



An tÚdarás Árachas Sláinte
The Health Insurance Authority

Consultation on assumptions for Risk Equalisation Credits to apply for contracts commencing from 01 April 2026

25 March 2025

Section 7E of the Health Insurance Act requires the Health Insurance Authority (HIA) to prepare a report to the Minister which sets out the amount of the risk equalisation credits that the HIA considers would need to be afforded under the Risk Equalisation Scheme (RES), having 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. The HIA must also recommend the amount of stamp duty required, having regard to the aim of avoiding the Risk Equalisation Fund (REF) sustaining surpluses or deficits from year to year, to meet the cost of the credits.

The HIA must evaluate and analyse all information returns made to it together with such other relevant information it considers appropriate in making these recommendations.

This recommendation occurs annually, and the credits and stamp duty decided on by the Minister are transposed into law typically by the end of the calendar year, if a change is to be made from the previous year.

The purpose of this paper is to discuss the assumptions which will be relevant to the recommendation for contracts commencing in the period 01 April 2026 to 31 March 2027 and to seek the views of each undertaking in relation to those assumptions. We have asked specific questions on each assumption, and we ask that in your response you also provide evidence to support your views.

We would also ask that you provide any other information which you believe the HIA should consider in their assumption setting.

We ask that you submit your responses to silehanley@hia.ie and ainemurphy@hia.ie by **25 April 2025**.

Note

Please note that we do not intend to publish the responses on the basis that they will contain commercially sensitive information. We will however, publish this paper on our website.

The Health Insurance Authority is subject to Freedom of Information legislation but in the event of such a request, which would include your responses, all commercially sensitive data will be redacted.

Key Assumptions

Setting the value of risk equalisation credits involves projecting claims, days and nights underpinning claims and membership (i.e. number of people that have a health insurance contract) in respect of contracts incepted between 01 April 2026 to 31 March 2027 ('2026 RES Calibration'). This involves a projection period of 24 months from the perspective of provision of health services if we consider that the last contract could be taken out on 31 March 2027 which would then cover provision of services to 31 March 2028.

The risk equalisation credits are made up of three elements:

- 1 Age related health credits (ARHC): these apply from age 65 onwards and vary by age, level of cover and sex;
- 2 Hospital utilisation credits (HUC): a fixed amount for each night/day that an insured person spends in private hospital accommodation; and
- 3 High-cost claims pool credit (HCCP): this credit is defined by two parameters;
 - The value of claims at which point the risks are shared (the Threshold)
 - The percentage of claims covered by the HCCP, above the Threshold (called the Quota Share). The HCCP credit does not vary by level of product, sex or age.

The stamp duty is payable for each person insured on a contract to which the RES applies. There are four rates of stamp duty, with different rates for adults and for children (persons under the age of 18) and different rates for advanced contracts and for non-advanced contracts.

Any surpluses or deficits in the REF are carried forward and allowed for in the setting of future credits and stamp duties.

The key assumptions which we have considered in this paper are:

- Insured population/membership at mid-point of projection period
- Base Year for projection of claims and hospital utilisation rates
- Hospital utilisation rates
- Claims mix and claims inflation
- Calibration of the HCCP
- Stamp Duty rates for insured members aged 17 and under

The assumptions to be determined are outlined on the following page together with the assumptions from last year.

RES Calibration	2025 Calibration	2026 Calibration
Contracts	01 April 2025 to 31 March 2026	01 April 2026 to 31 March 2027
Claims Adjustment		
Base Data	31-Dec-23	TBC
Inflation		
Public	0%	TBC
Private	5%	TBC
Consultant	6%	TBC
Number of years of inflation	2.25 years	TBC
Hospital Utilisation Rates		
Overnights	57%	TBC
Day	43%	TBC
Hospital Utilisation Credits		
Overnights	€163	TBC
Day	€81	TBC
High Cost Claims Pool		
Threshold	€50,000	TBC
Quota Share	45%	TBC
Rolling Claims	Yes	Yes
Insured Population Data		
Base Data	30-Jun-24	TBC
Other		
REF Surplus	€10m	TBC
Non-Adv Stamp Duty (% of Adv Stamp Duty)	20%	TBC
NCC	140.0%	TBC

1. Insured population

The outlook for participation levels in the health insurance market and the age profile of the insured population are important assumptions within the RES calibration.

The historical approach has typically been to increase the insured population in line with the actual increase experienced in the previous 12 months, apart from 2020 when it had been assumed that the population would contract.

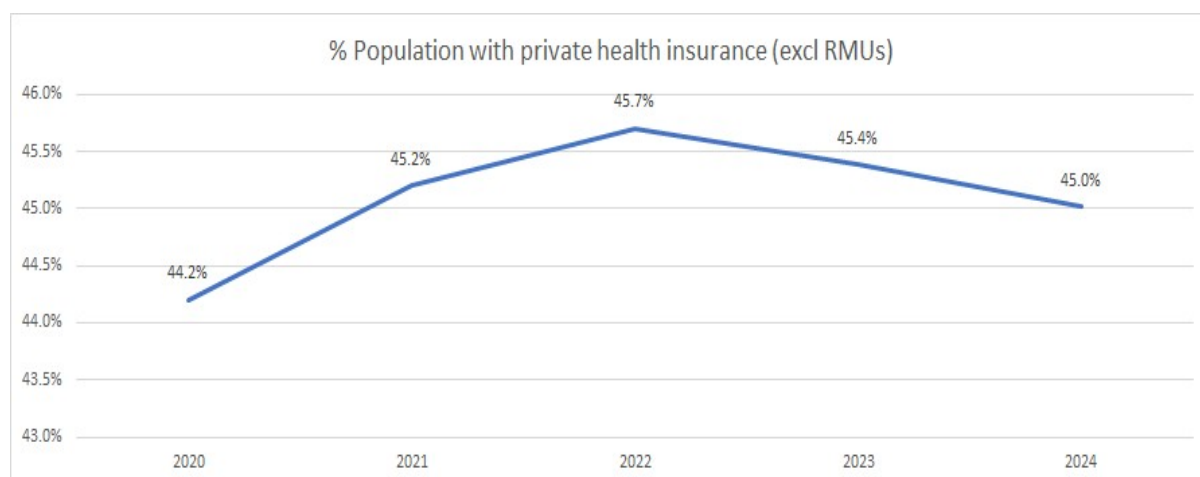
During 2024 the overall insured population increased by 24,908 lives over the 12 months to 01 January 2024 or by 1.0% compared to an increase of 65,297 or 2.8% in the previous calendar year as shown in the table below. The table shows that the insured population has continued to increase, and the market has remained resilient.

