THE HEALTH INSURANCE AUTHORITY

An tÚdarás Árachas Sláinte

Report to the Minister for Health and Children on Risk Equalisation in the Irish Private Health Insurance Market

December, 2010

Table of Contents

1. Introduction

The Health Insurance Authority

The Authority is a statutory regulator for the Irish private health insurance market. It was established in 2001 under the Health Insurance Acts 1994 to 2009. The principal functions of the Authority as provided for in the Health Insurance Acts include the following:

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

The Consultation Process

Provision for risk equalisation was first made in the Health Insurance Act, 1994, section 12 of which empowered the Minister to prescribe a scheme for risk equalisation. A Risk Equalsiation Scheme was introduced in 2003. In December 2005, the Minister decided, on the Authority's recommendation, which referred to risks now materialising, to commence risk equalisation payments under the Scheme as from 1 January 2006, but in the event the relevant legislation was overturned by the Courts in 2008.

Since 1994, there have been a number of studies and reports in relation to risk equalisation in Ireland. As such, the issue of risk equalisation has been the subject of extensive analysis and debate over many years. The arguments of interested parties have been considered throughout and the conclusion has consistently been reached that risk equalisation is necessary in order to maintain community rating.

Following the quashing of the 2003 Risk Equalisation Scheme, the Government announced its intention to introduce a new risk equalisation system that is "robust, transparent and effective". The Government introduced interim measures to support community rating in the Health Insurance (Miscellaneous Provisions) Act, 2009 while other long-term measures are being developed.

Following the Government Decision on health insurance in May 2010, the Minister wrote to the Authority on 8 June and asked it to carry out a consultation process regarding a new comprehensive risk equalisation system to take effect in 2013 and transitional arrangements to apply in 2012 and to report to the Minister. The Minister stated the following:

> "In setting out on this consultation, it is important to make clear to the Authority that the Government has decided that the new risk equalisation scheme should be comprehensive and cover as much as possible in terms of the levels and indicators of risk which can and should, where practicable, be taken into account. While not wishing to prejudge the outcome of the consultation, the Government has decided that the key elements of age, gender and health status must form part of any proposals on the new risk equalisation scheme, and that as much as possible of this should be included in the transitional arrangements to be put in place in advance of the introduction of the risk equalisation scheme
>
> Accordingly, I would wish to hear from the Authority, following the consultations, your views on what range of measures can be taken to allow for health status to be effectively incorporated into the new arrangements for the transitional scheme, for the risk equalisation scheme and your considered views on the mechanisms and any other observations on both schemes".

On 21 June 2010, the Authority published its Consultation Paper on Risk Equalisation in the Irish Private Health Insurance market. The Consultation Paper was advertised in the national press and interested parties were invited to make submissions.

It is important to note that, the purpose of this study is not to determine whether or not further regulation is required or to determine whether or not the necessary form of regulation is a robust risk equalisation system (these are matters that have already been determined following extensive analysis and consultation over many years). Rather, this study is a technical study to advise on the structure of the 2013 and Transitional Risk Equalisation Systems.

Having regard to the Government's guidelines on regulatory impact analysis, the Consultation Paper set out the policy context for the risk equalisation system and stated the objective of the system (i.e. "to support to the core principle of community rating"). The Paper also identified and analysed a number of options for the risk equalisation system and requested submissions that had regard to the principles of Necessity, Proportionality, Effectiveness, Accountability, Consistency and Transparency. This Report, particularly in Section 6, considers the costs, benefits and impacts of various different options for risk equalisation, having regard to the submissions received.

In August and September, the Authority received 15 submissions to the process. The Consultation Paper and the submissions can be viewed on the Authority's website at www.hia.ie.

The Report

This Report contains a brief background discussion on risk equalisation and relevant aspects of the health insurance system. A discussion of the risk factors that could be included in the 2013 and Transitional Risk Equalisation Systems is followed by the Authority's advice in relation to the structure of these systems.

2. Summary of Conclusions

A summary of the Authority's advice in relation to a Transitional Risk Equalisation System to take effect from 2012 and in relation to a Risk Equalisation System to take effect from 2013 is set out below.

Transitional Risk Equalisation System

The Minister has informed the Authority that the Government has determined that the taxation system will be used to effect payments under the Transitional Risk Equalisation System.

In relation to how payments are calculated, the Authority considers that the Transitional Risk Equalisation System should provide for more detailed returns and should take more factors into account in calculations. This will enable a greater understanding of the reasons for differences between the claims rates of different insurers, in particular as to the extent to which such differences relate to product differences, rather than health related risk factors or other factors. Specifically, the Authority recommends that the Transitional Risk Equalisation System should operate in the same way as the current Interim System, with the following changes:

- Insurers should be required to submit returns to the Authority detailing total claims paid and prescribed claims paid for each product, gender and year of age. Prescribed claims paid would be defined in the same way as they are under the current interim measures.
- Separate tax credits should be provided for 5-year age bands and for each gender.

Risk Equalisation System to Apply from 2013 (the "2013 Risk Equalisation System")

The Minister informed the Authority that the Government has determined that, from 2013, the risk equalisation system should be comprehensive and should cover as much as possible in terms of the levels and indicators of risk which can and should, where practicable, be taken into account. The Authority considers that, in general, the more risk factors that are provided for in a risk equalisation system, the more effective that system will be in supporting community rating. However it will never be possible or practicable to fully address all risk differences within a risk equalisation system. Consequently there will always be some incentives for insurers to select lower risk lives and to segment their insured populations so that older and less healthy people are charged more. The critical issue is for a risk equalisation system to address risk differences sufficiently to ensure that the selection and segmentation of risk does not frustrate community rating to the extent that the operation of the market suffers and less healthy and older people (on average) pay much more for their health insurance.

