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 2024 to 30 June 2025, including advice on Risk Equalisation Credits

19 September 2025

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 2026 to 31 March 2027.

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 2025 to 30 June 2025, 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:

- The recommendation is allocating more credits based on health status across all ages and is sharing risk for low incidence high-cost claims by increasing the High Cost Claims Pool (HCCP) Quota Share from 45% to 50%. This is contributing to more targeted distribution of health-related credits;
- The proportion of health-related credits has been further increased compared to the current calibration by increasing the HUC payments (2026 RES calibration €165 per night and €100 per day vs 2025 RES Calibration €163 per night and €81 per day). The increase in day rate reflects the increase in complexity of care that is now being provided on a day case basis.
- Stamp duty for adults on advanced policies has increased compared to the current calibration (2026 RES Calibration: €517 vs 2025 RES Calibration: €469). The increase in stamp duty is heavily driven by medical claims inflation during 2024 and an increase in the assumed level of future claims inflation for private hospitals which has increased from 5% to 8% p.a.

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 2027 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2026 RES Calibration. The Authority is of the view that the key drivers of surplus/deficit are:

- Insured 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.
- 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 is considered in Appendix 3.

In accordance with the provisions of the Act, when setting these recommendations, the Authority has fully allocated the small surplus of €8m likely to be in the REF when the credits and stamp duty

on all contracts that commence in advance of 1 April 2026 are fully earned. If there is a likely deficit in the REF in future years, stamp duty will need to be increased to bring the fund back into balance.

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 2026 to 31 March 2027 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 Aviva Insurance Ireland DAC, Irish Life Health DAC, Elips Insurance Limited and AXA Insurance dac, and Vhi Insurance DAC by their trading / brand names (Level Health, Irish Life Health, Laya Healthcare and Vhi Healthcare respectively). Elips Insurance Limited ceased to underwrite new policies from 1 January 2025; new and renewing Laya Healthcare plans were underwritten by AXA Insurance dac. These policies have been analysed together for this report.

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 2026 RES calibration, i.e. for health insurance contracts entered into in the period 1 April 2026 to 31 March 2027.

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 2025.

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 2026 and 31 March 2027, in order to support the risk equalisation credits, are as follows:

Table 2.1 Stamp Duty Recommendation for Contracts Incepted 1 April 2026 – 31 March 2027

Age Band	Stamp Duties from 1 April 2026 to 31 March 2027		Stamp Duties from 1 April 2025 to 31 March 2026		Change	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17 and Under	€34	€172	€31	€156	€3	€16
18 and Over	€103	€517	€94	€469	€9	€48

The recommendation is to utilise the €8m surplus expected to exist in the REF (when the credits and stamp duty on all contracts that commence in advance of 1 April 2026 are fully earned) to reduce the level of stamp duty. The surplus has built up in the REF over recent years, because claims on the REF have been below the income from stamp duty. The surplus has reduced by €2m compared to the

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

2025 RES Calibration when the surplus was €10m. Overall, for the 2026 RES Calibration, the level of credits to be paid are expected to exceed the stamp duty receipts, by a magnitude of €8m.

The increase in stamp duty on advanced plans is primarily driven by an increase in projected returned benefits (i.e. medical claims inflation observed during 2024 and an increase in the assumed level of claims inflation for private hospitals which has increased from 5% to 8% p.a.). Returned benefits are based on the latest 2024 claims data.

In last year's report the Authority noted that if the surplus in the REF was not applied to the 2025 RES Calibration, advanced stamp duties for adults would have been set at €475, as opposed to €469, and the non-advanced adult stamp duty would have been €95, as opposed to €94.

The Authority notes that if the surplus in the REF was not applied to the 2026 RES Calibration, advanced stamp duties for adults would be €523, as opposed to €517, and the non-advanced adult stamp duty would be €105, as opposed to €103.

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 2026 and 31 March 2027.

Table 2.2 Risk Equalisation Credits for Contracts Incepted 1 April 2026 – 31 March 2027

	Proposed 2026 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	€300	€175	€1,125	€600	€25	€25	€150	€75
70-74	€425	€325	€1,700	€1,100	€75	€75	€75	€125
75-79	€625	€450	€2,350	€1,625	€75	€50	€125	€125
80-84	€650	€500	€2,750	€1,875	€0	€25	€125	€100
85+	€650	€500	€2,750	€1,875	€0	€25	€125	€100
Hospital Utilisation Credit								
	Night		Day		Night		Day	
	€165		€100		€2		€19	
Hight Cost Claims Pool (HCCP)								
Quota Share	50%				5%			
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% (2025 RES Calibration: 140%) of the average net claims cost across all lives.

In the 2024 RES 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 has observed that the cost of a day in hospital has risen relative to the cost of a night in hospital, which appears to be partly due to the cost of drugs administered by day cases. As the amount of private care provided in public hospitals

reduces, public hospital charges become a less suitable basis on which to set HUC rates. For the 2026 RES Calibration the Authority is recommending increasing the HUC night rate from €163 to €165 and increasing the HUC day rate from €81 to €100. The proposed rates aim to strike a balance between remaining a suitably low proportion of the current public hospital charges while recognising the higher day charges that apply to private hospital claims.

The Authority recommends that the HCCP credits for the 2026 RES Calibration are based on a 50% quota share on claims in excess of €50,000. The 2025 RES Calibration was 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 the 2026 RES calibration is €166.6m or 16.3% of the overall credits (2025 RES Calibration: €126.6m of 13.7%). The calibration allows for rolling HCCP claims. 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 2026 and 2025 RES calibrations.

Table 2.3 Split of Total RES Credits Paid by Age Cohort

Age Cohort	Age Credit	HUC	HCCP	Total Credits
	Recommended 2026 RES Calibration, Amounts in €m			
0-17	0.0 (0.0%)	7.0 (61.7%)	4.4 (38.3%)	11.4 (100.0%)
18-29	0.0 (0.0%)	9.3 (57.2%)	7.0 (42.8%)	16.3 (100.0%)
30-39	0.0 (0.0%)	15.1 (72.5%)	5.7 (27.5%)	20.9 (100.0%)
40-49	0.0 (0.0%)	20.5 (61.0%)	13.1 (39.0%)	33.6 (100.0%)
50-54	0.0 (0.0%)	13.8 (58.3%)	9.9 (41.7%)	23.6 (100.0%)
55-59	0.0 (0.0%)	15.6 (57.2%)	11.7 (42.8%)	27.3 (100.0%)
60-64	0.0 (0.0%)	19.2 (54.1%)	16.3 (45.9%)	35.4 (100.0%)
65-69	104.8 (70.5%)	23.6 (15.9%)	20.2 (13.6%)	148.5 (100.0%)
70-74	148.9 (74.4%)	27.2 (13.6%)	24.0 (12.0%)	200.1 (100.0%)
75-79	170.9 (76.3%)	29.4 (13.1%)	23.8 (10.6%)	224.1 (100.0%)
80+	205.8 (73.8%)	42.5 (15.2%)	30.7 (11.0%)	279.0 (100.0%)
Total	**630.4 (61.8%)**	**223.1 (21.9%)**	**166.6 (16.3%)**	**1,020.1 (100.0%)**
	2025 RES Calibration			
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%)**

The level of credits allocated to both age credits and HCCP have increased significantly while the level of HUC credits has remained reasonably static. 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 increase in the level of the quota share has also been a contributing factor to the increase in the level of HCCP credits (€16.6m of the €40m increase in the HCCP credits is due to the change in the level of the quota share).

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 Authority notes that the proportion of credits related to health status has increased in the 2026 RES Calibration relative to the 2025 RES Calibration, from 37.6% to 38.2%. The increase in the level of HUC rates (primarily the increased day rate) and the increase to the HCCP quota share for the 2026 RES Calibration has been a contributing factor to the increase. Without these changes the proportion of credits related to health status would have reduced by c. 2%.

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 RES Calibration there was not enough data to credibly calibrate policyholders aged 85+ as a standalone age group and as a result the 2024 RES calibration grouped lives over 80 together for the purposes of calibrating ARHC. This practice has continued for the purposes of the 2026 RES calibration. Thus, the 2026 RES Calibration 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 2026 to 31 March 2027, will be as follows:

Table 2.4 Projected Financial Impacts

Recommendation	[redacted]	[redacted]	[redacted]	[redacted]	Market
ARHC €m	[redacted]	[redacted]	[redacted]	[redacted]	630
HUC €m	[redacted]	[redacted]	[redacted]	[redacted]	223
HCCP €m	[redacted]	[redacted]	[redacted]	[redacted]	167
Stamp Duty €m	[redacted]	[redacted]	[redacted]	[redacted]	(1,012)
Net Financial Impact* €m	[redacted]	[redacted]	[redacted]	[redacted]	8
Net Financial Impact per Insured Life €	[redacted]	[redacted]	[redacted]	[redacted]	

[redacted]

2.3. Key Assumptions and Basis of Calculation

The development of the recommendation for the 2026 RES Calibration 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 2025 and recommended 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 2025 RES Calibration vs Recommended 2026 RES Calibration

	2025 RES Calibration	Recommended 2026 Calibration
Claims Adjustment		
Base Data	31-Dec-23	31-Dec-24
Inflation		
Public	0%	0%
Private	5%	8%
Consultant	5%	6%
Number of Years of Inflation	2.25 years	2.25 years
Hospital Utilisation Credits		
Overnights	€163	€165
Day	€81	€100
Hospital Utilisation	Night/day split: as per base year data	Night/day split: as per base year data
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	45%	50%
Insured Population Data		
Base Data	30-Jun-24	31-Dec-24
Participation and midpoint of projection period	2.438m	2.448m
Other		
REF Surplus	€10m	€8m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	20%	20%
Net Claim Cost	140%	140%

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 2026 RES Calibration. 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 2026 RES Calibration.

The Authority notes that the cost of claims in private hospitals are also more exposed to inflationary increases. The ESRI also notes that while the rate of inflation in Ireland picked up towards the end of 2024, it remains below the target rate of 2% with Ireland below the euro area average. The Authority has considered these forecasts, and the views provided by insurers in proposing claims inflation rates of 8% for private and 6% for consultant to be used for the 2026 RES 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 2024 is a suitable base year for projecting claims for the 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 January 2025 by 24,908 or 1.0%.

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 17.3% to 17.6% over the last 12 months and from 16.6% to 17.6% over the last 4 years.

Table 2.6 Age Profile of Insured Members

Age Group	1 Jan 2021	1 Jan 2022	1 Jan 2023	1 Jan 2024	1 Jan 2025
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%
Under 65	83.4%	83.3%	83.2%	82.7%	82.4%
Over 65	16.6%	16.7%	16.8%	17.3%	17.6%

The Authority has projected the population at 1 January 2025 forward to 1 October 2026 (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.

- Lives under 65 are assumed to increase by 30,308 which is allocated to age bands in line with age distribution observed in the base population at 1 January 2025. 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. €10m 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. An allowance for mortality is included in 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 5,697 as a result.

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.

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

The historical approach has typically been to increase the insured population at 01 July in line with the actual increase experienced in the previous 12 months. An analysis of the difference between the calibrated stamp duty using 01 January population compared to 01 July population has been carried out. Of the 3 years tested, only in 2024 would an adjustment need to have been made for the influx of older lives from the ESB RMU.

During 2024 the overall insured population increased by 25,896 lives over the 12 months to 01 January 2025 or by 1.1% compared to an increase of 65,297 or 2.8% in the previous calendar year as shown in the table below. The growth in insured population has been showing signs of slowing.

