Subject: State Aid N 46/2003 - Ireland  
Risk equalisation scheme in the Irish health insurance market

Sir,

The Commission wishes to inform the Irish Authorities that, having examined the information supplied on the measure referred to above, it has decided not to raise objections.

1. Procedure

(1) On the 23rd January 2003, Irish authorities formally notified the Commission of their intention to introduce a Risk Equalisation scheme (hereafter RES) in the Irish health insurance market.

(2) The Commission requested information on the 10th, the 14th and the 17th February 2003. Irish authorities submitted information to the Commission on the 14th, the 17th and the 21st February 2003 and on the 4th and the 27th March 2003.

2. Background

(3) Private medical insurance (hereafter PMI) was formally inaugurated in Ireland in 1957 with the establishment by the government of the Voluntary Health Insurance Board (hereafter VHI). The primary reason for this initiative was to provide a means of insurance against hospitalisation costs to the 15% of the population who at the time were not eligible for public hospital services. The Voluntary Health Insurance Act of 1957 also required other bodies engaged in business of health insurance to be licensed by the Minister of Health. No licences were granted to other insurers and VHI had a monopoly position.
(4) The Irish PMI market was opened to competition under the provisions of the 1994 Health Insurance Act and the 1996 Health Insurance Regulations. The British United Provident Association (hereafter BUPA) entered the Irish PMI market in 1996 by establishing a branch (BUPA Ireland), with effect from 1st January 1997.

(5) The 1994 Health Insurance Act set the ground rules for the provision of health insurance in Ireland and enshrined in legislation the principles of community rating, lifetime cover and open enrolment, which had governed the operations of VHI since its establishment in 1957. The 1994 Act gave the relevant Minister power to prescribe a scheme or schemes of risk equalisation and to make Statutory Regulations accordingly, “if, but only if, he or she is satisfied that it is necessary to do so having regard to the effect of the operation of sections 7 to 11” (these are the sections prescribing community rating etc.). The 1996 Health Insurance Regulations also provided for the operation of a RES, but the scheme was never activated.

(6) In 1997, the Minister of Health and Children set up an Advisory Group on the RES with the mandate to make recommendations to the Minister on adequate improvements.

(7) The Group reported in April 1998. It concluded that risk equalisation was necessary in the context of the stated policy objectives and broadly supported the framework proposed in the 1996 Regulations, subject to a number of amendments. In December 1998, the Minister decided not to proceed with the commencement of the risk equalisation pending the publication of a White Paper on the issue.

(8) In 1998 the Commission received a complaint in relation with the planned RES. Several meetings with the Irish authorities and with the complainants were held and the Commission received information from both parties.

(9) In January 1999, the Department of Health published a technical paper on risk equalisation for consultation. In February 1999 the RES scheme foreseen by the 1996 Regulations was officially revoked. A White Paper proposing amendments to the RES was published in September 1999.

(10) The 2001 Health Insurance Act empowered the Minister for Health and Children to issue statutory regulations on a revised RES. It also specified the process to be adopted in deciding whether and when to implement the scheme and gave the Health Insurance Authority (hereafter HIA), a significant role in this process. The HIA was established in February 2001.

(11) In February 2002, the HIA issued a consultation paper seeking submissions on how it should exercise its responsibilities and in September 2002 it issued a policy paper setting out its considerations on its role in relation to the RES.

(12) In January 2003, Irish authorities formally notified to the Commission a revised RES which replaces the one set up in March 1996 and revoked in February 1999.
3. The Irish Health Care System

(13) The Irish health care system is a mixture of:

- a universal public health service, free at the point of consumption and
- a private system where individuals pay, generally by way of voluntary private medical insurance, for expenses incurred for private medical treatment.

3.1 Universal Public Health Service

(14) All those below a relatively low income level have free access to all health services (public hospital services, general practitioner and pharmaceutical services) which are mainly founded through general taxation. Currently such access is granted to about one third of the population, though this number is falling as more people become employed.

