



An tÚdarás Árachas Sláinte
The Health Insurance Authority

Consultation on assumptions for Risk Equalisation Credits to apply for contracts commencing from 01 April 2027 and potential future changes to the Information Returns Regulations

02 April 2026

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

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

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

The purpose of this paper is to discuss the assumptions which will be relevant to the recommendation for contracts commencing in the period 01 April 2027 to 31 March 2028 and to seek the views of each undertaking in relation to those assumptions. We have asked specific questions on each assumption, and we ask that in your response you also provide evidence to support your views.

The Department of Health is in the process of making submissions to the European Commission on the future of the RES. The HIA has recommended some technical and operational changes to the RES. If these recommendations are accepted and implemented they would necessitate changes to the Information Returns Regulations¹. The HIA is taking this opportunity to seek views on additional changes to the Information Returns Regulations that could be implemented at the same time.

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

We ask that you submit your responses to silehanley@hia.ie and ainemurphy@hia.ie by **08 May 2026**.

Note

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

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

¹ <https://revisedacts.lawreform.ie/eli/2009/si/294/front/revised/en/html>

Key Assumptions

Setting the value of risk equalisation credits involves projecting claims, days and nights underpinning claims and membership (i.e. number of people that have a health insurance contract) in respect of contracts incepted between 01 April 2027 to 31 March 2028. This involves a projection period of 24 months from the perspective of provision of health services if we consider that the last contract could be taken out on 31 March 2028 which would then cover provision of services to 31 March 2029.

The risk equalisation credits are made up of three elements:

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

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

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

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

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

The assumptions to be determined are outlined below together with the assumptions from last year:

<i>RES Calibration</i>	<i>2026 Calibration</i>	<i>2027 Calibration</i>
Contracts	01 April 2026 to 31 March 2027	01 April 2027 to 31 March 2028
Claims Adjustment		
Base Data	31-Dec-24	TBC
Inflation		
Public	0%	TBC
Private	8%	TBC
Consultant	6%	TBC
Number of years of inflation	2.25 years	TBC
Hospital Utilisation Credits		
Overnights	€165	TBC
Day	€100	TBC
Hospital Utilisation	Night/day split: as per base year data	
High Cost Claims Pool		
Threshold	€50,000	TBC
Quota Share	50%	TBC
Rolling Claims	Yes	Yes
Insured Population Data		
Base Data	31-Dec-24	TBC
Other		
REF Surplus	€8m	TBC
Non-Adv Stamp Duty (% of Adv Stamp Duty)	20%	TBC
NCC	140%	TBC

1. Insured population

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

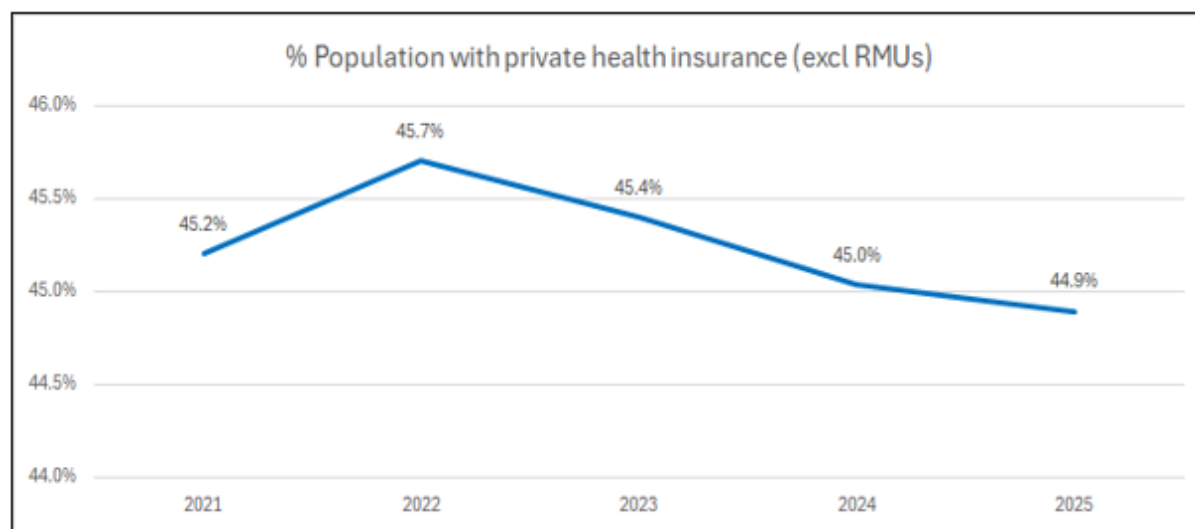
During 2025 the overall insured population increased by 27,395 lives over the 12 months to 01 January 2026 or by 1.1% compared to an increase of 25,896 or 1.1% in the previous calendar year as shown in the table below. The table shows that the insured population has continued to increase, and the market has remained resilient.