In relation to how payments are calculated under the 2013 Risk Equalisation System, the Authority considers that in addition to the measures outlined for the Transitional Risk Equalisation System, the 2013 system should take account of the prevalence of chronic illness within an insurer's population as well as the product mix sold by the insurer. Consequently, the 2013 system would provide for the following:

- Insurers should be required to submit returns to the Authority detailing total inpatient claims paid and other claims paid for each product, gender, chronic illness and year of age.
- Risk equalisation payments would depend on the following:
    - Age (with 5-year age bands).
    - Gender.
    - Diagnosis with a chronic illness.
    - Level of cover provided. (For example, a higher level of payment could arise in respect of plans that provide cover for higher cost private hospitals than for plans that only provide cover for public hospitals).
- The 2013 Risk Equalisation System would be regularly reviewed in order to address market developments and to optimise its effectiveness.

Methodology for administering payments
Payments under a risk equalisation system may be administered in a number of different ways, including the following:

- Through tax credits funded by the taxation system;
- Through a risk equalisation fund funded by the taxation system; or
- Through risk equalisation transfers between insurers via a risk equalisation fund.

In a number of other jurisdictions (e.g. the Netherlands) where community rating is Government policy, the taxation system has a role in funding the risk equalisation/loss compensation system, as such a system is a necessary element in maintaining a community rated market. This is consistent with the role of a taxation system in that taxes are raised and disbursed in order to fund the implementation of Government policy.

Also, in Ireland, the interim measures of age related tax credits to support community rating, which were introduced in 2009 for a period of three years, support community rating through the tax system. This methodology for effecting the payments has a number of advantages:

- Such a system has already been successfully implemented in Ireland. This system is currently providing practical support for the Principal Objective of community rating.
- The system is transparent in showing that the benefit is for older less healthy people irrespective of which insurer they are insured with. It is clear that all insured lives bear a proportionate cost of this support.
- The system is flexible and can be adapted so that it remains effective in achieving its objective of supporting community rating.

- The system uses well established systems and processes, both administrative and legal.
- There is experience of operating such a system in Ireland and the impact on the market has been observed.

The 2013 Risk Equalisation system will be significantly more complex to administer than either the interim or transitional systems. Nevertheless, the Authority would favour that it would continue to operate via the tax system for the reasons outlined above. If such an approach were not considered practicable, due to the large number of different age / gender / chronic illness / product tax credits that would be required, the system could be administered via a Risk Equalisation Fund operated by the Health Insurance Authority. Such a Risk Equalisation Fund could receive transfers directly from insurers or alternatively could be funded by a stamp duty payable in respect of insured people and disbursed by the Authority to all insurers in proportion to the number of older / less healthy people insured.

Other Recommendations

There should be a formal review of the Risk Equalisation System every three years.

The legislation should provide the Minister or the Authority with the power to publish the Authority's reports under the Transitional and 2013 Risk Equalisation Systems.

3. Background to Consultation Process

The Irish private health insurance regulatory system is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefit and aims to ensure that private health insurance does not cost more for those who need it most. The system is unfunded, meaning that there is no fund built up over the lifetime of an insured person to cover their expected claims cost. Instead, the total premium contributed by all insured people is used to cover the total cost of claims and expenses in that year.

Risk equalisation is a process that aims to equitably neutralise differences in insurers' claims costs that arise due to variations in the health status of their members. Where it applies, risk equalisation involves transfer payments between health insurers to spread some of the claims costs of high risk members amongst all the private health insurers in the market in proportion to their market share. Risk equalisation is a common mechanism in countries with community rated health insurance systems.

Provision for risk equalisation was first made in the Health Insurance Act, 1994, section 12 of which empowered the Minister to prescribe a scheme for risk equalisation. Since that time there have been a number of studies and reports in relation to risk equalisation in Ireland.

Specifically:

- On 25th June 1997, the Minister appointed an independent Advisory Group to consider risk equalisation. The Report of that Advisory Group (often referred to as "the Harvey Report" by reference to its Chairman) was issued on 8th April 1998.

- The Minister then engaged in a consultation process on private health insurance and risk equalisation. A Technical Paper on a Proposed Amended Scheme was published by the Department of Health and Children in January 1999.

- The Authority was established on 1 February 2001 and its principal functions include specific responsibility with regard to risk equalisation and to advise the Minister on matters relating to the functions of the Minister or the Authority and health insurance generally. On 19th February 2002, the Authority published a Consultation Paper on Risk Equalisation in the Private Health Insurance Market in Ireland. This was a wide ranging consultation process conducted in order to seek representations on issues relating to risk equalisation from stakeholders and interested parties in the private health insurance market in Ireland and, in particular, to seek views as to how the Authority should exercise its powers and duties in relation to risk equalisation. Having considered the submissions made, the Authority published a Policy Paper on Risk Equalisation in the Private Health Insurance Market in Ireland in September 2002.