Table 1 – Insured Population

Market	01-Jan-20	01-Jan-21	01-Jan-22	01-Jan-23	01-Jan-24	01-Jan-25
Members '000s	2,163	2,200	2,263	2,332	2,397	2,422
% Increase year on year		1.7%	2.8%	3.0%	2.8%	1.0%

The percentage of the Irish population estimated to have private health insurance (excluding restricted undertakings) has fallen slightly and is estimated to be 45.0% at the end of December 2024. This is 0.4% lower than the percentage observed at 31 December 2023. The chart below shows the movement in the percentage of population holding private health insurance over the last 5 years.

Chart 1 – Insured population by insurer



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

The autumn forecast for Ireland carried out by the European Commission¹, expected GDP to decline by 0.5% in the remainder of 2024 and grow by 4.0% and 3.6% in 2025 and 2026. HICP inflation eased significantly in 2024, reaching 0.0% in September, largely driven by lower energy and non-energy industrial goods inflation. It is expected to remain low, with headline inflation forecast to reach 1.4%, in 2024, 1.9% in 2025 and 1.8% in 2026. However, underlying price pressures remained strong and wage growth is expected to keep core inflation elevated. As a result, HICP inflation excluding energy and food is projected to stay above the headline rate.

¹ [European Economic Forecast. Autumn 2024 \(interim\) \(europa.eu\)](https://ec.europa.eu/economy_finance/economic-forecast-autumn-2024-interim)

The Central Bank quarterly forecasts² notes a significant rise in policy uncertainty in recent months which is the most prominent feature informing the current economic outlook. That rise in uncertainty, proportionately large in comparison to available data, centres on the shifts in geoeconomic relationships brought about by the signalled policy stances of the new US Administration, and the prospective responses from other major economies. Widespread announcements and the implementation of tariffs and non-tariff barriers, and the need for Europe to evolve geopolitical priorities, present a very different landscape for the Irish economy than that which has existed over recent history. While their current central forecast for the domestic economy continues to point to a steady pace of growth out to 2027, the shift in policy uncertainty weighs on the outlook for consumption, investment and exports, and leads to the slower growth now expected in comparison to the previous forecasts. They have projected GDP growth of 4.0% in 2025 and 4.0% in 2026. Central Bank inflation forecasts, as measured by HICP are 2.2% for 2025 with a slight reduction to 2.1% in 2026.

As of March 24th, the ESRI's 2025Q1 nowcast estimates that MDD is growing at 2.5% year-on-year. This is the first estimate for 2025 and is based on January data only.³The ESRI Winter 2024 report notes that the labour market has seen a continued increase in employment, with unemployment near to its historically low rate.⁴

Although inflation is projected to fall, the impact of the current inflationary environment on the cost of claims and in turn premiums combined with a potential drop in disposable income must be considered when projecting the insured population and indeed future claims. But it is also worth bearing in mind that the social profile of people with health insurance continues to be largely people from the white collar/ professional socio-economic group (ABC1s) who may be able to withstand impacts of what is expected to be short term high inflation.

As well as the total number of people with insurance the age distribution is also a consideration. Table 2 shows the historical age profile of the insured population and evidences that the market continues to age. At a market level there has been a gradual 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 and from 16.6% to 17.6% over the last 5 years.

Table 2 – Age profile of insured members

Market	01-Jan-21	01-Jan-22	01-Jan-23	01-Jan-24	01-Jan-25
0-17	22.9%	22.7%	22.4%	22.1%	21.7%
18-29	11.8%	12.2%	12.5%	12.5%	12.5%
30-39	13.1%	12.9%	13.0%	12.9%	12.9%
40-49	16.0%	16.0%	15.9%	15.7%	15.6%
50-59	13.6%	13.6%	13.5%	13.6%	13.7%
60-64	6.0%	5.9%	5.9%	5.9%	6.0%
65-69	5.3%	5.3%	5.2%	5.3%	5.3%
70-74	4.5%	4.5%	4.4%	4.5%	4.6%
75-79	3.2%	3.4%	3.5%	3.6%	3.7%
80-84	2.0%	2.1%	2.1%	2.2%	2.3%
85+	1.4%	1.5%	1.5%	1.6%	1.7%
64 and under	83.4%	83.3%	83.2%	82.7%	82.4%
65 and over	16.6%	16.7%	16.8%	17.3%	17.6%

² [Quarterly Bulletin Q1 2025 \(centralbank.ie\)](https://www.centralbank.ie/quarterly-bulletin/q1-2025)

³ [ESRI Nowcast \(as of 24 March 2025\) | ESRI](https://www.esri.ie/nowcast/as-of-24-march-2025)

⁴ [Quarterly Economic Commentary, Winter 2024](https://www.esri.ie/quarterly-economic-commentary/winter-2024)

Historical analysis of actual vs projected insured population used for RES calibration purposes

Details of the actual insured population at 01 January over the last 3 years have been compared to the projected insured population used for the purposes of the RES (adjusted to arrive at a consistent time period) are set out in Table 3.

