EUROPEAN COMMISSION

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**SENSITIVE**[*]: *COMP Operations*

**Subject:** **State Aid SA.64337 (2022/N) – Ireland**
**Risk Equalisation Scheme 2022**

Excellency,

## 1. PROCEDURE

(1) On 2 July 2019, pre-notification contacts started between the Commission and the Irish authorities in respect of the envisaged prolongation and amendment of a risk equalisation scheme ('RES') on the private medical insurance ('PMI') market. The RES mechanism provides for a compensation mechanism allowing better risk sharing between insurers relating to health insurance and promoting intergenerational solidarity in this sector in Ireland.

(2) The RES was introduced in 2016 ('RES 2016') following a decision by the Commission that the compensation granted through the RES 2016 constituted State aid that is compatible with the internal market ('the 2016 Decision').[1] The RES 2016 was approved for the period 1 January 2016 until 31 December 2020.

(3) On 2 October 2020, as a result of the uncertainty caused by the COVID-19 pandemic, Ireland decided to notify a prolongation of the RES 2016 until 31

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[1] Commission Decision C(2016) 380 final of 29 January 2016 in case SA.41702 (2016/NN) – Ireland, Risk Equalisation Scheme, OJ C 104, 18.3.2016, p. 1.

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March 2022 and put the pre-notified amendments on hold. On 14 December 2020, the Commission concluded that the notified prolongation was compatible with the internal market under Article 106(2) TFEU[2].

(4) On 29 July 2021, new pre-notification contacts were established between the Commission and the Irish authorities in respect of a further extension of the RES 2016, with amendments, from 1 April 2022 until 31 March 2027. The main pre-notified amendment was the creation of a High Cost Claims Pool ("HCCP"), see Section 2.5.2.

(5) On 20 January 2022, the pre-notification was turned into a notification. Ireland complemented its notification with submissions on 11 March 2022 and 29 March 2022.

(6) In parallel, already in the context of the pre-notification exchanges that started in 2019 (recital (1)), the Commission services received informal submissions from three insurers active on the Irish PMI market: Irish Life Health ('ILH') (submissions of 9 April 2020[3], 15 May 2020, 12 March 2021, 19 July 2021[4], 19 October 2021 and 16 December 2021[5]), Laya Healthcare ('Laya') (submission of 15 May 2020) and Vhi Insurance DAC ('Vhi') (submissions of 17 May 2020, 6 December 2021 and 17 March 2022).

(7) The Commission received comments from the Irish authorities on the different issues raised in the submissions from the insurers on 24 April 2020[6], 29 July 2021 (reply to insurer's submissions from May 2020, submitted as part of the start of the pre-notification contacts), 12 November 2021 (reply to ILH's submission from July and October 2021) and 20 January 2022 (reply to Vhi's submission of 6 December 2021).

(8) Ireland exceptionally agrees to waive its rights deriving from Article 342 of the Treaty on the Functioning of the European Union ("TFEU"), in conjunction with Article 3 of Regulation 1/1958[7] and to have this Decision adopted and notified in English.

## 2. DESCRIPTION OF THE MEASURE

### 2.1. The Irish health insurance market

(9) As set out at recitals (5) to (7) of the 2016 Decision, the Irish health system is characterised by a mix of public and privately funded health services. The public health system is governed by the Health Act 1970 as amended. The public health

[2] Commission Decision C(2020) 8730 final of 14 December 2020 in case SA.58851(2020/N) – Ireland, Prolongation of the Risk Equalisation Scheme, OJ C 17, 15.1.2021, p. 1.

[3] Submission addressed to the Irish authorities but the Commission was in cc of the correspondence.

[4] ILH attached again its submissions of 9 April 2020 and 12 March 2021. It also attached a submission it sent to the Irish authorities on 7 January 2021.

[5] Following a meeting held on 10 December 2021.

[6] This concerns a reply to ILH's submission of 9 April 2020.

[7] Regulation No 1 determining the languages to be used by the European Economic Community, OJ 17, 6.10.1958, p. 385.

system is administered by the Health Service Executive ('HSE'), and is financed by taxation.

(10) A large proportion of the Irish population is entitled to free medical services. Individuals whose income is below a certain threshold are entitled to a "medical card." This entitles the holder to prescription drugs (subject to small payment) and free access to public hospital services and to general practitioners. Medical card holders account for approximately 32% of the population.[8] Other individuals may not be entitled to a "medical card" because their income exceeds the threshold, but they may be entitled to a "GP visit card" which entitles them to free access to a general practitioner. GP visit card holders account for approximately 10.8% of the population. [9]

(11) Persons who have neither medical cards nor GP visit cards are entitled to use public hospital services, subject to paying out-of-pocket for some expenses.

(12) In addition to the public health system, Ireland also has a strong PMI market. This operates on a voluntary basis – customers are not obliged to take out any form of health insurance.

(13) As noted at recital (7) to the 2016 Decision, PMI fulfils two roles in Ireland. First, it is a complement to the public health system – holders of PMI can obtain reimbursement for charges levied by the public health system (e.g. for private patient treatment in public hospitals). Second, it is a supplement to the public health system – holders of PMI can avail, for example, of private hospitals.

(14) Following the 2016 Decision, the Irish PMI market continued to develop[10]. The relevant market developments are outlined in Section 2.3.

### 2.2. Public service obligations

(15) The public service obligations for PMI providers in Ireland are set out in the Health Insurance Act 1994 (as amended, hereinafter "the Act")[11], which defines the health insurance policy objective of the Irish State: "*The principal objective of this Act is to ensure that, in the interests of the common good and across the health insurance market, access to health insurance cover is available to consumers of health services with no differentiation made between them (whether effected by risk equalisation credits or stamp duty measures or other measures, or any combination thereof), in particular as regards the costs of health services, based in whole or in part on the health risk status, age or sex of, or frequency of provision of health services to, any such consumers or any class of such consumers*."[12]

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8 See the detailed statistics available at https://www.sspcrs.ie/portal/annual-reporting/report/eligibility

9 See the detailed statistics available at https://www.sspcrs.ie/portal/annual-reporting/report/eligibility

10 Commission Decision C(2016) 380 final of 29 January 2016 in case SA.41702 (2016/NN) – Ireland, Risk Equalisation Scheme, OJ C 104, 18.3.2016, p. 1, paragraphs 5-12.

11 Health Insurance Act 1994, Number 16 of 1994. The Act, including all amendments is available here: https://www.irishstatutebook.ie/eli/isbc/1994_16.html.

12 See section 1A-(1) (a) to (d) of the Act.

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

(a) Community Rating: Insured persons pay the same level of premium for a given level of benefit, regardless of health profile (age, gender or health status).[13]

(b) Open Enrolment: Health insurers must accept all applications, regardless of age or health status[14].

(c) Lifetime Cover: An insurance contract cannot be terminated or fail to be renewed by the insurer without the consent of the insured person, even as the insured person ages and/or his physical condition declines[15].

(d) Minimum Benefits: Insurers must provide a certain minimum level of benefits prescribed by legislation for all insurance products[16].

(17) The rationale behind these requirements is to promote solidarity among age groups, genders and people of different health status, as well as to guarantee a satisfactory quality level of health care.

(18) The Commission refers to recitals (10) to (12) of the 2016 Decision for a detailed description of the public service obligations for the private health insurers, which have remained unchanged.

## 2.3. Market developments since 2016

### *2.3.1. Market dynamics*

(19) In recent years, the Irish private medical insurance market has continued to expand, growing from a membership of 2.15 million people as of December 2016 to 2.2 million people in July 2021. The total membership as of July 2021 represents 46.7 % of the total population in Ireland. In the twelve months leading up to July 2021, the insured population has increased by 47 000 people or 2.2 %.

(20) The Irish PMI market was opened up to competition in 1994 by the Act and the number of providers in the market has decreased from four in 2016 to three today, with ILH's acquisition of GloHealth in 2017. The current providers are Vhi (the incumbent insurer with a market share of 50 %), Laya (market share of 26 %) and ILH (market share of 20 %)[17].

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13 Section 7(1)(b) of the Act. Some exceptions exist to this rule, including reduced rates for children and young adults (Section 7(5) of the Act).

14 Section 1A(1)(b) of the Act.

15 Section 9(1) of the Act.

16 Section 10 of the Act.

17 The figures are based the number of members that each insurer has and are taken from HIA report to the Minister for Health of September 2020 entitled "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits" published (in redacted form) at https://www.hia.ie/publication/risk-equalisation.

(21) Vhi continues to have a larger proportion of older customers (recital (9) of the 2016 Decision). This is partly caused by Vhi's historical presence as formerly the sole health insurer and its current position as the largest operator in Ireland. It also reflects the current market context, including the general ageing of the population and the fact that older, "higher risk" individuals who have a more acute need of PMI cover are less inclined to switch, compared to younger, "lower risk" individuals that have PMI cover who are more likely to either switch insurers or leave the PMI market altogether. This has the effect that in terms of insurance portfolio, Vhi has a larger share of the older age bands which are traditionally "higher risk" sections of the population.

### *2.3.2. Vertical integration of services*

(22) Health insurers in Ireland have begun to pursue tentative strategies of vertical integration. This means that the health insurance companies have closer control over healthcare provision as well as insurance provision. For example, Vhi took full ownership of the Swiftcare clinics (a primary care service with diagnostic facilities for minor injuries and illnesses) in September 2017, and both ILH and Laya have developed partnerships with diagnostic and primary care facilities in 2018 and 2019. The provision of services through these vertical integration strategies is not captured in the claims included in the RES calculation, which only includes hospital provided care.

(23) The healthcare activities from the three insurers are accounted for separately. The Swiftcare clinics are part of Vhi Health & Wellbeing DAC, which is a different entity from the part of Vhi that runs the insurance business (Vhi Insurance DAC). The healthcare activities from ILH and Laya are provided under a partnership agreement and therefore also provided by different entities[18] with their own accounts.

(24) Other activities, such as travel insurance and other non-health related insurance activities, are also separated from the health insurance activities of the three providers. These different insurance types have claim costs and premiums that are linked to individually identifiable policies.

### *2.3.3. Inflation*

(25) According to Ireland, inflation of healthcare costs has been significant for a number of years. By way of example, in their earlier projections[19], the Health Insurance Authority ('HIA') has assumed claims to be affected by inflation in the order of 4% per annum. This was driven by a number of factors and it is difficult to isolate the impact of individual factors. The increase in healthcare costs inflation has led to increased health insurance premiums. These increased health insurance costs may lead to younger people dropping cover, which in turn would threaten the continued feasibility of the system. In making recommendations to

[18] For Laya those different entities are 'Laya Health and Wellbeing Clinics', part of the same group as Laya. For ILH those entities are minor injury clinics, completely separate from ILH.

[19] HIA, Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits, September 2020, page 44, available at: https://www.hia.ie/sites/default/files/Report%20to%20the%20Minister%20for%20Health%20on%20Risk%20Equalisation%20Credits.pdf.

the Minister for Health on the amounts of risk equalisation credits to apply, the HIA is required to have regard to the aim of maintaining the sustainability of the health insurance market in addition to the principal objective of the Act[20].

(26) Ireland explains that in its most recent projections[21], the HIA proposes a reduction to 3% per annum expected claims inflation for the period 2022-2023. The insured population is expected to continue to grow during this period, and the ageing of that population is expected to contribute an additional 1% to claims inflation.

*2.3.4. Impact of COVID-19*

(27) The COVID-19 pandemic has had a huge impact on life in Ireland since March 2020, with different restrictions imposed in order to reduce the spread of the virus.

(28) There has been a reduction in the diagnosis and treatment of critical illnesses such as cancer, resulting in longer waiting lists for certain procedures and specialists. This has been caused by the impact of COVID-19 restrictions as the nation has grappled with the pandemic and some hospitals have attempted to limit the spread of the virus by reducing capacity for certain procedures. There is also concern amongst medical professionals that patients are delaying going to hospital because of the fear of contracting the virus. This may have a knock-on impact on the volume and/or severity of claims incurred by health insurers in the medium-term.

(29) In January 2021, all 18 private hospitals agreed to a 'safety net' agreement with the HSE which, if certain metrics were triggered, enabled the HSE to have access of up to 15% or 30% of those hospital's capacity. This depended on the levels of community infection, hospitalisation of patients with COVID-19, and numbers of patients being treated in Intensive Care Units. The agreement was put in place for 12 months. This agreement was invoked by the HSE in January 2021, however its use was ceased in May 2021. Subsequently, in January 2022, the HSE agreed a further 'safety net' agreement which provides for access to private hospitals on either a reasonable endeavours basis or on a guaranteed capacity notice. This agreement ends in June 2022.

(30) While the Commission's Spring 2021 forecast projected that Ireland's economy will grow by 4.6 % in 2021 and 5 % in 2022, the report also warned of the "scarring effect" of long-term unemployment on the Irish economy. An economic downturn may lead to a reduction in the proportion of the population with private health insurance cover and / or a reduction in the level of cover purchased by customers with health insurance being price sensitive. Indeed, during the previous recession, the proportion of the population with health insurance cover declined from 51 % to 46 % and many people actively moved to plans with lower cover to save costs while staying in the private health system.

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[20] This requirement flows from section 7E(1)(b)(iii)(I) of the Act, and the Minister for Health must also consider the sustainability of the market under section 7E(2)(a)(iv) in recommending the value of the stamp duty.

[21] HIA, Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2020 to 30 June 2021, including advice on Risk Equalisation Credits, October 2021, page 23, available at: https://www.hia.ie/sites/default/files/Autumn%20RES%20Report%202021_1.pdf.

(31) In calibrating the credits and stamp duty levels applicable from 1 April 2021[22], the HIA assumed that hospital utilisation rates would revert to levels observed before the pandemic and that membership would reduce slightly, particularly among younger lives. Initial concerns regarding impact of COVID-19 on employment and health insurance take-up seem to be unfounded in the short term. In January 2021, the number of overall health insurance customers has increased over the corresponding figure in January 2020 (+1.7 %). The assumptions used to calibrate credits and stamp duty levels are updated each year based on market trends. Early indications would show that 2021 claims and private healthcare usage are below long-term trends due to continued limitations on access due to COVID-19 and other operational issues in public hospitals, e.g. a cyber-attack against HSE systems in May 2021, which has resulted in postponed elective care.

### 2.4. The previous Risk Equalisation Schemes

(32) The Commission has approved a RES for the Irish PMI market on five occasions in the past: in 2003[23], 2009[24], 2013[25] and 2016[26] (prolonged in 2020[27]). The Commission refers to recitals (13) to (17) of the 2016 Decision for more detailed information on the 2003, 2009 and 2013 schemes and to recitals (18) to (50) of the 2016 Decision for more detailed information on the RES 2016.

### 2.5. The notified measure: the RES 2022

(33) The aim of the notified measure[28] has remained unchanged compared to the RES 2016, i.e. to ensure that insurers whose customers (on average) have a higher risk profile are compensated by insurers whose customers (on average) have a lower risk profile. The net beneficiary (or beneficiaries) of the system will be any insurer(s) whose customers (on average) are older and have greater health problems than the market average. There may therefore be more than one net beneficiary. Until now there is one net beneficiary (Vhi) and the other insurers have been net contributors to the scheme.

(34) The Irish RES does not aim to cover the full costs of the net beneficiary (or any insurer) in providing health insurance.[29]

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22 How the credits and stamp duty levels are calibrated is explained in Sections 2.5.1.1, 2.5.1.2 and 2.5.1.3.

