An tÚdarás Árachas Sláinte
The Health Insurance Authority

Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2023 to 30 June 2024, including advice on Risk Equalisation Credits

24 September 2024

Contents

1. Executive Summary

This report sets out the Health Insurance Authority's (the Authority) recommendations on Risk Equalisation Credits and the associated level of stamp duty for contracts commencing in the period 1 April 2025 to 31 March 2026.

The report also includes an analysis of the health insurance market information (information returns) received by the Authority in respect of the period 1 January 2024 to 30 June 2024, which influenced the recommendations.

The recommendation has been set to strike a balance between sustaining community rating by keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger, healthier consumers in the market while maintaining the effectiveness of the Risk Equalisation Scheme (RES).

The key components of the recommendation are as follows:

- Stamp duty for advanced products has increased compared to the current calibration (2025/2026 Calibration: €469 vs 2024/2025 Calibration: €420). The increase in stamp duty is heavily driven by medical claims inflation during 2023.
- Stamp duty for non-advanced products has decreased compared to the current calibration (2025/2026 Calibration: €94 vs 2024/2025 Calibration: €105). The reduction in stamp duty for non-advanced contracts should serve to address concerns about affordability and stability of the market. The Authority is of the view that it is fair that non-advanced customers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurers' product pricing.

In developing these recommendations, the Authority examined recent trends in the health insurance sector and consulted with the health insurance companies. The recommendations are based on the Authority's best estimates of how many people will have health insurance and what will be the type and cost of claims that they make on those health insurance plans.

If actual experience is in line with expectation this means that no surplus will exist when the credits and stamp duty on all contracts that commence in advance of 1 April 2026 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2026/2027 Calibration. The Authority is of the view that the key drivers of surplus/deficit are:

- Population: Impacts on the level of stamp duty received and the age credits paid.
- Hospital Utilisation: Impacts on the level of Hospital Utilisation Credit (HUC) credits paid and the level of High Cost Claims Pool (HCCP) credits paid. If drugs eligible for inclusion in HCCP claims are restricted to the PCRS list, it will cause a surplus.
- Inflation: Impacts on the level of HCCP credits paid.

It should be noted that there is considerable uncertainty in projecting future experience. The sensitivity of the Risk Equalisation Fund (REF) surplus to these assumptions are considered in Appendix 3.

The remainder of this report is laid out as follows:

Section 2 outlines the proposed recommendation and a high level summary of the content included in the remainder of the report.

Section 3 outlines the approach used by the Authority for the purposes of developing the recommendations.

Section 4 outlines the assumptions used to determine the recommendation for risk equalisation credits and stamp duty for contracts commencing in the period 1 April 2025 to 31 March 2026 and the data informing those assumptions.

Section 5 sets out market developments over the last 12 months.

Section 6 sets out overcompensation considerations as required under Section 7E(1)(b) of the Health Insurance Act 1994 (as amended).

Section 7 sets out the recommendation in respect of risk equalisation credits and stamp duty.

Section 8 highlights the projected impacts of the recommendations and the key metrics considered when making the recommendation.

Appendices include analyses of the information returns received and supporting documentation.

Note

The underlying figures in the various tables contained in this report are calculated to many decimal places. In the presentation of our results there may be reconciliation differences due to the effect of rounding.

Throughout this document we refer to Irish Life Health DAC, Elips Insurance Limited and Vhi Insurance DAC by their trading / brand names (Irish Life Health, Laya Healthcare and Vhi Healthcare respectively).

2. Background and Recommendations

The Minister for Health (the Minister) has requested that the Authority provide a Report to the Minister under Section 7E of the Health Insurance Act 1994 (as amended "the 1994 Act").

In preparing such a Report the Authority is required to include:

- Such matters concerning the carrying on of health insurance business that the Authority considers ought to be brought to the attention of the Minister; and
- The Authority's conclusions in relation to what risk equalisation credits and stamp duty are appropriate having had regard to the criteria set out in Section 7E(1)(b) of the Act.

Section 7E(1)(b) requires the Authority to have regard to the following objectives:

- The Principal Objective (community rating);
- Avoiding over-compensation being made to a registered undertaking;
- Maintaining the sustainability of the health insurance market;
- Fair and open competition in the health insurance market; and
- Avoiding the REF sustaining surpluses or deficits from year to year.

The purpose of this report is to recommend an appropriate level of stamp duty and risk equalisation credits for the 2025/2026 RES calibration, i.e. for health insurance contracts entered into in the period 1 April 2025 to 31 March 2026.

The report also contains an evaluation and analysis of the information returns[1] received by the Authority from undertakings for the 6-month period commencing on 1 January 2024.

2.1. Recommendation

2.1.1. Stamp Duty

The Authority recommends that the stamp duties to be paid by the insurers on health insurance contracts that are entered into between 1 April 2025 and 31 March 2026, in order to support the risk equalisation credits, are as follows:

Table 2.1 Stamp Duty Recommendation for Contracts Incepted 1 April 2025 – 31 March 2026

Age Band	**Stamp Duties from 1 April 2025 to 31 March 2026**		**Stamp Duties from 1 April 2024 to 31 March 2025**		**Change**	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17 and Under	€31	€156	€35	€140	(€4)	€16
18 and Over	€94	€469	€105	€420	(€11)	€49

The recommendation is to utilise the €10m surplus expected to exist in the REF (when the credits and stamp duty on all contracts that commence in advance of 1 April 2025 are fully earned) to reduce the level of stamp duty. The surplus has built up in the REF over recent years, because claims

[1] Under the Health Insurance Act 1994 (Information Returns) Regulations 2009, Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2011 as amended by Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2013, Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2015, and Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2022.

on the REF have been below the income from stamp duty. The surplus has reduced by €15m compared to the 2024/2025 Calibration when the surplus was €25m. Overall, for the 2025/2026 Calibration, the level of credits to be paid are expected to exceed the stamp duty receipts, by a magnitude of €10m.

The increase in stamp duty on advanced plans is primarily driven by an increase in projected returned benefits and a reduction in the REF surplus compared to the 2024/2025 RES. Returned benefits are based on the latest 2023 claims data.

In last year's report the Authority noted that if the surplus in the REF was not applied to the 2024/2025 stamp duty, advanced stamp duties for adults would have been set at €436, as opposed to €420, and the non-advanced adult stamp duty would have been €109, as opposed to €105.

The Authority notes that if the surplus in the REF was not applied to the 2025/2026 stamp duty, advanced stamp duties for adults would be €475, as opposed to €469, and the non-advanced adult stamp duty would be €95, as opposed to €94.

2.1.2. Risk Equalisation Credits

The Authority recommends that the following risk equalisation credits should apply for health insurance policies that are entered into between 1 April 2025 and 31 March 2026.

Table 2.2 Risk Equalisation Credits for Contracts Incepted 1 April 2025 – 31 March 2026

	Proposed 2025 RES Calibration				**Change From Current Credits**			
Age Related Health Credits								
	Non-Advanced		Advanced		Non-Advanced		Advanced	
	Men	Women	Men	Women	Men	Women	Men	Women
64 and Under	€0	€0	€0	€0	€0	€0	€0	€0
65-69	€275	€150	€975	€525	€25	€0	€125	€100
70-74	€350	€250	€1,625	€975	(€75)	(€50)	€250	€50
75-79	€550	€400	€2,225	€1,500	(€50)	(€75)	€200	€50
80-84	€650	€475	€2,625	€1,775	(€50)	(€25)	€200	€175
85+	€650	€475	€2,625	€1,775	(€50)	(€25)	€200	€175
Hospital Utilisation Credit								
	Night		Day		Night		Day	
	€163		€81		€0		€0	
Hight Cost Claims Pool (HCCP)								
Quota Share	45.0%				No Change			
Threshold	€50,000				No Change			

The Age Related Health Credits (ARHC) for plans that provide advanced cover are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). The ARHC for plans that provide non-advanced cover (which generally limit coverage to private care in public hospitals) are based on the average claim costs for non-advanced contracts. The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140% (2024/2025: 140%) of the average net claims cost across all lives.

In the 2024/25 calibration, the Authority recommended that the HUC rates were set at 20% of the charges for day cases and overnight admission as a private patient in a public hospital. This gave a

HUC night rate of €163 and a day rate of €81. The Authority does not recommend a further change for the 2025/26 RES.

The Authority recommends that the HCCP credits for 2025/2026 are based on a 45% quota share on claims in excess of €50,000. The calibration allows for rolling HCCP claims. The approach for HCCP credits is unchanged from the 2024/2025 RES. The estimated size of the credits to be distributed in respect of the HCCP for the 2025/2026 RES calibration is €126.6m or 13.7% of the overall credits. Further detail is available in Section 4.2.

The table below sets out the split of total RES credits paid out by different age cohorts for the 2025/2026 and 2024/2025 RES calibrations.

Table 2.3 Split of Total RES Credits Paid by Age Cohort

Age Cohort	Age Credit	HUC	HCCP	Total Credits
	Recommended 2025/2026 Calibration, Amounts in €m			
0-17	0.0 (0.0%)	8.2 (70.1%)	3.5 (29.9%)	11.7 (100.0%)
18-29	0.0 (0.0%)	9.4 (64.1%)	5.2 (35.9%)	14.6 (100.0%)
30-39	0.0 (0.0%)	14.8 (78.0%)	4.2 (22.0%)	19.0 (100.0%)
40-49	0.0 (0.0%)	20.0 (66.8%)	9.9 (33.2%)	29.9 (100.0%)
50-54	0.0 (0.0%)	13.2 (63.6%)	7.5 (36.4%)	20.7 (100.0%)
55-59	0.0 (0.0%)	14.8 (63.4%)	8.6 (36.6%)	23.4 (100.0%)
60-64	0.0 (0.0%)	18.5 (60.5%)	12.0 (39.5%)	30.5 (100.0%)
65-69	91.2 (70.4%)	22.7 (17.5%)	15.6 (12.0%)	129.4 (100.0%)
70-74	137.9 (75.1%)	27.3 (14.8%)	18.6 (10.1%)	183.7 (100.0%)
75-79	161.3 (77.0%)	29.7 (14.2%)	18.3 (8.8%)	209.4 (100.0%)
80+	185.7 (74.0%)	41.9 (16.7%)	23.2 (9.3%)	250.9 (100.0%)
Total	**576.1 (62.4%)**	**220.4 (23.9%)**	**126.6 (13.7%)**	**923.1 (100.0%)**
	2024/2025 Calibration			
0-17	0.0 (0.0%)	8.6 (72.6%)	3.2 (27.4%)	11.8 (100.0%)
18-29	0.0 (0.0%)	10.2 (78.6%)	2.8 (21.4%)	13.0 (100.0%)
30-39	0.0 (0.0%)	16.0 (79.1%)	4.2 (20.9%)	20.2 (100.0%)
40-49	0.0 (0.0%)	20.9 (72.7%)	7.9 (27.3%)	28.8 (100.0%)
50-54	0.0 (0.0%)	12.7 (70.5%)	5.3 (29.5%)	18.0 (100.0%)
55-59	0.0 (0.0%)	15.2 (65.1%)	8.1 (34.9%)	23.3 (100.0%)
60-64	0.0 (0.0%)	18.9 (63.7%)	10.8 (36.3%)	29.7 (100.0%)
65-69	78.3 (68.1%)	22.6 (19.7%)	14.1 (12.3%)	115.0 (100.0%)
70-74	123.2 (74.4%)	26.1 (15.8%)	16.2 (9.8%)	165.5 (100.0%)
75-79	153.5 (77.6%)	29.5 (14.9%)	14.9 (7.5%)	197.9 (100.0%)
80+	180.0 (73.8%)	43.3 (17.8%)	20.7 (8.5%)	243.9 (100.0%)
Total	**534.9 (61.7%)**	**224.0 (25.8%)**	**108.1 (12.5%)**	**867.0 (100.0%)**

Medical cost inflation has been a feature of the health insurance market and in aggregate, the age credits have increased as the percentage of the overall scheme. These increases have been driven by high levels of medical cost inflation observed over the past 12 months which have increased claims costs without corresponding increases in the level of hospital utilisation. The level of credits allocated to both age credits and HCCP have increased as a result while the level of HUC credits has remained reasonably static.

The Authority has been consistent in its aim that credits related to health status, should cover a higher proportion of the REF claims over time. The introduction of the HCCP in 2022 and expansion to allow for rolling HCCP claims from April 2023 were material steps towards this aim. The RES recommendation for 2024/2025 included a further, smaller, step towards having credits related to health status, make up a higher proportion of the REF claims by setting the hospital utilisation credits

(HUC) to 20% of the current charges for day cases and overnight admission as a private patient in a public hospital.

The Authority notes that the proportion of credits related to health status has reduced in the 2025/2026 Calibration relative to the 2024/2025 Calibration. While changes to the HUC and HCCP calibration could address this, the Authority considers that reasonable steps were taken in relation to HUC in the 2024/2025 Calibration and that the underlying issues with drugs allowed to be included in HCCP claims should be addressed before further changes are made to the HCCP calibration. This will be revisited in the 2026/2027 Calibration.

The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140.0% of the average net claims cost across all lives. For the 2024/2025 RES there was not enough data to credibly calibrate policyholders aged 85+ as a standalone age group and as a result the 2024/2025 RES calibration grouped lives over 80 together for the purposes of calibrating ARHC. This practice has continued for the purposes of the 2025/2026 RES calibration. Thus, the 2025/2026 RES calibrations groups lives over 80 together for the purposes of calibrating ARHC.

Setting credits and stamp duty to avoid risk selection and market segmentation are key in terms of maintaining market stability. The recommendation has been set to strike a balance between sustaining community rating by keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger, healthier consumers in the market while maintaining the effectiveness of the RES.

Further details on the recommendation are included in Section 7, 8, and Appendix 2 of the report.

2.2. Projected Financial Impact of the Recommendation

The Authority estimates that the projected net financial impacts on each of the insurers for a 12 month period, based on the credits and stamp duty proposed to apply for policies commencing in the period 1 April 2025 to 31 March 2026, will be as follows:

Table 2.4 Projected Financial Impacts

Recommendation	[redacted]	[redacted]	[redacted]	Market
ARHC €m				576
HUC €m				220
HCCP €m				127
Stamp Duty €m				(913)
Net Financial Impact* €m				10
Net Financial Impact per Insured Life €				

[redacted]

2.3. Key Assumptions and Basis of Calculation

The development of the RES recommendation for 2025/2026 is based on a number of key assumptions regarding the market for health insurance, the cost of consultants and hospital care, as well as assumptions around usage of health care services.

The primary assumptions underpinning the 2024/2025 and recommended 2025/2026 RES calibrations are shown in Table 2.5 below. An overview of the rationale for these assumptions is set out in the remainder of this section with further detail provided in Section 4.

Table 2.5 Assumptions Underpinning Recommended 2024/2025 Calibration vs 2025/2026 Calibration

	2024 RES Calibration	Recommended 2025 Calibration
Claims Adjustment		
Base Data	31-Dec-22	31-Dec-23
Inflation		
Public	0%	0%
Private	5%	5%
Consultant	5%	6%
Number of Years of Inflation	2.25 years	2.25 years
Hospital Utilisation Rates		
Overnights	59%	57%
Day	41%	43%
Hospital Utilisation Credits		
Overnights	€163	€163
Day	€81	€81
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	45.0%	45.0%
Rolling Claims	Yes	Yes
Insured Population Data		
Base Data	30-Jun-23	30-Jun-24
Other		
REF Surplus	€25m	€10m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	25%	20%
Net Claims Cost	140.0%	140.0%

2.3.1. Assumptions Used to Forecast Claims

The Authority uses claims and returned benefits data observed in the market to estimate the likely level of claims for the relevant RES period 2025/2026. The assumptions used are outlined below and were developed based on the Authority's knowledge and understanding of the health insurance market and feedback from the health insurance companies.

Claims Inflation

The Authority has assumed a 0% inflation for public hospital costs. The HSE has not indicated a change to the charge for privately insured patients for the period of the 2025/2026 RES.

The Authority notes that the cost of claims in private hospitals are also more exposed to inflationary increases. Both the Central Bank of Ireland and the European Commission have projected falls in the rate of inflation for Ireland – see Section 4.3.6. The ESRI forecasts slightly higher inflation. The Authority has considered these forecasts, and the view provided by insurers in proposing claims inflation rates of 5% for private and 6% for consultant to be used for the 2025/2026 Calibration. The Authority also examined the impact of a high inflation scenario, which are described in more detail in Appendix 3.

It is worth noting that, while claims inflation is a key assumption, it interacts with utilisation and insured population assumptions. A growing population or lower utilisation rates can dilute the impact of claims inflation.

Base Year Data

With the exception of necessary adjustments during the COVID-19 pandemic and HSE cyber-attack, the HIA has used the most recent 12 months of claims information in order to estimate the claims for the next contract period. The insurers have indicated that they are of a similar view. The Authority is therefore satisfied that 2023 is a suitable base year for projecting claims for the 2025/2026 RES calibration.

2.3.2. Insured Population Data

The proportion of the population with private health insurance has remained robust despite recent high inflation and drops in disposable income. The number of people with private health insurance has increased over the 12 months to 1 July 2024 by 35,249 or 1.5%.