Table 3 – Actual vs projected insured population used for RES calibration purposes

Age Group	Projected			Actual			Actual vs Projected		
	01-Jan-23	01-Jan-24	01-Jan-25	01-Jan-23	01-Jan-24	01-Jan-25	01-Jan-23	01-Jan-24	01-Jan-25
0-17	522,221	535,686	533,421	522,424	529,157	525,692	0.0%	1.2%	1.5%
18-29	290,287	301,384	304,610	291,773	299,075	302,953	(0.5%)	0.8%	0.5%
30-39	297,394	310,888	316,167	303,013	310,309	313,260	(1.9%)	0.2%	0.9%
40-49	371,441	378,839	382,380	369,672	376,437	378,333	0.5%	0.6%	1.1%
50-54	164,596	171,358	176,030	165,155	171,882	175,978	(0.3%)	(0.3%)	0.0%
55-59	150,289	155,269	156,228	150,518	153,951	155,525	(0.2%)	0.9%	0.5%
60-64	137,245	143,042	144,387	137,005	142,167	144,184	0.2%	0.6%	0.1%
65-69	122,500	128,089	128,090	122,365	126,076	127,774	0.1%	1.6%	0.2%
70-74	103,659	111,005	111,291	103,661	108,467	110,510	0.0%	2.3%	0.7%
75-79	81,527	90,734	90,514	81,168	87,296	89,959	0.4%	3.9%	0.6%
80+	84,439	103,336	89,961	85,070	92,304	97,861	(0.7%)	12.0%	(8.1%)
Total	2,325,598	2,429,630	2,433,078	2,331,824	2,397,121	2,422,029	(0.3%)	1.4%	0.5%
64 and under	1,933,473	1,996,466	2,013,222	1,939,560	1,982,978	1,995,925	(0.3%)	0.7%	0.9%
65 and over	392,125	433,164	419,856	392,264	414,143	426,104	0.0%	4.6%	(1.5%)

We can see at 01 January 2025 and 01 January 2024 the actual insured population was lower than expected, while at 01 January 2023 the actual insured population was higher, however in aggregate the differences are small.

As older lives are in receipt of age credits, differences in insured population will have a direct impact on surplus. We can see differences emerging at the different ages although the differences are small, all else considered. Where the actual insured population was more than expected, an increased level of age credits would be paid, although this would be offset by increased stamp duty, and vice versa. The same could be said in relation to HUC as older lives are more prone to hospitalisation.

Projected population for 2025 RES Calibration, i.e. membership at mid-point of projection period

The HIA updated the approach for projecting the population in the 2025 RES calibration. The population was projected from 1 July 2024 forward to 1 October 2025 (to allow for the natural ageing of the insured lives). There was no allowance for any market shrinkage which is a key judgement for the population projection.

The allocation of the increase in the projected population to different age cohorts was also updated:

- The increase in population aged under 65 was allocated to age bands in line with age distribution observed in the base population at 01 July 2024. This approach reflects the expectation that growth in the insured population will likely occur in younger lives.
- Lives over 65 were assumed to age by 1 year within the projections which implicitly assumed older lives would not take out health insurance for the first time, and equally assumed they will not cancel their insurance, which is a simplification. In addition, an allowance for mortality was 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.

The expectation is that the HIA will use a similar approach to project the insured population for the 2026 RES Calibration.

Questions for the insurers

What is your estimated projection for your insured population over the period 01 April 2026 to 31 March 2028 and for the market as a whole? What is your projected population at 01 October 2026?

Do you foresee any significant changes in population mix between advanced and non-advanced in your insured population?

Do you expect the age profile of the insured population changing significantly between now and the projection period i.e. 01 April 2026 to 31 March 2028 and if so in what way?

Do you think the insured population at a market level will continue to grow between now and 2028?

Do you have a view on potential additional refinements to population projection methodology?

2. Base Year Data

The HIA is minded to use 2024 data for the base year data from which to make projections in respect of return benefits and utilisation rates for contracts inception in the period 01 April 2026 to 31 March 2027.

The HIA notes the following observations:

- An increasing trend towards private hospital usage, and a corresponding decline in private patients claiming for public hospital beds.
- Day cases continue to be an increasing proportion of HUC payments, and there appears to be a general move towards day treatments in preference to overnight stays.
- Overcrowding and high waiting lists are a feature currently being observed in the public hospital system. These issues could in turn impact on the level of private usage within public hospitals. Given the level of the waiting lists, the HIA does not expect that the waiting lists will be sufficiently cleared by the end of exposure period, in respect of contracts entered into in the period 01 April 2026 – 31 March 2027, to significantly change the hospitalisation patterns observed in public hospitals in 2024.

Questions for the insurers

Do you agree to the use of 2024 data as the base data for projections? If not, what would you propose and why?

What proportion of policyholders cancel their policies mid-term? Is this different for advanced and non-advanced policies?

What is the average duration at which mid-term cancellations occur?

3. Utilisation

The average claim and average day and night utilisation rates (total days or nights divided by number of insured persons) is determined per insured person from the base year claims information, and then projected forward in line with the HIA's chosen assumptions. The average claims and average utilisation are applied to the projected population at each age band.

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 paid by the open membership undertakings since the first half of 2021 is set out in Table 4. We note there are distortions in the below information caused by historical data issues. We have not been provided with revised returns for prior periods which would impact the information presented below. The impacts of COVID-19 are also evident in the data below for 2021.

Table 4 – Total number of hospital days

€m's	Overnight	Day case	Total	% Relating to days
First Half 2021	373	269	643	42%
Second Half 2021	403	313	716	44%
2021 Total	776	582	1,359	43%
First Half 2022	459	320	779	41%
Second Half 2022	475	334	810	41%
2022 Total	934	655	1,589	41%
First Half 2023	478	355	833	43%
Second Half 2023	505	372	877	42%
2023 Total	983	727	1,710	43%
First Half 2024	462	366	828	44%
Second Half 2024	461	368	829	44%
2024 Total	923	734	1,657	44%

The data shows that the total hospital days have reduced in 2024 relative to 2023. We can also see that the proportion of treatment days relating to day cases has increased, with days representing 44% of total treatment days settled in 2024 compared to 43% in 2023 and 41% in 2022.