23 Commission Decision C(2003) 1322fin of 13 May 2003 in case N 46/2003 Risk equalisation scheme in the Irish health insurance market, OJ C 186, 6.8.2003, p.16. This decision was upheld by Case T-289/03 *BUPA and others v. Commission* ECLI:EU:T:2008:29.

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

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

26 Commission Decision C(2016) 380 final of 29 January 2016 in case SA.41702 (2016/NN) – Ireland, Risk Equalisation Scheme, OJ C 104, 18.3.2016, p. 1.

27 Commission Decision C(2020) 8730 final of 14 December 2020 in case SA.58851(2020/N) – Ireland, Prolongation of the Risk Equalisation Scheme, OJ C 17, 15.1.2021, p. 19.

28 Health Insurance (Amendment) Act 2021, Number 47 of 2021, available at: https://www.irishstatutebook.ie/eli/2021/act/47/enacted/en/print.html.

29 See recitals (119), (143) and (159) of the 2013 Decision (footnote 25).

(35) With the notified measure, Ireland seeks approval of a further prolongation of the RES 2016 until 31 March 2027 and a modification (i.e. the introduction of the HCCP) compared to the RES 2016. Apart from the introduction of the HCCP and an updated ROS to check whether overcompensation took place (see Section 2.5.3), there are no further amendments introduced by RES 2022 in comparison with the RES 2016. The envisaged new RES 2022 is described in the following recitals.

### *2.5.1. The RES 2022*

(36) The insurers receive payments from the Risk Equalisation Fund under three headings: Age Related Health Credits ('ARHC') (which reflect the age profile, gender and level of cover of the customer), hospital utilisation credits ('HUCs') (which are triggered if an insured person receives hospital treatment) and the HCCP (Section 2.5.2). The insurers pay into the Risk Equalisation Fund by means of stamp duties (Section 2.5.1.2). The RES and payments from the Risk Equalisation Fund are managed and administered by the HIA[30].

#### 2.5.1.1. Credits

(37) ARHCs are defined by section 11C of the Act and Schedule 4 thereto. They are paid to the insurers in respect of individuals who are insured under relevant health insurance products in Ireland.

(38) ARHC takes account of whether the insurance product is "advanced". An advanced insurance contract is defined as, in essence, one which covers more than 66 % of the full cost of hospital charges in a private hospital, or more than the prescribed minimum payments under the minimum benefit regulations.[31] A higher level of ARHC is available for advanced contracts.

(39) As noted at recital (24) of the 2016 Decision, the distinction between advanced and non-advanced products is intended to ensure that the support is proportionate and does not involve people with lower levels of benefit subsidising to a disproportionate degree high levels of cover than those they have chosen for themselves[32].

(40) HUCs are also paid to insurers in respect of all insured individuals for each overnight stay and day case admission in hospital. The level of HUCs is defined in Schedule 3 to the Act.[33] As noted at recital (25) to the 2016 Decision, the use of HUCs means that the costs associated with individuals who claim (representing less healthy lives) are shared with those who do not.

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30 Section 11D and 21 of the Act.

31 See section 11E(4) of the Act

32 According to the Irish authorities, 90 % of the health insurance contracts are "advanced". Within the category of advanced contracts there are many different "plans" distributed among 4 levels, level 2, 3, 4 and 5. Level 1 plans are the non-advanced contracts. 16 % of the population are in plans higher than level 2 and those plans are often referred to as "luxury benefits". The Irish authorities, taking into account the aim of market stability and affordability, do not propose at present to alter the RES by extending the calibration of the RES to also include luxury benefits as it will lead to an increase of the stamp duty.

33 HUC is defined in section 6A of the Act, which is drafted to be part of the definition of risk equalisation credits. The definition incorporates Schedule 3 through the term "relevant amount" which is also defined in section 6A.

(41) The proposed level of ARHC and HUC, at the commencement of RES 2022, are set out in Table 1. The rationale for those credits are set out in a report[34] from the HIA for the Minister of Health[35].

**Table 1: Credits applicable from 1 April 2022 to 31 March 2023**

| Age bands | HUCs (overnight/day case) | ARHCs | | | |
|---|---|---|---|---|---|
| | | Non-advanced | | Advanced | |
| | | Men | Women | Men | Women |
| 64 and under | € 125/75 | € 0 | € 0 | € 0 | € 0 |
| 65-69 | € 125/75 | € 325 | € 150 | € 950 | € 500 |
| 70-74 | € 125/75 | € 500 | € 350 | € 1 575 | € 1 075 |
| 75-79 | € 125/75 | € 775 | € 575 | € 2 375 | € 1 700 |
| 80-84 | € 125/75 | € 950 | € 650 | € 2 975 | € 2 125 |
| 85 and above | € 125/75 | € 1 150 | € 775 | € 3 550 | € 2 425 |

#### 2.5.1.2. Stamp duties

(42) The Risk Equalisation Fund is funded by stamp duties collected from the insurers on every insurance contract sold. Stamp duties reflect the type of insurance contract being sold. In particular, there is a higher level of stamp duty for "advanced" benefits which cover a minimum proportion of the cost of private treatment.

(43) Under section 11D(4)(a) of the Act, all stamp duties collected in respect of PMI contracts are paid into the Risk Equalisation Fund. The level of stamp duty is defined in section 125A of the Stamp Duties Consolidation Act 1999, and this is revised annually. The levels of stamp duty distinguish between (a) contracts concerning children as opposed to contracts concerning adults, and (b) advanced contracts versus non-advanced contracts (see recital (38)).

(44) The stamp duties for health insurance contracts from April 2022 to March 2023 have been reduced compared to April 2021 to March 2022[36]. This is possible as a result of lower claims activity by consumers of private health insurance due to the COVID-19 pandemic. This reduction in claims resulted in an estimated surplus of EUR 100 million built up in the Risk Equalisation Fund. While acknowledging that insurers can set their own prices, lower stamp duties should in principle result in a reduction in premiums for contracts commencing or renewing in the period 1 April 2022 to 31 March 2023. The stamp duties are expected to increase again from 1 April 2023 (see table 2).

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[34] HIA, Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2020 to 30 June 2021, including advice on Risk Equalisation Credits, October 2021, available at: https://www.hia.ie/sites/default/files/RES%20Report%202022_2023.pdf.

[35] The HIA is required by section 7E(1)(b)(iii)(I) of the Act to take account of a range of factors, including its views of the health insurance market and the sustainability of that market.

[36] Between 1 April 2021 and 31 March 2022 the stamp duties were € 52 (non-advanced, 17 and under), € 150 (advanced, 17 and under), € 157 (non-advanced, 18 and over), and € 449 (advanced, 18 and over).

**Table 2: Stamp duties applicable from 1 April 2022 to 31 March 2027**[37]

| Age bands | Stamp duties from 1 April 2022 to 31 March 2023 | |
|---|---|---|
| | Non-advanced | Advanced |
| 17 and under | € 41 | € 135 |
| 18 and over | € 122 | € 406 |
| Age bands | Stamp duties from 1 April 2022 to 31 March 2023 without surplus referred to in recital (44), hypothetical scenario | |
| | Non-advanced | Advanced |
| 17 and under | € 48 | € 158 |
| 18 and over | € 142 | € 475 |
| Age bands | Stamp duties from 1 April 2023 to 31 March 2024 | |
| | Non-advanced | Advanced |
| 17 and under | € 49 | € 163 |
| 18 and over | € 146 | € 489 |
| Age bands | Stamp duties from 1 April 2024 to 31 March 2025 | |
| | Non-advanced | Advanced |
| 17 and under | € 50 | € 168 |
| 18 and over | € 150 | € 503 |
| Age bands | Stamp duties from 1 April 2025 to 31 March 2026 | |
| | Non-advanced | Advanced |
| 17 and under | € 51 | € 173 |
| 18 and over | € 154 | € 518 |
| Age bands | Stamp duties from 1 April 2026 to 31 March 2027 | |
| | Non-advanced | Advanced |
| 17 and under | € 52 | € 178 |
| 18 and over | € 159 | € 534 |

2.5.1.3. Calculation of credits and stamp duties

(45) As noted in recitals (26) and (29) of the 2016 Decision, the level of credits and stamp duties is based on calculations by the HIA. Under section 7D of the Act, each insurer must provide the HIA with information (in a standardised form) every six months. These returns include detailed historical data relating to the number of lives insured in each age group, in respect of the relevant 6-month period, hospital utilisation data, relevant claims data, as well as detailed information product level. Under section 7E of the Act, the HIA is to analyse this information and advise on the appropriate levels of credits and stamp duties.

(46) The HIA analyses the claims experience of the market against each of the factors described above (age, gender, level of cover, health status) and identifies groups of insured persons where the average claims costs for the group exceed those for all insured persons together.

(47) Based on this analysis, the HIA recommends the Minister for Health the level of credit for each combination of age, gender and level of coverage, as well as the

[37] Stamp duties for contracts commencing on or after 1 April 2023 are estimates based on a 3 % increase per annum, all else being equal and with no allowance for a surplus in the Risk Equalisation Fund as is the case for the period 1 April 2022 to 31 March 2023 (see recital (44)).

level for HUCs. The Minister for Health then proposes the appropriate levels credits to be specified in the Act. The HIA also recommends the level of stamp duty necessary to fund the credits.

(48) Under section 7E(1)(b)(iii) of the Act this recommendation must take account of the "principal objective" (recital (15)) as well as the aim of avoiding overcompensation, the aim of maintaining the sustainability of the health insurance market and the aim of having fair and open competition in the health insurance market (see also recital (25)).

(49) Section 7E(1)(b)(iv) of the Act also provides that the amount of stamp duty recommended is to be sufficient to meet the costs of the credits, "having regard to the aim of avoiding the Risk Equalisation Fund sustaining surpluses or deficits from year to year". Thus, the aim is to make the scheme self-financing. The proposals of the HIA as regards stamp duty are then presented to the Minister for Health, who in turn makes a recommendation to the Minister for Finance[38] for appropriate amendments to the Stamp Duties Consolidation Act 1999. Nevertheless, in making these recommendations, the Minister for Health must also take into account "the aim of avoiding the Risk Equalisation Fund sustaining surpluses or deficits from year to year".[39] Again, this aims to make the scheme self-financing.

(50) As mentioned above, insurers must make returns to the HIA every 6 months. The obligation to provide such information is set out in section 7D(1) of the Act. This provides that regulations may be adopted to specify further details of the information required. The Irish authorities are currently drafting regulations that will require more detailed information from the insurers (see recitals (75) to (79) below), particularly in relation to high cost claims.

#### 2.5.1.4. Claims Cost Threshold

(51) In arriving at its recommended level of credits (and stamp duties required to fund these) the HIA must also take account of the "claims cost ceiling." Section 7E(1)(b)(iii)(II) lays down, among the objectives that the HIA must take into account,

> "*the objective that the projected net average insurance claim payment per insured person for a relevant age group of insured persons for any period of 12 consecutive months duration should be <u>not less than 125 per cent</u> of the projected net average insurance claim payment per insured person for all age groups of insured persons for that same period*" (emphasis added).

(52) Similarly, the Minister for Health must take account of this objective in recommending the level of stamp duties to the Minister for Finance[40].

(53) This means that the credits for individual aid groups are determined by comparing (a) the average claims cost for people within those age groups to (b) the average

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38 Section 7E(2) of the Act.

39 Section 7E(2)(a)(vi) of the Act.

40 Section 7E(2)(a)(vii) of the Act

claims costs across the whole insured population. The HIA determines average age credits for any age group such that, after allowing for the impact of credits and stamp duties, the average claims cost for each group would not go below 125% of the market average claims costs across all age groups.

(54) According to the Irish authorities, with reference to recital (32) of the 2016 Decision the claim cost threshold was originally 150%, and in the last year of the 2013 RES and during the application of the 2016 RES 130%. With the introduction of the HCCP, the claim cost threshold will be 137.7 % (up from 133.5 % for the period April 2021 – March 2022)[41].

(55) The Irish authorities note that there is a trade-off here: if the claims cost ceiling is brought closer to 100%, this would make the scheme more effective in terms of equalising differences in risk profile. However, there could be negative consequences. First, the sustainability of the market could be affected.[42] Second, if the credits were set at a level more closely reflecting the actual claims costs at older ages, they would be more heavily influenced by the claims cost of the net beneficiaries of the scheme.[43]

(56) As a result, recital (35) to the 2016 Decision noted that *"aiming at a total correction of the imbalances in claims costs could result in compensating more than differences in risk levels and oblige an insurer that achieves lower claims costs through efficiencies to compensate another less efficient insurer on the basis of its higher claims costs."*

(57) For this reason, the 125% floor is laid down in legislation (see recital (51)). The 125% threshold is forward-looking, and is used to set the level of credits and stamp duty for the future. It does not apply retrospectively.[44]

(58) Footnote 34 to the 2016 Decision records a comment by the Irish authorities that health status component of the scheme (i.e. the HUC) is limited, and that the Irish authorities would return to this point if more detailed data become available. The proposal for a High Cost Claims Pool ("HCCP") – see section 2.5.2 below – aims to address this issue.

(59) The Irish authorities consider that the threshold of 125 % provides additional comfort that competition will not be distorted in a disproportionate manner and that efficient insurers would remain able to make an adequate return.

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41 HIA, Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2020 to 30 June 2021, including advice on Risk Equalisation Credits, October 2021, page 58, available at: https://www.hia.ie/sites/default/files/Autumn%20RES%20Report%202021_1.pdf.

42 As noted at footnote 32 to the 2016 Decision, insurers would need to charge higher premiums to younger members, to cover the higher claims costs of the older, riskier members, which would tend to drive younger members out of the market. Further, this would increase the incentive to recruit younger members instead of older members. Footnote 32 to the 2016 Decision accepted that both effects would over time threaten the sustainability of the PMI market.

43 Footnote 33 to the 2016 Decision noted that such a situation would occur because net beneficiaries will typically have greater numbers for older lives, and therefore the average claims in respect of older lives generally will be more heavily weighted towards the claims costs of customers of those insurers.

44 See footnote 34 to the 2016 Decision.

### *2.5.2. The proposed modification: the High Cost Claims Pool*

(60) The Irish authorities propose a new feature to the RES 2022 compared to the 2016 RES.

(61) The new feature is the HCCP. With the HCCP insurers will be compensated from the Risk Equalisation Fund for individual claims costs which are much higher than the market average. In essence the HCCP is a new credit type on top of the already existing ARHCs and HUCs[45]. The Irish authorities have however confirmed that the HCCP will entail a redistribution of existing credits at the expense of ARHC and not the distribution of additional funds.

(62) The aim of the HCCP is to target high cost but low incidence claims. This will work by taking claims which are above a certain monetary threshold (the "excess") and paying a percentage of the total cost of that claim (the "quota share") separately to the rest of the Risk Equalisation Fund. While for those high cost claims, HUCs are already being paid and this might lead to double counting if on top of those HUC also payments are made as part of the HCCP, the threshold and therefore also the excess will be adjusted. In practice, this means that for almost all high cost claims an adjusted threshold will apply as the high cost claims generally include nights in hospital.

