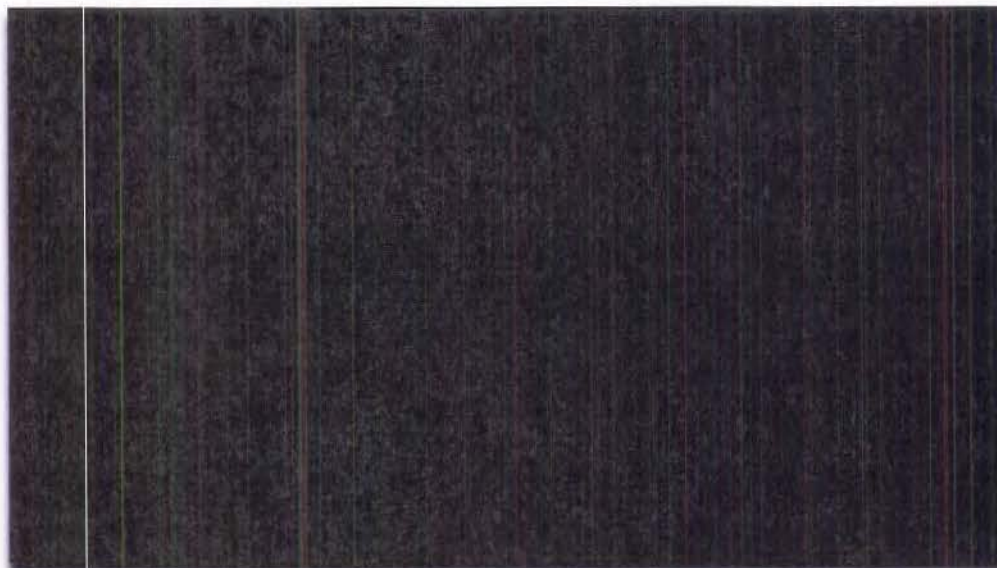
The Report also refers to Non-advanced and advanced contracts. These are references to definitions proposed to be included in the draft Bill. A contract considered to be "Level 1" may or may not fall within the legal definition of a Non-advanced contract (although there is an assumption later in this Report that if a Level 1 contract did not fall within the definition of a Non-advanced, in the main the insurer would amend the contract to come within the terms of the definition in order to qualify for the lower stamp duty).

Level 2 contracts and Higher contracts would all be "Advanced" contracts under the proposed definition.

Since 1 July 2011, the Information Returns also show benefits broken down by individual product. This data was used to break down the level of claims costs by the level of cover, so that products that contain significantly different levels of benefit can be looked at separately.

The data for products that offer similar levels of hospital cover was grouped by the Authority. The following charts show the average levels of returned benefits per insured

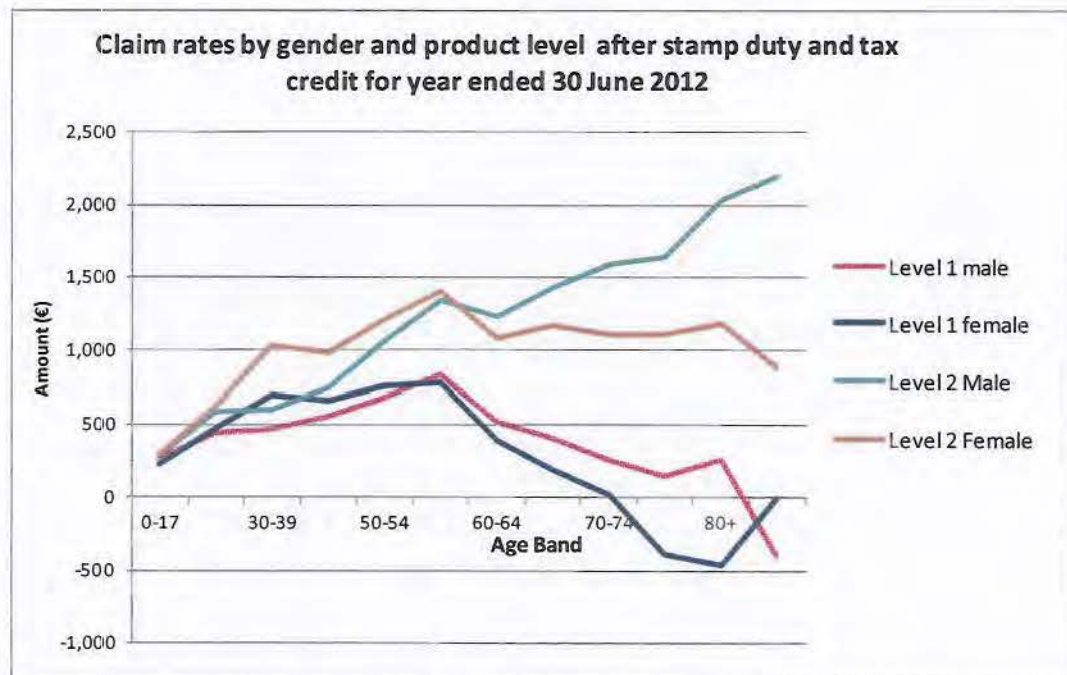
person for the year ending 30 June 2012 in respect of Level 1 only cover contracts (contracts mainly providing cover for public hospitals) and Level 2 cover contracts (contracts also providing cover for a semi private room in most private hospitals in addition to cover for public hospitals).



varying from 21% to 128% depending on age range. Claim costs for women with Level 2 type products are consistently higher than for corresponding Level 1 products with the percentage difference varying from 37% to 124% depending on age range. For men the percentage difference is lowest at the younger ages and for women the difference is lowest at the oldest age. Average male costs are higher than female costs for older ages for both Level 1 and Level 2 contracts but are smaller at younger adult ages.

Impact of 2012 Tax Credits on different market segments

The chart below shows the impact of the 2012 age related tax credits and stamp duties on the net claims by age for Level 1 and Level 2 products and men and women.



For Level 2 products the net cost generally increases with age for men although for women it broadly stabilises after age 55-59.

The Net Cost for Level 1 products reduces as age increases beyond age 55 and becomes negative at the highest age groups for both men and women.

Section C - Financial Data

Profitability of Insurers

The profitability of insurer's private health insurance business in 2011 is set out in the following table. These figures were provided by insurers to the Authority pursuant to its work in relation to assessing whether overcompensation occurred in 2011. The accounts of Vhi Healthcare and Aviva Health were certified by independent accountants. To date, Quinn Healthcare's accounts have not been certified by independent accountants. The accounts below may differ from published accounts, which may have been finalised on a different date and may include business other than private health insurance business.

	Aviva Health 12 months to end Dec 2011	Quinn Healthcare 12 months to end Dec 2011	Vhi Healthcare 12 months to end Dec 2011
Earned premiums before reinsurance and age related tax credit	€ 270.5m	€323.6m	€1,295.8m
Age related tax credits less levy earned in year	(€24.8m)	(€33.3m)	€41.1m
Claims incurred before reinsurance	(€221.6m)	(€265.8m)	(€1,216.1m)
Claims ratio (Gross of tax credits and levy)	81.9%	82.1%	93.8%
Claims ratio (Net of tax credits and levy)	91.1%	92.4%	90.7%
Expenses & reinsurance	(€13.6m)	(€ 32.4m)	(€ 98.1m)
Expenses & Reinsurance as % Earned Premiums	5.1%	10.0%	7.6%
Underwriting result	€ 10.5m	(€ 7.9m)	€ 22.7m
Underwriting profit as % earned premiums	3.9%	(2.4%)	1.8%
Impact of Investments	€ 2.0m	€15.2m	(€ 23.5m)
Profit before tax	€12.5m	€ 7.3m	(€ 0.8m)

Gross of the age related tax credits and stamp duty, Vhi Healthcare's claims ratio of 93.8% is significantly higher than Quinn Healthcare (81.9%) and Aviva Health (82.1%).

Net of age related tax credits and stamp duty, Vhi Healthcare's claims ratio of 90.7% is similar to Quinn Healthcare (91.1%) and to Aviva Health (92.4%).

Estimated Net Financial Impact of the Stamp Duty and Tax Credits

The Authority is required to assess the net financial impact on each registered undertaking of the relevant financial provisions in respect of the Relevant Periods. "Net Financial Impact" is not defined in the legislation, but "cumulative net financial impact" is defined as the difference between:

- The total amount of age related tax credits recorded in accounts for that undertaking in respect of that period and
- The total amount of the stamp duty recorded in accounts for that undertaking in respect of that period.

At the request of the Authority, insurers supplied estimates of the net financial impact of the current levels of tax credits and stamp duty in respect of 2012 and actual net financial impact in respect of 2009 to 2011. It should be noted that insurers' estimates are based on their view of membership figures over the full 2012 calendar year and on their methods of accounting for age related tax credits and stamp duty. The Authority considers that the figures provided, which are summarised in the following table, form the best available basis for assessing the net financial impact as required by the legislation. The Authority's assessment is that the net financial impact in the second half of 2011 and the first half of 2012 combined would be approximately half of the amounts shown in the 2011 and 2012 columns in the table.

		Net Financial Impact 2009	Net Financial Impact 2010	Net Financial Impact 2011	Estimated Net Financial Impact 2012	Estimated Net Fin Impact 1/7/11 – 30/6/12
Aviva Health						
Laya/Quinn Healthcare						
Vhi Healthcare						
Total						

[REDACTED]

The tax credits and stamp duty included in insurers accounts to the end of 2011, in aggregate, have a negative net impact of €25m on insurers' financial results. This amounts to approximately 2% of the stamp duty incurred over the 3-year period. This is a slightly larger impact than would have been anticipated on the basis of the Authority's projections, which would indicate an aggregate net impact of €10m to €15m for the 3-year period, arising from the higher stamp duty applied in 2010 (estimated impact €5m) and the [REDACTED]

[REDACTED]

For 2012, insurers have, in aggregate, projected a negative net impact on insurers' financial results of €17.5m, although it should be noted that these are based on projections and, in the past, the amounts included in accounts have varied significantly from initial projections.

It is to be expected that the impact on the Exchequer will vary from the Authority's projections as a result of differences between the projected insured population and the actual insured population. Other factors, not provided for in the Authority's calculations, including normal mid-term cancellations (including deaths) and switching, will also impact on the net transfers and are likely, on balance, to benefit the Exchequer.

The 2011 tax credits have a financial impact in 2011 and 2012. Likewise the 2012 tax credits have a financial impact in 2012 and 2013. Consequently, the actual cash outturn for policies commencing in 2011 and 2012 will not be available to the Revenue Commissioners until all associated tax credits have been disbursed (end 2012 and 2013 respectively).

Section D. Review of Market Developments and Discussions with Insurers

Price changes in the Market

The most significant general price increases made by insurers in the last year are set out below. There were also a large number of other price changes, each affecting a small number of plans.

- On 22 November 2011, Vhi Healthcare increased the cost of 42 plans by an average of 1.9%.
- The premiums of 16 Vhi Healthcare PMI plans were increased in December 2011 or January 2012 ranging from 1.4% to 15%.
- In March 2012, Vhi Healthcare increased its prices 6% to 12.5% depending on the plan.
- Quinn Healthcare increased the premium on 19 plans on 1 January 2012 by 7% - 25%. Its corporate plans increased on 1 February 2012 by 2% - 25%.
- Aviva Health increased its premiums by 15% from 15 February 2012 for individual plans and from 1 March for corporate plans.
- Quinn Healthcare increased the premiums on the majority of its plans by 6.5% on 1 March 2012
- Aviva Health increased its premiums by 2.7% on 16 May 2012 for all plans except the Level 2 Hospital plan suite.
- Aviva Health increased its premiums by 4% - 7% depending on plan on 15 October 2012.
- Vhi Healthcare are increasing its premiums on 22 November 2012 by 3%

Prices paid by consumers are impacted both by the price increases applied by insurers and by the actions of consumers. The number of consumers switching plans has increased in recent years. In the main consumers have been switching to lower cost plans. In some cases this involves a reduction in the level of cover, while in other cases it involves consumers switching to lower cost plans providing similar benefits.

In the 12 months to 30 June 2012, the average premium paid by consumers was €983, which represents an increase of 9.5% on the average premium paid in the 12 months to 30 June 2011 (€897). Net of tax relief, the average premiums were €786 for the 12 months ending 30 June 2012 and €718 for the 12 months to 30 June 2011.

Product developments

Level 1 Products

Level 1 products (i.e. products that mainly provide cover in public hospitals) make up c. 16% of the market. As can be seen from the analysis in the previous section, with the current level of age related tax credits and stamp duty, the net claims costs for older consumers of Level 1 products is lower than the net claim costs for younger consumers.

In the younger adult age ranges, males have a lower net claims cost than females. Insurers are therefore incentivised to target young male customers with products that offer minimal maternity benefits.

Other Products

The analysis in the previous section also shows that, in all other products, with the current level of age related tax credits, the net claims costs for older consumers on average continue to be higher than net claims costs for younger consumers with the result that younger consumers are on average profitable, while older consumers are on average unprofitable. Insurers are thereby incentivised to use various marketing and other strategies to target profitable segments of the market. Product developments and special offers in the period have reflected these incentives. Newer products offering better value than existing comparable products are marketed to new customers. Product developments have tended to concentrate on providing cover attractive to younger healthier customers but less attractive to older less healthy customers. While open enrolment means that anyone can buy any product, the marketing and product strategies adopted are resulting in extensive product segmentation in the market. This is evidenced in the behaviour of insurers, all of which have introduced a range of corporate plans at more competitive prices aimed at particular segments of the market.

Features of the market in the last twelve months have been:

- Large price increases - over 20% in many cases.
- Reduced orthopaedic and ophthalmic benefits in private hospitals becoming widespread.
- Corporate plans that are not marketed or offered to individual customers.
- Insurers have all introduced penalties for stopping policies during a policy year reflecting the fact that a full year's stamp duty liability is incurred even if a policy is terminated during a policy year.
- Special offers that give discounted or free cover to children.

Product developments continue to proliferate. On 22 October 2012 there were a total of 221 inpatient private health insurance plans in the market.

As result of these strategies, health insurance is currently being provided to different market segments at significantly different prices to an extent that, in the Authority's view, is tending to undermine community rating and, therefore, the achievement of the Principal Objective.

Other Regulatory Measures

This Report is focused on supporting community rating by enhancing the risk equalisation system. While this is critical in order to support community rating and

address the market strategies of segmentation and selection referred to herein, other regulatory measures are also necessary to support a community rated market, including strong minimum benefit rules and open enrolment. Such measures can also include further rules relating to the products that may be provided, information and notice requirements and measures to encourage younger people to purchase health insurance.

Product Comparisons

The table below compares the prices of older plans with the prices of newer plans, many of which are, in practice, only sold to a segment of the population.

Lower Cover Plans (Level 1)				
		Older Individual Plan	Similar Newer Plan with significant maternity	Newer plan with minimal maternity
Vhi Healthcare		€783.75 One Plan Access Plus	No significantly better value option	€524.80 One Plan Starter
Laya Healthcare		€691.93 Essential	No significantly better value option	€485 Essential First
Aviva Health		€807 Level 1 Hospital	No significantly better value option	€613 Health Starter

Standard Cover Plans (Level 2)			
		Older Individual Plan	Newer Plan
Vhi Healthcare		€1643.57 HealthPlus Extra	€ 830 Company Plan
Laya Healthcare		€1240.14 Essential Plus with Excess	€811 Health sense Excess
Aviva Health		€1383.60 Level 2 Hospital	€934 Family Value

While there are differences in the products being compared in the preceding tables (e.g. private hospital excesses, restrictions on orthopaedic cover in private hospitals and outpatient benefits), in the view of the Authority the products being compared are broadly similar.

Discussions with insurers

The Authority staff met with insurers to hear their views on what age related tax credits should apply for 2013 renewals and to ascertain their views on the assumptions that the Authority should apply in its projections. A summary of their views are set out below.

Aviva Health

[illegible]

GloHealth



Laya Healthcare



[REDACTED]

[REDACTED]

[REDACTED]

Vhi Healthcare

[REDACTED]

[REDACTED]

Section E – Projections

Retrospective review of projections in 2011 Report regarding 2012 tax credits

Review of Membership Projections in the Authority's 2011 Report

In the 2011 Report the Authority projected that the change in the age profile of the market in the year ending June 2011 would continue at the same pace over the next 18 months. The following table compares the projected open enrolment market at 1 July 2012, as set out in last year's report, with the actual market as at 1 July 2012 and the percentages of the total market for each age group.

Membership for the Market as of 1 July 2012			
Age Group	Actual	Projected	Net Difference
Aged 17 and under	486,020 (24.5%)	486,051 (24.4%)	-31
Aged 18 to age 29	241,221 (12.2%)	239,898 (12.0%)	1,323
Aged 30 to age 39	321,156 (16.2%)	324,778 (16.3%)	-3,622
Aged 40 to age 49	304,060 (15.3%)	304,534 (15.3%)	-474
Aged 50 to age 59	267,276 (13.5%)	268,942 (13.5%)	-1,666
Aged 60 to age 69	208,894 (10.5%)	211,677 (10.6%)	-2,783
Aged 70 to age 79	111,185 (5.6%)	112,492 (5.6%)	-1,307
Aged 80 and over	44,760 (2.3%)	45,152 (2.3%)	-392
Total	1,984,572 (100.0%)	1,993,524 (100.0%)	-8,952

The above table shows that the insured population for 1 July 2012 that was projected in 2011 is only c. 0.5% higher than the actual population at that date.

The projected age profile of the insured population, rather than the total size of the insured population, is the key assumption in deriving the age related tax credits and stamp duty and this is very much in line with the Authority's projection.

Review of Claims Inflation Assumptions in the Authority's 2010 Report

In its 2011 Report, the Authority assumed that, within age-bands prescribed benefit per insured person would increase by 6% over the two year period of the projection and that the ageing of the market would contribute a further c. 6% to claims inflation over the two year period. In addition, it was assumed that the budget 2012 announcement in December 2011 in relation to charging for private patients utilising public beds in public hospitals would result in an increase of 10% in claims costs for policies commencing / renewing in 2012. Accordingly, the 2012 credits and stamp duty assume that the average market claim would increase by c. 24% over the (on average) c. two year period from the 12 months ending 30 June 2011 to the 2012 policy year.¹

One year has now elapsed since these projections. This subsection reviews how claims rates have changed over the year.

The change in the average prescribed benefit per insured person from the twelve month period ending in June 2011 to the twelve month period ending in June 2012 for each insurer and for the market is shown in the following table.

Age Group	Aviva Health	Quinn/Elips	Vhi	Market
0-17				13%
18-29				15%
30-39				9%
40-49				6%
50-54				9%
55-59				4%
60-64				9%
65-69				7%
70-74				5%
75-79				10%
80+				15%
All Ages				12%

The 'all ages' percentages are impacted by the ageing of insurers' portfolios which would contribute about 3% to the 'all ages' inflation costs.

The "Market" column shows that market inflation is in line with the projection of an increase of c. 24% over two years. However, it is important to note that the Authority's projection included a significant allowance for increased costs arising due to charging for public beds and this has not been implemented. General age specific inflation has been much higher than projected by the Authority over the period. While the Authority had projected that general age specific inflation (excluding ageing) would be c. 3% over the year, in fact it was 9%.

¹ The centre point of the 12 month period ending 30 June 2011 is 31 December 2010, while the centre point of policies commencing in 2012 was assumed to be c. 31 December 2012.

There are significant variations in the increases between insurers and between different age groups for each insurer.

Projections for 2013 Tax Credits

Projected age profile of market in 2013

The number of insured lives at 1 July 2011 is taken from the returns for January to June 2011. The age definition for these returns is age attained at 1 January 2011. The population at 1 July 2012 is taken from the returns for January to June 2012. The age definition for these returns is age attained at 1 January 2012.

OPEN ENROLMENT MARKET				
		01-Jul-11	01-Jul-12	Net Diff
Aged 17 and under		497,919	486,020	-11,899
Aged 18 to age 29		267,720	241,221	-26,499
Aged 30 to age 39		340,372	321,156	-19,216
Aged 40 to age 49		310,949	304,060	- 6,889
Aged 50 to age 54		140,577	138,286	-2,291
Aged 55 to age 59		129,635	128,990	-645
Aged 60 to age 64		115,479	114,511	-968
Aged 65 to age 69		90,569	94,383	3,814
Aged 70 to age 74		63,854	65,294	1,440
Aged 75 to age 79		43,967	45,891	1,924
Aged 80 to age 84		26,184	27,407	1,223
Aged 85 and over		16,319	17,353	1,034
Total		2,043,544	1,984,572	-58,972

The Authority considers that the economic and other factors that impacted on the health insurance market in the year ending June 2012 will continue to have an impact over the next year. The scale and timescale of the economic downturn makes it particularly difficult to make predictions about the size and age profile of the health insurance market. While the total market size is not a critical factor in balancing the financial impact of credits and stamp duty, the forecast age profile is important. The Authority has assumed that the changes in age profile over the twelve months to June 2012 will continue at the same pace for the next 18 months for the market as a whole and by level of cover. The resulting numbers are set out in the table below.

	PROJECTED MARKET
	01-Jan-14
Aged 17 and under	468,172
Aged 18 to age 29	201,473
Aged 30 to age 39	292,332
Aged 40 to age 49	293,727
Aged 50 to age 54	134,857
Aged 55 to age 59	128,015
Aged 60 to age 64	113,098
Aged 65 to age 69	100,065
Aged 70 to age 74	67,480
Aged 75 to age 79	48,752
Aged 80+	48,146
Total	1,896,114

It is important to note that this projection assumes that there is no major shock to the market during the period of the projection. The arrival of GloHealth into the market in July 2012 is not anticipated to change the total size of the market as it is expected that its sales will predominantly be switches from the existing underwriters.

When projecting the market of non-advanced cover contracts, the Authority uses the population of "Level 1" cover contracts (i.e. contracts that mainly provide cover in public hospitals) as a base. While it is recognised, that many of these products would not be classified as "non-advanced" under the currently proposed definition, it is anticipated that insurers will amend such products in order to be classified as "non-advanced" and to qualify for the lower stamp duty. The methodology adopted to project the market of Non-advanced cover contracts to 1 January 2014 is similar to the methodology previously applied for the market as a whole. The number insured by these plans as at 1 July 2011 was 325,843 while at 1 July 2012 it was 308,851. This reducing trend is assumed to continue until 1 January 2014.

	PROJECTED MARKET
	01-Jan-14
Aged 17 and under	58,645
Aged 18 to age 29	42,580
Aged 30 to age 39	58,795
Aged 40 to age 49	48,923
Aged 50 to age 54	19,739
Aged 55 to age 59	18,010
Aged 60 to age 64	14,835
Aged 65 to age 69	10,075
Aged 70 to age 74	5,703
Aged 75 to age 79	3,341
Aged 80+	2,719
Total	283,363

Projected Returned Benefit for each insurer

The claims costs for the twelve months to end June 2012 are used as the base figures in order to reduce the impact of seasonality on claims paid and also the impact of random fluctuations.