Day cases increased in 2024 to 734,000 compared to 727,000 in 2023 while overnight stays reduced in 2024 to 923,000 compared to 983,000 in 2023. Day cases tend to typically be settled faster than overnight stays. Higher throughput for day procedures in private hospitals together with shorter lengths of stays for overnight procedures may also be a contributing factor. The question remains, will this increase in days be a permanent feature and will the proportion of day cases continue to grow.

In order to project utilisation rates for the 2026 RES Calibration, the average overnight stays and day case days per insured person for the 12 months from January 2024 to end December 2024 by age group/gender/level of cover/insurer will be used. The HIA then must apply an assumption regarding growth in utilisation for the 2026 RES Calibration period i.e. utilisation uplift.

Table 5 shows a 4-year history of the annual percentage change in hospital stays, e.g., for 2024 the data shown is the percentage change in days/nights in the 12 month period ending in December 2024 relative to the twelve month period ending in December 2023. The increase in 2022 is indicative of increased activity relative to the previous 2 years which was heavily disrupted by the pandemic and the HSE cyber-attack. The level of hospitalisation has reduced in 2024 which is driven by a reduction in overnight stays which was offset slightly by an increase in the day case activity.

Table 5 – Annual percentage change in Hospital Stays

Market	2021	2022	2023	2024
Nights	(8%)	20%	5%	(6%)
Days	24%	12%	11%	1%
Nights & Days	3%	17%	8%	(3%)

The historical change in average nights/days by insured person (i.e. utilisation rates) at each age is outlined below. Whilst the HIA notes that there have been historical data issues from the insurers in submitting this information which will have an impact on the analysis, the HIA does not consider that it would change the overall trends emerging. Both days and nights increased substantially in 2022 which continued through to 2023 particularly for days where material increases were experienced. Nights have reduced at all ages in 2024 with an overall reduction of 8% relative to the levels observed in 2023.

Table 6 – Change in average night case days per insured person

Market	2021	2022	2023	2024
0-17	(31%)	32%	(1%)	(20%)
18-29	10%	(2%)	(7%)	(8%)
30-39	(5%)	6%	(6%)	(5%)
40-49	(7%)	14%	(6%)	(9%)
50-54	2%	7%	2%	(9%)
55-59	1%	11%	(2%)	(5%)
60-64	(8%)	17%	(3%)	(7%)
65-69	(8%)	18%	0%	(6%)
70-74	(14%)	19%	4%	(9%)
75-79	(12%)	19%	3%	(9%)
80-84	(17%)	20%	3%	(11%)
85+	(22%)	22%	4%	(12%)
Total	(10%)	17%	2%	(8%)

Table 7 – Change in average day case days per insured person

Market	2021	2022	2023	2024
0-17	(2%)	19%	1%	(5%)
18-29	22%	1%	5%	(6%)
30-39	25%	4%	2%	(1%)
40-49	22%	7%	7%	(2%)
50-54	22%	12%	10%	0%
55-59	19%	12%	7%	(2%)
60-64	19%	11%	7%	(1%)
65-69	21%	9%	6%	1%
70-74	17%	10%	6%	(3%)
75-79	24%	9%	5%	(3%)
80-84	23%	8%	7%	0%
85+	29%	6%	7%	0%
Total	22%	17%	7%	(1%)

There is also a physical limit to capacity and supply of beds. Some supply in private hospitals is also being taken up by the HSE but it is uncertain as to the extent that this will occur in future years. The HIA is also aware of the new hospital in Ballysimon, Limerick, with the project on track to open its doors to patients, on a phased basis, in H2 2025, and the National Children's Hospital in Dublin expected to open in 2026.

The split between days and nights also needs to be considered.

Table 8 – Change in nights between 2023 and 2024:

Market	Total Nights claimed 2023	Total Nights claimed 2024	Average per Insured person 2023	Average per Insured person 2024	% Difference in Average
0-17	41,689	33,591	0.080	0.065	(20%)
18-29	41,742	38,968	0.141	0.130	(8%)
30-39	67,855	65,806	0.224	0.213	(5%)
40-49	75,122	69,310	0.202	0.184	(9%)
50-54	47,575	44,453	0.280	0.254	(9%)
55-59	55,713	53,784	0.364	0.347	(5%)
60-64	73,125	69,151	0.519	0.481	(7%)
65-69	95,747	91,038	0.763	0.713	(6%)
70-74	118,328	110,537	1.098	1.002	(9%)
75-79	134,498	127,438	1.558	1.421	(9%)
80-84	113,272	107,520	2.151	1.917	(11%)
85+	118,493	111,090	2.988	2.635	(12%)
All Ages	983,159	922,686	0.415	0.384	(8%)
64 and under	402,821	375,063	0.206	0.189	(8%)
65 and over	580,338	547,623	1.409	1.286	(9%)

The table above highlights average nights per insured person have fallen across all ages in the period, most notably for children.

Table 9 – Change in days between 2023 and 2024:

Market	Total Days claimed 2023	Total Days claimed 2024	Average per Insured person 2023	Average per Insured person 2024	% Difference in Average
0-17	14,318	13,638	0.028	0.026	(5%)
18-29	29,240	27,832	0.099	0.093	(6%)
30-39	40,390	40,730	0.133	0.132	(1%)
40-49	89,425	88,350	0.240	0.235	(2%)
50-54	60,670	62,767	0.357	0.359	0%
55-59	67,003	66,260	0.438	0.427	(2%)
60-64	75,351	76,163	0.534	0.530	(1%)
65-69	83,826	85,748	0.668	0.672	1%
70-74	91,221	90,146	0.846	0.817	(3%)
75-79	88,223	89,137	1.022	0.994	(3%)
80-84	53,680	57,421	1.019	1.024	0%
85+	33,773	35,857	0.852	0.850	0%
All Ages	727,120	734,049	0.307	0.305	(1%)
64 and under	376,397	375,740	0.193	0.190	(1%)
65 and over	350,723	358,309	0.851	0.841	(1%)

If we look at the number of day related hospital stays per insured person by age, we can see that the total days have reduced for the majority of age groups.

