Goodbody
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# Improving the Regulation of Private Health Insurance

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# Key Findings and Conclusions

The regulation of private health insurance, just like the regulation of any other industry, should have only one aim, the protection of consumer interests. The current regulatory regime for private health insurance in Ireland is based on two ideas, both of which are intended to benefit consumers. These are:

- **Competition**. The system introduced in 1994 aims to maximise consumer welfare by introducing competition in the provision of private health insurance. This could bring huge benefits to consumers of health insurance and to consumers of health care in general.
- **Community Rating**. Private health insurers are obliged to insure all applicants regardless of age or health status, and to apply the same premium rates to all customers regardless of their age and health status. This is one way of trying to ensure that affordable private health insurance is available to all.

A lack of regulatory action to promote competition, coupled with misguided use of the risk equalisation payments that are meant to protect community rating, has led to a crisis in private health insurance. The benefits of competition have never been fully realised for consumers.

## Absence of Competition

Since the theoretical opening of the market in 1994, competition has been smothered by the presence of the VHI, which:

- Enjoys a position of dominance with a market share consistently above 80 per cent[1]. A 40 per cent market share is normally enough to consider a firm dominant;
- Is not required to make a profit. The money value of this advantage is some €61m per annum; and,
- Is not required to maintain solvency reserves. The money value of this advantage is equivalent to a €148m capital grant;

In 2005, competition was further undermined by the decision to require new entrants to make risk equalisation payments of some €31m to VHI. This made it impossible for BUPA to make a profit in the Irish market (a fact acknowledged by the High Court). BUPA's parent left the market, selling its Irish business to the Quinn group. There is a clear risk that the benefits of competition will never be realised for Irish consumers.

[1] Market share based on premium income, which is a good measure of market power relative to competitors. VHI has a market share of over 77 per cent in terms of policy holders.

## Lack of Pro Competition Action

Experience in telecoms, energy, air transport and postal services shows that it is not enough to simply allow new entrants to enter an area that was previously a legal monopoly. The significant benefits of competition for consumers can only be realised if there is active enforcement of competition law. In addition there is a need for sector regulation where the incumbent is regulated for the benefit of consumers and is obliged to facilitate new entrants. Uniquely, the HIA has been given the task of protecting the incumbent. The role of the sector regulator should include:

- Maintaining access to essential facilities, in this case equal access to information on current and past private health insurance policy holders. VHI's unique position gives it access to information on many of the current policy holders of its competitors. This imbalance needs to be corrected by giving competitors access to VHI customers.
- Guarding against predatory behaviour by VHI. VHI's size and ability to run down its reserves could allow it to drive a competitor out of the market with a predatory strategy.
- Guarding against price discrimination and other forms of exclusionary behaviour. VHI is unique in having a legacy group of long standing, older policy holders who hold high premium, high benefit policies. The existence of this group reduces the cost of community rating for VHI. However this is not reflected in the calculation of risk equalisation payments. The net effect of this is to place VHI's competitors at a severe cost disadvantage. VHI also operates two ranges of polices: its original range which is favoured by its legacy customers, and a new range targeted at those buying health insurance for the first time which competes directly with the offerings of VIVAS and BUPA. The relative pricing of VHI's two ranges can place its competitors at an unfair competitive disadvantage.

## International Comparisons

Private health insurance markets are normally not community rated, and are subject to a great deal of competition. There are a few markets where private health insurers are subject to community rating. All of these have a large number of competitors, and there is no risk of risk equalisation harming competition.

## Urgent Action

The current situation represents a failure of the regulatory system for private health insurance. Urgent action is needed to preserve and expand competition and so benefit health insurance consumers and all consumers of health care. These actions pose no threat to the consumer benefits secured by community rating. Therefore, Government should:

- Suspend risk equalisation while VHI enjoys significant other regulatory advantages which obviate any need for risk equalisation payments;
- Clarify the situations where risk equalisation will be implemented in future. These should be confined to situations where predatory behaviour is taking place and threatening the viability of an insurer. This is the only situation where community rating is threatened and risk equalisation payments can address that threat;
- Amend the risk equalisation scheme so that when payments are required they will be scaled back in response to the lack of competition in the market. For example, risk equalisation payments could be scaled back to the extent that the market's HHI exceeds 1800, the usual threshold for a market to be considered fully competitive;
- Remove the anomalies in the calculation of risk equalisation payments that bias the scheme in favour of VHI e.g. the treatment of higher priced plans that are predominantly used by older policy holders; and,
- Actively promote competition through active sector regulation, based on concepts from competition law, which ensures effective competition against VHI.

# Executive Summary

## Introduction

In December 2006 VIVAS Health engaged Goodbody Economic Consultants to review the current regulatory structures in place in the private health insurance market in Ireland, identify any shortcomings and propose reforms that could safeguard consumer choice in the market, while continuing to preserve the other public policy objectives of the regulation of private health insurance.

## Competition and Consumers

The benefits that have already come from the emergence of two alternatives to VHI, and the potential future benefits of choice in health insurance, make it clear that choice should be preserved and extended in the health insurance market. The current system of regulation has led to a slow rate of entry to the market and the possible exit, and subsequent sale of one of the two new entrants.

## Lessons from Insurance Markets Abroad

The Irish approach of regulating private health insurance to achieve social ends by imposing obligations such as community rating open enrolment and lifetime cover is relatively unusual. Only four comparable systems could be identified world-wide for this review. In all of these markets (Australia, Switzerland, some states of the US including New York, South Africa) the state of the market is such that the risk equalisation payments pose no threat to competition.

## Identification and Evaluation of Options for Market Reform

A number of complementary approaches to reform exist.

The role of the Health Insurance Authority, or any other regulator of the Health Insurance market, should be broadened to include a mandate to foster competition in the market. The regulator should prevent anti-competitive conduct such as predatory pricing, discrimination or other exclusionary conduct by VHI. In addition, the regulator should impose "essential facility" type obligations on VHI to facilitate competition from new entrants e.g. some form of access to VHI's policy holder lists for competitors.

The impact of risk equalisation on competition needs to be reduced or removed. Methods to achieve this include:

- Narrowing the conditions for implementing risk equalisation to clear evidence of predation by a new entrant threatening the future of VHI;
- Suspend risk equalisation until VHI is subject to the same regulatory regime as other health insurers;

- Scale back risk equalisation payments to reflect the extent to which the market is not fully competitive.
- Correct omissions in the current system such as the absence of loading for late entry, and remove anomalies such as the treatment of high price plans.

## Conclusions and Recommendations

Urgent action is needed to preserve and expand competition and so benefit health insurance consumers and all consumers of health care. These actions pose no threat to the consumer benefits secured by community rating.

- Suspend risk equalisation while VHI enjoys significant other regulatory advantages which obviate any need for risk equalisation payments;
- Clarify the situations where risk equalisation will be implemented in future. These should be confined to situations where predatory behaviour is taking place and threatening the viability of an insurer. This is the only situation where community rating is threatened and risk equalisation payments can address that threat;
- Amend the risk equalisation scheme so that when payments are required they will be scaled back in response to the lack of competition in the market. For example, risk equalisation payments could be scaled back to the extent that the market's HHI exceeds 1800, the usual threshold for a market to be considered fully competitive;
- Remove the anomalies in the calculation of risk equalisation payments that bias the scheme in favour of VHI e.g. the treatment of higher priced plans that are predominantly used by older policy holders; and,
- Actively promote competition through active sector regulation, based on concepts from competition law, which ensures effective competition against VHI.

# 1. Introduction

## 1.1 Context and Terms of Reference

Recent events have focused public attention on the private health insurance market. BUPA Ireland, the second largest private health insurer responded to the commencement of risk equalisation by announcing its departure from the Irish market. The BUPA business in Ireland was subsequently bought by the Quinn group. This competitor is referred to as "BUPA" throughout this report. On 17th January 2007 the Minister for Health and Children announced the formation of an independent group to carry out a business appraisal of the private health insurance market. The main task of this group is to determine whether "an adequate rate of return is available in the Irish health insurance market to insurance undertakings in current conditions." This determination will have to include looking at the current regulatory arrangements in the private health insurance market, in particular, at the current form of risk equalisation.

In December 2006 VIVAS Health engaged Goodbody Economic Consultants to review the current regulatory structures in place in the private health insurance market in Ireland, identify any shortcomings and propose reforms that could safeguard consumer choice in the market, while continuing to preserve the other public policy objectives of the regulation of private health insurance.

This report documents the results of that review.

## 1.2 Approach and Layout of Report

Section 2 of this Report provides a context for this review by outlining the main steps in the development of the private health insurance market in Ireland and describing the regulatory regime currently in place. Section 3 sets out the key role that consumer choice has played in the development of the private health insurance market, and the importance of maintaining and increasing this level of choice in the future. An overview of the regulatory system in place in comparable markets around the world was prepared for this study. This overview is set out in Section 4 of this Report. The key results of this study are set out in Section 5, where the range of options available to restructure the regulatory regime for private health insurance in Ireland is described. Section 6 concludes this Report, summing up the results of the study and recommending next steps.

# 2. Development and Current State of the Insurance Market

## 2.1 Development of the Private Health Insurance Market

Private health insurance was introduced into Ireland in 1957 with the establishment of the Voluntary Health Insurance Board ("VHI"). The VHI is a non-profit statutory corporation established by the Voluntary Health Insurance Act of 1957. It is managed by a board of directors appointed by the Minister for Health and Children. VHI is a non-profit organisation that provides private health insurance to its subscribers on what it describes as a "mutual assistance basis".

VHI enjoyed a legal monopoly in the provision of private health insurance in Ireland until the adoption of the Health Insurance Act 1994, which implemented the EU's Third Non-Life Insurance Directive of 1992. Following this opening of the Irish private health insurance market, BUPA Ireland ("BUPA") entered the market in 1997, and VIVAS Health ("VIVAS") entered the market in 2004.

The market for private health insurance has expanded enormously since 1957. The VHI was originally intended to provide health insurance cover for the 15 per cent of the Irish population who were then excluded from public hospital services on grounds of income. In its first year of operation, it had just over 23,000 subscribers. Subsequent changes in the Irish economy and society have radically increased the significance of private health insurance. After nearly 50 years of continuous growth, VHI[2] now has 1.56m subscribers. BUPA provides health insurance to approximately 430,000 subscribers. VIVAS has a significantly smaller subscriber base as a recent entrant to the market. In total, some 51 per cent of the Irish population now holds private health insurance[3].

The introduction of consumer choice in 1997 has led to led to a revolution in the range and flexibility of private health insurance available to the Irish public. For the 40 years prior to the introduction of consumer choice, VHI offered what was effectively a single product, which did not change throughout the period. Policy holders who contracted an illness requiring hospitalisation were covered for the cost of attending a specialist doctor or surgeon as a private patient, and for the cost of "private" accommodation in a hospital. Policy holders were spared the waiting periods for hospital treatment imposed in the public medical service. The only element of consumer choice related to the type of hospital accommodation covered. For most of the period three options were available:

- "Semi-private" accommodation in a public hospital;

[2] The number of VHI policy holders has increased every year since 1957, with the exception of 1986.
[3] York Health Economics Consortium "Assessment of Risk equalisation and Competition in the Irish Health Insurance Market" November 2003. Available at www.hia.ie/publications/riskequalisation/index.html

- "Private" accommodation in a public hospital or "semi-private" accommodation in a private hospital; or,
- "Private" accommodation in a private hospital.

In 1984 a new type of high technology private hospital was introduced in Ireland with the opening of the Blackrock Clinic. VHI responded to this by adding two further options for the level of hospital accommodation:

- "Semi-private" accommodation in the Blackrock Clinic or the Mater Private Hospital; or
- "Private" accommodation in the Blackrock Clinic or the Mater Private Hospital.