(63) The initial calibration of the HCCP recommended by the HIA is a quota share percentage of 40% and a claims excess of EUR 50,000[46]. The recommendation is supported by a study from HIA's actuarial advisor's KPMG[47]. The initial calibration results in the following formula for calculating the HCCP credit in the period 1 April 2022 – 31 March 2023 is as follows:

40% x (HCCP Claim – (EUR 50 000 + HUC + ARHC))

(64) This means the scheme would compensate 40% of the cost of claims that are in excess of EUR 50,000 in respect of a specified period of cover. Based on claims data emerging from 2016 sales, less than 1% of the insured population made claims in excess of EUR 50,000 but these claims represent a much higher percentage of total claim amounts (around 16%). The average claim per person in this cohort was EUR 80,000 compared to the market average claim of EUR 1,100 observed in the same period. The market average claim for 2019 according to data received by the HIA was EUR 1,093.[48] The three examples in Table 3 show the credits to be paid without a HCCP, with a HCCP and with an adjusted HCCP (i.e. using the formula in recital (63) to limit the risk of double counting[49]. The example reflects a claim from an 80 year old woman. For persons below 65 years old, the ARHC would be zero.

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45 The HCCP is calibrated in the same way for advanced and non-advanced contracts (see footnote 32).

46 Section 7 of the Health Insurance (Amendment) Act 2021, Number 47 of 2021, available at: https://www.irishstatutebook.ie/eli/2021/act/47/enacted/en/print.html.

47 KPMG report to the Authority: "Report on final proposed calibrations of the HCCP", 12 May 2021.

48 Average "returned benefit" per insured member as per Information Returns provided to the HIA in respect of calendar year 2019. Not all benefits are included in "Returned Benefits".

49 Example based on the HIA report, page 17.

**Table 3**

Parameters for all three examples (see also Table 1): Claim of EUR 100 000; HUC: EUR 125 per night; ARHC: EUR 2 125 for an 80 year old woman; nights in hospital: 100; Quota share: 40 %.

| | No HCCP | HCCP, no adjustment | HCCP, with adjustment |
|---|---|---|---|
| Threshold | EUR 50 000 | EUR 50 000 | EUR 64 625 (50 000 + 12 500 + 2 125) |
| Excess | EUR 50 000 (100 000 – 50 000) | EUR 50 000 (100 000 – 50 000) | EUR 35 375 (100 000 – 64 625) |
| HUC | EUR 12 500 | EUR 12 500 | EUR 12 500 |
| ARHC | EUR 2 125 | EUR 2 125 | EUR 2 125 |
| HCCP | - | EUR 20 000 (40 % of 50 000) | EUR 14 150 (40 % of 35 375) |
| Total | EUR 14 625 | EUR 34 625 | EUR 28 775 |

(65) The Irish authorities propose to introduce the HCCP as an additional element of the Risk Equalisation Scheme in a phased manner, meaning that it can recalibrate the HCCP appropriately over time. Initially, the HCCP will make up only 10 % of the total credits paid out. The longer-term aim will be to increase the element of credits payable in respect of HCCP gradually whilst meeting the aims outlined in recital (61).

(66) The analysis carried out by the HIA in June 2021 shows that the introduction of the HCCP would lead to significant improvement to the effectiveness of the Scheme. The RES in place between 1 April 2021 and 31 March 2022 has an effectiveness[50] of 30,3 %. The same RES with the inclusion of an HCCP would have resulted in an effectiveness of 47,7 %[51].

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

[51] See Report from the HIA, Risk Equalisation Scheme 2022 - Recommendation to the Department of Health on proposed changes to be incorporated into the Risk Equalisation Scheme, 11 June 2021, page 40. An analysis performed in early 2019, showed a similar pattern. Based on a RES calibrated as it is now (excess of EUR 50 000 and a quota share of 40 %) and taking into account the circumstances of the RES 2016 in 2018, the efficiency would increase from 14.6 % (without HCCP) to 28.4 % (with HCCP), see a HIA report from January 2020 "Risk Equalisation Scheme Effectiveness Impact: Assessment of the Introduction of a HCCP and changes to other measures".

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

(67) The overcompensation test aims at verifying whether the Return on Sales (ROS)[52] of the net beneficiary (or beneficiaries) of the RES does not exceed a certain percentage. According to the Irish authorities an advantage of the ROS is that it only depends on accounting profit and sales data, which are both more easily observable in a company's accounts. Moreover, the ROS avoids the valuation and attribution of assets between different services, which is necessary for a capital-based benchmark.

(68) Under the RES 2016, overcompensation was deemed to have occurred where the net beneficiary's ROS gross of reinsurance[53] and excluding investment activities[54] exceeds 4.4 % per annum, calculated on a rolling three year basis[55]. This benchmark was devised by Oxera Consulting on the basis of a sample of European health insurers whose profile was considered sufficiently comparable to Vhi, the current net beneficiary of the scheme (see recital (42) of the 2016 Decision). The Irish Government has commissioned Oxera Consulting for a second time with the aim to verify whether a ROS of 4.4 % is still appropriate under the RES 2022.

(69) The new benchmark was devised using data available for the period 2017-2019. For the new benchmark, Oxera Consulting used again a sample of European health insurers with a sufficiently comparable profile to Vhi. Oxera consulting looked at the type of activities (i.e. health insurance), capital intensity, firm size and investment income of the sample companies to decide whether they are comparable. The selection of the sample is similar to the method explained in the 2016 Decision[56]; however, the sample was further limited by only looking at insurers included in this sample that were also included in Oxera's previous assessment, in order to ensure consistency. In addition, while for the previous assessment that led to a ROS of 4.4 % health insurers with high capital density were not present they were for the present assessment and therefore excluded from the sample. This resulted in a sample of 6 to 10 insurers. Figure 1, visualises the selection of insurers sufficiently comparable to Vhi[57].

(70) The Irish authorities have explained that it was not possible to use exactly the same sample as for the RES 2016. Some insurers included in the benchmark analysis for the RES 2016 were not represented in the Orbis database for the 2017

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52 ROS is a profitability measure, also known as operating profit margin. Generally, it is calculated as the ratio between net operating profit (before interest and tax) and sales revenues. More precisely, net operating profit is the difference between revenues and costs at operational level.

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

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

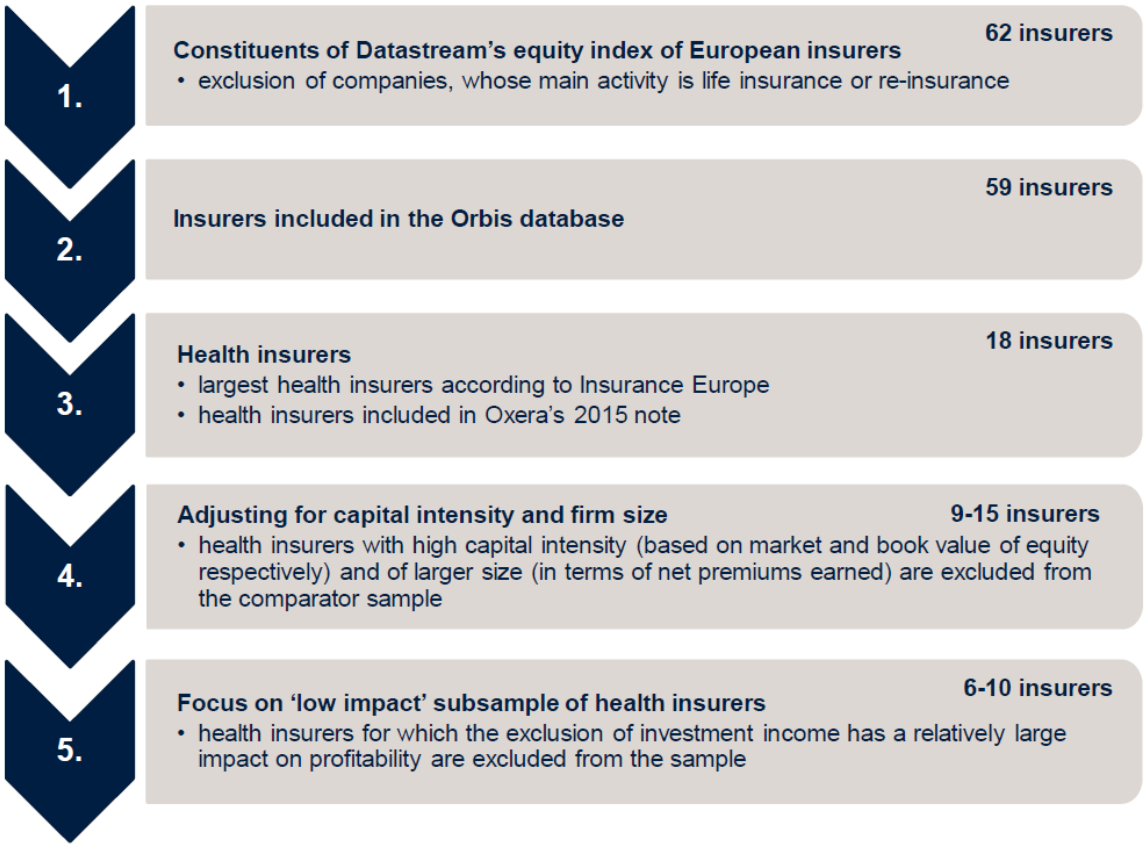
55 Section 7F(4A) of the Act, with the amendment of the Act in 2021, this percentage has been increased to 6 % (see recital (71) below).

56 Footnote 40 of the 2016 Decision.

57 The Orbis database referred to in step 2 in Figure 1 is a private database that contains an overview of entity data of close to 400 million companies and entities around the world.

to 2019 period or for not all of that period. For that reason, they were not included in the comparison.

**Figure 1 – Methodology to derive the sample of comparators**




Source: Oxera consulting, Estimating the forward-looking return on sales benchmark, Note prepared for the Health Insurance Authority, 12 July 2021[58].

(71) Having assessed the sample, for the RES 2022, Oxera consulting calculated a ROS in a range between 5.5 % and 8.6 %. The ROS is calculated gross of reinsurance, based on the earnings before tax (EBT)[59]. Taking into account Oxera consulting's findings, the HIA recommended a ROS as 6 % as the new benchmark to be used for the calculation of possible overcompensation. With a ROS of 6 %, which is on the lower end of the range proposed by Oxera consulting, the HIA claims to take into consideration the sustainability of the market and the maintenance of fair and open competition.

(72) By way of exception and transition, for the purposes of the overcompensation test under RES 2022 (which is performed taking account of the data from the three previous years), the Irish authorities have explained that for the period 1 January

[58] Available at: https://www.hia.ie/sites/default/files/Oxera%20note%20on%202022%20benchmark_12.07.2021%20Redacted%20-%20Final.pdf.

[59] The ROS is generally defined as earnings before interest and tax (EBIT) divided by revenues. However, it was not possible to obtain EBIT information from Orbis for the comparator insurers for all of the 2017 to 2019 period. In order to maximise the amount of comparator data that could be used to develop the benchmark, Oxera recommended the use of EBT instead.

2020 until end 2022 a ROS benchmark of 4.9 % will apply and for the period 1 January 2021 until end 2023 a ROS benchmark of 5.5 % will apply[60].

(73) The check carried out by HIA to decide whether overcompensation has occurred is laid down in the law. Under section 7F(1) of the Act, every provider of PMI in Ireland is required to provide the HIA with a statement of its profits and losses as regards health insurance, and its balance sheet in respect of health insurance. As part of the RES there are no specific rules as to which accounting standards should be used, other than that they are to be prepared using "approved accounting standards" (see also below recital (75)). Section 7F(3) of the Act requires the insurers to provide the HIA with "reasonable assistance" in relation to the information provided, so that (for example) it can request explanations concerning the figures provided by the insurers.

(74) Under section 7F(5) of the Act, the HIA is obliged to monitors overcompensation every year for the preceding three-year period taking the ROS, falling within the range as defined in Oxera's report, as a benchmark. The first such three-year period under the RES 2016 was from 1 January 2016 to 31 December 2018. The HIA determined that there had been no overcompensation. This report (dated 1 December 2019) is available on the HIA website.[61] Section 4.5 of the report found that Vhi had made a profit, over the relevant period, of 4.0%. Similarly, as regards the period from 1 January 2017 to 31 December 2019, the HIA determined that there had not been overcompensation, in a report dated 20 November 2020.[62] Section 4.5 of that report found that Vhi had made a profit, over the relevant period, of 3.0%. Since neither of these figures exceeds the statutory threshold of 4.4%, there was no overcompensation. The most recent report available (dated 10 July 2021) covers the period 1 January 2018 to 31 December 2020[63]. Section 4.5 of that report found that Vhi had made a profit, over the relevant period of 2.1 %. Like for previous periods, this is below the statutory threshold of 4.4 % and thus no overcompensation was present.

(75) Already now, insurance companies in Ireland need to prepare accounting submissions for the Central Bank on the basis of "Financial Reporting Standard" (FRS) 102[64] and FRS 103[65]. Taking into account those FRS standards, Ireland has

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60 Section 4 of the Health Insurance (Amendment) Act 2021, Number 47 of 2021, available at: https://www.irishstatutebook.ie/eli/2021/act/47/enacted/en/print.html.

61 KPMG, The Health Insurance Authority , Overcompensation assessment conclusion for the period 1 January 2016 to 31 December 2018 – Phase 2, 1 December 2019, available at: https://www.hia.ie/sites/default/files/Redacted%20Overcompensation%20report_dec2019.pdf.

62 KPMG, The Health Insurance Authority, Overcompensation assessment conclusion for the period 1 January 2017 to 31 December 2019, 28 November 2020, available at: https://www.hia.ie/sites/default/files/HIA%20Overcompensation%20report_20_11_2020_DRAFT_redacted.V1pdf.pdf.

63 KPMG, The Health Insurance Authority, Overcompensation assessment conclusion for the period 1 January 2018 to 31 December 2020, 10 July 2021, available at: https://www.hia.ie/sites/default/files/HIA%20Overcompensation%20Report%20issued%20by%20KPMG%202021%20Redacted_0.pdf.

64 FRS 102 is a single financial reporting standard applicable in the UK and Republic of Ireland that applies to the financial statements of entities that are not applying EU-adopted IFRS, FRS 101 or FRS 105. FRS 102 is designed to apply to the general purpose financial statements and financial reporting of entities including those that are not constituted as companies and those that are not profit-oriented. FRS 102 is subject to a periodic review at least every five years. The last periodic review, was completed in December 2017, with an effective date of 1 January 2019..

now proposed to introduce accounting regulations for the purpose of calculating possible overcompensation that would constrain the leeway in preparing the financial statements. The proposed accounting regulations are still a draft and Ireland has confirmed that the draft takes into account submissions made by the different insurers to the Irish authorities in July 2021.

(76) First, the proposed accounting regulations seek to address the use of a related entity, which is not subject to the ROS benchmark, to carry out certain functions related to the provision of health insurance. This should be achieved by provisions that set out fair restrictions on what a registered undertaking can pay to a related entity in a group or in connection with an outsourcing agreement.

(77) Second, any type of payment made to a substantial group of customers that appears in effect to be a partial refund of premium should be treated in the financial statements as a premium refund in the revenue line of the financial statements and not in the expenses line of the statements.

(78) Third, the proposed regulations circumscribe the leeway allowed by FRS 103, consisting of a significant degree of discretion allowed to the director's judgment as regards claim provision (which could be set a relatively high level and thereby reducing the ROS) by referring to the Solvency II Directive[66].

(79) Finally, the proposed regulation will identify a restricted list of costs and charges that are appropriate or might be appropriate in a non-life insurance business such as a health insurance company that the companies may include in their financial statements . An alternative to such a list would be default to FRS 102 and FRS 103; however, in practice there might be many unexpected and possibly unusual cost headings that are included in a company's financial statements that could have the effect of an unusual reduction in profits. Permitting such inclusions would militate against a fair and reasonable overcompensation assessment. For this reason, Ireland has opted to be more restrictive than FRS 102 and FRS 103 in this respect.