The age distribution is a material consideration as well as the total number of people with insurance. Table 2.6 shows the historical age profile of the insured population and evidences that the market ageing appears to have slowed down considerably in recent years. At a market level there has been a gradual ageing of the population with the proportion of the insured population over 65 increasing from 16.8% to 17.3% over the last 12 months and from 16.0% to 17.3% over the last 6 years.

Table 2.6 Age Profile of Insured Members

Age Group	1 Jan 2019	1 Jan 2020	1 Jan 2021	1 Jan 2022	1 Jan 2023	1 Jan 2024
0-17	23.5%	23.3%	22.9%	22.7%	22.4%	22.1%
18-29	11.1%	11.5%	11.8%	12.2%	12.5%	12.5%
30-39	13.6%	13.3%	13.1%	12.9%	13.0%	12.9%
40-49	16.0%	16.0%	16.0%	16.0%	15.9%	15.7%
50-59	13.8%	13.7%	13.6%	13.6%	13.5%	13.6%
60-64	6.1%	6.0%	6.0%	5.9%	5.9%	5.9%
65-69	5.3%	5.3%	5.3%	5.3%	5.2%	5.3%
70-74	4.5%	4.5%	4.5%	4.5%	4.4%	4.5%
75-79	3.0%	3.1%	3.2%	3.4%	3.5%	3.6%
80-84	1.9%	2.0%	2.0%	2.1%	2.1%	2.2%
85+	1.3%	1.4%	1.4%	1.5%	1.5%	1.6%
Under 65	84.0%	83.8%	83.4%	83.3%	83.2%	82.7%
Over 65	16.0%	16.2%	16.6%	16.7%	16.8%	17.3%

The Authority has projected the population at 1 July 2024 forward to 1 October 2025 (to allow for the natural ageing of the insured lives), we have not allowed for any market shrinkage, this is a key judgement for the population projection. The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2025/2026 Calibration.

- Lives under 65 are assumed to increase by 28,827 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2024. This approach reflects the expectation that growth in the insured population will likely occur in younger lives. Should the population not grow in line with the Authority's expectation, e.g. 1% lower population growth, the impact on surplus would be of the order of c. €8-9m due to reduced receipts of stamp duty.

- Lives over 65 are assumed to age by 1 year within the projections which implicitly assumes older lives will not take out health insurance for the first time, and equally assumes they will not cancel their insurance, which is a simplification. In addition, an allowance for mortality has been introduced to the projected population for lives aged 65 and over who are assumed to die in line with the decrements outlined in the industry table ILT 2017.[2] In aggregate, lives over 65 are assumed to decrease by 3,601 as a result.

Table 2.7 Change in Insured Population

(Members 000's)	01-Jul-21	01-Jul-22	01-Jul-23	01-Jul-24	Projected 1-Oct-25
Population	2,226	2,294	2,377	2,413	2,438
Difference		3.0%	3.6%	1.5%	1.0%

2.3.3. Estimated Claims Value

The cumulative impact of the assumptions used to forecast claims, and the population growth assumptions results in the projected returned benefits for the 2025/2026 RES calibration period as set out below:

Table 2.8 Estimated Claims Value

€ m	Public Hospitals	Private Hospitals	Consultant	Total
2019 Total	471	1,071	428	1,969
2020 Total	398	852	356	1,605
2021 Total	310	1,072	416	1,798
2022 Total	418	1,146	478	2,042
2023 Total	429	1,342	540	2,311
Estimate for 2024*				2,375
2024/25 Estimate	439	1,374	601	2,415
Rate of Annualised Growth**	1.0%	1.1%	4.9%	2.0%

**Estimate for Claims in 2024 is based on actual claims for the first half of 2024 multiplied by 2.*
*** Assumed rate of annualised growth over the period 31 December 2023 to 1 April 2026.*

As can be seen in the above table, the total value of returned benefits are assumed to increase by 2.0% p.a. in aggregate (for each of the two years from 2023/24 to 2025/26). This is driven by the projected population with health insurance forecast to increase and the cost of individual claims is assumed to increase in line with the inflation assumptions. This can be considered as a 1.0% p.a. increase in public hospital claims, a 1.1% p.a. increase in private hospital claims and 4.9% p.a. increase in consultant claims (annualised growth over the 2.25 years of inflation).

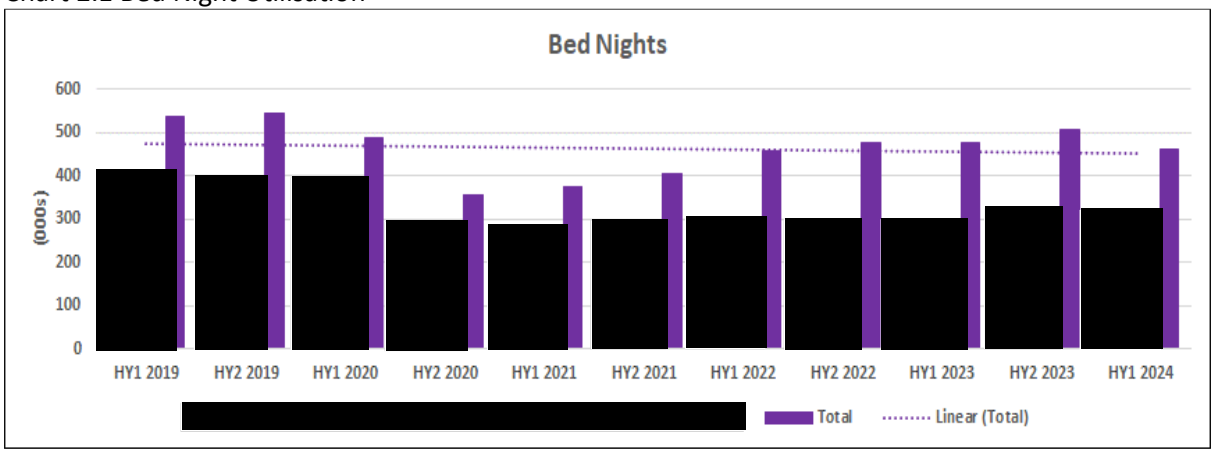
Within this estimate, we have assumed that any capacity constraints in any hospital (public and private) are not reached and that at all age cohorts are able to access healthcare at the same utilisation rates experienced in 2023. The Authority recognises that there are ultimate limits to the amount of care that can be provided but the growth assumed in these projections is considered sufficiently modest to not breach these limits.

[2] Irish Life Tables No. 17 2015-2017 - CSO - Central Statistics Office

2.3.4. Hospital Utilisation Rates

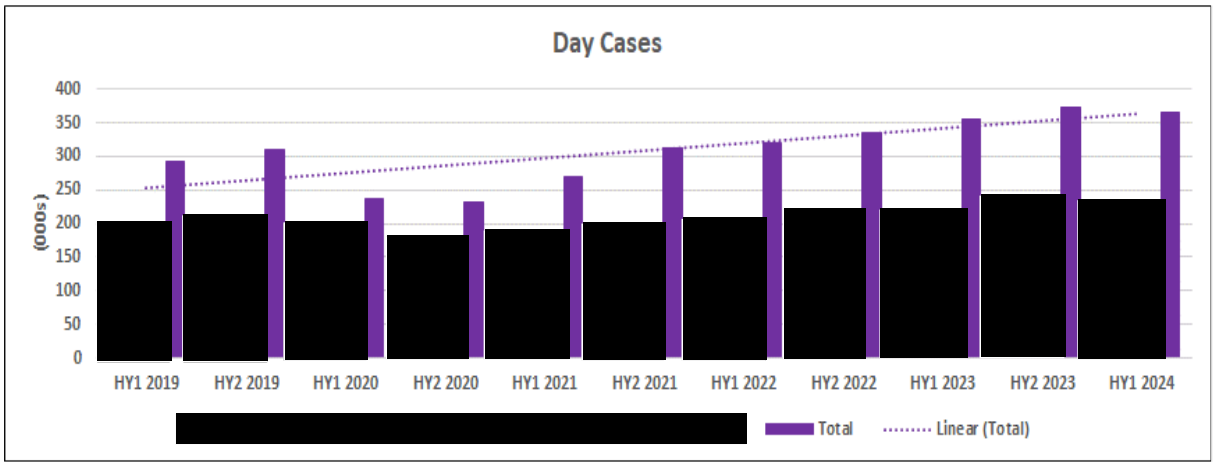
The picture with regard to hospital utilisation is mixed. We can see in Chart 2.1 that hospital nights have fallen over the last six months after a sustained period of growth observed since the recovery from the COVID-19 pandemic.

Chart 2.1 Bed Night Utilisation



Bed days have also reduced slightly as can be seen in Chart 2.2.

Chart 2.2 Day Case Utilisation



This shift towards day cases observed in recent periods continues to emerge in the latest claims data. The Authority does not have solid evidence on which to make an assumption about the future split between bed days and bed nights. Based on this, the Authority has assumed overall utilisation levels assumed in the 2025/2026 Calibration are consistent with those observed in 2023 data.

2.3.5. REF Surplus

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €10m (2024/2025 Calibration: €25m) in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2025 are fully earned. Although the REF surplus is lower than the €25m for the 2024/2025 RES, the Authority estimate that the REF will likely continue to be positively impacted.

The Authority therefore recommends that this estimated surplus of €10m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2025 to 31 March 2026.

2.3.6. Ratio of Non-Advanced to Advanced Stamp Duty

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. Non-advanced products do not provide more than 66% of the full cost for hospital charges in a private hospital. As a result, non-advanced policy holders are more likely to avail of public hospitals when using their health insurance. As at 1 July 2024, 7% of the market held a non-advanced contract which is consistent with the previous year. The ratio of non-advanced to advanced claims has fallen below 20% in recent years.

The level of affordability is a key factor in the attractiveness of non-advanced plans and raising stamp duty could risk losing these members from the health insurance market.

The Authority therefore recommends reducing the stamp duty for non-advanced contracts from 25% to 20% of the stamp duty relating to advanced contracts.

2.3.7. Net Claims Cost Ceiling

The calibration of the RES calculates credits by gender, product level and age, such that for each age group over 65, the net claims cost (i.e. after allowing for the payment of stamp duty net of the receipt of credits) should not be more than a specified percentage (the net claims cost ceiling) of the average net claims cost across all lives within each gender / product level grouping.

Consistent with the 2024/2025 Calibration the net claims cost ceiling has been maintained at 140%.

The aim of the RES calibration exercise is to determine the appropriate credits to fairly redistribute the burden of policyholders with a higher need for healthcare across providers, either through age or health related credits. The net claims cost ceiling acts as a mechanism to calculate the age credits by gender, product level and age after allowing for expected stamp duty and health related credits. Age credits are set for each gender / product level grouping such that the expected net claims costs for older lives do not exceed the specified percentage of the average net claims cost for each group.

The assumptions underpinning the RES calibration directly impact the distribution of health related credits, which in turn impacts on the level of age credits and stamp duty calculated. The level of the net claims cost ceiling can materially impact on the level of calculated age credits.

Increases to the net claims cost ceiling will, all else being equal, reduce the level of age credits and reduce the level of stamp duty. The opposite is true for reductions in the level of the claims cost ceiling. Thus while the claims cost ceiling can be used as a mechanism to manage stamp duty, any changes need to be considered in terms of other aims of the Authority and the overall effectiveness of the RES. Consistent with other RES calibrations the recommendation has been set to strike a balance between sustaining community rating by keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger, healthier consumers in the market while maintaining the effectiveness of the RES.

3. Approach to Developing Recommendations

The recommendations contained within the report have been developed with due regard to the principal objectives as set out in Section 1A of the 1994 Act (see Appendix 4).

3.1. Aims of the RES

The principal objective of the Authority is to ensure, in the interests of the common good, that access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by income tax or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the respective age range and general health status of the members of any particular generation (or part thereof).

The Authority, in developing its recommendations regarding risk equalisation credits and stamp duty, must have regard to, and strike an appropriate balance between, the following objectives as per Section 7E(1)(b) of the Act:

- The Principal Objective (community rating);
- Avoiding over-compensation being made to a registered undertaking;
- Maintaining the sustainability of the health insurance market;
- Fair and open competition in the health insurance market;
- Avoiding the REF sustaining surpluses or deficits from year to year; and
- Maintaining the stability of the market which implies that all age cohorts can purchase private health insurance. This is important to maintain the intergenerational solidarity that underpins the principal of community rating.

There are some areas of conservatism in the calibration. This conservatism means that it is more likely that there will be a surplus than a deficit in the Fund at the end of the period.

This, slightly higher, probability of surplus is recommended as a balance of the objectives of maintaining the sustainability of the health insurance market and community rating against the objective of avoiding sustained surplus from year to year. The Authority's view is that there is a greater risk to the health insurance market from a deficit than a small continued surplus. A deficit would lead to a sharp rise in stamp duty in order to recoup the deficit, and account for the continuation of market conditions that caused the deficit. Such a sharp increase in prices would threaten the affordability of health insurance premiums for all cohorts of members and provide a further incentive for insurers to target more profitable segments of the market.

3.2. RES Credits

It has been assumed that the RES calibration for health insurance policies that are entered into on or after 1 April 2025 will distribute risk equalisation credits in three ways:

1. ARHC: these apply from age 65 onwards and vary by age, level of cover and gender;
2. HUC: a fixed amount for each night/day that an insured person spends in private hospital accommodation; and
3. HCCP: an amount determined as a percentage (quota share) of claims in excess of a defined amount (threshold).

3.3. Data Informing Calibration

Half-yearly information returns for the period July to December 2023 and January to June 2024 periods were received from Irish Life Health DAC (trading as Irish Life Health), Great Lakes Reinsurance UK Ltd (formerly trading as GloHealth), Elips Insurances Ltd (trading as Laya Healthcare), and Vhi Insurance DAC (trading as Vhi Healthcare)). The returns were accompanied by independent accountants' reports and analyses of the differences between total claims paid and returned benefits. Other historic information returns (as previously provided to the Authority by the insurers) have also been used in arriving at the recommended calibration.

The information returns received by the Authority include data on "returned benefits".[3] These benefits exclude certain benefit payments. The main exclusions from returned benefits are:

- Benefits relating to services not involving a hospital stay; and
- Benefits relating to services otherwise excluded from the definition of "prescribed health services".

Details submissions are provided in respect of HCCP data. The amount of HCCP data is expected to continue to grow in future submissions.

3.4. Consultation with Insurers

The Authority requested insurers to provide a summary of their views on the outlook for the health insurance market. Information provided by insurers included projections of population and claims as well as responses to the Authority's questions regarding the RES calibration. The views were varied in terms of responses but covered the following areas:

- Expected future claims levels, claims mix and claims inflation, future market membership and ageing, hospital utilisation levels;
- Views on treatment settings and their eligibility for inclusion in the RES;
- Level and calibration of stamp duty;
- Specific considerations for non-advanced contracts and their future;
- ARHC and HUC;
- Views around the parameters used for HCCP and the effectiveness of this measure;
- A variety of proposals for development of the RES. In general, these proposals would require significant recalibration of the workings of the scheme and ultimately, EU approval;
- Views on the sustainability of the market, competition, with particular concerns about how Sláintecare implementation will affect the market in practice; and
- Concerns around the affordability of health insurance.

The Authority has considered the views of the insurers and the points raised when setting credits and stamp duty for policies commencing in the period from 1 April 2025 to 31 March 2026 and the assumptions impacting the recommendation set out in this report.

[3] Health Insurance Act 1994 (Information Returns) Regulations 2009 as amended.

4. Assumptions

In this section, we set out the key assumptions used in the calibration of the RES, and the data analysis that influenced the assumptions.

4.1. Summary of Key Assumptions

Whilst each individual assumption must be justifiable and within the range of reasonableness, it is the combined impact of the assumptions which will impact the recommendations to be made in relation to stamp duties and risk equalisation credits. In making the recommendation, as per Section 7 of the Act 1994, the Authority must have regard to the principal objective, the aim of avoiding overcompensation, maintaining the sustainability of the health insurance market and having fair and open competition in the market.

Set out below are details of the assumptions underpinning the 2024/2025 and recommended 2025/2026 RES calibrations. An overview of the rationale for these assumptions is set out in the remainder of this section.

Table 4.1 Assumptions Underpinning Recommended 2025 Calibration vs 2024 Calibration

	2024 RES Calibration	Recommended 2025 Calibration
Claims Adjustment		
Base Data	31-Dec-22	31-Dec-23
Inflation		
Public	0%	0%
Private	5%	5%
Consultant	5%	6%
Number of Years of Inflation	2.25 years	2.25 years
Hospital Utilisation Rates		
Overnights	59%	57%
Day	41%	43%
Hospital Utilisation Credits		
Overnights	€163	€163
Day	€81	€81
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	45%	45%
Rolling Claims	Yes	Yes
Insured Population Data		
Base Data	30-Jun-23	30-Jun-24
Other		
REF Surplus	€25m	€10m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	25%	20%
Net Claim Cost	140%	140%

Our recommendation based on the above assumptions is outlined in Section 7 and some sensitivities to the assumptions are included in Appendix 3.

