Seirbhís Leabharlainne 7 Taighde
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Bill Digest

Health Insurance (Amendment) Bill 2020

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Abstract

This Bill Digest examines the *Health Insurance (Amendment) Bill 2020*. The Bill seeks to amend the risk equalisation credits and provide for the level of stamp duties under the Risk Equalisation Scheme (RES) that operates in the private health insurance market.

The RES aims to spread risk across insurers – supporting the 'community rating' of health insurance – so that all insured people regardless of their age or health status pay the same price for their health insurance.

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Oireachtas Library & Research Service, 2020, *L&RS Bill Digest: Health Insurance (Amendment) Bill 2020*

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Summary

The *Health Insurance (Amendment) Bill 2020* (the Bill) was published on 19 November 2020. It seeks to amend the levels of some risk equalisation credits in the Risk Equalisation Scheme (RES) that operates in the private health insurance market. This Bill is the latest in a series of annual bills seeking to amend the RES. The Principal Act is the *Health Insurance Act 1994*. A glossary of terms is provided at page 5 of this Digest.

Risk equalisation is the system that seeks to spread insurance risks across insurers based on their relative exposure to customers at higher risk of making claims. It underpins the principle of 'community rating' – whereby all customers, regardless of their age or health status are charged the same price for a health insurance policy (this 'community rating' principle is limited by a late-entry loading, known as 'lifetime community rating' which means that people taking out health insurance for the first time later in life pay a higher premium).

The Risk Equalisation Scheme (illustrated in an infographic on page 9 of this Digest) uses stamp duty – levied on every health insurance policy in the state – to raise revenue. This is paid into a risk equalisation fund (managed by the Health Insurance Authority (HIA)). Risks are equalised by the payment of two credits paid to insurers. The first, the **'risk equalisation credit'** is paid prospectively (ahead of time) based on the age, gender and level of insurance cover of an insurers' customers. The second is a **'hospital utilisation credit'** paid retrospectively (after claims have been settled) based on hospital stays and day case attendance. Due to the historical position of the Voluntary Health Insurance (VHI) organisation in the health insurance market, and the older age profile of its customers, Vhi Healthcare is the net beneficiary of the Risk Equalisation Scheme. The Scheme is Exchequer-neutral, i.e. it is neither a cost nor a benefit to the State.

Given the ongoing challenges posed by the **Covid-19 pandemic** across society and the economy, the impact of the pandemic on private healthcare is discussed in the Digest. There are concerns about the impact the pandemic (in terms of private healthcare availability and poorer economic conditions more generally) on the take-up of private health insurance. The period March to June 2020 saw the first drop (albeit a modest one) in health insurance take up since 2014. The Department of Health (the Department) and the Health Insurance Authority describe the potential impact as 'uncertain' at this time.

The Risk Equalisation Scheme is subject to **EU oversight** as a form of state aid. It is currently approved to operate in the period 2016-2020. The new full application being pursued by the Department has been deferred due to the Covid-19 crisis. Instead, an extension of the current approval has been sought for a period of 15 months from January 2021.

The provisions of the Bill can be summarised as follows:

Hospital Utilisation Credit (Section 3): The Bill seeks to increase the Hospital Utilisation Credit HUC for overnight accommodation to €125 from €100 per night, and leave the HUC for day cases at €75. The new rates would apply from 1 April 2021.

Risk Equalisation Credits (Section 4): The Bill seeks to reduce credits payable across all categories except for three – two would remain unchanged and one would increase slightly (details set out on page 26). The new rates would apply from 1 April 2021.

Stamp Duties (Section 5): The Bill seeks to leave stamp duties unchanged – these stamp duties are levied (under the *Stamp Duties Consolidation Act 1999*) on each health insurance policy. The current rates are:

- on non-advanced contracts set at €52 per child and €157 per adult; and
- on advanced contracts €150 per child and €449 per adult (see glossary for definitions).

The vast majority of contracts fall into the 'advanced' category – 92% at the end of 2019. Non-advanced contracts are generally those that provide mainly cover for private care in public hospitals – these accounted for 8% of contracts at the end of 2019.

Stakeholder commentary: At the time of writing, no stakeholder commentary specific to the Bill had been identified.

Commencement: If enacted, different sections of the Act would come into force on different dates:

- Section 5 would come into operation on 1 January 2021;
- Sections 2, 3 and 4 would come into operation on 1 April 2021.

If enacted, the collective citation of the current Act and other health insurance legislation is the *Health Insurance Acts 1994 to 2020.*

Table of Provisions

Table 1: Provisions of the *Health Insurance (Amendment) Bill 2020*

Section	Focus	Detail
1	Definition	The "Principal Act" is the *Health Insurance Act 1994*.
2.	Amendment of Section 11C of the Principal Act	Provides for a change of the date in this section from 1 April 2020 to 1 April 2021. This is the date applicable for revised credits payable from the Risk Equalisation Fund.
3.	Hospital Utilisation Credit – amendment of specified amount	Seeks to replace Schedule 3 of the Principal Act. The new Schedule 3 provides for Hospital Utilisation Credit rate of €125 for overnight accommodation (up from €100 at present) and €75 for day cases (no change from present rate). These rates would apply to contracts entered into on or after 1 April 2021.
4.	Amendment of Schedule 4 to the Principal Act	This section seeks to replace Table 2 in Schedule 4 of the Principal Act. The Table contains revisions to risk equalisation credits payable from the Risk Equalisation Fund. Revised rates would apply on or after 1 April 2021. Full details of new rates (indicating changes from the current rates can be found in this Digest on page 26).
5.	Amendment of section 125A of Stamp Duties Consolidation Act 1999	This seeks to amend section 125A of the *Stamp Duties Consolidation Act 1999*, providing for the level of stamp duty rates from (i) 1 January 2021 to 31 March 2021; and (ii) from 1 April 2021 onwards. The rates provided for are the same as current rates (see details on page 27 below).
6.	Short title, commencement, collective citation and construction	Provides that Section 5 will be effective from 1 January 2021, while Sections 2, 3 and 4 would be effective from 1 April 2021. This Act and the Health Insurance Acts 1994 to 2019 may be cited together as the Health Insurance Acts 1994 to 2020, and will be construed together as one Act.

Source: Oireachtas Library & Research Service, based on the Health Insurance (Amendment) Bill 2020 and acts referred to herein.

