



## EUROPEAN COMMISSION

Brussels, 29.01.2016  
C(2016) 380 final

<p>In the published version of this decision, some information has been omitted, pursuant to articles 30 and 31 of Council Regulation (EU) 2015/1589 of 13 July 2015 laying down detailed rules for the application of Article 108 of the Treaty on the Functioning of the European Union, concerning non-disclosure of information covered by professional secrecy. The omissions are shown thus [...]</p>		<p style="text-align: center;"><b>PUBLIC VERSION</b></p> <p>This document is made available for information purposes only.</p>
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**Subject: State Aid SA.41702 (2016/NN) – Ireland  
Risk Equalisation Scheme**

Sir,

The Commission is pleased to inform Ireland that, having examined the information supplied by your authorities on the measure referred to above, the compensation granted through the risk equalisation scheme for the provision of private medical insurance in Ireland for the period 2016-2020 constitutes State aid that is compatible with the internal market.

### **1. PROCEDURE**

- (1) On 27 April 2015, pre-notification contacts were established between the Commission and the Irish authorities in respect of the prolongation of a risk equalisation scheme (hereafter “RES”) on the private medical insurance (hereafter “PMI”) market. The scheme consists of a compensation mechanism allowing for better risk sharing between insurers relating to health insurance and promoting intergenerational solidarity in this sector in Ireland.
- (2) The previous scheme was introduced in 2013 following a decision by the European Commission that the compensation granted through the scheme

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constituted State aid that is compatible with the internal market.<sup>1</sup> That scheme was approved for the period 1 January 2013 until 31 December 2015.

- (3) On 2 December 2015, Ireland notified, under Article 108(3) TFEU, the new RES for the period 1 January 2016 until 31 December 2020. The Irish authorities informed the Commission that the levels of credits and stamp duties applicable under the scheme are revised on a yearly basis and the new rates for the 2016 RES are applicable as of 1 March 2016. Therefore, the 2016 RES took effect on 1 January 2016, using the rates of credits and stamp duties that applied under the previous RES until 29 February 2016 with the revised rates for credits and stamp duties applying only as of 1 March 2016. These rates will themselves be revised and new rates will eventually apply as of 1 March 2017.<sup>2</sup>
- (4) In parallel, the Commission services received informal submissions from three insurers active on the Irish PMI market: GloHealth (submission of 31 July 2015), Aviva Health Insurance Ireland Ltd (submission of 8 September 2015) and Vhi Healthcare (submission of 22 October 2015). The Commission forwarded these submissions to the Irish authorities, who then reacted to the comments of the insurers (submissions of 26 August 2015, 29 September 2015, and 30 October 2015). On 3 September 2015, the Irish authorities also forwarded to the Commission a submission it had received from Laya Healthcare (dated 29 July 2015), together with its reaction thereto.

## **2. DESCRIPTION OF THE MEASURE**

### **2.1. The Irish health insurance market**

- (5) The Irish health system is characterised by a mix of public and privately funded health services.
- (6) The public health system is governed by the Health Act 1970 and the Health Act 2004. The system is funded by taxes and individuals situated below a certain income level are eligible for a medical card, which entitles the holder to prescription drugs (subject to a modest co-payment) and free access to public hospital services and general practitioners. Medical card holders account for approximately 37% of the population. A further 8% hold general practitioner visit cards which provides free access to general practitioner services. People without medical cards are entitled to public hospital services subject to some out-of-pocket expenses.
- (7) In addition to the public health system, Ireland has a strong private health insurance market which operates on a voluntary basis. Figures provided by the Health Insurance Authority (hereafter “HIA”), the statutory regulator of the PMI market in Ireland, showed that at end June 2015, 2.12 million people had PMI plans providing in-patient benefits.<sup>3</sup> This represents approximately 46% of the

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<sup>1</sup> Commission Decision C(2013) 793 final corr. of 20 February 2013 in case SA.34515 (2013/NN) – *Ireland, Risk equalisation scheme 2013*, OJ C 204, 18.7.2013, p.2.

<sup>2</sup> Rates always apply from March Year N to March Year N+1.

<sup>3</sup> In-patient care is the care of patients whose condition requires admission to a hospital. An in-patient is admitted to the hospital. Out-patient care is the care of patients who visit a hospital, clinic, or associated facility for diagnosis or treatment but who are not admitted to the hospital. Day case treatment is provided on an in-patient basis, i.e. the patient is admitted to the hospital for treatment and is discharged later the same day.

Irish population. PMI fulfils two roles in Ireland: first, it acts as a complement to the public health system, providing cover against charges levied on non-medical card holders in respect of private patient treatment in public hospitals, together with a more limited reimbursement of certain charges in the primary care sector;<sup>4</sup> second, PMI supplements the public system as subscribers pay for the policies offered by health insurers to cover possible hospitalisation costs in private hospitals or private treatment in public hospitals.

## 2.2. Market structure

- (8) The Irish PMI market was opened up to competition in 1994 by the Voluntary Health Insurance Act 1994, and it is currently operated by four health insurers with the following market structure: Vhi Healthcare<sup>5</sup> ([...]<sup>\*</sup>% market share), Laya Healthcare<sup>6</sup> ([...]<sup>\*</sup>% market share), Aviva Health ([...]<sup>\*</sup>% market share) and GloHealth<sup>7</sup> ([...]<sup>\*</sup>% market share).<sup>8</sup> A negligible proportion of the in-patient plans in the market are provided by Restricted Membership Undertakings (RMUs).<sup>9</sup>
- (9) Despite the opening of the PMI market in 1994, the age distribution of insured persons between insurers remains influenced by the fact that Vhi continues to

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<sup>4</sup> Primary care is the health care given by a health care provider in the community. Typically this provider acts as the principal point of consultation for patients within a health care system and coordinates other specialists that the patient may need (primary care physician, general practitioner or family physician, pharmacist, physician assistant, etc.). Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

<sup>5</sup> In July 2015, Vhi Healthcare was authorised by the Central Bank of Ireland to carry out non-life insurance business in line with the requirements of the EU Non-Life Insurance Directives, thus complying with the judgment of the European Court of Justice in Case C-82/10 *Commission v. Ireland* ECLI:EU:C:2011:621 and Commission decision C(2012) 5073 final of 25 July 2012, requiring Ireland to terminate the unlimited guarantee benefitting Vhi.

<sup>\*</sup> Business secret

<sup>6</sup> Following a management buy-out of the business of Quinn Healthcare, that company now trades as Laya Healthcare and is underwritten by Elips Insurance Limited, a wholly-owned subsidiary of Swiss Re. In April 2015 the business was acquired by AIG, though it continues to be underwritten by Elips Insurance Limited.

<sup>7</sup> GloHealth entered the Irish PMI market in mid-2012. Its health insurance business is underwritten by Great Lakes Reinsurance plc, a subsidiary of Munich Re.

<sup>8</sup> Source: “Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2014 to 30 June 2015 including advice on risk equalisation credits”, Health Insurance Authority, September 2015 (hereafter “September 2015 HIA Report”; see <http://health.gov.ie/blog/publications/report-to-the-minister-for-health-from-the-health-insurance-authority-redacted-on-an-evaluation-and-analysis-of-returns-for-1-july-2012-to-30-june-2013-including-advice-on-risk-equalisation-credits-2/>). Note that the market share figures are in respect of membership numbers as of 1 July 2015, and exclude Restricted Membership Undertakings.

In its submission, one of the insurers argued that the HIA and the Department of Health should use data on market shares based on premiums, rather than membership number when considering the determination of the parameters of the scheme. The figures for 2014 would show market shares based on premiums that are higher for Vhi ([...]<sup>\*</sup>%) and lower for Laya ([...]<sup>\*</sup>%), Aviva ([...]<sup>\*</sup>%) and GloHealth ([...]<sup>\*</sup>%). In their response, the Irish authorities argued that a comparative analysis of market shares based on earned premiums is incomplete without the inclusion of claims paid by insurers. In this respect, the figures for 2014 on market shares based on claims show a similar pattern, i.e. an even higher market share for Vhi ([...]<sup>\*</sup>%) and lower market shares for Laya ([...]<sup>\*</sup>%), Aviva ([...]<sup>\*</sup>%) and GloHealth ([...]<sup>\*</sup>%).

<sup>9</sup> RMUs provide insurance to members of a particular group, normally a vocational group or employees of a particular organisation, and their dependants.

have a much larger proportion of members in the older age groups compared with the other insurers active in the PMI market, in particular in the age group 65-69 and older. This is mainly a combined effect of Vhi’s historical presence as former monopolist and current position as largest operator. It also reflects the current market context, including the general aging of the population, the fact that younger, “better risk” individuals that have PMI cover are more likely to either switch insurers or leave the PMI market than older, “high risk” individuals who have a more acute need of PMI cover and are less inclined to switch.<sup>10</sup> This has the effect that in terms of insurance portfolio, Vhi is de facto dealing with the “high risk” section of the population (i.e. most of the elderly population).

*Table 1: Average age distribution (January – June 2015) of the portfolios of different insurers on the Irish PMI market (Source: September 2015 HIA Report)*

Age group	Aviva Health	GloHealth	Laya Healthcare	Vhi Healthcare
0-17 years	[...]	[...]	[...]	[...]
18-29 years	[...]	[...]	[...]	[...]
30-39 years	[...]	[...]	[...]	[...]
40-49 years	[...]	[...]	[...]	[...]
50-59 years	[...]	[...]	[...]	[...]
60-69 years	[...]	[...]	[...]	[...]
70-79 years	[...]	[...]	[...]	[...]
80 years and over	[...]	[...]	[...]	[...]

### 2.3. Public service obligations

- (10) The public service obligations in respect of Irish private health insurance are set out in the Health Insurance Act 1994 (as amended), which defines the health insurance policy objectives of the Irish State: *“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 health services 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 (...).”*<sup>11</sup>
- (11) The Health Insurance Act 1994 sets out the four PMI obligations, which are designed to support this objective, as follows:

<sup>10</sup> In general, the older population has a greater inertia to switching than the young population, due to factors such as perceived risk of changing insurer at the time of ill health and stronger brand loyalty acquired over many years with one insurer.

<sup>11</sup> See section 1A-(1) (a) to (d) of the Health Insurance Act 1994.

- *Community Rating*: Insured persons pay the same level of premium for a given level of benefit, regardless of health profile (age, gender or health status).<sup>12</sup> Lifetime Community Rating (hereafter “LCR”) was implemented in the Irish health insurance market on 1 May 2015. LCR is a modified version of community rating that means that the premium does not vary in respect of an individual's age but involves premium loadings that apply to people who enter the health insurance market for the first time after the age of 34. LCR has been introduced to encourage people to enter the health insurance market at younger ages, which is expected to improve the sustainability of the market as a whole, but does not undermine the fundamental principle of intergenerational solidarity.

