EUROPEAN COMMISSION

Brussels, 20.02.2013
C(2013) 793 final corr.

In the published version of this decision, some information has been omitted, pursuant to articles 24 and 25 of Council Regulation (EC) No 659/1999 of 22 March 1999 laying down detailed rules for the application of Article 93 of the EC Treaty, concerning non-disclosure of information covered by professional secrecy. The omissions are shown thus […].		PUBLIC VERSION This document is made available for information purposes only.

Subject: **State aid SA.34515 (2013/NN) – Ireland**
Risk equalisation scheme for 2013

Sir,

The Commission is pleased to inform Ireland that, having examined the information supplied by your authorities on the measures referred to above, the State compensations granted through the risk equalisation scheme for the provision of private medical insurance in Ireland for the period 2013-2015 constitute State aid that is compatible with the internal market under the European Union Framework for State aid in the form of public service compensation[1] (hereafter "the 2012 SGEI Framework"), which lays down the conditions that should be met for aid to be compatible with the internal market pursuant to Articles 106(2) and 107 TFEU.

[1] European Union framework for State aid in the form of public service compensation, OJ C8, 11.1.2012, p. 15-22.

Mr. Eamon Gilmore T.D.
Minister for Foreign Affairs,
Department of Foreign Affairs
80, St. Stephen's Green,
Dublin 2,
IRELAND

1. PROCEDURE

(1) On 15 March 2012, pre-notification contacts were established between the Commission and the Irish authorities in respect of a new risk equalisation scheme (hereafter the "RES 2013") on the private medical insurance (hereafter "PMI") market. The RES 2013 was to take effect as of 1 January 2013, replacing the Interim Scheme of tax and levies in place since 2009 which expired on 31 December 2012. Initially, the discussions with the Irish authorities focussed on the removal of the unlimited guarantee from which the Irish Voluntary Health Insurance Board (hereafter "VHI") benefited. The Commission adopted a decision on the unlimited guarantee on 25 July 2012.[2] On 22 May 2012, there was a technical meeting following which the Irish authorities submitted a draft "Heads of the RES 2013". The Commission also asked for additional information and clarifications during a telephone conference on 12 July 2012. In response to this meeting, the Irish authorities provided the Commission with supporting documentation on 21 August 2012. On 18 September 2012 the Commission sent a request for information to the Irish authorities to which Ireland replied by letter of 19 October 2012.

(2) On 25 October 2012, Ireland notified, under Article 108(3) TFEU, the new risk equalisation scheme consisting of a compensation mechanism for bad risks whose purpose is to allow better risk sharing between insurers relating to health insurance and to promote intergenerational solidarity in this sector in Ireland. The information submitted in the notification was incomplete, since it not only contained no data concerning the amount of aid but it also lacked information requested by the Commission in its letter of 18 September 2012, relating to important financial data relevant for the Commission's assessment. The notification was therefore supplemented by e-mail of 17 November 2012. This e-mail contained the Report of the Irish Health Insurance Authority (hereafter the "HIA") dated 16 November 2012, setting out the recommendations of the HIA concerning the proposed levels of credits and stamp duties for the RES 2013.

(3) By e-mails of 28 and 30 November and 7 December 2012, the Irish authorities informed the Commission of the Minister for Health's decision regarding the levels of credits and stamp duties, and submitted additional information on the case. In particular, the Irish authorities indicated to the Commission that Ireland had decided to delay the implementation of the new elements of the RES 2013 until 31 March 2013. Thus, the RES 2013 took effect on 1 January 2013, using the rates of age-credits and stamp duties that applied under the Interim Scheme until 31 March with the revised rates for credits and stamp duties applying only as of 31 March 2013.

(4) On 07 December 2012 the Commission sent a request for information asking for further clarification, to which the Irish authorities replied on 14 December 2012.

(5) In parallel, the Commission services have been approached by the three private insurers active on the Irish PMI market. They have submitted correspondence setting out why certain features of the RES 2013 are anti-competitive. On 3 and 17 October 2012, Laya Healthcare Ltd (previously BUPA, then Quinn, now and hereafter "Laya"[3]) forwarded correspondence between it and the Irish authorities. Aviva Health

[2] Decision adopted on 25.7.2012, ref. SA.18879 – E 6/2006 – Ireland, OJ C363, 23.11.2012.

[3] For clarity, in this decision, reference to "Quinn and Laya combined" refers to economic information covering both Quinn and Laya, given the takeover which occurred early in 2012 and led to the re-branding of the company as Laya in May 2012.

Insurance Ireland Ltd (formerly VIVAS Health then Hibernian, hereafter "Aviva") sent an e-mail to the Commission on 16 July 2012. The Commission also had two meetings on 13 September 2012 and on 5 December 2012 with the third existing competitor and a new entrant, GloHealth Ltd (hereafter "GloHealth"), to discuss their concerns. GloHealth sent e-mails to the Commission services on 14 September 2012, 1, 17 and 23 October 2012, 7 and 15 November 2012, 12 December 2012, and 4 and 10 January 2013.

2. DETAILED DESCRIPTION OF THE MEASURE

2.1. The Irish health insurance market

(6) Ireland has a mixture of a public health insurance system and a voluntary, private health insurance system.

(7) The public health insurance system is governed by the Health Act of 2004. Under the tax-funded public health insurance system, individuals situated below a certain income level are eligible for a medical card, which guarantees free access to all health services, including hospital services, general practitioners and prescription drugs. Medical card holders account for approximately one third of the population. The remaining two thirds of the population are, since 1991, entitled to hospital services upon payment of a modest charge and must pay for the services of a general practitioner and for prescription drugs.

(8) Due to the capacity limitations presented by the public system, however, about 46.3% of the population has voluntary health insurance in the form of Private Medical Insurance (PMI) cover.[4] 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 for in-patient bed use, together with a more limited reimbursement of certain charges in the primary care sector[5]; 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.

---

[4] According to the Irish Health Insurance Authority, about 2,16m people had PMI plans providing in-patient benefits at end-December 2011. In addition, 103,000 people had insurance plans solely providing outpatient benefits or health insurance cash plans. Figures based on the Health Insurance Authority Market News February 2012 edition, available at www.hia.ie.
For clarity, in-patient care is the care of patients whose condition requires admission to a hospital. An in-patient is admitted to the hospital and stays overnight or for an indeterminate time. 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 overnight.

[5] Primary care is the health care given by a health care provider. 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.
Secondary care is the health care provided by medical specialists and other health professionals who generally do not have first contact with patients (e.g. cardiologists, urologists, dermatologists). It includes acute care, *i.e.* necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.
Tertiary care is specialised consultative health care, usually for in-patients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment (such as cancer management, neurosurgery, cardiac surgery, plastic surgery, and other complex medical and surgical interventions).

(9) Both the public and the private health insurance schemes operate on the basis of open enrolment with lifetime cover and community rating, whereby everyone – regardless of their age/health profile – is charged the same premium for the same insurance package.[6]

Market structure

(10) The Irish PMI market was opened up to competition in 1994 by the Voluntary Health Insurance Act 1994, and it is currently operated by the four health insurers[7]: the dominant operator is the state-owned VHI (59.4% market share), followed by privately-owned Laya (22.1% market share), and privately-owned Aviva (18.5% market share), while a fourth privately-owned operator, GloHealth, officially entered the Irish PMI market on 1 July 2012 (0.5% market share).[8] So called Restricted Membership Undertakings have a negligible part of the market.[9]

(11) Due to the fact that the Irish PMI market was opened to competition only in 1994, the age distribution of insured persons between insurers remains influenced by the fact that VHI continues to have a much larger proportion of members in the higher 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 dominant operator. also 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.[10] 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 2012) between insurers on the Irish PMI market. Figures in brackets show January-June 2011 (source: the Irish Health Insurance Authority).

Age Group	Aviva Health	VHI Healthcare	Quinn/Laya combined	Market
0-17	[…][*]	[…]	[…]	[…]
18-29	[…]	[…]	[…]	[…]
30-39	[…]	[…]	[…]	[…]
40-49	[…]	[…]	[…]	[…]
50-54	[…]	[…]	[…]	[…]
55-59	[…]	[…]	[…]	[…]

6 See below, recital (16) for the definition of open enrolment, lifetime cover and community rating.

7 Figures for VHI, Laya and Aviva based on the 16 November 2012 HIA Report. Figure for GloHealth based on its own estimations.

[*] Business secret

8 In its submissions to the Commission, GloHealth stated that its establishment on the Irish PMI market dates from spring 2011 and that it started trading on 1 July 2012.

9 These undertakings mainly provide health insurance to certain vocational groups and their families and they constitute the only exception to the rule of open enrolment.

10 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.

60-64	[…]	[…]	[…]	[…]
65-69	[…]	[…]	[…]	[…]
70-74	[…]	[…]	[…]	[…]
75-79	[…]	[…]	[…]	[…]
80+	[…]	[…]	[…]	[…]

(12) Thus, according to the HIA, […] of the members of VHI are 65 years or older. For Aviva this proportion is […] and for Laya it is […].[11] In 2012 the percentage of insured persons in the older age groups increased for each insurer in the market.

(13) As indicated in the table below, the gender distribution of the membership of each of the insurers is relatively balanced (figures shown are for the period January to June 2012, but, according to the HIA, the proportions in each gender for each insurer have remained relatively static over time):

Gender	Aviva	VHI	Quinn and Laya combined
Male	48%	48%	49%
Female	52%	52%	51%

2.2. The PMI obligations

(14) Given the significance of the PMI market, covering nearly half of the Irish population, Ireland has always regarded voluntary health insurance as a sector deserving special treatment on the ground that it is a partial or complete alternative to the tax funded public health care system. In line with the principle of intergenerational solidarity, the Irish government introduced regulatory arrangements to prevent risk selection and to avoid the "cherry picking" of clients whose risk profile is better than average.

(15) Thus, the Health Insurance Act 1994, as amended, defines the principal objective as follows:

"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 (…)."[12]

(16) The Health Insurance Act 1994 sets out the four PMI obligations, which are designed to support this objective, as follows:

[11] In the first six months of 2012, VHI has […] times the proportion of members in the over 80 age group than Laya and […] times the proportion in this age group than Aviva. Aviva and Laya have higher proportions in the younger age groups. For instance in the 0 – 17 age group, Laya has […] of its members, Aviva Health has […], while VHI has […] (which represents a small increase over the figure of […] a year earlier).

[12] See section 1A-(1) (a) to (d) of the Health Insurance Act 1994.

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

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 ages and/or his physical condition declines.[15]

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

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).[18]

(17) These 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 ensure 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 complementary objective is to guarantee good quality health care by subjecting insurers to the minimum benefit obligation.

2.3. Historical background of the Risk Equalisation Scheme (RES)

(18) From 1957 until 1996 VHI was in a monopoly position. The principles incorporated in the PMI obligations also governed VHI's operations as a monopoly. VHI and its customers made up the vast majority of the PMI market.[19] In such circumstances the application of community rating had the result that premiums for a particular plan corresponded to the average risk on the market. Thus in a monopoly environment community rating alone was sufficient to guarantee intergenerational solidarity.

(19) The Irish PMI market was opened to competition under the provisions of the 1994 Health Insurance Act and the 1996 Health Insurance Regulations. Privately owned insurers have progressively entered the market since January 1997. In a competitive

---

13 See Section 8 of the Health Insurance Act1994.

14 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.