(15) The remaining two thirds of the population are entitled since 1991 to public hospital services on payment of a modest charge, but must pay privately for general practitioner and pharmaceutical services.

3.2 Private Medical Insurance and Private Medical Treatment

(16) Following principles apply currently in the Irish PMI market:

- **Open enrolment**: health insurance companies must accept anyone under 65 who wishes to join, regardless of age, sex or health status; restricted membership schemes must accept everyone who is qualified to join; waiting periods for the payment of benefits are subject to conditions.

- **Lifetime cover**: contracts can not be renounced by the insurer.

- **Community rating**: this means that the insurance company must charge the same rate for a given level of service, regardless of age, sex or health status. So all adults pay the same amount for the same benefits.

- **Minimum benefits policies**: insurance contracts must provide benefits above a prescribed level, which is referred to as “minimum level”; the minimum accommodation level is semi-private in a public hospital.

4. The Notified Scheme

* Objective

(17) Risk Equalisation is a process which aims to neutralise differences in health insurers’ costs that arise due to variations in their risk profiles. This results in cash transfers from insurers with healthier then average risk profiles to those with less favourable risk profiles.
Scope

(18) Restricted Membership Undertakings may opt to be permanently excluded from risk equalisation. These bodies are structured as friendly societies under Irish law and provide health insurance cover specifically for the members of a specific vocational group or employees of a public utility and their immediate families. Given their limited size, the very restricted nature of the membership base and the consequent lack of capacity to affect stability in the market, it is considered that in all the circumstances the imposition of an obligation to participate in the risk equalisation scheme is unnecessary. They are thus being given a ‘once-off’ choice to be excluded from risk equalisation. Nevertheless, they are subject to community rating, open enrolment and lifetime cover in relation to the persons that qualify for membership under their rules.

Administration

(19) The scheme will be managed by the Health Insurance Authority (hereafter HIA), an independent body created by the 1994 Health Insurance Act (Part IV). It consists of 5 members appointed and removable by the Minister of Health. The Authority makes annual reports of its activities to the Minister who is required to lay copies of the Report before the Parliament.

Submission of information to the HIA

(20) Participating insurers are required to submit to the HIA statutory returns (in a specified format) covering periods of six months enabling the HIA to evaluate the nature and distribution of insured risks between them. Insurers have up to 30 days after the completion of a period to submit their returns to the HIA. The scheme also includes arrangements for certification and validation of returns, as well as for corrections of data submitted.

Triggering of the RES

(21) The HIA is charged to prepare and submit reports and recommendations to the Minister for Health and Children on the basis of its evaluation and analysis of the returns received from insurers. When an important risk differential (“material imbalance”) can be observed in the market, the HIA can propose the triggering of the system. The market risk differential is expressed in terms of a percentage of the amount of equalised benefits insurers would be liable to pay to the risk equalisation fund in order to ensure that in total they have a risk profile at, or approximate to, the market average experience.

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1 There are, effectively, three such restricted membership undertakings covering in or about 86 000 members: a) The Gardai (the police service) with 46 000 persons; b) The Electricity Supply Board with just under 30 000 persons; c) Prison officers with 10 000 persons. As a comparison, the VHI has approximately 1 500 000 members, and BUPA Ireland, 300 000 members.

2 They can only have members that qualify under strict vocational or occupational rules, they cannot compete for business in the market generally, they do not offer health insurance to the general public and neither are they resourced or operationally geared to carry out such a role.
(22) Between two specified parameters, set out under the scheme as measures of
differentials in the risk profiles of insurers (2% and 10%), the HIA will recommend
for or against the commencement of the risk equalisation transfers between insurers.
Risk equalisation payments cannot be commenced below the lower parameter (2%).
Within these parameters it is not open to the Minister to commence actual risk
equalisation without a recommendation to that effect from the HIA (between 2% and
10%). If the measure of differentials exceeds the higher parameter, the Minister, after
consulting the HIA activates the scheme unless there are good reasons for not
commencing risk equalisation between insurers (more then 10%).