- The Risk Equalisation Scheme 2003 came into effect on 1 July 2003 and in the same month the Authority commissioned York Health Economics Consortium (a firm of consultants specialising in the area of health economics) in conjunction with the Office of Health Economics in the UK ("York") to undertake an independent review.

  York consulted extensively with the industry in this regard and in November 2003, York presented its report entitled "Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market" to the Authority.

- The Authority has submitted regular Reports to the Minister in relation to Risk Equalisation under the 2003 Risk Equalisation Scheme, under the Interim Measures and otherwise. These Reports has regard to the views of interested parties and many involved formal consultation with insurers.

It can be seen from the foregoing that the issue of risk equalisation has been the subject of extensive analysis and debate over many years. The arguments of interested parties have been considered throughout and the conclusion has consistently been reached that risk equalisation is necessary in order to maintain community rating.

Interim Measures to support Community Rating

In December 2005, the Minister decided, on the Authority's recommendation, which referred to risks now materialising, to commence risk equalisation under the then applicable legislation as from 1 January 2006, but in the event the relevant legislation was overturned in the Courts in 2008.

Following the quashing of the 2003 Risk Equalisation Scheme, the Government announced its intention to introduce a new risk equalisation system that is "robust, transparent and effective". The Government introduced interim measures to support community rating in the Health Insurance (Miscellaneous Provisions) Act, 2009 while other, more robust measures, are being developed.

The Health Insurance (Miscellaneous Provisions) Act, 2009 introduced a system of age related tax credits as interim measures to support community rating. The Act provides that Open Membership Insurers receive higher premiums in respect of insuring older people, but that older people receive tax credits equal to the amount of the additional premium so that all people continue to pay the same amount for their health insurance. In this way community rating is maintained but insurers receive higher premiums in respect of older people to partly compensate for the higher level of claims. The tax credits in respect of policies commencing / renewing in 2011 will be €625 for those aged 60 to 69; €1,275 for those aged 70 to 79 and €1,725 for those aged over 80.

The tax credits are funded through a community rating stamp duty. For policies commencing or renewing in 2011 this stamp duty will be €205 for adults and €66 for children.

The community rating stamp duty and tax credits, like the tax relief at source of 20% of premium, are administered by the health insurance undertakings and the Revenue Commissioners. The legislation provides that the interim measures are in place for three years with age related tax credits and levy reviewed annually.

Objective of risk equalisation system

In May 2010, the Government announced its decision to "Implement a new, robust, risk equalisation scheme to support the core policy of community rating." When announcing the decision the Minister referred to "the importance of solidarity in the health insurance market and that older and sicker customers should be supported by younger and healthier customers." The key decisions announced in relation to risk equalisation were the following:

- Implement a new, robust, risk equalisation scheme to support the core policy of community rating. The Health Insurance Authority will issue a consultation document to the market within a matter of weeks and the goal is to publish legislation in 2011 with enactment and implementation by the start of 2013.

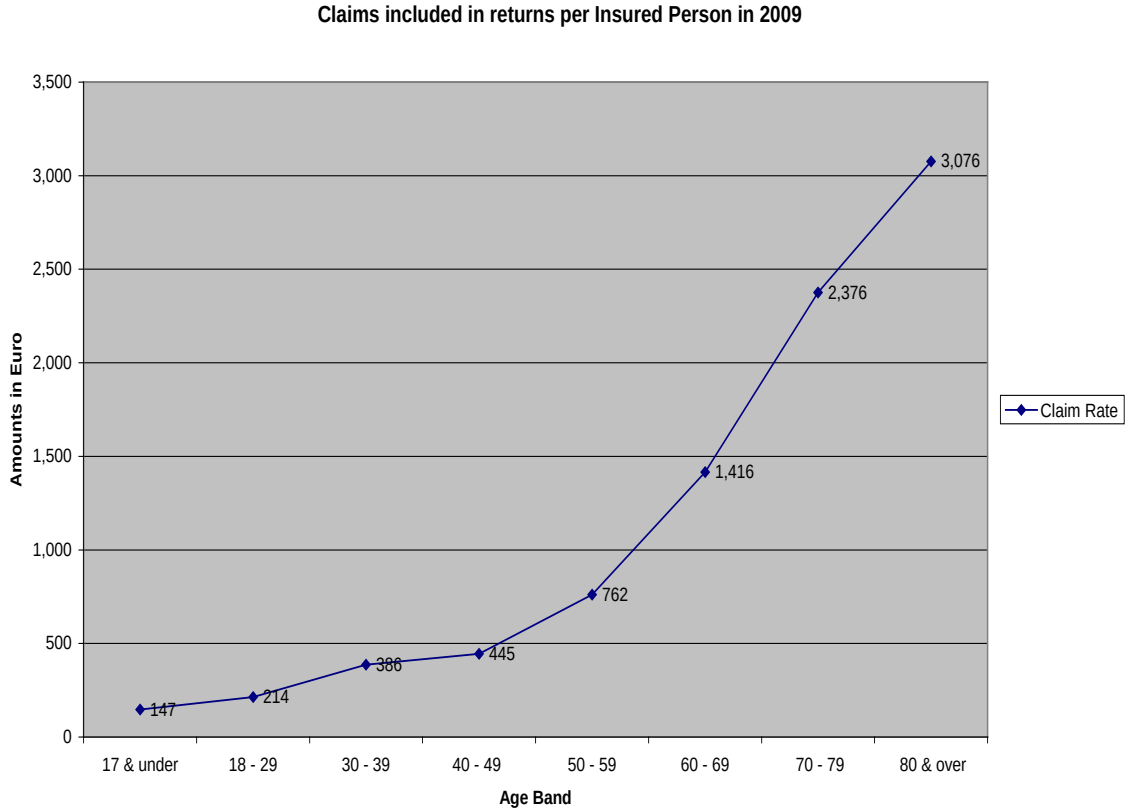
- The continuation of the present interim tax relief/levy system, and a new transitional arrangement from 2012 that will approximate as closely as possible to a full risk equalisation scheme. The HIA will advise on the level of tax-relief/levy for 2011 under the interim system".