Historical analysis of actual vs projected hospitalisation used for RES calibration purposes

Details of the actual overnight and day cases over the last 4 years have been compared to the projected overnight stays and day cases used for the purposes of the RES (adjusted to arrive at a consistent time period) are set out in Tables 10 and 11.

Table 10 – Actual vs projected overnight stays used for RES calibration purposes

Age Group	Projected				Actual				Actual vs Projected			
	2021	2022	2023	2024	2021	2022	2023	2024	2021	2022	2023	2024
0-17	55,561	57,146	43,767	42,785	30,695	41,378	41,689	33,591	81.0%	38.1%	5.0%	27.4%
18-29	46,325	49,200	46,496	42,608	41,124	42,984	41,742	38,968	12.6%	14.5%	11.4%	9.3%
30-39	83,210	85,691	74,693	69,799	64,116	69,546	67,855	65,806	29.8%	23.2%	10.1%	6.1%
40-49	92,507	95,546	81,870	76,707	66,659	77,774	75,122	69,310	38.8%	22.9%	9.0%	10.7%
50-54	51,085	53,410	47,375	49,184	40,098	44,673	47,575	44,453	27.4%	19.6%	(0.4%)	10.6%
55-59	68,145	69,500	58,302	56,795	49,521	55,683	55,713	53,784	37.6%	24.8%	4.6%	5.6%
60-64	89,737	91,714	76,634	74,572	60,914	72,444	73,125	69,151	47.3%	26.6%	4.8%	7.8%
65-69	114,203	116,833	97,558	97,210	76,724	92,687	95,747	91,038	48.8%	26.1%	1.9%	6.8%
70-74	135,699	138,320	116,238	121,604	89,807	108,651	118,328	110,537	51.1%	27.3%	(1.8%)	10.0%
75-79	143,839	153,681	136,838	138,864	95,541	121,398	134,498	127,438	50.6%	26.6%	1.7%	9.0%
80+	254,057	269,712	222,058	222,155	161,130	206,745	231,765	218,610	57.7%	30.5%	(4.2%)	1.6%
Total	1,134,368	1,180,753	1,001,829	992,282	776,329	933,963	983,159	922,686	46.1%	26.4%	1.9%	7.5%
64 and under	486,570	502,207	429,137	412,450	353,127	404,482	402,821	375,063	37.8%	24.2%	6.5%	10.0%
65 and over	647,798	678,546	572,692	579,832	423,202	529,481	580,338	547,623	53.1%	28.2%	(1.3%)	5.9%

The table above highlights that actual overnight stays in 2024 were 7.5% behind of the expectation for the same period.

Table 11 – Actual vs projected day cases used for RES calibration purposes

Age Group	Projected				Actual				Actual vs Projected			
	2021	2022	2023	2024	2021	2022	2023	2024	2021	2022	2023	2024
0-17	18,223	18,763	14,652	14,647	11,495	13,869	14,318	13,638	58.5%	35.3%	2.3%	7.4%
18-29	24,189	25,692	28,642	29,679	24,726	26,569	29,240	27,832	(2.2%)	(3.3%)	(2.0%)	6.6%
30-39	40,074	41,294	41,043	41,601	35,669	38,136	40,390	40,730	12.3%	8.3%	1.6%	2.1%
40-49	81,354	84,028	85,730	91,428	74,136	81,314	89,425	88,350	9.7%	3.3%	(4.1%)	3.5%
50-54	49,183	51,422	56,588	62,822	45,979	53,157	60,670	62,767	7.0%	(3.3%)	(6.7%)	0.1%
55-59	57,935	59,095	64,200	68,268	53,823	61,061	67,003	66,260	7.6%	(3.2%)	(4.2%)	3.0%
60-64	67,072	68,562	72,182	77,044	60,271	67,883	75,351	76,163	11.3%	1.0%	(4.2%)	1.2%
65-69	75,173	76,901	81,300	85,268	68,586	76,674	83,826	85,748	9.6%	0.3%	(3.0%)	(0.6%)
70-74	78,419	79,938	88,772	93,763	73,389	82,263	91,221	90,146	6.9%	(2.8%)	(2.7%)	4.0%
75-79	68,220	72,865	88,895	91,659	67,773	78,408	88,223	89,137	0.7%	(7.1%)	0.8%	2.8%
80+	65,420	69,133	83,792	85,029	66,501	75,498	87,453	93,278	(1.6%)	(8.4%)	(4.2%)	(8.8%)
Total	625,262	647,693	705,796	741,209	582,348	654,832	727,120	734,049	7.4%	(1.1%)	(2.9%)	1.0%
64 and under	338,030	348,856	363,037	385,489	306,099	341,989	376,397	375,740	10.4%	2.0%	(3.5%)	2.6%
65 and over	287,232	298,837	342,759	355,719	276,249	312,843	350,723	358,309	4.0%	(4.5%)	(2.3%)	(0.7%)

The table above highlights that actual day cases in 2024 were 1.0% behind of the expectation for the same period.

Actual overnight stays in 2024 were 7.5% behind expected while actual day cases were more aligned with expectations with actual cases being 1.0% lower than the forecast. This suggests more recent experience should be used for the purposes of the 2026 RES calibration.

Questions for the insurers

What do you forecast for the average days and nights per insured person by age?

Do you see the increase in days relative to nights as a stabilising or continuing to shift?

What percentage of stays do you expect to be day case and over night? Do you foresee this changing?

What have been the main drivers of change in the number and cost of day cases settled by your company in 2024?

What have been the main drivers of change in the number and cost of overnight cases settled by your company in 2024?