(80) Section 7F(7) and following of the Act describe the mechanism which is to apply if the HIA determines that there has been overcompensation. The HIA is to prepare a draft report on the relevant calculations and indicators that show the amount of overcompensation. The HIA will then send this draft report to the insurer concerned for comments. On the basis of any comments, the HIA is to prepare a final report.[67] If the final report of the HIA determines that there has been overcompensation, this is conclusive including for the purpose of any proceedings concerning the recovery of overcompensation.[68] The HIA submits the final report to the Minister for Health, who in turn provides a copy to the

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65 FRS 103 consolidates existing financial reporting requirements and guidance for insurance contracts. Entities that are applying FRS 102 whether or not they are 'insurance companies', also apply this FRS to insurance contracts (including reinsurance contracts) that the entity issues and reinsurance contracts that the entity holds, and to other financial instruments that the entity issues with a discretionary participation feature.

66 Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II), OJ L 335, 17.12.2009, p. 1–155, ELI: http://data.europa.eu/eli/dir/2009/138/oj.

67 Section 7F(8) of the Act.

68 Section 7F(8)(b) of the Act.

insurer concerned.[69] The insurer concerned is obliged to pay the Fund, within 2 months, the amount set out in the report.[70] Should the insurer concerned fails to comply with this obligation, the Minister for Health can bring court proceedings against the insurer.[71]

*2.5.4. Estimate net financial effect of the RES 2022*

(81) All insurers on the market are service of general economic interest ('SGEI') providers and will receive credits from the RES 2022. Vhi is expected to continue to be the net beneficiary of the RES 2022, while its competitors are expected to continue to be net contributors. The reason for this is that in terms of insurance portfolio, Vhi continues de facto to deal with the high-risk profile population (i.e. most of the elderly population with private insurance). However, Vhi's market share in the Irish health insurance market has continued to decrease (i.e. from 58.6 % in December 2012 to 54.1 % in July 2015[72] and 50 % in July 2020[73]), so the Irish authorities cannot exclude that another insurer may become a net beneficiary of the RES in the future.

(82) Should the insurers' risk profile change, the net financial effects of the scheme would change accordingly. However, according to the Irish authorities, even though individuals have the possibility to switch between insurers, this is unlikely to happen to an extent sufficient to make Vhi a net contributor and any of its competitors a net beneficiary in the medium term.

(83) The HIA calculates the annual stamp duty levels on the basis of the total amount paid annually in credits. The stamp duties need to be at least equal to the amount paid in credits; however, as can be seen from Table 4, there is often a surplus. Surpluses which arise at the end of the RES cycle are incorporated into the calculations on the level of stamp duty needed for the following cycle (see also recital (44)), and are used to meet the difference between credits and stamp duty.

69 Section 7F(9) of the Act.

70 Section 7F(10) of the Act.

71 Section 7F(11) of the Act.

72 Footnote 73 of the 2016 Decision.

73 See recital (20).

**Table 4**[74]

| In EUR million | 1 April 2018 to 31 March 2019 | 1 April 2019 to 31 March 2020 | 1 April 2020 to 31 March 2021 | 1 April 2021 to 31 March 2022 | 1 April 2022 to 31 March 2023[75] |
|---|---|---|---|---|---|
| Age Related Health Credits | EUR 592.1 | EUR 613.5 | EUR 658.8 | EUR 605 | EUR 590 |
| Hospital Utilisation Credit | EUR 175.7 | EUR 166.7 | EUR 171.2 | EUR 200 | EUR 199 |
| HCCP | - | - | - | - | EUR 55 |
| Stamp Duty | - EUR 737.8 | - EUR 752.2 | - EUR 800 | - EUR 763[76] | - EUR 745[77] |
| **Difference between credits and stamp duty (Estimated surplus in the REF)** | **EUR 30** | **EUR 28** | **EUR 30** | **EUR 42** | **EUR 100** |

(84) In a situation where the current account of the Risk Equalisation Fund cannot cover the payments of credits, the Minister for Health may request the Minister for Finance to advance funding to the Fund's account from the State budget[78]. Before any funding is advanced from the State budget both the Minister for Finance and the Minister for Public Expenditure and Reform need to be consulted. For those possible advancements a special account shall be set up. This special account would be managed and controlled by the Minister for Health, but the Minister of Finance can set conditions that it considers appropriate. Before any funds are transferred from the special account to the current account of the Risk Equalisation Fund, the Fund shall first use the funds it has available on its investment account. In case funding is needed from the special account, the Risk Equalisation Fund shall also be pay it back[79].

(85) The level of the stamp duty per contract was relatively stable over the most recent calibration period. For the periods 1 April 2018 until 31 March 2019 and 1 April 2019 until 31 March 2020, the stamp duty for advanced contracts for people 18 years old and above amounted to EUR 444. For the two subsequent periods, 1 April 2020 until 31 March 2021 and 1 April 2021 until 1 April 2022, there was only a minor increase of EUR 5 to EUR 449. Due to the surplus in the Risk Equalisation Fund as a consequence of the COVID-19 pandemic a reduction in the stamp duty to EUR 406 was possible (see recital (44)).

(86) The net financial impact per insurer is reflected in Table 5.

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74 Note that this table shows the level of credits and stamp duties also for past periods during which the HCCP did not yet apply.

75 Projections

76 Still a projection because the period has not yet ended.

77 The drop in stamp duties collected in 2021/2022 compared to the stamp duties expected to be collected in 2022/2023 is due to a lower stamp duty per contract (see recital (85)).

78 Pursuant to section 11D of the Act. See section 11D(5)(b) of the Act which refers to the possibility of money being advanced from the "Central Fund" to address any shortcomings in the Risk Equalisation Fund. The "Central Fund" means the assets of the State, which (pursuant to Article 11 of the Constitution of Ireland) are consolidated in a single fund (unless otherwise provided in legislation).

79 Section 11D(6)(b) of the Act.

**Table 5**

| EUR million | ILH | Laya | Vhi | Total |
|---|---|---|---|---|
| Age related health credits | 77 | 142 | 371 | 590 |
| HUCs | 26 | 48 | 126 | 199 |
| HCCP | 7 | 10 | 37 | 55 |
| Stamp duty | -151 | -206 | -387 | -745 |
| Total | -42 | -6 | 148 | 100 |
| Net financial impact per insured life in EUR (total impact / number of insured lives) | -103 | -11 | 147 | |

#### *2.5.5. Application of RES 2022*

(87) The Irish authorities committed that the RES 2022 will not come into effect before the Commission has decided on the notification. The act introducing the amendments states that the *"[The] Act […] shall come into operation on such day or days as the Minister for Health may by order or orders appoint either generally or with reference to any particular purpose or provision and different days may be so appointed for different purposes or different provisions.*"[80] Subject to this, the Irish authorities envisage that the revised scheme comes into effect for health insurance contracts incepted on or after 1 April 2022 with the first payments to insurers occurring in Q 3 2022.[81] As noted at recital (49) to the 2016 Decision, the Irish authorities may still continue with payments to insurers insofar as those payments are required under the previous RES 2016 approved by the Commission.

## 3. IRELAND'S POSITION OF THE STATE AID ASSESSMENT OF THE RES

### 3.1. Selectivity

(88) In the notification on the RES 2016 the Irish authorities have not disputed that the RES constitutes State aid within the meaning of Article 107(1) TFEU. However,

[80] Section 9(2)(b) of the Health Insurance (Amendment) Act 2021, Number 47 of 2021, available at: https://www.irishstatutebook.ie/eli/2021/act/47/enacted/en/print.html.

[81] It is unlikely there will be high cost claims right away, as the HCCP will only apply to contracts that start on or after 1 April 2022.

Ireland in its notification on the 2022 RES submitted that it agrees with the Commission's State aid assessment for the RES insofar as it concerns the conditions related to the imputability, State resources, the presence of an undertaking, the presence of an advantage, the distortion of competition and the effect on trade. However, in light of the *Lübeck* judgment of the Court of Justice[82], which was rendered after the 2016 Decision, Ireland disputes that the selectivity criterion is met as regards the RES 2022.

(89) Ireland considers that it is not sufficient to say that a scheme (in this case the RES 2022) is selective merely because it is only open to a certain sector (in this case the PMI sector):

*"contrary to the Commission's contentions, a measure which benefits only one economic sector or some of the undertakings in that sector is not necessarily selective.*"[83] (emphasis added)

(90) In addition, Ireland takes the view that it is not enough to show that the measure only benefits "*some of the undertakings in that sector*". In this light, Ireland refers to the Commission decisions approving the RES 2013 and RES 2016 respectively where the Commission stated that not every undertaking could benefit from the RES, while in the Commission's decision of 17 June 2009 the Commission commented that the scheme would benefit any insurer that has a worse age profile than the average market age profile[84].

(91) Ireland considers it is clear from the *Lübeck* judgment cited above that what matters is whether undertakings find themselves in a comparable factual and legal situation[85]. Moreover, the Court repeated the long-standing case-law that selectivity depends on

*"whether, under a particular legal regime, a national measure is such as to favour 'certain undertakings or the production of certain goods' over others which, in the light of the objective pursued by that regime, are in a comparable factual and legal situation. […] The concept of 'State aid' does not refer to State measures which differentiate between undertakings and which are, therefore, prima facie selective where that differentiation arises from the nature or the overall structure of the system of which they form part*"[86].

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82 Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraph 58.

83 Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraph 58.

84 Commission Decision State aid SA.26986 (ex No N 582/2008) of 17 June 2009 – Ireland – Health Insurance intergenerational solidarity relief, available at: https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_SA_26986, recital (27). It should be noted that in the same recital the Commission also concluded that "*However, regardless of this argument the scheme is in any event selective on the level of the sector as only health insurers as opposed to undertakings in other sectors can be beneficiaries of the scheme. Accordingly the Commission considers the scheme to be selective in nature.*"

85 Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraph 58.

86 Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraph 41.

(92) In doing so, Ireland observes that the Court of Justice applied the three-stage test[87] which is usually applied with regard to taxation, but can also be applied in other fields[88]. Ireland applied this test involving the following steps:

(a) identifying the reference framework;

(b) establishing whether the measure is a derogation from the system which "differentiates between operators who, in the light of the objective pursued by that ordinary tax system, are in a comparable factual and legal situation" and

(c) if there is such differentiation, considering whether this is justified by the "nature or the overall structure of the system".

*3.1.1. The reference framework*

(93) Ireland considers that the relevant rules are those which apply to undertakings offering PMI in Ireland. It is only those undertakings that are subject to the rights and obligations defined in the RES. The principal objective of the RES is ensuring that access to health insurance cover is available to consumers of health services with no differentiation made between them on grounds such as age or health. The legislation also refers to the principle of intergenerational solidarity and explicitly mentions the desirability of "a cost subsidy between the more healthy and the less healthy, including between the young and the old."

(94) According to Ireland, to achieve this objective, the legislation creates a risk equalisation system that necessarily involves payments to the insurer (or insurers) whose customers have a worse risk profile than the market average. Without such a compensatory mechanism, older customers or those in poor health would not be able to obtain health insurance cover. Equally, market forces would undermine the principal objective if it was not supplemented by the rules on community rating, open enrolment, lifetime cover and minimum benefits. The Act defines the scope of the system, and also the conditions under which it applies, the rights and obligations of undertakings subject to it and the technicalities of the functioning of the system.[89] The mechanisms of the RES only apply to undertakings which offer PMI. As a result, undertakings which do not offer PMI cannot benefit from the RES, and are not asked to contribute to it. The relevant reference framework is therefore the RES itself.

*3.1.2. Differentiation*

(95) The second step of the test as analysed by Ireland involves considering "whether certain undertakings are favoured over others which, in the light of the objective pursued by the legal regime concerned, are in a comparable factual and legal situation". Taking into account the objective of the RES (see recital (93)), Ireland first notes that the RES does not discriminate between undertakings and that, as

[87] See, for example, Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraphs 52-55 and Joined Cases C-20/15 P and C-21/15 P *World Duty Free Group* EU:C:2016:981, paragraphs 57-58.

[88] Paragraph 55 of the *Lübeck* judgment found as regards the three-step test that "*this method is not limited solely to the examination of tax measures*".

[89] Ancillary rules are also laid down in secondary legislation made under the Act.

pointed out at paragraph 53 of the *Lübeck* judgment, the notion of selectivity is linked to the notion of discrimination. Ireland brings forward that the RES rules apply to all undertakings in the same way and that the Commission has accepted this before when it stated that the RES

"*does not discriminate between insurers, as the calculation of contributions and payments is the same for each insurer. It does not discriminate between public and private undertakings either. No entity (public, private or new entrant) is granted exclusive or special rights.*"[90]

(96) Ireland considers that because, "even mid-term projections are extremely difficult to make"[91] it is difficult to establish in advance which undertaking(s) will be a net contributor or net beneficiary of the scheme. Ireland in this respects draws a parallel with the the *Gibraltar* case where the Commission considered that the proposed Gibraltar tax rules were selective because they only applied where the company made a profit and the total amount of tax was capped. According to the Commission, this was selective since it favoured companies which made no profits, or companies which made very large profits. The Court of Justice rejected this argument, pointing out that the rules were neutral and whether an individual taxpayer benefited from them would depend on random events in the future[92].

(97) Furthermore, Ireland notes that if an undertaking becomes a net beneficiary of the RES, this can only arise where its customers have a worse risk profile than the market average. In the light of the objectives of the RES, this is considered an objective criterion for distinguishing between undertakings. Thus, it is inherent in the scheme that there should be risk equalisation, and that payments should be made to support insurers whose customers have a worse risk profile.

(98) In Ireland's view, it is clear that such insurers are in a specific *legal* position: the Act creates a mechanism which entitles such insurers to funding at the expense of their competitors (and imposes on the beneficiary an obligation to repay the money if there is overcompensation). This is not an accident, but an intended feature of the scheme, which aims to prevent insurers from charging a risk-adjusted premium.[93]

(99) Further, Ireland considers that insurers which are net beneficiaries of the scheme are in a specific *factual* position: they are (by definition) providing PMI to a client base which has a worse risk profile than the market average. If matters were left entirely to market forces, a number of consequences would follow (higher premiums, shadow pricing and consequently the insurer with the worst risk profile could be forced out of the market)[94]. Such outcomes would, according to Ireland, clearly be contrary to the principal objective of the RES.

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90 Recital (99) of the 2016 Decision (footnotes omitted).

91 Recital (150) of the 2013 Decision.

92 Joined Cases C-106/09P and C-107/09P *Spain v Government of Gibraltar and United Kingdom* EU:C:2011:732, paragraph 83.

93 See recital (12) of the 2016 Decision.

94 Ireland refers to recitals (86)-(88) of the 2013 Decision.

(100) The RES therefore draws a distinction between insurers with a worse risk profile than the market average, and other insurers. Ireland submits that this distinction is comparable to the distinction accepted by the EU courts in the past, as justifying a difference in treatment between two categories of undertakings[95]. Similarly, in the light of the aims pursued by the RES, there are objective differences between (a) the net beneficiary (or beneficiaries) of the scheme, i.e. providers of PMI whose customers have a worse risk profile than the market average and (b) other insurers.

#### *3.1.3. Nature or overall structure of the system*

(101) Alternatively, under the third stage of the test, if the Commission would consider that the RES distinguishes between the net beneficiary (or beneficiaries) and other insurers, Ireland considers that such differentiation is permissible because it "arises from the nature or the overall structure of the system of which they form part"[96].

(102) Here, according to Ireland, it is clear that the nature and overall structure of the RES is to support insurers whose customers have a worse risk profile than the market average, by means of payments collected from insurers whose customers have a better risk profile. This is inherent in the whole design of the system.