The advent of consumer choice in private health insurance with the arrival of the first new entrant (BUPA) in 1997 has led to a wave of product innovation. Consumers can now choose from a broad range of health insurance policies offering a range of types and levels of cover. Health insurance products now include features that are appreciated by consumers, and that act in the common interest of consumers, insurers and society as a whole, by promoting preventive medicine and good health in general. The innovations and improvements introduced include:

- **Maternity Cover**. Although VHI has offered limited cover for maternity expenses since 1978, the level of maternity cover available from all insurers has expanded significantly since the introduction of consumer choice[4].
- **Primary Care**. Since the introduction of choice to the private health insurance market,it is now possible to obtain insurance for visits to general practitioners and other primary carers such as physiotherapists.
- **Alternative Therapies**. The new entrants to the market for private health insurance introduced cover for alternative and complementary treatments such as acupuncture, massage, reflexology, homeopathy and physical therapy. These broaden the range of healthcare options available to the insured public.
- **Health Checks and Preventive Medicine**. New entrants to the private health insurance market introduced the innovation of reimbursing the cost of regular health checks. In some cases free health screening is provided as a promotional offer. New entrants also pioneered actively promoting a healthy lifestyle for their subscribers by providing information and other supports to actively improving health rather then just responding to illness. This promotion of health is to the mutual benefit of insurers, their subscribers and society as a whole.

[4] From conversation with VIVAS executives.

As is typical in a market with consumer choice, VHI has responded to all of these innovations by new entrants. In some cases VHI has devised innovative new offerings that build on those offered by new entrants. In this way the benefits of increased consumer choice are enjoyed by all consumers of private health insurance. These consumers now enjoy a wider choice of packages and providers, and can choose a private health insurance product suitable for their personal needs and preferences.

Although VHI has responded to the opening of the health insurance market by improving the range and quality of its products, it has also acted in ways that have harmed consumer choice. VHI will only reimburse its members for care in facilities "approved" by it. On at least some occasions this approval may have gone beyond an assessment of the nature and quality of care offered by the facility. There have been reports of the VHI refusing approval to a facility on the grounds that it represents surplus capacity, which is properly speaking irrelevant to the VHI[5].

## 2.2 Regulatory Obligations of Private Health Insurers

The 1994 legislation that introduced the possibility of consumer choice into the private health insurance market also established a set of rules to govern the provision of private health insurance in Ireland[6]. These rules impose a set of three obligations on providers of private health insurance. These obligations reflect the social role played by private health insurance in Ireland. They are: Community Rating; Open Enrolment; and, Lifetime Cover. These are described briefly below:

### Community Rating

Private health insurance in Ireland must be “community rated” as opposed to “risk rated”. The premium charged by an insurer cannot vary according to the age, sex or health status of the policy holder. An insurer is required to set a single premium that will apply to all of its policy holders. The requirement to community rate promotes “solidarity” between generations and between those with good health and those with poor health. Policy holders who are young or in good health pay higher premiums than they would if risk rating were applied. Policy holders who are old, or in poor health, pay lower premiums than they would in a risk rated

[5] See for example James Sheehan “How VHI has hindered private hospital facilities” Irish Times 23rd July, 2005.

[6] The 1994 Act has been amended by subsequent legislation. The relevant legislation is: The Health Insurance Act, 1994; The Health Insurance (Amendment) Act, 2001; The Health Insurance (Amendment) Act 2003; The Health Insurance (Amendment) Act, 2007; a number of implementing Statutory Instruments; the EU Non-Life Insurance Directives; and, The European Commission Decision finding that risk equalisation was not in contravention of the State Aid rules. A full list of the relevant legislation is available at www.hia.ie/relevant-legislation/index.html.

system. Younger people are "repaid" for their subsidy to older insurance customers in later years, when they, in turn, enjoy the benefits of community rating as older policy holders.

Limited exceptions apply to the principle of community rating. An insurer must either waive, or discount by 50 per cent, the premium charged for the minor child of a policy holder. This has the effect of creating a further cross subsidy, from policy holders without children to those with children. In addition an insurer may offer discounts (from its generally applicable, community rated, premium) to students who are the dependents of a policy holder, to members of a group scheme and to certain pensioners.

### Open Enrolment

Open enrollment is a necessary corollary of community rating. Private health insurers must accept applications for cover from anyone, regardless of their age, sex, health or other indications of their likely levels of claims. The only qualification to this is that an insurer may impose a waiting period before cover commences.

### Lifetime Cover

The requirement to provide lifetime cover further reinforces the intended effect of community rating. Policy holders have a right to have their private health insurance renewed by their insurer, or a competing insurer, regardless of their risk factors or claims history. This requirement means that an individual who holds a health insurance policy can continue to renew it, at the same premium rate applied to the whole community, even if their health has deteriorated and they are making large claims from their health insurer.

A limited easing of these requirements has been proposed by the government, but is not yet in force. It is proposed to allow what is referred to as "lifetime" community rating or late entry loadings. Under this system, individuals who apply for private health insurance for the first time before they reach the age of thirty five will continue to enjoy the right to cover for the rest of their life at the community rated premium that their insurer charges to all policy holders. However, if a policy holder purchases private health insurance for their first time when they are older than thirty five, the insurer can charge them an extra loading on the general "community rate". This loading will range from 10 per cent for policy holders who take out their first private health insurance between the ages of 35 and 44, to 80 per cent for policy holders who take out their first private health insurance when they are over the age of 65. The rationale for this is that individuals who have not funded that community rated insurance system by paying community rated premiums while they were relatively young, should not

enjoy the full benefit of lower community rated premiums when they are older, and represent a higher risk to health insurers.

## 2.3 Need for Risk Equalisation

The combination of the obligations on private health insurers described in Section 2.2 above, and the introduction of consumer choice can have undesirable effects on the private health insurance market. A risk equalisation scheme exists to address these problems[7].

While the VHI was the only private health insurer operating in Ireland, its profile of policy holders in terms of age, sex and health status approximated that of the population as a whole. VHI set its premiums on the community rated basis described above and operated open enrolment and lifetime cover. This had the same result as the current regulatory system. All of the younger and healthier health insurance policy holders paid higher premiums than they would have under a risk rated system, and contributed equally to the cost of providing health insurance to older and sicker policy holders at premium rates well below those that would apply if risk rating was in force.

Once new private health insurers were allowed to enter the market there was a risk that the system would no longer work in this way. The stability of the market could be threatened and the social goals that the obligations outlined above aim to achieve could be compromised. There are two ways in which new entrants could, intentionally or unintentionally, threaten the system of community rating, open enrollment and lifetime cover. In summary these were:

### "Price Following"

A new entrant could enter the market and comply with all of its regulatory obligations, but this could still lead to an unnecessary upward drift of premium rates, and supernormal profits[8] for the new entrant.

A new entrant on the health insurance market will draw its customers from two sources: young people early in their careers buying health insurance for the first time and choosing between the new entrant and the incumbent; and, policy

[7] The need for a risk equalisation scheme is described comprehensively in the Health Insurance Authority's "Policy Paper on Risk Equalisation in the Private Health Insurance Market in Ireland" September 2002. This document is available at www.hia.ie/publications/riskequalisation/index.html.

[8] Supernormal profits are profits in excess of those that a firm must earn to have an incentive to stay active on a market. The level of profit necessary to persuade a firm to stay on a market is referred to as "normal" profit and must be regarded as a legitimate and necessary business expense. "Supernormal profits" represent a challenge to government and regulators because they represent an unnecessary transfer from consumers to producers and indicate that prices are higher, and output is lower than the economically and socially optimum level.

holders of the incumbent insurer deciding to "defect" to the new entrant. The cohort of people buying health insurance for the first time will necessarily be younger than the population as a whole, and so be less likely to make claims on a health insurer. There is also evidence that policy holders who decided to defect to a new entrant will be more likely to be the younger customers of the incumbent insurer.[9] As a result of these two factors, the age profile of the new entrant's policy holders will be younger than that of the incumbent. This difference in age profile of policy holders will be increased if the new entrant is able to act against the spirit of the regulations and either encourage applications from younger policy holders, or in some way discourage applications from older subscribers. However it is important to note that this phenomenon does not depend on a new entrant acting against the letter or intention of the regulations governing the health insurance market in this way.

The new entrant will, therefore, pay out less in claims per customer than the incumbent insurer. In addition, as the incumbent's existing customers grow older and it no longer enrolls all of the younger people buying health insurance for the first time, the age profile of the incumbent's policy holders will tend to get older as time passes. The average claims paid out by the incumbent will rise as a result of this.

Although the claim cost per policy holder of the new entrant may be significantly lower than that of the incumbent the new entrant may adopt a policy of "price following" i.e. setting its premiums slightly below those of the incumbent, but not to an extent reflecting its lower costs[10]. As the average costs of the incumbent increase for the reasons described above, it will increase its premiums and the new entrant will increase its premiums in tandem. This cycle of increasing costs for the incumbent, leading to increased premiums and further increases in the costs of the incumbent can continue for some time, with the new entrant constantly earning excess profits, and premiums increasing above their level before the introduction of consumer choice.

If this scenario was taking place, a transfer of some of the excess income from the new entrant to the incumbent, which was passed on to the policy holders of the incumbent in the form of lower premiums, could decrease premiums and be to the benefit of consumers without threatening the viability of the new entrant.

[9] See for example Section 4.3.1 of York Health Economics Consortium "Assessment of Risk equalisation and Competition in the Irish Health Insurance Market" November 2003. Available at www.hia.ie/publications/riskequalisation/index.html.

[10] This strategy for a new entrant to compete with an established incumbent is referred to as "Stackleberg competition". It is particularly likely to occur when there is only one incumbent and one "new entrant". When a third and fourth competitor enters the market it becomes more likely that one of the competitors will break ranks and adopt an aggressive strategy of low pricing to gain market shares from the more established competitors.

Addressing this scenario is one of the stated reasons for implementing risk equalisation on the Irish market.

### "Predatory Behaviour"

A more sinister phenomenon, which might be addressed through the implementation of risk equalisation, is what could be described as predatory behaviour. An aggressive new entrant could exploit the regulatory features of the Irish health insurance market in a way designed to yield a short term gain followed by an early exit from the market, or might actually intend to aggressively drive the incumbent from the market.

In this scenario, a new entrant plans to sign up a group of policy holders who are younger and represent a lower risk than the overall set of health insurance policy holders. The new entrant could either rely on the natural tendency for new insurance policy holders to be younger than average described above, or it could engage in a variety of measures to either encourage younger policy holders to sign up with it or to discourage older policy holders. This would give the new entrant a much lower rate of claims, and hence lower claims cost than the incumbent. The new entrant could aggressively set its premiums at a level well below that of the incumbent, while still making significant profits. As the incumbent lost its existing policy holders to the new entrant, and as first time policy holders tended to choose the new entrant, the average age of the incumbent's policy holders would rise, and its claims and costs would rise. However any attempt to raise its premiums would worsen the problem by encouraging more policy holders to seek insurance from the new entrant. The older and sicker policy holders remaining with the incumbent would face higher and higher premiums and could eventually lose health insurance cover altogether if the incumbent was driven out of business.

Payments from the new entrant to the incumbent under a risk equalisation scheme would prevent such a strategy from succeeding. In fact, it could be argued that even the possibility of risk equalisation payments being triggered if such a scenario developed could prevent new entrants from adopting such an opportunistic strategy.