(23) The following table illustrates the mechanism triggering the RES:

<table>
<thead>
<tr>
<th>Risk differentials between insurers expressed as a percentage of the amount of equalised benefits insurers would be liable to pay to the risk equalisation fund in order to ensure that in total they have a risk profile at, or approximate to, the market average experience</th>
<th>Triggering mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less then 2%</td>
<td>RES cannot be triggered</td>
</tr>
<tr>
<td>Between 2% and 10%</td>
<td>The HIA can recommend the triggering of the RES. The Minister cannot trigger the scheme without such a recommendation.</td>
</tr>
<tr>
<td>More then 10%</td>
<td>The Minister after consulting the HIA shall activate the scheme unless there are good reasons for not doing so.</td>
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(24) In formulating its recommendations, the HIA must take account of the best
overall interest of the health insurance consumers. It is thus not limited to the mere
outcome of a mathematical exercise, although this is part of the process. Furthermore,
the Minister and the HIA must give notice to, and consult with insurers in relation to
the proposed commencement of risk equalisation.

* General principle determining the payments into/by the Risk equalisation fund *

(25) On the basis of the information submitted by the insurers, a mathematical
formula allows to identify the benefits that would have been payable by each insurer
had the risk profile of that insurer’s policy holders been similar to the risk profile of
the entire insured population. By comparing these “standardised benefits” to the
benefits actually paid by the insurer, the HIA identifies the sum to be paid to/or received by the Risk equalisation fund.

* Costs to be equalised

(26) Not all benefits actually paid by the insurers are taken into account. Risk equalisation takes into account a maximum benefit level. The draft scheme prescribes the Maximum Equalised payments in respect of settled claims. It provides that these payments can include costs up to specified levels relating to public/private hospital charges, maternity and consultant fees. According to Irish authorities this benefit level is the level at which the majority of consumers in the market are covered. It does not extend to “luxury markets” but reflects the level that consumers see as a prudent and necessary level of private health insurance cover providing access to private care in public and private hospitals.

(27) Furthermore, the scheme takes into account the insurers own average claim cost, thus avoiding an equalisation of the insurers average costs per cell of insured population and allowing them to keep the benefit of their own efficiencies.

* Risk factors taken into account

(28) The HIA determines the basis on which risk equalisation payments are calculated. Age and gender differentials are automatically taken into account. The third factor included is a measure for health status based on hospital bed utilisation. The HIA has the power to determine the extent to which this factor is taken into account, within prescribed parameters, subject to the HIA having established that this is warranted by circumstances relating to the differences in risk profiles between insurers and is in the best overall interests of health insurance companies. This weighting can be in the range 0% to a maximum of 50%. The percentage is to be 0% on the scheme coming into operation. The maximum of 50% is a further protection to ensure that insurers retain an incentive to promote shorter hospital days, early detection and best practice generally.

(29) Thus, calculations are carried out in two independent streams.

- a calculation of potential equalisation payments using all three risk factors, namely, age, gender and health status;

- a calculation of potential equalisation payments taking into account age and gender only.

* Operation of payments into and by the Fund

(30) Article 12 of the draft scheme provides for the HIA to establish and operate a specific fund for the express purpose of receiving and making risk equalisation payments. The fund will be audited by the Controller and Auditor General. The accounts and the Controller and Auditor General’s report will be submitted to the Minister.
5. OBSERVATIONS OF PARTIES INVOLVED

5.1 Comments made by the Irish authorities

(31) Irish Authorities consider that the RES prevents new entrants in the market from "cherry picking" the good risks, leaving the traditional public operator (VHI), with the bad risks. In their view, such a scheme aims to prevent competition between insurance companies based on the risk profile of the insured individuals and to limit competition to other fields such as administration costs, profit margins and conditions of the insurance offered. Such an equalisation scheme is considered necessary to maintain respect of the basic principles applicable in the Irish PMI market, namely community rating, open enrolment and lifetime cover.

