Neutral Citation Number: [2006] IEHC 431

THE HIGH COURT
JUDICIAL REVIEW

[2005/532 JR]

BETWEEN

BUPA IRELAND LIMITED AND
BUPA INSURANCE LIMITED

APPLICANTS

and
THE HEALTH INSURANCE AUTHORITY,
THE MINISTER FOR HEALTH AND CHILDREN,
IRELAND AND THE ATTORNEY GENERAL

RESPONDENTS

and
VOLUNTARY HEALTH INSURANCE BOARD

NOTICE PARTY

Judgment of Mr. Justice William M. McKechnie delivered on the 23rd day of November, 2006

1. British Union Provident Association Limited is a company limited by guarantee incorporated under the laws of England and Wales. It is the parent company of both the first and second named applicants in these proceedings. The second named applicant is also a company incorporated under the laws of England and Wales and offers for sale products in the private medical insurance market. It operates in this jurisdiction through its branch, BUPA Ireland. The first named applicant is a limited liability company incorporated under the laws of this State and is an Irish registered insurance intermediary authorised to sell the products of the second applicant. It also provides certain services which facilitates that applicants business in this State. Collectively I shall refer to the applicants from time to time as BUPA.

2. The first named respondent is a statutory body established under Part IV of the Health Insurance Act, 1994, (hereinafter 'the 1994 Act') as amended, and is charged with the responsibility of carrying out the functions assigned to it under the provisions of that Act. At the date of the institution of these proceedings it had, in accordance with such functions, made a recommendation to the second named respondent under the provisions of S.I. No. 261 of 2003. As the Minister for Health and Children subsequently refused to act upon that recommendation, there was no resulting decision which adversely affected the interests of the applicants. Accordingly, by agreement, the Health Insurance Authority was not represented in these proceedings and took no active part therein.

3. The second named respondent who I shall refer to as "the Minister" or "the Minister for Health" is a party to these proceedings having exercised certain statutory powers whereunder she made a "Risk Equalisation Scheme" by virtue of the Statutory Instrument above mentioned. It is the validity of this scheme and the enabling statutory provision of the Health Insurance Act, 1994, as amended, which is the subject matter of this litigation.

4. The third named respondent is joined to answer the charge that the Risk Equalisation Scheme, together with s.12 of the 1994 Act, as amended, is unconstitutional, is contrary to fundamental provisions of the EC Treaty, in particular Articles 43, 49 and 86 thereof, and also that it is invalid, having regard to Council Directive 92/49/EEC of the 18th June, 1992, which was made on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (Third Non-Life Directive).

5. On the 30th May, 2005, the Voluntary Health Insurance Board, (VHI), was successful in its application to be joined as notice party to these proceedings. At the applicants instigation that order was discharged on the 22nd July, 2005, but on appeal therefrom the Supreme Court reinstated the VHI as a notice party on the 27th October, 2005. It is a notice party for the reasons outlined in the judgment of that court dated the 2nd December, 2005. In essence by reason of the business which that party conducts in this State it has a unique vested interest in the outcome of these proceedings, although it must be noted that this is an action against the respondents and not the notice party.

6. This case in substance concerns private medical insurance as it operates in the Irish market. Commencing in 1957 with the establishment of a State monopoly, namely the Voluntary Health Insurance Board, and continuing with the implementation of the Third Non-Life Directive in 1994, the Irish system of private medical insurance has a number of distinct features. One is the concept and mandatory requirement of "community rating". As that phrase has been, or at least is now understood by the respondents and/or the notice party, the State in the belief that the maintenance of "community rating" required it, introduced in 2003 for the second time a scheme known as the Risk Equalisation Scheme. That scheme, which is technical and complex, involves a process which aims to neutralise any difference in claims costs between health insurance providers arising out of variations in the health status of their members. In practice this is achieved by the insurer with the better risk profile, making cash transfers to the insurer, whose insured population has a higher risk profile with the differences in such profiles being measured by what is called the "market equalisation percentage" (MEP). In reality this means that, at least in the short term, BUPA will be obliged to transfer to the VHI substantial sums of money in absolute terms. Accordingly the mechanism which allow for this, namely the scheme together with the underlying enabling provision, being s.12 of the Health Insurance Act, 1994, as amended, are the focus of this substantial legal challenge by BUPA.

7. In that challenge the applicants claim the following reliefs:-

> "(a) A declaration that s.12 of the 1994 Act, as amended, is invalid having regard to the Constitution of Ireland and in particular Articles 15, 21, 40.3 and 43 thereof.
>
> (b) A declaration that the promulgation of the 2003 scheme is unconstitutional and represents a non-constitutional delegation of legislative function.
>
> (c) A declaration that s.12 of the 1994 Act, as amended, is invalid and/or the introduction of the 2003 scheme was ultra vires the powers of the second named respondent, and in particular represents a breach by the third named respondent of the provisions of Directive 92/49/EEC.
>
> (d) A declaration that the enactment of s.12 of the 1994 Act (as amended) and/or the introduction by the second named respondent of the 2003 scheme infringes the applicants rights to freedom of establishment and the freedom to provide services under Articles 43/49EC.

(e) A declaration that the enactment of s.12 of the 1994 Act (as amended) and/or the introduction by the second named respondent of the 2003 scheme are not authorised by Directive 92/49/EEC.

(f) A declaration that the enactment of s.12 of the 1994 Act (as amended) and/or the introduction by the second named respondent of the 2003 scheme was not a requirement imposed on respective insurance contracts as provided for in Article 54 of Directive 94/49/EEC.

(g) A declaration that private health insurance schemes in the State do not operate as or constitute a partial or complete alternative to health cover provided by 'a statutory social security system' within the meaning of Article 54 of Directive 92/49/EEC.

(h) A declaration that the existence of the 2003 scheme and/or any determination on the part of the first named respondent pursuant to the 2003 scheme would constitute a breach of Article 10 and Article 82 of the EC Treaty or a breach of Article 86 of the EC Treaty.

(i) An injunction, and if necessary, an interlocutory injunction, restraining the second named respondent from purporting to impose upon private health insurers in the State, and in particular the applicants, any obligation to contribute sums of money to other health insurers and in particular to the VHI, whether pursuant to the 2003 scheme or otherwise.

(j) Damages for breach of statutory duty and for breach of the applicants' rights under the EU law, and in particular Articles 43 and 49 thereof."

8. Having obtained leave on the 24th May, 2005 to commence these proceedings by way of judicial review, the applicants duly served the required documentation on the respondents and thereafter on the notice party. Such respondents and notice party have each filed statements of opposition. "Points of Claim" and "Points of Defence" were then exchanged. The affidavit evidence in the case, which was very substantial, was supplemented during the hearing by oral evidence. Each party filed extensive submissions, for which the court is grateful, and spoke to such submissions in both their respective opening and closing of the case.

Relevant Constitutional, Legislative and Community Provisions

9. Article 15.2 of the Constitution provides:

"1. The sole and exclusive power of making laws for the State is hereby vested in the Oireachteas: no other legislative authority has power to make laws for the State

2. Provision may however be made by law for the creation or recognition of subordinate legislatures and for the powers and functions of these legislatures."

10. Article 21.1.1 of the Constitution provides:

"Money Bills shall be initiated in Dáil Éireann only."

11. Article 40.3.2 of the Constitution provides:

"The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."

12. Article 43 of the Constitution states:

"1.1° The State acknowledges that man, in virtue of his rational being, has the natural right, antecedent to positive law, to the private ownership of external goods.

2.° The State accordingly guarantees to pass no law attempting to abolish the right of private ownership or the general right to transfer, bequeath, and inherit property.

2.1° The State recognises, however, that the exercise of the rights mentioned in the foregoing provisions of this Article ought, in civil society, to be regulated by the principles of social justice.

2.° The State, accordingly, may as occasion requires delimit by law the exercise of the said rights with a view to reconciling their exercise with the exigencies of the common good.ö

13. The 1994 Act makes provision for a number of things, including making provision for community rating (s. 7), open enrolment (s. 8), lifetime cover (s. 9), minimum benefits (s 10), and prohibiting inducements by registered undertaking (s. 11). Of particular significance is s. 12 which authorised the Minister to make a Risk Equalisation Scheme or Schemes having regard to the effects or likely effects of the operation of ss. 7 - 11. In addition, the Act makes provision for the Minister for Health to appoint a date for the establishment of a body known as the Health Insurance Authority (H.I.A.) and conferred on that body certain functions. The definition section of the Act as well as its Title are also relevant, in a manner which becomes clearer a little later in this judgment.

14. Section 5(1) of the Interpretation Act, 2005 provides:

"In construing a provision of any Act (other than a provision that relates to the imposition of a penal or other sanction)—

(a) that is obscure or ambiguous, or

(b) that on a literal interpretation would be absurd or would fail to reflect the plain intention of—

(i) in the case of an Act to which *paragraph (a)* of the definition of "Act" in *section 2(1)* relates, the Oireachtas, or

(ii) in the case of an Act to which *paragraph (b)* of that definition relates, the parliament concerned, the provision shall be given a construction that reflects the plain intention of the Oireachtas or parliament concerned, as the case may be, where that intention can be ascertained from the Act as a

whole."

15. Section 22(3) of the Interpretation Act, 2005, provides that:

> "A power conferred by an enactment to make a statutory instrument shall be read as including a power, exercisable in the like manner and subject to the like consent and conditions (if any), to repeal or amend a statutory instrument made under that power and (where required) to make another statutory instrument in place of the one so repealed."

16. Article 43 of the Treaty establishing the European Community provides:

> "Within the framework of the provisions set out below, restrictions on the freedom of establishment of nationals of a Member State in the territory of another Member State shall be prohibited. Such prohibition shall also apply to restrictions on the setting-up of agencies, branches or subsidiaries by nationals of any Member State established in the territory of any Member State.
>
> Freedom of establishment shall include the right to take up and pursue activities as self-employed persons and to set up and manage undertakings, in particular companies or firms within the meaning of the second paragraph of Article 48, under the conditions laid down for its own nationals by the law of the country where such establishment is effected, subject to the provisions of the chapter relating to capital."

17. Article 46(1) EC states:

> "The provisions of this chapter and measures taken in pursuance thereof shall not prejudice the applicability of provisions laid down by law, regulation or administrative action providing for special treatment for foreign nationals on grounds of public policy, public security or public health"

18. The first paragraph of Article 49 EC states

> "Within the framework of the provisions set out below, restrictions on freedom to provide services within the Community shall be prohibited in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended."

19. Article 55 EC states

> "The provisions of Articles 45 to 48 shall apply to the matters covered by this chapter."

20. Article 86(1) and (2) EC state

> "1. In the case of public undertakings and undertakings to which Member States grant special or exclusive rights, Member States shall neither enact or maintain in force any measure contrary to the rules contained in this Treaty, in particular to those rules provided for in this Article 12 and Articles 81 to 89.
>
> 2. Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Community."

21. Article 54(1) of Council Directive 92/49/EEC (see para. 4 above) states:

> "Notwithstanding any provision to the contrary, a Member State in which contracts covering the risks in class 2 of point A of the Annex to Directive 73/239/EEC may serve as a partial or complete alternative to health cover provided by the statutory social security system may require that those contracts comply with the specific legal provisions adopted by that Member State to protect the general good in that class of insurance, and that the general and special conditions of that insurance be communicated to the competent authorities of that Member State before use."

There are certain Recitals to the Directive which are also relevant and which are referred to later in this judgment.

22. In Ireland the provision of medical health care services is based on a mix of private and public funding with the former contributing to the effectiveness and viability of the latter. The public services are available through the State system whereas the former are available only by obtaining cover from a health insurance provider. With regard to the services available on the State system, a distinction has to be made between those who are the holders of medical cards and those who are not. Generally speaking, persons on low income are so entitled whereas those on higher income are not. Prior to 1991 the holders of such cards were entitled to free health services from the State. Those not so entitled had to make their own arrangements with employees being obliged to pay a health levy on their income up to a certain amount under the Health Contribution Act, 1979. In that year, 1991, every person, regardless of income, became entitled to free in-hospital health services. This was a major extension to what previously had been available. Progressively over the years various changes took place in the State system with the current position, again in very general terms, being as follows. Medical card holders are entitled to the full range of services offered by the State free of charge. These include General Practitioner services, prescribed drugs and medicines, public hospital services, dental, optical, and aural services, maternity and infant care and a range of other community care and personal social services. Even those who cannot avail of a medical card, may nevertheless, be entitled to some free and some subsidised services from the State. Perhaps the most important is the availability of free hospital services, including free maintenance and treatment in public hospital beds. Such a service, however, save for exempt persons, is subject to a statutory charge of €55 for outpatient service and €55 per day for inpatient treatment up to a maximum of €550 in any one year; (these figures may be slightly different as of today's date). Secondly, on being referred by a General Practitioner, there is no charge to a person who attends as an outpatient, or who goes to an accident and emergency department of a public hospital. Thirdly, there is free maternity and infant care service as well as speech and language therapy services. Prescribed drugs are subsidised for any cost in excess of €85 per month. Moreover, dental, optical and aural services are also subsidised under the treatment benefit scheme. In addition there are a variety of other services, either available free or subject to a charge. Finally, in 2002 the State put in place what is known as the National Treatment Purchase Fund for the purposes of guaranteeing that patients on public waiting lists would receive appropriate treatment within a definite period of time. This is of course free of charge.

Private Medical Insurance in Ireland
23. The following statutory provisions have all helped to shape the private health insurance market as it exists today in Ireland:-

(a) Voluntary Health Insurance Act, 1957;

(b) Third Non-Life Directive (92/49/EEC);

(c) Health Insurance Act, 1994;

(d) Voluntary Health Insurance (Amendment) Act, 1996;

(e) Health Insurance Act, 1994 (Registration) Regulations, 1996 (SI No. 80/1996);

(f) Health Insurance Act, 1994 (Open Enrolment) Regulations, 1996 (SI 81/1996);

(g) Heath Insurance Act, 1994, (Lifetime Cover) Regulations, 1996 (SI 82/1996);

(h) Health Insurance Act, 1994, (Minimum Benefit) Regulations, 1996 (SI 83/1996);

(i) Health Insurance Act, 1994, (Risk Equalisation Scheme) 1996 (SI 84/1996);

(j) Voluntary Health Insurance (Amendment) Act, 1998;

(k) Health Insurance Act, 1994, (Risk Equalisation) (Revocation) Regulations, 1999 (SI 32/1999);

(l) Health Insurance (Amendment) Act, 2001;

(m) Health Insurance (Amendment) Act, 2003;

(n) Risk Equalisation Scheme, 2003 (SI 261/2003);

(o) Risk Equalisation (Amendment) Scheme, 2003 (SI 710/2003);

(p) Risk Equalisation (Amendment) Scheme, 2005 (SI 334/2005).

The Development of Private Medical Insurance in Ireland
24. The commencing event for this market was the enactment of the Voluntary Health Insurance Act, 1957. Under s. 3 of that Act, a body corporate, known as the Voluntary Health Insurance Board, was established. Its functions were those as assigned to it under the provisions of the Act, which broadly speaking meant, that it was entrusted with the responsibility of making schemes of voluntary health insurance which defrayed the cost of medical, surgical, hospital and other health services. It was obliged to make such schemes as the Minister for Health from time to time may specify but in addition it could, with the consent of that Minister, make such other schemes as it saw fit. It was, "taking one year with another", non profit making. Its personnel were appointed by or under the control of the Minister.

25. The principal reason for the inauguration of such a system was to offer and make available cover, in consideration of a premium, in respect of hospital costs, to about 15% of the public who at that time were not eligible for public hospital services. It was also felt that others might also wish to avail of the scheme: (See Government White paper on Private Health Insurance (para 1.2) published in 1999). The numbers taking out such cover increased substantially over the years. By the late 1960s the number was over 300,000 with that figure being doubled over the following decade. A similar increase had occurred by the end of the 1980s. As of 1997 it had reached 1.5 million and by October 2005 (staff report of H.I.A.) it was over 1.9 million. In all about 50% of the population now have private health insurance, either with VHI, or BUPA or VIVAS.

26. From its establishment the VHI was the only provider of private health insurance in Ireland; apart from a number (about 10) of restricted members' undertakings which dealt with certain select groups, such as the E.S.B., Garda Síochána etc. This situation resulted from the licensing policy of the Minister for Health, who never sanctioned a competitor to the VHI. In effect, therefore, it was a statutory monopoly. There is evidence which I accept from a number of sources, including Mr. Vincent Shannon, the present Chief Executive of VHI, Mr. John Armstrong, an actuary employed by the VHI and the Harvey Report (para. 4.1), that a feature of all the major schemes placed on the market by the VHI was that these operated on the basis of applying what are now referred to as Community Rating, Open Enrolment and Lifetime Cover.

Community rating must be contrasted with Risk Rating. In very many types of insurances, the premium charged (or indeed even the offer of cover) is related to the likelihood of the risk occurring and the estimated cost of the resulting claim(s). This creates a problem for health insurance. It is an accepted fact that in general older people are more likely to get ill than younger people. Consequently the older a person gets, certainly over 50 years and onwards, the greater the risk and the greater the frequency of claims (though other factors may also influence this). Therefore an insurer could entirely refuse cover to a 70 year old or else demand a level of premium which would make its purchase unaffordable. To operate on this basis would be to risk rate policies. An alternative to this approach, is to community rate which prohibits any discrimination on the basis of age, gender or health status, and in principle where premiums for the same level of cover reflect the average cost of insuring all of the insured population. Disregarding for a moment the correct interpretation of community rating under the 1994 Act, and despite some lack of clarity in how precisely the process was conducted, I am satisfied that traditionally the VHI has always community rated their policies across the entire pool of their insured persons. As prior to competition it was the only provider this meant that its insured persons were Ireland's insured persons. And so that was the system operating in this Country in the lead up to the 1994 Act.

27. On the 18th June, 1992, Council Directive 92/49/EEC on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC, was issued. This Directive is known as the Third Non Life Directive. It required, those who were not entitled to a derogation (but subject to its transitional section) to have its provisions implemented into their domestic law not later than the 1st July, 1994. That Directive required Member States to abolish any existing monopolies, to end the classes of insurance covered thereby and to liberalise the non-life insurance sector. This Directive was implemented into Irish law by the Health Insurance Act, 1994. That Act, subsequently amended, together with the

existing risk equalisation scheme, now forms the substantial part of the statutory framework for the operation of private medical insurance in this Country.

1994 Act
28. The long title to the Act states that it is:-

> "An Act to regulate further, in the interests of the common good, the provision of voluntary health insurance so as to provide, *inter alia*, for the establishment of the Health Insurance Authority, for the establishment of schemes for the equalisation of risks between health benefits undertakings, for a minimum range of cover under such insurance, for uniformity of the premiums charged by each particular such undertaking in respect of specified ranges of such cover and for the establishment of a register of such undertakings and to provide for related matters."

29. Section 2 of the Act is the interpretive section with the following being the definitions or descriptions which are relevant to this case:

> · "the Authority" means the Health Insurance Authority established by s. 20;
>
> · "community rating" shall be construed in accordance with s. 7(1)(c);
>
> · "health benefits undertaking" means a person (including a body established under the laws of a place outside the State) carrying on health insurance business;
>
> · "health insurance contract" means, without prejudice to s. 2A, a contract of insurance, or any other insurance arrangement, the sole or principal purpose of which is to provide for the making of payments by undertakings, whether or not in conjunction with other payments, specifically for the reimbursement or discharge in whole or in part of fees or charges in respect of the provision of hospital in-patient services or ancillary health services, but does not include - … ;
>
> · "health services" means medical, surgical, diagnostic, nursing, dental, chiropody, chiropractic, eye therapy, occupational therapy, physiotherapy or speech therapy services or treatment or services or treatment provided in connection therewith, or similar services or treatment:
>
> · "ancillary health services" means out-patient services, general medical practitioner services and *inter alia* services consisting of the supply of drugs or medical preparations;
>
> · "restricted membership undertaking" means an undertaking which affects health insurance contracts with its members and the membership of which is restricted to persons and their dependents of a common vocational, occupational or other group or class;
>
> · "risk equalisation" means the sharing of prescribed costs of registered undertakings between the undertakings (being costs incurred in respect of payments under health insurance contracts to or in relation to the persons with whom the contracts have been effected) by means of payments made by or to such undertakings in accordance with the terms and conditions of a scheme;
>
> · "scheme" means a scheme of risk equalisation under s. 12.

Nothing of substance turns on the amendments made to this section by the Health Insurance (Amendment) Act, 2001, save to note that the description of a "health insurance contract" was extended somewhat by the substitution of the words " … the purpose or one of the purposes … "for"… the sole or principal purpose …". In particular the definition of "risk equalisation" was not in any way materially amended by the later Act.

30. Under s. 3 of the 1994 Act the Minister may by way of regulations provide for "any matter referred to in this Act as prescribed or to be prescribed" and secondly may make regulations "generally" for the purposes of giving effect to this Act. Where any such regulations are made *inter alia* under s. 12 of the Act, then in accordance with s. 3(4)(b), a draft of those regulations must obtain the approval of each House of the Oireachtas before it can in fact be made.

Section 4 creates a criminal offence whereby a person who contravenes a provision of the Act shall be liable on summary conviction, to a fine not exceeding £1,000 (€1,270) or on a conviction on indictment to a fine not exceeding £100,000 (€127,000).

Community Rating
31. Section 7(1) of the Act 1994, as inserted by s. 5 of the 2001 Act, provides:

> "(a) Subject to subsection (4) and section 7A, the premium payable under any health insurance contract effected by a particular registered undertaking shall be the same as that payable under every other such contract (after due allowance has been made in respect of the payment of any premium by instalments) that-
>
> (i) is effected by that undertaking,
>
> (ii) is in respect of the same period as that to which the first-mentioned contract relates,
>
> (iii) relates to the same health services as those to which the first-mentioned contract relates, and
>
> (iv) provides for the same payments by the undertaking in respect of those services as those provided for by the first-mentioned contract
>
> (b) A registered undertaking shall not effect a health insurance contract that contravenes paragraph *(a).*
>
> (c) A health insurance contract that complies with paragraph *(a)* (or which would comply with that paragraph but for its falling within subsection (4) or s. 7A) shall be known as a community rated health insurance contract and 'community rating' shall be construed accordingly."

These requirements of the section are subject to a variety of exceptions and qualifications none of which are directly relevant to the issues.

32. Section 7(2) is in the following terms:-

> "(2) Without prejudice to the generality of subsection (1), premiums payable under health insurance contracts shall not be varied by reference to –
>
> (a) the age, sex, or sexual orientation or the suffering or prospective suffering of a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind;
>
> (b) the frequency of the provision of health services to a person, or
>
> (c) the amounts of payments or the number of different payments to which a person becomes entitled under such a contract."

Section 7(3) prohibits an undertaking from varying in any way the amounts of payments provided for under a health insurance contract by reference to a person's age, sex or sexual orientation.

It is useful at this point to note that BUPA relies on s. 7(1)(c) as establishing that "community rating" has only one meaning in the overall legislative framework, with such meaning being confined to rating within a plan. In other words each insured person within a given policy must be charged the same premium but otherwise there is no community rating across the entire market of insured persons. This distinction for the purposes of the risk equalisation scheme is what separates the parties on this crucial issue.

33. Open Enrolment

> (a) Read in conjunction with the appropriate statutory instruments, namely the Health Insurance Act, 1994 (open enrolment) Regulations, 1996 (S.I. 81/1996) and also the Health Insurance (Open Enrolment) Regulations 2005 S.I. 332/2005, a health insurance provider, other than "a restricted membership undertaking" cannot refuse to effect a health insurance contract for any person under the age of 65 or for a person over that age whose previous health insurance contract expired less than 13 weeks prior to the date of the application.
>
> (b) Accordingly such a person has a right to go and purchase from a provider any health insurance contract on offer from that provider.
>
> (c) In the case of certain persons however, and in respect of certain illnesses, there are minimum waiting periods prior to being eligible for benefits. For these under age 55 that period is 26 weeks save in respect of maternity benefits where a period of one year is specified. For those over age 55 the period is also one year. Moreover for "pre-existing illnesses" there are waiting periods of five years, seven years and ten years for persons aged under 55, between 55 and 60 and between 60 and 65, respectively.

34. Lifetime Cover
Under s. 9 of the 1994 Act, which again must be read in conjunction with the appropriate statutory instrument, namely the Health Insurance Act, 1994 (Lifetime Cover) Regulations, 1996 (S.I. 82/1996), a health insurance provider cannot terminate or refuse to renew health insurance contracts (save with a customer's consent) other than in circumstances where there has been a misrepresentation which has or could have lead to that insurer suffering financial loss or where that insurer has ceased business in the State. A mere change in terms of a policy at renewal date is not to be regarded, on that account only, as a refusal to renew. In other words, the provider retains the freedom to alter the terms and conditions of a particular plan but cannot refuse a renewal of the current plan to any customer.

35. Minimum Benefits
Section 10, together with statutory instrument, the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 S.I. 83/1996), provide for certain minimum benefits which must be offered by health insurance providers. As all the plans or policies available on the market (save for one) contain benefits well in excess of the prescribed threshold, it is not necessary to further elaborate on this requirement of the insurance system.

36. None of the three pillars aforementioned are crucial to this case, though each one individually and collectively plays a pivotal role in the overall context of this market. The pillar however which is most crucial is that of community rating. In fact the correct definition of that term is the single most important issue in this case.

37. Provision for Risk Equalisation:
Section 12 of the 1994 Act (as inserted by section 9 of the Health Insurance (Amendment) Act, 2001, and as amended by section 5 of the Health Insurance (Amendment) Act, 2003), states:

> "(1) The Minister may prescribe a scheme or schemes of risk equalisation (which or each of which shall be known as a risk equalisation scheme and is referred to in this Act as 'a scheme').
>
> (2) (a) Subject to paragraphs (b) and (c), a scheme shall apply to each registered undertaking and each such undertaking shall comply with the terms and conditions of the scheme.
>
> (b) A scheme may include a provision specifying that the scheme shall not, at any time on and from the service on the Minister of the notice hereafter referred to, apply to a restricted membership undertaking which-
>
> (i) was carrying on business in the State before the commencement of section 9 of the Health Insurance (Amendment) Act, 2001, and
>
> (ii) was, on 1st May 2000, a registered undertaking, if, before a date specified for the purposes of this subsection by the Minister, the undertaking serves a notice on the Minister stating that it does not wish

any scheme to apply to it.

(c) A scheme may include a provision specifying that the scheme shall not apply to so much of the activities of a registered undertaking as consist of effecting health insurance contracts that solely provide for the making of payments for the reimbursement or discharge in whole or in part of fees or charges in respect of the provision of relevant health services.

(3) (a) A scheme shall include a provision requiring each registered undertaking to make returns (each of which is referred to in this Act as a 'return') to the Authority in relation to such matters concerning its health insurance business as may be prescribed.

(b) The provision referred to in paragraph (a) shall require a return to be made-

(i) in the case of the first return, in respect of such period as may be prescribed,

(ii) in the case of the second or any subsequent return, in respect of each period of:-

(I) 3 months, or

(II) such greater duration as may be prescribed, and to be so made not later than such number of days after the end of the period to which it relates as may be prescribed.

(4)(a) A scheme shall include a provision requiring-

(i) the making of payments by registered undertakings to the Authority of such amounts as may be determined by the Authority in such manner and by reference to such matters as may be specified in the scheme (including the nature and distribution of insured risks amongst the undertakings),

(ii) the making of payments by the Authority of such amounts as may be determined by the Authority to such registered undertakings as may be so determined in such manner and by reference to such matters as may be specified in the scheme (including the nature and distribution of insured risks amongst the undertakings).

(b) the provision referred to in paragraph (a) shall provide that the requirements of the provision shall not have effect until such day as the Minister determines and appoints for that purpose in accordance with the provision of the scheme referred to in paragraph (c).

(c) A scheme shall include a provision –

(i) requiring the Authority to –

(I) evaluate and analyse each return made to it (and such an evaluation and analysis shall be made by reference to the matters that are specified in the scheme for the purposes of the provision referred to in paragraph (a)),

(II) prepare and furnish to the Minister, at such intervals as may be prescribed, a report in relation to-

(A) such an evaluation and analysis in so far as it relates to returns made to it in a prescribed period, and

(B) matters concerning the carrying on of health insurance business and developments in relation to health insurance generally that the Authority considers ought to be included in the report as a result of that evaluation and analysis,

(III) include in that report a recommendation by the Authority that the Minister ought or ought not (as it considers appropriate having regard to the best overall interests of health insurance consumers) to exercise the power hereafter mentioned in this subsection, but no such recommendation shall be so included-

(A) unless it appears to the Authority from such an evaluation and analysis that conditions specified in the scheme related to the nature and distribution of insured risks among the registered undertakings are fulfilled, or

(B) if the Minister has already exercised that power,

(ii) providing that the Minister shall consider any such report made to him or her under the provision and-

(I) if the report includes a recommendation by the Authority that the Minister ought to exercise the power referred to in this subparagraph, may, or

(II) if it appears to the Minister that conditions specified in the scheme related to the nature and distribution of insured risks amongst the registered undertakings are fulfilled, shall (unless it appears to the Minister, having consulted with the Authority in relation to the best overall interests of health insurance consumers, that there are good reasons for not doing so), determine that the requirements of the provision referred to in paragraph (a) shall have effect on and from a specified day and appoint a day for that purpose accordingly,

(5) The provision of a scheme referred to in subsection (4)(c) shall require the Authority, if it appears to the Authority that a recommendation of the kind referred to in that provision is required to be included in a report under that provision, to-

(a) give notice to each registered undertaking (other than a restricted membership undertaking that has served a notice under subsection (2)(b)) of the fact that it proposes to include such a recommendation in the report, the nature of that proposed recommendation and the reasons therefor,

(b) invite, by means of that notice, the undertaking to make, within 21 days from the date of the service of the notice on the undertaking, representations to the Authority in relation to the nature of the recommendation that, in the undertakings opinion, ought to be included in the report, and

(c) take into account any such representations made to it within that period before finally deciding what the nature of the said recommendation ought to be.

(6) The provision of a scheme referred to in subsection (4)(c) shall require the Minister, if he or she proposes to make a determination of the kind referred to in subparagraph (ii) of that subsection, to-

(a) give notice to each registered undertaking (other than a restricted membership undertaking that has served a notice under subsection (2)(b)) of the fact that he or she proposes to make such a determination (and the day proposed to be appointed under that provision accordingly) and the reasons for that proposed determination,

(b) invite, by means of that notice, the undertaking to make, within 21 days from the date of the service of the notice on the undertaking, representations to the Minister as to why, in the undertaking s opinion, the said determination ought not to be made, and

(c) shall take into account any such representations made to him or her within that period before finally deciding whether to make the said determination.

(7) A scheme may provide-

(a) that a registered undertaking which has made a return shall, on request being made of it to do so by the Authority, furnish to the Authority such information or documents in its possession or capable of being procured by it and forming the basis of that return as is or are specified in the request and that the undertaking shall comply with such a request not later than 7 days from the date the request is made,

(b) that a report referred to in subsection (4)(c)(i)(II) shall be in such form, and contain such particulars in relation to the evaluation and analysis concerned, as the Minister determines.

(8) A scheme may provide that a registered undertaking which has made representations under the provision of the scheme referred to in subparagraph (i) or (ii) of subsection (4)(c) to the Authority or, as the case may be, the Minister shall, on request being made of it to do so by the Authority or the Minister, as appropriate, furnish to the Authority or the Minister such information or documents in its possession or capable of being procured by it and forming the basis of those representations as is or are specified in the request and that the undertaking shall comply with such a request not later than 7 days from the date the request is made.

(9) A scheme may provide-

(a) for the establishment and maintenance by the Authority of a fund into which all moneys paid to the Authority under the scheme shall be paid and out of which all moneys paid by the Authority under the scheme shall be paid, and

(b) for the keeping by the Authority of specified accounts in relation to the scheme and the furnishing of copies of those accounts, as audited by the Comptroller and Auditor General, and copies of the reports of the Comptroller and Auditor General thereon to the Minister at specified times.

(10)(a) A reference in this section to-

(i) a health insurance consumer is a reference to a person, other than the registered undertaking, who is party to, or named in, a health insurance contract or likely to be interested in being such a party or being so named,

(ii) insured risks among registered undertakings is a reference to the risks that have been respectively insured by the undertakings under health insurance contracts, and

(iii) the best overall interests of health insurance consumers includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings.

(b) The conditions specified in a scheme for the purposes of the provision of the scheme referred to in subsection (4)(c)(1)(III) may be different from the conditions specified in the scheme for the purposes of the provision of the scheme referred to in subsection (4)(c)(ii)(II).

(c) The nature and distribution of insured risks amongst registered undertakings to which conditions as aforesaid

relate may be expressed in the scheme concerned by reference to the amounts that would fall to be paid to or by a particular registered undertaking or undertakings under the provision of the scheme referred to in subsection (4)(a) if the requirements of that provision had effect at the time of the making of the evaluation and analysis to which the report concerned referred to in subsection (4)(c)(i)(II) relates"

38. As can be seen any such scheme shall apply to each undertaking (subject to s. 12(2)(b)) and shall require that body to make to the Health Insurance Authority, returns at specified intervals in relation to such matters as may be prescribed. The Authority must then evaluate and analyse such returns by reference to prescribed matters including the nature and distribution of insured risks amongst the undertakings. A provision must be made in any scheme for undertakings to make payments to the Health Insurance Authority in such amounts as that body may determine. These payments must then be transferred to another such undertaking. Both the amounts, of the transfers to and from the HIA, must be determined by reference to prescribed matters including the nature and distribution of insured risks. No such payments however shall be made until the Minister appoints a date for that purpose.

Having so evaluated and analysed the returns, the HIA, having regard "to the best overall interests of health insurance consumers" must report and must make a recommendation to the Minister as to whether or not she ought to nominate a date to trigger the transfer process. No such recommendation however can be made if the conditions as specified in the scheme with regard to the nature and distribution of insured risks amongst registered undertakings have not been fulfilled or if the Minister has already appointed such a date. On receipt of such a report and recommendation any scheme must provide for the Minister's consideration thereof and if the report contains a positive recommendation or if she is satisfied that the conditions of the scheme have been fulfilled, then, having consulted with the HIA with regard to the best overall interest of health insurance consumers, she must, unless there are good reasons for not so doing, specify a date for the commencement of the Risk Equalisation payments. Subsections (5) and (6) of s. 12 of the 1994 Act require provision be made that both the HIA and the Minister, if respectively minded to make a positive recommendation or appoint a specified date, to give undertakings, an opportunity to make submissions and to have the same duly considered by either such body as may be appreciate. Of particular relevance to this case is s. 12(10)(a)(iii) which gives guidance as to what the phrase "the best overall interest of health insurance consumers" means and also is s. 12(10)(c) of the Act.

39. Pursuant to section 12 of the 1994 Act, a Risk Equalisation Scheme was initially promulgated on 12th March 1996. This scheme was revoked on 12th February 1999. Its replacement, the current Risk Equalisation Scheme was not promulgated until the 26th of June, 2003, by the making of S.I. 261/2003; it took effect from 1st July of that year. During the currency of the first scheme, the Minister for Health established an advisory group which reported in April 1998. That report was the beginning of a consultative and reporting process which continued for a number of years and which, it is reasonable to assume, informed, at least to some extent and perhaps substantially, the Minister's decision to revoke the original scheme, to enact the 2001 Act and also to introduce the present scheme in 2003. Although it is necessary to consider in some detail what emerged during this process, a brief outline of the present scheme prior to that, will add to an appreciation of the evolution of "Risk Equalisation".

40. Risk Equalisation Scheme (RES):

(a) Risk Equalisation is a process which aims to "equitably neutralise differences in insurers costs" (H.I.A. Guide to RES – July 03) which result from variations in the health status of its members. It seeks to spread some the claims costs of high risk members amongst all insurers in proportion to their market share. The complex and detailed calculations, which are formatted in the scheme, seek to calculate what the claims costs of each insurer would be on the basis that such insurer had the average market risk profile instead of its own actual risk profile. On making this calculation equalisation is sought to be achieved by the insurer with the lower risk profile making money transfers, via the HIA, to the insurer who carries a higher risk profile. In this way it is said that claims costs are distributed across the entire market of health insurance providers.

(b) In general, age and gender are used to establish the risk profile of a provider. The mandatory returns provide this information by creating eight age cells separated by nine year gaps (once aged over 17) and eight gender cells. There are therefore in all 16 such cells. If however the HIA is not satisfied that age and gender alone, accurately reflect an undertaking's risk profile, it may use a third proxy, namely the utilisation of health care services (as measured by hospital bed nights) as an aid to this end. This is called "health status weight", which is presently set at zero. Care however must be taken with its use at it could involve the sharing of some efficiencies. Because of this it can therefore only be invoked after prescribed steps and certain standards have been met and can never exceed 50%.

(c) As well as giving the number of insured persons which each undertaking has, the returns must also specify the amounts paid, in a given period, in respect of claims settled by each provider, where such claims are subject to risk equalisation. Not all benefits paid are so included. It is only those up to the approximate level of the VHI Plan B that are equalised. The balance of all other such payments are disregarded. This process is known as "top slicing" and has the effect of excluding so called "luxury elements" of the contract. Those payments, the details of which must be returned are called the "Maximum Equalised Payment" (MEP) and are subject to the detailed rules as set out in the first schedule to this scheme.