Glossary

Term	Definition
Non-advanced health insurance policy	**Non-advanced policies**: Broadly speaking, these policies provide a lower level of cover than advanced policies. In general they provide cover mainly for public hospitals. ***More specifically:*** Non-advanced cover is defined as a relevant contract which provides health insurance cover for: Not more than 66 per cent of the full cost for hospital charges in a private hospital, or Not more than the prescribed minimum payments within the meaning of the *Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (S.I. No. 83 of 1996)*, whichever of the two is the greater.
Advanced health insurance policy	Advanced policies are all other policies – generally those that provide cover for care in private hospitals.
Community Rating	Community rating means that the level of risk that a particular consumer poses to an insurer does not directly affect the premium they pay. Everyone pays the same for the same cover – regardless of age, gender or health status. The system is built on inter-generational solidarity – with the premiums paid by younger people subsidising those paid by older people. Older consumers who have long held health insurance will themselves have subsidised the generation(s) before them. Ireland's system of community rating is now adjusted by 'Lifetime Community Rating' (see below) which applies different rules for 'late' entry and discounts for young adults.
Lifetime Community Rating (LCR)	LCR is a system of 'late-entry' loadings meaning that people who take out health insurance for the first time after a certain age (age 34 in Ireland) have to pay a higher premium than others. This is intended to act as a disincentive to people who might choose to delay taking out health insurance until later in life.
Risk Equalisation Scheme / System (RES)	The aim of the risk equalisation system is to fairly distribute the costs that arise for insurers as a result of the differing health status of all their customers. Risk equalisation aims to make health insurance more affordable for older people. It also aims to support competition within the market.
Risk Equalisation Fund	Administered by the Health Insurance Authority, the Fund is the pool of money that pays out the Risk equalisation credits / Hospital utilisation credit (HUC). Monies come into the Fund from the Revenue Commissioners through Stamp Duties levied on all open market health insurance policies provided by insurers. The Revenue Commissioners, in turn, pay the monies to the Health Insurance Authority (to the Risk Equalisation Fund). The Health Insurance Authority pays out monies to health insurers by way of two credits – Risk equalisation credits and Hospital utilisation credit (detailed below).

Introduction

This Digest examines the provisions of and context to the *Health Insurance (Amendment) Bill 2020* (the Bill). It is presented in sections as follows:

- Context to the Bill – explaining risk equalisation
- Key data on the health insurance market
- Covid-19 and health insurance
- EU State aid rules
- Broader policy context
- Principal provisions of the Bill
- Implications / Stakeholder commentary

An appendix to the Digest shows a timeline of regulation of the private health insurance market since the establishment of the Voluntary Health Insurance Board in 1957.

Context to the Bill - Explaining risk equalisation

The Bill seeks to adjust the Risk Equalisation Scheme (RES) that operates in the private health insurance market. This section describes the mechanics of this Scheme.

Risk equalisation is a system of compensating insurers who carry heavy risk burdens (in proportion to their market share), by transferring payments from other insurers who carry lighter ones. Heavy risk burdens include claims costs associated with policy holders who are older or less healthy than the rest of the population.

What is the purpose of the Risk Equalisation Scheme?

Ireland has traditionally adhered to a **community rating system** in relation to the health insurance market. This system assumes a principle of intergenerational solidarity between all insured persons, whereby all consumers, irrespective of age profile, gender or likely future health status, pay the same price for equivalent levels of cover. Risk equalisation is a common mechanism in countries with community rated health insurance markets. The purpose of which is to make it easier for insurers who insure policy holders with higher risk profiles, i.e. people more likely to have higher medical costs, to compete with other insurers.[1] The stated goal of the scheme is to ensure that private health insurance is affordable to as many people as possible in a sustainable, competitive market.

How does the Risk Equalisation Scheme work?

The information in Text Box 1 below describes in detail the operation of the Risk Equalisation Scheme (RES). The key points of operation of the scheme are represented in an **infographic** on page 9.

Box 1: How the Risk Equalisation Scheme operates (see Glossary at p.5 for definitions)

The *Health Insurance (Amendment) Act 2012* provided for the Risk Equalisation Scheme (RES) from 1 January 2013. The scheme applies to open-membership health insurance providers only and not to restricted membership providers. The scheme takes account of sex, health status and type of cover as well as age.

The scheme involves a transfer of credits to health insurance providers in respect of older and less healthy customers and a stamp duty levied on health insurance providers in order to pay for these credits. The *Health Insurance (Amendment) Act 2012* sought to establish a permanent fund from which risk equalisation credits are payable. The health insurance companies pay stamp duty on individual policies to the Revenue Commissioners, who then transfer the proceeds of the stamp duty to the fund. The fund is administered by the **Health Insurance Authority (HIA)**.

[1] Community rating is an approach in which an insurer spreads the cost of insuring risks evenly across the entire group of people being insured, rather than those with a higher risk profile paying higher premiums than those with lower risk profiles.

There are four rates of stamp duty. The rate that applies to each policy depends on whether the policy provides for advanced cover or non-advanced cover and whether the insured life is that of a child or an adult. The HIA can make regulations for the categorisation of health insurance products into advanced and non-advanced cover.

Risk equalisation (RE) credits are currently paid out to the health insurance companies in respect of the premiums of people aged 65 and over. The amount of the credit depends on the person's age, sex and the type of insurance cover (current and proposed rates are set out in the **Principal Provisions** section below).

Health status is also taken into account when calculating credits and a **Hospital utilisation credit** (HUC) is awarded based on each visit to hospital by an insured person. In effect, a hospital visit is used as an indicator of a policy holder's health status. The greater the number of hospital visits and the longer the stay in hospital, the sicker an insured person is deemed to be (for the purpose of HUC) and as a result, the greater the number of credits their insurer receives. At present, this credit is set at €100 for each overnight stay and €50 for each day case visit for insured people of all ages.

The health insurance provider claims the credits from the HIA. They receive a greater amount in respect of policy holders who are older and less healthy.

The levels of credits and the stamp duty payable are reassessed annually.

The HIA makes recommendations to the Department of Health on annual RE credit rates and on the corresponding stamp duty required to fund them under RES. The Minister for Health takes this into consideration when proposing rates for RE credits and recommends the corresponding stamp duty levy to the Minister for Finance.