Table 1 – Insured Population

Market	01 Jan 2021	01 Jan 2022	01 Jan 2023	01 Jan 2024	01 Jan 2025	01-Jan-26
Members '000s	2,200	2,263	2,332	2,397	2,423	2,450
% Increase year on year		2.8%	3.0%	2.8%	1.1%	1.1%

The percentage of the Irish population estimated to have private health insurance (excluding restricted undertakings) has fallen slightly and is estimated to be 44.9% at the end of December 2025. This is 0.1% lower than the percentage observed at 31 December 2024. The chart below shows the movement in the percentage of population holding private health insurance over the last 5 years.

Chart 1 – Insured population by insurer



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

In revised forecasts released on 19 March 2026², the European Central Bank now expects economic growth of 0.9% in 2026, and headline inflation to average 2.6% this year. The new ECB staff projections exceptionally incorporate information up to 11 March 2026, a later cut-off date than usual. In the baseline, headline inflation is seen to average 2.6% in 2026, 2.0% in 2027 and 2.1% in 2028. Inflation has been revised up compared with the December projections, especially for 2026. This is because energy prices will be higher owing to the war in the Middle East. For inflation excluding energy and food, staff project an average of 2.3% in 2026, 2.2% in 2027 and 2.1% in 2028. This is also higher than the path in the December projections, mainly owing to higher energy prices feeding into inflation excluding energy and food. Staff expect economic growth to average 0.9% in 2026, 1.3% in 2027 and 1.4% in 2028. This implies a downward revision, especially for 2026, reflecting the global effects of the war on commodity markets, real incomes and confidence. At the same time, low unemployment, solid private sector balance sheets, and public spending on defence and infrastructure should continue to

² [Monetary policy decisions](#)

underpin growth. The ECB President Christine Lagarde has noted that the central bank was watching data closely and would respond with interest rate hikes if necessary.

The Central Bank quarterly forecasts³ notes recent developments in the Middle East presenting additional challenges for the Irish and European economies, which were already having to adapt to a shifting geopolitical situation. Higher oil and gas prices are expected to lead to lower growth and higher inflation than previously anticipated. The extent of these effects will depend on the intensity and duration of the conflict, as well as the scale of damage to critical infrastructure in the Middle East. These events underline the sensitivity of the Irish economy to global developments and the need to maintain and build resilience in the economy and public finances to less favourable geoeconomic realities than what has been the norm of recent decades, affecting trade, supply-chain security and cross-border investment. They have projected GDP growth of 1.3% in 2026 and 4.3% in 2027. Central Bank inflation forecasts, as measured by HICP are 2.9% for 2026 with a slight reduction to 2.6% in 2027.

As of 25 March 2026, the ESRI⁴ expects CPI to be 3.2% in 2026 and 2.7% in 2027, noting that a more prolonged conflict would imply higher rates with energy price rises leading to price rises across a wide range of goods and services. This generalised inflation would dampen economic activity. Their expectation is that the economy will continue to grow in 2026 and 2027, although at a slower pace – their forecast for modified domestic demand ('MDD') growth in 2026 is 2.1% followed by 2.8% in 2027.

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

As well as the total number of people with insurance the age distribution is also a consideration. Table 2 shows the historical age profile of the insured population and shows that the market continues to age. At a market level there has been a gradual ageing of the population with the proportion of the insured population over 65 increasing from 17.6% to 17.9% over the last 12 months and from 16.7% to 17.9% over the last 5 years.

Table 2 – Age profile of insured members

Market	01 Jan 2022	01 Jan 2023	01 Jan 2024	01 Jan 2025	01-Jan-26
0-17	22.7%	22.4%	22.1%	21.7%	21.3%
18-29	12.2%	12.5%	12.5%	12.5%	12.7%
30-39	12.9%	13.0%	12.9%	12.9%	12.9%
40-49	16.0%	15.9%	15.7%	15.6%	15.5%
50-59	13.6%	13.5%	13.6%	13.7%	13.8%
60-64	5.9%	5.9%	5.9%	6.0%	6.0%
65-69	5.3%	5.2%	5.3%	5.3%	5.3%
70-74	4.5%	4.4%	4.5%	4.6%	4.6%
75-79	3.4%	3.5%	3.6%	3.7%	3.8%
80-84	2.1%	2.1%	2.2%	2.3%	2.4%
85+	1.5%	1.5%	1.6%	1.7%	1.8%
64 and under	83.3%	83.2%	82.7%	82.4%	82.1%
65 and over	16.7%	16.8%	17.3%	17.6%	17.9%

³ [Quarterly Bulletin Q1 2026 \(centralbank.ie\)](https://www.centralbank.ie/publications/quarterly-bulletin/q1-2026)

⁴ [Quarterly Economic Commentary, Spring 2026 | ESRI](https://www.esri.ie/publications/quarterly-economic-commentary/spring-2026)