#### *3.1.4. Ireland's conclusion on selectivity*

(103) Taking into account the above, Ireland submits that applying either the second or the third stage of the test identified in the *Lübeck* judgment, the RES is not selective. The Irish authorities have nevertheless notified the planned measure for reasons of legal certainty.

### 3.2. Compatibility

(104) As a subsidiary line of reasoning, Ireland argues that in any event, the RES 2022 is compatible with the internal market under Article 106(2) TFEU as interpreted in the SGEI Framework, see Section 4.5 below.

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95 Ireland has provided the following three examples: (i) Joined Cases C-78/08 to C-80/08 *Paint Graphos*, EU:C:2011:550, paragraphs 57-60. In Paint Graphos the Court of Justice held that co-operatives could be distinguished from ordinary companies. They were not managed in the interests of outside investors but instead were conducted for the mutual benefit of the members who are at the same time users, customers or suppliers. The Court found that cooperatives had little or no access to funding from equity markets. As a result, co-operatives had lower profit margins than ordinary companies. (ii) Case C-417/10 *3M Italia* EU:C:2012:184, paragraph 42. In 3M Italia the Court of Justice considered Italian rules by which claims by the tax authorities were to be written off if the claim had been pending before the courts for over 10 years, and the tax authorities had been unsuccessful at first instance and on appeal. The Court of Justice held that taxpayers coming within the above conditions were in a different factual and legal position to those who were unable to claim the benefit of the national provisions. (iii) Case C-493/15 *Agenzia delle Entrate v Marco Identi* EU:C:2017:219, paragraphs 20-29. In Idente the Court of Justice found that debtors who met the national criteria for bankruptcy (which included acting in good faith as a debtor) were not in a comparable factual or legal position to debtors who did not meet those conditions. This assessment was made having regard to the particular objective of the bankruptcy procedure.

96 Case C-524/14 P *Commission v Hansestadt Lübeck* EU:C:2016:971, paragraph 41.

## 4. ASSESSMENT OF THE MEASURE

### 4.1. Scope of the present decision

(105) The Commission has received several submissions from the three health insurers (see recital (6)). In its assessment the Commission, insofar as the points raised are relevant for the State aid assessment of the notified scheme, will address them and/or reply to them in a footnote. Insofar as the submissions addressed issues related to the past (for example in relation to the implementation of the RES 2016), the Commission considers this to fall outside the scope of the current decision, which is limited to the notified measure, RES 2022, including the introduction of the HCCP and the change in the level of reasonable profit.

### 4.2. Hypothecation of the stamp duties for the financing of the aid

(106) The Commission notes that the RES 2022, in essence, entails (i) the collection of stamp duties from all insurers active on the PMI market, on every insurance contract sold, to finance the Risk Equalisation Fund, and (ii) the payment of credits from the Risk Equalisation Fund to eligible insurers active on the said market.

(107) According to settled case-law, in the case of an aid financed by a tax or a levy assigned for a specified purpose, the financing of the aid might be an integral part of the aid measure itself. Indeed, if it is established that there is a compulsory hypothecation between the tax or levy revenue and the aid measure in question, then the underlying tax or levy and the aid are two elements of one and the same measure, which are inseparable,[97] and both have to be assessed together.

(108) According to settled case-law, for a tax to be regarded as forming an integral part of an aid measure, it must be hypothecated to the aid under the relevant national rules, in the sense that the revenue from the charge is necessarily allocated for the financing of the aid and has a direct impact on the amount of the aid and, consequently, on the assessment of the compatibility of that aid with the internal market.[98]

(109) Therefore, in the present case, the stamp duties, in order to be regarded as forming an integral part of the aid measure have to be hypothecated to the aid - i.e., the credits paid to the insurers whose customers have a worse risk profile - under the relevant national rules, in the sense that the revenue from the charge is necessarily allocated for the financing of the aid..

(110) In the present case, it is apparent from section 7E of the Act that the revenues generated by the stamp duties are earmarked for financing the credits paid to the insurers whose customer base have a worse risk profile than the market average. The stamp duty is levied specifically and solely for the purpose of financing those credits.

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97 See, by analogy, Case C-449/14 P, *DTS Distribuidora de Televisión Digital v Commission*, ECLI:EU:C:2016:848, paragraph 77.

98 Case C-449/14 P, *DTS Distribuidora de Televisión Digital v Commission*, ECLI:EU:C:2016:848, paragraph 68.

(111) The revenues from the stamp duty are wholly and exclusively used to finance the credits and therefore have a direct impact on the amount of that aid. The Irish authorities explained that the level of credits and stamp duties is adjusted every year: the HIA recommends the Minister of Health the level of credits and stamp duties which should apply for the coming year, based on its analysis of the market PMI market and detailed data provided by the insurers. The Minister of Health determines the appropriate levels of credits, and, subsequently, recommends the appropriate level of stamp duty to the Minster for Finance for inclusion in the Stamp Duties Consolidation Act 1999, as amended. Pursuant to sections 7E(1)(b)(iv) and 7E(2)(a)(vi) of the Act, the total amount of stamp duty recommended both by the HIA and the Minister of Health is to be sufficient to meet the total cost of the credits, having regard to the aim of avoiding the Fund sustaining surplus or deficits and making the scheme self-financing. The volume of aid paid to the insurers thus results directly from the revenue generated by the stamp duties. Therefore, the revenues obtained from the stamp duties have a direct impact on the amount of the aid granted in the form of credits to the insurers whose customers have a worse risk profile than the market average.

(112) There is therefore a link of compulsory hypothecation between the aid measure and the revenue arising from the stamp duties. This conclusion is not contested by the Irish authorities as they have indicated in their notification that the system of financing forms an integral part of the aid measure. Hence, the assessment has to take into account not only the stamp duties which finance the measure, but also the relevant characteristics of the aid measure itself.

(113) Since the stamp duties are hypothecated to the aid, the stamp duties financing the credits paid to certain insurers do not have to be assessed separately from the credits themselves.

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

(114) According to Article 107(1) TFEU for a measure to be qualified as State aid within the meaning of Article 107(1) TFEU, the following four cumulative conditions have to be met:

(a) it has to be imputable to the Member State and granted out of State resources;

(b) it has to confer an economic advantage on undertakings;

(c) the advantage has to be selective; and

(d) the measure has to distort or threaten to distort competition and affect trade between Member States.

(115) In this respect, the Commission first of all recalls that, in recitals (51)-(67) of its decision on the RES 2016, it noted that the scheme constituted State aid and that this was undisputed by the Irish authorities, for the following reasons:

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

(116) The RES 2022 is an act of the State, set up by a legislative act[99].. It is thus imputable to the State. The levels of risk equalisation credits and stamp duties are determined by the State (the Minister for Health, in consultation with the Minister for Finance, based on the HIA's recommendations). The State also orders the reimbursement of potential overcompensation, based on the HIA's recommendations.

(117) The RES 2022 operates via the creation of a fund, established by national legislation, which will be financed by compulsory contributions and controlled by public authorities, in this case the HIA (recital (36)).[100]

(118) Furthermore, if the situation of the current account of the Risk Equalisation Fund would be such that the sums that need to be paid from that account are insufficient, the Minister for Health may request the Minister for Finance to advance funding to the Fund's account from the State budget as per the procedure explained in recital (84).

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

#### *4.3.2. Economic advantage to undertakings*

(120) Public funding granted to an entity can only qualify as State aid if that entity is an "undertaking" within the meaning of Article 107(1) TFEU. The Court of Justice has consistently defined undertakings as entities engaged in an economic activity.[101] An activity is considered to be economic in nature where it consists in offering goods and services on a market.[102] The qualification of an entity as an undertaking thus depends on the nature of its activity, with no regard to the entity's legal status or the way in which it is financed.[103] In the present case, all insurers on the PMI market are SGEI providers and will receive credits from the RES 2022, and thus could potentially be net beneficiaries of the scheme (although Vhi Healthcare is expected to continue to be the net beneficiary of the RES 2022, the Irish authorities cannot exclude that another insurer may become a net beneficiary of the RES in the future). The four insurers on the Irish market offer

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99 Health Insurance (Amendment) Act 2021, Number 47 of 2021, available at: https://www.irishstatutebook.ie/eli/2021/act/47/enacted/en/print.html.

100 According to constant case law, *"the funds financed through compulsory contributions imposed by State legislation, which are managed and apportioned in accordance with the provisions of that legislation, must be regarded as State resources within the meaning of Article 87"* (Case 173-73 *Italian Republic v Commission* ECLI:EU:C:1974:71, p. 16; Case 78/76 *Steinike* ECLI:EU:C:1977:52, p. 22; Cases C-78/90 to C-83/90, *Sociétés Compagnie Commerciale de l'Ouest* ECLI:EU:C:1992:118; Cases C-149/91 and C-150/91 *Sanders* ECLI:EU:C:1992:261; Case C-17/91 *Lornooy* [1992] ECLI:EU:C:1992:514; Case C-114/91 *Claeys* ECLI:EU:C:1992:516; Case C-144/91 and C-145/91 *Demoor* ECLI:EU:C:1992:518.

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

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

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

highly diversified voluntary health insurance products at a price set by each insurer individually, in competition with each other. Offering voluntary health insurance on the Irish PMI market thus amounts to an economic activity. Accordingly, with respect to the activities financed by the measure in question, all insurers must be qualified as undertakings.[104]

(121) An advantage for the purposes of Article 107(1) TFEU is any economic benefit which an undertaking would not have obtained under normal market conditions, i.e. in the absence of State intervention.[105] Only the effect of the measure on the undertaking is relevant, not the cause or the objective of the State intervention.[106] Whenever the financial situation of the undertaking is improved as a result of State intervention, an advantage is granted.

(122) The measure under assessment is designed to ensure intergenerational solidarity through risk equalisation, by supporting insurers with a worse risk profile relative to the market. The measure thus improves the situation of the net beneficiaries of the scheme in the market. As a consequence, and without prejudice to the question whether the measure complies with the conditions set out in the *Altmark* judgment (considered below), the measure under assessment *prima facie* grants an advantage to the net beneficiary / beneficiaries of the scheme.

(123) Pursuant to the *Altmark* case law[107], where a State measure must be regarded as compensation for the services provided by the recipient undertakings in order to discharge public service obligations, so that those undertakings do not enjoy a real financial advantage and the measure thus does not have the effect of putting them in a more favourable competitive position than the undertakings competing with them, such a measure is not caught by Article 107(1) TFEU. However, for such compensation to escape qualification as State aid in a particular case, four cumulative conditions must be satisfied:

1. The recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined.
2. The parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner.
3. The compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of public service obligations, taking into account the relevant receipts and a reasonable profit.
4. Where the undertaking which is to discharge public service obligations is not chosen pursuant to a public procurement procedure which would allow for the selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined

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

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

[106] Case 173/73 *Italian Republic v Commission of the European Communities* ECLI:EU:C:1974:71, paragraph 13.

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

on the basis of an analysis of the costs which a typical undertaking, well run and adequately provided so as to be able to meet the necessary public service requirements, would have incurred in discharging those obligations, taking into account the relevant receipts and a reasonable profit for discharging the obligations.

(124) Given that the conditions of applicability of the *Altmark* case law are cumulative, non-compliance with any one of these conditions would lead to the qualification of the measure under review as State aid within the meaning of Article 107(1) TFEU. Similar to previous RES schemes, the RES 2022 appears not to comply with the fourth Altmark criterion, for the same reasons as those outlined by the Commission in recitals (72)-(76) of its decision on the RES 2013. Furthermore, the Irish authorities do not argue in their notification of the RES 2022 that the measure does not confer an advantage in line with the *Altmark* case law.

(125) Consequently, the Commission confirms the analysis carried out in its decisions on previous RES and concludes that the measure ought to be considered as conferring an advantage to the net beneficiary of the scheme, which can be qualified as an economic advantage granted to an undertaking within the meaning of Article 107(1) TFEU.

#### *4.3.3. Selectivity*

(126) To fall within the scope of Article 107(1) of the Treaty, a State measure must favour "certain undertakings or the production of certain goods", *i.e.* it must be selective. Not all measures which favour economic operators fall under the notion of aid, but only those which grant an advantage in a selective way to certain undertakings or categories of undertakings or to certain economic sectors.[108]

(127) Measures of purely general application which do not favour certain undertakings only or the production of certain goods only do not fall within the scope of Article 107(1) of the Treaty. However, the case-law has made it clear that even interventions which, at first appearance, apply to undertakings in general may be selective to a certain extent and, accordingly, be regarded as measures designed to favour certain undertakings or the production of certain goods.[109] Neither a large number of eligible undertakings (which can even include all undertakings of a given sector), nor the diversity and size of the sectors to which they belong, provide grounds for concluding that a State measure constitutes a general measure of economic policy, if not all economic sectors can benefit from it.[110] The fact that the aid is not aimed at one or more specific recipients defined in advance, but that it is subject to a series of objective criteria according to which it may be granted, within the framework of a predetermined overall budget allocation, to an

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[108] Commission Notice on the notion of State aid as referred to in Article 107(1) of the Treaty on the Functioning of the European Union C/2016/2946, OJ C 262, 19.7.2016, p. 1, , paragraph 117.

[109] Judgment of the Court of Justice of 29 June 1999, *DMTransport*, C-256/97, ECLI:EU:C:1999:332, paragraph 27; Judgment of the General Court of 6 March 2002, *Territorio Histórico de Álava — Diputación Foral de Álava et aL.* v *Commission*, Joined Cases T-127/99, T-129/99 and T-148/99, ECLI:EU:T:2002:59, paragraph 149.

[110] See, for instance, Judgment of the Court of Justice of 17 June 1999, *Belgium* v *Commission*, C-75/97, ECLI:EU:C:1999:311, paragraph 32; Judgment of the Court of Justice of 8 November 2001, *Adria-Wien Pipeline*, C-143/99, ECLI:EU:C:2001:598, paragraph 48.

indefinite number of beneficiaries who are not initially individually identified, is insufficient to call into question the selective nature of the measure.[111]

(128) Further, the Court has consistently held that Article 107 (1) TFEU does not distinguish between measures of State intervention by reference to their causes or their aims but defines them in relation to their effects, and thus independently of the techniques used.[112] In other words, a measure must be considered as selective if its concrete effect is to favour certain undertakings or categories of undertakings.

(129) In the case at hand, the Commission first notes that the measure at stake concerns only one sector, namely the private medical insurance sector. In this respect, it must be noted that, in accordance with settled case-law, an aid may be selective even where it concerns a whole economic sector.[113]

(130) Furthermore, the Irish authorities' argument that the RES 2022 is not selective since it could, in theory, benefit any health insurer that has a worse risk profile than the average market risk profile, cannot convince. The Commission recalls in this regard that *"the fact that the aid is not aimed at one or more specific recipients defined in advance, but that it is subject to a series of objective criteria according to which it may be granted, within the framework of a predetermined overall budget allocation, to an indefinite number of beneficiaries who are not initially individually identified, is insufficient to call into question the selective nature of the measure*".[114] Besides, in line with the case-law, the selectivity of a measure must be "*determined by taking all undertakings into account and not just the undertakings within the same group which enjoy the same advantage*".[115]

(131) It follows from the above that in the present case, the fact that the RES is open to any undertaking registered in The Register of Health Benefits Undertakings[116] and therefore is targeted to an indefinite number of beneficiaries not initially individually identified is insufficient to argue the absence of selectivity. Moreover, the absence of selectivity cannot follow from only looking at whether "the undertakings within the same group" enjoy the same advantage or, in the present case, *could* enjoy the same advantage. Indeed, one should take into account all undertakings and independently from whether only private medical insurance undertakings are looked at or the whole economy, there is in the present case a clear difference in treatment between the private medical insurance undertakings and others.

