An tÚdarás Árachas Sláinte
The Health Insurance Authority

Guide to 2013 Risk Equalisation Scheme

May 2013

Contents

1. Introduction

The role of the Health Insurance Authority (the Authority), in relation to risk equalisation, is set out in the Health Insurance Acts, 1994 - 2012.

In this document we describe the method of calculation of the payments made under the Risk Equalisation Scheme 2013. We also outline the regulatory structure of the market, the roles of the Minister for Health, the Health Insurance Authority and insurers.

The intention of The Health Insurance Authority (the Authority) in publishing this document is to give general guidance on the Risk Equalisation Scheme 2013. The document is not a legal interpretation. Its purpose is to explain, in non-legal language, the method of calculation of the payments made under the Risk Equalisation Scheme 2013. This document does not purport to set out all the requirements of the legislation.

2. Regulatory Structure of the Irish Private Health Insurance Market

The Health Insurance Acts, 1994 to 2012 and Regulations made thereunder provide for the regulation of the business of private health insurance in Ireland following the enactment of the European Union "Third Non-Life Insurance Directive". This Directive sets out the requirements of the internal market for Member States regarding non-life insurance, including health insurance. This European legislation allows individual Member States to adopt the specific requirements in a manner most appropriate to their particular national legal system and national healthcare system.

The Health Insurance Acts set out the principal objective of the Minister for Health (the Minister) and the Authority in carrying out their respective functions under the legislation as follows:

"(1) The principal objective of this Act is to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of 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, and taking into particular account for the purposes of that objective—

(*a*) the fact that the health needs of consumers of health services increase as they become less healthy, including as they approach and enter old age,

(*b*) the desirability of ensuring, in the interests of societal and intergenerational solidarity, and regardless of the health risk status or age of, or frequency of provision of health services to, any particular generation (or part thereof), that the burden of the costs of health services be shared by insured persons by providing for a cost subsidy between the more healthy and the less healthy, including between the young and the old, and, without prejudice to the generality of that objective, in particular that the less healthy, including the old, have access to health insurance cover by means of risk equalisation credits,

(*c*) the manner in which the health insurance market operates in respect of health insurance contracts, both in relation to individual registered undertakings and across the market, and

(*d*) the importance of discouraging registered undertakings from engaging in practices, or offering health insurance contracts, whether by segmentation of the health insurance market (by whatever means) or otherwise, which have as their object or effect the favouring of the coverage by the undertakings of the health insurance risk of the more healthy, including the young, over the coverage of the health insurance risk of the less healthy, including the old."

Community rating is defined as any measures that support the principal objective. The Acts also set out the other principles of health insurance regulation, open enrolment, lifetime cover and minimum benefit.

The Irish private health insurance regulatory system is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefit and aims to ensure that private health insurance does not cost more for those who need it most. The system is unfunded, meaning that there is no fund built up over the lifetime of an insured person to cover their expected claims cost. Instead, the money contributed by insured people is pooled by each insurer and the cost of claims in any given year taken from the pools.

It is in this context that the concept of community rating must be understood. This means that the level of risk that a particular consumer poses to an insurer does not affect the premium paid. In other words, everybody is charged the same premium for a particular plan, irrespective of age, gender and the current or likely future state of their health. A discounted premium is available for children and may be available for full time students up to age 23. A discounted premium may also be available for members of group schemes and pensioners of restricted membership undertakings.

Open enrolment and lifetime cover mean that, except in very limited circumstances specified in legislation, health insurers must accept all applicants for health insurance and all consumers are guaranteed the right to renew their policies regardless of their age or health status.

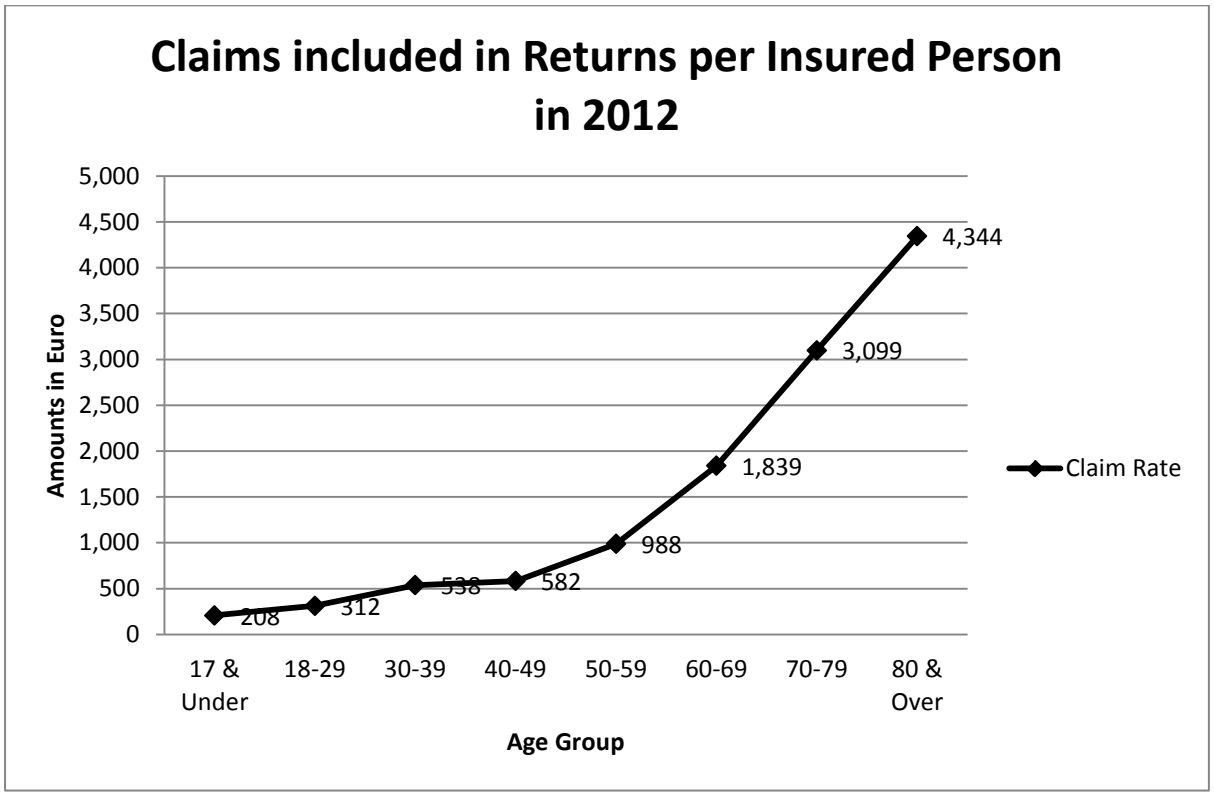
Under the Minimum Benefit Regulations (S.I. No 83/1996), all insurance products that provide cover for inpatient hospital treatment must provide a certain minimum level of benefits. It is considered necessary to regulate the minimum level of benefits because of the complex and specialist nature of private health insurance products, which without regulation, could result in consumers being provided with products that do not provide a sufficiently comprehensive level of cover.

Risk equalisation is a process that aims to address differences in insurers' claim costs that arise due to variations in the health status of their members. Risk equalisation involves payments to or from insurers related to the risk profile of their membership. Risk equalisation is a common mechanism in countries with community rated health insurance systems and the introduction of a Risk Equalisation Scheme in Ireland is provided for in the Health Insurance Acts.

3. The Necessity for Risk Equalisation in a Community Rated Market

In a community rated market without a robust risk equalisation system, older and unhealthy consumers tend to be extremely unprofitable on average.

The following chart illustrates how market claims increase with the age of the insured person.



In the absence of a risk equalisation system to support community rating, the chart shows that younger and healthier customers will be profitable while older and less healthy customers will be unprofitable. As a result the following consequences would be likely:

- Insurers would attempt to segment their risks so that older and unhealthier customers are sold products that cost more or include a lower level of benefits.
- Insurers would design and market products that are attractive to the better risks.
- Insurers with more favourable risk profiles would be protected from real competition from insurers with less favourable risk profiles. Product promotion would feature risk selection and marketing spend in preference to product quality and service.
- The most profitable insurers would be those that can best use marketing strategies to attract healthy lives and avoid unhealthy lives, not necessarily those that provide the best service.
- Insurers with worse risk profiles would be obliged to charge higher premiums or incur losses. Switching of younger customers would exacerbate their problems.

The only method of properly protecting community rating is to introduce a risk equalisation system that sufficiently reduces the financial incentive to avoid insuring old and unhealthy lives.

Likely market developments in the absence of a robust risk equalisation scheme

In a community rated market without robust risk equalisation, insurers with lower risk profiles will tend to be more profitable, other things being equal. Also, while insurers that meet the needs of healthier consumers would be expected to benefit from the profitable custom of healthier consumers, insurers that attract less healthy consumers by meeting their needs would be penalised by incurring claims costs that are higher than the community rated premium. As a result, in the absence of a robust risk equalisation system, insurers will be incentivised to design products so that they are not attractive to older and less healthy consumers. On the other hand, both consumers and efficient insurers would benefit from a properly functioning competitive market. Consumers would benefit from price and product competition. Insurers that design, sell and administer products in a cost effective manner that are attractive to the market would be profitable. This would not the case in a community rated health insurance market which does not have a robust risk equalisation system.