- *Open Enrolment*: Health insurers must accept all applications, regardless of age or health status.<sup>13</sup> A number of legislative measures aim to prevent adverse selection risk which could result in people taking out insurance just as they need it.<sup>14</sup>

- *Lifetime Cover*: An insurance contract cannot be terminated or fail to be renewed by the insurer without the consent of the insured person, even as the insured person ages and/or his physical condition declines.<sup>15</sup>

- *Minimum Benefits*: Insurers must provide a certain minimum level of benefits prescribed by legislation for all insurance products.<sup>16</sup> The minimum benefits requirements are designed to protect consumers from purchasing a product that does not provide at least a minimum level of cover.<sup>17</sup>

(12) Those PMI obligations imposed on market operators are defined as public service obligations in the Health Insurance Act 1994, the main rationale behind these requirements being to ensure intergenerational solidarity by preventing insurers from charging risk-adjusted premiums. In a risk rated market, insurers would charge higher premiums to high risk individuals and low premiums to low risk ones. The community rating obligation tackles this problem directly by imposing on insurers the obligation to charge the same premium for a plan regardless of age, gender or health status. This obligation would not, however, be sufficient to guarantee intergenerational solidarity if insurers were free to refuse clients on such grounds. Hence the principles of open enrolment and lifetime cover, which guarantee that insurers can neither refuse to contract with an individual seeking cover, nor cancel or fail to renew existing cover against the will of the insured. Although age is the main factor giving rise to differentiated premiums on a risk rated market, the same logic of ensuring solidarity applies in relation to the gender and the health status of the insured individuals. Besides promoting solidarity among age groups, genders and people of different health status, a

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<sup>12</sup> See section 7.3 of the Health Insurance Act 1994. Some exceptions exist to this rule, including lower charging for children (i.e. no more than 50% of the adult premium) and reduced rates for young adults aged 18-25, as well as limited group discounts.

<sup>13</sup> See section 8 of the Health Insurance Act 1994.

<sup>14</sup> See section 8.3 of the Health Insurance Act 1994. Maximum waiting periods are set before a new customer can claim; consumers who switch insurer do not have to go through the waiting period again, unless they allow more than 13 weeks to lapse between leaving one insurer and joining the other.

<sup>15</sup> See section 9 of the Health Insurance Act 1994.

<sup>16</sup> See section 10 of the Health Insurance Act 1994.

<sup>17</sup> Minimum Benefit Regulations were introduced in 1996.

complementary objective is to guarantee a good quality level of health care by subjecting insurers to minimum benefit obligations.

#### 2.4. The previous Risk Equalisation Schemes

- (13) The Irish PMI market was opened up to competition under the provisions of the Health Insurance Act 1994. Privately owned insurers have progressively entered the market since January 1997. In a competitive environment, maintaining intergenerational solidarity became more complex as differences in insurers' risk profiles could and did develop. Consequently, the introduction of a risk equalisation mechanism was envisaged by the Irish government.
- (14) **The 2003 RES:** In 2003, the Commission authorised a risk equalisation scheme notified by Ireland.<sup>18</sup> PMI services were considered to qualify as Services of General Economic Interest (SGEIs) and the 2003 RES was assessed and approved as compensation for the SGEIs rendered.<sup>19</sup>
- (15) **The Interim Scheme 2008-2012:** The Irish authorities introduced and notified to the Commission a scheme of tax reliefs and levies for an interim period of three to four years until a new RES could be devised in compliance with the conclusions of the Irish Supreme Court judgment. The Commission authorised the Interim Scheme in 2009, for a limited period of time, expiring on 31 December 2012.<sup>20</sup>
- (16) **The 2013 RES:** In 2012, the Irish authorities notified to the Commission the new 2013 RES. The Commission authorised the 2013 RES by decision of 20 February 2013.<sup>21</sup> The objective and operation of this Scheme was very similar to the Interim Scheme and the 2003 RES. The 2013 RES functioned through the establishment of a Risk Equalisation Fund administered by the HIA. It operated by levying a charge against insurers in the form of a stamp duty payment based on the numbers of insured lives, and issuing a payment to insurers in the form of a risk equalisation credit on behalf of each insured person falling into certain specific categories. In addition, a utilisation credit was also paid to insurers for each overnight stay in a hospital by an insured person. The 2013 RES started on 1 January 2013 using the rates that applied under the Interim Scheme up to 30 March 2013 and revised rates applied with effect from 31 March 2013. The rates of credits and stamp duties are revised every year and provided for in legislation.
- (17) The operation of the RES, given current customer profiles, has so far resulted in one net beneficiary and three net contributors. The market situation for each insurer with and without the RES in 2014 is provided in Table 2 below.

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<sup>18</sup> Commission Decision C(2003) 1322fin of 13 May 2003 in case N 46/2003 *Risk equalisation scheme in the Irish health insurance market*, OJ C 186, 6.8.2003, p.16.

<sup>19</sup> The Commission's decision was challenged (unsuccessfully) before the General Court (Case T-289/03 *BUPA and others v. Commission* ECLI:EU:T:2008:29, hereafter the "BUPA case law"). The system was also challenged under Irish law, and in July 2008 the Irish Supreme Court struck down the 2003 RES on domestic law grounds.

<sup>20</sup> Commission Decision C (2009) 3572 final of 17 June 2009 in case N 582/2008 *Health Insurance intergenerational solidarity relief*, OJ C 186, 8.8.2009, p.2.

<sup>21</sup> See footnote 1.

*Table 2: Profitability of insurers on the Irish PMI market in 2014 (Source: HIA)*

€m	Aviva Health	Great Lakes (GloHealth)	Elips (Laya Healthcare)	Quinn <sup>22</sup>	Vhi Healthcare
Earned premiums before reinsurance and risk equalisation credits	327.2	64.8	465.8	0	1,446.7
Claims incurred before reinsurance	(239.1)	(40.4)	(344.5)	1.4	(1,385.0)
Expenses and Reinsurance	(45.7)	(4.7)	(64.2)	0.5	(104.2)
Underwriting result (gross of RES)	42.4	19.7	57.1	1.8	(42.5)
Impact of RES	(31.5)	(17)	(48.1)	3.2	71.8
Underwriting result (net of RES)	10.9	2.7	9	5.0	29.3
Impact of investments	0.5	0	0.2		18.6
Profit before tax (gross of RES)	42.9	19.7	57.3	1.8	(23.9)
Profit before tax (net of RES)	11.4	2.7	9.2	5.0	47.9
Profit as a % earned premiums (gross of RES)	13.1%	30.4%	12.3%	n.a.	(1.7%)
Profit as a % earned premiums (net of RES)	3.5%	4.2%	2.0%	n.a.	3.3%

## **2.5. The notified measure: the 2016 RES**

- (18) The rationale for the 2016 RES is the same as that which underpinned the previous scheme. Its purpose is to support the health insurance policy objectives of the Irish State under the Health Insurance Act 1994 (as amended). The continued evidence of segmentation within the PMI market underlines the need for a robust RES to ensure the long-term sustainability of the market, given the public service obligations imposed on insurers.
- (19) The 2016 scheme will operate for five years, from 1 January 2016 to 31 December 2020, and will be substantially the same as the previous scheme.<sup>23</sup> The 2016 RES will operate by levying a charge against insurers in the form of a stamp duty payment based on the numbers of insured lives, and issuing a payment to insurers in the form of a credit on behalf of each insured person falling into a specific category. As under the previous scheme, the credits are paid directly to insurers on behalf of individuals, from a Risk Equalisation Fund administered by the HIA; insurers then charge net premiums to the insured persons.

<sup>22</sup> Quinn Insurance Ltd (under administration) (trading as Quinn Healthcare) closed to new business in May 2012, and existing policyholders were invited to renew their policies with Elips Insurance Ltd (trading as Laya Healthcare).

<sup>23</sup> As detailed throughout this decision, the 2016 RES contains some improvements as compared to the previous scheme: the Irish authorities have introduced life-time community rating, young adult rates and day-case utilisation credits to further enhance the sustainability of the market; the Return on Sales is used as a benchmark for reasonable profit instead of Return on Equity; and a limit on the claims cost threshold was set for the entire period 2016-2020 in order to avoid that competition is distorted in a disproportionate manner. The Irish State also took several actions to promote the general efficiency of the health insurance market, while insurers took several actions for cost-containment, which are designed to exert a downward pressure on the claims costs within the system.

- (20) Each year in September/October, the HIA recommends to the Minister for Health the levels of credits and stamp duty for the coming year. The HIA's recommendation is laid out in a detailed report, based on an analysis of data submitted by insurers, with a view to achieving the principal objective of the Act as mentioned in recital (10), while also aiming to avoid overcompensating any insurers, maintaining a sustainable PMI market and promoting open and fair competition.
- (21) In December each year, the Minister for Health, using his/her discretion with respect to State policy in the field of healthcare and health insurance, decides on the appropriate levels of credits to be specified in the Health Insurance Act 1994 (as amended). Subsequently, having regard to the principal objective of the Act, the HIA's report and the sometimes competing aims as set out in the legislation, the Minister for Health recommends the appropriate levels of stamp duty to the Minister for Finance for inclusion in the Stamp Duties Consolidation Act 1999.

### ***2.5.1. Credits***

- (22) Under the 2016 RES, the credits comprise of risk equalisation credits that vary by age, gender and level of cover, as well as hospital utilisation credits.
- (23) Risk equalisation credits are paid in respect of individuals who are insured through relevant health insurance contracts within Ireland<sup>24</sup> and who meet the specified age and gender criteria. 5-year age bands are currently used for determining credits. The different credits for men and women take into account some (relatively modest) differentiation based on claims experience.<sup>25</sup>
- (24) For the purposes of the RES, insurance products are categorised into products providing non-advanced cover and all other products. Non-advanced cover provides no more than 66% of the full cost for hospital charges in a private hospital or no more than the prescribed minimum payments under the minimum benefit regulations. Contracts providing higher coverage are considered to be advanced contracts.<sup>26</sup> Lower age related credits apply in respect of individuals who do not have advanced cover. The inclusion of a product differentiation in setting the levels of credits and stamp duties (see recital (28) below) is designed to ensure that the support is proportionate and does not involve people with lower levels of benefit subsidising to a disproportionate degree higher levels of cover than those they have chosen for themselves.
- (25) Hospital utilisation credits are also paid to insurers<sup>27</sup> in respect of all insured individuals for each overnight stay in hospital, as well as for all day-case

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<sup>24</sup> As defined in section 125A(1) of the Irish Stamp Duties Consolidation Act 1999, section 11E of the Health Insurance Act 1994 and specified in regulations under section 11E.

<sup>25</sup> For instance, for ages in excess of 50, male claims costs are significantly higher.

<sup>26</sup> As stipulated in Section 7AB of the Health Insurance Act 1994, the introduction of new products and changes to existing products, including changes that would trigger a recategorisation of such products from advanced to non-advanced or vice versa, is subject to notification by each insurer to the HIA not less than 30 days before the introduction/change takes effect. The HIA then has 30 days after such notification to decide on the categorisation of the contract.