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

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

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

Age Group	Projected			Actual			Actual vs Projected		
	01-Jan-24	01-Jan-25	01-Jan-26	01-Jan-24	01-Jan-25	01-Jan-26	01-Jan-24	01-Jan-25	01-Jan-26
0-17	535,686	533,421	528,370	529,157	525,692	521,232	1.2%	1.5%	1.4%
18-29	301,384	304,610	305,462	299,075	302,953	310,998	0.8%	0.5%	(1.8%)
30-39	310,888	316,167	315,229	310,309	313,260	317,191	0.2%	0.9%	(0.6%)
40-49	378,839	382,380	380,632	376,437	378,333	378,845	0.6%	1.1%	0.5%
50-54	171,358	176,030	176,982	171,882	175,978	179,514	(0.3%)	0.0%	(1.4%)
55-59	155,269	156,228	156,301	153,951	155,525	157,782	0.9%	0.5%	(0.9%)
60-64	143,042	144,387	144,990	142,167	144,184	146,625	0.6%	0.1%	(1.1%)
65-69	128,089	128,090	128,799	126,076	127,774	129,294	1.6%	0.2%	(0.4%)
70-74	111,005	111,291	112,515	108,467	110,510	112,891	2.3%	0.7%	(0.3%)
75-79	90,734	90,514	91,726	87,296	89,959	92,469	3.9%	0.6%	(0.8%)
80+	103,336	89,961	102,150	92,304	97,861	103,571	12.0%	(8.1%)	(1.4%)
Total	2,429,630	2,433,078	2,443,156	2,397,121	2,422,029	2,450,412	1.4%	0.5%	(0.3%)
64 and under	1,996,466	2,013,222	2,007,965	1,982,978	1,995,925	2,012,187	0.7%	0.9%	(0.2%)
65 and over	433,164	419,856	435,191	414,143	426,104	438,225	4.6%	(1.5%)	(0.7%)

We can see at 01 January 2026, the actual insured population was higher than expected, while at 01 January 2024 and 01 January 2025, the actual insured population was lower, however in aggregate the differences are small.

As lives aged 65 and over are in receipt of age credits, differences in insured population will have a direct impact on surplus. We can see the actual population is higher for all age cohorts over 65 although the differences are small, all else considered. Where the actual insured population was more than expected, an increased level of age credits would be paid, although this would be offset by increased stamp duty, and vice versa. The same could be said in relation to HUC as older lives are more prone to hospitalisation.

Projected population for 2027 RES calibration, i.e. membership at mid-point of projection period

For the purposes of the 2026 RES calibration, the Authority projected the population at 01 January 2025 forward to 01 October 2026 to allow for the natural ageing of the insured lives. There was no allowance for any market shrinkage which is a key judgement for the population projection:

- The increase in population aged under 65 was allocated to age bands in line with age distribution observed in the base population at 01 January 2025. This approach reflects the expectation that growth in the insured population will likely occur in younger lives.
- Lives over 65 were assumed to age by 1 year within the projections which implicitly assumed older lives would not take out health insurance for the first time, and equally assumed they will not cancel their insurance, which is a simplification. In addition, an allowance for mortality was 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.

Questions

What is your estimated projection for your insured population over the period 01 April 2027 to 31 March 2029 and for the market as a whole? What is your projected population at 01 October 2027?

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

Do you expect the age profile of the insured population changing significantly between now and the projection period i.e. 01 April 2027 to 31 March 2029 and if so in what way?

Do you think the insured population at a market level will continue to grow between now and 2029?

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

2. Base Year Data

The HIA is minded to use 2025 data for the base year data from which to make projections in respect of returned benefits and utilisation rates for contracts incepted in the period 01 April 2027 to 31 March 2028. If there are changes to Hospital Utilisation Credits (HUC) and returned benefits eligibility, the HIA will adjust the base year data as appropriate.

The HIA notes the following observations:

- An increasing trend towards private hospital usage, and a corresponding decline in private patients claiming for public hospital beds.
- Day cases continue to be an increasing proportion of HUC payments, and there appears to be a general move towards day treatments in preference to overnight stays.
- Overcrowding and high waiting lists are a feature currently being observed in the public hospital system. These issues could in turn impact on the level of private usage within public hospitals. Given the level of the waiting lists, the HIA does not expect that the waiting lists will be sufficiently cleared by the end of exposure period, in respect of contracts entered into in the period 01 April 2027 – 31 March 2028, to significantly change the hospitalisation patterns observed in public hospitals in 2025.

Questions

Do you agree to the use of 2025 data as the base data for projections? If not, what would you propose and why?

3. Utilisation

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

Information returns include separate details of the number of hospital in-patient days and day case admissions (hospital days) paid for by insurers in respect of their private patients' admissions. The total number of nights/ days paid by the open membership undertakings since the first half of 2022 is set out in Table 4. We note there are distortions in the below information caused by historical data issues. We have not been provided with revised returns for prior periods which would impact the information presented below. We note that certain registered undertakings have included ineligible claims in their information returns. The below data has not been adjusted to correct this.