The Need for a Robust Risk Equalisation System

While the interim measures support the operation of community rating, they do not equate to a robust risk equalisation system. In a community rated market without a robust risk equalisation system, older and unhealthy consumers tend to be extremely unprofitable on average.

The following chart illustrates how market claims increase with the age of the insured person.[1]

[1] Source of data: Information Returns for the first and second half of 2009



In the absence of a robust risk equalisation system to support community rating, the chart shows that younger and healthier customers will be profitable while older and less healthy customers will be unprofitable. As a result the following consequences are likely (in point of fact, the market has, in the opinion of the Authority, been exhibiting these effects for some time already):

- Insurers will attempt to segment their risks so that older and unhealthier customers are sold products that cost more or include a lower level of benefits.
- Insurers will design and market products that are attractive to the better risks.
- Insurers with more favourable risk profiles are protected from real competition from insurers with less favourable risk profiles. Product promotion will feature risk selection and marketing spend in preference to product quality and service.
- The most profitable insurers will be those that can best use marketing strategies to attract healthy lives and avoid unhealthy lives, not necessarily those that provide the best service.
- Insurers with worse risk profiles are obliged to charge higher premiums or incur losses. Switching of younger customers may exacerbate their problems.

Certain measures, for example prior notification of new products and minimum time periods of 31 days for any special offer, introduced by the Health Insurance (Miscellaneous Provisions) Act 2009 have addressed some of these issues to an

extent. However the Authority is of the view that the only method of properly protecting community rating is to introduce a risk equalisation system that sufficiently reduces the financial incentive to avoid insuring old and unhealthy lives.

Likely market developments in the absence of a robust risk equalisation scheme

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

Impact on consumers

Risk selection and segmentation are vital to the commercial success or failure of health insurance providers in a community rated market without a robust risk equalisation system. In order to compete in such a market, it would be expected that insurers would focus their commercial activity on improving their risk profiles rather than, for example, on improving their efficiency. As younger and healthier consumers are more likely to be profitable, insurers would actively seek them out as customers and these customers would be likely to benefit, in the short to medium term. As older less healthy consumers are not as profitable, insurers may make their products less attractive to them. Insurers may market themselves in a manner so that older and less healthy consumers are less likely to be aware of new more competitive plans aimed at younger healthier consumers. Despite the rules regarding community rating and open enrolment, a range of tactics are open to insurers to assist them in risk selection and risk segmentation and the Authority would expect insurers to increasingly adopt such tactics in the absence of a robust risk equalisation system. The result will be that older and less healthy people will increasingly pay more for health insurance than younger and healthier consumers. This is contrary to the principal objective of the Minister and the Authority under the Health Insurance Acts.

In the absence of a robust risk equalisation system the marketing of health insurance will be dominated by risk selection and segmentation. Insurance companies will comply with the law in relation to community rating and open enrolment but, in the absence of a robust risk equalisation system, the legislation will incentivise marketing and sales behaviour that will undermine these principles with a consequent negative

impact for older and less healthy people, who are particularly vulnerable in the context of healthcare costs.

Impact on the market

A systemic issue arises for the market because risks are created for the long term viability of insurers with less favourable risk profiles and consequently for the stability of the health insurance market as a whole. Regardless of its level of efficiency, an insurer with a less favourable risk profile at a product level will be obliged to either have higher premiums than the market or incur significant losses. If its premiums are higher than the market it is more likely to lose younger than older customers (as younger customers have a greater propensity to switch / lapse) and its worsening risk profile may oblige it to increase premiums further, resulting in a cycle. It is important to note that, because competition is distorted, an insurer would incur such difficulties regardless of its level of efficiency or the attractiveness of its products; such difficulties would result directly from its risk profile in the absence of a robust risk equalisation system.

A minority of submissions received to the Consultation Process argued that risk equalisation damages competition. For the reasons set out in this Section, the Authority does not agree with this view. Indeed, it is clear that competition will not operate to the benefit of consumers in a community rated market in the absence of risk equalisation.

One submission argued that the introduction of a robust risk equalisation system will cause an increase in the cost of health insurance leading to a negative impact on national competitiveness. The Authority does not agree with this argument. All of the approaches to risk equalisation proposed in this document are cost neutral to the health insurance market as a whole. Also, a robust risk equalisation system will have a positive impact on competition in the market and will have a consequent positive impact for national competitiveness.

4. Responses to Consultation Paper

The Authority issued a Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market on 21 June 2010.

Submissions were received from the following parties:

Aviva Health
Axa Insurance
Chambers Ireland
Dillon Eustace
Hospital Saturday Fund HSF
Independent Hospital Association of Ireland
Irish Brokers Association
Irish Hospital Consultant's Association
Irish Medical Organisation
Quinn Healthcare
St. Patrick's University Hospital
Society of Actuaries in Ireland
Dr. Brian Turner, University College Cork
Vhi Healthcare
VHI's Members Advisory Council

The Consultation Paper and the submissions are available on the Authority's website at www.hia.ie.