(d) The HIA, by virtue of this information will know the average number of persons insured, who are subject to risk equalisation (which excludes those serving initial waiting periods), of each provider at the commencement of the relevant six month period and also on a date three months thereafter. In addition it will also know the amount of equalised benefits paid during this period. It can then determine what the risk equalisation payment will be (technically known as the Market Positive Equalisation Adjustment (MPEA) and can also determine, which is of great importance, what the Market Equalisation Percentage is (MEP). This is done by dividing the MPEA by the Market Equalisation Benefits (MEB). It is this figure which has a crucial bearing, in the manner hereinafter outlined on the mechanics which are used to trigger risk equalisation payments.

41. The Involvement of the HIA

(a) The HIA was eventually established on 1st February, 2001. The Act of that year, as well as the 1994 Act, conferred on it, specific responsibility with regard to risk equalisation, including an obligation to report to the Minister on its evaluation of each set of returns and to make a recommendation, having regard to the best overall interests of insurance consumers, as to whether or not the Minister should trigger the making of RES payments. In addition as part of such reporting, or indeed quite separately, (see s. 21(1)(d) of the Act), the HIA may advise the Minister on matters relating, to her functions under the Health Insurance Acts 1994 – 2003, to the functions of the authority itself and also on the health

insurance industry in general, including any "developments" in relation thereto.

(b) In February, 2002, the HIA issued a consultation paper on Risk Equalisation and received, in response at least ten submissions from interested parties including BUPA, VHI, The Competition Authority, The Society of Actuaries of Ireland and Professor Ray Kinsella. It considered all such documents and issued in September of that year a policy paper on Risk Equalisation.

(c) Amongst the matters addressed in that paper were the factors which the HIA intended to take into account, when considering the best overall interest of consumers and when making a recommendation as to whether or not Risk Equalisation should be commenced. These factors, influenced no doubt by the statutory definition in s. 12(10)(a)(iii) of the Act - where such phrase is said to include "the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings" - were given as follows:-

· "The differences in risk profiles between insurers,

· The relative sizes of insurers,

· The age/sex profile of insurer's policy holders,

· The rate of premium inflation,

· The number of insurers in the market/new entrants to the market,

· The effect of any transfer on premiums payable by consumers,

· The overall size of the market,

· The effect of payments on the business plans or solvency of insurers and

· The commercial status of insurers."

42. The HIA's role in making a recommendation to the Minister, differs, depending on the level at which the MEP is set, which of course is based on that body's evaluation of the latest set of returns.

· If the level of risk difference between insurers results in an MEP below 2% then no recommendation is required as Risk Equalisation payments cannot be commenced

· If however the MEP figure is between 2 and 10%, the authority must make a recommendation to the Minister as to whether such payments should or should not be commenced. If minded to make a positive recommendation it must allow a period for and consider any representations made by health insurance providers. It will then come to a final view and so report to the Minister. If that view is that payments should not be commenced, then payments cannot be commenced. If however the opposite is the case then the Minister may decide to appoint a day for the commencement of such payments. If she does then similar provisions will apply to representations.

· If the MEP should be above 10% then no recommendation is required from the HIA as the Minister must commence the scheme, unless having consulted with the authority she is satisfied that it is not in the best overall interest of consumers to do so.

43. Before turning to the first major issue in this case it is necessary to consider what occurred between 1998 and the making of the current scheme in 2003.

The Consultative and Reporting Process:

44. Report of the Advisory Group on the risk equalisation scheme (the Harvey Report)

(a) Under the chairmanship of Mr. Gerard Harvey, this group initially received from the Minister of Health, an explanatory note together with its terms of reference. It is worth quoting this document in full as it indicates not only the Minister's view of this market but also what tasks the group was asked to consider and report on. It reads as follows:-

"Explanatory Notes and Terms of Reference:

Background:

1. The main objective of the statutory framework established for health insurance in Ireland is the protection of the key principles of community rating, open enrolment and lifetime cover set down in the Health Insurance Act, 1994.

2. A risk equalisation mechanism is an essential feature of a competitive health insurance market which operates under these principles. It provides protection for both health insurers and subscribers to health insurance schemes and without it the system of community rating/open enrolment would be inherently unstable.

3. A risk equalisation scheme has been introduced within the Irish health insurance regulatory framework by means of Statutory Instrument No. 84 of 1996, made pursuant to the Health Insurance Act 1994.

4. The objectives which the risk equalisation scheme seeks to achieve are:

(a) to preserve the stability of community rating in a competitive environment;

(b) subject to (a), to facilitate competition in the Irish health insurance market;

(c) to satisfy the general good principles underlying the 3rd EU Non-Life Directive (sic);

(d) to be self financing; and

(e) to meet, as far as possible, the following criteria:

(i) Equalisation of Risk Profiles
The scheme should provide a stable environment for community rating/open enrolment, through eliminating incentives for health insurers to select preferred risks, by ensuring that each health insurer bears the cost of a risk profile equivalent to the risk profile of all insured lives;

(ii) Equity
The scheme should be perceived to be equitable between health insurers and should not result in any health insurer having to share profits which it has made as a result of its own efficiencies and cost controls;

(iii) Cost Containment
The scheme should not contain any inherent disincentives for health insurers to seek to maximise efficiency and to control costs;

(iv) Non-Equalisation of Benefit Levels
The scheme should not equalise different levels of benefit paid by different health insurance plans.

(v) Practicality
The scheme should be understandable and practical to operate;

(vi) Predictability
The scheme should produce results which are as predictable as possible, in order to allow health insurers to cost their policies appropriately.

Terms of Reference

5. The Minister has set the following tasks for the Advisory Group:

- to consider the existing risk equalisation scheme;

- to seek submissions from interested parties on the scheme; and

- to make recommendations to him/her, in the light of its consideration of the submissions received, on the improvements (if any) which he/she may consider making to the scheme in the furtherance of the objectives set out at paragraph 4 above.

In its deliberations the Advisory Group should consider:

- the need for the Risk Equalisation Scheme to be clearly and effectively consistent with meaningful competition, commerciality, and innovation;

- risk equalisation schemes that operate in other community rated health insurance systems, the features of such mechanisms, those characteristics that are successful and those that are not in achieving the key objective of stability, while facilitating competition and innovation;

- the extent of benefit that should be subject to risk equalisation in order to achieve stability, considering the requirement to be proportionate in the protection of the general good."

45. The group adopted a particular methodology with regard to its work, and as part of that, placed a number of advertisements in national newspapers seeking submissions. It also wrote individually to several organisations including health insurance companies, health boards, hospitals and other bodies with an interest in the private health insurance sector. In response it received about nineteen presentations including contributions from BUPA, VHI, a number of hospitals and other bodies. Having reviewed the submissions and having conducted its own inquiries it produced a substantial report and delivered the same to the Minister in April, 1998.

46. The report was set out in chapter form together with five appendices:-

· Chapter 1: Introduction,

· Chapter 2: Terms of Reference,

· Chapter 3: Conclusions and Recommendations,

· Chapter 4: The Private Health Insurance Environment,

· Chapter 5: Community Rating,

· Chapter 6: Risk Equalisation,

· Chapter 7: Competition,

· Chapter 8: Regulation and Structure of the Market,

· Chapter 9: The Private Healthcare Industry,

· Chapter 10: Cost Containment,

· Appendices 1 – 8:

47. Chapter 3: Conclusions and Recommendations:
On Community Rating – Chapter 5

(a) The group supported the availability, to all members of society, of private health insurance in respect of health care products. It agreed that the same be available only on the basis of community rated premiums.

(b) However, it was pointed out that if the current system of single rate community rating had not existed in this jurisdiction, it would not recommend its introduction "because of the potential instability which arises from the need to ensure a continuing flow of new young members". Rather in its place it would suggest a system called "funded lifetime community rating" which means that premiums would be actuarily based. A move to such a system, was not feasible however, and for stated reasons was therefore not recommended.

(c) Given that the present system was "unduly unstable" it did, however, recommend a second option namely a system based on "unfunded lifetime community rating". This means that for a particular level of cover premiums would rise depending on age at entry. All policy holders, irrespective of their current age, would pay the same premium if they entered at the same age. Because of the "inherent instability" of the current system, compulsory community rating should not be extended further. Finally, under this heading it pointed out that medical inflation posed a major threat to the stability of this sector.

48. On Risk equalisation – Chapter 6

(a) The group concluded that risk equalisation was "essential to underpin community rating" and was "a necessary feature of the private health insurance market". It formed this view having regard to

"* the very high public priority given to preserving the stability of community rating and

* the fact that facilitation of competition is to be subject to the preservation of the stability of community rating".

(b) The group then went on to make specific comments about the 1996 risk equalisation scheme and suggested a number of amendments in respect thereof. These included the suggestion that as well as age and gender, claims intensity should be equalised. In addition claims rates and insurers' own claims costs should be used as a basis for risk equalisation but adjustments should be made to the minimum level of payment, under policies designed to cover private hospitals, by reference to a percentage of the average daily hospital charge for semi-private care in private hospitals, but excluding both Blackrock and the Mater Private Hospital.

49. On Competition – Chapter 7

(a) The group considered "that promoting competition in private health insurance and in the provision of healthcare services must be seen as a vital public policy objective".

(b) The group accepted "that risk equalisation on its own is a barrier to new entrants to the market. However, it is required because it is necessary to protect the stability of community rating which is the primary public policy objective. It remains essential that the parameters of the risk equalisation scheme are designed to minimise any disincentives to promoting competition and efficiency".

(c) The group also recommended that the VHI should be obliged to become a normal insurance company and be operated on a commercial basis, including a requirement to obtain an appropriate rate of return on capital. This was the only way in which "a marketplace conducive to competition can be created".

50. The report also expressed certain views and made certain recommendations *on Regulation and Structure of the market – Chapter 8; on the Private Healthcare Industry – Chapter 9; and On Cost Containment – Chapter 10.* However, it is not essential for present purposes to outline in any detail their views or recommendations on the matters set out in these chapters.

51. Chapter 4: The private health insurance environment:

(a) The report said that prior to 1st July, 1994, the provision of private health insurance in this jurisdiction was subject to the Voluntary Health Insurance Act, 1957, which was operated by the Minister for Health on the basis that health providers, other than the VHI, would only be licensed in respect of schemes not in competition with the VHI. In reality, only a very limited number of such schemes were so licensed and these were confined to certain groups or sectors of society.

(b) A feature of all VHI plans according to the report, "was that they operated on the basis of community rating, that is the same rate of premium was charged for an equal level of cover, regardless of age, gender or health status". It is unclear what motivated this approach, although it is likely that administrative convenience was a significant influence. In addition it was suggested that such schemes were operated on the basis of open enrolment and lifetime cover. Accordingly, though not required under the 1957 Act, these essential features of the sector were well established prior to the 1994 Act.

(c) The uptake of private health insurance by the general population, at that time (1998) stood at about 40%; in stark contrast to other European countries, for example Italy and the U.K. where the percentages were 10%, or indeed even Spain where it was only 15%.

(d) The spending of some IR £300 million on private health care accounted for about 10% of the total health care budget. In Harvey's view, though voluntary and though existing side by side with the public health system, private medical insurance (PMI) nevertheless acted in practice as an alternative to the former and in the process saved the exchequer a good deal of expenditure on some health care products. Other features of the private system were that it provided

speedier access to treatment, a better choice of practitioner, and in some cases provided, or provided a funding for, certain services and facilities which were not available on the public system. Lastly it offered greater facilities, including better accommodation, than the latter.

(e) Referring to the Health Insurance Act, 1994 and the several 'key pillar' regulations made thereunder in 1996, the report said that this Act incorporated the essential principles of the private health system as these had previously operated in this market. It referred to s. 7 of the Act and pointed out that all similar contracts, regardless of age, gender, sexual orientation or health status must be available at the same premium. Exceptions were noted.

(f) It then made mention at para. 4.5 of open enrolment and lifetime cover and at para. 4.6 continued by saying the following in relation to Risk Equalisation:

> "The 1994 Act permits, but does not require, the Minister to introduce a Risk Equalisation Scheme. The purpose of a Risk Equalisation Scheme is to make transfers between insurers with the objective of equalising their risk profiles. The 1996 Regulations introduced such a scheme, reflecting the view of the Department of Health and Children that risk equalisation is a necessary support for community rating. This is based on the premise that, without risk equalisation, each insurer would have a strong incentive to "cherry pick" low risk lives in order to charge a lower community rated premium or take a higher profit, leading ultimately to instability of private health insurance, a decrease in public confidence in private health insurance, and a consequent reduction in the numbers opting for private healthcare".

Chapter 5: Community Rating

52. (a) The report, at paragraphs 5.3 and 5.4, draws a distinction between a risk rating system and a community rating system. The former is where reference can be made to the health status of an individual when setting the premium whereas with community rating, health status must be disregarded. It offers the opinion that such a definition of community rating is wider than that used in the 1994 Act.

(b) Reference is then made to what "a funded lifetime community rating" system is, to what an "unfunded lifetime community rating" is and to what a "yearly community rating" system is. None of these apply in this jurisdiction. In Ireland, there is in existence a pay-as-you-go system with the type of rating being described as a "single rate community premium". It is said that such a premium "is set with the objective of ensuring that, for the totality of policyholders, the cost of claims in any one year is met principally by the premiums paid in that year".

(c) Dealing with "the stability of community rating" Harvey said that the "private health insurance as operated in Ireland is run on a pay-as-you-go basis, that is the cost of claims in any one year is met principally by the premiums paid in that year. The excess of premiums over claims for younger policy holders is used to pay the excess of claims over premiums for older policy holders. Funds to finance future excesses of claims over premiums for current policy holders are not built up." (para 5.6).

(d) The group then said that given the clear objectives of the Irish system, a single rate community rating "involves the surplus premiums of younger policy holders being used to pay the surplus claims of older policy holders. Many of these older lives will therefore have similarly subsidised the claims costs of an earlier generation of older lives. These subsidies between generations are referred to as "inter-generational solidarity". The risk of adverse selection (a process whereby higher risk people purchase insurance, and lower risk people either do not join or leave to avoid subsidising the high risks) obviously exists in this environment and such a process can be exacerbated by the availability of products which can partially substitute for health insurance.

In this part of the report the group is acknowledging that the single rate community rating system is dependent on inter-generational solidarity and also that overtime it serves each generation which participates in the system.

(e) The group then referred to certain comments made by the Australian Industry Commission which suggested that this reliance on intergenerational solidarity carried "the same risks as pyramid selling schemes". That Commission also described the system as follows:

> "A voluntary system of community rating intensifies adverse selection – [it is] the system's built-in self-destruct mechanism. Voluntary community rating amplifies adverse selection for two reasons:
>
> > There is just one big risk group – the community – used as the basis for setting premiums. As shown later this leads to premiums well in excess of expected benefits for the young and healthy and very favourable to the old and sick.
> >
> > Its voluntary nature means that the lower risk groups can exit, leaving a pool of people with higher risk. Premiums then rise reflecting the higher risk and the cycle begins again."

(f) Given these findings on the danger to community rating within this jurisdiction and having acknowledged that "adverse selection" was a major threat to its stability, the report, if unaffected by historical practices, would recommend a systems – transfer, to a funded lifetime community rating method as a means of providing for healthcare costs. This however in view of the traditional system, would not be feasible. It therefore suggested, as an alternative, a movement towards an unfunded lifetime community rating system.

(g) Finally under this heading it identified other potential sources of instability, including the ever increasing rate of medical inflation as well as greater access to an improving public health system which could encourage the withdrawal of younger people from the private insurance market.

53. Chapter 6 Risk Equalisation

(a) The Report described the objective of such a scheme as being to equalise the risk profile between insurers operating

in this market. It came to this conclusion for two reasons; firstly the "very high public policy priority given to preserving the stability of community rating" and secondly the fact that the facilitation of competition was subject to this objective. It came to this conclusion despite seeing merit in BUPA's presentation which included the argument that market forces would prevent different insurers from acquiring substantially different risk profiles.

(b) In addition having recorded the fact that the overwhelming majority of submissions received were in favour of some form of Risk Equalisation Scheme, it then quoted certain passages from these submissions including the following". The Society (of Actuaries in Ireland) is firmly of the view that a risk equalisation scheme is fundamentally necessary where health insurance is community rated. Where community rating and competition co-exist, community rating may be undermined if some or all of the insurers in the market practice preferred risk selection (sometime referred to as 'cherry picking' or 'cream skimming')". The advisory group also agreed with a quotation from the profession of actuaries in the United States of America which was also quoted by the Society of Actuaries in Ireland. This defined the goals of a risk equalisation system as being

> "(i) to help reduce the effects of either inadvertent or intentional risk selection, so that carriers in a competitive market can compete on the basis of medical and administrative efficiency and quality of service and care rather than on the ability to select risk;
>
> (ii) to compensate carriers fairly and equitably for risks they assume:
>
> (iii) to maintain consumer choice from among multiple health plans based on (premium) rates that reflect relative medical and administrative efficiencies; and
>
> (iv) to protect the financial soundness of the system."

(c) It then went on to consider various systems of risk equalisation and commented on individual aspects and features of the 1996 scheme. Whilst it recognised that age and gender were important in differentiating health risk, it concluded that these on their own were not sufficient and that claims utilisation with age and gender cells should also be used.

(d) It also had observations to make on the minimum benefits schedule and in fact set out its own views on what should be the maximum level of benefit in respect of hospital claims. It felt some adjustments were required to the 1996 situation.

54. Chapter 7: Competition

(a) The Advisory Group saw the promotion of competition in healthcare services as a vital public policy objective. Indeed its terms of reference so recognised when it was asked to consider, inter alia, "the need for the risk equalisation scheme to be clearly and effectively consistent with meaningful competition, commerciality and innovation".

(b) Having expressed difficulty in reconciling a truly competitive market with the need for risk equalisation, it went on to offer an opinion that the risk equalisation scheme was a barrier to entry. It did so by pointing out that a new entrant, in the absence of such a scheme, could obtain the full benefit of "cherry picking immediately after accessing the market". It defined this phrase in its glossary as referring to "what insurers do when they enrol only the healthiest people as a way of keeping claims down."

(c) As a result it felt that there was a conflict between the vital public policy objective of maintaining stability in the private health insurance market, with the objective of ensuring effective competition on that market.

(d) Notwithstanding this view however it did refer to a number of areas where it felt that competition could be encouraged promoted and facilitated. In this context it called for the restructuring of the VHI.

55. Technical Paper on a Proposed Amended Scheme: published by the Department of Health and Children: January 1999
Having received the report from the advisory group and being minded to issue a White Paper, the Department of Health set out its own views on an amended scheme by way of a technical paper which it published in January 1999. This paper was divided into nine chapters and had three appendices. The headings under which each chapter was constructed are as follows

Chapter 1: Introduction

Chapter 2: Summary

Chapter 3: Need for Risk Equalisation

Chapter 4: Objectives

Chapter 5: Methodology

Chapter 6: Utilisation Measures

Chapter 7: Mathematics

Chapter 8: Benefits to be Equalised

Chapter 9: Implementation and Operation

A summary of the more relevant parts of each chapter is as follows.

56. Chapter 2: Summary
On the need for risk equalisation – Chapter 3

(a) Community rating in Ireland was in the interest of the general good and had made private medical insurance accessible to a large number of people who otherwise would not be able to afford it. Any undermining of this principle would force multiple people to leave and/or not to enter the system.

(b) Because of community rating and open enrolment, a risk equalisation scheme was essential so as to protect the insured population and to maintain the stability of this market as a whole. In addition it "provided a disincentive for insurers to cherry pick younger, healthier lives".

On Objectives – Chapter 4:

(c) In addition to preferred risk selection being a threat to community rating, there would also be a threat to its stability if costs could not be contained and price increases followed. This may have a similar effect on younger and healthier people by such persons either not entering and/or by dropping out of the system. Consequently while maintaining the stability of this key objective was required, it was also essential to promote competition, in particular in the area of cost containment measures.

(d) Accordingly the Department was anxious to strike a balance between upholding community rating and encouraging competition.

On Methodology- Chapter 5:

(e) As with the original scheme any proposed amendment should operate on a retrospective basis whereunder "each health insurer's risk profile is assessed and a calculation is made to determine what the insurer's claims costs would have been if the lives which it covers had a risk profile equivalent to that of the total insured population".

(f) In addition to the use of age and gender as risk factors in any analysis of risk profile, the Department agreed with the Advisory Group that in addition "prior utilisation (should be) used within the method as a proxy for health status factors that cannot be readily identified nor measured".

On Utilisation Measures – Chapter 6:

(g) Subject to one variation, the Department was reasonably satisfied to accept the recommendation of the Advisory Group as to the choice of an appropriate measure of prior utilisation. That group suggested that: "claims rates and insurer's own claims costs, based on DRG data, (diagnostic related groups) be used as the basis of risk equalisation".

(h) Its criticism of this basis was largely related to the fact that it was biased in favour of hospitalising patients even where effective treatment outside hospital may also be available. In addition it failed to give due weight to the importance of preventative practices.

(i) Accordingly it proposed that the amended scheme "should adopt the utilisation measure that is 40% based on an insurer's own bed night experience and 60% based on the market experience."

On benefits to be equalised – Chapter 8:

(j) In the Department's view the charges equalised under the 1996 scheme should remain, save for an adjustment to take medical inflation into account and save for including all consultant's fees paid in respect of day care or in patient treatment rather than the level contained in the original schedule of such fees.

On implementation and operation – Chapter 9:

(k) The conditions or thresholds outlined in the original scheme which were used to trigger Risk Equalisation payments should remain. Some changes should be made regarding the first period for which payments would be required.

(l) In addition provision should be made to allow restricted members undertakings to permanently opt out of the scheme.

(m) Finally there should be a 12 month phasing in period for any new insurer.

57. Chapter 3: Need for Risk Equalisation;

(a) Following the implementation of the Third Non-Life Directive, it was essential in the Department's view that the general good be protected by maintaining social solidarity and by the widespread availability of private health insurance for the public generally, and in particular for the old, elderly or those who were chronically ill.

(b) The principle of inter generational solidarity was at the core of community rating and made private insurance affordable.

(c) As a result there had been a remarkably high take up on private medical insurance and any undermining of this type of community rating would create a great injustice for those who may have contributed to the system for many years. Instead of enjoying the benefits of this type of solidarity, they may be forced to entirely exit the market.

(d) Given therefore this method of community rating and also the requirement of open enrolment, it was essential in the Department's view, as it was in the view of the Advisory Group, that risk equalisation was necessary so as to underpin the operation of these key principles.

(e) Without such a supporting system there would be a strong opportunity and financial incentive for each health insurer to "cherry pick" low risk individuals (preferred risk selection) so as to charge a lower premium or else to take a higher profit. Even with the four key principles of the Irish system, an insurer could "select preferred risks by selective marketing techniques, targeting group occupational schemes, benefit design, or selective quality of service".

(f) If such an option was available, it is likely that insurers, acting commercially and economically sensible, would seek to select preferred risks. If that occurred the consequences would be that the claims costs for the insurer who is left with a relatively large pool of high risk, would significantly increase. That would instantly lead to market instability and a loss of public confidence which would erode a significant percentage of the present base population availing of such services.

(g) On the other hand this type of risk selection would not enhance the efficiency of the market as a whole as there would be no net benefit to that market. There would be significant expenditure on attracting the young and discouraging the old whilst the cost of insuring older lifes would simply move from one insurer to another. In the Department's view "it would be more beneficial to the market … if investment was invested towards activities that fundamentally reduce the cost of claims and improve services."

(h) Finally Risk Equalisation leaves untouched many potential areas in which one health insurance provider may obtain a competitive advantage over another. It is only in respect of risk profile where the prohibition lay. There is therefore ample scope for strong competition in many other areas.

58. Chapter 4: Objectives;

(a) The objectives of Risk Equalisation are as set out in the terms of reference given to the Advisory Group and include the preservation of community rating in a competitive environment, and subject to that, to facilitate competition, and to satisfy the "general good" principles contained in the Third Non-Life Directive.

(b) The Department acknowledges the priority given to maintaining community rating (and to defend that from preferred risk selection) but in addition it realises that a further threat may come from price increases caused by an uncompetitive cost structure. Therefore it is also important to facilitate competition in this latter regard.

59. Chapter 5: Methodology;

The summary given at paras. 56 (e) and (f) supra of the Department's views under this heading, are adequate to convey its general opinion in this regard.

60. Chapter 6: Utilisation Measure;

(a) Recognising the need to be as accurate as possible when measuring the risk profile of insurance providers, the Department felt that in addition to age and gender, the use of prior utilisation of services was a useful proxy in that it may affect health status. However care had to be taken with this factor as prior utilisation may not be a function of this status alone. It may also, at least in part, reflect differences in claims management and prevention efficiency levels, between insurers.

(b) Subject to this cautionary note, the Department would however support the use of prior utilisation as a further measure.

(c) The technical paper then set out a number of criteria which should be applied in the application of this measure. Ultimately it suggested that an amended scheme should adopt an utilisation measure which was 40% based on an insurer's bed night experience and 60% based on the market experience.

61. { Chapter 7: On Mathematics;

{Chapter 8: On Benefits to be Equalised;

(a) The mathematical formula involved in the original scheme and that suggested for any new scheme was technical in both composition and operation. Further reference should be made to paragraph 7 of the Paper.

(b) The Department rejected the view that the equalisation limit should be set at a level lower reduced than that pertaining in the original scheme. The reason for this was that any lower criteria would result in an insufficient equalisation of risk profiles. Subject to adjusting, from time to time, in respect of medical inflation, all consultants fees paid in respect of day care or in-patient treatment should be included in the equalised benefits.

62. Chapter 9: Implementation and Operation;

(a) Under the original scheme, Risk Equalisation payments would not commence until a number of conditions had been satisfied. These were that the total payments by insurers to the Risk Equalisation fund would have to exceed 2% of the market equalised benefits or the amount payable to any insurer would have to exceed 2.5% (provided this was more than IR £125,000) of equalised benefits and that insurer's own equalised benefits exceeded 5% of the market equalised benefits.

(b) The Department supported the continuation of these thresholds.

63. White paper – published by the Government in September 1999
In March 1998, the Department of Health and Children sought submissions, from any interested party, on the structure, financing, delivery, quality and development of private health insurance in this jurisdiction. It received 71 submissions and its officials held meetings with 27 organisations and individuals who indicated a wish to supplement their submissions with oral presentations. Having also received the Advisory Group's Report in April 1998, and in light of the Technical Paper above mentioned, the Government in September, 1999 published this White Paper in which it set out its policy objectives and proposals regarding this particular sector. In all, the document consists of an executive summary, three parts containing eight chapters and several appendices. The breakdown of the paper is as follows;

Chapter 1: Private health insurance in the Irish healthcare system,

Chapter 2: The State's role in relation to private health insurance,

Chapter 3: Preserving community rating,

Chapter 4: Risk equalisation,

Chapter 5: Further changes to the regulator framework,

Chapter 6: Consumer protection and quality assurance,

Chapter 7: Structural changes, and

Chapter 8: The Voluntary Health Insurance Board

64. Chapter 1: Private Health Insurance in the Irish Healthcare System

(a) Having referred to the establishment of the Voluntary Health Insurance Board by the inaugural act of 1957 the paper indicates that private health insurance was primarily established to cater for those who were not entitled to avail of the public services but it was also envisaged that perhaps "others who might wish to avail of alternative private health care would also avail of the system of private health insurance scheme". In fact those who did avail of the system increased substantially in number and by 1999 nearly 42% of the population had taken out some level of cover.

(b) This figure and the continuing uptake of such insurance should be looked at in the context of a reduction from the marginal to the standard rate of relief for tax purposes, and also of the considerable premium increases which occurred over this period. And yet people continued to avail of this service principally because it afforded protection against large hospital/medical bills and so gave peace of mind about healthcare needs. In addition it provided faster access to hospital beds and offered options for private or semi-private accommodation.

(c) Medical consultants are said to play a key role on the extent of insurance claims costs as their decisions and procedures determine, in a large measure the "intensity of utilisation of hospital services". It is a consensus amongst all people that the public at large should have access to a certain level of necessary health services, including "primary care, hospital care, long term care and personal social services". Since 1979 there has been a universal entitlement to public hospital accommodation. This was extended in 1991 with the introduction of eligibility for medical consultants in public hospitals. The public system is funded primarily from general taxation, though the overall provision of medical care and services, contains a unique mixture of both public and private with the latter contributing about 25% of the necessary funding.

65. Chapter 2: The State's role in relation to private health insurance

(a) The paper said that the Irish system, as expressed through community rating and open enrolment, was based on the principle of solidarity between insured persons. In view of the implementation of the Third Non-Life Directive, it became imperative to specify in law how these principles should work, as otherwise the stability of this established solidarity based system could be jeopardised.

(b) With competition each health insurance provider may well be tempted to seek out good risk and "eschew" bad risk. This possibility had the potential to seriously undermine the system. It should also be noted that the level of profit, that is surplus of premium over claims costs, is as much determined by the make up of an insurers' population as it is by its size.

(c) As a result the Government acknowledged that there may be a potential conflict between greater competition, which it seeks not only by way of new entrants but also in other areas, and the necessity to maintain the stability of solidarity. However in its view an open market would not adequately protect the vulnerable and in fact could easily "de-stabilise community rating and open enrolment." Therefore regulatory arrangements were essential in the common good but these must be applied fairly and consistently, and should only exist to the extent necessary "to secure the protection of the common good".

(d) At paragraph 2.2 of the document the purpose of a regulatory system as understood by the government was set out. It reads as follows:

> "The government considered that, in general terms, the existing health insurance framework represents an appropriate and balanced approach to securing the following objectives
>
> 1. Adequate statutory protection for the principles of community rating, open enrolment and lifetime

cover;

2. A broadly based and widely accessible private health insurance system;

3. A level playing field for all insurers as regards the application of the above mentioned principles in the competitive market;

4. Genuine competition based on cost, product quality, marketing and distribution; and

5. A regulatory environment which encourages insurers and healthcare providers to operate efficiently".

(e) In its view the existing health insurance framework was capable of meeting these goals and in particular could maintain community rating as well as facilitating competition based on quality and service. The paper however recognised that this existing framework warranted review so as to ensure that it supported the development of competition and efficiency in the system to the fullest possible extent.

(f) Finally in this context the paper pointed out that the uptake of private health insurance had been "resilient" in the face of both ever increasing premiums and a drop from the marginal to the standard rate of tax relief. Even with these difficulties however, it offered the view that price was capable of remaining an issue. In fact if premiums rose to a level where insurance became "markedly less affordable, it is likely that the young and healthy would be the first to leave the system, thereby generating a spiral of instability in the market for health insurance".

66. Chapter 3: Preserving Community Rating

(a) The first point to note was that the White Paper did not appear to offer any conclusive view on the legal definition of community rating for the purposes of risk equalisation. It referred to what requirements were specified, for a contract to be known "as a community rated health insurance contract" under s. 7 of the 1994 Act, but it did not, in any more specific and direct way, at least from a lawyer's point of view, deal with this issue.

(b) The paper continuously referred to the key importance of this concept and how today's healthy individuals could become tomorrow's uninsurable persons. It said that community rating "represents a broad protection to the community as a whole … (and) that the advent of chronic illness or sustaining serious injury will not render the cost of cover unaffordable". It once more emphasised that intergenerational solidarity was at the core of community rating and that such a mandatory requirement of the Irish system, made insurance accessible to the most vulnerable, including the elderly and the chronically ill.

(c) With such a system the long term vitality of its founding pillars required a continuous inflow of young people. In general the surplus created by such persons kept the premium rate for the old and the elderly at a level which was, but which otherwise may not be, affordable. If such persons did not continuously join, then this surplus would not be available, and inevitably premiums would have to increase to cover the ever increasing cost claims of a population with a worsening risk profile.

67. Chapter 4: Risk Equalisation

(a) Section 12 of the 1994 Act made provision for a risk equalisation scheme in order to support community rating and open enrolment. The Third Non-Life Directive, by its express terms, allowed Member States to protect the common good, by means of for example, a loss compensation scheme (otherwise known as risk equalisation). When introducing the 1994 Act the Department fully explained to all interested parties the nature and operational basis of the equalisation arrangements which were then being put in place (para. 4.1).

(b) The Government's view, as set out in the White Paper, had been facilitated and informed by the Harvey Report which the Minister for Health received in April 1998.

(c) Explaining the need "for risk equalisation", the White Paper said that in its absence each health insurance provider would have a strong incentive to target low risk (preferred low risk selection) so as to either charge a lower premium or else to take higher profits. Even with the advent of open enrolment such insurers, either by accident or design, could achieve a better risk profile, for example by "selective marketing techniques, targeting group occupational schemes, benefit design, or selective quality of service". Any such process which in its view gave rise "to significant differences in risk profiles between insurers" "was known as risk selection.

(d) In its opinion if this should occur then at least two adverse consequences would follow. Firstly, claims costs would "spiral" for the provider which was left with the greater proportion of high risk individuals and as a result this, as part of the Irish system, "would lead to significant market instability and erosion of public confidence". Secondly risk selection would not benefit the market as a whole, as considerable sums of money would have to be expended on attracting the young and low risk and on discouraging the older/high risk. It would be far more beneficial, in the Government's view, if such investment was directed towards activities that fundamentally reduced the cost of claims and improved services.

(e) Competition can operate effectively even with risk equalisation. Areas such as distribution, brand, customer responsiveness, provider relations, product innovation, claims management, purchasing efficiency and administrative efficiency are all, completely or substantially, unaffected by risk equalisation. Therefore such a scheme is compatible with the obligations imposed by the Third Non-Life Directive. Spelling it out in more detail, the Government expressed the view that a scheme meeting the following criteria could achieve the stability of community rating in a competitive market, and, subject to that, could facilitate competition and could also satisfy the "general good principles of the Third Non-Life Directive". These criteria which are specified at paragraph 4.10 of the Report are as following:

"Equalisation of Risk Profiles

* The scheme should provide a stable environment for community rating and open enrolment through eliminating incentives for health insurers to select preferred risks, and by ensuring that each health insurer bears the cost of a risk profile equivalent to the risk profile of all insured lives;

Equity

* The scheme should be perceived to be equitable between health insurers and should not result in any health insurer having to share profits which it has made as a result of its own efficiencies and cost controls:

Cost Containment

* The scheme should not present disincentives to health insurers to maximise efficiencies and control costs;

Non Equalisation of Benefit Levels

* The scheme should not equalise different levels of benefit paid by different health insurance plans;

Practicality

* The scheme should be understandable and practical to operate;

Predictability

* "the scheme should produce results which are as predictable as possible, to allow health insurers to cost their policies appropriately."

(f) In endeavouring to ensure that providers do not have to share profits which result from their own efficiencies and cost controls, the Government suggested that certain amendments be made to the initial scheme which would meet this objective, and would do so even though a provider would be obliged to bear the cost of a risk profile equivalent to the risk profile of all insured lives.

(g) This chapter of the White Paper then considered and commented upon what might be an appropriate utilisation measure, what benefits were to be equalised, what thresholds would have to be satisfied before risk equalisation payments would be triggered, on whom (namely the HIA) the responsibility to operate the scheme should fall, the position of restricted membership undertakings and an appropriate phasing in period for new entrants.

68. Chapter 5: Further Changes to the Regulatory Framework
In this section the existing framework and how that should be amended with regard to, *inter alia*, open enrolment and minimum benefits, was addressed.

69. Chapter 6: Consumer Protection and Quality Assurance
This chapter dealt with a variety of topics, including a possible code of practice for the sector, a structure for consumer grievances, accreditation of hospitals, technology etc.

70. Chapter 7: Structural Changes

(a) The role of the Minister for Health in and with the VHI was considered, with the Government recognising a potential "for conflicts of interest" to occur, arising out of that relationship. In giving approval for the establishment, in principal, of the Health Insurance Authority and for conferring significant functions on that body, the Government was attempting to redress a significant number of areas of potential conflict in the aforesaid relationship.

(b) In addition the functions of the Minister with regard to the VHI and the structure of that body itself were specifically addressed in the following chapter.

71. Chapter 8: The Voluntary Health Insurance Board

(a) Having reviewed the status of the VHI since its inception in 1957, and having acknowledged the important role which that entity had played in private health insurance over the past 40 years, the Government nevertheless recognised that with the transition from a closed market to a more open and competitive market, the VHI was in need of restructuring.

(b) The White Paper suggested that there was a compelling case for a change in VHI's corporate status and noted that the Government intended to enact legislation to give full commercial freedom to that body. Moreover there would be a "once off" financial injection to facilitate that restructuring and the Government would also involve itself, as a matter of urgency, with the question of outside investment so as to enhance the position and prospects of that company.

H.I.A. - Consultation Paper
72. The Health Insurance (Amendment) Act 2001 was enacted on 27th June of that year. Having been established on 1st February, 2001 the Health Insurance Authority issued what it described as a "consultation paper" on 19th February, 2002. In that paper it raised a number of issues with regard to risk equalisation. In the first place it addressed the meaning of "consumer interests" and pointed out that s. 12(10)(a)(iii) of the 1994 Act, said that "the best overall interests of consumers includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between the

undertakings" (emphasis added). In its view therefore this description implied that there were other elements of "consumer benefit" which, through this consultative process, it had hoped to identify. Secondly it pointed out that potentially there were several indicators which could be used for risk equalisation such as age and gender only, age gender and utilisation and case mix. It invited submissions from all interested parties on these issues.