Table 4 – Total number of hospital days

€m's	Overnight	Day case	Total	% Relating to days
First Half 2022	459	320	779	41%
Second Half 2022	475	334	810	41%
2022 Total	934	655	1,589	41%
First Half 2023	478	355	833	43%
Second Half 2023	505	372	877	42%
2023 Total	983	727	1,710	43%
First Half 2024	462	366	828	44%
Second Half 2024	461	368	829	44%
2024 Total	923	734	1,657	44%
First Half 2025	455	383	837	46%
Second Half 2025	427	399	826	48%
2025 Total	882	781	1,663	47%

The data shows that the total hospital days remained relatively stable. We can also see that the proportion of treatment days relating to day cases has increased, with days representing 47% of total treatment days settled in 2025 compared to 44% in 2024 and 43% in 2023. Thus, while the total number of hospital days has remained relatively stable relative to 2024 the increase in the number of day cases has been offset by a reduction in the number of overnight stays.

Day cases increased in 2025 to 781k compared to 734k in 2024 while overnight stays reduced in 2025 to 882k compared to 923k in 2024. Day cases tend to typically be settled faster than overnight stays. Higher throughput for day procedures in private hospitals together with shorter lengths of stays for overnight procedures may also be a contributing factor. The question remains, will this increase in days be a permanent feature and will the proportion of day cases continue to grow.

In order to project utilisation rates for the 2027 RES calibration, the average overnight stays and day case days per insured person for the 12 months from January 2025 to end December 2025 by age group/gender/level of cover/insurer will be used. The HIA then must apply an assumption regarding growth in utilisation for the 2027 RES calibration period i.e. utilisation uplift. Adjustments may also be included for any upcoming HUC eligibility changes.

Table 5 shows a 4-year history of the annual percentage change in hospital stays, e.g., for 2025 the data shown is the percentage change in days/nights in the 12 month period ending in December 2025 relative to the twelve month period ending in December 2024. The increase in 2022 is indicative of increased activity relative to the previous 2 years which was heavily disrupted by the pandemic and the HSE cyber-attack. The level of hospitalisation has increased slightly in 2025 which is driven by an increase in day case activity which was offset by a reduction in overnight stays.

Table 5 – Annual percentage change in Hospital Stays

Market	2022	2023	2024	2025
Nights	20%	5%	(6%)	(4%)
Days	12%	11%	1%	6%
Nights & Days	17%	8%	(3%)	0%

The historical change in average nights/days by insured person (i.e. utilisation rates) at each age is outlined below. Whilst the HIA notes that there have been historical data issues from the insurers in submitting this information which will have an impact on the analysis, the HIA does not consider that it would change the overall trends emerging. Both days and nights increased substantially in 2022 which continued through to 2023 particularly for days where material increases were experienced. Nights have reduced at all ages with the exception of the 40-49 cohort in 2025 with an overall reduction of 6% relative to the levels observed in 2024.

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

Market	2022	2023	2024	2025
0-17	32%	(1%)	(20%)	(14%)
18-29	(2%)	(7%)	(8%)	(7%)
30-39	6%	(6%)	(5%)	(0%)
40-49	14%	(6%)	(9%)	1%
50-54	7%	2%	(9%)	(1%)
55-59	11%	(2%)	(5%)	(5%)
60-64	17%	(3%)	(7%)	(3%)
65-69	18%	0%	(6%)	(4%)
70-74	19%	4%	(9%)	(8%)
75-79	19%	3%	(9%)	(11%)
80-84	20%	3%	(11%)	(11%)
85+	22%	4%	(12%)	(11%)
Total	17%	2%	(8%)	(6%)

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

Market	2022	2023	2024	2025
0-17	19%	1%	(5%)	1%
18-29	1%	5%	(6%)	2%
30-39	4%	2%	(1%)	4%
40-49	7%	7%	(2%)	4%
50-54	12%	10%	0%	2%
55-59	12%	7%	(2%)	5%
60-64	11%	7%	(1%)	6%
65-69	9%	6%	1%	5%
70-74	10%	6%	(3%)	4%
75-79	9%	5%	(3%)	3%
80-84	8%	7%	0%	6%
85+	6%	7%	0%	6%
Total	17%	7%	(1%)	5%

There is also a physical limit to capacity and supply of beds. Some supply in private hospitals is also being taken up by the HSE but it is uncertain as to the extent that this will occur in future years. The Bon Secours opened up a new hospital in Ballysimon, Limerick, late in 2025, and the National Children's Hospital in Dublin is now expected to open to patients in autumn 2027.

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

Table 8 – Change in nights between 2024 and 2025:

Market	Total Nights claimed 2024	Total Nights claimed 2025	Average per Insured person 2024	Average per Insured person 2025	% Difference in Average
0-17	33,591	28,893	0.065	0.056	(14%)
18-29	38,968	36,789	0.130	0.121	(7%)
30-39	65,806	66,486	0.213	0.214	(0%)
40-49	69,310	70,533	0.184	0.187	1%
50-54	44,453	44,929	0.254	0.254	(1%)
55-59	53,784	51,511	0.347	0.330	(5%)
60-64	69,151	67,825	0.481	0.468	(3%)
65-69	91,038	88,620	0.713	0.691	(4%)
70-74	110,537	104,103	1.002	0.935	(8%)
75-79	127,438	116,415	1.421	1.278	(11%)
80-84	107,520	101,491	1.917	1.757	(11%)
85+	111,090	104,427	2.635	2.416	(11%)
All Ages	922,686	882,022	0.384	0.365	(6%)
64 and under	375,063	366,966	0.189	0.185	(3%)
65 and over	547,623	515,056	1.286	1.193	(9%)

The table above highlights average nights per insured person have fallen for the majority of age cohorts in the period.