Table 2.7 Change in Insured Population

(Members 000's)	01-Jan-22	01-Jan-23	01-Jan-24	01-Jan-25	Projected 1-Oct-26
Population	2,263	2,332	2,397	2,422	2,448
Difference		3.0%	2.8%	1.0%	1.1%

2.3.3. Estimated Returned Benefits

The RES model is calibrated based on the average returned benefits for non-advanced and Level 2 contracts (with Level 2 being used as a proxy for Advanced contracts). Thus the age related health credits are based on a lower claim amount than occurs in practice. This is done so that the higher levels of contracts are not compensated for perceived luxury benefits. The level of total projected returned benefits for the 2026 RES Calibration are impacted by the level of the insured population, inflation (both cost and ageing) as set out below:

Table 2.8 Estimated Returned Benefits

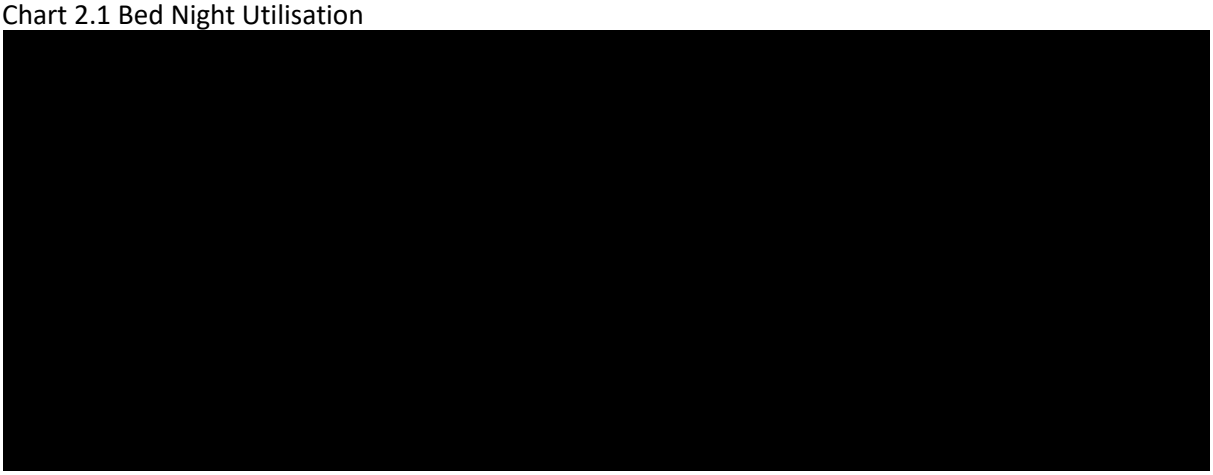
	Insured Population	Returned Benefits €m's	Change in Returned Benefits	% Change in Returned Benefits	Comment
Total Non Advanced and Level 2	2,026,599	1,775			2024 Insured Population and Returned Benefits
Total Population	2,405,655	2,107	332	18.7%	Increase modelled Returned Benefits to allow for full insured population
Total Projected Population	2,447,628	2,144	37	1.8%	Increase modelled Returned Benefits to allow for projected insured population when RES credits apply
Population Ageing	2,447,628	2,266	122	5.7% (2.5% annualised rate)	Increase modelled Returned Benefits to allow for aging of insured population. Ageing estimates allow for mortality of lives aged over 65 but no allowance is made in terms of lapsation.
Allowance for Inflation	2,447,628	2,596	330	14.6% (6.2% annualised rate)	Increase modelled Returned Benefits to allow for inflation of 0% Public, 8% Private and 6% Consultant
RES 2026 Calibration	**2,447,628**	**2,596**			

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 2024. 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.

2.3.4. Hospital Utilisation Rates

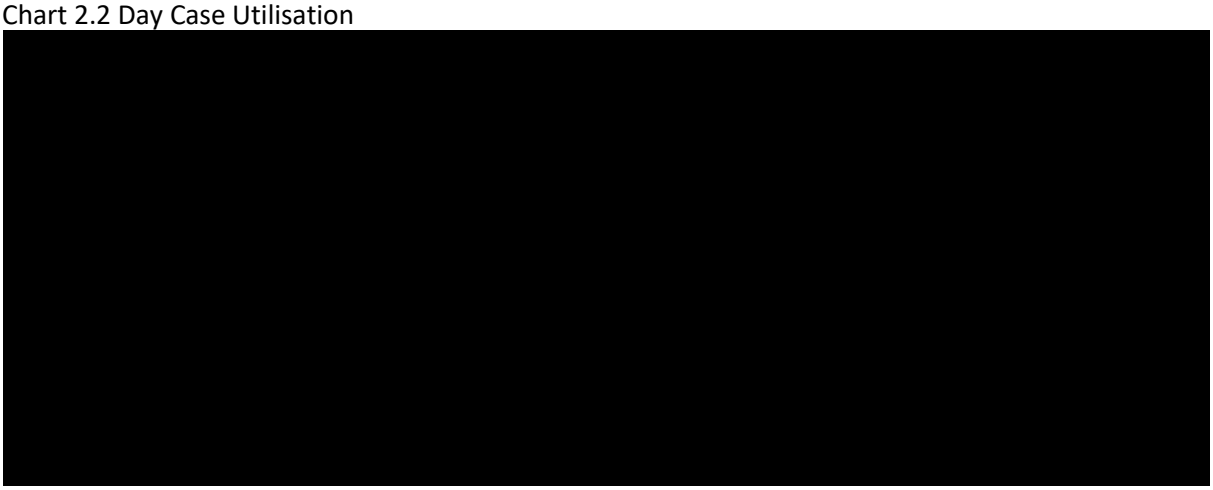
The picture with regard to hospital utilisation is mixed. We can see in Chart 2.1 that hospital nights fell in HY1 2024 following a sustained period of growth. There has been a slight reduction in overall bed nights over the last three periods.

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 2026/2027 Calibration are consistent with those observed in 2024 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 €8m (2025 RES Calibration: €10m) in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2026 are fully earned. Although the REF surplus is lower than the 2025 RES Calibration, the Authority estimate that the REF will likely continue to be positively impacted.

The Authority therefore recommends that this estimated surplus of €8m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2026 to 31 March 2027.

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 January 2025, 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.

Non advanced policies are likely to be disproportionately affected by changes to availability of private care in public hospitals. Returned benefits on non advanced plans were lower in 2024 than in 2023 despite additional members insured.

To address this, the ratio of non advanced stamp duty to advanced stamp duty was reduced to 20% for the 2025 RES calibration, which has been continued for the purposes of the 2026 RES Calibration.

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 2025 RES 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 stamp duty could 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 2026 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 January to June 2024 and July to December 2024 periods were received from Irish Life Health DAC (trading as Irish Life Health), Elips Insurances Ltd (trading as Laya Healthcare), Aviva Insurance Ireland DAC (branded as Level Health) 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 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:

- The effect of Sláintecare on the health insurance market;
- Concerns around the affordability of health insurance;
- Expected future claims levels, claims mix and claims inflation, future market membership and ageing, hospital utilisation levels;
- The effect of future developments in the use of specific treatment settings and care pathways;
- Level and calibration of stamp duty;
- 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;
- The sustainability of the market.

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 2026 to 31 March 2027 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 2025 RES Calibration and the recommended 2026 RES Calibration. An overview of the rationale for these assumptions is set out in the remainder of this section.

Table 4.1 Assumptions Underpinning 2025 RES Calibration vs Recommended 2026 RES Calibration

	2025 RES Calibration	Recommended 2026 Calibration
Claims Adjustment		
Base Data	31-Dec-23	31-Dec-24
Inflation		
Public	0%	0%
Private	5%	8%
Consultant	5%	6%
Number of Years of Inflation	2.25 years	2.25 years
Hospital Utilisation Credits		
Overnights	€163	€165
Day	€81	€100
Hospital Utilisation	Night/day split: as per base year data	Night/day split: as per base year data
High Cost Claims Pool		
Threshold	€50,000	€50,000
Quota Share	45%	50%
Insured Population Data		
Base Data	30-Jun-24	31-Dec-24
Participation at midpoint of projection period	2.438m	2.448m
Other		
REF Surplus	€10m	€8m
Non-Adv Stamp Duty (% of Adv Stamp Duty)	20%	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 Irish Life Health, Elips Insurance Limited and Vhi Insurance DAC 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 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 2026 RES Calibration was based on the 2022 exposure set. It 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 2026 RES Calibration has been updated to allow for assumed inflation of 0% for public hospital claims, 8% for private hospital claims and 6% for consultant claims. The corresponding assumed inflation rates in the 2025 RES Calibration were 0%, 5% and 6% 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 2026 RES Calibration are based on a 50% quota share on claims in excess of €50,000 with an allowance for rolling HCCP claims. The 2025 RES Calibration was 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 the 2026 RES calibration is €166.6m or 16.3% of the overall credits (2025 RES Calibration: €126.6m or 13.7%).

Table 4.2 HCCP Credits for 2026 RES Calibration

HCCP Credits		
Quota Share	*(a)*	50%
Threshold	*(b)*	€50,000
Rolling HCCP Claims Upflift Factor	*(c)*	70%
Projected High-Cost Claims in Respect of Policies Incepted in 2022 Allowing for Projected Claims Inflation	*(d)*	€565,104,515
Rolling HCCP Claims (Average Based on Historical Experience)	*(e) = [(d) – (h)] * (c)*	€163,033,160
HCCP Claims	*(f) = (d) + (e)*	€728,137,675
Projected HCCP Claim Policy Count	*(g)*	6,644
Threshold	*(h) = (g) * (b)*	€332,200,000
Credit Offsets		
ARHC	*(i)*	€6,929,075
HUC	*(j)*	€55,750,213
Final HCCP Credits	***(a) * ((f) – [(h)+(i)+(j)])***	**€166,629,194**

- 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 2024. This results in total projected developed claims of €565.1m and projected claim policy count of 6,644;
- 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 €163.0m which assumes a 70% uplift factor on HCCP claims emerging over a 12 month period. The 70% uplift factor was calibrated for the purposes of the 2024 RES Calibration based on the average impact that rolling claims would have had 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 €332.2m;

- HCCP credits are offset by ARHC of €6.9m and HUC of €55.8m; and
- Final credits are then calculated as the quota share x (HCCP claim – (threshold + HUC + ARHC)) resulting in the final HCCP credits of €166.6m.

It has been the stated aim of the Authority to increase the health related proportion of credits. The Authority notes that the proportion of credits related to health status has increased in the 2026 RES Calibration relative to the 2025 RES Calibration, from 37.6% to 38.2%. The increase in the level of HUC rates (primarily the increased day rate) and the increase to the HCCP quota share for the 2026 RES Calibration are the main drivers of this increase. Without these changes the proportion of credits related to health status would have reduced by c. 2%.

Increasing the HCCP quota share increases the support for the provision of health insurance to the sickest members. HCCP claims can include a wider breadth of the care that severely ill members require compared to HUC, which only covers a set amount of inpatient hospital costs. Treatments administered in other settings, such as drugs administered at home, can be included in HCCP claims.

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-Jan-24		01-Jul-24		01-Jan-25	
	Members '000s	Market Share	Members '000s	Market Share	Members '000s	Market Share
[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]	[redacted]
Total	2,397		2,413		2,423	

The overall insured population increased by 25,896 lives over the 12 months to 1 January 2025 (1 January 2023 to 1 January 2024: 65,297). Each of the insurers has experienced an increase in the number of insured lives and the changes in market share have not been material. Level Health entered the market late in 2024.

4.3.2. Gender Profile of Insurers' Members

The gender distributions of the memberships of the three insurers for the period July to December 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]	[redacted]	Market
Men	[redacted]	[redacted]	[redacted]	[redacted]	49%
Women	[redacted]	[redacted]	[redacted]	[redacted]	51%

4.3.3. Age Profile of Insurers Members

The current age distribution (average for the period July to December 2024) for each insurer and for the market is shown in Table 4.5 below. The figures shown in brackets are the corresponding averages for July to December 2023.