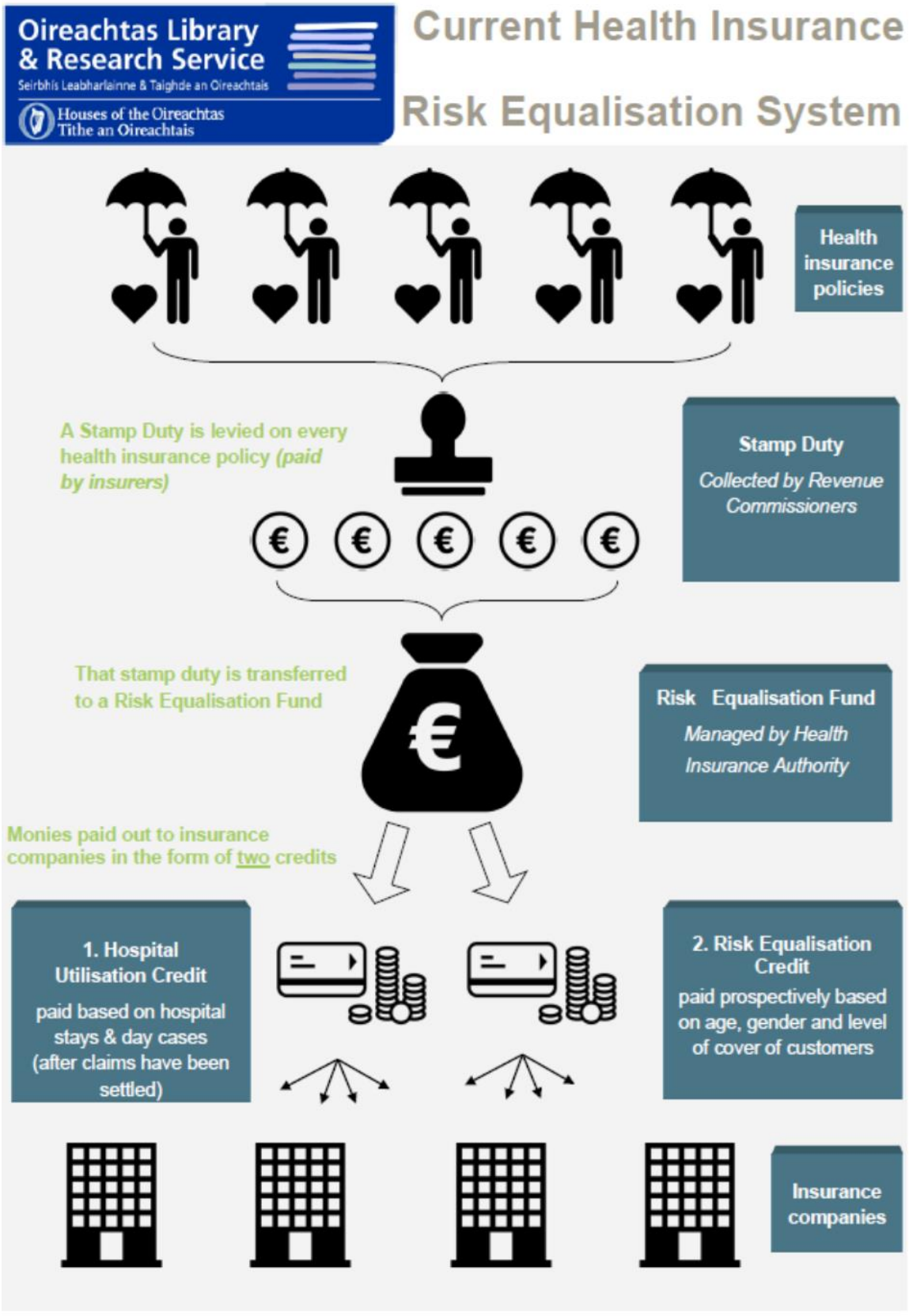
Source: Adapted from Citizens Information Board (2013) Relate, March 2013. Available at: http://www.citizensinformationboard.ie/publications/relate/relate_2013_03.pdf

The text box above describes how the Risk Equalisation Scheme operates within a community rated health insurance market. In 2015, two new schemes intended to support the health insurance market by attracting more younger adults, were introduced which altered the community rating system.[2] These are:

- **The Lifetime Community Rating Scheme:** This is a system of mandatory 'late-entry loading' which means that people who take out health insurance for the first time at age 35 or over pay a higher premium than others (2% per year of age up to a maximum of 70% for those aged 69 or over).
- **Discounted Schemes for Younger Adults:** Health insurers **may** offer reduced premiums for young people between the ages of 18 and 25 years, on a sliding scale. Also, health insurance premiums for children may not exceed 50% of the cost of an adult premium.

[2] Lifetime Community Rating was first provided for in 2014 by means of regulations under the *Health Insurance (Amendment) Act 2014*. Those regulations provided that Lifetime Community Rating would be mandatory for insurers and take effect on 1 May 2015.

Figure 1: Infographic of Risk Equalisation Scheme operating in the health insurance market



Key data on the health insurance market

Size of the market

The health insurance market is very large - HIA describes it as follows:

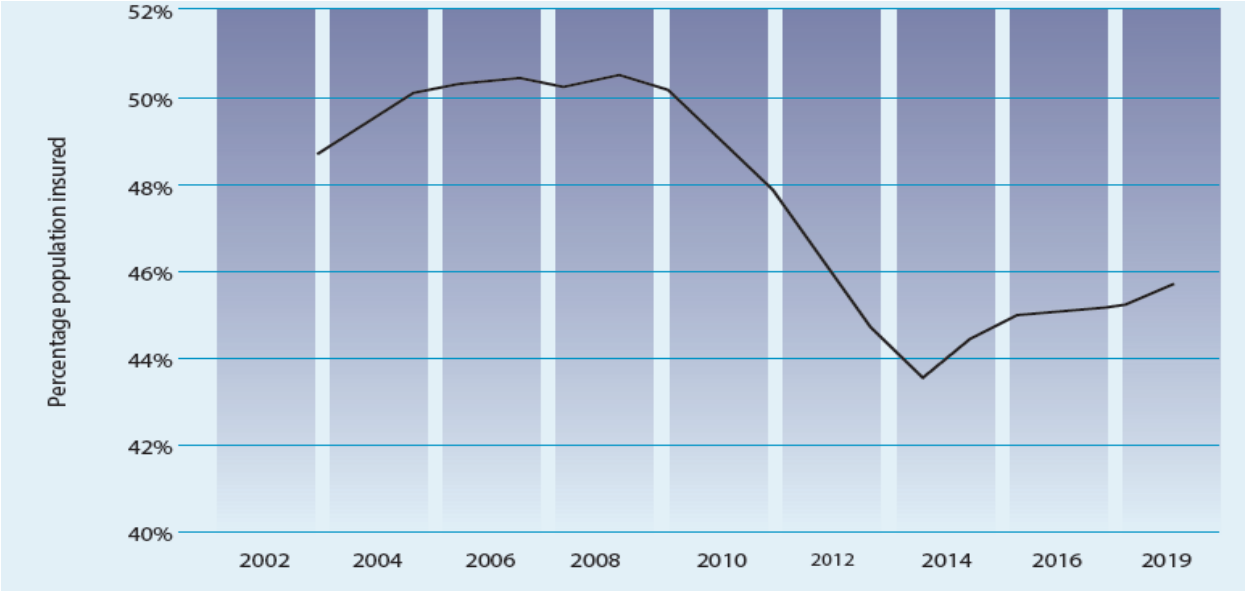
> "The health insurance market is the largest non-life insurance market in Ireland. Premium income in 2019 was €2.72bn, which represented an increase of 1.4% on 2018. The three insurers, Vhi, Laya and Irish Life Health accounted for 94% of this amount."[3]

Trend in take up of health insurance

Figure 2 and Table 2 below show the trend in take-up of health insurance since the early 2000s. They show the rise, decline and rise again of health insurance take-up in this period – these have been broadly in line with wider economic fortunes. They show that, during the last recession, the number of people with health insurance dropped. Subsequently, in better financial times, the market recovered well.

Table 2 shows that in June 2020, there were 2,289,000 people with private health insurance – 10,000 fewer than in March. This is the first dip in the take-up of health insurance since 2014.

Figure 2: Percentage of the population with private health insurance



Source: Health Insurance Authority, *Annual Report 2019* (p.15).

[3] Health Insurance Authority, *Annual Report 2019*.

Table 2: Number of people insured (in-patient plans) and proportion of the population (2003-2020)

Year ended / most recent	Total insured persons (000s)	Private health insurance coverage as % of population
December 2005	2,115	50.4%
December 2006	2,174	50.3%
December 2007	2,245	50.5%
December 2008	2,297	**50.9% (PEAK)**
December 2009	2,260	49.7%
December 2010	2,228	48.8%
December 2011	2,163	47.2%
December 2012	2,099	45.6%
December 2013	2,049	44.3%
December 2014	2,025	**43.4% (LOWEST)**
December 2015	2,122	45.0%
December 2016	2,152	45.2%
December 2017	2,174	45.1%
December 2018	2,220	45.5%
December 2019	2,276	46.0%
March 2020	2,290	n/a
June 2020	2,289	46.0%

Sources**:** Data from HIA annual reports and *HIA market statistics webpage*.