Table 9 – Change in days between 2024 and 2025:

Market	Total Days claimed 2024	Total Days claimed 2025	Average per Insured person 2024	Average per Insured person 2025	% Difference in Average
0-17	13,638	13,710	0.026	0.026	1%
18-29	27,832	28,723	0.093	0.095	2%
30-39	40,730	42,840	0.132	0.138	4%
40-49	88,350	92,228	0.235	0.245	4%
50-54	62,767	65,810	0.359	0.373	2%
55-59	66,260	70,520	0.427	0.452	5%
60-64	76,163	81,759	0.530	0.565	6%
65-69	85,748	91,462	0.672	0.713	5%
70-74	90,146	95,382	0.817	0.856	4%
75-79	89,137	94,386	0.994	1.036	3%
80-84	57,421	64,501	1.024	1.117	6%
85+	35,857	40,101	0.850	0.928	6%
All Ages	734,049	781,422	0.305	0.323	5%
64 and under	375,740	395,590	0.190	0.199	4%
65 and over	358,309	385,832	0.841	0.894	5%

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

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

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

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

Age Group	Projected			Actual			Actual vs Projected		
	2023	2024	2025	2023	2024	2025	2023	2024	2025
0-17	44,669	42,785	34,092	41,689	33,591	28,893	(6.7%)	(21.5%)	(15.3%)
18-29	47,466	42,608	39,208	41,742	38,968	36,789	(12.1%)	(8.5%)	(6.2%)
30-39	76,226	69,799	66,556	67,855	65,806	66,486	(11.0%)	(5.7%)	(0.1%)
40-49	83,564	76,707	69,860	75,122	69,310	70,533	(10.1%)	(9.6%)	1.0%
50-54	48,359	49,184	44,921	47,575	44,453	44,929	(1.6%)	(9.6%)	0.0%
55-59	59,522	56,795	54,013	55,713	53,784	51,511	(6.4%)	(5.3%)	(4.6%)
60-64	78,228	74,572	69,489	73,125	69,151	67,825	(6.5%)	(7.3%)	(2.4%)
65-69	97,981	97,210	91,154	95,747	91,038	88,620	(2.3%)	(6.3%)	(2.8%)
70-74	116,238	121,604	110,898	118,328	110,537	104,103	1.8%	(9.1%)	(6.1%)
75-79	136,838	138,864	126,271	134,498	127,438	116,415	(1.7%)	(8.2%)	(7.8%)
80+	224,856	222,155	211,482	231,765	218,610	205,918	3.1%	(1.6%)	(2.6%)
Total	1,013,948	992,282	917,944	983,159	922,686	882,022	(3.0%)	(7.0%)	(3.9%)
64 and under	438,035	412,450	378,140	402,821	375,063	366,966	(8.0%)	(9.1%)	(3.0%)
65 and over	575,913	579,832	539,805	580,338	547,623	515,056	0.8%	(5.6%)	(4.6%)

The table above highlights that actual overnight stays in 2025 were 3.9% behind expectation. We can see in each of the years that the projected bed nights exceeded actual experience due to the trend of overnight stays being replaced with day-cases.

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

Age Group	Projected			Actual			Actual vs Projected		
	2023	2024	2025	2023	2024	2025	2023	2024	2025
0-17	14,955	14,647	13,825	14,318	13,638	13,710	(4.3%)	(6.9%)	(0.8%)
18-29	29,240	29,679	27,990	29,240	27,832	28,723	(0.0%)	(6.2%)	2.6%
30-39	41,890	41,601	41,159	40,390	40,730	42,840	(3.6%)	(2.1%)	4.1%
40-49	87,504	91,428	89,063	89,425	88,350	92,228	2.2%	(3.4%)	3.6%
50-54	57,767	62,822	63,436	60,670	62,767	65,810	5.0%	(0.1%)	3.7%
55-59	65,541	68,268	66,651	67,003	66,260	70,520	2.2%	(2.9%)	5.8%
60-64	73,687	77,044	76,595	75,351	76,163	81,759	2.3%	(1.1%)	6.7%
65-69	81,653	85,268	85,759	83,826	85,748	91,462	2.7%	0.6%	6.6%
70-74	88,772	93,763	90,504	91,221	90,146	95,382	2.8%	(3.9%)	5.4%
75-79	88,895	91,659	88,488	88,223	89,137	94,386	(0.8%)	(2.8%)	6.7%
80+	83,185	85,029	90,580	87,453	93,278	104,602	5.1%	9.7%	15.5%
Total	713,088	741,209	734,052	727,120	734,049	781,422	2.0%	(1.0%)	6.5%
64 and under	370,583	385,489	378,720	376,397	375,740	395,590	1.6%	(2.5%)	4.5%
65 and over	342,505	355,719	355,332	350,723	358,309	385,832	2.4%	0.7%	8.6%

The table above highlights that actual day cases in 2025 were 6.5% ahead of expectation.