<sup>27</sup> Hospital utilisation is used as a proxy for health status. Two insurers argued that the use of a more sophisticated health status measure should be enacted as soon as possible. The Irish authorities explained that they are committed to further developing the RES over time, however, the introduction of a more robust measure such as Diagnosis Related Groups, which should significantly improve the



admissions to hospital.<sup>28</sup> The result is a sharing of the costs associated with individuals who claim (representing less healthy lives) with those who do not.

(26) For the calculation of the credits as well as of the stamp duties the HIA receives half-yearly data from each insurer in the market, in a standard format (i.e. information returns from insurers).<sup>29</sup> These include detailed historical data relating to the number of lives insured in each age group, the gender profile and type of cover of each age group, in respect of the relevant 6 months period, hospital utilisation data and relevant claims data, as well as detailed information at product level. Based on this information, the HIA analyses the claims experience of the market against each of the factors described above (age, gender, level of cover, health status) and identifies groups of insured persons where the average claims costs for the group exceed those for the market as a whole. Based on this analysis the HIA recommends to the Minister for Health a level of credit for each combination of age, gender and level of coverage, as well as a hospital utilisation credit. The Minister for Health then decides on the appropriate levels of credits to be specified in the Health Insurance Act 1994 (as amended).

(27) The proposed credits from 1 March 2016 are outlined in Table 3 below.

*Table 3: Risk equalisation credits applicable from 1 March 2016 to 28 February 2017*

Age Bands	Hospital utilisation credits (overnight/day case)	Age / gender / level of cover credits from 1 March 2015			
		Non-advanced		Advanced	
		Men	Women	Men	Women
64 and under	€90/€30	€0	€0	€0	€0
65-69	€90/€30	€575	€375	€1,125	€800
70-74	€90/€30	€900	€675	€1,800	€1,300
75-79	€90/€30	€1,175	€850	€2,550	€1,900
80-84	€90/€30	€1,550	€1,100	€3,375	€2,375
85 and above	€90/€30	€1,775	€1,250	€4,150	€2,775

### **2.5.2. Stamp duties**

(28) The credits are financed by stamp duties payable on all policies written by insurers. Four different levels of stamp duty apply in total, with insurers paying a lower level in respect of children as compared to adults<sup>30</sup>, and higher levels per

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effectiveness of the scheme, is constrained by the availability of the data (in particular as regards private hospitals). When this information is available, the Irish authorities intend to update the scheme and will notify any changes in this respect to the Commission.

<sup>28</sup> Hospital utilisation credits for day-case admissions will be introduced in the 2016 RES, to support the provision of health care services at the lowest level of complexity.

<sup>29</sup> See section 7D of the Health Insurance Act 1994. These information returns must be confined to health insurance business, and their form and content are set out in regulations of the Minister for Health.

<sup>30</sup> A lower level of stamp duty applies in respect of children to reflect the fact that premium levels for children are typically considerably lower than adult levels (ranging from 0% to 50%).

On 1 May 2015, tiered discounts were also introduced for young adults aged 18-25, in order to address the sudden increase in premium experienced by individuals once they reached adulthood. Two insurers argued in their submissions that this measure should be accompanied by proportionate stamp duties, as

insured person with advanced cover products compared with those holding non-advanced cover products.

- (29) Once the HIA determines the levels of credits, it calculates the stamp duty levels necessary to fund these credits. Thus, the level of stamp duty is determined with the objective of having the total amount raised in stamp duties equal to the total amount paid in credits, thereby seeking to ensure the functioning of the RES as a self-funding scheme. As with the credits, the HIA recommends to the Minister for Health the stamp duty levels that should apply, also taking into account anticipated surpluses or deficits in the Risk Equalisation Fund. The Minister for Health then decides on the appropriate levels of stamp duties to be specified in the Stamp Duties Consolidation Act 1999 (as amended).
- (30) The proposed stamp duties from 1 March 2016 are outlined in Table 4 below.

*Table 4: Stamp duties applicable from 1 March 2016 to 28 February 2017*

Age Bands	Stamp duties from 1 March 2016 to 28 February 2017	
	Non-advanced	Advanced
17 and under	€67	€134
18 and over	€202	€403

### **2.5.3. Claims cost threshold**

- (31) In arriving at its recommended level of credits (and stamp duties required to fund these), one of the key parameters that the HIA has applied so far is the claims cost ceiling. More specifically, as briefly mentioned in recital (26), the credits for individual age groups are determined by comparing the average claims costs for people within those age groups with the average claims costs across the whole insured population. The HIA determines the age related credit for an age group such that, after allowing for the impact of credits and stamp duties, the average claims cost for that age group would be at most a fixed percentage (i.e. the claims cost ceiling) of the market average claims costs across all age groups.<sup>31</sup>
- (32) Since its introduction, the 2013 RES has been adapted in order to increase its effectiveness. The initial parameters of the scheme were designed by the Irish authorities to ensure that the claims costs for any age and gender group would not be more than 150% of the market average, after allowing for the impact of the

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the current adult rates of stamp duties that apply for young adults provide a cost disincentive for insurers to offer discounts to young adults. However, the Irish authorities explained that, although this represents a cost to insurers who opt to offer young adult rates on some of their plans, the measure was not designed to reduce the costs of insurance for this age group, but to phase-in full adult rates and ease the effect of the dramatic price increase experienced when discounted rates related to the student status of the insured person no longer applied. The introduction of young adult rates was carefully considered in the context of its dilution of the principle of community rating versus its potential to retain young people in the market. In this context, the Irish authorities explained that introducing reduced stamp duties for plans provided at young adult rates is considered an unwarranted and unnecessary further dilution of the key principle. Insurers retain discretion in relation to offering discounted rates for young adults for any particular product.

<sup>31</sup> As previously mentioned in recital (20), and detailed in the following subsection, the HIA and the Minister for Health must also have regard to the aim of avoiding overcompensation when recommending and setting the levels of credits and stamp duties.

scheme. Each year, the parameterisation of the scheme has been updated and the effectiveness of the scheme at older ages has gradually increased over time, with the claims cost ceiling being set at 130% in the last year of application of the 2013 RES.

- (33) In principle, the lower the claims cost ceiling is set (i.e. typically closer to 100%), the more effective the scheme will be at an overall level in terms of equalising differences in risk profile. However, there are limitations in this approach that need to be taken into account: apart from a potentially adverse impact on the sustainability of the market<sup>32</sup>, a lower claims cost ceiling could also have an impact on competition.
- (34) As the credits are based on actual claims costs at older ages, they will typically be more heavily influenced by the claims costs of the net beneficiaries of the scheme.<sup>33</sup> The characteristics of these net beneficiaries and notably their efficiency may therefore significantly influence the level of the credits.
- (35) For that reason, aiming at a total correction of the imbalance in claims cost could result in compensating more than differences in risk levels and oblige an insurer that achieves lower claims costs through efficiencies to compensate another less efficient insurer on the basis of its higher claims costs.
- (36) In light of the above, while the principal objective of the Health Insurance Acts would support an equalization of average claims costs across all categories, the HIA must also take into consideration the sustainability of the market, overcompensation and competition, when making its recommendation for the level of credits and stamp duties.
- (37) Taking these constraints into account for the 2016 RES, the HIA proposed an additional limit that will be set on the credits provided under the 2016 RES, so that, over the period 2016 to 2020, the net projected average claims cost for any age group in receipt of age-related credits will not go below 125% of the projected market average net claims cost. Such constraint limits *de facto* the redistributive impact of the RES and thereby the maximum level of the credits and stamp duties under the RES. This additional limitation was endorsed by the Minister for Health, which means that it will be applied to the actual credits provided under the scheme by legislation and not just to those recommended by the HIA.<sup>34</sup> The Irish authorities consider that such commitment would provide

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<sup>32</sup> First, for a full correction of the risk differences, insurers would need to charge higher premiums at young ages, in order to cover for the higher claims costs of the older, more risky population insured, which would eventually lead to young people exiting the market. Second, if claims costs are fully covered for all age groups through the RES, it would become less attractive to some insurers to recruit younger people than older people. Both effects would over time threaten the sustainability of the PMI market.

<sup>33</sup> Such situation occurs because net beneficiaries will typically have greater numbers of older lives, and therefore the average claims in respect of older lives generally will be more heavily weighted towards the claims costs of customers of those insurers.

<sup>34</sup> Furthermore, in light of differences in claims cost inflation levels that can occur at different age groups, the Irish authorities clarify that the limit of 125% on the claims cost threshold relates to the forward-looking view when setting credits, as any retrospective assessment would be difficult to administer and the outcome would be quite variable.

The Irish authorities also explain that the health status component of the scheme (i.e. the utilisation credit) is quite limited currently, due to limitations in the availability of granular underlying data on

additional comfort that competition would not be distorted in a disproportionate manner and that efficient insurers would remain able to make an adequate return.

#### ***2.5.4. Mechanisms for avoiding and recovering potential overcompensation***

- (38) As described in recital (20), from an *ex ante* perspective, the HIA in recommending the level of risk equalisation credits and stamp duties will take account of the need to avoid overcompensation. In addition, the *ex post* verification that the compensation paid to a beneficiary of the 2016 RES did not involve overcompensation will remain in place as under the 2013 scheme.
- (39) In determining the recommended level of credits for each category, the HIA takes into account the information returns made to it by insurers, as explained in recital (26). 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. It must have particular regard to the average insurance claim payment per insured person made by the relevant market sector during the relevant periods, to the hospital utilisation, and to the net financial impact on each registered undertaking or former registered undertaking of the relevant financial provisions during the relevant periods.<sup>35</sup>
- (40) From an *ex post* perspective, the HIA carries out an overcompensation test in accordance with the 2012 SGEI Framework<sup>36</sup> (the text of which was included in 2012 in an annex to the legislation). Thus, all insurers are required to maintain and give to the HIA yearly statements of profit and loss as well as certified balance sheets in respect of its health insurance business, and any other information the HIA may deem necessary.
- (41) In its overcompensation test for the 2016 RES, the HIA will determine the reasonable profit with reference to Return on Sales (ROS)<sup>37</sup> achieved by the net beneficiaries of the RES. As opposed to the indicator previously used in the 2013 RES (i.e. Return on Equity), one advantage of the ROS is that it only depends on accounting profit and sales data, which are both more easily observable in a company's accounts. Moreover, the ROS avoids the valuation and attribution of assets between different services, which is necessary for a capital-based benchmark.

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health status. The use of more granular data in the future may facilitate a better understanding of the extent to which differences in claims costs between insurers are driven by differences in underlying risk profile. Therefore, the commitment provided by the Irish authorities regarding the limit of 125% on the claims cost threshold over the entire duration of the 2016 RES would need to be revisited should more granular or robust health status measures be developed. As mentioned in footnote 26, the Irish authorities will notify any changes in this respect to the Commission.

<sup>35</sup> See section 7E of the Health Insurance Act 1994.

<sup>36</sup> Communication from the Commission: European Framework for State aid in the form of public service compensation, OJ C 8, 11.1.2012, p. 15-22.

<sup>37</sup> The Return on Sales is a profitability measure, also known as operating profit margin. It is calculated as the ratio between net operating profit (before interest and tax) and sales revenues. More precisely, net operating profit is the difference between revenues and costs at operational level.