For each age group, the average returned benefit per insured person for the year ending June 2012 was calculated for each insurer and for the market. Products were categorised as Level 1 contracts if they primarily provide cover in public hospitals. Level 2 average claim costs were based on the claims data for products categorised as providing cover for a semi private room (but not a private room) in private hospitals. Figures for ages over 80 were combined due to the small volumes of data when broken down by product/gender. The average returned benefit across all ages was also calculated (giving a one third weighting to the 0 -17 age group). The claim figures for the twelve months ending 30 June 2012 are as set out in the following tables.

Male Level 1

Age Group	Aviva Health €	Laya/Quinn €	Vhi €	Weighted Market Average €
0-17				164
18-29				155
30-39				179
40-49				258
50-54				390
55-59				546
60-64				822
65-69				1,087
70-74				1,364
75-79				1,881
80+				2,243
All Ages				386

Male Level 2

Age Group	Aviva Health €	Laya/Quinn €	Vhi €	Weighted Market Average €
0-17				198
18-29				295
30-39				315
40-49				460
50-54				764
55-59				1,059
60-64				1,541
65-69				2,121
70-74				2,702
75-79				3,382
80+				4,294
All Ages				864

Female Level 1

Age Group	Aviva Health €	Laya/Quinn €	Vhi €	Weighted Market Average €
0-17				133
18-29				194
30-39				416
40-49				373
50-54				472
55-59				498
60-64				705
65-69				883
70-74				1,125
75-79				1,341
80+				1,962
All Ages				434

Female Level 2

Age Group	Aviva Health €	Laya/Quinn €	Vhi €	Weighted Market Average €
0-17				190
18-29				337
30-39				743
40-49				692
50-54				917
55-59				1,116
60-64				1,397
65-69				1,862
70-74				2,219
75-79				2,840
80+				3,297
All Ages				974

The figures show an increasing trend by age with the market average claims rates for age groups from age 55+ exceeding the weighted market average for “All Ages”. Level 2 costs and male costs are normally higher than Level 1 costs and female costs for each age range. The average claims cost across all ages is higher for females than for males due to the higher proportion of older lives in the female insured population.

Claims rates differ between insurers. Such differences may arise for a number of reasons, including differences in health status, differences in product mix and benefits provided, the proportion of people serving waiting periods, differences in the way business is conducted and differences in the rate of growth of insurers’ memberships.



Insurers were asked for their views on the expected increase in the average returned benefit per insured person for their portfolios. Having regard to the responses received and recent experience, the Authority considers that a reasonable method for projecting the average returned benefit per insured person for renewals in 2013 would be to apply an inflation factor of 5% per annum (for the two years of the projection) to the age specific market claims cost per insured person for the twelve months to end June 2012. The same level of claims inflation rate of 5% per annum has been assumed across insurers/age groups / gender and level of cover. As the projected ageing of the insured population will

contribute an additional increase of 3% p.a. in the average claims costs, the overall increase in average claims cost is anticipated to be approximately 8% per annum.²

This figure does not take account of the potential impact of any measures in the Budget 2013 that may impact on the private health insurance market.

Hospital Bed Utilisation

Information returns include details of the number of hospital inpatient days that insurers paid for in respect of their customers. Admissions, on a day case basis, are classified as a duration of 1 day. The total number of days paid for by the open membership undertakings in the last two years are as follows:

	000's
Second Half 2010	794
First Half of 2011	764
Second Half 2011	808
First Half 2012	779

There appears to be some seasonality in these figures with higher bed utilisation in the second half of a year than in the first half of the year. The numbers tend to increase year on year.

The Draft Health Insurance (Amendment) Bill 2012 provides for a hospital bed utilisation credit in respect of each overnight stay in a hospital bed in private hospital accommodation. The Authority asked insurers to split the data on hospital utilisation in their information returns for the January to June 2012 time period into those relating to overnight stays and those relating to admissions on a day case basis. The following table shows the split for the January – June 2012 time period.

000's	In Patient	Day case	Total
Aviva Health			
Laya / Quinn Healthcare			
Vhi Healthcare			
Total			

² These assumptions are under review in light of discussions with the insurers and the Department. The effect of an increase of x% to these assumptions would be to increase the age credits and stamp duty by around 2x%.



The number of inpatient days has been assumed to grow by 1% per annum for each insurer, age group, gender and product level.

Section F. Credits and stamp duty for policies commencing in 2013

Calculation of risk equalisation credits

After projecting the market profile, claims rates and nights spent in hospital, it is necessary to consider to what extent the higher claim rates³ of older people and less healthy people should be compensated for through the provision of risk equalisation credits. This is critical to the degree to which the system addresses the imbalance in claims rates between younger and healthier people and older and less healthy people and to the extent to which the system supports the achievement of the Principal Objective, the aim of avoiding overcompensation, the aim of maintaining the sustainability of the health insurance market and the aim of having fair and open competition.

For policy years commencing in 2012, the age-related tax credits for each age group over the age of 60 were calculated to be the greater of:

- a) the amount necessary to compensate for 65% of the excess of the claim rate for the age group over the claim rate across the market, and
- b) the amount necessary so that the net claims cost for the age group (after adjusting for the credit and stamp duty) does not exceed 150% of the market average claim rate.

The Health Insurance (Amendment) Bill 2012 provides for significant changes to the calculation of the payments to compensate insurers for differences in their risk profiles. In particular, the Bill states that the risk equalisation credits (which replace the age-related tax reliefs that apply in 2012) to be recommended should comprise two elements:

- > a hospital bed utilisation credit, representing a payment in respect of each night that an insured person spends in a hospital bed in private hospital accommodation.
- > a risk equalisation credit that varies by age, gender and level of cover.

Risk equalisation credits and stamp duties for policies commencing in 2013

Having regard to the proposed criteria set out in the Bill, the Authority has concluded that the calculation of risk equalisation credits and stamp duties for 2013 should be based on the following criteria. The rationale for the criteria adopted is provided later in the document.

- Calculations should be based on returned benefits rather than prescribed benefits.
- Calculations should be made separately for advanced cover and non-advanced cover contracts. The credits for non-advanced cover contracts should be based on claims rates for Level 1 products (products that provide cover mainly for public hospitals). The credits for advanced cover contracts should be based on claims rates for Level 2 products (products that provide cover for semi-private

³ The claim rate is the average returned benefit per insured person.

accommodation in private hospitals, rather than private accommodation). In all cases, the stamp duty calculation is based on the market membership profile.

- Calculations should also be made separately for men and women, so that different credits will apply to each, although they will be subject to the same stamp duty
- A bed utilisation credit of €100 should be made for each night that an insured person spends in a hospital bed.
- Credits for each gender, product level and age group should be calculated to be the amount necessary so that the net claims cost⁴ for the age group does not exceed 140% of the average net claims cost for the level of cover.⁵
- The ratio of the stamp duty for advanced / non advanced products is set by reference to the ratio of the cost of the age related and hospital utilisation credits for 2013 each based on the total projected insured population.

Date of introduction of credits based on level of cover, Gender and bed utilisation

This report was prepared on the basis that the new structure of credits would commence on 1 January 2013. On 14 November, the Department of Health stated that it is proposed that the new credits will apply for policies commencing in the period 31 March 2013 to 31 December 2013 and that the 2012 rates of stamp duty and credits will apply for the period 1 January 2013 to 30 March 2013.

Changes in the periods for which rates apply impact on the calculations in the following ways:

- Due to ageing consumers will, on average, be slightly older over the period 1 January 2013 to 30 March 2013 than over the calendar year 2012, which means that the Risk Equalisation Fund would be projected to make a small loss in respect of the period 1 January 2013 to 30 March 2013 if 2012 rates are applied for this period.
- Likewise, due to ageing, consumers will, on average, be slightly older over the period 31 March 2013 to 31 December 2013 than over the calendar year 2013.
- Due to inflation, average claim rates are likely to be higher over the period 31 March 2013 to 31 December than over the full year 2013

It is considered that the inflationary impact referred to above is small in the context of the assumptions and within the margin of rounding.

The combination of the two ageing effects is more significant and could be addressed by adding less than €5 to the adult stamp duty rates, resulting in the slightly increased stamp duties (c. 1.5%).

This slight increase in stamp duty is reflected in this section and in the Summary and Conclusions Section but not in the Appendices.

⁴ This is the average returned benefit per insured person adjusted for the stamp duty, bed utilisation credit and health credit.

⁵ This average is calculated by weighting the net claims rates for the level of cover with the market age / gender profile. The average is calculated across all age groups with both genders combined (so the same market average is used in calculating the credits for men and women).

Applying these criteria, and on the basis of its projections of market profile, claims rates and nights spent in hospital, the Authority considers that the following risk equalisation credits need to be afforded to insured persons for health insurance policies that are renewed or entered into on or after 1 January 2013.

Age Bands	Age-related tax credits applied in 2012	Recommended bed utilisation credits for 2013	Recommended age / gender / level of cover credits for 2013			
			Non advanced		Advanced	
			Men	Women	Men	Women
59 and under	€ NIL	€100				
60-64	€600	€100	€175	€125	€400	€275
65-69	€975	€100	€450	€250	€1,025	€725
70-74	€1,400	€100	€750	€475	€1,625	€1,100
75-79	€2,025	€100	€1,250	€700	€2,275	€1,700
80-84	€2,400	€100	€1,600	€1,300	€3,150	€2,125
85 and above	€2,700	€100	€1,600	€1,300	€3,150	€2,125

The Authority considers that the following stamp duties would need to be paid by the insurers of policies that are renewed or entered into on or after 1 January 2013 in order to meet the cost to the Risk Equalisation Fund of the risk equalisation credits:

Age Bands	Stamp duty applied in 2012	Stamp duties for 2013	
		Non-advanced	Advanced
17 and under	€ 95	€ 63	€120
18 and over	€285	€190	€360

Tables illustrating the calculations (before rounding) are included in Appendix 2 along with calculations of alternative of risk equalisation credits on different bases.

The stamp duty recommended for policies commencing in 2013 is €190 for non-advanced products and €360 for advanced products. Across all policies, the average stamp duty is estimated to be €334, which is an increase of 17% over the stamp duty of €285 for 2012 renewals. The main reasons for this difference are analysed in the following:

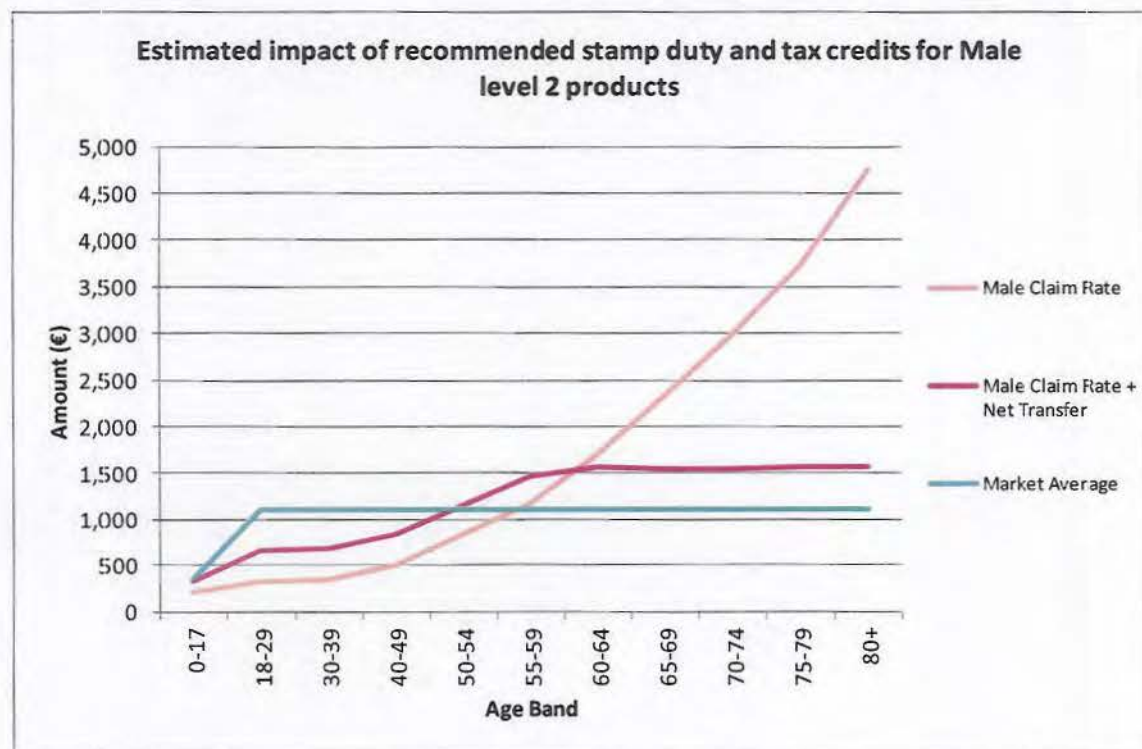
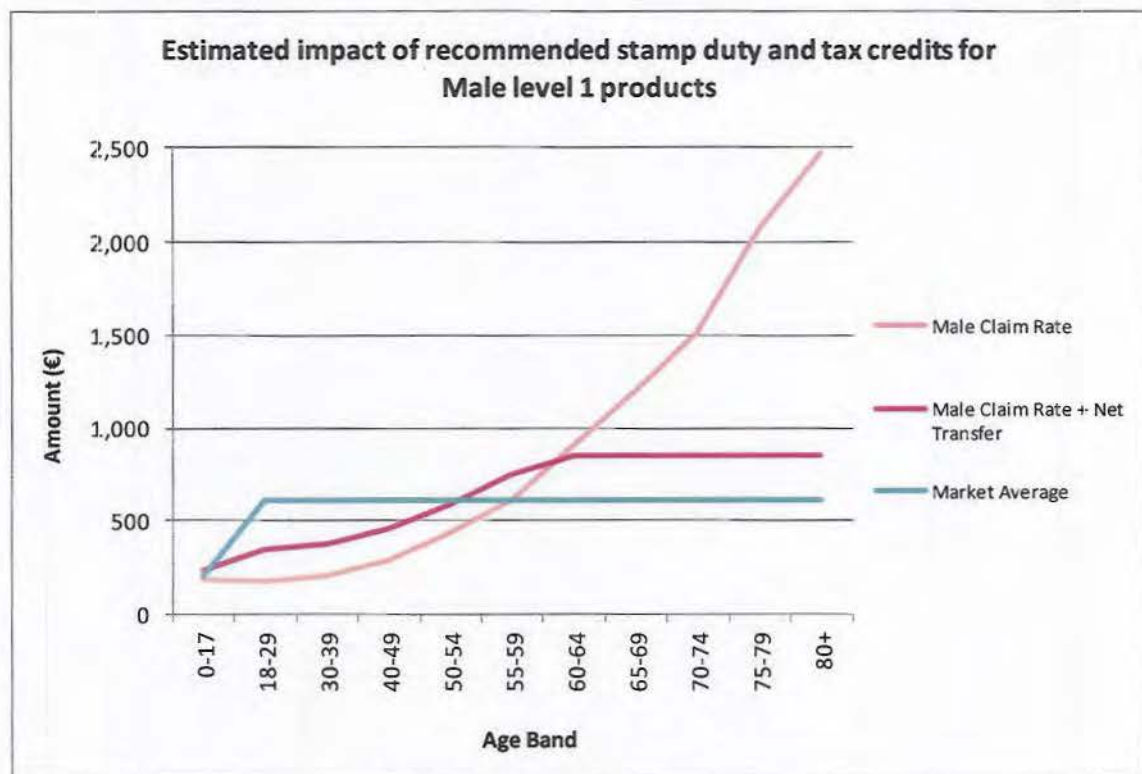
Change from 2012 to 2013 calculations	Effect on stamp duty
Change in membership profile, in particular ageing	6%
Higher projected claim rates	4%
Use of returned benefits rather than prescribed benefits	15%
Exclusion of claims data for products providing cover for private rooms in private hospitals	-17%
Separate risk equalisation credits for men and women	0%
Credits calculated as amount necessary so that the net claims cost for the age group does not exceed 140% of the market average claims cost ⁶	-6%
Adoption of bed utilisation payment of €100	15%

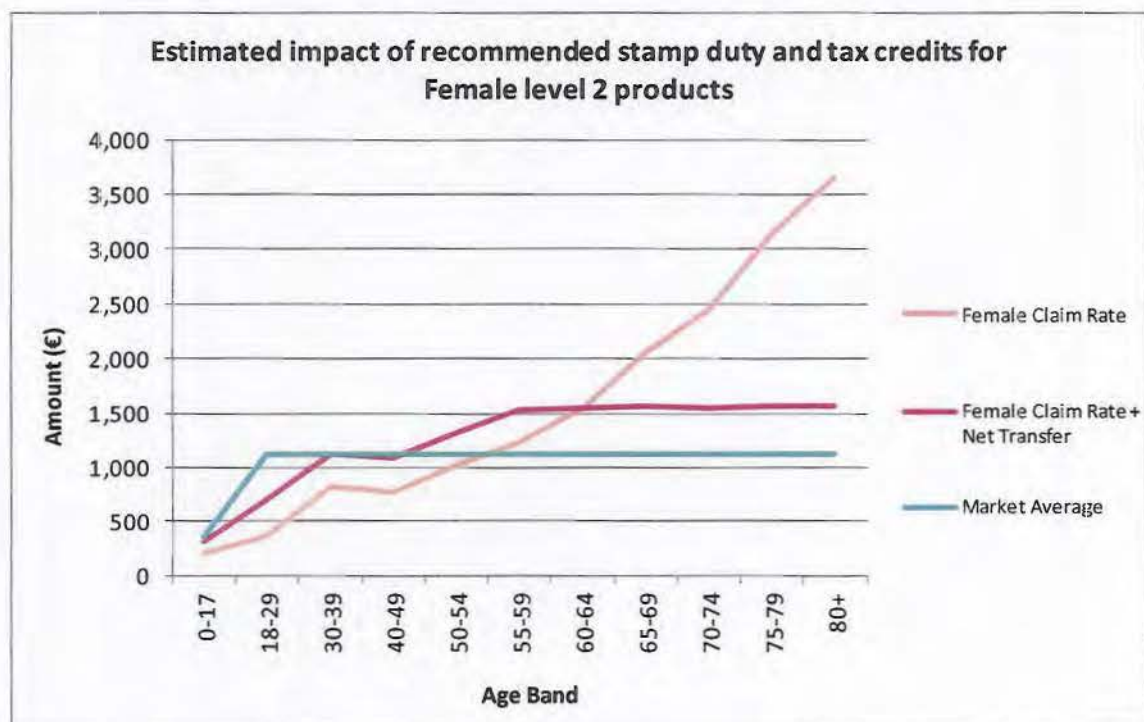
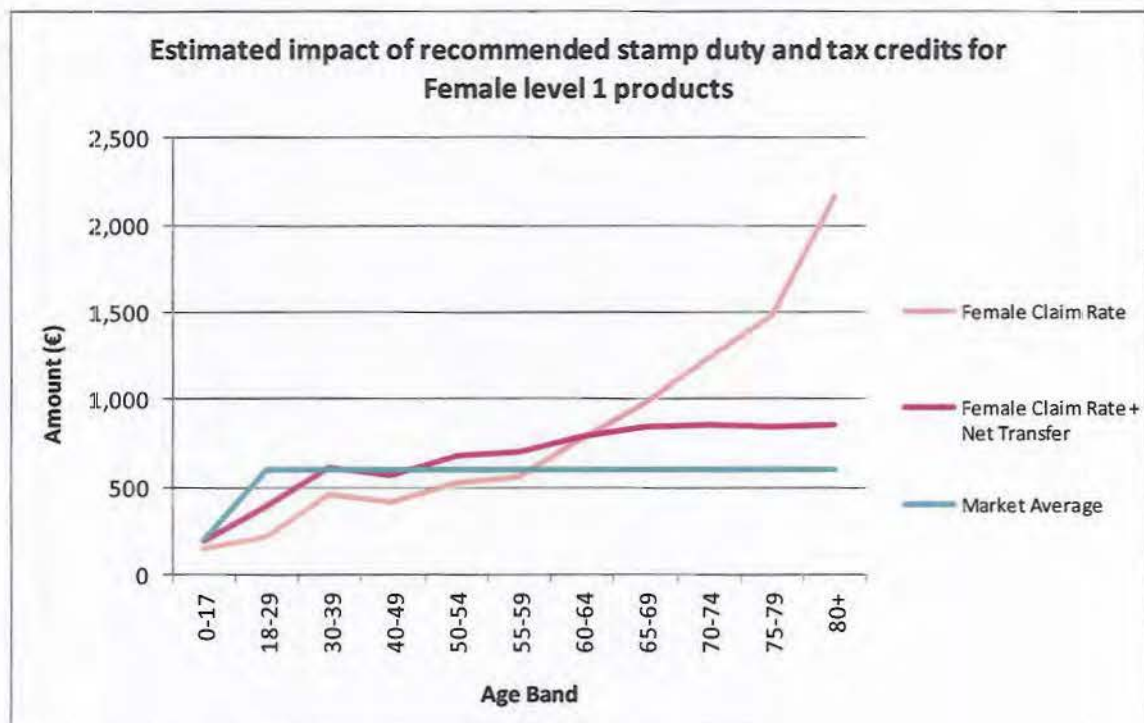
Projected impact of the recommendation on market net costs

The following charts show estimates of the projected claim rate in the policy year commencing in 2013 before and after adjusting for the net effect of the recommended bed utilisation credits, health credits and stamp duties. Separate charts are shown for Level 1 and Level 2 products and for men and women, showing the impact of the system on contracts that mainly provide cover for public hospitals and contracts that provide substantial cover in semi-private rooms in private hospitals.

⁶ For the policy year 2012, the age-related tax credits for each age group over the age of 60 were calculated to be the greater of:

- a. the amount necessary to compensate for 65% of the excess of the claim rate for the age group over the claim rate across the market, and
- b. the amount necessary so that the net claims cost for the age group (after adjusting for the credit and stamp duty) does not exceed 150% of the market average claim rate.