73. By way of response the members of the advisory group in a letter dated 2nd May, 2002 made a submission on some of these points. In general it re-confirmed the two major themes which ran through its original report. Firstly it repeated its belief that with the existing Irish system, a risk equalisation scheme was necessary, but warned that such a system must also allow for competition, as otherwise there would be a return to the former uncompetitive situation. In addition having pointed out that medical inflation, in itself, caused a threat to the stability of community rating, it expressed a view that the best way of dealing with this was to encourage competition.

It then made observations on a system based on age and gender only and highlighted what it felt were the major advantages of such a system.

The Actuary Department of the Government of the United Kingdom (G.A.D.) were commissioned by the HIA to advise on the competing views with regard to risk equalisation and did so by letter dated 29th July, 2002.

74. From the above statutory provisions, documents and practices, the following would appear to be the position:-

(i) The overall healthcare system in Ireland is comprised of a unique mix of public and private care. At its inception over half a century ago, the private system had a rather limited population target but as of 2005 it provides services to approximately 50% (1.9 million) of the relevant population. This is a significant increase over virtually all other countries in the EU.

(ii) From the beginning, the system was built on community rating, open enrolment and lifetime cover. Given the absence of competition, its particular structure and its non profit making mandate, the VHI in operating these provisions, effectively treated its entire population as the community for the purposes of rating. Thus the question of risk selection never arose. At no stage was risk rating allowed or practiced in this jurisdiction.

(iii) With the incorporation into domestic law of the Third Non-Life Directive, - involving the abolition of the VHI as a monopoly and the liberalisation of the market, – the Government had to consider the future structure of the sector and did so by enacting the 1994 Act. Given its unconditional commitment to furthering the common good by making private medical insurance affordable, and thus available to all, it established a framework which incorporated the principles of community rating, open enrolment, lifetime cover and made provision for a risk equalisation scheme. This regulatory intervention was deemed essential because of the strong incentive which a new entrant would have, in a community rated market, to seek out good risk and avoid the poorer risks, generally the older people. This business approach known as risk selection, would enable an insurer to charge a lower community rated premium or else to take a higher profit. In either case, if this risk selection procedure, even inadvertently or unconsciously, produced significant results, the same could seriously undermine the system and could lead to market instability. By charging a lower community rate, the new entrant would most likely attract the younger people, who it must be accepted, are generally the better risk. The insurer who is then left with the greater percentage of the higher risk, would have to seek a significant increase in its claims costs. More people would then leave being either unable to afford the higher premium or else finding the product poor value. A further increase in premium would then follow. In addition this cherry picking would not add anything to the overall market and would be bad for consumers generally.

(iv) The aforementioned principle of community rating, is a rating which applies without regard being had to a person's age, gender or health status. It must be contrasted with risk rating where the individual characteristics of a would-be policy holder are vital in determining the package offered. Though the "community" involved in this type of rating, may have been somewhat ambiguously stated in some of the documentation, there is however no doubt but that Harvey recognised a wider meaning for this phrase than that used in the description of "community rated health insurance contracts" under s. 7 of the 1994 Act as amended. See, inter alia, paras. 5.3 and 5.4 of the Report. A similar view was expressed by the Department in its technical paper – see p. 9.

(v) This type of community rating is based, as indeed are the other pillars of open enrolment and lifetime cover, on what has been referred to as intergenerational solidarity. This operates on the basis that today's young people, will subsidise today's old people by paying somewhat more for their plan than is actuarially justified. In turn the next generation will offer the same cross subsidisation to today's young people. As a result this support structure is in existence on a continuous basis.

(vi) The Government had always been of the view that though important as they were, the principles of community rating, open enrolment and lifetime cover were not sufficient in themselves to preserve the stability of the Irish system. This of course in the context of a competitive market. Therefore, from the outset some system of risk equalisation had always been provided for or in order to support and maintain these three pillars. Indeed, the consultative process above outlined shows a remarkable level of support for such a scheme. The overwhelming majority of contributors to Harvey were in favour, as of course were the Department of Health in its technical paper and the Government in its White Paper. There was therefore never a period since 1994 when that type of support was not in principle considered necessary.

(vii) Realising that the 1996 scheme was capable of improvement, the Minister for Health, as we know, established the Harvey Group in 1998. The terms of reference given to that group are set forth at para. above. It is worth recording however that whilst her first priority was to preserve the stability of community rating, the Minister nevertheless unequivocally endorsed the necessity of combining that with a competitive market. This is evident by her request to the group to consider "the need for (a) … scheme … to be clearly and effectively consistent with meaningful competition, commerciality and innovation. "Accordingly, the achievement of these twin objectives was foremost in that respondent's mind.

(viii) It should be noted that the Advisory Group, if unencumbered by history and if free to devise a new private system for this country, would not have recommended a comparable system to what presently exist. However any radical departure from the provisions of the 1994 Act would not, in the short term now be feasible.

(ix) Risk equalisation is a scheme which attempts to equitably spread the differences in the claims costs of health

insurance providers which arise from variations in the health status of its members. The scheme is said to have anti-competitive effects. Indeed Harvey found it difficult to reconcile a truly competitive market with the need for risk equalisation. However it is also said that the restrictions which exist, such as they are, apply only to health status and that otherwise health insurers are not prevented by this scheme from gaining competitive advantage. For example, in areas such as distribution, brand, customer responsiveness, provider relations, product innovations, claims management, purchasing efficiencies and administrative efficiencies. Moreover the White Paper clearly recognised the need for competition on price as uncompetitive prices could seriously affect market stability.

75. The above constitutes a review of the literature which I propose to refer to in this judgment. I now turn to the problems in this case.

BUPA to leave the market

76. (a) Before dealing with the major issues which arise in this case, I would like to make a comment about the declared intention of BUPA to close its business and leave the Irish market in the event of this challenge been unsuccessful. Mr. O'Rourke gave evidence of a board meeting of the group held in April 2005 at which this issue was discussed. There is available a copy of the documentary information which was placed before the Board at that time and also a copy of a two and half page minute of that meeting; although the identity of those who attended is not recorded. Under the heading of "Closure", the following is stated

> "Mr. Kee said that sadly, but inevitably, depending on events, BUPA may have no alternative other than to close the BUPA Ireland business. Mr. Kee sought the authority of the Board to close the business, should the decision to implement risk equalisation commence. Mr. Kee emphasised that, for the avoidance of any misunderstanding, it would be important to be able to say categorically to the HIA and the Minister, if the Board so decided, that in the event of implementation the Board's authority for closure had been given. Ideally it would be preferable to head off the possible introduction of risk equalisation not merely now, but for future periods, as it was extremely time consuming and expensive to have to fight it off, every six months. Mr. O'Rourke told the Board that it was becoming impossible to run the business with the threat of closure hanging over it all the time. The Board went on to consider numerous aspects of the risk equalisation regime, and in particular, the impact on BUPA Ireland. In particular the Board reaffirmed that subject to having a viable business plan that would support a RES which was confined to substitutional PMI.
>
> Following these deliberations the Board resolved that BUPA group is totally committed to doing everything to save the business but that if risk equalisation is commenced closure (subject to ?) be authorised forthwith. The Board requested Mr. O'Rourke to convey their support to colleagues throughout BUPA Ireland".

(b) There then followed a meeting of the Irish Board on 9th June, 2005. Again the documentary material, which was headed "Provisions and financial implications of awaiting court decision (draft figures)" is available. The minute of that meeting contains various estimates in the event of the business being closed as and from a variety of dates. Apparently, in the event of the Scheme being introduced, the closure of the business would follow.

(c) Mr. O'Rourke in evidence outlined a very firm view in this regard. He went so far as to indicate that a specific time and event table had been agreed, right down to where, who would attend, and what would be said at a press conference announcing the cessation of business. He saw no scope for a reconsideration of these decisions either by the Group Board or the Irish Board.

(d) As I understand the position of all parties who have a direct interest in this case, not one of them, apart from BUPA are anxious that the applicants would depart from this market. In fact both the Minister and the VHI would very much wish that BUPA would continue operating in this jurisdiction even in the event of a Risk Equalisation Scheme applying. I can confidentially say that this would also represent the public view. I therefore do not want to say anything which might render more difficult, or jeopardise, a reconsideration of these decisions either in foreseen or unforeseen circumstances. I only wish to add that given an average underwriting profit of more than 18% per annum over the four years up to 2004, it is very difficult for me to understand, how purely in a business sense, both the Irish and the group Board could make such irreversible decisions, in the circumstances and at the time when they did. These decisions are also somewhat surprising given the rather limited information which was placed before them. Finally I will leave it to Mr. Kee to explain why he felt it is so important to be is a position to so categorically tell the Minister of the decision to close.

77. Issue No. 1: Delay/Laches

The respondents and the notice party, but in particular the former, make a complaint about the delay of the applicants in the institution of these proceedings. It is said that such delay is inordinate and inexcusable given the fact that since the 1994 Act, there has been a provision dealing with risk equalisation. In addition there was no challenge to the scheme made in 1996 which was in place when the applicants announced their intention to enter the market on 22nd April, 1996. Moreover that scheme, in draft form was available to BUPA in both 1994 and 1995 and that company entered into discussions with the Department of Health and Children on these matters as early as 17th December, 1993. In addition over four years have elapsed between the institution of the within proceedings and the passing of the 2001 Act which amended the statutory provisions of 1994. Likewise over two years have passed before a challenge was mounted to the present scheme. In these circumstances it is claimed that by virtue of the Rules of the Superior Courts, as well as the relevant case law, the applicants should not be permitted to proceed with this action.

78. Order 84 rule 21(1) of the Rules of the Superior Courts obliges every applicant to move for judicial review "promptly" and in any event within three months from the date upon which the issues first arose or six months where the relief sought is certiorari. In *deRoiste v. Minister for Defence* [2001] 1 I.R. 190 Denham J. noted, that where an issue of delay had been raised a trial court had to consider the matter from both a procedural and substantive point of view. The learned judge said "the analysis commences with the obligation to bring the application promptly". It is the key word, which is the foundation of the process. As to whether the application is prompt will depend on all the circumstances of the case. In *O'Donnell v. Dun Laoghaire Corporation*, [1991] ILRM 301, Costello J. in emphasising the discretionary nature of relief in judicial review proceedings said " … it is well established that a plaintiff's delay in instituting proceedings may, in the opinion of the court, disentitle the plaintiff to relief. Even if there has been no delay and even if the application is brought within the three or six months mentioned in Order 84 rule 21, the court could nevertheless decline relief where the application was not brought promptly". In the *deRoiste* decision, Mr. Justice McCracken in the High Court said "the primary provision (is) Order 84 rule 21 (and) therefore … an application for judicial review must be made promptly and it is only a secondary provision, that in any event, the application must be made within the stated time depending on the nature of the application. It would appear, therefore, that an application for judicial review may fail even if it is made within the stated time unless it is also made

promptly. There is, however, the overall power of the court to extend the period where the court considers there is good reason to so do. While it may not be an absolute rule, I have no doubt but that in the vast majority of cases the onus is on the applicant to produce evidence to show such a good reason". See also the judgment of Fennelly J. in that case as well as the judgment of Kearns J. in *O'Brien v. Moriarty* (Unreported, Supreme Court 12/5/2005). Finally, the decision of Fennelly J. in *Dekra Eireann Teoranta v. Minister for Environment* [2003] 2 I.R. 270 at 304 was also relied upon where the learned judge said "an applicant who is unable to furnish good reason for his own failure to issue proceedings for judicial review at the earliest opportunity and in any event within three months from the date when grounds for the application first arose, will not normally be able to show good reason for an extension of time. … the strictness with which the courts approach to question of extension of time will vary with the circumstances. However, public procurement decisions …".

79. In paras. 18 to 25 inclusive, of his affidavit sworn on the 12th September, 2005, Mr. Martin O'Rourke on behalf of the applicants, offers a response to this allegation. In addition in support of his reply, it was submitted that Section 12, of the 1994 Act as amended, which is under challenge in these proceedings, was replaced in its entirety by s. 9 of the 2001 Health Insurance (Amendment) Act. That provision took effect as and from the 19th November of that year. The current scheme, under S.I. 261/2003 was made on 26th June, 2003. Given that the original s. 12 was repealed in total, it was suggested, and I agree, that a more correct starting period for any consideration of the question of delay should commence in 2001 and not as far back as 1994. This equally applies in relation to the 1996 scheme which was repealed in its entirety in 1998.

80. The facts in this case show that effectively from the very beginning, BUPA expressed in correspondence with the Department, their misgivings about any risk equalisation scheme. Secondly, the applicants seem to have taken a certain degree of comfort from a speech given by the Minister in 2001 when he said that the commencement of risk equalisation "was very much (a) reserve power" and that it would "not be commenced without good reason". Thirdly, the applicants instituted proceedings in the Court of First Instance challenging the Commission's approval, given by decision of 13th May, 2003 under the State Aid Provisions of the EC Treaty (Article 87). Finally it could only be said that the applicants were under threat when the HIA made a recommendation to the Minister in April 2005 to commence payments under the scheme. Whilst the Minister declined to so do on 27th June, 2005, she made it clear in that communication that if circumstances changed, her decision might likewise change. In any event proceedings were instituted within a matter of weeks of the first date upon which it could truly be said that the applicants position was directly impacted upon, and adversely affected by, both s. 12 of the 1994 Act as amended and by the Risk Equalisation Scheme. In these circumstances it seems to me that there has been no delay on the part of BUPA in instituting these proceedings and accordingly this submission, made on behalf of the respondents and notice party, must fail.

81. "Issue No. 2": The Correct legal interpretation of "Community Rating"
The Applicants submissions on this point – which can be decided without further evaluation of the facts of this case:

As appears from para. 29 above, s. 2 of the 1994 Act states that "community rating shall be construed in accordance with s. 7(1)(c)" of the Act. Section 7 obliges all health insurance providers to charge a person the same premium for a health insurance contract as it charges to all other persons for "every other such contract", which is effected for the same period, which relates to the same health services and which provides for the same payments. Under s. 7(1)(c) such a contract "shall be known as a community rated health insurance contract" and "community rating" shall be construed accordingly. This definition, according to the applicants, applies with equal force to the concept of community rating for the purposes of risk equalisation.

82. The correct principles of statutory construction are, in essence, not in dispute and can be found in the judgments of the Supreme Court in *Howard v. The Commissioner of Public Works* [1994] 1 I.R. 101 and *Crilly v. Farrington* [2001] 3 I.R. 251. In *Howard*, Mr. Justice Blayney at p. 151, quoting Maxwell on "The Interpretation of Statutes" said "the rule of construction is 'to intend the legislature to have meant what they have actually expressed' … The object of all interpretation is to discover the intention of Parliament 'but the intention of Parliament must be deduced from the language used' … for 'it is well accepted that the beliefs of those who frame acts of parliament cannot make the law."

In *Crilly*, Mr. Justice Murray, as he then was, at p. 295 - 296 added the following:

> "The role of the courts in the interpretation of statutes, as a matter of principle, is summed up with great clarity by Lord Nicholls in *R v. Secretary of State for the Environment, ex parte Spath Holme Limited* [2001] 2 WLR 15 at p. 37 when he said:
>
> > "statutory interpretation is an exercise which requires the court to identify the meaning borne by the words in question in the particular context. The task of the court is often said to be to ascertain the intention of parliament expressed in the language under consideration. This is correct and may be, helpful, so long as it is remembered that the 'intention of Parliament' is an objective concept, not subjective. The phrase is a shorthand reference to the intention which the court reasonably imputes to Parliament in respect of the language used. It is not the subjective intention of the minister or other persons who promoted the legislation. Nor is it the subjective intention of the draftsman, or of individual members or even of a majority of individual members of either House. These individuals will often have widely varying intentions. Their understanding of the legislation and the words used may be impressively complete or woefully inadequate. Thus when the court say that such and such a meaning "cannot be what Parliament intended", they are saying only that the words under consideration cannot reasonably be taken as used by parliament with that meaning. As Lord Reid said … "we often say that we are looking for the intention of Parliament, but that is not quite accurate. We are seeking the meaning of the words which a parliament used.'
> >
> > The principle of objective intent at the root of the role of the courts in interpreting statutes is, as I have indicated, the same in this country. The intent of the Oireachtas is imputed to it on the basis of the text of an Act adopted and promulgated as law in accordance with the Constitution."

83. There is no dispute about these rules to which I would only add, that in construing any provision of an Act of the Oireachtas, the court is entitled, and sometimes obliged, to take into account other provisions, or indeed all other provisions, of the given statute and perhaps also, where relevant, its title. Although s. 5 of the Interpretation Act 2005 has on occasions being referred to, I do not believe that recourse to it is necessary, in order to determine this issue. Accordingly I propose to apply the principles of construction as herein outlined.

84. On behalf of BUPA it is said that "community rating", which can only have one meaning, must be defined strictly in accordance with the statutory definition (s. 2 and s. 7(1)(c)) of the1994 Act, and as is evident therefrom, the phrase refers only to those persons who purchase a particular policy. It must therefore be understood as being confined to an identifiable contract or plan and cannot be said to have a wider meaning than that. People in the Irish system are not rated individually but must be offered a

particular plan at exactly the same premium as that particular plan is offered to all other intending purchasers. This regulatory framework demands this, but no more. It does not provide for a standard policy at a pre-set charge nor does it require every insured person who takes out a policy, whatever the terms of that might be, to pay the same premium. A provider can offer multiple choice plans, some even with very minor variations. The only requirement in the present context is that each plan must be offered at the same uniform premium.

85. Provided community rating is so understood, there is room for suggesting that such a system may offer intergenerational solidarity, in that within a given plan, the excess of premia over costs, generally obtainable from young persons, helps to subsidise the excess of claims costs over premiums, generally incurred with regard to older people. So, but strictly within contract, there is some cross-subsidy with each person being obliged to pay only the average premium for the same product. In such circumstances the total of all premiums will cover the entire cost of that product.

This understanding of community rating is the only one permitted by the 1994 Act, and is fully in conformity with a legislature which has put in place and created a very pro-competitive market. Providers can offer different products, different policy terms, different benefits and different prices, and persons can self select any one of the plans on offer which best suits themselves. Moreover, the opening words of s. 7(2) support this interpretation where it is said:

> " … Without prejudice to the generality of subsection (1), premiums payable under health insurance contracts shall not be varied by reference to ...",
>
> such matters as age, sex, sexual orientation, health status etc. In other words there shall be no discrimination on these grounds.

86. Disregarding for a moment the conflict which appears in the affidavits of the respondents and notice party, as to what precise meaning each one is giving to community rating, it would appear from the submissions of Counsel made on their respective behalf, that for the purposes of risk equalisation, it has a meaning which includes the entire community of insured persons, regardless of product and regardless of who the provider might be. In this regard significant reliance is placed on s. 12(10)(a)(iii) of the Act, as well as its long title. As will be recalled the HIA, when making a recommendation to the Minister, must have regard "to the best overall interests of health insurance consumers". That phrase in the section just mentioned is described as including "a reference to the need to maintain the application of community rating *across the market* for health insurance and to facilitate competition between undertakings". (emphasis added). It is the phrase which is underlined that the respondents/notice party place major emphasis on in suggesting this extended meaning of community rating. This, it is submitted by BUPA, is entirely misconceived.

87. In the first instance, the applicants say that risk equalisation is an entirely different concept from the statutory definition of community rating. Indeed "risk equalisation" has its own definition. Secondly, the material reference in s. 12(10)(a)(iii), as inserted by the 2001 Act, is to "maintain" the application of community rating across the market. To "maintain" is to "preserve" and that must relate to the existing definition of community rating already provided for in s. 7. There is therefore no conflict between what the HIA must consider when advising the Minister and BUPA's single definition of community rating.

88. When dealing with the Act's long title, it is clear that provision is made for the creation of a risk equalisation scheme involving the sharing of prescribed costs, amongst registered undertakings. That cannot be read in the manner suggested by the respondents/notice party. Such an interpretation, is simply not open on the clear wording of s. 7 and fails to recognise, as previously pointed out, the separation of a res scheme from community rating. There could only be a community rate across the entire market if the statute so allowed or mandated. It does neither.

89. The concept of intergenerational solidarity is a non statutory one and cannot inform the correct meaning of a statutory definition. Even however if reference could be made to this notion, it could never amend such a definition. This however is not to deny that intergenerational solidarity, whereby the young subsidises the old, had played an important part in the public policy thinking that led to the enactment of the 1994 Act, and its later amendment. This concept of support however was given legislative expression through the s. 7 definition of community rating (and open enrolment, lifetime cover etc), and is entirely satisfied by providers being obliged to charge a uniform premium for the same policy.

90. This phrase according to BUPA was not defined with any precision in the Government White Paper and certainly no particular mechanism was outlined, by which the young would subsidise the old. Indeed any reference in that document to intergenerational solidarity would tend to place it in the context of a s. 7 definition which was expressly set out at para. 3(1) of the paper. There is therefore no reason to believe that the Government intended that any of the key pillars of the private system would have a meaning other than that given to them through the statutory definition. In addition it is striking to note that the White Paper did not express, as an object of risk equalisation, the support or maintenance of intergenerational solidarity. Instead of course, it gave as the schemes object the preservation of community rating and, subject to that, the facilitation of competition.

91. Another peculiar feature of the current argument advanced by the State and the notice party, emerged from a consideration of the evidence given by Mr. O'Flaherty. This actuary played a central role in drafting the 1996 and 2003 schemes, and he and his colleagues in Mercers, have been advising the Department in this area since 1994. Throughout his evidence he admitted on a number of occasions that he had always operated on the basis of the "community" being spread across the entire market and in fact prior to this trial, had not realised that there might be different versions of that term. Similarly so with the phrase intergenerational solidarity. In fact both his general and working understanding of the latter term was to the effect, that it was co-extensive with his understanding of community rating. Therefore he was largely ignorant of or else had disregarded the section 7 definition.

92. It was further submitted that merely because a risk equalisation scheme forced the insurer with the lower claims profile to bear a set of costs which it would allegedly face if it had the market average profile, it could not be the case that the reference in section 12 to the 'best overall interests of the consumer' amounted to the introduction of a new definition of community rating. The words of section 7 were plain, simple and straightforward. That section controlled the definition of community rating and section 12(10) was simply a warning to the HIA to keep the concept of community rating foremost in its mind when advising the Minister on whether or not to introduce RES payments. Therefore in conclusion since the form of community rating put forward as a justification for the Risk Equalisation Scheme, is *ultra vires* the correct interpretation of the 1994 Act, as amended, that scheme, being without justification cannot be valid.

93. In my view the submissions made on behalf of BUPA on this issue are not well founded and I am persuaded that the correct interpretation of the Act is that as suggested by the notice party. In the reasons which follow I have incorporated the arguments made on their behalf by Mr. Paul Gallagher S.C.

94. It is important I feel, to realise that the substantive part of 1994 Act, as amended, as well as the 2003 Scheme, (indeed also the 1996 Scheme) were conceived against the backdrop of the system of private medical insurance which had operated in this country for several decades. Disregarding restricted members undertakings, the sole provider permitted by law until 1994 was the VHI. As such it seems to be accepted that it operated a *de facto* system of community rating, open enrolment and lifetime cover, even though there was no statutory obligation to so do. How precisely it achieved a uniformity of premium for the same bundle of benefits across its entire population, was never a pressing issue, as it operated on a non-profit basis and in a single player market. How precisely it put into practice, what has been described as intergenerational solidarity, was likewise never a matter of concern. But what emerges from the evidence is that its system of PMI incorporated a provision of community rating which had the effect of young people, generally low risk, subsidising to some extent older people, generally higher risk.

In so doing the premiums paid by the young people were more than what could be actuarially justified with the reverse applying to the older people. This system continued from one generation to another and so on, so that one can easily understand how the phrase, intergenerational solidarity, came about. The practical effect of this system was that PMI was financially available to the vast majority of those who sought it.

95. After the passing of the Third Non-Life Directive, this Country was obliged to implement its provisions by the 1st July, 1994. In the process the state monopoly had to go, a new system of authorisation and supervision had to be established and the market had to be opened to competition.

There is no doubt in my mind but that the Directive recognised that differences existed within the EU, with regard to PMI systems and that a full realisation of a true internal market in that sector was not possible. But consistent with the retention of key elements, such as community rating, open enrolment and loss compensation schemes, (Recitals 22, 23, and 24) - which did not "unduly restrict" Treaty freedoms, - the Directive sought the putting in place of the most competitive market possible in each Member State. By allowing a domestic input however, it realised that in this area pure competition, unaffected by regulation, either did not work or was not achievable. So in addition to a move to prudential control and the creation of a new authorisation and regulatory system, the Directive was satisfied to achieve its competitive objectives in a way, which conditionally respected a country's right to preserve its own system. In Ireland this included of course, community rating, open enrolment and lifetime cover.

96. Leaving aside for a moment, as to whether or not, the State can avail of Article 54 of the Directive, that Article recognised that those countries, to whom it applied, could impose certain specific legal provisions in the post-liberated world so as to protect the general good. The Recitals acknowledged, that unlike other insurance sectors, health insurance had a peculiarity all of its own which made risk rating undesirable. This is because such a system was potentially incapable of giving meaningful access to all persons, young and old, regardless of age, gender or health status. To that end some measures, conditionally, could be introduced to give effect to open enrolment, some form of community rating and some form of lost compensation schemes.

97. It seems to me that whether or not a better system could have been created, this State decided in its wisdom, to implement the Directive in a manner which would preserve (and perhaps enhance) the key pillars under which the then existing system worked; as well as creating a machinery to open up the market to competition and to encourage and promote competition therein. It sought to achieve this by way of creating a balance between the priority of preserving the existing system and of creating a business and legal environment, in which for the first time, the incumbent insurer would have to face competition.

98. From the very outset, a system of risk equalisation was part of the legislative plan. It so said in the preamble to the 1994 Act which I will come back to. It created four pillars, community rating, (s. 7), open enrolment, (s. 8), lifetime cover, (s. 9), and minimum benefits, (s. 10). In addition in s. 12 it gave the Minister power to make a risk equalisation scheme or schemes by way of statutory instrument. The reason or necessity for making such provision arose from the State's view that its preferred system, in particular community rating, open enrolment and lifetime cover, was potentially unstable in view of the adverse consequences, which could result from an effective operation within the market by a new entrant(s) of "cherry picking" or "risk selection". That this is so, is evident from the report of the Advisory Group where at para. 4.6 it describes how health insurance providers, without risk equalisation, would have a strong incentive to "cherry pick" low risk in order to reduce its premiums or else to increase its profits. That practice could lead to instability in the market, a decrease in public confidence and a drop in the insured population. At para. 6.2, the group concluded that with the Irish principle of community rating, styled by it as "Single Rate Community Rating", a system of risk equalisation was essential to underpin these pillars.

99. The technical paper likewise expressed a view that some system of risk equalisation (whatever its precise details might be) was "an essential feature of the health insurance market where health insurers are required to operate on a community rating/open enrolment basis" (para. 2.3).

The White Paper is even more emphatic in this regard. In a community rated market it referred to the incentive for providers to cherry pick either intentionally or inadvertently. The consequences of such risk selection would, in its view, create significant market instability, would lead to a loss of public confidence and in any event would not be an enhancement to the efficiency of the market (para. 4.8(i)).

Whilst these reports all post-date the passing of the 1994 Act, they were evidently in existence prior to the amendments in 2001 which effectively continued the general principles of private medical insurance, as these had previously existed in the Irish market. Together with the evidence of Mr. Barrett, Mr. Shannon and Mr. Armstrong, I am satisfied that at all times the State intended to make provision for a risk equalisation scheme and to have that scheme form an integral part of the overall structure of the market in this jurisdiction. Equally so I am satisfied that the State also had an understanding of community rating which was not confined to the four corners of a given plan but rather extended to all of the insured population.

Given these circumstances it could never have been the State's intention to isolate any scheme from the established pillars.

100. The long title to the Act is informative and sets out the general purpose and aim thereof. It is an Act to regulate, in the interest of the common good, the voluntary health insurance business in Ireland, by *inter alia* providing:-

(a) for the establishment of the Health Insurance Authority

(b) for the establishment of a scheme(s) …for the equalisation of risk between health benefit undertakings and

(c) for the uniformity of premiums within contracts

So, in addition to the HIA, the title sets out to make provision for two key points which would appear to be inter-related but also

separate. Unless there was a distinctive feature lying between the twin concepts of uniformity of premium within each plan and a scheme for the equalisation of risk between health insurance providers, it is difficult to see why the title should have set these out individually. Moreover the wording used in respect of these two aims is in one sense quite different. The reference to uniformity of premium would appear to relate to specific contracts, whereas in respect of risk equalisation, the title provides for the setting up of a scheme so that risks may be equalised, which, in accordance with its definition, is achieved by the sharing of prescribed costs. Incidentally it should also be noted that the phrase "community rating" is not mentioned in the title either where it deals with risk equalisation or at all. In any event the Act seems to follow on, this distinction by creating a separate description or definition of what community rating is and what risk equalisation is. Risk equalisation means the sharing of prescribed costs of registered undertakings between such undertakings to be achieved by payments either made to or received by such undertakings. These costs relate to payments made under health insurance contracts. Accordingly it would appear that the equalisation of risk is implemented through a payment mechanism whereby prescribed costs of undertakings are shared between such undertakings.

101. It therefore seems, at least on its face, that the sharing arrangements under such a scheme are not confined to individual policies and indeed are not even confined to all the policies on offer from any one health insurance provider. It seems quite clear that what is being spoken of is to apply for the benefit of undertakings and also between undertakings. Moreover the linkage of prescribed costs with 'health insurance contracts' is of significance because of the definition of such contracts which involves all such contracts and not simply a specific one within the portfolio of plans held by an individual provider.

102. Community rating is said to be "construed" in accordance with the meaning of a community rated health insurance contract (s. 2). Immediately one notices the choice of legislative words. The phrase, "community rating", is not "defined" either in s. 2 or in s. 7, but rather its meaning must be construed in accordance with both. Section 7 contains a unique mixture of freedoms and obligations. Gone is the ex-anti regulatory regime. In its place the provider can offer a menu of plans with a variety of benefits and can set whatever premiums it wishes. It has a considerable choice in this regard. However it must disregard, amongst other things, age, gender, sex, sexual orientation and the health status (both current and prospective) of an individual when setting a premium and it must of course charge each person who wishes to avail of a particular plan the same premium. Taking the community as comprising a pool of insured persons who avail of any such plan, it can be said that this is a form of community rating within plan, suspecting as one might that the premium would reflect the average claims costs of that pool. It is therefore not in the slightest surprising that s. 7(1)(c) refers to such a contract as a "community rated health insurance contract".

103. Immediately after so describing such a contract, the section says that "community rating" shall be construed accordingly. Again it must be noted that the section does not say that community rating "means" or that it is "a community rated health insurance contract". The section in my view must be understood as meaning that by reference to what is known as a community rated health insurance contract the words community rating must be interpreted accordingly. Community rating is therefore a sharing within a community, which in a contractual sense is a sharing of costs/risk within that particular community of subscribers. But if used in a different context I can see nothing in s. 7 which would prohibit the "community" part of this phrase from comprising a class different to the class within a given plan. Accordingly there is in my view no reason in principle why the phrase "community rating", even with a singular meaning, cannot be qualified by the context of its use either as in a contractual sense or as s. 12 says "across the market generally".

104. The reason why this type of framework had been chosen is not that difficult to understand. The legislature in the post 1994 world, remained concerned about cherry picking and risk selection and yet remained committed to the establishment of a competitive market. It could have, but did not specify, that health insurance providers would have to offer a statutory plan, containing identical benefits, at a pre-set charge or premium. That type of regulation would be a return to the regime which existed prior to the Third Non-Life Directive. In the process it would of course be far more restrictive than what is presently in existence. Instead it was decided that a provider should be able to operate on a much more open basis, offering all types of plans or policies but subject to the conditions which I have mentioned. However it was also felt that with such a system it was crucial to have available a corrective mechanism in the event of the open market creating a substantial imbalance between the risk profiles of different health insurance providers. If such an unequal distribution did not occur then the mechanism would not be activated and an operator could lawfully conduct its business by rating within a plan only. But if the liberalised regime displayed such characteristics, then a scheme to correct that imbalance, so as to preserve the stability of the market, was crucial. Hence the power given to the Minister to make such a scheme.

105. It is therefore in my view a highly sophisticated system, offering what the State believes, to be the minimum of regulatory control consistent with the maintenance of community rating, supported by social solidarity, all with the purpose of maintaining market stability; whilst at the same time permitting, or as the State would see it by encouraging, to the maximum possible extent the competitiveness of the market force. The respondents see this approach as serving the best interest of the consumer, as well as fully implementing the Third Non-Life Directive.

106. In my view the wording of s. 12 is not only entirely consistent with this but as regards the meaning of community rating fully supports Mr. Gallagher's submission thereon. What therefore in general may the Minister do under s. 12?

> (a) She may make a scheme to equalise risk by the sharing of prescribed costs incurred by and between undertakings,
>
> (b) She must provide for the making of returns and for the same to be evaluated and analysed by the HIA. That exercise is carried out *inter alia* by reference to the nature and distribution of insured risks between undertakings.
>
> (c) She must, with any such scheme, provide that payments be made by or to health insurance providers, in such amounts as may be determined by the H.I.A. How does that body so decide? It does so on the returns made by reference to prescribed matters including "the nature and distribution of insured risks amongst undertakings". Not by reference to contract it should be noted.

107. Section 12 then specifies the guiding objective which the H.I.A. must adhere to in making a recommendation to the Minister. That is "the best overall interests of health insurance consumers". That phrase is also heavily influential in deciding what the Minister can do with regard to the commencement of the scheme. So what does this mean? Section 12(10)(a)(iii) tells us that "the best overall interests of health insurance consumers includes a reference to the need to maintain the application of *community rating across the market* for health insurance and to facilitate competition between undertakings". So the scheme envisaged by the section is fundamentally based on the sharing of risks across the market to be directly related to, or indeed even determined by, a consumer interest which includes this very concept of "community rating across the market". These features together with the wide definition of a health insurance contract as well as the definition of "insured risks", lead me, in the context of an overall consideration of the Act, to the firm conclusion that for the purposes of risk equalisation, the community which must be rated, is not a community within plan, but rather is the community which comprises the entire insured population within the Irish private medical insurance sector.

Accordingly for these reasons I reject the submissions of BUPA in this regard.

108. It is also worth noting that the Minister felt that the 1996 Scheme was not operating in a satisfactory manner, perhaps, *inter alia*, by being too inflexible and competitively too restrictive. As a result she and the Department, having established and obtained a report from the advisory group, revoked that scheme pending the issue of a Government White Paper and presumably the enactment of any legislative changes which might follow. The consultation process engaged in by this group, by the Department of Health who also as we know, issued a technical paper in 1999, by the Government after issuing the White Paper, and by the HIA after it was established, was it can only be said breathtaking in its scope. Every individual, entity and body, no matter how remotely connected with PMI, was either given an opportunity to or else was specifically asked to comment on, the various discussion papers then in existence.

109. Whatever about the arguments there might be with regard to the finer detail, I am satisfied that community rating when so discussed was not confined to a uniformity of premium within a particular plan or contract. This was equally so when the phrase "inter generational solidarity" was spoken of. This phrase to me is no more than a way of describing the basis of community rating. It is not at all surprising therefore that it is widely used in discussion documents, though the true concept and the statutory phrase remain that of community rating. As I have previously stated, when one looks at the Harvey Report, the authors were clearly aware of the distinction between what I might call the s. 7 community rating and the type of community rating mentioned by it (at paras. 5.3 and 5.4) when (contrasting) that with risk rating. Whether it was right or wrong it clearly said that "this definition of community rating is a wider one than that used in the 1994 Act". A similar understanding emerges from both the technical paper and the White Paper. It therefore comes as no surprise to me that my interpretation of this phrase is in general representative of the above discussions. I therefore believe that the respondents/notice party's interpretation of community rating for the purpose of s. 12 is correct.

110. This conclusion has considerable significance for several other major issues in this case. For example a great deal of the expert evidence called on behalf of BUPA was premised on the applicants understanding of this phrase for Risk Equalisation purposes. Obviously therefore such evidence can no longer apply given the conclusions above reached.

111. Issue No 3: Unauthorised delegation of legislative power
Under this generalised heading of unlawful delegation, BUPA made a number of submissions all to the effect that the risk equalisation scheme was unlawful. Firstly it was claimed that the powers given by Article 43.2.10 and 20, of the Constitution, whereby the exercise of "Private property" rights may be regulated by the principles of social justice and may be curtailed in the interests of the common good, can only be achieved "by law", by which it means the primary legislator and even then only by an Act of the Oireachtas. Secondly it is alleged that the Risk Equalisation scheme is a "Money Bill" within the meaning of Article 21 and Article 22 of the Constitution and accordingly, as these Articles should properly be understood, such bills, no matter how described or even disguised (for example as a statutory instrument) cannot be introduced save by the procedures specified in such Articles. Thirdly if the State is correct in saying that "community rating" has, for the purposes of s. 12, a meaning different from that as set out in s. 7 of the 1994 Act, then the same could only have come about as a result of the statutory instrument which created the scheme which must therefore have necessarily amended s. 7. No Minister can so do. And finally the scheme, read in conjunction with s. 12, fails the "principles and policies test" as outlined in *Cityview Press* [1980] I.R. 381.