4.2. High Cost Claims

HCCP data has been provided by the three open market insurers to support the calibration of the HCCP both on an incurred basis (timing of provision of health services) and on a claims paid basis. The data was prepared by the insurers on a best endeavours basis and has not been subject to

external review or audit. As the process is not fully embedded in the insurers' processes, it is possible that further refinements may be made which may impact on the results of the analysis prepared.

The HCCP was introduced from 1 April 2022 and actual HCCP claims data has been included in information returns received from insurers.

The HCCP data used for the purposes of the 2024/2025 Calibration was based on the 2018 exposure set. For the purposes of the 2025/2026 Calibration the 2022 exposure set has been used on the basis that it is sufficiently developed and does not contain the COVID-19 distortions contained within the 2019-2021 exposure sets.

The 2025/2026 Calibration has been updated to allow for assumed inflation of 0% for public hospital claims, 5% for private hospital claims and 6% for consultant claims. The corresponding assumed inflation rates in the 2024/2025 Calibration were 0%, 5% and 5% respectively. In addition, the claims data allows for one more year's inflationary impact to allow for the expectation that claims costs will increase over time.

The Authority recommends that the HCCP credits for 2025/2026 are based on a 45% quota share on claims in excess of €50,000 with an allowance for rolling HCCP claims. This is unchanged from the 2024/2025 Calibration. The estimated size of the credits to be distributed in respect of the HCCP for the 2025/2026 Calibration being €126.6m or 13.7% of the overall credits (2024/2025 Calibration: €108.5m or 12.5%).

Table 4.2 HCCP Credits for 2025/2026 RES Calibration

HCCP Credits		
Quota Share	*(a)*	45.00%
Threshold	*(b)*	€50,000
High-Cost Claims in Respect of Policies Incepted in 2022		€393,436,155
Projected High-Cost Claims in Respect of Policies Incepted in 2022 Allowing for Projected Claims Inflation	*(c)*	€468,281,075
Rolling HCCP Claims (Average Based on Historical Experience)	*(d)*	€137,466,753
HCCP Claims	*(e) = (c) + (d)*	€605,747,828
Projected HCCP Policy Count	*(f)*	5,438
Threshold	*(g) = (f) * (b)*	€271,900,000
Credit Offsets		
ARHC	*(h)*	€5,330,725
HUC	*(i)*	€47,093,999
Final HCCP Credits	***(a) * ((e) – [(g)+(h)+(i)])***	**€126,640,397**

- Claims data is based on policies incepted between 1 January 2022 and 31 December 2022. These claims and policy counts are then developed (and inflated) based on information received from the insurers up to 31 December 2023. This results in total projected developed claims of €468.3m and projected policy count of 5,438;
- Rolling HCCP claims are calculated to reflect claims which occur and overlap the policy renewal date which would otherwise receive lower credits in aggregate when compared to claims that do not occur near the policy renewal date as the claim would be allocated to two contract periods. For example, if a policy had a high cost claim of €100,000 and this claim was equally split between contract periods, then under the initial HCCP calibration the insurer would not receive any HCCP credits. However, if the claim occurred just before the renewal date, then the insurer

would receive HCCP credits. Total rolling HCCP claims are €137.5m. This figure is based on the average impact that rolling claims would have on the HCCP based on high-cost claims data arising in the periods 2017-2018, 2018-2019 and 2019-2020 further adjusted for inflation;

- The threshold for the first €50,000 of the claims to be excluded from the HCCP is €271.9m;
- HCCP credits are offset by ARHC of €5.3m and HUC of €47.1m; and
- Final credits are then calculated as the quota share x (HCCP claim – (threshold + HUC + ARHC)) resulting in the final HCCP credits of €126.6m.

The data updates and changes to inflation modelling increase the proportion of credits paid out through HCCP claims.

It has been the stated aim of the HIA to increase the health related proportion of credits. The Authority notes that the proportion of credits related to health status has reduced slightly in the 2025/2026 Calibration relative to the 2024/2025 Calibration. While changes to the HUC and HCCP calibration could address this, the Authority considers that reasonable steps were taken in relation to HUC in the 2024/2025 Calibration and that the underlying issues with drugs allowed to be included in HCCP claims should be addressed before further changes are made to the HCCP calibration. This will be revisited in the 2026/2027 Calibration.

4.3. Membership and Population Forecasts

4.3.1. Membership

Table 4.3 sets out the membership details and market shares of the open market insurers. The data excludes members serving initial waiting periods.

Table 4.3 Insured Population by Insurer

Insurer	01-Jul-23		01-Jan-24		01-Jul-24	
	Members 000's	Market Share (%)	Members 000's	Market Share (%)	Members 000's	Market Share (%)
[redacted]						
Total	**2,377**		**2,397**		**2,413**	

The overall insured population increased by 35,249 lives over the 12 months to 1 July 2024 (1 July 2022 to 1 July 2023: 83,440). Each of the insurers has experienced an increase in the number of insured lives and the changes in market share have not been material.

As of end June 2024, 46.8% of the Irish population are estimated to have private health insurance (including restricted membership undertakings but excluding those serving initial waiting periods), which is 0.8% lower than the percentages observed at end June 2023.

4.3.2. Gender Profile of Insurers' Members

The gender distributions of the memberships of the three insurers for the period January to June 2024 are set out in Table 4.4. The proportions in each gender for each insurer have remained relatively static for some time.

Table 4.4 Gender Distribution of Insured Population

Gender	[redacted]	[redacted]	[redacted]	Market
Men				49%
Women				51%

4.3.3. Age Profile of Insurers Members

The age distribution (average for the period January to June 2024) of each insurer's membership is shown in Table 4.5. The figures shown in brackets are the corresponding averages for the period January to June 2023.

Table 4.5 Age Profile of Insured Members

Age Group	[redacted]	[redacted]	[redacted]	Market
0-17				21.7% (22.0%)
18-29				12.5% (12.5%)
30-39				12.8% (12.8%)
40-49				15.7% (15.8%)
50-54				7.3% (22.0%)
55-59				6.4% (12.5%)
60-64				6.0% (5.9%)
65-69				5.3% (5.3%)
70-74				4.6% (4.5%)
75-79				3.7% (3.6%)
80-84				2.3% (2.2%)
85+				1.7% (1.6%)
Under 65				82.4% (82.7%)
Over 65				17.6% (17.3%)

[redacted]

[redacted]

At a market level there has been an ageing of the population with the proportion of the insured population over 65 increasing from 17.3% to 17.6% over the last 12 months.

4.3.4. Level of Cover by the Insured Population

In analysing the information returns, we have split the products into the following levels of cover:

- Level 1 products provide cover mainly in public hospitals[4];
- Level 2 products provide substantial cover in private hospitals but this cover is mainly provided for semi-private accommodation[5];
- Higher levels of cover relate to products that provide cover for private rooms in private hospitals.

[4] A contract considered to be "Level 1" may or may not fall within the legal definition of a non-advanced contract.
[5] Level 2 contracts and higher contracts are all advanced contracts.

The proportion of each insurer's membership in each market segment on 1 July 2024 is shown in the Tables 4.6 and 4.7 (1 July 2023 figures are shown in brackets).

Table 4.6 Proportion of Each Insurers' Population with Each Level of Cover

	Level 1 Products	Level 2 Products	Higher Cover Products
[redacted]	[redacted]	[redacted]	[redacted]
Total	7% (8%)	77% (76%)	16% (16%)

Non-advanced products cannot provide more than 66% of the full cost for hospital charges in a private hospital. As at 1 July 2024, there were 37 products (Irish Life Health: 24, Laya Healthcare: 11 and Vhi Healthcare: 2) being marketed classified as non-advanced with 172,660 members insured.

Table 4.7 Proportion of Each Insurer's Population with Non-Advanced/Advanced Level

	Non-Advanced	Advanced
[redacted]	[redacted]	[redacted]
Total	7% (7%)	93% (93%)

4.3.5. Actual vs Expected Population Forecasts

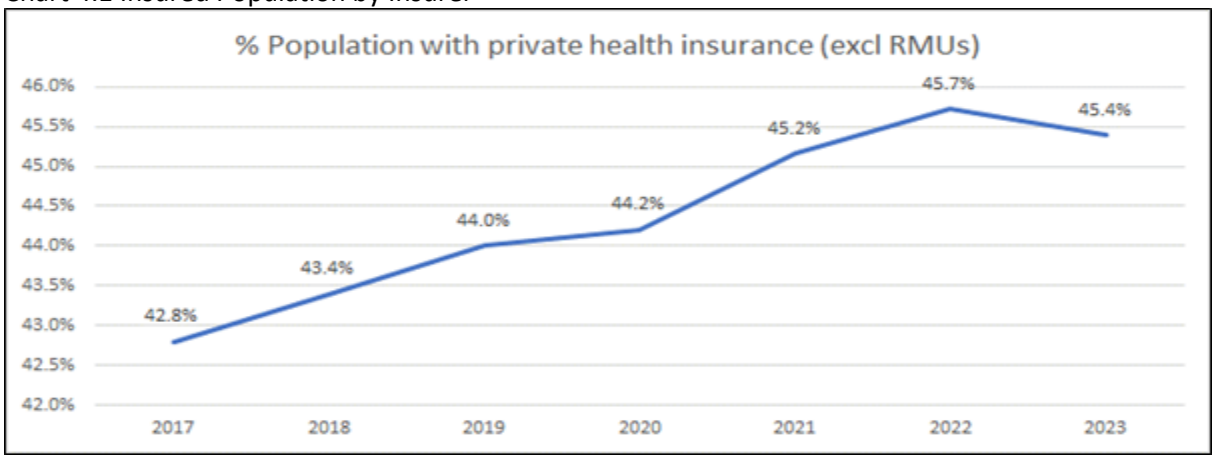
Table 4.8 shows that the insured population has continued to increase (the average increase over the last 4 years is 2.6% p.a.) and the market has remained resilient.

Table 4.8 Insured Population

Insurer	01-Jan-20	01-Jan-21	01-Jan-22	01-Jan-23	01-Jan-24
Members 000's	2,163	2,200	2,263	2,332	2,397
% Increase Year on Year		1.7%	2.8%	3.0%	2.8%

Chart 4.1 shows the increase in those holding private health insurance over the 5 years to 31 December 2023. We note the percentage of population with private health insurance at 30 June 2024 is 46.8%.

Chart 4.1 Insured Population by Insurer



If we project using last year's assumption to 1 July 2024, we can see the assumption was overstated by 69,051 lives at 1 July 2024, showing that the insured population has grown less than expected.

See Table 4.9 below. Most of the reduction has taken place in the younger cohorts. This is a result of the assumption that the overall market would continue to grow in line with the growth over the previous 12 months, but that there would be no growth for older lives and the growth would occur for lives aged 65 and younger. For the 2025/2026 Calibration we have allowed for mortality for lives aged 65 and over and have assumed that lives aged 65 and under will grow in line with the change observed over the previous 12 months. This significantly reduces the expected population growth in the period. Overall, the expected population growth to when the credits will apply (1 October 2025) is 25,226 (increase of 28,827 lives under 65, decrease of 3,601 lives aged 65 and over) compared to assumed growth of 104,300 in last year's RES. At 1 January 2024 the actual insured population was 4.6% lower than expected for policyholders over the age of 65. The gap has narrowed for 1 July 2024, illustrating the difficulty in forecasting insured population growth.

Table 4.9 Actual vs Expected Population Growth to 1 July 2024

Difference Actual vs Assumption as at 1 July 2024				
Insured Membership	**Assumed Population 1 July 2024**	**Actual Population 1 July 2024**	**Net Diff**	**% Diff**
Aged 17 and under	546,724	528,323	(18,401)	(3.4%)
Aged 18 to Age 29	307,624	301,501	(6,123)	(2.0%)
Aged 30 to Age 39	317,272	312,694	(4,578)	(1.4%)
Aged 40 to Age 49	386,627	378,345	(8,282)	(2.1%)
Aged 50 to Age 54	174,900	174,313	(587)	(0.3%)
Aged 55 to Age 59	158,485	154,802	(3,683)	(2.3%)
Aged 60 to Age 64	146,003	143,121	(2,882)	(2.0%)
Aged 65 to Age 69	128,641	126,975	(1,666)	(1.3%)
Aged 70 to Age 74	111,005	109,421	(1,584)	(1.4%)
Aged 75 to Age 79	90,734	88,449	(2,285)	(2.5%)
Aged 80 to Age 84	92,702	94,583	1,881	2.0%
Total	**2,460,718**	**2,412,527**	**(48,191)**	**(2.0%)**
64 and under	2,037,636	1,993,099	(44,537)	(2.2%)
65 and over	423,082	419,428	(3,654)	(0.9%)

4.3.6. Economic Outlook

The economic outlook is also a consideration given previous evidence of strong correlation between unemployment and private health insurance take up. We also know from the last recession there can be a delay between economic shocks and consumers dropping their health insurance.

The spring forecast for Ireland carried out by the European Commission,[6] projects GDP growth of 1.2% in 2024 and 3.6% in 2025 supported by an improvement in global trade, falling inflation and a strong labour market. Inflation is projected to continue easing to 1.9% in 2024 and 1.8% in 2025.

The Central bank quarterly forecasts[7] have projected Modified Domestic Demand (MDD) to grow at an annual average rate of 2.6 per cent per annum from 2024-26. Its inflation forecasts, as measured by Harmonised Index of Consumer Prices (HICP) is similar to the European Commission with a fall to 1.8% in 2024 and a further fall to 1.4% in 2025.

[6] https://ireland.representation.ec.europa.eu/news-and-events/news/spring-2024-economic-forecast-commission-maintains-its-growth-forecast-ireland-2024-2024-05-15_en#:~:text=For%202025%2C%20Ireland%20is%20forecast,predicted%20in%20the%20Winter%20forecast.

[7] https://www.centralbank.ie/docs/default-source/publications/quarterly-bulletins/qb-archive/2024/quarterly-bulletin-q3-2024.pdf?sfvrsn=a87b661a_5

The ESRI[8] believes that MDD will grow by 2.3% in 2024 and by 2.5% in 2025. The ESRI has higher inflation expectations; it forecasts HICP measured inflation to be 2.4% in 2024 and 2.1% in 2025.

Participation rates have been robust despite recent high inflation and drops in disposable income. The social profile of people with health insurance continues to be largely people from the white collar/ professional socio-economic group (ABC1s). Growth in insured population may have slowed due to the slow in employment growth.

Growth in insured population is believed to have been strongly linked to growth in employment. This growth is likely to slow as employment growth slows.

All insurers are predicting lower growth in the overall insured population than has been seen in the market in recent years.

4.3.7. Projected Population for RES 2024/2025

Having considered the views of the insurers, the economic outlook and the forecasts for Ireland carried out by the European Commission and the Central Bank, the Authority has taken the view that the insured population will continue to grow over the next projection period. In our projections the base population is the 1 July 2024 population, and this is projected forward 1.25 years to 1 October 2025 (mid-point of the contracts from 1 April 2025 to 31 March 2026).

Table 4.10 Change in Insured Population

Change in Insured Lives by Age			
Insured Membership	**01-Jul-23**	**01-Jul-24**	**Net Diff**
Aged 17 and Under	527,570	528,323	753
Aged 18 to Age 29	298,129	301,501	3,372
Aged 30 to Age 39	308,162	312,694	4,532
Aged 40 to Age 49	374,389	378,345	3,956
Aged 50 to Age 54	168,986	174,313	5,327
Aged 55 to Age 59	152,877	154,802	1,925
Aged 60 to Age 64	140,633	143,121	2,488
Aged 65 to Age 69	125,242	126,975	1,733
Aged 70 to Age 74	107,275	109,421	2,146
Aged 75 to Age 79	84,957	88,449	3,492
Aged 80 to Age 84	51,368	54,477	3,109
Aged 85 and Over	37,690	40,106	2,416
Total	**2,377,278**	**2,412,527**	**35,249**

The Authority is of the view that while the total market size is important, the forecast age profile and product mix is more important as these drive the relative levels of credits and stamp duties and the expected financial impact for the insurers. Sensitivities have been performed in the past which support this conclusion, including considerations around changes to the level of the insured population at younger ages (which was tested on the back of COVID-19 and the potential market fallout due to restrictions in place and private hospital usage).

The Authority has projected the population at 1 July 2024 forward to 1 October 2025 (to allow for the natural ageing of the insured lives), we have not allowed for any market shrinkage, this is a key

[8] https://www.esri.ie/publications/quarterly-economic-commentary-spring-2024#:~:text=The%20Irish%20Economy%20%E2%80%93%20Overview&text=We%20now%20believe%20MDD%20will,2.5%20per%20cent%20in%202025.

judgement for the population projection. The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2025/2026 Calibration.

- Lives under 65 are assumed to increase by 28,827 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2024. This approach reflects the expectation that growth in the insured population will likely occur in younger lives. Should the population not grow in line with the Authority's expectation, e.g. 1% lower population growth, the impact on surplus would be of the order of c. €8-9m due to reduced receipts of stamp duty.

- Lives over 65 are assumed to age by 1 year within the projections which implicitly assumes older lives will not take out health insurance for the first time, and equally assumes they will not cancel their insurance, which is a simplification. In addition, an allowance for mortality has been introduced to the projected population for lives aged 65 and over who are assumed to die in line with the decrements outlined in the industry table ILT 2017. In aggregate, lives over 65 are assumed to decrease by 3,601 as a result.