- (42) Overcompensation will be deemed to have occurred where the net beneficiary's ROS gross of reinsurance<sup>38</sup> and excluding investment activities<sup>39</sup> exceeds 4.4% per annum, calculated on a rolling three year basis. This benchmark was devised by Oxera Consulting on the basis of a sample of European health insurers whose profile was considered sufficiently comparable to Vhi Healthcare, the current net beneficiary of the scheme.<sup>40</sup> The Irish Government will make the legislative provision for this revised benchmark for reasonable profit in 2016, while the first test will fall due in 2019 and will reflect the period 2016-2018 inclusive.
- (43) If the HIA has determined that the cumulative net financial impact of the RES on an insurer was positive and that this insurer has made a profit in excess of the reasonable profit, the HIA shall prepare a draft report on the relevant calculations and indicators that show the amount of overcompensation. The HIA will send this draft report to the concerned insurer for comments and will then prepare a final report, which shall be conclusive including for the purpose of any proceedings concerning the recovery of overcompensation. The HIA will then submit the final report to the Minister for Health, who will in turn provide a copy to the concerned insurer, with the obligation for it to pay to the Fund, within 2 months, the amount set out in the report.<sup>41</sup>

#### ***2.5.5. Estimated net financial effect of the 2016 RES***

- (44) All insurers on the market are SGEI providers and will receive credits from the 2016 RES. Vhi Healthcare is expected to continue to be the net beneficiary of the RES 2016, while its competitors will be net contributors. In terms of insurance portfolio, VHI continues *de facto* to deal with the high-risk profile population (i.e. most of the elderly population). However, Vhi Healthcare's market share has continued to decrease, so the Irish authorities cannot exclude that another insurer may become a net beneficiary of the RES in the future.
- (45) Should the insurers' risk profile change, the net financial effects of the scheme would change accordingly. However, according to the Irish authorities, even though individuals have the possibility to switch between insurers, this is unlikely

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<sup>38</sup> i.e. before reinsurance – insurance companies, including Vhi, purchase reinsurance from other insurance companies as a means of better risk management, although this means that they have to forego some profit (driving down the ROS net of, i.e. after, reinsurance).

<sup>39</sup> Investment income as recorded in the income statement of a net beneficiary undertaking is excluded from both the profit and sales figures in the calculation of return on sales.

<sup>40</sup> Oxera first identified a set of European health insurers to be used as comparators. The initial set of 80 comparators was then limited to 70 insurers, for which the Orbis database contained the relevant financial information. From these, Oxera identified those 36 companies focusing on health insurance (alongside other types of insurance). As the characteristics of life insurers may differ significantly from those of health insurers, 16 companies whose main activity is life insurance were further excluded, thus the final sample comprised 20 European health insurers. In order to ensure the robustness of the benchmark, Oxera also verified that the capital intensity of the comparable European health insurers identified does not differ significantly from that of Vhi, the current net beneficiary of the scheme. Finally, as investment activities can have a significantly different impact on insurers, Oxera provided the ROS estimates for two subsamples based on the impact of excluding investment activities on estimates of the ROS. Given Vhi's profile in terms of investment activities, it was considered that it is more appropriate to use the ROS of the 'low impact' subsample, consisting of insurers for which the exclusion of investment activities has a smaller impact on ROS than the median impact for the whole sample.

<sup>41</sup> See section 7F of the Health Insurance Act 1994.

to happen to an extent sufficient to make Vhi a net contributor and any of its competitors a net beneficiary in the medium term.

- (46) Following the decision of the Minister for Health regarding the levels of credits and stamp duties in 2016, it is estimated that the expected net financial impact on insurers of the final credits and stamp duties for policies commencing from 1 March 2016 onwards will be as outlined in Table 5 below.

*Table 5: Projected net financial impact of the RES based on the credits and stamp duties applying for policies commencing in the period 1 March 2016 to 28 February 2017*

€ million	Aviva Health	GloHealth	Laya Healthcare	Vhi Healthcare	Total <sup>42</sup>
Age Related Health Credits	[...]	[...]	[...]	[...]	525.3
Hospital Bed Utilisation Charge	[...]	[...]	[...]	[...]	131.7
Stamp Duty	[...]	[...]	[...]	[...]	-647.0
<b>Total</b>	[...]	[...]	[...]	[...]	<b>10.0</b>
Net Financial Impact per Insured Life (€) = Total impact/ Number of insured lives	[...]	[...]	[...]	[...]	6

- (47) It is important to note that the above figures constitute projections that are subject to a number of assumptions made by the HIA. The net benefit for each insurer will depend on changes in number, age category and type of cover of its customers, including the number of persons resigning from private health insurance cover throughout the year. These factors can be influenced by product or pricing strategy of an insurer, thus the projections of the net financial impact on individual insurers are subject to some uncertainty and should be viewed as indicative only.

#### **2.5.6. Timing of payments to insurers**

- (48) The 2016 RES is a continuation of the 2013 RES which was the subject of the Commission decision of 20 February 2013. The 2016 RES will be in place as of 1 January 2016. The Irish authorities have noted that that is before the expected date of any Commission decision. The Irish authorities have explained that the financial effect of the 2016 RES will come into force only after the adoption of the Commission decision.
- (49) Payments for age-related credits for contracts commenced prior to 1 January 2016 and hospital bed utilisation credits for overnight stays incurred prior to 1 January

<sup>42</sup> An explanation for relatively small surpluses and deficits that may arise in the Risk Equalisation Fund is provided in the September 2015 HIA Report: “In view of the accounting position of the Fund at 30 June 2015, the likely progression of the fund position due to older people continuing to renew contracts earlier in the year than younger people and insurers’ financial results and projections, the Authority is of the view that there is likely to be a small surplus in the fund when the credits and stamp duty on all contracts that commenced in advance of 1 March 2016 are fully earned. The Authority estimates that the ultimate amount of this surplus will be of the order of €10m. Having regard to the aim of avoiding the fund sustaining surpluses or deficits from year to year, the Authority is allowing for this anticipated surplus in its recommendation of the stamp duty for policies commencing in the period 1 March 2016 to 28 February 2017.”

2016 are payments required under the 2013 RES, as authorised by the Commission Decision of 20 February 2013, and could be paid in arrears as normal, even if that happened in 2016 before the Commission decision on the 2016 RES is available.<sup>43</sup> The same principle applies to the stamp duties from insurers for the quarter ended 31 December 2015, which are authorised under the 2013 RES, although they are payable to the Revenue Commissioners in February 2016.

- (50) The Irish authorities also explained that claims made for payments due in 2016 under the 2016 RES (i.e. age-related credits for contracts commenced from 1 January 2016 and hospital utilisation credits for admissions to hospital from 1 January 2016) will not fall due until after the Commission decision.

### **3. ASSESSMENT OF THE MEASURE**

#### **3.1. Existence of aid within the meaning of Article 107(1) TFEU**

- (51) According to Article 107(1) TFEU “*any aid granted by a Member State or through State resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods shall, in so far as it affects trade between Member States, be incompatible with the internal market*”.

- (52) It follows that, in order for a measure to be qualified as State aid within the meaning of Article 107(1) TFEU, the following four cumulative conditions have to be met:

- i. it has to be imputable to the Member State and granted out of State resources;
- ii. it has to confer an economic advantage on undertakings;
- iii. the advantage has to be selective; and
- iv. the measure has to distort or threaten to distort competition and affect trade between Member States.

- (53) In this respect, the Commission first of all recalls that, in recitals (60)-(76) of its decision on the 2013 RES, it noted that the scheme was selectively advantageous to Vhi and that it was likely to have an effect on trade between Member States and to lead to a distortion of competition. This assessment regarding the presence of an economic advantage, its selectivity and its impact on competition and trade remains valid for the substantially unchanged measure regarding the current funding period, for the following reasons:

##### ***3.1.1. Aid imputable to the State and granted through State resources***

- (54) The 2016 RES 2016 is an act of the State, set up on the initiative of the State, and a tool of government policy in ensuring intergenerational solidarity on the PMI market. It is thus imputable to the State. The levels of risk equalisation credits and stamp duties are determined by the State (the Minister for Health, in consultation with the Minister for Finance, based on the HIA’s recommendations). The State also orders the reimbursement of potential overcompensation, based on the HIA’s recommendations.

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<sup>43</sup> In fact, these claims and corresponding payments normally occur in January-February 2016.

- (55) The 2016 RES operates via the creation of a fund, established by national legislation, which will be financed by compulsory contributions and controlled by public authorities.<sup>44</sup> The State, ultimately acting through the Minister for Health and the Minister for Finance, has discretion over the use and destination of the totality of the funds available under the 2016 RES, which are under State control.
- (56) Furthermore, the self-financing nature of the RES is not guaranteed; the stamp duties are set in anticipation of the risk equalisation credits (based on estimations of the levels of risk equalisation credits required for the RES to function correctly), but no *ex post* reduction of the credits is applied if the raised stamp duties are insufficient, and the funding gap is charged to the general budget of the State.<sup>45</sup>
- (57) Consequently the Commission considers that the measure involves the transfer of State resources.

### ***3.1.2. Economic advantage to undertakings***

- (58) Public funding granted to an entity can only qualify as State aid if that entity is an “undertaking” within the meaning of Article 107(1) TFEU. The Court of Justice has consistently defined undertakings as entities engaged in an economic activity.<sup>46</sup> An activity is considered to be economic in nature where it consists in offering goods and services on a market.<sup>47</sup> The qualification of an entity as an undertaking thus depends on the nature of its activity, with no regard to the entity’s legal status or the way in which it is financed.<sup>48</sup> In the present case, all four insurers on the PMI market are SGEI providers and will receive credits from the 2016 RES, and thus could potentially be net beneficiaries of the scheme (although Vhi Healthcare is expected to continue to be the net beneficiary of the 2016 RES, the Irish authorities cannot exclude that another insurer may become a net beneficiary of the RES in the future). The four insurers on the Irish market offer highly diversified voluntary health insurance products at a price set by each insurer individually, in competition with each other. Offering voluntary health insurance on the Irish PMI market thus amounts to an economic activity.

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<sup>44</sup> According to 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* ECLI:EU:C:1974:71, p. 16; Case 78/76 *Steinike* ECLI:EU:C:1977:52, p. 22; Cases C-78/90 to C-83/90, *Sociétés Compagnie Commerciale de l’Ouest* ECLI:EU:C:1992:118; Cases C-149/91 and C-150/91 *Sanders* ECLI:EU:C:1992:261; Case C-17/91 *Lornooy* [1992] ECLI:EU:C:1992:514; Case C-114/91 *Claeys* ECLI:EU:C:1992:516; Case C-144/91 and C-145/91 *Demoor* ECLI:EU:C:1992:518).

<sup>45</sup> Pursuant to section 11D of the Health Insurance Act 1994 (as amended).

<sup>46</sup> Joined Cases C-180/98 to C-184/98 *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten* ECLI:EU:C:2000:428, paragraph 74.

<sup>47</sup> Case C-118/85 *Commission of the European Communities v Italian Republic* ECLI:EU:C:1987:283, paragraph 7.