112. As appears from para. 12 above, the State in Article 43.2 of the Constitution, recognises that in a civil society the exercise of the rights given therein, may be regulated by the principles of social justice. This can be achieved "as occasion requires" by the State delimiting "by law the exercise of the said rights with a view to reconciling their exercise with the exigencies of the common good". It is said by *BUPA* that the reference to "law" in Article 43.3(2) is a reference to laws passed by the Oireachtas and not to any form of secondary legislation, and in particular for the purpose of this case, not by a statutory instrument. In other words it is for the Oireachtas to determine what the principles of social justice are in any given set of circumstances, what the exigencies of the common good are and how the exercise of private property should be reconciled within and by these principles.

113. The applicants then make a distinction between a delegatory power which, for example, may allow a subordinate authority to decide, whether a fully inclusive and existing legislative scheme should apply at all to a particular case, and a power which enables a Minister to determine whether a particular scheme should be made law and if so on what terms. In doing the latter it is said that the Oireachtas has created an impermissible delegation of legislative authority which is contrary to Article 43.2 and Article 15 of the Constitution.

114. The decision in *Pigs Marketing Board v. Donnelly (Dublin) Limited* [1939] I.R. 413 was referred to. In that case the plaintiff, a statutory body, was directed by law, to fix the price per hundredweight, of different categories of pigs in respect of certain periods. In so doing it had to consider specified matters. The defendants, who were bacon manufacturers and licensees under the Pigs and Bacon Act 1933, were prohibited from purchasing pigs at prices other than those calculated by reference to the fixed price. The Board also fixed what was described as a 'hypothetical price' but in that instance the Act did not provide any scheduled matters which had to be considered. As a result the defendants argued that in respect of the latter the Board acted as a legislator. At p. 421, when discussing a delegation of power by the legislature, Hanna J. said, in relation to subordinate bodies, that "such bodies are not law makers; they put into execution the law as made by the governing authority and strictly in pursuance therewith, so as to bring about, not their own views but the result directed by the Government".

115. It is further claimed that the making of laws which reconcile the exercise of private rights with the exigencies of the common good, raises matters of fundamental state policy and accordingly it is wholly correct that constitutionally, this can only be performed by the national parliament. The following passage from *O'Neill v. The Minister for Agriculture* [1998] 1 I.R. 539 was quoted. At p. 556 Murphy J. said:

> "It is the scope of such regulations and above all the manner in which they affect or touch upon the property or other constitutional rights of the citizens which may raise doubts as to how far they were within the contemplation of the Oireachtas … The scheme manifestly affects the right of citizens to work in an industry for which they may be qualified and the rights of potential customers to avail of such potential services. It is not that there is any reason to doubt that the scheme ultimately devised by the first respondent was desirable, and may well have operated in the national interest, … It is simply that such a scheme is so radical in qualifying a limited number of persons and disqualifying all others who may be equally competent from engaging in the business. It may be that such a far reaching power could not be delegated by the national parliament at all. Certainly I would be unwilling to accept that in using general words the Oireachtas contemplated such a far reaching intrusion on the rights of citizens".

116. In further support of this argument the following comments of Barrington J. in *Laurentiu v. The Minister for Justice* [1999] 4 I.R. 26 were outlined. At pp. 70-71 the learned judge said

> "One of the tasks of legislation is to strike a balance between the rights of individual citizens and the exigencies of the common good. If the legislature can strike a definitive balance in its legislation so much the better. But the problem which confronted the court in the *Cityview Press v. An Chomhairle Oiliúna* [1980] I.R. 381, is that the facts of modern society are often so complex that the legislature cannot always give a definitive answer to all problems in its legislation. In such a situation the legislature may have to leave complex problems to be worked out on a case by case basis by the executive. But even in such a situation the legislature should not abdicate its position by simply handing over an absolute discretion to the executive. It should set out standards or guidelines to control the executive discretion and should leave to the executive only a residual discretion to deal with matters which the legislature cannot foresee".

117. Considerable emphasis has been placed by BUPA, in this context, on what it describes as "the expropriation" of its property rights. This categorisation of alleged infringements, runs right through their submissions and if correct would in their view make it all the more mandatory, that any reconciliation had to be carried out by and achieved under primary legislation. Finally it denies that the case of *Leontjava v. D.P.P* [2004] 1 I.R. 591 decided that a statutory instrument was "law" for the purposes of Article 43.2.2 or Article 15 of the Constitution.

118. On the first argument under this general heading, I do not accept that the submissions of the applicants are correct. It seems to me that Article 43 of the Constitution does not in anyway offer a qualification on the precise status of what type of statutory "law" might be used for the purposes of that Article. Nor in my view is there any reason to restrict its meaning by way of implication. Once such a law "is passed" by "the State" then in my opinion, assuming that the appropriate constitutional and (where applicable) statutory framework are adhered to, the resulting matter is a "law" for the purposes of that Article. Since there can be no doubt but that a validly passed statutory instrument is and has the force of "law" in the State, this method in my view is an acceptable mechanism to operate the regulation within the provisions of Article 43.2.

I accept that *Leontjava* did not in fact decide that a statutory instrument was "law" for the purposes of Article 43.2; it being concerned with the validity of a specific provision which provided that certain orders "shall have statutory effect as if (it) were an Act of the Oireachtas". In upholding the validity of this method of legislation (by incorporation), the Supreme Court through Chief Justice Keane did however point out at p. 636 "that the Constitution affords a strikingly wide latitude to the Oireachtas in adopting whatever form of legislation it considers appropriate in particular cases". Unless therefore the "law" in this case, namely the statutory instrument which created the risk equalisation scheme, conflicts with some other specific provision of the Constitution, then in my view it is valid for the purposes under present discussion. Since I cannot find any such conflict, this argument in my judgment fails.

119. In any event this point is premised on the basis that the decision on what are the principles of social justice, the decision as to what constitutes the common good in this regard and the decision to reconcile the applicants property rights, were all made by this statutory instrument. In my view this is not the case. As appears further in this judgment, when dealing with the submission based on the "principles and policies test", it seems to me that these factors have been adequately set out in the 1994 Act as amended and accordingly the submission also fails on this ground.

120. Money Bill
Articles 21 and 22 of the Constitution, (see para. 10 above), deal with Money Bills. Under Article 21 every such Bill must be initiated in Dáil Eireann which is free on its return from the Seanad, to accept or reject any recommendations made by that body. If such a Bill is not returned within a period of 21 days or if the Dáil does not accept the recommendations of the Seanad, then the Bill shall be deemed to have been passed by both Houses at the expiration of the 21 day period". (Article 21.2.20).

121. A Bill is then described in Article 22 as being one "which contains only provisions dealing with all or any of the following matters, namely, the imposition, … or (the) the regulation of taxation: the imposition for … financial purposes of charges and public moneys …; the appropriation, receipt … of accounts of public money …"

It is submitted on behalf of BUPA that certain provisions of the Risk Equalisation scheme make that scheme, in reality, a money bill and accordingly for its lawful existence both Articles 21 and 22 must be complied with. It is said that given the specific role of Dáil Eireann with such Bills, and recognising the subordination of the Seanad to that chamber, it is not possible to validly create a Money Bill by way of secondary legislation. By reason of these provisions, it is submitted that the Oireachtas cannot delegate power to make, by way of a statutory instrument, what is in effect a Money Bill. See in *Re Irish Employers Mutual Insurance Association Limited,* [1955] I.R. 176.

122. Referring to s. 12 of the 1994 Act as amended, it is claimed that the Risk Equalisation scheme made thereunder, permits the Minister to raise funds which are placed in a bank account and which are managed and controlled by the HIA; which in turn has its accounts audited by the Comptroller and Auditor General. All such funds so raised are "for public purposes" and therefore are a form of "imposition of taxation" within Article 22.1.10. In addition under the scheme, the Minister through the HIA's involvement, is dealing with both the receipt and custody of "accounts of public money". Moreover in determining how the funds are ultimately disposed of, it is said that the Minister exercises a discretion in respect of the "appropriation … of accounts of public money" and the "imposition for … financial purposes of charges and public moneys."

123. The response to these submissions by both the respondents and notice party are twofold in number. Firstly, it is suggested that even if the Risk Equalisation scheme should qualify as a Money Bill, that issue is simply not justicable *inter partes* and secondly, that in any event the scheme does not fall within the description of such a Bill.

Mr. Gerard Hogan S.C. on behalf of the State makes the argument that Articles 21 and 22 of the Constitution make special provisions which are referable solely to Money Bills. These are designed to regulate the internal legislative procedures governing the enactment of such Bills. The Articles in question are accordingly procedural in nature and deal with the internal affairs of the Oireachtas. Consequently even if BUPA's submission on these Articles is correct, they would still not be permitted to raise this irregularity as an issue between the parties. *O'Malley v. An Ceann Comhairle* [1997] 1 I.R. 427 was cited in respect thereof.

124. In paras. 4.5.08 to 4.5.11 inclusive, on Kelly on the Irish Constitution, 4th Edition, there is an interesting and informative discussion on Articles 21 and 22, in fact precisely on this point. In addition to *O'Malley's* case, the cases of *O'Crowley v. Minister for Justice* [1935] I.R. 536 (dealing with Article 35 of the 1922 Constitution) and the more recent case of *Maguire v. Ardagh* [2002] 1 I.R. 385 are also discussed. It is suggested in the body of the text, that given the provision of Article 22.2, it could be persuasively argued that the procedure therein specified is all inclusive and that no other body, including the courts can be involved outside the framework of that Article. There is of course a contrary argument supporting the view that an issue, such as whether a Bill is or is not a Money Bill or whether the provisions of Articles 21 and 22 have or have not been complied with, are justicable. Given the constitutional review jurisdiction of the superior courts, it could well be that notwithstanding the regulation contained within Article 22, resort can still be had to this court on such an issue.

125. In any event in my opinion this particular argument does not require resolution in these proceedings. This because in my view the underlying assumption in BUPA's submission is incorrect; in that the risk equalisation scheme is not a "Money Bill" within Articles 21 and 22. As appears from the detailed discussion outlined above, the proper characterisation of the scheme, and the entire purpose of it, (as evinced by the 1994 Act), is to equalise, in a certain specified manner, the risk (arising from health status) between insurers operating on this market. That is one of its central purposes; the method of so doing is by "sharing prescribed costs"; again in the manner as outlined. This manner, undoubtedly involves the transfer of money from one undertaking to another with that transfer being facilitated by the HIA who receives all such monies on trust. It is evident that the amounts in question come from a registered undertaking and go to another registered undertaking. I therefore cannot see how one could describe this regime as involving matters of taxation, such as we are all familiar with e.g. Finance Bills or as the raising, or receipt or the making use of public monies, such as appropriation bills. In my view consequently the submission fails.

126. Section 7 definition of Community Rating Amended by the S.I. 261/2003
Under the generalised heading of unauthorised delegation, BUPA's third argument in this regard is as follows. It claims that there is only one definition of community rating within the statute and that is the s. 7 definition. Accordingly if the State is correct in suggesting that for the purposes of s. 12, there is a second meaning, then that can only have resulted from the statutory instrument which created the scheme. In effect therefore the Minister has amended this statutory definition, which by law she cannot do. Consequently this alternative meaning is invalid. Accordingly the scheme must also be invalid in this way.

Given the views already expressed on the correct interpretation of "community rating" for the purposes of s. 12, it must inevitably follow that this submission has to be rejected. As so stated it appears to me, that in addition to the definition of a "community rated health insurance contract" under s. 7, the phrase "community rating" as it applies to a risk equalisation scheme under s. 12, has a different meaning. Or more accurately it is the plan which is community rated under s. 7 whereas it is the entire market under s. 12. The latter meaning derives from a consideration of the 1994 Act as amended and does not depend on and is not deducible from the scheme itself. Therefore I do not believe there is any substance in this argument.

127. The Principles and Policies Argument
There is no doubt but that this fourth limb of the applicants' argument on delegatory power, was by far their most substantial and most important one. Under Article 15.2 of the Constitution the sole and exclusive power of making laws for this State is vested in the Oireachtas and no other body has such power. However under Article 15.2.20 , it is provided that: "Provision may however be made by law for the creation or recognition of subordinate legislatures and for the powers and functions of these legislatures". As the principles which emerge from the judicial interpretation of this Article are not in dispute between the parties, although of course their application is, it would be convenient to initially outline what these principles are. In *Pigs Marketing Board v. Donnelly* [1939] I.R. 413, Hanna J. stated at p. 421: " … The Oireachtas is the only constitutional agency by which laws can be made. But the Legislature may, it has always been conceded, delegate to subordinate bodies or departments not only the making of administrative rules and regulations, but the power to exercise, within the principles laid down by the Legislature, the powers so delegated and the manner in which the statutory provision shall be carried out. The functions of every Government are now so numerous and complex that of necessity a wider sphere has been recognised for subordinate agencies, such as boards and commissions. This has been especially so in this State in matters of industry and commerce … " The reference in that judgment to the requirement of exercising the power "within the principles laid down by the legislature" has of course been endorsed in numerous subsequent cases, one of which was *Cassidy v. Minister for Industry and Commerce* [1978] 1 I.R. 297 where Henchy J. said that the exercise by a secondary body, of a power conferred by a statute would be ultra vires the enabling provision unless it is "within the limitations of that power as they are expressed or necessarily implied in the statutory delegation".

128. In 1978 the Supreme Court in *Cityview Press Ltd & Anor v. An Chomhairle Oiliuna & Others* [1980] I.R. 381, issued a significant statement outlining what the appropriate test might be in any challenge to the validity of delegated legislation. O'Higgins C.J. stated at p. 399 that in the court's view "the test is whether that which is challenged by as an unauthorised delegation of parliamentary power is more than a mere giving effect to principles and policies which are contained in the statute itself. If it be, then it is not authorised; for such would constitute a purported exercise of legislative power by an authority which is not permitted to do so under the Constitution. On the other hand, if it be within the permitted limits, if the law is laid down in the statute and details only are filled in or completed by the designated Minister or subordinate body – there is no unauthorised delegation of the legislative power." In that judgment the Court was dismissing an appeal from the decision of Mr. Justice McMahon in the High Court, a passage from whose judgment is also highly relevant. The learned High Court judge said at p. 389-390: "It is apparent from the authorities cited that there is no universal and apt formula to determine the extent to which legislative power may be delegated. The subject matter of regulation may be so fluid that a detailed prescription of standards could make effective administration impossible and delegated powers would have to include wide areas of judgments and of discretion. The present case does not involve those difficulties. The delegation of a legislative power which is challenged by the plaintiffs is confined to a narrow field. It confers a discretion, but it is a discretion which relates to the implementation of policy and not to the determination of policy."

129. A decision which the applicant relies upon is *McDaid v. Sheehy* [1991] 1 I.R. 1. That case was concerned with the power of the Government to impose duty under the imposition of Duties Act, 1957. It is the judgment of Mr. Justice Blayney in the High Court which is relevant. The learned judge said at p. 9: "The question to be answered is: Are the powers contained in these provisions more than a mere giving effect to principles and policies contained in the Act itself? In my opinion they clearly are. There are no principles or policies contained in the Act. Section 1 states baldly that "the Government may by order" do a number of things one of which is to impose a customs duty or an excise duty of such amount as they think proper on any particular description of goods imported into the State. In my opinion the power given to the Government here is a power to legislate. It is left to the Government to determine what imported goods are to have a customs or excise duty imposed on them and to determine the amount of such duty. And the Government is left totally free in exercising this power. It is far from a case of the Government filling in only the details. The fundamental question in regard to the imposition of customs or excise duties on imported goods is first, on what goods should a duty be imposed, and secondly, what should be the amount of the duty? The decision on both these matters is left to the Government. In my opinion, it was a proper subject for legislation and could not be delegated by the Oireachtas. I am satisfied accordingly that the provisions of the Act of 1957 which I cited earlier are invalid having regard to the provisions of the Constitution".

130. *Cronin v. The Competition Authority*, [1998] 1 I.R. 265 was then cited. That case concerned certain provisions of the Competition Act, 1991. Under s. 4(1) of the Act, any agreement, or decision, or concerted practice engaged in by undertakings or associations of undertakings, which, either by object or effect, prevented restricted or distorted competition were prohibited and void. Section 4(2) however effectively disapplied this prohibition in respect of any such agreement, decision or concerted practice which in the opinion of the Competition Authority " … contributes to improving the production or distribution of goods or provision of services or to promoting technical or economic progress, whilst allowing consumers a fair share of the resulting benefit and which does not:-

(i) impose on the undertakings concerned terms which are not indispensable to the attainment of those objectives;

(ii) afford undertakings the possibility of eliminating competition in respect of a substantial part of the products or services in question".

The plaintiff alleged in *Cronin* that this power given to the Competition Authority was unconstitutional as an impermissible delegation of legislative function. Speaking for the Court, Barrington J. said at p. 276, when dealing with this submission. "The powers [(s. 4(2)] are indeed extensive and may involve the analysis of very complex questions of fact but the legislative bounds within which these powers must be exercised are clearly laid down and are outlined by me earlier in this judgment under the heading "Legislative Framework" but nevertheless they appear to amount to no more than the implementation of principles and policies contained in the statute itself". The learned judge then quoted the principles and policies test as outlined in *Cityview Press* and held that this submission failed.

131. The decision of Mr. Justice Murphy in *O'Neill v. Minister for Agriculture* [1998] 1 I.R. 539, is of interest. That was a case dealing with the licensing regime for the artificial insemination of certain animals within the State. In essence for this purpose the State was divided into nine areas, in each one of which was located an artificial insemination centre. This was licensed with the licensee being obliged to provide such services in that area. Only one such person in each area was so licensed. The issue before the court therefore was whether *inter alia* this type of regime was *ultra vires* the Minister under a particular provision of the Livestock (Artificial Insemination) Act, 1947. The learned judge said at p. 556 of the judgment:

> "It has never been suggested that the power to make statutory regulations should be confined to some stereotyped administrative provisions. It may be, and I see no reason why it should not be, that regulations designed by a minister and his officials to secure a particular statutory objective would be novel and innovative and accordingly, not in their terms anticipated by the legislature".

He then however went on to consider the scope of such regulations and how those might touch upon the property and other constitutional rights of individuals. Whilst he doubted whether the Oireachtas would have agreed to divide the State into nine areas for the purposes at hand, he found it "inconceivable" that it would have conferred such a power on the executive. Because the scheme effected the rights of citizens to work and having described it as "so radical in qualifying limited numbers of persons and disqualifying others who may have been equally competent from engaging in the business" the learned judge felt that such a "far reaching intrusion on the rights of citizens" could not be delegated by the use of "general words".

132. The next case of importance, in date sequence, is *Laurentiu v. Minister for Justice* [1999] 4 I.R. 26. That case concerned the constitutionality of s. 5(1)(e) of the Aliens Act, 1935 which provided that "the Minister may, if and whenever he thinks proper, do by order … all or any of the following things in respect either of all aliens or of aliens of a particular nationality or otherwise of a particular class, or of particular aliens, that is to say:-

> (e) … make provision for the exclusion or the deportation and exclusion of such aliens from Saorstát Éireann and provide for and authorise the making by the Minister of orders for that purpose".

In applying the test set out in *Cityview Press*, the majority of the Court held that s. 5(1)(e) was not in conformity with the Constitution. Denham J. said at p. 61: "According to the Constitution and the law it is for the Oireachtas to establish the principles and policies of legislation. It may delegate administrative, regulatory and technical matters. The principles and policies test has been part of Irish case law since 1939 – as has been set out earlier in this judgment. It is somewhat similar to the case law requiring standards to be set by the legislature, for delegated legislation, in the United States of America. The principles and policies test must be applied in accordance with constitutional presumptions as to the interpretation of legislation (favouring that which is constitutional) and presuming actions by ministers and officials will be made in a constitutional fashion … There has not been extensive analysis of the principles and policies test. Partly this is because of the very nature of the issue. Each case depends on its own facts and requires that the principles and policies of those matters be set out in the legislation."

Commenting specifically on the facts of *Laurentiu* Denham J. observed at p. 63 that "One searches in vain to find principles and policies regarding deportation of aliens in the Act" and also that "standards, goals, factors, and purposes such as those set out in *Mistretta v. United States* (1989) 488 U.S. 361, are absent." (p. 62).

133. While dissenting on the particular facts of the case Barrington J. did approve of the principles and policies test adding his voice on this topic by stating at pp. 70-71 "One of the tasks of legislation is to strike a balance between the rights of individual citizens and the exigencies of the common good. If the legislature can strike a definitive balance in its legislation so much the better. But the problem which confronted the Court in *Cityview Press v. An Chomhairle Oiliúna* [1980] I.R. 381, is that the facts of modern society are often so complex that the legislature cannot always give a definitive answer to all problems in its legislation. In such a situation the legislature may have to leave complex problems to be worked out on a case by case basis by the executive. But even in such a situation the legislature should not abdicate its position by simply handing over an absolute discretion to the executive. It should set out standards or guidelines to control the executive discretion and should leave to the executive only a residual discretion to deal with matters which the legislature cannot foresee".

134. There are two further cases to which reference ought to be made. The first *is Maher v. Minister for Agriculture* [2001] 2 I.R. 139. In that case the Court had to consider whether regulations made by the Minister infringed the provisions of Article 15.2.1 of the Constitution. These regulations were not required to be made in any particular form, though they were enacted pursuant to Regulation of the Council of the European Communities. Fennelly J. at pp. 245-246 of the judgment said "An enormous body of substantive law is, nonetheless, constantly passed by means of statutory instruments, regulations and orders. This type of delegated legislation is, by common accord, indispensable for the functioning of the modern state. The necessary regulation of many branches of social and economic activity involves the framing of rules at a level of detail that would inappropriately burden the capacity of the legislature. The evaluation of complex technical problems is better left to the implementing rules. They are not, in their nature such as to involve the concerns and take up the time of the legislature. Furthermore, there is frequently a need for a measure of flexibility and capacity for rapid adjustment to meet changing circumstances. Without suggesting that a different approach is required for the present case, by reason of the fact that it concerns the implementation of European Community legislation, it is obvious that the adoption of detailed rules regulating production and trade in agricultural products is a particular notable example of the exigencies of this type of law making. There is, for example, an obvious need to be able to react rapidly and often severely to sudden trading problems or so to protect human and animal health in the face of the outbreak of a disease. On the other hand, it is obvious that secondary legislation largely by-passes parliamentary scrutiny and the democratic process. Thus, the courts have found it necessary to strike an appropriate balance between the protection of the exclusive law making domain of the Oireachtas and the proper function of the executive. The distinction is a functional one, aimed at designating the proper bounds of legislative and executive power. Delegated legislation is permitted and does not infringe Article 15.2.1., provided that the principles and policies which it is the objective of the law to pursue, can be discerned from an Act passed by the Oireachtas, so that the delegated power can only be

exercised within the four walls of the law".

135. And finally there is the case of *Leontjava v. Director of Public Prosecutions* [2004] 1 I.R. 591. Giving the judgment of the Court, Keane C.J. said at p. 624: "No such considerations, in my view, arise in the case of s. 5(1)(h) (contrasting it with s. 5(1)(e) – see *Laurentiu*). The policy enunciated is plain: the desirability of regulating the registration, change of abode, travelling, employment and occupation of aliens while in the State and the further desirability of regulating "other like matters". The use of the expression "particular provision" in this context is, in my view, unexceptionable: it was entirely appropriate for the legislature to specify the matters which it considered required regulation, while leaving it to the Minister to put in place specific regulatory provisions. Similarly, the use of the expression "other like matters" is what one would expect in a provision conferring a power of delegated legislation, the use of the phrase "other like matters" is peculiarly appropriate where the broad scope of the envisaged regulations is being set out in statutory form. To require the legislature either to specify the "particular provisions" or the "other like matters" in the parent legislation itself would be to negate the whole purpose of the power admittedly enjoyed by the Oireachtas to provide for delegated legislation". See also *Gilligan v. Governor of Portlaoise Prison*, High Court, Unreported, 12/4/01.

136. It is submitted on behalf of BUPA that on any detailed examination of the section, it is clear that judged by any of the above recited statements of principle, the scheme is the result of an unlawful delegation of parliamentary power. It is the exercise of legislative power in several respects with the scheme far exceeding even the outer limits of what could be authorised. It is not the mere giving effect to the principles and policies as set out in the Act of 1994 and in particular in s. 12 thereof. On this occasion the Oireachtas has failed to strike the correct balance between a functioning executive and a primary legislature. This legislature has abdicated its authority and has abandoned all discretion to the Minister for Health. Where and what are the "standards, the goals, the factors and the purposes"? (see para. 132 above). It is suggested by the applicants that these simply are not to be found.

137. If as is submitted by BUPA, that the State's major response in this regard, is that the principles and policies are to be found in s. 12 of the Act and in particular where that section deals with the circumstances in which the HIA may make a recommendation to the Minister for Health and the circumstances in which she may accept or decline that recommendation, then the statutory meaning of community rating across the market, in s. 12, becomes critical. Of equal importance are the various meanings which the State, from time to time, has ascribed to this term, and in this regard reference was made to the evidence of Mr. Paul O'Flaherty. In essence it is the view of the applicants that if the State's interpretation of community rating for the purposes of s. 12 is correct, then all health insurance providers must set premia at a rate which reflects the average cost of insuring all insured persons. In the light of the s. 7 definition, it is therefore said that the legislature has delegated to the Minister "quite an extraordinary discretion" to effectively put in place and implement a scheme, the objective of which is to achieve a completely different form of community rating to that expressly mandated by the Oireachtas in s. 7. The submission goes on to argue that if the State is correct then the Oireachtas has conferred upon the Minister a discretion to *de facto* amend primarily legislation by replacing the policy of intra contract community rating (s. 7) with a policy of community rating across all plans and all insurers. No guidance whatsoever is given as to the circumstances in which the s. 7 definition should be disregarded.

138. To underpin this argument the evidence of Mr. O'Flaherty was extensively opened, in particular where he indicated that the Department looked at different ways whereby risks could be pooled, including different types of pools and whether or not products could be split to achieve this purpose. All the policy decisions in these areas were, he said, taken by the Minister. Reference was also made to the concepts of inter- generational solidarity and the sharing of risks across the market, which the State and the VHI claim were at the root of their suggested definition of community rating for the purposes of s. 12. It was however argued by BUPA that if the s. 12 reference to community rating across the market could be reduced to such generalised concepts then the Minister, impermissibly, had been given power to determine policy and not simply the power to implement the policy as determined. This cannot be done in our constitutional framework.

139. A quick look at some of the decided cases (set out above) will demonstrate these points. In the *Cityview Press* case the discretion left to ANCO was much more limited than, and could not be further removed from, the nature and significance of the levy in the present case. That is but one example. Many more are readily deducible from the case law. Therefore as a matter of principle, it is clear that the scheme virtually on its face, is significantly broader than any regime which the legislature could ever have contemplated by virtue of s. 12.

140. Turning to the specifics, it is submitted by the applicants that no guidelines are given to the Minister for Health or the HIA on a range of issues which logically should be central to the scheme and their respective roles within. At the most fundamental level s. 12 did not outline what circumstances ought to exist before the Minister should even contemplate the making of a scheme in the first instance. As with this, the section is absolutely silent on several other important points such as for example;

- the purpose of any risk equalisation schemes;

- whether there should be a number of schemes, or just one scheme;

- under what circumstances should the Minister make a scheme;

- how much should be paid and by reference to what factors, including whether revenue ought to be taken into account;

- the significance of the different types of health insurance contracts offered by undertakings;

- the significance, if any, to be given to the impact upon insurers and their solvency, the revenue or their premia of payments;

- the conditions in respect of review or termination of payments once commenced.

141. Some matters in respect of which complaint is made were then dealt with in more detail. These included:-

(1) What costs should be prescribed for the purposes of the risk equalisation scheme:

> this issue according to BUPA is at the core of any scheme and determines to what extent the market is interfered with. The greater the range of benefits which are prescribed, the larger any transfer will be. The converse would equally apply which means that if the threshold was specified, at say the statutory minimum benefit level, the resulting amounts would be significantly lower.

(2) Should restricted membership undertakings have a discretion to come in or opt out of the scheme?

It is part of the applicants case that a decision by such an undertaking to remain in or opt out has "profound significance" because the inevitable consequences of inclusion is to increase the amount of any risk equalisation payment, which is particularly burdensome for any relatively new entrant into the market. Evidently the taking of any such decision will be entirely influenced by the anticipated result. Not only is it illogical to confer such discretion but the situation is greatly accentuated when no guidance of any description is given to the Minister.

(3) The conditions and circumstances in which risk equalisation payments would be commenced;

In deciding whether to make a scheme in the first place, in being able to specify the matters by reference to which any recommendation of the HIA must be made, and in being able to specify the matters which control her decision to trigger RES payments, the Minister is given an extremely broad discretion with little or no statutory guidelines. Moreover the introduction of the concept of the MEP (together with the accompanying bands) are matters to do with policy decisions but yet again are determined solely by the Minister.

(4) The amounts of the transfer:

Once more amounts paid by one undertaking for the benefit of another are to be determined by the HIA by reference to such matters as may be specified (including the nature and distribution of insured risks amongst undertakings). The Minister determines these matters. In addition she is given no assistance as to any relieving measures which might be appropriate in the event of a financial obligation forcing a participant out of the market. Moreover there is no guidance as to the reasons why the amounts paid out must be equal to the amounts paid in and likewise with the introduction of the health status weighting which once more is a concept purely engineered by the Minister.

(5) Whether to exclude out patients cost from the scheme:

Whilst s. 12(2)(c) of the 1994 Act gives the Minister a discretion to exclude from the scheme, benefits paid in respect of "relevant health service", which are largely out patient services, no further assistance is given in this regard.

(6) The contents and frequency of returns to the HIA:

Whilst s. 12(3) makes provision that the scheme should specify the periods covered by any returns and the extent of the information which must be supplied therein, it does not otherwise offer any guidance as to the extent to which businesses must disclose confidential information, including matters of grave financial importance.

The above are only some examples by way of specific illustrations as to how the principle and policy test has been breached in this case. It is therefore claimed on behalf of the applicants that the Minister has acted unconstitutionally in purporting to make this scheme pursuant to the provisions of s. 12 of the 1994 Act as amended.

142. For very many decades it has been recognised that with a tripartite system of government – where there is a constitution separating the legislature, executive and judiciary – an essential feature of legislation involves the delegation of powers to subordinate bodies such as Ministers and the like. First principles of functionality dictate why this is and must be so. In principle this is perfectly permissible and is no more than a recognition of the role which the Government, in this Country, plays under Article 28 of the Constitution. In practice the difficulty has always centred on achieving the correct and proportionate balance between that function and the law making role vested in the legislature under Article 15. Whilst it is crucial to uphold the exclusive position of the legislature and in the process to maintain public scrutiny by way of parliamentary debate, it is also crucial not to unduly stifle the executive when, by not so doing, Article 15 can still be preserved. So while a certain tension is theoretically inherent in the co-existence of Articles 15 and 28, in both truth and reality this has not been so in practice. The reason largely, is the manner in which this arm of government has approached this potential conflict when dealing with an allegation under Article 15.2. In fact insofar as one can trace, the Supreme Court has only on one occasion upheld a challenge within this Article.

143. As far back as the late thirties, Hanna J., in *The Pigs Marketing Board v. Donnelly (Dublin) Ltd* [1939] 1 I.R. 413 recognised that "the functions of every Government are now so numerous and complex that of necessity a wider sphere has been recognised for subordinate agencies, such as boards and commissions. This has been specially so in this State in matters of industry and commerce". Those citizens of this country who can recall the 1930s and 1940s would be quite amused at such a description given society as it exists today. Time itself brings changes, but time coupled with technology, the establishment of the European Union, communications, prosperity, international treaties and conventions, etc, all mean that Ireland's role in the modern world is simply unrecognisable to the position in which she found herself more than 60 years ago. In any event since the *Pigs Marketing Board* decision the courts, in virtually every case where this issue has arisen, has repeatedly upheld, in a variety of language, the primacy of the Oireachtas as the only constitutional agency which can create laws for this State. Nevertheless – the courts have also being prepared to recognise the ever increasing complex and technical structure of society with the consequent demands on the executive within that society. A brief review of some of the case law will demonstrate this point.

144. Under s. 21(1) of the Industrial Training Act, 1967, AnCO was given power, by way of order, to impose a levy on certain classes of employers operating within the industry (in *Cityview Press Ltd & Anor v. An Chomhairle Oiliuna & Ors* [1980] 1 I.R. 381). This was to cover the expenses of AnCO in performing the functions assigned to it under the Act. In challenging the section's constitutionality as amounting to an inordinate delegation of power, the plaintiffs argued that neither this section nor the Act itself gave precise guidelines as to the basis upon which the levy was to be made, that is whether on the basis of turnover, salaries and wages, profit, or otherwise. In the High Court Mr. Justice McMahon made observations of both a general and specific nature. It is again worth noting (see para. 128 above) the observations of the learned judge at p. 389 when he said that "the subject matter of regulation may be so fluid that detailed prescription of standards could make effective administration impossible and delegated powers would have to include wide areas of judgment and of discretion".

In addition dealing specifically with the facts of the *CityView Press* case, the judge stated at p. 391: "The Act of 1967 does not specify the considerations or factors which are to be taken into account in selecting the class of levy to be chosen as appropriate for a particular industry. For instance, it is not stated that the levy shall be designed to distribute the burden of expense as fairly as may be over the employers involved in the industry. In my opinion, the intention which must be attributed to the legislature was an

intention to leave to AnCO a discretion to devise the kind of levy in respect of each industry which, in the opinion of AnCO, is best calculated to promote the objects of the Act. For the legislature to do this, it would have to familiarize itself with the conditions of the particular industry and the views of the persons engaged in it as employers and employees. *If the industry was subject to changing conditions, the legislature would have to go through the process from time to time and vary the levy to meet changed conditions. I think it is clear that it would not be practicable for the legislature to undertake a task of that kind and that, unless the task could be delegated to some subordinate agency, the objects of the Act could not be achieved*." (emphasis added).

In this passage the trial judge, dealing with a scheme which must be considered a great deal more straightforward than the risk equalisation scheme, was expressly conscious of the inability, or at least the inappropriateness, of compelling the Oireachtas to engage in matters of such detail which, when put into the context of changing conditions would impose upon it a requirement simply incapable of practicable delivery. Accordingly unless a delegatory body could exercise such a power, the social objects of the Industrial Training Act, 1967, simply could not be implemented. The challenge was unsuccessful.

145. Can I move to the judgment of Murphy J. in *O'Neill v. Minister for Agriculture* [1998] I.R. 539, which was decided almost twenty years later, (see para. 131 above). Some of the general remarks made by the learned judge reflect some of the enormous changes which had been experienced over those 20 years. Once again it is worth repeating the observations at p. 556 – "it has never been suggested that the power to make statutory regulations should be confined to some stereotyped administrative provisions. It may be, and I see no reason why it should not be, that regulations designed by a minister and his officials to secure a particular statutory objective would be novel and innovative and accordingly, not in their terms anticipated by the legislature."

To these may I add the observations of Fennelly J. in *Maher v. Minister for Agriculture* [2001] 2 I.R. 139 (see para. 134 above). The learned judge refers to (a) the enormous body of substantive law made by secondary legislation, (b) such form of legislation being "indispensable for the functioning of the modern state" and (e), how inappropriate it is to burden the legislature with such matters and in particular where the subject matter requires a "flexibility and capacity for rapid adjustment to meet changing circumstances".

It would be better, in the view of Fennelly J. that the evaluation of complex and technical problems be left to the implementing rules.

146. These decisions offer a clear view that in adjudicating upon an issue involving Article 15 of the Constitution, the courts must reflect the reality of the subject which the legislature is addressing and of the implementing method best chosen by it for that purpose. If what is involved, or sought to be achieved, is complex, technical or designed to operate as part of a dynamic and evolving model, capable of business like adjustment, then a subordinate body may be a much more suitable vehicle (indeed on occasions perhaps the only suitable vehicle) for the implementation and achievement of legislative objectives. If, on the other hand, the subject matter is easily capable of exact definition with established parameters then there may be no justification whatsoever in the exercise of delegatory power. So it all depends on the individual circumstances of a given case, which however must always be determined against the backdrop of a statutory framework in which "the principles and policies" of the legislator are set forth. If this should not be the situation, as the High Court found in *McDaid v. Sheehy*, [1991] 1 I.R. 1 then the delegation is and will always remain invalid.