Do you expect the trend of reducing overnight cases to continue?

What percentage of day case stays do you expect to be attributable to private hospitals?

What percentage of nights do you expect to be attributable to private hospitals?

Do you believe the shorter lengths of stays will continue?

What are your views on the future availability of beds in private hospitals and how is this likely to impact capacity available for your customers?

Do you foresee any additional private hospital facilities coming on line that would meet current criteria to be added to definitive hospital list?

4. Claims

A key assumption in the development of the RES recommendation is the assumption regarding changes in the average claim per insured person year on year.

The total claims payments made by the open market insurers over the last 4 years are outlined in Table 12. Claims levels continue to grow year on year with total claims in 2024 being 6% higher compared to 2023.

Table 12 – Claims paid excluding claim payments by restricted membership insurers

€m's	2021	2022	2023	2024
Total Claims	2,122	2,472	2,850	3,025
Returned Benefits	1,798	2,042	2,311	2,429
Private	1,072	1,146	1,342	1,485
Public	310	418	429	380
Consultant	416	478	540	564

Table 13 – Returned benefits⁵ by category

€m's	2021	2022	2023	2024
Returned Benefits / Claims	85%	83%	81%	80%
Split of Returned Benefits				
Private	60%	56%	58%	61%
Public	17%	20%	19%	16%
Consultant	23%	23%	23%	23%

The benefits excluded from Returned Benefits are primarily claims in respect of outpatient benefits which are not included in the RES although an allowance for these claims are included in the HCCP credits. As we can see from Table 13 the proportion of total returned benefits to total claims is reducing year on year.

Table 13 also splits out the returned benefit payments between those attributable to public hospitals, private hospitals and to hospital consultants. We can see that the proportion of returned benefits attributable to care in private hospitals has seen an increasing trend over the last three years. The cost of claims in private hospitals is also more exposed to inflationary increases which could also contribute to the increase, while the reimbursement rate paid for public hospital claims has not changed since 2014. The balance between private and public claims is an important consideration in the assumption regarding overall claims inflation.

Questions for the insurers

What is your view of claims inflation and the view of claims inflation relating to private hospitals, public hospitals, and consultants over the period 2025 - 2027?

What percentage of your claims is projected to relate to public hospitals, private hospitals, and consultants over the period 2025 – 2027?

⁵ Returned benefits as per the Health Insurance Act 1994 (Information Returns) Regulations 2009 as amended.

Average claim per member

In setting the claims inflation assumption, the HIA must consider the average returned benefit per insured person across the market.

Table 14 below shows the percentage change in the average returned benefit per insured person for all levels of cover in a 12-month period relative to the previous 12 months, e.g., for 2024 the data shown is the percentage change in average returns benefits per insured person from the 12 month period ending in June 2023 to the 12 month period ending in June 2024.

Table 14 – Change in average returned benefits relative to prior 12 months

Market	2021	2022	2023	2024
0-17	(30%)	5%	14%	(4%)
18-29	(4%)	10%	2%	5%
30-39	(10%)	11%	(1%)	5%
40-49	(7%)	12%	7%	5%
50-54	1%	12%	10%	8%
55-59	(6%)	13%	7%	9%
60-64	(8%)	10%	10%	8%
65-69	(12%)	13%	11%	10%
70-74	(16%)	15%	11%	7%
75-79	(18%)	19%	7%	8%
80-84	(24%)	21%	6%	9%
85+	(30%)	18%	9%	6%
Total	(13%)	15%	8%	8%

The average returned benefit has fallen for the 0-17 cohort but has increased for all other age groups when compared to 2023. Table 15 shows the actual average claims cost for each age group over the last four years. Again, the average returns benefit per insured person for the 12-month period in the table is in respect of the 12-month period to June.

Table 15 – Average returned benefits

Market	2021	2022	2023	2024
0-17	105	111	126	122
18-29	238	261	267	280
30-39	386	427	423	444
40-49	465	522	559	588
50-54	684	763	837	906
55-59	906	1,022	1,093	1,190
60-64	1,240	1,362	1,492	1,618
65-69	1,617	1,822	2,017	2,217
70-74	2,102	2,420	2,680	2,865
75-79	2,658	3,162	3,371	3,636
80-84	2,968	3,606	3,828	4,171
85+	3,253	3,851	4,215	4,462
Total	741	851	924	1,004

The average returned benefits have increased for most age groups in 2024 which continues the trend of growth in average returned benefits observed in 2022 and 2023. It should be noted that experience in 2021 would have been distorted by the pandemic.

The tables below show the experience split by category of claim, but it must be noted it is average claim per insured person across the market and not by number of actual claimants. Claims experience was heavily distorted during the pandemic and average returned benefits increased substantially in 2022 and 2023.

Table 16 – Change in average consultant element of returned benefits relative to prior 12 months

Market	2021	2022	2023	2024
0-17	(30%)	9%	19%	3%
18-29	(8%)	15%	7%	5%
30-39	(6%)	12%	3%	5%
40-49	(6%)	17%	9%	5%
50-54	(4%)	17%	13%	6%
55-59	(8%)	17%	11%	7%
60-64	(8%)	14%	12%	6%
65-69	(11%)	16%	13%	6%
70-74	(14%)	20%	11%	5%
75-79	(16%)	24%	7%	5%
80-84	(21%)	27%	6%	7%
85+	(24%)	24%	7%	3%
Total	(11%)	19%	10%	7%

Table 17 – Average consultant element of returned benefits

Market	2021	2022	2023	2024
0-17	25	27	32	33
18-29	55	64	68	72
30-39	96	107	110	115
40-49	120	141	154	161
50-54	170	199	225	239
55-59	219	257	284	304
60-64	288	329	369	393
65-69	370	428	484	511
70-74	458	549	612	643
75-79	554	690	736	774
80-84	567	720	766	817
85+	522	648	690	712
Total	167	198	218	233

Table 18 – Change in average public hospital element of returned benefits relative to prior 12 months