<sup>48</sup> Case C-41/90 *Höfner & Fritz Elser v Macrotron GmbH* ECLI:EU:C:1991:161, paragraph 21 and Joined Cases C-180/98 to C-184/98 *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten* ECLI:EU:C:2000:428, paragraph 74.



Accordingly, with respect to the activities financed by the measure in question, all insurers must be qualified as undertakings.<sup>49</sup>

- (59) An advantage for the purposes of Article 107(1) TFEU is any economic benefit which an undertaking would not have obtained under normal market conditions, i.e. in the absence of State intervention.<sup>50</sup> Only the effect of the measure on the undertaking is relevant, not the cause or the objective of the State intervention.<sup>51</sup> Whenever the financial situation of the undertaking is improved as a result of State intervention, an advantage is granted.
- (60) The measure under assessment is designed to ensure intergenerational solidarity through risk equalisation, by supporting insurers with a worse risk profile relative to the market. The measure thus improves the situation of the net beneficiaries of the scheme in the market. As a consequence, and without prejudice to the question whether the measure complies with the conditions set out in the *Altmark* judgment (considered below), the measure under assessment *prima facie* grants an advantage to the net beneficiary / beneficiaries of the scheme.
- (61) Pursuant to the *Altmark* case law<sup>52</sup>, where a State measure must be regarded as compensation for the services provided by the recipient undertakings in order to discharge public service obligations, so that those undertakings do not enjoy a real financial advantage and the measure thus does not have the effect of putting them in a more favourable competitive position than the undertakings competing with them, such a measure is not caught by Article 107(1) TFEU. However, for such compensation to escape qualification as State aid in a particular case, four cumulative conditions must be satisfied:
1. The recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined.
  2. The parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner.
  3. The compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of public service obligations, taking into account the relevant receipts and a reasonable profit.
  4. Where the undertaking which is to discharge public service obligations is not chosen pursuant to a public procurement procedure which would allow for the selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well run and adequately provided so as to be able to meet the necessary public service requirements, would have incurred in discharging those obligations, taking

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<sup>49</sup> See, for an assessment of whether an activity is economic or not, for example, Case C-67/96 *Albany* ECLI:EU:C:1999:430; Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01 *AOK Bundesverband* ECLI:EU:C:2004:150; Case C-350/07 *Kattner Stahlbau* ECLI:EU:C:2009:127.

<sup>50</sup> Case C-39/94 *Syndicat français de l'Express international (SFEI) and others v La Poste and others* ECLI:EU:C:1996:285, paragraph 60 and Case C-342/96 *Kingdom of Spain v Commission of the European Communities* ECLI:EU:C:1999:210, paragraph 41.

<sup>51</sup> Case 173/73 *Italian Republic v Commission of the European Communities* ECLI:EU:C:1974:71, paragraph 13.

<sup>52</sup> Judgment of the Court of 24 July 2003, *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH*, case C-280/00 ECLI:EU:C:2003:415.

into account the relevant receipts and a reasonable profit for discharging the obligations.

- (62) Given that the conditions of applicability of the *Altmark* case law are cumulative, non-compliance with any one of these conditions would lead to the qualification of the measure under review as State aid within the meaning of Article 107(1) TFEU. Like the Interim Scheme and the 2013 RES, the 2016 RES appears not to comply with the fourth *Altmark* criterion, for the same reasons as outlined by the Commission in recitals (72)-(75) of its decision on the 2013 RES. Furthermore, the Irish authorities no longer argue in their notification of the 2016 RES that the measure does not confer an advantage in line with the *Altmark* case law.
- (63) Consequently, the Commission confirms the analysis carried out in its decision on the 2013 RES and concludes that the measure ought to be considered as conferring an advantage to the net beneficiary of the scheme, which can be qualified as an economic advantage granted to an undertaking within the meaning of Article 107(1) TFEU.

### ***3.1.3. Selectivity***

- (64) Concerning the selectivity of the measure, in addition to the fact that only health insurers, as opposed to undertakings in other sectors, can be beneficiaries of the scheme, it is inherent in the very design of a risk equalisation scheme that only some undertakings within that sector can benefit – not all operators on the market can have a worse than average risk profile. The fact that it might not be stated with certainty at the outset which undertaking or undertakings will benefit does not alter that conclusion, although the Commission notes that in the present case it is common ground that only Vhi Healthcare will be a net beneficiary of the scheme. Accordingly the Commission considers that the RES 2016 is selective in nature.

### ***3.1.4. Distortion of competition and effect on trade***

- (65) The 2016 RES, under the current conditions on the Irish PMI market, will lead to a net payment in favour of Vhi Healthcare, the State-owned former monopolist. The Fund making that payment will have been financed by net contributions from the other insurers on the market (namely Aviva Health, GloHealth and Laya Healthcare). The scheme has a clear potential to affect competition as it is anticipated that it will require, in effect, the private operators on the market to make payments in favour of the dominant operator, i.e. Vhi Healthcare. In this context, as net contributors to the RES, the private operators might increase their premiums (which are not subject to price regulation), and this could lead to some young customers that can barely afford private health insurance opting out of the PMI market. Thus, the competitive positions of the respective operators on the market might be affected by the RES. Accordingly, the Commission considers that there exists a threat of distortion of competition within the meaning of Article 107(1) TFEU.
- (66) Moreover, PMI is part of the internal market for services of voluntary health insurance. The Commission notes that cross-border trade and investment activity in this sector is substantial across Europe, as demonstrated by the numerous takeovers of insurance business (BUPA taken over by Quinn and then by Laya; and Vivas by Hibernian and then by Aviva) and by the various examples of

insurers moving in and out of the Irish PMI market (e.g. the establishment of GloHealth in 2012). Furthermore, new insurers can and do enter the market indirectly through underwriting contracts (in 2012, both Swiss Re, underwriting Laya through its subsidiary Elips Insurance Ltd<sup>53</sup>, and Munich Re, underwriting GloHealth through its subsidiary Great Lakes Reinsurance UK plc). The actors behind some of the insurers on the market are international groups, with activities in various EU Member States and worldwide. In this context, the Commission considers that the measure is also liable to have an effect on trade between Member States.

### ***3.1.5. Conclusion on the existence of aid***

- (67) The Commission considers that the 2016 RES, like the Interim Scheme and the 2013 RES, constitutes State aid within the meaning of Article 107(1) TFEU. This conclusion is undisputed by the Irish authorities.

## **3.2. Legality of the aid**

- (68) The Commission takes note of Ireland's explanation that it will not pay out any aid due under the 2016 RES until the Commission reaches a decision authorising the notified measure.
- (69) While it acknowledges that the 2016 RES, which aims at protecting the solidarity principle in voluntary health insurance in Ireland, is an essential pillar of the PMI market and of Ireland's health policy as a whole, the Commission regrets that the 2016 RES was put in place as of 1 January 2016, before the Commission adopted its decision on the measure.

## **3.3. Compatibility of the aid under the 2012 SGEI Framework**

- (70) Under certain conditions, Article 106(2) TFEU allows the Commission to declare compensation for SGEIs compatible with the internal market. The 2012 SGEI Framework<sup>54</sup> sets out guidelines for assessing the compatibility of SGEI compensation which exceeds € 15 million per year.

### ***3.3.1. Genuine service of general economic interest and public consultation***

- (71) Pursuant to paragraph 12 of the 2012 SGEI Framework, aid must be granted for a genuine and correctly defined SGEI. The Court of Justice has held that SGEIs are services that exhibit special characteristics as compared with those of other economic activities.<sup>55</sup>
- (72) As indicated in the 2012 SGEI Framework, Member States have a wide margin of discretion regarding the nature of services that could be classified as SGEIs. The Commission's task is to ensure that the margin of discretion as regards the definition of an SGEI is applied without manifest error.

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<sup>53</sup> Laya was acquired by AIG in January 2015, but it continues to be underwritten by Elips.

<sup>54</sup> See footnote 36.

<sup>55</sup> Cases C-179/90 *Merici convenzionali porto di Genova* ECLI:EU:C:1991:464, paragraph 27; Case C-242/95 *GT-Link A/S* ECLI:EU:C:1997:376, paragraph 53; and Case C-266/96, *Corsica Ferries France SA* ECLI:EU:C:1998:306, paragraph 45.

- (73) The previous Commission decisions on the 2003 RES, the Interim Scheme for 2008-2012 and the 2013 RES, as well as the BUPA case law<sup>56</sup>, accepted that the provision of private health insurance cover under the conditions of community rating, open enrolment, lifetime cover and minimum benefits is an SGEI. The obligations imposed on health insurers operating in the market were also accepted as SGEI obligations. The 2016 RES does not alter the nature of either the service provided or the obligations on insurers.
- (74) In particular, the Commission observes that the 2016 RES aims to ensure that PMI services in Ireland continue to be provided in conformity with the public service obligations defined by legislation and the principal objective of the Health Insurance Act 1994 (i.e. supporting, in the interest of citizens, intergenerational solidarity on the Irish PMI market). Intergenerational solidarity continues to be essential to the functioning of the market and this cannot be achieved without a robust risk equalisation scheme. In this respect, the Irish authorities consider that the provision of PMI services and in particular the continued support of intergenerational solidarity would not be ensured satisfactorily otherwise than under conditions imposed in the public interest.
- (75) In light of the above, the Commission considers that the provision of private health insurance cover under the conditions of community rating, open enrolment, lifetime cover and minimum benefits over the period 2016-2020 qualify as a genuine SGEI.
- (76) Paragraph 14 of the 2012 SGEI Framework provides that “*Member States should show that they have given proper consideration to the public service needs supported by way of a public consultation or other appropriate instruments to take the interests of users and providers into account.*”
- (77) In this respect, the Commission notes that the interests of both users and providers of private health insurance are regularly taken into account by the Department of Health and the HIA. More specifically, the HIA conducts a consumer survey every two years, to gauge attitudes towards private health insurance, identify trends and assess the impact of the economic climate on customer perceptions. The results of this survey are published on the HIA’s website. In recommending the level of credits that should apply under the RES, the HIA must take account of a range of factors, including its views of the health insurance market and the sustainability of the market. The consumer research it carries out informs the HIA’s views and helps inform its recommendations to the Minister for Health. In addition to the topics previously covered, additional questions will be asked from 2015 onwards to assess consumers’ perceptions of the public service nature of private health insurance. These findings will be published by the HIA.
- (78) According to recent consumer research of users of private health insurance in Ireland, the SGEI entrusted to the Irish health insurance providers has widespread support:

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<sup>56</sup> See footnote 19.