Impact on consumers

Risk selection and segmentation are vital to the commercial success or failure of health insurance providers in a community rated market without a robust risk equalisation system. In order to compete in such a market, it would be expected that insurers would focus their commercial activity on improving their risk profiles rather than, for example, on improving their efficiency. As younger and healthier consumers are more likely to be profitable, insurers would actively seek them out as customers and these customers would be likely to benefit, in the short to medium term. As older less healthy consumers are not as profitable, insurers may make their products less attractive to them. Insurers may market themselves in a manner so that older and less healthy consumers are less likely to be aware of new more competitive plans aimed at younger healthier consumers. Despite the rules regarding community rating and open enrolment, a range of tactics are open to insurers to assist them in risk selection and risk segmentation and the Authority would expect insurers to increasingly adopt such tactics in the absence of a robust risk equalisation system. The result would be that older and less healthy people would increasingly pay more for health insurance than younger and healthier consumers. This is contrary to the principal objective of the Minister and the Authority under the Health Insurance Acts.

In the absence of a risk equalisation system, the marketing of health insurance would be dominated by risk selection and segmentation. Insurance companies would comply with the law in relation to community rating and open enrolment but, in the absence of a robust risk equalisation system, the legislation would incentivise marketing and sales behaviour that

would undermine these principles with a consequent negative impact for older and less healthy people, who are particularly vulnerable in the context of healthcare costs.

Impact on the market

A systemic issue would arise for the market because risks are created for the long term viability of insurers with less favourable risk profiles and consequently for the stability of the health insurance market as a whole. Regardless of its level of efficiency, an insurer with a less favourable risk profile at a product level would be obliged to either have higher premiums than the market or incur significant losses. If its premiums were higher than the market it is more likely to lose younger than older customers (as younger customers have a greater propensity to switch / lapse) and its worsening risk profile might oblige it to increase premiums further, resulting in a cycle. It is important to note that, because competition is distorted, an insurer would incur such difficulties regardless of its level of efficiency or the attractiveness of its products; such difficulties would result directly from its risk profile in the absence of a robust risk equalisation system.

4. The Role of the Health Insurance Authority

The Authority was established by Ministerial Order on 1 February 2001 under the Health Insurance Acts and operates in accordance with the provisions of these Acts.

The functions of the Authority are summarised as follows:

- To monitor the health insurance market and to advise the Minister (either at his or her request or on its own initiative) on matters relating to health insurance;
- To monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts or take prosecutions;
- To carry out certain functions in relation to risk equalisation, including to manage and administer the Risk Equalisation Fund;
- To take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
- To maintain "The Register of Health Benefits Undertakings" and "The Register of Health Insurance Contracts".

The Authority shall exercise such powers as are necessary for the performance of its functions. The Minister for Health ("the Minister") may assign further responsibilities to the Authority as provided for in the Acts.

5. The History of Risk Equalisation in Ireland

The system of private health insurance was formally inaugurated in 1957, when, as a result of the Voluntary Health Insurance Act, 1957, the Voluntary Health Insurance Board (now trading as Vhi Healthcare) was established. Between 1957 and 1994, the provision of private health insurance in Ireland was subject to the terms of this Act. During this time Vhi Healthcare were the only providers of private health insurance in Ireland, apart from a number of restricted membership undertakings that could only provide cover to members of certain groups (these groups are normally vocational, e.g. the Garda Síochána).

1994 to 2000 (The 1996 Risk Equalisation Scheme)

Following the introduction of the European Council Directive 92/49/EEC (the Third Non Life Directive) in 1992, the Health Insurance Act, 1994 was introduced. This Act made provision for the opening of the health insurance market to competition and gave legal effect to the principles of community rating, open enrolment, lifetime cover and minimum benefits. The Act also included provision for the establishment of the Authority and for a Risk Equalisation Scheme. BUPA Ireland was the first insurer to enter the health insurance market following the Act (in 1997) and stayed in the market until 2007. There are currently four registered undertakings effecting health insurance contracts in Ireland:

- The Voluntary Health Insurance Board (trading as Vhi Healthcare).
- Aviva Health Insurance Ireland Ltd (trading as Aviva Health)
- Elips Insurances Ltd (trading as Laya Healthcare)
- Great Lakes Reinsurance (UK) Ltd (trading as GloHealth)

The power to make a Risk Equalisation Scheme, which was provided for in the 1994 Act, was exercised by the Minister who introduced the Health Insurance Act (Risk Equalisation Scheme) 1996 (the "1996 Scheme"). Under the 1996 Scheme, risk equalisation was triggered once the relevant threshold set down in the 1996 Scheme was met. No payments were ever made on foot of that Scheme (which was revoked in 1999).

On 25th June 1997, the Minister appointed an independent Advisory Group (the members of which included Gerard Harvey (former CEO of An Post and Chairman of the Advisory Group), William Hannan (former President of the Society of Actuaries in Ireland) and James Golden (economist, Senior Treasury Manager at the National Treasury Management Agency and Lecturer in Finance at University College Dublin)) to consider risk equalisation.

In the preparation of its Report, the Advisory Group engaged in an extensive public consultation process and interested persons were given the opportunity to make written and oral submissions. The Report of that Advisory Group (often referred to as "the Harvey Report" by reference to its Chairman) was issued on 8 April 1998. The conclusions of the Advisory Group in relation to risk equalisation were set out at page 7 of the Harvey Report and included the following:

> "The Advisory Group concludes, based on its own deliberations and on the basis of the arguments made and evidence presented to it, that risk equalisation is essential to underpin community rating.

> The Advisory Group agrees, therefore, that a Risk Equalisation Scheme is a necessary feature of the private health insurance market."

The Minister then engaged in a consultation process on private health insurance and risk equalisation. A Technical Paper on a Proposed Amended Scheme was published by the Department of Health and Children in January 1999. A White Paper on Private Health Insurance was then published in September 1999. This set out the Government's policy objectives and proposals regarding, *inter alia*, the role of private health insurance in the overall healthcare system. It was stated therein (page 40, paragraph 3) that:

> "The Government's view, supported by a wide range of independent experts, and interests is that risk equalisation is essential to underpin community rating. The key objective of risk equalisation is to protect the stability of community rating. Subject to this objective, it should facilitate and encourage competition. The Government have decided to make changes to the existing risk equalisation scheme to further encourage competition."

The 1996 Scheme was revoked in February 1999 by the Health Insurance Act, 1994 (Risk Equalisation) (Revocation) Regulations 1999.

2001 – 2008 (The 2003 Risk Equalisation Scheme)

The establishment of the Authority was provided for under section 20 of the 1994 Act and one of the main recommendations of the Advisory Group, arising from its review of the 1996 risk equalisation scheme (at page 8 of the Harvey Report), was the immediate establishment of the Authority. The Authority was established on 1 February 2001.

The year 2001 also saw the enactment of the Health Insurance (Amendment) Act 2001, which provided for the introduction of a Risk Equalisation Scheme by the Minister for Health, and provided that the Health Insurance Authority would have a significant role in relation to the commencement of payments under any such scheme.

On 1 July, 2003 a Risk Equalisation Scheme came into effect (RES 2003). This Risk Equalisation Scheme differed significantly from the Scheme defined in 1996. The 2003 Scheme invested significant responsibilities in the Health Insurance Authority in relation to the operation of the Scheme and in particular and crucially in relation to whether or not payments under the Scheme would commence. A guide to RES 2003 is published on the Health Insurance Authority's website.

In 2005, the Authority recommended that risk equalisation would be commenced under RES 2003 and the Minister determined that payments would commence from 1 January 2006. BUPA Insurance Ltd, which would have been required to make payments under the Scheme, commenced legal actions challenging the Scheme and the decision to commence payments thereunder. There was a stay in payments under the Scheme pending the conclusion of the legal action.

In December 2006, the Scheme was upheld in the High Court. BUPA appealed to the Supreme Court. In 2008, the Supreme Court upheld the appeal and RES 2003 was set aside.

2009 to 2012 (The Interim Risk Equalisation System)

Following the Supreme Court judgment in July 2008, the Authority wrote to the Minister for Health and Children in August 2008 providing advice in relation to the consequences of the Supreme Court judgment. The Authority advised that, in the Irish community rated market without Risk Equalisation, younger consumers (those under the age of 50) were, on average, profitable, while those over the age of 50 were unprofitable. In particular, those over the age of 70 tended to be extremely unprofitable. In the absence of Risk Equalisation, the following consequences were likely (in point of fact, the market had been trending in some of these directions for some time already):

- Insurers would design and market products so as to reduce their attraction to older customers.
- Insurers would attempt to segment their risks so that older customers were sold products that cost more or include a lower level of benefits.
- Insurers with more favourable risk profiles would be protected from real competition.
- Product promotion would feature risk selection and marketing spend rather than product quality and service.
- The most successful insurers would be those that could best select and segment risk, not necessarily those that provided the best service.
- Insurers with worse risk profiles would be obliged to charge higher premiums or incur losses. Switching of younger customers might exacerbate their problems.