This differs from the approach taken for the 2024/2025 Calibration where the membership was assumed to increase in line with the change in the market membership in the period 1 July 2022 to 1 July 2023 (83,440) until 1 October 2024. The approach has been updated as the number of lives expected in last year's RES was materially higher than has actually been the case – see Section 4.3.5 for further details.

Table 4.11 Projected Population for Contracts Incepted Between 1 April 2025 and 31 March 2026

	Actual Population as at 1 July 2024		Projected Population as at 1 October 2025		Change	
Age	**Population**	**Age Distribution**	**Population**	**Age Distribution**	**Population**	**Age Distribution**
0-17	528,323	21.9%	535,695	22.0%	7,372	0.1%
18-29	301,501	12.5%	305,918	12.5%	4,417	0.1%
30-39	312,694	13.0%	317,618	13.0%	4,924	0.1%
40-49	378,345	15.7%	384,100	15.8%	5,755	0.1%
50-54	174,313	7.2%	176,778	7.3%	2,465	0.0%
55-59	154,802	6.4%	156,860	6.4%	2,058	0.0%
60-64	143,121	5.9%	144,958	5.9%	1,837	0.0%
65-69	126,975	5.3%	127,863	5.2%	888	0.0%
70-74	109,421	4.5%	110,684	4.5%	1,263	0.0%
75-79	88,449	3.7%	89,612	3.7%	1,163	0.0%
80+	94,583	3.9%	87,669	3.6%	(6,914)	(0.3%)
Total	**2,412,527**		**2,437,753**		**25,226**	

4.4. Claims Data

4.4.1. Historical Claims Experience

The total claims payments made by the open market insurers in 2020, 2021, 2022, 2023 and the first half of 2024 are set out in Table 4.12. It is noted that these figures exclude claim payments by restricted membership insurers.

Table 4.12 Claims Paid by Insurer

€ m	[redacted]	[redacted]	[redacted]	Total
First Half 2020				970
Second Half 2020				906
2020 Total				**1,876**
First Half 2021				1,026
Second Half 2021				1,097
2021 Total				**2,122**
First Half 2022				1,187
Second Half 2022				1,285
2022 Total				**2,472**
First Half 2023				1,368
Second Half 2023				1,482
2023 Total				**2,850**
First Half 2024				1,481

The total claims paid in the first half of 2024 were €113m (8%) higher than the first half of 2023. This is significantly less than the increase observed in the first half of 2023 when total claims were €182m (15%) higher than the first half of 2022.

The reduction in total claims observed in 2020 driven by COVID-19 (primarily due to the nationalisation of the private hospitals from April – June 2020, the cancellation of non-essential surgical procedures in both private and public hospital settings and reduced capacity) has been reversed and claims continue to revert to pre COVID-19 levels.

Based on the above and feedback from the three insurers, the Authority is of the view that the information returns for 2023 is a reasonable data set to use for calibrating the 2025/2026 RES.

Insurers provide details of claim payments that fall within the definition of "returned benefits" in information returns. The benefits included in information returns (described as "returned benefits") as a percentage of total claims paid from the second half of 2022 to the first half of 2024 are set out in Table 4.13. The RES is primarily aimed at equalising returned benefits rather than total claims although most elements of total claims can be included in HCCP claims.

Table 4.13 Returned Benefits as a Percentage of Total Claims

Insurer	July – Dec 2022	Jan – June 2023	July – Dec 2023	Jan – June 2024
[redacted]				
Total	82%	80%	82%	80%

The benefits excluded from returned benefits are primarily claims in respect of outpatient benefits. As we can see the proportion of total returned benefits included in total claims continues to reduce, suggesting an increased proportion of outpatient benefits.

Table 4.14 splits out the returned benefit payments between those attributable to public hospitals, private hospitals, and to hospital consultants. The total returned benefits paid were €1,187m in the first half of 2024 compared to €1,100m in the first half of 2023. The increase of €87m is made up of increases in the payments to private hospitals (€90m) and consultants (€15m) offset by reductions in respect of public hospitals (€18m). The reduction in public hospital claims in H1 2024 may be linked to the implementation of the public only consultant contract.

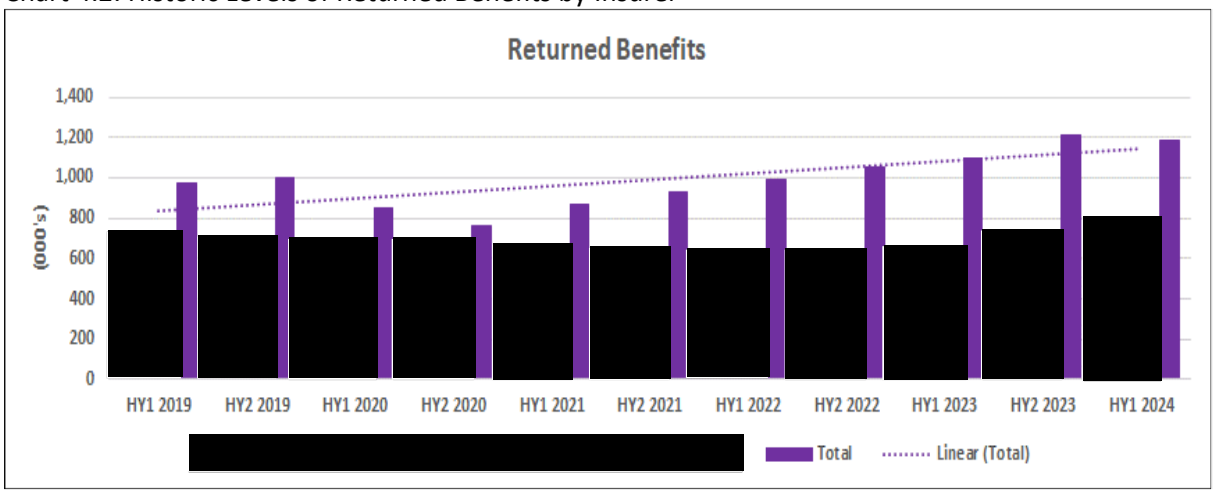
Table 4.14 Returned Benefits Broken Down by Service Provider

		[redacted]	[redacted]	[redacted]	Total €m
First Half 2019	Public Hospital				234 (24%)
	Private Hospital				526 (54%)
	Consultant				214 (22%)
	Sub Total				*974*
Second Half 2019	Public Hospital				237 (24%)
	Private Hospital				544 (55%)
	Consultant				214 (21%)
	Sub Total				*995*
2019 Total					**1,969**
First Half 2020	Public Hospital				224 (26%)
	Private Hospital				431 (51%)
	Consultant				191 (23%)
	Sub Total				*847*
Second Half 2020	Public Hospital				173 (23%)
	Private Hospital				421 (55%)
	Consultant				164 (22%)
	Sub Total				*758*
2020 Total					**1,605**
First Half 2021	Public Hospital				152 (17%)
	Private Hospital				517 (59%)
	Consultant				202 (23%)
	Sub Total				*870*
Second Half 2021	Public Hospital				158 (17%)
	Private Hospital				556 (60%)
	Consultant				214 (23%)
	Sub Total				*928*
2021 Total					**1,798**
First Half 2022	Public Hospital				211 (21%)
	Private Hospital				547 (55%)
	Consultant				231 (23%)
	Sub Total				*989*
Second Half 2022	Public Hospital				207 (20%)
	Private Hospital				599 (57%)
	Consultant				247 (23%)
	Sub Total				*1,053*
2022 Total					**2,042**
First Half 2023	Public Hospital				212 (19%)
	Private Hospital				626 (57%)
	Consultant				262 (24%)
	Sub Total				*1,100*
Second Half 2023	Public Hospital				217 (18%)
	Private Hospital				716 (59%)
	Consultant				278 (23%)
	Sub Total				*1,211*
2023 Total					**2,311**
First Half 2024	Public Hospital				194 (16%)
	Private Hospital				716 (60%)
	Consultant				277 (23%)
	Sub Total				*1,187*

4.4.2. Claims Inflation

We can see from Chart 4.2 (which shows a history of claims since 2019) that in general the level of claims has continued to grow since 2020.

Chart 4.2: Historic Levels of Returned Benefits by Insurer



Looking at historical returned benefits, as set out in Table 4.14, the proportion of returned benefits attributable to care in private hospitals has been increasing over the last five years. The cost of claims in private hospitals are also more exposed to inflationary increases which could contribute to the increase, while the reimbursement rates paid for public hospital claims has not changed since 2014.

The level of claims inflation experienced within the RES is impacted by a broader range of factors than just the actual costs of medical treatments covered by private health insurance, including the health status of the insured population and the availability of medical services. There are ultimate limits on the capacity of public hospitals, private hospitals and consultants to provide care. The Authority has used claims inflation rates of 0% for public, 5% for private and 6% for consultant in the 2025/2026 Calibration. The corresponding assumptions in the 2024/2025 Calibration were 0% for public, 5% for private and 5% for consultant.

The inflation assumptions used allow for claims inflation in respect of the average returned benefits for each age/ gender/ level of cover cohort. The inflation assumptions do not include the impact of changing demographics which is provided for in the population projections, which historically has contributed a further 1% p.a. to claims inflation over the period. Ageing of the insured population is allowed for in the population projections. The forecasted combined effect of changes to the assumed claims mix, different inflation rates and ageing of the population can be seen in Section 4.4.4.

Due to the difficulty in deriving more granular claims inflation assumptions, scenario and sensitivity testing has been performed and results are available in Appendix 3.

4.4.3. Base Year Data

With the exception of necessary adjustments during the COVID-19 pandemic and HSE cyber-attack, the HIA has used the most recent 12 months of claims information in order to estimate the claims for the next contract period. The insurers have indicated that they are of a similar view. The Authority is

therefore satisfied that 2023 is a suitable base year for projecting claims for the 2025/2026 RES calibration.

4.5. Hospital Utilisation Rates

Information returns include separate details of the number of hospital inpatient days and day case admissions (hospital days) paid for by insurers in respect of their private patients' admissions. The total number of nights / days in the last three years paid by the open membership undertakings is set out in Table 4.15. The impacts of COVID-19 are also evident in the data below for 2020 and 2021.

Table 4.15 Total Number of Hospital Days

000's	Overnight	Day Case	Total	Day Case as % of Total
First Half 2020	489	237	726	33%
Second Half 2020	356	231	587	39%
First Half 2021	373	269	643	42%
Second Half 2021	403	313	716	44%
First Half 2022	459	320	779	41%
Second Half 2022	475	334	810	41%
First Half 2023	478	355	833	43%
Second Half 2023	505	372	877	42%
First Half 2024	462	366	828	44%

Table 4.16 Total Number of Nights/Days by Insurer - January to June 2024 (January to June 2023)

000's	[redacted]	[redacted]	[redacted]	Total
Day Case				
Public	[redacted]	[redacted]	[redacted]	54 (55)
Private	[redacted]	[redacted]	[redacted]	312 (300)
Total	[redacted]	[redacted]	[redacted]	**366 (355)**
Overnight				
Public	[redacted]	[redacted]	[redacted]	211 (225)
Private	[redacted]	[redacted]	[redacted]	251 (253)
Total	[redacted]	[redacted]	[redacted]	**462 (478)**
Treatment Days				
Public	[redacted]	[redacted]	[redacted]	265 (280)
Private	[redacted]	[redacted]	[redacted]	563 (553)
Total	[redacted]	[redacted]	[redacted]	**828 (833)**

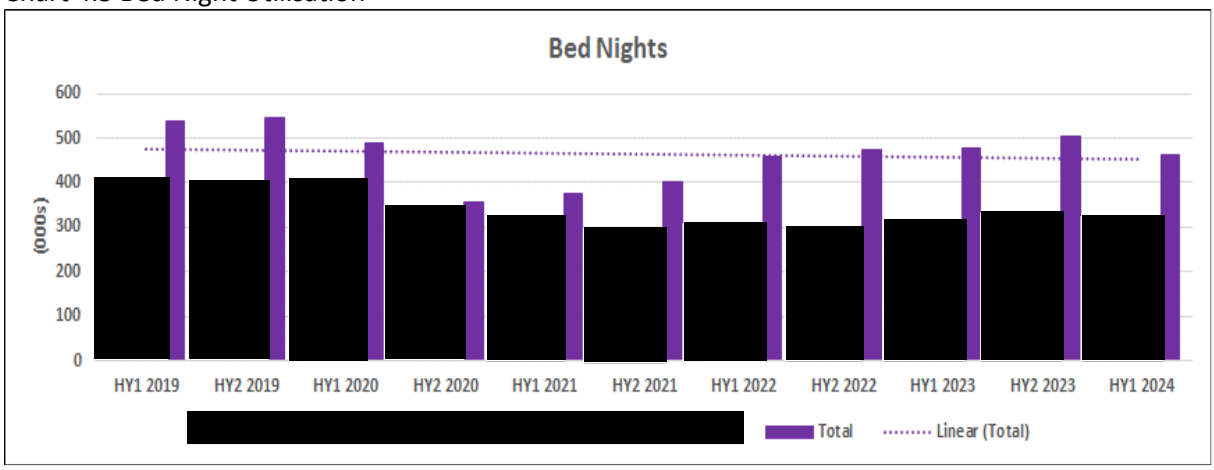
The proportion of day cases has been volatile in recent years. Across the market, day cases represent 44% of treatment day. This compares to days representing on average 36% of total hospital days and nights during 2020. The trend toward an increasing proportion of days looks less likely to be a short-term impact. This appears to align with returned benefits representing a falling proportion of total claims and the narrative that care has been shifting to lower acuity settings where appropriate. This shift towards lower acuity settings has been a stated goal of healthcare delivery systems in recent years.

The reduction in public treatment days may be linked to the implementation of the public only consultant contract. The increase in private day cases reflects private hospital's ability to increase capacity by extending treatment hours to see more cases in a day. Overnight capacity in private

hospitals is expected to increase with additional capacity coming from the new Barringtons hospital in Limerick and expansion of other private hospitals.

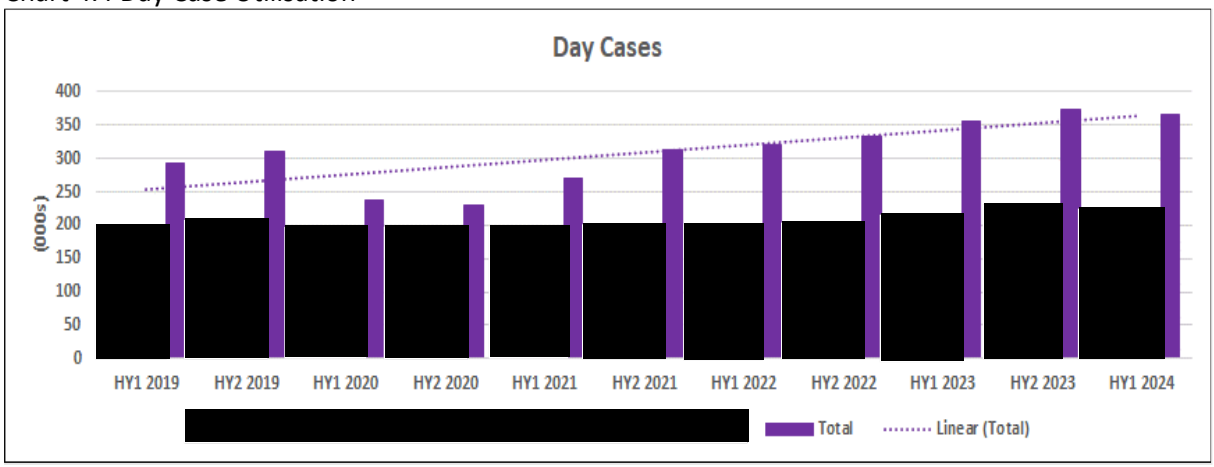
The picture with regard to hospital utilisation is mixed. We can see in Chart 2.1 that up to 2023 hospital nights were continuing to recover to pre-pandemic levels but had not yet reached 2019 levels. In 2024, the number of hospital nights has reduced compared to the same period in 2023.

Chart 4.3 Bed Night Utilisation



Bed days, on the other hand, have surpassed pre-pandemic levels, as can be seen in Chart 4.2.

Chart 4.4 Day Case Utilisation



This shift towards day cases may be a permanent change in the provision of healthcare in Ireland, or it may be the case that bed night utilisation is just slower to return to previous proportions. The Authority does not have solid evidence on which to make an assumption about the future split between bed days and bed nights. Based on this, the Authority has assumed overall utilisation levels assumed in the 2025/2026 Calibration are consistent with those observed in 2023 data.

4.6. Financial Position of the Risk Equalisation Fund

In the RES, the Authority recommends the amounts of stamp duty having considered the aims set out in Section 7E(1)(b) one of which is to have regard to the aim of avoiding the REF sustaining surpluses or deficits from year to year.

