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 2022 to 30 June 2023, including advice on Risk Equalisation Credits**

**29 September 2023**

# 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 2024 to 31 March 2025.

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 2023 to 30 June 2023, 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 increases the effectiveness of the RES from 50.4% to 64.9% based on the Authority's defined measure of effectiveness[1];
- The recommendation is allocating more credits based on health status across all ages and is sharing risk for low incidence high-cost claims. This is contributing to more targeted distribution of health-related credits;
- Stamp duty for advanced products has reduced compared to the current calibration (2023/2024 Calibration: €438 vs 2024/2025 Calibration: €420). The reduction in stamp duty should serve to address concerns about affordability and stability of the market. The Authority is of the view that it is fair that consumers get the full benefit of this reduction in stamp duty and that it should be incorporated into the insurer's product pricing.

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

If actual experience is in line with expectation this means that no surplus will exist when the credits and stamp duty on all contracts that commence in advance of 1 April 2025 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2025/2026 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.

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

The remainder of this report is laid out as follows:

[1] "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.

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 2024 to 31 March 2025 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 recommendation and the key metrics considered when making the recommendation.

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

### *Note*

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

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

## 2. Background and Recommendations

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

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 2024/2025 RES calibration, i.e. for health insurance contracts entered into in the period 1 April 2024 to 31 March 2025.

The report also contains an evaluation and analysis of the Information Returns[2] received by the Authority from undertakings for the 6-month period commencing on 1 January 2023.

### 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 2024 and 31 March 2025, in order to support the risk equalisation credits, are as follows:

Table 2.1 Stamp Duty Recommendation for Contracts Incepted 1 April 2024 – 31 March 2025

| **Age Band** | **Stamp Duties from 1 April 2024 to 31 March 2025** | | **Stamp Duties from 1 April 2023 to 31 March 2024** | | **Change** | |
|---|---|---|---|---|---|---|
| | Non-Advanced | Advanced | Non-Advanced | Advanced | Non-Advanced | Advanced |
| **17 and Under** | €35 | €140 | €36 | €146 | (€1) | (€6) |
| **18 and Over** | €105 | €420 | €109 | €438 | (€4) | (€18) |

The recommendation is to utilise the €25m surplus expected to exist in the REF (when the credits and stamp duty on all contracts that commence in advance of 1 April 2024 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 €30m

[2] Under the Health Insurance Act 1994 (Information Returns) Regulations 2009, Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2011 and Health Insurance Act 1994 (Information Returns) (Amendment) Regulations 2013.

compared to the 2023/2024 Calibration when the surplus was €55m. Overall, for the 2024/2025 Calibration, the level of credits to be paid are expected to exceed the stamp duty receipts, by a magnitude of €25m.

The reduction in stamp duty on advanced plans is primarily driven by a reduction in the projected average returned benefits. Returned benefits are based on the latest 2022 claims data compared to the pre COVID-19 2019 claims data used to calibrate the 2023/2024 RES.

In last year's report the Authority noted that if the surplus in the REF was not applied to the 2023/2024 stamp duty, advanced stamp duties for adults would have been set at €474, as opposed to €438, and the non-advanced adult stamp duty would have been €118, as opposed to €109. With a smaller surplus available for the 2024/2025 stamp duty (as the gap between expected and actual credits paid to date was reduced), the stamp duty would increase in 2024/2025, all other things being equal.

The Authority notes that if the surplus in the REF was not applied to the 2024/2025 stamp duty, advanced stamp duties for adults would be €436, as opposed to €420, and the non-advanced adult stamp duty would be €109, as opposed to €105.

### 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 2024 and 31 March 2025.

Table 2.2 Risk Equalisation Credits for Contracts Incepted 1 April 2024 – 31 March 2025

| | **Proposed 2024 RES Calibration** | | | | **Change From Current Credits** | | | |
|---|---|---|---|---|---|---|---|---|
| **Age Related Health Credits** | | | | | | | | |
| | Non-Advanced | | Advanced | | Non-Advanced | | Advanced | |
| | Male | Female | Male | Female | Male | Female | Male | Female |
| 64 and Under | €0 | €0 | €0 | €0 | €0 | €0 | €0 | €0 |
| 65-69 | €250 | €150 | €850 | €425 | (€100) | (€50) | (€100) | (€100) |
| 70-74 | €425 | €300 | €1,375 | €925 | (€100) | (€100) | (€175) | (€150) |
| 75-79 | €600 | €475 | €2,025 | €1,450 | (€175) | (€100) | (€275) | (€200) |
| 80-84 | €700 | €500 | €2,425 | €1,600 | (€200) | (€125) | (€300) | (€350) |
| 85+ | €700 | €500 | €2,425 | €1,600 | (€300) | (€200) | (€575) | (€450) |
| **Hospital Utilisation Credit** | | | | | | | | |
| | Night | | Day | | Night | | Day | |
| | €163 | | €81 | | €38 | | €6 | |
| **Hight Cost Claims Pool (HCCP)** | | | | | | | | |
| Quota Share | 45.0% | | | | 5.0% | | | |
| 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% (2023/2024: 140%) of the average net claims cost across all lives.

The Authority recommends the HUC are set at 20% of the current charges for day cases and overnight admission as a private patient in a public hospital. These amounts are recommended to be rounded to the nearest whole euro and to remain as fixed amounts.

The Authority recommends that the HCCP credits for 2024/2025 are based on a 45% quota share on claims in excess of €50,000. The excess is unchanged from the 2023/2024 RES while the quota share has been increased by 5.0% (2023/2024 RES: 40%). We note the calibration of the 2023/2024 RES was updated to allow for rolling HCCP claims which resulted in an increase in proportion of total credits allocated to HCCP credits (2022/2023 Calibration: 6.5% vs 2023/2024 Calibration: 11.4%). The combination of data updates and the increase to the quota share results in estimated size of the credits to be distributed in respect of the HCCP for the 2024/2025 RES calibration being €108.1m or 12.5% of the overall credits. Further detail is available in Section 4.2.

The table below sets out the split of total RES credits paid out by different age cohorts for the 2024/2025 and 2023/2024 RES calibrations.

Table 2.3 Split of Total RES Credits Paid by Age Cohort

| Age Cohort | Age Credit | HUC | HCCP | Total Credits |
|---|---|---|---|---|
| | **Recommended 2024/2025 Calibration** | | | |
| 0-17 | 0.0 (0.0%) | 8.6 (72.6%) | 3.2 (27.4%) | 11.8 (100.0%) |
| 18-29 | 0.0 (0.0%) | 10.2 (78.6%) | 2.8 (21.4%) | 13.0 (100.0%) |
| 30-39 | 0.0 (0.0%) | 16.0 (79.1%) | 4.2 (20.9%) | 20.2 (100.0%) |
| 40-49 | 0.0 (0.0%) | 20.9 (72.7%) | 7.9 (27.3%) | 28.8 (100.0%) |
| 50-54 | 0.0 (0.0%) | 12.7 (70.5%) | 5.3 (29.5%) | 18.0 (100.0%) |
| 55-59 | 0.0 (0.0%) | 15.2 (65.1%) | 8.1 (34.9%) | 23.3 (100.0%) |
| 60-64 | 0.0 (0.0%) | 18.9 (63.7%) | 10.8 (36.3%) | 29.7 (100.0%) |
| 65-69 | 78.3 (68.1%) | 22.6 (19.7%) | 14.1 (12.3%) | 115.0 (100.0%) |
| 70-74 | 123.2 (74.4%) | 26.1 (15.8%) | 16.2 (9.8%) | 165.5 (100.0%) |
| 75-79 | 153.5 (77.6%) | 29.5 (14.9%) | 14.9 (7.5%) | 197.9 (100.0%) |
| 80+ | 180.0 (73.8%) | 43.3 (17.8%) | 20.7 (8.5%) | 243.9 (100.0%) |
| **Total** | **534.9 (61.7%)** | **224.0 (25.8%)** | **108.1 (12.5%)** | **867.0 (100.0%)** |
| | **2023/2024 Calibration** | | | |
| 0-17 | 0.0 (0.0%) | 8.8 (72.9%) | 3.3 (27.1%) | 12.0 (100.0%) |
| 18-29 | 0.0 (0.0%) | 8.2 (76.9%) | 2.5 (23.1%) | 10.7 (100.0%) |
| 30-39 | 0.0 (0.0%) | 13.9 (78.8%) | 3.7 (21.2%) | 17.6 (100.0%) |
| 40-49 | 0.0 (0.0%) | 18.5 (72.2%) | 7.1 (27.8%) | 25.6 (100.0%) |
| 50-54 | 0.0 (0.0%) | 11.0 (69.5%) | 4.9 (30.5%) | 15.9 (100.0%) |
| 55-59 | 0.0 (0.0%) | 13.4 (63.6%) | 7.7 (36.4%) | 21.1 (100.0%) |
| 60-64 | 0.0 (0.0%) | 17.0 (62.8%) | 10.0 (37.2%) | 27.0 (100.0%) |
| 65-69 | 88.3 (72.2%) | 20.8 (17.0%) | 13.2 (10.8%) | 122.2 (100.0%) |
| 70-74 | 132.9 (77.3%) | 23.6 (13.7%) | 15.4 (9.0%) | 171.9 (100.0%) |
| 75-79 | 162.9 (80.2%) | 26.1 (12.8%) | 14.2 (7.0%) | 203.1 (100.0%) |
| 80-84 | 113.3 (77.8%) | 20.6 (14.1%) | 11.7 (8.0%) | 145.6 (100.0%) |
| 85+ | 90.4 (75.6%) | 20.8 (17.4%) | 8.4 (7.0%) | 119.5 (100.0%) |
| **Total** | **587.7 (65.9%)** | **202.7 (22.7%)** | **102.1 (11.4%)** | **892.5 (100.0%)** |

Across all age bands, the age credits have decreased as the percentage of the overall scheme covered by the ARHC decreases as the level of HUC and HCCP increases. These reductions have been offset somewhat by an increase in the level of health related credits, noting that HUC has materially increased to align the payments to a percentage of public hospital charges.

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. Due to the smaller volume of claims falling within returned benefits after HUC and HCCP are applied, there was not enough data to credibly calibrate policyholders aged 85+ as a stand alone age group. The 2024/2025 RES calibration grouped 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 2024 to 31 March 2025, will be as follows:

Table 2.4 Projected Financial Impacts

| Recommendation | Irish Life Health | Laya Health Care | Vhi Healthcare | Market |
|---|---|---|---|---|
| **ARHC €m** | [redacted] | [redacted] | [redacted] | 535 |
| **HUC €m** | [redacted] | [redacted] | [redacted] | 224 |
| **HCCP €m** | [redacted] | [redacted] | [redacted] | 108 |
| **Stamp Duty €m** | [redacted] | [redacted] | [redacted] | (841) |
| **Net Financial Impact* €m** | [redacted] | [redacted] | [redacted] | 26 |
| **Net Financial Impact per Insured Life €m** | [redacted] | [redacted] | [redacted] | |

[redacted]

## 2.3. Key Assumptions and Basis of Calculation

The development of the RES recommendation for 2024/2025 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 2023/2024 and recommended 2024/2025 RES calibrations are shown in Table 2.5 below. An overview of the rationale for these assumptions is set out in the remainder of this section with further detail provided in Section 4.

Table 2.5 Assumptions Underpinning Recommended 2023/2024 Calibration vs 2024/2025 Calibration

| | 2023 RES Calibration | Recommended 2024 Calibration |
|---|---|---|
| Claims Adjustment | | |
| Base Data | 31-Dec-19 | 31-Dec-22 |
| Claims Mix | | |
| Public | 17% | 21% |
| Private | 60% | 56% |
| Consultant | 23% | 23% |
| Inflation | | |
| Public | 0% | 0% |
| Private | 5% | 5% |
| Consultant | 5% | 5% |
| Number of Years of Inflation | 2.25 years * | 2.25 years |
| Hospital Utilisation Rates | | |
| Overnights | 64% | 59% |
| Day | 36% | 41% |
| Hospital Utilisation Credits | | |
| Overnights | €125 | €163 |
| Day | €75 | €81 |
| High Cost Claims Pool | | |
| Threshold | €50,000 | €50,000 |
| Quota Share | 40.0% | 45.0% |
| Insured Population Data | | |
| Base Data | 30-Jun-22 | 30-Jun-23 |
| Other | | |
| REF Surplus | €55m | €25m |
| Non-Adv Stamp Duty (% of Adv Stamp Duty) | 25% | 25% |
| NCC | 140.0% | 140.0% |

** The mid-point of incurred claims for contracts entered into in the period 01/04/23 – 31/03/2024 was 01/04/24. Under normal circumstances, claims would be inflated for a period of 4.25 years (from 31/12/19 to 01/04/24). Thus, the projection period of 2.25 years effectively assumed 0% inflation for private and consultant for the two years to 31/12/2021 and 5% for the 2.25 years from 01/01/2022 to 01/04/2024.*

### 2.3.1. Level of Hospital Utilisation Credit

The Authority, has been consistent in its aim that credits related to health status, should cover a higher proportion of the REF claims over time. The introduction of the HCCP in 2022 and expansion to allow for rolling HCCP claims from April 2023 were material steps towards this aim.

The RES recommendation for 2024/2025 includes a further, smaller, step towards having credits related to health status, make up a higher proportion of the REF claims. The Authority recommends that the hospital utilisation credits (HUC) are set at 20% of the current charges for day cases and overnight admission as a private patient in a public hospital. These amounts are recommended to be rounded to the nearest whole euro. This represents an increase in the day rate for HUC from €75 to €81. The corresponding increase to the overnight rate of HUC is from €125 to €163.

Medical cost inflation has been a feature of the health insurance market and while public hospital charges have remained stable the Authority understands that private hospital charges have not. In the absence of consistent private hospital charges HUC has been set relative to public hospital charges.

### 2.3.2. Assumptions Used to Forecast Claims

The Authority uses claims and returned benefits data observed in the market to estimate the likely level of claims for the relevant RES period 2024/2025. 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 that a change to the charge for privately insured patients for the period of the 2024/2025 RES.

The Authority notes that the cost of claims in private hospitals are also more exposed to inflationary increases. Both the Central Bank of Ireland[3] and the European Commission[4] have projected falls in the rate of inflation for Ireland. The Authority has considered these forecasts and the view provided by insurers in proposing claims inflation rates of 5% for private and 5% for consultant to be used for the 2023 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*

Prior to 2020/2021, the Authority usually used the most recent 12 months of claims information in order to estimate the claims for the next contract period. The COVID-19 pandemic and the cyber-attack on the HSE had significant impacts on health services, and the reliability of data on the provision of health services. This led to 2019 continuing to be used as the base year for the 2020/2023 and 2023/2024 Calibrations. There was significant uncertainty as to the credibility of data from 2020 and 2021 and whether changes to the market at this time would be permanent or short lived.