Notes: *All figures relate to the total private health insurance market, i.e. open enrolment and restricted undertakings. Population figures are based on Central Statistics Office population estimates.

Issues relating to trends in take-up

- Decreases in take-up during the last recession (with a low of 43.4% of the population having health insurance at the end of December 2014) were particularly linked to cuts to income and the decline in employment among people of working age.[4] They were also linked to cost increases for consumers.[5]
- This decline prompted concerns about the stability of the current model of private health insurance and the impact on the public health system of meeting fully the care needs of those patients who may previously have used private healthcare.[6]
- Increases in 2015 and subsequently may be attributed to increases in the rate of employment, reduction in net migration and broader positive economic conditions. Some of

[4] Health Insurance Authority (2015) *Annual Report 2014*, p. 21.
[5] Turner, B (2013) 'Premium inflation in the Irish private health insurance market: drivers and consequences'. *Irish Journal of Medical Science*, 182:545-550.
[6] Weston, C. (2014) '21,000 drop health insurance in first quarter of year', *Irish Independent* http://www.independent.ie/business/personal-finance/latest-news/21000-drop-health-insurance-in-first-quarter-of-year-30327125.html

the increase may be attributed to the introduction of a system of discounts for young adults and Lifetime Community Rating (a mandatory loading on premiums making it more expensive for consumers to take out insurers the older they get – starting at age 35).

- By 2019, the number of people insured had recovered to 2007 levels, however the proportion of the population with cover was lower (46% vs 50.3%) because of overall population growth in the interim.
- Take up dropped back between March and June this year, and there is some uncertainty now about the impact of the Covid-19 pandemic and the related poorer economic conditions may have on the take up of private health insurance.

Who has insurance?

A nationally representative survey of adults, published by the HIA in early 2020 found:

> "Those with PHI [private health insurance] are more likely to be from the more affluent white collar workers/professional cohort (ABC1s), whilst those from more manual professions or reliant on state benefits are significantly less likely to have cover. Additionally, PHI holders are more likely to be living in Dublin (36% compared to 28% in 2017) suggesting that the overall increase in PHI incidence is being driven by this region."[7]

This finding on the social divide is consistent with previous surveys commissioned by the HIA. [8]

What do people see as the value in having health insurance?

The same survey found that faster access and better service are the major attractions of health insurance for consumers:

> "At an overall level, there is growing belief that having PHI allows people to skip queues (64%) and ensures they receive a better level of service (62%). In line with previous years, it is also deemed a necessity, not a luxury by nearly six in ten (58%)."[9]

Recent research by the Economic and Social Research Institute (ESRI) has found that patients with private health insurance do have shorter waiting times (than those without insurance) for outpatient and in-patient care.[10]

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[7] https://www.hia.ie/sites/default/files/17th%20January%20Kantar%20Report_0.pdf
[8] Health Insurance Authority (2017) *A review of Private Health Insurance in Ireland, 2017*
[9] https://www.hia.ie/sites/default/files/17th%20January%20Kantar%20Report_0.pdf
[10] Whyte, R, *et al* (2020) *Insurance status and waiting times for hospital-based services in Ireland.* Economic and Social Research Institute. This research looked at data from 2007 and 2010.

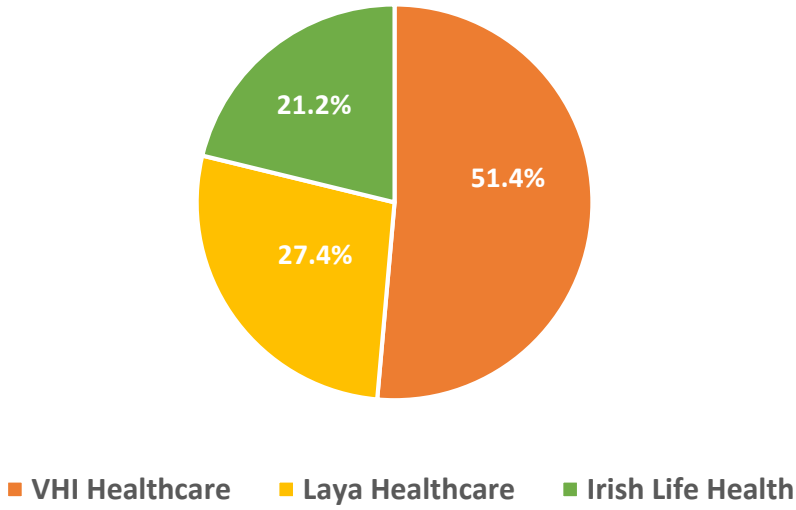
Market shares and the position of Vhi Healthcare

Originally, when the Voluntary Health Insurance (VHI) body was established in 1957, health insurance was envisaged as something that would be of interest to/held by a minority – about 10% of the population,[11] drawn from the top 15% of earners[12] who, by virtue of their high incomes were ineligible for free or heavily subsidised hospital services. Over time, however, despite expanded eligibility for public care, the number/proportion of people paying for private health insurance grew (peaking at just over half the population in 2008).

Currently, the open health insurance market is operated by three insurers: Vhi Healthcare, Laya Healthcare and Irish Life Health. Their proportions of the market as of July 2020 are displayed in the figure below. Vhi Healthcare remains the biggest operator, holding more than half of policies – more than the two other providers combined. A briefing note from the Department of Health indicates that the market share for each insurer has remained broadly the same when compared to the end of June 2019.[13]

As a legacy of its long standing in the market, Vhi Healthcare has a greater proportion of older customers than other insurers - making it the net beneficiary of the risk equalisation scheme.

Figure 3: Health insurance market share, July 2020



Source: L&RS using data from 'Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020'.

[11] Lynch, B (2018) 'Significant developments in Irish health insurance and healthcare since 1950', Health Insurance Authority, *The Irish healthcare system – An historical and comparative Review*. Dublin: Health Insurance Authority.
[12] Turner, B (2013) as before.
[13] Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020. 18/11/2020.

Price of health insurance

The average amount paid for health insurance per person fell slightly in 2019 compared with 2018. Indeed, premiums per person fell by an average of 0.8% in both 2019 and 2018: [14]

> "The average amount paid for a health insurance premium for in-patient cover in 2019 was €1,200, compared to €1,210 in 2018. These figures are based on gross premium levels[15] but child premiums and young adult discounts have a lowering effect on the average."[16]

These prices are before tax relief to consumers. The State subsidises private health insurance by providing consumers with tax relief on premiums at the standard rate of tax (20%). The degree of subsidy has been reduced in recent years by a reduction to the standard rate of tax from the marginal rate and a cap placed on the premium price that will be allowed for tax relief (€1,000 for an adult, €500 for a child).[17]

Nonetheless, in 2018, the cost to the Exchequer of this tax relief was €355.7 million.[18] This has raised issues of equity – forgoing the tax is a public subsidy, the cost of which is spread across all taxpayers including those who cannot afford / do not purchase private health insurance. Academics Brian Turner and Samantha Smith[19] note that this tax relief on premiums has been justified on the basis:

> "…that those who opt for private cover effectively forgo a statutory entitlement while continuing to contribute to the funding of the public health service through taxation."[20]

Tax relief

Tax relief on private health insurance (held by fewer than half the population) cost the Exchequer €355.7m in 2018.