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

5. Structure of Risk Equalisation Systems

Risk equalisation systems vary significantly between countries. The Consultation Paper describes the systems in place in a number of countries. The table below summarises the risk factors used in the jurisdictions that the Authority researched. Age is used in all of the systems reviewed. Gender is used in Belgium, the Netherlands and the United States. All of the systems reviewed also include other measures of risk status and each of them pools expenditure rates (to some extent) when calculating risk equalisation / compensation rates. Pooling expenditure in this way, in effect, includes expenditure as a risk factor.

Country	**Age**	**Gender**	**Other risk factors**
Australia	Yes	No	Claims exceeding AUS $50,000 (currently approximately equal to €30,000)
Belgium	Yes	Yes	-In receipt of benefit for a specific disability -Address of insured person -In receipt of welfare benefits -Mortality in the time period -Home nursing care
Israel	Yes	No	Diagnosis in respect of 5 "severe diseases"
Netherlands	Yes	Yes	-Address of insured person -Employment status -Prescription drug group -Diagnostic cost groups based on hospital admission -Claims exceeding €12,500
South Africa	Yes	No	-Diagnosed with specific conditions -Maternity
US Medicare prior to recent reforms	Yes	Yes	-In receipt of benefit from specific disability -Disability/welfare status -Institutional status -Diagnosis with a specific condition

This review of international systems shows it is the norm in other jurisdictions to include measures of health status other than age and gender in a risk equalisation / loss compensation system. It also shows that it is the norm to pool expenditure rates of different insurers when estimating the claims rates underlying risk equalisation payments. More detailed analyses of these systems are published in the Authority's Consultation Paper.

6. Risk Factors to be Included

The Authority's Consultation Paper considered a range of risk factors for possible inclusion in a risk equalisation system. These risk factors might be categorised under three main headings:

- Underlying risk factors
- Diagnosis related risk factors
- Resource usage factors

Underlying Risk factors

Underlying risk factor are factors for which there is an objective classification method which the insurer has no or limited effective means of controlling or interpreting but which may be expected to be correlated to the claims cost of an individual.

Examples of such factors used in other jurisdictions are age, gender, disability status, address, occupation status, occupation, welfare support, mortality, living alone or maternity. Another underlying risk factor suggested in the responses to the consultation paper was "in receipt of benefit from the long term illness scheme".

A significant benefit of using underlying risk factors in a risk equalisation system is that they have no or limited impact on incentives for insurers to control costs or resource usage.

Amongst those that supported the need for a risk equalisation system, there was a general consensus in relation to the need to include age and gender as risk factors. There were differing views amongst respondents about using other underlying risk factors and in relation to which factors should be used. There were varieties of risk factors mentioned, but little consensus on the issue.

With regard to the underlying risk factors used in other jurisdictions, some of them are proxies for socio-economic group. On average, members of the lowest income socio-economic groups are less healthy than members of higher income socio-economic groups. Proxies for socio-economic group are, therefore, particularly relevant in risk equalisation systems applicable in compulsory private health insurance markets, where all groups are insured. In Ireland, only c. 9% of the insured population is from the two lowest income socio-economic groups. As such, there may be less benefit in including these proxies for socio-economic group as risk factors.

Other underlying risk factors, such as mortality and disability status are also used in other jurisdictions. However, the Authority considers that sufficient data is not available in the Irish system either to allow insurers to make reliable returns relating to these risk factors or to enable the Authority to satisfactorily validate such returns.

The Authority considers that any future risk equalisation system should include gender and a more detailed analysis of age differences. The current interim system

results in tax credits being paid for each of 4 (mostly 10 year) age bands. The level of tax credits are calculated by reference to claims rates across age bands. These claims rates differ significantly between insurers, particularly at the older ages. Reasons for the differences in claims rates include differences in products, differences in business practices and differences in health status. Differences in health status within the 10-year age bands are correlated to the following factors:

- Differences in gender profile (adult women have higher claims rates at younger ages and lower claims rates at older ages).
- Age differences within the 10 year age cells (claims rates increase rapidly with age after age 60).
- Other factors.

The Authority recommends that differences in gender profile and in age profile within 10-year age bands should be addressed in any new risk equalisation system. This could be done by using cells broken down by gender and 5 year age groups rather than just by 10 year age groups.[2]

While using age and gender as risk factors benefits those with higher claims costs associated with age and gender, further measures are required in order to support community rating for other groups who are vulnerable in the context of higher claims costs (for example the chronically ill).

Diagnosis related risk factors

Diagnosis related factors relate to medical conditions that are medically certified or are being investigated in an insured life which might be expected to be correlated to the claims cost of an individual. Examples might be specific conditions or groups of conditions. In its consultation paper, the Authority mooted using a comprehensive diagnosis related system based on Diagnosis Related Groups ("DRGs").

In the responses to the consultation paper, there was little support for the use of a comprehensive diagnosis related system. Practical difficulties were raised including the large volume of data generated, the lack of a credible volume of data in each cell given the large number of DRGs that would exist, issues with consistency of data and whether it would promote a bias towards in-patient treatment.