- 84% feel the government has a responsibility to ensure people can afford private health insurance and 75% believe private health insurance minimises pressure on the public hospital system;<sup>57</sup>

- 56% agree with the statement “Private health insurance is a necessity not a luxury”, while only 20% believe there is no need for private health insurance in Ireland.<sup>58</sup>

(79) In addition, a nationally representative sample of adults was surveyed face-to-face in 66 points nationwide, taking account of the actual size and spread of urban and rural localities. Fieldwork was carried out in August and September 2015. The results demonstrated high levels of support for community rating in the Irish market:

- 76% of respondents felt a person’s health should not affect the price they pay for health insurance;

- 77% agreed that older people should not pay more for health insurance;

- 84% supported the policy of open enrolment;

- 62% agreed or strongly agreed that private health insurance eases pressure on the public health system.<sup>59</sup>

(80) Based on the above, the Commission considers that paragraph 14 of the 2012 SGEI Framework has been met for the period covered by the current notification.

### ***3.3.2. Need for an entrustment act specifying the public service obligations and the methods for calculating compensation***

(81) As indicated in Section 2.3 of the 2012 SGEI Framework, and in particular in paragraphs 15 and 16 thereof, the provision of the SGEI for the purposes of Article 106(2) TFEU must be entrusted to the undertaking in question by way of one or more official acts. These acts must specify, in particular: the precise nature of the public service obligation and its duration; the undertaking and territory concerned; the nature of the exclusive rights assigned to the undertaking; the description of the compensation mechanism and the parameters for calculating, monitoring and reviewing the compensation; and the arrangements for avoiding and repaying any overcompensation.

(82) The content of the PMI obligations is clearly described in the Health Insurance Act 1994, as outlined in recital (11). The 2016 RES relies on the explicit entrustment via the Health Insurance Act 1994 (as amended), together with the Stamp Duties Consolidation Act 1999 (as amended), of all undertakings wishing to provide their services on the health insurance market in Ireland. The Commission observes that it is essential to the proper functioning of the RES that all PMI insurers active on the Irish market are entrusted with the PMI obligations

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<sup>57</sup> Independent Hospital Association of Ireland, Red C Consumer Survey 2014, private health insurance users, see IHA submission 11 April 2014 on <http://health.gov.ie/blog/publications/review-of-measures-to-reduce-costs-in-the-private-health-insurance-market-2014/>

<sup>58</sup> HIA The Private Health Insurance Market in Ireland, (2014) Millward Brown <http://www.hia.ie/publication/consumer-surveys>

<sup>59</sup> HIA Survey of Public Opinion Towards the Regulatory Structure of Irish Health Insurance 2015, Millward Brown <http://www.hia.ie/publication/consumer-surveys>

and participate in the 2016 RES. In other words, if an insurer wishes to offer PMI, it must do so in compliance with the PMI obligations and participate in the RES.

- (83) The method for compensation depends on objective and easily verifiable parameters, namely the number of persons insured by each insurer in each of the clear and transparent categories, i.e. depending on age, gender, and defined level of coverage, as well as with reference to hospital bed utilisation. As concerns the age and health status calculations, the Commission is of the view that the parameters put in place for the 2016 RES are sufficiently clear and defined in advance.<sup>60</sup> Moreover, as with the previous schemes, the level of the risk equalisation credits and stamp duties will be set in advance each year for the whole year and communicated to insurers accordingly, so that they are able to factor the effects of the risk equalisation credits and the stamp duties into their business decisions.
- (84) Finally, the Health Insurance Act 1994 (as amended) establishes the criteria for calculating reasonable profit, which must be calculated under section 7F of the Health Insurance Act (regarding overcompensation), in accordance with the 2012 SGEI Framework. As mentioned in recital (42), given that the indicator for reasonable profit will be Return on Sales under the 2016 RES, the Irish Government will make the legislative provision for this revised benchmark of reasonable profit in 2016.
- (85) In conclusion, the Commission considers that the entrustment for the period 2016-2020 is in line with the 2012 SGEI Framework requirements.

### ***3.3.3. Duration of the period of entrustment***

- (86) Although the PMI obligations are set for an indefinite period of time and the RES is designed to be open-ended under domestic law, the Irish authorities in their notification to the Commission sought approval of the scheme for another five years, i.e. for the period 1 January 2016 to 31 December 2020.
- (87) While paragraph 17 of the 2012 SGEI Framework requires that the duration of the period of entrustment is justified by reference to objective criteria, the Commission is of the view that, given the peculiarities of the 2016 RES (as was the case under the 2013 RES), the unspecified duration does not raise particular concerns. The requirement that the entrustment is limited in time is meant to avoid long-term foreclosure of the market, but under the RES all insurers are entrusted with the SGEI and are therefore potential beneficiaries of the scheme. The Commission also notes that Ireland has in any event notified the 2016 RES for a period of five years. As Ireland may in time notify prolongations or modifications of the measure, the 2016 RES will be periodically reviewed, thereby ensuring a check on the correct functioning of the Irish PMI market and avoiding the risk of foreclosure of the market.
- (88) The Commission therefore considers that no concerns are raised in relation to paragraph 17 of the 2012 SGEI Framework.

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<sup>60</sup> As explained in recital (26), the legislation sets out in full the information that all health insurers must provide to the HIA for the purposes of enabling it to make the necessary calculations regarding the credits and stamp duty levels, as well as for the HIA to have the data necessary to conduct the overcompensation test.

### 3.3.4. Compliance with the Directive 2006/111/EC

- (89) According to paragraph 18 of the 2012 SGEI Framework, “aid will be considered compatible with the internal market on the basis of Article 106(2) of the Treaty only where the undertaking complies, where applicable, with Directive 2006/111/EC on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings”.<sup>61</sup> In addition, according to paragraph 44 of the 2012 SGEI Framework, “[w]here an undertaking carries out activities falling both inside and outside the scope of the SGEI, the internal accounts must show separately the costs and revenues associated with the SGEI and those of the other services.”
- (90) Concerning the separation of the costs and revenues of the SGEI from those of non-SGEI related activities, the claims costs and the premiums relating to private health insurance are easy to separate from for example travel insurance and other non-health insurance related activities as both claims costs and premiums are linked to individually identifiable policies. As explained in recital (26), the Health Insurance Act 1994 foresees that all insurers are by law obliged to submit to the HIA half-yearly information returns, in a standard form, containing detailed historical data relating to the number of lives insured in each age group, the gender profile and type of cover of each age group, hospital utilisation data and relevant claims data, as well as detailed information at product level. Moreover, as outlined in recital (40), all insurers are required to maintain and give to the HIA yearly statements of profit and loss as well as certified balance sheets in respect of its health insurance business.
- (91) In general terms, all insurers are required to maintain separate accounts for their health insurance business and submit this financial data to the HIA. The annual HIA Report to the Minister for Health on the evaluation and analysis of returns including advice on risk equalisation credits sets out the profitability of insurers for the previous calendar year. The accounts submitted to the HIA differ from published accounts, which may have been finalised on a different date and may include business other than private health insurance business. As the insurers are in competition, the accounts submitted are not publicly disclosed. The data submitted by insurers to the HIA provides transparency to the HIA on the impact of the scheme on individual insurers and the market and is critical in informing the HIA’s assessment of any overcompensation that may occur.
- (92) Finally, the HIA’s annual report, which is published on its website and laid before the Houses of the Oireachtas, also contains a report on the Risk Equalisation Fund and associated financial statements for the calendar year. The financial statements of the Risk Equalisation Fund are independently audited by the Comptroller and Auditor General and set out a true and fair view of the transactions of the Fund and of the state of its affairs.
- (93) In light of the above, the Commission considers that undertakings entrusted with the provision of the SGEI in this case comply with Directive 2006/111/EC.

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<sup>61</sup> OJ L 318 17.11.2006, p.17.

### **3.3.5. Compliance with EU Public Procurement Rules**

- (94) Paragraph 19 of the 2012 SGEI Framework makes the compatibility of SGEI compensation conditional upon compliance with Union public procurement rules, where applicable.
- (95) The Commission notes that, since any operator wishing to provide its services on the PMI market is entrusted with the SGEI and may potentially benefit from the 2016 RES, it is not necessary to use the public procurement rules in order to ensure compliance with the 2012 SGEI Framework in this case.

### **3.3.6. Absence of discrimination**

- (96) According to paragraph 20 of the 2012 SGEI Framework, “[w]here an authority assigns the provision of the same SGEI to several undertakings, the compensation should be calculated on the basis of the same method in respect of each undertaking.”
- (97) The Commission observes that the 2016 RES operates in an identical manner in respect of all insurers on the Irish PMI market, as it is based on objective criteria. First, the stamp duties levied under the RES are levied on individual plans, thus the total amount paid by an insurer is dependent on the number of policies sold and the level of cover provided under each plan. Second, the credits received by insurers under the RES are based on individual customer characteristics (age, gender and level of cover) and actual number of hospital admissions.
- (98) The HIA is an independent authority and follows an objective procedure for recommending the proposed levels of credits and stamp duties. The Minister for Health in cooperation with the Minister for Finance, in their respective capacities, determine the levels of credits and stamp duties, taking into account the objective of achieving community rating and thereby intergenerational solidarity.
- (99) The RES does not constitute a barrier to entry to the Irish private health insurance market. The SGEI is entrusted to all insurers offering or seeking to offer open-market, in-patient private health insurance. The scheme does not discriminate between insurers, as the calculation of contributions and payments is the same for each insurer. It does not discriminate between public and private undertakings either.<sup>62</sup> No entity (public, private or new entrant) is granted exclusive or special rights.<sup>63</sup>
- (100) Therefore, the Commission considers that the notified measure complies with paragraph 20 of the 2012 SGEI Framework.

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<sup>62</sup> A clear distinction is made between the role of the State as public authority and its role as proprietor. The status of Vhi Healthcare as a public undertaking is not considered as part of the process for determining the rates of stamp duties and credits for the following year.

<sup>63</sup> In its submission, one of the insurers argued that the health insurance market in Ireland was not subject to fair and open competition given the delay in authorisation of Vhi Healthcare to carry out insurance business in line with the requirements of the Third Non-Life Directive. In this respect, the Commission notes that Vhi Healthcare was authorised by the Central Bank of Ireland, the independent regulator, in July 2015 and is now subject to the same level of regulation as other health insurers in the Irish market.



### **3.3.7. Amount of compensation**

- (101) According to paragraph 21 of the 2012 SGEI Framework, “[t]he amount of compensation must not exceed what is necessary to cover the net cost of discharging the public service obligations, including a reasonable profit.” In this respect, paragraph 24 of the 2012 SGEI Framework foresees that “[t]he net cost necessary, or expected to be necessary, to discharge the public service obligations should be calculated using the net avoided cost methodology where this is required by Union or national legislation and in other cases where this is possible.” According to paragraph 25 of the 2012 SGEI Framework, “under the net avoided cost methodology, the net cost expected necessary to discharge the public service obligations is calculated as the difference between the net cost for the provider of operating with the public service obligation and the net cost or profit for the same provider of operating without that obligation [...]”