15 See Section 9 of the Health Insurance Act 1994.

16 See Section 10 of the Health Insurance Act 1994.

17 Minimum Benefit Regulations were introduced in 1996.

18 See section 7.3 of the Health Insurance Act 1994.

19 See recital (10) and footnote 9 above.

environment maintaining intergenerational solidarity becomes more complex as differences in insurers' risk profiles (*i.e.* the riskiness of their client portfolio) could (and did) develop. Consequently, ever since the market was opened up to competition the issue of introducing a risk equalisation mechanism has been on the Irish government's agenda.

The RES 2003

(20) In 2003, the Commission authorised a risk equalisation scheme notified by Ireland (hereafter the "RES 2003").[20] The decision of the Commission was based on the PMI obligations and the consideration that PMI services played a significant role in the overall Irish health care system, it being a partial substitute for social security. Therefore, PMI services were considered to qualify as Services of General Economic Interest (SGEIs) and the RES 2003 was justified as compensation for the SGEIs rendered.

(21) The Commission's decision was challenged (unsuccessfully) before the General Court (Case T-289/03 *BUPA and others v. Commission*, hereafter the "BUPA case law").[21] The system was also challenged under Irish law, and in July 2008 the Irish Supreme Court struck down the RES 2003 on domestic law grounds.

The Interim Scheme 2009-2012

(22) 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 (hereafter the "Interim Scheme") until a new RES, compliant with the conclusions of the Irish Supreme Court judgment, could be devised. The Commission authorised the Interim Scheme in 2009[22], for a limited period of time, expiring on 31 December 2012.

(23) The purpose of the Interim Scheme was the same as that of a risk equalisation scheme, which is to maintain intergenerational solidarity by supporting insurers with a worse risk profile relative to the market. This was achieved by a tax and levy scheme, initially based on the pre-existing tax relief/subsidy[23] for individuals holding a PMI policy in Ireland which had also served as the basis for the RES 2003.

2.4. The Notified RES 2013

(24) The Irish authorities have notified to the Commission their intention to amend the provisions of the Health Insurance Act 1994 to provide for the implementation of the new RES 2013.

(25) The RES 2013 is very similar to the Interim Scheme and the previous RES 2003.

(26) The RES 2013 will function through the establishment of a Risk Equalisation Fund administered by the HIA. Similar to the Interim Scheme, the RES 2013 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 risk

---

[20] Decision of 13.5.2003 under State aid No. N 46/2003, OJ C 186 of 6.8.2003.

[21] Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81.

[22] Decision of 17.6.2009 under State aid No N 582/2008, OJ C 186 of 8.8.2009 (hereafter the "2009 Decision").

[23] Although labelled as a tax relief, this mechanism was not offset against taxes paid by the individual but always awarded, regardless of the taxpayer's tax liability and provided even when the individual did not have any tax liability (e.g. in the absence of taxable income). Therefore the tax relief was deemed more in the nature of a subsidy, the use of which is tied to taking up PMI cover.

equalisation credit on behalf of each insured person falling into certain specific categories.

(27) Ireland has decided to delay the implementation of the innovative elements of the RES 2013 until 31 March 2013.[24] Consequently, the new RES 2013 starts on 1 January 2013 using the rates that currently apply under the Interim Scheme[25] and the revised rates will apply with effect from 31 March 2013.

2.4.1. The Credits

(28) Unlike the Interim Scheme, under which a series of age-related tax credits were paid to insurers through the taxation system, the proposed RES 2013 will involve the payment of credits to insurers from a Risk Equalisation Fund, administered by the HIA.

(29) Under the RES 2013, the credits (which replace the age-related tax relief that applied under the Interim Scheme) will comprise a risk equalisation credit that varies by age, gender and level of cover, as well as a hospital bed utilisation credit, representing a payment in respect of each night that an insured person spends in a hospital bed in private hospital accommodation (together further referred to as "the credits").

(30) Risk equalisation credits are set by legislation (in the Health Insurance Act 1994, as amended). The credits will be paid in respect of all individuals who are insured on relevant health insurance contracts[26] within Ireland and who meet the specified age and gender criteria. The credits based on age underlying the RES 2013 use 5-year age bands. However, the HIA will over time continue to review whether this level of banding is sufficient. The credits based on gender take into account some (relatively modest) differentiation based on claims experience for men and women.[27] The application of credits based on gender would result in different gross premiums for different insured people taking out the same product (although the net premium paid by the insured person would be the same).

(31) Furthermore, insurance products are split into two categories: those providing "advanced cover" and those which do not.[28] A lower level of age and gender credits applies in respect of individuals who do not have advanced cover. The Irish authorities have explained that products to be classified as non-advanced are those which provide cover for up to 66% of the full cost of hospital charges in private hospital accommodation. In practice, this means that a contract that provides more than 66% cover for charges arising in relation to any overnight stay in any private hospital accommodation would be considered to be an "advanced" contract. The introduction of new products and changes to existing products, including changes that would

---

[24] Split level of cover, gender and hospital utilisation credits, risk equalisation credits and corresponding stamp duty rates.

[25] Payments will be based on age-related tax credits and stamp duties under the current Interim Scheme.

[26] A relevant contract for advanced or non-advanced cover, 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.

[27] For instance, for ages in excess of 50, male claims costs are significantly higher.

[28] Pursuant to section 11E 4 of the Health Insurance Act 1994, " *(a)* a relevant contract which provides health insurance cover for (i) not more than 66 per cent of the full cost for hospital charges in a private hospital, or (ii) not more than the prescribed minimum payments within the meaning of the Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (S.I. No. 83 of 1996), whichever is the greater, is a relevant contract which provides for non-advanced cover, and (*b*) any other relevant contract is a relevant contract which provides for advanced cover."

trigger a requalification of such products from advanced to non-advanced or vice versa, is subject to notification by each insurer to the HIA within 30 days before the introduction/change takes effect.[29] The HIA then has 30 days after such notification to decide on the qualification of the contract.

(32) The implementation of these credits will reflect the fact that, given the considerable range of health insurance products available on the Irish PMI market, with considerable variation in relation to the core hospital and ancillary benefits provided, consumers range from those with products offering a higher level of benefits, such as access to semi-private accommodation in private hospitals, as well as private and semi-private accommodation in public hospitals to consumers of products which cover public hospitals only. The inclusion of a product differentiation in setting the levels of credits and stamp duties (see below) is designed to ensure that the support is proportionate and does not involve people with lower levels of benefit subsidising higher levels of cover than they have chosen for themselves to a disproportionate degree.

(33) In addition, a hospital bed utilisation credit is also specified in the Health Insurance Act 1994. That credit will be paid in respect of all individuals for each overnight stay in private hospital accommodation (including overnight stays in beds which have been designated as private beds in public hospitals). The result will be a sharing of the costs associated with individuals who claim (representing less healthy lives) with those who do not. It is noted that the RES 2003, which was approved by the Commission, also had the capacity to reflect hospital utilisation in determining payment amounts to and from the risk equalisation fund.

(34) For ease of administration, the credits will be paid, through the Risk Equalisation Fund, directly to insurers on behalf of the individuals (and insurers will then charge net premiums to insured persons).

(35) The levels of credits are set in legislation (in the Health Insurance Act 1994).

2.4.2. The Stamp Duty

(36) The cost of the credits will be financed by a stamp duty charged to all insurers, depending on the number of lives insured by each insurer. Four different levels of stamp duty will apply in total, with insurers paying higher levels of stamp duty per insured person with advanced cover products, compared with those holding non-advanced cover products, and with insurers paying a lower level of stamp duty in respect of children than they will pay in respect of adults. Thus, as under the current Interim Scheme, a lower level of stamp duty will apply in respect of children (one third of the adult level), to reflect the fact that premium levels for children are typically considerably lower than adult levels (ranging from 0% to 50%).

(37) The level of the stamp duty is set in legislation (in the Stamp Duties Consolidation Act 1999, as amended).

2.4.3. Calculation of the credits and stamp duty

(38) Each year, the HIA recommends to the Minister of Health the levels of credits and stamp duty. Based on the HIA's recommendations, the Minister of Health, using

[29] Health Insurance Act 1994, Section 7AB.

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, and recommends the appropriate levels of stamp duty to the Minister for Finance for inclusion in the Stamp Duties Consolidation Act 1999.

(39) For the purposes of the calculation of the credits and the stamp duty, the HIA receives half-yearly data from each insurer in the market in a standard format (information returns from insurers). These half-yearly information returns from insurers include detailed historical data relating to numbers of lives insured, in each age group, the gender profile of each age group, the 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.

(40) 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 of Health a level of credit for each combination of age, gender and level of coverage, as well as a hospital bed utilisation credit.

(41) Once the HIA determines the levels of credits, the HIA calculates the stamp duty levels necessary to fund the credits. Thus, the level of stamp duty is determined with the objective of having the total amount raised in stamp duties equal the total amount paid in credits – thereby seeking to ensure the functioning of the RES 2013 as a self-funding scheme.

(42) Under the RES 2013, the calculation of risk equalisation credits and stamp duties for 2013 are based on the following principles:

(a) calculations are based on returned benefits[30];

(b) calculations are made separately for advanced cover and non-advanced cover contracts;

(c) calculations are made separately for men and women, so that different credits will apply to each, although they will be subject to the same stamp duty;

(d) a hospital bed utilisation credit was determined for each night that an insured person spends in private hospital accommodation;

(e) the rates of the stamp duty for advanced / non advanced products are set by reference to the rates of the projected credits for 2013 each of those two sections of the insured population.

(43) The levels of credits and stamp duty to be applied to PMI policies renewed or entered in 2013 are as follows:

(a) Stamp duty:

[30] The Irish authorities have explained that the calculation uses returned benefits (*i.e.* the sum of net health provider payments under a settled claim) but excludes claims in relation to benefits in excess of the level of cover ordinarily purchased by consumers.

Table 2: Stamp duty rates under the RES 2013 to be applied in 2013

Stamp duty rates				
	1 Jan 2013 to 30 Mar 2013		31 March 2013 onwards	
Age range	**Non-advanced**	**Advanced**	**Non-advanced**	**Advanced**
17 and under	€95	€95	€100	€120
18 and over	€285	€285	€290	€350

(b) Risk equalisation credits by age and gender:

Table 3: Risk equalisation credits under the RES 2013 to be applied in 2013

Age/gender risk equalisation credits								
	Contracts commenced or renewed 1 Jan 2013 to30 Mar 2013				Contracts commenced or renewed 31 March 2013 onwards			
	Non-advanced		Advanced		Non-advanced		Advanced	
Age range	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
60-64	€600	€600	€600	€600	€375	€250	€425	€275
65-69	€975	€975	€975	€975	€900	€650	€1,050	€775
70-74	€1,400	€1,400	€1,400	€1,400	€1,450	€975	€1,700	€1,150
75-79	€2,025	€2,025	€2,025	€2,025	€2,050	€1,550	€2,425	€1,800
80-84	€2,400	€2,400	€2,400	€2,400	€2,850	€1,925	€3,375	€2,275
85+	€2,700	€2,700	€2,700	€2,700	€2,850	€1,925	€3,375	€2,275

(c) The hospital bed utilisation credit was set at EUR 75 for each night that an insured person spends in private hospital accommodation, where the contract is effected after 31 March 2013.

2.4.4. Mechanisms for avoiding and recovering potential overcompensation

(44) Both the Minister and the HIA are required to have regard to the objective of ensuring community rating, as well as the aims of avoiding overcompensation being made to any insurer for discharging its public service obligations, maintaining the sustainability of the PMI market, and fostering fair and open competition in the PMI market.