Table 4.17 Projected Surplus in REF

€m	Projected Surplus/Deficit at end of Claim Period		
	2025/ 2026 RES Calibration	2024/ 2025 RES Calibration	Variance
01/01/2013 – 31/03/2019 Contracts	49.0	48.5	0.5
01/04/2019 – 31/03/2020 Contracts	37.5	37.9	(0.4)
01/04/2020 – 31/03/2021 Contracts	9.1	4.1	5.0
01/04/2021 – 31/03/2022 Contracts	45.9	47.0	(1.1)
01/04/2022 – 31/03/2023 Contracts	(78.0)	(53.7)	(24.3)
01/04/2023 – 31/03/2024 Contracts	(30.8)	(58.1)	27.3
01/04/2024 – 31/03/2025 Contracts	(27.7)		(27.7)
Expected Surplus Last RES			25.0
Other Incl. Investment Income Less Expenses	6.0	(0.8)	6.8
Total	**10.8**	**24.9**	**10.8**

When setting credits in last year's report, the Authority assumed an initial surplus of €25m which was expected to be exhausted. The expected allocated credits were set so as to exceed expected stamp duty receipts by €25m.

Table 4.17 sets out details of the expected surplus by contract period and shows how experience in aggregate has changed since the 2024/2025 Calibration. The sources of this variation are set out in Table 4.18 below.

Table 4.18 Variation in Projected Surplus in REF

€m	Variance	Stamp Duty	ARHC	HUC	HCCP
01/01/2013 – 31/03/2019 Contracts	0.4	0.0	0.0	0.4	0.0
01/04/2019 – 31/03/2020 Contracts	(0.4)	(0.3)	0.0	(0.1)	0.0
01/04/2020 – 31/03/2021 Contracts	5.0	0.0	0.0	5.0	0.0
01/04/2021 – 31/03/2022 Contracts	(1.1)	(0.2)	0.2	(1.1)	0.0
01/04/2022 – 31/03/2023 Contracts	(24.3)	(0.5)	(9.4)	(13.9)	(0.4)
01/04/2023 – 31/03/2024 Contracts	27.3	4.7	(11.4)	25.0	8.9
01/04/2024 – 31/03/2025 Contracts	(2.8)*	(3.6)	2.1	2.4	(3.7)
Other incl. Investment Income Less expenses	6.8				
Total	**10.8**	**0.1**	**(18.4)**	**17.7**	**4.8**

** The €2.8m negative variance in respect of contracts entered into in the period 1 April 2024 to 31 March 2025 has been reduced to allow for the €25m surplus expected when the 2024/2025 Calibration was prepared.*

The key drivers of the variance are:

- A material deficit in respect of contracts entered into in the period 1 April 2022 to 31 March 2023 which is driven by higher insured population and higher levels of hospitalisation than expected. This resulted in more ARHC and HUC being paid out (-€9.4m and -€13.9m respectively).

- A material surplus in respect of contracts entered into in the period 1 April 2023 to 31 March 2024 which is driven by reduced levels of hospitalisation compared to those originally budgeted for resulting in lower HUC and HCCP claims (+€25.0m and +€8.9m respectively) offset by higher insured population than expected (resulting in higher levels of stamp duty (+€4.7m) offset by more ARHC being paid out (-€11.4m).

- From 1 January 2025 Elips Insurance Limited will no longer underwrite new health insurance contracts. This will impact the allocation of credits from last year and also the rollover credits going forward. The Authority has judgementally increased the surplus by €5m to reflect this.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €10m in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2025 are fully earned. The REF surplus is lower than the €25m assumed in the 2024/2025 Calibration.

In line with the requirement to avoid sustaining a surplus or deficit from year to year, the Authority recommends that this estimated surplus of €10m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2025 to 31 March 2026.

It should be noted that claims presented to the HCCP are expected to be volatile. This will contribute to further volatility in any surplus or deficit arising in the REF in future years.

4.7. Ratio of Non-Advanced to Advanced Stamp Duty

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. Non-advanced products do not provide more than 66% of the full cost for hospital charges in a private hospital and as a result, non-advanced policy holders are more likely to avail of public hospitals when using their health insurance.

As at 1 July 2024, 7% of the market held a non-advanced contract which is consistent with the previous year.

The ratio of non-advanced to advanced claims has fallen below 20% in recent years as set out in Table 4.19.

Table 4.19 Ratio of Non-Advanced to Advanced Claims

Year	**2020**	**2021**	**2022**	**2023**
Advanced				
Average Population	851,045	862,175	879,256	895,339
Returned Benefits	1,789,486,318	1,960,280,554	2,077,062,139	2,235,139,469
Average Returned Benefit	2,103	2,274	2,362	2,496
Non-Advanced				
Average Population	78,033	78,290	77,141	78,267
Returned Benefits	27,952,281	27,354,040	32,998,745	31,076,167
Average Returned Benefit	358	349	428	397
% Non-Advanced to Advanced Average Returned Benefit	**17%**	**15%**	**18%**	**16%**

The Authority therefore recommends the stamp duty for non-advanced contracts is set at 20% of the stamp duty relating to advanced contracts. This is a reduction from the 25% calibration for 2024/2025 Calibration. This means that stamp duty will reduce for non-advanced contracts and helps to maintain affordability of these price sensitive plans.

4.8. Net Claims Cost Ceiling

The calibration of the RES calculates credits by gender, product level and age such that for each age group over 65, the net cost should not be more than a specified percentage, the net claims cost ceiling, of the average net cost across all groups. The impact of the net claims cost ceiling on the ARHC could be considered as follows:

- The average returned benefit amount is calculated for the market as a whole for each cohort where age credits are applied (i.e., advanced / non-advanced and men / women). Level 2 average claims are used in the calibration for advanced cover contracts;
- In theory, if there was no surplus in the REF, then the net claims cost across the market as a whole, before and after RES would be the same, i.e. stamp duty collected would equal credits paid out. Thus, the average claim before and after RES is impacted by the level of surplus in the REF.
- When calculating the Net Claim Cost or average claim after RES (by age and level of cover), the formula is as follows:

  Average Claim before RES + Stamp Duty (to cover all credits) – ARHC Credits – HUC Credit – HCCP Credit = Average Claim After RES = Net Claims Cost.
- The ARHC credits for advanced cover products are calculated to be the amount necessary so that the net claims cost for no age group from age 65 and over exceeds 140% of the average net claims cost for Level 2 contracts.

In the 2024/2025 Calibration the net claims cost ceiling was 140%, which resulted in an estimated 61.8% of credits being in respect of age and, 25.8% in respect of HUC and 12.5% in respect of HCCP.

For the 2025/2026 Calibration, the Authority recommends that the net claims cost ceiling remain at 140%, which results in an estimated 62.4% of credits being in respect of age, 23.9% in respect of HUC and 13.7% in respect of HCCP.

The principal aims of the Authority in terms of avoiding risk selection and market segmentation are key in terms of maintaining market stability. Keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger, healthier consumers in the market. A more targeted allocation of credits based on health status rather than age helps to reduce incentives for insurers to segment the market.

5. Market Developments

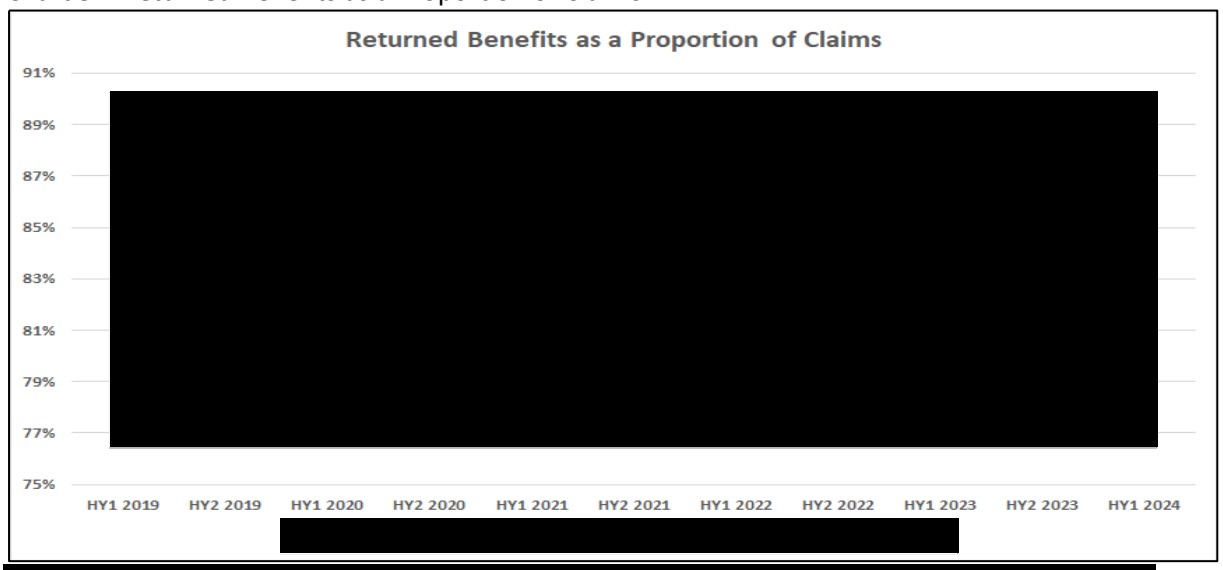
Key market developments:

- The number of people with health insurance continues to increase (01/07/2024: 2.413m vs 01/07/2023: 2.377m). Growth has been behind our forecasts from last year, particularly for the younger age cohorts.
- The average adult premium across the market is €1,683 for 01/07/2024 which is an increase of c. 12% since the 01/07/2023.
- On average, all insurers put through price increases on their plans when compared to the same period last year, in response to increased claims levels.
- The number of inpatient plans on sale in the market by open membership insurers has increased in the last year with 348[9] inpatient private health insurance plans on the Product Register on 1st July 2024 (excluding restricted membership undertakings). The number of new products introduced so far in 2024 are 2.
- Table 5.1 below shows the total claims payments for the insurers for the last four years. Chart 5.1 shows how the proportion of claims that meet the criteria to be considered returned benefits is falling. This supports the assumption that treatment is being provided in non-inpatient settings and that preventative care may be making up a larger portion of claims.

Table 5.1 Total Claims Payments by Insurer

€m	[redacted]	[redacted]	[redacted]	Total
2020 Total	[redacted]	[redacted]	[redacted]	1,876
2021 Total	[redacted]	[redacted]	[redacted]	2,123
2022 Total	[redacted]	[redacted]	[redacted]	2,472
2023 Total	[redacted]	[redacted]	[redacted]	2,850

Chart 5.1 Returned Benefits as a Proportion of Claims



[redacted] This combined with the fall in both hospital overnight cases and day cases supports the view that care is taking place in lower acuity settings to the extent possible. If this trend continues it may limit the ability of the RES to equalise risk between providers as the level of care falling outside of returned benefits and in settings not eligible for HUC continues to grow.

[9] This counts each of Irish Life Health's core plans as one plan, rather than counting each permutation of cover linked to a core plan as one plan.

Average Returned Benefit & Average Net Claims Cost

Table 5.2 below sets out the average net claims and average premiums for lives aged 64 and under and lives aged 65 and over.

Table 5.2 Average Premium and Average Net Claims

Average Gross of Tax Relief Premiums Less Average Net Claims per Insured Person				
	[redacted]	[redacted]	[redacted]	Weighted Market Average €
Average Net Claims Cost per Insured Person (June 2023 - June 2024)				
18-64	[redacted]	[redacted]	[redacted]	1,027
Over 65's	[redacted]	[redacted]	[redacted]	1,791
Average Gross of Tax Relief Premiums per Insured Person (June 2023 - June 2024)				
18-64	[redacted]	[redacted]	[redacted]	1,567
65 and Above	[redacted]	[redacted]	[redacted]	2,076
Average Difference per Insured Person (June 2023 - June 2024)				
18-64	[redacted]	[redacted]	[redacted]	540
65 and Above	[redacted]	[redacted]	[redacted]	285
Average Difference per Insured Person (June 2022 - June 2023)				
18-64	[redacted]	[redacted]	[redacted]	539
65 and Above	[redacted]	[redacted]	[redacted]	607
Average Difference per Insured Person (June 2021 - June 2022)				
18-64	[redacted]	[redacted]	[redacted]	537
65 and Above	[redacted]	[redacted]	[redacted]	830
Average Difference per Insured Person (June 2020 - June 2021)				
18-64	[redacted]	[redacted]	[redacted]	598
65 and Above	[redacted]	[redacted]	[redacted]	1,253
Average Difference per Insured Person (June 2019 - June 2020)				
18-64	[redacted]	[redacted]	[redacted]	523
65 and Above	[redacted]	[redacted]	[redacted]	928
Average Difference per Insured Person (June 2018 - June 2019)				
18-59	[redacted]	[redacted]	[redacted]	411
60 and Above	[redacted]	[redacted]	[redacted]	281

The “Difference” column in the above table does not represent profit for different age groups with different insurers. This is because *inter alia* the average premium, average claim and Risk Equalisation Credits do not relate to precisely the same time period, there is no allowance for expenses and there is no allowance for claims not included in returns to the Authority. The average premium figures do not allow for any COVID-19 related refunds/benefit payments. However, the above table does provide an indication of the relative level of profitability (before expenses and claims not included in returns are allowed for) for different age groups.

We can see that the relative level of profitability for older lives (before expenses and claims not included in returns are allowed for) has reduced in the last year and is broadly in line with pre COVID-19 levels.

6. Overcompensation

Accounts of the Net Beneficiary

Profitability of Registered Undertakings

Section 7E(1)(b)(iii)(I) of the 1994 Act requires that credits are set with a view to avoiding overcompensation for a net beneficiary of the RES:

> *"the amounts of the risk equalisation credits that the Authority considers, after having regard to such evaluation and analysis, would need to be afforded, under the Risk Equalisation Scheme, to persons insured by registered undertakings (other than restricted membership undertakings) having regard to the principal objective (in so far as the principal objective relates to relevant contracts), the aim of avoiding overcompensation being made to a registered undertaking or former registered undertaking…."*

The 1994 Act (Preparation of Financial Statements) Regulations 2022 [S.I. No. 146 of 2022] came into effect on 30 March 2022, which impacts on how profitability and expenses are recognised by insurers in the financial statements furnished to the Authority. These Regulations apply to financial statements furnished to the Authority pursuant to Section 7F(1) of the Act of 1994 in respect of the calendar year 2022 and for every year thereafter. Additionally, Section 7F of the Health Insurance (Amendment) Act 2021 updated the threshold for the level of reasonable profit from 4.4% p.a. to 6% although this is to be transitioned in on a phased basis with a threshold of 5.5% applying to the assessment in respect of the three-year period 2021 – 2023.

The Authority carried out an assessment of whether overcompensation has occurred in the three-year period 2021 – 2023 using actual insurers' certified financial statements. [redacted]

The Authority is of the view that the 2025/2026 Calibration once enacted should be factored into the insurers' pricing basis. [redacted]

7. Recommendation on Risk Equalisation Credits and Stamp Duty

The Authority acknowledges that there is a range of potentially acceptable options for the stamp duty and Risk Equalisation Credits that could apply for contracts commencing in the period 1 April 2025 to 31 March 2026. In developing these recommendations, the Authority has struck a balance between the level of stamp duty paid by all policyholders and the level of compensation paid to insurers in respect of older and/or sicker lives. In considering this balance, the Authority has had regard to all of the objectives set out in Section 7E(1)(b) and in particular this year the objectives of market sustainability and fair and open competition.

The recommendation calculates credits by gender, product level and age such that for each age group over 65, the net cost should not be more than a specified percentage, the net claims cost ceiling, of the average net cost across all groups. A Hospital Utilisation Credit is applied for overnight inpatient stays and for day stays. A specified proportion of claims above the HCCP threshold are paid out as HCCP credits.

7.1. Stamp Duty

The Authority recommends that the stamp duties to be paid by the insurers on policies that are entered into between 1 April 2025 and 31 March 2026, in order to meet the cost to the REF of the recommended Risk Equalisation Credits, are as follows:

Table 7.1 Stamp Duty Recommendation for Contracts Incepted 1 April 2025 – 31 March 2026

Age Band	**Stamp Duties from 1 April 2025 to 31 March 2026**		**Stamp Duties from 1 April 2024 to 31 March 2025**		**Change**	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17 and Under	€31	€156	€35	€140	(€4)	€16
18 and Over	€94	€469	€105	€420	(€11)	€48

The drivers of the changes in stamp duty are set out in Appendix 3.

In last year's report the Authority noted that if the surplus in the REF was not applied to the 2024/2025 stamp duty, advanced stamp duties for adults would be €435, as opposed to €420, and the non-advanced adult stamp duty would be €109, as opposed to €105. The Authority notes that if the surplus in the REF was not applied to the 2025/2026 stamp duty, advanced stamp duties for adults would be closer to €475 compared to the recommended rate of €469.

7.2. Risk Equalisation Credits

The Authority recommends that the following Risk Equalisation Credits should apply for health insurance policies that are entered into between 1 April 2025 and 31 March 2026.