In order to address these two risks, a risk equalisation scheme exists. This scheme, which is operated by the Health Insurance Authority ("HIA"), provides for risk equalisation payments to be made between private health insurers with different risk profiles if there is evidence that the health insurance market is distorted in one of the ways described above.

## 2.4 Role of the Health Insurance Authority

There is a potential conflict between the role of the Department of Health and Children as a regulator of the private health insurance market, and its role as the owner, and ultimate controller, of the largest private health insurer on a market with consumer choice. To address this issue, and in line with best regulatory practice worldwide, the market is regulated by an independent regulator, the HIA. The HIA licenses firms to provide private health insurance in Ireland; enforces the rules summarised above; and, plays a central role in a risk equalisation scheme[11]. The role of the HIA in risk equalisation can be summarised as follows:

- Each private health insurer makes bi-annual returns to the HIA. These returns give details of their total number of policy holders, and show the split of this total number by age and sex of the policy holders. The return also gives details of the total claims paid out by the health insurer, and analyse this total amount by the age and sex of the policy holders in question.
- Based on these returns the HIA compiles the aggregate numbers of health insurance policy holders analysed by ages and sex, and the total value of claims paid analysed by age and sex of the policy holders in question,.
- The HIA then calculates, for each health insurer, what their total claims paid would have been if their policy holders had had the same profile in term of age and sex as the total population of policy holders. This hypothetical figure will be greater than actual claims for a health insurer whole group of policy holders has a lower risk than the general population of policy holders. Conversely, the value calculated for an insurer with a higher risk customer base will be lower than its actual value of claims paid.
- Based on the difference between the actual and "equalised" claim figures for each health insurer the HIA calculates a set of risk equalisation payments between insurers that would counteract the effect of the different insurers having higher or lower than average risk profiles.
- The scale of the differences between the actual and "equalised" claim figures is measured in terms of a Market Equalisation Percentage ("MEP"). If the MEP is below 2 per cent, the risk equalisation payments can not be commenced. If the MEP is between 2 per cent and 10 per cent, the HIA must make a recommendation to the Minister for Health and Children either to commence risk equalisation payments or otherwise. The Minister cannot commence payments unless a recommendation to do so

[11] This risk equalisation scheme is described in full in the HIA's publication "Guide to the Risk Equalisation Scheme" July 2003 available at www.hia.ie/publications/riskequalisation/index.html.

has been made by the HIA. If the MEP is above 10 per cent, the Minister "shall" commence the payments, unless he or she decides that this would not be in the best interests of consumers, having consulted with the HIA.

- Once the risk equalisation payments have been "commenced" the HIA is responsible for collecting and distributing the payments. This will be done twice a year based on the bi-annual returns made by health insurers.

## 2.5 Current Condition of the Health Insurance Market

A number of current features of the Irish private health insurance market make it timely to review the regulatory structure in place.

- VHI has found itself with an older set of policy holders than its competitors, and incurs a higher rate of claims;
- BUPA's parent company responded to the commencement of risk equalisation by announcing its withdrawal from the Irish market and selling its Irish business to the Quinn group; and,
- Significant anomalies exist in the regulatory environment for health insurance that place VHI at an advantage relative to other health insurers.
- There has been a disappointingly low level of entry into the Irish health insurance market.
- Recent regulatory changes have made the market even less attractive to new entrants by ending the three year exemption from risk equalisation payments that was previously available to new entrants.

The depth of concern about these issues is shown by the number of legal and regulatory challenges to the current regime that have taken place or are in progress. Complaints have been filed with the European Commission on both the State Aid and Internal Market implications of the current regulatory regime. The regime has also been the subject of a lengthy challenge in the Irish High Court. In addition the European Commission Decision clearing the system from a State Aid point of view has been appealed to the Court of First Instance.

### 2.5.1 Cost to VHI of Community Rating

By the time BUPA entered the Irish health insurance market in 1997, VHI already had 1.4m policy holders. These had joined VHI as policy holders at various times over the preceding forty years. As a new entrant, BUPA has sought to win these policy holders from VHI and has competed against VHI for the business of those buying health insurance for the first time.

In practice, VHI has lost relatively few of its policy holders since the introduction of consumer choice, and the policy holders who have left VHI have been younger than the average VHI policy holder. The effect of switches to new entrants has

therefore been to increase marginally the average age of VHI policy holders. According to the HIA's "staff report" on the returns for the first half of 2005, VHI has lost between 3 and 4 percent of its policy holders per annum since 1997, and the average age of the lost policy holders was between 30 and 32 in the first half of 2005[12].

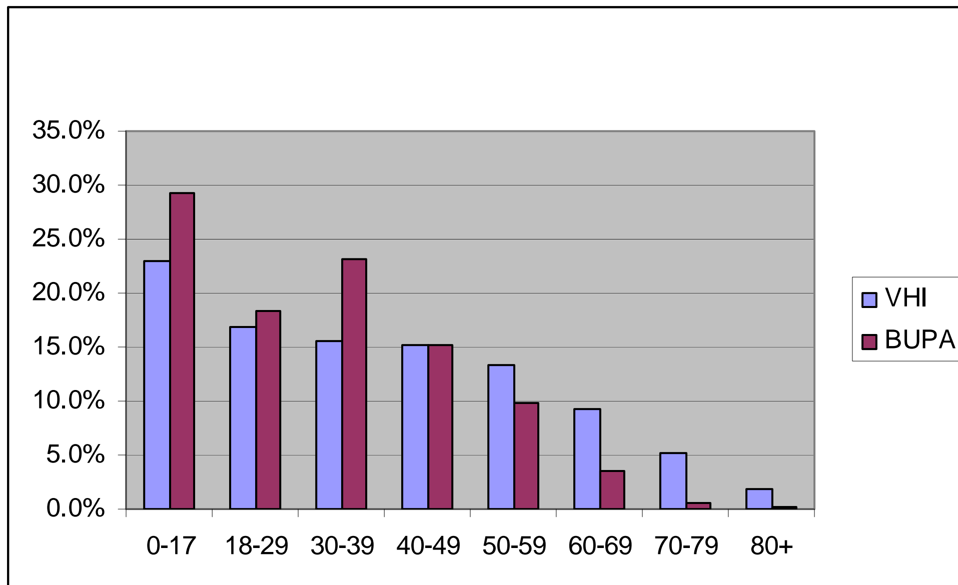
VHI has been successful in gaining new policy holders since the introduction of consumer choice. These new customers have been a mixture of policy holders switching from BUPA and individuals buying health insurance for the first time and choosing VHI over its rivals. VHI has gained between 60,000 and 90,000 new policy holders every year since 1997. The average age of these subscribers has been approximately 29 years. These new policy holders have tended to lower the average age of VHI's[13] policy holders.

BUPA, obviously, started with no "legacy" policy holders in 1997. Over the period since 1997 it has successfully attracted new policy holders. By the middle of 2005 BUPA had 417,000 policy holders after eight years on the Irish market. The average age of the new policy holders added in the first half of 2005 was approximately 25 years.

The effect of the above patterns of sales by VHI and BUPA was a widely different age profile of policy holders for VHI and BUPA. VHI policy holders are older than BUPA policy holders, and VHI experiences a much higher rate of claims than BUPA. Due to community rating VHI must charge the same premium for a given insurance package to all of its subscribers regardless of their age. As a result of this, the premiums charged by VHI are only marginally higher than those charged by BUPA despite its higher claims cost, and VHI makes less underwriting profit per policy holder than BUPA.

[12] HIA "Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation". October 2005. Available at www.hia.ie/publications/riskequalisation/index.html
[13] Ibid.

**Figure 2.1: Age Profile of Health Insurance Policy Holders 2005**




Source: HIA Staff Report, October 2005

The effect of this is to boost the profitability of BUPA relative to that of VHI. The HIA prepared estimates of the profitability of VHI and BUPA for the year to the end of June 2005 which shows the magnitude of this effect. According to the HIA calculations, based on returns from health insurers, VHI had to pay out the equivalent of 89 per cent of its premium income in claims. Over the same period BUPA paid out only 74 per cent of its premium income in claims. Perhaps due to its larger scale, VHI's operating costs only amounted to 8 percent of its premium income, compared to 13 per cent for BUPA. This cost advantage was not enough to overcome the difference in claim rates and the HIA estimated that VHI only earned a net profit of 3 per cent on its premium income, compared to 13 per cent for BUPA. According to the HIA, if risk equalisation payments had been in effect for this period BUPA would have had to make a payment of €33m and VHI would have received a risk equalisation payment of €31m. (The remaining €2m would have been paid to a 30,000 member scheme for current and past staff members of the ESB.) The HIA figures are set out in the table below:

**Table 2.1: Possible Impact of Risk Equalisation, 12 Months to June 2005**

| | VHI | | BUPA | | ESB Staff | |
|---|---|---|---|---|---|---|
| | €m | % | €m | % | €m | % |
| Premium Income | 890 | 100 | 163 | 100 | 18 | 100 |
| Claims Paid | 790 | 89 | 120 | 74 | 13 | 72 |
| Underwriting Profit | 100 | 11 | 43 | 26 | 5 | 28 |
| Operating Costs | 75 | 8 | 21 | 13 | 0 | 0 |
| Pre RE Profit | 25 | 3 | 22 | 13 | 5 | 28 |
| Risk Equalisation | 31 | 3 | (33) | (20) | 2 | 11 |
| Post RE Profit/(Loss) | 56 | 6 | (11) | (7) | 7 | 39 |

Source: HIA Staff Report, October 2005

During the High Court case brought by BUPA (see Section 2.5.2 below) more up-to-date figures than these HIA estimates emerged. The Court found that the effect of commencing risk equalisation payments would be to cause BUPA to operate at a loss. In fact, the court found that BUPA would make a loss even if it were to increase it premiums to the extent that the Health Insurance Authority believed would be possible after risk equalisation payments started.

BUPA's estimates of the cost of risk equalisation have often been higher than the figures discussed in public by the HIA or VHI. This appears to arise from the fact that BUPA correctly follows normal accounting conventions and recognizes Risk Equalisation costs as they are incurred, rather than when cash payments would have to be made.

### 2.5.2 BUPA Response to Risk Equalisation Commencing

In April 2005, having reviewed the returns from health insurers for the period from July to December 2004, the HIA recommended to the Minister for Health and Children that risk equalisation payments commence. The Minister did not follow this recommendation. In October 2005, having examined the returns for the period from January to June 2005 the HIA again recommended that risk equalisation payments should commence. The HIA was concerned that the "price following" behaviour described at Section 2.3 above was taking place and that the introduction of risk equalisation would lead to a reduction in premiums. This view was based on a finding that VHI would pass on any risk equalisation payments to its policy holders in the form of lower premiums. This finding was based on assurances from the management of VHI, and the non-profit, "mutual" nature of

VHI[14]. The Minister accepted this recommendation and announced the commencement of risk equalisation payments on 23rd December 2005[15]. At the same time the Minister directed the HIA and the Competition Authority to conduct a joint investigation of possible strategies to encourage competition on the health insurance market and to create greater balance in market shares. The Competition Authority and the Health Insurance Authority published separate reports in February 2007[16].

In May 2005, BUPA launched a legal challenge to the risk equalisation system in the High Court, arguing that it was in breach of the Constitution of Ireland and various provisions of EU law. The judgment in this case was delivered on 23rd November 2006. The High Court rejected BUPA's arguments, and found that the risk equalisation scheme was lawful. During the court case it was established that if risk equalisation payments were commenced that they would lead to BUPA operating at a loss. The court found that this loss would persist even if BUPA was able to raise it premiums in response to the commencement of risk equalisation payments.