#### **Net cost calculation**

- (102) In the RES, all operators are obliged to participate, rather than the SGEI provision being entrusted to a single operator. As with the previous schemes, the 2016 RES does not aim to compensate the net costs of providing private health insurance in Ireland, but rather to reduce the differences in these net costs arising from divergences in the risk profiles of insurers active on the Irish PMI market. This very specific objective is achieved by the specific methodology used under the RES, with the determination of the appropriate level of credits and stamp duties.<sup>64</sup>
- (103) The net cost of the obligation still has to be calculated to verify the absence of overcompensation. However, the net avoided cost methodology does not appear adequate for such verification, as that approach relies on the difference between the situation of the net beneficiary with the public service obligations and a situation without the public service obligations. In the net avoided cost model, it is assumed that competitors do not have the same public service obligations and compensation could be granted up to a level that would render the SGEI provider indifferent to delivering the SGEI or not, and would therefore offset the specific burden put on the SGEI provider in comparison with its competitors. The situation under the RES is peculiar, as all competitors are entrusted with the same public service obligations and there is no possibility to operate on the market without them. There is no counterfactual scenario in which the net beneficiary would nevertheless operate as a provider of PMI services. For these reasons, the net avoided cost method does not seem appropriate and, as foreseen by footnote 2

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<sup>64</sup> In their submission, the insurers made a number of specific comments on the actual level of credits (by age, level of cover and health status) and of stamp duties applicable under the scheme as of 1 March 2016, and what they believed was the appropriate evolution of these rates as compared to the previous year. In this respect, the Commission notes that, while the relevant figures for 2016 are provided as way of example in the decision to reflect the functioning of the scheme, the Commission’s assessment concerns the general methodology established by the Irish authorities for the functioning of the scheme (outlined in sections 2.5.1-2.5.3 above) and not the yearly levels of credits and stamp duties. The Commission also notes that these are set by the HIA following an in-depth analysis of the relevant data and all insurers are consulted on their views on the RES in the framework of the Health Insurance Consultative Forum, as explained in recital (124) below.

of the 2012 SGEI Framework, the net cost should be calculated as cost minus revenues.<sup>65</sup>

- (104) The operation of the RES, given current customer profiles, has so far resulted in one net beneficiary and three net contributors. As regards the 2016 RES, Vhi Healthcare is expected to continue to be the net beneficiary of the scheme, while its competitors will be net contributors. The projected net financial impact of the RES based on the credits and stamp duties applying for policies commencing in the period 1 March 2016 to 28 February 2017 is outlined in Table 5. However, as insurers' customer profiles change over time, in future years there may be more than one net beneficiary and the net amount paid by net contributors may reduce. Over the next decade, as the market ages, the risk profiles of all insurers are likely to become more homogenous. This would reduce the net gain or loss for each insurer from the RES. In this regard, the design of the RES ensures that the impact on each insurer is proportionate to the relative differences in customer profile between insurers and the overall market.
- (105) It should be noted that even if all insurers had similar customer risk profiles which matched the total market profile, a risk equalisation scheme (albeit one with low rates of net contributions and net benefits) would still be required to prevent existing insurers or new entrants targeting low risk customer groups to the detriment of high risk customer groups. While there is still some incentive to compete based on risk as the scheme is not fully effective, one of the key objectives of the RES is to reduce this incentive to compete based on risk, which should drive competition to other areas, e.g. efficiency, claims cost management and product design. Without the RES, the incentive to compete on risk, i.e. by targeting healthier customers, would be much greater and would threaten the sustainability of the PMI market in Ireland as a necessary complement to the public health system and reduce the incentive to compete in areas such as efficiency and quality, which would be more beneficial to the long-term operation of the market.

#### ***Reasonable profit and verification of the absence of overcompensation***

- (106) Paragraph 34 of the 2012 SGEI Framework foresees that “[w]here duly justified, profit level indicators other than the rate of return on capital can be used to determine what the reasonable profit should be, such as the average return on equity over the entrustment period, the return on capital employed, the return on assets or the return on sales.” Furthermore, as laid out in paragraph 49 of the 2012 SGEI Framework, “Member States must ensure [...] that undertakings are not receiving compensation in excess of the amount determined in accordance with the requirements set out in this section. They must provide evidence upon request from the Commission. They must carry out regular checks, or ensure that such checks are carried out, at the end of the period of entrustment and, in any event, at intervals of not more than three years.”
- (107) As explained in recitals (41)-(42), the HIA will determine the reasonable profit with reference to Return on Sales (ROS) excluding reinsurance and investment activities. This indicator replaces the Return on Equity previously used, and also

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<sup>65</sup> Footnote 2 of the 2012 SGEI Framework reads as follows “*In this context, net cost means net cost as determined in paragraph 25 or costs minus revenues where the net avoided cost methodology cannot be applied.*”

addresses the comments of two insurers, which suggested an update of the benchmark for reasonable profit. In particular, one insurer argued that Return on Equity can be impacted by capital structure and reinsurance, which are not strictly speaking related to the SGEI itself. The other insurer considers that the ROS is a more robust measure, that can be easily implemented and commonly understood, and that ensures better comparability across insurers (in particular when calculated gross of reinsurance).

- (108) Based on forward-looking benchmarking calculations carried out by Oxera Consulting, overcompensation will be deemed to have occurred where the net beneficiary's ROS gross of reinsurance<sup>66</sup> exceeds 4.4% per annum, calculated on a rolling three year basis.
- (109) Based on historical figures and financial information for the period 2010-2014, Oxera has estimated that the ROS gross of reinsurance of the expected net beneficiary (Vhi Healthcare) will be [...] % in 2016 and [...] % in 2017. Therefore, although an estimation is not available for 2018, it does not appear likely that Vhi Healthcare will be overcompensated in the future. In any event, HIA will carry out the first overcompensation test in 2019 for the period 2016-2018 inclusive. The HIA will carry out the overcompensation test during the entire period covered by the present decision (i.e. 2016-2020), on a rolling three year basis. Furthermore, as outlined in recital (43), a clear procedure has been established for the recovery of any overcompensation that may be found to have occurred under the RES.
- (110) That said, it results from the manner in which the system is set up that overcompensation is highly unlikely. The operation of the RES aims to ensure that insurers are not impacted beyond the degree necessary to ensure an efficient and sustainable, community-rated private health insurance market. A key feature of the RES is that the amount of compensation provided to all insurers does not exceed what is necessary to cover the net cost of discharging the public service obligations, including a reasonable profit (in fact, as noted below, it does not even reach that level). In the absence of community rating, an insurer would not charge below the expected cost of insuring an individual (or at least the expected cost of insuring all individuals in its portfolio). However, under the RES, the amount of compensation received (gross premium plus any applicable credits) is lower than what is necessary to cover the net cost of discharging the public service obligation, i.e. the cost of insuring older lives.<sup>67</sup> This is the result of the fact that, as explained in section 2.5.3, the level of credits is determined so that, after allowing for the impact of the scheme, the claims costs for any age and gender group would not be more than a fixed percentage of the market average (i.e. 130% in the last year of application of the 2013 RES, rather than 100% of the market average, which would represent a full equalisation of risk differences).
- (111) The fact that the RES is not 100% effective in equalising the differences in the risk profiles of the insurers' portfolios reduces the level of credits and thereby the likelihood of overcompensation. Table 6 below shows the RES effectiveness (i.e.

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<sup>66</sup> This indicator does not include the impact of investments of the PMI provider.

<sup>67</sup> Other insurance activities offered by the four health insurers are excluded and insurers are required to keep separate accounts for their health insurance business. The costs of luxury benefits, e.g. private accommodation in private hospitals, are excluded from the calculation of credits. Payments made to insurers reflect actual customer profiles and utilisation rates.

the extent to which risk in excess of the market average was smoothed over as a result of the credits provided under the scheme for all levels of cover combined) over the period 2013-2015. The level of compensation for older ages has remained partial over the last three years and will remain partial in the future.

*Table 6: RES effectiveness over the period 2013-2015*

Age Bands	Autumn 2014	Autumn 2013	Autumn 2012
65-69	62%	60%	60%
70-74	76%	74%	72%
75-79	82%	82%	78%
80-84	86%	85%	83%
85+	88%	87%	83%

(112) The fact that the scheme does not fully compensate for the risks associated with less healthy lives means that insurers with a portfolio composed of a higher proportion of healthy lives will always have the capacity for profitability (at the expense of insurers with less healthy lives) and the RES will never fully compensate the net beneficiary of the scheme for the risks associated with their population of insured lives. Therefore, the scheme will not distort competition in the market by driving the profits down to an unsustainable level.

(113) In light of the above, the Commission considers that the reasonable profit calculation and the verification of the absence of overcompensation are also in line with the 2012 SGEI Framework.

### ***Efficiency Incentives***

(114) Paragraph 39 of the 2012 SGEI Framework reads: *“In devising the method of compensation, Member States must introduce incentives for the efficient provision of SGEI of a high standard, unless they can duly justify that it is not feasible or appropriate to do so.”*

(115) The RES represents a *sui generis* SGEI system, based on equalising ‘bad risk’ against ‘good risk’ differentials between insurers that remain exposed to competition and are not compensated on the basis of the full cost of providing health insurance. These differentials are not under the control of health insurers, as they result from the health status of the population and from the open enrolment obligation. Therefore, in the Commission decision on the 2013 RES, it was not considered particularly appropriate to introduce additional efficiency incentives; the effect of normal market forces in the regulated environment of healthcare provision and health insurance in Ireland was considered sufficient.<sup>68</sup> The same reasoning applies to the 2016 RES, and the Commission accepts the submission of Ireland that further efficiency incentives within the meaning of paragraphs 39 to 43 of the 2012 SGEI Framework are not required in the present case. The efficiency mechanisms that are built into the system are described below.

<sup>68</sup> See recitals (159) and (160) of the Commission decision of 20 February 2013 on the 2013 RES.