At the time, the Authority suggested that alternatives for addressing these issues would be either to reconstitute the Risk Equalisation Scheme in some form or introduce some form of levy-based or tax-based loss compensation system.

Following this initial memorandum, the Authority continued to provide advice to the Minister and the Department on how community rating could be supported. This process culminated in the Health Insurance (Miscellaneous Provisions) Act, 2009.

The 2009 Act provided for the introduction of a system of age-based tax credits to support community rating. The Act provided that Open Membership Insurers would receive higher premiums in respect of insuring older people, but older people would receive tax credits equal to the amount of the additional premium so that all adults were charged the same net amount for a particular level of cover. In this way community rating is maintained but insurers receive higher premiums in respect of older people to partly compensate for the higher level of claims.

In order to fund the system, open membership insurers would pay a community rating stamp duty in respect of all individuals covered for health insurance.

The community rating stamp duty and tax credits, would be administered by the health insurance undertakings. The Act provided that the measures would be in place for three years in order to allow time for a comprehensive risk equalisation / loss compensation system to be put in place. These measures were extended for a further year by the Health Insurance (Miscellaneous Provisions) Act, 2011 before being replaced by the Risk Equalisation System 2013 provided for in the Health Insurance (Amendment) Act 2012, which is the subject of this Guide.

6. Overview of the 2013 Risk Equalisation System

Like the interim system, the 2013 Risk Equalisation System involves insurers receiving higher premiums for insuring members of less healthy groups of the population. Again, like the interim system, the higher part of the premium arising for these individuals is not paid by the individual, rather it is paid in the form risk equalisation credits. It follows that, while each individual pays the same net premium for the same product, the insurer receives higher premiums for insuring members of less healthy groups. Another similarity with the interim system is that the credits are funded by a stamp duty payable by insurers for each person that they insure.

The main differences between the interim system and the 2013 Risk Equalisation System are the following:

- Risk Equalisation Credits are paid from a fund operated by The Health Insurance Authority rather than in the form of tax credits.
- Risk Equalisation Credits payable in respect of premiums vary on the basis of age, gender, and level of cover, rather than just on the basis of age.
- Stamp duty rates vary between children and adults and between two levels of cover.
- Risk Equalisation Credits are now also payable in respect of claims, with a fixed amount payable from the Risk Equalisation Fund for each night an insured person spends in private hospital accommodation. This reduces the cost to the insurer of insuring less healthy individuals.

The health credits and the community rating health insurance stamp duty are administered by the health insurance companies and the Risk Equalisation Fund. Community rating health insurance stamp duty payments for renewals from 1 January 2013 are paid by insurers to the Revenue Commissioners who in turn transfer the money to the Risk Equalisation Fund. Risk Equalisation Credits are paid out of the Fund to the insurers by the Health Insurance Authority. Any surpluses or deficits in the Fund are carried forward and allowed for in setting future stamp duty amounts.

7. Undertakings and Contracts Subject to Risk Equalisation

The legislation (Section 11B of the Health Insurance Act 1994- 2012) provides that the Risk Equalisation Scheme applies all registered undertakings and all undertakings that are no longer registered undertakings but were registered undertakings at some time when the Scheme was in force, with the following exceptions:

- The Scheme does not apply to Restricted Membership Undertakings.
- The Scheme does not apply to contracts that do not include indemnity cover for inpatient services (e.g. contracts that only cover outpatient services, or contracts that insofar as they provide cover for inpatient services, such cover is in the form of cash rather than indemnity benefits).
- The Scheme does not apply to contracts that relate solely to the public hospital daily in-patient charges made under the Health (In-patient Charges) Regulations 1987 (S.I. No. 116 of 1987), i.e. the charges for treatment as a public patient in public hospitals.

8. Risk Factors Included in the 2013 Risk Equalisation System

Risk Equalisation Credits payable under the 2013 Risk Equalisation Scheme vary by age, gender and level of cover. In addition, Risk Equalisation Credits are payable with respect to hospital utilisation. These factors will be discussed further in this section.

Premium Related Risk Equalisation Credits

Under the 2013 Risk Equalisation System, open membership insurers receive higher premiums in respect of insuring older people, but the higher part of the premium in respect of older people is payable from the Risk Equalisation Fund in the form of risk equalisation credits, so that all people continue to pay the same amount for their health insurance. In this way community rating is maintained but insurers receive higher premiums in respect of older people to partly compensate for the higher level of claims.

These risk equalisation credits, payable in respect of older people vary by the age and gender of the insured person and the level of cover of the contract held.

Age and Gender

The legislation provides for risk equalisation credits varying in 5 year age bands from age 50 up to age 85 and for age 85 and above. The legislation also provides for different credits for each gender in order to allow for significant differences in average claims costs between males and females (at higher ages average claims costs for males significantly exceed those for females).

Level of Cover

Risk Equalisation Credits also vary across two levels of cover (advanced and non advanced), risk equalisation credits for advanced contracts being higher than those for non advanced contracts.

Advanced Cover/Non Advanced Cover rules are set out in Section 11E of the Health Insurance Act, 1994 (as inserted by Section 15 of the Health Insurance (Amendment) Act 201)2. A contract is specified as providing for non advanced cover if not more than 66 per cent of the full cost for hospital charges in a private hospital or prescribed minimum benefits, if lower, is always provided. If the Authority determines that a contract is a Non Advanced contract, it shall effect regulations to that effect and enter such particulars in the Register of Health Insurance Contracts. Advanced Cover contracts are relevant contracts that are not Non Advanced contracts.

A registered undertaking shall not alter the benefits under a contract so that it changes from advanced to non advanced cover or vice versa except from 31 March 2013 or 1 January of any subsequent year.

Hospital Bed Utilisation Credits

The 2013 Risk Equalisation System pays a fixed amount for each night that an insured person spends in private hospital. In this way, the cost of claims arising for those who spend nights in hospitals is reduced, reducing the cost to the insurer of insuring less healthy people.

The same Hospital Bed Utilisation Credit applies across all age / gender and level of cover groups.

Community Rating Stamp Duty

The system is funded by the community rating stamp duty, which is payable by open membership undertakings to the Revenue Commissioners who pass the money to the Risk Equalisation Fund.

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

Any surpluses or deficits in the Risk equalisation Fund are carried forward and allowed for in setting future stamp duty amounts.

9. Determination and Specification of the Rates of Credit and Stamp Duty

Report of the Health Insurance Authority

The Authority receives Returns from insurers every six months under S.I No 294/2099 as amended by S.I. No 690/2011 providing detail on the age and gender of insured persons and claims data (claims cost and hospital utilisation) for each age / gender / product cell. These returns are evaluated and analysed by the Authority.

As specified by the Minister (normally every 12 months), the Authority prepares and furnishes a Report to the Minister in relation to:

(i) Its evaluation and analysis of returns received.

(ii) Such matters concerning the carrying on of health insurance business and developments in relation to health insurance generally that the Authority considers ought to be brought to the attention of the Minister (including information in relation to the profitability of any registered undertaking or former registered undertaking where the operation of the relevant financial provisions is expected to result in a positive cumulative net financial impact on the undertaking).

(iii) Subject to the principal objective, the amounts of the risk equalisation credits that the Authority considers, after having regard its evaluation and analysis, would need to be effected under the Risk Equalisation Scheme, having regard to the principal objective (in so far as the principal objective relates to relevant contracts), the aim of avoiding overcompensation, the sustainability of the health insurance market and the aim of having fair and open competition in the health insurance market.

(iv) If the risk equalisation credits proposed by the Authority were given effect by a statutory provision, the amount of the stamp duty that the Authority considers, (after having regard to the aim of avoiding the Fund sustaining surpluses or deficits from year to year), would need to be paid, by registered undertakings in respect of the persons insured by them in order to meet the cost to the Fund of the proposed credits.

Legislating for the Credits and Stamp Duty

While the Authority makes recommendations to Minister in relation to Risk Equalsiation Credits and Community Rating Stamp Duty, the rates that apply are specified in legislation. The rates of the Risk Equalisation Credits are specified in Schedules to the Health Insurance Acts. The rates of the Community Rating Stamp Duty are specified in the Stamp Duties Consolidation Act.

After considering the Authority's Report, the Minister may decide to propose that the Oireachtas amend the credits specified in the Schedules to the Health Insurance Acts.