On 14th December 2006, BUPA announced that it would be leaving the Irish market. BUPA stated that it intended to honour all polices in force at that date, but would not be renewing any of these polices or enrolling any new members. This would result in a total exit from the market within one year.

On 31st January 2007 the Quinn group announced its purchase of the BUPA business. There were indications that the Quinn group expected to benefit from the three year exemption for risk equalisation that was then available to new entrants to the health insurance market. The Government response to this was to end this exemption[17]. Any new entrant now has to make risk equalisation payments immediately.

### 2.5.3 Advantages Enjoyed by VHI

Market conditions, and some anomalies in the regulation of health insurance, give VHI significant advantages over its competitors. As discussed above, a combination of the age profile of its policy holders and the obligation to community rate could be said to put VHI at a financial disadvantage relative to its competitors. The commencement of risk equalisation payments is intended to

[14] See for example page 64 of the HIA's "Staff Report" of October 2005.
[15] See Department of Health and Children press release of 23rd December 2005, available at www.dohc.ie/press/releases/2005.
[16] Competition Authority report published on 13th February 2007, available on www.tca.ie. Health Insurance Authority Report published on 16th February 2007, available on www.hia.ie.
[17] The Health Insurance (Amendment) Act 2007 was adopted on 22nd February 2007.

counter this disadvantage. The decision to commence risk equalisation payments does not, however, take account of the advantages enjoyed by VHI:

- The VHI has a significant market share, accounting for approximately 78 per cent of policy holders and 83 per cent of health insurance premiums. It has unequalled brand recognition, having been in existence for 50 years, with a monopoly for 40 of those years. Most important of all, it has a large customer base from its time as a monopoly that shows relatively little inclination to switch health insurer. A combination of all of these factors allows VHI to charge a higher price than its competitors for comparable health insurance polices[18].

- The experience of BUPA, and more recently VIVAS, in entering the Irish health insurance market is that a sustainable large base of policy holders takes time to build up. New policy holders are won relatively slowly as new customers enter the market and are persuaded to take out health insurance for the first time, or as existing policy holders of a rival are persuaded to change insurer. Once new policy holders have been won they will usually stay a policy holder for a number of years. In this way the customer base of a new entrant will increase gradually over its first years of operation. New entrants have to bear significant launch and marketing costs in their early years of operation at a time when their base of policy holders is still small. In addition, there will be significant economies of scale in operating a health insurance firm, which a new entrant will not be able to achieve for a number of years after launch. As a long established insurer with a large existing base of customers VHI is, therefore, at a significant cost advantage over its rivals.

- VHI's competitors are regulated by IFSRA as insurance undertakings. In common with other insurers that are required to maintain reserves equal to at least 40 per cent of their premium income, to guarantee their ability to pay their policy holders' claims, VHI is exempt from this requirement. According to its latest accounts VHI had premium income of €920m for the year ended 28th February 2006. If VHI was subject to the same reserve requirement as its competitors, it would have to maintain reserves of €368m. However, on 28th February 2006 its reserves amounted to only €220m. This shortfall of €148m represents a real financial advantage to VHI relative to its competitors. A competitor that reached the same size as VHI would have to raise €148m more capital from investors than the VHI has had to, to reach its current size. The exemption from the normal rules applied to insurance companies granted to VHI by the government, has the same benefit to VHI as a capital grant of €148m.

[18] See for example Figure 4.1 of York Health Economics Consortium "Assessment of Risk equalisation and Competition in the Irish health insurance Market" November 2003 comparing the premium for VHI's plan B and BUPA's "Essentials Plus" from 1997 to 2003.

- In the past VHI has run down its reserves to adopt certain pricing policies. Even the €220m of solvency reserves that VHI currently holds is available to it in a way that other insurers' reserves are not available to them. The full extent of VHI's advantage is not just the €148m of reserves that it does not hold, but also the €220m that it refers to as reserves, but to which it actually has access.

- The absence of a reserve requirement on VHI has a significant effect on the margin where it competes with new entrants for new policy holders. If a new entrant sells an additional policy it will have to increase its reserves by 40 per cent of the premium. VHI has no such requirement which places it at an advantage in pricing its policies.

- VHI enjoys a significant advantage over rival providers of health insurance from its non-commercial mandate. New entrants to the market have to earn a return on their capital. In contrast, VHI is not required to earn any return for the State. A commercial rival to VHI, that was the same size as it, would not only have to raise €368m in shareholders funds, it would have to pay its shareholders a return on this capital. The cost of equity capital for insurers varies over time, however the average cost over the twenty years from 1981 to 2000 was 16.7 per cent[19]. If VHI had to earn this rate of return on normal shareholders' funds it would have to make a profit of €61m each year. VHI has an advantage over its rivals equivalent to an annual grant of €61m. This is significantly greater than risk equalisation payments of some €31m.

  VHI itself has indicated that its target rate of profitability is a net profit margin of 5% on sales. If its reserves were at the normal industry minimum, this would be equivalent to a 12.5 per cent cost of capital. Even at this lower cost of capital the annual value of VHI's non-commercial status is €46m.

  It should be noted that the appropriate benchmark for return on capital for VHI is the return required of Irish insurers. Insurers in other countries will have different required returns, reflecting overall equity market returns and other economic features of those countries. Even if one of these foreign insurers wanted to invest in Ireland, the return they would require would be that appropriate to an investment in the Irish market, rather than the return in their home market.

  As an aside, if the VHI has a cost of capital in the region of 13 per cent to 17 percent, the required return for a new entrant would have to be higher than this to reflect the extra risk incurred in investing in such a new

[19] Ryan, Keane "Economic profitability in non-life insurance: a historic perspective on the Irish market. Paper presented to the Society of Actuaries in Ireland, November 2002. www.actuaries.ie

entrant. The relevant cost of capital for a new entrant could be as high as 20 or 25 per cent.

### 2.5.4 Disappointingly Low Level of Market Entry

In the thirteen years since the ending of VHI's legal monopoly, only two other insurers have entered the market. The backer of one of these, BUPA, recently sold its Irish business, stating that risk equalisation made the Irish market uneconomic from their point of view. This is despite the fact that many international insurers that provide health insurance elsewhere are active on other insurance markets in Ireland, and that the Irish market is by no means insignificant in size. For example, the Irish health insurance market is similar in scale to the motor insurance market (€1.2bn as against €1.6bn[20] worth of premiums for motor insurance in 2005). Despite this a total of fifteen motor insurers operate on the motor insurance market, compared to three on the health insurance market.

[20] IFSRA Insurance Statistical Report for 2005

# 3. Competition and Consumer Choice and Value

## 3.1 Consumer Choice is under Threat

As described in Section 2, the current operation of the health insurance regulatory system has put consumer choice under threat. The requirement to community rate and allow open enrolment has put VHI at a financial disadvantage, relative to more recent market entrants who have younger policy holders. Risk equalisation payments have been commenced to address this problem, despite the fact that other anomalies in the market structure and regulatory system could be argued to create compensating advantages for VHI. Following the commencement of risk equalisation payments, BUPA's parent company sold its Irish business to the Quinn group. It cited risk equalisation as its reason for ending its involvement with the Irish market. This is not the vigorous market that would be best for consumers of private health insurance, and of health services. It is now essential that the regulatory system governing health insurance be reviewed to ensure that it acts to promote, rather than stifle, consumer choice. An improved regulatory system should not just aim to restore the level of consumer choice in place before the recent announcement by BUPA. The full benefits of consumer choice, for health insurance policy holders, and for the health system as a whole, might only emerge when there are four or five evenly matched players in the health insurance market.

## 3.2 Current and Future Benefits of Choice

The consumer choice that has existed in the market for health insurance since 1997 has already had significant benefits for consumers. These benefits in terms of a wider range of insurance products that take account of recent developments in health care, and are tailored to the need of a range of different policy holders, are summarised in Section 2.1 above. Consumer choice in the health insurance market has the potential to deliver significant additional benefits to policy holders. In fact, a vigorous and innovative health insurance sector can be the engine of significant improvements in the whole health care sector.

- Following the introduction of choice to the market, health insurance underwent a wave of innovation in product design that brought the sector up to date with the variety of needs of potential policy holders, and the variety of health care providers in existence. Customer needs and the types of care available will continue to develop and increase in the future, and experience has shown that only a health insurance market with choice will deliver the necessary level of innovation and choice for policy holders.
- It should be remembered that, unlike the situation in some continental European markets, such as Germany and the Netherlands, private health

insurance is not a luxury product aimed at a small number of affluent consumers who wish to opt out of the public system. Approximately 51% of the population are health insurance policy holders. Private health insurance is therefore a key component in the health care of over half of the population. Policies that encourage choice in this market and improve the performance of the sector in terms of product quality and efficiency will have widespread benefits for a significant portion of the public.

- Since the introduction of choice in the health insurance market, the sector has been the driving force behind many important innovations in the health care sector. The growth of private hospitals, the introduction of the National Treatment Purchase Fund, and the plans to introduce co-location at hospitals all depend on the existence of a growing market for private medical care, which is driven by the medical insurance firms.

- A vibrant health insurance sector with consumer choice is a model for efficient administration of health care, and could be the basis of a new design of health care system for the whole population. A vigorous private health care sector with consumer choice would provide a useful foundation for the introduction of consumer led, insurance based universal health care.

- Consumer choice makes private health insurance, and private health care, more efficient and affordable for consumers. To the extent that consumers are able to opt for private health insurance and private health care, the burden of public care on the public finances is reduced.

- Inward investors who provide high quality jobs to the Irish economy regard the availability of a choice of health insurance providers as a small but crucial part of the services required for their Irish operations. A reduction in the choice and quality of private health insurance available in Ireland can only have a negative impact on inward investment.

- In general the fact the Irish regulatory system has been seen to drive out a foreign investor who was competing with a state owned firm in the health insurance market damages the image of Ireland as an attractive destination for international investment.

## 3.3 Conclusion

The benefits that have already come from the emergence of two alternatives to VHI, and the potential future benefits of choice in health insurance, make it clear that choice should be preserved and extended in the health insurance market. The current system of regulation has led to a disappointingly slow rate of entry to the market, and, at one point, threatened to actually drive a major competitor to VHI from the market.

The current system of regulation needs to be revised so as to allow and even encourage entry on to the system, while of course preserving the important social goals of community rating, open enrolment and lifetime cover. Policy makers should aim to see as many as five or six evenly matched health insurers available to consumers.

# 4. Lessons from Insurance Markets Abroad

## 4.1 International Comparisons

As part of this study Goodbody Economic Consultants researched comparable private health insurance regulatory systems in other jurisdictions that might have useful lessons for the Irish market. The results of this work are summarised in Appendix I. This Appendix sets out some relevant features of the structure and regulation of health insurance in the EU15 and in any third countries where there is a well developed private health insurance system.

A number of relevant general features of private health insurance in the EU and around the world emerge:

### 4.1.1 No Comparable System in the EU15

No comparable system to regulate private health insurance has been put in place in any of the other EU15 states.

States that have a public system which is free at the point of use, such as the UK National Health Service, do not regulate private health insurance to achieve social ends. All of the social objectives of the health sector are to be achieved through the National Health Service. Individuals are free to opt out of this system by buying private health insurance and paying for their own medical care, but this activity is not regulated so as to achieve a social objective.

Other states, such as Belgium and Germany, have “insurance based” public health systems, which involve risk pooling between the non-profit insurers. These operate on a completely different basis from private health insurance. The “insurers” are non-profit risk pools that do not set their own premiums. “Premiums” are set by government as a percentage of salaries and collected as a payroll tax. The State then allocates this “premium income” and any additional government subsidies (for example for covering the unemployed) to the “insurers” on the basis of the number and risk profile of their members. This exercise is sometimes referred to as “risk equalisation” but is a different process to that in Ireland. The objective is not, as in Ireland, to mandate payments between commercial organisations that compete on the basis of premium levels.