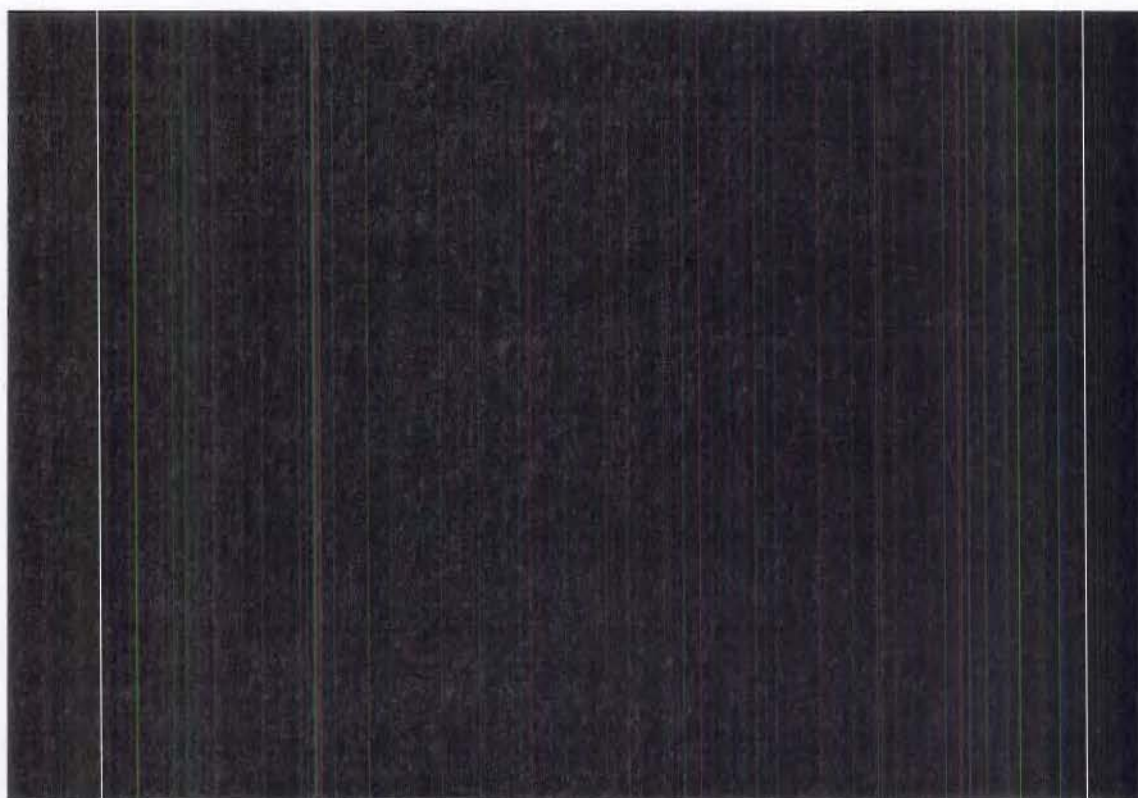


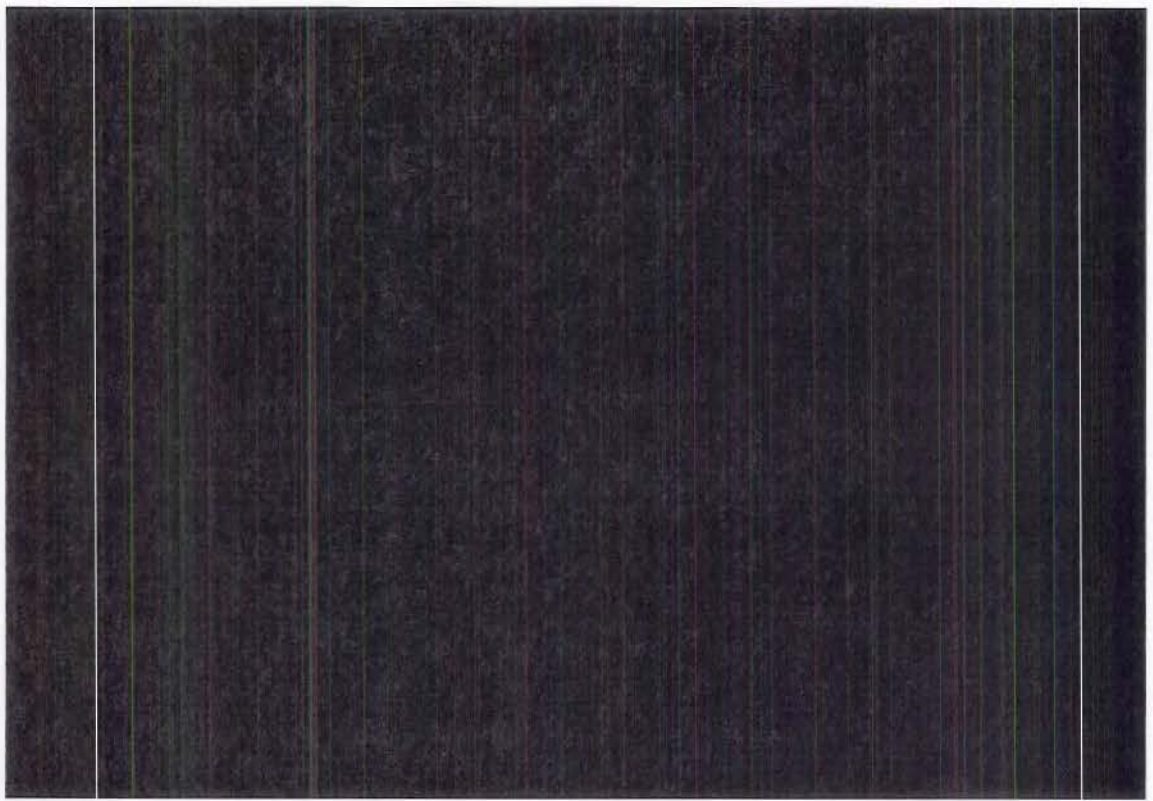
It can be seen that the claim rate after adjusting for the risk equalisation credits and stamp duties (“the net claim cost”) come together for men and women at older ages. This is because the credits are set so that the net claim cost does not exceed 140% of the market average claims cost, calculated for men and women combined.

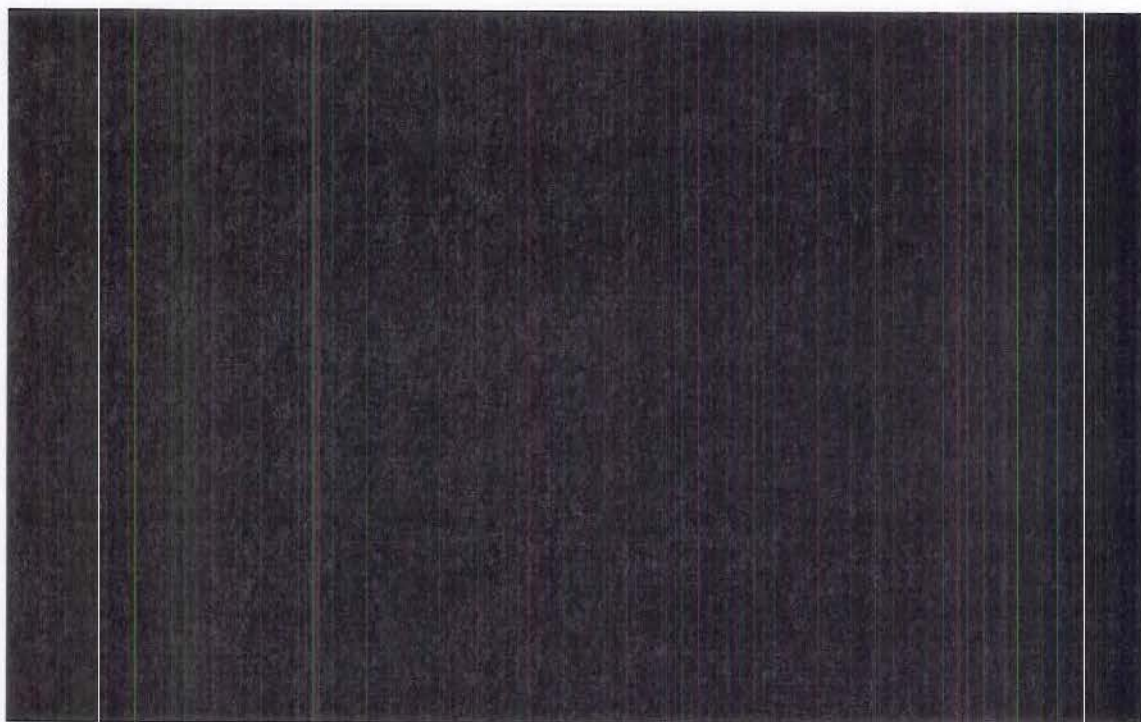
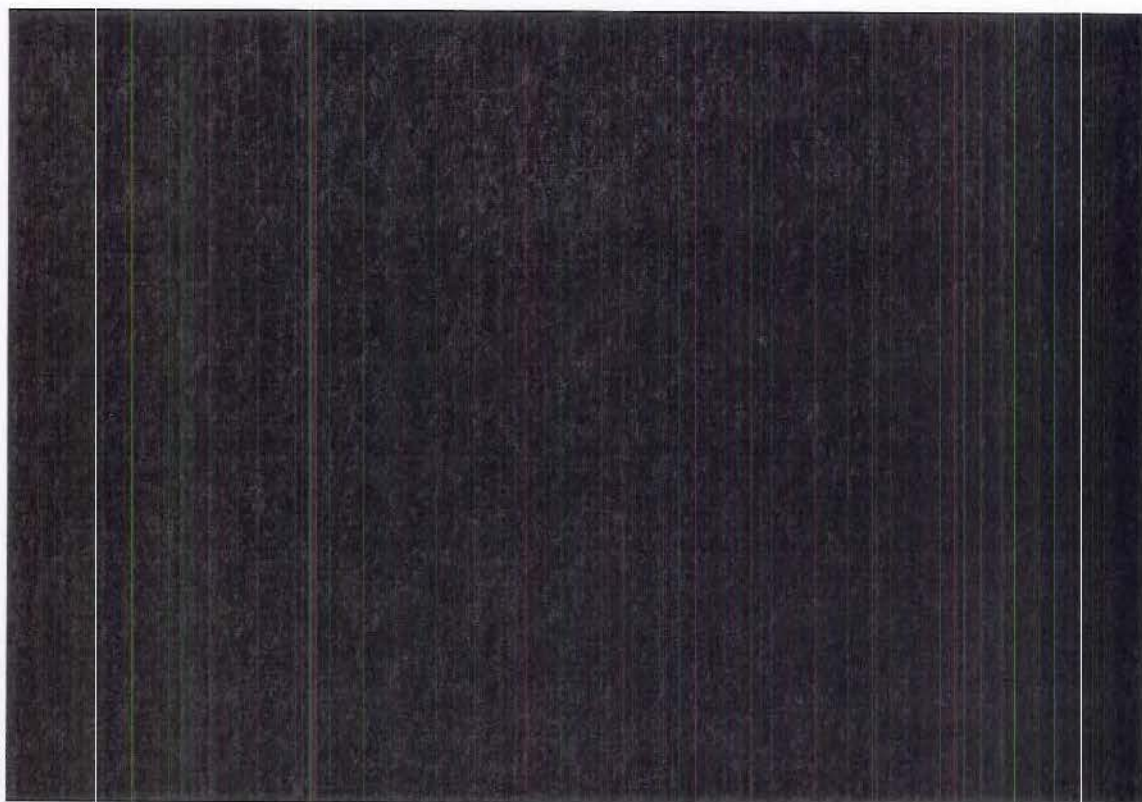
It should also be noted that the 140% ceiling is set by reference to the market average claims cost after adjusting for the bed utilisation credits and the stamp duty needed to finance them.

Projected impact of the recommendation on net claim costs by insurer

The projected net claim costs in the 2013 policy year are illustrated in the following charts. Separate charts are shown for Level 1 and Level 2 products and for men and women, showing the impact of the system on contracts that mainly provide cover for public hospitals and contracts that provide substantial cover in semi-private rooms in private hospitals.







[REDACTED]

[REDACTED]

[REDACTED]

Commentary on the recommended risk equalisation credits and stamp duties

Legislation

In framing its recommendation on risk equalisation credits and stamp duties, the Authority has been asked to have apply the criteria included in the Bill including having regard to the “Principal Objective” set out in that Bill. This objective, as proposed, is set out in Section 1A of the Health Insurance (Amendment) Bill 2012, and includes the following:

“The principal objective of this Act is to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by risk equalisation credits or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the health risk status, age or sex of, or frequency of provision of health services to, any such consumers or any class of such consumers...”

The Health Insurance (Amendment) Bill 2012 also states that, in addition, the Authority would have regard to the aims of:

- avoiding overcompensation to any undertakings
- maintaining the sustainability of the health insurance market
- having fair and open competition in the market

Principal Objective

There are, in general, much higher costs associated with insuring older less healthy people compared with younger healthier lives. As a result, in a community rated market where it is not possible to load premiums to reflect the expected costs for each individual insured person, insurers have a large incentive to target younger healthier people when selling health insurance. There is also an incentive for insurers to segment their insured populations so that younger healthier people and older less healthy people are sold

different products, charging higher premiums on average to the older less healthy group. Despite the legislation governing community rating, insurers can achieve this segmentation through target marketing and product development. This impacts negatively on the achievement of the Principal Objective because older people pay more on average for health insurance.

The risk equalisation credits and stamp duties provide a means of reducing the disincentive against insuring older people and the incentive to segment the insured population by age.

The incentive for insurers to differentiate between age groups would be addressed if the expected average claim costs for an age group plus the risk equalisation credits were the same across all age groups for each insurer. The expected claim costs net of risk equalisation credits of insuring an 85 year old would then be the same as for insuring a 25 year old and an insurer would have no incentive, based on claims rates, to differentiate between them.

However, as expected claim costs by age differ between insurers and across products, no level of age related tax credits would achieve this objective in respect of all insurers and all products. In addition, as the credits and duties would be set across all insurers, those insurers with lower claim rates could argue that the level of payments would result in compensating less efficient insurers or sharing the benefit of product features such as excesses, thereby undermining competition.

Recommendation

The Authority's recommendation for risk equalisation credits for policy years commencing from 31 March 2013 to 31 December 2013 corresponds to an average stamp duty of €334, which is a 17% increase over that applied in 2012 (€285). However, for 2013, the stamp duty is proposed to vary by level of cover, so the duty will reduce for non-advanced cover products (€190) but increase for advanced cover products (€360).

The Authority considers that there continues to be a high level of segmentation in the market whereby older people are on average paying more for health insurance. In particular, a high level of segmentation persists in the largest segment of the market (products providing cover for a semi-private room in a private hospital), with Vhi Healthcare, Aviva Health and GloHealth reducing cover for orthopaedic treatment on many products in this segment.

It is in this context that the Authority is proposing the changes to the risk equalisation credits set out earlier.

The recommendation incorporates the following main changes from the current age-related tax reliefs:

- a bed utilisation credit of €100 is applied

- Basing claims rates on returned benefits, excluding products providing cover for private rooms in private hospitals, rather than on prescribed, benefits
- calculations are split by level of cover and gender
- the age-related credits are set so that the net claims cost should not exceed 140% of the market average claim costs

Each of these changes is discussed below.

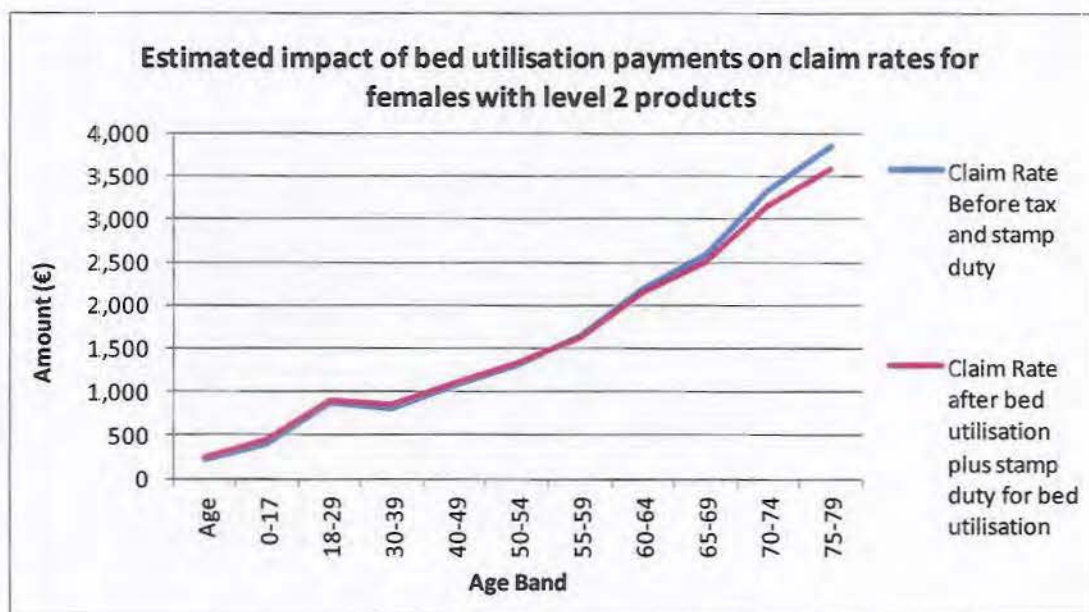
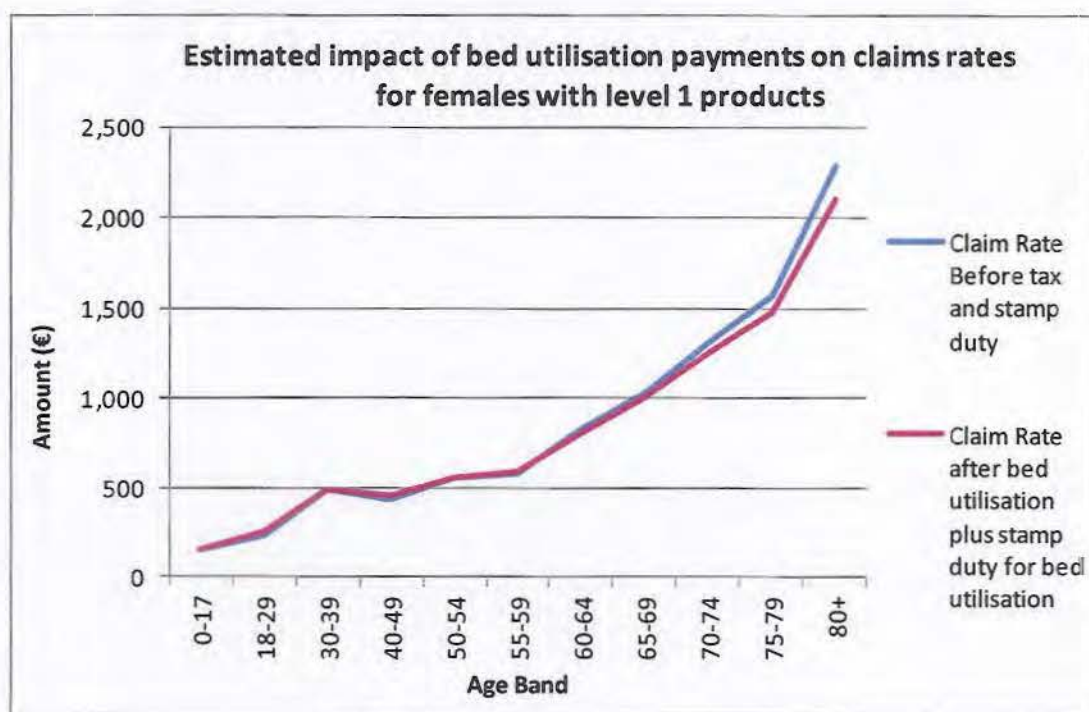
It must be accepted that, even if the Authority's recommendation is applied, an incentive to select against older, less healthy consumers and segment risks is likely to remain.

Hospital Bed Utilisation Credit

The current age-related tax reliefs only vary according to age and cannot make any allowance for the health status of insured persons. This means that there is a clear incentive for an insurer to select healthy consumers in preference to unhealthy consumers (of whatever age).

In order to help compensate for differences in health status between the memberships of the insurers, the Authority has recommended a hospital bed utilisation credit of €100 for each night spent in hospital. It is important that this payment is large enough to have a meaningful impact but not so large that it creates perverse incentives, e.g. it becomes cheaper for the insurer to keep a patient in a bed overnight rather than treating them as a day patient. Having discussed the level of hospital bed utilisation with the insurers, the Authority is satisfied that a €100 payment would provide some support and would not lead to perverse incentives.

The following two charts illustrate, for Level 1 and Level 2 products respectively, the impact of the bed utilisation credit and the associated stamp duty on the claims rate. For clarity, results are only shown for women, but a similar pattern applies to men.



Use of returned benefits

The Authority has recommended risk equalisation credits based on returned benefits excluding claims data for products covering private accommodation in private hospitals, rather than the prescribed benefits used to calculate the current age-related tax reliefs.

Both returned and prescribed benefits make various exclusions, in particular benefits not provided by a hospital or those provided to outpatients. However, prescribed benefits

incorporate maximum limits on the amount of benefits that can be counted. These maximum limits might be considered as a means of excluding “luxury” benefits from the calculations. However, the monetary limits included in the definition of prescribed benefits have not been updated for a number of years.

A clearer approach is to use returned benefits (i.e. without the maximum limits) but then to exclude those products that are considered to provide benefits in excess of the level of cover ordinarily purchased by consumers. This approach is now possible as the data provided by insurers gives information separately for each product.

Split by level of cover and gender

Where the stamp duty does not differentiate by product type, this can lead to disproportionately high stamp duties for lower cost products. This could cause a significant reduction in the proportionate discount of a non advanced contract versus an advanced contract.

Furthermore, it can be seen from the charts at the end of Section B of this report that, under the current system of tax credits, the pattern of net claims cost of Level 1 products reduces with age after the application of the current stamp duties and tax credits. This is because the 2012 tax credits and stamp duties do not differentiate by level of cover.

It is recommended that credits and stamp duties should be set separately for advanced and non-advanced products. The ratio of the stamp duty for advanced to non-advanced cover contracts is based on the relative cost of the proposed age and hospital utilisation credits based on the total projected insured population.

The Authority also considers that the credits and stamp duties should reflect the level of benefits ordinarily purchased by consumers. To this end, the recommended credits for advanced cover contracts have been set by reference to the projected claim rates for Level 2 products only (i.e. excluding higher level contracts).

Calculations have also been made separately for men and women, as their underlying claim rates are significantly different for most age groups. This means that there are different credits for men and women although the same stamp duty applies to both.

140% limit

As already mentioned, the 2012 age-related tax credits were calculated as the greater of:

- a) the amount necessary to compensate for 65% of the claim rate of the age group in excess of the claim rate across the market, and

- b) the amount necessary so that the net claims cost for the age group (after adjusting for the credit and stamp duty) does not exceed 150% of the market average claims rate.

In light of the continuing risk segmentation and selection in the market having a negative impact on the achievement of the principal objective the Authority has decided to increase the support for older people so that, at each level of cover, the average net claim for each age group will be no greater than 140% of the average net claims cost for that level of cover, weighted by the market age profile. Making this change reduces the need for the 65% parameter. Removing the 65% parameter also reduces the stamp duty and avoids a reduction in the net claims costs for 60-64 age group compared to 55-59..