The Minister for Health may also make recommendations to the Minister for Finance relating to the rates of stamp duty that may apply. In making such recommendations, the Minister has regard to:

(i) The principal objective,
(ii) The Authority's Report on the evaluation and analysis of returns,
(iii) The aim of avoiding overcompensation,
(iv) The aim of maintaining the sustainability of the health insurance market,
(v) The aim of having fair and open competition in the health insurance market, and
(vi) The aim of avoiding the Risk Equalisation Fund sustaining surpluses or deficits from year to year.

The Minister will also take into account the amendments that he or she wishes to propose to the rates of the risk equalisation credits.

The rates of Risk Equalisation Credits and Community Rating Stamp Duty become law if enacted by the Oireachtas.

Cashflows

Section 125A of the Stamp Duties Consolidation Act 1999 deals with the payment of the Community Rating Stamp Duty by registered undertakings to the Revenue Commissioners. Stamp duty is payable for each quarterly accounting period in respect of relevant contracts renewed or entered into in that period. The due dates for payment are the 21st day of the second next month following the end of each accounting period. The Revenue Commissioners pay the amount collected in to the Risk Equalisation Fund. The Revenue Commissioners' procedures in relation to open membership undertakings paying stamp duty are set out in Appendix 2.

The Minister for Health may, for the purpose of maintaining a sufficient amount of money in the Risk Equalisation Fund, having regard to the sums payable from fund, request the Minister for Finance to advance moneys to a special account. The procedures in relation to the special account are set out in Section 11D (5) of the Health Insurance Act, 1994 – 2012 (as inserted by S. 15 of the Health Insurance (Amendment) Act 201).2

Registered undertakings make claims monthly from the Risk Equalisation Fund for the risk equalization credits that arise in that month. When the Authority receives a claim, it shall pay out of the fund the amount that it is satisfied is so payable.

The Health Insurance Authority procedures in relation to making interim claims are set out in Appendix 3.

10. Overcompensation

A registered undertaking is considered to be overcompensated by the Risk Equalisation Scheme if, over a three year period, it makes a surplus that exceeds a "reasonable profit" and it is a net beneficiary of the Risk Equalisation Scheme.

In making its recommendation to the Minister for Health on the level of Risk Equalisation credits to apply, the Authority must have regard to the need to avoid overcompensation. The Minister for Health must also have regard to the aim of avoiding overcompensation when making his or her recommendations to the Minister for Finance in relation to the level of stamp duty.

The Authority must also conduct ex-post analyses and if the Authority finds that a registered undertaking has been overcompensated by the Risk Equalisation Scheme, the amount of overcompensation must be repaid to the Risk Equalisation Fund.

Ex-post overcompensation analysis

Registered undertakings are required to provide the Authority with profit and loss accounts and balance sheets for its relevant health insurance business for each calendar year by 1 April of the following year. The Authority then:

- Determines what would constitute a reasonable profit for a registered undertaking in respect of its relevant health insurance business in the State in respect of each 3 year time period ending on 31 December of the year to which the accounts apply. The "reasonable profit" will be determined in accordance with the provisions of the European Union Framework for State Aid in the Form of Public Service Compensation (2011) (2012/C8/03), which is set out in Appendix 3..
- Determines whether the cumulative net financial impact of the Risk Equalization Scheme for each registered undertaking is positive for each 3 year period and its amount. Where the Interim Risk Equalisation System had an impact for part of this three year period, it will also be taken into account.
- If an undertaking is a net beneficiary of the Risk Equalisation Scheme, the Authority determines whether its profit is in excess of a reasonable profit and the amount of the excess, if applicable.
- If the Authority determines that the profit made is in excess of reasonable profit, it prepares a draft report on the monetary equivalent amount of the profit in excess of a reasonable profit and the cumulative amount of overcompensation to be paid to the Risk Equalisation Fund.
- The Authority furnishes a copy of the draft Report to the registered undertaking the subject of the Report, invites the undertaking to make representation in relation to the draft Report and take such representations into account before finalising the Report.
- The Authority then furnishes its final Report to the Minister for Health, who furnishes it to the registered undertaking.
- The undertaking pays within two months to the Risk Equalisation Fund the amount of the overcompensation set out in the Report.

Appendix 1 - Health credits and community rating stamp duty for policies renewing from 31 March 2013

Contract Type	Non-Advanced		Advanced	
Health Credits	**Male**	**Female**	**Male**	**Female**
60-64	€ 375	€ 250	€ 425	€ 275
65-69	€ 900	€ 650	€1,050	€ 775
70-74	€1,450	€ 975	€1,700	€1,150
75-79	€2,050	€1,550	€2,425	€1,800
80+	€2,850	€1,925	€3,375	€2,275

A hospital bed utilisation payment of €75 is paid in respect on each night spent in private or semi-private accommodation by an insured person.

Community Rating Stamp Duty	Non-Advanced	Advanced
Adult	€290	€350
Child	€100	€120

Interim System age related tax credits and community rating stamp duty amounts for renewals in 2009 to 2012

Tax Credits	2009	2010	2011	2012/ Q1 2013
50-59	€ 200	€200	Nil	Nil
60-64	€ 500	€ 525	€ 625	€ 600
65-69	€ 500	€ 525	€ 625	€ 975
70-74	€ 950	€ 975	€1,275	€1,400
75-79	€ 950	€ 975	€1,275	€2,025
80-84	€1,175	€1,250	€1,725	€2,400
85+	€1,175	€1,250	€1,725	€2,700

Community Rating stamp duty	2009	2010	2011	2012/ Q1 2013
Adult	€160	€185	€205	€285
Child	€ 53	€ 55	€ 66	€ 95

Appendix 2 - Revenue Commissioners Procedures in relation to open membership insurers paying stamp duty – May 2013

Health Insurance Levy
Section 125A of the Stamp Duties Consolidation Act 1999
(as amended by Finance Act 2013)

Guidelines for Insurers in relation to particular situations

Purpose:

The purpose of this document is to set out the guidelines for insurers to use in calculating the relevant stamp duty to pay to the Collector General.

Principle:

The principle underpinning the guidelines is that one levy is paid in any 12-month period for each insured person regardless of the number of health insurance contracts that person has entered into in the 12-month period. Thus in making a levy return to the Collector General, insurers may exclude from that return any person for which a levy has already been paid in the 12-month period in question.

A 12-month period is not necessarily a calendar year. A particular 12-month period commences when an insured person enters into or renews an insurance contract. So, for example, where a contract commences or is renewed on 1 January the 12-month period is the calendar year. However, where a contract commences or is renewed on (say) 1 July, the 12 month period is 1 July to the following 30 June.

Example Scenarios:

Example Number	Situation	Revenue Treatment
1.	An insured person renews or enters into an annual contract, then cancels it and enters into another contract with the same insurer in the same 12-month period- Is the levy payable for the second contract? For example, an insured person renews or takes out a policy for a period of 12 months on 1 January 2013. During the	The second contract entered into by the individual during the same 12-month period is considered a renegotiation of the terms of the first contract. Similarly, where a contract is entered into by an individual and a midterm adjustment occurs to that contract then the adjustment is also considered a renegotiation of the terms of the first contract. The levy is payable in the accounting

	course of the contract he or she cancels the contract and then enters into another replacement contract. (e.g. 1 July 2013)	period that the individual enters into the first contract. A second levy is not payable for the same individual for subsequent contracts entered into in the same 12-month period.
2	Are there a maximum number of contracts a member can enter during a 12-month period for the levy? For example person joins the first insurer on 1 January 2013, leaves and joins a second insurer on 1 March 2013, leaves the second insurer and re-joins the first insurer on 30 March 2013 on a new policy? How many times is the levy payable?	One levy is paid per person in a 12-month period. It is up to any subsequent insurer to ensure that satisfactory evidence is obtained from the insured person to show that the levy was paid by the first insurer in respect of the 12-month period in question.
3	What date is used to determine the age of the individual, to assess whether an adult or child levy rate is payable?	The age is determined on the 1st day of the accounting period.
4	If the contract is endorsed mid-term to change from advanced cover to non-advanced cover or from non-advanced cover to advanced cover, is a portion of levy repayable to the insurer or is an additional levy payable? Example 1: If a member enters into a contract for an advanced cover on 1 January and then switches to a non- advanced cover on 1 May, can a portion of the levy be reclaimed? Example 2: If a member enters into a contract for non-advanced cover on 1 January and then switches to advanced cover on 1 May, does an additional levy need to be paid?	No, in both examples. The status of the contract as "advanced cover" or "non- advanced" cover on the first day of the accounting period determines the rate of levy payable.
5	Where a member dies during the term of the contract is the levy payable for that member?	Yes