In the majority of the EU 15 states some individuals do purchase private health insurance to either top up the cover available from the State system, or because they are excluded form the State systems on grounds of income or employment status. In two States, Belgium and the Netherlands, there is a government subsidy to bodies providing insurance to those who cannot obtain it elsewhere. These subsidies are risk based. These States did not find it necessary or desirable to

equalise risks between insurers competing on the basis of price. Instead these States intervened in a way that minimized the distortion of competition.

### 4.1.2 Australian System

The Australian system faces similar issues to the Irish system of private health insurance. In Australia an individual has the option of opting out of the State health system and purchasing private health insurance. An individual who does this receives a rebate of their tax contribution to the State system. Private health insurers are obliged to accept all new members. They are also obliged to community rate. However, a private health insurer can charge an extra loading to an individual who takes private health insurance for the first time when they are above the age of 30. There are a large number of private insurers in Australia (26) with none having a significantly larger market share than the others, so there is limited scope for risk equalisation payments to distort consumer choice. Despite this the Australian risk equalisation system is less comprehensive that the Irish system and does not aim to eliminate all difference in risk profile between private insurers. Instead equalisation payments are calculated to “equalise” 79 per cent of the cost of claims made by policy holders who are over the age of 65 or chronically ill.

### 4.1.3 Swiss System

The Swiss public health system is based entirely on allowing consumers a choice between private health insurers. Approximately 100 private health insurers operate on the Swiss market. All of these are obliged to operate community rating, open enrollment, and lifetime cover. Given the large number of insurers it is unlikely that risk equalisation would interfere with consumer choice by affecting competition between insurers. Despite this, the Swiss system of risk equalisation is only temporary. Regular reviews are conducted as to whether risk equalisation payments are still needed.

### 4.1.4 New York State System

The New York State government ensures widespread health coverage by regulating and subsidizing the private health insurance sector in New York. These subsidies used to be given to a large insurer of last resort, “Empire” that had a very large market share. This system was reformed to allow consumer choice to people who held subsidised health insurance. In the transition from the old to the new system Empire’s finances suffered as it lost a disproportionate number of its lower risk, more profitable customers to new entrants. The State government responded by introducing a temporary risk equalisation type system. The market structure has now stabilized, with 74 competing insurers operating on the New York market, the largest of which has an 18.5 per cent market share. The

temporary risk equalisation system was brought to an end once the threat of a destabilising exit by a large insurer had receded. Similar systems are operated by some other states including New Jersey.

### 4.1.5 South African System

South Africa has a large public system which is free at the point of use. To relieve pressure on this system the government has been encouraging those who can afford to do so, to opt for private care financed by private health insurance. A new regulatory structure for private health insurance was implemented in 2000. Insurers face similar obligations to those in Ireland to community rate and provide open enrollment and lifetime cover. This system operated for six years without risk equalisation. Late in 2006 the government announced the introduction of a risk equalisation scheme. The concern leading to the introduction of risk equalisation was adverse selection by the insurers, threatening the principle of open enrolment[21]. No Irish insurer has been accused of adverse selection, and there are no indications that this is an issue in the Irish market.

## 4.2 Lessons for Ireland

A number of lessons emerge for the design of the Irish private health insurance system:

- The Irish approach of regulating private health insurance to achieve social ends by imposing obligation such as community rating, open enrolment and lifetime cover is relatively unusual. Only four comparable systems could be identified world-wide for this review.
- Many apparent examples of risk equalisation (e.g. the risk pooling payments in the Belgian or German systems) arise where a public health system is structured in a similar way to insurance. In these systems, the public have a choice of health care providers. These providers do not set premiums but rather are allocated tax revenue collected by government in the form of payroll taxes. The allocation of this money is based on the number and risk profile of the insurers' membership. The systems involved are similar to the risk equalisation at issue here. However, these systems are not necessarily a good guide to the form of risk equalisation that would be appropriate in our system which is based on price competition between insurers.
- In the comparable markets where risk equalisation has been introduced, important factors are present to limit the effect of the risk equalisation payments on consumer choice.

[21] See for example the opening address by Dr. Ayanda Ntsaluba, Director-General of the South African Department of Health to a consultative forum on risk equalisation, available at www.doh.gov.za/docs/sp/2003/sp0710a.html.

    - The Australian system does not aim to equalise all risks, so the impact on the relative financial position of insurers would be reduced.
    - Under the Swiss system risk equalisation is introduced for a limited period and reviewed at the end of the period.
    - Risk equalisation payments were introduced temporarily in the New York system when a large incumbent was making substantial losses due to risk selection be new entrants and there was a danger of it being driven from the market. Risk equalisation was ended when this threat receded.
    - The South African system has many features in common with the Irish system. The introduction of risk equalisation was announced recently, six years after the regulation of the sector.
- In all four "comparable" markets with some form of risk equalisation, health insurers are numerous, with no one insurer clearly dominant. This limits the possibility of risk equalisation, limiting competition between insurers and so harming consumer choice, and so slowing improvements in service provision.

# 5. Identification and Evaluation of Options for Market Reform

## 5.1 Policy Priorities

Before making suggestions to improve the current system of regulation for private health insurance, it is essential to identify the policy objectives which the current system of regulation is designed to promote or protect. Any new or revised system can only be judged by the extent to which it better serves these policy objectives.

The main objective of the current system of regulation is to create a private health sector which is open to all, regardless of age and health status, and where there is "solidarity" between generations and between those at different risks of illness. This is achieved by imposing the three related obligations of community rating, open enrolment and lifetime cover on all private health insurers.

This aspect of the regulation of private health insurance works well, although there are differences in the profile of policy holders of the three insurers currently operating on the market. These arise because:

- VHI has been established on the market for a long time;
- Policy holders are slow to change insurer unless given a large incentive to do so; and,
- Those taking out health insurance for the first time are predominantly younger people early in their careers.

It is clear from the HIA's monitoring of the market that all of the open enrolment health insurers are effective at gaining new policy holders among those buying health insurance or the first time[22]. There is equally no evidence that the two "new entrants" BUPA and VIVAS take any action designed to discourage older application for health insurance. Both of these insurers have policy holders spread across all age groups.

As a result of this aspect of the regulation of health insurance, all individuals have access to health insurance at community rates from at least two potential insurers.

The Irish system of regulation for private health insurance also aims to promote consumer choice. Consumer choice is a goal of the system as it tends to promote low prices and efficiency. It also leads to flexibility and innovation in the design of health insurance products and in the provision of health services themselves. The record here has been more mixed. Only two insurers have entered the market since the adoption of the new regulatory system. The larger of these, BUPA, was

[22] i.e. VHI, BUPA and VIVAS. There is a fourth private health insurer that participates in the Risk Equalisation Scheme, the ESB scheme. This insurer is confined to current and past staff members of the ESB group.

sold to the Quinn group early in 2007. The previous owner stated that risk equalisation payments made their investment in Ireland unviable.

Even the limited increase in consumer choice following the introduction of the new regulatory regime in 1994, has had significant public benefits as described in Section 3.2. above.

The priority for any changes in the regulatory system must be to preserve and increase the current level of consumer choice while maintaining the current commitment to community rating, open enrolment and lifetime cover.

The level of choice available to consumers depends on two things: the number of health insurers active on the market, and the intensity with which these insurers attempt to gain market share from each other by competing on price, and on the range and quality of the services they offer. Policy measures can be identified to affect both of these factors.

The best way to ensure implementation of these policies is to review the structures in place to regulate the industry. Currently the Health Insurance Authority is the only regulator with oversight of all health insurers. The insurers that compete with VHI are subject to IFSRA regulation as financial firms, but the firm that accounts for 80 per cent of the health insurance market is exempt form this supervision. The mandate and priorities of the Health Insurance Authority need to be reviewed to ensure that it is able to fulfil its role as sector regulator of a liberalising sector.

## 5.2 Practical Measures to Increase Rivalry

Independently of any measures to encourage all of the current Irish health insurers to stay on the market, or to encourage the entry of new insurers, there are a number of practical measures that could be taken to facilitate and encourage productive rivalry between health insurers. Such an increase in rivalry would increase the benefits of choice in the health insurance market for consumers. The measures possible include the following:

### 5.2.1 Active Promotion of Switching by Authorities

The HIA has already made important strides in increasing consumer awareness of the availability of choice in health insurance. The HIA website provides comprehensive, clear information and advice on switching health insurers. This has been supplemented by print advertising directing people to their website[23]. This is a useful initiative, and it would contribute further to consumer choice if it were continued and extended. Additional actions by the HIA and the Department of Health and Children could be introduced to encourage policy holders to

[23] The HIA material for consumers is at www.hia.ie/pcaci/.

actively compare the products of different insurers when taking out health insurance polices. The first step would be to bring the HIA material actively to the attention of policy holders, perhaps through direct mail.

### 5.2.2 Opening the VHI Database

In addition to its database of existing customers, VHI also has access to information on BUPA and VIVAS policy holders who previously held VHI health insurance polices. This places VHI in a unique position in the market, and is a legacy of four decades as a monopoly. Active comparison of insurers and policies by health insurance customers could be encouraged and increased if some measure to address this situation was introduced. Difficult issues of privacy and data protection would be raised by giving other health insurers access to VHI's databases of customers; however it should be possible to devise a system whereby new entrant insurers can communicate with VHI's policy holders.

VHI could either be required to distribute material to its policy holders provided by other insurers and approved by the HIA, or the HIA itself could prepare material on the options available to policy holders and require VHI, or all insurers, to distribute this material.

### 5.2.3 Reduce Barriers to Switching

A common problem in markets where consumer choice has been introduced after a long period of monopoly is that consumers may initially seem reluctant to switch supplier. This makes it difficult for new entrants to gain a foothold in the market and delaying the benefits of consumer choice. This arises for very understandable reasons. Switching involves costs for consumers, in terms of their own time and effort. Also, by definition, it is hard for consumers to be aware of the potential benefits of switching before they undertake these costs and research alternative suppliers. The measures described above to increase consumer knowledge of their right to switch, and of the range of insurance products available go some way towards addressing this problem.

Other practices around the renewal of health insurance policies could also be increasing the perceived cost, difficulty and risk of changing health insurance provider. For example it should be ensured that policy holders are given adequate notice of the renewal date of their policies and properly informed of their right to change policy without losing cover. This type of issue was highlighted in a recent Competition Authority review of the general insurance market. The Competition Authority recommendations included measures to make it easier for a policy holder to change insurer at the time of policy renewal. In particular the Authority recommended that renewal notices automatically include a "certified history of

claims” to facilitate the policy holders obtaining insurance from other insurers[24]. The equivalent for the health insurance market would be requirement to inform policy holders that they have a right to obtain insurance from any health insurer without a break in cover, or having to undergo a waiting period.

## 5.3 Practical Measures to Increase the Number of Market Players

To realise the full benefits of consumer choice on a market there needs to be a certain number of competing suppliers. The greater the choice of suppliers the greater the benefits of introducing choice will be and the faster these benefits will be realised. For example, where there are only two suppliers active on a market there is a risk that the smaller and newer of the two will simply follow the prices and service standards set by the incumbent. This will significantly reduce and delay the benefits of introducing consumer choice. As described in Section 2 above, the introduction of consumer choice in health insurance has realised significant benefits for consumers of health insurance, and of health services in general. There is a serious risk that the imminent reduction in the number of health insurers from three to two will prevent further benefits being realised, and may even reverse some of the progress that has been made on this market.