Questions

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

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

What have been the main drivers of change in the number and cost of day cases settled by your company in 2025?

What have been the main drivers of change in the number and cost of overnight cases settled by your company in 2025?

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

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

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

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

Please provide the number of treatment days and nights in each of the following settings over 2025:

- ***Satellite oncology centres***
- ***Remote Psychiatric***
- ***Surgical day hospitals***

Please include any definitions you use to allocate care to these centres.

4. Claims

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

The total claims payments made by the open market insurers over the last 4 years are outlined in Table 12. Claims levels continue to grow year on year with total claims in 2025 being 9.6% higher compared to 2024.

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

€m's	2022	2023	2024	2025
Total Claims	2,472	2,850	3,025	3,316
Returned Benefits	2,042	2,311	2,429	2,609
Private	1,146	1,342	1,485	1,691
Public	418	429	380	312
Consultant	478	540	564	606

Table 13 – Returned benefits⁵ by category

€m's	2022	2023	2024	2025
Returned Benefits / Claims	83%	81%	80%	79%
Split of Returned Benefits				
Private	56%	58%	61%	65%
Public	20%	19%	16%	12%
Consultant	23%	23%	23%	23%

The benefits excluded from returned benefits are primarily claims in respect of out-patient benefits which are not included in the RES. As we can see from Table 13 the proportion of total returned benefits to total claims continues to reduce year on year.

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

Questions

What is your view of claims inflation and the view of claims inflation relating to private hospitals, public hospitals, and consultants over the period 2026 - 2028?

What percentage of your claims is projected to relate to public hospitals, private hospitals, and consultants over the period 2026 – 2028?

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

Average claim per member

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

Table 14 – Average returned benefits

Market	2022	2023	2024	2025
0-17	126	130	114	106
18-29	276	277	283	285
30-39	438	445	451	469
40-49	551	586	600	643
50-54	815	902	926	991
55-59	1,063	1,174	1,226	1,315
60-64	1,460	1,592	1,623	1,741
65-69	1,960	2,144	2,252	2,392
70-74	2,579	2,874	2,901	3,052
75-79	3,372	3,699	3,671	3,831
80-84	3,825	4,226	4,247	4,424
85+	4,198	4,637	4,475	4,547
Total	906	992	1,016	1,079

The average returned benefits have increased for all age groups in 2025, excluding 0-17, which continues the trend of growth in average returned benefits observed in 2023 and 2024.

Table 15 below shows the percentage change in the average returned benefit per insured person for all levels of cover in a 12-month period relative to the previous 12 months, e.g. for 2025 the data shown is the percentage change in average returned benefits per insured person from the 12 month period ending in December 2024 to the twelve month period ending in December 2025.

Table 15 – Change in average returned benefits relative to prior 12 months

Market	2023	2024	2025
0-17	3%	(12%)	(8%)
18-29	1%	2%	1%
30-39	2%	1%	4%
40-49	6%	2%	7%
50-54	11%	3%	7%
55-59	10%	4%	7%
60-64	9%	2%	7%
65-69	9%	5%	6%
70-74	11%	1%	5%
75-79	10%	(1%)	4%
80-84	11%	0%	4%
85+	10%	(3%)	2%
Total	9%	2%	6%

The average returned benefit has fallen for the 0-17 cohort but has increased for all other age groups when compared to 2024.

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

Table 16 – Average consultant element of returned benefits

Market	2022	2023	2024	2025
0-17	32	34	31	30
18-29	69	72	72	75
30-39	113	115	116	121
40-49	149	161	163	173
50-54	217	239	245	260
55-59	273	302	309	327
60-64	358	391	394	423
65-69	461	506	521	548
70-74	587	650	650	686
75-79	734	792	794	833
80-84	764	831	844	894
85+	690	745	726	764
Total	212	232	236	251

Table 17 – Change in average consultant element of returned benefits relative to prior 12 months

Market	2023	2024	2025
0-17	8%	(9%)	(5%)
18-29	4%	1%	3%
30-39	2%	1%	4%
40-49	8%	1%	6%
50-54	10%	3%	6%
55-59	11%	2%	6%
60-64	9%	1%	7%
65-69	10%	3%	5%
70-74	11%	0%	5%
75-79	8%	0%	5%
80-84	9%	2%	6%
85+	8%	(2%)	5%
Total	9%	2%	6%