Age bands

Tax credits are not proposed for ages 50-54 or 55-59 (other than the hospital bed utilisation credit, which applies across all ages) because the net claims costs for these age groups are already lower than 140% of the market average claims costs.

As the calculations are now being broken down by gender and level of cover, the number of lives included in some of the highest age groups is small. For example, at 1 July 2012, there were just 360 men aged 85 and over with Level 1 products. This means that the claims experience of this group will be more subject to statistical variation. In order to reduce the possible impact of this variation, the calculations have been made combining the 80-84 and 85 and over age groups.

Avoiding overcompensation

In proposing the amounts of risk equalisation credits for 2013, the Authority would be required under the Health Insurance (Amendment) Bill 2012 to have regard to “the aim of avoiding overcompensation being made to a registered undertaking ... under the operation of the relevant financial provisions”. The credits and duties proposed in this report will have a financial impact on insurers in the years 2013 and 2014.

The net impact of the credits and duties proposed by the Authority in this Report in respect of older people is less than the estimate of the extra cost of providing cover to older people, calculated across all insurers.

It is also important to note that the recent activity of all insurers has

been to continue to target younger consumers, providing further evidence that this remains the more profitable segment of the market.

The above indicates that insurers with older less healthy populations than average would not be facilitated in making more than a reasonable profit by virtue of the credits and stamp duties proposed in this Report. Consequently, the proposed credits and stamp duties have regard to the need to avoid overcompensation.

The application of hospital bed utilisation credits does not affect this conclusion, as the rate of credit is low compared to the cost of hospitalisation so that insurers with less healthy consumers would continue to be at a disadvantage notwithstanding these credits.

If the measures were to result in overcompensation, the legislation, as proposed in the Health Insurance (Amendment) Bill 2012, would provide that the amount of overcompensation be repaid to the Fund. The Authority has carried out and will carry out the following assessments in relation to whether, in the context of the European State Aid regime, any undertaking has been overcompensated under risk equalisation system.

- In 2010 the Authority determined that there was no overcompensation in respect of the period 1 January 2009 to 31 December 2009.
- In 2011 the Authority determined that there was no overcompensation in respect of the period 1 January 2009 to 31 December 2010.
- In 2012 the Authority determined that there was no overcompensation in respect of the period 1 January 2009 to 31 December 2011.
- In 2013 the Authority will carry out an assessment in respect of the period 1 January 2010 to 31 December 2012.
- In 2014 the Authority will carry out an assessment in respect of the period 1 January 2011 to 31 December 2013.
- In each subsequent year, the Authority will make an assessment in respect of the preceding three years.

Summary income and expenditure accounts for Vhi Healthcare for year ended 31 December 2011 are included in Appendix 3 along with projected results for 2012 and 2013.

Maintaining the sustainability of the market

The unfunded Irish voluntary health insurance system is, effectively, a “pay as you go” system, with the claims in any one year paid mainly out of the premiums received in that year. There is no fund built up over the life of an insured person to meet the higher level of claims expected when that person gets older.

Everybody is charged the same premium for a health insurance product (with some limited exceptions), so that a younger, healthier person pays a premium significantly in excess of their expected level of claims and an older, less healthy person pays a premium

much lower than their expected level of claims. Instead of the excess premium paid by the younger person being used to build up a fund for later in life (as would be the case in a funded system), it is instead used to pay the claims arising with respect to older people. However, the voluntary nature of the market means that lower risk people can choose not to join the system or can choose to opt out at any time, and potentially re-join at an older age.

A community-rated market, therefore, requires a balance of younger and older, and healthy and less healthy members for it to operate effectively. In this way, premiums can be kept at affordable levels across the market, with the younger and healthier members helping to support the older and less healthy members. There is a danger in a voluntary community rated market that if premiums increase too much, younger and healthier members will be deterred from taking out health insurance (or encouraged to lapse their existing policies), which will in turn lead to further increases in the premiums needed to cover average claim costs. The proportion of people insured aged under age 50 has been reducing in recent years and while this is partly due to the ageing of the general population, it also reflects both economic conditions and premium increases.

The Authority's recommended approach of setting lower stamp duties and credits for non-advanced cover products compared with advanced cover products, means that the stamp duty for the non-advanced cover products will reduce compared with that in force for 2012. This should help to maintain the attractiveness of these products to younger consumers entering the health insurance market for the first time and thereby supporting the sustainability of the market.

The Authority considered, whether a higher level of credits could be warranted in order to support the Principal Objective. Such a case could be made. However, the conclusions in this Report already provide for a significant increase in credits and in the stamp duty payable for "advanced" contracts and the Authority would be concerned that to apply further increases at this stage could give rise to risks in the context of the sustainability of the market, particularly in the context of the current challenging market conditions.

It is noted that the risks to the sustainability of voluntary community rated markets arise from the facts that the market is voluntary and community rated. The Authority does not consider that, over the longer term, such risks should be reduced by implementing a less than effective risk equalisation system which incentivises insurers to undermine community rating and find ways to charge lower premiums to lower risks. If the policy decision is to allow for lower premiums for lower risk groups, this should be allowed for explicitly in the legislation (by, for example, providing for discounts for those in the age range 18-29).

Other tools to support voluntary community rating might include lifetime community rating, where the community rated premium rises for those who first take insurance at a later age, or other penalties to encourage a greater take up of insurance among the healthier segment of the population.

Economic Circumstances

The health insurance market has now been in continuous decline for almost four years because of the deep economic recession that occurred in late 2008 and 2009 and subsequent protracted economic conditions. In fact, the decline in numbers insured is only a fraction of the coterminous decline in employment. However, the decline in health insurance numbers gives rise to issues for the market because of the concentration of the decline in younger adults. It is important to note that the economic circumstances of the late 1990s and first half of the 2000's represented unusually favourable economic conditions for many businesses, including health insurance, due to the very large increase in employment and job opportunities, especially in large companies with company health insurance schemes, often subsidised by employers. Since late 2008, the number of job opportunities for young adults has been much less, including in large companies with company health insurance schemes. Until 2007, employment in Ireland was growing at over 3% per annum, which is exceptionally high compared to past Irish experience and most recent trends in western developed economies. However in the four years from Q2 2008 to Q2 2012, employment has fallen by over 15%. In addition, real disposable incomes have fallen. While the Government is forecasting modest economic next year, there is little immediate prospect of achieving strong growth in employment, especially with the weak economic outlook in Europe in the short term.

Fair and open competition

In the view of the Authority, fair and open competition is achieved by having a level playing field between all insurers regardless of their level of risk. Consequently a robust risk equalisation system is a prerequisite for having fair and open competition.

Without a sufficiently robust risk equalisation system, an insurer with a less favourable risk profile will be obliged to charge higher premiums than the market or incur significant losses, other things being equal. If its premiums are higher than the market, it is more likely to lose younger than older customers and its worsening risk profile may oblige it to increase premiums further, resulting in a cycle which ultimately could drive the insurer from the market. As discussed earlier in this section, one response of the insurer might be to segment its insured population so that younger healthier people and older less healthy people are sold different products, charging higher premiums on average to older less healthy group.

It is important to note that, because competition is distorted, an insurer with a poorer risk profile is likely to incur these difficulties regardless of its level of efficiency or the attractiveness of its products; the difficulties would result directly from its risk profile in the absence of a robust risk equalisation system.

The Authority's recommended risk equalisation credits are intended to provide additional compensation for older and less healthy members. This should therefore provide a fairer basis on which insurers can compete, leading them to concentrate on seeking competitive

advantage in terms of value for money, customer service and product design etc. Setting separate credits and stamp duties for non-advanced and advanced products should also provide a sounder basis for competition between such products.

It is of course equally important that the level of risk equalisation is not so great that it confers advantages on insurers with an older and less healthy risk profile. As mentioned above, the recommended credits and stamp duties are not expected to lead to over-compensation to those insurers with, on average, older memberships.

Furthermore, the bed utilisation credit is set at a low level which retains the incentive on the insurers to work to minimise hospital stays and to implement the most cost effective treatment pathways.

Projected financial impact of the recommendation on each insurer and on the Risk Equalisation Fund

The calculations of net financial impact are based on credits and stamp duty applying for the whole of 2013 and are also based on the stamp duty before the application of the adjustment to reflect the impact of postponing the commencement date of the credits, although, the impacts of these two factors will largely cancel each other out in terms of their effects on the Net Financial Impacts.

	Aviva €m	Laya €m	Vhi €m	Fund €m
Credits				524
Stamp Duty				524
Net benefit				-

These figures are an estimate of the credits and stamp duties that would be payable to / by each insurer in respect of policies commencing in 2013 and are based on the projected memberships described in Section E of this report. In particular, this means that there is no figure shown for GloHealth as there was no projection of its membership. This is because it did not start trading until 1 July 2012 and therefore did not appear in the data for the year to 30 June 2012.

In practice, GloHealth would pay stamp duties and receive credits in respect of its policies that commence or renew in 2013. On the assumption that the entry of GloHealth into the market does not change materially the overall market size or the membership profile, the impact would be to reduce the stamp duties and credits payable/receivable by those insurers who lose members to GloHealth, with a corresponding increase in the amounts for GloHealth.

The projections for individual insurers are sensitive to factors affecting the market as a whole (see below), as well as developments specific to each insurer's membership profile (by age, gender and level of cover) and their bed utilisation. This will, in turn, be

influenced by product or pricing strategy and other developments specific to the insurer, which it is not possible to predict. As such, projections of the net financial impact on individual insurers are subject to considerable uncertainty and should be viewed as indicative only.

The timing of the risk equalisation credits payable from the Fund is not yet clear as it is not specified in the Bill. Similarly, it is not clear when the Revenue Commissioners would remit the stamp duties to the Fund. However, in practice, it is likely that the estimated payments set out in the above table would be spread over 2013 and 2014.

During 2013, the Exchequer will also collect the remaining stamp duties and pay the relevant age-related tax credits in respect of policies that commenced or were renewed in 2012.

Cost neutrality for the Fund

The recommended risk equalisation credits and stamp duties have been calculated such that, based on the assumptions made, the total stamp duties receivable should equal the total credits payable.

The extent to which the system is cost neutral will depend on how closely the assumptions are borne out in practice. In particular, it will depend on whether the profile of the market membership is consistent with the assumptions made. The Authority has assumed that the number of insured persons, for each age group, gender and level of cover, will continue to decline (or in some cases increase) at the same rate as it declined (or increased) over the year to 30 June 2012. Overall, the Authority makes the assumption that the total market will decline by a further c. 90,000 from 1 July 2012 to the end of 2013.

However, there is considerable uncertainty in relation to this assumption, as the shape of the market will depend on a wide range of factors, for example:

- > general economic conditions
- > perceptions about the quality of State provision
- > developments in the health insurance market, such as any move to increase charges for private patients in public hospitals
- > pricing changes, including as a result of the adoption of the new system of risk equalisation credits and stamp duties

To help illustrate the uncertainty, if, compared with the Authority's projections, an additional 50,000 younger people with non-advanced Cover products leave the health insurance market by the end of 2013 than is projected there would be a negative impact on the Fund of approximately €9m.

Similarly, if 50,000 younger members with advanced cover products decided to downgrade their cover to non-advanced cover products at the 2013 renewal (in addition

to any such downgrades already allowed for in the projections), this would result in a loss to the Fund of nearly €9m.

In addition, the projected bed utilisation payments will be sensitive to the assumption about average bed utilisation. A particular risk is that the introduction of the bed utilisation credits will in itself lead to a change in treatment patterns, although the Authority has recommended a relatively low credit of €100 in order to avoid this risk. However, if, for example, there were a 10% increase in bed stays this would lead to a loss to the Fund of €11m.

Summary of impact of using alternative approaches

The following table summarises the risk equalisation credits and stamp duty that would arise if alternative approaches to determining the credits were used. Alternative 1 represents calculations made using the approach adopted in 2012. Full details are set out in Appendix 2.

	Recommendation	Alternative 1	Alternative 2	Alternative 3	Alternative 4	Alternative 5	Alternative 6	Alternative 7	Alternative 8
	Age /Gender credits based on ceiling of 140% market average cost	Age /Gender credits equalise 65% of cost difference and 150% ceiling; not split by gender/cover	Age /Gender credits equalise 65% of cost difference and 150% ceiling	Age /Gender credits based on ceiling of 150% market average cost	Age /Gender credits based on ceiling of 140% market average cost	Age /Gender credits equalise 65% of cost difference and 150% ceiling	Age /Gender credits based on ceiling of 150% market average cost	Age /Gender credits based on ceiling of 140% market average cost	Age /Gender credits based on ceiling of 130% market average cost
Benefits used	Returned	Prescribed	Returned	Returned	Returned	Returned	Returned	Returned	Returned
Bed utilisation payment	€100	Nil	Nil	Nil	Nil	€100	€100	€200	€100
Stamp Duty (adult rate)									
Non-advanced	€186	€310	€162	€138	€156	€201	€171	€219	€203
Advanced	€357		€331	€283	€313	€376	€326	€400	€392
Projected Net Financial Impact									
Aviva									
Quinn/Laya									
Vhi									

Counting each child as 1/3rd and each adult as 1, the average prescribed benefit per insured person for each insurer is outlined in the following tables.

Average Prescribed Benefits or Returned Benefits per Insured Person (€)					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Prescribed benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	363	384	373	425	424
Returned benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market				487	486

The market prescribed benefits per insured person has remained broadly stable at €424 in the current period, but within this there has been a fall in the average benefits XXXXXX XXXXXX Comparing the first half of 2012 with the first half of 2011 shows a 13.5% increase for the market average prescribed benefit. The returned benefits per insured person are higher than the corresponding average prescribed benefits, with the market average returned benefits being €486 for the six months ended 30 June 2012.

Average Benefits per Insured Person as a % of the Market Average					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Prescribed benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	100%	100%	100%	100%	100%
Returned benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market				100%	100%



Average prescribed benefit per treatment day

The differences in the average prescribed or returned benefit per member is partly due to differences in the average benefit per treatment day for each insurer and partly to differences in the average number of treatment days per insured person for each insurer. The average prescribed or returned benefit per treatment day varies between insurers as set out in the following tables.

Average Benefit per Treatment Day (€)					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Prescribed benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	849	842	845	896	909
Returned benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market				1,026	1,042

Average Prescribed Benefit per Treatment Day as a % of the Market Average					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Prescribed benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	100%	100%	100%	100%	100%
Returned benefits					
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market				100%	100%

Average number of treatment days per insured person

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

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

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

Average Treatment Days per Insured Person					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	0.427	0.456	0.442	0.474	0.466

Average Treatment Days per Insured Person as a % of the Market Average					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	100%	100%	100%	100%	100%

Age/Sex Risk Profile Index

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

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

The use of the number of treatment days as the basis for setting the risk weights is not without its disadvantages. As already mentioned, the number of treatment days will not provide a pure measure of risk, since it could include an element of efficiency and other factors. Also, as noted earlier, it does not take account of differences in the value of treatment days. It is not necessary to adjust for children by counting each child as 1/3 in the calculation of this index.

Age / Sex Risk Profile Index					
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012
Aviva Health					
Vhi Healthcare					
Quinn					
Laya					
Quinn/Laya combined					
Market	100%	100%	100%	100%	100%


























Hospital Utilisation Risk Profile Index

Of course the Age/Sex Risk Profile Index ignores differences in risk profiles due to other factors, i.e. it ignores whether insurers' risk profiles vary within age/sex bands. It therefore ignores differences in hospital utilisation within age /gender cells. In order to gauge the significance of variations of risk profile within age/sex bands we calculate an

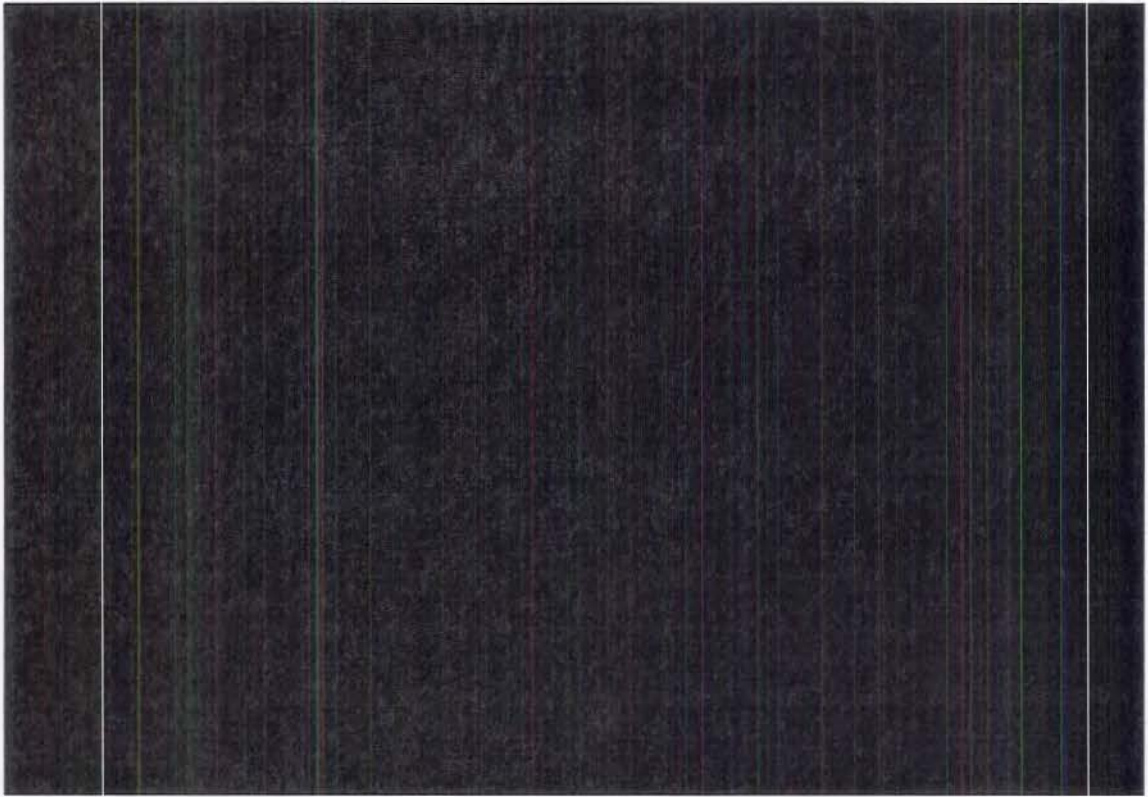
overall index of the hospital utilisation risk profile (ignoring the effect of differences in the age/sex distributions of the memberships). We call this index the Hospital Utilisation Risk Profile Index.

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

As we aim to ignore the effect of the age and sex profile with this index, there is no need to adjust for the number of children. The following table shows the relative values of the Hospital Utilisation Risk Profile Index over time.

Hospital Utilisation Risk Profile Index (Percentage of Vhi Healthcare's Index)						
Insurer	Jan - June 2010	July - Dec 2010	Jan - June 2011	July - Dec 2011	Jan - June 2012	
Aviva Health						
Vhi Healthcare						
Quinn						
Laya						
Quinn/Laya combined						

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Appendix 2: Credits and Stamp Duty (SD) for 2013 on the recommended and alternative scenarios

The four tables below show the projected membership, returned and prescribed benefits and bed nights as at 1 January 2014 (the midpoint of the average policy incepted in 2013). This data was used in the calculation of the stamp duty and risk equalisation credits in the scenarios shown below.