There is therefore a clear interest in adopting regulatory and other measures that will maintain, or even increase, the number of health insurers active on the Irish market. The range of possible measures includes:

### 5.3.1 Split VHI into Competing Firms

One way to very quickly and effectively increase the number of competing insurers on the Irish health insurance market would be to split VHI into two or more competing health insurance firms. This would not require any change in the general regulatory regime and would not threaten any of the principles of health insurance regulation such as community rating, open enrolment or lifetime cover. However a number of practical barriers would have to be overcome, which could lead to this being a more expensive and lengthy process than it might appear at first.

- Splitting the assets and liabilities of a state owned commercial entity must be done in a way that meets various legal and taxation requirements, respects the rights of employees, and is acceptable to the numerous stakeholders affected by the decision. The experience of splitting Aer Rianta shows that this can be a long, complex and often fractious process.

[24] The Competition Authority “Competition issues in the Non-Life Insurance Market”. March 2005. Available at http://www.tca.ie/PromotingCompetition/MarketStudies/Insurance/Insurance.aspx.

- If one of the entities retained the VHI brand, this would leave it with a significant advantage on the market for health insurance, and would reduce the increase in competition arising from the split. If new names and identities were devised and marketed for all of the newly formed insurers this would involve considerable expense that could be seen as wasteful.
- Following a split, all of the newly formed insurers would remain under State ownership[25] and control. Some structure of management and governance would have to be devised to ensure that the new insurers competed actively against each other and aimed to recruit each others policy holders. The only certain way to achieve this would be to sell at least one of the new insurers. This would raise a further set of legal, taxation, employee and policy issues.

Selling part of the VHI's book of policy holders would avoid some of these issues, but would not address the problems of limited competition. If a block or blocks of business were sold with the VHI retaining the customer relationship and the right to determine premiums, then:

- VHI would retain the same need for risk equalisation payments.
- There would be no increase in customer choice or competition between health insurers.

In essence VHI would be engaging in a reinsurance type transaction.

If a block of business were sold, with the new owner being able to set premiums, many of the issues of a split of the VHI would arise. The staff of VHI, and the policy holders "sold", would have much the same issues as they would with a split of the VHI.

### 5.3.2 Narrow Criteria for Commencing Risk Equalisation Payments

The BUPA business has been sold to the Quinn group. The previous owners cited the start of risk equalisation payments as their reason for leaving the Irish market. Subsequent changes to the risk equalisation system mean that future new entrants will have to make risk equalisation payments immediately, rather than enjoying the three year exemption that was previously available to new entrants. This will act as a further discouragement to new entrants. It is timely to revisit the policy underlying the risk equalisation scheme to see if a different policy towards risk equalisation could be devised which would still protect the important principles of community rating, open enrolment and lifetime cover.

[25] VHI is not formally a State owned company, being a statutory board; however legislation has been announced to put it on a fully commercial footing.

Risk equalisation payments do not directly lead to insurers applying the principles of community rating, open enrolment and lifetime cover. These are a direct obligation of insurers and the first line of defence for these obligations is the direct supervision and enforcement activity of the HIA. Risk equalisation exists because a combination of these obligations and significant differences in the risk profile of insurers can give rise to situations where commencing risk equalisation payments is of benefit to health insurance policy holders. As is explained in more detail in Section 2.3 above, the HIA has identified two such situations which give rise to the need to commence risk equalisation payments. These are:

- The new entrant or entrants on the health insurance market adopts a "price following" strategy which has the effect of driving up premiums for the policy holders of all insurers.
- A new entrant is engaging in predatory behaviour that is endangering the survival of the incumbent.

The HIA's recommendation to commence risk equalisation payments was based on two findings:

- Price following was taking place and was causing prices from all insurers to rise above the level at which they would otherwise be; and,
- If risk equalisation payments were commenced, the payments would be passed on to VHI policy holders, undoing the harm from price following. This finding was based on the non-profit status of the VHI, and assurances from VHI management.

Both of these findings were necessary to justify commencing risk equalisation.

In fact, commencing risk equalisation is not the best way to address price following. Price following is most likely in a situation where there is a large "incumbent" and a significantly smaller follower firm. In such a situation, price following is very likely to be the best strategy available to the second firm. The strategy breaks down if a third competitor enters the market. Third and subsequent entrants will have to follow a more aggressive strategy of competing actively with the market incumbents. This is a common finding in industrial organisation theory, and can be observed in many liberalised markets. Clearly, the best response to price following is to encourage new entrants onto the health insurance market.

In contrast, risk equalisation payments only undo the harm from price following in very specific circumstances, and actually discourage new entrants. They may delay or prevent a long-term solution to the problem of price following.

The best approach to the problem of price following would be to concentrate on attracting new entrants, and adopting the policies described at Section 5.2 above to make it easier for these new entrants to compete on equal terms with incumbents.

It follows from this that risk equalisation payments should only be commenced where an opportunistic new entrant is behaving in a "predatory" fashion and so threatening to harm consumers by endangering the incumbent. The main role of risk equalisation should be as a reserve power to be implemented if such a new entrant emerged. Ideally, the existence of risk equalisation would deter opportunistic behaviour, and it might never be necessary to actually commence risk equalisation payments.

This policy towards risk equalisation would not have caused BUPA to announce its departure from the market, and would make the Irish market more attractive to legitimate new entrants who believed that they could profitably enter the Irish market by being more efficient and/or providing a better service than the incumbent health insurers.

### 5.3.3 Delay Risk Equalisation until VHI no longer Enjoys Other Advantages

The criteria for introducing risk equalisation take no account of certain anomalies in the regulation and structure of the health insurance market that place VHI at a significant financial advantage with respect to competing health insurers. These anomalies are described in detail at Section 2.5.3 above. In summary these advantages are:

- VHI enjoys a position of market dominance, which places it at a financial advantage relative to its competitors;
- VHI enjoys significant economies of scale, which other insurers will not be able to emulate for many years, due to the historical development of the market;
- VHI's derogation from reserve requirements is the equivalent of a €148m capital grant from the State in terms of the advantage it gives it over other health insurers.
- VHI's non-commercial status is the equivalent of annual revenue grants approximately €61m in terms of the advantage it gives it over other health insurers.

Even if the decision to commence risk equalisation is valid and necessary on its own terms, the need to commence payments now is obviated by these other "parallel" advantages to the VHI. Adopting this approach would delay commencement of risk equalisation, at least until the VHI is placed on a normal

commercial footing and meets its reserve requirements. This would induce BUPA to stay in the market and would make the market more attractive to new entrants.

It is important to note that our study has identified no market where risk equalisation payments are used to support a dominant insurer who enjoys other competitive advantages. Rather it is used to even out random differences in risk profile between large numbers of insurers of broadly similar size, and to discouraging possible opportunistic behaviour of a relatively small insurer that is evading its obligations to operate open enrolment.

### 5.3.4 Scale Back or Reduce the Impact of Risk Equalisation Payments

There are a number of changes that could be made to the current risk equalisation system that would have the effect of scaling back the risk equalisation payments, or of reducing their impact on VHI's competitors. Introducing some or all of these should achieve the desirable outcome of maintaining the current level of choice on the health insurance market and encouraging new entry without threatening community rating. These include:

- Maintaining the current system of risk equalisation payments, but scaling the amount of the payments based on an objective criterion to reflect the relative size and strength of VHI. A number of schemes can be devised to do this.
  - Scale back risk equalisation by the extent to which the market Herfindahl-Hirschman Index ("HHI")[26] exceeds a target value of 1,800. Applying this system to the latest publicly available set of risk equalisation figures would have led to BUPA making a payment of €8.3m rather than €33m, which would have left BUPA with a profit of €13.7m. This calculation would ensure that full risk equalisation only took place when competition between insurers was not otherwise distorted.
  - Scale back risk equalisation to the extent that VHI's market share exceeds 40 per cent, the usual indicator of a risk of market dominance. Applying this approach would have led to a risk equalisation payment of €17m for BUPA, leaving it with a profit of €5m. This would allow a target to be set for the market share of VHI, in a similar way to the market share target for ESB in the electricity market. VHI would have the incentive of full risk equalisation payments to reach this target.

[26] The HHI is a standard method of measuring the degree of concentration in an industry. It is used by competition authorities to measure the impact of mergers. It is calculated by adding the squares of the percentage market shares of all competitors in the market. The maximum HHI is 10,000 where the industry is a monopoly. An industry with five competitors with a 20 per cent market share would have a HHI of 2,000. The Competition Authority regards mergers that leave an industry's HHI above 1,800 as requiring investigation unless the change caused by the merger in question was particularly small.

- o Scale back risk equalisation to the extent that VHI's market share exceeds the ideal for consumer choice, for example the 20 per cent share it would have in a market with five evenly matched competitors. This would reduce BUPA's risk equalisation payment to €9m and leave it with a profit of €13m.
- o Cap risk equalisation payments at a selected percentage of claims, premium income or gross margin. This would act as a safeguard against any insurer being forced into a loss making situation by risk equalisation payments. However the effect of the cap would be arbitrary as it would not relate to any measure of the extent to which VHI's position obviated the need for risk equalisation.
- o Only require risk equalization payments from insurers that have a substantial market share, for example those that have a market share of 10 per cent or more.
- o Only require risk equalisation payments from insurers that are well established on the market, for example those that have been operating for seven years or more.

The effect of these schemes is summarised in Table 5.1 below:

## Table 5.1: Options to Scale Back Risk Equalisation Payments

**Example of Actual Risk Equalsiation Calcualtion from HIA Report of October 2005**
**Year Ended June 2005**

| | VHI | | BUPA | | ESB | |
|---|---|---|---|---|---|---|
| No of Subscribers ('000) | 1565 | | 417 | | 30 | |
| Premium Income (€m) | 890 | 100% | 163 | 100% | 18 | 100% |
| Claims Paid (€m) | 790 | 89% | 120 | 74% | 13 | 72% |
| "Underwriting Profit" | 100 | 11% | 43 | 26% | 5 | 28% |
| **Risk Equalisation Payment** | **31** | **3%** | **-33** | **-20%** | **2** | **11%** |
| Post Risk Equalisation Underwriting Profit | 131 | 15% | 10 | 6% | 7 | 39% |
| Operating Costs | 75 | 8% | 21 | 13% | 0 | 0% |
| Post RE Profit/Loss | 56 | 6% | -11 | -7% | 7 | 39% |

*Options to Scale back RE payments*

| | | VHI | BUPA | ESB |
|---|---|---|---|---|
| 1. | Adjust to the extent that HHI > 1800 | 7.8 | -8.3 | 0.5 |
| | Post RE Profit/Loss | 32.8 | 13.7 | 5.5 |
| 2. | Adjust based on "dominance" (i.e. VHI share > 40%) | 15 | -17 | 2 |
| | Post RE Profit/Loss | 40 | 5 | 7 |
| 3. | Adjust to the extent VHI share greater than 20% | 7 | -9 | 2 |
| | Post RE Profit/Loss | 32 | 13 | 7 |
| 4. | Cap payment at 3% of market claims | 26 | -28 | 2 |
| | Post RE Profit/Loss | 51 | -6 | 7 |
| 5. | Cap payment at 10% of premiums | 15 | -16 | 1 |
| | Post RE Profit/Loss | 40 | 6 | 6 |
| 6. | Cap payment at 30% of gross margin | 12 | -13 | 1 |
| | Post RE Profit/Loss | 37 | 9 | 6 |

Source: Goodbody Economic Consultants

- The basis of calculating risk equalisation payments could be changed. As is described in Section 2.4, the current system aims to eliminate the effect of the policy holders of different health insurers having a different profile in terms of age and sex. Other schemes exist which do not aim to eliminate all of the risk differences between health insurers. For example, the Australian system only eliminates the difference in claims due to having an above or below average number of policy holders who are over the age of 65, or who suffer from a chronic illness. Changing the risk equalisation system in this way would reduce the scale of payments and so reduce the pressure on BUPA to leave, and make the market more attractive to new entrants. However, the Australian experience would suggest that the payment would be sufficient to address any threat to community rating.