(45) In an *ex ante* approach, each year, in determining the recommended level of credits for each category the HIA will analyse and evaluate the market, on the basis of all information returns made to it. Section 7D of the Health Insurance Act 1994 provides for the submission of information returns by insurers to the HIA and provides that the information returns must be confined to health insurance business. The form and

content of the information returns are set out in regulations made by the Minister for Health. The HIA may also take into account such other information relevant to those purposes as it considers appropriate, and must have particular regard to the following:

(i) the average insurance claim payment per insured person made by the relevant market sector during the relevant periods in respect of the total number of persons insured, or a class thereof, during the relevant periods,

(ii) the average insurance claim payment per insured person made by the relevant market sector during the relevant periods in respect of subgroups of the total number of persons insured, or a class thereof, during the relevant periods, where such subgroups include such combinations of the following groups of insured persons as the HIA determines to be relevant: (1) those in different age groups: (2) those of differing sex; (3) those with differing types of cover,

(iii) the hospital bed utilisation in respect of each group and subgroup referred to in points (i) and (ii), and

(iv) the net financial impact on each registered undertaking or former registered undertaking of the relevant financial provisions during the relevant periods.

(46) From an *ex post* perspective, under the RES 2013, the HIA will carry out an overcompensation test in a similar manner to the test that the HIA carries out under the Interim Scheme. The RES 2013 requires the HIA to carry out the test in accordance with the 2012 SGEI Framework (the text of which is included in an annex to the legislation).

(47) Thus, all insurers are required to maintain and furnish to the HIA, in respect of each year, statements of profit and loss as well as certified balance sheets in respect of its health insurance business, as well as to furnish to the HIA such other information relating to the year as may be prescribed.

(48) In its over-compensation test, the HIA determines reasonable profit with reference to both internal benchmarks (the insurer's own cost of equity) and external benchmarks (profitability measures for comparable European insurers) for the health insurer that is expected to be the net beneficiary of the risk equalisation scheme (VHI).

(49) Where, in respect of any 3-year period, the HIA has determined that the cumulative net financial impact of the relevant financial provisions on an insurer was positive, and determined that the insurer has made a profit which is in excess of the reasonable profit, the HIA shall prepare a draft report setting out the following:

(a) the reasonable profit it has calculated,

(b) the amount determined to be the positive cumulative net financial impact on the insurer,

(c) the monetary equivalent amount determined to be the excess profit of the insurer (*i.e.* in excess of the reasonable profit),

(d) the cumulative amount of overcompensation, being the lower of the amounts referred to in points (b) and (c);

(e) the amount of overcompensation to be paid to the Fund by the insurer, being the cumulative amount of overcompensation referred to in point (d) reduced by the total amount of overcompensation paid or due to be paid to the Fund for previous periods, and

(f) the bases on which it made the determinations, and calculated the amounts, referred to in points (a) to (e).

(50) The HIA will provide a copy of the draft report to the insurer concerned, and invite it to submit its observations to the HIA and will take into account any such observations before preparing a final report. The final report shall be final and conclusive, including for the purposes of any proceedings concerning the recovery of overcompensation. The HIA shall submit the final report to the Minister for Health. The Minister will again furnish a copy of the report to the concerned insurer, and the insurer will be obliged to pay to the Fund, not later than 2 months from the date on which it is given the report, the amount set out in the report.

(51) Furthermore, the Minister for Health, on behalf of the Minister for Finance, shall recover, as a simple contract debt in any court of competent jurisdiction, from the concerned insurer, any amount due and owing to the Fund pursuant to the above. Moreover, the Minister for Health may request in writing the HIA to provide, within a reasonable timeframe, information relating to any determination it has made as above described, in respect of a particular insurer, including information relating to the basis on which such determination was made.

2.4.5. Estimated net financial effect of the RES 2013

(52) In principle all insurers on the market are SGEI providers and may receive compensations from the RES 2013, provided that the conditions set under the scheme are met.

(53) However, it is undisputed by all parties concerned that only the dominant incumbent, *i.e.* the state-owned VHI, will be a net beneficiary of the RES 2013, while its competitors will be net contributors. VHI is the former monopolist and today still remains the main operator. In terms of insurance portfolio, VHI is *de facto* dealing with the high-risk profile population (*i.e.* most of the elderly population).

(54) Should the insurers' risk profile change, the net financial effects of the scheme would change accordingly (the credits being due to any insurer that insures an eligible person).

(55) However, it is also common ground that even though individuals have the possibility to switch between insurers this is unlikely to happen to an extent sufficient to make VHI a net contributor and its competitors net beneficiaries in the medium term.

(56) Following the decision of the Minister for Health regarding levels of credits and stamp duty in 2013, it is estimated that the expected net financial impact on insurers of the final credits and stamp duty for policies commencing in the calendar year 2013 will be as follows:

Table 4: Net projected financial impact of RES in 2013[31]

€m	**Aviva**	**Laya**	**VHI**	**Total**
Credits	[…]	[…]	[…]	[…]
Stamp duties	[…]	[…]	[…]	[…]
Net benefit	[…]	[…]	[…]	[…]

** The difference due to rounding of overall figures*

(57) It is noted that the above figures, provided by the HIA, take into account the different levels of credits and stamp duty that apply to policies commencing both in the first three months using the Interim Scheme rates and policies commencing anytime in the last 9 months of 2013. It is important to note that the above constitute projections, and as such 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, importantly, the number of persons resigning from private health insurance cover throughout the year.

3. ASSESSMENT

3.1. Presence of aid within the meaning of article 107 (1) TFEU

(58) Article 107 TFEU provides that "*[s]ave as otherwise provided in this Treaty, 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, insofar as it affects trade between Member States, be incompatible with the internal market*".

(59) Thus for a measure to constitute State aid it has to:

- be imputable to the State or granted through State resources
- provide the beneficiary with an advantage
- be selective in nature
- distort or threaten to distort competition and
- affect trade between Member States.

State resources

(60) The RES 2013 is obviously 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 reimbursement of potential over-compensation, based on HIA recommendations.

(61) The RES 2013 involves the creation of a fund, established by national legislation, which will be financed by compulsory contributions and controlled by public authorities.[32] The State, acting ultimately through the Minister for Health and the

[31] Data for GloHealth ([…]% market share) not included.

[32] 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* [1974] ECR 709, p. 16; Case 78/76 *Steinike* [1977], ECR 595, p. 22; Cases C-78/99 to C-83/90, *Sociétés*

Minister for Finance, has discretion over the use and destination of the totality of the funds available under the RES 2013, which are under State control.

(62) 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 if the stamp duties raised are insufficient no *ex post* reduction of the credits is applied, and the funding gap is charged to the general budget of the State[33].

(63) Consequently the Commission considers that the measure involves the transfer of State resources.

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 will be a net beneficiary of the scheme. Accordingly the Commission considers that the RES 2013 is selective in nature.

Distortion of competition

(65) The RES 2013, under the conditions currently prevailing on the Irish PMI market, will lead to a net payment in favour of VHI, 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 Laya, Aviva and GloHealth). 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. What is more, as net contributors in the RES, the private operators might increase their premiums. Furthermore, due to possible price increases, some young customers who could barely afford private health insurance could opt 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 TFEU.

(66) Indeed, it is precisely on the basis of this effect on competition that the private insurers have been in contact with the Commission (see recital (5) above). They allege that the RES 2013 is likely to have a negative impact on price competition and product innovation.

(67) And yet, the RES 2013 only compensates for deviations in risk in relation to the average of the Irish population. It does not achieve full risk compensation and would therefore not normally lead to overcompensation (this will be verified in section 3.2.3. below). PMI premiums in Ireland are not subject to price regulation. Thus, any reduction in the price advantage that VHI's competitors currently enjoy will, in effect,

---

Compagnie Commerciale de l'Ouest [1992], ECR I- 1847; Cases C-149/91 and C-150/91 *Sanders* [1992], ECR I-3899; Case C-17/91 *Lornooy* [1992] ECR I-6523; Case C-114/91 *Claeys* [1992] ECR I-6559; Case C-114 and C-145/91 *Demoor* [1992] ECR I-6613).

33 Pursuant to section 11D of the Health Insurance Act 1994 (as amended).

reduce competition based on risk differentials. That is precisely the aim of the RES 2013, to reduce the effects of different risk profiles between insurers. This is both acceptable and appropriate based on the principle of intergenerational solidarity (see section 3.2.1. below in relation to the definition of the SGEI in the present case). In this respect, the Commission is of the view that, contrary to what is alleged by VHI's competitors, the likely effect is that the focus of competition will shift to factors other than risk, such as product innovation, marketing, administrative and claims efficiency etc., which is the kind of competition that primarily benefits consumers.[34] Moreover, as pointed out by the HIA[35], in the absence of a RES, insurers would be incentivised to design products so that they are not attractive to older and less healthy consumers. In fact, a range of tactics would be open to insurers which would lead to unwanted risk selection and segmentation of the market (see section 3.2.1. below). As regards concerns that, as a result of the RES 2013, insurers may become less able to attract the most price sensitive customers (if they choose to reflect the potentially higher stamp duty in the price of their product[36]), the Commission observes that the purpose of the RES 2013 is not to support competition for the most price sensitive customers, but to equalise risks and ensure intergenerational solidarity.

Effect on trade

(68) The measure is also liable to have an effect on trade between the Member States given that PMI, as voluntary health insurance, is part of the internal market for services (PMI obligations notwithstanding). The Commission notes that cross-border trade and investment activity in the sector across Europe is substantial. This is amply demonstrated by the various examples of insurers moving in and out of the Irish PMI market and the numerous takeovers of insurance business (BUPA taken over by Quinn and then by Laya, and Vivas by Hibernian then rebranded Aviva, recent establishment of GloHealth). Furthermore, new insurers can and do enter the market indirectly through underwriting contracts – two insurers thus entered the Irish PMI market in 2012: Swiss Re, underwriting Laya through its subsidiary Elips Insurance Ltd, and Munich Re, underwriting GloHealth through its subsidiary Great Lakes Reinsurance (UK) plc. The actors behind the insurers on the market are thus international groups, with activities in various EU Member States and worldwide.

Advantage

(69) Finally, the Commission notes that Ireland considers that the measure under assessment only compensates for the cost of SGEI obligations in such a way that the cumulative criteria laid down in the Altmark judgment[37] are fulfilled and the measure does not confer an advantage on any beneficiary of the RES 2013.

(70) Pursuant to the Altmark case law, 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

[34] See also paragraphs 90 to 96 in the Commission's Decision of 2009, N 582/2008.

[35] See HIA's Report to the Minister of Health and Children on Risk Equalisation in the Irish Private Health Insurance Market from December 2010, the HIA's website at www.hia.ie

[36] All insurers are able to adapt to the new RES 2013, as they each consider appropriate, including by changing their products in order to qualify as advanced or non-advanced cover, and thus for the higher or the lower level of stamp duty (and health credits), according to the insurers' own business objectives.

[37] Case C-280/00 *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH*, [2003] ECR I-7747, p. 87 to 93.

more favourable competitive position than the undertakings competing with them, such a measure is not caught by Article (107(1) of the Treaty (*Altmark*, paragraph 87). However, for such compensation to escape qualification as State aid in a particular case, a number of conditions must be satisfied (*Altmark*, paragraphs 88 to 93).

a) First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined.

b) Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner, to avoid conferring an economic advantage which may favour the recipient undertaking over competing undertakings.

c) Third, 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.

d) Fourth, where the undertaking which is to discharge public service obligations, in a specific case, 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 into account the relevant receipts and a reasonable profit for discharging the obligations.