In 2022, overall claims and returned benefits were higher than those observed in 2019, and they have further increased in the first half of 2023. The reduction in total claims observed in 2020 driven by COVID-19 appears to have been reversed and claims continue to revert to pre COVID-19 levels. The insurers have indicated that they are of a similar view. The Authority is therefore satisfied that 2022 is a suitable base year for projecting claims for the 2024/2025 RES calibration.

### 2.3.3. Insured Population Data

The proportion of the population with private health insurance has remained robust despite recent high inflation and drops in disposable income. The number of people with private health insurance has increased over the 12 months to 1 July 2023 by 83,440 or 3.6%.

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

[3] https://www.centralbank.ie/news/article/quarterly-bulletin-2022-2-economic-growth-set-to-continue-but-slower-higher-inflation-expected-6-Apr-2022#:~:text=Exports%20are%20forecast%20to%20grow,substantially%20over%20the%20coming%20months

[4] https://economy-finance.ec.europa.eu/economic-surveillance-eu-economies/ireland/economic-forecast-ireland_en

ageing appears to have slowed down considerably in recent years. At a market level there has been a gradual ageing of the population with the proportion of the insured population over 65 increasing from 16.7% to 16.8% over the last 12 months and from 15.7% to 16.8% over the last 6 years.

Table 2.6 Age Profile of Insured Members

| Age Group | 1 Jan 2018 | 1 Jan 2019 | 1 Jan 2020 | 1 Jan 2021 | 1 Jan 2022 | 1 Jan 2023 |
|---|---|---|---|---|---|---|
| 0-17 | 23.5% | 23.5% | 23.3% | 22.9% | 22.7% | 22.4% |
| 18-29 | 10.8% | 11.1% | 11.5% | 11.8% | 12.2% | 12.5% |
| 30-39 | 13.9% | 13.6% | 13.3% | 13.1% | 12.9% | 13.0% |
| 40-49 | 16.0% | 16.0% | 16.0% | 16.0% | 16.0% | 15.9% |
| 50-59 | 13.9% | 13.8% | 13.7% | 13.6% | 13.6% | 13.5% |
| 60-64 | 6.2% | 6.1% | 6.0% | 6.0% | 5.9% | 5.9% |
| 65-69 | 5.3% | 5.3% | 5.3% | 5.3% | 5.3% | 5.2% |
| 70-74 | 4.4% | 4.5% | 4.5% | 4.5% | 4.5% | 4.4% |
| 75-79 | 2.9% | 3.0% | 3.1% | 3.2% | 3.4% | 3.5% |
| 80-84 | 1.8% | 1.9% | 2.0% | 2.0% | 2.1% | 2.1% |
| 85+ | 1.2% | 1.3% | 1.4% | 1.4% | 1.5% | 1.5% |
| | | | | | | |
| Under 65 | 84.3% | 84.0% | 83.8% | 83.4% | 83.3% | 83.2% |
| Over 65 | 15.7% | 16.0% | 16.2% | 16.6% | 16.7% | 16.8% |

The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2024/2025 Calibration. Lives under 65 are assumed to increase by 104,300 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2023. This approach reflects the expectation that growth in the insured population will likely occur in younger lives. Should the population not grow in line with the Authority's expectation, e.g. 1% lower population growth, the impact on surplus would be of the order of c. €8-9m due to reduced receipts of stamp duty.

Lives over 65 are assumed to age by 1 year within the projections which implicitly assumes older lives will not take out health insurance for the first time, and equally assumes they will not cancel their insurance, which is a simplification.

Table 2.7 Change in Insured Population

| (Members 000's) | 01-Jul-20 | 01-Jul-21 | 01-Jul-22 | 01-Jul-23 | Projected 1-Oct-24 |
|---|---|---|---|---|---|
| Population | 2,179 | 2,226 | 2,294 | 2,377 | 2,482 |
| Difference | | 2.1% | 3.0% | 3.6% | 4.4% |

### 2.3.4. Estimated Claims Value

The cumulative impact of the assumptions used to forecast claims, and the population growth assumptions results in the projected returned benefits for the 2024/25 RES calibration period as set out below:

Table 2.8 Estimated Claims Value

| € m | Public Hospitals | Private Hospitals | Consultant | Total |
|---|---|---|---|---|
| 2019 Total | 471 | 1,071 | 428 | 1,969 |
| 2020 Total | 398 | 852 | 356 | 1,605 |
| 2021 Total | 310 | 1072 | 416 | 1,798 |
| 2022 Total | 418 | 1,146 | 478 | 2,042 |
| Estimate for 2023* | | | | 1,978 |
| Estimated 2024/25 | 427 | 1,222 | 533 | 2,182 |
| Percentage Change | 2.1% | 6.6% | 11.5% | 6.8% |
| Rate of Annualised Growth** | 0.9% | 2.9% | 5.0% | 3.0% |

**Estimate for Claims in 2023 is based on actual claims for the first half of 2023 multiplied by 2.*
*** Assumed rate of annualised growth over the period 31 December 2022 to 1 April 2025.*

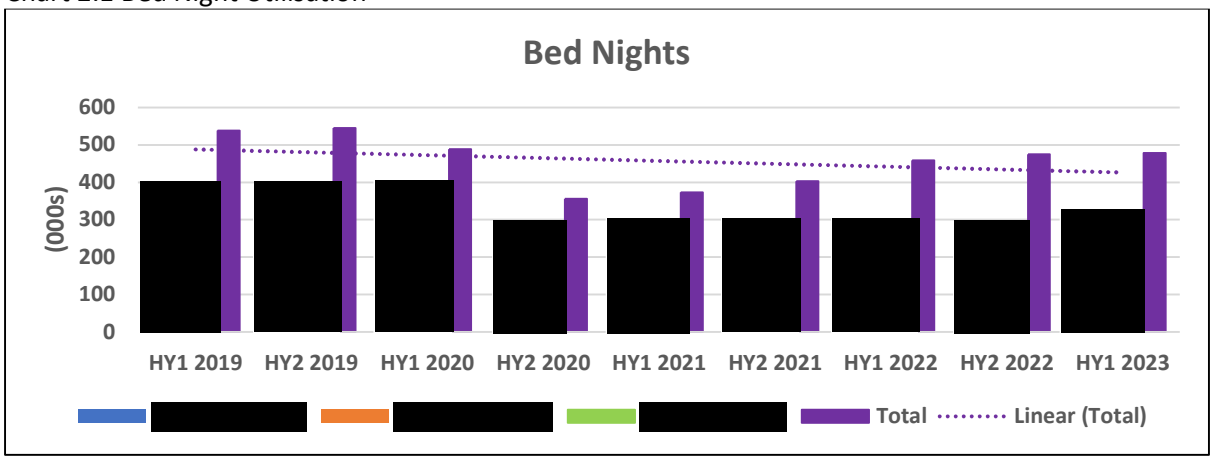
As can be seen in the above table, the total value of returned benefits are assumed to increase by 3% p.a. in aggregate (for each of the two years from 2022/23 to 2024/25. This accounts for the fact that the numbers of people with health insurance is forecast to increase, the population with health insurance is assumed to age (with higher claims for older age cohorts), and the cost of individual claims is assumed to increase in line with the inflation assumptions discussed above. This can be considered as a 0.9% p.a. increase in public hospital claims, a 2.9% p.a. increase in private hospital claims and 5.0% p.a. increase in consultant claims (annualised growth over the 2.25 years of inflation).

Within this estimate, we have assumed that any capacity constraints in any hospital (public and private) are not reached and that at all age cohorts are able to access healthcare at the same utilisation rates experienced in 2022. 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.

### 2.3.5. Hospital Utilisation Rates

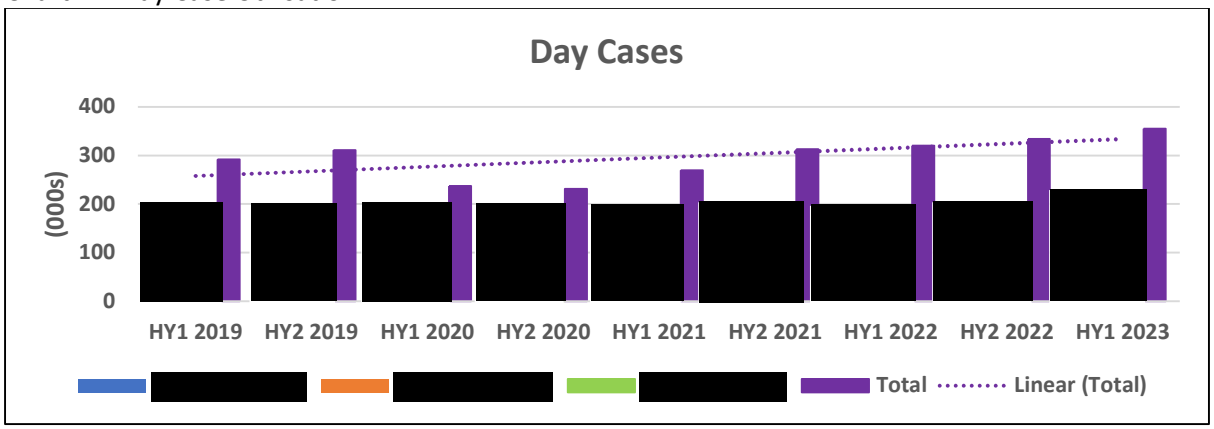
The picture with regard to hospital utilisation is mixed. We can see in chart 2.1 that hospital nights are continuing to recover to pre-pandemic levels but have not yet reached 2019 levels.

Chart 2.1 Bed Night Utilisation




Bed days, on the other hand, have surpassed pre-pandemic levels, as can be seen in chart 2.2.

Chart 2.2 Day Case Utilisation




This shift towards day cases may be a permanent change in the provision of healthcare in Ireland, or it may be the case that bed night utilisation is just slower to return to previous proportions. The Authority does not have solid evidence on which to make an assumption about the future split between bed days and bed nights. Based on this, the Authority has assumed overall utilisation levels assumed in the 2024/2025 Calibration are consistent with those observed in 2022 data.

### 2.3.6. REF Surplus

Based on the claims made to date to the REF for contracts incepted over the 2022/2023 and 2023/2024 periods, the Authority continues to see a surplus build up in the REF. This is due to claims paid from the fund being lower than estimated.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €25m (2023/2024 Calibration: €55m) in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2024 are fully earned. Although the REF surplus is lower than for the €55m for the 2023/2024 RES, the Authority estimate that the REF will likely continue to be positively impacted due to lower levels of hospitalisations, together with an increase in expected levels of stamp duty receipts. The lower level of hospitalisations appears to be due to a change in healthcare provision, more procedures appear to be carried out in settings not eligible for HUC. This is implied by the slower growth of HUC compared to the growth in returned benefits. The additional stamp duty receipts are due to the population with health insurance exceeding the Authority's forecast for the 2023/2024 timeframe and is partly negated by the increased ARHC paid out.

The Authority therefore recommends that this estimated surplus of €25m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2024 to 31 March 2025.

### 2.3.7. 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. As a result, non-advanced policy holders are more likely to avail of public hospitals when using their health insurance. As at 1 July 2023, 7.5% of the market held a non-advanced contract which is down 0.5% from the previous year. The ratio of non-advanced claims to advanced claims is 29% for all ages which has marginally increased from 28% in the 2023/2024 Calibration.

The acute public in-patient charge of €80 per day, up to a maximum of €800 in a year (including day-case charges), for people accessing care as a public patient in all public hospitals was removed for

children in September 2022 and adults in April 2023. This measure will likely have a bigger impact on non-advanced plans compared to advanced, given the greater proportion of public hospital care claimed on non-advanced plans.

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

The Authority therefore recommends to keep the stamp duty for non-advanced contracts at 25% of the stamp duty relating to advanced contracts.

### 2.3.8. 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 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 2023/2024 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 Health Insurance 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. A data error in the submission from an insurer was not corrected in time for the calibration (Section 3.5). 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 probability of surplus is recommended as a balance of the objectives of maintaining the sustainability of the health insurance market and community rating against the objective of avoiding sustained surplus from year to year. The Authority's view is that there is a greater risk to the health insurance market from a deficit than a small continued surplus. A deficit would lead to a sharp rise in stamp duty in order to recoup the deficit, and account for the continuation of market conditions that caused the deficit. Such a sharp increase in prices would threaten the affordability of health insurance premiums for all cohorts of members and provide a further incentive for insurers to target more profitable segments of the market.

## 3.2. RES Credits

It has been assumed that the RES calibration for health insurance policies that are entered into on or after 1 April 2024 will distribute risk equalisation credits in three ways:

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

## 3.3. Data Informing Calibration

Half-yearly information returns for the period July to December 2022 and January to June 2023 periods were received from Irish Life Health DAC (trading as Irish Life Health), Great Lakes Reinsurance UK Ltd (formerly trading as GloHealth), Elips Insurances Ltd (trading as Laya Healthcare), and Vhi Insurance DAC (trading as Vhi Healthcare)). The returns were accompanied by independent accountants' reports and analyses of the differences between total claims paid and returned benefits. Other historic information returns (as previously provided to the Authority by the insurers) have also been used in arriving at the recommended calibration.

The information returns received by the Authority include data on "returned benefits[5]". 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 "Returned Health Services".

For the first time submissions included a material amount of HCCP data, although the amount of HCCP data is expected to continue to grow in future submissions.

## 3.4. Consultation with Insurers

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

- Expected future claims levels, claims mix and claims inflation, future market membership and ageing, hospital utilisation levels;
- Use of 2022 claims data as the base data for projections;
- Move to treatment outside hospital settings;
- Level of stamp duty and approach for non-advanced contracts;
- ARHC and HUC;
- Views around the parameters used for HCCP;
- A variety of proposals that are overall, well aligned with the principal of providing a higher proportion of credits through health related measures. In general, these proposals would require significant recalibration of the workings of the scheme and ultimately, EU approval;
- Views on the sustainability of the market, competition, structure and size of the market with particular concerns about how Sláintecare implementation will affect the market in practice; and
- Concerns around the affordability of health insurance.

The Authority has considered the views of the insurers and the points raised when setting credits and stamp duty for policies commencing in the period from 1 April 2024 to 31 March 2025 and the assumptions impacting the recommendation set out in this report.

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

## 3.5. Data Errors

[redacted]

# 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 Health Insurance 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 2023/2024 and recommended 2024/2025 RES calibrations. An overview of the rationale for these assumptions is set out in the remainder of this section.