6	Does the adult levy apply to those 18 years and over, in full time education who are charged a lower student premium?	Yes
7	Is the levy payable if a premium is due but has not been paid by the insured person? E.g. if the contract is rendered void.	The levy need not be paid in circumstances where a contract of insurance is rendered void where no premium has been paid, where no TRS or risk equalisation credit is paid to the insurer from the Risk Equalisation Fund and where no benefit has been received by the insured person under the contract.
8	Is the levy payable in respect of newborns added to a policy who are free until the next renewal?	Where no premium is charged by the insurer for a newborn added to a policy of insurance during the year of birth, the levy is not payable in respect of that child for the period of that contract. A levy is payable in respect of the newborn when the policy is renewed.
9	Is the levy payable if there are no premiums due to the insurer because the insured person is an employee of the health insurer?	Yes
10	For risk equalisation credits that are claimed from the Risk Equalisation Fund, if a member lapses during the year, then a refund of credit must be made to Risk Equalisation Fund. In the case of the levy will the health insurer receive a refund of the levy?	No The legislation imposes a levy on an insurer at a point in time in respect of policies of insurance renewed or entered into during an accounting period. The legislation in relation to the levy makes no provision for a refund in the circumstances outlined.
11	In the exceptional circumstances where a member backdates their joining date to a previous accounting period, when is the levy payable? A member joins their Employer's Group Scheme, but	On the basis this happens in exceptional circumstances the member is included as an adjustment to the next quarterly return due. In this example, the adjustment required in respect of the Accounting Period 1 July 2013 to 30 September 2013 will be included in the Return for the period 01

	the Employer fails to notify the insurer. The insurer facilitates backdating of the health insurance policy so that the member does not have a break in cover. For example, the member joined the employer on 5 July 2013, but employer did not notify the insurer until 5 November 2013 in error. The insurer agrees to backdate the policy to 5 July 2013.	October 2013 to 31 December 2013, which must be submitted on or before 21 February 2014 A "Prior Accounting Period" adjustment facility is being added to the Return to enable such adjustments to be made. To enable reconciliation of such adjustments to prior accounting periods, the same information as required in the original return must be provided in relation to the adjustments being made.

Appendix 3 - Health Insurance Authority Procedures in relation to open membership insurers making interim RES claims

1. The Health Insurance Act 1994 (Risk Equalisation Scheme) Regulations 2013 (the "Regulations") requires The Health Insurance Authority (the "Authority") to establish procedures with undertakings in relation to the making of interim Risk Equalisation Scheme ("RES") claims

2. Section 11G of the Health Insurance Act 1994 (the "Principal Act") as inserted by section 15 of The Health Insurance (Amendment) Act 2012 provides for the Authority to specify the form of documents for the purposes of the RES

3. Prior to an undertaking making its first interim RES claim, it must:

   3.1 Give notice to the Authority in the specified form, the names and posts held by the persons who are authorised by the undertaking to make interim RES claims and annual RES returns on its behalf as required by section 3 (1) of the Regulations. The specified form is included in Annex I
   3.2 The nominated persons authorised should include the managing director or the chief executive officer or the secretary or a member of the Board of the undertaking or a person of similar status in relation to the undertaking
   3.3 The notice should be completed and signed in accordance with section 3 (2) of the Regulations
   3.4 Nominate a bank account held by the undertaking within the State into which interim RES claims are paid by providing the following details to the Authority:

Bank name	
Address	
Account Name	
Bank Sort Code	
Account Number	
IBAN	

4. Completion of interim RES claim form

   4.1 Each undertaking will complete an interim RES claim form in the specified form outlined in Annex II
   4.2 The registered undertaking name is the name of the undertaking as listed on The Register of Health Benefit Undertakings and specified on the undertaking's Certificate of Registration
   4.3 The registered undertaking address is the address as listed on The Register of Health Benefit Undertakings and specified on the undertaking's Certificate of Registration

4.4 The primary contact name and e-mail address is the name and e-mail address of the person(s) indicated by the undertaking that the Authority may contact in relation to information contained in the interim RES claim
4.5 The claim period is the period in respect of which an interim RES claim is made as outlined in section 2 of the Regulations
4.6 The risk equalisation credits in relation to an undertaking is defined in section 6A of the Principal Act as inserted by section 6 of The Health Insurance (Amendment) Act 2012
4.7 The risk equalisation credits in claim period should be net of any repayments due to the Risk Equalisation Fund
4.8 Any adjustment in respect of previously submitted interim RES claims should be explained in the box provided at the end of the claim form
4.9 The interim RES claim form must be signed by two persons authorised by the undertaking to make interim RES claims on its behalf, one of whom is the managing director or chief executive officer or secretary or member of the Board of the undertaking or a person of similar status in relation to the undertaking

5. Description of data required in respect of interim RES claim

5.1 Premium credit

5.1.1 There are 2 tables in this section for non-advanced cover and advanced cover with each table split by gender
5.1.2 The rows are classified by age category in accordance with schedule 4 of section 11C of the Principal Act as inserted by section 15 of The Health Insurance (Amendment) Act 2012
5.1.3 The column headings in each table for each gender type are:
a) Monthly: the amount of premium credit claimed in respect of premiums payable monthly in the claim period, by age category, gender and level of cover
b) Quarterly: the amount of premium credit claimed in respect of premiums payable quarterly in the claim period, by age category, gender and level of cover
c) Annually: the amount of premium credit claimed in respect of premiums payable annually in the claim period, by age category, gender and level of cover
d) Other: the amount of premium credit claimed in respect of premiums payable in the claim period other than premiums payable monthly, quarterly or annually, by age category, gender and level of cover
e) Premium credit: such part of the premium payable (or, if that premium is payable by instalments, pro rata from the instalments) not collected from policyholders in the claim period in accordance with section 11C of the Principal Act as inserted by section 15 of The Health Insurance (Amendment) Act 2012
5.1.4 The total premium credit is the total of the premium credit figures in e) above
5.1.5 Premium credit figures should be rounded to the nearest whole number
5.1.6 As the first interim RES claim period runs from 1 January 2013 to 30 March 2013, separate tables (non-advanced cover and advanced cover) for January, February and period 1 March 2013 to 30 March 2013 are required
5.1.7 As different risk equalisation credits apply for contracts commencing on and after 31 March 2013, separate tables (non-advanced cover and advanced

cover) are required for period 1 January 2013 to 30 March 2013 and for periods thereafter

5.1.8 The data required in respect of interim RES claim for period 31 March 2013 to 30 April 2013 will include;

a) tables (non-advanced cover and advanced cover) for contracts commencing between 1 January 2013 to 30 March 2013

b) tables (non-advanced cover and advanced cover) for contracts commencing between 31 March 2013 to 30 April 2013

5.2 Hospital Bed Utilisation Credit (HBUC)

5.2.1 The HBUC table details the total number of nights insured persons stayed in private hospital accommodation for which HBUC is claimed

5.2.2 Private hospital means private hospital in the State

5.2.3 The table is split by calendar month commencing April 2013. Hospital accommodation on 31 March 2013 should be included in April 2013

5.2.4 The HBUC is claimed in respect of private hospital accommodation by insured persons under health insurance contracts commencing on or after 31 March 2013. No HBUC is payable in respect of insurance contracts commencing in period 1 January 2013 to 30 March 2013

5.2.5 The relevant amount in relation to HBUC is defined in section 6A of the Principal Act as inserted by section 6 of The Health Insurance (Amendment) Act 2012

6. Submission of interim RES claim

6.1 Completed interim RES claims should be submitted by e-mail to the following e-mail address:
resclaimform@hia.ie

6.2 File attachments should be password protected with password details submitted by separate mail

6.3 An original signed copy of the interim RES claim should be sent to the Authority by registered post

6.4 Interim RES claims cannot be submitted to the Authority before the first day of the month immediately following the period to which the interim RES claim relates and not later than the 21st day of that month

7. Queries on the completion of interim RES claims should be addressed to:
colmfarrell@hia.ie tel. 01-4988041
michealobriain@hia.ie tel. 01-4988052

Annex I – Notice to the Authority of the names and posts held by the persons who are authorised by the undertaking to make RES claims and annual RES returns on its behalf

I/We hereby give notice to The Health Insurance Authority of the following names and posts held by persons who are authorised by (insert undertaking name) to make RES claims and annual RES returns on its behalf.

Name	**Position Held**	**Signature**

……. ……..
Secretary Date

Annex II - Interim RES Claim Form in Respect of Risk Equalisation Credits

Registered Undertaking Name	
Registered Undertaking Address	
Name of Primary Contact	
E-mail address of Primary Contact	
Claim Period	to

A. Risk equalisation credits in claim period **(net of any repayments due to Risk Equalisation Fund)**	€
B. Adjustment in respect of previous interim RES claims **(Please provide explanation for adjustment at end of form)**	€
C. Interim RES claim amount **(A plus or minus B whichever is applicable)**	€

We, as nominated authorised individuals, declare to the best of our knowledge and belief, having made due and careful enquiry, that the information contained in this interim RES claim is true and correct. Appropriately detailed supporting information is retained and is readily available for inspection in respect of this claim.