(71) 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 TFEU. Like the Interim Scheme, the RES 2013 appears not to comply with the fourth Altmark criterion and the Commission will therefore begin its analysis by assessing whether the amount of compensation is the minimum necessary within the meaning of that case law. The Commission recalls that in its decision concerning the Interim Scheme, the conclusion was reached that the fourth Altmark criterion had not been complied with. The factual elements on which the Commission's decision on the Interim Scheme was based have not changed. Consequently, the Commission confirms the position it had expressed in that decision.[38]

(72) As was the case under the Interim Scheme, all insurers on the PMI market are entrusted with the PMI obligations and are participants in the RES 2013.[39] The Commission notes that, given the nature of the Irish PMI market, it is not appropriate for the discharge of the PMI obligations, and the participation in the RES to be achieved through a public procurement process. In principle, competition between insurers could, theoretically, ensure that the most efficient undertaking is chosen. However, given customers' reluctance to switch insurers, VHI's historical presence and the fact that if consumers opt for an insurer other than VHI they primarily do so because of their lower level of premiums, which in turn primarily results from risk profile (*i.e.* the switching of customers is not necessarily the result of differences in efficiency), consumers' choice is not a substitute for public procurement for the purposes of compliance with the fourth Altmark criterion. The purpose of the requirement set under the fourth Altmark criterion that the recipient of the

[38] See in particular recitals 70-73 in the 2009 decision concerning the Interim Scheme.

[39] With the minor exception of Restricted Membership Undertakings, as with the Interim Scheme.

compensation is chosen as being capable of providing those services at the least cost to the community cannot be deemed fulfilled. Indeed, the Commission has no evidence that VHI, as net beneficiary, is capable of providing these services at the least cost to the community. Therefore the Commission cannot verify that indeed only the most efficient undertaking will be a net beneficiary of the system.

(73) Accordingly, the only possibility to consider that the fourth criterion is complied with is if the costs of the insurers and in particular of VHI (as net beneficiary) can be regarded as those of an efficient undertaking. However, no evidence has been submitted to the Commission which would enable it to consider that the costs of the PMI providers and in particular of VHI (as net beneficiary) can be regarded as those of an efficient undertaking within the meaning of the fourth Altmark criterion. In particular, the Commission has not received information which would allow it to assess the relative efficiency of insurers, given the differences in claims costs and other expenses, the differences in risk profiles of the insured persons in their portfolios, as well as the operating costs, price management techniques, investment policies, and other criteria regarding the efficiency of the insurers. Indeed, the measure does not calculate compensation on the basis of the costs of providing private health insurance to the community and the scheme operates on the basis of actuarial calculations about expected claims costs and divergences in risk profile.

(74) In those circumstances, the compensation paid for the provision of SGEIs under assessment cannot be found to have been determined on the basis of the costs of the so-called "typical undertaking".

(75) Based on the above, the Commission cannot verify whether the compensation under the RES 2013 is the minimum necessary in order for it not to qualify as aid.

(76) The Commission considers therefore that the RES 2013, like the Interim Scheme, fails the fourth Altmark criterion and thus constitutes aid within the meaning of Article 107 TFEU.

3.2. Compatibility

(77) Article 106(2) TFEU provides that "*Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union.*"

(78) Pursuant to Article 106(3) it is for the Commission to ensure the application of that provision. The Commission set out its approach in this respect in the 2012 SGEI Framework and it is in light of the requirements laid down in that document that the Commission will assess the compatibility of the RES 2013.

(79) Point 11 of that Framework stipulates that State aid may be declared compatible with Article 106(2) TFEU if it is necessary for the operation of the service of general economic interest concerned and does not affect the development of trade to such an extent as to be contrary to the interests of the Union. Sections 2.2 to 2.10 of the Framework identify the conditions that must be met in order to achieve that balance.

3.2.1. Definition and entrustment of an SGEI mission

(80) Point 12 of the 2012 SGEI Framework requires that the aid be granted for a genuine and correctly defined service of general economic interest.

(81) Both Commission decisions, on the RES 2003 and on the Interim Scheme, as well as the BUPA case-law accepted that the PMI services were SGEIs and that the PMI obligations were SGEI obligations.[40] The RES 2013 does not alter the nature of either PMI services or the PMI obligations.

(82) In particular, the Commission observes that the RES 2013 aims to ensure that PMI services in Ireland continue to be provided in conformity with the PMI obligations defined by legislation and the principal objective of the Health Insurance Act 1994, which in this respect continues to be the support, in the interest of citizens, of intergenerational solidarity on the Irish PMI market. The Irish authorities demonstrated that intergenerational solidarity continues to be essential to the functioning of the Irish PMI market and that it is not possible to achieve intergenerational solidarity without a robust risk equalisation scheme.[41]

(83) 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 (see point 13 of the 2012 SGEI Framework).

(84) The Irish authorities consider that the starting point is that in the competitive environment of the Irish market, differences in risk profiles between insurers can and do develop.

(85) In fact, PMI obligations alone cannot fully ensure that each insurer has a risk profile corresponding to the market average risk profile. Intergenerational solidarity can be undermined by market practices given that insurers can in fact cherry-pick good risks primarily by designing policies, beyond the minimum benefits requirement, in such a way that they are only attractive to good risks. For example, by including benefits that are attractive to younger clients and excluding benefits that older clients need or prefer (such as, for instance, orthopaedic benefits), an insurer could increase its chances of acquiring younger clients. Advertising that is directed towards selected segments of the market (such as for instance targeting corporate clients with a large number of young employees) is another means by which an insurer can attempt to shape its risk profile. Such market practices can be explained by the fact that the natural growth area for new entrants is first subscribers to PMI (as opposed to existing PMI members of

[40] See also recitals 40-49 in the decision concerning the RES 2003, recitals 33-40 in the 2009 Decision and paragraphs 174-208 in Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81.

[41] Furthermore, there exists a body of scholarly evidence to support the claim that intergenerational solidarity cannot be maintained in the absence of a risk equalisation mechanism: Dunn, D. (1998): *Applications of Health Risk Adjustment: What Can Be Learned From Experience To Date?* Inquiry, 35 (2), pp 132-147; Eggleston, K. (2000): *Risk Selection and Optimal Health Insurance-Provider Payment Systems*. The Journal of Risk and Insurance, 67 (2), pp 173-196; Enthoven, A. (1993): *The History and Principles of Managed Competition*. Health Affairs, Supplement, pp. 24-48 http://content.healthaffairs.org/content/vol12/suppl_1/index.shtml; Feldman, R. & Dowd, B. (2000): *Risk Segmentation: Goal or Problem?* Journal of Health Economics, 19 (4), pp 499-512; Newhouse, J. (1998): *Risk Adjustment: Where Are We Now?* Inquiry, 35 (2), pp 122-131; Sewry, S., Hunt, S., Ramey, J. & Bertko, J. (1996): *Risk Adjustment: The Missing Piece of Market Competition*. Health Affairs, 15 (1), pp 171-181 http://content.healthaffairs.org/content/vol15/issue1/.

the incumbent(s)), and these tend to be young individuals. As a result, an insurer recent on the market is likely to have a higher share of good risks than the market average. These effects have already been seen in the Irish PMI market.

(86) As there is no regulation of premiums, the different risk profiles of insurers will be reflected in their premium levels. Insurers with better risk profiles will be able to afford to offer lower premiums while those with a worse risk profile will have higher premiums. This in itself compromises the policy of intergenerational solidarity as in such a situation older policyholders on average pay more for the same level of cover than younger ones.

(87) Moreover, it can lead to a situation where the differences become self-reinforcing if younger, better risk individuals that are with the insurer with the worse risk profile are more likely to switch insurers than older ones.[42] Following a loss in its young client base, the insurer with the worse risk profile would have to raise its premiums to cover its increased average claims costs, reducing the benefits in terms of competition that the liberalisation of the non-life insurance market is supposed to foster and ultimately the insurer with the worse risk profile would have to face unsustainable claims costs and could be forced out of the market. Its customers would then join the insurer charging the lower premium. This insurer's average premium would have to rise to cover the higher risk consumers and another insurer with a low risk profile could pursue the same price undercutting strategy and the whole cycle would be repeated. It is likely that over a considerable period, significant differences between insurers' risk profiles and premium levels would persist and the whole market would be characterised by increased uncertainty and instability.

(88) An alternative scenario involves so-called shadow-pricing or price following strategy, according to which the insurer with the better risk profile may be tempted to set its premium levels just below that of the insurer with a significantly worse risk profile in order to maintain the inertia of the clients of the latter against switching.[43] With significantly lower claims costs but almost the same revenue the insurer with a better risk profile will make extraordinary profits and the overall premium level will be close to what is necessary to cover the claims of the insurers with the worse risk profiles. This process is also self-reinforcing as new entrant consumers, who tend to be young and not yet tied to any insurer, will opt for the insurer with the better risk profile on account of its slightly lower premiums and thus the insurer with the worse risk profile would have to raise its premiums in the absence of young lives to cross-subsidize older ones. The insurer with the better risk profile would continue to follow these price increases and the process would continue driving all premiums to very high levels.

(89) The potential for these situations stems directly from the attempt to combine intergenerational solidarity (*i.e.* premiums that correspond to the market average risk) with a competitive market. If intergenerational solidarity were abolished as a policy, unrestrained market segmentation would arise, which is deemed undesirable as public policy by Ireland.

(90) The Commission observes that, according to various Reports by the HIA, despite increases in the robustness and sophistication of the Interim Scheme, the PMI market

[42] See footnote 10 for reference.

[43] There is evidence that shadow pricing already occurred in the Irish PMI market: Report of the Health Insurance Authority of April 2005 to the Minister for Health and Children for the period July to December 2005, page 51 http://www.hia.ie/sec3_reports/RE-Report-April-2005.pdf.

in Ireland has continued to show evidence of segmentation strategies designed to allow insurers to target younger and healthier lives and charge higher premiums for older and riskier lives. Various HIA reports suggest that the Interim Scheme did not entirely succeed in addressing the key challenges of segmentation in the market.[44]

(91) Based on the above the Commission considers that intergenerational solidarity is an acceptable policy objective given the SGEI nature of PMI when subject to the PMI obligations and that, for this principle to be maintained in a competitive environment, a mechanism to mitigate the effects of different risk profiles is necessary. Consequently it is an appropriate definition of an SGEI to address the situation with a risk equalisation mechanism.

(92) The aim is to make the RES 2013 more robust than the Interim Scheme by compensating insurers more fully for insuring bad risks (*i.e.* as a result of using better, more granular data and including explicit measures regarding level of coverage and hospital bed utilisation). The more fully the RES compensates for bad risks, the less scope there will be for cherry-picking good risks. The levels of risk equalisation credits and of stamp duties (presented in recital (43)) are aimed at discouraging insurers from cherry-picking only the younger, lower risk members. The variation of stamp duties and credits by level of cover is designed to enable the system to better support community rating for higher cover plans without the stamp duties and age related tax credits being too high for lower cover plans.

(93) Thus, the objective of the Irish authorities is that intergenerational solidarity will be achieved by all insured persons paying the same premium for a given product, regardless of age or health status (community rating).