Table 4.1 Assumptions Underpinning Recommended 2024 Calibration vs 2023 Calibration

| | 2023 RES Calibration | Recommended 2024 Calibration |
|---|---|---|
| Claims Adjustment | | |
| Base Data | 31-Dec-19 | 31-Dec-22 |
| Claims Mix | | |
| Public | 17% | 21% |
| Private | 60% | 56% |
| Consultant | 23% | 23% |
| Inflation | | |
| Public | 0% | 0% |
| Private | 5% | 5% |
| Consultant | 5% | 5% |
| Number of Years of Inflation | 2.25 Years * | 2.25 Years |
| Hospital Utilisation Rates | | |
| Overnights | 64% | 59% |
| Day | 36% | 41% |
| Hospital Utilisation Credits | | |
| Overnights | €125 | €163 |
| Day | €75 | €81 |
| High Cost Claims Pool | | |
| Threshold | €50,000 | €50,000 |
| Quota Share | 40.0% | 45.0% |
| Insured Population Data | | |
| Base Data | 30-Jun-22 | 30-Jun-23 |
| Other | | |
| REF Surplus | €55m | €25m |
| Non-Adv Stamp Duty (% of Adv Stamp Duty) | 25% | 25% |
| NCC | 140.0% | 140.0% |

** The mid-point of incurred claims for contracts entered into in the period 01/04/23 – 31/03/2024 was 01/04/24. Under normal circumstances, claims would be inflated for a period of 4.25 years (from 31/12/19 to 01/04/24). Thus, the projection period of 2.25 years effectively assumed 0% inflation for private and consultant for the two years to 31/12/2021 and 5% for the 2.25 years from 01/01/2022 to 01/04/2024.*

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

The HCCP data provided by the three open market insurers was provided during 2022 to support the calibration of the HCCP both on an incurred basis (timing of provision of health services) and on a claims paid basis. The data was prepared by the insurers on a best endeavours basis and has not been subject to external review or audit. As the process is not fully embedded in the insurers' processes, it is possible that further refinements may be made which may impact on the results of the analysis prepared.

The HCCP was introduced from 1 April 2022 and actual HCCP claims data has been included in information returns received from insurers. The volume of this data is small and insufficient to be considered a credible basis for making assumptions about future HCCP experience. The lag in build up of reliable claims data is expected due to, the time taken for claims to reach the €50,000 threshold, the four-quarter lookback period, and the fact that claims must have been paid by the insurer before submission to the HIA.

For this reason, the only change to the HCCP modelling has been to enhance the consideration of the impact of inflation on HCCP claims. The 2024/2025 Calibration allows for inflation to be applied in a more granular way, with inflation of 0% assumed for public hospital claims and 5% for all other sources of claims.

In addition, the allowance for rolling claims has been updated to allow for increased claims costs due to inflation, based on an assumption of similar claims mix (i.e. public / private / consultant / other) to the HCCP claims data provided by the insurers.

The HCCP data used for the purposes of the calibration is based on the same exposure set as in the 2023/2024 Calibration although it has been updated for the latest information provided by the insurers. 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. While more recent HCCP data was available it continues to be distorted as a result of COVID-19 or insufficiently developed at this stage. The HIA proposes a 45% quota share with a €50,000 claims excess. We have set out how the HCCP credits for the 2024 recommendation have been calculated.

The Authority recommends that the HCCP credits for 2024/2025 are based on a 45% quota share on claims in excess of €50,000. The excess is unchanged from the 2023/2024 RES while the quota share has been increased by 5.0% (2023/2024 RES: 40%). We note the calibration of the 2023/2024 RES was updated to allow for rolling HCCP claims which resulted in an increase in proportion of total credits allocated to HCCP credits (2022/2023 Calibration: 6.5% vs 2023/2024 Calibration: 11.4%). The combination of data updates and the increase to the quota share results in estimated size of the credits to be distributed in respect of the HCCP for the 2024/2025 RES calibration being €108.1m or 12.5% of the overall credits.

Table 4.2 HCCP Credits for 2024/2025 RES Calibration

| **HCCP Credits** | | |
|---|---|---|
| Quota Share | *(a)* | 45.00% |
| Threshold | *(b)* | €50,000 |
| | | |
| High-Cost Claims in Respect of Policies Incepted in 2018 | | €346,930,854 |
| Projected High-Cost Claims in Respect of Policies Incepted in 2018 Allowing for Projected Claims Inflation | *(c)* | €452,219,065 |
| Rolling HCCP Claims (Average Based on Historical Experience) | *(d)* | €123,178,346 |
| HCCP Claims | *(e) = (c) + (d)* | €575,397,411 |
| | | |
| Projected HCCP Policy Count | *(f)* | 5,525 |
| Threshold | *(g) = (f) * (b)* | €276,250,000 |
| | | |
| Credit Offsets | | |
| ARHC | *(h)* | €5,737,675 |
| HUC | *(i)* | €53,133,004 |
| | | |
| **Final HCCP Credits** | ***(a) * ((e) – [(g)+(h)+(i)])*** | **€108,124,529** |

- Claims data is based on policies incepted between 1 January 2018 and 31 December 2018. These claims and policy counts are then developed (and inflated) based on information received from the insurers up to 31 December 2022. This results in total projected developed claims of €452.2m and projected policy count of 5,525;
- 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 €123.2m. This figure is based on the average impact that rolling claims would have on the HCCP based on high-cost claims data arising in the periods 2017-2018, 2018-2019 and 2019-2020 further adjusted for inflation. More recent data was available but deemed unsuitable due to the impact of COVID-19;
- The threshold for the first €50,000 of the claims to be excluded from the HCCP is €276.3m;
- HCCP credits are offset by ARHC of €5.7m and HUC of €53.1m; and
- Final credits are then calculated as the quota share x (HCCP claim – (threshold + HUC + ARHC)) resulting in the final HCCP credits of €108.1m

The data updates and changes to inflation modelling increase the proportion of credits paid out through HCCP claims. The increase to HUC rates reduces the proportion of credits paid out through HCCP claims. Increasing the HCCP quota share counteracts this reduction and preserves the proportion of claims paid out through HCCP credits.

It has been the stated aim of the HIA to increase the health related proportion of credits. The proposed increase in HUC rates forms part of the delivery of this aim. If the proportion of credits paid through HCCP was not increased by raising the quota share rate it would work against this aim.

## 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 | 1-Jul-22 | | 1-Jan-23 | | 1-Jul-23 | |
|---|---|---|---|---|---|---|
| | Members 000's | Market Share (%) | Members 000's | Market Share (%) | Members 000's | Market Share (%) |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| **Total** | **2,294** | | **2,332** | | **2,377** | |

The overall insured population increased by 83,440 lives over the 12 months to 1 July 2023 (1 July 2021 to 1 July 2022: 67,603). Each of the insurers has experienced an increase in the number of insured lives and the changes in market share have not been material.

As of end June 2023, 47.6% of the Irish population are estimated to have private health insurance (including restricted membership undertakings but excluding those serving initial waiting periods), which is 0.2% lower than the percentages observed at end June 2022.

### 4.3.2. Gender Profile of Insurers' Members

The gender distributions of the memberships of the three insurers for the period January to July 2023 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 | Irish Life Health | Laya Healthcare | Vhi Healthcare | Market |
|---|---|---|---|---|
| Male | [redacted] | [redacted] | [redacted] | 49% |
| Female | [redacted] | [redacted] | [redacted] | 51% |

### 4.3.3. Age Profile of Insurers Members

The age distribution (average for the period January to June 2023) of each insurer's membership is shown in Table 4.5. The figures shown in brackets are the corresponding averages for the period January to June 2022.

Table 4.5 Age Profile of Insured Members

| Age Group | Irish Life Health | Laya Healthcare | Vhi Healthcare | Market |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 22.0% (22.3%) |
| 18-29 | [redacted] | [redacted] | [redacted] | 12.5% (12.3%) |
| 30-39 | [redacted] | [redacted] | [redacted] | 12.8% (12.8%) |
| 40-49 | [redacted] | [redacted] | [redacted] | 15.8% (16.0%) |
| 50-54 | [redacted] | [redacted] | [redacted] | 7.1% (7.1%) |
| 55-59 | [redacted] | [redacted] | [redacted] | 6.5% (6.6%) |
| 60-64 | [redacted] | [redacted] | [redacted] | 5.9% (6.0%) |
| 65-69 | [redacted] | [redacted] | [redacted] | 5.3% (5.4%) |
| 70-74 | [redacted] | [redacted] | [redacted] | 4.5% (4.5%) |
| 75-79 | [redacted] | [redacted] | [redacted] | 3.6% (3.5%) |
| 80-84 | [redacted] | [redacted] | [redacted] | 2.2% (2.1%) |
| 85+ | [redacted] | [redacted] | [redacted] | 1.6% (1.6%) |
| | | | | |
| Under 65 | [redacted] | [redacted] | [redacted] | 82.7% (82.9%) |
| Over 65 | [redacted] | [redacted] | [redacted] | 17.3% (17.1%) |

[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 17.1% to 17.3% 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[6];
- Level 2 products provide substantial cover in private hospitals but this cover is mainly provided for semi-private accommodation[7];
- 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 July 2023 is shown in the Tables 4.6 and 4.7 (1 July 2022 figures are shown in brackets).

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

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

| | Level 1 Products | Level 2 Products | Higher Cover Products |
|---|---|---|---|
| Irish Life Health | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] |
| Total | 7% (8%) | 76% (76%) | 16% (16%) |

[redacted]

Non-advanced products cannot provide more than 66% of the full cost for hospital charges in a private hospital. [redacted]

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

| | Non-Advanced | Advanced |
|---|---|---|
| Irish Life Health | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] |
| Total | 7% (8%) | 93% (92%) |

### 4.3.5. Actual vs Expected Population Forecasts

Table 4.8 shows that the insured population has continued to increase (the average increase over the last 4 years is 2.6% p.a.) and the market has remained resilient despite the economic and health impacts of COVID-19. This was also evident in the consumer survey carried out by the Authority which demonstrated that the attitudes to health insurance were not impacted by COVID-19[8].

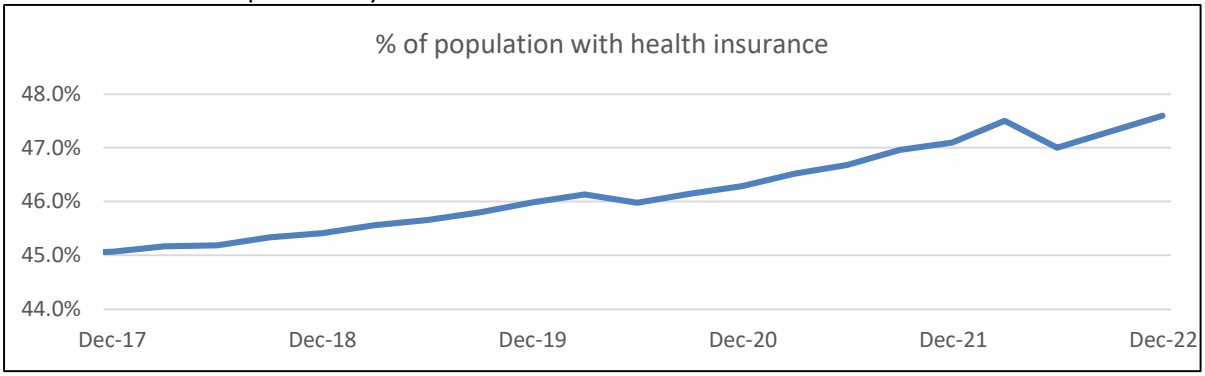
Table 4.8 Insured Population

| Insurer | 1-Jan-19 | 1-Jan-20 | 1-Jan-21 | 1-Jan-22 | 1-Jan-23 |
|---|---|---|---|---|---|
| Members 000's | 2,107 | 2,163 | 2,200 | 2,263 | 2,332 |
| % Increase Year on Year | | 2.7% | 1.7% | 2.8% | 3.0% |

The percentage of the Irish population estimated to have private health insurance (including restricted undertakings) also continues to increase. Chart 4.1 shows the increase in those holding private health insurance over the 5 years to 31 December 2023.

8 https://www.hia.ie/sites/default/files/Health%20Insurance%20Authority%20Kantar%20Report%202021%20Jan%202022%20Final.pdf

Chart 4.1 Insured Population by Insurer




If we project using last year's assumption to 1 July 2023, we can see the assumption was understated by 15,837 lives at 1 July 2023, showing that the insured population has grown more than expected. See Table 4.9 below. Most of the growth has taken place in the younger cohorts, which is consistent with the growth in the level of employment in the economy.

Table 4.9 Actual vs Expected Population Growth to 1 July 2023

| **Difference Actual vs Assumption as at 1 July 2022** | | | |
|---|---|---|---|
| **Insured Membership** | **Assumed Population 1 July 2023** | **Actual Population 1 July 2023** | **Net Diff** |
| Aged 17 and Under | 526,866 | 527,570 | 704 |
| Aged 18 to Age 29 | 300,319 | 298,129 | (2,190) |
| Aged 30 to Age 39 | 304,700 | 308,162 | 3,462 |
| Aged 40 to Age 49 | 373,896 | 374,389 | 493 |
| Aged 50 to Age 54 | 167,712 | 168,986 | 1,274 |
| Aged 55 to Age 59 | 151,687 | 152,877 | 1,190 |
| Aged 60 to Age 64 | 137,937 | 140,633 | 2,696 |
| Aged 65 to Age 69 | 124,233 | 125,242 | 1,009 |
| Aged 70 to Age 74 | 104,117 | 107,275 | 3,158 |
| Aged 75 to Age 79 | 83,432 | 84,957 | 1,525 |
| Aged 80 to Age 84 | 49,426 | 51,368 | 1,942 |
| Aged 85 and Over | 37,116 | 37,690 | 574 |
| **Total** | **2,361,441** | **2,377,278** | **15,837** |

### 4.3.6. Economic Outlook

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

The spring forecast for Ireland carried out by the European Commission[9], projects GDP growth of 5.5% in 2023 and 5% in 2024. Private consumption, a stable driver of domestic growth, is expected to remain solid thanks to increasing household income and employment. Inflation is projected to decrease to 4.6% in 2023 and 2.6% in 2024 as energy prices decrease. The fiscal outlook is set to further improve, with the budget balance set to reach a surplus of 1.7% of GDP in 2023 supported by a robust labour market, and strong dynamics in the economy.

[9] https://economy-finance.ec.europa.eu/economic-surveillance-eu-economies/ireland/economic-forecast-ireland_en

The Central Bank quarterly forecasts[10] have projected GDP growth of 4.3% in 2023 and falling to 3.9% in 2024. Its inflation forecasts, as measured by the Harmonised Index of Consumer Prices (HICP) is similar to the European Commission for 2022 at 6.5% and a fall to 2.8% in 2023 and a further fall to 2.1% in 2024.

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) may be able to withstand impacts of what is expected to be short to medium term high inflation.

Growth in corporate members may be behind the robust growth. The proportion of the population with private health insurance did not grow between end March 2023 and end June 2023. Recent lay offs in the tech sector are a potential reason for this.

### 4.3.7. Views of Insurers

[redacted]

### 4.3.8. Projected Population for RES 2024/2025

Having considered the views of the insurers, the economic outlook and the forecasts for Ireland carried out by the European Commission and the Central Bank, the Authority has taken the view that the insured population will continue to grow over the next projection period. In our projections the base population is the 1 July 2023 population, and this is projected forward 1.25 years to 1 October 2024 (mid-point of the contracts from 1 April 2024 to 31 March 2025). The membership is assumed to increase in line with the change in the market membership in the period 1 July 2022 to 1 July 2023 (83,440) until 1 October 2024 (i.e., 1.25 * 83,440 = 104,300. This is consistent with the methodology used in past RES calibrations.