……..	**……..**
Authorised signatory	**Date**
……..	**……..**
Authorised signatory	**Date**

Registered Undertaking Name

Data required in respect of interim RES claim

A. Premium credit

Period to

Age category	Non-advanced cover - Male					Non-advanced cover - Female					Total premium credit
	Monthly	Quarterly	Annually	Other	Premium credit	Monthly	Quarterly	Annually	Other	Premium credit	
	€	€	€	€	€	€	€	€	€	€	€
60-64											
65-69											
70-74											
75-79											
80-84											
85+											
Sub-Total											

Age category	Advanced cover - Male					Advanced cover - Female					Total premium credit
	Monthly	Quarterly	Annually	Other	Premium credit	Monthly	Quarterly	Annually	Other	Premium credit	
	€	€	€	€	€	€	€	€	€	€	€
60-64											
65-69											
70-74											
75-79											
80-84											
85+											
Sub-Total											

Total A											

Registered Undertaking Name	

B. Hospital bed utilisation credit

Number of nights insured persons stayed in private hospital accommodation for which hospital bed utilisation credit is claimed									
April 2013	**May 2013**	**June 2013**	**July 2013**	**August 2013**	**September 2013**	**October 2013**	**November 2013**	**December 2013**	**Total 2013**
Relevant amount payable in respect of hospital stay (Total B)									**€**

Risk equalisation credits in claim period (Total A + Total B)	**€**

Adjustment in respect of previous interim RES claims

Appendix 4 – European Union Framework for State Aid in the form of Public Service Compensation (2011) (2012/C8/03)

(Text with EEA relevance)

2012/C 8/03

1. PURPOSE AND SCOPE

1. For certain services of general economic interest (SGEIs) to operate on the basis of principles and under conditions that enable them to fulfil their missions, financial support from the public authorities may prove necessary where revenues accruing from the provision of the service do not allow the costs resulting from the public service obligation to be covered.

2. It follows from the case-law of the Court of Justice of the European Union [1] that public service compensation does not constitute State aid within the meaning of Article 107(1) of the Treaty on the Functioning of the European Union if it fulfils a certain number of conditions [2]. Where those conditions are met, Article 108 of the Treaty does not apply.

3. Where public service compensation does not meet those conditions, and to the extent the general criteria for the applicability of Article 107(1) of the Treaty are satisfied, such compensation constitutes State aid and is subject to Articles 106, 107 and 108 of the Treaty.

4. In its Communication on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest [3], the Commission has clarified the conditions under which public service compensation is to be regarded as State aid. Furthermore, in its Commission Regulation on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid granted to undertakings providing services of general economic interest [4], the Commission will set out the conditions under which small amounts of public service compensation should be deemed not to affect trade between Member States and/or not to distort or threaten to distort competition. In those circumstances, compensation is not caught by Article 107(1) of the Treaty and consequently does not fall under the notification procedure provided for in Article 108(3) of the Treaty.

5. Article 106(2) of the Treaty provides the legal basis for assessing the compatibility of State aid for SGEIs. It states that undertakings entrusted with the operation of SGEIs or having the character of a revenue-producing monopoly are subject to the rules contained in the Treaty, in particular to the rules on competition. However, Article 106(2) of the Treaty provides for an exception from the rules contained in the Treaty insofar as the application of the competition rules would obstruct, in law or in fact, the performance of the tasks assigned. This exception only applies where the development of trade is not affected to such an extent as would be contrary to the interests of the Union.

6. Commission Decision 2012/21/EU [5] on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of

general economic interest [6] lays down the conditions under which certain types of public service compensation are to be regarded as compatible with the internal market pursuant to Article 106(2) of the Treaty and exempt from the requirement of prior notification under Article 108(3) of the Treaty.

7. The principles set out in this Communication apply to public service compensation only in so far as it constitutes State aid not covered by Decision 2012/21/EU. Such compensation is subject to the prior notification requirement under Article 108(3) of the Treaty. This Communication spells out the conditions under which such State aid can be found compatible with the internal market pursuant to Article 106(2) of the Treaty. It replaces the Community framework for State aid in the form of public service compensation [7].

8. The principles set out in this Communication apply to public service compensation in the field of air and maritime transport, without prejudice to stricter specific provisions contained in sectoral Union legislation. They apply neither to the land transport sector, nor to the public service broadcasting sector, which is covered by the Communication from the Commission on the application of State aid rules to public service broadcasting [8].

9. Aid for providers of SGEIs in difficulty will be assessed under the Community guidelines on State aid for rescuing and restructuring firms in difficulty [9].

10. The principles set out in this Communication apply without prejudice to:

(*a*) requirements imposed by Union law in the field of competition (in particular Articles 101 and 102 of the Treaty);

(*b*) requirements imposed by Union law in the field of public procurement;

(*c*) the provisions of the Commission Directive 2006/111/EC of 16 November 2006 on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings [10];

(*d*) additional requirements flowing from the Treaty or from sectoral Union legislation.

2. CONDITIONS GOVERNING THE COMPATIBILITY OF PUBLIC SERVICE COMPENSATION THAT CONSTITUTES STATE AID

2.1. General provisions

11. At the current stage of development of the internal market, State aid falling outside the scope of Decision 2012/21/EU may be declared compatible with Article 106(2) of the Treaty 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. The conditions set out in sections 2.2 to 2.10 must be met in order to achieve that balance.

2.2. Genuine service of general economic interest as referred to in Article 106 of the Treaty

12. The aid must be granted for a genuine and correctly defined service of general economic interest as referred to in Article 106(2) of the Treaty.

13. In its Communication on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest, the Commission has provided guidance on the requirements concerning the definition of a service of general economic interest. In particular, Member States cannot attach specific

public service obligations to services that are already provided or can be provided satisfactorily and under conditions, such as price, objective quality characteristics, continuity and access to the service, consistent with the public interest, as defined by the State, by undertakings operating under normal market conditions. As for the question of whether a service can be provided by the market, the Commission's assessment is limited to checking whether the Member State's definition is vitiated by a manifest error, unless provisions of Union law provide a stricter standard.

14. For the scope of application of the principles set out in this Communication, Member States should show that they have given proper consideration to the public service needs supported by way of a public consultation or other appropriate instruments to take the interests of users and providers into account. This does not apply where it is clear that a new consultation will not bring any significant added value to a recent consultation.

2.3. Need for an entrustment act specifying the public service obligations and the methods of calculating compensation

15. Responsibility for the operation of the SGEI must be entrusted to the undertaking concerned by way of one or more acts, the form of which may be determined by each Member State. The term "Member State" covers the central, regional and local authorities.

16. The act or acts must include, in particular:

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

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

(*c*) the nature of any exclusive or special rights assigned to the undertaking by the granting authority;

(*d*) the description of the compensation mechanism and the parameters for calculating, monitoring and reviewing the compensation; and

(*e*) the arrangements for avoiding and recovering any overcompensation.

2.4. Duration of the period of entrustment

17. The duration of the period of entrustment should be justified by reference to objective criteria such as the need to amortise non-transferable fixed assets. In principle, the duration of the period of entrustment should not exceed the period required for the depreciation of the most significant assets required to provide the SGEI.

2.5. Compliance with the Directive 2006/111/EC

18. Aid will be considered compatible with the internal market on the basis of Article 106(2) of the Treaty only where the undertaking complies, where applicable, with Directive 2006/111/EC [11]. Aid that does not comply with that Directive is considered to affect the development of trade to an extent that would be contrary to the interest of the Union within the meaning of Article 106(2) of the Treaty.

2.6. Compliance with Union public procurement rules

19. Aid will be considered compatible with the internal market on the basis of Article 106(2) of the Treaty only where the responsible authority, when entrusting the provision of the service to the undertaking in question, has complied or commits to comply with the

applicable Union rules in the area of public procurement. This includes any requirements of transparency, equal treatment and non-discrimination resulting directly from the Treaty and, where applicable, secondary Union law. Aid that does not comply with such rules and requirements is considered to affect the development of trade to an extent that would be contrary to the interests of the Union within the meaning of Article 106(2) of the Treaty.

2.7. Absence of discrimination

20. Where an authority assigns the provision of the same SGEI to several undertakings, the compensation should be calculated on the basis of the same method in respect of each undertaking.

2.8. Amount of compensation

21. The amount of compensation must not exceed what is necessary to cover the net cost [12] of discharging the public service obligations, including a reasonable profit.

22. The amount of compensation can be established on the basis of either the expected costs and revenues, or the costs and revenues actually incurred, or a combination of the two, depending on the efficiency incentives that the Member State wishes to provide from the outset, in accordance with paragraphs 40 and 41.

23. Where the compensation is based, in whole or in part, on expected costs and revenues, they must be specified in the entrustment act. They must be based on plausible and observable parameters concerning the economic environment in which the SGEI is being provided. They must rely, where appropriate, on the expertise of sector regulators or of other entities independent from the undertaking. Member States must indicate the sources on which these expectations are based [13]. The cost estimation must reflect the expectations of efficiency gains achieved by the SGEI provider over the lifetime of the entrustment.

Net cost necessary to discharge the public service obligations

24. The net cost necessary, or expected to be necessary, to discharge the public service obligations should be calculated using the net avoided cost methodology where this is required by Union or national legislation and in other cases where this is possible.