147. Before moving to the precise facts of the present case mention must again be made of both s. 5(1)(e) and s. 5(1)(h) of the Aliens Act 1935. In *Laurentiu v. The Minister for Justice* [1999] 4 I.R. 26 a majority of the Supreme Court found that s. 5(1), of the 1935 Act was inconsistent with the Constitution insofar as it empowered the Minister, under subparagraph (e) to … "make provision for the exclusion or the deportation and exclusion of such aliens from Saorstát Éireann and provide for and authorise the making by the Minister of orders for that purpose". In her judgment Mrs. Justice Denham pointed out that each case ought to be considered on its own facts, that administrative, regulatory and technical matters could be left to an implementing body but that the "principles and policies" or as set out in *Mistretta v. United States* (1989) 488 U.S. 361 "the standards, goals, factors and purposes", must be set out in the primary legislation. As this had not been done the section in question, as previously noted, was by majority, deemed to be inconsistent with the Constitution. In passing Mr. Justice Barrington, while dissenting from that conclusion, did make the observation (see para. 133 above) that it was lawful "to leave complex problems to be worked out on a case by case basis by the executive".

148. The title of the 1994 Act, as amended, tells us that a key objective of the legislation is to provide for the establishment of schemes for "the equalisation of risks between health benefits undertakings". That, therefore, is a clear policy driver of the Act. What is risk equalisation? Section 2 defines it as being the "sharing of prescribed costs of registered undertakings between the undertakings (being costs incurred in respect of payments under health insurance contracts to or in relation to the persons party to or named in such contracts) by means of payments made by or to such undertakings in accordance with the terms and conditions of a scheme" So costs are to be shared, with the Minister being able to determine what those costs should be. The parties involved are expressly stated to be registered undertakings and the Act informs us pretty accurately who these may be. It also tells us the means by which equalisation is to be achieved, namely by way of money transfer from one undertaking to another. The business which gives rise to these costs is also outlined, as being that conducted through, "health insurance contracts" which is statutorily defined. The Act therefore, even in its title and definition section, sets out at least some of the significant principles involved.

149. When considering what s. 12 of the Act of 1994 as amended provides for, it is important to bear in mind that subs. 10(a) of that section contains the following definitions:-

> (ii) "insured risks amongst registered undertakings is a reference to the risks that have been respectively insured by the undertakings under health insurance contracts and
>
> (iii) the best overall interest of health insurance consumers includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings".

150. Section 12 contains a mixture of mandatory powers which the Minister must exercise by incorporating certain provisions in any risk equalisation scheme as well as provisions conferring certain discretionary powers on her. In looking at the section in a little more detail, the following situation would appear to result:-

> (a) The Minister is not obliged to make a scheme(s) but she may do so: s. 12(1);
>
> (b) In any such scheme provision *must* be made to apply its terms and conditions to all registered undertakings but the Minister may permit restricted membership undertakings, in certain circumstances, to opt out of the scheme s. 12(2)(a) and (b).
>
> (c) Provision *must* be made to apply any such scheme to "health insurance contracts" (which is statutorily defined) though the Minister *may* exclude outpatient services, G.P. services and drug services, from the business activity of the subject undertakings – s. 12(2)(c);

(d) Provision *must* be made requiring undertakings to make returns and to do so, save for the first return, in respect of each period of three months or such greater periods as may be prescribed. The delivery date for such returns cannot be later than " … such number of days …" after the end of each period as may be prescribed. The returns *must* be made to the H.I.A. Whilst the matters covered by such returns may be prescribed, the same can only relate to an undertakings' "health insurance business:" Section 12(3)(a);

(e) Provision *must* be made requiring undertakings to make payments to the H.I.A. and requiring the H.I.A. to make payments to undertakings. The amounts of such payments must be determined by the H.I.A. but the Minister may prescribe matters by reference to which such amounts are calculated. However such matters *must* include "the nature and distribution of insured risks amongst the undertakings". S. 12(4)(a). In addition payments *cannot* commence until the Minister appoints a date for their commencement, -Section 12(4)(b);

(f) Provision *must* be made requiring the H.I.A:-

(i) to evaluate and analyse every return and to do so by reference to the matters last mentioned – including the statutorily prescribed nature and distribution of insured risk, - S. 12(4)(c)(1)(i);

(ii) to report to the Minister on its evaluation and analysis and to do so, on and on the development of, the health insurance business generally, and also on such other matters as it sees fit, - Section 12(4)(c)(1)(ii).

(iii) to make a recommendation within that report to the Minister as to whether or not she ought to trigger the commencement of risk equalisation payments, but no such recommendation can be made, if a date has already been appointed for such purpose, or if the conditions specified in this scheme, relating to the nature and distribution of insured risks amongst the registered undertakings, have not been fulfilled; and

(vi) to make such a recommendation having regard to the best overall interests of health insurance consumers;

(g) provision *must* be made compelling the Minister to consider such report and if the recommendation is positive, she may, or, on being satisfied that the conditions of the scheme, relating to the nature and distribution of insured risks amongst the registered undertakings have been fulfilled, she *must*, unless having consulted with the H.I.A. in relation to the best overall interest of health consumers, there are good reasons for not doing so, appoint a date for the commencement of the scheme.

151. Section 12(5) and (6), which are procedural in nature, are very important in their own right but not significantly so in the present context. Subsections (7) and (8) speak of undertakings being required to furnish back up information and documentation relative to their returns or to any representations made by them. Subsection (9) provides for the establishment and maintenance of a fund by the H.I.A. into which and out of which the aforesaid payments pass. The balance of the section is largely not an issue in this case.

152. Pausing at this juncture for a movement, one must now consider, whether and if so to what extent, the Oireachtas in the 1994 Act as amended, and in particular in the title thereof, in the definition section and in s. 12, has set out any principles and policies to govern the exercise of the discretionary powers given to the Minister under s. 12. In my view the following emerge as being the situation in that regard:-

(a) The power which is given to the Minister to decide whether or not to make a scheme in the first place, is heavily circumscribed by the entire underlying purpose of such a scheme if one should exist. The Act unequivocally identifies the core purpose of such a scheme, namely the equalisation of risks. There are two elements to this. One refers to 'risks' and the other to the 'equalisation' of such risks. If the relevant circumstances in the health insurance market, did not merit investigation as to whether the equalisation of risks may be necessary, then it is difficult to see how any such scheme could be made or continued. This comment must be understood however in context, in that without the information obtainable from the scheme, it may be impossible to know whether equalisation is or is not required.

(b) In any event the Act specifically tells us "who the parties" to any such scheme might be – with the possible exception of providers who service only small cohorts of occupational or vocational groups. It also informs the reader of the 'scope of the business' to be included, with the Minister being given only a very narrow discretion to exclude by way of category, from the generality of that business, activities which in effect are confined to outpatient services. The method by which the equalisation of risk is achieved is specified, namely the sharing of costs. What is left to the Minister is the determination of what these costs should be. This undoubtedly confers on her a discretion, a point I will revert to in a moment;

(c) A method must be identified by which the body charged with the operation of such a scheme, namely the H.I.A., can obtain the relevant facts, data, information and documents from the subject undertakings. Thus the requirement to make returns. Whilst the period covered by such returns and the due date for their delivery have been left to the Minister, s. 12(3) nevertheless puts a structure on both of these matters when, in the context of the relevant period it refers to months and in the context of the due date to "a number of days" after the end of each such period. With regard to the contents of such returns the Minister is given discretion;

(d) Something must then be done with this information. The Act obliges the H.I.A. to evaluate and analyse it. But by reference to what? Obviously by reference to certain matters which the Minister may prescribe, but, within such matters the H.I.A. must consider "the nature and distribution of insured risks amongst the undertakings:-

which for brevity I shall refer to as 'the nature and distribution of insured risks';

(e) In my view this statutory phase is highly significant. It must, as we know, form part of the matters by reference to which the above analysis and evaluation is carried out, and must also be used as a reference point when the H.I.A. is determining the amounts of any payments to and from its fund. In addition this yardstick or criteria plays a crucial role in whether or not the H.I.A. can make a recommendation to the Minister to commence the scheme. Unless the conditions

specified in the scheme – relating to the nature and distribution of insured risks - have been satisfied, the H.I.A., irrespective of any other specified matter, cannot make a recommendation nor can the Minister commence the scheme. S. 12(4)(c)(i)(III) and (ii). Moreover, "insured risks" are a reference to "the risks that have been respectively insured by the undertakings under health insurance contracts": see para. 37 above. It therefore seems to me that the Oireachtas has established this as a key reference point for the operation of any such scheme. This by relating the exercise of vital functions to the 'nature … of insured risks', to 'the … distribution of insured risks' and 'to a combination of both amongst undertakings". This phrase therefore and its use by the legislature, cannot in my view be read as otherwise than specifying a core principle, in all probability the core principle, and one which occupies a fundamental role, in the overall scheme;

(f) A further key policy driver outlined in s. 12 stems from the definition and use of the phrase "best overall interest of health insurance consumers". Many previous references have been made to this phrase. It includes a need "to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings". (See para. 37 above). Once again no recommendation can be made by the H.I.A. to the Minister unless that body considers it appropriate to so do, having regard to the best overall interests of consumers and likewise the Minister must have regard to this matter when considering the commencement of the scheme. Noting the statutory description of this phrase it seems to me that once more the Oireachtas has identified another core principle which underpins the entire scheme.

153. It appears to me from this analysis, that a number of specific complaints made by the applicants are not well founded. In the first place, and whether this be justified or not, the Act of 1994 never contemplated a scheme taking account of revenue, premia models, solvency or profit. This is clear from the definition of risk equalisation which speaks of "costs" but makes no mention of any other financial reference point. This conclusion is also evident from the overall purpose of the scheme which is designed to cancel out any advantage which a health insurance provider might get from operating a policy of risk selection. Secondly, given this Court's interpretation of "community rating" for the purposes of s. 12, of the Act of 1994, it seems more likely that the power given to the Minister, to make more than one scheme, is a reference to the making of a replacement scheme(s) rather than the existence of two or more schemes at any one time. Thirdly, under s. 15(3) of the Interpretation Act, 1937, and now s. 22(3) of the Interpretation Act, 2005, a power conferred by an Act of the Oireachtas to make a Statutory Instrument includes a power to repeal or amend that instrument. Even if this was presumptive only, I cannot see any contra indicators in s. 12 of the Act of 1994. In addition, the HIA, would in my view, be under an obligation to inform the Minister if at any given time the nature and distribution of the insured risks between undertakings, was not such, as would merit a continuation of an existing risk equalisation scheme. If such circumstances were to occur it would be very difficult, to see how legally, the Minister could do anything other than terminate the scheme. Fourthly, matters such as the type of business in question, the parties involved, the establishment and general role of the HIA, the broad method and means of equalising risk, namely the sharing of insured's cost with the resulting financial adjustments, are all identified in the Act as constituting essential principles of the scheme. Moreover, and as previously stated, s. 12 of the Act of 1994 outlines the hugely significant role which the nature and distribution of insured risks play in any such scheme. And finally, the purpose of any such scheme, being the equalisation of risk amongst undertakings, is in my view adequately set out as a matter of legislative policy in the Act itself.

I therefore cannot agree with the submissions that in respect of these matters the Act of 1994 constitutes an impermissible delegation of subordinate power, which in the process would be a breach of Article 15.2 of the Constitution.

154. In the context of this issue it is also of course important to consider the Risk Equalisation Scheme itself, (S.I. No. 261 of 2003) and the scope of those measures, which are said to result from the exercise by the Minister of her discretionary powers given under s. 12 of the Act of 1994 as amended:

(a) The scheme commences with a definition section in which meanings are ascribed to a variety of phrases such as "equalisation contributions", "fixed price procedures", "period", "prescribed age bands", "prescribed equalised benefits", "risk equalisation", and "settled claims". In Part II (article 8) and the First Schedule, the benefits to be equalised in respect of settled claims are dealt with. Article 8 obliges each subject undertaking to record and supply certain information to the HIA. The First Schedule is of interest in that it sets out how the maximum equalised payments for prescribed health services, provided in public or private hospitals, other than in respect of fixed price procedures, are to be calculated. For example, in respect of in-patient services provided for a patient in a private hospital, the maximum payment is the lesser of €550 for each in-patient day or "100% of the charge made by the private hospital less €100 for each day during which the insured person was accommodated in a single room". Where such services are provided in a publicly funded hospital the maximum equalised payment is referenced to ss. 53 and 55 of the Health Act, 1970, and the regulations made thereunder. The costs allowed in respect of services obtained on a day patient basis are also provided for;

(b) Article 9 in Part III deals with matters such as the making and verification of returns, the frequency thereof and the due date by which these must be lodged. Form No. 1 in the Third Schedule is the prescribed form for this purpose and as can be seen therefrom, the required information must be supplied by reference to age and gender cells with eight being specified under each heading;

(c) Part IV is headed and deals with the "Analysis of Returns, Preparation of a Report, Consultation and Determination Process". Article 10(2) obliges the HIA to evaluate and analyse such turns "for the purpose of ascertaining the differences, if any, in the nature and distribution of insured risks among scheme undertakings". Having conducted this exercise the HIA must then determine, in accordance with the Second Schedule, the market equalisation percentage (MEP) and must specify what health status weight (HSW), if any, it has adopted for the purposes of this calculation. Sub-para. (4) of article 10 deals with the recommendation which the HIA must, subject to s. 12(4)(c)(i)(III) of the Act of 1994, as amended, make to the Minister. This recommendation is heavily influenced by its findings with regard to the nature and distribution of insured risks, which of course is expressed in the scheme by reference to the MEP. If the MEP for any given period is under two per cent then payments cannot be commenced. If it is between two and ten per cent the HIA must make a recommendation to the Minister, as to whether having had regard "to the best overall interests of health insurance consumers", she should or should not exercise her powers under the scheme. If the MEP has a reading above ten per cent then no recommendation is required;

(d) Article 10 then deals with certain procedural matters in order to implement the requirements as set out in s. 12(5) and (6) of the Act of 1994 as amended. It also sets out the steps which the Minister must take before she can finally exercise her powers to commence the scheme.

155. The Second Schedule, which must be read in the context of Article 10, contains the "risk equalisation calculations". It is not, I believe, necessary to set out the details of these calculations but it would be informative to give some flavour, by way of sample, of what is covered by this Schedule. Purely as an illustration I set out paras. 5 to 8 of the Schedule. Whilst the establishment *per se* of a matrix involving interactive calculations, no matter how numerous and complex, cannot by itself be taken as otherwise justifying the conferring of subordinate power, nevertheless the necessity to have and to operate such a web of formula is in my view of very considerable significance when deciding upon the principles and policies argument.

156. 5. Scheme Undertakings Definitions (with respect to a specific period and each scheme undertaking) shall be as follows:

"undertaking insured population" and "UIP" means the sum for all cells of CIP

"undertaking equalised benefits" and "UEB" means the sum for all cells of CEB

"undertaking adult lives" and "UAL" means the sum for all cells, other than the cell or cells which comprise the prescribed age band "age 17 and under", of CIP

"undertaking child lives" and "UCL" means the sum for the cell or cells which comprise the prescribed age band "age 17 and under" of CIP

"undertaking equivalent adult lives" and "UEAL" means a value determined in accordance with the formula:

UAL + *UCL* 3

"undertaking equivalent adult ratio" and "UEAR" means a value determined in accordance with the formula:

UEAL

UIP

6. Market Specific Definitions (with respect to a specific period) shall be as follows:

"market insured population (cell)" and "MIP(Cell)" means the sum, for all scheme undertakings for a specified cell, of CIP

"market insured population (total)" and "MIP (Total)" means the sum, for all cells, of MIP(Cells)

"market equalised benefits (cell) and "MEB(Cell)" means the sum, for all scheme undertakings for a specified cell, of CEB

"market equalised benefit (total)" means the sum, for all cells, of MEB(Cell)

"market claim value" and "MCV(Cell)" means the sum, for all scheme undertakings for a specified cell, of CCV

"market equalised benefits average" and "MEBA(Cell)" means an amount, for a specified cell, calculated in accordance with the formula:

MEB(Cell)

MCV(Cell)

"market utilisation" and "MU(Cell)" means a value, for a specified cell, calculated in accordance with the formula:

MCV(Cell)

MIP(Cell)

"market proportion" and "MP(Cell)" means a value calculated in accordance with the formula:

MIP(Cell)

MIP(Total)

"market equivalent adult lives" and "MEAL" means the sum for all scheme undertakings of UEAL

"market equivalent adult ratio" and "MEAR" means a value determined in accordance with the formula:

MEAL

MIP(Total)

7. Age, Gender and Health Status (AGHS) Calculations shall be determined in accordance with the following provisions:

"cell standardised benefits – age, gender and health status basis" and "CSBAGHS" with respect to a specific period, each scheme undertaking and a specified cell, means an amount calculated in accordance with the formula:

CEBA x MP(Cell) x MU(Cell) x UIP

Except where CCV is less than 20 for that cell, in which case, CSBAGHS shall be calculated in accordance with the formula:

MEBA(Cell) x MP(Cell) x MU(Cell) x UIP

"undertaking standardised benefits – age, gender and health status basis – first calculation" and "USBAGHS1" with respect to a specific period and each scheme undertaking means the sum for all cells of CSBAGHS

"undertaking standardised benefits – age, gender and health status basis – second calculation" and "USBAGHS2" with respect to a specific period and each scheme undertaking means a value determined in accordance with the formula:

USBAGHS1 x *UEAR*

MEAR

"market standardised benefits – age, gender and health status basis" and "MSBAGHS" with respect to a specific period means the sum, for all scheme undertakings, of USBAGHS2

"undertaking standardised benefits – age, gender and health status basis" and "USBAGHS" with respect to a specific period and each scheme undertaking means an amount determined in accordance with the formula:

USBAGHS2 x *MEB(Total)*

MSBAGHS

"undertaking equalisation adjustment – age, gender and health status basis" and "UEAAGHS" with respect to a specific period and each scheme undertaking shall be determined in accordance with the formula:

USBAGHS – UEB

8. Age and Gender (AG) Calculations shall be determined in accordance with the following provisions:

"cell standardised benefits – age and gender basis" and "CSBAG" with respect to a specific period, each scheme undertaking and a specified cell means an amount calculated in accordance with the formula:

CEB x UIP x MP(Cell)

CIP

Except where CEB is less than €5,000, or if CIP is less than 20, in which case CSBAG shall be calculated in accordance with the following formula:

MEB(Cell) x UIP x MP(Cell)

MIP(Cell)

"undertaking standardised benefits – age and gender basis – first calculation" and "USBAG1" with respect to a specific period and each scheme undertaking means the sum for all cells of CSBAG

"undertaking standardised benefits – age and gender basis – second calculation" and "USBAG2" with respect to a specific period and each scheme undertaking means a value determined in accordance with the formula:

USBAG1 *x UEAR*

MEAR

"market standardised benefits – age and gender basis" and "MSBAG" with respect to a specific period means the sum, for all scheme undertakings, of USBAG2

"undertaking standardised benefits – age and gender basis" and "USBAG" with respect to a specific period and each scheme undertaking means an amount determined in accordance with the formula:

USBAG2 x *MEB(Total)*

MSBAG

"undertaking equalisation adjustment – age and gender" and "UEAAG" with respect to a specific period and each scheme undertaking means an amount determined in accordance with the formula:

USBAG – UEB

157. It seems clear to me that the facts in this case are totally at variance with the circumstances which presented themselves in *McDaid v. Sheehy* [1991] 1 I.R.I and in *Laurentiu v. Minister for Justice* [1999] 4 I.R. 26. In the former there were no principles or policies contained in the Act whilst in the latter, s. 5 of the Aliens Act 1935, effectively gave to the Minister 'power to do as he thought fit'. In the present case, as I have previously stated, the 1994 Act as amended, unquestionably sets out certain principles and policies by which the legislature wanted the PMI sector in this Country to be governed. Of that there is no doubt, with the only issue being one of degree or adequacy. The question therefore is whether the outlined matters constitute a sufficient compliance with the relevant legal test which has been established through court precedent. From this case law, which includes the judgments of McMahon J. in *Cityview Press*, and Denham J. in *Laurentiu*, each case must be individually considered with no pre-judgment by universal or general formula. Administrative regulatory and technical matters can, without argument, be left to subordinate bodies (Hanna J. *Pigs Marketing Board*, and Denham J. in *Laurentiu*). As can matters, involving the exercise of "wide areas" of judgment and discretion (McMahon J. in *Cityview Press*). If the functions and responsibilities of government were technical and difficult in 1940 it is trite to say how much more difficult these are today.

158. Particularly apt to the present case are the views of McMahon J. in *Cityview Press* when he cautioned against making effective administration impossible. So also are the observations of Murphy J. in *O'Neill v. Minister for Agriculture* [1998] 1 I.R. 539 where the learned judge saw no invalidity in regulations, which were designed to secure a "particular statutory objective" even being, as he put it "novel and innovative" and indeed even being "not in their terms anticipated by the legislator". Cr*onin v. The Competition Authority* [1998] 1 I.R. 265 is a serious illustration of delegated power, where the Authority was permitted to involve itself, by way of evaluation, analysis, and conclusion, on matters of enormous complexity with very grave financial consequences, and this in the most technical and difficult areas of economics and law and the inter-relationship between both of these disciplines. In addition, I would adopt without reservation, the entirety of the judgment of Fennelly J. in *Maher v. The Minister for Agriculture* [2001] 2 I.R. 139 where he addresses the role of law by regulation in the modern law. I respectfully agree that delegated legislation is "indispensable for the functioning of the modern state". Moreover, given the constitutional and statutory framework which operates in this Country, it would be impossible, or at least highly impracticable, to oblige the Oireachtas to respond in a timely manner to ever changing and evolving circumstances which could have a major impact on fundamental issues, such as the provision of health services in this Country. Therefore I take the view that where the subject matter in question does not lend itself to incorporation into statutory provisions, this Court should strive to achieve a harmonious working relationship between the primacy of Article 15.2 of the Constitution and the legitimate pursuit of executive business.

159. Against the objectives of what the Oireachtas has established by statute as being fundamental to the operation of the private medical insurance sector in this country, it seems to me that the areas covered by the exercise of the Minister's discretionary powers are of a nature and type which fall within the parameters of the case law above cited. There can be no doubt in my mind but that given the twin requirements of s. 12 of the 1994 Act, of maintaining community rating across the market and of facilitating competition between undertakings, with each objective being given equal status, it would be virtually impossible for the Oireachtas itself to set out in primary legislation the precise details of a risk equalisation scheme. Moreover, it is quite clear that the circumstances operating within the sector are capable of and do change. There is no doubt but that the statutory ambition to preserve community rating and to drive competition can only be achieved, to their maximum level, if the underlying scheme is fluid, capable of adjustment, and ready to respond to a model which is forever evolving and dynamic in nature. A national Parliament is neither designed nor capable of fulfilling such a role. A Minister with the expertise available to her, can. In addition, the establishment of the HIA and its role in this continuous process is crucial given not only its independence but also its expertise.

160. In my view matters, such as the precise level of benefits to be equalised, the method of measuring risk difference, including the monitoring and review obligations of the *HIA inter alia* with regard to the "Health Status Weight" and the market as a whole, the mechanism giving rise to the MEP, the calculation of the payments in and out of the fund, including the technical reason giving rise to the what is known as the 'zero sum adjustment', the precise content, period covered and delivery date of the returns and the use of the furnished material, are all measures designed to implement the policies outlined in the 1994 Act, as amended. I do not see in any of these or in the other matters contained in the scheme, the creation for the first time of policy or principle. Rather these provisions give effect to the statutory framework.

161. Consequently I am of the opinion that this ground of challenge also fails.

162. Issue No. 3: Breach of the Third Non-Life Directive
As explained in para.1 of this judgment the second named applicant, which is an English company, carries on the business of private health insurance providers in this jurisdiction and does so through a branch called "BUPA Ireland". BUPA Ireland Limited, an Irish company, provides services to this second named applicant and is a tied agent of BUPA Insurance Limited. Accordingly given this business structure, the applicants, in their challenge under European Law, rely on certain Treaty provisions including those dealing with the right of establishment and the freedom to provide services as well as relying on the secondary provisions in relation to the establishment of an internal market in the non-life insurance business. Articles 43 and 49 of the Treaty establishing the European Community have been opened in this regard as has the Third Non-Life Directive. Whilst to a degree these provisions overlap, the same nevertheless from BUPA's point of view ought to be treated as constituting individual challenges made under these separate headings.

163. Article 43, which deals with the right of establishment (see para. 16 above) includes " … the right to take up and pursue activities as self employed persons and to set up and manage undertakings … under the conditions laid down for its own nationals by the law of the country where such establishment is effected …" (second para.). Article 49 prohibits any restriction on the freedom to provide services in respect of nationals who are established in one Member State but who wish to provide services in another Member State. These Treaty provisions, in the event of conflict, take precedence over any Directive which of course, in any event cannot validly derogate from such provisions. Moreover, I accept that the risk equalisation scheme in this case must be compatible with both the Treaty provisions and also with this Directive.

164. This Directive, which was a third generation measure (Council Directive 73/239/EEC and 88/357/EEC having preceded it), was adopted with the view of establishing an internal market in the provision of non-life insurance and was based on Articles 57(2) and 66 (now 47(2) and 55) of the Treaty. In general it obliged Member States to abolish any existing monopoly by 1st July, 1994 (Article 3), and created a system of financial or prudential regulation, whereby the assets and liabilities of firms were monitored, in order to ensure that they met and adhered to certain financial standards. This meant that the contract or material type of regulation, which involved a prior examination of policy conditions and premiums, was rejected. No longer could Member States adopt measures

"requiring the prior approval or systematic notification of general and special policy conditions, scales of premiums and forms and other printed documents which an undertaking intends to use in its dealing with policyholders". (See Article 8 of Directive 72/239 (as inserted by Article 6 of Directive 92/49) as well as Articles 29 and 39 of the Directive 92/49). A new system of authorisation and monitoring was put in place in that control was vested in the home state, which save for exceptional circumstances had its role recognised throughout the entire community. (See Articles 6, 7 and 13 of Directive 73/239 as inserted by Articles 4, 5 and 9, respectively, of Directive 92/49). Article 54 is the primary source of attention in this part of the case. That Article, which is set out at para. 21 above, should in the present context be again quoted. It reads:

> "1. Notwithstanding any provision to the contrary, a Member State in which contracts covering the risks in class 2 of point A of the Annex to Directive 73/239/EEC may serve as a partial or complete alternative to health cover provided by the statutory social security system may require that those contracts comply with the specific legal provisions adopted by that Member State to protect the general good in that class of insurance, and that the general and special conditions of that insurance be communicated to the competent authorities of that Member State before use".

Certain recitals, which are hereinafter referred to, must be read and considered in the context of this Article.

165. On this issue the following matters were raised on behalf of BUPA:-

> (a) The opening words of Article 54(1) – "Notwithstanding any provision to the contrary" – clearly indicate that the entire Article is in the form of a derogation from the primary rules of the Directive and accordingly must be narrowly construed. This is a proposition which I respectfully agree with. (See Case 46/76 *Bauhuis v. The Netherlands* [1977] ECR 5 – 27: and Case C 185/89 *Velker* [1990] ECR 1-2561);
>
> (b) It is only those Member States whose "relevant" contracts act as a "partial or complete alternative to health cover provided by the statutory social security system" that may avail of these provisions. This requirement of the Article has three elements. Firstly, the health insurance *contract* must be an alternative to the cover provided by the statutory *social security system* (emphasis added); secondly the State system must be a social security system (emphasis added) and thirdly, the private contract must act as an *alternative, in whole or in part*, (emphasis added) to the state social security system;
>
> (c) On these conditions being met Member States may insist that the (relevant) contract complies with specific legislative provisions so as to "protect the general good in that class of insurance";
>
> (d) Para. 1 of Article 54 should be contrasted with para. 2 which deals with the operation of the system. In this regard particular note should be made of a Member State's entitlement to require the setting up of "a reserve … for increasing age". Thus the distinction between para. 1 and para. 2 means that there are two ways in which Member States may exercise control, firstly with regard to the content of certain contracts and secondly as to the manner in which the system as a whole should operate.

166. The Recitals of the Directive, which I readily accept can be considered when construing its provisions, are highly relevant and in particular recital numbers 22, 23 and 24. These read as follows:-

> "(22) Whereas in some Member States private or voluntary health insurance serves as a partial or complete alternative to health cover provided for by the social security systems;
>
> (23) Whereas the nature and social consequences of health insurance contracts justify the competent authorities of the Member State in which a risk is situated in requiring systematic notification of the general and special policy conditions in order to verify that such contracts are a partial or complete alternative to the health cover provided by the social security system; whereas such verification must not be a prior condition for the marketing of the products; whereas the particular nature of health insurance, serving as a partial or complete alternative to the health cover provided by the social security system, distinguishes it from other classes of indemnity insurance and life assurance insofar as it is necessary to ensure that policyholders have effective access to private health cover or health cover taken out on a voluntary basis regardless of their age or risk profile;
>
> (24) Whereas to this end some Member States have adopted specific legal provisions; whereas, to protect the general good, it is possible to adopt or maintain such legal provisions insofar as they do not unduly restrict the right of establishment or the freedom to provide services, it being understood that such provisions must apply in an identical manner whatever the home Member State of the undertaking may be; whereas these legal provisions may differ in nature according to the conditions in each Member State; whereas these measures may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover; whereas that objective may also be achieved by requiring undertakings offering private health cover or health cover taken out on a voluntary basis to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes; whereas, as a further possibility, it may be required that the technical basis of private health cover or health cover taken out on a voluntary basis be similar to that of life assurance."

167. Reference should also be made to Recital 19 where the desirability of having available the widest possible range of insurance products is highlighted as is the desirability of being able to market such products " … as long as they do not conflict with the legal provisions protecting the general good in force in the Member State in which the risk is situated". (See also Recitals numbers 20 and 21).

168. The applicants, who believe that these recitals, in particular those numbered 23 and 24, are crucial, make a number of points in this regard. Firstly, it is claimed that recital number 23 enables a Member State, in which the private sector offers contracts which are an alternative to the cover available under its social security system, to have a verification role with regard to such private contracts. Secondly, it also both acknowledges and recognises that in such states where alternative cover is available, it is necessary that the insured population has access to such private cover "regardless of their age or risk profile". Thirdly, it is claimed that the first part of recital 24 - "Whereas to this end …", - establishes a clear link between that recital and the one immediately preceding. Fourthly, given that the general aim of the legislation is to harmonise, in so far as it can, the powers conferred on Member States to adopt specific legal provisions, the phrase in Recital 24 which reads that such provisions may "differ in nature according to the conditions in each Member State" must be read in the context of this objective.

169. This recital (No. 24) then goes on to list the options that might be available to such a Member State. These include open

enrolment, as well as rating on a uniform basis according to policy type and lifetime cover. Effective access, regardless of age or health, may also be achieved, (according to this recital), by requiring undertakings to offer a standard policy with specified benefits, at a rate not exceeding a prescribed maximum "and *to participate in loss compensation schemes*". According to the applicants the reference to the passage which I have underlined, can only be read in the context of the standard policy option, and not otherwise. Secondly, it is claimed that the reference to "that objective" refers back to recital number 23 and in particular is referable to policy holders having access to private cover regardless of age or risk profile. As a result this provision can only be considered in the context of State control over the contents of private cover. Thirdly, what is being referred to, is an entitlement of the State to insist on health insurance providers offering a policy, the terms and conditions of which are set by that State. This, in BUPA's view, emphasises the alternative role of cover. Fourthly, this recital provides for a loss compensation scheme but only in association with a standard package, the terms of which have been regulated by the State.

170. This last point means that it would have been open to the legislature to insist upon the availability of a plan(s), with prescribed benefits, and at a pre-determined price. If it had opted for this method, this particular objection to the risk equalisation scheme could no longer exist.

171. Before giving consideration to the different types of private medical insurance available in the EU, it is convenient to set out a number of general propositions with regard to Article 54, which I believe, at least in principle, are largely uncontroversial. These are that Article 54, as previously stated, must be narrowly construed with the burden of proof being on the State which seeks to invoke its provisions. Secondly, any measures adopted pursuant thereto must have the objective of protecting "the general good". Thirdly, such measures must not "unduly restrict the right of establishment or the freedom to provide services" and lastly, the general principles of necessity, proportionality and non-discrimination must be observed.

172. In order to determine whether or not the type of private medical insurance operating in this country, can be said to act as a partial or complete alternative to the cover available under the State's system, it is necessary to have a brief look at other models pertaining throughout Europe. Relying on an analysis conducted by Mossialos and Thomson, entitled "Voluntary Health Insurance in the European Union", published on 27th February, 2002, BUPA strongly submits that the private domestic system in Ireland cannot be said to come within Article 54. In that survey, where the phrase "voluntary health insurance" (VHI) has the same meaning as Private Health Insurance (P.M.I.) in Ireland, the authors have placed the different types of VHI available throughout Europe into three categories namely substitutive, complementary or supplementary. (See pp. 45 – 63 of the Report). "Substitutive cover" refers to a situation which applies where private policies act as a substitute for cover that would otherwise be available from the State. Those who might make use of this product are for example people who are excluded from state cover or who can exempt themselves from statutory contributions and thus opt out of the system: (see p. 46 of the report where this type of cover is defined). Such cover is available to specific population groups in a handful of Member States such as Austria, Belgium, Germany, The Netherlands and Spain (p. 46). "Complementary cover" relates to services which are excluded or not fully covered by the state scheme (p. 60 of Report) and "Supplementary cover", refers to payments made in respect of the same treatment that is available under a statutory scheme, with its attraction being an increase in consumer choice, access to different health services, including access to top range hospitals with superior accommodation, and overall faster access to medical care.

173. Adopting this categorisation as a working basis, the applicants submit that with the possible exception of VHI's plan P, which provides cover in respect of hospital inpatient charges, the private medical business in Ireland could not be said to be a substitute for or act as an alternative to the State cover. BUPA says that this is supported by Mr. Barret when in his evidence he confirmed that since 1991 Irish citizens, whether they hold PMI or not, are universally entitled to enjoy State health services. These are free of charge. Consequently, it is argued that the Irish system can only be correctly described as a supplementary system and not otherwise. Money spent on private insurance involves discretionary expenditure with many people being primarily interested in a better and higher class of accommodation which can only be accessed through certain plans. Whilst 51% of the population has private medical insurance, another very substantial portion, namely 49%, have not.

174. Dealing more specifically with some of the requirements of Article 54, the applicants suggest that the Irish system is not in fact a "social security system". It is not based on social security contributions as are the systems pertaining in Belgium, Germany, France, Luxembourg, The Netherlands, Austria etc. Rather the Irish system is one based on taxation similar to Denmark, Greece, Spain, Italy and several other countries. Accordingly, on this ground alone Ireland cannot avail of Article 54.

In addition it is submitted that a risk equalisation scheme, by such name, is nowhere to be identified in either the Articles or the Recitals of the Third Non-Life Directive. Whilst "loss compensation schemes" are referred to in Article 24, these as previously stated, are only authorised where a standard policy, containing certain benefits at a preset premium, is available. Outside of that a loss compensation scheme is not authorised.

175. Finally, it is also claimed that the State has not proved that a risk equalisation scheme is required for the general good. The Interpretative Communication of the Commission, (2000/C43/03) concerning "the freedom to provide services and the general good in the insurance sector", published on 16th February, 2000, was referred to and relied upon. At pp. 16-17, the Commission has attempted to generalise on what the European Court of Justice requires, in order to uphold a restriction in this sector on the exercise of a fundamental right such as that of establishment or to provide services. The relevant passage reads:

> "- it [national provision] must come within a field which is not harmonised,
>
> - It must pursue an objective of the general good,
>
> - It must be non-discriminatory,
>
> - It must be objectively necessary,
>
> - It must be proportionate to the objective pursued,
>
> - It is also necessary for the general-good objective not to be safeguarded by rules to which the provider of services is already subject in the Member State where he is established".

In conclusion, it is claimed that for several reasons, including those outlined above, the risk equalisation scheme is incompatible with the Third Non-Life Directive and in particular is not saved by the terms of the derogation contained in Article 54 thereof.

176. Amongst the many aims of this Directive, were those designed to protect Treaty freedoms, and to liberalise the market. These were to be achieved by prohibiting unnecessary obstacles to competition, by firmly opting for regulation through financial supervision

and by outlawing discrimination. As previously stated its provisions were incorporated into domestic law by the 1994 Act. By this Directive, which was the third in a series of Directives concerning this sector, the first now being more than 30 years old, the market was not harmonised, a fact which the Commission acknowledged in its decision of 13th May, 2003, (para. 46 which is hereinafter referred to), and did so by indicating that in the area of health insurance, harmonisation was still "limited".

177. In considering what general approach this Court should adopt to the interpretation of this Directive, and in particular, to the relevant recitals and to Article 54 thereof, it is I think of the first importance to identify the aims which the Directive set for itself and to recognise the immediately proceeding state of the non-life insurance business as it then existed throughout the community. As I have outlined earlier, this Directive, in establishing a single market in this business, introduced a single system of authorisation and financial supervision. The giving of this control to the home Member State facilitated the carrying on of any business throughout the community, either by way of establishment, including the creation of branches, or through the provision of direct services. The Directive was designed to promote consumer welfare by not only abolishing all existing monopolies but also by giving positive encouragement to competition, in any and every aspect of competing businesses between rivals. It sought the greatest uniformity possible in this sector within and between Member States. It recognised however the prematurity of seeking cross border harmonisation and accordingly had to make provisions, of a general nature, to reflect the ongoing differences in the systems and structures which operated throughout the Community. In the process leading up to the passing of the Directive, it would be unthinkable to believe that the Council did not fully appreciate the individuality of each Member State's regime, and equally so that it failed, without even the effected Member State's knowledge, (Ireland), to have due regard where possible to such differences in the Directive itself. Of course if such a conclusion has to follow from its provisions then so be it. But certainly that would a surprising feature of this legislative document.