(94) Compared with a risk rated market, this means that younger and healthier persons may pay increased premiums for their PMI cover, which, given the voluntary nature of the PMI, may in turn trigger their potential exit from the market. This presents a challenge to the sustainability of the market, to the extent it may result in a reduction in the insured population coupled with an increase in the average age of those remaining in the PMI market. The net result could be that the introduction of a measure designed to protect the interests of older and less healthy individuals could ultimately see those very individuals pay more for their health insurance.

---

[44] According to the Report of the HIA to the Minister for Health, in accordance with Section 7E(1)(b) of the Health Insurance Acts, of November 2011, p. 3, "*throughout the period under review [i.e. 1 July 2010-30 June 2011] the impact of segmentation and selection strategies have continued to undermine community rating, reflecting the incentives referred to above. These strategies have included price increases of up to 45% on products mostly held by older people, continuing proliferation of products and product amendments and the marketing of lower cost plans to lower risk corporate schemes. A significant development during the period has been the proliferation of products with reduced orthopaedic cover. Two insurers have introduced these products at a significantly lower cost than similar products providing full orthopaedic cover. Few older peopled are insured with these products*." In addition, for the period 1 July 2011- 30 June 2012, the HIA's Report to the Minister for Health on an evaluation and analysis of returns for 1 July 2011 to 30 June 2012 including advice on risk equalisation credits of November 2012, the HIA observes that "*insurers have continued to adopt strategies to segment and select profitable business through differential pricing to targeted groups. This undermines community rating and the principal objective. These strategies have included the maintenance of a large number of plans offering similar benefits but with significant differences in pricing, with lower cost plans being marketed to lower risk groups. Three out of the four open membership insurers also maintain lower cost products with reduced orthopaedic and ophthalmic benefits in private hospitals (for products that cover private hospitals). Few older people are insured on these plans*".

(95) Based on the various reports detailing the HIA's analysis of market developments in recent years, the Irish authorities introduced the RES 2013, modelled on the Interim Scheme, but which incorporating a number of refinements and specifically obliging the HIA and the Minister for Health to consider the sustainability of the market in relation to any recommendations or decisions concerning the level of risk equalisation credits payable under the scheme.

(96) The basis for the system is therefore that PMI services occupy an essential role in Ireland's health policy. PMI services are open to anybody and are of such significance in terms of number of members that without them the public system would be inadequate to ensure proper health care to Ireland's citizens.[45] Indeed, even though in principle the public system provides coverage to the whole population that coverage is not free of charge to everybody and it lacks the necessary capacity. As the Commission concluded in its decision authorising the Interim Scheme, the PMI obligations exhibit the typical nature of public service obligations in that they aim to make a service accessible to a significant share of the population (open enrolment, lifetime cover), on a certain quality level (minimum benefits), at affordable, uniform prices which do not strictly reflect the cost of the service supplied to the individual (community rating instead of premiums corresponding to risk).The Commission observes that pursuant to the lifetime cover obligation, insurers must contract with any applicant upon request, in full respect of the principle of community rating.[46] The entrustment of the PMI obligations implies the supply of services which, if it were considering its own commercial interest, an insurer may not assume or would not assume to the same extent or under the same conditions, in particular as concerns the riskier coverage of the older, less healthy section of the population (representing "bad risks"). The PMI obligations restrict the commercial freedom of insurers to an extent going considerably beyond the constraints of ordinary sectoral regulations, and therefore cannot be regarded as such[47] (particularly, the obligation to contract upon request and the prohibition of risk rating rarely if at all form part of ordinary sectoral regulation).

(97) The Irish authorities demonstrated that PMI fulfils a mandatory objective pursued by Ireland's health policy of social cohesion and solidarity between generations, and constitutes the second pillar of the Irish health system, helping as it does to ensure the effectiveness and profitability of public health insurance, by reducing pressure on the costs which it would otherwise bear.

(98) The Commission recalls that, pursuant to paragraph 46 of the 2012 Communication on SGEIs[48], in the absence of specific EU rules defining the scope for the existence of an SGEI, Member States have a wide margin of discretion in defining a given service as an SGEI. Based on the above considerations, the Commission considers that PMI services are used by Ireland, in the general interest, as an instrument for the smooth administration of the national health system and that in determining the basis for risk

[45] Indeed, universality per se does not mean that the service must be supplied to the whole population or throughout the whole territory of a country. (Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81, p. 186 and following).

[46] It is not necessary to actually oblige the SGEI provider to supply the service (Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81, p. 190).

[47] Case T-289/03 *BUPA and others v Commission* [2008] ECR II-81, p. 182.

[48] Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest, OJ C 8, 11.1.2012, p. 4–14.

equalisation on the PMI market, Ireland has identified a genuine and correctly defined SGEI.[49]

(99) Pursuant to point 15 of the 2012 SGEI Framework, responsibility for the operation of the SGEI must be entrusted by way of one or several acts, the form of which may be determined by the Member State. The act or series of acts must specify at least: the content and duration of the public service obligations; the undertaking and, where applicable, the territory concerned; the nature of any exclusive or special rights assigned to the undertaking by the authority in question; the parameters for calculating, controlling and reviewing the compensation; and the arrangements for avoiding and recovering any overcompensation.

(100) The RES 2013 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 and participate in the RES 2013. 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. In any event, since PMI was liberalised by the Third Non-Life Directive[50], Ireland cannot, under EU law, limit PMI provision to one insurer.[51]

(101) The content of the PMI obligations is clearly described in the Health Insurance Act 1994 (see recital (16) above) and they are set for an indefinite period of time. Indeed, the RES 2013 is designed to be open-ended.

(102) While point 17 of the 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 RES 2013, the unspecified duration does not raise particular concerns. The requirement that entrustment be limited in time is meant to avoid long-term foreclosure of the market, but under the RES 2013 all insurers are entrusted with the SGEI and all are potential beneficiaries of the scheme. The Commission notes that, in any event, Ireland notified the RES 2013 for an initial period of 3 years (2013-2015). While Ireland may in time notify prolongations / modifications of the measure, the RES 2013 will thus 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.

(103) Point 19 of the 2012 SGEI Framework requires compliance with EU public procurement rules. The Commission notes since any operator wishing to provide its services on the PMI market is entrusted with the SGEI and may potentially benefit from the RES 2013, it is not necessary to use the public procurement rules in order to ensure compliance with the 2012 SGEI Framework in this case.

---

[49] Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81, p. 204.

[50] Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life insurance and amending Directives 73/239/EEC and 88/357/EEC (Third Non-Life Insurance Directive) , OJ L 228, 11.8.1992, p. 1 – 23.

[51] In any case, it is not inherent in the nature of SGEIs that there can be only one provider or that the operators must be entrusted separately. On the contrary, it would be an unjustified restriction of the Member States' discretion as to the organisation of SGEIs if a Member State could not provide for the delivery of an SGEI through competing undertakings (Case T-289/03 *BUPA and others v. Commission* [2008] ECR II-81, p. 183).

(104) Similarly, in view of point 20 of the 2012 SGEI Framework (absence of discrimination), the Commission observes that the RES 2013 operates in an identical manner in respect of all insurers on the Irish PMI market. It is based on objective criteria: the credits and stamp duties are determined based on the number of insured individuals falling within clearly defined categories (depending on age, gender and level of coverage as well as hospital bed utilisation). The HIA is an independent authority and follows an objective procedure for recommending the proposed levels of credits and stamp duties. The Minister of Health, in cooperation with the Minister of Finance, in their respective capacities, determine the levels of credits and stamp duties. Both the HIA and the Minister for Health are obliged to respect the objective of achieving community rating and thereby intergenerational solidarity.

(105) The Commission notes in this respect GloHealth's concerns regarding the commercial viability of new entrants on the market and its request for an initial exemption period from payments in order to obtain a sufficient commercial presence before having to pay fully into the system. Not only would such an exemption run counter to the principle of non-discrimination, it could (considering the key principles on which the RES 2013 is based) undermine the operation of the scheme as a whole. It would amount to allowing the new entrant to practice "cherry picking" techniques throughout the transitional period, likely leading to risk selection, segmentation and higher premiums for older less healthy people. It would also lead to an increase in the stamp duty which will have to be supported by the other insurers in the market, to cover the cost of the exemption for the new entrant.[52]

3.2.2. Parameters for the compensation of the SGEI mission

(106) Pursuant to point 15(d) of the 2012 SGEI Framework, the compensation mechanism and the parameters for calculating, monitoring and reviewing the compensation are described in the act of entrustment. 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.

(107) As concerns the age and health status calculations, the Commission is of the view that the parameters put in place for the RES 2013 are sufficiently clear in advance. Only a portion of the additional costs in any category (*i.e.* in excess of the market average claims costs across all categories) will be compensated, and the compensation levels

[52] It is further noted that GloHealth has stated that its establishment on the Irish PMI market started as of spring 2011 and they started trading on 1 July 2012. According to GloHealth itself (informal submission of 15 November 2012), its market share by end-October 2012 was […] of the market, while their expected market share after 36 months would be […]. In these circumstances, it can be observed that GloHealth entered the market under the Interim Scheme, when no transition period for new entrants was effectively granted or foreseen. GloHealth was thus part in the Interim Scheme mechanism, with the same rights and obligations and under the same terms and conditions as the other market participants. It has chosen to enter the market and prepared its forecasts of its future business activity in full knowledge of the coming entry into force of the foreseen RES and has been part of the consultation process launched by the Irish authorities in this respect. Furthermore, in the current situation, and given the delayed implementation of the financial elements of the RES until March 2013, GloHealth will enjoy the same period of transition as other market operators to accommodate the passage from financial impact of the Interim Scheme to the RES 2013. Under these circumstances, there can be little expectation to receive a more favourable treatment than other market participants (see also point 20 of the 2012 SGEI Framework).

will be based on average claims for the market as a whole. Age has been a constant parameter, used under both the RES 2003 and the Interim Scheme. The health status parameter (hospital bed utilisation) was also foreseen in the RES 2003. The hospital bed utilisation credit is set as a fixed value, which remains significantly inferior to the actual cost involved.

(108) Furthermore, under the RES 2013, the Irish authorities agreed, following consultation with insurers, to introduce a more objective delineation between products that provide non advanced cover and advanced cover (see also recital (31) above). In addition, the Health Insurance Act 1994 establishes a short 30 days notification period necessary for the HIA to categorise products in order to allow insurers to adjust their products in a timely matter and notify such changes to the HIA. This will help to allow insurers to react quickly to market changes and adjust their policies accordingly. It is further noted, according to the Health Insurance Act[53], that the HIA will make regulations to specify products that the HIA deems to be non-advanced products. This should allow the HIA and the public authorities to deal with any issues arising in relation to the categorisation of products.

(109) These parameters are set publicly in law. Moreover, as with the Interim Scheme, 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 insurers are able to factor the effects of the risk equalisation credits and the stamp duties into their business decisions.[54]

(110) Only costs directly related to the health insurance business are used as the source material for calculating the credits and stamp duty.

(111) While the Interim Scheme used "prescribed benefits" in calculating the age-related credits, the RES 2013 uses "returned benefits". These exclude the so-called "luxury benefits" (e.g. products that fully cover private accommodation in private hospitals). and allow a more detailed analysis at product level. The Irish authorities explained what while prescribed benefits incorporate maximum limits on the amount of benefits that can be counted, these maximum limits have not been updated for a number of years. Therefore, the Commission considers appropriate the change in approach, that is the use of "returned benefits" (*i.e.* without the maximum limits) minus any costs related to benefits that are considered to be in excess of the level of cover ordinarily purchased by consumers.