It is applied at source at a 20% rate, with caps in place.

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[14] Health Insurance Authority, *Annual Report 2019.*
[15] The net premiums that consumers are billed for by insurers are reduced by income tax relief, which is 20% of the gross premium up to a maximum of €200 and which the insurers receive directly from the Revenue Commissioners.
[16] Health Insurance Authority, *Annual Report 2019.*
[17] See Citizens Information webpage on: Taxation and Medical Expenses.
[18] Written Answer to Parliamentary Question, 1 October 2020. https://data.oireachtas.ie/ie/oireachtas/debateRecord/dail/2020-10-01/writtens/mul@/main.pdf
[19] Turner, B and Smith, S (2020) 'Uncovering the complex role of private health insurance in Ireland' in Eds. Thomson, S, *et al*, *Private Health Insurance: History, Politics and Performance*, World Health Organization, European Observatory for Health Systems and Policies and Cambridge University Press.
[20] Turner and Smith cite this quote from Department of Health and Children (1999) *White paper on health insurance*. p.24. (This document can be found on HSE's Lenus database: https://www.lenus.ie/discover)

Covid-19 and health insurance

This year, 2020, saw the Covid-19 pandemic effect all aspects of healthcare in Ireland. This section considers the impact of this on private health insurance.

State take-over of private hospitals

At the end of March 2020, there was an unprecedented contract put in place to effect State take-over of private hospitals.[21] The then Minister for Health, Simon Harris, TD, was reported to have stated at the time that:

> "We must of course have equality of treatment, patients with this virus will be treated for free, and they'll be treated as part of a single, national hospital service.
>
> For the duration of this crisis the State will take control of all private hospital facilities and manage all of the resources for the common benefit of all of our people. There can be no room for public versus private when it comes to [the] pandemic."[22]

This move agreed with private hospitals was a contingency plan to allow the public hospital system to access the additional capacity in private facilities in the event of a surge in demand due to Covid-19 infections.[23] As it turned out, this surge did not occur.

The contract for use of the private hospitals was between the Government and the hospitals. Health insurers were not party to this agreement.[24] However, as a result of the take-over, people holding private health insurance were not able to access the services normally available to them on the same basis. As a result, all insurers made partial refunds/some form of financial compensation to their customers. [25]

The Department of Health stated that:

> "COVID-19 has had a major impact on the private health insurance market in Ireland, as it has on the entire public and private health sectors. This has resulted in reductions in the usage of

Private hospital capacity

There are 19 private hospitals in the State. These have an estimated bed capacity of 1,900 inpatient beds, 600 day beds as well as 47 ICU and 54 HDU beds. This includes almost 1,000 single bed inpatient rooms. The sector also has 194 ventilators as well as 9 laboratory services on sites.

This additional capacity was considered critically important in responding to the respond to the national health emergency caused

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[21] *Speech of An Taoiseach, Leo Varadkar TD, Post Cabinet Statement*, Tuesday 24 March 2020; This contract was the subject to the scrutiny of the Oireachtas Special Committee on Covid-19 Response.

[22] https://www.thejournal.ie/private-hospitals-ireland-coronavirus-5056334-Mar2020/

[23] The text box on this page details this capacity. Source: Government press release, *Taoiseach and Minister for Health welcome public private partnership to help increase hospital capacity in Covid-19 emergency*, 30 March 2020.

[24] *Insurance Ireland Submission to the Oireachtas Committee on Covid-19 - Overview of health system capacity for non-Covid 19 healthcare* - 2020.

[25] However, beyond financial measures, patients of private consultants/hospitals complained of the negative impact this take-over had on on-going care. See Health Insurance Authority submission to the Special Committee on the Covid-19 Response (May 2020).

> hospitalisation services and health insurance over the first half of 2020. There has been significantly reduced claims activity as a result of the suspension of most elective hospital treatment and the three-month utilisation of private hospitals by Government." [26]

Giving some insight into official plans in this area, the Programme for Government, states that the Government will:

> "Ensure capacity for a COVID-19 rapid response, including bed and ICU capacity and for non-COVID emergencies into the longer term, by utilising some private hospital capacity, if necessary."

In a PQ response in September 2020, Minister for Health, Stephen Donnelly, TD, indicated what and how further arrangements for tapping into private healthcare capacity are being made:

> "A major part of the Government's Action Plan in response to Covid-19 was to substantially increase the capacity of public healthcare facilities to cope with the anticipated additional demand. In order to urgently ramp up capacity for acute care facilities, an arrangement was agreed with the private hospitals to use their facilities as part of the public system on a temporary basis, to provide essential services. A Heads of Terms of Agreement between the HSE and the Private Hospitals was agreed at the end of March 2020 and all 18[27] of the acute private hospitals signed up to it. Under the arrangement, all patients in the private hospitals were treated as public patients and their treatment was prioritised based on clinical need.
>
> The agreement was reviewed at the end of May and the Government decided that the existing arrangement should not be extended beyond the end of June. It mandated the HSE to negotiate a new arrangement with private hospitals which would provide the HSE with full access to private hospital capacity in the event of a surge of Covid-19 and separately with ongoing agreed access, to enable the HSE to meet essential and elective care needs.
>
> The HSE is currently working to secure access to private hospital facilities to support capacity requirements. A procurement process is currently in train to secure access to additional acute services and diagnostic capacity from private providers which is required to address capacity needs over the next two years.
>
> The HSE is also undertaking bilateral discussions with individual private hospitals to seek to agree new arrangements which would provide the HSE with access to private hospital capacity in the event of a surge of Covid-19 cases."[28]

Impact of Covid-19 on health insurance market

The Department of Health provides the following summary the impact of Covid-19 on the private health insurance market:

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[26] Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020. 18/11/2020.
[27] There are 19 private hospitals (as noted in the box above), of these 18 are acute hospitals.
[28] Dáil Éireann Debate, Tuesday - 15 September 2020: Covid-19 Pandemic (Question 801).

- "Ireland entered a lockdown period between end-March and end-June 2020.
- During this time Government utilised private hospitals with patients being treated as public patients in private hospital settings. Non-essential surgical procedures in both private and public hospital settings were affected as a result of the pandemic. Overall, this has resulted in lower claims and lower bed utilisation in Q2 2020.
- Each of the insurers refunded part of the favourable experience back to their customers, either through reduced premium payments or special COVID-19 payments.
- The claims experience in Q2 2020 (and in Q1 2020 to a lesser extent) is distorted relative to what might have been expected to be observed had COVID-19 not happened.
- The HIA requested insurers views on the outlook of claims and membership as a result of COVID-19 and these views are considered in their projections."[29]

In this context, the Health Insurance Authority's CEO, Mr Don Gallagher, has stated:

> "As yet, we are uncertain of the impact Covid-19 may have on the market. the combination of the health shock and economic shock as a result of Covid-19 could potentially result in people cancelling their health insurance for a variety of reasons in the short to medium term. A significant increase in cancellations at younger ages could potentially impact the sustainability and stability of a community rated health insurance market."[30]

Unemployment and Covid-19

As noted above, during the last recession, health insurance take-up dropped and this was found to be related to increased unemployment and decreased incomes. The economic impact of the Covid-19 infection and related public health measures include reduced tax receipts, increased government spending and increased unemployment. As Table 3 (next page) shows, the standard measure of unemployment put the rate at 7.5% in October - (representing 180,500 people). However, the CSO has prepared a **Covid-19 adjusted unemployment rate** – which includes those on the different payments/wage subsidies available to those unable to work due to the pandemic. Using this adjusted method, the CSO estimate unemployment to have been 20.2% in October 2020 (representing just over 501,000 people). This compares with to 15.9% in September 2020.