178. As is common case, the pre-1994 situation in this jurisdiction was that the VHI operated a system of community rating, open enrolment and lifetime cover. In addition, whatever the precise mechanism may have been, it has been established as a matter of fact, that it also had a system of cross subsidy between young and old people. This was based on what is described as inter-generational solidarity, or, to give it a different name but with the same effect, on a method of community rating throughout its entire (being Ireland's) insured population. Moreover, the legislator was undoubtedly mindful (though it had no previous experience to work from) of the potential damage which competition could do to this type of community rating. Hence in the same Act which gave effect to the Third Non-Life Directive, the Oireachtas provided for a system of risk equalisation, believing, as it must have done, that the supports of open enrolment and lifetime cover were not in themselves sufficient to maintain the type of community rating practiced in this jurisdiction up to then.

I therefore believe that this general background can help to inform the court as to the correct meaning of the Directive and that a purposeful or schematic approach is justified when looking at its relevant provisions.

179. Recital No. 23 immediately recognises that health insurance, because of its nature and social consequence, is distinguishable from other forms of indemnity cover and accordingly can merit separate treatment. It is so different because of the desirability to have private medical insurance open to all, in a real and effective way, regardless of age or health status, current or prospective. Therefore a provider may be required to submit its policy conditions for verification to a Member State, where the underlying contract is "a partial or complete alternative to the health cover provided by the social security system".

Recital No. 24, which applies to such contracts enables Member States to adopt "specific legal provisions" in order to provide such effective access to private medical insurance. Such measures must be in the general good but on satisfying these conditions they may constitute a restriction or an impediment to the rights exercisable by Articles 43 and 49 of the Treaty, so long as they do not "unduly restrict" such rights. Domestic measures for this purpose may differ "according to the conditions in each Member State". They may include open enrolment, uniform rating per policy and lifetime cover. This "access objective" may also be achieved by requiring health insurance providers to operate a standard policy similar to the State's system and to participate in loss compensation schemes. Another means to achieve this objective is to require the operation of private health cover on a technical basis similar to that required when dealing with life assurance.

180. It seems to me that these provisions were general in focus and insofar as they went, were intended to recognise a variety of domestic differences which existed across the newly created single market. Moreover the Directive also recognised that, within limits, each Member State could adopt legal provisions in the "general good" and that such provisions did not have to be uniform. In fact these could differ to reflect the individual conditions of each State. At that time, and indeed still, they are at least two broad methods by which a state's health system is funded. One is by direct and general taxation with the other being by way of social security contributions. Whether the initial contributions are immediately segregated upon receipt and thereafter specifically designated to fund the system or whether such funding is out of general taxation, is a distinction which in my view is not captured by these recitals or by Article 54 of the Directive. I believe that such a distinction was not intended to act as a disqualifying criterion in the application of Article 54, nor in my view would it have been justified, as I cannot identify any rational basis why the precise form of public funding could have such far reaching effects. In addition it escapes me why the Member States affected (those who fund by general taxation) would have agreed to such an exclusion. Accordingly in my opinion, this argument is not sustainable and cannot be justified. I therefore believe that the Irish system of general taxation which supports the public health sector comes within this Directive.

181. A great deal of debate on these recitals has centred on whether or not contracts offered under the private system, are an alternative to the health cover provided by the State. The applicants, as is evident from a summary of their submissions on this topic, have gone to considerable lengths to argue that the correct designation of the Irish private sector is that as contained in the Mossialos and Thomson Report, and accordingly, the system operable in this country is neither a substitutive nor a complementary one but rather is a supplementary one. These particular designations however only came about some ten years after the passing of the Third Non-Life Directive and, accordingly, cannot be said to have had any widespread currency even informally at the relevant time. Indeed, at p. 13 of the Report, the authors state that private medical insurance (referred to therein as voluntary health insurance) "can be classified in many different ways, as demonstrated by the numerous definitions in current use". Therefore, on this particular issue Mossialos and Thomson cannot be regarded as definitive.

Again, as I have said in the previous para, but only by way of general observation, it would be very surprising if this State, in agreeing with the terms of the Third Non-Life Directive, voluntarily ceded the application and potential use of Article 54 in the domestic framework. While some dispute exists as to how many Member States had, in 1992, what is now categorised as substitutive cover, the number was not numerically large. It would therefore once again be rather surprising to find that countries like Germany and Holland could avail of Article 54, whereas others, including Ireland as a matter of principle could not.

182. As a matter of practice it seems to me that the vast majority of the 51% of our population, which avail of private medical insurance, considers it as an alternative to the public system. Whilst it is true to say that the availability of private cover does not

affect one's entitlement to State cover, nevertheless given the pressure on public finances, and the unquestionable waiting lists which still persists (notwithstanding the National Purchase Fund) on the one hand and the vastly enhanced timely access to medical and surgical services on the other, I am driven to believe that the Irish system can be regarded as an alternative, either in whole or in part, to the care provided for, out of public funds. This view appears to be supported by the results of a survey contained in the HIA's market review of this sector published in September 2005, where at p. 87 it says that 93% of the consumers interviewed agreed that P.M.I. was a necessity and not a luxury. At least in some way it also sets support from the Competition Authority's member John Cava, who at p. 6 of a paper published in October 2003, said a person's entitlement under the public system did "not equate to timely access to many medical and surgical services".

In this regard the applicants produced in evidence a translation of the relevant recitals and Article 54, from the German, French, Dutch, and Spanish language versions. Whilst the wording in none of the four is identical, it can be said that in broad terms the French translation uses the word "substitute" whereas the other three speak of 'replacement'. These however cannot be the guiding force in interpreting the phrase now under consideration.

183. Indeed, whilst not binding upon this Court, it is instructive to note that as far back as 1993, the Commission, when giving its assessment on a draft risk equalisation scheme then intended for incorporation into the 1994 Act, stated in a letter dated 1st December, 1993 that "in our view a private health plan is 'alternative' if it provides for at least the same type of benefit payment as a social security plan does. Thus the same types of risk must be covered under both systems. If the risk covered under the social security system is hospital care, this risk should be covered by the private health scheme … To the extent that community rating is a necessity we can see that a loss compensation scheme will have to be applied. Therefore we have again in principle no problems with the risk equalisation scheme you are envisaging".

A letter dated 1st March, 1996 from Commissioner Monti confirmed that " … On the basis of the evidence available we believe that, in principle, Ireland is entitled to benefit from the rules referred to in Article 54 of the Third Non-Life Directive". And finally, Mr. Mogg of the European Commission in a letter dated 20th July, 1999 said "there have been longstanding discussions dating back to the adoption of the Third Non-Life Directive between the Commission and the Irish authorities on the issue of whether Irish private health insurance could be classified as "alternative" to the statutory social security regime for the purposes of Article 54 of the Directive. These discussions have resulted in acceptance that, subject to developments in jurisprudence of EU case law to the emergence of new doubts over the proportionality of the arrangements, the Irish private health insurance could be regarded as "alternative". By virtue of this position, Ireland has been able to adopt specific provisions in order to protect the general good, namely to ensure access by the population to health care as well as stability in the health insurance market. This has allowed Irish private health insurance legislation to be construed around the basic principles of community rating, open enrolment and lifetime cover. In order to ensure the sustainable financing of the community rating requirement principle, a risk equalisation scheme and minimum benefits are also foreseen. Your services have emphasised that the risk equalisation scheme is an essential adjunct to community rating as it avoids the commercial targeting of better risks and ensures the long term stability of what is essentially "pay as you go" system … On the basis of the evidence available to the Commission services, the principles of community rating, open enrolment, lifetime cover, as well as a risk equalisation scheme and minimum benefits at present appear justified to ensure the aforementioned objectives. These principles must also be applied in a manner which realises the objectives laid down in the legislation by safeguarding the proper functioning of the internal market. Commissioner Monti had the occasion to confirm this position in his letter of 1st March, 1996, that, subject to respect for the principles of necessity and proportionality and any rulings of the ECJ, the Commission continued to regard the Irish private health insurance as "alternative"." Noting these views as I do and in particular Mr. Mogg's reference to "long standing discussion(s)", it would be very surprising to see how the Commission approved the scheme, even under the State aid provisions as it did, if otherwise it was in principle seriously concerned about the applicability of Article 54.

184. As can therefore be seen, having given due consideration to the Irish system in the context of Article 54, these views were unanimous in their conclusion that in principle there was no difficulty with that Article. Although clearly not binding on this court these observations could nevertheless have some persuasive substance with regard to the correct meaning of this phrase in the Directive. Moreover, as can evidently be seen from all three pieces of correspondence, the Commission raised no other issue of principle nor did it cast any doubt about the availability of Article 54, within the Irish system. As I respectfully agree with the analysis so outlined, I am of the opinion that the Irish PMI system acts as an alternative, either partially or completely, to the public health system operating in this country.

185. Another point of major dispute is whether or not in principle a risk equalisation scheme is, envisaged, by recital no. 24. In response to the applicants submissions, the respondents and notice party make the point that, since there is no specific provision in the Directive which prohibits the establishment of a risk equalisation scheme, then it is permitted, and in such circumstances its legality is not dependent on either Article 54(1) or (2). The opening words of Article 54(1) have been referred to in this context. These read "Notwithstanding any provision to the contrary … ". This means it is claimed, that unless BUPA can identify a prohibitory provision in the Directive with regard to risk equalisation, then as a matter of principle, Article 54 does not apply. An example was given by reference to Articles 28 and 29, which contain certain restrictions. It is only when such restrictions exist that Article 54 is required to disapply such legislative provisions. Whilst I have some sympathy for this view point, I have nevertheless decided, as is evident from the aforegoing, to resolve this issue by proceeding on the basis that the respondents must satisfy the court that the risk equalisation scheme comes within the provisions of Article 54.

186. A further significant argument of the applicants with regard to the scheme, is that the reference in Recital 24 to a loss compensation scheme is restrictively linked to a system which provides for a standard policy, at a maximum premium and giving specified minimum cover. It is claimed that with any other regime the establishment of a loss compensation scheme cannot be legally justified.

187. In my view this is a mistaken construction of recital No. 24. It seems to me that one of the overriding objectives of the recitals mentioned, is to provide a method by which all policy holders can have the greatest possible access to private medical insurance, all regardless of health status or age. In that context, and having permitted Member States to adopt specific provisions, this recital recognises that such provisions may differ as between Member States. What the recital does in my view is to gives examples of how this major objective may be achieved through domestic measures.

188. One example relates to the provision for open enrolment, uniform rating on a contractual basis and lifetime cover. Another is the standard type of policy which I have mentioned and a third is to require the entire sector to be conducted on a technical basis much like that operable in the life assurance business. By recognising that differences exist within Member States, I am of the view that it was never the intention of the Council to exclude from a Member State, the possibility of adopting one or other of the examples given or a combination of all three. The crucial focus of the recital was geared to maximising access, without regard to age or health, and obviously, in such circumstances, any implementing measures, had to take cognisance of the variable systems which existed throughout Europe. Consistent with encouraging the greatest possible competition, the Directive in my opinion left to Member States,

at least within the examples given in recital No. 24, a series of options or choices as to how best to achieve access to this non-discriminatory objective. Therefore I am satisfied that it is not correct to interpret recital no. 24 as rigidly linking the establishment of a loss compensation scheme to a single policy regime and outside of that to exclude it from all other options. Consequently I do not think that the applicants are correct in this submission. Finally in this regard, although touched upon and mentioned during the course of the case, I do not believe that it has been seriously put in issue, either by evidence or submission, that a risk equalisation scheme, or a risk adjustment scheme, is not in fact a "loss compensation scheme", as that term is used in the Directive.

189. In my view when considering the potential application of Article 54 and these recitals, it is necessary to keep in mind the totality of a given regime as it exists in a Member State. In Ireland that includes community rating in the s. 7 sense, open enrolment, lifetime cover and also a risk equalisation scheme with the attendant meaning of community rating within s. 12. As the overall intention of a risk equalisation scheme is to support this latter form of community rating, it seems to me, that though somewhat circuitous, the existence of such a scheme does in fact impact upon the contractual policy conditions on offer in the private service. Therefore in this way contracts are affected.

190. Finally, Article 54 can only be availed of where the measures taken are in the "general good". If this and the other requirements of the Article are satisfied then the domestic provision cannot be said to be unduly restrictive of competition. This phrase "general good" has never been statutorily defined. Its meaning is based on case law from the European Court of Justice. That case law originally developed in the context of the free movement of services and goods and was subsequently applied to the right of establishment. (See Case 55-94 Gebhard [1995] ECR 1 – 4165). Despite its frequent relevance to many individual cases, the court however has never given an exclusive definition of the "general good". It approaches the correct meaning of this term on a case by case basis, incorporating, where appropriate, its evolving nature. The Commission, in its Interpretative Communication on the freedom to provide services and the general good in the insurance sector (Official Journal of the European Communities 43/5 16th February, 2000), sums up what the Court requires of a national provision which attempts to restrict the right of establishment or the freedom to provide services. These requirements are (that the measure in question)

- must come within a field which has not been harmonised;

- must pursue an objective of the general good;

- must be non-discriminatory;

- must be objectively necessary;

- must be proportionate to the objective pursued.

- it is also necessary for the general good objective not to be safeguarded by rules to which the provider of services is already subject to in the Member State where he is established.

191. I accept that this is an accurate summary of the requirements in this regard and that the conditions specified are cumulative. The risk equalisation scheme must therefore comply with all of these conditions so as to render it compatible with Article 54 of the Directive.

192. There is I believe no dispute but that this field has not been harmonised. There can in my view be no sustainable argument for challenging the requirement of compliance with an objective of the general good, particularly given my conclusions on Issue No. 2. That objective has been outlined in several policy documents, including the Government White Paper, extracts of which have been quoted above. In brief at para. 3.2 it is stated that community rating (which for clarity in this context has the s. 12 meaning) is the corner stone of the private health system and that inter-generational solidarity plays a key supporting role in that regard. Having pointed out how this pillar could be vulnerable in a competitive world, the document goes on in Chapter 4 to deal with the need for risk equalisation. In this therefore as well as in other sections of the report, the Government's view is emphatically stated with regard to the establishment of such a scheme for the general good. In addition, virtually all, if indeed not all, of the Reports and Submissions compiled and created as part of the consultative and evaluation process above mentioned, support a Risk Equalisation Scheme given the form of community rating which it is intended to support. Moreover any measures which come within Article 46 of the Treaty, (which by its reference to public health must implicitly impact on private health) and those offering consumer protection (Case 205/84 *Commission v. Germany*) must, a fortiori, be included within the general good concept (see p. 17 of Commission document). I am therefore completely satisfied about this requirement, as I am about the non discriminatory nature of the scheme.

193. The other conditions which must be satisfied, namely that the scheme must be objectively justified and proportionate are also requirements common to the applicants challenge under the fundamental Treaty provisions as well as to their constitutional attack under Articles 43 and 40 of the Constitution. Accordingly as these matters are considered in a later section of this judgment the conclusions reached thereon equally apply to and ultimately determine this particular issue.

Alleged Breach of Articles 43 and 49 of the Treaty

194. As part of their overall challenge under European law it is alleged by the applicants that the RES scheme is in breach of Article 43 of the Treaty, which confers the right of establishment and Article 49, which deals with the freedom to provide services, with both of these being set out at para. above. These Articles equally apply to legal persons as they do to natural persons. (See Article 48 and Article 55). Moreover it has been established through a long and authoritative line of decisions from the ECJ, that these provisions apply regardless of whether the domestic restriction is discriminatory or non-discriminatory. (See e.g. Case 8/74 *Dassonville* (1974) ECR 387: *Case 120/78 Cassis de Dijon* (1979) ECR 649 and *Criminal Proceedings Against Teck and Mithuard* (1993) ECR 1/6097). The latter type of measure, which is described as being "indistinctly applicable"; can create a resulting infringement, in the case of both Articles 43 and 49, if it is liable to hinder or make less attractive the exercise of these rights. This is made clear from the above decisions, a further most recent example of which is the case of *MacQuen* (2001) ECR 1/837 where the Court of Justice said that "according to the courts case law, however, national measures liable to hinder or make less attractive the exercise of fundamental freedoms guaranteed by the Treaty can be justified only if they fulfil four conditions: they must be applied in a non-discriminatory manner: they must be justified by overriding reasons based on the general interests: they must be suitable for securing the attainment of the objective which they pursue: and they must not go beyond what is necessary in order to attain that objective".

195. This last mentioned passage of the court's judgment in *MacQuean* is largely based on *Kraus v. Land Baden-Wuerttemberg* (1993) ECR 1/1663, (para. 32), and also on *Gebhard*, Case C 55/1994; in particular at para. 37 of that judgment where virtually the same quotation is outlined.

196. On behalf of the respondents/notice party, it was argued that the general principles above specified were developed in

circumstances which were not analogous to those pertaining in this case. Taking *Stanton v. Inasti*, case number 143/87, as an example, where the Head note at para. 2 gives a flavour of the type of issue which those principles were intended to cover. That para. reads as follows:-

> "2. Articles 48 and 52 of the Treaty preclude national legislation which might place Community citizens at a disadvantage when they wish to extend their activities beyond the territory of a single Member State. Those articles must therefore be interpreted as meaning that a Member State may not refuse to exempt self employed persons working within its territory from the contributions provided for under the national legislation on social security for self employed persons, where employment is coupled with a self-employment activity, on the ground that the employment which is capable of giving entitlement to such exemption is pursued within the territory of another Member State."

Another illustration of this point can be seen in the case of *RSVZ v. Wolf*, case 154/155 – 1987, which concerned the payment of contributions to the Belgian Social Security Scheme for self employed persons in respect of their employment activities.

A third case of similar interest might be *Kraus v. Land Baden-Wurttemberj*, case number C/19/92, which involved the refusal by the respondent ministry to accept that the use of a post-graduate academic title, awarded to Mr. Kraus in the United Kingdom was not subject to the rules on prior authorisation established by German legislation. (See also *Inasti v. Eennlen* 53/95).

197. It is submitted on behalf of the State and the VHI that the underlying framework which gave rise to these cases is fundamentally different from the Irish system of private medical insurance which includes the Risk Equalisation Scheme. In addition, these cases can also be explained on the basis, that on closer scrutiny the national measures in question, whilst appearing non discriminatory *ex facie*, were in truth bias in favour of national undertakings. Consequently, this line of authority has no application to this case. It is further urged that this conclusion is supported by the undoubted fact that the 1994 Act, as amended, and the scheme, apply to all health insurance providers in this jurisdiction and, in truth, it is said that this regime is no different from a taxation requirement imposing a specified rate of tax on all those who conduct business in this Country.

198. Notwithstanding the submissions just outlined, it seems to me that there can be no doubt from these precedents, of which the cases mentioned are but examples, that the phrase "liable to hinder or make less attractive the exercise of treaty freedoms" has to be understood in a general sense and that this court is not permitted to engage in any type of a "relative value assessment", that is as between the impact of a measure on national and non national persons of Member States. This phrase, in my opinion, must be applied in a global sense and can be invoked even where the impugned provision applies equally to all undertakings irrespective of their place of establishment.

199. However, these general principles, when applied to the non-life insurance sector, must be looked at in the context of the Third Non-Life Directive. It is a fact that since 1996/1997 BUPA, as of right has been established in this State and has provided services. What is also a fact is that this State has regulated those rights and if such regulation is in conformity with the Directive, it is very difficult to see how, as a separate ground of challenge, this submission on Articles 43 and 49 can succeed. Particularly so when it has not been suggested that the Directive is either inconsistent or otherwise incompatible with Treaty provisions. Accordingly in my opinion the court's decision on the Third Non Life Directive also determines this issue.

200. The applicants also rely on Article 49, and the Scheme's alleged interference with the free movement of services, as grounding a further allegation that the State is in breach of Article 86.

Alleged Breach of Article 86 and 82 of the Treaty

201. Article 2 of the Treaty specifies as an objective of the Community the promotion of a "high degree of competition" with Article 3 speaking of a system wherein "competition in the internal market is not distorted". There is a further reference to "free competition" in Article 4(1), as well as in Article 157. That effective competition is essential to key treaty provisions cannot be disputed, (see Bellamy and Child, European Law of Competition 5th Edition 2001, p. 39), with specific provisions in this regard being set out to cover both private undertakings and Member States . Article 10 obliges all such states " … to take all appropriate measures … to ensure fulfilment of the obligations arising out of this Treaty … They shall facilitate the achievement of the Community's tasks".

202. Article 86 of the Treaty provides as follows:-

> (1) In the case of public undertakings and undertakings to which Member States grant special or exclusive rights, Member States shall neither enact nor maintain in force any measure contrary to the rules contained in this Treaty, in particular to those rules provided for in Article 12 and Articles 81 to 89.
>
> (2) Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the community.
>
> (3) …"

203. In *INNO v. ATAB* (1977) ECR 2115, the court held that no Member State could have in existence any measure which deprived competition of its effectiveness. Commencing at para. 28, the judgment reads "28. First, the single market system which the Treaty seeks to create excludes any national system of regulation hindering directly or indirectly, actually or potentially, trade within the Community.

> 29. Secondly the general objective set out in Article 3(1)(g) is made special in several Treaty provisions concerning the rules and competition, including Article (82), which states that any abuse by one or more undertakings of a dominant position shall be prohibited as incompatible with the common market insofar as it may affect trade between .
>
> 30. The second paragraph of Article (10) of the Treaty provides that shall abstain from any measure which could jeopardise the attainment of the objectives of the Treaty.
>
> 31. Accordingly, whilst it is true that Article (82) is directed at undertakings, nonetheless it is also true that the Treaty imposes a duty on Member States not to adopt or maintain and enforce any measure which could deprive that provision of its effectiveness.

> 32. Thus Article (86) provides that, in the case of public undertakings and undertakings to which Member States grant special or exclusive rights, Member States shall neither enact nor maintain in force any measure contrary, inter alia, to the rules provided for in Articles (81) to (89).
>
> 33. Likewise, Member States may not enact measures enabling private undertakings to escape from the constraints imposed by Articles (81) to (89) of the Treaty."

204. There is no doubt but that the notice party, the VHI, is a public undertaking within the meaning of Article 86(1). (See *Deane v. VHI* [1992] 2 I.R. 319). Equally so, it would appear to be a "public undertaking", by reference to what the European Court of Justice has said in *France, Italy and UK v. Commission* (1982) ECR 2545 (The Transparency Case), where the judgment stated

> "Any undertaking over which the public authorities may exercise, directly or indirectly a dominant influence by virtue of their ownership of it, their financial participation therein or the rules which govern it. A dominant influence is to be presumed when the public authority holds the major part of the undertaking's subscribed capital, controls the majority of votes attached to the shares issued or can appoint more than half of the members of the undertakings administrative, managerial or supervisory body".

In addition following the *Buy-Irish* case – *Commission v. Ireland ECR* (1992) 4005, there can be no dispute but that the risk equalisation scheme is a "measure" for the purposes of, in the present context, Article 86 of the Treaty.

205. The applicants further submit on this issue, that it is not necessary for the public undertaking in question, to have in itself, in a voluntary way, engaged in conduct which is alleged to constitute abuse under Article 82. The entire purpose of Article 86 is to capture conduct, brought about by a State measure, which if unilaterally engaged in by an undertaking, would constitute such abuse. In *RTT v. GB – INNO – BMSA* (1991) ECR 5973 the court, of Article 86(1), said the following "However, Article (82) applies only to anti-competitive conduct engaged in by undertakings on their own initiative … not to measures adopted by States. As regards measures adopted by States it is Article 86(1) that applies. Under that provision, Member States must not, by laws, regulations or administrative measures put public undertakings … in a position which the said undertakings could not themselves attain by their own conduct without infringing Article 82. Accordingly where the extension of the dominant position of a public undertaking … results from a State measure, such a measure constitutes an infringement of Article 86 in conjunction with Article 82 of the Treaty … As competition may not be eliminated in that manner it may not be distorted either."

206. The *Corbeau* case (1993) ECR 1-2533 (the Belgium Post Office monopoly case) was also referred to as establishing that, whilst the creation of a dominant position resulting from the grant of an exclusive right, may not by itself be incompatible with Article 82, the continuing existence of the underlying measure, in changed circumstances, may be such as to deprive the competition rules of their effectiveness. In 2000, the court again considered this matter in the *Deutsche Post* case (2000 ECR 1-825). That was a case concerning a practice by the German postal authority, to charge the full internal rate for delivering foreign mail, notwithstanding the fact that the rate paid for international mail in the home country (Denmark) was lower than the internal rate prevailing in Germany. The postal authority claimed to have such a right under the Universal Postal Convention of 1989. The Court of Justice, in holding that this practice was in breach of Article 86(1) of the Treaty said that: "the Court has had occasion to state in this respect that although the mere fact that a Member State has created a dominant position by the grant of exclusive rights is not as such incompatible with Article 82, the Treaty nonetheless requires Member States not to adopt or maintain in force any measure which might deprive that provision of its effectiveness.

207. The meaning of the word "entrusted" as it appears in Article 86(2), was then touched upon with BUPA submitting that in the circumstances of the present case, the defence available under that sub para. could not be availed of by the respondent State. This because, the only obligation ever imposed on the VHI by the Minister was in respect of Plan P, which covers liability for public hospital inpatient charges, without any waiting period or underwriting rules and at a maximum premium. Under the 1996 Act however, save for Plan P, the Minister could no longer oblige the VHI to offer to the public any particular policy. Consequently it cannot be said that the Notice Party is "entrusted" by the State with the carrying out of any activity. The mere endorsement or approval of such activity is insufficient. (See *Uniform Eurocheques* (1995) 3 CMLR 434 and *Gema* (1971) OJL 134-35). Accordingly, in BUPA's view Article 86(2) cannot apply.

208. As an alternative to this submission however, it is further claimed that even if Article 86(2), could apply, the State has not discharged the burden of proving that the execution of the tasks given to the VHI, cannot be carried out without infringing competition rules. (See *Air Inter v. Commission* (1997) ECR 11-997). Here the Court of First Instance, at paras. 138, 140 and 141 of its judgment said that;

> "the application of those Articles could, however, be excluded only in as much as they obstructed performance of the tasks entrusted to the applicant. Since that condition must be interpreted strictly, it was not sufficient for such performance to be simply hindered or made more difficult. Furthermore it was for the applicant to establish any obstruction of its tasks … ".

208. Based on these general principles the applicants essential argument under Article 86 is that the Risk Equalisation Scheme is contrary to the competition rules in that it deprives Article 82 of its effectiveness. They suggest that the appropriate approach in this regard is to firstly consider whether the Scheme distorts competition, secondly to evaluate the proffered justification offered by the State in order to see if this meets the "objective justification", standard under Article 82, and thirdly to then ask if the State can invoke the defence which is available under Article 86(2).

209. On the first question it is claimed that the Equalisation Scheme distorts competition in that, it acts as a deterrent to new entrants coming into the market; it is deigned to force the smaller undertaking (BUPA) to alter its pricing strategy by increasing its prices – whilst leaving VHI untouched; - and in that it confiscates or expropriates huge amounts of the applicants assets being far in excess of their annual profits – so that the same can be directly transferred to the VHI.

210. The second part of this suggested approach involves testing the tentative justification put forward by the State in order to see if what is offered is sustainable and if it comes within the jurisprudence of the European Court of Justice with regard to "objective justification" under Article 82. A number of points in this respect must be made. Firstly, if community rating has only a s. 7 meaning, then the fundamental basis of the State's justification fails. Secondly, given the conflicting theories advanced by the State in this regard, it is impossible for it to discharge the onus of proof which is upon it. In this respect a death spiral has been mentioned but the underlying basis for this concept has varied. It has been suggested that BUPA has pitched its premiums slighter lower than the VHI, with the result that consumers are paying more than what they truly ought to pay, and at the other end of the spectrum, that BUPA's pricing has been too aggressive. Market stability, in a variety of ways, has been mentioned, as has the theory of inter-

generational support. Moreover, the VHI has even put forward a novel point in its closing, when it suggested that Risk Equalisation payment is a compensatory mechanism for the regulatory regime (s. 7 – 10 of 1994 Act) imposed upon all health insurance providers. Whichever one of these alternatives should ultimately be relied upon, it is claimed that no proper evidential basis has been established in respect of any of them and accordingly this court should not support the justification as proffered.

211. Another point in this context is that any scheme which forces a player with only 20% of the market to transfer to the dominant undertaking, such massive funds, could not meet, almost on a point of principle, the proportionality test. In this regard the State must prove that BUPA can raise its prices and retain its business to such an extent that its resulting revenue can cover the RES payments as well as getting an adequate return on capital. The evidence offered in support of this was that of BDO, Simpson Xavier (Mr. David Hargaden) in respect of which, if one made just a single adjustment (for example to allow for medical inflation) the resulting figures show that the applicants would trade at a loss in the post RES regime. Even however if BUPA could survive, the extent of the interference is so great that almost in absolute terms the proportionality test could not be satisfied.

212. The third part of this assessment relates to the possible defence available under Article 86(2) of the Treaty. In this regard, it is submitted that the VHI has not been "entrusted" with the operation of any service of a general economic interest with Plan P being the only obligation which was ever mandatorily imposed by the Minister. In the *Dusseldorp* case the Advocate General said that an undertaking is "entrusted with" a service where "certain obligations are imposed upon it by the State in the general economic interests" (para. 103). In this regard, and as previously stated, the mere fact that the notice party is controlled by the Minister is not sufficient. *Uniform Euro Cheques* 1995 3 CMLR 434 and *Gema* (1971) OJL 134/15 confirm this. Accordingly Article 86(2) cannot apply to the present case.

213. There is a further reason to support this conclusion. Even if contrary to the above submission it could be said that the VHI was so entrusted, the State nevertheless would have to prove that the notice party could not carry out the imposed obligation unless it was exempt from the provisions of Article 82. In other words, to use the exact phraseology of Article 86(2) itself, the performance of such a task must be subject to the competition rules "insofar as the application of such rules do not obstruct the performance" of that task. There is no reason whatsoever why the VHI should not be capable of conducting its business, in conformity with Irish law, whilst at the same time observing Article 82. Accordingly there is no defence available under Article 86(2).

214. Reverting to the first question namely distorting competition, the court in *Hoffman-La Roche v. Commission* (1979) ECR 461 at para. 91 described the concept of abuse as being "an objective concept relating to the behaviour of an undertaking in a dominant position which is such as to influence the structure of a market where, as a result of the very presence of the undertaking in question, the degree of competition is weakened, and which, through a recourse to methods different from those which condition normal competition in products or services on the basis of the transactions of commercial operators, has the effect of hindering the maintenance of the degree of competition still existing in the market or the growth of that competition". Though that was a case dealing with a private undertaking, these observations equally apply, where the behaviour in question is not that of an undertaking but rather is that of the State.

215. Remaining with this particular allegation, it is claimed that the Scheme is deliberately designed to impose a liability of sufficient magnitude on BUPA which would inevitably compel it to increase its prices and in that way would inescapably affect its competitive position vis a vis the VHI. The State's intervention through the Scheme is directly responsible for this anti-competitive result. In addition, the alteration of its pricing policy would influence the structure of the market and would both weaken BUPA's own position therein and its interaction with its competitors. To make matters worse, this occurs in circumstances where there was no corresponding obligation on the dominant player. In fact, the HIA in its Staff Report of October 2005, agreed that following the implementation of Risk Equalisation Payments the competitive pressure on the VHI should decrease. A similar anti-competitive result comes about by reason of the compulsory transfer of large sums of money from the applicants to the VHI. This inevitably weakens the position of the payer and enhances the economic manoeuvrability of the recipient. The VHI could, for example, lower its prices and in the process eliminate or reduce the price differential which BUPA presently enjoys as an advantage over the incumbent. Alternatively it could invest these moneys in marketing, advertising new products, getting better hospital terms etc., or it could simply use them as an addition to its solvency fund. Furthermore virtually all the economists agree that the presence of the scheme acts as a deterrent to new entrants with Dr. Koboldt, in fact, going so far as to suggest that potentially the scheme could "eliminate competition". Without even going that far, the Competition Authority, the Harvey Report and virtually all others in this area, have agreed that the scheme had some deterring effect on new entrants. And finally, in this regard there is the anti-competitive effect of the sharing of efficiencies which by reason of the zero sum adjustment accounted for a figure of over €900,000 in the six months to June 2005. Therefore in all of these areas there is overwhelming evidence of the scheme being anti-competitive.

216. In determining what the correct legal principles are, which should apply to this challenge, the position in my view, appears to be as follows. Articles 81 and 82 of the Treaty are directed towards undertakings and not to Member States, though the latter may be subject to such rules if they carry on an economic activity. These provisions, in respect of which the State has a policing role, constitute one part of an overall scheme of maintaining effective competition within the integrated market. The second and complimentary method (for present purposes) is contained in Article 86 of the Treaty. Sub-para. 1 is not directed "per se" to undertakings but rather is focused on Member States, with sub-para. 2 dealing with undertakings but only those of a particular kind. The courts, and not the State, are the effective guardians of this Article.

217. This Article (sub-para. 1) applies to public undertakings and undertakings (simpliciter) to which Member States grant special or exclusive rights. In respect of such undertakings, Member States are prohibited from creating or sustaining any national measure which is contrary to Treaty provisions. In particular Article 12 is mentioned, which outlaws discrimination based on nationality, as are Articles 81 to 89, which of course include the competition rules. Therefore, in general such undertakings are subject to (these) Treaty provisions. Sub-para. 2 however provides for a limited derogation from the provisions of sub-para. 1 and, accordingly, must be narrowly construed. Both provisions should be read together and in appropriate circumstances Article 86(2) can absolve a measure from illegality even though it may breach a Treaty provision. Commenting specifically on the use of this provision the Court of Justice in *France v. Commission* [1991] E.C.R. 1-1223 said that it –

> "Seeks to reconcile the Member States interests in using certain undertakings, in particular in the public sector, as an instrument of economic or fiscal policy with the communities' interest in ensuring compliance with the rules on competition and preservation of the unity of the common market". (para. 12)

218. At first glance there may appear to be some ambiguity in the relevant case law when deciding certain aspects of an allegation that a Member State has breached the provisions of Article 86(1). In *Inno v. Atab* (see para. 196 above), which was decided in 1977, the court condemned any measure which deprived Article 82 of "its effectiveness". This phrase has been repeated several times in later cases, for example in *Corbeau* (para. 11 of the judgment), and *Deutsche Post* (para. 39). In other cases a slightly different type of phraseology has been used. Some three years earlier the Court in *Sacchi* (Case 155 – 73) said that the Competition Rules apply "so

long as it is not shown that … (such rules) are incompatible with the performance of their tasks". In *Hoffner and Elser v. Macroton GmBH* [1991] E.C.R. 1-1979 the Court at paras. 29 and 34 of the judgment, described the effect of Article 86(2) by stating:-

> "The simple fact of creating a dominant position…is not as such incompatible with Article 86 of the Treaty…a Member State is in breach of the prohibition…only if the undertaking in question merely by exercising the exclusive right granted to it, cannot avoid abusing its dominant position."

In *La Crespllе* – case C/323/93 the following appears at p. 18 of the judgment:-

> "The mere creation of such a dominant position by the granting of an exclusive right within the meaning of Article 90(1) (now 86(1)) is not as such incompatible with Article 86 (now 82) of the Treaty. A Member State contravenes the prohibitions contained in these two provisions only if, in merely exercising the exclusive right granted to it, the undertaking in question cannot avoid abusing its dominant position…"

A virtually identical statement appears at para. 51 of the judgment in *Banchero* – case C/387/93.

219. The references to the consequence of creating a dominant position, *per se*, is simply a re-affirmation of a common thread which runs throughout many of the cases, *Bellamy and Child*, in European Community Law of Competition 5th Ed. at para. 13.013 speaks of an infringement occurring when the national measure must "inevitably lead the undertaking to contravene the Treaty". The authors cite "*La Crespelle*" in support of this text. Given that cases like *La Crespelle* and *Banchero* post dated *Inno* but predated *Deutsche Post*, (10/2/2000), it seems to me that if the European Court of Justice intended that the phraseology used should have different meanings or that one formulation should take priority to the exclusion of the other, it would and easily could have said so. In the cases above mentioned I cannot find any discussion which would lead either expressly or by implication to the conclusion, that a trial court in determining this issue, is restricted to using one formula rather than the other. I therefore conclude that in essence both have a similar application.

220. In addition to the above it is I think quite useful to note certain observations of the court, again made in a number of cases, an example of which is the *Corbeau* decision. That was a case in which Mr. Corbeau wished to offer additional postal services, not offered by the State monopoly, to certain individuals with regard to the collection and delivery of correspondence. He was charged with infringing Belgian legislation which conferred a statutory postal monopoly on the post office. In answer to this charge the applicant alleged that the measure infringed Articles 86/82. At para. 19 of the judgment the court said:-

> "However, the exclusion of competition is not justified, as regards specific services dissociable from the service of general economic interest which meets special needs of economic operators and which call for certain additional services not offered by the traditional postal service, such as collection from the senders address, greater speed or reliability of distribution or the possibility of changing the destination in the course of transit, insofar as such specific services, by their nature or the conditions in which they are offered, such the geographical market in which they are provided, do not compromise the economic equilibrium of the service of general economic interest performed by the holder of the exclusive right."