(32) As regards State aid rules, Irish Authorities argue that the RES does not involve any transfer of State resources and thus does not constitute a State aid. Furthermore, in their view, the RES is justified as a compensation for obligations imposed on all health insurance companies in Ireland (namely lifetime cover, open enrolment, community rating).

5.2 Comments made by the complainant

(33) The complainant considers that risk equalisation among insurers distorts competition and acts as a disincentive to cost containment in the health sector. In its view, the planned RES constitutes an aid to the State owned company, the VHI, which under the projected scheme would benefit from the payments. If the RES was activated, it would be impossible for a new entrant to compete with the VHI given the importance of payments he would have to make.

(34) Furthermore the complainant considers that health insurers in Ireland are not charged with the provision of a services of general economic interest (hereafter SGEI) and therefore that the RES cannot be justified as a compensation for SGEI obligations. A SGEI is a service which would not otherwise be supplied from the market, or would not be generally affordable (even if available), which is not the case for PMI in Ireland. In particular, the obligations imposed involve a very limited burden on insurers:

- Minimum benefits requirements don’t impose to health insurers to provide any cover beyond what competition would any way deliver;

- Community rating does not prevent product differentiation. Thus community rating does not exclude the possibility to vary the insurance products prices in relation with the risk profile of the consumers mostly interested by a certain type of product.

- Open enrolment is limited to the extent that there is no specification of the type of cover which must be offered (subject to minimum cover). Open enrolment is not applicable to people contracting for the first time private medical insurance above 65.
Life time cover is limited since cover is provided on a 12 month rolling basis. Thus, insurers can modify the products offered and are not obliged to ensure people on the same conditions over a life time.

Moreover, the complainant considers that a RES is not necessary to ensure the stability of the PMI market. Finally, a scheme such as the planned RES does not guarantee that payments are limited to the minimum necessary, since it does not take into account the overall result (loss/profit) of insurers and does not limit compensation to losses strictly linked with the alleged SGEI obligations.

6. ASSESSMENT

In accordance with Article 4(2) of the Council Regulation n° 659/1999 of 22 March 1999, where the Commission, after a preliminary examination, finds that the notified measure does not constitute aid, it shall record that finding by way of a decision. Furthermore, according to Article 4(3) of the Council Regulation n° 659/1999 of 22 March 1999, where the Commission, after a preliminary examination, finds that no doubts are raised as to the compatibility with the common market of a notified measure, in so far as it falls within the scope of Article 87(1) EC, it shall decide that the measure is compatible with the common market.

The Commission considers, on the basis of the following considerations, that the measure at issue does not constitute State aid within the meaning of Article 87(1) EC or can be declared compatible with the common market pursuant to Article 86(2) of the Treaty.

6.1 The PMI is an economic activity

Independently from any consideration as to whether the Irish PMI can be considered as "a partial or complete alternative to health cover provided by the statutory social security system" in the meaning of Council Directive 92/49/EEC, also known as the III non-life Directive, it clearly constitutes an economic activity, which is subject to competition rules. Indeed, the present decision only assesses the compatibility of the Irish scheme with State aid rules, without prejudice to the analysis of its compatibility with other relevant EU rules, in particular with Council Directive 92/49/EEC.

6.2 Applicability of Article 87 (1) EC

The RES fulfils in principle the criteria set out in Article 87 (1) EC

- It is a measure initiated by the State and will be imposed by State regulations.
- It involves the creation of a fund, which will be financed by compulsory contributions and controlled by a public authority entitled to decide upon the

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necessity of triggering the payments in favour of certain insurers and their amount, in accordance with legal provisions. Thus, it affects State resources.

- It compensates some undertakings for costs that they normally have to bear. Under normal market conditions, insurance companies have to bear the costs arising due to their risk profile and adapt their policy in consequence. Thus, a scheme imposed by the State which compensates with public funds some undertakings for costs that they normally have to bear, could be considered as “advantaging” these undertakings.