Market	2021	2022	2023	2024
0-17	(39%)	9%	10%	(11%)
18-29	(25%)	21%	3%	(9%)
30-39	(20%)	9%	(2%)	(4%)
40-49	(24%)	12%	2%	(9%)
50-54	(17%)	3%	14%	(10%)
55-59	(29%)	15%	5%	(7%)
60-64	(30%)	7%	10%	(8%)
65-69	(32%)	13%	14%	(8%)
70-74	(34%)	10%	14%	(5%)
75-79	(34%)	8%	12%	(6%)
80-84	(38%)	10%	13%	(2%)
85+	(40%)	5%	12%	(2%)
Total	(31%)	10%	10%	(4%)

Table 19 – Average public hospital element of returned benefits

Market	2021	2022	2023	2024
0-17	47	52	57	50
18-29	35	42	43	39
30-39	132	144	141	136
40-49	80	89	91	82
50-54	100	103	117	105
55-59	124	143	150	140
60-64	183	196	216	199
65-69	245	278	318	294
70-74	354	389	443	421
75-79	507	549	614	579
80-84	708	776	876	862
85+	1,081	1,140	1,281	1,257
Total	148	164	180	172

Table 20 – Change in average private hospital element of returned benefits relative to prior 12 months

Market	2021	2022	2023	2024
0-17	(11%)	(4%)	15%	2%
18-29	5%	5%	0%	9%
30-39	(1%)	11%	(2%)	12%
40-49	0%	10%	8%	10%
50-54	8%	11%	7%	13%
55-59	2%	10%	6%	13%
60-64	(2%)	9%	8%	13%
65-69	(7%)	11%	9%	16%
70-74	(9%)	15%	10%	11%
75-79	(13%)	20%	5%	13%
80-84	(17%)	25%	4%	14%
85+	(24%)	25%	9%	11%
Total	(6%)	15%	7%	14%

Table 21 – Average private hospital element of returned benefits

Market	2021	2022	2023	2024
0-17	33	32	37	38
18-29	148	155	156	170
30-39	158	175	172	193
40-49	265	292	315	345
50-54	414	461	496	562
55-59	563	622	660	746
60-64	769	837	907	1,026
65-69	1,002	1,116	1,215	1,411
70-74	1,291	1,482	1,626	1,801
75-79	1,596	1,923	2,021	2,283
80-84	1,694	2,110	2,185	2,491
85+	1,651	2,063	2,244	2,493
Total	427	489	526	599

The overall level of claims is impacted by several factors. One of the drivers is the mix between procedures in public and private hospitals which is evidenced in the tables above. Public hospital charges are set by the HSE/Department of Health. Claims in public hospitals accounted for approximately 16% of total claims in 2024 (19% in 2023). Assuming no change in the daily rate charged for private patients in public hospitals, this leaves an estimated 84% of claims which may be subject to inflation. Therefore, it is important to understand the expected source of claims.

Another factor is the mix of over-night and day cases. If the sector transitions from over-night to day cases on a more permanent basis for some procedures, the value of claims would be expected to decline.

The method for projecting the average returned benefit per insured person for renewals from 01 April 2026 is to project an increase of x% p.a. over the term of the projection to the actual age specific market claims cost per insured person determined for the 12 months to end December 2024. These costs are inflated separately for public hospital, private hospital and consultant. This allows for inflation from 2024 to the midpoint of the projection period.

This assumption does not include the impact of changing demographics which is provided for in the population projections and historically has contributed a further 1% p.a. to claims inflation on average each year.

Historical analysis of actual vs projected returned benefits used for RES calibration purposes

Details of the actual returned benefits over the last 4 years have been compared to the projected returned benefits used for the purposes of the RES (adjusted to arrive at a consistent time period) are set out in Table 22.

Table 22 – Actual vs projected returned benefits used for RES calibration purposes

Age Group	Projected				Actual				Actual vs Projected			
	2021	2022	2023	2024	2021	2022	2023	2024	2021	2022	2023	2024
0-17	83.6	81.3	65.8	67.4	49.8	63.7	67.0	59.6	67.8%	27.7%	(1.8%)	13.2%
18-29	75.6	83.7	85.7	83.8	68.3	75.6	80.7	84.5	10.7%	10.7%	6.1%	(0.8%)
30-39	138.0	139.2	138.9	142.0	118.2	125.8	132.9	138.4	16.8%	10.7%	4.5%	2.6%
40-49	204.9	219.2	215.5	228.0	179.2	198.6	216.3	225.0	14.4%	10.4%	(0.4%)	1.3%
50-54	121.7	133.7	141.5	156.8	116.6	130.3	150.0	159.9	4.4%	2.6%	(5.7%)	(1.9%)
55-59	159.0	171.6	164.3	181.7	145.3	157.5	177.5	189.0	9.4%	8.9%	(7.4%)	(3.9%)
60-64	199.7	214.5	205.8	223.5	177.1	196.9	220.2	231.6	12.7%	9.0%	(6.6%)	(3.5%)
65-69	241.3	261.2	244.3	266.6	210.4	236.6	265.0	285.2	14.7%	10.4%	(7.8%)	(6.5%)
70-74	268.8	288.0	273.9	298.4	232.2	264.1	303.0	316.9	15.8%	9.1%	(9.6%)	(5.8%)
75-79	259.9	288.6	284.9	300.3	223.1	262.9	308.0	324.3	16.5%	9.8%	(7.5%)	(7.4%)
80+	332.9	354.1	325.6	341.7	278.0	330.2	390.3	414.4	19.7%	7.2%	(16.6%)	(17.5%)
Total	2,085.4	2,235.1	2,146.2	2,290.2	1,798.1	2,042.1	2,310.9	2,428.6	16.0%	9.4%	(7.1%)	(5.7%)
64 and under	982.5	1,043.2	1,017.5	1,083.2	854.5	948.4	1,044.6	1,087.9	15.0%	10.0%	(2.6%)	(0.4%)
65 and over	1,102.9	1,191.9	1,128.7	1,207.0	943.6	1,093.8	1,266.3	1,340.7	16.9%	9.0%	(10.9%)	(10.0%)

We can see from the above tables that in 2024, the actual returned benefits were 5.7% higher than projected which continues the trend observed in 2023 when actual returned benefits were 7.1% higher than expected. The differences will have been impacted by the projected insured population, projected utilisation and projected claims amounts. The market has seen high levels of claims activity and claims inflation, and the key question is whether this experience will be repeated in the future.