Table 4.5 Age Profile of Insured Members

Age Group	[redacted]	[redacted]	[redacted]	[redacted]	Market
0-17	[redacted]	[redacted]	[redacted]	[redacted]	21.7% (22.1%)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	12.5% (12.5%)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	12.9% (12.9%)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	15.6% (15.7%)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	13.7% (13.6%)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	6.0% (5.9%)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	5.3% (5.3%)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	4.6% (4.5%)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	3.7% (3.6%)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	2.3% (2.2%)
80+	[redacted]	[redacted]	[redacted]	[redacted]	1.7% (1.6%)
Under 65	[redacted]	[redacted]	[redacted]	[redacted]	82.4% (82.7%)
Over 65	[redacted]	[redacted]	[redacted]	[redacted]	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.

The proportion of each insurer's membership in each market segment on 1 January 2025 is shown in the Tables 4.6 and 4.7 (1 January 2024 figures are shown in brackets).

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

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

[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.

Non-advanced products cannot provide more than 66% of the full cost for hospital charges in a private hospital. As at 1 January 2025, there were 33 products (Irish Life Health: 19, Laya Healthcare: 11, Level Health: 1 and Vhi Healthcare: 2) being marketed classified as non-advanced with 180,626 members insured.

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

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

4.3.5. Actual vs Expected Population Forecasts

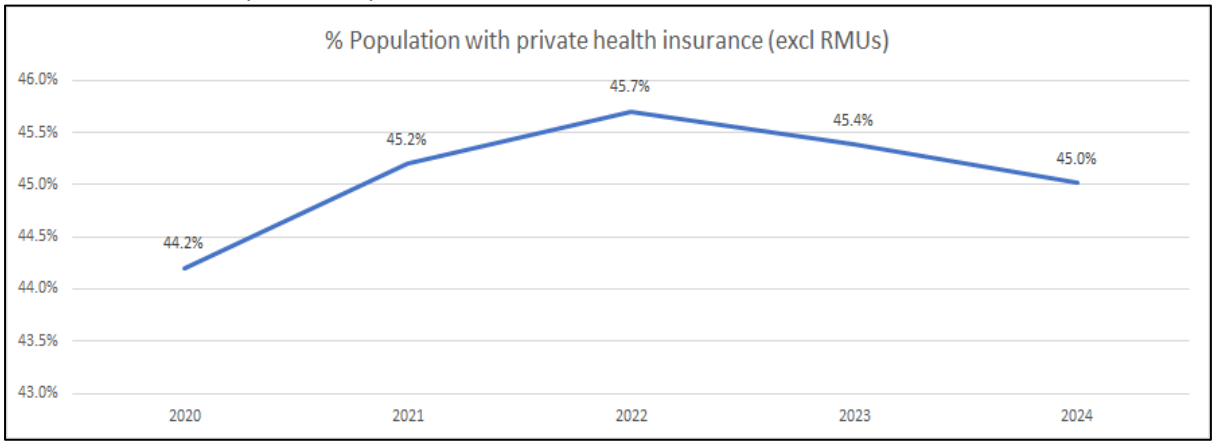
Table 4.8 shows that the insured population has continued to increase (the average increase over the last 4 years is 2.4% p.a.) and the market has remained resilient.

Table 4.8 Insured Population

(Members 000's)	01-Jan-21	01-Jan-22	01-Jan-23	01-Jan-24	01-Jan-25
Population	2,200	2,263	2,332	2,397	2,422
Difference		2.9%	3.0%	2.8%	1.0%

The Irish population is estimated to be growing faster than the insured population. Despite the increase in number of persons insured, the estimated proportion of the population with health insurance from open market insurers dropped from 45.4% on 1 January 2024 to 45.0% on 1 January 2025. Chart 4.1 shows the movement in the percentage of those holding private health insurance over the 5 years to 31 December 2024.

Chart 4.1 Insured Population by Insurer



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 4.9.

Table 4.9 – 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.

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 2025 forecast for Ireland carried out by the European Commission[6], expects Ireland's GDP to grow by 3.4% in 2025 and 2.5% in 2026 supported by a strong labour market. However, the high uncertainty and deterioration in global trading conditions are expected to detract from growth. Moreover, Ireland's deep economic ties to the US pose notable downward risks in the context of rising protectionism. HICP inflation remained low in early 2025, averaging 1.6% in the first quarter. However, an uptick in food prices, along with a slower decline in energy prices and still elevated services inflation kept rates slightly higher than previous quarters. Looking ahead, lower prices for non-energy industrial goods and decreases in commodity prices are expected to dampen inflation, and headline inflation is forecast to reach 1.6% in 2025 and 1.4% in 2026.

The Central Bank quarterly bulletin forecasts the pace of growth in economic activity to slow amid heightened global uncertainty with Modified Domestic Demand (MDD) to fall to 2.5% in 2026 and to

[6] Economic forecast for Ireland - European Commission

2.2% in 2027. While the outlook is challenged by global events, the domestic economy has for the most part continued to perform well. This is most evident in the labour market, with the unemployment rate remaining at historical lows over the longest period of time since data are available[7].

The ESRI Spring 2025 Economic Commentary confirms that at the start of 2025, the Irish economy was in a strong position. Unemployment stood at 3.9%, while real income growth is set to exceed 3.5% in 2025[8]. As of May 22nd, the ESRI's now estimates that MDD is growing at 3.1% year-on-year, based on all data from January, February and March 2025[9]. The ESRI also notes that while the rate of inflation in Ireland picked up towards the end of 2024, it remains below the target rate of 2% with Ireland below the euro area average.

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 or affordability concerns.

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.

Insurers who provided substantive responses had varied views from shrinkage of up to 2% to 3% growth.

4.3.7. Projected Population for 2026 RES Calibration

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 January 2025 population, and this is projected forward 1.75 years to 1 October 2026 (mid-point of the contracts from 1 April 2026 to 31 March 2027).

Table 4.10 Change in Insured Population

Change in Insured Lives by Age			
Insured Membership	**01-Jan-24**	**01- Jan-25**	**Net Diff**
Aged 17 and Under	529,157	525,692	(3,465)
Aged 18 to Age 29	299,075	302,953	3,878
Aged 30 to Age 39	310,309	313,260	2,951
Aged 40 to Age 49	376,437	378,333	1,896
Aged 50 to Age 54	171,882	175,978	4,096
Aged 55 to Age 59	153,951	155,525	1,574
Aged 60 to Age 64	142,167	144,184	2,017
Aged 65 to Age 69	126,076	127,774	1,698
Aged 70 to Age 74	108,467	110,510	2,043
Aged 75 to Age 79	87,296	89,959	2,663
Aged 80 and Over	92,304	97,861	5,557
Total	**2,397,121**	**2,422,029**	**24,908**

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

[7] Quarterly Bulletin Q1 2025 | Central Bank of Ireland
[8] Quarterly Economic Commentary, Spring 2025 | ESRI
[9] ESRI Nowcast (as of 22 May) | ESRI

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 January 2025 forward to 1 October 2026 (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.

- Lives under 65 are assumed to increase by 30,308 which is allocated to age bands in line with age distribution observed in the base population at 1 January 2025. 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. €10m 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. An allowance for mortality is included in 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. Granular population data is not available for lives aged 90 and over and these lives are assumed to have the same mortality as 95 year olds in the industry table ILT 2017 based on historical experience of population movements to date. In aggregate, lives over 65 are assumed to decrease by 5,697 as a result.

Table 4.11 Projected Population for Contracts Incepted Between 1 April 2026 and 31 March 2027

	Actual Population as at 1 January 2025		Projected Population as at 1 October 2026		Change	
Age	Population	Age Distribution	Population	Age Distribution	Population	Age Distribution
0-17	525,692	21.7%	533,268	21.8%	7,530	0.1%
18-29	302,953	12.5%	308,308	12.6%	4,544	0.1%
30-39	313,260	12.9%	318,403	13.0%	5,127	0.1%
40-49	378,333	15.6%	384,437	15.7%	6,097	0.1%
50-54	175,978	7.3%	178,681	7.3%	2,702	0.0%
55-59	155,525	6.4%	157,690	6.4%	2,157	0.0%
60-64	144,184	6.0%	146,342	6.0%	2,150	0.0%
65-69	127,774	5.3%	128,045	5.2%	249	0.0%
70-74	110,510	4.6%	110,671	4.5%	143	0.0%
75-79	89,959	3.7%	88,979	3.6%	(1,001)	(0.1%)
80+	97,861	4.0%	92,804	3.8%	(5,087)	(0.2%)
Total	**2,422,029**		**2,447,628**		**24,611**	

4.4. Claims Data

4.4.1. Historical Claims Experience

The total claims payments made by the open market insurers in 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]	[redacted]	Total
First Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	1,481
Second Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	1,544
2024 Total	[redacted]	[redacted]	[redacted]	[redacted]	**3,025**

The total claims paid in 2024 were €175m (6%) higher than claims paid in 2023.

Based on the above and feedback from the insurers, the Authority is of the view that the information returns for 2024 is a reasonable data set to use for calibrating the 2026/2027 RES.

Insurers provide details of claim payments that fall within the definition of "returned benefits" in information returns. The benefits included in the 2024 information returns (described as "returned benefits") as a percentage of total claims paid 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

€ m	[redacted]	[redacted]	[redacted]	[redacted]	Total
First Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	80%
Second Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	79%
2024 Total	[redacted]	[redacted]	[redacted]	[redacted]	**80%**

The benefits excluded from returned benefits are primarily claims in respect of outpatient benefits. 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 in 2024 were €2,429m compared to €2,311m in 2023. The increase of €118m is made up of increases in the payments to private hospitals (€143m) and consultants (€23m) offset by reductions in respect of public hospitals (€49m).

Table 4.14 Returned Benefits Split by Type

	Public Hospital €m's	Private Hospital €m's	Consultant €m's	Total €m's
First Half 2024	194	716	277	1,187
Second Half 2024	186	769	286	1,241
2024 Total	380	1,485	564	2,429

4.4.2. Claims Inflation

We can see from Chart 4.2 shows that in general the level of claims has continued to grow.

Chart 4.2: Historic Levels of Returned Benefits by Insurer

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, 8% for private and 6% for consultant in the 2026/2027 Calibration. The corresponding assumptions in the 2025/2026 Calibration were 0% for public, 5% for private and 6% 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.

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 2024 is a suitable base year for projecting claims for the 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 two years paid by the open membership undertakings is set out in Table 4.15.

Table 4.15 Total Number of Hospital Treatment Days

000's	Overnight	Day Case	Total	Day Case as % of Total
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 treatment 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.

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.

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 was used.

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		
	2026 RES Calibration	2025 RES Calibration	Variance
01/01/2013 – 31/03/2021 Contracts	95.1	95.6	(0.5)
01/04/2021 – 31/03/2022 Contracts	46.3	45.9	0.4
01/04/2022 – 31/03/2023 Contracts	(81.6)	(78.0)	(3.6)
01/04/2023 – 31/03/2024 Contracts	(28.6)	(30.8)	2.3
01/04/2024 – 31/03/2025 Contracts	(15.0)	(27.7)	12.7
01/04/2025 – 31/03/2026 Contracts	(11.0)		(11.0)
Expected Surplus Last RES			10.8
Other Incl. Investment Income Less Expenses	3.0	6.0	(3.0)
Total	**8.2**	**10.8**	**8.2**

When setting credits in last year's report, the Authority assumed an initial surplus of €10m which was expected to be exhausted. The expected allocated credits were set so as to exceed expected stamp duty receipts by €10m.