Net avoided cost methodology

25. Under the net avoided cost methodology, the net cost necessary, or expected to be 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. Due attention must be given to correctly assessing the costs that the service provider is expected to avoid and the revenues it is expected not to receive, in the absence of the public service obligation. The net cost calculation should assess the benefits, including intangible benefits as far as possible, to the SGEI provider.

26. Annex IV to Directive 2002/22/EC of the European Parliament and of the Council of 7 March 2002 on universal service and users' rights relating to electronic communications networks and services [14], and Annex I to Directive 97/67/EC of the European Parliament and of the Council of 15 December 1997 on common rules for the development of the internal market of Community postal services and the improvement of quality of service [15], contain more detailed guidance on how to apply the net avoided cost methodology.

27. Although the Commission regards the net avoided cost methodology as the most accurate method for determining the cost of a public service obligation, there may be cases where the use of that methodology is not feasible or appropriate. In such cases, where duly justified, the Commission can accept alternative methods for calculating the net cost necessary to discharge the public service obligations, such as the methodology based on cost allocation.

Methodology based on cost allocation

28. Under the cost allocation methodology, the net cost necessary to discharge the public service obligations can be calculated as the difference between the costs and the revenues for a designated provider of fulfilling the public service obligations, as specified and estimated in the entrustment act.

29. The costs to be taken into consideration include all the costs necessary to operate the SGEI.

30. Where the activities of the undertaking in question are confined to the SGEI, all its costs may be taken into consideration.

31. Where the undertaking also carries out activities falling outside the scope of the SGEI, the costs to be taken into consideration may cover all the direct costs necessary to discharge the public service obligations and an appropriate contribution to the indirect costs common to both the SGEI and other activities. The costs linked to any activities outside the scope of the SGEI must include all the direct costs and an appropriate contribution to the common costs. To determine the appropriate contribution to the common costs, market prices for the use of the resources, where available, can be taken as a benchmark [16]. In the absence of such market prices, the appropriate contribution to the common costs can be determined by reference to the level of reasonable profit [17] the undertaking is expected to make on the activities falling outside the scope of the SGEI or by other methodologies where more appropriate.

Revenue

32. The revenue to be taken into account must include at least the entire revenue earned from the SGEI, as specified in the entrustment act, and the excessive profits generated from special or exclusive rights even if linked to other activities as provided in paragraph 45, regardless of whether those excessive profits are classified as State aid within the meaning of Article 107(1) of the Treaty.

Reasonable profit

33. Reasonable profit should be taken to mean the rate of return on capital [18] that would be required by a typical company considering whether or not to provide the service of general economic interest for the whole duration of the entrustment act, taking into account the level of risk. The level of risk depends on the sector concerned, the type of service and the characteristics of the compensation mechanism.

34. Where duly justified, profit level indicators other than the rate of return on capital can be used to determine what the reasonable profit should be, such as the average return on equity [19] over the entrustment period, the return on capital employed, the return on assets or the return on sales.

35. Whatever indicator is chosen, the Member State must provide the Commission with evidence that the projected profit does not exceed what would be required by a typical company considering whether or not to provide the service, for instance by providing references to returns achieved on similar types of contracts awarded under competitive conditions.

36. A rate of return on capital that does not exceed the relevant swap rate [20] plus a premium of 100 basis points [21] is regarded as reasonable in any event. The relevant swap rate is the swap rate whose maturity and currency correspond to the duration and currency of the entrustment act.

37. Where the provision of the SGEI is connected with a substantial commercial or contractual risk, for instance because the compensation takes the form of a fixed lump sum payment covering expected net costs and a reasonable profit and the undertaking operates in a competitive environment, the reasonable profit may not exceed the level that corresponds to a rate of return on capital that is commensurate with the level of risk. That rate should be determined where possible by reference to the rate of return on capital that is achieved on similar types of public service contracts awarded under competitive conditions (for example, contracts awarded under a tender). Where it is not possible to apply that method, other methods for establishing a return on capital may also be used, upon justification [22].

38. Where the provision of the SGEI is not connected with a substantial commercial or contractual risk, for instance because the net cost incurred in providing the service of general economic interest is essentially compensated ex post in full, the reasonable profit may not exceed the level that corresponds to the level specified in paragraph 36. Such a compensation mechanism provides no efficiency incentives for the public service provider. Hence its use is strictly limited to cases where the Member State is able to justify that it is not feasible or appropriate to take into account productive efficiency and to have a contract design which gives incentives to achieve efficiency gains.

Efficiency incentives

39. In devising the method of compensation, Member States must introduce incentives for the efficient provision of SGEI of a high standard, unless they can duly justify that it is not feasible or appropriate to do so.

40. Efficiency incentives can be designed in different ways to best suit the specificity of each case or sector. For instance, Member States can define upfront a fixed compensation level which anticipates and incorporates the efficiency gains that the undertaking can be expected to make over the lifetime of the entrustment act.

41. Alternatively, Member States can define productive efficiency targets in the entrustment act whereby the level of compensation is made dependent upon the extent to which the targets have been met. If the undertaking does not meet the objectives, the compensation should be reduced following a calculation method specified in the entrustment act. In contrast, if the undertaking exceeds the objectives, the compensation should be increased following a method specified in the entrustment act. Rewards linked to productive efficiency gains are to be set at a level such as to allow balanced sharing of those gains between the undertaking and the Member State and/or the users.

42. Any such mechanism for incentivising efficiency improvements must be based on objective and measurable criteria set out in the entrustment act and subject to transparent ex

post assessment carried out by an entity independent from the SGEI provider.

43. Efficiency gains should be achieved without prejudice to the quality of the service provided and should meet the standards laid down in Union legislation.

Provisions applicable to undertakings also carrying out activities outside the scope of the SGEI or providing several SGEIs

44. Where an undertaking carries out activities falling both inside and outside the scope of the SGEI, the internal accounts must show separately the costs and revenues associated with the SGEI and those of the other services in line with the principles set out in paragraph 31. Where an undertaking is entrusted with the operation of several SGEIs because the granting authority or the nature of the SGEI is different, the undertaking's internal accounts must make it possible to verify whether there has been any overcompensation at the level of each SGEI.

45. If the undertaking in question holds special or exclusive rights linked to activities, other than the SGEI for which aid is granted, that generate profits in excess of the reasonable profit, or benefits from other advantages granted by the State, these must be taken into consideration, irrespective of their classification for the purposes of Article 107(1) of the Treaty, and added to the undertaking's revenue. The reasonable profit on the activities for which the undertaking holds special or exclusive rights has to be assessed from an ex ante perspective, in the light of the risk, or the absence of risk, incurred by the undertaking in question. That assessment also has to take into account the efficiency incentives that the Member State has introduced in relation to the provision of the services in question.

46. The Member State may decide that the profits accruing from other activities outside the scope of the SGEI, in particular those activities which rely on the infrastructure necessary to provide the SGEI, must be allocated in whole or in part to the financing of the SGEI.

Overcompensation

47. Overcompensation should be understood as compensation that the undertaking receives in excess of the amount of aid as defined in paragraph 21 for the whole duration of the contract. As stated in paragraphs 39 to 42, a surplus that results from higher than expected efficiency gains may be retained by the undertaking as additional reasonable profit as specified in the entrustment act [23].

48. Since overcompensation is not necessary for the operation of the SGEI, it constitutes incompatible State aid.

49. Member States must ensure that the compensation granted for operating the SGEI meets the requirements set out in this Communication and in particular that undertakings are not receiving compensation in excess of the amount determined in accordance with this the requirements set out in this section. They must provide evidence upon request from the Commission. They must carry out regular checks, or ensure that such checks are carried out, at the end of the period of entrustment and, in any event, at intervals of not more than three years. For aid granted by means other than a public procurement procedure with publication [24], checks should normally be made at least every two years.

50. Where the Member State has defined upfront a fixed compensation level which adequately anticipates and incorporates the efficiency gains that the public service provider can be expected to make over the period of entrustment, on the basis of a correct allocation

of costs and revenues and of reasonable expectations as described in this section, the overcompensation check is in principle confined to verifying that the level of profit to which the provider is entitled in accordance with the entrustment act is indeed reasonable from an ex ante perspective.

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

51. The requirements set out in sections 2.1 to 2.8 are usually sufficient to ensure that aid does not distort competition in a way that is contrary to the interests of the Union.

52. It is conceivable, however, that in some exceptional circumstances, serious competition distortions in the internal market could remain unaddressed and the aid could affect trade to such an extent as would be contrary to the interest of the Union.

53. In such a case, the Commission will examine whether such distortions can be mitigated by requiring conditions or requesting commitments from the Member State.

54. Serious competition distortions such as to be contrary to the interests of the Union are only expected to occur in exceptional circumstances. The Commission will restrict its attention to those distortions where the aid has significant adverse effects on other Member States and the functioning of the internal market, for example, because they deny undertakings in important sectors of the economy the possibility to achieve the scale of operations necessary to operate efficiently.