[10] https://www.centralbank.ie/news/article/quarterly-bulletin-2022-2-economic-growth-set-to-continue-but-slower-higher-inflation-expected-6-Apr-2022#:~:text=Exports%20are%20forecast%20to%20grow,substantially%20over%20the%20coming%20months

Table 4.10 Change in Insured Population

| Change in insured lives by age | | | |
|---|---|---|---|
| **Insured Membership** | **1-Jul-22** | **1-Jul-23** | **Net Diff** |
| Aged 17 and Under | 516,816 | 527,570 | 10,754 |
| Aged 18 to Age 29 | 283,577 | 298,129 | 14,552 |
| Aged 30 to Age 39 | 297,097 | 308,162 | 11,065 |
| Aged 40 to Age 49 | 365,326 | 374,389 | 9,063 |
| Aged 50 to Age 54 | 161,967 | 168,986 | 7,019 |
| Aged 55 to Age 59 | 149,095 | 152,877 | 3,782 |
| Aged 60 to Age 64 | 135,478 | 140,633 | 5,155 |
| Aged 65 to Age 69 | 121,337 | 125,242 | 3,905 |
| Aged 70 to Age 74 | 102,413 | 107,275 | 4,862 |
| Aged 75 to Age 79 | 78,618 | 84,957 | 6,339 |
| Aged 80 to Age 84 | 47,401 | 51,368 | 3,967 |
| Aged 85 and Over | 34,713 | 37,690 | 2,977 |
| **Total** | **2,293,838** | **2,377,278** | **83,440** |

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

The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2024/2025 Calibration. Lives under 65 are assumed to increase by 104,300 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2023. This approach reflects the expectation that growth in the insured population will likely occur in younger lives. Should the population not grow in line with the Authority's expectation, e.g. 1% lower population growth, the impact on surplus would be of the order of c. €8-9m due to reduced receipts of stamp duty.

Lives over 65 are assumed to age by 1 year within the projections which implicitly assumes older lives will not take out health insurance for the first time, and equally assumes they will not cancel their insurance, which is a simplification.

Table 4.11 Projected Population for Contracts Incepted Between 1 April 2024 and 31 March 2025

| | **Actual Population as at 1 July 2023** | | **Projected Population as at 1 October 2024** | | **Change** | |
|---|---|---|---|---|---|---|
| **Age** | **Population** | **Age Distribution** | **Population** | **Age Distribution** | **Population** | **Age Distribution** |
| 0-17 | 527,570 | 22.2% | 552,244 | 22.3% | 24,674 | 0.1% |
| 18-29 | 298,129 | 12.5% | 310,744 | 12.5% | 12,615 | 0.0% |
| 30-39 | 308,162 | 13.0% | 320,463 | 12.9% | 12,301 | 0.0% |
| 40-49 | 374,389 | 15.7% | 390,521 | 15.7% | 16,132 | 0.0% |
| 50-54 | 168,986 | 7.1% | 176,672 | 7.1% | 7,686 | 0.0% |
| 55-59 | 152,877 | 6.4% | 160,093 | 6.5% | 7,216 | 0.0% |
| 60-64 | 140,633 | 5.9% | 147,483 | 5.9% | 6,850 | 0.0% |
| 65-69 | 125,242 | 5.3% | 128,917 | 5.2% | 3,675 | -0.1% |
| 70-74 | 107,275 | 4.5% | 111,005 | 4.5% | 3,730 | 0.0% |
| 75-79 | 84,957 | 3.6% | 90,734 | 3.7% | 5,777 | 0.1% |
| 80+ | 89,058 | 3.7% | 92,702 | 3.7% | 3,644 | 0.0% |
| **Total** | **2,377,278** | | **2,481,578** | | **104,300** | |

## 4.4. Claims Data

### 4.4.1. Historical Claims Experience

The total claims payments made by the open market insurers in 2019, 2020, 2021, 2022 and the first half of 2023 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 | Irish Life Health | Laya Healthcare | Vhi Healthcare | Total |
|---|---|---|---|---|
| First Half 2019 | [redacted] | [redacted] | [redacted] | 1,113 |
| Second Half 2019 | [redacted] | [redacted] | [redacted] | 1,135 |
| **2019 Total** | [redacted] | [redacted] | [redacted] | **2,248** |
| First Half 2020 | [redacted] | [redacted] | [redacted] | 970 |
| Second Half 2020 | [redacted] | [redacted] | [redacted] | 906 |
| **2020 Total** | [redacted] | [redacted] | [redacted] | **1,876** |
| First Half 2021 | [redacted] | [redacted] | [redacted] | 1,026 |
| Second Half 2021 | [redacted] | [redacted] | [redacted] | 1,097 |
| **2021 Total** | [redacted] | [redacted] | [redacted] | **2,122** |
| First Half 2022 | [redacted] | [redacted] | [redacted] | 1,187 |
| Second Half 2022 | [redacted] | [redacted] | [redacted] | 1,285 |
| **2022 Total** | [redacted] | [redacted] | [redacted] | **2,472** |
| First Half 2023 | [redacted] | [redacted] | [redacted] | 1,368 |

The total claims paid in the first half of 2023 were €182m (15%) higher than the first half of 2022. This is similar to the increase observed in the first half of 2022 when total claims were €161m (16%) higher than the first half of 2021.

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

Based on the above and feedback from the three insurers, the Authority is of the view that the information returns for 2022 is a reasonable data set to use for calibrating the 2024/2025 RES.

Insurers provide details of claim payments that fall within the definition of "returned benefits" in information returns. The benefits included in information returns (described as "returned benefits") as a percentage of total claims paid from the second half of 2021 to the first half of 2023 are set out in Table 4.13. The RES is primarily aimed at equalising returned benefits rather than total claims although most elements of total claims can be included in HCCP claims.

Table 4.13 Returned Benefits as a Percentage of Total Claims

| Insurer | Returned Benefits July – Dec 2021 | Returned Benefits Jan – June 2022 | Returned Benefits July – Dec 2022 | Returned Benefits Jan – June 2023 |
|---|---|---|---|---|
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Total | 85% | 83% | 82% | 80% |

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

Table 4.14 splits out the returned benefit payments between those attributable to public hospitals, private hospitals, and to hospital consultants. The total returned benefits paid were €1,100m in the first half of 2023 compared to €1,053m in the second half of 2022. The increase of €47m is made up of increases in the payments to public hospitals (€5m), Consultants (€15m) and private hospitals (€27m). This is indicative of capacity in public hospitals recovering following the impacts of COVID-19 although they continue to be lower than the claims observed in the first half of 2019 (2023: €212m vs 2019: €234m).

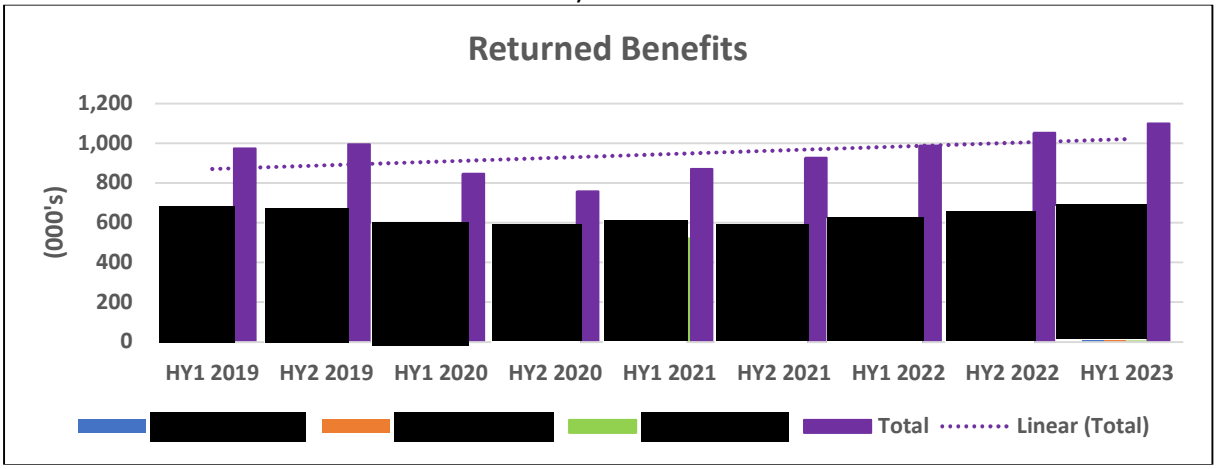
Table 4.14 Returned Benefits Broken Down by Service Provider

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

### 4.4.2. Claims Inflation

We can see from Chart 4.2 (which shows a history of claims since 2017) that while the level of claims in HY1 2023 is slightly ahead of the claims in the same period in 2019 for each of the insurers. While this demonstrates that claims have returned back to pre COVID-19 levels, the expectations around future inflation relative to 2019 need to be tempered.

Chart 4.2: Historic Levels of Returned Benefits by Insurer




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

The level of claims inflation experienced within the RES is impacted by a broader range of factors than just the actual costs of medical treatments covered by private health insurance, including the health status of the insured population and the availability of medical services. There are ultimate limits on the capacity of public hospitals, private hospitals and consultants to provide care. The Authority has used claims inflation rates of 0% for public, 5% for private and 5% for consultant in the 2023 calibration.

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, and which is expected to contribute a further 1% p.a. to claims inflation over the period. Ageing of the insured population is allowed for in the population projections. The forecasted combined effect of changes to the assumed claims mix, different inflation rates and ageing of the population can be seen in Section 4.4.4.

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

### 4.4.3. Base Year Data

Prior to 2020/2021, the Authority usually used the most recent 12 months of claims information in order to estimate the claims for the next contract period. The COVID-19 pandemic and the cyber-attack on the HSE had significant impacts on health services, and the reliability of data on the provision of health services. This led to 2019 continuing to be used as the base year for the

2020/2023 and 2023/2024 Calibrations. There was significant uncertainty as to the credibility of data from 2020 and 2021 and whether changes to the market at this time would be permanent or short lived.

In 2022, overall claims and returned benefits were higher than those observed in 2019. In H1 2023. Returned benefits were above those in H1 or H2 2019. The Authority is therefore satisfied that 2022 is a suitable base year for projecting claims for the 2024/2025 RES calibration.

The mix between public, private and consultant costs has an impact on the overall cost of claims. Similarly, the mix of bed days and bed nights has an impact on the overall cost of claims. In line with the view that 2022 is a suitable base year for projecting claims, no additional adjustment has been made to the claims mix implied by the 2022 data.

All three insurers were in agreement that 2022 data is a reasonable data set to use as the base data for 2024/2025 claims.

### 4.4.4. Forecast Returned Benefits by Source

The cumulative impact of the assumed claims adjustments results in the projected returned benefits as set out below:

Table 4.15 Projected Returned Benefits by Source

| € m | Public Hospitals | Private Hospitals | Consultant | Total |
|---|---|---|---|---|
| 2022 Total | 418 | 1,146 | 478 | 2,042 |
| Estimated 2024/25 | 427 | 1,222 | 533 | 2,182 |
| Percentage Change | 2.1% | 6.6% | 11.5% | 6.8% |
| Rate of Annualised Growth* | 0.9% | 2.9% | 5.0% | 3.0% |

** Assumed rate of annualised growth over the period 31 December 2021 to 1 April 2024.*

As can be seen in the above table, returned benefits are assumed to increase by 3.0% p.a. in aggregate. This can be considered as a 0.9% p.a. increase in public hospital claims, a 2.9% p.a. increase in private hospital claims and a 5.0% p.a. increase in consultant claims. This is driven by the combined effect of changes to the assumed claims mix, different inflation rates and ageing of the population.

## 4.5. Hospital Utilisation Rates

Information returns include separate details of the number of hospital inpatient days and day case admissions (hospital days) paid for by insurers in respect of their private patients' admissions. The total number of nights/ days in the last three years paid by the open membership undertakings is set out in Table 4.16. We note there are distortions in the below information caused by data issues as noted in Appendix 5. We have not been provided with revised returns for prior periods which impacts the information presented below. The impacts of COVID-19 are also evident in the data below for 2020 and 2021.

Table 4.16 Total Number of Hospital Days

| 000's | Overnight | Day Case | Total |
|---|---|---|---|
| First Half 2019 | 538 | 292 | 830 |
| Second Half 2019 | 546 | 311 | 856 |
| First Half 2020 | 489 | 237 | 726 |
| Second Half 2020 | 356 | 231 | 587 |
| First Half 2021 | 373 | 269 | 643 |
| Second Half 2021 | 403 | 313 | 716 |
| First Half 2022 | 459 | 320 | 779 |
| Second Half 2022 | 475 | 334 | 810 |
| First Half 2023 | 478 | 355 | 833 |

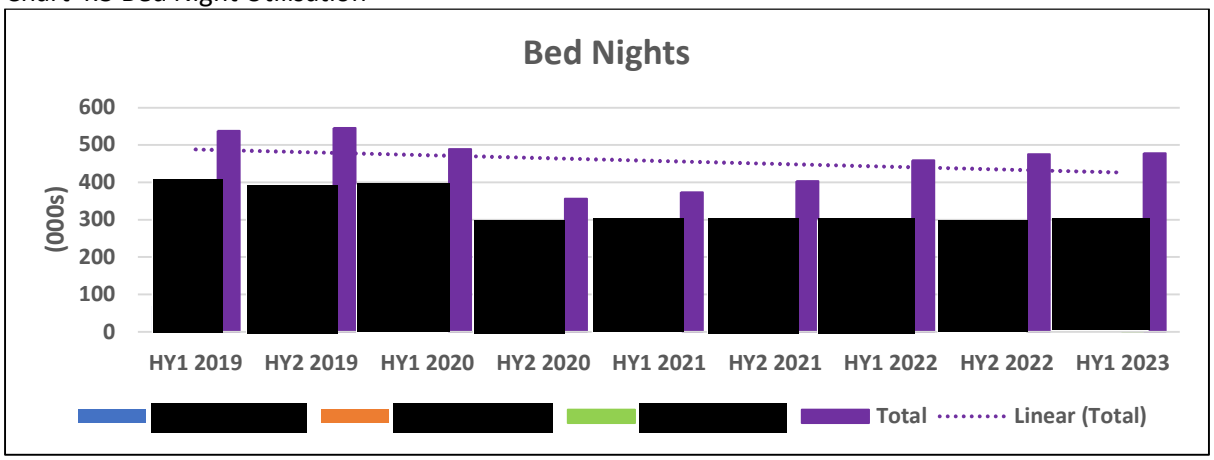
Table 4.17 Total Number of Nights/Days by Insurer - January to June 2023

| 000's | Overnight | Day Case | Total |
|---|---|---|---|
| Irish Life Health | [redacted] | [redacted] | 135 |
| Laya Healthcare | [redacted] | [redacted] | 203 |
| Vhi Healthcare | [redacted] | [redacted] | 494 |
| **Total** | [redacted] | [redacted] | **833** |

The proportion of day cases to has been volatile in recent years. [redacted] Across the market, days represent 43%. This compares to days representing on average 36% of total hospital days and nights during 2019. 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.