Table 4.17 sets out details of the expected surplus by contract period and shows how experience in aggregate has changed since the 2025 RES 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 – 31/03/2021 Contracts	(0.5)	(0.0)	0.1	(0.6)	0.0
01/04/2021 – 31/03/2022 Contracts	0.4	(0.1)	0.0	0.4	0.0
01/04/2022 – 31/03/2023 Contracts	(3.6)	(0.1)	0.1	4.1	(7.8)
01/04/2023 – 31/03/2024 Contracts	2.3	4.0	(23.8)	15.8	6.2
01/04/2024 – 31/03/2025 Contracts	12.7	(26.3)	29.4	7.9	1.7
01/04/2025 – 31/03/2026 Contracts	0.0	0.0	0.0	0.0	0.0
Other incl. Investment Income Less expenses	(3.0)				
Total	**8.2**	**(22.4)**	**5.9**	**27.6**	**0.2**

The key drivers of the variance are:

- A deficit of €3.6m in respect of contracts entered into in the period 1 April 2022 to 31 March 2023 which is driven by higher levels of HCCP than expected (-€7.8m) offset by lower levels of HUC than expected (+€4.1m).

- A surplus of €2.3m 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 (+€15.8m and +€6.2m respectively) offset by higher insured population than expected (resulting in higher levels of stamp duty (+€4.0m) offset by more ARHC being paid out (-€23.8m).

- A surplus of €12.7m in respect of contracts entered into in the period 1 April 2024 to 31 March 2025 which is driven by reduced levels of credits being paid out compared to those originally budgeted (ARHC: +€29.4m, HUC: +€7.9m, HCCP +€1.7m) offset by lower insured population than expected (resulting in lower levels of stamp duty (-€26.3m).

- A deficit of €3.0m driven by negative variances caused by the one off change in underwriter of the Laya book of business.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €8m in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2026 are fully earned. The REF surplus is lower than the €10m assumed in the 2025 RES 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 €8m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2026 to 31 March 2027.

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 January 2025, 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	2021	2022	2023	2024
Advanced				
Average Population	862,175	879,256	895,339	949,388
Returned Benefits	1,960,280,554	2,077,062,139	2,235,139,469	2,360,539,553
Average Returned Benefit	2,274	2,362	2,496	2,486
Non-Advanced				
Average Population	78,290	77,141	78,267	80,028
Returned Benefits	27,354,040	32,998,745	31,076,167	28,338,884
Average Returned Benefit	349	428	397	354
% Non-Advanced to Advanced Average Returned Benefit	**15%**	**18%**	**16%**	**14%**

The Authority therefore recommends the stamp duty for non-advanced contracts remains at 20% of the stamp duty relating to advanced contracts. The reduction in stamp duty for the 2025 calibration did not lead to widespread corresponding price reductions for non-advanced 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 2025 RES Calibration the net claims cost ceiling was 140%, which resulted in an estimated 62.4% of credits being in respect of age and, 23.9% in respect of HUC and 13.7% in respect of HCCP.

For the 2026 RES Calibration, the Authority recommends that the net claims cost ceiling remain at 140%, which results in an estimated 61.8% of credits being in respect of age, 21.9% in respect of HUC and 16.3% 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. Overcompensation

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 was 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, and a threshold of 6% applying to the assessment in respect of the three-year period 2022 – 2024.

The Authority carried out an assessment of whether overcompensation has occurred in the three-year period 2022 – 2024 using actual insurers' certified financial statements. [redacted]

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

6. 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 2026 to 31 March 2027. 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.

6.1. Stamp Duty

The Authority recommends that the stamp duties to be paid by the insurers on policies that are entered into between 1 April 2026 and 31 March 2027, 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 2026 – 31 March 2027

Age Band	**Stamp Duties from 1 April 2026 to 31 March 2027**		**Stamp Duties from 1 April 2025 to 31 March 2026**		**Change**	
	Non-Advanced	Advanced	Non-Advanced	Advanced	Non-Advanced	Advanced
17 and Under	€34	€172	€31	€156	€3	€16
18 and Over	€103	€517	€94	€469	€9	€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 2025 RES Calibration, 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. The Authority notes that if the surplus in the REF was not applied to the 2026 RES Calibration, advanced stamp duties for adults would be €523 compared to the recommended rate of €517, and the non-advanced adult stamp duty would be €105, as opposed to €103.

6.2. 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 2026 and 31 March 2027.

Table 7.2 Risk Equalisation Credits for Contracts Incepted 1 April 2026 – 31 March 2027

	Proposed 2026 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	€300	€175	€1,125	€600	€25	€25	€150	€75
70-74	€425	€325	€1,700	€1,100	€75	€75	€75	€125
75-79	€625	€450	€2,350	€1,625	€75	€50	€125	€125
80-84	€650	€500	€2,750	€1,875	€0	€25	€125	€100
85+	€650	€500	€2,750	€1,875	€0	€25	€125	€100
Hospital Utilisation Credit (HUC)								
	Night		Day		Night		Day	
	€165		€100		€2		€19	
Hight Cost Claims Pool (HCCP)								
Quota Share	50%				5%			
Threshold	€50,000				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 2024 – Dec 2024 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% (2025 RES Calibration: 140%) of the average net claims cost across all lives.

For the 2024 RES Calibration there was not enough data to credibly calibrate policyholders aged 85+ as a standalone age group and as a result the 2024 RES calibration grouped lives over 80 together for the purposes of calibrating ARHC. This was 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. This practice has continued for the purposes of the 2026 RES calibration. Thus, the 2026 RES Calibration groups lives over 80 together for the purposes of calibrating ARHC.

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 RES 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 has observed that the cost of a day in hospital has risen relative to the cost of a night in hospital, which is likely to be partly due to the cost of drugs administered during day cases. As the amount of private care provided in public hospitals reduces, public hospital charges become a less suitable basis on which to set HUC rates. For the 2026 RES Calibration the Authority is recommending increasing the HUC night rate from €163 to €165 and increasing the HUC day rate from €81 to €100. The proposed rates aim to strike a balance between remaining a suitably low proportion of the current public hospital charges while recognising the higher day charges that apply to private hospital claims.

The Authority recommends that the HCCP credits for the 2026 RES Calibration are based on a 50% quota share on claims in excess of €50,000. The 2025 RES Calibration was 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 the 2026 RES calibration is €166.6m or 16.3% of the overall credits (2025 RES Calibration: €126.6m of 13.7%).

6.3. Alternative Scenarios Considered

In coming to the recommendations, the Authority has looked at two alternative scenarios to the recommendations for the 2026 RES Calibration. The first assumes that claims inflation will be higher at 10% p.a. for private hospitals and 8% p.a. for consultants (compared to 8% and 6% respectively in the recommended 2027 RES Calibration). The second investigates the level of claims cost ceiling necessary to keep the adult advanced stamp duty close to the current levels. Details of these scenarios are included in Appendix 3.

6.4. 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 (2026 RES Calibration: €517 vs 2025 RES Calibration: €469). The increase in stamp duty is heavily driven by medical claims inflation during 2024 and an increase in the assumed level of future claims inflation for private hospitals which has increased from 5% to 8% p.a.
- Stamp duty for non-advanced products has increased compared to the current calibration (2026 RES Calibration: €103 vs 2025 RES Calibration: €94). The increase in stamp duty is driven by the same drivers as for advanced contracts.
- The RES effectiveness measure is broadly unchanged as a result of the recommendation (2025 RES Calibration: 53.9% vs 2026 RES Calibration: 53.4%) based on the R-squared weighted average

variance.[10] 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 RES Calibration: 37.6% vs 2026 RES Calibration: 38.2%).

[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.

7. 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 primarily driven by an increase in projected returned benefits (i.e. medical claims inflation observed during 2024 and an increase in the assumed level of claims inflation for private hospitals which has increased from 5% to 8% p.a.). 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 7.1 Reconciliation of Change in Stamp Duty

	Stamp Duty				Credits Allocated				
	Stamp Duty	Diff	Effectiveness (all)	Diff	Age Related	HUC	HCCP	Total Credits	Diff
2025 RES Calibration	**€469**		**53.9%**		**€576.1m (62.4%)**	**€220.4m (23.9%)**	**€126.6m (13.7%)**	**€923.1m**	
Opening Adjustment	€470	*€1*	54.1%	*0.2%*	€578.2m (62.6%)	€220.4m (23.9%)	€125.5m (13.6%)	€924.2m	*€1.1m*
Roll Forward HCCP Claims	*€474*	*€4*	*54.4%*	*0.3%*	€572.6m (61.3%)	€220.4m (23.6%)	€140.5m (15.1%)	€933.6m	*€9.4m*
Model Update – Mortality Refinement	*€482*	*€8*	*54.6%*	*0.2%*	€589.2m (61.8%)	€224.4m (23.5%)	€140.5m (14.7%)	€954.2m	*€20.6m*
Updated Claims	*€497*	*€15*	*47.4%*	*(7.2%)*	€618.1m (62.9%)	€224.4m (22.8%)	€140.5m (14.3%)	€983.0m	*€28.8m*
Updated Returned Benefits Claims Inflation	*€513*	*€16*	*46.0%*	*(1.4%)*	€648.9m (64.0%)	€224.4m (22.1%)	€140.4m (13.9%)	€1,013.7m	*€30.7m*
Updated Utilisation	*€509*	*(€4)*	*47.8%*	*1.8%*	€657.1m (65.3%)	€209.3m (20.8%)	€140.3m (13.9%)	€1,006.8m	*(€6.9m)*
Updated HUC Rates	*€514*	*€5*	*48.6%*	*0.8%*	€651.3m (64.1%)	€225.2m (22.2%)	€139.6m (13.7%)	€1,016.1m	*€9.3m*
Updated Population	*€509*	*(€5)*	*49.9%*	*1.3%*	€642.3m (63.9%)	€223.1m (22.2%)	€139.6m (13.9%)	€1,005.0m	*(€11.1m)*
Updated HCCP Claims Inflation	*€514*	*€5*	*51.7%*	*1.8%*	€632.6m (62.4%)	€223.1m (22.0%)	€158.7m (15.6%)	€1,014.4m	*€9.4m*
Updated HCCP Data	*€512*	*(€2)*	*51.4%*	*(0.3%)*	€638.5m (63.1%)	€223.1m (22.1%)	€150.0m (14.8%)	€1,011.6m	*(€2.8m)*
Updated HCCP Quota Share	€516	*€4*	53.4%	*2.0%*	€630.4m (61.8%)	€223.1m (21.9%)	€166.6m (16.3%)	€1,020.1m	*€8.5m*
Updated RES Surplus	*€517*	*€1*	*53.4%*	*(0.0%)*	€630.4m (61.8%)	€223.1m (21.9%)	€166.6m (16.3%)	€1,020.1m	*€0.0m*
Recommended 2026 Calibration	**€517**		**53.4%**		**€630.4m (61.8%)**	**€223.1m (21.9%)**	**€166.6m (16.3%)**	**€1,020.1m**	

The Authority has a defined measure of effectiveness and in making its recommendations this is one of a number of metrics which is considered. While worsening claims experience in 2024 and increased levels of expected future claims inflation have reduced the level of effectiveness, this has been largely offset by other factors including RES calibration changes. Thus, the effectiveness of the RES is broadly unchanged as a result of the recommendation (2025 RES Calibration: 53.9% vs 2026 RES Calibration: 53.4%).