(112) The Health Insurance Act 1994 establishes the criteria for calculating reasonable profit, which must be calculated under section 7F(4) of the Health Insurance Act (regarding over-compensation), in accordance with the 2012 SGEI Framework (the text of which is attached to the Health Insurance Act), and any factors that are prescribed by national legislation as factors that may be taken into account for the purposes of so determining reasonable profit in accordance with the 2012 SGEI Framework. The methodology used by the HIA for determining reasonable profit is based on references to both internal and external benchmarks for VHI on the basis that it will be the net beneficiary of the risk equalisation scheme. The Commission

[53] Health Insurance Act 1994, Section 11E.

[54] In addition, certain mechanism in the legislation ensure that the RES remains a flexible and transparent instrument, which can be quickly adjusted to reflect market changes and the cooperation between insurers and the HIA, in particular the accuracy of the information provided by insurers to the HIA for its analysis, is an essential element in ensuring the correct functioning and appropriate adjustment of the RES 2013.

considers appropriate the use of the internal benchmarks based on the insurer's own cost of equity[55], as well as external benchmarks based on comparisons with a sample of European insurers.

(113) In addition, various regulations set out in full detail the information that all health insurers must provide to the HIA for the purposes of enabling the HIA 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.

(114) The Commission also observes that, as indicated in point 55 of the 2012 Communication on SGEI, the need to establish the compensation parameters in advance does not mean that the compensation has to be calculated on the basis of a specific formula (for example, a certain price per day, per meal, per passenger or per number of users). What matters is only that it is clear from the outset how the compensation is to be determined.

(115) In addition, the Irish authorities committed to ensure the creation and publication of a guide to the operation of the scheme, to be available early in 2013. Similarly to the Guide published by the HIA in 2008, entitled "Updated Guide to the Risk Equalisation Scheme 2003", this document is expected to explain in as much detail as possible the method of calculation of the payments made under the RES 2013, thereby contributing to the predictability and the transparency of the measure.

3.2.3. Absence of overcompensation

(116) Point 15(e) of the 2012 SGEI Framework requires that the act of entrustment include arrangements for avoiding and recovering overcompensation.

(117) As indicated above (see recital (53) concerning the net financial impact of the RES); it is undisputed by all parties concerned that VHI will be a net beneficiary of the scheme while its competitors will be net contributors. Therefore the RES 2013 must not lead to overcompensation of VHI.

(118) Pursuant to point 21 of the 2012 SGEI Framework, the amount of compensation must not exceed what is necessary to cover the net cost of discharging the public service obligations, including a reasonable profit.

(119) As indicated above (recital (73)), the RES 2013 does not aim to compensate the full costs of providing PMI services as such, but operates on the basis of actuarial calculations about expected claims costs in order to equalise to a certain degree the divergences in the risk profiles of insurers active on the Irish PMI market.

Risk of overcompensation of VHI

(120) The RES 2013 will decrease the cost of insuring older lives and increase that of younger lives, with the effect of equalising to a certain degree the risks insurers undertake when they underwrite the policies of individuals with different risk

[55] Both estimates of cost of equity and cost of capital were calculated for the VHI as internal benchmarks and the respective external benchmarks were estimated as the return on equity and the return on capital employed for comparable insurers. However, the benchmarks concerning cost of equity and return on equity were preferred, since the comparators used to derive the estimates of the return on capital employed for the external benchmark may have different debt to equity ratios compared to VHI.

characteristics. The equalisation is intended to be more complete under the RES 2013 than under the Interim Scheme.

(121) In terms of the profitability of insurers in the PMI market, the recently available 2011 accounts indicate that only VHI generated a loss in 2011 of EUR 0.8 million (see table 5). Thus, despite the redistribution mechanism via the Interim Scheme, which was based on conditions similar to those of the RES, at the end of 2011 VHI was the only company to report losses. This is an important indication that risk equalisation is on one hand needed, and that on the other hand, it does not undermine the sustainability of the PMI market in Ireland.

Table 5: Profitability of insurers on the Irish PMI market (source HIA)

12 months to end Dec 2011	***Aviva Health***	***Quinn Healthcare***[56]	***VHI***
Earned premiums before reinsurance and age related tax credit	€ 270.5m	€323.6m	€1,295.8m
Age related tax credits less levy earned in year	(€24.8m)	(€33.3m)	€41.1m
Claims incurred before reinsurance	(€221.6m)	(€265.8m)	(€1,216.1m)
Claims ratio (gross of tax credits and levy)	81.9%	82.10%	93.8%
Claims ratio (net of tax credits and levy)	91.1%	92.40%	90.7%
Expenses & reinsurance	(€13.6m)	(€ 32.4m)	(€ 98.1m)
Expenses & Reinsurance as % earned Premiums	5.10%	10.00%	7.6%
Underwriting result	€ 10.5m	(€ 7.9m)	€ 22.7m
Underwriting profit as % earned premiums	3.9%	-2.4%	1.8%
Impact of Investments	€ 2.0m	€15.2m	(€ 23.5m)
Profit before tax	€12.5m	€ 7.3m	(€ 0.8m)

(122) The table below indicates the operating costs of companies active in the Irish health insurance market based on figures for 2010 and 2011. It appears that VHI does not have an operating cost above the market average. That said, a number of factors influence the level of operating costs, including the size of operations of the insurer (economies of scale), selling services via brokers, allocation of expenses within a group, etc. Some administrative cost may also reduce other expenses, e.g. investment in claims management (operating cost) may reduce claims costs substantially.

[56] Data in relation to Quinn Healthcare is provisional.

Table 6: Approximate operating costs of companies in the private health insurance market 2010-2011 (source VHI's own projections, provided by the Irish Authorities)

	Operating costs as % of premium income	**Cost per member €**
Aviva (2011)*	19%	170
Laya / Quinn (2010)*	11.9%	69
Vhi Healthcare 2011	6.7%	69
Vhi Healthcare 2010	6.8%	65
** Figures based on most recent statutory filings to the Companies Office*		

(123) The table below reproduces the financial projections of VHI for the years 2013-2015. These projections take into account the final levels of risk equalisation credits, stamp duties and bed utilisation credit, as decided by the Minister for Health (see recital (43)). Projections are based on a number of assumptions of *i.a.* changes in number, age category and type of cover of customers (aging of customers and number of insured customers resigning from cover[57]), actual claims level (e.g. number of days in hospital influencing the bed utilisation credit) and increases in the price of cover of […], […] and […] in 2013, 2014 and 2015, respectively.

Table 7: Projections of profit and loss account for VHI 2013-2015

€m	**2013**	**2014**	**2015**
Earned Income	[…]	[…]	[…]
Claims	[…]	[…]	[…]
Net Risk Equalisation Transfer	[…]	[…]	[…]
Contribution	[…]	[…]	[…]
Administration Cost	[…]	[…]	[…]
Underwriting Profit	[…]	[…]	[…]
Investment Income on capital reserves	[…]	[…]	[…]
Profit before tax	[…]	[…]	[…]
Tax	[…]	[…]	[…]

** This amount was estimated by VHI based on its assumptions of their portfolio of insured lives in 2013.*

(124) The projections are prepared by VHI and are based on historical data, taking into account the new levels of stamp duties and health credits. They extrapolate the adverse trend of lowering the number of insured customers, estimating membership losses at […] annually in the years 2013-1015. This not only reduces the number of insured lives by VHI but also adversely affects the structure of VHI's portfolio, because it is predominantly the younger generation of customers that is more inclined to resign from a PMI cover.

[57] This corresponds to the current trend on the PMI market.

(125) The level of net benefit projected by the HIA is EUR […] million. The difference, as compared to the EUR […] million estimated by VHI (see table 7 above) results mainly from the assumption made by VHI that in the short term it will have a lower customer base. It should be noted that in this scenario, the estimated level of net benefit of the RES is expected to rise to € […]m in 2015, which would represent a […] increase from 2013 to 2015.

(126) Many factors may influence these projections, including the level of credits and stamp duties, which is subject to review annually. The Commission observes that the regulatory authority, *i.e.* the HIA, is responsible for ensuring that the credits and stamp duties are each year evaluated and set at levels that ensure not only the absence of overcompensation of any insurer in the market, but also the stability and sustainability of the market as a whole, and that each year the HIA will verify that the *ex ante* approach taken in setting the levels of credits and stamp duties has indeed produced the expected results. While adjustments may be made to the levels of credits and stamp duties to reflect market changes, which may lead to increases in net benefits derived from the RES in favour of the VHI (such as the estimated potential twofold increase from 2013 to 2015), it is essential to ensure that no overcompensation occurs.

Overcompensation test by HIA – methodology

(127) In its control of overcompensation, the HIA calculates reasonable profit on SGEI-related activities with reference to both internal and external benchmarks. Internal benchmarks are set according to the insurer's own cost of equity, whereas external benchmarks are set as a measure of the profitability of comparable insurance firms.

(128) In order to establish a level of reasonable profit for 2013-2015, as a return on equity (ROE), HIA commissioned an external consultant (Oxera Consulting Ltd) to calculate the appropriate benchmark. This consultant had already assessed the absence of overcompensation under the Interim Scheme (the 2009-2011 assessment).

External benchmark

(129) Oxera based the determination of the external benchmarks on a sample of European insurers as well as a sub-sample of companies that only provide health insurance. The ROE estimates for these companies over the period 2007-2011 were aggregated in order to determine a return on equity benchmark for the sector.

Table 8: ROE calculations

	Book value						Market value					
	2007	2008	2009	2010	2011	Pld'	2007	2008	2009	2010	2011	Pid'
All insurers												
No. of obs[2]	44	46	49	52	51	240	44	46	49	52	51	240
ROE estimates	**(%):**											
Lower quartile	15	-2	1	**8**	2	3	10	-1	1	6	1	1
Median	21	4	12	13	11	12	14	2	9	13	11	11
Upper quartile	31	11	18	17	16	18	19	9	15	17	16	16
Avg[3]	23	-5	5	10	5	8	14	-10	6	9	-0	4
Weighted avg[4]	20	0	12	13	7	11	13	-0	9	13	2	8
Health insurers												
No. of obs[2]	19	20	21	21	21	102	19	20	21	21	21	102
ROE estimates (%):												
Lower quartile	15	-1	5	9	4	4	10	-1	4	8	4	3
Median	20	3	12	13	12	12	13	1	10	13	11	11
Upper quartile	27	14	14	16	16	18	17	6	14	18	15	16
Avg[3]	22	1	8	13	7	**10**	12	1	3	13	6	**7**
Weighted avg[4]	22	1	12	14	11	**12**	14	1	10	15	15	**11**

Note: The ROE is calculated as profits before interest and tax divided by equity.[1] To avoid estimating an average of an average, the numbers are calculated by pooling all available data (íe, by considering each estimate for each company in each year as a separate data item).[2] The number of observations is calculated as an average of the number of companies used for the simple average and the weighted average.[3] The numbers are calculated as a simple average across the different companies. The weights to derive the weighted averages are defined as the relative sizes of net earned premia. If the net earned premium is not available for a particular company, the ROE for that company is not included in the calculation. Hence, the weighted average may consist of a smaller sample than the simple average. Companies that provide health insurance are identified using the description provided by ORBIS[58].
Source: Oxera analysis, based on Datastream and ORBIS.