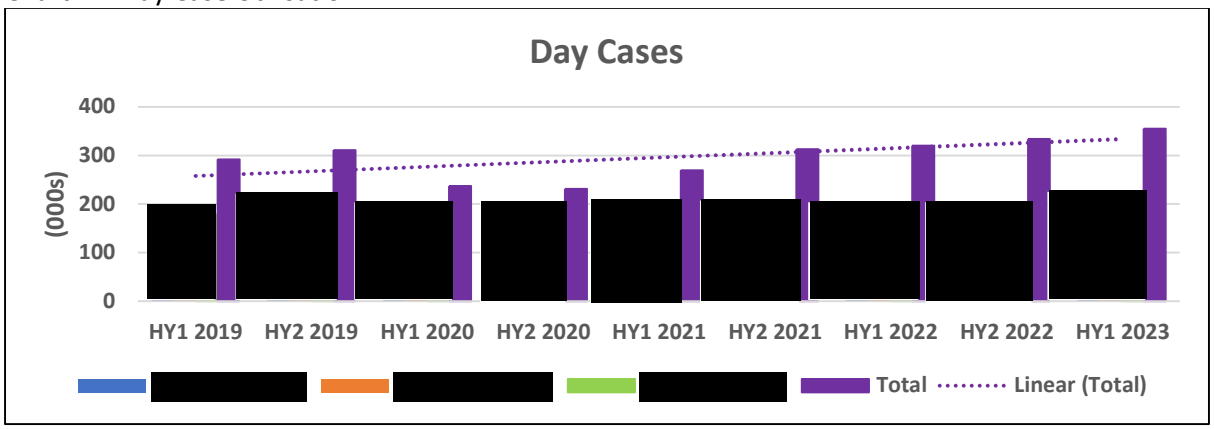
The picture with regard to hospital utilisation is mixed. We can see in chart 2.1 that hospital nights are continuing to recover to pre-pandemic levels but have not yet reached 2019 levels.

Chart 4.3 Bed Night Utilisation




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

Chart 4.4 Day Case Utilisation




This shift towards day cases may be a permanent change in the provision of healthcare in Ireland, or it may be the case that bed night utilisation is just slower to return to previous proportions. The Authority does not have solid evidence on which to make an assumption about the future split between bed days and bed nights. Based on this, the Authority has assumed overall utilisation levels assumed in the 2024/2025 Calibration are consistent with those observed in 2022 data.

## 4.6. Financial Position of the Risk Equalisation Fund

In the Risk Equalisation Scheme, 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 4.18 Projected Surplus in REF

| €m | Projected Surplus/Deficit at end of Claim Period | | |
|---|---|---|---|
| | 2024/ 2025 RES Calibration | 2023/ 2024 RES Calibration | Variance |
| 01/01/2013 – 31/03/2019 Contracts | 48.5 | 52.5 | (4.0) |
| 01/04/2019 – 31/03/2020 Contracts | 37.9 | 39.2 | (1.3) |
| 01/04/2020 – 31/03/2021 Contracts | 4.1 | 12.4 | (8.3) |
| 01/04/2021 – 31/03/2022 Contracts | 47.0 | 51.7 | (4.7) |
| 01/04/2022 – 31/03/2023 Contracts | (53.7) | (100.0) | 46.3 |
| 01/04/2023 – 31/03/2024 Contracts | (58.1) | | (58.1) |
| Expected Surplus Last RES | | | 55.0 |
| Other Incl. Investment Income Less Expenses | (0.8) | (0.8) | 0.0 |
| **Total** | **25.0** | **55.0** | **25.0** |

When setting credits in last year's report, the Authority assumed an initial surplus of €55m which was expected to be exhausted. The expected allocated credits were set so as to exceed expected stamp duty receipts by €55m.

Table 4.18 sets out details of the expected surplus by contract period and shows how experience in aggregate has changed since the 2023/2024 Calibration. The sources of this variation are set out in Table 4.19 below.

Table 4.19 Variation in Projected Surplus in REF

| €m | Variance | Stamp Duty | ARHC | HUC | HCCP |
|---|---|---|---|---|---|
| 01/01/2013 – 31/03/2019 Contracts | (4.0) | 0.0 | 0.0 | (4.0) | 0.0 |
| 01/04/2019 – 31/03/2020 Contracts | (1.3) | 0.0 | 0.0 | (1.2) | 0.0 |
| 01/04/2020 – 31/03/2021 Contracts | (8.3) | (0.1) | 0.1 | (8.4) | 0.0 |
| 01/04/2021 – 31/03/2022 Contracts | (4.7) | 0.4 | (0.6) | (4.5) | 0.0 |
| 01/04/2022 – 31/03/2023 Contracts | 46.3 | 29.7 | (20.6) | 37.2 | 0.1 |
| 01/04/2023 – 31/03/2024 Contracts | (3.1)* | (2.7) | 1.1 | (2.2) | 0.7 |
| Other incl. Investment Income Less expenses | 0.0 | | | | |
| **Total** | **25.0** | **27.3** | **(20.1)** | **16.9** | **0.8** |

** The €3.1m negative variance in respect of contracts entered into in the period 1 April 2023 to 31 March 2024 has been reduced to allow for the €55m surplus expected when the 2023/2024 Calibration was prepared.*

A material surplus has arisen in respect of HUC in respect of contracts entered into in the period 1 April 2022 to 31 March 2023 which is driven by reduced levels of hospitalisation compared to those originally budgeted for which was based on an expectation that activity would return to pre-COVID-19 levels. More stamp duty was collected than expected (+€29.7m) in respect of contracts entered into in the period 1 April 2022 to 31 March 2023 although this is offset by more ARHC being paid out (-€20.6m) which is due to a higher insured population that expected.

After careful consideration, the Authority is of the view that there is likely to be a surplus of circa €25m in the REF when the credits and stamp duty on all contracts that commence in advance of 1 April 2024 are fully earned. Although the REF surplus is lower than for the €55m used in the 2023/24 Calibration, the Authority estimates that the REF will likely be positively impacted by additional growth in insured population than was expected at the time of calibration.

The Authority therefore recommends that this estimated surplus of €25m is applied to reduce stamp duty by a corresponding amount for policies commencing in the period 1 April 2024 to 31 March 2025.

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

## 4.7. Ratio of Non-Advanced to Advanced Stamp Duty

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

As at 1 July 2023, 7.5% of the market held a non-advanced contract which is 0.5% lower than the previous year. The ratio of non-advanced to advanced claims is 29% for all ages which has marginally increased from 28% in the 2023/2024 Calibration.

The acute public in-patient charge of €80 per day, up to a maximum of €800 in a year (including day-case charges), for people accessing care as a public patient in all public hospitals was removed for children in September 2022 and adults in April 2023. This measure will likely have a bigger impact on non-advanced plans compared to advanced, given the greater proportion of public hospital care claimed on non-advanced plans.

The Authority therefore recommends the stamp duty for non-advanced contracts is set at 25% of the stamp duty relating to advanced contracts. This is no change from the calibration for 2023/24. This means that stamp duty will not increase for non-advanced contracts and helps to maintain affordability of these price sensitive plans.

## 4.8. Net Claims Cost Ceiling

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

- The average returned benefit amount is calculated for the market as a whole for each cohort where age credits are applied (i.e., advanced / non-advanced and male / female). Level 2 average claims are used in the calibration for advanced cover contracts;
- In theory, if there was no surplus then the NCC 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 NCC 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 2023/2024 Calibration the net claims cost ceiling was 140%, which resulted in an estimated 65.9% of credits being in respect of age and, 22.7% in respect of HUC and 11.4% in respect of HCCP.

For the 2024/2025 Calibration, the Authority recommends that the net claims cost ceiling to remain at 140.0%, which results in an estimated 61.8% of credits being in respect of age, 25.8% in respect of HUC and 12.5% in respect of HCCP. The allocation to HUC credits has increased as a result of the higher assumed HUC rates used in the 2024/2025 Calibration (Nights: €163; Days; €81). The allocation to HCCP credits has increased, largely driven by the increase in the quota share from 40% to 45%.

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 market segmentation and reduce incentives for insurers.

The overall effectiveness of the RES has increased from 50.4% in 2023/2024 to 64.9% in the 2024/2025 Calibration. In more simpler terms, the 2024/2025 Calibration shows a significant reduction in the relative differences between the net claims costs of the insurers as a result of the RES when compared to the 2023/2024 Calibration. This is largely driven by the higher allocation of credits based on health status through HUC and HCCP rather than ARHC.

## 5. Market Developments

Key market developments:

- The number of people with health insurance continues to increase (01/07/2023: 2.377m vs 01/07/2022: 2.294m). Growth has exceeded our forecasts from last year, particularly for the younger age cohorts;
- The average adult premium across the market is €1,509 for 01/07/23 which is an increase of c. 5% since the 01/07/22;
- On average, all insurers put through price increases on their plans when compared to the same period last year, in response to the stamp duty increases which came into force on 1st April 2023.
- The number of inpatient plans on sale in the market by the three open membership insurers has increased in the last year with 338[11] inpatient private health insurance plans on the Product Register on 1st July 2023 (excluding restricted undertakings). The number of new products introduced so far in 2023 are 12.
- [redacted] Table 5.1 below shows the total claims payments for the insurers for the last four years. Chart 5.1 shows how the proportion of claims that meet the criteria to be considered returned benefits is falling. This supports the assumption that 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 | Irish Life Health | Laya Healthcare | Vhi Healthcare | Total |
|---|---|---|---|---|
| 2019 Total | [redacted] | [redacted] | [redacted] | 2,248 |
| 2020 Total | [redacted] | [redacted] | [redacted] | 1,876 |
| 2021 Total | [redacted] | [redacted] | [redacted] | 2,123 |
| 2022 Total | [redacted] | [redacted] | [redacted] | 2,472 |

Chart 5.1 Returned Benefits as a Proportion of Claims

[redacted]

While total claims have been increasing, returned benefits as a proportion of claims has been dropping. This combined with the slower growth of hospital overnight cases compared to day cases supports the view that care is taking place in lower acuity settings to the extent possible. If this

[11] [redacted]

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.

### *Average Returned Benefit & Average Net Claims Cost*

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

Table 5.2 Average Returned Benefits and Average Net Claims

| **Average Gross of Tax Relief Premiums Less Average Net Claims per Insured Person** | | | | |
|---|---|---|---|---|
| | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
| **Average Net Claims Cost per Insured Person (June 2022 - June 2023)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 1,059 |
| Over 65's | [redacted] | [redacted] | [redacted] | 1,457 |
| **Average Gross of Tax Relief Premiums per Insured Person (June 2022 - June 2023)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 1,599 |
| 65 and Above | [redacted] | [redacted] | [redacted] | 2,064 |
| **Average Difference per Insured Person (June 2022 - June 2023)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 539 |
| 65 and Above | [redacted] | [redacted] | [redacted] | 607 |
| **Average Difference per Insured Person (June 2021 - June 2022)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 537 |
| 65 and Above | [redacted] | [redacted] | [redacted] | 830 |
| **Average Difference per Insured Person (June 2020 - June 2021)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 598 |
| 65 and Above | [redacted] | [redacted] | [redacted] | 1,253 |
| **Average Difference per Insured Person (June 2019 - June 2020)** | | | | |
| 18-64 | [redacted] | [redacted] | [redacted] | 523 |
| 65 and Above | [redacted] | [redacted] | [redacted] | 928 |
| **Average Difference per Insured Person (June 2018 - June 2019)** | | | | |
| 18-59 | [redacted] | [redacted] | [redacted] | 411 |
| 60 and Above | [redacted] | [redacted] | [redacted] | 281 |

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

It can be seen that prior to the COVID-19, relative levels of profit were higher for the younger age cohort when compared to older lives. During the pandemic, this was significantly higher which may be indicative of reduced claims as a result of COVID-19. The impact was more pronounced for older lives as the age credits received assumed a higher level of average claims.

We can see that the relative level of profitability (before expenses and claims not included in returns are allowed for) has reduced in the last year although it continues to be in excess of pre COVID-19 levels.

## 6. Overcompensation

### *Accounts of the Net Beneficiary*

*Profitability of Registered Undertakings*

Section 7E(1)(b)(iii)(I) of the Health Insurance Act 1994 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 Health Insurance Act 1994 (Preparation of Financial Statements) Regulations 2022 [S.I. No. 146 of 2022] came into effect on 30 March 2022, which impact on how profitability and expenses are recognised by insurers in the financial statements furnished to the Authority. These Regulations apply to financial statements furnished to the Authority pursuant to Section 7F(1) of the Act of 1994 in respect of the calendar year 2022 and for every year thereafter. Additionally, Section 7F of the Health Insurance (Amendment) Act 2021 updated the threshold for the level of reasonable profit from 4.4% p.a. to 6% although this is to be transitioned in on a phased basis with a threshold of 4.9% applying to the assessment in respect of the three-year period 2020 – 2022.

## 7. Recommendation on Risk Equalisation Credits and Stamp Duty

The Authority acknowledges that there is a range of potentially acceptable options for the stamp duty and Risk Equalisation Credits that could apply for contracts commencing in the period 1 April 2024 to 31 March 2025. The impact of the COVID-19 pandemic on recent years and the extent to which changes to the provision of health services will prove to be permanent bring a greater degree of uncertainty. In developing these recommendations, the Authority has struck a balance between the level of stamp duty paid by all policyholders and the level of compensation paid to insurers in respect of older and/or sicker lives. In considering this balance, the Authority has had regard to all of the objectives set out in Section 7E(1)(b) and in particular this year the objectives of market sustainability and fair and open competition.

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

### 7.1. Stamp Duty

The Authority recommends that the stamp duties to be paid by the insurers on policies that are entered into between 1 April 2024 and 31 March 2025, 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 2024 – 31 March 2025

| **Age Band** | **Stamp Duties from 1 April 2024 to 31 March 2025** | | **Stamp Duties from 1 April 2023 to 31 March 2024** | | **Change** | |
|---|---|---|---|---|---|---|
| | Non-Advanced | Advanced | Non-Advanced | Advanced | Non-Advanced | Advanced |
| **17 and Under** | €35 | €140 | €36 | €146 | (€1) | (€6) |
| **18 and Over** | €105 | €420 | €109 | €438 | (€4) | (€18) |

The drivers of the reduction 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 2023/2024 stamp duty, advanced stamp duties for adults would be €474, as opposed to €438, and the non-advanced adult stamp duty would be €118, as opposed to €109. The Authority notes that if the surplus in the REF was not applied to the 2024/2025 stamp duty, advanced stamp duties for adults would be closer to €435 compared to the recommended rate of €420.