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111 Judgment of the General Court of 29 September 2000, *Confederación Espanola de Transporte de Mercancías* v *Commission*, T-55/99, ECLI:EU:T:2000:223, paragraph 40. See also Judgment of the General Court of 13 September 2012, *Italy* v *Commission*, T-379/09, ECLI:EU:T:2012:422, paragraph 47.

112 Judgment of the Court of Justice of 22 December 2008, *British Aggregates Association v Commission*, Case C-487/06, paragraph 89.

113 Case C-148/04 *Unicredito Italiano*, ECLI:EU:C:2005:774, paragraph 45.

114 Case T-55/99, *Confederación Espanola de Transporte de Mercancías v Commission*, ECLI:EU:T:2000:223, paragraph 40.

115 Case T-222/04 *Italy v Commission*, ECLI:EU:T:2009:194, paragraph 66.

116 Section 14 of the Act.

(132) The RES 2022 is not only selective when comparing the private medical insurance sector to other sectors of the economy as a whole, it is also selective within the insurance sector overall. Indeed, it specifically benefits insurers active on the private medical insurance market with a worse risk profile relative to the market. The net beneficiaries of the scheme are therefore also favoured compared to other segments of the insurance sector, where the risks – and the associated costs – are inherent to the economic activity and supported by the undertakings which are providing insurance services on the market and for which Ireland does not provide for a similar risk equalisation scheme. Hence, insurers with a worse risk profile on the PMI market are favoured in comparison with insurers active in other segments of the market (for example in life insurance) having the same risk profile .

(133) It should be underlined that the very logic of the RES 2022 consists in introducing a distortion of competition in the private medical insurance sector, by using State resources so as to depart from the traditional basic features of the insurance activity, namely setting the insurance premiums according to the degree of risk induced by every insured party. The purpose of the Irish authorities is the creation of a SGEI[117].

(134) Further, the Commission notes that there are only three operators active in the PMI market in Ireland. The RES scheme has the **effect** of addressing the specific situation of Vhi, which, compared to the other operators, has currently relatively more contracts with customers with a worse risk profile than the average of the market. Since the beginning of the scheme there has been only one net beneficiary (Vhi) from the scheme; the other insurers being – on a continuous basis – net contributors to the scheme. The effect of the scheme is therefore to benefit only one undertaking over its competitors. Based on the data provided by Ireland, the Commission has no indication that this situation would change in the foreseeable future.

(135) For this reason, the scheme appears to be *de facto* selective as the combined effect of the aid scheme and its financing mechanism (the stamp duties on health insurance contracts) favours one particular undertaking only, i.e. at the moment Vhi. The Commission recalls that "*de facto selectivity can be established in cases where, although the formal criteria for the application of the measure are formulated in general and objective terms, the structure of the measure is such that its effects significantly favour a particular group of undertakings*"[118]. In that regard, it should be observed that the fact that, currently, only Vhi receives more from the Risk Equalisation Fund than that it contributes is not a random consequence of the scheme at issue, but the inevitable consequence of the fact that the RES is specifically designed so that, while stamp duties are collected from all insurers active on the PMI market, only private insurers whose customers have a worse risk profile than the market average receive payments in the form of credits exceeding the value of stamp duties contributed by those insurers from the Risk Equalisation Fund. Thus, the fact that those insurers (and, currently, only Vhi) receive risk equalisation credits precisely on account of the specific features

[117] See, by analogy, Case C-526/04, Laboratoires Boiron SA, ECLI:EU:C:2006:528, paragraphs 33 to 37.

[118] Commission Notice on the Notion of aid, paragraph 121.

of their customers leads the Commission to conclude that those undertakings enjoy *de facto* a selective advantage.

(136) As regards the judgment in *Lübeck* cited by the Irish authorities, while the Commission has doubts on its relevance for the present case, it does not affect the conclusion the Commission drew on the selective character of the RES in its previous decisions.

(137) Whether it is necessary or not to apply formally the three-step test in the situation at stake is doubtful. It is true that the Court also applied the three-step test in other fields than taxation (see recital (92)). Nevertheless this test was primarily conceived for the selectivity assessment of measures mitigating charges that undertakings would normally have to bear (for instance, tax or social security exemptions for undertakings fulfilling certain criteria) and technically justified by the very nature of these negative measures. Thus the *Lübeck* case concerned a 'negative measure', i.e., a schedule of charges of an airport providing for low charging rates.

(138) The fact is that a positive measure (in particular a subsidy) is more easily identified as selective because normally not all the undertakings but only certain undertakings benefit from that type of measures.

(139) As, in the case at issue, the stamp duties must be seen as the financing mechanism of the aid scheme and therefore as being an integral part of that aid scheme (see above section 4.2). The RES 2022 is a positive measure benefitting insurers whose customers have a worse risk profile than the market average and its analysis of selectivity can rely simply on the above-mentioned considerations.

(140) In fact, the Commission considers that if it would apply the three-step test to the RES 2022, the conclusion reached would still be that the RES 2022 is selective. Taking into account that the aid is in the form of subsidies (i.e. the credits) from a State-managed fund, the system of reference in this case is the operation of the same undertakings under the normal market conditions, that is to say in the absence of subsidies compensating for risks related to composition of the customers' portfolio of insurers.

(141) As the RES 2022 aims to compensate undertakings for costs for risks that they would normally incur under normal market conditions, the reference system is the functioning of the PMI market in the absence of the risk equalisation schemes. As underlined above, the very logic of the scheme is to distort the conditions of competition which would result from the mere implementation of the ordinary and usual criteria applied by private insurers. The fact that the RES rather also aims at ensuring access to health insurance cover available to users of health services without distinction between themis rather a characteristic of the SGEI as defined, which aims to provide the service in conditions different from those that would be otherwise ensured by the market. However, the SGEI itself, or one of its characteristics cannot define the normal market conditions under the reference system. The measure therefore constitutes a derogation from the system of reference (i.e. normal market conditions), since it alleviates the normal costs for certain companies.

(142) Ireland argues that the system of reference is the RES itself. In this respect, as explained in recital (140), the Commission notes that the RES is a system which

deviates from the rules applicable under the normal market conditions as it addresses a market failure, resulting from the Act itself by compensating the insurer(s) with the customer portfolio with the highest health risks compared to the market average. Therefore, the RES itself cannot be seen as the reference framework. In addition, the General Court has stated in Belgium v Commission that "*the selective nature of a measure must be assessed by reference to all undertakings and not by reference to the undertakings which benefit from the same advantage within the same group"*[119] Here, by contrast, Ireland only refers to the (three) undertakings in the same group, namely the group of private medical insurers in Ireland. On appeal, in Belgium v. Commission, the Court upheld the judgment of the General Court and the reasoning followed by the Commission[120]. In that case, the Commission was right to take the view 'that operators in the bovine sector benefited from an advantage which was not available for undertakings in other sectors, since the tests which they were required to perform before placing their products on the market or trading in them were provided free of charge, whereas undertakings in other sectors were unable to avail themselves of that possibility. The scope of reference framework covered all the undertakings subject to inspections which they are required to perform before placing their products on the market and the scope of the comparison between these undertakings also covered all these undertakings. The point of comparison was the normal situation on the market. This analysis can be transposed *mutatis mutandis* to the present case.

(143) The beneficiary or potentially beneficiaries of the scheme is/are therefore favoured compared to all other undertakings in all other sectors and in the same sector, which have to bear their own costs related to the risks derived from their customers portfolio. The measure is therefore prima facie selective.

(144) Should the scheme be found *prima facie* selective in accordance with the second step (derogation) of the three-step approach, the Irish authorities have claimed that a distinction between the net beneficiary (or beneficiaries) and other insurers would be justified because it "arises from the nature or the overall structure of the system of which they form part". In other words, under the third step (justification) of the three-step approach, the scheme would be justified by the logic of the reference system. According to Ireland, the nature and overall structure of the RES is to support insurers whose customers have a worse risk profile than the market average, by means of payments collected from insurers whose customers have a better risk profile. This would be inherent in the whole design of the system. In this regard, the Commission considers that the justification put forward by the Irish authorities relies on the incorrect assumption that the reference system is the RES (see also recital (142)).

(145) Moreover, any justification under the third step should be inherent to the nature (or overall structure) of the reference system identified in the first step of the three-step approach (identification of the reference system). Accordingly, any such justification should be based on the nature of the normal market conditions under which undertakings should operate. The Commission cannot see and

[119] Case T-538/11, Belgium v Commission, ECLI:EU:T:2015:188, paragraph 114.

[120] Case C-270/15P, Belgium v. Commission, ECLI:EU:C: 2016:489, paragraphs 51 and 53.

Ireland has not put forward any relevant justification that would be inherent to a system that would apply under normal market conditions.

(146) On the basis of the above, the Commission considers that the RES 2022 is selective within the meaning of Article 107(1) TFEU.

*4.3.4. Distortion of competition and effect on trade*

(147) The RES 2022, under the current conditions on the Irish PMI market, will lead to a net payment in favour of Vhi, the State-owned former monopolist. The Fund making that payment will have been financed by net contributions from the other insurers on the market (namely ILH and Laya), but also by Vhi itself. The scheme has a clear potential to affect competition as it is anticipated that it will require, in effect, the private operators on the market to make payments in favour of the dominant operator, i.e. Vhi. In this context, as net contributors to the RES, the private operators might increase their premiums (which are not subject to price regulation), and this could lead to some young customers that can barely afford private health insurance opting out of the PMI market. Thus, the competitive positions of the respective operators on the market might be affected by the RES. Accordingly, the Commission considers that there exists a threat of distortion of competition within the meaning of Article 107(1) TFEU.

(148) Moreover, PMI is part of the internal market for services of voluntary health insurance. The Commission notes that cross-border trade and investment activity in this sector is substantial across Europe, as demonstrated by the several takeovers of insurance business in the past (BUPA taken over by Quinn and then by Laya; and Hibernian by Aviva and then by ILH) and by the various examples of insurers moving in and out of the Irish PMI market (e.g. the establishment of GloHealth in 2012). Furthermore, new insurers can and do enter the market indirectly through underwriting contracts. The actors behind some of the insurers on the market are international groups, with activities in various EU Member States and worldwide. In this context, the Commission considers that the measure is also liable to have an effect on trade between Member States.

*4.3.5. Conclusion on the existence of aid*

(149) The Commission considers that the RES 2022, like the RES 2016, constitutes State aid within the meaning of Article 107(1) TFEU.

### 4.4. Legality of the aid

(150) The Irish authorities committed not to put into effect the proposed RES 2022 before the Commission has decided on its notification. The legal basis that will enable the RES contains a clause that the Minister for Health can set the commencement date for the amended legislation (recital (87)). The Minister for Health has not yet set the commencement date and the will not do that before a positive decision from the Commission.

### 4.5. Compatibility of the aid under the 2012 SGEI Framework

(151) Under certain conditions, Article 106(2) TFEU allows the Commission to declare compensation for SGEIs compatible with the internal market. The 2012 SGEI

Framework[121] sets out guidelines for assessing the compatibility of SGEI compensation which exceeds € 15 million per year.

*4.5.1. Genuine service of general economic interest and public consultation*

(152) Pursuant to paragraph 12 of the 2012 SGEI Framework, aid must be granted for a genuine and correctly defined SGEI. The Court of Justice has held that SGEIs are services that exhibit special characteristics as compared with those of other economic activities.[122]

(153) As indicated in the 2012 SGEI Framework, Member States have a wide margin of discretion regarding the nature of services that could be classified as SGEIs. The Commission's task is to ensure that the margin of discretion as regards the definition of an SGEI is applied without manifest error.

(154) The previous Commission decisions on the RES 2003 (see also BUPA case law[123]), the Interim Scheme for 2008-2012, the RES 2013 and the RES 2016 (see recital (32)), accepted that the provision of private health insurance cover under the conditions of community rating, open enrolment, lifetime cover and minimum benefits is an SGEI. The obligations imposed on health insurers operating in the market were also accepted as SGEI obligations. The RES 2022 does not alter the nature of either the service provided or the obligations on insurers.

(155) In particular, the Commission observes that the RES 2022 aims to ensure that PMI services in Ireland continue to be provided in conformity with the public service obligations defined by legislation and the principal objective of the Act (i.e. supporting, in the interest of citizens, intergenerational solidarity on the Irish PMI market). Intergenerational solidarity continues to be essential to the functioning of the market and this cannot be achieved without a robust risk equalisation scheme. The robustness of the scheme is further improved with the proposed introduction of a HCCP (Section 2.5.2). In this respect, the Irish authorities consider that the provision of PMI services and in particular the continued support of intergenerational solidarity would not be ensured satisfactorily otherwise than under conditions imposed in the public interest.

(156) In light of the above, the Commission considers that the provision of private health insurance cover under the conditions of community rating, open enrolment, lifetime cover and minimum benefits over the period 1 April 2022 to 31 March 2027 qualifies as a genuine SGEI.

(157) Paragraph 14 of the 2012 SGEI Framework provides that "*Member States should show that they have given proper consideration to the public service needs supported by way of a public consultation or other appropriate instruments to take the interests of users and providers into account.*"

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[121] Communication from the Commission — European Union framework for State aid in the form of public service compensation (2011), OJ C 8, 11.1.2012, p. 15–22.

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

[123] See footnote 23.

(158) In this respect, the Commission notes that the interests of both users and providers of private health insurance are regularly taken into account by the Department of Health and the HIA. More specifically, the HIA conducts a consumer survey every two years, to gauge attitudes towards private health insurance, identify trends and assess the impact of the economic climate on customer perceptions. The results of this survey are published on the HIA's website[124]. The latest surveys were carried out in 2020 and 2021 (see recitals (159) and (161) below). This research assists the HIA in recommending the level of credits that should apply under the RES. In recommending the level of credits, the HIA is required by section 7E(1)(b)(iii)(I) of the Act to take account of a range of factors, including its views of the health insurance market and the sustainability of that market.

(159) Furthermore, a survey of a nationally representative sample of adults aged 16-64 was conducted by Kantar in December 2020 concerning the public service obligations underpinning the RES, which showed an overall positive perception of the RES and the objectives it pursues as follows from the answers to (a selection of the) questions asked:

(a) 76 % of the respondents agreed with the statement that health insurers should be obliged to sell health insurance to anyone that wants it, regardless of their health or age.

(b) 67 % of the respondents agreed with the statement that a person's health should not affect the price they pay for health insurance.

(c) 72 % of the respondents agreed with the statement that older people should not be charged more for health insurance.

(d) 83 % of the respondents agreed with the statement that all private health insurance plans should cover a minimum level of health care, e.g. it should at least cover the cost of a hospital stay in a multi-occupant hospital room.

(e) 71 % of the respondents agreed with the statement that the current policy that an individual cannot be financially discriminated against for health insurance because of their health status is the correct policy

(f) 59 % of the respondents agreed that the current policy that a portion of all health insurance premiums is used to subsidise the health insurance premium costs of older and sicker people is the correct policy.

(160) The results of the Kantar consultation are broadly in line with the results of the consultation carried out in 2015 (see recital (78) and (79) of the 2016 Decision).

(161) Members of the public were also invited to give detailed views on the proposed amendments to the RES (i.e. the introduction of the HCCP). This consultation was published on the HIA and Department of Health websites on 5 January 2021

[124] See https://www.hia.ie/publication/consumer-surveys

and received 20 submissions from PMI providers, organisations, and individuals[125]. The results of the public consultation have been published[126].