The court was therefore indicating that competition restrictions on services detached from those of a general economic interest were only justified if such service did not "compromise the economic equilibrium" in and by which the service of a general economic interest was performed.

221. Another case of interest in this regard is the *Commission v. the Netherlands, Italy and France* [1997] ECR 1-5699. These cases, which are collectively known as the 'gas and electricity cases', involved monopolies on the import and export of electricity and natural gas. The Commission alleged that the Member States had not discharged the onus upon them, of proving that the continuing existence of these bodies would be threatened by the application of Article 31 or that there was no alternative way to achieve the performance of the task entrusted to them. *Van Bael* and *Bellis*, on Competition Law of the European Community 4th Ed., at p. 1016, summarises the court's approach to these issue. The passage reads as follows:-

> "Then the court explained that, in determining whether the exemption is justified, it is only necessary to assess whether applying the Treaty rules would obstruct the performance of a firm's public service tasks (under economically acceptable conditions) and it need not be shown that the application of those rules would jeopardise the firms very existence. Furthermore, once it is established that the elimination of the contested measures would compromise the fulfilment of the public service functions, a Member State is not obliged to go so far as to demonstrate that no other conceivable measure could enable the firm to perform those tasks under the same economically acceptable conditions."

In applying that criteria the court held that the Commission's arguments were not sufficiently sustainable to merit relief.

222. There are a number of other points to be made in this context. First, for s. 86(2) to apply, there must exist a service of general economic interest, secondly the performance of that service must have been "entrusted" to an undertaking and thirdly, as referred to above, the competition rules will apply but only insofar as they do not "obstruct the performance, in law or in fact, of the particular tasks" assigned to such undertakings. For a service to be "entrusted" they must be an "act of a public body" and that body, ie the State in this case, must have taken legal steps to secure the provision of such services; *BRT v. SABA M* [1974] E.C.R. 313; *Ahmed Saeed* [1989] E.C.R. 803. Some action falling short of this, such as approval or endorsement is not sufficient. See *Uniform Eurocheques* O.J. 1985 case. A national measure, as in a national law is certainly sufficient to constitute an act of a public authority, see *Commission v. Italy* [1985] E.C.R. 873. What is sought to be covered by the provisions of Article 86(2) is not the undertaking as such but rather "the particular task" given to that undertaking. These "tasks" must of course be identified as otherwise it would be impossible to assess whether the restrictions in question, which impinge on the exercise of treaty provisions, can be justified. The "services" referred to, must be broadly understood, must be performed on an ongoing and regular basis, must be economic in nature, must effect a large section of the population and must be carried out and performed in the interests of the general public. See p. 1011 of *Van Bael v. Bellis*. Examples of such "services" have been held to include activities in the field of transport, energy, communications, telephone networks, universal postal services. Finally with regard to s. 86, and as dealt with above, competition rules apply unless these "obstruct" the performance of the task in question.

223. Reference must also be made to a Communication from the Commission, on Services of General Interest in Europe, which issued in February 2001, and which incidentally has been followed by a Green Paper published in 2003. In the communication, the Commission makes a number of observations with which I respectfully agree. These can be summarised as follows:-

> (a) The pre-dominant purpose of and the core reason behind services of general economic interest, is the well being of

the citizen. This type of service make an "important contribution to the overall competitiveness of … industry" and also helps economic and social integration as well as the internalisation of the market (para. 8)

(b) Many, of these services indeed a substantial number have been provided for the benefit of the general public by the market, but in some instances, perhaps because of a lack of incentive, market forces in themselves cannot be relied upon to provide satisfactory cover. Accordingly public authorities can identify services of general economic interest and for their effective implementation, can lay down a number of specific service provisions.

(c) Public authorities in this regard may "decide to apply general interest obligations on all operators in a market", or may grant special or exclusive rights or may designate, falling short of conferring such rights a limited number of operators to provide such services. If the first or third options are followed, it is the Commission's view that "in this way, the greatest competition is allowed and users retain maximum freedom with regard to choice of service provider" para. 15.

(d) However, the nature of the service in question is important in this regard as some such services are suitable for "a plurality of providers" whereas others are not. Such as for instance when only a single provider can be economically viable (para. 17).

(e) The Treaty provisions, in particular the rules on competition are "fully compatible" with the concept of services of general economic interest. At para. 19 of the communication the Commission says "Article 86 of the Treaty and in particular Article 86(2) is the central provision for reconciling the Community's objectives, including those of competition and internal market freedoms on the one hand, with the effective fulfilment of the mission of general economic interest entrusted by public authorities on the other hand.

(f) The Commission then points out that in its view there are three principles underlining Article 86. These are neutrality, freedom to define and proportionality (para. 20).

(g) Neutrality is concerned with ownership either public or private and in that regard speaks for itself.

(h) Freedom to define means "that Member States are primarily responsible for defining what they regard as services of general economic interest on the basis of the specific features of the activities. This definition can only be subject to control for manifest error" (22).

(i) Proportionality is then described as applying that "the means used to fulfil the general interest mission shall not create unnecessary distortions of trade. Specifically, it has to be ensured that any restrictions to the rules of the EC Treaty, and in particular, restrictions on competition … do not exceed what is necessary to guarantee effective fulfilment of the mission" (23).

(j) Commenting on the CFI's decision in *FFSA* – (1997) *Case T* -106/95, where it was held that compensation granted by a State in response to the performance of a service of general economic interest may amount to State aid, the Commission says that such compensation, if compatible with Article 86(2), will not be so described. Para. 26 of the Commission says "this is the case where all conditions of this provision are fulfilled and, in particular, the compensation does not exceed the net extra costs of the particular task entrusted to the undertaking …"

(k) The communication deals with several other matters including what are services of a general economic interest.

224. The last general observation which I wish to make in this regard has already been touched upon in the extract from the Commission's Communication, referred to at sub-para (h) above. It is the margin of appreciation which a Member State enjoys in this context. At para. 13.011, *Bellamy and Child* in European Community Law of Competition describes this concept as follows "this (Article 86(1)) does not mean, however, that a grant of exclusive rights will be unlawful if it can be shown that there was a different way of achieving the same result. Thus where a measure making adherence to a particular pension scheme compulsorily was challenged, it was argued that the Member State could have achieved the social objective of ensuring adequate pension provisions by simply laying down minimum levels that insurers must provide. But the Court held that the State concerned enjoyed a "margin of appreciation" in deciding, in view of the particular features of its national pension system, the best way to guarantee adequate provision". See the *Dutch Sectorial Pension Fund* cases, [1999] ECR 1-5751.

225. There is no doubt but that there is a conflict of evidence between the experts in this case on whether or not the scheme distorts competition. As explained above, Dr. Koboldt goes so far as to suggest that potentially it eliminates competition. On behalf of the State and Notice Party, both Dr. O'Toole and Dr. Mike Walker take the opposite view, when the totality of their evidence is considered. Dr. O'Toole gives two definitions of what constitutes a barrier to entry. The first comes from Stigler, *The Organisation of Industry*, Chicago, University of Chicago Press, 1968, where it is said that such a barrier is represented by " … costs that must be borne by an entrant that were not incurred by established firms" and the second, from Bain on *Barriers to New Competition*, Cambridge, Harvard University Press, 1956 which relies on "factors that enable established firms to earn *supra* – competitive profits without threat of entry". Based on either of these descriptions of what constitutes such a barrier, Dr. O'Toole is of the opinion that technically, the scheme cannot be said to constitute an entry inhibition as all players within the market are treated symmetrically, with no distinction in principle being made between any one of them. Rightly so in my opinion, he points out that entrants do not necessarily have to be the payer under the equalisation system, but could for example take steps to minimise, at least to some extent such payments by product innovation or by targeting at the "relatively" unhealthy population. On the other hand, he undoubtedly agrees that equalisation transfers "decrease the incentive" to enter the market. That observation of his is however tempered by a strongly expressed belief that this disincentive, such as it is, is both necessary and appropriate from a public and indeed from a competition policy perspective. In this regard, he relies upon the York Report, the response to the HIA by the Competition Authority in 2002 and on the Harvey Report.

226. Dr. Mike Walker disputes that the scheme is anti-competitive and in that regard I cannot agrees that his evidence on Day 24, p. 17 and Day 26, pp. 150/151 can be construed as being of the opposite effect. In fact from a general point of view, his argument on that occasion was to the contrary effect. Broadly speaking Dr. Walker suggested that competition in a market place should not be equated with, or dependant on, the number of players who operate within that sector, or on the ease to which access to such a market might be achieved. Rather the focus at all times should be firmly on consumer welfare.

227. This economist argues that without risk equalisation it would of course, be easier for new entrants to enter the market, to attract young low risk consumers by way of risk selection, and thus earn and have available clear profit opportunities. Consumers however are not concerned with profit, they are concerned with prices. His view was that in the absence of risk equalisation higher

prices were likely. This would occur because a new entrant would essentially compete for customers, who either had no previous cover and thus were likely to be young and healthy, or else were the type of persons who were insured with the incumbent. Shadow pricing incumbent would be likely to take place. The result would increase prices whilst a new entrant to make excessive profits. Risk equalisation prevents this occurring, by neutralising differences in risk profile caused by reason of age, gender and health status.

228. Dr. Walker goes on to argue that in the absence of an equalisation scheme there is no competitive pressure on the providers to serve the relatively bad risk. This is because the new entrant, who predominantly attracts the younger, healthier and low risk individuals, can retain its entire profits which have been achieved in no small way by risk selection. The equalisation scheme prevents this. Consequently it encourages competition for high risk customers, a fact which the Actuary Department of the UK Government commented upon. This scheme offsets the natural business tendency of a provider, to attract those risks whose premiums are predicted to exceed their estimated claims cost. As the reverse applies to old and elderly people, it inevitably follows that providers would have no positively interest in pursuing them.

229. Another competitive aspect of risk equalisation is that it directs providers to focus on competition in areas other than risk selection. For example on premium, on mix of policy, on efficiencies, etc; all of this is good for the consumer and therefore this scheme is pro-competitive.

230. In my opinion, notwithstanding the evidence of Dr. O'Toole and Dr. Walker, I believe that the applicants have established that this scheme involves some elements of anti-competitive behaviour in that the pricing structure of the market is interfered with and entry is less attractive. (See the York Report of November 2003). Therefore competition is distorted. However I do not agree with the characterisation of the transfer payments as expropriation or confiscation. These are designed to compensate for a loss or disadvantage and seek to restore profile balance where that has been lost, on this market largely due to historical reasons. In addition the scheme is surrounded both in principle and practice with multiple safeguards. I therefore cannot agree with the use of the words confiscation or expropriation.

231. Given this finding the State must, if it is to successfully answer this challenge, prove the existence of objective justification under Article 82 of the Treaty and or satisfy the court that Article 86(2) applies. With regard to the "justification" defence, the Commissions discussion paper on the application of Article 82 to exclusionary abuses, published in December 2005, should be referred to. In that paper there is a description of what has become know as the "objective necessity defence". As well as the "meeting competition defence". In applying these to an Article 86 the following appears to be the position:-

1. The State must satisfy the proportionality test;

2. The aim of the measure must be defined;

3. The chosen means must be suitable to achieve the aims;

4. The measure must be indispensable to the aim, i.e. the result cannot be achieved by less anti competitive means and the measure cannot last longer than what is absolutely necessary; and

5. The measure must constitute an appropriate response in the context of Article 82.

As virtually all of these matters are common to the domestic constitutional challenge, it would be convenient to deal with both at the same time: This I will do later in the judgment.

232. In order to avail of the derogation provided for in Article 86(2) of the Treaty, the respondents must satisfy the court that, (a) the operation of private medical insurance in this country, involving due compliance with the Risk Equalisation Scheme and with the mandatory requirements specified in ss. 7 to 10 of the 1994 Act as amended, constitute a service of general economic interest, (b) the health insurance providers including the notice party, who operate on this market are "undertakings", (c) such undertakings have been entrusted with the performance of this service and that as a result, (d) the implementation of this statutory scheme justifies, in accordance with case law, the disapplication, in the manner above described, of the provisions of Article 82.

233. With regard to the first point, it cannot, I think, be seriously disputed but that the provision of private medical insurance, within a statutory scheme, is a "service" of an economic nature, and that it is directed towards the general population and is availed of by a large section of it. Equally so, it cannot be, and it is not doubted, but that the health insurance providers in this market are "undertakings" for purposes of the relevant Articles. In addition, these undertakings are compelled by force of law, both civil and criminal, to operate the key pillars, and the scheme, as part of their insurance business within the statutory framework. The Oireachtas has so ordained. Consequently I am satisfied that this service has been "entrusted" to the undertakings in question.

234. The final requirement which must be established under Article 86(2) is that the application of Article 82 would "obstruct" the performance of the tasks entrusted to such undertakings. In other words it must be shown that any restrictions on competition are necessary in order to ensure that the service can be carried out in economically acceptable conditions. Or to use the terminology of the court in *Corbeau* in conditions of financial equilibrium. Whilst this requirement essentially involves a proportionality test, (a matter dealt with later in this judgment), I am satisfied that community rating, open enrolment and lifetime cover could not operate in this country, in economically acceptable conditions, without the presence of a Risk Equalisation Scheme. The entire purpose of the Scheme is to re-establish financial equilibrium which would not exist if there was no compensatory mechanism to neutralise the differences in risk profiles. So long as there is a fundamental State commitment to community rating across the market, no sustainable case exists, or has been made out, even by BUPA that such a system can survive without some form of Risk Equalisation Scheme. In fact there is almost unanimity amongst the experts and reports that this is so. In addition and as also appears later in this judgment, there is in my view sufficient evidence to demonstrate, that without the Scheme, there is a real possibility of the death spiral syndrome applying or price following being implemented, either of which could result in serious market instability and certainly either of which would be contrary to the best interest of consumers. Moreover I do not accept that competition alone would correct the imbalance which is targeted by this Scheme. At least not so for several years perhaps somewhere between 20 and 30 years. Whilst it may be largely incontrovertible, that with an entirely different system of private medical insurance, there would be no necessity for the existence of such a Scheme, that submission in my view is not an answer to the point at issue. There is no obligation on the State to satisfy the court that the Irish system is the only conceivable way of providing medical insurance in this jurisdiction (see para 221 supra). Rather the question is, given the established and preferred state method of providing private cover, enjoying as it does a margin of appreciation in this regard, are the resulting restrictions proportionate to the aims. In my view they are, because if one were to apply the Treaty Rules on Competition, the provision of such a service could not take place and certainly could not take place in conditions of economic acceptability. Accordingly I believe that Article 86(2) is available in this case.

Incidentally it should be pointed out to the provisions of Article 86(3) were never an issue in this case.

235. This conclusion is I think supported by the Commission's decision given on 13th May, 2003. Whilst that decision was made in the context of an Article 87 application, nevertheless certain observations of the Commission have considerable relevance to this point in particular, and to this case in general. Having acknowledged that services of a general economic interest, play a key role in the European model and help both social and territorial unity, the Commission pointed out that the primary responsibility for identifying what they constitute services of a general economic interest is with the national authority, whose decision in this regard is reviewable only for manifest error. The obligation to perform particular tasks, which arises from any such designation, may be placed on the market as a whole, or on one or more operators within the market.

236. On behalf of the applicants, it was also alleged that the statutory scheme would not deliver on cover, or products, beyond these which would be obtainable through the normal competitive process. Secondly it was claimed that since providers could (at least conditionally) design a product and determine their pricing policy, such freedom contradicts the notion of an SGEI, and thirdly, the notified scheme involved services well in excess of those available under the basic social security scheme and therefore were well outside the correct definition of SGEI. The Commission in its aforementioned decision rejected all of these grounds and concluded that the above stated statutory requirements, which were imposed on all insurers in the Irish market, did constitute SGEI obligations for the purpose of Treaty rules. I respectfully agree with these views on this matter.

In addition the Commission went on to consider other aspects of the Scheme which are dealt with later in this judgment.

I am therefore satisfied that the State has discharged the onus of proof which is upon it, of bringing this scheme within the provisions of Article 86(2) of the Treaty.

Breaches of Article 43 and Article 40.3 of the Constitution
237. In this part of the applicants' case, they challenge the constitutionality of s. 12 of the Act of 1994 as amended and the Risk Equalisation Scheme. It is said that both breach their property rights under Article 40.3.2. of the Constitution and Article 43 of the Constitution. In dealing with this submission it is claimed that the correct approach which this Court should adopt, is to examine the nature of the property rights in question, to consider whether the impugned provisions constitute a regulation of those rights in accordance with the principles of social justice, to see whether those provisions are required so as to delimit the exercise of those rights in accordance with the exigencies of the common good and having come to a conclusion on these issues to determine whether the legislative provisions constitute an unjust attack on the applicants property rights.

238. In accepting the validity of this approach there are a number of general observations which can comfortable be made, even at this juncture:-

> (a) In *Re: Article 26 of the Constitution and the Planning and Development Bill* [1999], [2000] 2 I. R. 321, Keane C.J. in delivering the judgment of the court said "the challenge (to property rights under Articles 40.3.2. and 43) typically arises however, as it has done here, in circumstances where the State contends that the legislation is required by the exigencies of the common good. In such cases, it is inevitable that there would have been enquiries as to whether, objectively viewed, that could be regarded as so required and as to whether the restrictions or delimitations effected of the property rights of individual citizens (including the plaintiff in cases other than references under Article 26) are reasonably proportionate to the ends sought to be achieved."
>
> (b) A passage from the judgment of Finlay C.J., in *Touhy v. Courtney*, [1994] 3 I. R. 1, was recited with approval by the court in *re: Article 26 of the Constitution and the Health (Amendment) (No. 2) Bill* [2004], [2005], 1 I. R. 105. This passage, which is one of general application when dealing with a constitutional challenge, reads as follows:-
>
> > "The court is satisfied that in a challenge to the Constitutional validity of any statute in the enactment of which the Oireachtas has been engaged in such a balancing function, the role of the courts is not to impose their view of the correct or desirable balance in substitution for the view of the legislature as displayed in their legislation but rather to determine from an objective stance whether the balance contained in the impugned legislation is so contrary to reason and fairness as to constitute an unjust attack on some individuals constitutional rights."

239. The above reference to "proportionality" is a reference to the incorporation of that doctrine in this jurisdiction by the decision of Costello J. in *Heaney v. Ireland* [1994] 3 I.R. 593. Embracing what was said in that case, the Supreme Court in the above mentioned reference of the Planning and Development Bill 1999 said, at p. 349/350 of the report of its judgment.

> "In considering whether a restriction on the exercise of rights is permitted by the Constitution, the courts in this county and elsewhere have found it helpful to apply the test of proportionality, a test which contains the notions of minimal restraint on the exercise of protective rights, and of the exigencies of the common good in a democratic society. This is the test frequently adopted by the European Court of Human Rights… .. and has recently been formulated by the Supreme Court in Canada in the following terms. The objective of the impugned provision must be of sufficient importance to warrant over-riding a constitutionally protected right. It must relate to concerns pressing and substantial in a free and democratic society. The means chosen must pass a proportionality test. They must:-
>
> > (a) be rationally connected to the objective and not be arbitrary, unfair or based on irrational considerations,
> >
> > (b) impaired the right as little as possible:
> >
> > (c) be such that their effects on rights are proportional to the objective."

240. In this context the decision of *Chaoulli v. Quebec* (2005) 1 SCR 591 was referred to. In that case the Canadian Supreme Court held that certain statutory provisions which had the effect of excluding a person's ability to obtain private health insurance cover, in respect of the same services as obtainable under the Public Insurance Scheme, was incompatible with the Canadian Charter of Rights and Freedoms. In effect the restrictions amounted to a "virtual monopoly for the public health scheme". Certain observations of Macklin CJ were relied upon. These were as follows:-

> "108. The government defends the prohibition on medical insurance on the ground that the existing system is the only approach to adequate universal health care for all Canadians. The question in this case, however, is not whether a single

> tiered health care is preferable to two tier health care. Even if one accepts the government's goal, the legal question raised by the applicant must be addressed: is it a violation of … the Charter to prohibit private insurance for health care, when the result is to subject Canadians to long delays with resultant risk of physical and psychological harm? The mere fact that the question may have policy ramifications does not permit us to avoid answering it …
>
> 151. (The dissenting judgments) suggest that the Government's continued commitment to a monopoly on the provision of health insurance, be arbitrary because it is routed in reliance on "a series of authoritative reports (that analysed) health care in this country and in other countries". They are referring here to the reports of … but the conclusions of other bodies on other material cannot be determinative of this ? They cannot relieve the courts of their obligations to review Government action for consistency with the Charter on the evidence before them …
>
> 130. … A law is arbitrary where there is no relation to, or inconsistent with, the objective that lies behind it.
>
> 131. … The more serious the infringement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legitimate goals.
>
> 155. The Government undeniably has an interest in protecting the public health regime. However, given the absence of evidence that the prohibition on the purchase and sale of private health insurance protects the health care system, the rational connection between the prohibition and the objective is not made out".

241. Having thus considered the extent of the alleged encroachment on the applicants constitutional rights, it is claimed on behalf of BUPA, that the State respondents have failed to discharge the onus upon them, of proving that the relevant section together with the scheme, fall within the permitted parameters of Article 43 of the Constitution. As a result it must follow that in respect of BUPA's property rights, both this Article and Article 40.3.2. of the Constitution have been breached.

242. By way of general reply the respondents made a number of submissions. On their behalf it was said that the applicants rights of establishment and to provide services, were regulated in this jurisdiction by the Third Life Directive and that if s. 12 and the RES were valid thereunder, then a *fortorori*, it could not be said that their property rights were unlawfully interfered with. Secondly, whilst all such property rights of any party are duly accredited fundamental importance in our Constitution system, nevertheless the same are not absolute and in certain circumstances have to be balanced or measured against other rights. *Dreher v. Irish Land Commission* [1994] I.L.R.M. 94 and *O'Callaghan v. Commissioners of Public Works* [1985] I.L.R.M. 364 were referred to in this regard. Whilst the absence of compensation was a factor in assessing any alleged impact on the legality of such rights, the unavailability of such a mechanism could not per se amount to a constitutional breach. *Caffolla v. The Attorney General* [1985] I.R. 486 was cited in support as was *Madigan v. The Attorney General* [1986] I.L.R.M. 136 where the court held that certain tax measures, which interfered with property rights could not be challenged as being unjust on the basis that " … if what has been done can be regarded as action by the State in accordance with the principles of social justice and having regard to the exigencies of the common good as envisaged by Article 43.2." This general approach is again evident from *Moynihan v. Greensmith* [1977] I.R. 55 where the words "as best it may " in Article 40.3.2 were noted. The court said, with regard to this phrase that it "implies circumstances in which the State may have to balance its protection of the right as against other obligations arising from its regard for the common good." See also in *Re Article 26 of the Employment Equality Act* [1996], [1997] 2 I.R. 321 and the D.P.P. *(Long) v. McDonald* [1983] I.R. 213. An interesting case in this regard is *Hempensdell and Others v. Minister for the Environment* [1994] 2 I.R. 90 where the court held that the legislative removal of restrictions with regard to the operations of taxis did not constitute an unjust attack on a holders property right. Even if such intervention by the State led to a reduction in the value of the applicant's property, that by itself, which was authorised by legislative authority, did not constitute an infringement unless some invalidity existed apart from that diminution. In conclusion there cannot be an argument, according to the respondents on the point that the conditions inherent in the exercise of any property rights which BUPA may have, such as due compliance with the key pillars set out in the 1994 Act, together with the Risk Equalisation Scheme, are required in the "interests of the common good" and are "in the best interest of consumers". Accordingly the applicants cannot proceed on this ground of challenge.

243. The Notice Party, while supporting these submissions of the respondents, made some additional points in their own right. In the first instance they point out that any health insurance undertaking, which wishes to conduct business in this State, including the VHI, is subject to s. 12 of the 1994 Act as amended and the 2003 scheme. With full knowledge of these national measures, the applicants voluntarily entered this sector and conducted its business herein. They were therefore well aware of what restrictions existed and what obligations applied. Indeed the applicants have throughout the years earned substantial profits very much by reason of the existing legislative regime. Having so operated in this environment, it is claimed that BUPA cannot now constitutionally challenge the validity of the impugned legislation.

244. In support of their contention that no property rights of the applicants have been infringed by these provisions, the Supreme Court's decision in *Maher v. Minister for Finance and Rural Development* [2001] 2 I.R. 139 has been opened to this Court. Indeed this was a case also relied upon by the respondents. Whilst not offering a perfect comparison with the circumstances of the present case, nevertheless the structure of the events which gave rise to the judgment in Maher had a direct bearing on the present issue. Murray J., as he then was, having referred to the decision of the Court of Justice in *Schrader v. Hauptzollamt Gronau* (1989) E.C.R. 2237 said, in dealing with an allegation that Mr. Maher's rights in milk quotas were adversely effected by community measures, that "there is in any case parallel jurisprudence of the Court of Justice in its approach to the assertion of property rights in the context of the common organisation of the market in the agricultural sector. In this approach the Court of Justice, without declaring that the rights in question are in fact property rights, has dealt with the issue by defining the proper restrictions which may in any event be placed on the exercise of property rights in the context of a common organisation of the market. In *Schreder v. Hauptzollamt Gronau* …, the court stated at p. 2238;

> "Both the right to property and the freedom to pursue a trade or profession … do not constitute an unfettered prerogative, but must be viewed in the light of the social function of the activities protected thereunder. Consequently, the right to property and this freedom to pursue a trade or profession, may be restricted, particularly in the context of a common organisation of the market, provided that those restrictions in fact correspond the objectives of general interest pursued by the community and that they do not constitute as regards the aim pursued a disproportionate and intolerable interference which infringes upon the very substance of the rights thus guaranteed."

In applying these principles it is denied by the notice party that any property right of the applicants has been infringed.

245. If however such a right has been interfered with, then both s. 12 of the 1994 Act and the scheme, did so with a view to reconciling the exercise of the applicants rights with "the exigencies of the common good" under Article 43.2 of the Constitution. The

objects and the need for the scheme have been clearly identified in the evidence given on behalf of the respondents and the notice party. Moreover these provisions apply equally between all providers and it is only because of the applicants superior risk profile that they are accountable to neutralise such advantage by the making of transfers as determined by the HIA. In these circumstances it is claimed that the proportionality test in *Heaney v. Ireland* [1994] 3 I.R. 593 is fully satisfied and that there is no basis for this particular allegation.

246. Although written and oral evidence was offered by the State in respect of BUPA's obligations under the equalisation scheme and in particular their ability to meet such obligations, it was suggested by counsel on behalf of the respondents in closing, that the amounts of any such transfer were really a matter of BUPA's profitability and accordingly, whatever the extent thereof, the same were from the court's point of view "a red herring". He referred by way of analogy to a variety of legislation which had imposed many restrictions in such diverse areas, as fishing, opening hours, minimum wages etc., and suggested that any consequential diminution in earnings in these areas were without court redress. Whatever about the substance of this argument, I cannot agree that this Court can simply ignore the financial effect of this scheme on BUPA. Disregarding for a moment all other arguments, it seems to me that from the case law above recited, it would be quite impossible for this court to conduct any type of inquiry, with regard to the scope of the alleged property right and its alleged infringement, if in fact the extent of payments were irrelevant. Moreover and in this respect I agree with the submissions of the applicants, it would be quite impossible to apply the proportionality test if this suggestion was correct. Therefore I do not accept the State's point in this regard.

247. There is no argument but that the presumption of constitutionality applies to the provisions which are impugned in this case. Equally so there is no dispute but that the onus of proof is on the applicants to prove an infringement of their rights. Once so established however the State must then justify. In this context however it is important to point out, that the framing and putting in place of a legislative scheme for private medical insurance, involves as it must, major issues of national policy and accordingly the courts must show due difference to the State in this regard. This is, in no way to imply that the function of this arm of government is unduly restricted or curtailed; rather it is a reminder of what the court must remain conscious of in determining this issue.

248. In addition to the point last made it is also important in my view to bear in mind that the task of this Court is not to try and identify what is, or from an unencumbered start, what would be the best possible scheme for the insured population of this country. This task of mine is not to exercise a preferment of any scheme supported by BUPA as against the scheme supported by the State and the notice party. My essential function as I see it, is, in the event of a *prima facie* infringement being established, to consider and evaluate the evidence offered in purported justification of the statutory provisions and in the process to apply the relevant case law as above outlined. This includes the test propounded by the Supreme Court in *Tuohy v. Courtney* [1994] 3 I.R.I where the question asked was whether the impugned legalisation "was so contrary to reason and fairness as to constitute an unjust attack" on a person's constitutional rights. Even if this generalised application is somehow not applicable to the circumstances of this case, the courts function nevertheless cannot be more than to decide, on the totality of the evidence, as to whether the State has discharged the onus of proof which is upon it.

249. In order to decide whether there is a prima facie infringement of BUPA's constitutional rights, it is not in my view necessary to exhaustively review the detailed evidence given, on the extent of what the RES payments might be in the future, of what the likely future profits of BUPA may be and of how and in what way their market share and revenue may be effected in the event of an alteration in its prizing structure. It is sufficient to recall that the independent body, the HIA, in the Staff Report of October 2005, calculated that if payments were mandatory for that year, the amount of the transfer would be approximately €33 million. This ignored a temporary phasing in period. That amount compared to a gross underwriting profit of €22 million for the year ending June 2005. Over a three year plan, BUPA estimates a projected liability of approximately €160 million as against anticipated profits of €60 million. Even allowing for BUPA's historical understating of its anticipated profits and building in a capacity for price increases, which would not unduly effect its revenue generating capacity, there can be no doubt but that on these figures it would be difficult for the applicants, without major structural changes and with its current business model, to cover payments and also obtain an acceptable return on capital. Therefore it is likely that in the short term the scheme will have a significant impact on, at least their profitability, if not also on their reserve fund.

In this context it is to be noted that despite a very lengthy trial, BUPA felt unable to inform the court as to what they would regard as an acceptable level of return so as to continue operating in this market. Whilst the applicants could not be compelled to give this information nevertheless it would have been quite useful in evaluating certain features of this case.

250. The above general conclusions are largely supported by the evidence called on behalf of the respondents. Their experts in this regard were BDO Simpson Xavier, in the person of Mr. Hargaden. Over a three year business plan prepared by BUPA to cover the years 2006 to 2008, BDO made certain adjustments which resulted in a projected profit of €43 million for that period, whereas payments under the RES Scheme came to about €90 million. Making one adjustment to the underlying assumptions used in this analysis, which was to incorporate the cost of medical inflation, the figures show a resulting loss of €4 million for this period. As no one can dispute the correctness of this single adjustment, and even disregarding the validity or otherwise of all other assumptions used by Mr. Hargaden the above conclusions can I think be safely arrived at. I am therefore satisfied that with their current business regime, the financial liability resulting from equalisation payments will have a significant impact on BUPA.

251. Accordingly in my view, and without any necessity to further elaborate on the evidence, it is safe to proceed on the basis that there is a *prima facie* infringement of the applicants constitutional right to property. Therefore the State must justify.

252. In dealing with this aspect of the case I will cover all of the major components which apply, to the "general good" requirement of Article 54 of the Third Non Life Directive, to the "objective justification" element of Article 82 when looked at from the point of view of Article 86 of the Treaty and to the "obstruct" component of Article 86 itself.

253. Before again mentioning the material which emerged from the consultative process and prior to commenting upon the expert evidence adduced during the course of the trial, reference must be made to the two reports prepared by the staff of the HIA which issued in April, 2005 and October, 2005. These reports, known as the "staff reports", have been compiled largely in the same format. Both reports after an introduction, have sections dealing with, a review of the authority's policy paper, the proposed views of that authority, the returns made for the purposes of the risk equalisation scheme, a note and comment on any relevant developments since the last decision of the HIA, and a listing of the issues to be considered. There are two further sections which respectively contain the staff review and the staff's comments on representations received from the insurers in the market. There are then a number of appendices dealing with the comments made by Arthur Anderson Consulting, in relation to the arguments for and against the scheme and a like review of these contributions by York Health Economics Consortium. Finally appendix (iv) contains a review of the submissions received by the HIA during the consultative process.

254. By simply outlining the format of the Reports, it will become immediately apparent that the following extracts are but a fraction

of the information, analysis and opinion contained within each such report. In fact both reports are extremely detailed and cover most if not all, of the major information and data areas which are relevant to the HIA in the performance of its statutory functions. The information therefore which appears in the following paras should not be read in isolation and it is only manageability and relevance which inhibits me from setting out much more comprehensively the contents of these reports. I have however considered in significant detail all of the information contained in these documents, and thus by way of incorporation, one can proceed on the basis that the totality of these reports form an essential part of the overall body of evidence before this Court.

255. For the purposes of this case there has been four returns made to the HIA, each covering a separate six month period commencing on the 1st July, 2003 and ending on the 30th June, 2005. In all of its calculations the HIA has used a health status weight (HSW) of zero. This body has determined on the material supplied, the MEP (see paras 40, 42) for each of these said periods, with the relevant figures being 3.7% (for the six months ending the 31st December, 2003), 3.5% (for the following six month period), 4.7% (for the six months ending the 31st December, 2004), and 4.2% for the last period. In respect of the first two periods the HIA made a negative recommendation to the Minister but for the period ending the 31st December, 2004, it recommended that she should take steps to trigger the risk equalisation payments. As was her right, she rejected that recommendation but accepted a similar one for the following period. It was of course the Ministers acceptance of this recommendation that was the immediate cause of triggering these proceedings.

256. At the end of 2004, it can be taken that there were 1.9 million insured persons for the purposes of the risk equalisation scheme, with BUPA having 19.6% of the population and VHI 78.9%. In that six month period BUPA's membership had increased by 6% to over 400,000 with VHI's membership remaining relatively static. In all over 2.05 million (2.08 million as of the 30th June, 2005) people had insurance cover (with some of these, for reasons not relevant, being excluded from the scheme). For the following six month period BUPA added a further 3.8% bringing its membership to 415,000 whilst the VHI added .6% bringing its membership to 1.565 million. Their respective shares of the open membership market were 20.9% BUPA (up from 20.5%) and 78.7% for VHI (down from 79.4%). As of December, 2004, BUPA had 86.4% of its membership in the under 50 age group with VHI having 70.8% of its members in that bracket. BUPA had 13.7% over age 50 and the VHI had 29.3%. As of April, 2005, BUPA's percentage of the under 50's was 85.9% with the VHI having 75.5%. In the over 50 age bracket the respective figures were 14.1% and 29.44%. In the April, 2005 report, it is noted that in the 18 to 29 age group, which is a very profitable cell base, BUPA's percentage share fell by approximately 0.9% in comparison to the previous year but it still had a greater proportion in that bracket than the VHI. The average age of the VHI's membership as of the 30th December, 2004, was 36.9 with BUPA's average being 29.6 years, an increase of 0.3% over the previous year. The average age of VHI's lapses for the year ending 30th June, 2005, was 31.6 years. This average age is considerably lower than the average age of its membership and therefore a high rate of lapses could be problematic for the VHI.

257. Having covered several other areas and having analysed, cross-referenced, and commented on the data supplied and on the events intervening since the last review, the October, 2005, report, at p. 62 contains section F which deals with the "staff review". Having taken legal advice, the report adopts an interpretation of "community rating" to include inter generational solidarity and thus did not confine the meaning of that phrase to a pure s. 7 definition. With that meaning therefore, the report then deals with the stability of the market, the facilitation (and other aspects) of competition, intergenerational solidarity, the MEP and the pros and cons of commencing risk equalisation payments. Because this case does not involve a challenge to the HIA's recommendation to the Minister based on such a report, it is not necessary to further comment on, or reach any conclusions on the above aspects of the report. In particular it is for other proceedings (which are in existence) to decide on the legality of and the *vires* of the actions of both the HIA and the Minister. However, given that the HIA is a statutory body, entrusted with a highly influential but neutral role in the performance of its functions, and is staffed by persons with particular expertise in this area, its views on price following and predatory pricing/death spiral are of considerable significance. These appear at p. 5 and 6 of the October report and read follows: -

"Price Following

> (a) An insurer with a significantly lower risk profile might be in a position to charge a considerably lower premium as a result of its lower claim costs. However it might choose instead to set its premium at a level slightly below the premium of other insurers with higher risk profiles. From the point of view of the insurer with the lower risk profile this could be viewed as a sensible strategy. Setting its price slightly below the prices of other insurers would assist in its attracting a significant proportion of the new entrants to the market and some better risks from the other insurers, but would avoid attracting too many higher risks from the other insurers. This could result in the claim costs of the insurers with the higher risk profiles rising further as they fail to attract or retain sufficient low risk consumers. The insurer with the lower risk profile could again follow these price increases and the process would continue.
>
> The overall market effect would be that all consumers would pay a premium close to the premium required to cover the claims of all the insurers with the highest risk profiles and if the risk profiles of these insurers continued to worsen as described above, the premiums for all consumers would continue to rise.
>
> *Predatory pricing/Death Spiral*
>
> (b) The scenario is that an insurer with a much lower risk profile chooses to charge a significantly lower premium because it experiences lower claim costs. This premium might be significantly lower than the cost of insuring the market as a whole. The average claim of other insurers may increase, as the insurer charging a low premium might primarily attract younger, healthier, more mobile consumers with relatively low claim costs. The other insurers may not be able to reduce premiums to attract the low risk consumers back as their average claim would be too high. These insurers may ultimately be forced out of the market.
>
> (c) Older consumers would have the option of course, of joining the insurer charging the lower premium, however, many older consumers might be more reluctant to move their insurance. If the insurers with higher risk profiles were driven out of the market, older consumers would join the insurer charging the lower premium. This insurer's average premium would have to rise to cover the higher risk consumers and another insurer with a low risk profile could pursue a predatory pricing strategy. Alternatively the insurer may not be willing to accept all of the high risk consumers and may opt instead to leave the market entirely or another possibility is that confidence in the market might be undermined causing some consumers to opt out of health insurance completely.
>
> (d) In the absence of other mitigating factors, the above scenarios are clearly not in the "best overall interests of health insurance consumers". The potential for them to arise stems directly from a significant difference in risk profiles existing in a community rated market with open enrolment and lifetime cover. The Authority is therefore of the view that the commencement of risk equalisation payments could be justified in the appropriate circumstances. However, the Authority recognises that intervention may not always be appropriate to address difficulties in the private health insurance market

and intervention is necessary the commencement of risk equalisation payments may not be the most appropriate or even an appropriate form of intervention to use.