### 7.2. Risk Equalisation Credits

The Authority recommends that the following Risk Equalisation Credits should apply for health insurance policies that are entered into between 1 April 2024 and 31 March 2025.

Table 7.2 Risk Equalisation Credits for Contracts Incepted 1 April 2024 – 31 March 2025

| | Proposed 2024 RES Calibration | | | | Change from Current Credits | | | |
|---|---|---|---|---|---|---|---|---|
| **Age Related Health Credits** | | | | | | | | |
| | Non-Advanced | | Advanced | | Non-Advanced | | Advanced | |
| | Male | Female | Male | Female | Male | Female | Male | Female |
| 64 and Under | €0 | €0 | €0 | €0 | €0 | €0 | €0 | €0 |
| 65-69 | €250 | €150 | €850 | €425 | (€100) | (€50) | (€100) | (€100) |
| 70-74 | €425 | €300 | €1,375 | €925 | (€100) | (€100) | (€175) | (€150) |
| 75-79 | €600 | €475 | €2,025 | €1,450 | (€175) | (€100) | (€275) | (€200) |
| 80-84 | €700 | €500 | €2,425 | €1,600 | (€200) | (€125) | (€300) | (€350) |
| 85+ | €700 | €500 | €2,425 | €1,600 | (€300) | (€200) | (€575) | (€450) |
| **Hospital Utilisation Credit (HUC)** | | | | | | | | |
| | Night | | Day | | Night | | Day | |
| | €163 | | €81 | | €38 | | €6 | |
| **Hight Cost Claims Pool (HCCP)** | | | | | | | | |
| Quota Share | 45.00% | | | | 5.00% | | | |
| 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 2022 – Dec 2022 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 140.0% (2023/2024: 140.0%) of the average net claims cost across all lives.

It should be noted that customers aged 80 or over have been grouped together for the purposes of calculating the age credits for the 2024/2025 Calibration, as opposed to having two separate groupings (i.e. ages 80-84 and 85+) as was the case for the 2023/2024 Calibration. This has been done due to variable levels of claims experience observed in the data due to low levels of insured older lives, which would have resulted in lower credits for insured lives aged 85 or over when compared to the credits for the 80-84 age groups. As such the age credits for all customers aged 80 or over are proposed to be the same although they will vary by gender and level of cover.

The 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.

The Authority recommends that HUC be calculated as 20% of the current standard charges for private care in public hospitals as set out in the fourth schedule to the Health Act, 1970 (Act No.

1/1970)[12]. The Authority further recommends that these amounts are rounded to the nearest whole euro and remain as specified amounts. The Authority is not proposing to have HUC rates that automatically change if there were to be a change in the amounts set out in the Health Act, 1970.

For overnight cases, the Authority recommends that HUC is calculated as 20% of the current 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 recommends that HUC is 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.

This increase in HUC rates is being recommended in line with the Authority's view that a higher proportion of RES credits should be allocated to health status related credits rather than age related credits.

The Authority recommends that the HCCP credits are based on a 45% quota share (increased from 40%) on claims in excess of €50,000. The estimated size of the credits to be distributed in respect of the HCCP for 2024/2025 RES calibration is €108.1m or 12.5% of the overall credits (2023/2024 Calibration: €101.2m or 11.4%).

Without increasing the HCCP quota share percentage, the estimated size of the credits to be distributed in respect of the HCCP for 2024/2025 RES calibration would have dropped to €96.1m or 11.2%). The Authority is of the view that small, frequent, increments to HCCP would put an undue administrative burden on insurance providers and is unlikely to recommend annual changes to the HCCP in the absence of material changes in the health insurance market.

## 7.3. Alternative Scenarios Considered

In coming to the recommendations, the Authority has looked at two alternative scenarios to the recommendations for the 2023/2024 RES. The first is based on no change to HUC rates. The second is based on no change to the HCCP quota share percentage. Details of these scenarios are included in Appendix 3.

## 7.4. Rationale for the Recommendations

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

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

[12] The Fourth Schedule to the Health Act, 1970 was inserted by the Health (Amendment) Act 2013 (Act No. 31/2013).

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

- The recommendation increases the effectiveness of the RES from 50.4% to 64.9% based on the Authority's defined measure of effectiveness[13];
- The recommendation is allocating more credits based on health status across all ages and is sharing risk for low incidence high-cost claims. This is contributing to more targeted distribution of health-related credits;
- Stamp duty for advanced products has reduced compared to the current calibration (2023/2024 Calibration: €438 vs 2024/2025 Calibration: €420). The reduction in stamp duty should serve to address concerns about affordability and stability of the market. The Authority is of the view that it is fair that consumers get the full benefit of this reduction in stamp duty and that it must be incorporated into the insurer's product pricing.

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

## 8. Projected Impact of Recommendation

The table below reconciles the change in stamp duty (and other key metrics) between last year's and this year's recommendations. The reduction in stamp duty is largely driven by improved claims experience in 2022 (relative to 2019) offset by reduced surplus and increased distribution of health status related credits. Further detail on the movement of other key metrics, including details of the financial impact on each of the insurers, is included in Appendix 3.

Table 8.1 Reconciliation of Change in Stamp Duty

| | Stamp Duty | | | | Credits Allocated | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Stamp Duty | Diff | Effectiveness (all) | Diff | Age Related | HUC | HCCP | Total Credits | Diff |
| **2023 RES Calibration** | **€438** | | **50.4%** | | **€587.7m (65.9%)** | **€202.7m (22.7%)** | **€102.1m (11.4%)** | **€892.5m** | |
| *RES Surplus* | *€458* | *€20* | *50.3%* | *(0.1%)* | *€594.6m (66.1%)* | *€202.7m (22.5%)* | *€102.1m (11.3%)* | *€899.4m* | *€6.9m* |
| *Claims Adjustment* | *€411* | *(€46)* | *68.9%* | *18.6%* | *€505.2m (62.4%)* | *€202.7m (25.0%)* | *€102.1m (12.6%)* | *€809.9m* | *(€89.5m)* |
| *Hospital Utilisation Rates* | *€404* | *(€7)* | *59.7%* | *(9.2%)* | *€525.2m (65.9%)* | *€170.2m (21.3%)* | *€102.1m (12.8%)* | *€797.4m* | *(€12.5m)* |
| *Insured Population Data* | *€406* | *€2* | *59.5%* | *(0.2%)* | *€557.9m (66.5%)* | *€178.8m (21.3%)* | *€102.1m (12.2%)* | *€838.7m* | *€41.3m* |
| *HUC Credit Update* | *€417* | *€11* | *61.3%* | *1.8%* | *€538.7m (62.7%)* | *€223.6m (26.0%)* | *€96.7m (11.3%)* | *€859.0m* | *€20.3m* |
| *HCCP Update* | *€420* | *€3* | *62.9%* | *1.7%* | *€536.4m (61.8%)* | *€223.6m (25.8%)* | *€108.1m (12.5%)* | *€868.0m* | *€9.1m* |
| *ARHC Grouping* | *€420* | *€0* | *64.9%* | *2.0%* | *€534.9m (61.7%)* | *€224.0m (25.8%)* | *€108.1m (12.5%)* | *€867.0m* | *(€1.0m)* |
| **Recommended 2024 Calibration** | **€420** | | **64.9%** | | **€534.9m (61.7%)** | **€224.0m (25.8%)** | **€108.1m (12.5%)** | **€867.0m** | |

The Authority has a defined measure of effectiveness and in making its recommendations this is one of a number of metrics which is considered. The proposed changes to the RES calibration result in a material increase in effectiveness.

### 8.1. Impact on Projected Net Claims Cost

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

- The average claims cost which tends to increase with age as, on average, older lives incur higher costs than younger lives;
- ARHC which serves to significantly reduce the net claims cost for those over 65 (who typically have larger claims). The level of the ARHC is calculated to be the amount necessary so that the net claims cost for age groups 65 and over does not exceed the claims cost ceiling of 140.0% (2023/2024: 140.0%) of the average net claims cost across all lives;
- HUC reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience episodes of hospitalisation and acts as a proxy for health status;

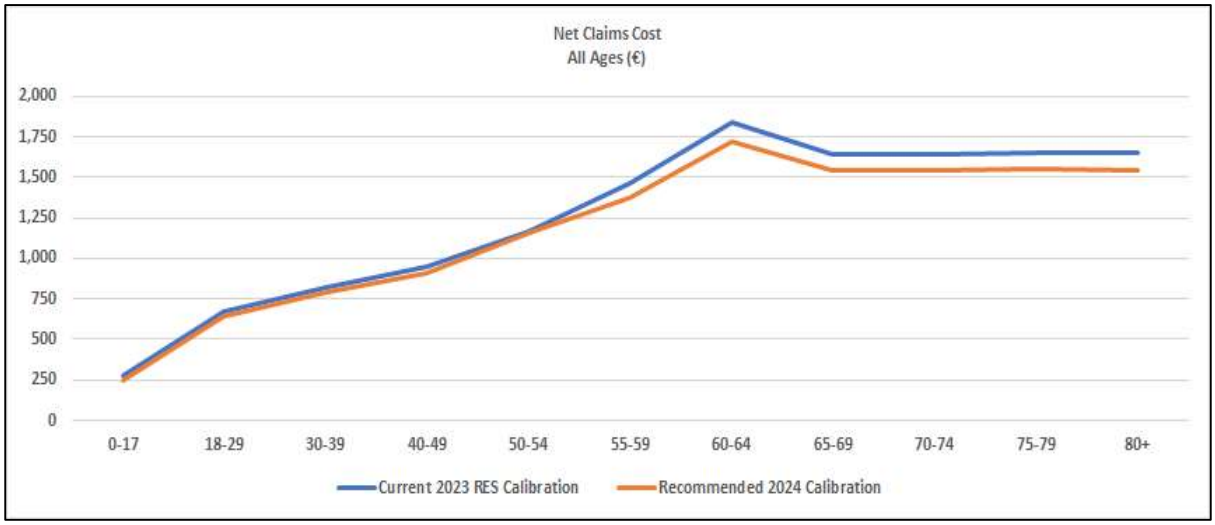
- HCCP reduces the net claims cost for less healthy people of all ages through compensatory payments for members who experience claims above a defined amount (threshold) and acts as a proxy for health status; and
- Stamp duty increases the net claims cost for all lives, stamp duty is collected from insurers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

The projected net claims cost of insured lives by age is one of the metrics which is considered by the Authority when making its recommendation to ensure the recommendation will not cause instability in the market, and also to gauge projected impact on the market. Set out in the table below are details of the change in net claims cost (and impact) by age for the recommended 2024/2025 RES calibration. A graphical representation of the net claims cost by all ages is included in Chart 9.1. We can see that the net claims cost has fallen for all age groups under the 2024 recommendation.

Table 8.2 Projected Net Claims Cost By Age

| **Net Claims Cost After RES** | Current 2023 RES Calibration | Recommended 2024 Calibration | Impact of Recommended Calibration |
|---|---|---|---|
| 0-17 | 272 | 243 | *(29)* |
| 18-29 | 668 | 645 | *(23)* |
| 30-39 | 821 | 786 | *(35)* |
| 40-49 | 951 | 910 | *(41)* |
| 50-54 | 1,162 | 1,155 | *(7)* |
| 55-59 | 1,459 | 1,369 | *(90)* |
| 60-64 | 1,837 | 1,723 | *(114)* |
| 65-69 | 1,640 | 1,541 | *(99)* |
| 70-74 | 1,640 | 1,544 | *(96)* |
| 75-79 | 1,654 | 1,550 | *(104)* |
| 80+ | 1,656 | 1,546 | *(110)* |

Chart 8.1: Net Claims Cost Comparison (All Ages)




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

The projected net financial impacts for each insurer, for a 12-month period, based on the credits and stamp duty applying for policies commencing in the period 1 April 2024 to 31 March 2025 are outlined in Table 9.3 below.

The projections for individual insurers are based on historic patterns of 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.

Table 8.3 Projected Net Financial Impacts by Insurer

| **Projected RES Flows** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **From 1 April 2023** | | | | | | | | |
| **€m** | **Irish Life Health** | **Laya Healthcare** | **Vhi Healthcare** | **Market** | | | | |
| Age Credits | [redacted] | [redacted] | [redacted] | 588 | | | | |
| HUC | [redacted] | [redacted] | [redacted] | 203 | | | | |
| HCCP | [redacted] | [redacted] | [redacted] | 102 | | | | |
| Stamp Duty | [redacted] | [redacted] | [redacted] | (838) | | | | |
| *NFI* | [redacted] | [redacted] | [redacted] | 55 | | | | |
| **From 1 April 2024** | | | | | **Change from 1 April 2023 Credits** | | | |
| **€m** | **Irish Life Health** | **Laya Healthcare** | **Vhi Healthcare** | **Market** | **Irish Life Health** | **Laya Healthcare** | **Vhi Healthcare** | **Market** |
| Age Credits | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | (53) |
| HUC | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | 21 |
| HCCP | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | 6 |
| Stamp Duty | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | (3) |
| *NFI* | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | (29) |

## Appendix 1: Further Analysis of Information Returns

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

[redacted]

### *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/sex risk profile of each insurer; complementary to this index, we also gauge the significance of variations in treatment days not captured by the age/sex risk profile index by calculating a Hospital Utilisation Risk Profile Index.

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

### *Benefit per Insured Person*

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

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

Table A1.1 Average Returned Benefit per Insured Person €

| **Average Returned Benefits per Insured Person (€)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Insurer** | **July-Dec 2019** | **Jan-June 2020** | **July-Dec 2020** | **Jan-June 2021** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-June 2023** |
| Irish Life Health | [redacted] | | | | | | | |
| Laya Healthcare | [redacted] | | | | | | | |
| Vhi Healthcare | [redacted] | | | | | | | |
| **Market** | **548** | **461** | **409** | **464** | **488** | **512** | **536** | **548** |
| **% change vs July-Dec 2019** | | (16%) | (25%) | (15%) | (11%) | (7%) | (2%) | (0%) |

The market returned benefit per insured person for Jan-June 2023 is €548 which is the first period this metric has reverted to the pre COVID-19 levels observed in July-Dec 2019 period (€548). This metric has been trending upwards since July-Dec 2020 as the impacts of COVID-19 are reversed from

the market. [redacted]

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

Table A1.2 Average Returned Benefits per Insured Person

| Average Returned Benefits per Insured Person as a % of the Market Average | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Insurer** | **July-Dec 2019** | **Jan-June 2020** | **July-Dec 2020** | **Jan-June 2021** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-June 2023** |
| Irish Life Health | [redacted] | | | | | | | |
| Laya Healthcare | [redacted] | | | | | | | |
| Vhi Healthcare | [redacted] | | | | | | | |
| **Market** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

[redacted]

Average returned benefits per insured person for the 12 months to the end of June 2023 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 2022 are shown in brackets.