(130) Reflecting the range of average estimates of the ROE for the sample of health insurers, based on both unweighted and weighted averages, the range for the ROE for the health insurer industry is 7-12% (with a midpoint of 10%).

Internal benchmarks

(131) Estimates of VHI's cost of equity as calculated by Oxera are shown in table 10 below. Oxera has extrapolated from the previous 2009-2011 assessment (see table 9 below) the values of the cost of equity for 2013-2015 taking into account different assumptions about future macroeconomic conditions in Ireland.

The 2009-2011 Assessment:

(132) The 2009-2011 assessment relied on a Capital Asset Pricing Model (CAPM) to calculate an internal benchmark for the cost of equity of VHI over the period 2009-2011 which is described below:

[58] ORBIS is a global database containing financial information, including ratios, on public and private companies.

COST OF EQUITY =

RISK-FREE RATE$_{GER, NED}$ + EQUITY BETA$_{GER, NED}$ X ERP $_{GER, NED}$ + SOVEREIGN RISK PREMIUM

- **RISK-FREE RATE$_{GER, NED}$:** the estimates of the risk-free rate used for the calculation were the lowest and the highest value of the average of German and Dutch yields, which for 2009 were 3.4-3.5%, for 2010 2.6-3.0% and for 2011 2.0-2.8%,
- **SOVEREIGN RISK PREMIUM:** A sovereign risk premium was added to reflect the additional risk in Ireland. This sovereign risk was defined as the difference between yields on investment-grade, non-financial corporate bonds in Ireland and equivalent yields in Germany or the Netherlands
- **ERP** $_{GER, NED}$ **:** the ranges of the equity risk premium (ERP) were defined by the lowest and the highest values for the arithmetic means of historical risk premium estimates for the relevant years *i.e.* 4.9-5.9% in 2009, 5.0-5.4% in 2010 and 4.8-5.6% in 2011 based on approximately 110 years of data provided by Dimson, Marsh and Staunton (DMS).

  EQUITY BETA[59]$_{GER, NED}$: to calculate the equity betas for VHI, a sample of listed firms with similar risk characteristics was used as VHI was not traded.

  As an explicit adjustment was introduced for sovereign risk, only comparable companies from countries with lower risk were used, *i.e.* Austria, Finland, Germany, the Netherlands, Switzerland and the UK.

  The set was composed of companies from three insurance sectors: full-line insurance, life insurance and property and casualty.

  Betas were calculated for the companies in the sample, considering the three sub-sectors separately. The betas were estimated based on daily data over estimation periods of five years (ending 31 December 2009, 31 December 2010 and 31 December 2011). The equity betas of the companies which take into account both their exposure to market risk and the amount of debt in their capital structures were corrected in order to take into account the different gearing ratio between VHI and the sample and adjusted asset betas were calculated.

  On that basis, the calculations of the beta were 0.8 for 2009, 0.9 for 2010 and 0.7 for 2011.

(133) On the basis of the model above, Oxera determined that the cost of equity of VHI for the period 2009-2011 ranged between 12% and 14% (see table below) and proposed an estimate of 13%:

[59] In general beta measures the responsiveness of a firm's stock to the overall market. As a firm increases its financial leverage the firm's equity beta increases. Equity beta is the beta that is usually associated with a stock. One of the most common uses of a firm's equity beta is to be used as a component of the Capital Asset Pricing Model (CAPM) which is a model used to find the expected return of a stock.

Table 9: Cost of equity

	2009		2010		2011	
	Low	High	Low	High	Low	High
Cost of equity						
Risk-free rate and sovereign risk premium (%)	5.2	5.5	5.1	7.6	6.4	8.0
Equity risk premium	4.9	5.9	5.0	5.4	4.8	5.6
Asset beta	0.8	0.8	0.9	0.9	0.7	0.7
Equity beta	1.0	1.0	1.0	1.0	0.9	0.9
Post-tax cost of equity (%)	9.9	11.1	9.9	12.7	10.5	12.8
Nominal pre-tax cost of equity (%)	11.3	12.7	11.3	14.5	12.0	14.7

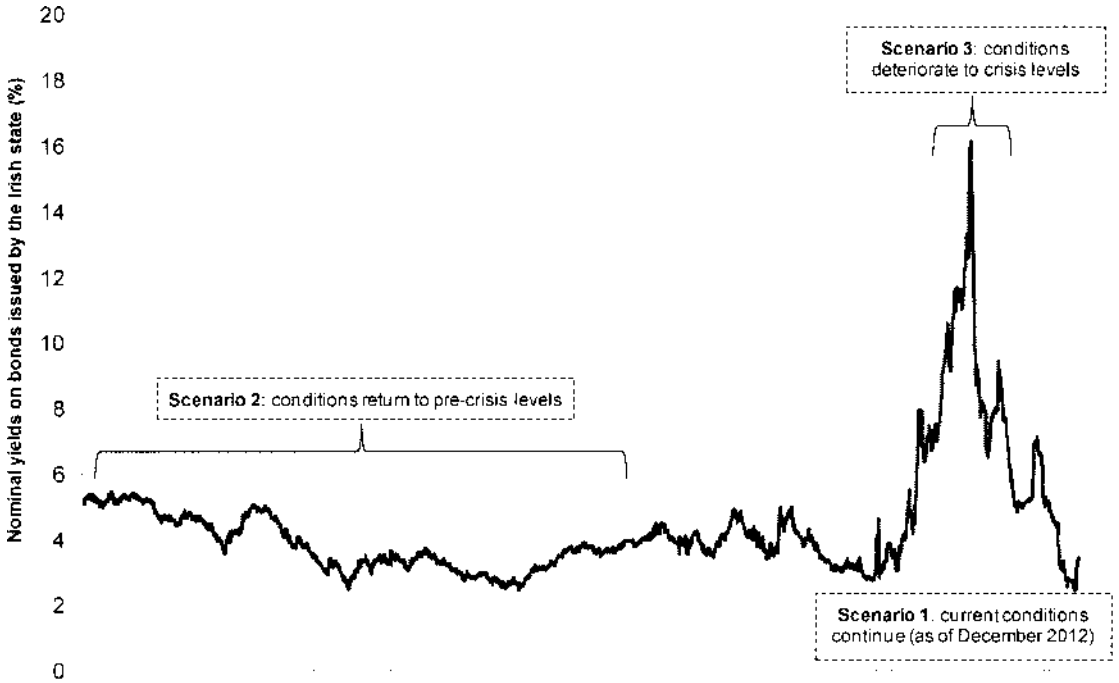
The 2013-2015 ROE estimates:

(134) On the basis of actual observed figures, Oxera used as a starting point the value of 13% ROE, which had been calculated as part of the 2009-2011 assessment.

(135) Then the following scenarios were considered:

- Scenario 1: the current macroeconomic conditions as of December 2012 continue
- Scenario 2: conditions return to pre-crisis level 2000-2007
- Scenario 3: conditions deteriorate to crisis level 2011

(136) The graph below presents the nominal yields on bonds issued by the Irish State for the different period



(137) Based on the historical financial information for the years 2009-2011 and taking into account the different possible scenarios about future macroeconomic conditions in Ireland (see table below), Oxera estimated that VHI's ROE for 2013-2015 should range between 9 and 15% (midpoint 12%).

(138) The table below presents observed yields on bonds and calculated the cost of equity in the years 2009-2011 and estimates of VHI's forward-looking cost of equity, varying the projected levels of yields on bonds and cost of equity depending on the 3 different scenarios of future economic situation in Ireland.

Table 10: Indicative estimates of VHI's forward-looking cost of equity (%)

Scenarios	Nominal yields on bonds issued by the Irish State (%)	Nominal (pre-tax) cost of equity (%)
2009-2011	**9**	**13**
Scenario 1: continuation of current conditions	**3**	**9**
Scenario 2: conditions return to pre-crisis levels	**6**	**11**
Scenario 3: conditions deteriorate to crisis level	**11**	**15**

Source: Oxera analysis, based on Datastream.

Conclusion

(139) On the basis of the external and internal benchmarks calculations, Oxera considers that an acceptable range for the ROE of VHI for the period 2013-2015 is 10% to 12%.

(140) The Commission considers that the approach above is coherent and in line with the state of the art. Considering the intrinsic variability present in such calculations, the Commission accepts the proposal of the Irish authorities to consider that VHI is overcompensated if its return on equity is above 12%.

Conclusions on the overcompensation test

(141) First, the Commission notes that, as concerns the methodology used for the calculation of the net costs expected to be necessary to discharge the public service obligations, the 2012 SGEI Framework requires the use of the net avoided cost methodology where this is possible. Under the net avoided cost methodology, the net cost 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. In the RES, all operators are obliged to participate, instead of a single operator entrusted with the SGEI. As with the previous RES 2003 and the Interim Scheme, the RES 2013 does not aim at calculating the costs of providing private health insurance in Ireland, but is aimed at equalising risks between insurers, as described above. Under these circumstances, the specific methodology used under the RES can therefore be accepted as more appropriate than the net avoided cost methodology.

(142) Consequently, for verifying the absence of overcompensation of VHI, the overcompensation test can consist in a simple comparison between the profit level of VHI for its SGEI activities and the benchmark defined in recital (140).

(143) The Commission observes that, in Ireland, while the PMI obligations (qualified as SGEI obligations) refer to the PMI market as a whole (thus including the potential provision of benefits which could be qualified as "luxury"), the RES mechanism is not designed to calculate and compensate all the costs related to the provision of PMI services, but aims to equalise to a certain degree the divergences in the risk profiles of the insurers, by mitigating in particular the costs related to ensuring the high-risk population (excluding "luxury benefits").

(144) In this context, the Commission takes note that the Irish authorities clarified that the overcompensation test is and will continue to be carried out on the basis of the entire PMI business including the "luxury" elements.

(145) The Commission agrees with the approach proposed by the Irish authorities, which ensures that not only the RES does not subsidise "luxury" products, but profits made from "luxury" products are used to subsidise the general provision of the SGEI (PMI services) and therefore the compensation from the RES 2013 remains at the minimum necessary for the proper functioning of the SGEI.

(146) The Irish authorities committed to ensure that as part of the overcompensation test to be performed throughout the period 2013-2015, the profitability of all the companies on the Irish PMI market, and of VHI in particular (due to the fact that VHI will most likely be the only beneficiary of the RES during this period), will be assessed in order to verify that no company is compensated above the level corresponding to 12% return on equity and established as the level of reasonable profit that is acceptable for the purposes of applying the 2012 SGEI Framework.

Profit projections for VHI

(147) ROE projections for VHI for the years 2013-2015 are provided in table 11 below.

(148) The projected return on equity for VHI over the period 2013-2015 of […] and […] for 2013 and 2014, respectively, and […] indicate that any overcompensation is very unlikely.

Table 11: VHI ROE projections 2013-2015

€m	**2013**	**2014**	**2015**
Profit after tax	[…]	[…]	[…]
Equity*	[…]	[…]	[…]
Projected Return on Equity (ROE)	[…]	[…]	[…]

** This value is based on closing General Reserves figure of VHI projections that are used as a proxy for equity*

(149) It can be observed from the above projections, that VHI would appear to be loss-making in 2015 despite the RES. This could put in question the capacity of the RES 2013 to ensure the sustainability of the system and could potentially plead for higher transfers between operators.

