The Insurance Institute

Personal General Insurance

CIP-03 KEY POINTS

Advancing *Your* Career.

CHAPTER 6

PRIVATE HEALTH INSURANCE

There are currently 11 organisations that offer private health insurance in Ireland. In order to offer private health insurance, an undertaking must be registered with the Health Insurance Authority (HIA) on the Register of Health Benefits Undertakings.

The 4 open membership undertakings are Irish Life Health DAC (known as Irish Life Health), HSF Health Plan Ltd (trading as HSF Health Plan), Elips Insurance Ltd. (trading as laya healthcare) and Vhi Insurance DAC (trading as Vhi Healthcare) and are obliged to provide health insurance cover to anyone who seeks it.

The other 7 providers are restricted membership undertakings and are not open to the general public.

Only one of the private health insurers appoints intermediaries, so an adviser who is required to give a 'fair analysis of the market', may have to provide advice on the basis of no-commission earnings.

PRINCIPLES OF PRIVATE HEALTH INSURANCE

The **Health Insurance Acts 1994–2016** are the primary source of regulation for the private health insurance market and also established an independent statutory regulator, the HIA.

The principles on which the market operates are:

- **Community rating**
- **Open enrolment**
- **Lifetime cover**
- **Minimum benefits**.

Waiting periods

The circumstances in which the waiting periods may be applied, and the maximum waiting periods and age bands are all set out in Regulations made under the **Health Insurance Acts 1994-2016**.

Waiting periods apply primarily in respect of in-patient treatment.

There are four types of waiting periods:

- Initial waiting period
- Maternity waiting period
- Pre-existing waiting period
- Upgrade waiting period.

Risk equalisation

The **risk equalisation** process aims to equitably neutralise differences in insurers' claims costs arising from variations in the age profile of the persons they insure.

The **Health Insurance (Amendment) Act 2012** introduced the Risk Equalisation Scheme (RES), which became effective in January 2013.

The process works through a system of levies and credits. The health credits vary by policyholders' age, gender and level of cover, and the levy varies by adult, child and level of cover.

In addition to the health credits, there is a hospital bed utilisation credit designed to compensate insurers for claims costs associated with people requiring more frequent or longer periods of hospitalisation. From March 2016, a payment of €30 is made for a day case admission.

The **Health Insurance (Amendment) Act 2016** provides for an increase in the community rating levies, from 1 April 2017. Unlike previous years, the changes in the rates of credits and stamp duty will come into effect on the 1 April rather than on 1 March to facilitate the smooth administration of stamp duty collection by the Revenue Commissioners.

MINIMUM BENEFITS

The **Health Insurance Act 1994 (Minimum Benefit) Regulations 1996** require that a minimum level of cover must be provided in respect of a broad range of investigative and medical interventions.

These must be appropriate and necessary and provided on an in-patient or day-patient basis, with some very limited cover required in respect of out-patient benefits. There is no requirement for the inclusion of GP services.

The Regulations also provide for a number of items that private health insurers are not required to cover. However, most insurers provide cover for some of these exclusions, such as screening or more recently, infertility treatment.

Private health insurers may adjust the rate they pay to reflect the appropriate setting for the treatment provided - otherwise there is nothing to deter the policyholder from 'overspending' on unnecessary facilities or accommodation.

PRIVATE HEALTH INSURANCE PRODUCTS

There are essentially three main types of community rated products.

Hospital-only products

The core of a private health insurance product is its hospital cover.

There are three main categories of hospital, and within each hospital category there are three main hospital settings for which insurers provide cover:

- Public hospitals
- Private hospitals (standard)
- Private hospitals (high-tech).

Differences in levels

There are five main levels of hospital cover which are based on hospital category and bed type. There are different private health insurance products, ranging from those that provide cover in public hospitals only, to those that provide cover in both public and private hospitals. They can typically be categorised as follows:

- **Level 1**: cover for a multiple occupancy (semi-private) room and a single occupancy (or private) room in a public hospital.
- **Level 2**: cover for semi-private room in a standard private hospital.
- **Level 3**: cover for a private room in a standard private hospital.
- **Level 4**: cover for a semi-private room in a high-tech private hospital.
- **Level 5**: cover for a private room in a high-tech private hospital.

In addition to the accommodation cover, separate cover is provided for a number of specified procedures:

- Specified cardiac procedures
- Specified other procedures

Hospital with 'day-to-day' products

These products add comprehensive 'day-to-day' and out-patient benefits to the ‘hospital only’ products.

Out-patient benefits include those associated with the out-patient component of a hospital stay (e.g. consultants’ fees, radiology and pathology services) and other services (e.g. GP services, physiotherapy and other complementary therapies).

'Day-to-day' only products and health insurance cash plans

These products do not provide hospital cover and tend to fall into two categories:

- ‘Day-to-day’ products that offer benefits in respect of a wide range of everyday medical expenses only
- Health insurance cash plans that provide cover on a fixed amount or fixed percentage basis and are subject to community rating, open enrolment and lifetime cover.

DIFFERENCES IN BENEFITS – PRIVATE HEALTH INSURANCE PRODUCTS

Although there are few product providers, there are a vast array of plans geared to meet particular needs, aimed at particular target groups. The adviser’s task is to recognise key differences and unique aspects of cover.