Projected Membership as at 1 January 2014					
Age Group	Level 1		Level 2 +		
	Male	Female	Male	Female	
0-17	30,223	28,422	209,759	199,769	
18-29	20,208	22,373	78,225	80,668	
30-39	25,573	33,222	106,046	127,492	
40-49	23,619	25,305	116,147	128,657	
50-54	9,604	10,135	53,825	61,294	
55-59	8,748	9,263	52,301	57,704	
60-64	7,492	7,343	46,870	51,394	
65-69	5,117	4,959	43,264	46,726	
70-74	2,839	2,865	29,077	32,700	
75-79	1,683	1,658	20,406	25,005	
80+	1,106	1,613	17,645	27,782	
Total	136,208	147,155	773,561	839,190	

Projected Average Returned Benefit at 1 January 2014 (€)					
Age Group	Level 1		Level 2		
	Male	Female	Male	Female	
0-17	181	147	218	209	
18-29	171	214	325	371	
30-39	197	458	347	820	
40-49	284	412	508	763	
50-54	430	520	843	1,011	
55-59	602	549	1,168	1,231	
60-64	906	777	1,699	1,540	
65-69	1,199	974	2,338	2,053	
70-74	1,504	1,240	2,979	2,447	
75-79	2,073	1,479	3,728	3,132	
80+	2,473	2,163	4,735	3,635	

Projected Average Prescribed Benefit at 1 January 2014 (€)	
Age Group	All product levels
	Male & Female
0-17	192
18-29	269
30-39	474
40-49	540
50-54	804
55-59	1,036
60-64	1,463
65-69	1,990
70-74	2,509
75-79	3,269
80+	3,929

Projected Total Bed Nights at 1 January 2014					
Age Group	Level 1		Level 2+		
	Male	Female	Male	Female	
0-17	4,478	4,568	29,694	29,688	
18-29	2,884	3,599	18,676	23,053	
30-39	3,815	12,195	21,651	73,869	
40-49	4,782	7,174	32,841	54,201	
50-54	3,018	3,641	22,993	35,302	
55-59	3,701	3,318	32,070	40,266	
60-64	5,088	4,098	41,603	44,652	
65-69	4,635	3,371	53,374	58,543	
70-74	2,860	2,797	50,512	54,916	
75-79	2,856	1,994	53,674	61,641	
80+	2,337	3,254	73,881	94,947	

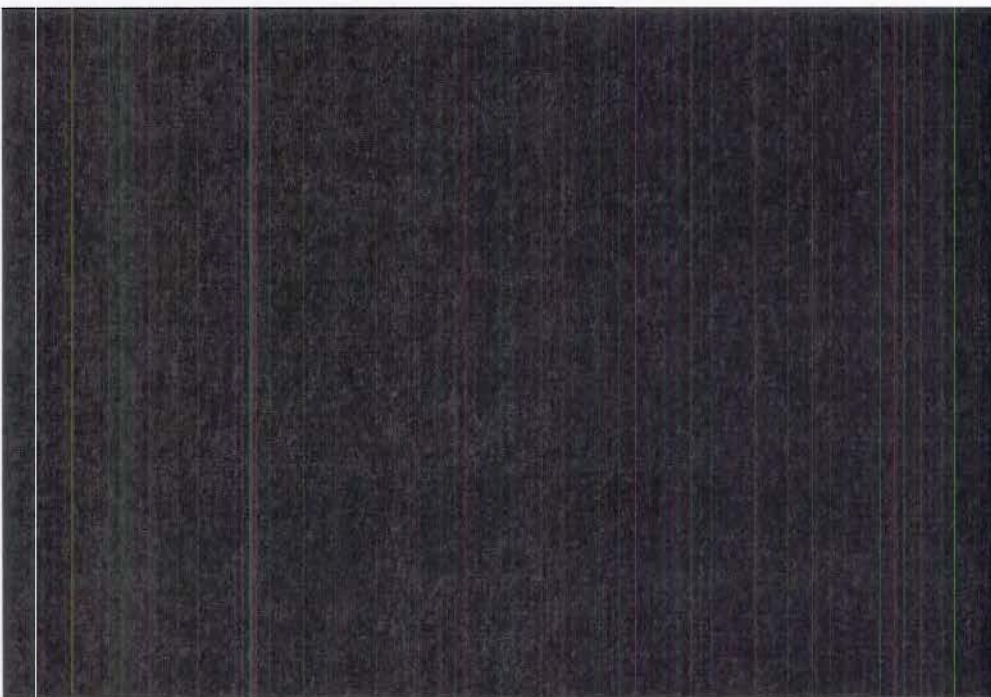
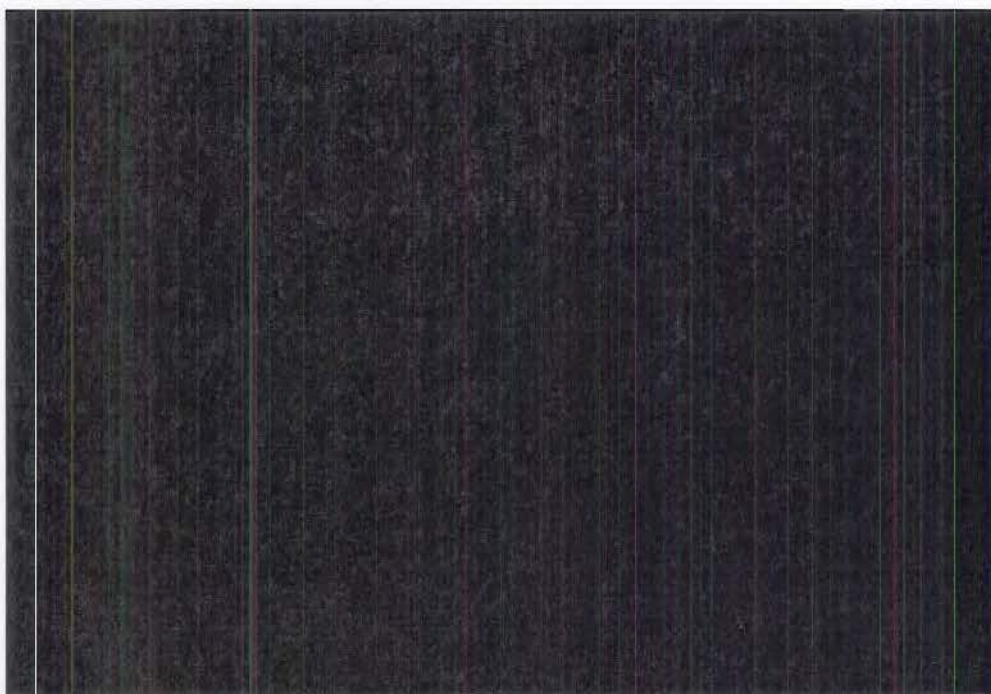
Non advanced

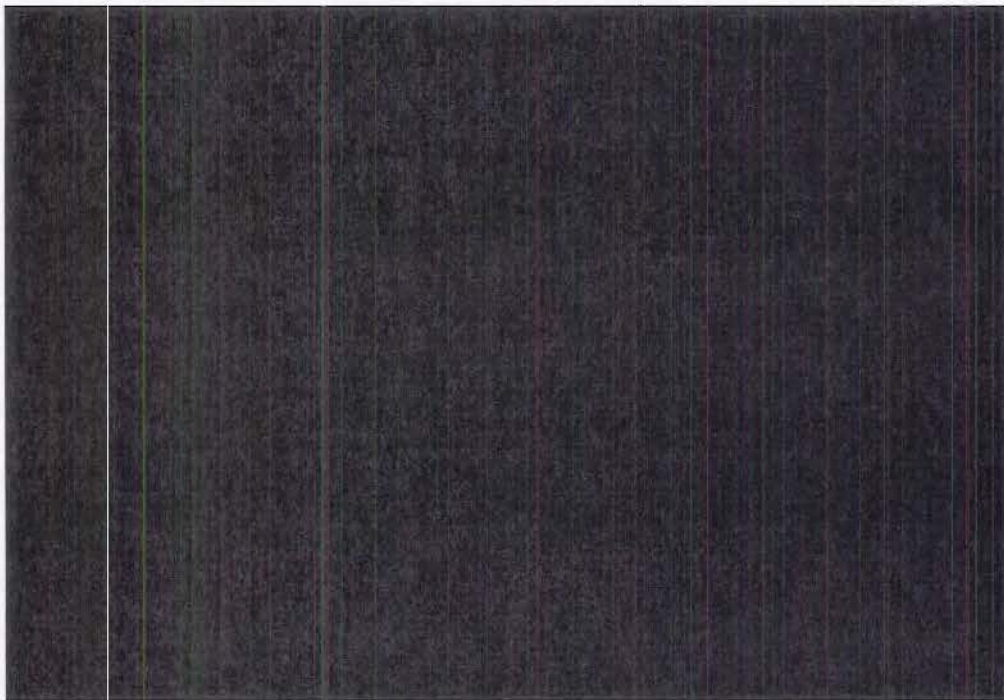
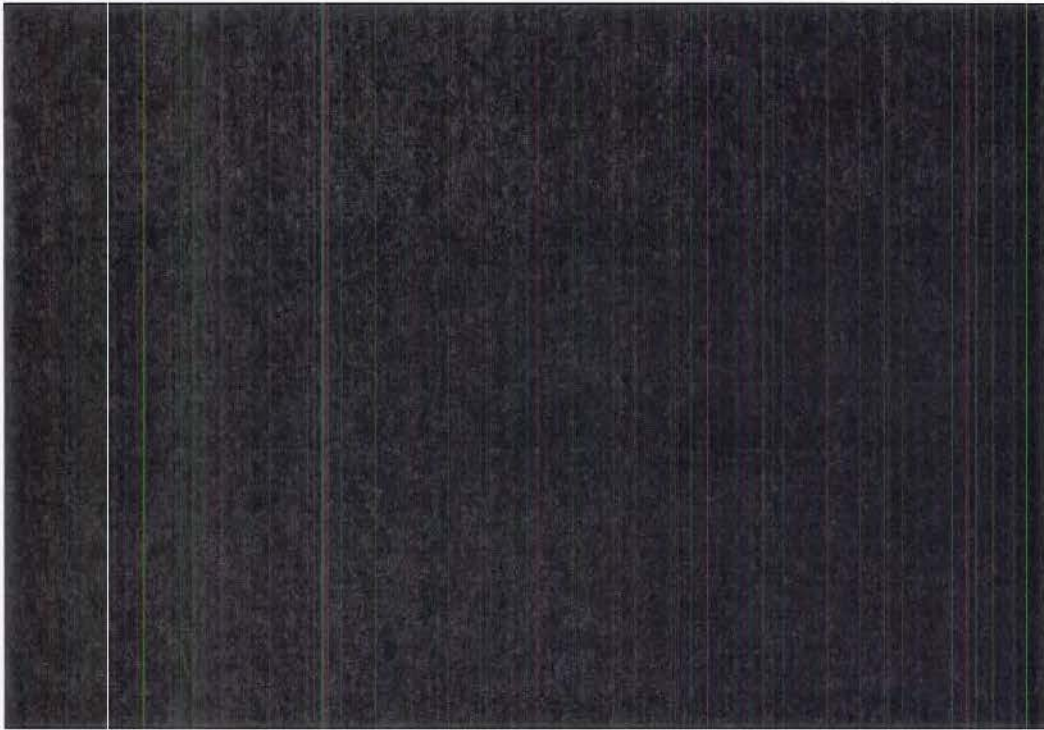
Recommended Scenario

This method calculates a credit by gender, product level and age (over 60's only). An additional bed utilisation credit of €100 is applied. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or by age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 140% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 48% of the stamp duty relating to age and gender credits for Advanced and above products. The stamp duty relating to bed utilisation credits for Level 1 products is set at 68% of the stamp duty relating to bed utilisation credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non- advd	Advd	Non-advanced		Advanced				
			Men	Women	Men	Women			
0-17	62	119	-	-	-	-	6.8	0.0	52.4
18-29	186	357	-	-	-	-	4.8	0.0	64.6
30-39	186	357	-	-	-	-	11.2	0.0	94.3
40-49	186	357	-	-	-	-	9.9	0.0	96.5
50-54	186	357	-	-	-	-	6.5	0.0	44.8
55-59	186	357	-	-	-	-	7.9	0.0	42.6
60-64	186	357	181	136	410	284	9.5	36.2	37.8
65-69	186	357	453	251	1,013	730	12.0	81.5	34.0
70-74	186	357	750	487	1,611	1,085	11.1	85.8	23.1
75-79	186	357	1,252	702	2,281	1,703	12.0	92.4	16.8
80+	186	357	1,599	1,312	3,154	2,119	17.4	118.4	16.7
Total							109.3	414.3	523.6



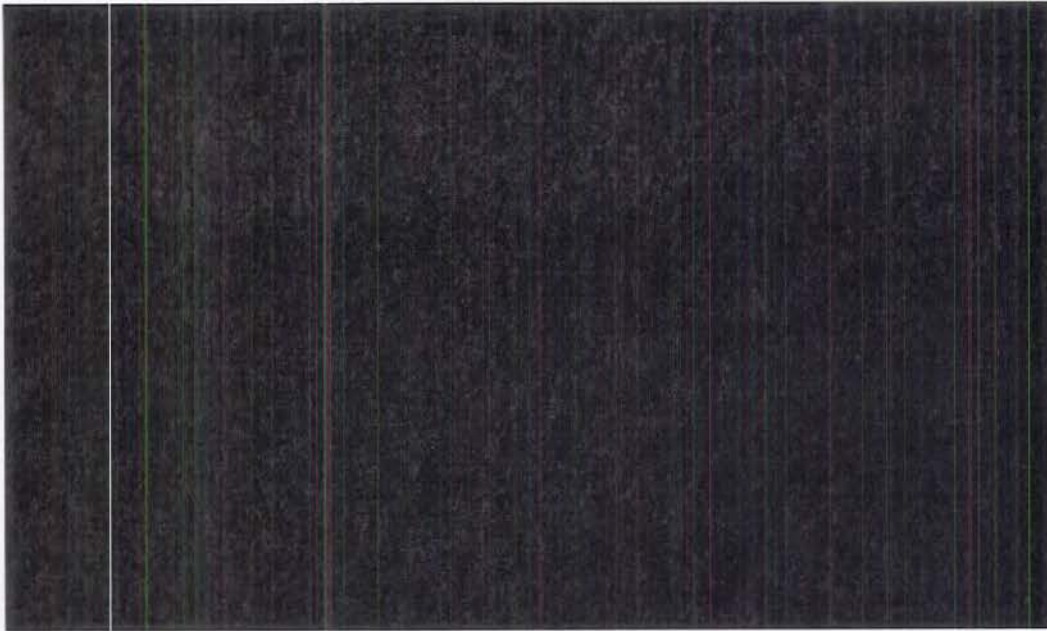


Alternative Scenario 1

This method mirrors the approach adopted for the age-related tax credits in 2012. It calculates an age-related credit for over 60's only, which does not vary by product level or gender and there is no additional bed utilisation credit. The risk equalisation credits (REC) are financed by a single stamp duty. The stamp duty does not vary with product level, gender or age except that children pay 1/3 of the adult rate.

The credits are calculated such that the credit less the stamp duty is equal to 65% of the difference between the cost of benefits for the age group and the average cost of benefits across all age groups. It is also subject to a limit, for each age group over 60, that the cost of benefits for that group should not be more than 150% of the average net cost across all ages. In this scenario the REC and stamp duty calculation is based on prescribed benefits.

Age		Stamp duty per person (€)	Credit per person (€)	Total Credits (€ million)	Total Stamp Duty (€ million)
0-17		103	-	0.0	48.4
18-29		310	-	0.0	62.5
30-39		310	-	0.0	90.7
40-49		310	-	0.0	91.1
50-54		310	-	0.0	41.8
55-59		310	-	0.0	39.7
60-64		310	619	70.0	35.1
65-69		310	962	96.2	31.1
70-74		310	1,338	90.3	20.9
75-79		310	2,097	102.3	15.1
80+		310	2,757	132.8	14.9
Total				491.6	491.6

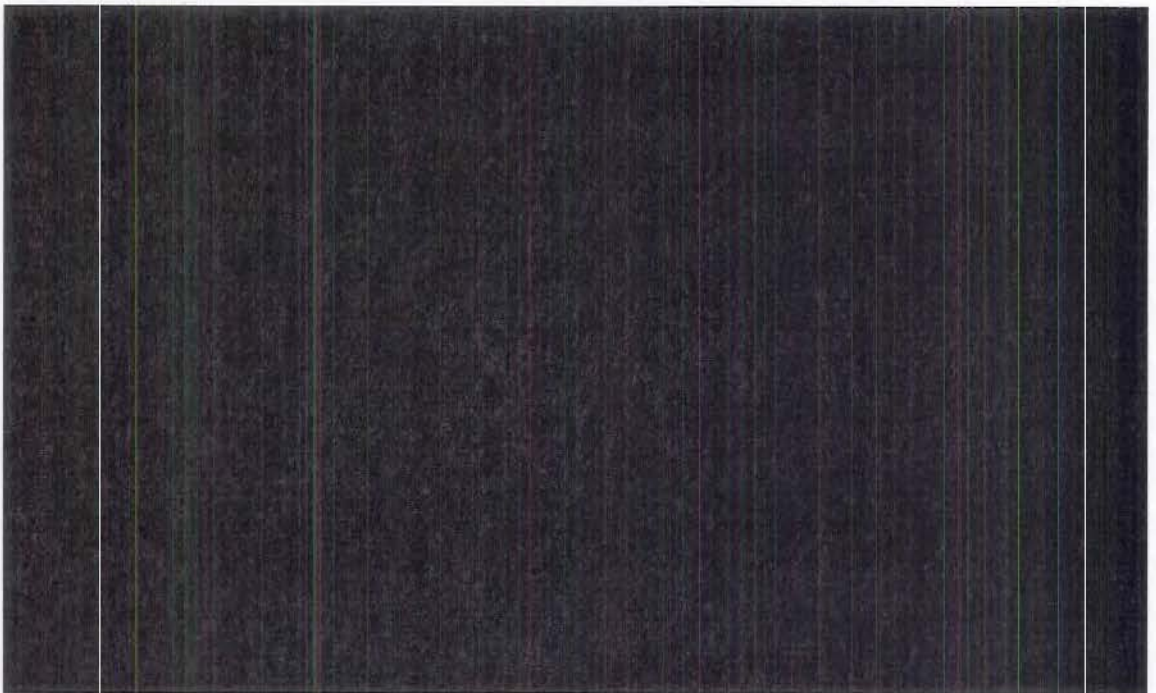
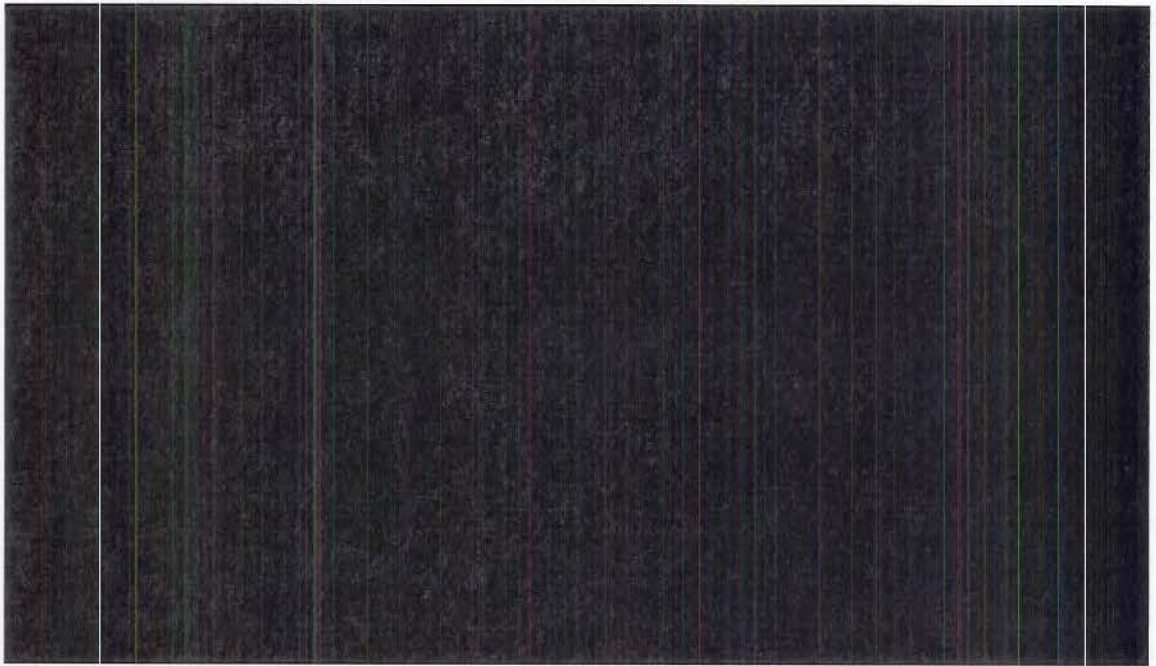


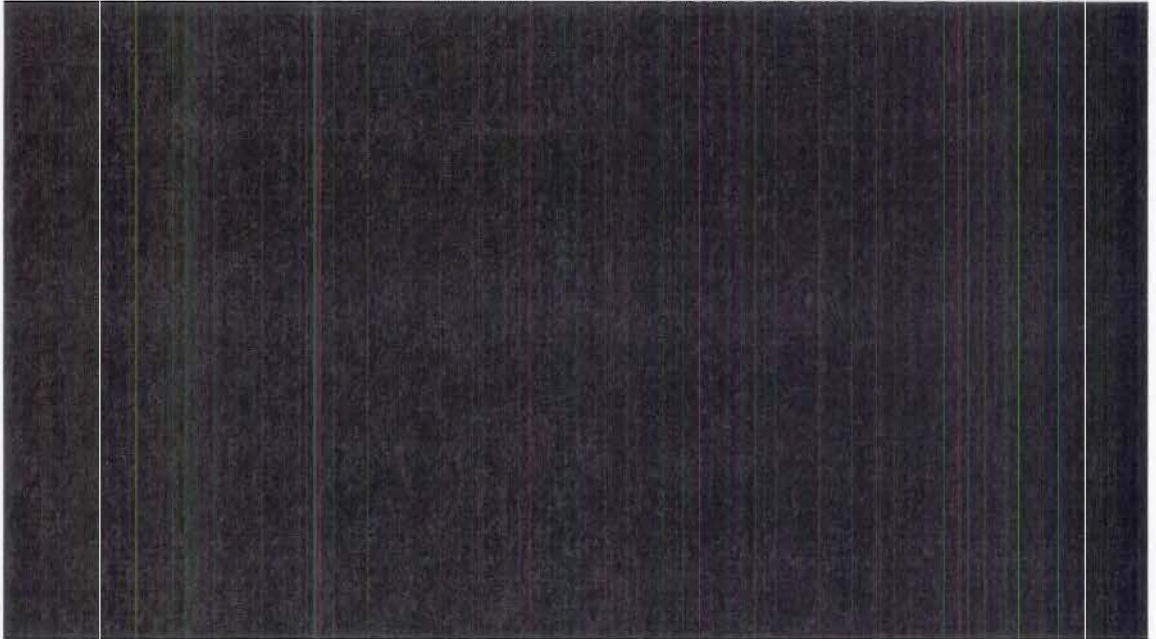
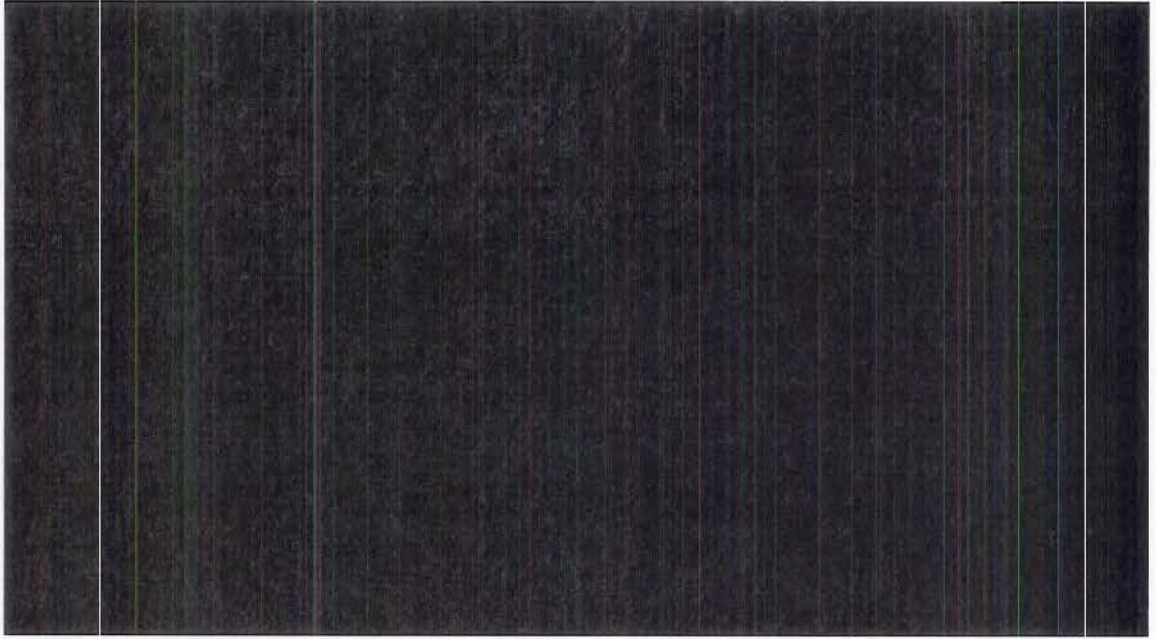
Alternative Scenario 2

This method calculates a credit by gender, product level and age (over 60's only). There is no additional bed utilisation credit. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or age except that children pay 1/3 of the adult rate.