55. Such distortions may arise, for instance, where the entrustment either has a duration which cannot be justified by reference to objective criteria (such as the need to amortise non-transferable fixed assets) or bundles a series of tasks (typically subject to separate entrustments with no loss of social benefit and no additional costs in terms of efficiency and effectiveness in the provision of the services). In such a case, the Commission would examine whether the same public service could equally well be provided in a less distortive manner, for instance by way of a more limited entrustment in terms of duration or scope or through separate entrustments.

56. Another situation in which a more detailed assessment may be necessary is where the Member State entrusts a public service provider, without a competitive selection procedure, with the task of providing an SGEI in a non-reserved market where very similar services are already being provided or can be expected to be provided in the near future in the absence of the SGEI. Those adverse effects on the development of trade may be more pronounced where the SGEI is to be offered at a tariff below the costs of any actual or potential provider, so as to cause market foreclosure. The Commission, while fully respecting the Member State's wide margin of discretion to define the SGEI, may therefore require amendments, for instance in the allocation of the aid, where it can reasonably show that it would be possible to provide the same SGEI at equivalent conditions for the users, in a less distortive manner and at lower cost for the State.

57. Closer scrutiny is also warranted where the entrustment of the service obligation is connected with special or exclusive rights that seriously restrict competition in the internal market to an extent contrary to the interest of the Union. While the primary route for apprehending such a case remains Article 106(1) of the Treaty, the State aid may not be deemed compatible where the exclusive right provides for advantages that could not be properly assessed, quantified or apprehended according to the methodologies to calculate the net costs of the SGEI described in section 2.8.

58. The Commission will also pay attention to situations where the aid allows the undertaking to finance the creation or use of an infrastructure that is not replicable and enables it to foreclose the market where the SGEI is provided or related relevant markets. Where this is the case, it may be appropriate to require that competitors are given fair and non-discriminatory access to the infrastructure under appropriate conditions.

59. If distortions of competition are a consequence of the entrustment hindering effective implementation or enforcement of Union legislation aimed at safeguarding the proper functioning of the internal market, the Commission will examine whether the public service could equally well be provided in a less distortive manner, for instance by fully implementing the sectoral Union legislation.

2.10. Transparency

60. For each SGEI compensation falling within the scope of this Communication, the Member State concerned must publish the following information on the internet or by other appropriate means:

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

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

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

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

2.11. Aid which meets the conditions laid down in Article 2(1) of Decision 2012/21/EU

61. The principles set out in paragraphs 14, 19, 20, 24, 39, 51 to 59 and 60(*a*) do not apply to aid which meets the conditions laid down in Article 2(1) of Decision 2012/21/EU.

3. REPORTING AND EVALUATION

62. Member States shall report to the Commission on the compliance with this Communication every two years. The reports must provide an overview of the application of this Communication to the different sectors of service providers, including:

(*a*) a description of the application of the principles set out in this Communication to the services falling within its scope, including in-house activities;

(*b*) the total amount of aid granted to undertakings falling within the scope of this Communication with a breakdown by the economic sector of the beneficiaries;

(*c*) an indication of whether, for a particular type of service, the application of the principles set out in this Communication has given rise to difficulties or complaints by third parties; and

(*d*) any other information concerning the application of the principles set out in this Communication required by the Commission and to be specified in due time before the report is to be submitted.

The first report shall be submitted by 30 June 2014.

63. In addition, in accordance with the requirements 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 [25] (now Article 108 of the Treaty) and Commission Regulation (EC) No 794/2004 of 21 April 2004 implementing Council Regulation (EC) No 659/1999 laying down detailed rules for the application of Article 93 of the EC Treaty [26], Member States must submit annual reports to the Commission on the aid granted following a decision of the Commission based on this Communication.

64. The reports will be published on the internet site of the Commission.

65. The Commission intends to carry out a review of this Communication by 31 January 2017.

4. CONDITIONS AND OBLIGATIONS ATTACHED TO COMMISSION DECISIONS

66. Pursuant to Article 7(4) of Regulation (EC) No 659/1999, the Commission may attach to a positive decision conditions subject to which aid may be considered compatible with the internal market, and lay down obligations to enable compliance with the decision to be monitored. In the field of SGEI, conditions and obligations may be necessary in particular to ensure that aid granted to the undertakings concerned does not lead to undue distortions of competition and trade in the internal market. In this context, periodic reports or other obligations may be necessary, in the light of the specific situation of each service of general economic interest.

5. APPLICATION

67. The Commission will apply the provisions of this Communication from 31 January 2012.

68. The Commission will apply the principles set out in this Communication to all aid projects notified to it and will take a decision on those projects in accordance with those principles, even if the projects were notified prior to 31 January 2012.

69. The Commission will apply the principles set out in this Communication to unlawful aid on which it takes a decision after 31 January 2012 even if the aid was granted before this date. However, where the aid was granted before 31 January 2012, the principles set out in paragraphs 14, 19, 20, 24, 39 and 60 do not apply.

6. APPROPRIATE MEASURES

70. The Commission proposes as appropriate measures for the purposes of Article 108(1) of the Treaty that Member States publish the list of existing aid schemes regarding public service compensation which have to be brought into line with this Communication by 31 January 2013, and that they bring those aid schemes into line with this Communication by 31 January 2014.

71. Member States should confirm to the Commission by 29 February 2012 that they agree to the appropriate measures proposed. In the absence of any reply, the Commission will take it that the Member State concerned does not agree.

[1] Judgments in Case C-280/00 Altmark Trans GmbH and Regierungspräsidium Magdeburgv Nahverkehrsgesellschaft Altmark GmbH (“Altmark”) [2003] ECR I-7747 and Joined Cases C-34/01 to C-38/01 Enirisorse SpA v Ministero delle Finanze [2003] ECR I-14243.

[2] In its judgment in Altmark, the Court of Justice held that public service compensation does not constitute State aid if four cumulative criteria are met. First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined. Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner. Third, the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit. Finally, 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 with the relevant means, would have incurred.

[3] See page 23 of this Official Journal.

[4] See page 4 of this Official Journal.

[5] OJ L 7, 11.1.2012, p. 3.

[6] OJ L 7, 11.1.2012.

[7] OJ C 297, 29.11.2005, p. 4.

[8] OJ C 257, 27.10.2009, p. 1.

[9] OJ C 244, 1.10.2004, p. 2.

[10] OJ L 318, 17.11.2006, p. 17.

[11] Directive 2006/111/EC on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings.

[12] In this context, net cost means net cost as determined in paragraph 25 or costs minus revenues where the net avoided cost methodology cannot be applied.

[13] Public sources of information, cost levels incurred by the SGEI provider in the past, cost levels of competitors, business plans, industry reports, etc.

[14] OJ L 108, 24.4.2002, p. 51.

[15] OJ L 15, 21.1.1998, p. 14.

[16] In Chronopost (Joined Cases C-83/01 P, C-93/01 P and C-94/01 P Chronopost SA [2003] ECR I-6993), the European Court of Justice referred to “normal market conditions”: “In the absence of any possibility of comparing the situation of La Poste with that of a private group of undertakings not operating in a reserved sector, “normal market conditions”, which are necessarily hypothetical, must be assessed by reference to the objective and verifiable elements which are available”.

[17] The reasonable profit will be assessed from an ex ante perspective (based on expected profits rather than on realised profits) in order not to remove the incentives for the undertaking to make efficiency gains when operating activities outside the SGEI.

[18] The rate of return on capital is defined here as the Internal Rate of Return (IRR) that the company makes on its invested capital over the lifetime of the project, that is to say the IRR on the cash flows of the contract.

[19] In any given year the accounting measure return on equity (ROE) is defined as the ratio between earnings before interests and taxes (EBIT) and equity capital in that year. The average annual return should be computed over the lifetime of the entrustment by applying as discount factor either the company's cost of capital or the rate set by the Commission Reference rate Communication, whatever more appropriate.

[20] The swap rate is the longer maturity equivalent to the Inter-Bank Offered Rate (IBOR rate). It is used in the financial markets as a benchmark rate for establishing the funding rate.

[21] The premium of 100 basis points serves, inter alia, to compensate for liquidity risk related to the fact that an SGEI provider that invests capital in an SGEI contract commits that capital for the duration of the entrustment act and will be unable to sell its stake as rapidly and at as low a cost as is the case with a widely held and liquid risk-free asset.

[22] For instance, by comparing the return with the weighted average cost of capital (WACC) of the company in relation to the activity in question, or with the average return on capital for the sector in recent years, taking into account whether historical data can be appropriate for forward-looking purposes.

[23] Similarly, a deficit which results from efficiency gains lower than expected should be partially borne by the undertaking when stipulated in the entrustment act.

[24] Such as aid granted in relation to in-house contracts, concessions with no competitive allocation, public procurement procedures with no prior publication.

[25] OJ L 83, 27.3.1999, p. 1.

[26] OJ L 140, 30.4.2004, p. 1.