The HIA comparison tool is a good source of information, though it will only work where the adviser knows which products to compare.

The common variations in cover can be considered under the following headings:

- Public hospitals
- Private hospitals (standard)
- Private hospitals (high-tech)
- Specified cardiac procedures
- Specified other procedures
- Restricted procedures
- Consultants’ fees
- Psychiatric treatment
- Alcohol and substance abuse
- Convalescent care
- Maternity
- Treatment abroad
- MRI, CT and PET-CT scans
- Out-patient benefits
- Nurse advice line.

Participating consultants

Currently, insurers in Ireland have full cover fee agreements for in-patient services, with approximately 99% of consultants (termed fully participating consultants).

The remaining consultants are paid for their services at the insurer’s ‘standard rate’, but reserve the right to ‘balance bill’ the patient.

Premium variations

Premium rates vary between adult, young adult and child. The young adult rate varies based on age up to and including 25. Each insurer can decide whether to offer a young adult rate on a particular product so this may vary from insurer to insurer and even from product to product within an insurer’s product range.

Guidance for advisers

In order to be able to provide appropriate advice to consumers, the adviser must be fully familiar with all of the health insurance products available, and also have a thorough understanding of the consumer's needs and wants.

The types of generic questions that inform this process include:

- Consumer details
- Previous insurance history
- Details of illnesses or injuries, pre-existing conditions
- Key priorities
- Date of contact
- Authorisation to contact and full disclosure requirements.

TAX RELIEF

It is important to note that in the context of private health insurance, tax relief arises on:

- Private health insurance premiums
- Medical expenses.

Tax relief on private health insurance premiums

Section 470 of the **Taxes Consolidation Act 1997** provides for tax relief in respect of premiums paid to an authorised private health insurer.

The current rate of tax relief is 20% of gross premium up to a maximum relief of €200 for an adult and €100 for a child. Example 6.3 shows how this is applied.

To be eligible for tax relief the contract must be made up of a significant level of actual health expenses.

The system applies differently to those whose health insurance premiums are paid (or part paid) by their employers as it results in certain tax liabilities for the employee.

Tax relief on medical expenses

Section 469 of the **Taxes Consolidation Act 1997** provides that taxpayers are entitled to tax relief in respect of 'allowable expenses' incurred in the provision of health care.

If some of the expenses are claimable under a private health insurance policy the level of 'allowable expenses' would be reduced by this sum.

In relation to the rate of tax relief on health expenses, the standard rate (20%) of relief applies irrespective of whether you are taxed at the standard or higher rate (40%) of tax. Relief in respect of nursing home expenses will be provided at the highest rate of tax you pay. So where a person pays the standard rate of tax, the relief will be 20%, but where a person pays the higher rate of tax, the relief will be 40%. Claims may be submitted for up to 4 years. These claims are not subject to an excess.

Tax relief can be claimed for health expenses incurred by the claimant in respect of any individual. There does not need to be any relationship of dependency.

Allowable expenses for health care relate to the 'prevention, diagnosis, alleviation or treatment of an ailment, injury, infirmary, defect or disability'.

There are two categories: automatically allowable expenses and those that must be prescribed by a medical practitioner.

Tax relief is not given for routine dental and ophthalmic care.

Making a claim

Tax relief is not available for any expenses that can be reimbursed from another source, e.g. under a private health insurance policy.

Tax relief can be claimed after 31 December of the year in which expenses are incurred, for up to 4 years. A person can choose whether they want the relief given for the year in which the payments were made or the year in which the expenses were incurred.

There is no requirement to submit receipts with a claim, however Revenue do reserve the right to ask for these receipts, for auditing purposes, for a period of up to 6 years post claim.

POLICY CONTINUITY AND TRANSFER

Private health insurance contracts are generally for a period of 12 months. Each insurer has specific rules regarding mid-term adjustments. Current market practice is that the insurer will seek the pro-rata amount of the outstanding levy paid at inception from the policyholder as well as an administration fee for policy cancellation.

If insurers enhance benefits on certain plans they may choose to do so from a current date rather than the next renewal date.

If an insurer increases the price or reduces the benefits on a plan, this only affects existing policyholders from their next renewal date. In the event that an insurer removes a hospital from their approved listing mid-term, they must write to all affected policyholders advising them of this change.

Renewal process

The health insurers provide a renewal notice with certain prescribed information not less than 15 working days before the renewal date.

The renewal notice will also include an up-to-date policy document outlining any benefit or rule changes made since the last renewal.

At renewal, policyholders can:

- Renew the cover as proposed
- Contact the insurer for other product solutions
- Contact alternative insurers
- Cancel their cover.

Transferring to another private health insurer

One of the key features of the private health insurance system in Ireland is that a policyholder can transfer from one private health insurer to another without having to re-serve waiting periods.

The new insurer may impose a waiting period in respect of any additional benefits that fall within the ‘upgrade of cover’ rule or in respect of any portion of the original waiting periods that have not been fully served.

However, this entitlement does not apply where a consumer has had a break in cover of more than 13 weeks.