7.1. 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:

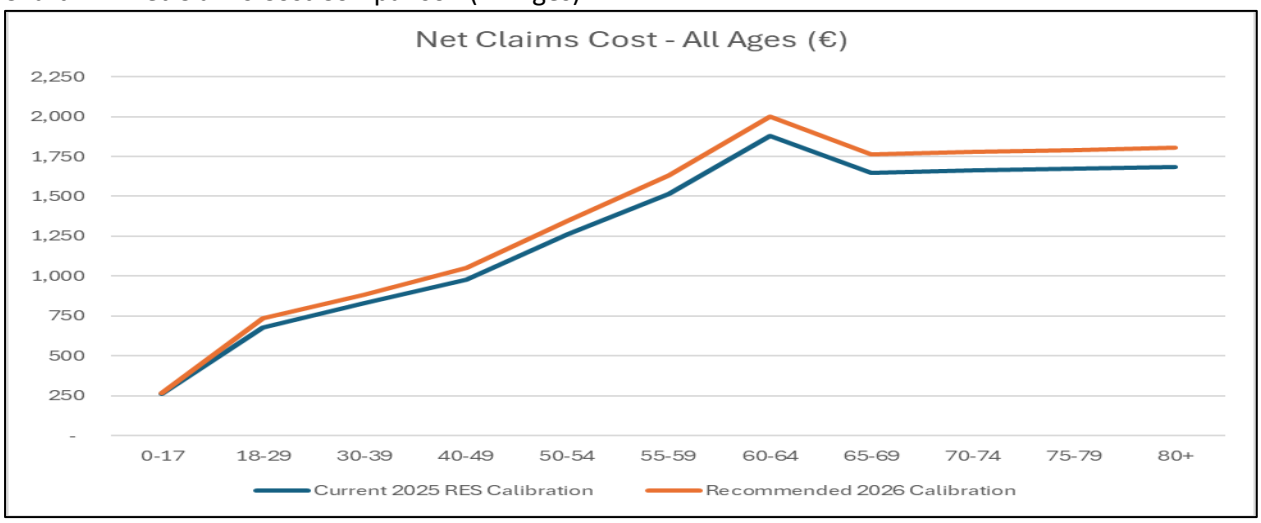
- The average claims cost which tends to increase with age as, on average, older lives incur higher costs than younger lives;
- ARHC which serves to significantly reduce the net claims cost for those over 65 (who typically have larger claims). The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140% (2025 RES Calibration: 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 the Authority considers 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 2026 RES Calibration. A graphical representation of the net claims cost by all ages is included in Chart 7.1. We can see that the net claims cost has increased for all age groups under the recommended 2026 RES Calibration.

Table 7.2 Projected Net Claims Cost by Age

Net Claims Cost After RES	Current 2025 RES Calibration	Recommended 2026 Calibration	Impact of Recommended Calibration
0-17	261	266	*5*
18-29	674	735	*61*
30-39	826	884	*58*
40-49	978	1,049	*71*
50-54	1,258	1,347	*89*
55-59	1,515	1,629	*115*
60-64	1,874	1,999	*125*
65-69	1,647	1,763	*116*
70-74	1,664	1,780	*115*
75-79	1,660	1,791	*131*
80+	1,679	1,805	*126*

Chart 7.1: Net Claims Cost Comparison (All Ages)



7.2. 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 2026 to 31 March 2027 are outlined in Table 7.3 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.

Level Health entered the market in 2024. This is not expected to have a material impact on the RES calibration as they have indicated that 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 7.3 Projected Net Financial Impacts by Insurer

Projected RES Flows										
From 1 April 2025										
€m	[redacted]	[redacted]	[redacted]	[redacted]	**Market**					
Age Credits	[redacted]	[redacted]	[redacted]	[redacted]	576					
HUC	[redacted]	[redacted]	[redacted]	[redacted]	220					
HCCP	[redacted]	[redacted]	[redacted]	[redacted]	127					
Stamp Duty	[redacted]	[redacted]	[redacted]	[redacted]	(913)					
NFI	[redacted]	[redacted]	[redacted]	[redacted]	10					
From 1 April 2026						**Change from 1 April 2025 Credits**				
€m	[redacted]	[redacted]	[redacted]	[redacted]	**Market**	[redacted]	[redacted]	[redacted]	[redacted]	**Market**
Age Credits	[redacted]	[redacted]	[redacted]	[redacted]	630	[redacted]	[redacted]	[redacted]	[redacted]	54
HUC	[redacted]	[redacted]	[redacted]	[redacted]	223	[redacted]	[redacted]	[redacted]	[redacted]	3
HCCP	[redacted]	[redacted]	[redacted]	[redacted]	167	[redacted]	[redacted]	[redacted]	[redacted]	40
Stamp Duty	[redacted]	[redacted]	[redacted]	[redacted]	(1,012)	[redacted]	[redacted]	[redacted]	[redacted]	(99)
NFI	[redacted]	[redacted]	[redacted]	[redacted]	8	[redacted]	[redacted]	[redacted]	[redacted]	(2)

Appendix 1: Further Analysis of Information Returns

The information returns for 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. More recent information returns appear to be reverting to normal and do not appear to be materially impacted by these distortions.

Key market developments

- The number of people with health insurance continues to increase (01/07/2025: 2.436m vs 01/07/2024: 2.413m). Growth has been behind our forecasts from last year, particularly for the younger age cohorts.
- The average adult premium across the market is €1,839 for 01/07/2025 which is an increase of c. 9% since the 01/07/2024.
- On average, all insurers (excluding Level Health who started selling business in late 2024) 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 remained the same in the last year at 348[11] inpatient private health insurance plans on the Product Register on 1st July 2025 (excluding restricted membership undertakings). The number of new products introduced so far in 2025 are 18.
- Table 5.1 below shows the total claims payments for the insurers for the last three 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]	[redacted]	Total
2022 Total	[redacted]	[redacted]	[redacted]	[redacted]	2,472
2023 Total	[redacted]	[redacted]	[redacted]	[redacted]	2,850
2024 Total	[redacted]	[redacted]	[redacted]	[redacted]	3,025

Chart 5.1 Returned Benefits as a Proportion of Claims

[11] 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.

Chart 5.1 sets out the Returned Benefits as a proportion of Claims for the insurers up to June 2025. Level Health have been excluded given the low level of claims as a result of only starting to sell business in late 2024. These proportions have fallen over the 12 month period to June 2025 for all insurers. 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.

Profitability Analysis

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 for the 12-month period to 1 July 2025. The figures shown in brackets are the corresponding averages for 12-month period to 1 July 2024.

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] €	[redacted] €	**Weighted Market Average €**
Average Net Claims Cost per Insured Person					
18-64	[redacted]	[redacted]	[redacted]	[redacted]	1,099 (1,027)
Over 65's	[redacted]	[redacted]	[redacted]	[redacted]	1,860 (1,791)
Average Gross of Tax Relief Premiums per Insured Person **					
18-64	[redacted]	[redacted]	[redacted]	[redacted]	1,899 (1,763)
65 and Above	[redacted]	[redacted]	[redacted]	[redacted]	2,306 (2,258)
Average Difference per Insured Person					
18-64	[redacted]	[redacted]	[redacted]	[redacted]	800 (540)
65 and Above	[redacted]	[redacted]	[redacted]	[redacted]	447 (285)

** Level Health entered the market in late 2024 resulting in the volatile net claims costs given the small volumes of business.*
*** As at 1 January 2025, the rate of tax relief applied varies by insurer with Irish Life Health and Laya Healthcare subject to relief at 19% while Level Health and Vhi Healthcare subject to relief at 20%. An overall rate of relief of 20% is used for all insurers for the table above as a simplification which does not materially impact the results.*

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.

[redacted]

Insured Population

Table A1.1 sets out the membership details and market shares of the open market insurers. The data excludes members serving initial waiting periods.

Table A1.1 Insured Population by Insurer

Insurer	01-Jul-24		01-Jan-25		01- Jul -25	
	Members '000s	Market Share	Members '000s	Market Share	Members '000s	Market Share
[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]	[redacted]
Total	2,413		2,423		2,436	

The overall insured population increased by 23,046 lives over the 12 months to 1 July 2025 (1 July 2023 to 1 July 2024: 35,249). Each of the insurers has experienced an increase in the number of insured lives and the changes in market share have not been material. Level Health entered the market late in 2024.

Table A1.2 sets out the changes in the insured population over the last three years of the insured populations included in returns. The number of people with private health insurance has increased over the 12 months to 1 July 2025 by 23,046 or 1.0%.

Table A1.2 – Change in Insured Population

(Members 000's)	01-Jul-21	01-Jul-22	01-Jul-23	01-Jul-24	01-Jul-25
Population	2,226	2,294	2,377	2,413	2,436
Difference		3.0%	3.6%	1.5%	1.0%

The historical age profiles of the insured population are set out in Table A1.3 below 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 17.3% to 17.4% over the last 12 months and from 16.6% to 17.4% over the last 4 years.

Table A1.3 – Age Profile of Insured Members

Age Group	01-Jul-21	01-Jul-22	01-Jul-23	01-Jul-24	01-Jul-25
0-17	22.9%	22.7%	22.4%	22.1%	21.9%
18-29	11.8%	12.2%	12.5%	12.5%	12.5%
30-39	13.1%	12.9%	13.0%	12.9%	13.0%
40-49	16.0%	16.0%	15.9%	15.7%	15.7%
50-59	13.6%	13.6%	13.5%	13.6%	13.6%
60-64	6.0%	5.9%	5.9%	5.9%	5.9%
65-69	5.3%	5.3%	5.2%	5.3%	5.3%
70-74	4.5%	4.5%	4.4%	4.5%	4.5%
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%
Under 65	83.4%	83.3%	83.2%	82.7%	82.6%
Over 65	16.6%	16.7%	16.8%	17.3%	17.4%

The gender distributions of the memberships of the three insurers for the period December to July 2025 are set out in Table A1.4. The proportions in each gender for each insurer have remained relatively static for some time.

Table A1.4 Gender Distribution of Insured Population

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

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.

Returned Benefits

The total claims payments made by the open market insurers in 2023, 2024 and the first half of 2025 are set out in Table A1.5. It is noted that these figures exclude claim payments by restricted membership insurers.

Table A1.5 Claims Paid by Insurer

€ m	[redacted]	[redacted]	[redacted]	[redacted]	Total
First Half 2022	[redacted]	[redacted]	[redacted]	[redacted]	1,187
Second Half 2022	[redacted]	[redacted]	[redacted]	[redacted]	1,285
2022 Total	[redacted]	[redacted]	[redacted]	[redacted]	**2,472**
First Half 2023	[redacted]	[redacted]	[redacted]	[redacted]	1,368
Second Half 2023	[redacted]	[redacted]	[redacted]	[redacted]	1,482
2023 Total	[redacted]	[redacted]	[redacted]	[redacted]	**2,850**
First Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	1,481
Second Half 2024	[redacted]	[redacted]	[redacted]	[redacted]	1,544
2024 Total	[redacted]	[redacted]	[redacted]	[redacted]	**3,025**
First Half 2025	[redacted]	[redacted]	[redacted]	[redacted]	1,512

The total claims paid in the first half of 2025 were €31m (2%) higher than the first half of 2024. This is significantly less than the increase observed in the first half of 2024 when total claims were €113m (8%) higher than the first half of 2023.

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 2023 to the first half of 2025 are set out in Table A1.6. 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 A1.6 Returned Benefits as a Percentage of Total Claims

Insurer	July – Dec 2023	Jan – June 2024	July – Dec 2024	Jan – June 2025
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	82%	80%	80%	79%

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 A1.7 splits out the returned benefit payments between those attributable to public hospitals, private hospitals, and to hospital consultants. The total returned benefits paid were €1,282m in the first half of 2025 compared to €1,187m in the first half of 2024. The increase of €95m is made up of increases in the payments to private hospitals (€49m) and consultants (€13m) offset by reductions in respect of public hospitals (€20m). The reduction in public hospital claims in H1 2025 which was also observed in H1 2024 may be linked to the implementation of the public only consultant contract.