The analysis of international risk equalisation systems also shows that comprehensive diagnosis related systems are not normally used. The Authority considers that moving to a risk equalisation system based on DRGs would be highly complex, not least with respect to defining the DRG system, dealing with the level of data involved and establishing processes within the insurers and within the Health Insurance Authority

[2] Regard would need to be had to the pending judgment of the European Court of Justice in the Association Belge des Consommateurs Test Achats and others (Case C-236/09) in relation to whether it is compatible with EU fundamental rights to take the sex of an insured person into account as a risk factor in insurance contracts. The recently published opinion of the Advocate General asserts that it is not compatible.

for the preparation and auditing of returns and for ensuring consistency between insurers. A comprehensive diagnosis related system would also involve a very significant compliance burden for insurers. It is considered that implementing such a system would take years of development and of reviewing shadow returns as has been the case with a less complex diagnosis related system in South Africa, where shadow returns have been made since 2005 but the system has yet to come into operation. In this context, the Authority considers that it would not be practical to implement such a system in a risk equalisation system to commence in 2013.

However, less complex diagnosis related systems are used in a number of jurisdictions reviewed by the Authority. In addition to the diagnosis related system in South Africa referred to in the preceding paragraph, "diagnosed with a specific condition" is a risk factor used in Israel, the Netherlands and US Medicare.

In its December 2010 Report on Minimum Benefit, the Authority recommends that people diagnosed with a chronic illness would be entitled to certain primary care benefits. In these circumstances, insurers will have data in relation to the individuals that have been diagnosed with a chronic illness and are entitled to these benefits. The Authority recommends that the risk equalisation system commencing in 2013 would provide for the higher costs associated with the chronically ill by requiring that insurers provide the Authority with data on the number of chronically ill members that they have and the cost of claims for this membership. The higher costs associated with providing healthcare for the chronically ill could then be shared across the market in the same way as the costs associated with providing healthcare to older people.

Resource usage related risk factors

Resource usage factors are factors that are directly related to the claims experience of insurers. Examples might be expenditure incurred, hospital bed utilisation or pharmaceutical cost groups.

Risk equalisation systems in many jurisdictions use resource usage as a proxy for health status risk factors. This has the advantage that the data is readily available and easy to verify, resulting in a lower compliance burden than other approaches. A disadvantage of including resource usage in a risk equalisation system is that insurers receive compensation when their insured persons use healthcare resources. This reduces the incentive for insurers to control the use of valuable healthcare resources, which can impact health insurance premium inflation.

A further complication in Ireland is that different products provide different levels of cover. For instance some products only provide cover for semi private rooms in a public hospital while other products cover private rooms in all private hospitals. Therefore, in part, expenditure differences will relate to product differences rather than health status differences. This issue might be mitigated by excluding higher levels of cover from the system or by only partially equalising differences in expenditure per insured person, as for instance in the Australian system.

In responses received to the consultation process there were mixed views in relation to resource utilisation factors. Some responses were concerned that they rewarded consumption of medical resources and that it would be difficult to allow for variations in levels of cover in different plans. On the other hand, a number of respondents considered that there would be fewer difficulties in implementing a resource usage system than using underlying risk factors or diagnosis related risk factors. Amongst the suggestions made was a high cost pool for claims in excess of a certain threshold and a risk factor based on whether there was a claim made in the previous five years.

One relevant resource usage factor is expenditure and many risk equalisation systems equalise expenditure to an extent. In Ireland, there has been concern in relation to equalising expenditure because differences in expenditure would be expected to reflect differences in products and business practices as well as differences in health status.

The Authority recommends that differences in products be addressed by banding products and providing for lower levels of transfers for products with lower levels of benefits (e.g. applying lower tax credits and stamp duty to products with lower levels of benefits). Addressing the issue of product differences in this way might allow equalisation of a higher level of expenditure. Further confidence for equalising a higher level of expenditure could be gained through market analysis and the provision of more detailed data to the Authority.

7. Other Considerations

Benefits included in returns

Statutory Instrument No 294 of 2009 sets out what benefits are included in the returns made to the Authority. These rules were initially set so that the claims costs included in returns were based on the benefits that were provided by the majority of health insurance contracts but excluded some claims costs that were not provided by the majority of contracts. A number of issues arise with respect to the benefits included in returns:

- The monetary amounts are based on amounts set in 2003 when the Risk Equalisation Regulations were enacted. These amounts are now far less than the costs incurred in providing treatment.
- The amounts included in returns in respect of treatment in private hospitals, other than treatment provided under a fixed price procedure, is much less than if the treatment were provided in a public hospital because the monetary limit does not apply in respect of public hospitals.
- The exclusion of primary care and care in the community costs from the returns may impact on relative incentives between such care and hospitalisation.
- The different treatment of fixed price procedures and other procedures may impact on relative incentives for insurers in negotiating contract terms with providers.
- Differences in interpretation of what benefits should be included/ excluded can arise.
- The Authority is proposing changes to minimum benefits regulation following consultation in this area. Specifically, the Authority is proposing that certain primary care treatment for chronic diseases be included in minimum benefits.

In responses to the consultation paper, there were mixed views as to whether costs incurred in primary care, preventative treatment / care and care in the community should be part of returns used in a risk equalisation system though the majority of responses were in favour of their inclusion. There was also some support for the benefits included in returns being only those covered by minimum benefits.