Table 7.2 Risk Equalisation Credits for Contracts Incepted 1 April 2025 – 31 March 2026

	Proposed 2025 RES Calibration				Change from Current Credits			
Age Related Health Credits								
	Non-Advanced		Advanced		Non-Advanced		Advanced	
	Men	Women	Men	Women	Men	Women	Men	Women
64 and Under	€0	€0	€0	€0	€0	€0	€0	€0
65-69	€275	€150	€975	€525	€25	€0	€125	€100
70-74	€350	€250	€1,625	€975	(€75)	(€50)	€250	€50
75-79	€550	€400	€2,225	€1,500	(€50)	(€75)	€200	€50
80-84	€650	€475	€2,625	€1,775	(€50)	(€25)	€200	€175
85+	€650	€475	€2,625	€1,775	(€50)	(€25)	€200	€175
Hospital Utilisation Credit (HUC)								
	Night		Day		Night		Day	
	€163		€81		€0		€0	
Hight Cost Claims Pool (HCCP)								
Quota Share	45%				0%			
Threshold	€50,000				No Change			
Rolling HCCP (Cross Over Period Allowance)	Included				No Change			

The ARHC for advanced cover contracts are based on the average claim costs for Level 2 products. In the main, Level 2 products provide cover for semi-private accommodation in private hospitals, rather than private accommodation.

The ARHC for non-advanced cover contracts are based on the average claim costs for non-advanced contracts. Adjusted claims costs for non-advanced contracts aged over 65 are calculated by applying the average ratio of non-advanced claims cost to Level 2 claims cost for all ages over age 65 combined. The average claims costs are based on claims arising in the Jan 2023 – Dec 2023 time period, adjusted for inflation. The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140% (2024/2025: 140%) of the average net claims cost across all lives.

It should be noted that customers aged 80 or over have been grouped together for the purposes of calculating the age credits for the 2025/2026 Calibration, as opposed to having two separate groupings (i.e. ages 80-84 and 85+). This has been done due to variable levels of claims experience observed in the data due to low levels of insured older lives, which would have resulted in lower credits for insured lives aged 85 or over when compared to the credits for the 80-84 age groups. As such the age credits for all customers aged 80 or over are proposed to be the same although they will vary by gender and level of cover. The approach is unchanged from the 2024/2025 Calibration.

The Authority also considered whether it was appropriate to include age credits for age group 60-64. Based on analysis previously performed, such a move would lead to an increase in stamp duty without having a material impact on the net financial impact of the insurers as the proportion of lives within that age group are similar across all the insurers. As this proportion has not materially changed, the Authority does not recommend the inclusion of age credits for age group 60-64 at this time.

In the 2024/25 calibration, the Authority recommended that the HUC rates were set at 20% of the charges for day cases and overnight admission as a private patient in a public hospital.

- For overnight cases, the Authority HUC was calculated as 20% of the daily charge for in-patient services, where overnight accommodation is provided, in a multiple occupancy room, in a hospital specified in the fifth schedule to the Health Act, 1970, rounded to the nearest whole euro. That is 20% of €813 = €163.
- For day cases, the Authority HUC was calculated as 20% of the daily charge for day case in-patient services, where overnight accommodation is not provided, in a hospital specified in the fifth schedule to the Health Act, 1970 rounded to the nearest whole euro. That is 20% of €407 = €81.

The Authority does not recommend a further change for the 2025/26 RES.

The Authority recommends that the HCCP credits are based on a 45% quota share on claims in excess of €50,000. The estimated size of the credits to be distributed in respect of the HCCP for 2025/2026 RES calibration is €126.6m or 13.7% of the overall credits (2024/2025 Calibration: €108.1m or 12.5%).

7.3. Alternative Scenarios Considered

In coming to the recommendations, the Authority has looked at two alternative scenarios to the recommendations for the 2025/2026 RES. The first assumes that the stamp duty for non-advanced contracts is set at 25% of the stamp duty relating to advanced contracts. The second assumes that HCCP Claims in respect of drugs payments will be restricted to the PCRS List. Details of these scenarios are included in Appendix 3.

7.4. Rationale for the Recommendations

The principal aims of the Authority, in terms of avoiding risk selection and market segmentation, are key in terms of maintaining market stability. There is a balance between an increased effectiveness percentage and the levers available to calibrate the RES.

The recommendation has been set as so to strike a balance between sustaining community rating by keeping health insurance affordable for older, less healthy consumers and maintaining the sustainability of the market by keeping younger healthier consumers in the market while maintaining the effectiveness of the RES.

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

- Stamp duty for advanced products has increased compared to the current calibration (2025/2026 Calibration: €469 vs 2024/2025 Calibration: €420). The increase in stamp duty is heavily driven by medical claims inflation during 2023.
- Stamp duty for non-advanced products has decreased compared to the current calibration (2025/2026 Calibration: €94 vs 2024/2025 Calibration: €105). The reduction in stamp duty for non-advanced contracts should serve to address concerns about affordability and stability of the market. The Authority is of the view that it is fair that non-advanced customers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurers' product pricing.

- The recommendation reduces the effectiveness of the RES from 64.8% to 53.9% based on the Authority's defined measure of effectiveness.[10] The reduction in the Authority's defined measure of effectiveness is driven by actual claims experience during 2023 suggesting that claims experience was more volatile in 2022. Actual claims experience during 2023 accounted for 9.9% of the 10.9% reduction observed since last year's RES calibration. This measure is only one measure in determining how well the RES achieves the aim of supporting community rating.
- The recommendation maintains a reasonable proportion of health related credits (2025/26 calibration: 37.6% 2025/26 vs 38.3% 2024/25 calibration). The underlying issues with drugs allowed to be included in HCCP claims should be addressed before further changes are made to the HCCP calibration and hence the proportion of credits allocated to health status.

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

8. Projected Impact of Recommendation

The table below reconciles the change in stamp duty (and other key metrics) between last year's and this year's recommendations. The increase in stamp duty is largely driven by worsened claims experience in 2023 (relative to 2022) and reduced surplus levels. Further detail on the movement of other key metrics, including details of the financial impact on each of the insurers, is included in Appendix 3.

Table 8.1 Reconciliation of Change in Stamp Duty

	Stamp Duty				Credits Allocated				
	Stamp Duty	Diff	Effectiveness (all)	Diff	Age Related	HUC	HCCP	Total Credits	Diff
2024 RES Calibration	**€420**		**64.8%**		**€534.9m (61.7%)**	**€224.0m (25.8%)**	**€108.5m (12.5%)**	**€867.4m**	
Updated Claims	*€453*	*€33*	*54.9%*	*(9.9%)*	*€602.6m (64.5%)*	*€224.0m (24.0%)*	*€108.2m (11.6%)*	*€934.7m*	*€67.4m*
Updated Utilisation	*€452*	*(€1)*	*55.6%*	*0.7%*	*€596.4m (64.0%)*	*€226.7m (24.3%)*	*€108.2m (11.6%)*	*€931.3m*	*(€3.5m)*
Updated Population	*€464*	*€12*	*56.9%*	*1.3%*	*€611.3m (64.5%)*	*€228.8m (24.1%)*	*€108.2m (11.4%)*	*€948.3m*	*€17.1m*
Updated Population (incl Ageing Impact)	*€451*	*(€13)*	*57.6%*	*0.7%*	*€579.5m (63.8%)*	*€220.4m (24.3%)*	*€108.2m (11.9%)*	*€908.2m*	*(€40.2m)*
Updated Non-Adv %	*€453*	*€2*	*57.5%*	*(0.1%)*	*€579.3m (63.8%)*	*€220.4m (24.3%)*	*€108.2m (11.9%)*	*€907.9m*	*(€0.3m)*
Updated HCCP	*€459*	*€6*	*53.9%*	*(3.6%)*	*€572.6m (62.3%)*	*€220.4m (24.0%)*	*€126.7m (13.8%)*	*€919.7m*	*€11.8m*
Updated RES Surplus	*€469*	*€10*	*53.9%*	*(0.0%)*	*€576.1m (62.4%)*	*€220.4m (23.9%)*	*€126.6m (13.7%)*	*€923.1m*	*€3.4m*
Recommended 2025 Calibration	**€469**		**53.9%**		**€576.1m (62.4%)**	**€220.4m (23.9%)**	**€126.6m (13.7%)**	**€923.1m**	

The Authority has a defined measure of effectiveness and in making its recommendations this is one of a number of metrics which is considered. The proposed changes to the RES calibration result in a material reduction in effectiveness, although we note the majority of this is due to emerging claims experience which is a key driver of the calibration.

8.1. Impact on Projected Net Claims Cost

The net claims cost is the claims cost an insurer incurs in respect of an insured life after payment of stamp duty and receipt of risk equalisation credits. For an insurer the average net claims cost for a given age, gender and level of cover is influenced by the following:

- The average claims cost which tends to increase with age as, on average, older lives incur higher costs than younger lives;
- ARHC which serves to significantly reduce the net claims cost for those over 65 (who typically have larger claims). The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140% (2024/2025: 140%) of the average net claims cost across all lives;

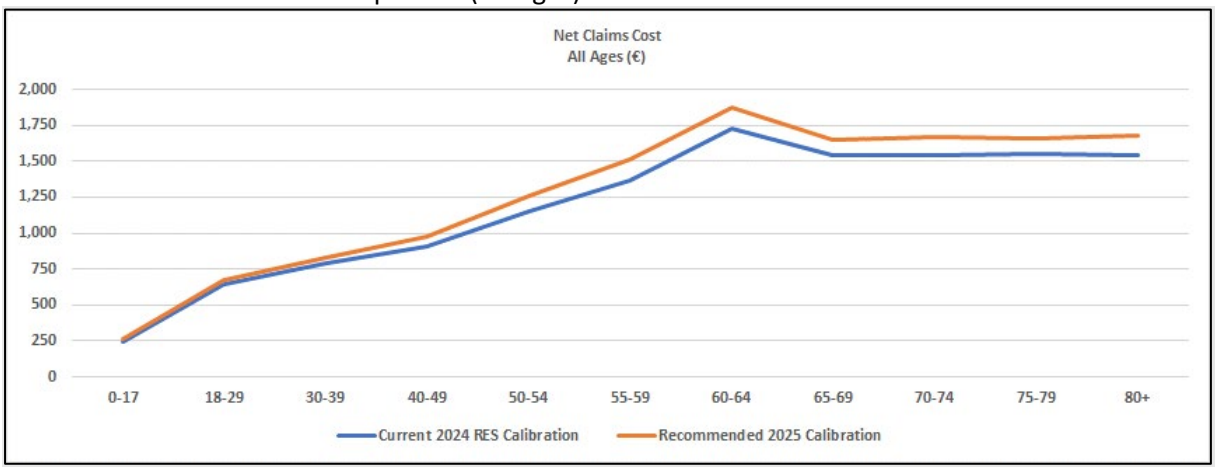
- HUC reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience episodes of hospitalisation and acts as a proxy for health status;
- HCCP reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience claims above a defined amount (threshold) and acts as a proxy for health status; and
- Stamp duty increases the net claims cost for all lives, stamp duty is collected from insurers to fund the distribution of credits. The level of ARHC (influenced by the claims cost ceiling) is a key driver of the level of stamp duty.

The projected net claims cost of insured lives by age is one of the metrics which is considered by the Authority when making its recommendation to ensure the recommendation will not cause instability in the market, and also to gauge projected impact on the market. Set out in the table below are details of the change in net claims cost (and impact) by age for the recommended 2025/2026 RES calibration. A graphical representation of the net claims cost by all ages is included in Chart 8.1. We can see that the net claims cost has increased for all age groups under the 2025 recommendation.

Table 8.2 Projected Net Claims Cost by Age

Net Claims Cost After RES	Current 2024 RES Calibration	Recommended 2025 Calibration	Impact of Recommended Calibration
0-17	243	261	*18*
18-29	645	674	*29*
30-39	786	826	*40*
40-49	910	978	*68*
50-54	1,155	1,258	*103*
55-59	1,369	1,515	*145*
60-64	1,723	1,874	*151*
65-69	1,541	1,647	*106*
70-74	1,544	1,664	*120*
75-79	1,550	1,660	*110*
80+	1,546	1,679	*133*

Chart 8.1: Net Claims Cost Comparison (All Ages)



8.2. Impact on Projected Net Financial Impact of the RES for Each Insurer

The projected net financial impacts for each insurer, for a 12 month period, based on the credits and stamp duty applying for policies commencing in the period 1 April 2025 to 31 March 2026 are outlined in Table 8.3 below.

The projections for individual insurers are based on historic patterns of the insurer's age profile and market share by age group. The actual net financial impacts will be influenced by their product and pricing strategy or by developments in any one particular insurer. The net financial impact on the REF is sensitive to the rate of ageing of the insured population, which in turn is impacted by the rate of growth / decline in the market. It follows that the extent to which the REF is cost neutral will depend on how closely the assumptions made in this report are borne out in practice. HCCP claims are a growing source of uncertainty as they are covering low frequency high cost claims which will vary from year to year.

A fourth insurance company is expected to enter the market. This is not expected to have a material impact on the RES calibration as they are focused primarily on attracting policyholders from other insurers. The changes in net financial impact per insurer will depend on how successful the new entrant is in attracting policyholders, and from which competitors.

Table 8.3 Projected Net Financial Impacts by Insurer

Projected RES Flows								
From 1 April 2024								
€m	[redacted]	[redacted]	[redacted]	**Market**				
Age Credits	[redacted]	[redacted]	[redacted]	535				
HUC	[redacted]	[redacted]	[redacted]	224				
HCCP	[redacted]	[redacted]	[redacted]	108				
Stamp Duty	[redacted]	[redacted]	[redacted]	(841)				
NFI	[redacted]	[redacted]	[redacted]	26				
From 1 April 2025					**Change from 1 April 2024 Credits**			
€m	[redacted]	[redacted]	[redacted]	**Market**	[redacted]	[redacted]	[redacted]	**Market**
Age Credits	[redacted]	[redacted]	[redacted]	576	[redacted]	[redacted]	[redacted]	41
HUC	[redacted]	[redacted]	[redacted]	220	[redacted]	[redacted]	[redacted]	(4)
HCCP	[redacted]	[redacted]	[redacted]	127	[redacted]	[redacted]	[redacted]	19
Stamp Duty	[redacted]	[redacted]	[redacted]	(913)	[redacted]	[redacted]	[redacted]	(72)
NFI	[redacted]	[redacted]	[redacted]	10	[redacted]	[redacted]	[redacted]	(15)

Appendix 1: Further Analysis of Information Returns

The information returns for 2020, 2021 and H1 2022 have been somewhat distorted as a result of COVID-19 and more recently the HSE cyber-attack, and thus the information presented below may not give a true indication of long-term trends in experience. Information returns in respect of 2019 and before do not contain such distortions. More recent information returns appear to be reverting to normal and do not appear to be materially impacted by these distortions.

Risk Profiles

The three insurers have different product mixes and conduct their business differently. This makes risk profile comparison complex. In order to compare risk profiles, we looked at the following measures:

- Average claim per insured person;
- Average treatment days per insured person; and
- An index based on the age/gender risk profile of each insurer; complementary to this index, we also gauge the significance of variations in treatment days not captured by the age/gender risk profile index by calculating a Hospital Utilisation Risk Profile Index.

In each case the Authority will note the disadvantages of the index being used. Also, where appropriate, when calculating indices, the Authority will treat each insured child as one third of an insured adult to reflect the fact that they are not charged a full premium.

Benefit per Insured Person

Comparing risk profiles by comparing the average returned benefit per insured person of each insurer is not completely reliable. It does not allow for the fact that insurers may conduct business in different ways and have different age profiles or that one insurer may sell more of a product that provides less benefits or provides a different level of cover (for example, by applying different excesses, exclusions or waiting periods).

Counting each child as one third and each adult as one, the average returned benefit per insured person for each insurer is outlined in Table A1.1 below.

Table A1.1 Average Returned Benefit per Insured Person (€)

Average Returned Benefits per Insured Person (€)								
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**	**July-Dec 2022**	**Jan-June 2023**	**July-Dec 2023**	**Jan-June 2024**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	**409**	**464**	**488**	**512**	**536**	**548**	**595**	**579**
% change vs July-Dec 2020		**13%**	**19%**	**25%**	**31%**	**34%**	**46%**	**42%**

The pre COVID-19 market returned benefit per insured person observed in July-Dec 2019 was €548. This metric has been trending upwards since July-Dec 2020 as the impacts of COVID-19 are reversed from the market.

The average returned benefit per insured person as a percentage of the market average for each insurer is set out in Table A1.2 below.

Table A1.2 Average Returned Benefits per Insured Person

Average Returned Benefits per Insured Person as a % of the Market Average								
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**	**July-Dec 2022**	**Jan-June 2023**	**July-Dec 2023**	**Jan-June 2024**
[redacted]								
[redacted]								
[redacted]								
Market	100%	100%	100%	100%	100%	100%	100%	100%

[redacted]

Average returned benefits per insured person for the 12 months to the end of June 2024 broken down by age group and level of cover are shown in the following tables. Figures for older ages, in particular for non-advanced contracts, are particularly prone to random fluctuation. The corresponding market figures for the 12 months to the end of June 2023 are shown in brackets.