- (116) As mentioned in recital (105), through its design, the RES promotes competition on the basis of price and/or quality rather than risk selection by insurers. More specifically, the compensation provided to all insurers is based on a combination of expected costs (age-based risk equalisation credits) and incurred costs (hospital bed utilisation credits) and neither payment to insurers removes an insurer's incentive to be efficient, as the insurer always makes higher profits when efficient.
- (117) Age-based risk equalisation credits are calculated on the basis of market average claims costs. Therefore, as insurers receive for a certain category of insured person credits which are determined on an *ex ante* basis, they are able to extract a benefit from those payments by having claims costs below the average market claims costs. The provision of age-based risk equalisation credits thus provides an incentive to insurers to reduce costs, as they retain the full benefit of any efficiency savings.
- (118) The utilisation credits paid for overnight stays in hospital are set at a level considerably below actual cost; therefore, insurers retain an incentive to avoid unnecessary overnight stays and reduce length of stay where medically appropriate. As mentioned in recital (25), the utilisation credits will be refined under the 2016 RES by extending the payment of credits to day-case admissions to hospitals (at a correspondingly lower level compared to the utilisation credits for overnight stays). While a considerable proportion of insurers' claims costs arise from treatment that is carried out in a day-case setting, this extension will provide a further incentive for insurers to reduce unnecessary overnight stays and encourage the transition of procedures to lower cost, medically appropriate settings.
- (119) The Commission also notes that, beyond the specific context of the RES, the State took several actions to promote the general efficiency of the health insurance market:
- As regards consumer choice and information, the HIA provides an online comparison tool which enables consumers to compare benefits and prices of all health insurance plans offered by insurers and is intended to assist consumers in accessing the most appropriate policy at the most competitive premium.
  - In terms of provider competition, insurers are allowed to contract selectively with healthcare providers, and are not required to cover treatment in any particular hospital, public or private.
  - The Health Service Executive developed a range of clinical guidelines to promote cost-effective healthcare that is evidence-based, with subsequent improved clinical decision making and clinical outcomes, which are used by insurers to determine the most appropriate treatment for patients.
- (120) In addition, several actions for cost-containment were also taken by insurers, which will drive down the claims costs in the system. For example, in June 2013, a review group consisting of the insurance companies, the HIA and the Department of Health was established to effect real cost reductions in the private health insurance market. The independent report to the Minister for Health in October 2014 stated "It is clear that insurers have put more resources and effort into clinical audit, utilisation reviews and challenging of claims, which may already be having an impact." Other cost-containment measures include, for

example, reductions in payments to clinicians and billing audits to verify that a valid claim was submitted, that the treatment provided was necessary, adequate and effective and that the charges are appropriate and accurate. Moreover, each of the four health insurers have both appointed members to an Anti-Fraud Forum which will address fraud, abuse and inefficiencies in the healthcare system, and made their own respective investments in personnel and IT system infrastructure to alert and protect them from provider fraud. Finally, Vhi Healthcare, has publicly stated its commitment to managing costs and improving efficiencies. The Irish authorities provided concrete evidence in relation to cost management measures employed by Vhi, such as targeted claims efficiency programmes, reductions in fees paid to providers, increased activity of its special claims investigation unit and the continued transition of procedures to lower cost, medically appropriate settings.

### ***Conclusion on the amount of compensation***

(121) For the above-mentioned reasons, the Commission considers that no concerns are raised by the measure under assessment in relation to the requirements under section 2.8 of the 2012 SGEI Framework.

### ***3.3.8. Transparency***

(122) Paragraph 60 of the 2012 SGEI Framework states that: *“For each SGEI compensation falling within the scope of this Communication, the Member State concerned must publish the following information on the internet or by other appropriate means:*

*(a) the results of the public consultation or other appropriate instruments referred to in paragraph 14;*

*(b) the content and duration of the public service obligations;*

*(c) the undertaking and, where applicable, the territory concerned;*

*(d) the amounts of aid granted to the undertaking on a yearly basis”.*

(123) As regards the results of the public consultation carried out in 2014, the Commission notes that these were made available on the internet, as mentioned in recital (78) above. The content and duration of the public service obligations are clearly specified in the Health Insurance Acts 1994 to 2014, which are published in the Irish Statute Book. The undertakings entrusted with the provision of the public service obligations (i.e. the health insurers) are published in the Register of Health Benefits Undertakings, maintained by the HIA.<sup>69</sup> As regards the amounts of aid granted on a yearly basis, the impact of risk equalisation for each undertaking is set out in the HIA’s Report to the Minister for Health on an evaluation and analysis of returns from the previous 12 month period and advice

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<sup>69</sup> In order to carry on the business of health insurance in Ireland, it is necessary for health insurers to be registered and to obtain a certificate of registration from the HIA under Section 14 of the Health Insurance Act 1994. All insurers that provide in-patient health insurance cover and that must accept, subject to certain limited terms and condition, all persons who wish to purchase private health insurance cover are listed on the HIA’s register and receive payments under the RES (published online on <http://www.hia.ie/regulation/register-of-health-benefit-undertakings>; note: HSF Health Plan Limited is an open market insurer but does not provide in-patient health insurance cover so is not part of the RES).

on risk equalisation credits<sup>70</sup>, which is published every year on the websites of the Department for Health and of the HIA.

- (124) In addition, the Irish authorities outlined the steps taken each year to ensure transparency in the process of recommending and setting the rates of credits and stamp duties, as well as to warrant that each year insurers are informed in a timely manner of the proposed changes to these rates.<sup>71</sup> Furthermore, the establishment of a Health Insurance Consultative Forum by the Minister for Health in 2012 provides a regular mechanism for consultation with the market. The Forum brings together the insurers, the Department of Health and the HIA, meeting regularly to discuss developments in the private health insurance market, including any proposed changes to the credits and stamp duties.<sup>72</sup>
- (125) As regards the recommended level of credits and stamp duties applicable as of 1 March 2016, a detailed explanation of the methodology used by the HIA to determine these rates is set out in the September 2015 HIA Report, which was published in redacted form on the Department of Health's website in November 2015. The Irish authorities argued that sufficient notice is provided to insurers to allow them to adjust to the new levels of stamp duties and credits and to make any adjustments to the prices of their plans if they so wish. Finally, if an insurer is not satisfied that the requirements of the Health Insurance Acts 1994 to 2014 have been complied with by the HIA or the Minister for Health, then they may initiate legal proceedings.
- (126) In light of the above, the Commission considers that the transparency requirements set out in the 2012 SGEI Framework are fulfilled.

***3.3.9. Additional requirements which may be necessary to ensure that the development of trade is not affected to an extent contrary to the interests of the Union***

- (127) As explained in paragraph 51 of the 2012 SGEI Framework, *“The requirements set out in sections 2.1 to 2.8 are usually sufficient to ensure that aid does not distort competition in a way that is contrary to the interests of the Union.”* According to paragraph 52 of the 2012 SGEI Framework, *“[i]t is conceivable, however, that in some exceptional circumstances, serious competition distortions*

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<sup>70</sup> See table C1 on page 22 of the September 2015 HIA Report.

<sup>71</sup> In its submission, one insurer argued that, although the risk equalisation scheme is meant to be transparent and the setting of the levies is supposed to be subject to objective criteria based on the market, on two occasions the Minister for Health has unilaterally changed the recommended levy from that proposed by the HIA. However, the Irish authorities explained that the Minister for Health does not have the power to “unilaterally change” the stamp duties and credits. Under section 7E (2) of the Health Insurance Act 1994 (as amended), when recommending the stamp duties the Minister for Health must have regard to the principal objective, the HIA's report and the sometimes competing aims as set out in the legislation (i.e. the sustainability of the market on the one hand and the need to ensure open and fair competition on the other hand). The determination of the stamp duties rests with the Minister for Finance. Under section 7E (2) of the Health Insurance Act 1994 (as amended), the Minister for Health must make recommendations to the Minister for Finance with regard to the level of stamp duties which are then enacted through amendment to the Stamp Duties Consolidation Act 1999.

<sup>72</sup> For example, following feedback from insurers as part of the Consultative Forum, the notice period for the introduction of revised rates of credits and stamp duties was extended in order to address insurers' requirements in terms of changes to IT systems and renewal notices.

*in the internal market could remain unaddressed and the aid could affect trade to such an extent as would be contrary to the interest of the Union.”*

- (128) The Commission recalls that fulfilment of the other requirements set out in the 2012 SGEI Framework is usually sufficient to ensure that the aid does not distort competition in a way that is contrary to the interests of the Union. The Commission concludes that that is the case in relation to the measure under examination.
- (129) However, the Irish authorities have decided to specifically address the concern that the measure could lead to a serious distortion of competition and have undertaken to limit the impact of the 2016 RES by ensuring that the net projected average claims cost for any age group in receipt of age-related credits will not go below 125% of the projected market average net claims cost over the entire period 2016 to 2020. That commitment should protect competition as explained below.
- (130) In recent years, the operation of the scheme allowed for strong competition within the marketplace against a backdrop of reductions in the claims cost ceiling, from 150% in January 2013 to 130% currently. The introduction of a claims cost ceiling and a progressive lowering of that ceiling reflects a continued attempt to improve the effectiveness of the scheme, in the context of persistent evidence of risk segmentation and risk selection within the market. The strength of competition in the market is proven by the evolution of market shares<sup>73</sup>, entry and investment into the market by a number of large multinational insurance groups<sup>74</sup>, as well as the significant decline in premium inflation.<sup>75</sup>
- (131) The proposal to limit the claims cost threshold reduces the potential for the scheme to result in a sharing of claims cost differences that arise due to inefficiencies and other factors, rather than purely from differences in risk. In this manner, the issues raised in recitals (33)-(35) should be addressed.
- (132) The impact of various claims cost thresholds has been analysed by the HIA, as shown in Table 7 below. A claims cost threshold of 130% could encourage an increase in risk segmentation in the marketplace by insurers, knowing that the Minister for Health has limited recourse to react by strengthening the scheme. Setting the claims cost threshold at a level below the current 130% may act as deterrent against further segmentation, as it would leave the Minister for Health with an ability to react to such segmentation by further increasing the effectiveness of the RES. Therefore, a limit of 125% is proposed as more reasonable from this perspective.

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<sup>73</sup> The market share of the largest insurer, Vhi Healthcare, has continued to reduce from [...] % in December 2012 to [...] % in July 2015, while its competitors have increased market share over the period (on aggregate).

<sup>74</sup> GloHealth commenced selling health insurance in July 2012 and has increased its market share to [...] % by July 2015. GloHealth's business is underwritten by Great Lakes Reinsurance, a UK subsidiary of the Munich Re Group. In addition, AIG, Swiss Re, Berkshire Hathaway and Irish Life have all taken significant roles in the Irish health insurance market in recent years through acquisition of an insurer, underwriting or reinsurance.

<sup>75</sup> The consumer price index measures changes in the price of 'insurance connected with health' and adjusts for changes in product type. The cost of health insurance, as measured by the consumer price index, increased by 22.9% in 2011, 16.5% in 2012, 8.7% in 2011, 8% in 2014 and by 0.7% in the first nine months of 2015.



*Table 7: The impact of various claims cost thresholds*

Claims Cost Threshold	Scope for improved effectiveness of the RES	Risk of equalising inefficiencies	Deterrent for insurers engaging in market segmentation
130%	Low	Low	Low
125%	Medium	Low	Medium
100%	High	High	High

- (133) On balance, providing an assurance on the claims cost threshold demonstrates Ireland’s commitment to preserve fair competition between competitors. This is a concrete mechanism that will ensure that, even though the monetary amounts of credits and stamp duties are not known for the full period 2016 to 2020, there is a sufficient guarantee that fair competition will be preserved. This limit therefore provides additional comfort that competition will not be distorted in a disproportionate manner and that efficient insurers remain able to make an adequate return.
- (134) Considering the above, the Commission welcomes the solution proposed by the Irish authorities as an additional measure to ensure that no serious distortion of competition will be induced by the RES.

#### **4. CONCLUSION**

- (135) The Commission has accordingly decided not to raise objections to the notified aid scheme on the grounds that it is compatible with the internal market pursuant to Article 106(2) TFEU.

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://ec.europa.eu/competition/elojade/isef/index.cfm>.

Your request should be sent electronically to the following address:

European Commission,  
Directorate-General Competition  
State Aid Greffe  
B-1049 Brussels  
[Stateaidgreffe@ec.europa.eu](mailto:Stateaidgreffe@ec.europa.eu)

Yours faithfully  
For the Commission

Margrethe VESTAGER  
Member of the Commission