Questions for the insurers

What are your forecasts for your split of claims over the 2026/2027 period between public, private hospital and consultant?

What are your projections for your projected average claim per insured person over the period 2026/2027 and how does this differ between public private and consultant?

Do you foresee a continued increase in the percentage of claims that falls outside the definition of "returned benefits"?

What factors do you believe will contribute to the cost of claims over the projection period? E.g. supply issues, length of stays

What is your expected split of claims between non-advanced and advanced?

What is your average cost for a day and night in a private hospital? Please provide an indication of the range of costs for a day and night in a private hospital.

What is your expectation on the change in average returned benefits?

5. HCCP Parameters

The HCCP is currently calibrated such that HCCP credits are based on a 45% quota share on claims in excess of €50,000 on a rolling 12 month basis for policies written on or after 01 April 2024. For policies written between 01 April 2022 and 31 March 2024 the quota share rate is 40%.

The aim of the HCCP is to target high cost but low incidence claims.

The estimated size of the credits to be distributed in respect of the HCCP for the 2025 RES calibration was €126.6m or 13.7% of the overall credit (2024 RES Calibration: €108.1m or 12.5%, 2023 RES Calibration: €101.2m or 11.7%). The increase in HCCP credits for the 2025 RES Calibration was largely driven by the increased level of projected high-cost claims.

The HIA considers that the HCCP needs to be large enough to lead to a targeted distribution of Risk Equalisation credits but not so large that it is likely to materially disrupt the market. Issues with the drafting of HCCP have limited the ability of the HIA to perform meaningful analysis on HCCP claims in the initial years of implementation. The HIA considers that any changes made to the HCCP calibration would need to be done on a phased basis and carefully managed over time. Additionally, the HIA is mindful of the overall level of Risk Equalisation credits distributed through health-related credits, and therefore any changes to the amount of credits distributed as HCCP need to be considered in conjunction with the amount of credits distributed in the form of HUC payments.

The HIA has worked with the Department of Health to implement a definition that allows HSE approved drugs to be included in HCCP claims, as originally intended. The HIA will consider if changes to the quota share or threshold are warranted to increase the proportion of claims allocated to health-related credits.

Questions for the insurers

Please share your views on the quota share and threshold for HCCP purposes and whether or not you believe these should be changed together with supporting evidence of your views.

Please share your views on any expected technical difficulties with an adjustment to the threshold of HCCP claims.

What level of HCCP claims do you think the RES should be targeting as a percentage of overall claims?

6. Child Stamp Duty Rates

Stamp Duty for members aged 17 and under has historically been set at 1/3 of the adult rate for both advanced and non-advanced plans.

The table below sets out the average returned benefits for child members (aged 17 and under) versus young adult members (aged 18 to 29) for advanced contracts, non-advanced contracts and the market as a whole over the last four years.

Table 23 – Average returned benefits for child members vs adult members

Ret Benefits	2021	2022	2023	2024
Market				
Children (0-17)	49.8	62.5	64.5	57.3
Adults (18+)	507.7	556.0	607.1	628.3
Children / Adults	10%	11%	11%	9%
Advanced Contracts				
Children (0-17)	51.7	64.5	66.7	59.2
Adults (18+)	546.9	594.9	650.2	675.0
Children / Adults	9%	11%	10%	9%
Non-Advanced Contracts				
Children (0-17)	19.3	28.0	24.3	22.1
Adults (18+)	89.6	116.7	105.0	92.4
Children / Adults	22%	24%	23%	24%

Table 23 – Average returned benefits for child members vs young adult members (aged 18 and under)

Ret Benefits	2021	2022	2023	2024
Market				
Children (0-17)	49.8	62.5	64.5	57.3
Adults (18 - 64)	299.2	318.7	340.4	352.3
Children / Adults	17%	20%	19%	16%
Advanced Contracts				
Children (0-17)	51.7	64.5	66.7	59.2
Adults (18 - 64)	325.0	343.1	367.5	382.1
Children / Adults	16%	19%	18%	15%
Non-Advanced Contracts				
Children (0-17)	19.3	28.0	24.3	22.1
Adults (18 - 64)	67.5	85.6	74.2	65.0
Children / Adults	29%	33%	33%	34%

Questions for the insurers

Do you agree that the current rate of 1/3 of the adult rate should continue to apply for insured members aged 17 and under? If not, what would you propose and why?

Do you think a different proportion rate should apply for advanced and non-advanced contracts?

7. Rationale for the Recommendations

The purpose of this paper is to discuss assumptions in advance of the calibration of the RES which will be carried out later in the year. 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. The HIA has set out its current thinking, but this does not in any way pre-determine the outcome of the recommendation to be made to the Minister in September 2025.

At the time of the actual calibration of the RES, the HIA in making its recommendation to the Minister, will use the levers it has at its disposal to balance the conflicting requirements of the RES, in particular the achievement of the principal objective versus the need to promote sustainability and competition, and the need to avoid over-compensation.

In recommending the credits and stamp duties in respect of new contracts commenced in the period 01 April 2026 – 31 March 2027, the HIA will consider the most up to date data available to it, the market circumstances at that time and the estimated surplus within the Risk Equalisation Fund. Any changes between now and the calibration must be considered as will the information returns submitted in July 2025.

Questions for the insurers

Are there other matters related to the RES calibration that you would like to raise?