(162) Out of the 20 responses, two responses indicated that the introduction of the HCCP would affect them. One response came from the general public and no explanation was provided. The other response came from ILH which stated that in theory the HCCP may increase the effectiveness of the RES. However, their view is that, based on the information available to them at the time, it is likely that HCCP increases the cost of health insurance for those who can least afford it. ILH were also of the opinion that the HCCP will share inefficiencies across the market and increase claims cost to the detriment of customers and cause further instability within the market. Later on, ILH indicated that they agree with the introduction of an HCCP as long as it would be in line with the paper from the HIA of 11 June 2021 (recital (66)).

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

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

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

(165) The content of the PMI obligations is clearly described in the Act, as outlined in recital (16). The RES 2022 relies on the explicit entrustment via the Act, together with the Stamp Duties Consolidation Act 1999 (as amended), of the SGEI to all undertakings wishing to provide their services on the health insurance market in Ireland. The Commission observes that it is essential to the proper functioning of the RES that all PMI insurers active on the Irish market are entrusted with the PMI obligations and participate in the RES 2022. In other words, if an insurer wishes to offer PMI, it must do so in compliance with the PMI obligations and participate in the RES.

(166) The method for compensation depends on objective and easily verifiable parameters, namely the number of persons insured by each insurer in each of the clear and transparent categories, i.e. depending on age, gender, and defined level

[125] Alliance of Retirement Public Servants; AON (Health Care Advisors for large multinationals); Dr Conor Keegan; ESB Staff Medical Provident Fund; Irish Life Health; Irish Society of Physicians in Geriatric Medicine; Laya Healthcare; Retired Civil and Public Servants Association; Ruth Barrington, Former Assistant Secretary, Department of Health Chief Executive, Health Research; Board Director, Voluntary Health Insurance Board; Society of Actuaries in Ireland; Vhi Insurance Dac; and 9 members of the public.

[126] The HIA has published a report on the consultation, which can be seen at https://www.hia.ie/sites/default/files/Report%20on%20public%20consultation%20_Final%20June%202021_1.pdf

of coverage, as well as with reference to hospital bed utilisation. As concerns the age and health status calculations, the Commission is of the view that the parameters put in place for the RES 2022 are sufficiently clear and defined in advance.[127] This is also valid for the HCCP whereby the parameters are clearly defined in advance (see notably recital (63)). Moreover, as with the previous schemes, the level of age related health credits and HUCs and stamp duties will be set in advance each year for the whole year and communicated to insurers accordingly, so that they are able to factor the effects of the risk equalisation credits and the stamp duties into their business decisions.

(167) Finally, the Act establishes the criteria for calculating the reasonable profit (see recitals (69) to (79)), in accordance with section 7F of the Act and the 2012 SGEI Framework[128].

(168) In conclusion, the Commission considers that the entrustment for the period 1 April 2022 to 31 March 2027 is in line with the 2012 SGEI Framework requirements.

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

(169) The Irish authorities in their notification to the Commission sought approval for compensation under the scheme for five years, i.e. for the period 1 April 2022 to 31 March 2027. For the SGEI entrustment as such, Ireland commits to end the entrustment after a period of not longer than 5 years, with an end date of 31 March 2027. Ireland commits to do this in Irish law at the earliest opportunity, meaning during 2022, however in any event by the end of 2023 at the latest.

(170) The Commission therefore considers that no concerns are raised in relation to paragraph 17 of the 2012 SGEI Framework.

#### *4.5.4. Compliance with the Directive 2006/111/EC and separation of accounts*

(171) According to paragraph 18 of the 2012 SGEI Framework, *"aid will be considered compatible with the internal market on the basis of Article 106(2) of the Treaty only where the undertaking complies, where applicable, with Directive 2006/111/EC on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings"*.[129] In addition, according to paragraph 44 of the 2012 SGEI Framework, *"[w]here an undertaking carries out activities falling both inside and outside the scope of the SGEI, the internal accounts must show separately the costs and revenues associated with the SGEI and those of the other services."*

(172) Under Section 7D of the Act, each insurer must provide the HIA with information (in a standardised form) every six months (see recital (45)). This provision,

[127] As explained in recital (45), the legislation sets out in full the information that all health insurers must provide to the HIA for the purposes of enabling it to make the necessary calculations regarding the credits and stamp duty levels, as well as for the HIA to have the data necessary to conduct the overcompensation test.

[128] Section 7F(4A)(a) and (b) of the Act.

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

together with Section 7F of the Act (see recital (73)), requires insurers to keep separate accounts of their PMI activities, separate from any other activities (e.g. travel insurance)[130]. Moreover, the claims costs and premiums related to PMI are linked to individually identifiable policies.[131]

(173) Thus, all insurers are required to maintain separate accounts for their health insurance business and provide financial data to the HIA. At recital (91) to its 2016 Decision, the Commission accepted that the accounts submitted to the HIA were different from the published accounts (which may have been finalised on a different date and may include businesses other than PMI). As the insurers are in competition, the accounts submitted to the HIA are not publicly disclosed. Nevertheless, the Commission accepted that

*"the data submitted by insurers to the HIA provides transparency to the HIA on the impact of the scheme on individual insurers and the market and is critical in informing the HIA's assessment of any overcompensation that may occur"*[132]

(174) Finally, the Risk Equalisation Fund administered by the HIA is subject to audit by the Comptroller and Auditor General[133] under section 11D(9) of the Act. The audit report is provided to the Minister, and made available to the Oireachtas (the national parliament) under section 11D(10) of the Act. It is also published on the HIA website.[134]

(175) In light of the above, the Commission considers that undertakings entrusted with the provision of the SGEI in this case comply with Directive 2006/111/EC[135] and keep separate accounts in line with paragraph 44 of the SGEI Framework.

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130 Laya expressed concerns over the acquisition of a building by Vhi in South County Dublin. According to Laya, it would never be in a position itself to acquire such a building to leave it unoccupied with no real sign of it opening or being put to any use. Ireland has explained that the building was acquired by Vhi Group (more specifically Vhi Health and Wellbeing Holdings DAC), which is different from Vhi Insurance DAC. This also follows from the 2018 and 2019 consolidated accounts for Vhi Group, which are separate from those of Vhi Insurance DAC. The accounts show that land/building assets on the balance sheet increased with approximately EUR 30 million whereas for Vhi Insurance DAC the land/building assets remained broadly the same.

131 Recital (90) to the 2016 Decision.

132 Recital (91) to the 2016 Decision.

133 The office of Comptroller and Auditor General is defined in Article 33 of the Constitution of Ireland, which provides that duty of the Comptroller and Auditor General is to "*control on behalf of the State all disbursements and to audit all accounts of moneys administered by or under the authority of the Oireachtas [the national parliament]"*.

134 See: https://www.hia.ie/publication/annual-reports-accounts.

135 ILH claimed that Vhi and the Irish Department of Health have too close of a relationship that would exemplify an inherent conflict of interest. In the same vein, Laya argues that contrary to other semi-State bodies in Ireland, Vhi does not pay dividends to the Irish State. The Commission is of the view that the relationship between Vhi and the Irish government is merely a reporting relationship between Vhi and the Department of Health, which cannot be considered such that this entails a conflict of interest. As regards the absence of any dividend payments from Vhi to the Irish State, Ireland has explained to the Commission that as a statutory corporation established by the Voluntary Health Insurance Act 1957, Vhi does not have a shareholder by law. The Minister for Health is the de facto shareholder and responsible for corporate oversight of Vhi. Moreover, Vhi is subject to the same commercial rules as the other insurers and subject to regular commercial rates to raise funds, this means that the RES does not discriminate between the different insurers (recitals (178) to (182)). As to the reference of Laya to a cash flow arrangement between the HSE and Vhi, Ireland has noted that any insurer is free to enter into a similar agreement with the HSE.

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

(176) Paragraph 19 of the 2012 SGEI Framework makes the compatibility of SGEI compensation conditional upon compliance with Union public procurement rules, where applicable.

(177) The Commission notes that, since any operator wishing to provide its services on the PMI market is entrusted with the SGEI under the RES 2022, it is not necessary to use the public procurement rules in order to ensure compliance with the 2012 SGEI Framework in this case.

#### *4.5.6. Absence of discrimination*

(178) According to paragraph 20 of the 2012 SGEI Framework, *"[w]here an authority assigns the provision of the same SGEI to several undertakings, the compensation should be calculated on the basis of the same method in respect of each undertaking."*

(179) The Commission observes that the RES 2022 operates in an identical manner in respect of all insurers on the Irish PMI market, as it is based on objective criteria. First, the stamp duties levied under the RES are levied on individual plans, thus the total amount paid by an insurer is dependent on the number of policies sold and the level of cover provided under each plan[136]. Second, the credits received by insurers under the RES are based on individual customer characteristics (age, gender and level of cover), actual number of hospital admissions and level of claims submitted (i.e. the HCCP).

(180) The HIA is an independent authority and follows an objective procedure for recommending the proposed levels of credits and stamp duties. The Minister for Health in cooperation with the Minister for Finance, in their respective capacities, determine the levels of credits and stamp duties, taking into account the objective of achieving community rating and thereby intergenerational solidarity.

(181) The RES does not constitute a barrier to entry to the Irish private health insurance market. The SGEI is entrusted to all insurers offering or seeking to offer open-market, in-patient private health insurance. The scheme provides for the calculation of contributions and payments on the basis of non-discriminatory criteria. It does not discriminate between public and private undertakings.[137] No entity (public, private or new entrant) is granted exclusive or special rights.

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[136] ILH considered that the system of stamp duties should be replaced with a system based on a percentage-based levy. The Commission considers that allowing this would be contrary to the objective of the RES, which is to ensure that access to health insurance cover is available to consumers of health services with no differentiation made between them. The objective takes into account the desirability of ensuring 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. It follows from a HIA report from September 2020 that already now the average premiums paid by those aged under 60 were lower than the average premiums for those aged over 60, for the most popular levels of cover. An approach whereby the credits paid from the RES are funded by a levy charged as a percentage of premium would place a higher financial burden on those paying higher premiums, meaning that older and less healthy people would fund a higher proportion of the credits. This would be a fundamental dilution of the objective and effectiveness of the RES.

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

(182) Therefore, the Commission considers that the notified measure complies with paragraph 20 of the 2012 SGEI Framework.

*4.5.7. Amount of compensation*

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

4.5.7.1. Net cost calculation

(184) In the RES, all operators are obliged to participate, rather than the SGEI provision being entrusted to a single operator. As with the previous schemes, the RES 2022 does not aim to compensate the net costs of providing private health insurance in Ireland, but rather to reduce the differences in these net costs arising from divergences in the risk profiles of insurers active on the Irish PMI market. This very specific objective is achieved by the specific methodology used under the RES, with the determination of the appropriate level of credits and stamp duties.

(185) The net cost of the obligation still has to be calculated to verify the absence of overcompensation. However, the net avoided cost methodology does not appear adequate for such verification, as that approach relies on the difference between the situation of the net beneficiary with the public service obligations and a situation without the public service obligations. In the net avoided cost model, it is assumed that competitors do not have the same public service obligations and compensation could be granted up to a level that would render the SGEI provider indifferent to delivering the SGEI or not, and would therefore offset the specific burden put on the SGEI provider in comparison with its competitors. The situation under the RES is peculiar, as all competitors are entrusted with the same public service obligations and there is no possibility to operate on the market without them. There is no counterfactual scenario in which the net beneficiary would nevertheless operate as a provider of PMI services. For these reasons, the net avoided cost method does not seem appropriate and, as foreseen by footnote 2 of the 2012 SGEI Framework, the net cost should be calculated as cost minus revenues.[138]

(186) The operation of the RES, given current customer profiles, has resulted in one net beneficiary and two net contributors. As regards the RES 2022, Vhi Healthcare is expected to continue to be the net beneficiary of the scheme, while its competitors will be net contributors. The projected net financial impact of the RES based on

[138] Footnote 2 of the 2012 SGEI Framework reads as follows "*In this context, net cost means net cost as determined in paragraph 25 or costs minus revenues where the net avoided cost methodology cannot be applied*."

the credits and stamp duties applying for policies commencing on 1 April 2022 is outlined in Table 5. However, as insurers' customer profiles change over time, in future years there may be more than one net beneficiary and the net amount paid by net contributors may reduce. Over the next decade, as the market ages, the risk profiles of all insurers are likely to become more homogenous. This would reduce the net gain or loss for each insurer from the RES. In this regard, the design of the RES ensures that the impact on each insurer is proportionate to the relative differences in customer profile between insurers and the overall market.

(187) It should be noted that even if all insurers had similar customer risk profiles which matched the total market profile, a risk equalisation scheme (albeit one with low rates of net contributions and net benefits) would still be necessary to prevent existing insurers or new entrants targeting low risk customer groups to the detriment of high risk customer groups. While the HCCP improves the efficiency of the RES, there is still some incentive to compete based on risk as the scheme is still not fully effective, one of the key objectives of the RES is to reduce this incentive to compete based on risk, which should drive competition to other areas, e.g. efficiency, claims cost management and product design. Without the RES, the incentive to compete on risk, i.e. by targeting healthier customers, would be much greater and would threaten the sustainability of the PMI market in Ireland as a necessary complement to the public health system and reduce the incentive to compete in areas such as efficiency and quality, which would be more beneficial to the long-term operation of the market.

#### 4.5.7.2. Reasonable profit and verification of the absence of overcompensation

(188) Paragraph 34 of the 2012 SGEI Framework foresees that *"[w]here duly justified, profit level indicators other than the rate of return on capital can be used to determine what the reasonable profit should be, such as the average return on equity over the entrustment period, the return on capital employed, the return on assets or the return on sales."* Furthermore, as laid out in paragraph 49 of the 2012 SGEI Framework, *"Member States must ensure […] that undertakings are not receiving compensation in excess of the amount determined in accordance with the requirements set out in this section. They must provide evidence upon request from the Commission. They must carry out regular checks, or ensure that such checks are carried out, at the end of the period of entrustment and, in any event, at intervals of not more than three years."*

(189) As explained in recitals (67) to (71), the HIA will determine the reasonable profit with reference to Return on Sales (ROS), defined as earnings before tax (EBT) divided by revenues, excluding reinsurance and investment activities.

(190) Based on forward-looking benchmarking calculations carried out by Oxera Consulting, overcompensation will be deemed to have occurred where the net beneficiary's ROS gross of reinsurance[139] exceeds 6 % per annum, calculated on a rolling three year basis[140].

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[139] This indicator does not include the impact of investments of the PMI provider.

[140] The calculation is carried out based on the financial accounts of the health insurers. Those accounts were drawn up in accordance with Generally Accepted Accounting Principles ('GAAP'). With the newly proposed accounting

(191) Considering that a ROS of 6 % falls within the range established by Oxera Consulting (see recital (71)), the Commission considers that it can be considered a reasonable profit[141].

(192) Based on Vhi's business plan and historical figures, Oxera has estimated that the ROS gross of reinsurance of the expected net beneficiary (Vhi Healthcare) will be 3.2 % in 2022 and 2.8 % in 2023 and 3.8 % in 2024, 2025 and 2026. Therefore, it does not appear likely that Vhi Healthcare will be overcompensated in the future. In any event, HIA will carry out an overcompensation test during the entire period covered by the present decision (i.e. 2022-2027), on a rolling three year basis[142]. The fact that the overcompensation test is carried out on a rolling three year basis (so effectively every year an overcompensation test is carried out) is in line with the SGEI Framework, which requires in paragraph 49 that overcompensation checks are carried out at least at intervals of not more than three years. Furthermore, as outlined in recital (80), a clear procedure has been established for the recovery of any overcompensation that may be found to have occurred under the RES.