Table A1.3: Non-Advanced Average Returned Benefits per Insured Man

Age Group	[redacted]	[redacted]	[redacted]	**Weighted Market Average €**
0-17				43 (56)
18-29				50 (71)
30-39				56 (82)
40-49				111 (131)
50-54				272 (223)
55-59				310 (358)
60-64				415 (481)
65-69				539 (619)
70-74				1,060 (1,148)
75-79				986 (1,482)
80-84				1,353 (1,630)
85+				1,289 (1,930)
All Ages				**193 (228)**

Table A1.4: Level 1 Average Returned Benefits per Insured Man

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				45 (59)
18-29				53 (80)
30-39				60 (87)
40-49				115 (146)
50-54				277 (236)
55-59				338 (370)
60-64				443 (536)
65-69				651 (746)
70-74				1,104 (1,392)
75-79				1,123 (1,803)
80-84				1,628 (2,180)
85+				2,113 (2,761)
All Ages				**216 (283)**

Table A1.5: Level 2 Average Returned Benefits per Insured Man

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				121 (125)
18-29				291 (268)
30-39				319 (291)
40-49				500 (485)
50-54				836 (780)
55-59				1,257 (1,126)
60-64				1,783 (1,599)
65-69				2,382 (2,242)
70-74				3,074 (2,870)
75-79				3,761 (3,482)
80-84				4,333 (3,953)
85+				4,478 (4,277)
All Ages				**1,124 (1,038)**

Table A1.6: Level 2+ Average Returned Benefits per Insured Man

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				140 (129)
18-29				282 (265)
30-39				318 (292)
40-49				603 (493)
50-54				1,199 (815)
55-59				1,673 (1,181)
60-64				2,267 (1,668)
65-69				3,057 (2,328)
70-74				4,103 (3,101)
75-79				4,921 (3,784)
80-84				5,734 (4,315)
85+				6,815 (4,999)
All Ages				**1,918 (1,155)**

Table A1.7: Non-Advanced Average Returned Benefits per Insured Woman

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				41 (48)
18-29				62 (65)
30-39				94 (117)
40-49				154 (163)
50-54				224 (277)
55-59				258 (251)
60-64				361 (454)
65-69				485 (521)
70-74				700 (678)
75-79				891 (791)
80-84				857 (874)
85+				1,146 (1,299)
All Ages				**190 (208)**

Table A1.8: Level 1 Average Returned Benefits per Insured Woman

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				40 (50)
18-29				66 (71)
30-39				100 (129)
40-49				160 (171)
50-54				228 (285)
55-59				274 (289)
60-64				412 (498)
65-69				523 (662)
70-74				780 (858)
75-79				1,099 (1,346)
80-84				1,089 (1,441)
85+				1,636 (2,065)
All Ages				**212 (261)**

Table A.9: Level 2 Average Returned Benefits per Insured Woman

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				123 (126)
18-29				310 (300)
30-39				627 (605)
40-49				717 (680)
50-54				986 (926)
55-59				1,126 (1,072)
60-64				1,442 (1,361)
65-69				1,955 (1,765)
70-74				2,402 (2,284)
75-79				2,994 (2,848)
80-84				3,398 (3,127)
85+				3,527 (3,303)
All Ages				**1,106 (1,038)**

Table A1.10: Level 2+ Average Returned Benefits per Insured Woman

Age Group	[redacted]	[redacted]	[redacted]	Weighted Market Average €
0-17				156 (132)
18-29				367 (311)
30-39				725 (618)
40-49				866 (702)
50-54				1,244 (961)
55-59				1,561 (1,131)
60-64				1,892 (1,455)
65-69				2,526 (1,870)
70-74				3,078 (2,432)
75-79				4,324 (3,113)
80-84				4,822 (3,535)
85+				5,369 (3,784)
All Ages				**1,852 (1,153)**

Average Returned Benefit per Treatment Day

The differences in the average returned benefit per member is partly due to differences in the average benefit per treatment day for each insurer and partly to differences in the average number of treatment days per insured person for each insurer. The average returned benefit per treatment day varies between insurers as set out in Tables A1.11 and A1.12 below.

Table A1.11 Average Returned Benefit per Treatment Day

Average Returned Benefits per Treatment Day (€)				
Insurer	**July-Dec 2022**	**Jan-Jun 2023**	**July-Dec 2023**	**Jan-Jun 2024**
[redacted]				
Market	1,301	1,320	1,381	1,434

Average returned benefits per treatment day have increased across the market as a whole over the past 12 months by 8.6% (i.e. increase between Jan-June 2023 and Jan-June 2024). [redacted]

Table A1.12 Average Returned Benefit per Treatment Day Relative to Market

Average Returned Benefits per Treatment Day as a % of the Market Average				
Insurer	**July-Dec 2022**	**Jan-Jun 2023**	**July-Dec 2023**	**Jan-Jun 2024**
[redacted]				
Market	100%	100%	100%	100%

[redacted]

Average number of treatment days per insured person

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

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

The average number of treatment days per member for each insurer is set out in Tables A1.13 and A1.14 below. Again, each insured child counts as one third when counting the number of insured persons in order to allow for the fact that children are not charged a full premium.

Table A1.13 Average Treatment Day per Insured Person

Average Treatment Day per Insured Person								
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**	**July-Dec 2022**	**Jan-June 2023**	**July-Dec 2023**	**Jan-June 2024**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	0.317	0.343	0.376	0.403	0.412	0.415	0.431	0.404

Table A.14 Average Treatment Day per Insured Person as a % of the Market Average

Average Treatment Day per Insured Person as a % of the Market Average								
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**	**July-Dec 2022**	**Jan-June 2023**	**July-Dec 2023**	**Jan-June 2024**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Market	100%	100%	100%	100%	100%	100%	100%	100%

The average treatment days per insured person was relatively stable in periods before December 2019. Due to the impact of COVID-19, the average treatment days per insured person has reduced from 0.472 observed in the 6-month period to December 2019 before the pandemic compared to 0.404 in the 6-month period to June 2024, a fall of 14%. [redacted]

[redacted]

Age/Gender Risk Profile Index

Another approach is to compare the risk profiles based on the age/gender profile of each insurer. We do this by applying a "risk weighting" to each member of the insured population. This weighting

will be based on the age/gender of the insured person. We can then compare the average weighting for each insurer. We refer to this average weighting as the age/gender risk profile index.

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

The use of the number of treatment days as the basis for setting the risk weights is not without its disadvantages. As already mentioned, the number of treatment days will not provide a pure measure of risk, since it could include an element of efficiency and other factors. Also, as noted earlier, it does not take account differences in the value of treatment days.

Table A1.15 Age/Gender Risk Profile Index

Age/Gender Risk Profile Index								
Insurer	**July-Dec 2020**	**Jan-June 2021**	**July-Dec 2021**	**Jan-June 2022**	**July-Dec 2022**	**Jan-June 2023**	**July-Dec 2023**	**Jan-June 2024**
[redacted]								
[redacted]								
[redacted]								
Market	100%	100%	100%	100%	100%	100%	100%	100%

[redacted]

Hospital Utilisation Risk Profile Index

Of course, the age/gender risk profile index ignores differences in risk profiles due to other factors, i.e. it ignores whether insurers' risk profiles vary within age/gender bands. It therefore ignores differences in hospital utilisation within age/gender cells. In order to gauge the significance of variations of risk profile within age/gender bands we calculate an overall index of the hospital utilisation risk profile (ignoring the effect of differences in the age/gender distributions of the memberships). We call this index the Hospital Utilisation Risk Profile Index.

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

As we aim to ignore the effect of the age and gender profile with this index, there is no need to adjust for the number of children. [redacted]

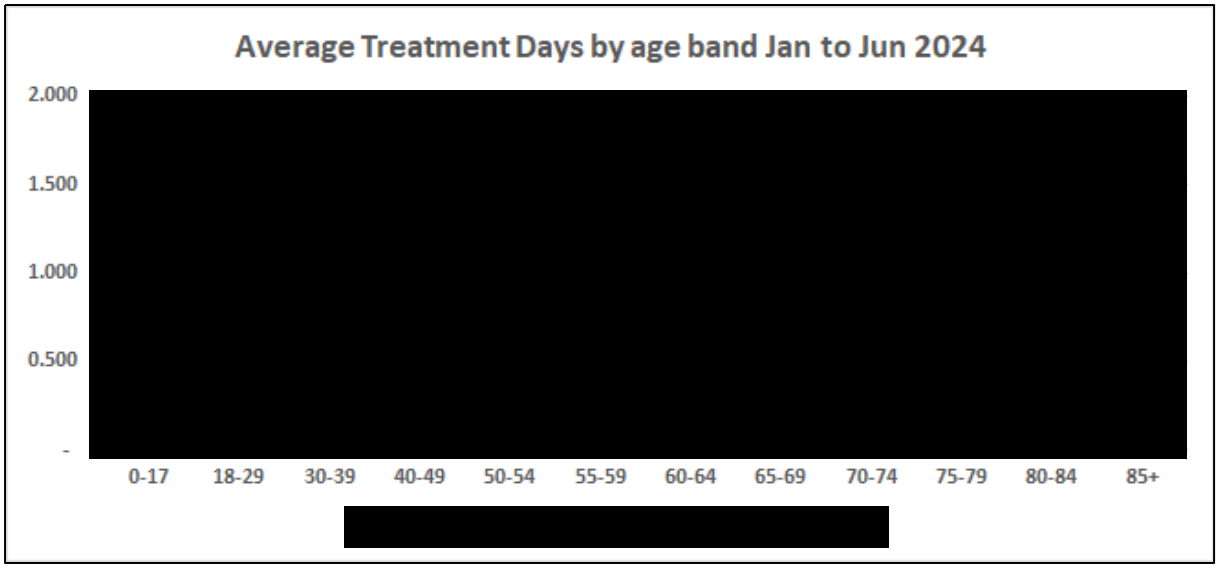
Table A1.16 Hospital Utilisation Risk Profile Index

Hospital Utilisation Risk Profile Index [redacted]								
Insurer	July-Dec 2020	Jan-June 2021	July-Dec 2021	Jan-June 2022	July-Dec 2022	Jan-June 2023	July-Dec 2023	Jan-June 2024
[redacted]								
[redacted]								
[redacted]								

[redacted]

[redacted]

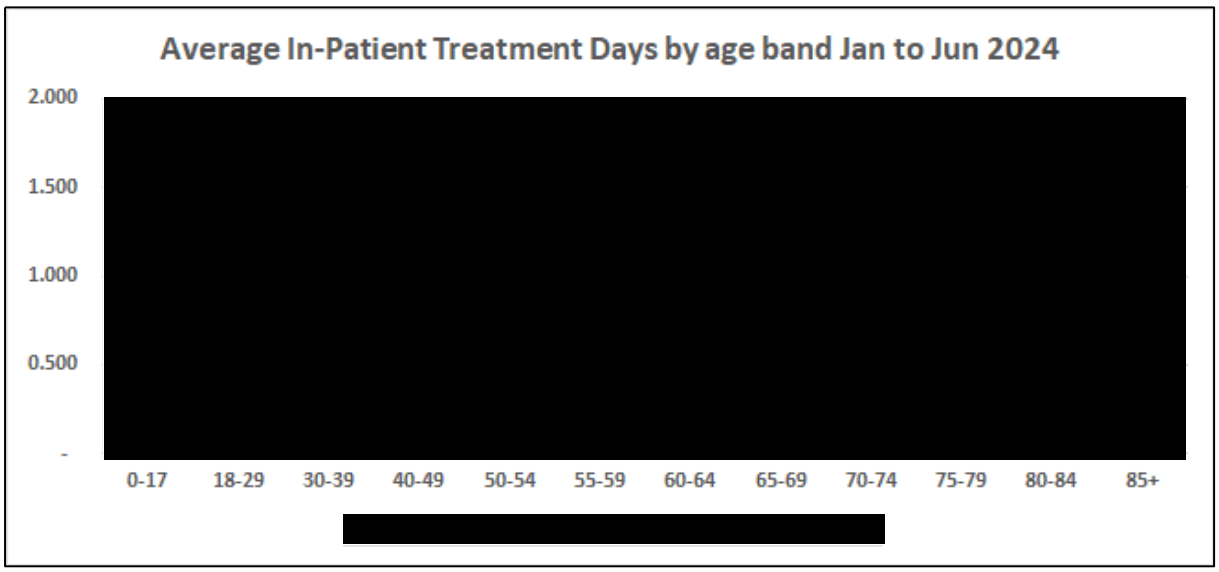
Chart A1.1



The corresponding in-patient overnight and day case averages are shown in Charts A1.2 and A1.3 respectively.

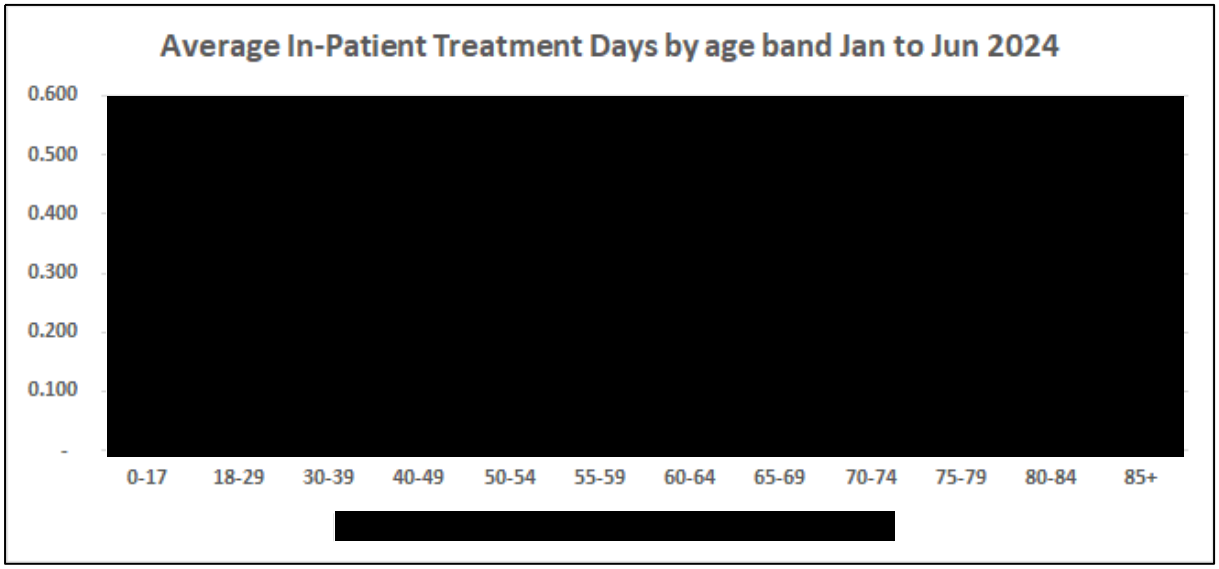
As Chart A1.2 shows, [redacted]

Chart A1.2



[redacted]

Chart A1.3


Average In-Patient Treatment Days by age band Jan to Jun 2024
0.600
0.500
0.400
0.300
0.200
0.100
-
0-17
18-29
30-39
40-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+

Appendix 2: Risk Equalisation Credits and Stamp Duty from 1 April 2025

Table A2.1 below shows the projected membership as at 1 October 2025 (the time the average policy incepted between 1 April 2025 and 31 March 2026). Tables A2.2 to A2.4 show the projected returned benefits, hospital nights and day case admissions as at 1 April 2025. This data was used in the calculation of the stamp duty and Risk Equalisation Credits in the scenario shown below.

Table A2.1 Projected Membership as at 1 October 2025

Projected Membership as at 1 October 2025				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	14,648	13,233	261,373	246,441
18-29	15,854	17,253	136,407	136,403
30-39	20,531	18,311	131,535	147,241
40-49	19,702	17,533	163,562	183,304
50-54	7,190	6,948	78,482	84,159
55-59	5,644	5,346	69,691	76,179
60-64	4,121	4,048	64,484	72,305
65-69	3,004	3,034	57,582	64,242
70-74	1,946	1,995	50,206	56,537
75-79	1,215	1,221	40,559	46,616
80+	758	848	37,680	48,382
Total	**94,613**	**89,770**	**1,091,560**	**1,161,810**

Table A2.2 Projected Average Returned Benefit at 1 April 2025 (€)

Projected Average Returned Benefit at 1 April 2025 (€)				
Age Group	**Non-Advanced**		**Advanced**	
	Men	Women	Men	Women
0-17	48	52	132	129
18-29	56	62	290	313
30-39	77	109	334	645
40-49	122	177	529	747
50-54	260	243	876	1,012
55-59	323	294	1,286	1,173
60-64	464	428	1,778	1,467
65-69	664	537	2,396	1,938
70-74	865	671	3,119	2,422
75-79	1,053	836	3,800	3,016
80+	1,208	952	4,358	3,435
All Ages	**180**	**185**	**999**	**994**

Table A2.3 Projected Total Bed Nights at 1 April 2025

Projected Total Bed Nights at 1 April 2025				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	417	540	20,218	21,784
18-29	497	489	17,756	24,038
30-39	806	1,193	16,235	51,842
40-49	1,086	1,310	28,271	46,351
50-54	963	670	22,664	25,077
55-59	942	712	27,977	27,372
60-64	1,025	1,038	36,704	36,073
65-69	832	926	45,503	49,767
70-74	1,921	918	62,875	55,205
75-79	1,184	772	68,200	67,297
80+	953	687	100,874	113,893
Total	**10,627**	**9,257**	**447,276**	**518,698**

Table A2.4 Projected Total Day Case Admissions at 1 April 2025

Projected Total Day Case Admissions at 1 April 2025				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	186	117	8,172	6,228
18-29	295	365	12,393	16,732
30-39	619	658	16,153	24,332
40-49	1,085	1,371	33,360	55,972
50-54	678	744	24,220	37,424
55-59	731	742	29,183	37,862
60-64	626	574	35,238	40,876
65-69	554	506	42,171	41,875
70-74	697	478	47,401	44,663
75-79	394	286	47,091	42,951
80+	203	173	42,048	40,387
Total	**6,068**	**6,012**	**337,429**	**389,301**

Recommendation

The recommendation calculates credits by gender, product level and age such that for each age group over 65, the net cost should not be more than 140% of the average net cost across all groups. The Authority recommends that a HUC of €163 is applied for overnight inpatient stays and €81 is applied for day stays. Claims inflation is assumed to be 0%, 5% and 6% per annum for public hospital, private hospital, and consultant respectively. Bed night inflation is assumed to be 0% per annum.