It is not certain what impact this increase in unemployment will have on health insurance take-up. However, figures for June 2020 showed the first dip in the number of people with health insurance for over five years.

[29] Briefing paper, as before.
[30] Health Insurance Authority (2020) *Private Health Insurance Market continued to rise in 2019 but impact of Covid19 is yet to be quantified*, Press release: 30 July 2020.

Table 3: Unemployment, October 2020

	Standard/traditional	Covid-19 adjusted
Unemployment rate	5.2%	20.2%
Number of people	180,500	501,640[31]
	Annual increase: 66,300	

Source: L&RS using data from Central Statistics Office Statistical Release, 04 November 2020.

[31] Data used is upper bound of persons aged 15-74 – in accordance with the headline percentage figure reported by the CSO.

The RES and EU state aid rules

> "For this [Risk Equalisation] Scheme to operate appropriately within the parameters of EU law, the Scheme must be notified to the European Commission and approved as a State Aid under the Services of General Economic Interest (SGEI) Framework." [32]

The process around the EU's approval of the RES as an acceptable form of state aid has been impacted by the Covid-19 crisis and arising uncertainty. As noted above, the RES is subject to approval of the EU as a form of State Aid.[33] The HIA explains that:

> "The 2016-2020 Risk Equalisation Scheme was notified to the European Commission as a State Aid that was compatible with the internal market. In February 2016 the European Commission stated that it was not raising objections to this notified aid scheme."[34]

This status was due to expire at the end of 2020 and the Department of Health had entered into a process to re-apply. The Department planned for a restructuring of the RES to allow for a different treatment of high cost claims. The Department's Briefing to the Incoming Minister in June 2020 explains that this would need to be negotiated with the European Commission and would have implications for future domestic health insurance legislation, as follows:

> "The 2021 scheme currently under negotiation with the CION [European Commission] differs from the current version by including a High Cost Claims Pool, the aim of which is to increase the effectiveness by removing very high cost outliers. The negotiation process, which is complex and of several month's duration, will need to be concluded with CION before end Q3 [2020] to align with timelines for legislative amendments necessary to underpin the Scheme."[35]

However, given the Covid-19 pandemic, the Department has changed its approach - putting the re-negotiation of a new scheme on hold, and seeking an extension of the current RES instead. The Department explains:

> "Officials from the Department of Health have engaged with the CION during 2020 and, taking account of current market uncertainty, have requested an extension of current approval beyond end-December (for a period of 15 months). A decision in this regard is expected shortly, and the Department will re-engage with the CION next year [2021] regarding longer-term RES development."[36]

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[32] Department of Health (2020) *Briefing for Incoming Minister for Health*
[33] See European Commission press release on 2013 decision: https://ec.europa.eu/commission/presscorner/detail/en/IP_13_132
[34] Health Insurance Authority, *Annual Report 2019*.
[35] Department of Health (2020) *Briefing for Incoming Minister for Health*
[36] Private communication from the Department of Health, 19/11/2020.

Broader policy context

This section looks at the broader policy context to the *Health Insurance (Amendment) Bill 2020.* It is organised into the following parts:

- Equity in healthcare in Ireland; and
- The Sláintecare report and its implementation – implications for private health insurance

Equity in healthcare in Ireland

A commonly occurring theme in debates on healthcare is equity. As noted above, the Risk Equalisation Scheme seeks to address issues of **equity of access to private health insurance** in Ireland, so that, in general, premiums can be (with the exception of young adult discounts and the loadings under Lifetime Community Rating) charged at the same price to all customers. This is considered more equitable than charging older or sicker people more, i.e. for premiums to be risk-related - like car insurance.

More broadly, the issue of **equity of access to healthcare** is also relevant to the Bill. Ireland has a mix of public and private healthcare, in terms of both financing and delivery. Despite there being universal eligibility for public hospital care in Ireland, as shown above, a large minority of the population continue to pay for private health insurance. Due to different access provided to the insured and uninsured groups it has become known as a 'two-tier health system'. There is much literature around the pros and cons of private market provision, and issues relating to the gap between those with and without health insurance.

The international literature indicates that people have different motivations for taking up voluntary (private) health insurance depending on the type of cover it bestows. In Ireland, cover is generally seen as 'supplementary'[37] – meaning that it:

> "…offers access to health care that is covered publicly, but gives policy holders greater choice of provider and level of amenity (usually including access to private providers) and may enable them to bypass waiting lists for publicly financed services." [38]

The motivations for people to take out supplementary health insurance are considered to be "perceptions about the quality and timeliness of publicly financed health services." [39] As seen above, attitudinal studies in Ireland are in line with this, suggesting that people want health insurance to avoid delays in accessing care, and have some issues with the quality of care in public services.[40]

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[37] See Turner, B (2013) as before.
[38] Saagan, A and Thompson, S (2016) *Voluntary health insurance in Europe – Role and regulation.* Copenhagen: WHO Regional Office for Europe and European Observatory on Health System and Policies.
[39] Saagan A and Thompson, S (2016) as before.p.29.
[40] See: Nolan, B. (2001) *Health Insurance in Ireland: Issues and Challenges*; ESRI Working Paper No. 10; and HIA commissioned Millward Brown Landsdowne Consumer Survey (2011) http://lenus.ie/hse/bitstream/10147/312355/1/xHIAConsumerSurvey2012Report.pdf ; also NESF (2004) *Equity of Access to Hospital Care - Forum Report No. 25*; http://files.nesc.ie/nesf_archive/nesf_reports/NESF_25.pdf

However, there are long-running concerns about fairness in the system. For example, Professor Brian Nolan, in an Economic and Social Research Institute (ESRI) paper, has argued that:

> "The…two-tier system is now widely regarded as problematic from an equity perspective."[41]

In 2009, Dr Samantha Smith, ESRI, while acknowledging that there is no universally agreed definition of equity, noted that:

> "In health care, empirical investigation of equity has focused on adherence to two principles: that healthcare should be financed according to ability to pay, and delivered according to need."[42]

The Sláintecare report and its implementation – implications for private health insurance

These principles (noted above by Dr Smith) were influential in the terms of reference of the Special Oireachtas Committee on the Future of Healthcare (2016-2017). This Committee was formed on a cross-party basis, following an acknowledgement that the health service was under severe pressure and, that amongst other issues, waiting lists were excessive.