Table 18 – Average private hospital element of returned benefits

Market	2022	2023	2024	2025
0-17	34	38	39	40
18-29	159	163	177	180
30-39	172	189	203	225
40-49	305	336	359	403
50-54	480	546	586	646
55-59	634	720	788	879
60-64	881	988	1,050	1,169
65-69	1,171	1,327	1,462	1,618
70-74	1,544	1,762	1,865	2,074
75-79	2,017	2,262	2,319	2,585
80-84	2,159	2,456	2,614	2,972
85+	2,178	2,518	2,601	2,942
Total	509	576	621	699

Table 19 – Change in average private hospital element of returned benefits relative to prior 12 months

Market	2023	2024	2025
0-17	13%	2%	3%
18-29	2%	9%	2%
30-39	10%	7%	11%
40-49	10%	7%	12%
50-54	14%	7%	10%
55-59	14%	10%	12%
60-64	12%	6%	11%
65-69	13%	10%	11%
70-74	14%	6%	11%
75-79	12%	3%	11%
80-84	14%	6%	14%
85+	16%	3%	13%
Total	13%	8%	13%

Table 20 – Average public hospital element of returned benefits

Market	2022	2023	2024	2025
0-17	60	58	44	36
18-29	48	43	34	30
30-39	153	141	132	123
40-49	97	89	77	67
50-54	118	116	96	85
55-59	156	152	129	109
60-64	221	212	180	149
65-69	328	311	269	225
70-74	447	462	386	292
75-79	621	645	558	413
80-84	901	939	789	558
85+	1,330	1,374	1,148	840
Total	186	184	159	129

Table 21 – Change in average public hospital element of returned benefits relative to prior 12 months

Market	2023	2024	2025
0-17	(5%)	(23%)	(19%)
18-29	(10%)	(22%)	(11%)
30-39	(8%)	(6%)	(7%)
40-49	(8%)	(13%)	(14%)
50-54	(1%)	(18%)	(12%)
55-59	(3%)	(15%)	(16%)
60-64	(4%)	(15%)	(17%)
65-69	(5%)	(14%)	(16%)
70-74	3%	(17%)	(24%)
75-79	4%	(13%)	(26%)
80-84	4%	(16%)	(29%)
85+	3%	(16%)	(27%)
Total	(1%)	(14%)	(19%)

The overall level of claims is impacted by several factors. One of the drivers is the mix between procedures in public and private hospitals which is evidenced in the tables above. Public hospital charges are set by the HSE/Department of Health. Claims in public hospitals accounted for approximately 12% of total claims in 2025 (16% in 2024). Assuming no change in the daily rate charged for private patients in public hospitals, this leaves an estimated 88% of claims which may be subject to inflation. Therefore, it is important to understand the expected source of claims.

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

The method for projecting the average returned benefit per insured person for renewals from 01 April 2027 is to project an increase of x% p.a. over the term of the projection to the actual age specific market claims cost per insured person determined for the 12 months to end December 2025. These costs are inflated separately for public hospital, private hospital and consultant. This allows for inflation from 2025 to the midpoint of the projection period.

This assumption does not include the impact of changing demographics which is provided for in the population projections which will further contribute to claims inflation.

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

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

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

Age Group	Projected			Actual			Actual vs Projected		
	2023	2024	2025	2023	2024	2025	2023	2024	2025
0-17	69	70	61	67	60	55	(3.4%)	(14.3%)	(10.8%)
18-29	88	87	89	81	84	86	(8.1%)	(2.4%)	(3.1%)
30-39	143	142	143	133	138	146	(7.0%)	(2.9%)	1.7%
40-49	222	231	233	216	225	242	(2.4%)	(2.5%)	4.2%
50-54	146	159	163	150	160	175	3.0%	0.3%	7.6%
55-59	171	184	190	177	189	205	3.7%	2.4%	8.1%
60-64	215	229	234	220	232	252	2.4%	1.3%	7.8%
65-69	253	274	287	265	285	307	4.8%	4.0%	6.8%
70-74	283	308	320	303	317	340	7.1%	2.8%	6.2%
75-79	292	310	322	308	324	349	5.4%	4.6%	8.2%
80+	340	357	409	390	414	452	15.0%	16.2%	10.6%
Total	2,221	2,351	2,451	2,311	2,429	2,609	4.1%	3.3%	6.4%
64 and under	1,054	1,102	1,112	1,045	1,088	1,161	(0.9%)	(1.3%)	4.4%
65 and over	1,167	1,249	1,339	1,266	1,341	1,448	8.5%	7.3%	8.2%

We can see from the above tables that in 2025, the actual returned benefits were 6.4% higher than projected which continues the trend observed in 2024 when actual returned benefits were 3.3% higher than expected. The impacts are more pronounced for older lives, as the reverse can be seen for younger ages. The differences will have been impacted by the projected insured population, projected utilisation (level and location) and projected claims amounts. The market has seen high levels of claims activity and claims inflation, and the key question is whether this experience will be repeated in the future.

Questions

What are your forecasts for your split of claims over the 2027/2028 period between public, private hospital and consultant?

What are your projections for your projected average claim per insured person over the period 2027/2028 and how does this differ between public, private and consultant?