Table A1.7 Returned Benefits Broken Down by Service Provider

		[redacted] €m	[redacted] €m	[redacted] €m	[redacted] €m	Total €m
First Half 2023	Public Hospital	[redacted]	[redacted]	[redacted]	[redacted]	212 (18%)
	Private Hospital	[redacted]	[redacted]	[redacted]	[redacted]	626 (52%)
	Consultant	[redacted]	[redacted]	[redacted]	[redacted]	262 (22%)
	Sub Total	[redacted]	[redacted]	[redacted]	[redacted]	*1,100*
Second Half 2023	Public Hospital	[redacted]	[redacted]	[redacted]	[redacted]	217 (18%)
	Private Hospital	[redacted]	[redacted]	[redacted]	[redacted]	716 (59%)
	Consultant	[redacted]	[redacted]	[redacted]	[redacted]	278 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	[redacted]	*1,211*
2023 Total		[redacted]	[redacted]	[redacted]	[redacted]	**2,311**
First Half 2024	Public Hospital	[redacted]	[redacted]	[redacted]	[redacted]	194 (16%)
	Private Hospital	[redacted]	[redacted]	[redacted]	[redacted]	716 (60%)
	Consultant	[redacted]	[redacted]	[redacted]	[redacted]	277 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	[redacted]	*1,187*
Second Half 2024	Public Hospital	[redacted]	[redacted]	[redacted]	[redacted]	186 (15%)
	Private Hospital	[redacted]	[redacted]	[redacted]	[redacted]	769 (62%)
	Consultant	[redacted]	[redacted]	[redacted]	[redacted]	286 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	[redacted]	*1,241*
2024 Total		[redacted]	[redacted]	[redacted]	[redacted]	**2,429**
First Half 2025	Public Hospital	[redacted]	[redacted]	[redacted]	[redacted]	166 (13%)
	Private Hospital	[redacted]	[redacted]	[redacted]	[redacted]	818 (64%)
	Consultant	[redacted]	[redacted]	[redacted]	[redacted]	299 (23%)
	Sub Total	[redacted]	[redacted]	[redacted]	[redacted]	*1,282*

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 A1.8 below.

Table A1.8 Average Returned Benefit per Insured Person (€)

Insurer	Average Returned Benefit per Insured Person					
	July-Dec 2023	Jan-Jun 2024	12 Month Total	July-Dec 2024	Jan-Jun 2025	12 Month Total
[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]	[redacted]
Market	**€595**	**€579**	**€1,175**	**€600**	**€617**	**€1,218**

If we compare the 12 month periods July 2023 – June 2024 with July 2025 – June 2025, the average returned benefit per insured life has increased by [redacted] 3.7% for the market as a whole. As a new entrant towards the latter end of 2024 Level Health has no prior comparatives.

The average returned benefit per insured person as a percentage of the market average for each insurer is set out in Table A1.9 below.

Table A1.9 Average Returned Benefits per Insured Person

Insurer	Average Returned Benefit per Insured Person as a % of the Market Average					
	July-Dec 2023	Jan-Jun 2024	12 Month Total	July-Dec 2024	Jan-Jun 2025	12 Month Total
[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]	[redacted]
Market	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

[redacted]

Average returned benefits per insured person for the 12 months to the end of June 2025 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 2024 are shown in brackets.

Table A1.10: Non-Advanced Average Returned Benefits per Insured Man

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	45 (43)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	40 (50)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	57 (56)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	97 (111)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	172 (272)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	299 (310)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	334 (415)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	710 (539)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	835 (1,060)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	871 (986)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	1,332 (1,353)
85+	[redacted]	[redacted]	[redacted]	[redacted]	1,660 (1,289)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**174 (193)**

Table A1.11: Level 1 Average Returned Benefits per Insured Man

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	45 (45)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	44 (53)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	63 (60)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	101 (115)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	176 (277)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	312 (338)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	347 (443)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	749 (651)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	861 (1,104)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	942 (1,123)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	1,399 (1,628)
85+	[redacted]	[redacted]	[redacted]	[redacted]	1,572 (2,113)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**188 (216)**

Table A1.12: Level 2 Average Returned Benefits per Insured Man

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	117 (121)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	282 (291)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	322 (319)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	517 (500)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	848 (836)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	1,259 (1,257)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	1,796 (1,783)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	2,470 (2,382)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	3,063 (3,074)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	3,782 (3,761)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	4,252 (4,333)
85+	[redacted]	[redacted]	[redacted]	[redacted]	4,626 (4,478)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**1,116 (1,124)**

Table A1.13: Level 2+ Average Returned Benefits per Insured Man

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	151 (140)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	292 (282)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	361 (318)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	701 (603)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	1,272 (1,199)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	1,850 (1,673)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	2,283 (2,267)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	3,224 (3,057)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	4,218 (4,103)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	5,035 (4,921)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	5,515 (5,734)
85+	[redacted]	[redacted]	[redacted]	[redacted]	6,193 (6,815)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**2,129 (1,918)**

Table A1.14: Non-Advanced Average Returned Benefits per Insured Woman

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	47 (41)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	37 (62)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	89 (94)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	119 (154)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	242 (224)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	244 (258)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	312 (361)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	431 (485)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	597 (700)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	794 (891)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	1,064 (857)
85+	[redacted]	[redacted]	[redacted]	[redacted]	1,176 (1,146)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**170 (190)**

Table A1.15: Level 1 Average Returned Benefits per Insured Woman

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	49 (40)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	39 (66)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	94 (100)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	124 (160)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	259 (228)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	253 (274)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	332 (412)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	448 (523)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	638 (780)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	877 (1,099)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	1,117 (1,089)
85+	[redacted]	[redacted]	[redacted]	[redacted]	1,209 (1,636)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**185 (212)**

Table A.16: Level 2 Average Returned Benefits per Insured Woman

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	109 (123)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	310 (310)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	650 (627)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	762 (717)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	1,061 (986)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	1,214 (1,126)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	1,453 (1,442)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	1,955 (1,955)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	2,470 (2,402)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	3,115 (2,994)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	3,483 (3,398)
85+	[redacted]	[redacted]	[redacted]	[redacted]	3,637 (3,527)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**1,126 (1,106)**

Table A1.17: Level 2+ Average Returned Benefits per Insured Woman

Age Group	[redacted] €	[redacted] €	[redacted] €	[redacted] €	Weighted Market Average €
0-17	[redacted]	[redacted]	[redacted]	[redacted]	145 (156)
18-29	[redacted]	[redacted]	[redacted]	[redacted]	394 (367)
30-39	[redacted]	[redacted]	[redacted]	[redacted]	795 (725)
40-49	[redacted]	[redacted]	[redacted]	[redacted]	932 (866)
50-54	[redacted]	[redacted]	[redacted]	[redacted]	1,378 (1,244)
55-59	[redacted]	[redacted]	[redacted]	[redacted]	1,882 (1,561)
60-64	[redacted]	[redacted]	[redacted]	[redacted]	2,140 (1,892)
65-69	[redacted]	[redacted]	[redacted]	[redacted]	2,772 (2,526)
70-74	[redacted]	[redacted]	[redacted]	[redacted]	3,224 (3,078)
75-79	[redacted]	[redacted]	[redacted]	[redacted]	4,105 (4,324)
80-84	[redacted]	[redacted]	[redacted]	[redacted]	4,706 (4,822)
85+	[redacted]	[redacted]	[redacted]	[redacted]	4,707 (5,369)
All Ages	[redacted]	[redacted]	[redacted]	[redacted]	**2,045 (1,852)**

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 A1.18 and A1.19 below.

Table A1.18 Average Returned Benefit per Treatment Day

Insurer	Returned Benefit Paid per Treatment Day					
	July-Dec 2023	Jan-Jun 2024	12 Month Total	July-Dec 2024	Jan-Jun 2025	12 Month Total
[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]	[redacted]
Market	**€1,381**	**€1,434**	**€2,815**	**€1,498**	**€1,531**	**€3,029**

Average returned benefits per treatment day have increased across the market as a whole over the past 12 months by 7.6% (i.e. increase between July 2023 - June 2024 and July 2024 - July 2025). [redacted]

Table A1.19 Average Returned Benefit per Treatment Day Relative to Market

Insurer	Returned Benefit Paid per Treatment Day as a % of the Market Average					
	July-Dec 2023	Jan-Jun 2024	12 Month Total	July-Dec 2024	Jan-Jun 2025	12 Month Total
[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]	[redacted]
Market	**100%**	**100%**	**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 A1.20 and A1.21 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 A1.20 Average Treatment Day per Insured Person

Insurer	Average Treatment Days per Insured Person by Insurer					
	July-Dec 2023	Jan-Jun 2024	Total	July-Dec 2024	Jan-Jun 2025	Total
[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]	[redacted]
Market	**0.431**	**0.404**	**0.835**	**0.401**	**0.403**	**0.804**

Table A.21 Average Treatment Day per Insured Person as a % of the Market Average

Insurer	Average Treatment Days per Insured Person by Insurer as a % of the Market Average					
	July-Dec 2023	Jan-Jun 2024	Total	July-Dec 2024	Jan-Jun 2025	Total
[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]	[redacted]
Market	**0.431**	**0.404**	**0.835**	**0.401**	**0.403**	**0.804**

Average treatment days per insured person have reduced across the market as a whole over the past 12 months by 3.7% (i.e. decrease between July 2023 - June 2024 and July 2024 - July 2025). [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 A1.22 Age/Gender Risk Profile Index

Insurer	July-Dec 2023	Jan-Jun 2024	July-Dec 2024	Jan-Jun 2025
[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%**

[redacted]

Hospital Utilisation

Information returns include separate details of the number of hospital inpatient days and day case admissions (hospital treatment days) paid for by insurers in respect of their private patients' admissions. The total number of nights / days in the last three years to 1 July 2025 paid by the open membership undertakings is set out in Table A1.23 below.

Table A1.23 Total Number of Hospital Treatment Days

000's	Overnight	Day Case	Total	Day Case as % of Total
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%
Second Half 2024	461	368	829	44%
First Half 2025	455	383	837	46%

The data shows that the total hospital days have increased in the first half of 2025 compared to the same period in 2024. We can also see that the proportion of treatment days relating to day cases has increased, with days representing 46% of total treatment days settled in the first half of 2025 compared to 44% in 2024.

Table A1.24 Total Number of Nights/Days by Insurer - January to June 2025 (January to June 2024)

000's	[redacted]	[redacted]	[redacted]	[redacted]	Total
Day Case					
Public	[redacted]	[redacted]	[redacted]	[redacted]	47 (54)
Private	[redacted]	[redacted]	[redacted]	[redacted]	335 (312)
Total	[redacted]	[redacted]	[redacted]	[redacted]	**383 (366)**
Overnight					
Public	[redacted]	[redacted]	[redacted]	[redacted]	179 (211)
Private	[redacted]	[redacted]	[redacted]	[redacted]	276 (251)
Total	[redacted]	[redacted]	[redacted]	[redacted]	**455 (462)**
Treatment Days					
Public	[redacted]	[redacted]	[redacted]	[redacted]	226 (265)
Private	[redacted]	[redacted]	[redacted]	[redacted]	611 (563)
Total	[redacted]	[redacted]	[redacted]	[redacted]	**837 (828)**

The proportion of day cases has been volatile in recent years. Across the market, day cases represent 46% 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.

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 A1.25 Hospital Utilisation Risk Profile Index

Insurer	July-Dec 2023	Jan-Jun 2024	July-Dec 2024	Jan-Jun 2025
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[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.

[redacted]

Chart A1.2

[redacted]

Chart A1.3

HCCP Analysis

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 2026 RES Calibration was based on the 2022 exposure set. It 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 2026 RES HCCP credits were based on a 45% quota share on claims in excess of a €50,000 threshold based on rolling claims over a 12-month period. The table below shows the total claimants as a percentage of the insured population across the market included in the HCCP for different levels of excess. It can be seen that lower excess thresholds lead to a significant increase in the number of claimants being included.

Table A1.26 Total claimants as a percentage of the insured population included in the HCCP

	€50k Threshold	€40k Threshold	€30k Threshold	€20k Threshold	€10k Threshold
Percentage of Total Claimants	0.2%	0.3%	0.5%	1.0%	2.5%

Chart A1.4 below shows the impact on the total claimants as a percentage of the insured population across the market included in the HCCP at different age bands when varying the excess.