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

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | | | 56 (41) |
| 18-29 | | | | 71 (66) |
| 30-39 | | | | 82 (87) |
| 40-49 | | | | 131 (130) |
| 50-54 | | | | 223 (195) |
| 55-59 | | | | 358 (324) |
| 60-64 | | | | 481 (438) |
| 65-69 | | | | 619 (721) |
| 70-74 | | | | 1,148 (793) |
| 75-79 | | | | 1,482 (1,134) |
| 80-84 | | | | 1,630 (1,313) |
| 85+ | | | | 1,930 (1,589) |
| **All Ages** | | | | **228 (206)** |

Table A1.4: Male Level 1

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 59 (43) |
| 18-29 | [redacted] | [redacted] | [redacted] | 80 (74) |
| 30-39 | [redacted] | [redacted] | [redacted] | 87 (94) |
| 40-49 | [redacted] | [redacted] | [redacted] | 146 (136) |
| 50-54 | [redacted] | [redacted] | [redacted] | 236 (209) |
| 55-59 | [redacted] | [redacted] | [redacted] | 370 (335) |
| 60-64 | [redacted] | [redacted] | [redacted] | 536 (484) |
| 65-69 | [redacted] | [redacted] | [redacted] | 746 (812) |
| 70-74 | [redacted] | [redacted] | [redacted] | 1,392 (1,093) |
| 75-79 | [redacted] | [redacted] | [redacted] | 1,803 (1,387) |
| 80-84 | [redacted] | [redacted] | [redacted] | 2,180 (2,020) |
| 85+ | [redacted] | [redacted] | [redacted] | 2,761 (1,944) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **283 (272)** |

Table A1.5: Male Level 2

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 125 (108) |
| 18-29 | [redacted] | [redacted] | [redacted] | 268 (263) |
| 30-39 | [redacted] | [redacted] | [redacted] | 291 (288) |
| 40-49 | [redacted] | [redacted] | [redacted] | 485 (462) |
| 50-54 | [redacted] | [redacted] | [redacted] | 780 (721) |
| 55-59 | [redacted] | [redacted] | [redacted] | 1,126 (1,034) |
| 60-64 | [redacted] | [redacted] | [redacted] | 1,599 (1,471) |
| 65-69 | [redacted] | [redacted] | [redacted] | 2,242 (1,970) |
| 70-74 | [redacted] | [redacted] | [redacted] | 2,870 (2,568) |
| 75-79 | [redacted] | [redacted] | [redacted] | 3,482 (3,302) |
| 80-84 | [redacted] | [redacted] | [redacted] | 3,953 (3,676) |
| 85+ | [redacted] | [redacted] | [redacted] | 4,277 (4,010) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **1,038 (951)** |

Table A1.6: Male Level 2+

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 129 (112) |
| 18-29 | [redacted] | [redacted] | [redacted] | 265 (260) |
| 30-39 | [redacted] | [redacted] | [redacted] | 292 (288) |
| 40-49 | [redacted] | [redacted] | [redacted] | 493 (470) |
| 50-54 | [redacted] | [redacted] | [redacted] | 815 (752) |
| 55-59 | [redacted] | [redacted] | [redacted] | 1,181 (1,082) |
| 60-64 | [redacted] | [redacted] | [redacted] | 1,668 (1,526) |
| 65-69 | [redacted] | [redacted] | [redacted] | 2,328 (2,091) |
| 70-74 | [redacted] | [redacted] | [redacted] | 3,101 (2,750) |
| 75-79 | [redacted] | [redacted] | [redacted] | 3,784 (3,575) |
| 80-84 | [redacted] | [redacted] | [redacted] | 4,315 (4,077) |
| 85+ | [redacted] | [redacted] | [redacted] | 4,999 (4,762) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **1,155 (1,063)** |

Table A1.7: Female Non-Advanced

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 48 (44) |
| 18-29 | [redacted] | [redacted] | [redacted] | 65 (48) |
| 30-39 | [redacted] | [redacted] | [redacted] | 117 (124) |
| 40-49 | [redacted] | [redacted] | [redacted] | 163 (158) |
| 50-54 | [redacted] | [redacted] | [redacted] | 277 (260) |
| 55-59 | [redacted] | [redacted] | [redacted] | 251 (296) |
| 60-64 | [redacted] | [redacted] | [redacted] | 454 (379) |
| 65-69 | [redacted] | [redacted] | [redacted] | 521 (563) |
| 70-74 | [redacted] | [redacted] | [redacted] | 678 (583) |
| 75-79 | [redacted] | [redacted] | [redacted] | 791 (810) |
| 80-84 | [redacted] | [redacted] | [redacted] | 874 (924) |
| 85+ | [redacted] | [redacted] | [redacted] | 1,299 (1,288) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **208 (202)** |

Table A1.8: Female Level 1

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 50 (50) |
| 18-29 | [redacted] | [redacted] | [redacted] | 71 (54) |
| 30-39 | [redacted] | [redacted] | [redacted] | 129 (142) |
| 40-49 | [redacted] | [redacted] | [redacted] | 171 (168) |
| 50-54 | [redacted] | [redacted] | [redacted] | 285 (276) |
| 55-59 | [redacted] | [redacted] | [redacted] | 289 (311) |
| 60-64 | [redacted] | [redacted] | [redacted] | 498 (392) |
| 65-69 | [redacted] | [redacted] | [redacted] | 662 (661) |
| 70-74 | [redacted] | [redacted] | [redacted] | 858 (826) |
| 75-79 | [redacted] | [redacted] | [redacted] | 1,346 (1,095) |
| 80-84 | [redacted] | [redacted] | [redacted] | 1,441 (1,326) |
| 85+ | [redacted] | [redacted] | [redacted] | 2,065 (1,718) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **261 (262)** |

Table A.9: Female Level 2

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 126 (114) |
| 18-29 | [redacted] | [redacted] | [redacted] | 300 (306) |
| 30-39 | [redacted] | [redacted] | [redacted] | 605 (618) |
| 40-49 | [redacted] | [redacted] | [redacted] | 680 (636) |
| 50-54 | [redacted] | [redacted] | [redacted] | 926 (852) |
| 55-59 | [redacted] | [redacted] | [redacted] | 1,072 (1,033) |
| 60-64 | [redacted] | [redacted] | [redacted] | 1,361 (1,260) |
| 65-69 | [redacted] | [redacted] | [redacted] | 1,765 (1,644) |
| 70-74 | [redacted] | [redacted] | [redacted] | 2,284 (2,137) |
| 75-79 | [redacted] | [redacted] | [redacted] | 2,848 (2,687) |
| 80-84 | [redacted] | [redacted] | [redacted] | 3,127 (3,070) |
| 85+ | [redacted] | [redacted] | [redacted] | 3,303 (3,059) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **1,038 (981)** |

Table A1.10: Female Level 2+

| Age Group | Irish Life Health € | Laya Healthcare € | Vhi Healthcare € | Weighted Market Average € |
|---|---|---|---|---|
| 0-17 | [redacted] | [redacted] | [redacted] | 132 (118) |
| 18-29 | [redacted] | [redacted] | [redacted] | 311 (310) |
| 30-39 | [redacted] | [redacted] | [redacted] | 618 (632) |
| 40-49 | [redacted] | [redacted] | [redacted] | 702 (655) |
| 50-54 | [redacted] | [redacted] | [redacted] | 961 (876) |
| 55-59 | [redacted] | [redacted] | [redacted] | 1,131 (1,083) |
| 60-64 | [redacted] | [redacted] | [redacted] | 1,455 (1,346) |
| 65-69 | [redacted] | [redacted] | [redacted] | 1,870 (1,711) |
| 70-74 | [redacted] | [redacted] | [redacted] | 2,432 (2,277) |
| 75-79 | [redacted] | [redacted] | [redacted] | 3,113 (2,958) |
| 80-84 | [redacted] | [redacted] | [redacted] | 3,535 (3,386) |
| 85+ | [redacted] | [redacted] | [redacted] | 3,784 (3,413) |
| **All Ages** | [redacted] | [redacted] | [redacted] | **1,153 (1,081)** |

### *Average Returned Benefit per Treatment Day*

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

We note the figures below are impacted by the CCV data issues set out in Section 3.5.

Table A1.11 Average Returned Benefit per Treatment Day

| Average Returned Benefits per Treatment day (€) | | | | |
|---|---|---|---|---|
| **Insurer** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-Jun 2023** |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Market | 1,296 | 1,269 | 1,301 | 1,320 |

Average returned benefits per treatment day have increased across the market as a whole over the past 12 months by 4.0% (i.e. increase between Jan-June 2022 and Jan-June 2023). [redacted]

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

| Average Returned Benefits per Treatment day as a % of the Market Average | | | | |
|---|---|---|---|---|
| **Insurer** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-Jun 2023** |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Market | 100% | 100% | 100% | 100% |

[redacted]

*Average number of treatment days per insured person*

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

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

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

We note again the figures below are impacted by the data issues set out in Section 3.5.

Table A1.13 Average Treatment Day per Insured Person

| **Average Treatment Day per Insured Person** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Insurer** | **July-Dec 2019** | **Jan-June 2020** | **July-Dec 2020** | **Jan-June 2021** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-June 2023** |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Market | 0.472 | 0.395 | 0.317 | 0.343 | 0.376 | 0.403 | 0.412 | 0.415 |

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

| **Average Treatment Day per Insured Person as a % of the Market Average** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Insurer** | **July-Dec 2019** | **Jan-June 2020** | **July-Dec 2020** | **Jan-June 2021** | **July-Dec 2021** | **Jan-June 2022** | **July-Dec 2022** | **Jan-June 2023** |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Market | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

The average treatment days per insured person was relatively stable in periods before December 2019. Due to the impact of COVID-19, the average treatment days per insured person has reduced from 0.472 to 0.415 in the 6-month period to June 2023, a fall of 12%. Over the past 12 months the average treatment days per insured person has increased for all the insurers.

[redacted]

*Age/Sex Risk Profile Index*

Another approach is to compare the risk profiles based on the age/sex 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/sex of the insured person. We can then compare the average weighting for each insurer. We refer to this average weighting as the age/sex risk profile index.

The difficulty with this approach lies in finding an appropriate weight for each age/sex combination. One weight that may be considered appropriate is the market average number of treatment days for each age/sex 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.

[redacted]

[redacted]

### *Hospital Utilisation Risk Profile Index*

Of course, the age/sex risk profile index ignores differences in risk profiles due to other factors, i.e. it ignores whether insurers' risk profiles vary within age/sex 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/sex bands we calculate an overall index of the hospital utilisation risk profile (ignoring the effect of differences in the age/sex 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/sex profile and their own level of treatment days for each age/sex group. The standard age/sex profile that we use is the profile for the market as a whole.

[redacted]

[redacted]

## Appendix 2: Risk Equalisation Credits and Stamp Duty from 1 April 2024

Table A2.1 below shows the projected membership as at 1 October 2024 (the time the average policy incepted between 1 April 2024 and 31 March 2025). Tables A2.2 to A2.4 show the projected returned benefits, hospital nights and day case admissions as at 1 April 2024. This data was used in the calculation of the stamp duty and Risk Equalisation Credits in the scenario shown below.

Table A2.1 Projected Membership as at 1 October 2024

| **Projected Membership as at 1 October 2023** | | | | |
|---|---|---|---|---|
| **Age Group** | **Non-Advanced** | | **Advanced** | |
| | **Male** | **Female** | **Male** | **Female** |
| 0-17 | 13,106 | 12,195 | 269,471 | 257,471 |
| 18-29 | 13,246 | 14,661 | 140,370 | 142,466 |
| 30-39 | 17,068 | 15,971 | 134,272 | 153,153 |
| 40-49 | 17,633 | 16,385 | 167,243 | 189,261 |
| 50-54 | 6,471 | 6,416 | 78,547 | 85,237 |
| 55-59 | 5,222 | 4,975 | 70,589 | 79,309 |
| 60-64 | 3,704 | 3,827 | 65,635 | 74,317 |
| 65-69 | 2,966 | 2,874 | 58,386 | 64,690 |
| 70-74 | 1,988 | 2,016 | 50,614 | 56,387 |
| 75-79 | 1,186 | 1,151 | 41,826 | 46,571 |
| 80+ | 786 | 877 | 40,365 | 50,674 |
| **Total** | **83,376** | **81,348** | **1,117,318** | **1,199,536** |

Table A2.2 Projected Average Returned Benefit at 1 April 2024 (€)

| **Projected Average Returned Benefit at 1 April 2024 (€)** | | | | |
|---|---|---|---|---|
| **Age Group** | **Non-Advanced** | | **Advanced** | |
| | Male | Female | Male | Female |
| 0-17 | 56 | 51 | 125 | 128 |
| 18-29 | 79 | 70 | 293 | 318 |
| 30-39 | 97 | 136 | 299 | 649 |
| 40-49 | 147 | 170 | 504 | 702 |
| 50-54 | 245 | 315 | 795 | 939 |
| 55-59 | 363 | 294 | 1,140 | 1,083 |
| 60-64 | 517 | 478 | 1,638 | 1,364 |
| 65-69 | 718 | 578 | 2,193 | 1,765 |
| 70-74 | 911 | 754 | 2,782 | 2,302 |
| 75-79 | 1,155 | 949 | 3,526 | 2,897 |
| 80+ | 1,331 | 1,035 | 4,065 | 3,160 |
| **All Ages** | **213** | **210** | **922** | **931** |

Table A2.3 Projected Total Bed Nights at 1 April 2024

| Projected Total Bed Nights at 1 April 2024 | | | | |
|---|---|---|---|---|
| **Age Group** | **Non-Advanced** | | **Advanced** | |
| | **Male** | **Female** | **Male** | **Female** |
| 0-17 | 522 | 525 | 21,271 | 22,802 |
| 18-29 | 619 | 547 | 19,036 | 27,749 |
| 30-39 | 919 | 1,324 | 16,417 | 58,333 |
| 40-49 | 1,265 | 1,286 | 30,264 | 51,595 |
| 50-54 | 886 | 1,272 | 21,401 | 25,293 |
| 55-59 | 1,137 | 706 | 27,926 | 30,362 |
| 60-64 | 1,087 | 1,175 | 36,903 | 39,861 |
| 65-69 | 1,609 | 984 | 48,276 | 47,323 |
| 70-74 | 1,251 | 1,109 | 58,086 | 55,792 |
| 75-79 | 1,178 | 711 | 68,761 | 66,189 |
| 80+ | 1,178 | 806 | 109,026 | 113,846 |
| **Total** | **11,651** | **10,445** | **457,367** | **539,144** |

Table A2.4 Projected Total Day Case Admissions at 1 April 2024

| Projected Total Day Case Admissions at 1 April 2024 | | | | |
|---|---|---|---|---|
| **Age Group** | **Non-Advanced** | | **Advanced** | |
| | **Male** | **Female** | **Male** | **Female** |
| 0-17 | 199 | 117 | 8,298 | 6,491 |
| 18-29 | 357 | 347 | 12,254 | 16,581 |
| 30-39 | 607 | 696 | 16,095 | 24,914 |
| 40-49 | 977 | 1,293 | 32,680 | 53,439 |
| 50-54 | 558 | 716 | 22,364 | 34,718 |
| 55-59 | 727 | 671 | 27,812 | 37,002 |
| 60-64 | 660 | 569 | 33,708 | 39,503 |
| 65-69 | 573 | 483 | 40,560 | 40,214 |
| 70-74 | 446 | 399 | 46,051 | 41,875 |
| 75-79 | 421 | 247 | 47,084 | 41,143 |
| 80+ | 224 | 184 | 42,136 | 40,641 |
| **Total** | **5,750** | **5,722** | **329,042** | **376,523** |

### *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 140.0% of the average net cost across all groups. The Authority recommends that a HUC of €163 is applied for overnight inpatient stays and €81 is applied for day stays. Claims inflation is assumed to be 0%, 5% and 5% 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 25% of the stamp duty relating to advanced contracts. The REF is projected to have a surplus of €25m when the contracts written prior to 1 April 2024 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 2022 – Dec 2022.