The credits are calculated such that the credit less the stamp duty is equal to 65% of the difference between the cost of benefits for the age group and the average cost of benefits across all age groups. It is also subject to a limit, for each age group over 60, that the cost of benefits for that group should not be more than 150% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 49% of the stamp duty relating to age and gender credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanced	Advanced	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	54	110	-	-	-	-	-	0.0	48.4
18-29	162	331	-	-	-	-	-	0.0	59.5
30-39	162	331	-	-	-	-	-	0.0	86.9
40-49	162	331	-	-	-	-	-	0.0	89.0
50-54	162	331	-	-	-	-	-	0.0	41.3
55-59	162	331	-	-	-	-	-	0.0	39.3
60-64	162	331	363	279	713	610	-	69.5	34.9
65-69	162	331	553	406	1,128	943	-	97.7	31.4
70-74	162	331	770	580	1,643	1,199	-	90.8	21.4
75-79	162	331	1,339	744	2,392	1,795	-	97.2	15.6
80+	162	331	1,739	1,429	3,398	2,298	-	128.0	15.5
Total								483.3	483.3



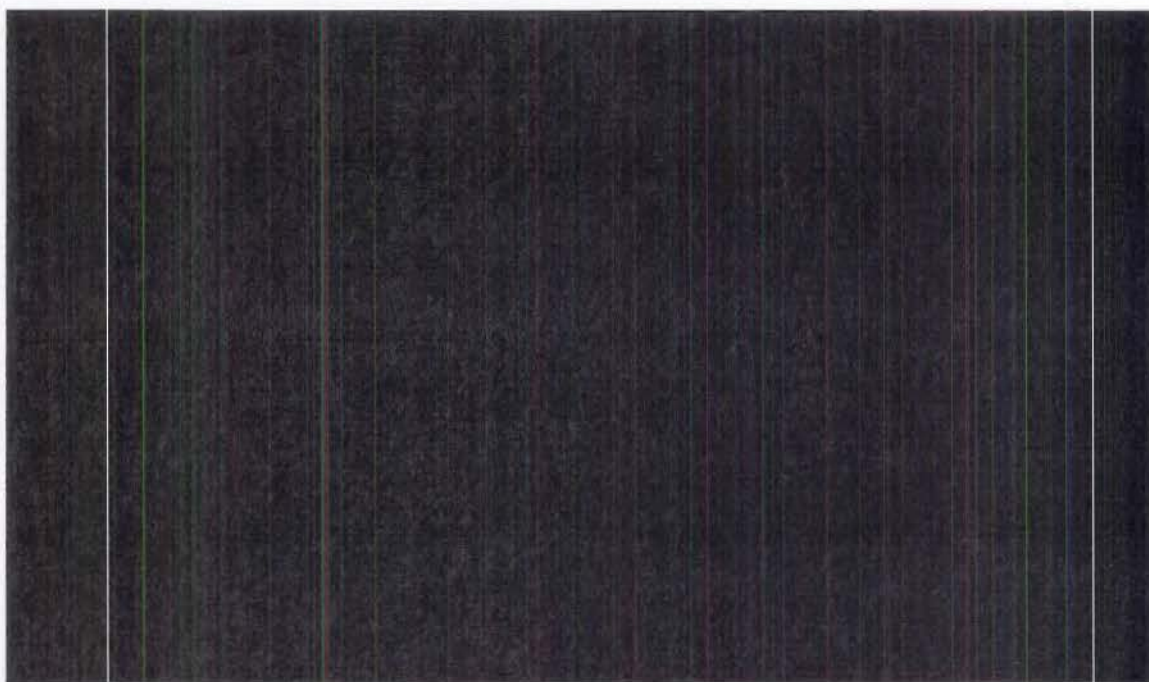
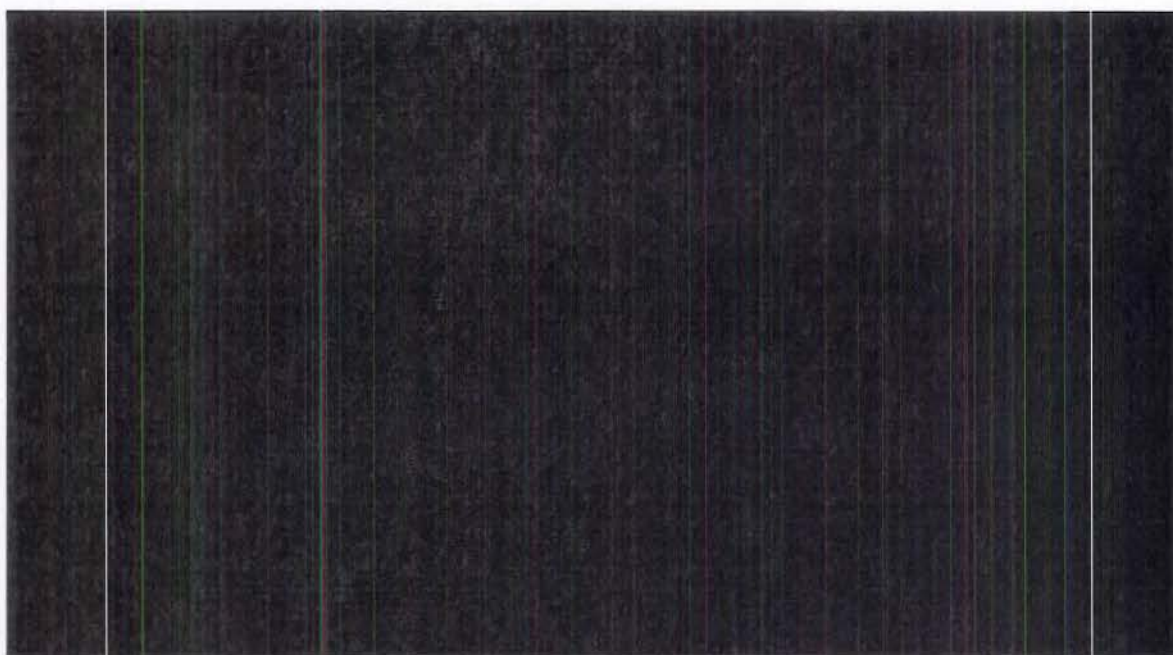


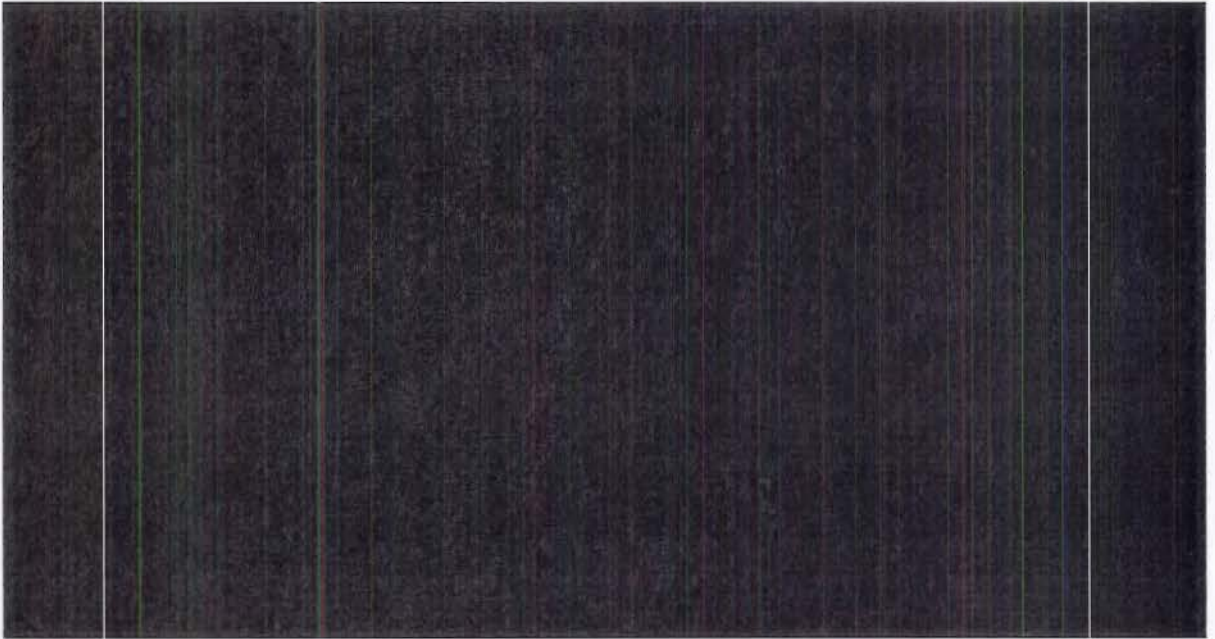
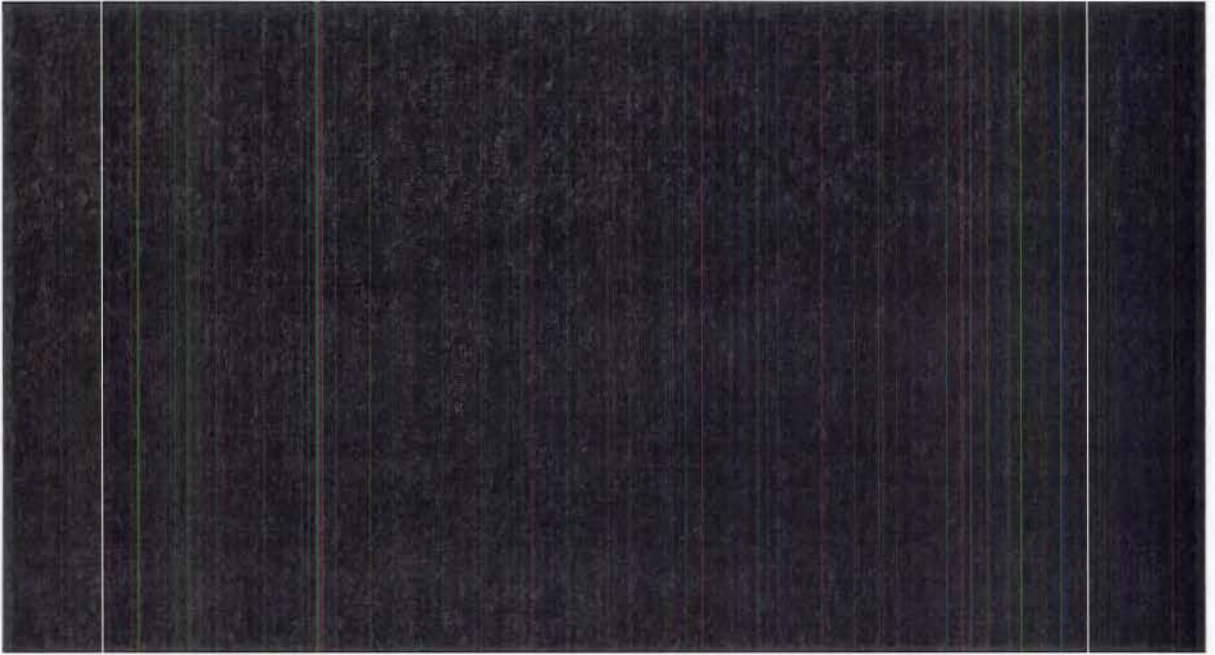
Alternative Scenario 3

This method calculates a credit by gender, product level and age (over 60's only). There is no additional bed utilisation credit. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 150% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 49% of the stamp duty relating to age and gender credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisatio n Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanc ed	Advance d	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	46	94	-	-	-	-	-	0.0	41.3
18-29	138	283	-	-	-	-	-	0.0	50.8
30-39	138	283	-	-	-	-	-	0.0	74.1
40-49	138	283	-	-	-	-	-	0.0	75.9
50-54	138	283	-	-	-	-	-	0.0	35.3
55-59	138	283	-	-	-	-	-	0.0	33.6
60-64	138	283	148	138	314	283	-	31.4	29.8
65-69	138	283	441	215	953	668	-	75.7	26.8
70-74	138	283	746	482	1,594	1,062	-	84.6	18.2
75-79	138	283	1,315	721	2,343	1,746	-	94.9	13.3
80+	138	283	1,715	1,405	3,350	2,250	-	125.8	13.2
Total								412.3	412.3



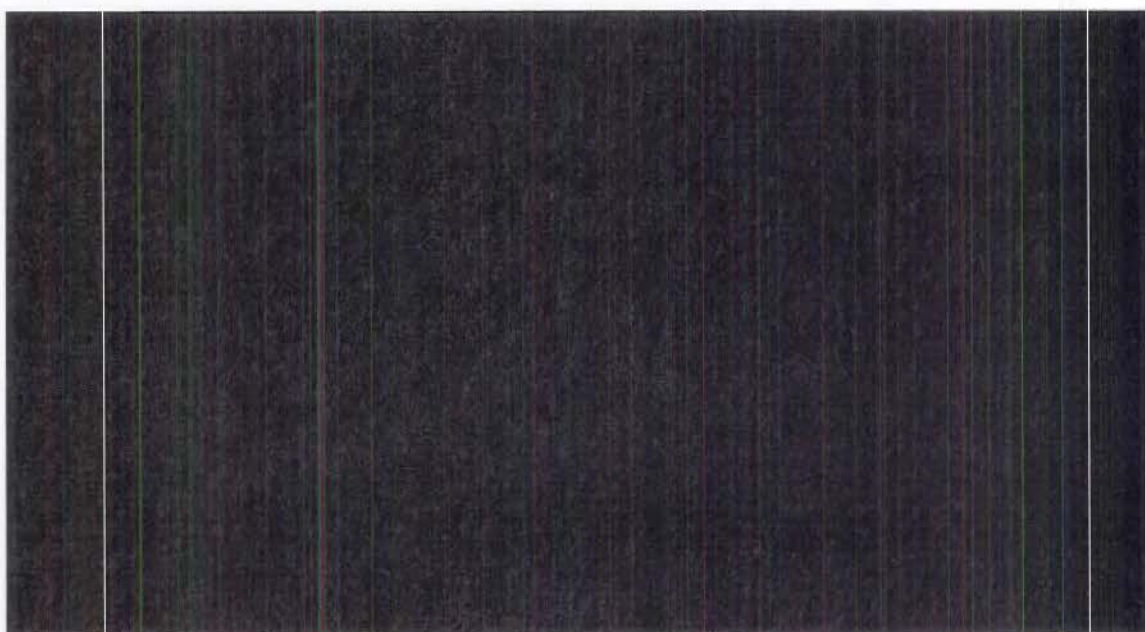
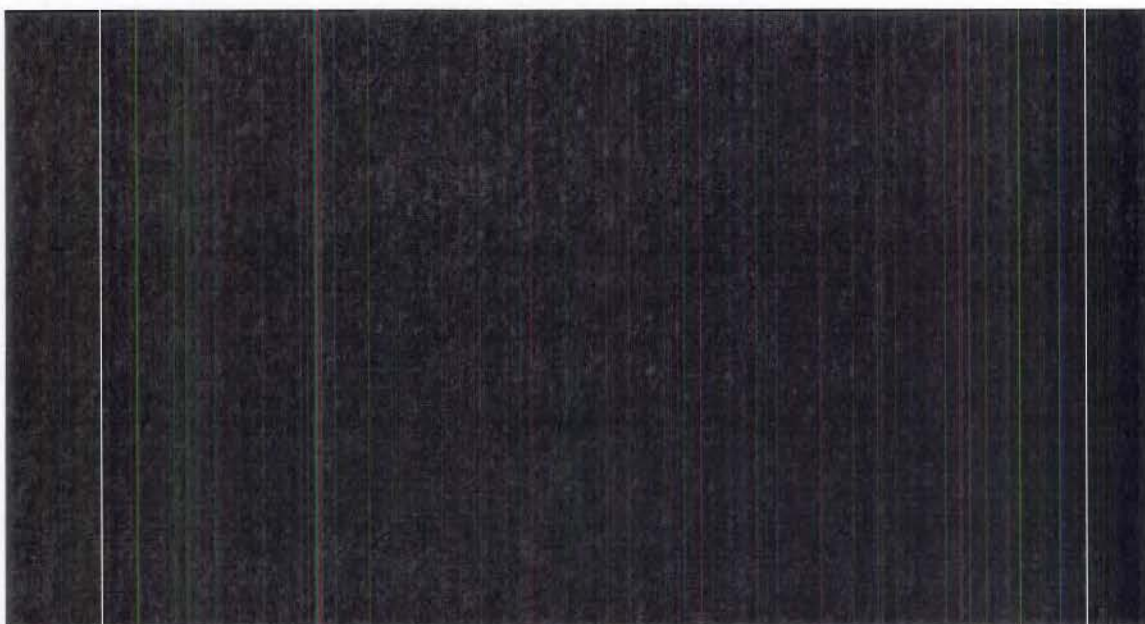


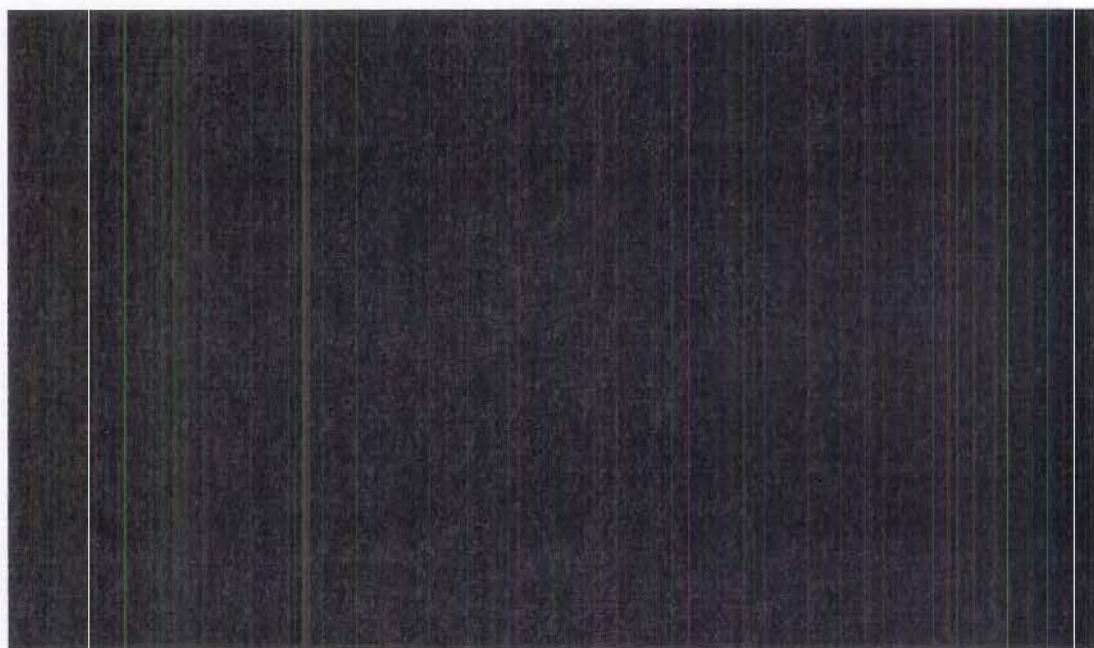
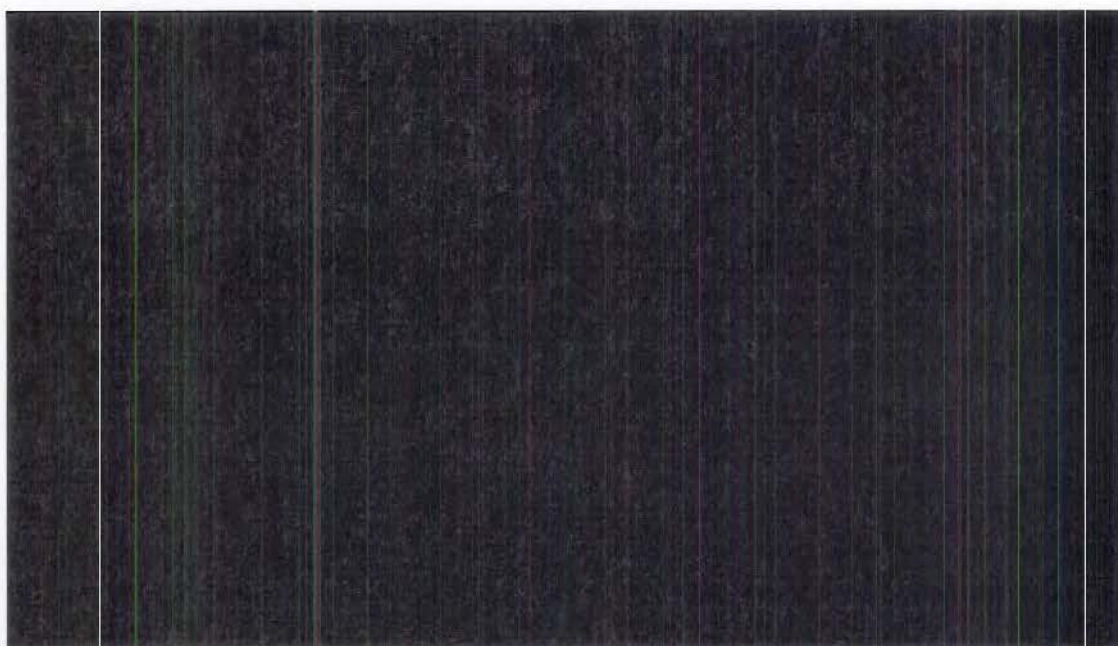
Alternative Scenario 4

This method calculates a credit by gender, product level and age (over 60's only). There is no additional bed utilisation credit. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 140% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 50% of the stamp duty relating to age and gender credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanced	Advanced	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	52	104	-	-	-	-	-	0.0	45.8
18-29	156	313	-	-	-	-	-	0.0	56.4
30-39	156	313	-	-	-	-	-	0.0	82.2
40-49	156	313	-	-	-	-	-	0.0	84.2
50-54	156	313	-	-	-	-	-	0.0	39.1
55-59	156	313	-	-	-	-	-	0.0	37.2
60-64	156	313	226	156	455	313	-	40.3	33.1
65-69	156	313	518	293	1,095	809	-	89.3	29.7
70-74	156	313	823	560	1,736	1,203	-	93.7	20.2
75-79	156	313	1,393	798	2,484	1,888	-	101.6	14.7
80+	156	313	1,793	1,482	3,491	2,391	-	132.4	14.6
Total								457.2	457.2