### 5.3.5 Correct Anomalies in the System of Risk Equalisation Payments

There are a number of improvements that could be made to the current system of risk equalisation that would have the effect of reducing the impact of the payments on competition. These include:

- The risk equalisation system does not work as intended where insurers offer a range of policies at different premium levels. If insurers only sold one type of policy, the current system of calculating risk equalisation would work to eliminate the effect of different insurers having different proportions of young and old policy holders. However, in reality all insurers sell a range of polices. The premiums for these policies vary greatly. In the case of VHI an annual premium for a single person can range from €767 for Plan A to €2,273 for Plan E. The experience of insurers is that older policy holders are more likely to choose the more expensive policies.

  If an insurer has a higher than average proportion of older policy holders it will also have a higher than average proportion of policy holders paying for the more expensive polices. The higher average age of policy holders will tend to increase its claims cost. This is the issue that risk equalisation is intended to address. However, the fact that it sells a higher number of more expensive, higher margin, policies will also help to address this extra cost. The combined effects of the boost in margin from selling more expensive polices and the receipt of risk equalisation payments will over compensate for the extra cost of having a higher proportion of older policy holders. As a result it will be almost impossible for a newer insurer with a younger age profile of policy holder to make a profit in a market with risk equalisation payments. This effect was examined, and accepted by the court, in the recent BUPA High Court case. The example in Table 5.2 below illustrates the magnitude of this effect. A similar effect of the

combination of different margins on different types of policy and risk equalisation payments forcing a newer insurer into a situation of inadequate profits is observed across a whole range of likely market conditions.

**Table 5.2: Risk Equalisation in a Multi Product Market**

| | VHI | | | Competitor | | |
|---|---|---|---|---|---|---|
| | Plan B | Plan D | Total | Plan B | Plan D | Total |
| Subscribers (000) | 810 | 90 | 900 | 97 | 3 | 100 |
| Premium (€) | 766 | 1,522 | | 766 | 1,522 | |
| Income (€000) | 620,460 | 136,980 | 757,440 | 74,302 | 4,566 | 78,868 |
| Claim cost | | 85% | 643,824 | | 65% | 51,264 |
| Gross profit pre risk equalisation | | 15% | 113,616 | | 35% | 27,604 |
| Risk equalisation | | 2% | 16,420 | | (21%) | (16,420) |
| Gross profit | | 17% | 130,036 | | 14% | 11,184 |

**Assumptions**: Use actual premium levels for these representative products, in reality competitor would have to charge less than VHI
1m policy holders
VHI 90 per cent share, of which 10 per cent take high price policy
"Competitor" 10 per cent share, of which 3 per cent take high price policy
VHI claims equal 85 per cent of premium income
"Competitor" claims equal 65 per cent of premium income.
Risk equalisation equalises 90 per cent of difference between actual claims and equalised claims
Combined effect of risk equalisation and product mix leaves competitor with gross margin 3 percentage points lower than VHI. As VHI aims for a 5 per cent net margin, competitor is unlikely to make an adequate return, even if it could charge same premium as VHI.

Source: Goodbody Economic Consultants

- A significant and unusual feature of the Irish risk equalisation system as it stands is its permanent nature. Once the decision has been taken to commence risk equalisation payments they will continue indefinitely. This was an important element in the decision by BUPA's parent to sell its Irish business to the Quinn group, and is a factor in the attractiveness of the Irish market to new entrants. If risk equalisation payments were introduced for a fixed term, or were subject to review and possible cessation when market conditions change, this would reduce their impact on consumer choice. Of the four comparable systems identified world wide, two are temporary. The New York system was introduced in response to a threat to the viability of a key incumbent insurer that was filling an important social role, and has now ended. The Swiss system is activated for fixed terms and is reviewed at the end of these terms.

- The system as originally designed included life time community rating i.e. the ability to add a loading to the premium of those who buy health insurance for the first time when they are over the age of 35. This aspect of the system has not yet been introduced. The introduction of this would offset some of the impact of risk equalisation payments on new entrants. The sale of health insurance to individuals buying health insurance for the first time is of more importance to new entrants than to the VHI, which has the largest group of existing customers. The benefit of this change would therefore be concentrated on recent and potential new entrants.

- An element of the current method of calculating risk equalisation payments referred to as the "Zero Sum Adjustment" has an unintended distortive effect which reduces the incentives for heath insurers to seek efficiencies in their claims and improvements in the health of their policy holders. In the first stage of calculating risk equalisation payments the payment from insurers with lower risk profiles is calculated based on their own claims experience. If they have sought efficiency, by for example, effective negotiations with health care providers or encouraging preventive medicine amongst their policy holders this will be reflected in a lower risk equalisation payment. The payment owed to an insurer with a higher than average risk profile is based on its own claims experience. In order to ensure that the payments from insurers actually equal the payments to another the "Zero Sum Adjustment", effectively splits the difference between these two amounts. This has the effect of reducing the incentive for new competitors to seek efficiencies and health improvements, and increases the payments that must be made by new entrants. For example, according to Health Insurance Authority figures for the six months to June 2006 the effect of the Zero Sum Adjustment was to add €1.3m to the risk equalisation payments due to VHI for the period. This is an increase of 8 per cent in the payments.

- As noted above, the current system is based on the actual claims experience of health insurers in the period under review. This is referred to as a retrospective system. A system based on what future claims should be given the age and sex profile of a health insurer is referred to as a prospective system. Prospective systems give increased certainty and reduce volatility of risk equalisation payments. This makes the market more attractive to new entrants, not least as it will lower their cost of capital by lowering the riskiness of their income. Prospective systems have been advocated by independent commentators such as the Competition Authority and the Society of Actuaries.

- The risk equalisation system is only meant to equalise the cost of claims that would be made if all policy holders had a “standard” level of health insurance. If insurers sell higher specification products, the cost of this is not supposed to be equalised through the risk equalisation system. However, since the risk equalisation system was designed, health insurers have changed the basis on which they negotiate the charges they will pay private hospitals for stays by their policy holders. This has had the effect that almost all of the cost of stays in expensive private hospitals by holders of high specification insurance polices are included in the calculation of risk equalisation payments. Correcting this anomaly would improve the operation of the system in its own terms and reduce the impact of the payments on competition.

- Participation in the risk equalisation system is compulsory for health insurers who are authorised to offer insurance to the general public. A number of other insurers that can only insure members of certain defined groups also exist. These can opt to take part in the risk equalisation system. One of these, the health insurance scheme for ESB staff members has opted to take part, and will receive payments. Two other “restricted membership undertakings” exist, for prison officers and for the Gardaí. These have not opted to join the risk equalisation system. If they have done this to avoid having to make risk equalisation payments, this represents an inequitable feature of the system. To the extent that the risk equalisation system is necessary, all insurers should be required to take part. Alternatively all of these restricted membership undertakings should be excluded from the risk equalisation system.

- There is a clear need to reintroduce some form of temporary exemption from risk equalisation payments or a transition period for new entrants to the health insurance market.

## 5.4 A Comprehensive Approach to Regulating the Sector

As is described in Sections 5.2 and 5.3 above, there are numerous regulatory measures that could be taken, and should have been taken in the past, to preserve and enhance competition in the private health insurance market. None of these have been considered to date due to a gap in the regulation of private health insurance. As discussed above, VHI is exempt from regulation by IFSRA, unlike its competitors. The only regulator that is concerned with the entire private health insurance sector, including VHI, is the Health Insurance Authority.

The role and powers of the Health Insurance Authority centre on enforcement of the sector specific rules requiring community rating, open enrolment and lifetime cover. As an element of this task, it has a key role in any decision to commence risk equalisation payments, and in the administration of the scheme once these payments have commenced. There has never been any suggestion of an Irish health insurer evading, or trying to evade, its obligation to community rate, enrol openly and provide lifetime cover. The vast bulk of the Health Insurance Authority's activity has been monitoring the health insurance market and making recommendations as to whether risk equalisation payments should be commenced or not.

The Health Insurance Authority has been in a unique situation for a sector regulator of a recently liberalised sector. Unlike the situation in other liberalised markets, the Health Insurance Authority's main priority is to protect the incumbent, VHI, from new entrants. Its only weapon to provide this protection is a draconian power to compel new entrants to make large risk equalisation payments to the VHI. The presence of this threat may have deterred new entrants in the past[27], and the commencement of these payments has driven one significant competitor from the market.

This is in stark contrast to the aims and powers of other sector regulators. There has been a marked increase in the number of sector regulators in Ireland in recent years. ComReg regulates fixed line and mobile telephony, postal services and cable. The Commission for Energy Regulation regulates the electricity and gas industries and the Commission for Aviation Regulation regulates the airport sector. All of these regulators were introduced in the same economic and legal context as the Health Insurance Authority. In all cases, a non-commercial state body that held a monopoly over an important activity was being placed on a commercial basis, and the market in question was being opened to competition.

The key role of the regulator in all cases, other than health insurance, is to enforce a set of obligations on the incumbent operator that force it to facilitate the entry of

[27] Risk equalisation, and the uncertainty about its introduction was raised as a concern by many potential entrants participating in the UCD health insurance conferences organised by Professor Ray Kinsella.

competitors. In telecommunications the incumbent is forced to carry calls to and from competitors' networks at regulated wholesale rates, and is required to lease lines to its competitors at regulated wholesale rates. In the energy sector the key role of the regulator is to design and supervise an energy market that allows open competition in the generation and distribution of electricity. To facilitate this, all competitors have a right to access the transmission grid for electricity on transparent, non-discriminatory terms. In general, the role of these regulators could be said to be to protect the new entrants from the incumbent.

The role and powers of the Health Insurance Authority need to be re-examined with this in mind. The Health Insurance Authority, or other regulator of the health insurance market, needs to be given a mandate to ensure that:

- The standards expected of a dominant firm under competition law are imposed on VHI. This would best be done in conjunction with the Competition Authority; and,
- VHI is subject to regulatory obligations that counteract the commercial advantages it enjoys due to its past role as a legal monopoly. This would be the equivalent of the network opening and unbundling imposed on other incumbents in liberalised markets.

This would allow the Health Insurance Authority or other regulator to pursue the type of regulatory action described at Section 5.2 above to promote completion in the market. In particular the regulator could aim to:

- Maintain access to essential facilities, in this case equal access to information on current and past private health insurance policy holders. VHI's unique position gives it access to information on many of the current policy holders of its competitors. This imbalance needs to be corrected by giving competitors access to VHI customers;
- Guard against predatory behaviour by VHI. VHI's size and ability to run down its reserves could allow it to drive a competitor out of the market with a predatory strategy; and,
- Guard against price discrimination and other forms of exclusionary behaviour. VHI is unique in having a legacy group of long standing, older policy holders who hold high premium, high benefit policies. The existence of this group reduces the cost of community rating for VHI. However this is not reflected in the calculation of risk equalisation payments. The net effect of this is to place VHI's competitors at a severe cost disadvantage. VHI also operates two ranges of polices: its original range which is favoured by its legacy customers, and a new range targeted at those buying health insurance for the first time, which competes directly with the offerings of VIVAS and BUPA. The relative pricing of VHI's two ranges can place its competitors at an unfair competitive disadvantage.