The Authority considers that risk equalisation should only apply to the level of benefit held by the majority of people with private health insurance ("the standard level of benefit"). Most health insurance products sold in the Irish market do not include significant cover for primary care, although the Authority has recommended that a significant primary care benefit, payable in respect of those with chronic illnesses, be included in Minimum Benefit Regulations. The Authority recommends that the data returns should be based on the total payments made in the period broken down by product and between in-patient and out-patient / primary care costs.

This approach allows for medical developments over time, inflation of costs etc. to be included in returns. The impact of some products providing more expensive hospital or primary care benefits than other products can be addressed by requiring insurers to submit returns for each policy type. The Authority can then group the products by

level of benefits into “Higher level of benefit products”, “Standard level of benefit products” and “Lower level of benefit products”.

The risk equalisation transfers in respect of products with a lower level of benefit would be based on the claims rates for those products, while transfers for products with a standard or higher level of benefits would be based on claims rates for products with a standard level of benefits.

Other Issues

New entrants
It is not proposed to include any measures to encourage new entrants due to the practical difficulty of distinguishing a genuine new entrant from an insurer purchasing a business.

Lifetime Community Rating
It is not proposed to allow for Lifetime Community Rating payments in the calculations as it is considered that these will not be significant. The Authority will monitor the level of Lifetime Community Rating payments and make recommendations in relation to how to provide for these in a risk equalisation system if they become significant.

Publication of Calculations / Data
The legislation currently restricts the publication of data received by the Authority under the Interim Measures. The Authority considers that, in certain circumstances, it may be deemed appropriate to publish its Reports to the Minister under the Transitional or 2013 Risk Equalisation Systems. For example:

- It may enhance transparency regarding the basis for the amounts payable under the system so that payers and payees of the large sums involved have an understanding of the basis for the amounts due.
- The Reports may assist undertakings in their assessment of future liabilities under any system.
- The Reports may be of benefit to consumers and other stakeholders in understanding the need for risk equalisation.

Therefore, the Authority recommends that the legislation provide the Minister or the Authority with the power to publish the Authority’s reports under the Transitional and 2013 Risk Equalisation Systems.

Review
International and Irish experience shows that risk equalisation systems need to be regularly reviewed and amended to reflect market and medical developments as well as experience. The Authority recommends that the legislation include provision for a formal periodic review of the 2013 Risk Equalisation System.

8. Transitional Risk Equalisation System

The Government has determined that the Transitional Risk Equalisation System applying in 2012 would use the tax credits model used by the interim system.

In relation to how payments are calculated, the Authority considers that the Transitional Risk Equalisation System should provide for more detailed returns and should take more factors into account in calculations. This will enable a greater understanding of the reasons for differences between the claims rates of different insurers, in particular as to the extent to which such differences relate to product differences, rather than health related risk factors or other factors. Specifically, the Authority recommends that the Transitional Risk Equalisation System should operate in the same way as the current Interim System, with the following changes:

- Insurers should be required to submit returns to the Authority detailing total claims paid and prescribed claims paid for each product, gender and year of age. Prescribed claims paid would be defined in the same way as they are under the current interim measures.
- Separate tax credits should be provided for 5-year age bands and for each gender.

Specifically, in January and July of each year, insurers would be required to submit returns to the Authority for the preceding 6-month period detailing total claims paid and prescribed claims paid for each gender and year of age. Prescribed claims paid would be defined in the same way as they are under the current interim measures. In order to facilitate an understanding of the impact of different levels of cover on claims costs, the returns would be provided separately for each policy type. The returns would be provided electronically. This would mean that the Authority would receive separate returns for each of the approximately 200 policy types that are on the Product Register. This additional information would be required for the first half of 2011.

The Authority would evaluate and analyse the data received and relevant market behaviour and having regard to the evaluation and analysis, the Authority's Principal Objective and the objective of avoiding overcompensation, the Authority would recommend 16 age and gender related tax credits in respect of the following groups:

Males aged 50 to 54	Females aged 50 to 54
Males aged 55 to 59	Females aged 55 to 59
Males aged 60 to 64	Females aged 60 to 64
Males aged 65 to 69	Females aged 65 to 69
Males aged 70 to 74	Females aged 70 to 74
Males aged 75 to 79	Females aged 75 to 79
Males aged 80 to 84	Females aged 80 to 84
Males aged 85 and over	Females aged 85 and over

The Authority would also recommend the levels of stamp duty payable in respect of insured adults and insured children that it considers would be necessary to meet the cost of the tax credits.

The tax credits and stamp duty decided upon by the Government would be put in place by an Act of the Oireachtas.

9. 2013 Risk Equalisation System

In addition to the measures outlined for the Transitional Risk Equalisation System, the 2013 Risk Equalisation System should take account of the prevalence of chronic illness within an insurer's population as well as the product mix sold by the insurer.

Consequently, the 2013 system would provide for the following:

- Insurers should be required to submit returns to the Authority detailing total inpatient claims paid and other claims paid for each product, gender, chronic illness and year of age. This data will be available to insurers and consequently the compliance burden of providing the data will not be excessive.
- Risk equalisation payments would depend on the following:
    - Age (with 5-year age bands).
    - Gender.
    - Diagnosis with a chronic illness.
    - Level of cover provided. (For example, a lower level of payment could arise in respect of plans that only provide cover for public hospitals than for plans that also provide cover for private hospitals).
- The 2013 Risk Equalisation System would be regularly reviewed in order to address market developments and to optimise its effectiveness.