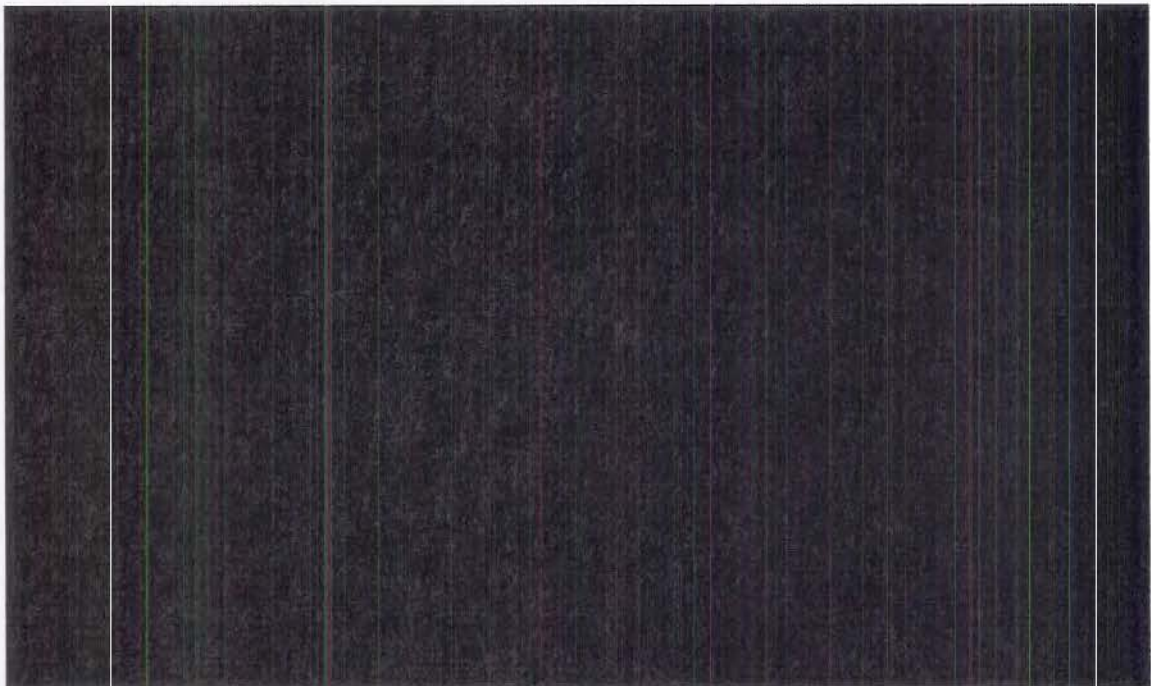
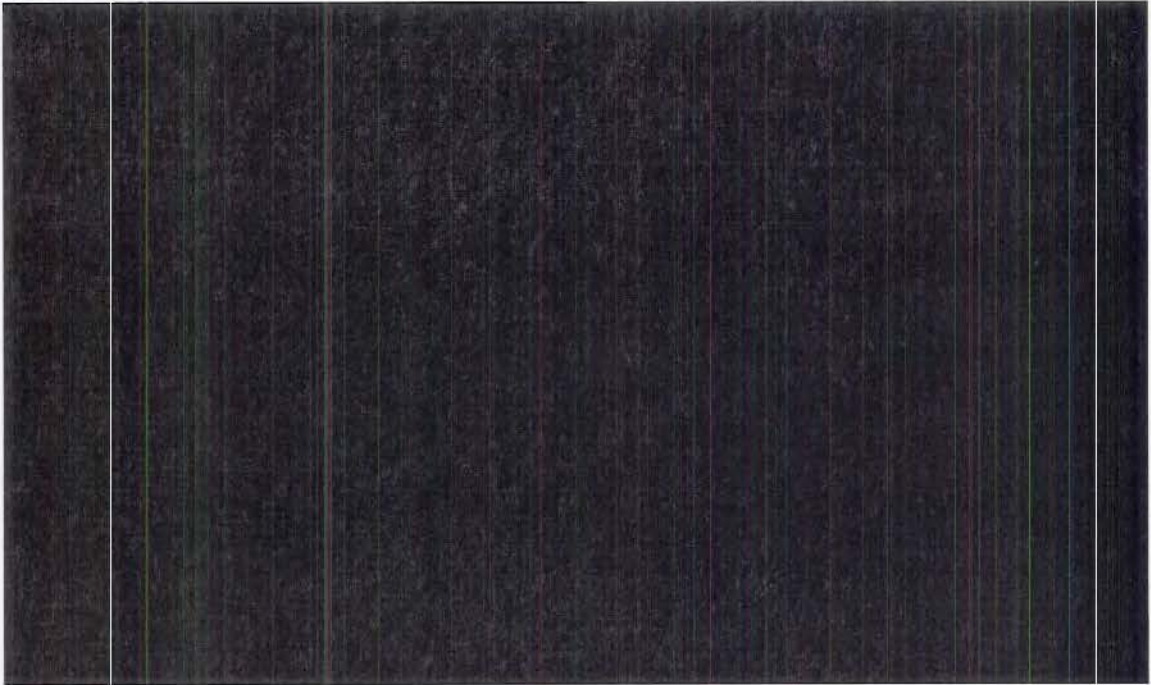


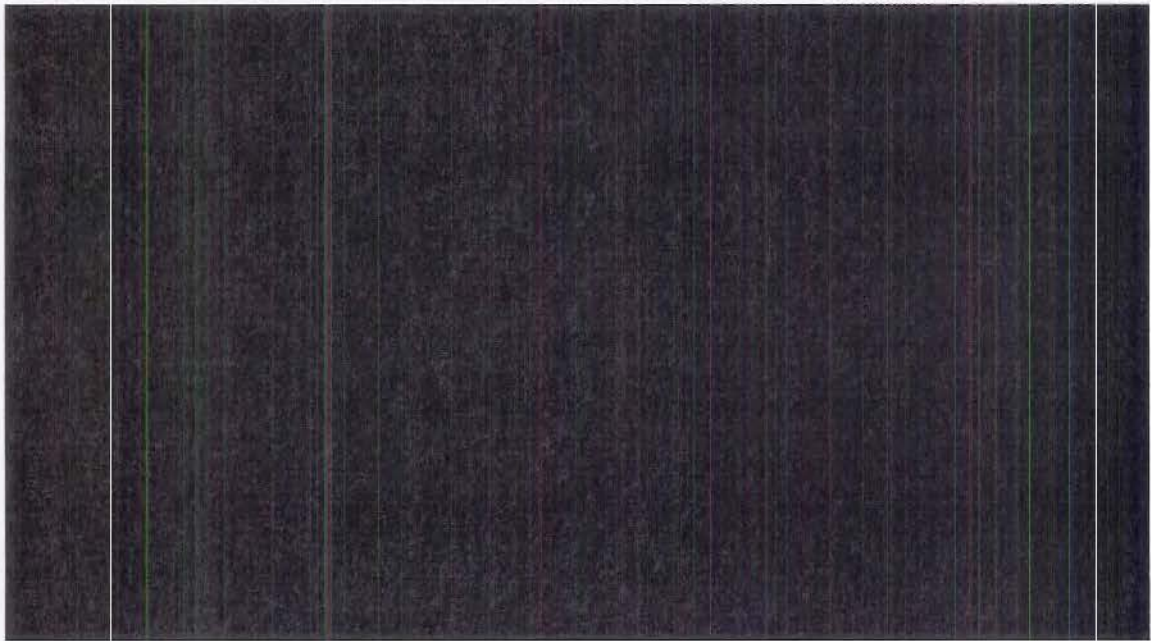
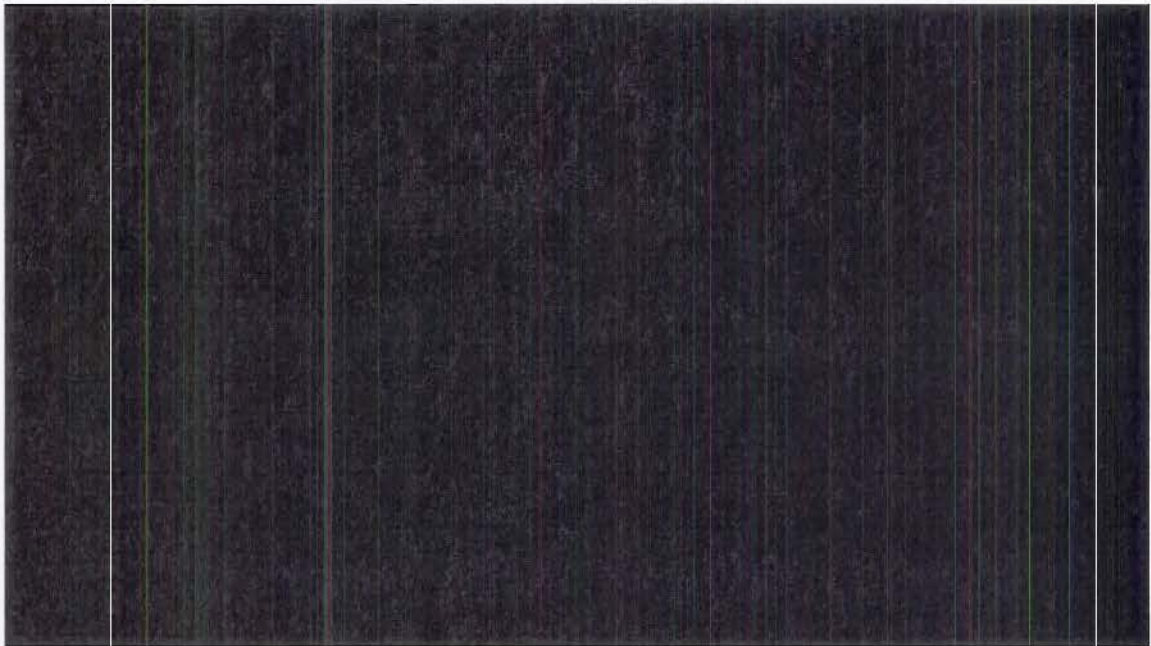
Alternative Scenario 5

This method calculates a credit by gender, product level and age (over 60's only). An additional bed utilisation credit of €100 is applied. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or by age except that children pay 1/3 of the adult rate.

The credits are calculated such that the credit less the stamp duty is equal to 65% of the difference between the cost of benefits for the age group and the average cost of benefits across all age groups. It is also subject to a limit, for each age group over 60, that the cost of benefits for that group should not be more than 150% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 50% of the stamp duty relating to age and gender credits for Advanced and above products. The stamp duty relating to bed utilisation credits for Non advanced products is set at 68% of the stamp duty relating to bed utilisation credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanced	Advanced	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	67	125	-	-	-	-	6.8	0.0	55.3
18-29	201	376	-	-	-	-	4.8	0.0	68.3
30-39	201	376	-	-	-	-	11.2	0.0	99.7
40-49	201	376	-	-	-	-	9.9	0.0	101.9
50-54	201	376	-	-	-	-	6.5	0.0	47.3
55-59	201	376	-	-	-	-	7.9	0.0	45.0
60-64	201	376	337	261	676	573	9.5	65.6	39.9
65-69	201	376	514	382	1,067	884	12.0	92.0	35.9
70-74	201	376	707	536	1,519	1,114	11.1	84.1	24.4
75-79	201	376	1,208	676	2,188	1,611	12.0	88.1	17.8
80+	201	376	1,555	1,267	3,061	2,026	17.4	114.1	17.6
Total							109.3	443.9	553.1



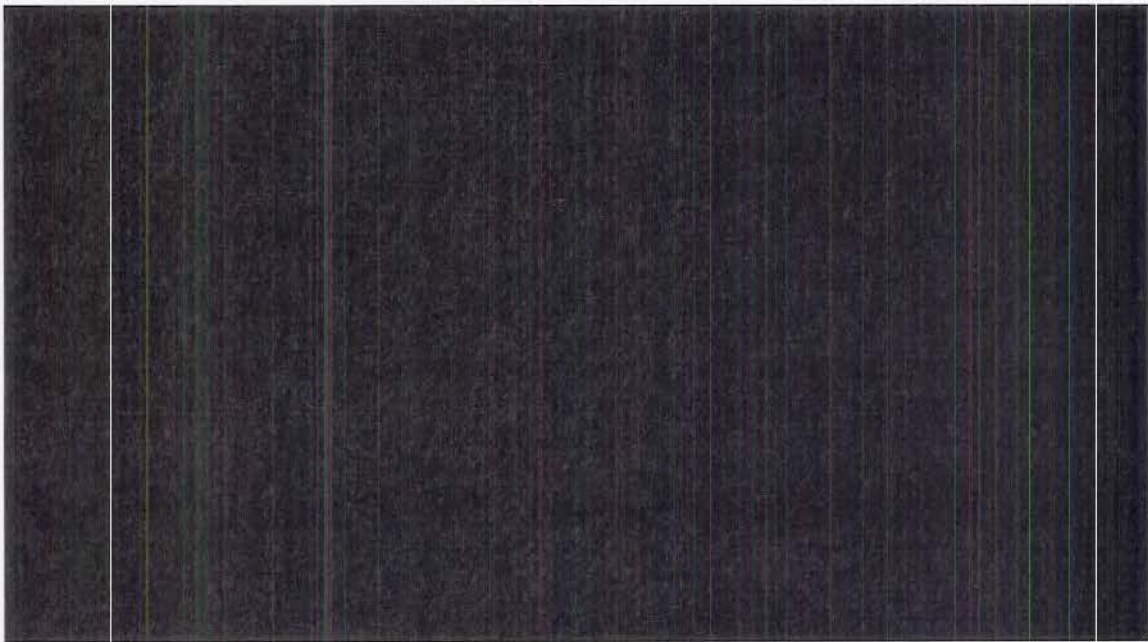
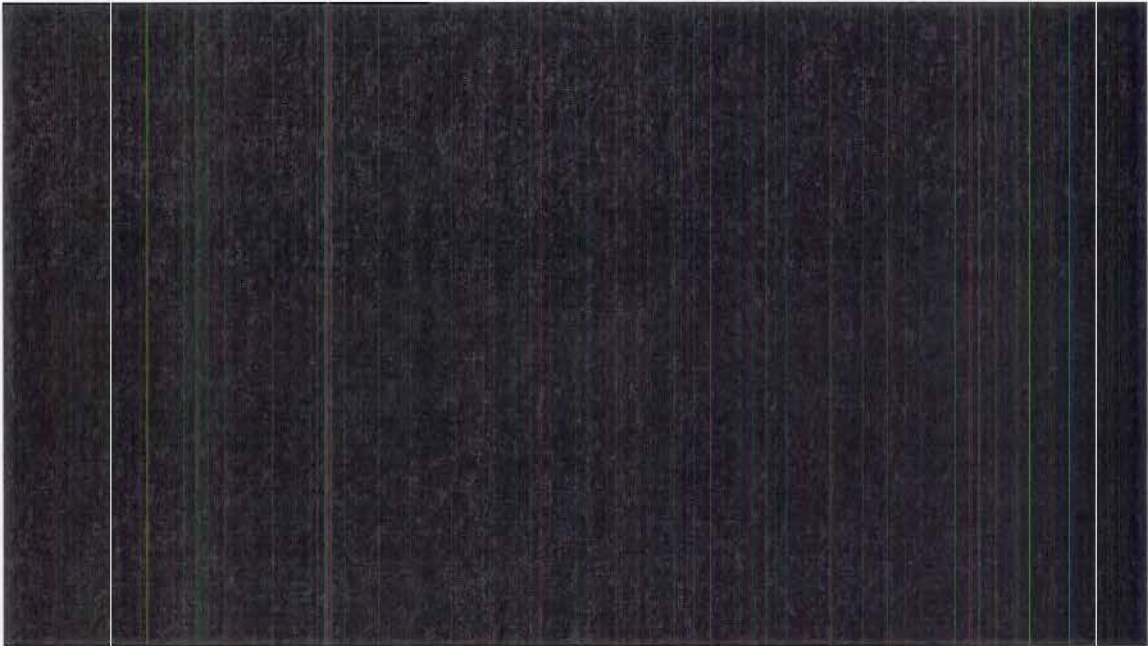


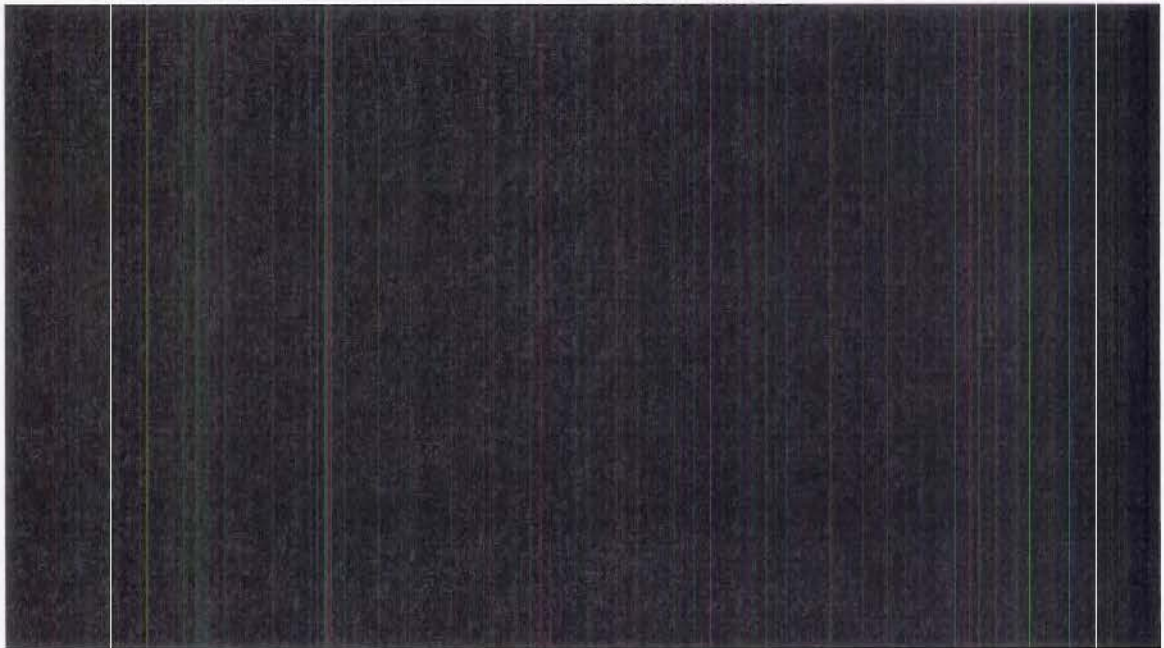
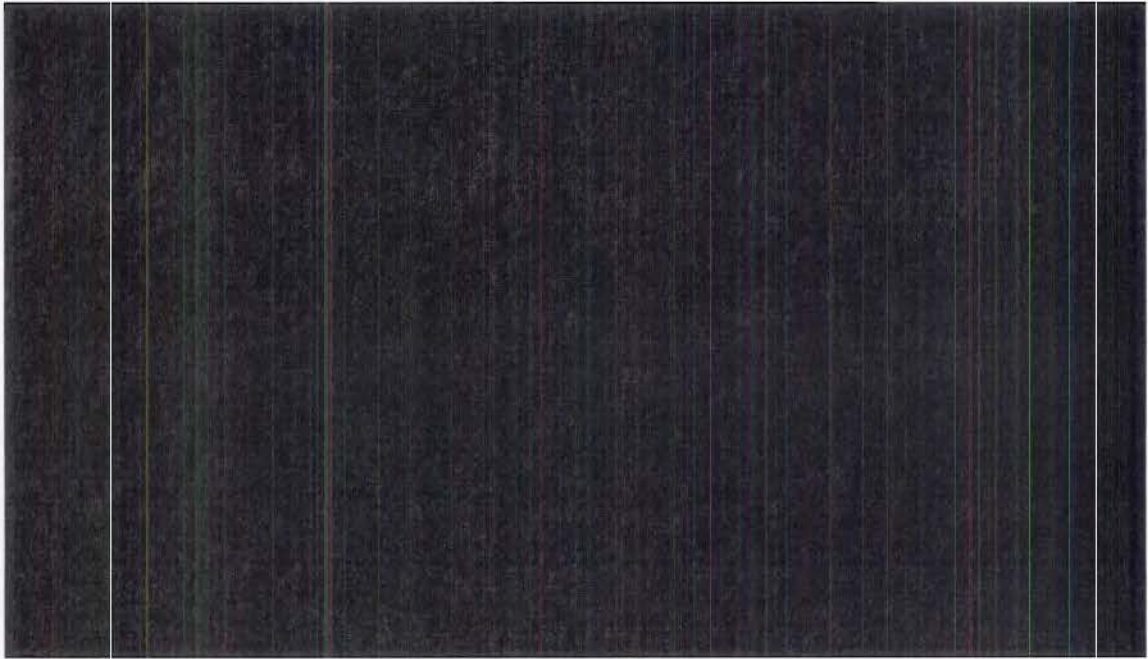
Alternative Scenario 6

This method calculates a credit by gender, product level and age (over 60's only). An additional bed utilisation credit of €100 is applied. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or by age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 150% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 48% of the stamp duty relating to age and gender credits for Advanced and above products. The stamp duty relating to bed utilisation credits for Non advanced products is set at 68% of the stamp duty relating to bed utilisation credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanced	Advanced	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	57	109	-	-	-	-	6.8	0.0	47.8
18-29	171	326	-	-	-	-	4.8	0.0	59.1
30-39	171	326	-	-	-	-	11.2	0.0	86.2
40-49	171	326	-	-	-	-	9.9	0.0	88.2
50-54	171	326	-	-	-	-	6.5	0.0	40.9
55-59	171	326	-	-	-	-	7.9	0.0	38.9
60-64	171	326	12	122	268	253	9.5	27.4	34.6
65-69	171	326	378	176	870	587	12.0	67.9	31.1
70-74	171	326	675	412	1,469	942	11.1	76.6	21.1
75-79	171	326	1,177	627	2,138	1,560	12.0	85.7	15.4
80+	171	326	1,525	1,237	3,011	1,976	17.4	111.7	15.3
Total							109.3	369.2	478.5