The Committee's report, known as the *Sláintecare Report*, concluded that the healthcare system must be:

> "Re-oriented to ensure equitable access to a universal, single tier system, and …[in which] the vast majority of care takes place in the primary and social care settings." (p.14)

The Committee envisaged that in a reformed system:

> "…everyone has equitable access to services based on need and not ability to pay."[43]

A range of measures were recommended across all domains of healthcare – a re-orientation of care towards primary care, addressing understaffing, providing more timely access to public hospital care (including waiting times guarantees).

The Sláintecare recommendations of most relevance to health insurance are those that propose changes to the private / public mix of healthcare provision and funding – such as expanding eligibility to primary care to achieve universal coverage and the removal of private practice from public hospitals.

In relation to private hospital care (generally paid for, at least in part, by health insurance), the Committee recommended **ceasing all private care in public hospitals.** Specifically, the Committee recommended:

> "…a model where private insurance will no longer confer faster access to healthcare in the public sector, but is limited to covering private care in private hospitals." (p.28)

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[41] Nolan, B. (2001) *Health Insurance in Ireland: Issues and Challenges*; ESRI Working Paper No. 10

[42] Smith, S (2009) *Equity in Health Care – A view from the Irish Health Care System*, Adelaide Hospital Society, and University of Dublin, Trinity College. http://www.esri.ie/UserFiles/publications/20090406113247/BKMNEXT136.pdf

[43] Committee on the Future of Healthcare (2017) *Press release: Future of Healthcare Committee publishes Sláintecare – a plan to radically transform Irish healthcare.*

In terms of funding healthcare, the Committee recommended the establishment of a single 'National Health Fund' – funded by general tax revenues and some earmarked taxes, levies or charges.

Implementation of Sláintecare

The last Government published a *Sláintecare Implementation Strategy*. This set out the case for change, including the following:

> **"Access to healthcare is unequal; the tiers we have created are both unfair and a fundamental barrier to progress.**
>
> Ireland is the only western European health system that does not provide universal access to primary care. In addition, access to public acute hospitals is inequitable. The majority of our population pays out-of-pocket fees to access primary healthcare and 45% of the population purchase inpatient health insurance plans, which can provide faster access to private health services in both public and private hospitals. This inequality of access is embedded in our current system and creates barriers and perverse incentives that stand in the way of doing the right things for patients that need care. Moreover, wider health inequalities persist among some groups of the population."

The current Government, in its Programme for Government, *Our Shared Future*, said it would: "…accelerate the implementation of Sláintecare." In addition, the Government is explicit in its support of private healthcare as a consumer choice, stating it will:

> "Retain access to private health services, ensuring choice for those accessing health care."[44]

Developments around removing private care from public hospitals – and the potential impact on private health insurance

A number of reports (see table below) have been published looking at the removal of private care from public hospitals.

Table 4: Reports on private care in public hospitals

Title and publication date	Author	Notes
Assessing Private Practice in Public Hospitals (October 2018)	OECD	Commissioned by the Department of Health.
Report of the Independent Review Group established to examine Private Activity in Public Hospitals (February 2019)	Independent Review Group	Known as the 'de Buitléir Report' after Group Chairperson, Dr Donal de Buitléir.

[44] Government of Ireland (2020) *Our Shared Future*.

Report on the possible impact of the removal of private practice from Irish public hospitals (June 2019)	Deloitte	Although published later, it is understood this analysis was available to the Independent Review Group.

The first report listed above, from the OECD, summarised the pros and cons of have private care in public hospitals as follows (negative points on the left, positive on the right). See table below:

Table 5: OECD summary of the negative and positives of having private practice in public hospitals

Private practice in public hospitals	
-	+
reduces access to care for public patients	makes public employment more attractive
reduces responsiveness of care for public patients	facilitates hiring and retention of health professionals in short supply
More complex and cumbersome hospital administration	contributes to development and training of physicians through higher volume and diversity of cases
erodes public trust (by creating inequities in access between public and private patients)	provides additional revenue for hospitals when public budgets are tight
	enhances patients' choice

Source: OECD (2018) *Assessing Private Practice in Public Hospitals*, p. 29.

According to the Independent Review Group Report, it is very difficult to predict with great accuracy the full range of consequences of removing private care from public hospitals.[45] The OECD report highlighted that there would clearly be fewer providers for private patients, and that future demand for private health insurance would hinge on how reforms turn out in terms of public and private sector capacity/levels of service.[46]

The key relevant findings of the Independent Review Group, are:[47]

- The health insurance market would likely shrink by a minimum of 10% due to the exit from the market of people whose insurance covers only public hospital care (per Figure 3 above currently 9% of insured people have these policies).
- Currently about 810,000 people with health insurance receive all their care in public hospitals. These people would be most directly affected by the proposed change. If all these people gave up their health insurance, this would reduce the market size from about 45% of the population to 28% of the population.
- Initially there may be price reductions for consumers (as insurers would no longer have to pay for care received in public hospitals). In the longer-run however, it is very difficult to predict the impact on consumer prices. They may drop by 1% or rise by up to one-third.

[45] https://assets.gov.ie/26529/aed7ee0317ff49a7a609974772cf2191.pdf
[46] OECD (2018) *Assessing Private Practice in Public Hospitals, p. 34.*
[47] https://assets.gov.ie/26529/aed7ee0317ff49a7a609974772cf2191.pdf

- There are likely to be regional effects on who leaves the health insurance market – as there are not private hospitals in all areas of the country. People without a local private hospital are not likely to see the benefit of keeping their health insurance. The report identifies the regions with few or no private hospitals as: the Midlands and the North West.
- If the market shrinks, it will also age - as older people are considered more likely to want to keep their cover as they are more concerned about their health. This would have implications for the cost of premiums and for the level of stamp duty levy required to maintain the community rating of the system. (The Review Group also note that beyond the removal of private care from public hospitals, there are other factors likely to put upward pressure on the cost of health insurance premiums – population ageing and the rising cost of claims).
- Overall, if the public health system improves (especially through increased finance and human resources), the market for private health insurance is likely to reduce.
- A progressive and phased approach to the removal of private care from public hospitals should mitigate against the shock to the health insurance market.

The HIA has stated:

> "The Authority acknowledges that Sláintecare has cross-party approval and private health insurance may ultimately fulfil a different role with different regulatory supports within that model. However, any transition should be planned over several years and carefully consider the fair treatment of health insurance consumer." [48]

[48] Health Insurance Authority (2020) *Private Health Insurance Market continued to rise in 2019 but impact of Covid19 is yet to be quantified*, Press release: 30 July 2020.

Principal provisions of the Bill

This part of the Digest describes and examines the Bill, section by section. The key provisions deal with risk equalisation credits and stamp duties in the Risk Equalisation Scheme (described above).

Each year the Health Insurance Authority (HIA) assesses the returns made to it from health insurers. It then provides a report to the Minister making recommendations on the level of risk equalisation credits and stamp duty levies required to fund them for the following year. This report is not published in advance of the subsequent Bill proposing the credits and levies being brought before the Houses of the Oireachtas. According to the Department of Health:

> "The Minister has accepted the HIA recommendations in relation to the required rates and Minister of Finance has agreed to the levies to operate from 1 April 2021." [49]

Section 1 provides the definition of the 'Principal Act' as the *Health Insurance Act 1994*.