Chart A1.4

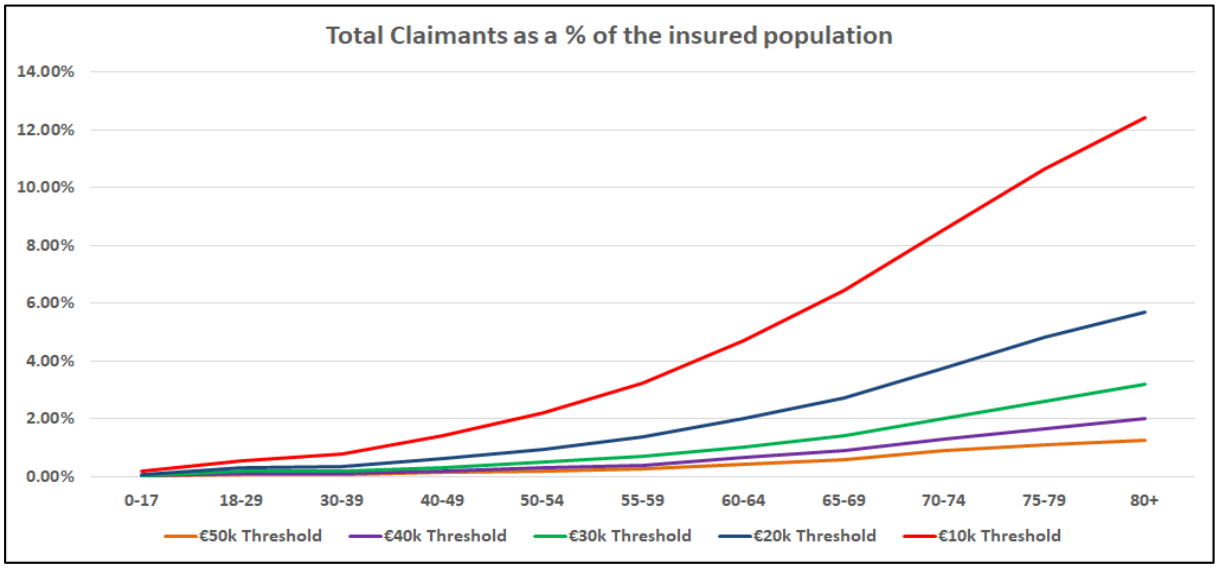


Table A1.26 below sets out the experience to date for the market for claims above the €50,000 excess threshold.

Table A1.26 Claims in excess of the HCCP excess threshold of €50,000 for Market

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	517,542	142	0.0%	11,464,397	80,735
18-29	283,550	213	0.1%	16,329,389	76,664
30-39	297,472	160	0.1%	12,589,439	78,684
40-49	365,582	387	0.1%	31,189,933	80,594
50-54	162,217	284	0.2%	22,930,143	80,740
55-59	149,189	340	0.2%	28,654,188	84,277
60-64	135,617	472	0.3%	37,456,361	79,357
65-69	121,208	621	0.5%	51,494,969	82,923
70-74	102,630	759	0.7%	65,116,269	85,792
75-79	78,733	732	0.9%	60,399,850	82,513
80+	82,492	944	1.1%	72,840,944	77,162
Total	**2,296,232**	**5,054**	**0.2%**	**410,465,883**	**81,216**

Table A1.27 & A1.28 below set out the experience to date for males and females for claims above the €50,000 excess threshold. There is a slightly higher proportion of female claimants included in the HCCP (52% females vs 48% males). This compares to an overall market population split of 51% females and 49% males.

Table A1.27 Claims in excess of the HCCP excess threshold of €50,000 for Males

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	266,924	47	0.0%	3,534,407	75,200
18-29	141,577	74	0.1%	5,489,203	74,178
30-39	140,340	57	0.0%	3,912,032	68,632
40-49	174,806	143	0.1%	12,206,819	85,362
50-54	78,687	130	0.2%	10,070,536	77,466
55-59	71,125	165	0.2%	14,333,595	86,870
60-64	64,423	230	0.4%	18,076,346	78,593
65-69	57,813	301	0.5%	24,651,605	81,899
70-74	48,717	427	0.9%	37,232,946	87,197
75-79	37,163	395	1.1%	33,170,147	83,975
80+	34,885	482	1.4%	37,373,130	77,538
Total	**1,116,460**	**2,451**	**0.2%**	**200,050,768**	**81,620**

Table A1.28 Claims in excess of the HCCP excess threshold of €50,000 for Females

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	250,618	95	0.0%	7,929,989	83,474
18-29	141,973	139	0.1%	10,840,187	77,987
30-39	157,132	103	0.1%	8,677,407	84,247
40-49	190,776	244	0.1%	18,983,114	77,800
50-54	83,529	154	0.2%	12,859,607	83,504
55-59	78,065	175	0.2%	14,320,592	81,832
60-64	71,195	242	0.3%	19,380,015	80,083
65-69	63,395	320	0.5%	26,843,364	83,886
70-74	53,914	332	0.6%	27,883,323	83,986
75-79	41,569	337	0.8%	27,229,704	80,800
80+	47,607	462	1.0%	35,467,814	76,770
Total	**1,179,772**	**2,603**	**0.2%**	**210,415,115**	**80,836**

Table A1.29 & A1.30 below set out the experience to date for advanced and non-advanced contracts for claims above the €50,000 excess threshold. Advanced contracts account for 99% of the claimants included in the HCCP. This compares to an overall market population split of 92% advanced and 8% non-advanced contracts.

Table A1.29 Claims in excess of the HCCP excess threshold of €50,000 for Advanced Contracts

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	489,558	141	0.0%	11,342,450	80,443
18-29	254,757	212	0.1%	16,256,780	76,683
30-39	262,745	159	0.1%	12,516,690	78,721
40-49	328,907	385	0.1%	30,984,910	80,480
50-54	148,510	281	0.2%	22,713,559	80,831
55-59	138,344	336	0.2%	28,326,398	84,305
60-64	127,558	471	0.4%	37,402,539	79,411
65-69	115,604	617	0.5%	51,162,125	82,921
70-74	98,987	754	0.8%	64,786,367	85,924
75-79	76,847	728	0.9%	60,048,548	82,484
80+	81,026	942	1.2%	72,717,041	77,194
Total	**2,122,843**	**5,026**	**0.2%**	**408,257,408**	**81,229**

Table A1.30 Claims in excess of the HCCP excess threshold of €50,000 for Non-Advanced Contracts

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	27,984	1	0.0%	121,947	121,947
18-29	28,793	1	0.0%	72,609	72,609
30-39	34,727	1	0.0%	72,748	72,748
40-49	36,674	2	0.0%	205,023	102,511
50-54	13,707	3	0.0%	216,585	72,195
55-59	10,845	4	0.0%	327,790	81,947
60-64	8,060	1	0.0%	53,822	53,822
65-69	5,604	4	0.1%	332,844	83,211
70-74	3,643	5	0.1%	329,902	65,980
75-79	1,886	4	0.2%	351,303	87,826
80+	1,466	2	0.1%	123,903	61,951
Total	**173,388**	**28**	**0.0%**	**2,208,475**	**78,874**

Table A1.31, A1.32 & A1.33 below set out the experience to date for the individual insurers for claims above the €50,000 excess threshold. [redacted]

Table A1.31 Claims in excess of the HCCP excess threshold of €50,000 for [redacted]

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
18-29	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
30-39	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
40-49	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
50-54	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
55-59	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
60-64	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
65-69	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
70-74	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
75-79	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
80+	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table A1.32 Claims in excess of the HCCP excess threshold of €50,000 for [redacted]

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
18-29	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
30-39	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
40-49	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
50-54	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
55-59	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
60-64	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
65-69	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
70-74	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
75-79	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
80+	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table A1.33 Claims in excess of the HCCP excess threshold of €50,000 for [redacted]

Insurer	Total Insured Population	Number of Claims	% Insured Population with Claims	Total Claim Amount	Average Claim Amount
0-17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
18-29	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
30-39	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
40-49	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
50-54	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
55-59	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
60-64	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
65-69	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
70-74	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
75-79	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
80+	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Chart A1.5 below shows the average claim amount is similar across all segments for different age bands of the insured population although the average claim amounts for non-advanced contracts are more volatile given the low number of HCCP claimants for this cohort.

Appendix 2: Risk Equalisation Credits and Stamp Duty from 1 April 2026

Table A2.1 below shows the projected membership as at 1 October 2026 (the time the average policy incepted between 1 April 2026 and 31 March 2027). Tables A2.2 to A2.4 show the projected returned benefits, hospital nights and day case admissions as at 1 April 2026. This data was used in the calculation of the stamp duty and Risk Equalisation Credits in the scenario shown below.

Returned Benefits set out in the tables below are net of HCCP claims. The Returned Benefits are used for the purposes of calibrating the Age Related Health Credits. They have been reduced for the impact of HCCP claims as otherwise there would be a double count of credits distributed.

Table A2.1 Projected Membership as at 1 October 2026

Projected Membership as at 1 October 2026				
Age Group	**Non-Advanced**		**Advanced**	
	Men	Women	Men	Women
0-17	14,851	13,626	259,879	244,913
18-29	15,793	17,748	137,469	137,299
30-39	21,104	18,947	131,412	146,940
40-49	20,194	17,935	162,974	183,335
50-54	7,358	7,134	79,177	85,012
55-59	5,777	5,588	69,970	76,355
60-64	4,247	4,168	65,057	72,870
65-69	2,994	3,079	57,414	64,558
70-74	1,960	2,024	50,040	56,648
75-79	1,240	1,243	40,018	46,478
80+	750	937	38,886	52,231
Total	**96,266**	**92,428**	**1,092,297**	**1,166,638**

Table A2.2 Projected Average Returned Benefit* at 1 April 2027 (€)

Projected Average Returned Benefit at 1 April 2026 (€)				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	48	43	122	114
18-29	52	48	319	326
30-39	59	101	344	680
40-49	119	145	556	791
50-54	214	264	885	1,112
55-59	349	257	1,374	1,258
60-64	395	364	1,907	1,540
65-69	695	549	2,628	2,078
70-74	864	698	3,269	2,642
75-79	1,061	855	4,014	3,235
80+	1,202	952	4,548	3,601
All Ages	**171**	**171**	**1,056**	**1,065**

** Returned Benefits set out in the table above are net of HCCP claims. The Returned Benefits are used for the purposes of calibrating the Age Related Health Credits. They have been reduced for the impact of HCCP claims as otherwise there would be a double count of credits distributed.*

Table A2.3 Projected Total Bed Nights at 1 April 2027

Projected Total Bed Nights at 1 April 2026				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	438	486	16,096	17,157
18-29	427	449	16,368	22,052
30-39	499	1,087	14,201	50,938
40-49	1,161	982	25,524	42,365
50-54	799	857	20,068	23,307
55-59	1,059	593	26,964	25,506
60-64	768	798	34,430	33,635
65-69	1,365	816	43,255	45,516
70-74	1,390	690	55,568	52,623
75-79	698	626	61,261	62,378
80+	1,002	721	93,736	109,016
Total	**9,607**	**8,106**	**407,470**	**484,494**

Table A2.4 Projected Total Day Case Admissions at 1 April 2027

Projected Total Day Case Admissions at 1 April 2026				
Age Group	**Non-Advanced**		**Advanced**	
	Men	**Women**	**Men**	**Women**
0-17	131	83	7,911	5,732
18-29	256	265	12,273	15,255
30-39	480	539	16,234	24,008
40-49	903	1,217	32,647	54,520
50-54	587	698	24,339	37,961
55-59	655	553	28,902	36,683
60-64	600	528	35,600	40,021
65-69	548	428	41,578	43,014
70-74	455	369	46,329	42,839
75-79	328	288	44,752	42,195
80+	171	157	42,774	44,480
Total	**5,115**	**5,125**	**333,341**	**386,709**

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 €165 is applied for overnight inpatient stays and €100 is applied for day stays. Claims inflation is assumed to be 0%, 8% 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 €8m when the contracts written prior to 1 April 2026 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 2024 – Dec 2024.

The Authority recommends that the HCCP credits are based on a 50% 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 31 December 2024 forward to 1 October 2026 (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.