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

In our projections we have projected the population at 1 July 2023 forward to 1 October 2024 (to allow for the natural ageing of the insured lives), we have not allowed for any market shrinkage, this is a key judgement for the population projection. The Authority has updated how the increase in the projected population is allocated to age cohorts for the 2024/2025 Calibration. Lives under 65 are assumed to increase by 104,300 which is allocated to age bands in line with age distribution observed in the base population at 1 July 2023. 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.

[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[14] (€m) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Non-Advanced | | Advanced | | | | | |
| | Non-Adv | Adv | Men | Women | Men | Women | | | | |
| 0-17 | 35 | 140 | 0 | 0 | 0 | 0 | 9 | 0 | 3 | 12 |
| 18-29 | 105 | 420 | 0 | 0 | 0 | 0 | 10 | 0 | 3 | 13 |
| 30-39 | 105 | 420 | 0 | 0 | 0 | 0 | 16 | 0 | 4 | 20 |
| 40-49 | 105 | 420 | 0 | 0 | 0 | 0 | 21 | 0 | 8 | 29 |
| 50-54 | 105 | 420 | 0 | 0 | 0 | 0 | 13 | 0 | 5 | 18 |
| 55-59 | 105 | 420 | 0 | 0 | 0 | 0 | 15 | 0 | 8 | 23 |
| 60-64 | 105 | 420 | 0 | 0 | 0 | 0 | 19 | 0 | 11 | 30 |
| 65-69 | 105 | 420 | 250 | 150 | 850 | 425 | 23 | 78 | 14 | 115 |
| 70-74 | 105 | 420 | 425 | 300 | 1,375 | 925 | 26 | 123 | 16 | 166 |
| 75-79 | 105 | 420 | 600 | 475 | 2,025 | 1,450 | 29 | 153 | 15 | 198 |
| 80+ | 105 | 420 | 700 | 500 | 2,425 | 1,600 | 43 | 180 | 21 | 244 |
| **Total** | | | | | | | **224** | **535** | **108** | **867** |

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

| €m | Irish Life Health | Laya Healthcare | VHI Healthcare | Total |
|---|---|---|---|---|
| Age Related Health Credits | [redacted] | [redacted] | [redacted] | 535 |
| Hospital Bed Utilisation Credit | [redacted] | [redacted] | [redacted] | 224 |
| HCCP | [redacted] | [redacted] | [redacted] | 108 |
| Stamp Duty | [redacted] | [redacted] | [redacted] | (841) |
| **Total** | [redacted] | [redacted] | [redacted] | 26 |

[14] This total credit applied is the sum of the stamp duty income of €841m and surplus in the fund of €25m.

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

The table below reconciles the change in stamp duty and other key metrics from the current 2023/2024 Calibration to the recommended 2024/2025 Calibration.

Table A3.1 2024/2025 Calibration – Analysis of Movement

| | 2023 RES Calibration | RES Surplus | Claims Adjustment | Hospital Utilisation Rates | Insured Population Data | HUC Credit Update | HCCP Update | ARHC Grouping | Recommended 2024 Calibration |
|---|---|---|---|---|---|---|---|---|---|
| **Stamp Duty** | | | | | | | | | |
| Advanced | **€438** | €458 | €411 | €404 | €406 | €417 | €420 | €420 | **€420** |
| Non-Advanced | **€109** | €114 | €103 | €101 | €101 | €104 | €105 | €105 | **€105** |
| CCC | **140.0%** | 140.0% | 140.0% | 140.0% | 140.0% | 140.0% | 140.0% | 140.0% | **140.0%** |
| **Projected RES Flows** | | | | | | | | | |
| Stamp Duty | **€837.5m** | €875.2m | €786.4m | €772.4m | €812.4m | €834.9m | €840.9m | €841.4m | **€841.4m** |
| Total Credits | **€892.5m** | €899.4m | €809.9m | €797.4m | €838.7m | €859.0m | €868.0m | €867.0m | **€867.0m** |
| *ARHC* | ***€587.7m (65.9%)*** | *€594.6m (66.1%)* | *€505.2m (62.4%)* | *€525.2m (65.9%)* | *€557.9m (66.5%)* | *€538.7m (62.7%)* | *€536.4m (61.8%)* | *€534.9m (61.7%)* | ***€534.9m (61.7%)*** |
| *HUC* | ***€202.7m (22.7%)*** | *€202.7m (22.5%)* | *€202.7m (25.0%)* | *€170.2m (21.3%)* | *€178.8m (21.3%)* | *€223.6m (26.0%)* | *€223.6m (25.8%)* | *€224.0m (25.8%)* | ***€224.0m (25.8%)*** |
| *HCCP* | ***€102.1m (11.4%)*** | *€102.1m (11.3%)* | *€102.1m (12.6%)* | *€102.1m (12.8%)* | *€102.1m (12.2%)* | *€96.7m (11.3%)* | *€108.1m (12.5%)* | *€108.1m (12.5%)* | ***€108.1m (12.5%)*** |
| **Effectiveness** | | | | | | | | | |
| All Ages | **50.4%** | 50.3% | 68.9% | 59.7% | 59.5% | 61.3% | 62.9% | 64.9% | **64.9%** |
| Over 65 | **53.6%** | 53.4% | 73.7% | 64.1% | 64.3% | 66.1% | 67.7% | 70.2% | **70.2%** |
| **Total Projected NFI** | | | | | | | | | |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Total | **€55m** | €24m | €23m | €25m | €26m | €24m | €27m | €26m | **€26m** |

The 2023 RES Calibration plus RES surplus can be thought of as the opening position for the REF. The claims adjustment, hospital utilisation rates and insured population data columns apply the data and assumption updates. The HUC Credit update and HCCP update apply the recommended policy changes to the RES as set out in Section 7.2. The final ARHC grouping is necessary to ensure a reasonable progression of stamp duty in the 2024 calibration and is also discussed in Section 7.2.

## Alternative Scenarios Considered

Below is a summary of the alternatives considered for setting credits and stamp duty from 1 April 2024.

Table A3.2 2024/2025 Calibration – Alternative Scenario

| | 2023/2024 RES Calibration | Recommended 2024/2025 Calibration | Alternative Scenarios | |
|---|---|---|---|---|
| | | | HUC Credits as per 2023/2024 RES Calibration | HCCP QS Remains 40% |
| **Stamp Duty** | | | | |
| Advanced | €438 | €420 | €409 | €417 |
| Non-Advanced | €109 | €105 | €102 | €104 |
| CCC | 140.0% | 140.0% | 140.0% | 140.0% |
| Projected RES Flows | | | | |
| Stamp Duty | €837.5m | €841.4m | €819.2m | €836.0m |
| Total Credits | €892.5m | €867.0m | €844.1m | €860.1m |
| *ARHC* | *€587.7m (65.9%)* | *€534.9m (61.7%)* | *€549.6m (65.1%)* | *€540.0m (62.8%)* |
| *HUC* | *€202.7m (22.7%)* | *€224.0m (25.8%)* | *€181.1m (21.5%)* | *€224.0m (26%)* |
| *HCCP* | *€102.1m (11.4%)* | *€108.1m (12.5%)* | *€113.4m (13.4%)* | *€96.1m (11.2%)* |
| Effectiveness | | | | |
| All Ages | 50.4% | 64.9% | 63.1% | 62.2% |
| Over 65 | 53.5% | 70.2% | 68.3% | 67.4% |
| Total Projected NFI €m | | | | |
| Irish Life Health | [redacted] | [redacted] | [redacted] | [redacted] |
| Laya Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Vhi Healthcare | [redacted] | [redacted] | [redacted] | [redacted] |
| Total | €55m | €26m | €25m | €24m |

In order to investigate the potential impact of the proposed change to HUC rates a scenario test was performed using the same assumptions as the recommended calibration and HUC rates that applied to the 2023/2024 RES calibration. This resulted in lower stamp duty and a lower proportion of credits being applied through health status related credits. The reduction in credits paid through HUC was somewhat mitigated by a higher proportion of claims projected to be eligible for HCCP credit. This is to be expected because the HCCP threshold on an individual claim is increased by the HUC credit already paid on that claim. See Table 4.2 for details.

In order to better understand the implications of increasing the quota share parameter in the HCCP from 40% to 45%, a scenario test was performed assuming the quota share remained at 40%. Due to the interaction of HUC and HCCP the impact on stamp duty and proportion of credits being applied through health status related credits is small. It should be noted however, that HCCP credits support a broader range of healthcare. One particular example of healthcare supported by HCCP that is not eligible for HUC is certain mental health care can be high cost but take place in a setting not eligible for HUC. For the avoidance of doubt, this scenario, and indeed the recommended calibration, do not include a change to the €50,000 threshold that must be reached before the quota share applies.

## Sensitivity of 2024/2025 Calibration to Actual Experience

The 2024/2025 Calibration assumes that the level of credits expected to be paid will exceed the expected stamp duty receipts, by a magnitude of €25m. 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 2025 are fully earned. If actual experience differs from expectation, a surplus or deficit will emerge which will feed into the 2025/2026 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 HUC credits paid and the level of 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 2024/2025 Calibration - Sensitivities

| | Recommended 2024/2025 Calibration | Population 2% Lower Than Expected | Hospital Utilisation 5% Lower Than Expected | Claims 5% Higher Than Expected | Claims 10% Higher Than Expected |
|---|---|---|---|---|---|
| Additional Information | | Assumes population reductions only happen at ages less than age 65. | 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 claims costs increase by 5% which impacts on the amount and number of insured lives having a high cost claim. | Assumes hospitalisation utilisation unchanged but claims costs increase by 10% which impacts on the amount and number of insured lives having a high cost claim. |
| Projected RES Flows | | | | | |
| Stamp Duty | €841.4m | €824.6m | €841.4m | €841.4m | €841.4m |
| Total Credits | €867.0m | €867.0m | €855.8m | €900.6m | €941.3m |
| *ARHC* | *€534.9m* | *€534.9m* | *€534.9m* | *€534.9m* | *€534.9m* |
| *HUC* | *€224.0m* | *€224.0m* | *€212.8m* | *€224.0m* | *€224.0m* |
| *HCCP* | *€108.1m* | *€108.1m* | *€108.1m* | *€141.7m* | *€182.4m* |
| | | | | | |
| Impact on Surplus (Deficit) | | (€16.8m) | €11.2m | (€33.6m) | (€74.3m) |

## Appendix 4: Principal Objective

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

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

## Appendix 5: RES Recommendation for Contracts Incepted 1 April 2023 to 31 March 2024

Table A5.1 Risk Equalisation Credits

| Age Bands | Utilisation Credits (Overnight / Day Case) From 1 April 2023 | Age / Gender / Level of Cover Credits from 1 April 2023 | | | |
|---|---|---|---|---|---|
| | | Non-Advanced | | Advanced | |
| | | Men | Women | Men | Women |
| 64 and under | €125 / €75 | €0 | €0 | €0 | €0 |
| 65-69 | €125 / €75 | €350 | €200 | €950 | €525 |
| 70-74 | €125 / €75 | €525 | €400 | €1,550 | €1,075 |
| 75-79 | €125 / €75 | €775 | €575 | €2,300 | €1,650 |
| 80-84 | €125 / €75 | €900 | €625 | €2,725 | €1,950 |
| 85 and above | €125 / €75 | €1,000 | €700 | €3,000 | €2,050 |

Table A5.2 Stamp Duty

| Age Bands | Stamp Duties from 1 April 2023 to 31 March 2024 | |
|---|---|---|
| | Non-Advanced | Advanced |
| 17 and under | €36 | €146 |
| 18 and over | €109 | €438 |

## 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 140.0% of average by level of cover, the RES will not be 100% effective, particularly at the older ages. This reflects competing aims of maintaining the sustainability of the market and stability of the market which relies on younger members to maintain the intergenerational solidarity that underpins the principal of community rating.
- The applicable rates of Risk Equalisation Credits and Community Rating Stamp Duty are set out in law.

Calibration Calculation Approach

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

- The age credits for advanced cover contracts are based on the average claim costs for Level 2 products (products that, in the main, provide cover for semi-private accommodation in private hospitals, rather than private accommodation). These credits apply from ages 65 and over. Claims inflation over the term of the projection is calibrated by element of returned benefit (public: 0% p.a., private: 5% p.a., consultant: 5% 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 140.0% of the average net claims cost for Level 2 contracts.
- The average net claims costs are adjusted to allow for HUC and HCCP. In simple terms the stamp duty in respect of HUC and HCCP is added to the net claims costs while the credits expected to be received are deducted. Thus the claims cost ceiling applies to the adjusted Level 2 net claims cost amount.
- When a HCCP is included, the projected average returned benefit reduces as average HCCP for the cohort of lives has been removed from the average returned benefit and as such the claims cost ceiling is applied to a lower amount. The amount of HCCP depends on the level of the quota share and claims excess.
- The calculated age credits are rounded to the nearest €25.
- The age credits for non-advanced contracts are based on the average claim costs for non-advanced products. Adjusted claim costs for non-advanced contracts aged 65 and over are calculated by applying the average ratio of non-advanced claims costs to Level 2 claims costs for all ages 65 and over combined. The age credits for non-advanced contracts are calculated using the same methods as advanced contracts although the results are smoothed due to lack of claims data at older ages.

- Hospital Utilisation Credits:
  - A hospital utilisation credit of €163 is made for each night that an insured person spends in a hospital.
  - A hospital utilisation credit of €81 is made in respect of each day case admission.
  - The total number of lives is used to derive the stamp duty required in respect of HUC.
- High Cost Claim Pool Credits:
  - Total HCCP (which depends on the level of the quota share and claims excess) is paid out in credits.
  - The claims excess is defined as the HCCP Threshold plus (Total ARHC for contract year) plus (HUC received in claim quarter and previous 3 quarters).
  - The total number of lives is used to derive the stamp duty required in respect of HCCP.
- The stamp duty for non-advanced reflects the lower credits paid in respect of these contracts, and, accordingly, be set at 25% 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.