Section 2 provides for a change of date applicable for revised credits payable from the Risk Equalisation Fund. It would change the date from 1 April 2020 to 1 April 2021. This is in line the annual nature of this Bill to set out payment amounts and dates.

Section 3 seeks to replace Schedule 3 of the Principal Act. The new Schedule 3 provides for Hospital Utilisation Credit (HUC) rate of €125 for overnight accommodation (up from €100 at present) and €75 for day cases (no change from present rate).

These rates would apply to contracts entered into on or after 1 April 2021.

The Hospital Utilisation Credit is a payment from the Risk Equalisation Fund to insurers based on the number of days their customers have spent in hospital – so it used as a proxy for health status/ the level of claims to be met. It seeks to compensate those insurers with sicker customers more.

Section 4 seeks to replace Table 2 in Schedule 4 of the Principal Act. The proposed new Table 2 contains revisions to risk equalisation credits payable from the Risk Equalisation Fund. Revised rates would apply on or after 1 April 2021.

The various proposed rates are presented in the table below, where they are compared with the rates currently in place.

[49] Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020. 18/11/2020.

Table 6: Risk equalisation credits – current rates and those proposed in the *Health Insurance (Amendment) Bill 2020*

Age Bands	Advanced policies				Non- Advanced policies			
	Men		Women		Men		Women	
	Now	From 01/04/2021	Now	From 01/04/2021	Now	From 01/04/2021	Now	From 01/04/2021
64 & under	€0		€0		€0		€0	
65-69	€1,150	€1,025	€675	€550	€350	€350	€225	€200
70-74	€1,850	€1,675	€1,300	€1,150	€575	€550	€425	€400
75-79	€2,650	€2,500	€1,950	€1,800	€850	€825	€625	€625
80-84	€3,350	€3,150	€2,525	€2,250	€1,075	€1,025	€775	€700
85 and over	€4,300	€3,750	€3,025	€2,550	€1,225	€1,250	€925	€825

Code to the changes proposed in the Bill, displayed in this table:

Green = Credit decrease	Yellow = Credit increase	Orange = No change

Source: L&RS using data from *Health Insurance Amendment Act 2019* (current rates) and Table 2 of the Bill (proposed rates).

The Department has described the changes proposed to risk equalisation credit as a 'marginal decrease' in almost all credits. The Department notes that it can be challenging to balance the sometimes conflicting policy priorities in the area of risk equalisation. These are: [50]

- supporting community rating, so that older people and less healthy people can be charged the same for their health insurance policies as younger and healthier people,
- having regard for the sustainability of the private health insurance market; and
- the need for fair and open competition (as required under the EU framework for State aid).

The effect of the changes would likely be to reduce the payments insurers receive for their older customers. Vhi Healthcare would likely be most affected as it has a greater relative proportion of older customers and is the net beneficiary of the RES.

Section 5 seeks to amend section 125A of the *Stamp Duties Consolidation Act 1999*, providing for the level of stamp duty rates from (i) 1 January 2021 to 31 March 2021; and (ii) from 1 April 2021 onwards. The rates provided for are unchanged from the current rates, with the stamp duty:

- on non-advanced contracts set at €52 per child and €157 per adult; and
- on advanced contracts €150 per child and €449 per adult.

[50] Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020. 18/11/2020.

The vast majority of contracts fall into the 'advanced' category – 92% at the end of 2019.[51] Non-advanced contracts are generally those that provide mainly cover for private care in public hospitals – these accounted for 8% of contracts at the end of 2019.[52]

The Department of Health has indicated that the reason for proposing to leave the rates as they are is due to uncertainty in the health insurance market given the Covid-19 pandemic and its effect on healthcare. The Department has stated:

> "The future impact of the ongoing health and economic crisis created by the [Covid-19] virus is uncertain, which strongly affects the calibration of the Risk Equalisation Scheme for policies renewing in the period 1 April 2021 to 31 March 2022. This uncertain situation has been taken into account by the HIA when determining the levels of credits and stamp duties to apply next year. In view of this uncertainty (and potential for market disruption), the view of the HIA is that sustainability of the market can be aided by keeping stamp duty unchanged at this time."[53]

Finally, **Section 6** – 'Short title, commencement, collective citation and construction' - provides that Section 5 will be effective from 1 January 2021, while Sections 2, 3 and 4 would be effective from 1 April 2021.

This Act and the *Health Insurance Acts 1994 to 2019* may be cited together as the *Health Insurance Acts 1994 to 2020*, and will be construed together as one Act.

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[51] Health Insurance Authority, *Annual Report 2019*.
[52] Health Insurance Authority, *Annual Report 2019*.
[53] Briefing from the Department of Health on the Health Insurance (Amendment) Bill 2020. 18/11/2020.

Appendix: Regulation of private health insurance, 1957- 2020

Summary of main events in the regulation of private health insurance	
1957	Establishment of Voluntary Health Insurance
1992	Third Life EU Directive requires an end to monopolies
1994	Health Insurance Act 1994 provides for liberalisation of the market
1996	Regulations to introduce Risk Equalisation Scheme (RES)
1997	BUPA enters the market
1999	"Harvey Report" submitted to the Department of Health; Department of Health publishes *White Paper on Private Health Insurance*; 1996 Risk Equalisation Scheme regulations revoked
2001	Health Insurance Authority is established Three-year exemption from RES for new market entrants to promote competition
2003	New Risk Equalisation Scheme introduced RES does not contravene state aid rules according to European Commission
2004	VIVAS Health enters the market
2005	HIA recommends payments to be commenced under RES Minister decides not to act on recommendation and to defer payments
2006	The High Court upholds the RES
2007	BUPA is taken over by Quinn Healthcare. Three-year exemption from RES for new market entrants removed
2008	BUPA unsuccessfully challenges European Commission's 2003 decision RES deemed ultra vires (beyond the powers of the Minister) by the Supreme Court as it was based on a misinterpretation of community rating in the 1994 Act. Minister announces new initiative to stabilise the system to be implemented by the *Health Insurance (Amendment) Bill 2008*
2009	VIVAS is taken over by Hibernian Health
2009	Interim RES introduced based on tax credits *(Health Insurance (Miscellaneous Provisions) Act 2009*
2010	Administrators appointed to Quinn Insurance Limited HIA consultation on risk equalisation in private health insurance
2011	Amendments to RES and one-year extension of Interim Scheme *(Health Insurance (Miscellaneous Provisions) Act 2011. (*see also *Health Insurance Act 1995 (Information Returns) (Amendment) Regulations 2011*)
2012	Glo Health enters insurance market, bringing the number of insurers in the market to four
2013	Introduction of permanent Risk Equalisation Scheme – *Health Insurance (Amendment) Act 2012*
2015	Introduction of 'Lifetime Community Rating' of late entry loadings for people aged 35 and over taking out health insurance for the first time, and discounts for young adults.
2016	RES 2016-2020 approved and introduced; Gets EU approval as an acceptable form of State aid – compatible with the internal market Aviva Health Insurance becomes Irish Life Health and Irish Life Group increases ownership of GloHealth to 100% (from 49%)
2017	Irish Life Health and Glo Health merged their operations, effective February 2017

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