- Lives under 65 are assumed to increase by 30,308 which is allocated to age bands in line with age distribution observed in the base population at 1 January 2025. 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. An allowance for mortality is included in 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. Granular population data is not available for lives aged 90 and over and these lives are assumed to have the same mortality as 95 year olds in the industry table ILT 2017 based on historical experience of population movements to date. In aggregate, lives over 65 are assumed to decrease by 5,697 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[12] (€m)
			Non-Advanced		Advanced					
	Non-Adv	Adv	Men	Women	Men	Women				
0-17	34	172	0	0	0	0	7	0	4	11
18-29	103	517	0	0	0	0	9	0	7	16
30-39	103	517	0	0	0	0	15	0	6	21
40-49	103	517	0	0	0	0	20	0	13	34
50-54	103	517	0	0	0	0	14	0	10	24
55-59	103	517	0	0	0	0	16	0	12	27
60-64	103	517	0	0	0	0	19	0	16	35
65-69	103	517	300	175	1,125	600	24	105	20	149
70-74	103	517	425	325	1,700	1,100	27	149	24	200
75-79	103	517	625	450	2,350	1,625	29	171	24	224
80+	103	517	650	500	2,750	1,875	42	206	31	279
Total							**223**	**630**	**167**	**1,020**

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

€m	[redacted]	[redacted]	[redacted]	[redacted]	Total
Age Related Health Credits	[redacted]	[redacted]	[redacted]	[redacted]	630
Hospital Bed Utilisation Credit	[redacted]	[redacted]	[redacted]	[redacted]	223
HCCP	[redacted]	[redacted]	[redacted]	[redacted]	167
Stamp Duty	[redacted]	[redacted]	[redacted]	[redacted]	(1,012)
Total	[redacted]	[redacted]	[redacted]	[redacted]	8

[12] This total credit applied is the sum of the stamp duty income of €1,012m and surplus in the fund of €8m.

Appendix 3: Analysis of Movement & Sensitivity Analysis on Credits and Stamp Duty from 1 April 2025 for Recommended Methodology

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

Table A3.1 2026 RES Calibration – Analysis of Movement

	2025 RES Calibration	Opening Adjustment	Roll Forward HCCP Claims	Model Update – Mortality Refinement	Updated Claims	Updated Returned Benefits Claims Inflation	Updated Utilisation	Updated HUC Rates	Updated Population	Updated HCCP Claims Inflation	Updated HCCP Data	Updated HCCP Quota Share	Updated RES Surplus	2026 RES Calibration
Stamp Duty														
Advanced	**€469**	€470	*€474*	*€482*	*€497*	*€513*	*€509*	*€514*	*€509*	*€514*	*€512*	€516	*€517*	**€517**
Non-Advanced	**€94**	€94	*€95*	*€96*	*€99*	*€103*	*€102*	*€103*	*€102*	*€103*	*€102*	€103	*€103*	**€103**
Claims Cost Ceiling	**140%**	140%	*140%*	*140%*	*140%*	*140%*	*140%*	*140%*	*140%*	*140%*	*140%*	140%	*140%*	**140%**
Projected RES Flows														
Stamp Duty	**€912.9m**	€916.1m	€923.5m	€943.3m	€972.3m	€1,004.4m	€996.0m	€1,006.0m	€995.4m	€1,005.1m	€1,001.6m	€1,010.0m	€1,012.3m	**€1,012.3m**
Total Credits	**€923.1m**	€924.2m	€933.6m	€954.2m	€983.0m	€1,013.7m	€1,006.8m	€1,016.1m	€1,005.0m	€1,014.4m	€1,011.6m	€1,020.1m	€1,020.1m	**€1,020.1m**
ARHC	**€576.1m (62.4%)**	€578.2m (62.6%)	€572.6m (61.3%)	€589.2m (61.8%)	€618.1m (62.9%)	€648.9m (64.0%)	€657.1m (65.3%)	€651.3m (64.1%)	€642.3m (63.9%)	€632.6m (62.4%)	€638.5m (63.1%)	€630.4m (61.8%)	€630.4m (61.8%)	**€630.4m (61.8%)**
HUC	**€220.4m (23.9%)**	€220.4m (23.9%)	€220.4m (23.6%)	€224.4m (23.5%)	€224.4m (22.8%)	€224.4m (22.1%)	€209.3m (20.8%)	€225.2m (22.2%)	€223.1m (22.2%)	€223.1m (22.0%)	€223.1m (22.1%)	€223.1m (21.9%)	€223.1m (21.9%)	**€223.1m (21.9%)**
HCCP	**€126.6m (13.7%)**	€125.5m (13.6%)	€140.5m (15.1%)	€140.5m (14.7%)	€140.5m (14.3%)	€140.4m (13.9%)	€140.3m (13.9%)	€139.6m (13.7%)	€139.6m (13.9%)	€158.7m (15.6%)	€150.0m (14.8%)	€166.6m (16.3%)	€166.6m (16.3%)	**€166.6m (16.3%)**
Effectiveness														
All Ages	**53.9%**	54.1%	*54.4%*	*54.6%*	*47.4%*	*46.0%*	*47.8%*	*48.6%*	*49.9%*	*51.7%*	*51.4%*	53.4%	*53.4%*	**53.4%**
Over 65	**58.3%**	58.5%	*58.7%*	*59.0%*	*50.6%*	*49.3%*	*50.8%*	*51.6%*	*53.0%*	*54.8%*	*54.3%*	56.3%	*56.3%*	**56.3%**
Total Projected NFI														
[redacted]														
Projected Claims & Population Metrics														
*Returned Benefits**	**€2,290.2m**	€2,290.2m	€2,275.2m	€2,307.6m	€2,368.0m	€2,466.8m	€2,466.9m	€2,467.7m	€2,455.8m	€2,436.7m	€2,445.4m	€2,428.7m	€2,428.7m	**€2,428.7m**
Claims	**€3,158.5m**	€3,158.5m	€3,159.0m	€3,200.9m	€3,247.8m	€3,368.8m	€3,377.3m	€3,377.6m	€3,348.1m	€3,349.2m	€3,349.1m	€3,349.8m	€3,349.8m	**€3,349.8m**
Population	**2.438m**	2.438m	2.438m	2.446m	2.446m	2.446m	2.446m	2.446m	2.448m	2.448m	2.448m	2.448m	2.448m	**2.448m**
Total Credits / Ret Ben	**40.3%**	40.4%	41.0%	41.3%	41.5%	41.1%	40.8%	41.2%	40.9%	41.6%	41.4%	42.0%	42.0%	42.0%
Total Credits / Claims	**29.2%**	29.3%	29.6%	29.8%	30.3%	30.1%	29.8%	30.1%	30.0%	30.3%	30.2%	30.5%	30.5%	30.5%
Ret Ben / Claims	**72.5%**	72.5%	72.0%	72.1%	72.9%	73.2%	73.0%	73.1%	73.4%	72.8%	73.0%	72.5%	72.5%	72.5%
HCCP Claim Count	**5,444**	5,444	5,902	5,902	5,902	5,902	5,902	5,902	5,902	6,445	6,644	6,644	6,644	6,644

** Returned Benefits set out in the table above are net of HCCP claims. The Returned Benefits are used for the purposes of calibrating the Age Related Health Credits. They have been reduced for the impact of HCCP claims as otherwise there would be a double count of credits distributed.*

Alternative Scenarios Considered

Below is a summary of the alternatives considered for setting credits and stamp duty from 1 April 2026.

Table A3.2 2026 RES Calibration – Alternative Scenarios

	2025 RES Calibration	Recommended 2026 RES Calibration	Alternative Scenarios		
			45% HCCP Quota Share	10% Private and 8% Consultant Claims Inflation	Claims Cost Ceiling to maintain 2025 RES Calibration adult advanced stamp duty
Stamp Duty					
Advanced	€469	€517	€513	€536	€469
Non-Advanced	€94	€103	€103	€107	€94
Claims Cost Ceiling	140%	140%	140%	140%	154%
Projected RES Flows					
Stamp Duty	€912.9m	€1,012.3m	€1,003.9m	€1,049.6m	€917.5m
Total Credits	€923.1m	€1,020.1m	€1,011.6m	€1,057.9m	€925.6m
ARHC	€576.1m (62.4%)	€630.4m (61.8%)	€638.5m (63.1%)	€651.1m (61.5%)	*€535.4m (57.8%)*
HUC	€220.4m (23.9%)	€223.1m (21.9%)	€223.1m (22.1%)	€223.1m (21.1%)	*€223.1m (24.1%)*
HCCP	€126.6m (13.7%)	€166.6m (16.3%)	€149.9m (14.8%)	€183.7m (17.4%)	*€167.1m (18.1%)*
Effectiveness					
All Ages	53.9%	53.4%	51.4%	54.2%	52.8%
Over 65	58.3%	56.3%	54.3%	57.3%	55.5%
Total Projected NFI €m					
[redacted]					
[redacted]					
[redacted]					
[redacted]					
[redacted]					
Projected Claims & Population Metrics					
*Returned Benefits**	€2,290.2m	€2,428.7m	€2,445.4m	€2,505.4m	€2,428.2m
Claims	€3,158.5m	€3,349.8m	€3,349.1m	€3,468.3m	€3,349.8m
Population	2.438m	2.448m	2.448m	2.448m	2.448m
Total Credits / Returned Benefits	40.3%	42.0%	41.4%	42.2%	38.1%
Total Credits / Claims	29.2%	30.5%	30.2%	30.5%	27.6%
Ret Ben / Claims	72.5%	72.5%	73.0%	72.2%	72.5%
HCCP Claim Count	5,444	6,644	6,644	7,103	6,644

** Returned Benefits set out in the table above are net of HCCP claims. The Returned Benefits are used for the purposes of calibrating the Age Related Health Credits. They have been reduced for the impact of HCCP claims as otherwise there would be a double count of credits distributed.*

Sensitivity of 2026 RES Calibration to Actual Experience

The 2026 RES Calibration assumes that the level of credits expected to be paid will exceed the expected stamp duty receipts, by a magnitude of €8m. 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 2027 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2027 RES 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.
- 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 2026 RES Calibration	**Select Lapses**	**Hospital Utilisation 5% Lower Than Expected**	**Increased HCCP Claims Inflation**
Additional Information		Selective Lapses for Younger Lives (5% reduction in insured population)	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 8% for consultants.
Projected RES Flows				
Stamp Duty	€1,012.3m	€961.7m	€1,012.3m	€1,012.3m
Total Credits	€1,020.1m	€1,020.1m	€1,008.9m	€1,037.2m
ARHC	€630.4m	€630.4m	*€630.4m*	*€630.4m*
HUC	€223.1m	€223.1m	*€211.9m*	*€223.1m*
HCCP	€166.6m	€166.6m	*€166.6m*	*€183.7m*
Impact on Surplus (Deficit)		(€50.6m)	€11.2m	(€17.1m)

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 2025 to 31 March 2026

Table A5.1 Risk Equalisation Credits

Age Bands	Utilisation Credits (Overnight / Day Case) From 1 April 2025	Age / Gender / Level of Cover Credits from 1 April 2025			
		Non-Advanced		Advanced	
		Men	Women	Men	Women
64 and under	€163 / €81	€0	€0	€0	€0
65-69	€163 / €81	€275	€150	€975	€525
70-74	€163 / €81	€350	€250	€1,625	€975
75-79	€163 / €81	€550	€400	€2,225	€1,500
80-84	€163 / €81	€650	€475	€2,625	€1,775
85 and above	€163 / €81	€650	€475	€2,625	€1,775

Table A5.2 Stamp Duty

Age Bands	Stamp Duties from 1 April 2025 to 31 March 2026	
	Non-Advanced	Advanced
17 and under	€351	€156
18 and over	€94	€469

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: 8% 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 €165 is made for each night that an insured person spends in a hospital.
    - A hospital utilisation credit of €100 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.