- The RES, if activated, would lead to payments from BUPA (the Irish branch of the well known British insurer) to VHI, the State owned Irish company, former monopoly. A scheme such as the RES which advantages an undertaking (the VHI) in dominant position (the VHI owns 85% of the market) comparing to its competitors and may discourage foreign companies to establish in Ireland can be considered as capable of affecting competition and intracommunity trade.

For these reasons, the RES could be qualified as a State aid in the sense of the EC Treaty.

6.3 The RES compensates insurers for SGEI obligations

(40) According to the “Ferring” judgement, an advantage given to undertakings charged with public service obligations which corresponds to the additional costs actually incurred by these undertakings in discharging their public service obligations, may be regarded as compensation for the services they provide and hence not State aid within the meaning of Article 87 of the Treaty. In the case at issue, Irish authorities consider that the RES does not involve the grant of a selective advantage and that it is justified as a compensation for obligations (namely open enrolment, community rating and lifetime cover) imposed on all insurers in the health insurance market.

* Public service obligations

(41) The obligations at issue aim to ensure a minimum level of PMI to all persons living in Ireland, at an affordable price and on similar quality conditions. This objective is achieved by installing a solidarity between policy holders. In particular:

- the open enrolment requirement avoids the exclusion of old or chronically ill persons from private medical insurance;

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5 According to a constant case law “the funds financed through compulsory contributions imposed by State legislation, which are managed and apportioned in accordance with the provisions of that legislation must be regarded as State resources within the meaning of Article 87” (Case 173-73 Italian Republic v Commission [1974] ECR 709, paragraph 16; Case 78/76 Steinkie [1977], ECR 595, paragraph 22; Cases C-78/99 to C-83/90, Sociétés Compagnie Commerciale de l'Ouest [1992], ECR I-1847; Cases C-149/91 and C-150/91 Sanders [1992], ECR I-3899; Case C-17/91 Lornooy [1992] ECR I- I-6523; Case C-114/91 Claeys [1992] ECR I-6559; Case C-114 and C-145/91 Demoor [1992] ECR I-6613).

6 Case C-53/00 Ferring SA v Agence centrale des organismes de sécurité sociale (ACOSS) [2001] ECR I-9067, paragraph 27.
the lifetime cover requirement avoids that insurers reject the policy holders when these become sick or old;

community rating imposes upon the insurers the obligation to apply the same premium on all policy holders for the same type of product irrespective of their health status, their age or sex. As a result, the premiums are fixed at a higher rate than that younger people would have to pay in a risk rated PMI market and premiums for older or sicker people are much more affordable. Thus, community rating is at the very corner of inter-generational solidarity: it provides all insured persons with the certainty that the advent of a chronic illness or sustaining of serious injury will not render the cost of cover unaffordable;

finally regulations on minimum benefits ensure that the products proposed will respect certain minimum quality standards although insurers are free to design their insurance products.

According to the Irish authorities, these requirements legally imposed on all insurers in the PMI market are to be considered as SGEI obligations, which can legitimately give rise to compensation.

(42) However, the complainant contests this qualification and considers that these requirements don’t provide cover or products going beyond what competition would deliver. He considers that the possibility given to the insurers to design their products (subject to minimum benefits) and to determine their pricing policy contradicts the notion of a SGEI which implies the obligation to provide a specific service at a specific price and at certain quality conditions. Finally, the complainant considers that the definition of SGEI is much too wide, as it includes services going beyond what the basic social security scheme offers. In his view, the SGEI should be limited to the provision of a product which “mirrors” the basic security scheme and provides to the two thirds of the population which are not entitled to the “medical card” the same services, at the same conditions as the “medical card” holders (free access to public hospital services, general practitioner and pharmaceutical services).

(43) The question thus arises whether the Commission can accept the qualification of the above mentioned requirements as SGEI obligations.