(150) However, it must be taken into account that even mid-term projections are extremely difficult to make in this sector which is in particular the reason why an *ex post* control of the overcompensation is indispensable. The Commission observes that, as noted in recital (126) above, the RES is based on an annual review of the system, under the responsibility of the HIA and the Minister for Health in their respective capacities, which aims to ensure that the RES functions correctly, without overcompensating any

participant in the RES, and that at the same time the sustainability of the PMI market is maintained. It is further observed that in order to preserve the proportionality of the RES 2013 and at the same time the sustainability of the PMI market, it is important that the calculations that form the basis for the RES 2013 remain conservative and rely in the first place on the result for 2013.

3.2.4. Compliance with the transparency directive and separation of accounts

(151) The Commission notes that for the purposes of the above analysis, the numbers relate only to private medical insurance, *i.e.* numbers relating to travel insurance and other activities that are carried on by VHI were not taken into account.

(152) 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. The Commission considers therefore that the separation of the costs and revenues relating to the SGEI business of VHI was properly carried out for the purposes of the overcompensation test, in line with the requirements of the Transparency Directive.

(153) In addition, the Irish authorities committed to ensure that appropriate national measures are implemented in 2013 to provide for the appropriate separation of accounts for all operators, in line with the overcompensation test above and the requirements of the Transparency Directive.

(154) Currently, insurers have to submit information on health insurance premium revenue and claims costs to the HIA, which means they are in any event already obliged to keep track of these data.

(155) Indeed 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, concerning the company's health insurance business or former health insurance business, as the case may be, during the respective period of 6 months concerned, and in particular:

(a) the total number of persons insured, or a class thereof, with the insurer concerned during the relevant period,

(b) the total number of persons insured, or a class thereof, in each age group, the gender profile of each age group, and the type of cover of each age group, in respect of the relevant period,

(c) the total number of persons in each age group, or a class thereof, effecting health insurance contracts during the relevant period,

(d) the in-patient indemnity payments, or a class thereof, made by the insurer concerned during the relevant period,

(e) information relating to the health insurance services provided during the relevant period, and

(f) other information relating to the relevant 6 months period, other than personal data, which may reasonably be considered to be information which will enable or assist the Minister or the HIA to perform their respective functions under the Health Insurance Act.

(156) All insurers are required to maintain and furnish to the HIA, in respect of each year, statements of profit and loss as well as balance sheets in respect of its health insurance

business, and must provide such other information relating to the year as may be prescribed and, in particular, statements of profit and loss and balance sheets in respect of its health insurance business as it relates to those persons receiving age-related tax credits in respect of health insurance contracts effected for any period before 1 January 2013, or receiving risk equalisation credits. The statements of profit and loss and/or balance sheets must be certified by an independent accountant prior to being furnished to the HIA.

(157) As concerns the disclosure of contents of information returns, the Health Insurance Act 1994 provides that the contents of information returns shall, in so far as they can be related to individual insurers, be disclosed only where necessary for the purposes of the functions of the Minister or the HIA. Subject to this, the HIA may, where it considers it appropriate to do so, disclose aggregate data derived from information returns. All information in the information returns can be disclosed to the Minister of Health by means of a report furnished to the Minister by the HIA.

(158) All insurers are obliged to maintain the records relating to their respective health insurance business as prescribed by law, and to furnish to the Minister for Health or the HIA, as the case may be, such information regarding the health insurance business as the Minister or the HIA may require for their functions under the Health Insurance Act.

3.2.5. Efficiency incentives

(159) With regard to efficiency incentives, point 39 of the 2012 SGEI Framework requires that Member States introduce incentives for the efficient provision of SGEI of a high standard unless it can be justified that such incentives are not feasible or appropriate. The introduction of efficiency incentives means that operators would be remunerated in a way that encourages their efficiency. The RES represents a sui-generis SGEI system, based on equalising "bad risks" 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. The levels of compensation are calculated based on claims costs (at market average). Claims costs represent payments made by insurers to healthcare providers (e.g. hospitals) for healthcare provided to individuals (e.g. treatment, hospital stay, etc.). Requiring specific efficiency incentives would likely mean obliging insurers to lower their claims costs (e.g. through better prevention practices instead of expensive treatment, encouraging shorter hospital stays). This would likely have a direct impact on how healthcare is provided in Ireland and thus a direct systemic impact that would affect not only insurers, but also healthcare providers and would impact healthcare consumers. Consequently, introducing efficiency incentives would affect the health policy of the Irish State. In this context, Ireland decided it is not appropriate to introduce additional efficiency incentives in the RES other than what results from normal market forces in the regulated environment of healthcare provision and health insurance in Ireland. In the specific circumstances of the present case, the Commission does not consider appropriate to intervene, by imposing efficiency requirements, in this policy matter of the Irish State. The Commission therefore would not at this point in time require the introduction of efficiency incentives in the specific case of the RES.[60]

[60] Indeed, the Framework leaves the option of introducing such incentives where "feasible or appropriate to do so".

(160) On the basis of all of the above, the Commission considers that the RES 2013 will not result in overcompensation. There is indeed a need for a mechanism to equalise risks in the Irish PMI market. Given that such a mechanism is necessary, the Commission considers the compensation to be justified as long as it does not lead to an overcompensation of the net beneficiary. On the basis of VHI's projections and the mechanisms to avoid and to repay possible overcompensation, the Commission is satisfied that the scheme does not involve overcompensation.

3.2.6. Transparency according to the 2012 SGEI Framework

(161) The RES 2013 appears to comply with the transparency requirements set out at point 60 of the 2012 SGEI Framework. In particular, the Irish authorities carried out an extensive public consultation in relation to the development of a long term risk equalisation scheme in 2010 and the results of this public consultation are available on the HIA's website (www.hia.ie). The legislation governing the RES 2013 is already available in its current form on the internet site www.irishstatutebook.ie). Reports published yearly by HIA are also available on its website.

(162) In addition, the Commission notes that the Irish authorities have taken numerous steps to consult all the market players on the envisaged implementation of the RES 2013.

(163) Risk equalisation in Ireland has been the subject of extensive public consultation over more than 15 years[61]. In May 2010, the Government announced that it had decided to implement a new and more robust RES to support the core policy of community rating in the PMI market. The Minister asked the HIA to carry out a consultation process with a view to having the new scheme take effect in 2013 (including any transitional arrangements). The HIA published a Consultation Paper in June 2010, inviting submissions in relation to a wide range of issues relating to risk equalisation and specifically addressing issues relating to the main proposed enhancements to the risk equalisation system, *i.e.* the inclusion of gender and hospital bed utilisation as risk factors and addressing the impact of differences in products. The HIA received 15 written submissions in response to the Consultation Paper (which are published on its website). In addition, in the autumn of 2010, the Board of the HIA met with each of the open market insurers in order to discuss their submissions to the Consultation

[61] Public consultation engaged as of 1997, on the Report to the Minister of Health prepared by an independent Advisory Group to consider risk equalisation on the PMI market, published in 1998. A Technical Paper on a proposed risk equalisation scheme was published in January 1999 and a White Paper on PMI was published in September 1999. Further to the establishment of the HIA in 2001, the HIA published a consultation paper on risk equalisation in February 2002 and a Policy Paper in September 2002. In July 2003 the HIA organized public consultation, focussing on the competition issues raised by risk equalisation, resulting in a Report of November 2003 "Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market". The 2003 Risk Equalisation Scheme commenced on 1 July 2003 and the HIA conducted a further consultation with insurers each time it considered recommending the commencement of RES payments under the 2003 RES (Autumn 2003, Spring and Autumn in 2004 and Spring and Autumn in 2005). In 2006, further to a request by the Minister, the Competition Authority and the HIA organised public consultations, concluded with their respective reports to the Minister on competition in the PMI market and risk equalisation, published in January 2007. Another public consultation was organised in 2007 on a business appraisal of the PMI market, concluded by a report which addressed risk equalisation. In 2008 the Supreme Court ruled that the introduction of the RES 2003 was ultra vires the powers of the Minister but it did not rule against the principal of risk equalisation and community rating across the whole market of insured persons. Following the judgement and the termination of the RES 2003, the market required corrective measures in order to protect the common good, which were addressed through the current Interim Scheme introduced in 2009.

Process. The HIA submitted its report, with recommendations on risk equalisation, to the Minister in December 2010. That Report is published on the website of the Department of Health (http://www.dohc.ie/).

(164) The Irish authorities have explained that, having examined the HIA's proposals and consulted further with the Minister for Finance and the Minister for Public Expenditure and Reform, the Minister sought and received Government approval to the text of the 2012 Bill which provides for the introduction of a robust RES from 2013. Following the Government decision in December 2011 to introduce the RES 2013, the Department of Health wrote to each insurer in the market on 11 January 2012 informing them of the decision and briefly outlining the main features of the scheme. In February 2012, the Minister established the Health Insurance Consultative Forum, which comprises representatives of all insurers, the HIA and the Department of Health. At a meeting of the Health Insurance Consultative Forum on 21 February 2012, the Department of Health made a presentation to all insurers which set out the details of the new RES. Over recent months, bilateral meetings and exchanges have continuously taken place with each of the private insurers. In November 2012, the Irish authorities informed all insurers on the market of their intention to delay the implementation of the new elements of the RES (as compared to the Interim Scheme), and in particular of the new credits and stamp duties, until 31 March 2013.

(165) Meetings within the Consultative Forum provided insurers with an opportunity to participate in, and directly contribute to, discussions on the planned working of the RES. As a result of these meetings, and following consideration of suggestions made therein, a number of the proposed restrictions on product notifications were eased. Thus, the definition of products "not providing advanced cover" was adapted to provide for an objective delineation of the product categorisation, which in turn allows the HIA to categorise products in a more timely manner. Secondly, as a result of this clarity on product categorisation, the impact of the product notification periods specified in section 7AB is now set at 30 days for new and changed products, where the product classification does not change. Where a change to an existing product alters its product classification, such changes will take effect from 31 March 2013 and from 1 January each year thereafter. Finally, the length of time a product must be maintained on the market was set at 60 days. These agreed amendments[62] also allow insurers time to trade into the new system and lessen the impact of the revised notification periods on business planning. The Consultative Forum will allow the insurance companies to consult continuously with the Department of Health throughout the functioning of the RES.

4. CONCLUSIONS

(166) The Commission regrets that the RES 2013 was put in place as of 1 January 2013, *i.e.* before the Commission concluded its assessment of the measure. However, the Commission acknowledges that the RES 2013, which is aimed 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 understands the need to have the structure of the RES in place as of 1 January 2013 to replace the Interim Scheme, which expired on 31 December 2012. The Commission also takes note that the delayed implementation of the new elements of the RES, and in particular

[62] Reflected in particular in Section 7AB of the Health Insurance Act 1994.

of the new credits and stamp duties, has as its consequence that the financial effect of the RES 2013 will come into force only as of 31 March 2013.

(167) Based on the foregoing considerations, the Commission considers that the RES 2013 fulfils the conditions laid down in the 2012 SGEI Framework and is compatible with Article 106(2) TFEU.

5. DECISION

(168) The Commission has accordingly decided not to raise any objections to the above-mentioned measure in respect of the years 2013 to 2015 on the ground that it constitutes compatible aid under Article 106(2) TFEU.

(169) 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 by registered letter or fax to:

European Commission
Directorate-General for Competition
Directorate F
State Aid Greffe
1049 Brussels
Belgium
Fax No: +32 2 296 12 42

Yours faithfully,
For the Commission

Joaquín ALMUNIA
Vice-President