(193) That said, it results from the manner in which the system is set up that overcompensation is highly unlikely. The operation of the RES aims to ensure that insurers are not impacted beyond the degree necessary to ensure an efficient and sustainable, community-rated PMI market. A key feature of the RES is that the amount of compensation provided to all insurers does not exceed what is necessary to cover the net cost of discharging the public service obligations, including a reasonable profit. In the absence of community rating, an insurer

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regulations (see recital (75) to (79)), Ireland has further detailed the accounting requirements. According to Vhi, those new accounting regulations diverge from GAAP and would introduce a "manifest error" in the overcompensation test since the accounts of the companies on the basis of which Oxera established a ROS in the range of 5.5 % to 8.6 % are drawn up in accordance with GAAP. The Commission notes that with the minimal deviation from GAAP, the Irish authorities address concerns expressed by the HIA in March 2020 when it provided the results of the overcompensation test for 2016-2018. The Commission acknowledges that imposing the same accounting standards on all insurers ensures equal treatment in the accounting and makes the calculation of possible overcompensation more reliable and consistent.

141 Vhi considers that the ROS benchmark should have been set at the upper end of the range calculated by Oxera Consulting because in Oxera Consulting's report the following statement is included: "*given the fact that [ILH and Laya] exhibit a relatively high level of profitability, the appropriate ROS benchmark could lie towards the upper end of the range*." (emphasis added) The Commission notes that this is a mere suggestion and that in principle every benchmark falling within the range calculated by Oxera Consulting would be "reasonable". In addition, the Commission notes that it was Vhi that in the context of a public consultation leading to the HIA report "HIA Recommendation for an Appropriate Benchmark for the Overcompensation Assessment" of July 2021 stated that it believes that the ROS benchmark should be increased "*to a minimum of between 5.6% and 7.5% (based on comparable companies operating in Ireland)*". The Commission notes that a ROS of 6 % falls within the range proposed by Vhi.

142 ILH has claimed that the overcompensation test as approved in the 2016 Decision could be circumvented by the net beneficiary. The Commission notes that the overcompensation test applies to all insurers in the same way. The accounts on the basis of which the overcompensation test is carried out were certified by an independent accountant as required under Irish legislation and prepared according to standard international accounting principles. As part of the overcompensation test 2017-2019 (published in 2020), the HIA had concerns as to the accounting treatment of some items and the inability to prescribe the bases of accounting used to prepare the financial statements or adjust the results for known anomalies. The Department of Health took this seriously and requested the HIA to review the overcompensation test and to provide a recommendation for a draft of regulations which would make such prescription (see Section 7F of the Act which provides that the Minister for Health can issue regulations concerning the statements of profit and loss which are to be given to the Health Insurance Authority). As a result, there were changes proposed to the accounting standards which are described in recitals (75) to (79). In addition, ILH indicated its preference to refer to the Solvency II Directive when preparing the accounts. Ireland in its proposal for updating the accounting standards does take into account the Solvency II Directive where relevant (see recital (78)).

would not charge below the expected cost of insuring an individual (or at least the expected cost of insuring all individuals in its portfolio). However, under the RES, the amount of compensation received (gross premium plus any applicable credits) is lower than what is necessary to cover the net cost of discharging the public service obligation, i.e. the cost of insuring older lives.[143] This is the result of the fact that the level of credits is determined so that, after allowing for the impact of the scheme, the claims costs for any age and gender group would not be more than a fixed percentage of the market average (i.e. 137.5 %, rather than 100 % of the market average, which would represent a full equalisation of risk differences[144]).

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

(195) The introduction of the HCCP does not affect the above assessment in recitals (193) and (194). Under the HCCP only a portion of the high cost claims will be paid out of the Risk Equalisation Fund. Insurers will only apply to the Fund in respect of a percentage (i.e. initially set at of 40 %) of the claims above a certain amount (i.e. initially set at EUR 50 000), so the insurers will have to bear the remaining costs themselves[145]. This will apply in particular to individual customers who have complex medical needs[146]. Thus, it remains true that the

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

144 See recitals (54)-(55).

145 The current calibration of the RES (excess of EUR 50 000 and quota share of 40 %) is considered as an improvement of the RES by Vhi; however, Vhi considered a quota share of 80 % and claims excess of EUR 70 000 (later to be lowered to EUR 30 000) more appropriate. In general, the Commission notes that, while the relevant figures for the RES' functioning between 1 April 2022 and 31 December 2023 are provided to reflect the functioning of the scheme, the Commission's assessment concerns the general methodology established by the Irish authorities for the functioning of the scheme (outlined in Section 2.5 above) and not the exact calibration of the stamp duties, HCCP and other credits within the RES. The Commission also notes that the calibration is done by the HIA following an in-depth analysis of the relevant data and all insurers are consulted on their views on the RES, for example in the framework of the Health Insurance Consultative Forum (recital (208)).

146 ILH expressed concerns that as a consequence of the HCCP very expensive treatments would be disproportionally paid for by the net contributors to the Risk Equalisation Fund. In particular, ILH referred to of drugs that are not approved by the HSE and high cost (or "luxury") hospital accommodation. Laya expressed similar concerns, notably as regards high-cost drugs. As part of the process in setting up the HCCP, Ireland has confirmed that drugs not approved by the HSE cannot be reimbursed as part of a high cost claim, but only an equivalent drug that is approved by the HSE (Section 2 of the Health Insurance (Amendment) Act 2021). As regards accommodation costs, the Irish authorities have explained that there is scope currently for the HIA to make further recommendations to the Minister for Health for categories of claims costs to be excluded from high cost claims credits, as more information on the drivers of high cost claims becomes available during the operation of RES 2022. Section 7E of the Act (as amended) provides that the Health Insurance Authority can make recommendations to the Minister for Health on "*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*", and also "*the amounts of the risk equalisation credits that the Authority considers, after having regard to such evaluation and analysis, would need to be afforded, under the Risk Equalisation Scheme, to persons insured by registered undertakings*" which includes the parameters of high cost claim credits.

amount of compensation received is lower than the cost of discharging the SGEI, which boils down to insuring older lives[147]. In this respect, the Commission also notes that the HCCP will not lead to additional credits being distributed from the Risk Equalisation Fund, rather it will be a redistribution of existing credits (recital (61)).

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

#### 4.5.7.3. Efficiency Incentives

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

(198) The RES represents a *sui generis* SGEI system, based on equalising 'bad risk' against 'good risk' differentials between insurers that remain exposed to competition and are not compensated on the basis of the full cost of providing health insurance. These differentials are not under the control of health insurers, as they result from the health status of the population and from the open enrolment obligation.

(199) Furthermore, the RES has a number of features which encourage efficiency. As acknowledged at recital (105) of the 2016 Decision, the RES promotes competition on the basis of price and/or quality and discourages competition based on risk selection by insurers. The compensation provided to all insurers is based on a combination of expected costs (ARHC) and incurred costs (HUC). The HCCP would require insurers to bear a large proportion of the cost of meeting certain claims, since the Fund would only bear 40% of the cost exceeding the threshold of €50,000. This will continue the competitive pressure on insurers to be efficient. The conclusion in recital (116) of the 2016 Decision remains valid also under the RES 2022 as neither the credit payments nor the HCCP payment will remove an insurer's incentive to be efficient, as the insurer always makes higher profits when efficient.

(200) Further, at recital (118), the 2016 Decision noted that the utilisation credits paid for overnight stays in hospital are set at a level considerably below actual cost. As a result, insurers retain an incentive to avoid unnecessary overnight stays. The utilisation credits now also include day-case admissions to hospitals. The latter provides a further incentive for insurers to reduce unnecessary overnight stays, and thus encourage the transition of procedures to lower cost medically appropriate settings. This efficiency incentive remains a feature of the proposed RES 2022.

[147] ILH expressed concerns that the introduction of the HCCP would lead to overcompensation of the insurer that is the net beneficiary. It follows from recital (195) that this concern is unsubstantiated. In addition, the RES is under constant monitoring of the HIA, which has as one of its aims the avoidance of overcompensation. It does this by recommending to the Minister of Health the levels of the stamp duties, credits and calibration of the HCCP. The Commission also notes that ILH has indicated that if the HCCP is introduced in line with the recommendations from the HIA that it in principle does not object to it.

(201) At recital (119) of the 2016 Decision, other features beyond the specific context of the RES by which the Irish authorities promoted the general efficiency of the health insurance market were listed:

(a) In terms of consumer choice and information, the HIA provides an online comparison tool[148] which enables consumers to compare benefits and prices of all health insurance plans, and is intended to assist consumers in accessing the most appropriate policy at the most competitive premium. This tends to encourage consumer choice and information.

(b) As regards competition between providers, insurers are free to contract selectively with healthcare providers, and are not required to cover treatment in any particular hospital, whether public or private.[149]

(202) Further, the actions for cost-containment[150] referred to recital (120) to the 2016 Decision bore fruit. According to Vhi, since 2016, these actions and additional initiatives, such as auto-adjudication of primary care benefits through online solutions, have resulted in significant savings for Vhi. Additionally, Vhi Healthcare conducted an information campaign in 2018 among its customers to educate them on entitlements to public treatment in public hospitals, which along with similar information campaigns by the other insurers has led to a significant reduction in public hospital claims costs, from a peak of EUR 629 million in 2016 to EUR 471 million in 2019.[151]

(203) On this basis, the Commission concludes that also under the RES 2022 it is not necessary to require further efficiency incentives and that the introduction of the HCCP will only strengthen the incentive for insurers to be efficient.

4.5.7.4. Conclusion on the amount of compensation

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

*4.5.8. Transparency*

(205) Paragraph 60 of the 2012 SGEI Framework states that: *"For each SGEI compensation falling within the scope of this Communication, the Member State*

148 See: https://www.hia.ie/health-insurance-comparison.

149 This is subject to the application of Irish and EU competition law.

150 E.g. a review group established by insurance companies, the HIA and the Department of Health to effect real cost reductions in the PMI market, reduce payments to clinicians, and ask for audited bills to verify that charges were appropriate. In addition an Anti-Fraud Forum was set up to address fraud, abuse and inefficiency the healthcare system. Vhi, in addition, also took several initiatives to manage costs, such as targeted claims efficiency programs, reduction of the fees paid to providers, increased activity of Vhi's special claims investigation unit and the continued transition of procedures for lower cost, medically appropriate settings.

151 The 2016 figures come from p.14 of the "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2016 to 30 June 2017, including advice on risk equalisation credits." The 2019 figures come from p.21 of the "Report of the Authority to the Minister for Health on an evaluation and analysis of returns from 1 July 2019 to 30 June 2020, including advice on Risk Equalisation Credits." Both can be found at https://www.hia.ie/publication/risk-equalisation.

*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*".

(206) As regards the results of the public consultations referred to in recitals (159) to (162), the Commission notes that these were made available on the internet[152]. The content and duration of the public service obligations are clearly specified in the Act, which are published in the Irish Statute Book[153]. The undertakings entrusted with the provision of the public service obligations (i.e. the health insurers) are published in the Register of Health Benefits Undertakings, maintained by the HIA.[154] As regards the amounts of aid granted on a yearly basis, the impact of risk equalisation for each undertaking is set out in the HIA's Report to the Minister for Health on an evaluation and analysis of returns from the previous 12 month period and advice on risk equalisation credits, which is published every year on the websites of the Department for Health and of the HIA[155].

(207) Furthermore, the Irish authorities outlined the steps taken to ensure transparency for insurers. The HIA has published a detailed explanation of the methodology it uses to determine the recommended level of credits and stamp duties.[156] The Irish authorities ensure that any changes to the level of credits and stamp duties are made known to the industry well in advance, so that insurers can prepare (see section 2.5.1.3.).

(208) In addition, in 2012 the Minister for Health established a Health Insurance Consultative Forum, which provides a regular mechanism for consultation with the market. This brings together the insurers, the Department of Health and the HIA meeting regularly to discuss developments in the PMI market, including any proposed changes to the credits and stamp duties.

(209) In light of the above, the Commission considers that the transparency requirements set out in the 2012 SGEI Framework are fulfilled.

*4.5.9. 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*

(210) As explained in paragraph 51 of the 2012 SGEI Framework, *"The requirements set out in sections 2.1 to 2.8 are usually sufficient to ensure that aid does not*

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152 See footnotes 124 and 126.

153 The electronic text of legislation can be found at http://www.irishstatutebook.ie/.

154 See http://www.hia.ie/regulation/register-of-health-benefit-undertakings.

155 See: https://www.hia.ie/publication/risk-equalisation.

156 See the HIA's yearly reports published at https://www.hia.ie/publication/risk-equalisation.

*distort competition in a way that is contrary to the interests of the Union."* According to paragraph 52 of the 2012 SGEI Framework, *"[i]t is conceivable, however, that in some exceptional circumstances, serious competition distortions 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."*

(211) The Commission recalls that fulfilment of the other requirements set out in the 2012 SGEI Framework is usually sufficient to ensure that the aid does not distort competition in a way that is contrary to the interests of the Union. The Commission concludes that that is the case in relation to the measure under examination.

(212) Nevertheless, in the 2016 Decision, the Commission commented on a proposal by the Irish authorities which later became the 125% floor mentioned at recital (51) of the present decision. As explained in recitals (37) and (130)-(133) to the 2016 Decision, this threshold was intended to protect competition and ensure that efficient insurers remain able to make an adequate return. The 125% floor is laid down in sections 7E(1)(b)(iii)(II) and 7E(2)(a)(vii) of the Act and it is not proposed to change under the RES 2022[157].

(213) Considering the above, the Commission welcomes that Ireland maintains the 125 % floor in the Act to ensure that no serious distortion of competition will be induced by the RES.

[157] Vhi proposed to abolish the 125 % floor from the Act. The Commission notes that in the 2016 Decision (footnote 34) it was explained that the floor would only be revisited once more granular or robust health status measures would be developed as part of the RES. Those more granular or robust health status measures would be the use of diagnostic related groups coding (DRG) to develop DRG-based credits. DRG is a more refined and granular health status measure whereby the RES would take into account more risk factors than just age and gender. Thus far, Ireland has not managed to develop DRG based credits based on the information available to it and the HIA. While the HCCP will improve the distribution of credits based on health status, the HCCP is not of such a refined and granular nature that it offers information on the health status of all customers using healthcare. Therefore, the conditions set out in the 2016 Decision to revisit the 125 % floor have not been met.

## 5. CONCLUSION

The Commission has accordingly decided not to raise objections to the aid on the grounds that it is compatible with the internal market pursuant to Article 106(2) of the Treaty on the Functioning of the European Union.

If this letter contains confidential information which should not be disclosed to third parties, please inform the Commission within fifteen working days of the date of receipt. If the Commission does not receive a reasoned request by that deadline, you will be deemed to agree to the disclosure to third parties and to the publication of the full text of the letter in the authentic language on the Internet site: http://ec.europa.eu/competition/elojade/isef/index.cfm.

Your request should be sent electronically to the following address:

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Directorate-General Competition
State Aid Greffe
B-1049 Brussels
Stateaidgreffe@ec.europa.eu

Yours faithfully,

For the Commission

Margrethe VESTAGER
Executive Vice-President

CERTIFIED COPY
For the Secretary-General

Martine DEPREZ
Director
Decision-making & Collegiality
EUROPEAN COMMISSION