(44) In this respect, the Commission wishes to note that it recognises the importance of services of general interest as a key element in the European model of society (see the Communication on the Services of general interest in Europe C 17 19.01.2001, p. 4). Article 16 in the EC Treaty confirms their place among the shared values of the Union and their role in promoting social and territorial cohesion. The Commission considers that it is above all the responsibility of national authorities at the appropriate level (local, regional or national) to define the missions of services of general interest and the way they will be fulfilled (see the above mentioned Communication, §22). This definition can be subject to control by the Commission only for manifest error.

(45) If the public authorities consider that certain services are in the general interest and market forces may not result in a satisfactory provision, they can lay down a number of specific service provisions to meet these needs in the form of service of general interest obligations. Public authorities may decide to apply general interest obligations on all operators on a market or, in some cases, to designate one or a
limited number of operators with specific obligations (see the above mentioned Communication, §15). This is in particular the case where there is no harmonisation of a SGEI at a Community level, as it is the case for health insurance.

(46) Indeed, harmonisation in the field of health insurance is still limited. The third non-life insurance Directive introduced a mutual recognition of authorisations and prudential control systems but didn’t introduce a common definition of the SGEI, as this is the case in other sectors, for example the postal sector. Moreover, the EC Treaty also recognises that Member States have a large competence in relation with public health and protection of the consumers.

(47) As to the complainant’s argument that the insurers latitude to design their products (subject to minimum benefits) and to fix the prices contradicts the notion of a SGEI, the Commission notes that the definition of a specific mission of general interest and the attendant service required to fulfil that mission does not imply any specific method of service provision (see the above mentioned communication, §14). While the classical type of SGEI involves an undertaking obliged to provide a certain service throughout the territory at affordable tariffs and on similar quality conditions, public authorities may also decide to apply general interest obligations on all operators on a market, as this is the case in Ireland. To the extent that these obligations aim to ensure the achievement of a general interest mission, i.e. a certain level of PMI to all persons living in Ireland, at affordable price and on similar quality conditions, the insurers freedom to define the prices and to design the insurers products (subject to minimum benefits) does not put in question the qualification of these requirements as SGEI obligations.

(48) Finally, as to the complainant’s argument that the definition of SGEI is much too wide since it includes services going beyond what the basic social security scheme offers, the Commission considers that the Irish authorities do not commit a manifest error in including in their notion of SGEI services which go beyond those offered by the basic security scheme and which are open to everybody at an affordable price.

(49) In conclusion, the Commission accepts the qualification of the requirements imposed on all insurers in the health insurance market, namely open enrolment, community rating and lifetime cover, as SGEI obligations in the meaning of currently applicable EU rules.

* Necessity of the RES

(50) Economic studies support Irish authorities claim that without risk equalisation, each health insurer would have a strong incentive to target low-risk individuals (preferred risk selection) so as to be able to charge a lower community rate (or take a higher profit margin) than its competitors. Even with compulsory open enrolment, health insurers could seek to achieve a better risk profile by, for example, selective marketing techniques, targeting group occupational schemes, benefit design or selective quality of service. There is almost always information asymmetry between

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7 According to a constant case-law “Community law does not detract from the power of the Member States to organise their social security systems”, ECJ case 238/82 Duphar and Others v Netherlands [1984] ECR 523, paragraph 16, case C-70/95 Sodemare and Others v Regione Lombardia [1997] ECR I-3395, paragraph 27, and case C-158/96 Kohli v Union des caisses de maladie, paragraph 17.”
insurers and the regulator. As a result some risk selection is always possible. Although insurers may not deliberately set out to attract healthier than average individuals, this could still arise because these individuals tend to be more willing to consider moving between insurers. If risk selection arises, it would be expected that per capita claims costs would spiral for those insurers who are left with a higher proportion of less healthy individuals. This, in a community rated environment, would lead to significant instability and erosion of public confidence, ultimately leading to a down-sizing of the market. For these reasons, it seems that a RES is necessary to preserve market stability, where the government imposes to insurers community rating, open enrolment and lifetime cover.