Methodology for effecting payments under the 2013 Risk equalisation System

Apart from considering the range of risk factors that should be included in a risk equalisation system, consideration must be given to the means of effecting the payments arising. In this regard, the Authority has considered three options for effecting risk equalisation payments:

- Through tax credits funded by the taxation system;
- Through a risk equalisation fund funded by the taxation system; or
- Through risk equalisation transfers between insurers via a risk equalisation fund.

In a number of other jurisdictions where community rating is Government policy, the taxation system has a role in funding the risk equalisation/loss compensation system, as such a system is a necessary element in maintaining a community rated market. This is consistent with the role of a taxation system in that taxes are raised and disbursed in order to fund the implementation of Government policy.

Also, in Ireland, the interim measures of age related tax credits to support community rating, which were introduced in 2009 for a period of three years, support community rating through the tax system. This methodology for effecting the payments has a number of advantages:

- Such a system has already been successfully implemented in Ireland. This system is currently providing practical support for the Principal Objective of community rating.
- The system is transparent in showing that the benefit is for older less healthy people irrespective of which insurer they are insured with. It is clear that all insured lives bear a proportionate cost of this support.
- The system is flexible and can be adapted so that it remains effective in achieving its objective of supporting community rating.
- The system uses well established systems and processes, both administrative and legal.
- There is experience of operating such a system in Ireland and the impact on the market has been observed.

The 2013 Risk Equalisation System will be significantly more complex to administer than either the interim or transitional systems. Nevertheless, the Authority would favour that it would continue to operate via the tax system for the reasons outlined above. If such an approach were not considered practicable, due to the large number of different age/ gender/ chronic illness/ product tax credits that would be required, the system could be administered via a Risk Equalisation Fund operated by the Health Insurance Authority. Such a Risk Equalisation Fund could receive transfers directly from insurers.

Alternatively, the Risk Equalisation Fund could be funded by a stamp duty payable in respect of insured people and disbursed by the Authority to all insurers in proportion to the number of older / less healthy people insured. Under this approach, the acquisition of funds for the operation of the system would be through the tax system, while the disbursement of the funds (which would involve payments to all insurers) would be done under health insurance legislation.

The operation of the 2013 Risk Equalisation System under each approach for effecting payments is outlined below.

Effecting payments through the taxation system:

Every 12 months the Authority would make recommendations to the Minister for Health and Children in relation to the tax credits to apply in respect of older and less healthy lives for each combination of Age (by 5 year age band), gender, product group and diagnosis with a chronic illness. The full range of tax credits required would need to be determined by reference to the data collected, but it is likely that there would be in excess of 100 different tax credits. The Authority's recommendation in respect of the tax credits payable would have regard to its evaluation and analysis of returns received, the Authority's Principal Objective under the health insurance legislation and the need to avoid overcompensation. The Authority would also recommend the levels of stamp duty that it considers would be necessary in order to fund the tax credits. The stamp duties would vary by product level (one stamp duty for lower benefit products and one stamp duty for standard and

higher benefit products) and between children and adults, so that, in total, 4 different stamp duty amounts would be recommended.

The system would then operate through the tax system in the same way that the current interim measures operate.

Effecting payments through a risk equalisation fund funded by the taxation system:

Every 12 months, the Authority would project the total amount that it considers should be paid in respect of each member of an older / less healthy cell in order to compensate for the higher cost incurred in insuring them. Tax credits would vary between lower benefit and other products. The Authority's assessment would have regard to its evaluation and analysis of returns received and of the market, the Authority's Principal Objective under the health insurance legislation and the need to avoid overcompensation. Based on this assessment, the Authority would recommend, to the Minister, the levels of stamp duty that it considers would need to be applied in order to fund this level of compensation. The stamp duty, which would vary between adults and children and between lower benefit and other products would be given effect through legislation.

For each calendar year, the stamp duty would be collected by the Revenue Commissioners and paid into a Risk Equalisation Fund. After the end of the calendar year, the Authority would assess the number of people each insurer had in each older / less healthy cell. The cells would be defined by (age, gender, diagnosis with a chronic illness and product level). The Authority would also determine the market claims rate underlying each cell for lower benefit and standard benefit products. The money in the Risk Equalisation Fund would be disbursed to insurers in proportion to the number of people they insure in each cell and in proportion to the extra cost of insuring a member of that cell.

Effecting payments through a risk equalisation fund funded by transfers from insurers:

This approach would operate in the same way as the 2003 Risk Equalisation Scheme, except that there would be refinements in respect of the inclusion of diagnosis with a chronic illness and the provisions for different levels of product.

Another difference with the 2003 Scheme would be that the transfers would no longer be based solely on the claims rates of the insurers making risk equalisation payments, because under the approach in the 2003 Scheme there is no allowance made for differences in health status within risk cells, which undermines the effectiveness of the system in supporting community rating. Instead the Authority would recommend, to the Minister, the percentage of the market claims rates that should underlie the transfers and this percentage would be provided for in legislation. This approach would be consistent with the international norm, which is to pool expenditure rates when calculating the claims rates underlying risk equalisation payments. The

approach is also consistent with the approach adopted under the current interim measures. The Authority's recommendation in this regard would have regard to its evaluation and analysis of returns received and of the market, the Authority's Principal Objective under the health insurance legislation and the need to avoid overcompensation.