- Guard against other abuses such as tying and exclusionary behaviour where VHI attempts to extend its dominance into other markets through linking sales of other products such as travel insurance to its sales of health insurance.

Another lesson from the regulation of other liberalised sectors is the importance of avoiding regulatory capture. Where a regulator is small and has relatively few resources compared to the firms it regulates it can easily become dependent on the firms it regulates for information and analysis of the market in question. This leads to the phenomenon of regulatory capture, where, in good faith, the decisions of the regulator begin to reflect the interests of the industry or of incumbent players in the industry. Where a regulator has a large remit, and significant resources, such as IFSRA or ComReg the chances of this happening are minimized. The Health Insurance Authority is responsible for only one, relatively small, industry. Of necessity its resources are therefore quite limited. This places a great burden on it in developing and defending its own independent view of the issues facing the market.

There is therefore a need to extend the scope of regulation of the health insurance market in general and of VHI in particular. In addition, there is a need to ensure that the body regulating the health insurance market has sufficient resources and is not at risk of regulatory capture. At a minimum, the role and powers of the Health Insurance Authority should be extended, and it should be given the necessary resources to pursue this extended mandate. A more comprehensive solution would be to merge the Health Insurance Authority into IFSRA and extend the role and responsibilities of the merged body with respect to health insurance. This would also place the VHI and other health insurers on the same regulatory basis.

# 6. Conclusions and Recommendations

## 6.1 Conclusions

As explained in Section 3, it is essential to reform the regulation of health insurance to preserve and expand consumer choice. These regulatory reforms should aim to retain all of the current health insurers, and make the market more attractive to new entrants. At the same time, the important social values underlying the design of the Irish health insurance system must be preserved. The obligations of community rating, open enrolment and lifetime cover must be maintained.

As described in Section 5, a wide range of useful regulatory improvements are possible. In order to make useful policy recommendations, three possible packages of measures have been identified. These represent a maximum, intermediate and minimum approach to reform. Each of these packages, together with their advantages and disadvantages, is described below.

### 6.1.1 Maximum Approach

The most direct way to increase consumer choice through changes in regulation would be to change the current policy on when risk equalisation payments should commence. The current policy is to commence risk equalisation payments if there is evidence of either price following, or predatory behaviour. As described in Section 5.3.2 above, the most effective approach to price following is to encourage more health insurers to enter the market. Risk equalisation payments are a poor response to price following. The effect of risk equalisation payments on the harm done by price following is indirect, and depends on other factors being present on the market. In addition, risk equalisation payments will delay or even prevent a permanent solution to the problem of price following by discouraging new entrants to the market. Risk equalisation payments should only be commenced where there is evidence of predatory behaviour. This major change in the policy on risk equalisation would place the risk equalisation scheme on a sounder basis. In addition, as payments would not be required in the current market conditions, it would remove the threat to consumer choice posed by the current policy towards risk equalisation. This change in policy could usefully be supplemented by the measures to increase the intensity of competition between insurers described at Section 5.2 above.

This approach has a number of significant advantages:

- It clarifies and improves the current policy on risk equalisation by focusing the scheme on situation where the commencement of payments

effectively supports the principles of community rating, open enrolment and lifetime cover.

- By not requiring payments in the current situation it removes the pressure on BUPA to leave the Irish market, so preserving the current level of consumer choice.
- The Irish market would become more attractive to new entrants, leading to increased consumer choice in the future.

This approach would require significant legislative and regulatory action, to bring the current risk equalisation scheme to an end and to revise the policy on when it might be reactivated. In addition VHI has anticipated the commencement of risk equalisation payments for a long time. The cancellation of payments when the scheme has already commenced could force it to make an unexpected increase in premium rates.

### 6.1.2 Intermediate Approach

Even if the current policy on when to commence risk equalisation is maintained, it is clear that the existence of other financial benefits and subsidies for VHI obviates the need to commence payments in the current market conditions. Payment under the risk equalisation scheme should be suspended at least until the VHI meets normal reserve requirements and operates on a commercial basis. Since VHI enjoys a significant commercial advantage from its market position, independently of its regulatory and governance advantages, the payments should be suspended until VHI is no longer in a dominant position. This change could also be usefully supplemented with the measures to increase the intensity of competition discussed at Section 5.2 above.

This approach has a number of advantages:

- By suspending risk equalisation payments it removes the pressure that led to BUPA's decision to leave the market;
- The initial suspension of payments followed by the end of the advantages enjoyed by VHI should also make the Irish market more attractive to new entrants; and,
- This would not represent change in policy towards risk equalisation. VHI would be assured that risk equalisation payments would be forthcoming in the future, once other advantages it currently enjoys come to an end.

This approach would require legislative action to suspend the current risk equalisation scheme. In addition, even a suspension of risk equalisation payments might force VHI to raise premiums.

### 6.1.3 Minimum Approach

Risk equalisation payments threaten consumer choice by requiring large payments from a new entrant, BUPA, to a powerful incumbent firm. The projected payments are sufficiently large to force BUPA into a loss making situation. Even if it is not possible to reform the policy on the commencement of risk equalisation, or to suspend the payments until other market distortions are dealt with, there are a number of ways that the payments could be scaled back to reflect the distorted state of competition on the market. Other useful amendments to the regulatory system would also reduce the impact of risk equalisation payments on new entrants. The measures in question are:

- Scaling back risk equalisation payments based on market shares, HHI or the extent of VHI dominance;
- Removing anomalies in the calculation of risk equalisation payments; and
- Introducing lifetime community rating.

These measures, together with the measures to increase the intensity of competition described at Section 5.2 above, could go some way towards preserving consumer choice. The advantages of this approach are:

- It represents a pragmatic, practical approach to the problem raised by BUPA's exit from the market;
- The scaling back of payments would be transparent and objective;
- The scaling back would be sufficient to allow BUPA to make a profit while making risk equalisation payments. This could be enough to preserve the current level of consumer choice in the market.

This approach does little to make the market more attractive to future new entrants. In addition, it does not address important issues on the reasons for commencing risk equalisation and on the current advantages enjoyed by VHI.

## 6.2 Recommendations

The best way to reform the regulation of health insurance is the "maximum" approach described above. This places risk equalisation on the correct policy basis, preserves the current level of consumer choice and, promotes future increases in consumer choice. Unfortunately, this approach also involves the greatest change in legislation and policy, may be resisted by VHI and may involve short term premium increases.

If these barriers to the maximum approach are insurmountable, the intermediate approach described above represents a good next best option. For at least the period until VHI meets reserve requirement and operates on a commercial basis it

would have the same practical effect as the maximum option. i.e. risk equalisation payments would not be made. This period might be longer if the payments were suspended until VHI was no longer dominant. The prospect of future risk equalisation payments could reduce resistance to this approach, and reduce the need for VHI to raise premiums.

The third approach described above has the least prospect of increasing consumer choice. However, if the scale back of risk equalisation payments was sufficiently large, it could preserve the current level of consumer choice.

# Appendix 1 – International Comparisons

| | Universal Public Care | Exclusions | Rating basis for Private Health insurance | Number of Insurers | Largest Insurer | Share of Three Largest | Risk Equalisation for Private Health Insurance | Comments |
|---|---|---|---|---|---|---|---|---|
| Austria | Yes | Yes | Risk. | | | 84 | No | Small numbers of self employed may opt out of public system for private insurance. This private system is not community rated, and does not have risk equalisation |
| Belgium | Yes | Yes | Risk. Community rated complementary polices available | | | 49 | Risk based subsidy from Govt fund to mutual funds providing substitute PHI | Self employed excluded from minor risks statutory scheme. Self employed can substitute private insurance for this cover. This insurance is community rated, and is cross subsidised from the Public insurance funds. |
| Denmark | Yes | Yes | Risk or Group | | | | No | |
| Finland | Yes | Yes | Risk or Group | | | 62 | No | |
| France | Yes | Yes | Risk or Group | | | 60 | No | |
| Germany | Yes | Yes | Risk | 55 | | | No | Self employed and civil servants excluded from statutory, High earners may opt out of statutory. |
| Greece | Yes | Yes | Risk or Group | | | 70 | No | |
| Italy | Yes | | Risk (Commercial insurers) Group (mutuals) | 104 | | 33 | No | |

| | Universal Public Care | Exclusions | Rating basis for Private Health insurance | Number of Insurers | Largest Insurer | Share of Three Largest | Risk Equalisation for Private Health Insurance | Comments |
|---|---|---|---|---|---|---|---|---|
| Luxembourg | Yes | Mutual:Open Enrolment. Commercial:Pre Existing | Risk (Commercial insurers). Community rated complementary polices available | 11 | | 92 | No | |
| Netherlands | 75% + | | No, but flat rate "WTZ" scheme is available, regulated by state, to those refused Private Health Insurance, or paying excessive amount. Subsidised by solidarity payment from those with Private Health Insurance. | 27 | | Concentrated | Solidarity payment form Private Health Insurance holders to WTZ | High earners are excluded from statutory system and purchase Private Health Insurance. NL is reforming system to be compulsory Private Health Insurance model. |
| Portugal | Yes | Yes | Risk or Group | 39 | | 31 | No | |
| Spain | Yes | Yes | Risk | 100 | | | No | Some occupations excluded from statutory |
| Sweden | Yes | Yes | Risk or Group | | | 80-90 | No | |
| UK | Yes | Yes | Risk or Group | | | 75 | No | |

| | Universal Public Care | Exclusions | Rating basis for Private Health insurance | Number of Insurers | Largest Insurer | Share of Three Largest | Risk Equalisation for Private Health Insurance | Comments |
|---|---|---|---|---|---|---|---|---|
| Australia | Yes | | Lifetime Community Rating (i.e. penalty for late entry). Rebate of public health contributions from state if you take Private Health Insurance | 26 | | | Limited, recharge 79% of claims by >65 and chronically ill | There are still incentives to risk select by excluding other high risk groups |
| Columbia | Yes, can opt to join an insurance based public system | | | | | | "Premium" for statutory insurance is a % of salary paid. This premium income is shared between insurers based on numbers and some risk factors by a govt body. Incentives to risk select as a number of risk factors not taken in to account. | No indication of Risk Equalisation for supplementary Private Health Insurance |
| Czech | An insurance based public system | | | | | | "Premium" for statutory insurance is a % of salary paid. This premium income is shared between insurers based on numbers and some risk factors by a govt body. Incentives to risk select as a number of risk factors not taken in to account. | Supplementary Private Health Insurance not allowed |
| Israel | An insurance based public system. | | Supplementary Private Health Insurance is available and community rated | | | | Not clear if the supplementary PHI is subject to RE. The insurance based Public system is RE | |

| | Universal Public Care | Exclusions | Rating basis for Private Health insurance | Number of Insurers | Largest Insurer | Share of Three Largest | Risk Equalisation for Private Health Insurance | Comments |
|---|---|---|---|---|---|---|---|---|
| Russia | An insurance based public system | | | | | | No regulation or Risk Equalisaiton for supplementary Private Health Insurance | |
| Switzerland | PHI based system | Open Enrolment | Community Rating | 100 | | | RE based on age and gender | Some commentators believe that the Swiss Risk Equalisation scheme misses some risk factors and leaves incentives to risk select. Limited term scheme 1993-2005, believe that consumer mobility will end need for it. Recently extended for 5 more years |
| USA, NY | | | | 74 | 18.5 | | Market stabilisation pool revoked when market settled. Had been in place to rescue legacy non-profit insurer, | |
| South Africa | No | Open Enrolment | Community Rating | | | | Risk Equalisation System now in place | |

Source: Mossialos & Thomson "Voluntary health insurance in the European Union" WHO 2004
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