(51) In the case of the Irish health insurance market, the complainant argues that the RES is not necessary because there has been no instability problem, although the market was opened up to competition in 1994 and a competitor to the incumbent insurer operates in this market since 1997, without a RES. However, this is explained by the population development and the buoyant economic conditions. The current environment could alter and “spiralling down” could happen relatively quickly. The Commission notes that available data suggest that some insurers in the Irish PMI market have been trying to attract younger, and presumably healthier subscribers, thereby following a policy of competition based on risk selection rather than quality or efficiency. Thus, although the above mentioned requirements (community rating, lifetime cover and open enrolment) were applied since 1994 without a RES, and although no market instability has yet been observed, the risk of risk selection in the Irish PMI cannot be excluded.

(52) In conclusion, the RES is necessary to underpin the principles enforced by the Irish authorities that govern the PMI market (community rating, lifetime cover and open enrolment). It ensures that risks are shared appropriately across the market and allows for a level playing field in respect of the particular constraints of the Irish system. If, as an alternative the Irish PMI market were risk rated, the RES would not be necessary.

* Proportionality of the RES

(53) Irish authorities designed the scheme in a way that limits the transfers of payments among insurers to what is strictly necessary to neutralise the difference in their risk profiles. Contrary to what the complainant claims, a scheme which compensates insurers for the expenses they incur for covering bad risks at a proportion above the market average is limited to what is strictly necessary to

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9 See the report “Voluntary health insurance in the European Union” prepared for the DG for employment by the European Observatory on health Care Systems and the London School of Economics, February 2002, p. 107. Insurers can benefit from offering reduced premiums and favourable conditions to groups of employees because those too ill or to old to work are excluded from the workplace, allowing insurers to cover a younger, healthier and more homogenous population. Comparisons of the group premiums of VHI’s most popular policy and BUPA’s competing policy in Ireland in the late 1990’s showed that BUPA Ireland’s premiums were 10% lower for subscribers under 19 years old, 4% lower for those aged 19 to 49 and 20% higher for those aged over 54.
compensate them for the already mentioned SGEI obligations which prohibit to risk rate the premiums and to reject the bad risks.

(54) As to the proportionnality of the scheme, the Commission notes that any imbalance in the distribution of risks among insurers does not lead automatically to the activation of the RES. The payments are activated only when a material imbalance in the distribution of risks among insurers can be observed. This imbalance is expressed as a percentage of the amount of equalised benefits insurers would be liable to pay to the risk equalisation fund in order to ensure that in total they have a risk profile at market level. The payments cannot be activated until a lower threshold is reached (2%). Even when this threshold is reached, the activation of RES is not automatic. In formulating its recommendations, the HIA must take account of the best overall interest of the health insurance consumers and is not limited to the mere outcome of a mathematical exercise. When the material imbalance is between 2% and 10%, the Minister can only activate payments with a recommendation to that effect by the HIA and it is only when the imbalance exceeds 10% that the Minister may activate payments without such a recommendation by the HIA.

(55) Furthermore, all payments made by the insurers in favour of the policyholders are not equalised. The scheme prescribes the Maximum Equalised payments in respect of settled claims. It provides that these payments can include costs up to specified levels relating to public/private hospital charges, maternity and consultant fees. This benefit level is the one at which the majority of consumers in the market is covered (it corresponds to VHI HealthCare’s Plan B and BUPA’s Essential Plus which covers approximately 70% of the policy holders). It does not extend to “luxury markets” but reflects the level that consumers see as a prudent level of private health insurance cover.