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

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

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

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

Do you expect variation of returned benefits inflation by age cohort? If so please provide your view of expected inflation by age cohort at the level of granularity you have available.

5. High Cost Claims Pool Parameters

The HCCP is currently calibrated such that HCCP credits are based on a 50% quota share on claims in excess of €50,000 on a rolling 12 month basis for policies written on or after 01 April 2025. For policies written between 01 April 2024 and 31 March 2025 the quota share rate was 45%. For policies written between 01 April 2022 and 31 March 2024 the quota share rate was 40%.

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

It should be noted that the rolling HCCP allowance for policies written after 01 April 2027 is proposed to be reduced from 70% to 32.5% which will reduce the level of HCCP credits, all else being equal. The updated calibration is based on analysis performed on the latest individual HCCP data in respect of individual claims provided by the insurers, dating back to 2016. The reduced calibration reflects emerging experience and a more complete dataset compared to that available for original calibration of 70% for RES 2022. It should be noted that the calibration of the rolling allowance is dependent on the level of the claims excess and it has been observed by the Authority that the rolling allowance reduces in line with reductions in the claims excess.

The estimated size of the credits to be distributed in respect of the HCCP for the 2026 RES calibration was €166.6m or 16.3% of the overall credit (2025 calibration: €126.6m or 13.7%, 2024 calibration: €108.1m or 12.5%). The increase in HCCP credits for the 2026 calibration was largely driven by the increase in the quota share from 45% to 50% and also high levels of medical cost inflation observed which have increased claims costs without corresponding increases in the level of hospital utilisation.

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

The HIA will consider if changes to the quota share or threshold are warranted to increase the proportion of claims allocated to health-related credits.

Questions

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

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

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

6. Child Stamp Duty Rates

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

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

	2022	2023	2024	2025
Market				
Child Members (0-17)	62.5	64.5	57.3	53.0
Adult Members (18+)	556.0	607.1	628.3	666.4
Child / Adult	11.2%	10.6%	9.1%	8.0%
Non-Advanced Contracts				
Child Members (0-17)	28.0	24.3	22.1	14.5
Adult Members (18+)	116.7	105.0	92.4	78.9
Child / Adult	23.9%	23.2%	23.9%	18.4%
Advanced Contracts				
Child Members (0-17)	64.5	66.7	59.2	55.1
Adult Members (18+)	594.9	650.2	675.0	719.1
Child / Adult	10.8%	10.3%	8.8%	7.7%

The above table sets out the average returned benefits for child members versus adult members for advanced contracts, non-advanced contracts and the market as a whole over the last four years. On average over the period, average returned benefits for child members were 9.7% of adults for the market, 22.3% for non-advanced contracts and 9.4% for advanced contracts.

Questions

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

7. Rationale for the Recommendations

The purpose of this paper is to discuss assumptions in advance of the calibration of the RES which will be carried out later in the year. Whilst each individual assumption must be justifiable and within the range of reasonableness, it is the combined impact of the assumptions which will impact the recommendations to be made in relation to stamp duties and risk equalisation credits. The HIA has set out its current thinking, but this does not in any way pre-determine the outcome of the recommendation to be made to the Minister in September 2026.

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

In recommending the credits and stamp duties in respect of new contracts commenced in the period 01 April 2027 – 31 March 2028, the HIA will consider the most up to date data available to it, the market circumstances at that time and the estimated surplus within the Risk Equalisation Fund. Any changes between now and the calibration will be considered as will the information returns submitted in July 2026.

Questions

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

8. Information Returns

The HIA is taking this opportunity to seek views on additional changes to the Information Returns Regulations that could be made concurrently with the implementation of any changes to the RES being considered by the Department of Health. The HIA is open to views of insurers, but notes these views carry most weight when they are supported by evidence.

The HIA is considering the benefit of requiring returned benefits for day and night treatment in private hospitals to be reported separately. More granular information will support the RES calibration, allowing the RES to operate more efficiently.

The regulations require an opinion from an independent accountant. The HIA is considering whether a “Reasonable Assurance” Report would be more appropriate.

The HIA is considering removal of the requirement to report prescribed benefits. This would reduce the reporting burden on insurers.

There is currently no time limit on inclusion of historical claims in the Information Returns. The HIA is considering adding a limit on the lookback. For example, claims that are ineligible for RES credits to be excluded from returned benefits and CCV.

The HCCP Information Returns are required to be prepared with reference to the Reimbursement List established by the Health Service Executive under section 17 of the Health (Pricing and Supply of Medical Goods) Act 2013. The HIA is considering updating the regulations so that the HCCP return is prepared with reference to “Health Service Executive approved drugs” as defined in Section 6A of the Health Insurance Act. This would allow greater consistency between reporting for claims and for Information Returns.

Data in respect of members who are aged 90 and above is currently required to be consolidated. The HIA is considering removing this extra step of consolidation.

Questions

Do you foresee reporting difficulties with any of these potential changes?

Do you have opinions for or against any of these potential changes?

Are there any other changes to the Information Returns Regulations that you think would streamline reporting or benefit the quality of data collected?