(e) The Authority will need to be mindful of the likely effectiveness of risk equalisation in addressing any problems existing in the market and any potential harm in the commencement of risk equalisation payments may cause to the best overall interests of health insurance consumers. In this context the Authority will be particularly mindful of the level of competition existing in the market at the time and of the likely effect that risk equalisation would have on competition in the market.

(f) When considering whether or not risk equalisation payments should be commenced in the best overall interests of health insurance consumers, the Authority will therefore consider, *inter alia*, matters such as:

· the differences in risk profiles between insurers;

· the relative sizes of insurers;

· the age/sex profile of insurers' policyholders;

· the rate of premium inflation;

· the number of insurers in the market/new entrants to the market;

· the effect of any transfer on premiums payable by consumers;

· the overall size of the market;

· the effect of payments on the business plans or solvency of insurers; and

· the commercial status of insurers."

Please note that the use of the phrase "predatory pricing", in the extract has a meaning of aggressive pricing rather than the more conventional meaning of that phrase.

258. Evidence of Robert Parke
Mr. Robert Parke, a Principal and Consultant Actuary with the New York office of Millman, gave evidence on behalf of the applicants. Mr. Parke is a fellow of the Institute of Actuaries of the United Kingdom, is an associate of the Society of Actuaries in the US and is also a member of the Academy of Actuaries in that Country. He has worked extensively in health insurance in the United Kingdom and in South Africa and also in the US. He is unquestionably highly qualified. His role in this case was to advise BUPA on the following three issues referred to him by their legal advisors;

· An explanation of the mechanics of the formulae:

· The robustness of the calculation of transfer payments and deficiencies and/or anomalies in the formulae:

· The potential for the manipulation of the calculations by insurers.

As requested he prepared a report dated 12th September, 2005 and during the course of his oral evidence supplemented his views with a paper entitled "Application of the Risk Equalisation Scheme (RES) in a multi – product environment".

259. The other principal actuary involved in this case was Mr. Paul O'Flaherty, who is a world wide partner in Mercer and who is the Chief Executive of its Irish business. He is a fellow of the Society of Actuaries in Ireland and in the UK. He, and the team under him, have been involved in the health insurance business for several years and in particular have been the principal consultant to the Department for Health and Children, on health insurance regulation, since 1993. In that context he has been heavily involved in many of the papers and reports which have issued from that Department, including the Technical Paper (January 1999)and the White Paper (September 1999) He co-authored a major study on the financing of long term care in Ireland. He also participated in other health related projects for public and private sector clients. Moreover he was intimately involved in the preparation and finalisation of the Risk Equalisation Scheme.

260. In evaluating any conflict which has emerged in the evidence of Mr. Parke and Mr. O'Flaherty, a number of general observations can be made at the outset. Firstly Mr. Parke did not have, and did not claim to have, any direct experience of the Irish system; whereas, if one had to identify within this discipline, any one individual who was most familiar with the domestic structure, it would have to be Mr. O'Flaherty. Secondly, even allowing for Mr. Parke's lack of first hand knowledge of the Irish system, it was nevertheless still somewhat surprising, to discover that even for the purposes of his evidence written and oral, his familiarity with important elements of the system was not good. For example, he was not really *au fait* with the process which had taken place between say 1996 and 2003; he could not recall the mandatory requirements of s. 7 to 10 of the 1994 Act as amended, or the various factors which the HIA had to take into account when making a recommendation to the Minister; he relied upon the potential "inefficiencies" of Irish hospitals without having any reasonable knowledge of their workings; he was wrong, as a matter of fact, in making a number of criticisms, such as that the scheme equalised insurers claims costs in *total* (his emphasis) or that the MEP "was the central triggering mechanism" for the implementation of equalisation transfers. Furthermore he may very well have been reflecting the US situation when he indicated that the different preferment within hospitals for what constituted optimum treatment, was a driver of claims costs. Thirdly several of the matters raised by him as constituting "deficiencies" could not, on closer examination, be so described. Rather these particular features of the scheme resulted from a policy choice taken after careful consideration and close examination. These could not therefore be described as "defects" as such. Fourthly, and this is only a small point, he confused Plan "A" with Plan "E" when referring to the VHI luxury plan. Fifthly the scheme never sought to equalise 95% of benefits. Sixthly his concluded view, (perhaps indeed even the view itself), that the scheme in a multi-product market had a competitive bias against smaller insurers, only came to light during the course of his oral evidence. Finally in looking at this evidence it is important to recall, as I have said previously, that it is not a function of this court to try and create the best type of scheme (even if that were possible) or to determine which variation or adjustment may improve the existing scheme: rather its role is to decide whether the scheme as presented, can survive the legal challenge mounted to it on behalf of the applicants.

261. Before dealing with the individual criticisms of the scheme, as advanced by Mr. Parke, I should also say that his mistrust of the use of age and gender as predictors of risk, or as factors which are a predisposition to claims, is one which respectfully I do not agree with. The use of age and gender as the "primary" indicators of risk or of a disposition to claim, must be viewed against the background of the State trying to establish a feasible and functional Risk Equalisation Scheme, which endeavours to satisfy a multiple of components, some of which are competing and/or are asymmetrical one with the other. In fact Mr. Parke agrees that age and gender are indicators, but in his view are poor indicators as there may be other variable factors which influence risk and claims. Of course there are other factors, in fact multiple other factors, including such matters as morbidity, past health history, family history, location, salary, socio-economic group, education, environment etc. Indeed, in a risk rated world, these very matters would be utilised by an insurer as perhaps they would also be, if one was dealing only with a small cohort of persons. Individual cases with individual risk factors. But the Irish system is not risk rating and for its efficacy any scheme must try and cover about 50% of the population. With such a large group of insured people the tendency for randomisation is significantly eliminated. Therefore age and gender are in my view good proxies to use in this regard.

262. In 2001 Parkin and McLeod produced a study of Risk Equalisation Schemes which had developed in several countries throughout the world. Dr. Walker showed, in Table 10 of his report, the risk factors which were used in these countries. As can be seen age is universally included with gender being the next most common factor. Other indicators such as disability, religion, hospitalisation etc have a much less user frequency than age and gender. This is quite evident from the following reproduction of this Table:-

Table 10: International Risk Equalisation Factors

Country	Age	Gender	Disability	Region	Other
Australia	X				Hospitalisation
Belgium	X	X	X	X	Mortality, Unemployment
Colombia	X	X			
Czech Republic	X				
Germany	X	X	X		Income, Dependents
Israel	X				
Netherlands	X	X		X	
Switzerland	X	X		X	
United Kingdom	X	X			Prior utilisation, Local factors

263. Moreover, in my view, there is no evidence which points to a more accurate factor(s) than age and gender. It must be understood that for a scheme to be operational it must be workable. Age and gender are two obvious matters which are both observable and recordable. Others, such as prior history, geographical area of residence, education, etc, are much less obvious and are evidently capable of obvious manipulation. There is in addition significant evidence to establish that claims frequency rises with age. During the course of his evidence Mr. O'Flaherty handed in a table, marked as O'Flaherty "Exhibit 1", which was headed "age and gender as risk factors". In fact it was a reproduction of material used by Dr. Koboldt at p. 17 of his report. This demonstrates that when cross referencing each plan, with age bands, there was a definite increase in claims frequency as one travelled up such bands. For example, in the age bracket 30 to 39, when dealing with males there was a claims frequency in Plan B of .15% whereas with the same Plan, though this time using the age cell of 70 to 79 that frequency had risen to 0.6%, and in the bracket 80 to 90 it had risen further to 0.66%. The co-efficient of correlation and the co-efficient of determination are also given. Therefore I am satisfied that the criticism of Dr. Parke with the use of age and gender has not materially impacted on the cogency of the evidence adduced on behalf of the State.

264. In the following para. I set out the major criticisms made of the Scheme by Mr. Parke and by reference to the evidence of Mr. O'Flaherty my conclusions thereon;

(a) The Scheme fails to take into account the differences between insurers premiums or overheads:

This viewpoint in my opinion is misplaced and demonstrates, by way of sharp contrast, the difference between the role of a critic and the role of a designer and creator of a Scheme. The RES was not intended to equalise any factors other than risk. To do so would have resulted in a statutory intervention in areas such as product innovation, brand strength, pricing, marketing etc, when in fact it was though desirable to allow the greatest freedom possible to compete in these areas.

(b) That because premiums and overheads are not taken into account the dominant insurer could strategically follow a policy that would maximise both its premium return and also the extent of risk equalisation payments.

I do not accept the validity of this kind of strategy. Firstly it ignores the fact that 72% of VHI customers are on Plan B and 10% on Plan A and that overall, about 70% of its subscribers, aged 50 and over, are on these plans. Secondly, and as Mr. O'Flaherty says, given the limits which have been placed on the benefits which can be equalised, such a move would not make any financial sense, in that the anticipated payments would not be expected to cover the additional cost of claims

(c) That the Scheme equalises claims in total and secondly that the calculation is not carried out separately for each product line and type

Upper limits have been placed on what percentage of payments can be taken into account for the purposes of any financial transfers, and secondly no material consequences follow from the Scheme's preferred option of not having a calculation based on individual products and lines.

(d) The Scheme results in the lesser well off subsidising the more affluent.

The response of the State to this criticism, which I agree with, is as follows "As higher level plans have less healthy risk profiles the Scheme can give rise to notional or actual transfers between plan types. This phenomenon has

been characterised as cross-subsidisation. This is incorrect. What is simply happening is the equalisation of the effect of the differing risk profiles across the whole market and all plans (however, within the upper limits on eligible benefits). The less affluent to affluent subsidy point ignores the fact that the majority of the transfers relate to older customers (including retirees). It also disregards the effect of the limit on eligible benefits.

(e) The Scheme should have equalised benefits only at the level specified in the minimum benefit regulations.

If the State adopted this level for the purposes of risk equalisation, it would mean that only about 10% of the insured population would be included. This, evidently, would result in a dysfunctional and ineffective system. A policy decision was taken to equalise benefits at or slightly below the level of the most common benefits available in the market so that a substantial number of insurers would be involved. Accordingly this level becomes an "effective tool" for regulating the market whilst at the same time avoiding what might be described as the top end or luxury aspect of the plans.

(f) Efficiencies may be shared across the market:

There is no doubt but that such a possibility exists and that the framers of the Scheme were quite conscious of this fact. Safeguards were therefore put in place so as to reduce and minimise as much as possible this possibility. With regard to the prior utilisation measure, it would appear that in Ireland, perhaps unlike New York, the decision to admit to hospital and/or the duration of the resulting stay, are largely made by the treating physician and are not determined by plan type.

(g) The MEP is the central triggering mechanism.

This as a matter of fact is simply not so.

(h) The Scheme will have a major impact on the finances of the smaller insurer.

There is no doubt but that whatever insurer has the more favourable risk profile, the Scheme will operate in such a way as to effect the financial position of that insurer. Steps have been suggested as to how the impact could be ameliorated. In principle this Scheme works, and should work, without any dependency on financial positions.

(i) That in a group such as those over 80, where the numbers are limited, the Scheme is potentially volatile in respect of claims costs.

As explained by Mr. O'Flaherty, if for statistical reliability there are too few claims in any age and gender cell, then the market experience is substituted for the insured's own claims experience in that cell. He points out that the limit has been set at 20 bed nights for a six month period and gives the corresponding information in the case of the age and gender calculations. These are designed to create a balance in the very context in which this criticism is made. He has given evidence, which I accept, that the HIA has sought external actuarial advice on the above limits and have decided that in current circumstances these are appropriate and should remain.

(j) That the practice of using settled claims is inappropriate and is capable of manipulation.

This basis has been chosen because the information is available and can be verified. Whilst it is true that there is a time interval between the discharge or payment of a claim and its settlement, the consequences of this, in terms of the Scheme, are not significant and over time will have little, if any, impact on either providers or the Scheme. If however the integrity of the process should be questioned by this time lag, then the HIA has a role in observing this and in making the appropriate recommendations to the Minister.

(k) That the six monthly periods for making returns are inappropriate inter alia because of seasonal volatility.

I am satisfied that this is a reasonable period given the desire for the orderly conduct of business and the operation of the Scheme. Again, over time any seasonal effects will be ironed out and in any event the financial consequences would be quite small. If a settled claim is not paid in one six month period it will be included in the calculations for the following period.

(l) That the use of ten year age bands are inappropriate.

It is acknowledged that one could debate whether some other age band might have been used. The essential point however is that the 10 year bands would appear to be reasonable so as to ensure that sufficient information in each cell is available and secondly so that randomisation is avoided or minimised. The mere fact that another actuary has a different opinion on this point is in my view not of legal significance.

(m) The zero sum adjustment results in payments greater than the difference between the pre and post equalisation claims costs.

Unfortunately the "mathematics" of the Scheme means that the calculated amount of a payment in, may not be the same as or equal to, the amount paid out. This has been caused at least in part by the decision to leave insurers with their own claims costs but with a market risk profile. So when the post equalisation claims situation of all the parties are worked out the transfers in both directions will be equal. As the system must be self financing, a process, call the zero sum adjustment, is used to achieve this.

265. Dr. Koboldt's Evidence

Dr. Koboldt is a Director and Co-Founder of the Economic Consultancy firm DotEcon Limited, and he now advises on a worldwide basis, corporate and public sector bodies, in competition regulatory and other related fields. Previously he was a Managing Consultant with the economic consultancy, London Economics and worked as part of their competition and litigation teams. He was a research fellow

and lecturer in economics at the University of Saarbrücken, where he obtained his doctorate.

266. His essential findings, as articulated in both his report and in his oral evidence were as follows:-

(1) There was no justification for the Risk Equalisation Scheme;

(2) This scheme was anti-competitive, in fact potentially it eliminated competition, in that the transfers payable under the Scheme will protect the VHI and will act as a deterrent to new entrants;

(3) The Scheme acted as a disincentive to reducing costs and creating efficiencies, and as a result it will add to medical inflation which in itself is a real danger to community rating; and

(4) The Scheme in its operation had the effect of young people subsiding old people.

267. He outlined to this court his views on the complications which follow from a process, known as adverse selection (which results in an insured being obliged to set a premium which reflects the average risks of the insured population), as well as his belief that the level of cover taken out by a person affects the behaviour of that individual's propensity to claim. He demonstrated the point about adverse selection by illustration and gave several examples, based on different assumptions, as to how the operation of this practice could affect the availability at affordable prices, of medical insurance to persons interested in acquiring that product. Likewise with regard to how a person behaves in the knowledge that he/she has cover against certain losses. It is likely that the taking of precautionary measures, which such a person may voluntary take to reduce risk, would be less than those adopted by a person who had no indemnity against risk. In the health system this type of reaction is usually demonstrated, not by way of "risk taking behaviour", but rather by the level of care which is sought and demanded. This in his opinion has an important bearing on the use of claims costs when assessing the risk profile of the insured population.

268. Having discussed risk rating as a response to adverse selection, which is not allowed by the 1994 Act, he then spoke of the difficulty created by this concept, in the context of an insured being able to offer a choice or menu of policies. If such are on offer, customers will self select according to their risk characteristics. Therefore it is alleged that those with a lower probability of making a claim will choose a cheaper policy even if the benefits on offer are restricted. The converse will also apply. However he warned that getting the mix of policies right was a difficult and complicated task. He was firmly of the opinion that the Risk Equalisation Scheme did not fully take customer self selection into account.

269. In a competitive market, Dr. Koboldt's view was that there was no reason to believe that providers will compete only for "low risk"; rather he said that there were incentives to compete for those customers who are paying a premium above the cost of their cover. Reliance was placed on information extracted from the Harvey Report to support these general points, including the information on distribution of population throughout plans, and the claims frequency, of both males and females by age and again by plan.

270. This data unquestionably shows that apart from a high claims frequency for females in the 30 to 39 age group (most likely explained by maternity claims), claims increase with age; thus suggesting that whilst it is not the only indicator of risk, age might be a "relatively good indicator of risk".

271. At para. 62 of his report, he uses information from the April 2005 HIA Report, when setting out the age distribution of the insured population of both the VHI and BUPA. For present purposes it is sufficient to state that up to age 50, the respective percentages are 86.5% (BUPA) and 70.8% (VHI) and for those over 50, 13.7% (BUPA) and 29.3% (VHI). He claimed in this context that differences in risk profile, which are linked to differences in strategy and policy mix, do not confer a cost advantage.

272. In summary, on this part of his evidence he relied heavily on self selection as being an important tool in this market, as he did on the availability of a choice of policy. He said that the operation of these will result in the separation of risk. In addition he concluded that self selection was a factor which explained differences in the claims profile of insurers with the other major event being a person's behaviour. Moreover he was satisfied that new entrants, who were likely to focus on low risk customers, did so, not because such a cohort would result in lower claims costs but rather because such a group had being faced with higher prices from the established incumbent.

273. On the question of whether the Risk Equalisation Scheme is necessary to support community rating, he rejected the various supporting views, which were recorded in the Harvey Report. He described the underlying basis, put forward to justify this scheme as being "naïve". Passing over his analysis of the Scheme in a risk rating world, he then discussed Risk Equalisation in a market where risk rating was prohibited, but crucial to this part of his analysis was his insistence that community rating had a s. 7 meaning only.

274. In summary he rejected the view that an insurer had any incentive to cherry pick or that any adverse consequences would result from the operation of various design or targeting devices. Whilst he acknowledged that insurers may have a preference for low risk customers, his view nevertheless of the legal situation was that, this could not occur within the statutory framework of the 1994 Act. Consequently given the requirements of community rating, open enrolment and lifetime cover, insurers could not be believed, prevent high risk clients from being attracted to policies predominantly aimed at the low risk. Moreover any transfers under the Risk Equalisation Scheme would weaken the competitive process and would protect the incumbent. Therefore in his concluded opinion there were no reasons which could justify the risk equalisation scheme.

275. Dr. Koboldt, relying on the "weaknesses" of the scheme as identified by Mr. Parke, suggested that risk equalisation deterred entry and potentially forced incumbents to exit the market. In addition it significantly distorted competition and reduced any incentive for cost efficiency; in fact it obliged a new entrant to share efficiencies with the incumbent, and thirdly, it gave rise to what he called "regressive transfers".

276. The witness then argued that differences in risk profile, resulting from the exercise of customer self selection in a multi menu market, did not confer any advantage on an insurer with a higher proportion of low risk. Apart from customer inertia, there was no other reason for differences in risk profile. What RES in fact was doing, was penalising new entrants who must attract low risk clients in order to overcome existing entry barriers. For example BUPA have had to offer significantly lower prices in order to attract its cohort of clients. He said that the differences between insurers risk profile, as measured across their entire customer base, was matched by differences in the available premium per customer. There was therefore no need for the scheme.

277. In support of the opinion that the scheme was a deterrent to new entrants, he relied on the submissions of the Competition Authority given in response to the HIA's consultative paper. He also referred to the Harvey Report. The effect of the suggested scheme would be to enhance the "dominance" of the existing incumbent.

278. In summary he claimed that community rating, with a s. 7 definition, was not under threat from competition and there were no fears of market instability. He said that the main reason for differences in risk profile resulted from the differences in the mix of policies on offer, and there uptake, through the practice of customer self selection. In practice, given the requirements of ss. 7 to 10 of the 1994 Act, the scheme was not necessary to support community rating and in any event over time, competition would equalise the risk profile of the various health insurance providers in this market. However because of customer inertia, an incumbent may have to retain a high risk profile for a period whilst at the same time having to compete with the new entrant for low risk policy holders. He continued by suggesting that the advantage given to a new entrant, to attract the low risk, will be disapplied when the scheme comes into existence and will inevitably further enhance the position of, in this case, the VHI. In any event any advantage which a new entrant may have in this way had to be looked at against the overall package of the structural support available to the VHI. Moreover he emphasised the importance of customer self selection and that RES will harm competition in the manner above described. Finally it operated as a disincentive to reducing costs and creating efficiencies.

279. There are a number of general observations which can be made on Dr. Koboldt's evidence. In the first place, he offered a view that community rating, in the sense of community rating within plan (or the s. 7 definition) did not require a risk equalisation system to support it. There is no dispute about this proposition. However, his report and his evidence, are crucially defective in this central area because both proceeded on a basis that community rating had no meaning other than that as just described. Therefore a great deal of his evidence is virtually redundant given my finding on the correct legal meaning of community rating for the purposes of s. 12 of the 1994 Act, and of course for the purposes of the risk equalisation scheme.

280. Secondly he criticised, what he said had been a failure of those who framed the scheme to take due cognisance of customer self selection and accordingly the justification offered for res was deficient in this regard. In particular Dr. Koboldt was referring to the targeting of would-be customers through product design, as distinct from the use of marketing techniques. In my view this is not so and there is ample evidence to prove that the State was fully conscious of the potential impact of plan design. For example, at para. 4.6 of the White Paper, the following is stated:

> "Without risk equalisation, each health insurer will have a strong incentive to target low risk individuals (preferred risk selection) so as to be able to charge a lower community rate or take a higher profit margin than its competitors. Even with compulsory open enrolment, health insurers could seek to achieve a better risk profile by, for example, selective marketing techniques, targeting group occupational schemes, benefit design or selective quality service. Although insurers may not deliberately set out to attract healthier than average individuals, this could still arise because it is these individuals who tend to be more willing to consider moving between insurers. Any process whether deliberate or accidental, which gives rise to significant differences in risk profiles between insurers is knows as risk selection."

281. In paras. 63 – 65 of his report, Dr. Koboldt said that there was no cost advantage in respect of differences in risk profiles which were linked to differences in commercial strategy and policy mix. What only became clear on cross-examination was that this statement was but a stylised example built on several assumptions, all or virtually all of which were absent to the Irish market. The model thus created was not realistic in the domestic context. (See day 24, p. 9). Therefore Tables 6 and 7 have little real relevance to our situation. In any event, what he was really saying was that, if two insurers offered similar policies and attracted similar risk profile by virtue of these policies, neither would obtain a cost advantage. But, as he conceded, a cost advantage would in fact arise if there was a difference in risk profile in respect of those on the "low benefit" policy, as understood in the context of the example under discussion. In addition, when one looks at para. 163 of his report, it would appear to contain an example, inconsistent with his main point, of where differences in risk profile can enable an insured to lower its premiums as against its rival and in that way to get a cost advantage.

282. Dr. Koboldt did not deal with price following, in any effective way with the relevant section of his report (para 136) containing only a passing reference to this subject. This is surprising given the number of references to price following in the documentation and in particular in the papers produced by the HIA, some of which even preceded the making of the scheme. If price following should exist, the market could be described as being anti-competitive and that element in itself would further delay any equalisation which might result from market forces. In any event, the suggestion that without intervention, equalisation would occur through self selection and a choice of plans is not borne out by the evidence as self selection is not a decisive tool in this regard. Moreover this suggestion, even if correct, is not in my view capable of producing any real or concrete benefit in that the most optimistic time period mentioned is several years. In addition "inertia" which exists in this market would further inhibit any timely benefits obtainable from market force.

283. There seems little justification for the conclusions which this witness has reached on the material which appears in Table 20 of his report. Or to put it more accurately, to arrive at any conclusion of value, as to how many price reductions are necessary so as to create a percentage probability of people switching, would depend on the actual conditions of a real market and not on the assumptions made. Whilst I accept that self selection will not only attract low risk but will also attract some high risk, nevertheless I am absolutely satisfied on the evidence, that an insurer, by clever marketing techniques, can substantially increase the probability of getting a very significant percentage of its targeted group. Typically this will result in the separation of health risks, and depending on success, the process can probably lead to a health provider having a significantly different (better) profile from that pertaining in the market generally. In my view, in a market system which prohibits the charging of a premium to reflect the actuarialised cost of a claim, the greater the percentage of low risk which an insurer has the more attractive will be its resulting claims costs. That being so it is difficult to see what incentive there is to actively pursue old people.

284. Dr. Koboldt in support of the acceptability of self selection, referred to what had been the practice of the VHI in this regard prior to the 1994 Act. In effect, he said that this body, by the manner in which it conducted its business, encouraged self selection. In light of the evidence of Mr. Armstrong, who is an actuary with the VHI, I cannot accept that the latter ever had a policy of self selection. In his affidavit, Mr. Armstrong traces the history of all VHI plans, and gives a reasonable and coherent explanation for the public offering of each such plan. Moreover, given the statutory prohibition against profit taking, and the practice of inter-generation solidarity, I do not believe that the VHI had been motivated by, or had adapted the monopolistic practice of maximising profits, either by its premium rate or by the design of its plans. Accordingly that much of Dr. Koboldt's evidence which was based on this supposed practice of the VHI is not in my view relevant in the past 1994 world.

285. In this context it is worth concentrating a little more on the evidence of Mr. Armstrong. At para. 17 of his affidavit he refers to the suggestion made by Dr. Koboldt that the customers in Plan 'A' possibly pay 60% more than the average claims cost of that group, whereas those on Plan 'B' pay only about 3% more. This, according to Dr. Koboldt, is typically what one would expect of a monopoly.

286. This conclusion is rejected by Mr. Armstrong and I accept his reasoning in this regard. He said that the differences in mark up are due to the implementation of community rating, that is where the young people (healthier people) offer support to the older people (less healthy people). In fact those on the more expensive plans contribute a greater proportion of the cost of providing cover

to themselves than the high-risk subscribers in VHI's lower benefit plans. In table 4.2 of his affidavit he compares three sets of prices, the actual premiums charged for each plan, the premiums that could "actuarially" have been properly charged, on such plans and the premiums that would have been charged if actual risk equalisation had been applied. By the use of these figures Mr. Armstrong says that:

> "at one end of the scale the actual premium charged to subscribers to Plan 'A' … exceeded the cost of their average actual cost of claims by IR£45 whereas full risk equalisation within VHI's own membership would have justified charging a high premium to Plan 'A' subscribers – exceeding their actual cost of claims by IR£85 rather than IR£45. On the other hand subscribers to Plan 'E' were charged premiums discounted by IR£83 against their cost of claims whereas a full application of risk equalisation would have justified a premium discounted by IR£200 against their cost of claims. Far from over crediting Plan 'E' high-risk subscribers therefore, VHI's premiums gave subscribers for less comprehensive plans, relief against what an internal risk equalisation process would demand. VHI's approach was the reverse of what Dr. Koboldt suggests which would have been that of a monopolist."

In this context could I also refer to paras. 21 to 25 inclusive of Mr. Armstrong's affidavit where he deals with regressive transfers and adverse selection, and does so in such a way that leads me to accept substantially his evidence over that of Dr. Koboldt where conflict exists between both. See also the evidence of Mr. Sheridan who is the Chief Executive of VHI. Finally I cannot accept Dr. Koboldt's view that there is no incentive to cherry pick and that the same would have no consequences for the market in light of the statutory framework.

287. Dr. Walker and Dr. O'Toole, both economists, were called as witnesses on behalf of the respondents and notice party respectively. In substance the following are matters on which they gave evidence and with which I substantially agree. In a community rated market, which is underpinned by open enrolment and lifetime cover, the concept of inter-generational solidarity works in that young customers continuously subsidise the medical cost of older customers. When the young customers in turn become old, the next generation will perform this task. In a market, with more than one health insurance provider, a new entrant would be expected to search for and attract predominantly people who have not availed of PMI up to then; in essence this would be the younger generation. As these people, as a group, are relatively good risk, the cost per claim per customer is relatively low. That being so the new entrant has a choice to make. He can price his premiums at or immediately below the community rated premium and in that way can earn excessive profits. This is not a result of efficiencies but is entirely due to the risk profile of its customer base. However in such a scenario the customer pays more than what he should.

288. The problem for the incumbent in such a process is that it attracts fewer young people and thus will have less, by way of subsidisation, to cover the costs of the older, unhealthier element of its population. It will therefore have to raise its prices. This will also harm its customers. Moreover in such circumstances the new entrant has a further choice to make, and in this regard could also increase its prices but still pitch them at or immediately below that charged by the incumbent. In all such situations the consumer is worse off.

289. Accordingly to Dr. Walker, whose evidence I generally prefer, the Risk Equalisation Scheme was designed to undo the unacceptable consequences of this situation. Some of these, which include cherry picking and could include shadow pricing, could result in a death spiral occurring and thus creating enormous market instability. This evidentially would be catastrophic for the consumer and would have serious knock-on consequences for public health and public finances.

290. Risk equalisation is solely concerned with equalising differences in risk profile and uses age, gender and the utilisation of bed nights as proxies in this regard. It does not in anyway reward failure or inefficiency and the size of transfers are not driven by these factors. Moreover the scheme as established will encourage the greatest possible competition in all areas other than risk profile. There is no doubt, according to the evidence of these economists, that with the particular statutory framework of the Irish system, this market is potentially unstable without risk equalisation. The scheme is therefore absolutely necessary to support the present system. Moreover it is fair, reasonable and proportionate and the respondents evidence has not undermined this view.

291. During the course of this case an issue was canvassed as to whether or not the practice of BUPA since its entry into this market has been to shadow price or price follow the VHI. The evidence shows that the percentage increase between September 1998 and March 2005 has in both cases been approximately 98%. It has strenuously being argued on behalf of BUPA, that it is misleading to use this figure in this way as it does not take into account the time gap between the respective insurers price increases or the date of BUPA's entry into the market. It is said that when the figures are adjusted for these matters there is a 26% differential. In my view there is evidence to suggest, that at least on occasions throughout this period, BUPA has adopted a practice, which if technically not price following, is something very close to it. In September 1998 the VHI raised its premiums by 9% as it did in September 1999. In the following February, i.e. February 1999 and also in February 2000, BUPA increased its prices by the same percentage figure. In February 2001 the incumbent imposed a 6.25% increase with a 9% increase occurring in September of that year. In March 2001 BUPA increased its prices by 6.25% and in March 2002 by 9%. Its increase in March 2003 was 4% less than the 18% imposed by the VHI. There was relatively no difference between the September 2003 figure of 8.04% for the VHI and the March 2004 figure, being 8.25% for BUPA. In September 2004 the VHI, for reasons which it explained, charged only a 3% increase whereas BUPA charged 6%. This level of increase by BUPA is in my view significant, as it is inconsistent with their suggestion that the parity of increases was largely due to the similarity of input cost. The cost of public beds increased greatly in January 2005 and yet that was not reflected in BUPA's increase. In that regard I do not accept the explanation offered by Mr. O'Rourke. I therefore believe that there is evidence, at least a strong suspicion, that BUPA has shadow priced the premium policy of the VHI.

292. Another issue which arose was whether or not it could be said that BUPA was earning super profits in this market. The figures in respect of this submission are given above and on their face show, that if one also takes 2001 into account, BUPA's average underwriting profit, as a percentage of earned premium, in the relevant four year period, was 18.25%. This was substantially above the comparable figure for the VHI. In their defence BUPA have suggested to the HIA that by comparison with non life insurers in this country this level of profit was not excessive. That explanation however fails to take into account the volatility of the non life business and in any event by its nature, such a business is not directly comparable. Indeed, a much more meaningful comparison would be the return made by its parent company in the UK which is about 5 or 6% annually. Again therefore whether one technically describes this level of profit as being a "super profit" or not, it is evidentially clear that the percentage earned by BUPA is substantially in excess of any other relative indicator in this sector.

293. The Government has decided that a core principle of private health insurance in this country should be community rating across the market. In addition it has legislated for open enrolment, lifetime cover and minimum benefits. The belief is that this system is for the general good and will result in all persons, irrespective of health status, age or gender, being able to obtain cover at affordable prices. The objective of risk equalisation, as has been repeatedly stated, is to support this community rating -across the market. It does so by way of inter generational solidarity. The State's belief is that without a risk equalisation scheme there are potential vices

which could seriously disturb the ordinarily functioning of this type of system. In fact, full support for the attachment of a risk equalisation scheme, with such a system is forthcoming from several international studies as well as from a variety of other expert opinion. The report of the Advisory Group is clear-cut in the necessity for a risk equalisation scheme. As referred to earlier in this judgment, the report also quoted similar supporting views which it had received from many of those who made submissions to it during the course of its work. The White Paper comprehensively endorses the Government's position on this regulatory framework. Mr. Barrett in his affidavit evidence repeated the objective of the scheme and the justification therefor. He referred to the danger of cherry picking which in my view is a real danger and is capable of leading to the existence of a significant difference in risk profile between insurers. Community rating and open enrolment are not in themselves sufficient to guard against this. Risk selection, consciously or sub consciously can lead to this undesirable result. Such a situation is not sustainable even in the immediate term. It can lead to practices such as shadow pricing, excessive profits and more sinisterly a death spiral resulting in market instability. For the purposes of this case it is not essential to determine the precise academic parameters of what constitutes a death spiral. In my view there is sufficient evidence of a compelling nature to support this possibility occurring. There cannot be an obligation on the State to defer corrective action until the presence of a worst case scenario is established. In my opinion therefore, the availability of a risk equalisation scheme, which depending on circumstances may or may not be activated, has been in principle justified as being a necessary measure to underpin the operation of the regulatory regime in this country. There is no doubt in my mind but that a collapse of the private market would heavily impact on the availability of public health services. Therefore the creation of a risk equalisation scheme, pursuant to s. 12, is in my view a pressing and substantial need in a free and democratic society. I believe that the provision of such a scheme, (in a regulated market) and its impact on the property rights of BUPA is a regulation of the exercise of those rights in accordance with the principles of social justice and that the limitations placed on such rights are essential in the common good. Such rights are not absolute and their exercise may be curtailed when balanced against the common good. (See paras 242 – 245 supra).

294. The State has always put forward, as a justification for this scheme, the maintenance of community rating. In this regard much has been made of the phrase inter-generational solidarity. In my view this expression is purely descriptive and helps to explain a means by which such community rating in fact operates. It is no more than that and otherwise the correct statutory phase is 'community rating across the market'. In any event Mr. Barrett evidence is that community rating across the market, and the stability of private medical insurance in this country would be extremely vulnerable without risk equalisation. A scheme is therefore essential to remove the incentive of insurers to target young people, and in that way to drive their own profits, rather than to concentrate on creating efficiencies in the many areas still open to them.

295. In the context of justification the State aid decision of the Commission, dated the 13th of May 2003 although given under Article 87, is highly relevant for its views on the necessity and proportionality of the risk equalisation scheme. Full support for the position of the respondents on the necessity of the scheme, is evident from the contents of para. 50, which speak, of the operation of risk selection either by design or by accident, of the disparity in claims costs if in fact an insurer should be left with a higher proportion of the less healthy individuals than its competitor, and of the possibility of significant market instability leading to an erosion of public confidence. At para. 52 it concludes that RES "is necessary to underpin the principles enforced by the Irish authorities …It ensures that risks are shared appropriately across the market and allows for a level playing field in respect of the particular constraints of the Irish system. If, as an alternative the Irish PMI market were risk rated, the RES would not be necessary".

296. The decision also deals with the proportionality of the scheme in paras. 53 to 59 inclusive. It agrees that the design of this scheme restricts payments to what are "strictly necessary" to neutralise the differences in risk profiles. Moreover as part of its proportionality analysis, it refers to the criteria which must be met before the scheme is activated and in particular to the role of the HIA's as well as the Minister's, which varies depending on the threshold which the MEP should be at, at any given time. Moreover it highlight to the level at which benefits were equalised and comments upon the exclusion of the luxury elements of the VHI's plans. In addition it points out that an insured was able to retain its own claims costs with the resulting benefit which that entailed. The exclusionary period for new entrants and the phasing in time thereafter were also mentioned. It concluded therefore that the scheme had passed both the necessity and the proportionality test. With this conclusion I respectfully agree.

297. For the reasons above given I am satisfied that the respondents have discharged the justification and the objective justification test which they must in order to succeed in defending these proceedings. Moreover the impact upon BUPA's constitutional rights are required within the terms of Article 43 and therefore do not amount to an unjust attack under Article 40.3. In conclusion therefore I dismiss these proceedings.