(56) Moreover, the scheme takes into account the insurers own average claim cost, thus avoiding an equalisation of the insurers average costs per cell of insured population and allowing them to keep the benefit of their own efficiencies (for instance development of systematic or better illness detection techniques);

(57) Also, while full equalisation would imply that 100% of market experience relating to the health status measure is taken into account, the draft scheme limits the use of the health status as a risk factor to not more than 50% of the market experience. The implication of this provision is that the scheme does not fully equalise the effect of risk differentials in the market even when payments are fully operational. Thus, it does not introduce any perverse incentive to hospitalise patients. In other words, the advantage in terms of loss compensation which an insurer could gain from “gaming” the system and “over-hospitalising” patients is negative to the point where such attempt would be counter-productive.

(58) In addition, as the participation to the RES could induce a too heavy burden on new entrants in the market, the scheme provides for a temporary exclusion of the « new entrants » in the health insurance market (first 36 months of their activities) in order to allow them to face the difficulties of a fist establishment and consolidate their position before facing the potentially heavy administrative and financial obligations linked with the RES.
Finally, the Commission notes that the Minister’s decision to activate the RES and the HIA recommendations can be subject to judicial review like all decisions of a public authority or body in Ireland and that a legal challenge may also have suspensory effect if the Court decides that it is “just and convenient” to grant such a relief according to well settled principles of equity law.

6.4 Conclusion

Taking into account that health care issues come primarily under the responsibility of the Member States, that national governments are in principle free to impose regulations with view to promote the public good, that the RES is necessary for the stability of a community rated health insurance market and given that the scheme, as it is designed involves payments which are limited to the minimum necessary to neutralise differences in health insurers’ risk profiles, the Commission considers that the RES is justified as a compensation for obligations (namely open enrolment, community rating and lifetime cover) imposed on all insurers in the Irish health insurance market, which qualify as SGEI.

Therefore, the RES does not constitute a State aid within the meaning of Article 87(1) of the Treaty or if it were assumed that compensation for extra costs of services of general economic interest constituted state aid within the meaning of Art. 87(1) of the Treaty, these aid elements could be considered compatible with the common market pursuant to Article 86(2) of the Treaty. This positive State aid assessment is however without prejudice to the analysis of the compatibility of this scheme with other relevant EU rules, and in particular with Council Directive 92/49/EEC. In any event, if the RES were to be considered as a State aid, the Commission considers that this aid would not by itself amount to a violation of the Directive. Any separate violation of Community rules by the Irish legislation would be dealt with in the framework of the appropriate procedures.

The Commission considers that the scheme should be reviewed regularly in order to ensure that the payments involved are effectively limited to what is strictly necessary to neutralise the difference in the insurers risk profile. National legislation provides for the HIA to evaluate and report on the operation of the scheme within 12 months of any actual equalisation transfers commencing and to do likewise annually thereafter. These reports are made to the Minister for Health and Children who is required by law to lay them before the Irish Parliament. Irish authorities have taken the engagement to submit these reports to the Commission to ensure a regular check of the actual application of the system.

Accordingly the Commission

HAS ADOPTED THIS DECISION:

Article 1

The Risk equalisation scheme involves payments which are limited to the minimum necessary to compensate insurers for service of general economic interest obligations and therefore does not involve State aids in the sense of Article 87 (1) EC.
Article 2

The Commission takes note of the Irish authorities engagement to submit annual reports giving all the information the Commission needs in order to monitor the implementation of the scheme. The first of these reports shall be submitted not later than twelve months after the date of this Decision.

Article 3

This Decision is addressed to the Republic of Ireland.

Yours faithfully,

For the Commission

Mario Monti
Member of the Commission

Notice
If this letter contains confidential information which should not be disclosed to third parties, please inform the Commission within fifteen working days of the date of receipt. If the Commission does not receive a reasoned request by that deadline, you will be deemed to agree to the disclosure to third parties and to the publication of the full text of the letter in the authentic language on the Internet site: http://europa.eu.int/comm/secretariat_general/sgb/state_aids/. Your request should be sent by registered letter or fax to:

European Commission
Directorate-General for Competition
State Aid Greffe
B-1049 Brussels

Fax No: 32.2.296.12.42