The total Risk Equalisation Credits are financed by a stamp duty which varies by product level. The stamp duty for non-advanced contracts is set at 20% of the stamp duty relating to advanced contracts. The REF is projected to have a surplus of €10m when the contracts written prior to 1 April 2025 have fully earned credits and stamp duty.

The ARHC for advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). The ARHC for non-advanced cover contracts are based on the average claim costs for non-advanced contracts. Adjusted claims costs for non-advanced contracts aged over 65 are calculated by applying the average ratio of non-advanced claims cost to Level 2

claims cost for all ages over age 65 combined. The average claims costs are based on claims arising in the Jan 2023 – Dec 2023.

The Authority recommends that the HCCP credits are based on a 45% quota share on claims in excess of €50,000 based on rolling claims over a 12 month period.

In our projections we have projected the population at 1 July 2024 forward to 1 October 2025 (to allow for the natural ageing of the insured lives), we have not allowed for any market shrinkage, this is a key judgement for the population projection. The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2025/2026 Calibration.

- Lives under 65 are assumed to increase by 28,827 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2024. This approach reflects the expectation that growth in the insured population will likely occur in younger lives.

- Lives over 65 are assumed to age by 1 year within the projections which implicitly assumes older lives will not take out health insurance for the first time, and equally assumes they will not cancel their insurance, which is a simplification. In addition, an allowance for mortality has been introduced to the projected population for lives aged 65 and over who are assumed to die in line with the decrements outlined in the industry table ILT 2017. In aggregate, lives over 65 are assumed to decrease by 3,601 as a result.

[redacted]

Table A2.5a – Recommended Stamp Duty and Credits and Market Level Financial Impact

Age	Stamp Duty per Person (€)		Credit per Person (€)				Total HUC (€m)	Total ARHC (€m)	Total HCCP (€m)	Total Credit Applied[11] (€m)
			Non-Advanced		Advanced					
	Non-Adv	Adv	Men	Women	Men	Women				
0-17	31	156	0	0	0	0	8	0	3	12
18-29	94	469	0	0	0	0	9	0	5	15
30-39	94	469	0	0	0	0	15	0	4	19
40-49	94	469	0	0	0	0	20	0	10	30
50-54	94	469	0	0	0	0	13	0	8	21
55-59	94	469	0	0	0	0	15	0	9	23
60-64	94	469	0	0	0	0	18	0	12	30
65-69	94	469	275	150	975	525	23	91	16	129
70-74	94	469	350	250	1,625	975	27	138	19	184
75-79	94	469	550	400	2,225	1,500	30	161	18	209
80+	94	469	650	475	2,625	1,775	42	186	23	251
Total							**220**	**576**	**127**	**923**

Table A2.5b – Projected Net Financial Impact by Insurer

€m	[redacted]	[redacted]	[redacted]	Total
Age Related Health Credits				576
Hospital Bed Utilisation Credit				220
HCCP				127
Stamp Duty				(913)
Total				10

[11] This total credit applied is the sum of the stamp duty income of €913m and surplus in the fund of €10m.

Appendix 3: Analysis of Movement & Sensitivity Analysis on Credits and Stamp Duty from 1 April 2024 for Recommended Methodology

The table below reconciles the change in stamp duty and other key metrics from the current 2024/2025 Calibration to the recommended 2025/2026 Calibration.

Table A3.1 2025/2026 Calibration – Analysis of Movement

	2024 RES Calibration	Updated Claims	Updated Utilisation	Updated Population	Updated Population (incl Ageing Impact)	Updated Non-Adv %	Updated HCCP	Updated RES Surplus	Recommended 2025 Calibration
Stamp Duty									
Advanced	**€420**	€453	€452	€464	€451	€453	€459	€469	**€469**
Non-Advanced	**€105**	€113	€113	€116	€113	€91	€92	€94	**€94**
CCC	**140%**	140%	140%	140%	140%	140%	140%	140%	**140%**
Projected RES Flows									
Stamp Duty	***€841.2m***	*€907.3m*	*€906.0m*	*€922.2m*	*€883.0m*	*€883.2m*	*€894.0m*	*€912.9m*	***€912.9m***
Total Credits	***€867.4m***	*€934.7m*	*€931.3m*	*€948.3m*	*€908.2m*	*€907.9m*	*€919.7m*	*€923.1m*	***€923.1m***
ARHC	***€534.9m (61.7%)***	*€602.6m (64.5%)*	*€596.4m (64.0%)*	*€611.3m (64.5%)*	*€579.5m (63.8%)*	*€579.3m (63.8%)*	*€572.6m (62.3%)*	*€576.1m (62.4%)*	***€576.1m (62.4%)***
HUC	***€224.0m (25.8%)***	*€224.0m (24.0%)*	*€226.7m (24.3%)*	*€228.8m (24.1%)*	*€220.4m (24.3%)*	*€220.4m (24.3%)*	*€220.4m (24.0%)*	*€220.4m (23.9%)*	***€220.4m (23.9%)***
HCCP	***€108.5m (12.5%)***	*€108.2m (11.6%)*	*€108.2m (11.6%)*	*€108.2m (11.4%)*	*€108.2m (11.9%)*	*€108.2m (11.9%)*	*€126.7m (13.8%)*	*€126.6m (13.7%)*	***€126.6m (13.7%)***
Effectiveness									
All Ages	**64.8%**	54.9%	55.6%	56.9%	57.6%	57.5%	53.9%	53.9%	**53.9%**
Over 65	**70.0%**	60.8%	61.5%	62.2%	62.6%	62.6%	58.2%	58.3%	**58.3%**
Total Projected NFI									
[redacted]									
[redacted]									
[redacted]									
Total	**€26m**	€27m	€25m	€26m	€25m	€25m	€26m	€10m	**€10m**

Alternative Scenarios Considered

Below is a summary of the alternatives considered for setting credits and stamp duty from 1 April 2025.

Table A3.2 2025/2026 Calibration – Alternative Scenario

	2024/2025 RES Calibration	Recommended 2025/2026 Calibration	Alternative Scenarios		
			25% Non-Advanced Stamp Duty	7% Private and 8% Consultant Claims Inflation	HCCP Claims restricted to PCRS List & €50m Surplus *
Stamp Duty					
Advanced	€420	€469	€465	€484	€435
Non-Advanced	€105	€94	€116	€97	€87
CCC	140%	140%	140%	140%	140%
Projected RES Flows					
Stamp Duty	€841.4m	€912.9m	€909.2m	€942.1m	€848.1m
Total Credits	€867.0m	€923.1m	€919.3m	€953.2m	€896.3m
ARHC	*€534.9m (61.7%)*	*€576.1m (62.4%)*	*€574.9m (62.5%)*	*€598.9m (62.8%)*	*€580.2m (64.7%)*
HUC	*€224.0m (25.8%)*	*€220.4m (23.9%)*	*€220.4m (24.0%)*	*€220.4m (23.1%)*	*€220.4m (24.6%)*
HCCP	*€108.1m (12.5%)*	*€126.6m (13.7%)*	*€124.0m (13.5%)*	*€133.8m (14.0%)*	*€95.7m (10.7%)*
Effectiveness					
All Ages	64.9%	53.9%	59.7%	52.5%	49.9%
Over 65	70.2%	58.3%	64.8%	56.9%	54.3%
Total Projected NFI €m					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	€26m	€10m	€10m	€11m	€48m

**The additional surplus in the HCCP claims restricted to PCRS list scenario is an estimate based on a small volume of data.*

Sensitivity of 2025/2026 Calibration to Actual Experience

The 2025/2026 Calibration assumes that the level of credits expected to be paid will exceed the expected stamp duty receipts, by a magnitude of €10m. If actual experience is in line with expectation this means that no surplus will exist when the credits and stamp duty on all contracts that commence in advance of 1 April 2026 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2026/2027 Calibration.

The Authority is of the view that the key drivers of surplus/deficit are:

- Population: Impacts on the level of stamp duty received and the age credits paid.
- Hospital Utilisation: Impacts on the level of Hospital Utilisation Credit (HUC) credits paid and the level of High Cost Claims Pool (HCCP) credits paid. If drugs eligible for inclusion in HCCP claims are restricted to those on the PCRS list only, it will cause a surplus.
- Inflation: Impacts on the level of HCCP credits paid.

Set out below are a number of sensitivities to these drivers and their expected impact on the surplus/deficit. Please note that these are simplified sensitivity tests that are designed to capture the key impacts of the changes.

Table A3.3 2025/2026 Calibration - Sensitivities

	Recommended 2025/2026 Calibration	Population Growth in line with 2024/2025 RES Methodology	Hospital Utilisation 5% Lower Than Expected	HCCP Claims Inflation Doubles
Additional Information		Assumes population growth at younger ages and no mortality on older lives.	Assumes 5% lower levels of hospitalisation. For simplification level of hospitalisation in respect of HCCP claims is assumed to be unchanged.	Assumes hospitalisation utilisation unchanged but inflation on HCCP claims increases to 10% for private hospitals and 12% for consultants.
Projected RES Flows				
Stamp Duty	€912.9m	€921.6m	€912.9m	€912.9m
Total Credits	€923.1m	€952.4m	€912.1m	€942.4m
ARHC	*€576.1m*	*€611.4m*	*€576.1m*	*€576.1m*
HUC	*€220.4m*	*€227.9m*	*€209.4m*	*€220.4m*
HCCP	*€126.6m*	*€126.6m*	*€126.6m*	*€145.9m*
Impact on Surplus (Deficit)		(€34.6m)	€11.0m	(€19.3m)

Appendix 4: Principal Objective

1A. Principal objective of Minister and Authority in performing respective functions under Act.

1. The principal objective of this Act is to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of with no differentiation made between them (whether effected by risk equalisation credits or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the health risk status, age or sex of, or frequency of provision of health services to, any such consumers or any class of such consumers, and taking into particular account for the purposes of that objective –
    a. the fact that the health needs of consumers of health services increase as they become less healthy, including as they approach and enter old age,
    b. the desirability of ensuring, in the interests of societal and intergenerational solidarity, and regardless of the health risk status or age of, or frequency of provision of health services to, any particular generation (or part thereof), that the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the more healthy and the less healthy, including between the young and the old, and, without prejudice to the generality of that objective, in particular that the less healthy, including the old, have access to health insurance cover by means of risk equalisation credits,
    c. the manner in which the health insurance market operates in respect of health insurance contracts, both in relation to individual registered undertakings and across the market, and
    d. the importance of discouraging registered undertakings from engaging in practices, or offering health insurance contracts, whether by segmentation of the health insurance market (by whatever means) or otherwise, which have as their object or effect the favouring of the coverage by the undertakings of the health insurance risk of the more healthy, including the young, over the coverage of the health insurance risk of the less healthy, including the old.
2. A registered undertaking shall not engage in a practice or effect an agreement (including a health insurance contract), which has as its object or effect (whether in whole or in part) the avoidance of the achievement of the principal objective.
3. Nothing in this section shall affect the operation of Section 7(5) or 7A.

Appendix 5: RES Recommendation for Contracts Incepted 1 April 2024 to 31 March 2025

Table A5.1 Risk Equalisation Credits

Age Bands	Utilisation Credits (Overnight / Day Case) From 1 April 2024	Age / Gender / Level of Cover Credits from 1 April 2024			
		Non-Advanced		Advanced	
		Men	Women	Men	Women
64 and under	€163 / €81	€0	€0	€0	€0
65-69	€163 / €81	€250	€150	€850	€425
70-74	€163 / €81	€425	€300	€1,375	€925
75-79	€163 / €81	€600	€475	€2,025	€1,450
80-84	€163 / €81	€700	€500	€2,425	€1,600
85 and above	€163 / €81	€700	€500	€2,425	€1,600

Table A5.2 Stamp Duty

Age Bands	Stamp Duties from 1 April 2024 to 31 March 2025	
	Non-Advanced	Advanced
17 and under	€35	€140
18 and over	€105	€420

Appendix 6: Calibration of RES

- In determining the recommended level of credits for each category, the HIA takes into account the information returns made to it by insurers. The HIA analyses and evaluates the market, on the basis of all information returns and, if necessary, on the basis of other information it considers relevant to those purposes, e.g. future expectations of claims and bed utilisation inflation.
- The recommended credits make allowance for expected market position when the credits are expected to apply, i.e. number insured, average claims and overnight and day hospitalisation rates split by age and between advanced and non-advanced levels of cover.
- Risk equalisation credits are paid in respect of individuals who are insured through relevant health insurance contracts within Ireland (as defined in Section 125A(1) of the Stamp Duties Consolidation Act 1999, Section 11E of the Health Insurance Act 1994 and specified in regulations under Section 11E) and who meet the specified age and gender criteria. Age bands with a minimum size of 5 years are currently used for determining credits.
- For the purposes of the RES, insurance products are categorised into products providing non-advanced cover and all other products. Non-advanced means a contract which provides health insurance cover for not more than 66% of the full cost for hospital charges in a private hospital, or not more than the prescribed minimum payments within the meanings of the Health Insurance Act 1994 (Minimum benefit) or Regulations 1996 whichever is greater. Contracts providing higher coverage are advanced contracts.
- Lower age related credits and stamp duties apply in respect of individuals who have non-advanced cover. The inclusion of a product differentiation in setting the levels of credits and stamp duties is designed to ensure that the support is proportionate and does not involve people with lower levels of benefit subsidising to a disproportionate degree people with higher levels of cover than those that they have chosen for themselves.
- As risk equalisation credits are set so that no age group has a projected net of RES claims cost which exceeds 140% of average by level of cover, the RES will not be 100% effective, particularly at the older ages. This reflects competing aims of maintaining the sustainability of the market and stability of the market which relies on younger members to maintain the intergenerational solidarity that underpins the principal of community rating.
- The applicable rates of Risk Equalisation Credits and Community Rating Stamp Duty are set out in law.

Calibration Calculation Approach

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

- The age credits for advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). These credits apply from ages 65 and over. Claims inflation over the term of the projection is calibrated by element of returned benefit (public: 0% p.a., private: 5% p.a., consultant: 6% p.a.).
- The age credits for advanced cover products are calculated to be the amount necessary so that the net claims cost for no age group from age 65 and over exceeds 140% of the average net claims cost for Level 2 contracts.
- The average net claims costs are adjusted to allow for HUC and HCCP. In simple terms the stamp duty in respect of HUC and HCCP is added to the net claims costs while the credits expected to be received are deducted. Thus the claims cost ceiling applies to the adjusted Level 2 net claims cost amount.
- When a HCCP is included, the projected average returned benefit reduces as average HCCP for the cohort of lives has been removed from the average returned benefit and as such the claims cost ceiling is applied to a lower amount. The amount of HCCP depends on the level of the quota share and claims excess.
- The calculated age credits are rounded to the nearest €25.
- The age credits for non-advanced contracts are based on the average claim costs for non-advanced products. Adjusted claim costs for non-advanced contracts aged 65 and over are calculated by applying the average ratio of non-advanced claims costs to Level 2 claims costs for all ages 65 and over combined. The age credits for non-advanced contracts are calculated using the same methods as advanced contracts although the results are smoothed due to lack of claims data at older ages.

- Hospital Utilisation Credits:
  - A hospital utilisation credit of €163 is made for each night that an insured person spends in a hospital.
  - A hospital utilisation credit of €81 is made in respect of each day case admission.
  - The total number of lives is used to derive the stamp duty required in respect of HUC.
- High Cost Claim Pool Credits:
  - Total HCCP (which depends on the level of the quota share and claims excess) is paid out in credits.
  - The claims excess is defined as the HCCP Threshold plus (Total ARHC for contract year) plus (HUC received in claim quarter and previous 3 quarters).
  - The total number of lives is used to derive the stamp duty required in respect of HCCP.
- The stamp duty for non-advanced reflects the lower credits paid in respect of these contracts, and, accordingly, be set at 20% of the rate applying for advanced contracts.
- The stamp duty levels incorporate any anticipated surplus or deficit in the REF when all payments into/out of the REF have been made in respect of contracts that commence prior to the start of the period.