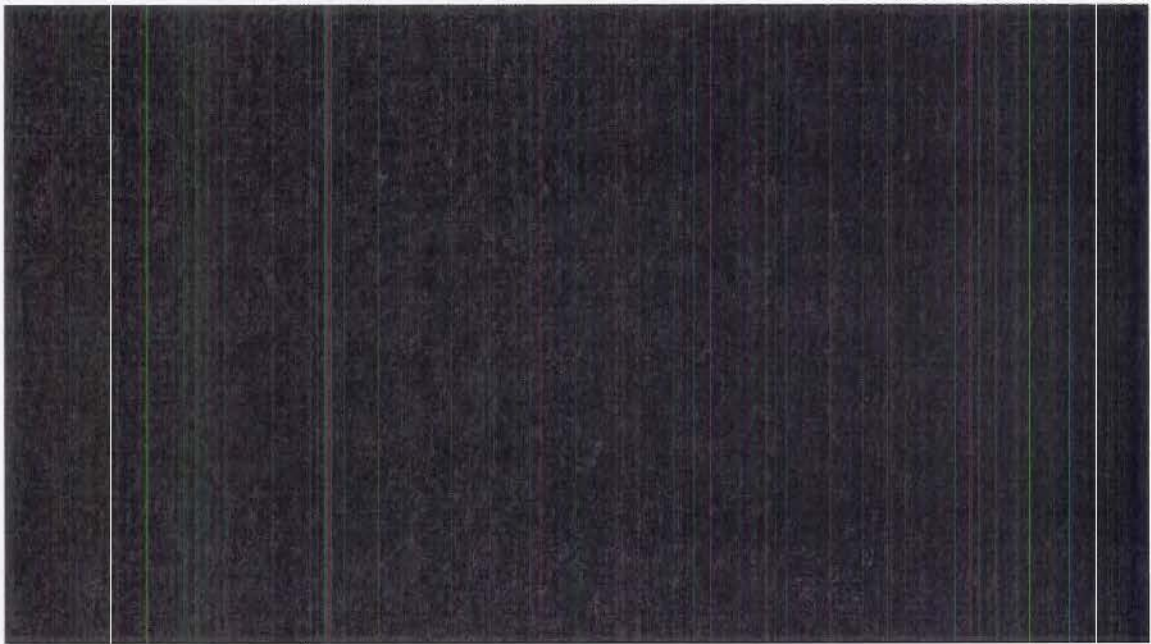
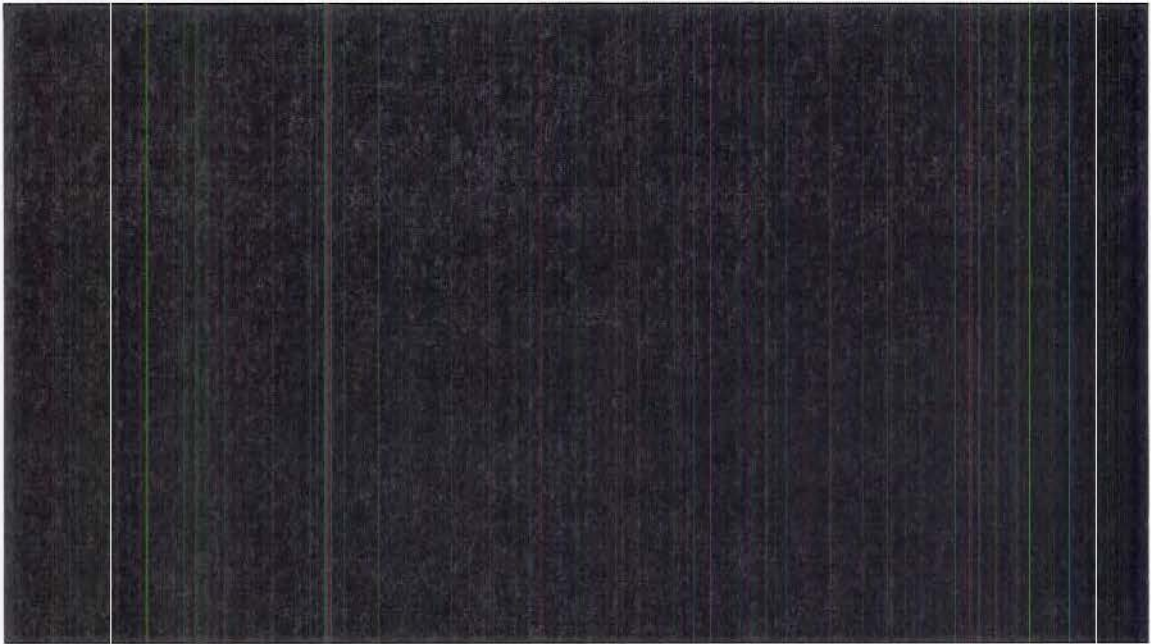


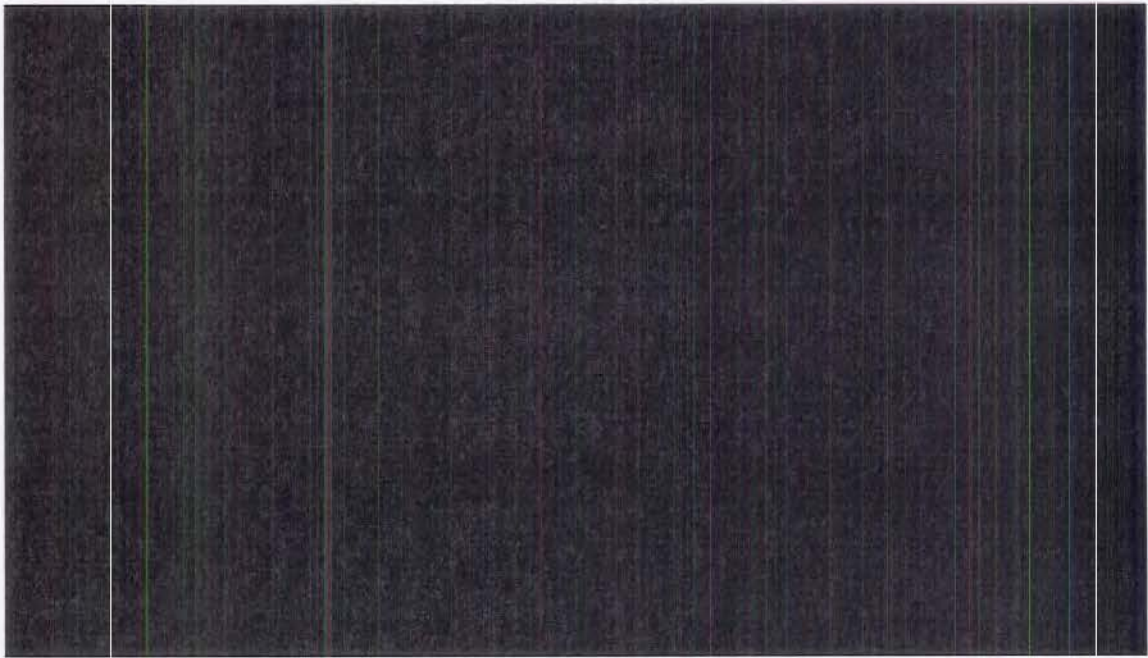
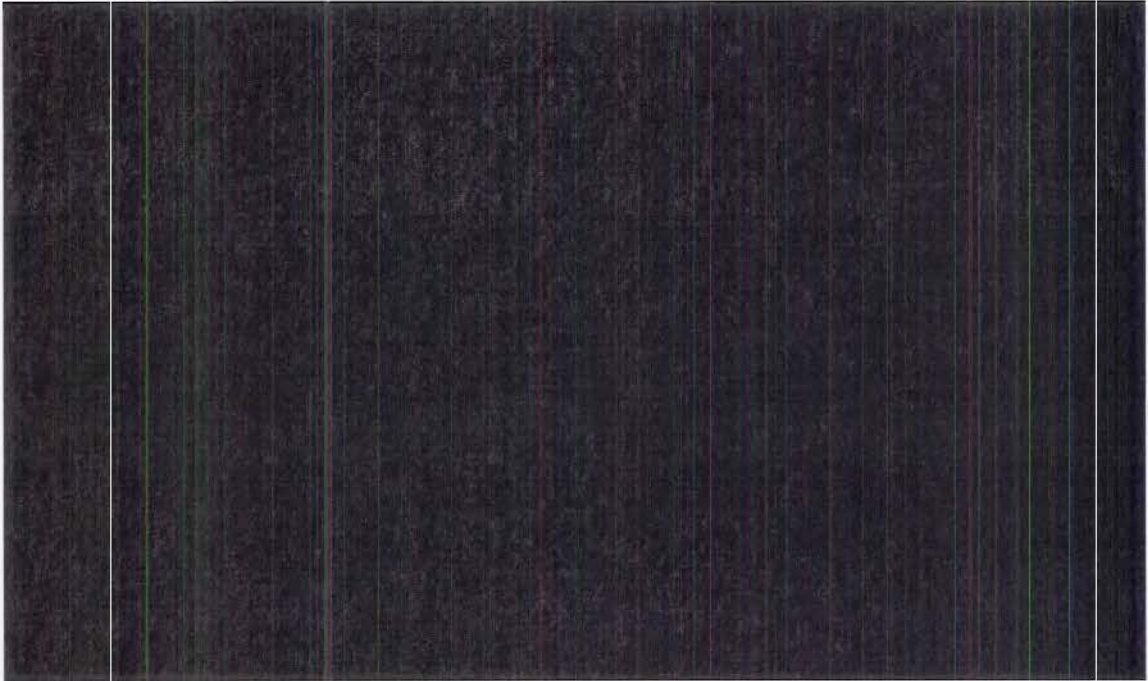
Alternative Scenario 7

This method calculates a credit by gender, product level and age (over 60's only). An additional bed utilisation credit of €200 is applied. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or by age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 140% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 47% of the stamp duty relating to age and gender credits for Advanced and above products. The stamp duty relating to bed utilisation credits for Non advanced products is set at 68% of the stamp duty relating to bed utilisation credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advance d	Advance d	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	73	133	-	-	-	-	13.7	0.0	58.9
18-29	219	400	-	-	-	-	9.6	0.0	72.9
30-39	219	400	-	-	-	-	22.3	0.0	106.4
40-49	219	400	-	-	-	-	19.8	0.0	108.7
50-54	219	400	-	-	-	-	13.0	0.0	50.4
55-59	219	400	-	-	-	-	15.9	0.0	48.0
60-64	219	400	140	120	364	255	19.1	32.1	42.6
65-69	219	400	391	212	930	650	24.0	73.7	38.2
70-74	219	400	680	417	1,487	965	22.2	77.9	26.0
75-79	219	400	1,116	609	2,077	1,518	24.0	83.2	18.9
80+	219	400	1,410	1,145	2,816	1,846	34.9	104.4	18.8
Total							218.5	371.3	589.8



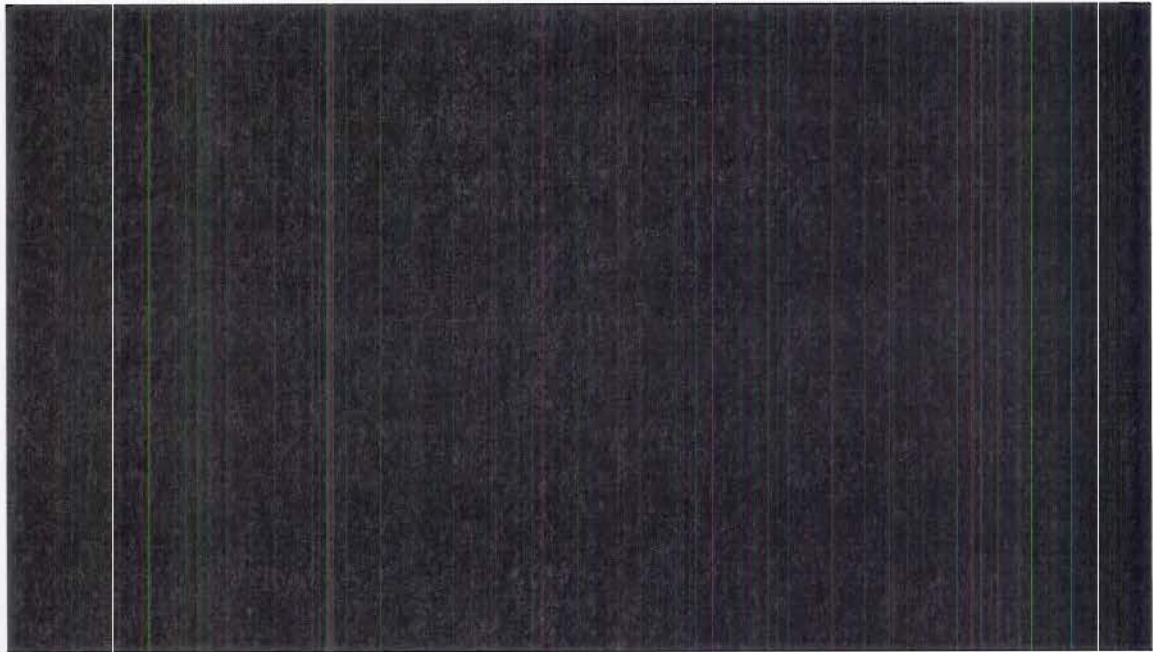
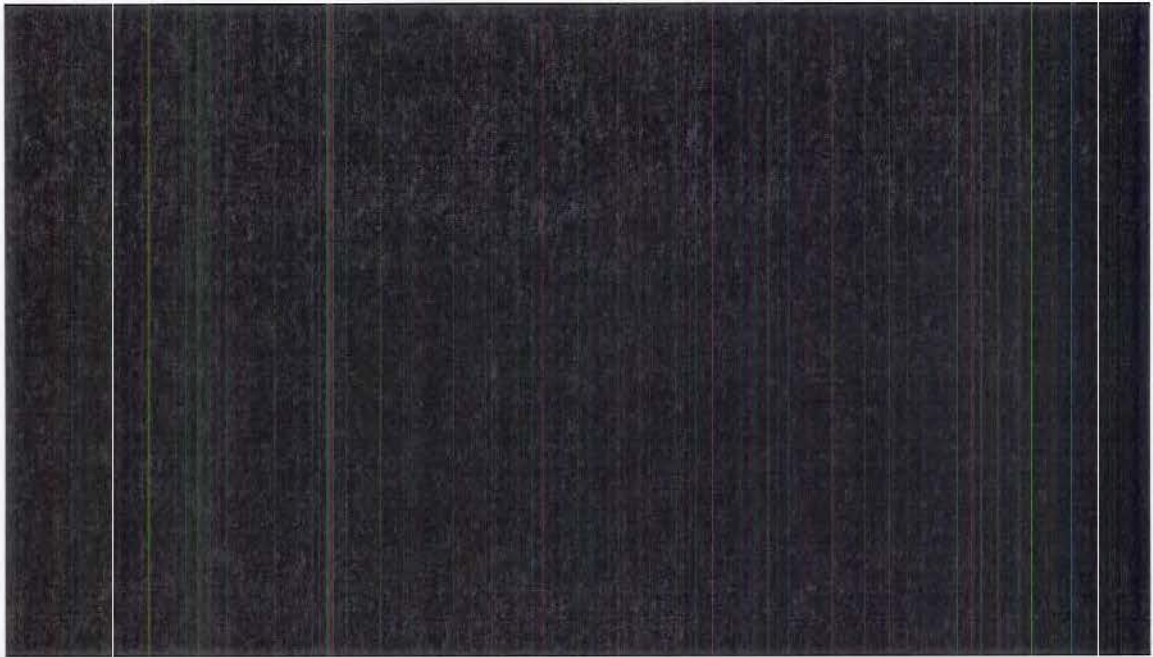


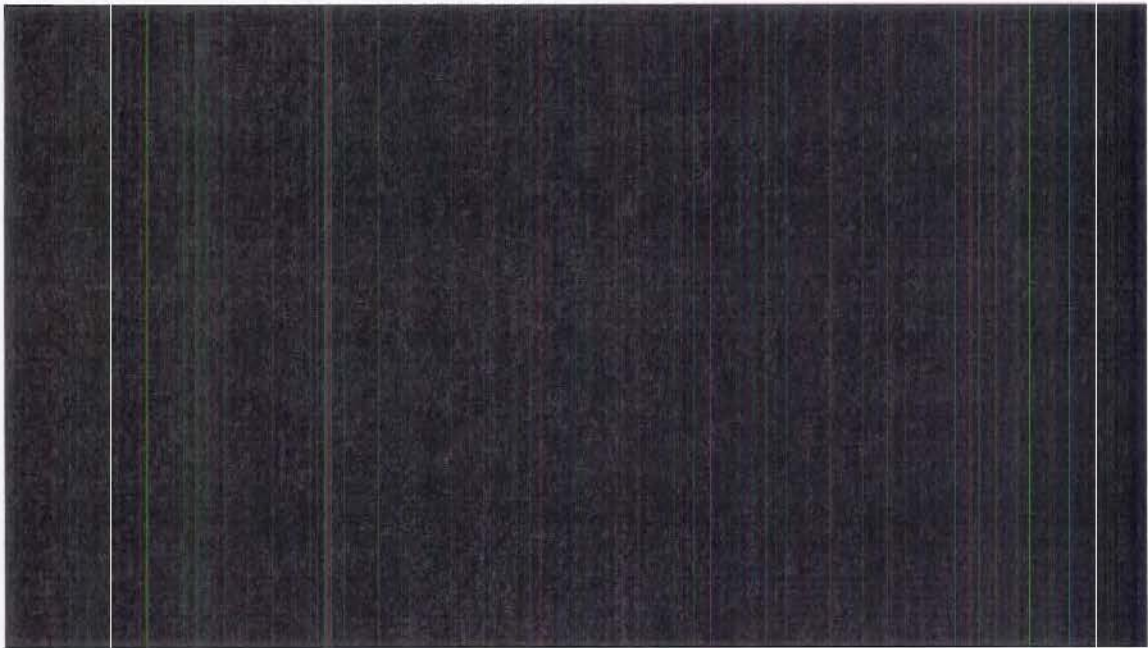
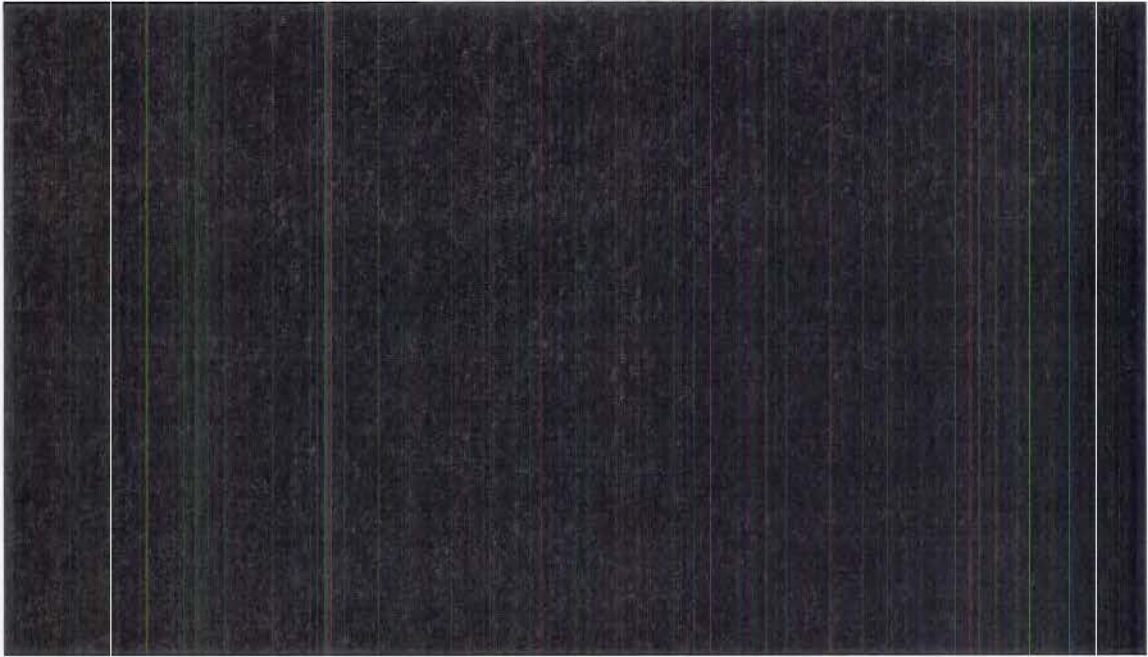
Alternative Scenario 8

This method calculates a credit by gender, product level and age (over 60's only). An additional bed utilisation credit of €100 is applied. The total risk equalisation credits (REC) are financed by a stamp duty which varies by product level. The stamp duty does not vary by gender or by age except that children pay 1/3 of the adult rate.

The credits are calculated such that, for each age group over 60, the cost of benefits for that group should not be more than 130% of the average net cost across all ages. The stamp duty relating to age and gender credits for Non advanced products is set at 48% of the stamp duty relating to age and gender credits for Advanced and above products. The stamp duty relating to bed utilisation credits for Non advanced products is set at 68% of the stamp duty relating to bed utilisation credits for Advanced and above products. In this scenario the REC and stamp duty calculation is based on returned benefits.

Age	Stamp duty per person (€)		Credit per person (€)				Total Bed Utilisation Credits (€ million)	Total Credits (€ million)	Total Stamp Duty (€ million)
	Non advanced	Advanced	Non advanced		Advanced				
			Men	Women	Men	Women			
0-17	68	131	-	-	-	-	6.8	0.0	57.4
18-29	203	392	-	-	-	-	4.8	0.0	70.9
30-39	203	392	-	-	-	-	11.2	0.0	103.4
40-49	203	392	-	-	-	-	9.9	0.0	105.8
50-54	203	392	-	-	-	-	6.5	0.0	49.1
55-59	203	392	-	-	-	-	7.9	0.0	46.7
60-64	203	392	258	153	557	398	9.5	49.6	41.5
65-69	203	392	530	328	1,159	876	12.0	95.4	37.3
70-74	203	392	827	564	1,758	1,231	11.1	95.3	25.4
75-79	203	392	1,329	779	2,427	1,850	12.0	99.3	18.5
80+	203	392	1,676	1,389	3,300	2,265	17.4	125.3	18.3
Total							109.3	465.0	574.2





Appendix 3 – Accounts and Projections for Vhi Healthcare

The Authority has received (via the Department of Health) financial projections prepared by Vhi Healthcare. The projections received included projections based on different assumptions of the impact of the risk equalisation system. The table below includes the projections with the closest projected risk equalisation impact for 2013.

The projections received also included projections for 2014 and 2015, but as these will be impacted by credits and levies in relation to which the Authority is yet to Report, these projections have not been included here.

	2011 €m	2012 €m	2013 €m	2013 €m
Earned Premiums before age related tax credits	1,295.8			
Claims incurred	(1,232.8)			
Change in Unexpired risk reserve	-			
Impact of Risk Equalisation System ⁷	41.1			
Expenses	(81.4)			
Underwriting Profit	22.7			
Impact of investments	(23.5)			
Profit before tax	(0.8)			
Tax	(0.1)			
Profit after tax	(0.7)			
End Year capital	295.2			
Projected Return on Equity	(0.2%)			
Average return on equity over 3 years				

In respect of the period 2009 to 2011 the Authority determined that a reasonable profit equates to a return on equity of 13%. Accordingly, the Authority concluded that no undertaking had been overcompensated in the period 2009 to 2011.

This supports the Authority's view (see pages 50 and 51) that

⁷ These figures relate to the calendar year and, as such, differ from figures provided elsewhere in this Report which relate to the policy year. The projected Risk Equalisation Impact for future years is also rounded up.

the Authority's conclusion on the appropriate risk equalisation credits will avoid overcompensation.

The Authority will, as soon as may be after the expiration of 2013 and each future year, determine what constituted a reasonable profit in respect of the three year period ending at end 2013 and each future year and whether any undertakings were overcompensated.