Competition in the Private Health Insurance Market

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The Competition Authority
An tÚdarás Iomaíochta

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GLOSSARY OF TERMS

BUPA Ireland

BUPA Ireland commenced the sale of private health insurance in 1997, the first firm to do so following the ending of Vhi Healthcare's statutory monopoly in the provision of private health insurance under the 1994 Health Insurance Act. On December 14th 2006, BUPA Ireland announced its intention to withdraw from the Irish market.

Community Rating

Community rating means that, subject to certain exceptions, a health insurer cannot charge different premiums to different people for the same level of cover, irrespective of age, gender, health status or other risk factors.

Day-Patient Treatment

Elective treatment in a hospital or by persons attached to a hospital, but only for one day and with no overnight stay.

HIA

The Health Insurance Authority was established on 1st February 2001 in accordance with the terms of the Health Insurance Act, 1994. It is the regulatory body for private health insurance in Ireland.

Intergenerational Solidarity

Intergenerational Solidarity is the concept whereby younger, healthier people effectively subsidise older people, who tend to have higher claims, in the expectation that they (the younger generation) will themselves be subsidised by future generations. People pay more than is actuarially required in their younger years, but less than actuarially required in their later years. Intergenerational solidarity is Government policy, underpinned by regulation, not a statutory requirement of itself.

Lifetime Community Rating

Under a system of Lifetime Community Rating, the health insurance premium which a person pays is determined by the age at which they entered the health insurance market, but does not vary in relation to their current age. For example, a 60 year old who first took out health insurance at the age of 58 would pay a higher premium than a 60 year old who first took out (and continued to have) health insurance at the age of 25.

Lifetime Cover

Lifetime cover is a system that guarantees all consumers the right to renew their policies, irrespective of factors such as age, risk status or claims history. The system is governed by the Lifetime Cover Regulations, 1996. The effect of this system in Ireland is that private health insurers may not refuse to insure anyone who had health insurance at any time during the previous 13 weeks (except in very limited circumstances). This obligation extends to all insurers and applies to all insurance products.

Minimum Benefit Regulations

The Minimum Benefit Regulations, established under the Health Insurance Act, 1994 (Minimum Benefit) Regulations 1996, detail prescriptive schedules of treatments and minimum amounts of cover that insurers are required to offer for a wide range of treatments, as well as fees for treatments in public hospitals. The minimum amounts specified for treatments in the current regulations are in monetary terms.

National Treatment Purchase Fund (NTPF)

The National Treatment Purchase Fund was established in 2002 under the Government's Health Strategy to reduce long term waiting lists. The fund pays for the treatment of patients who have been on long term waiting lists in private or public hospitals in Ireland or England. The vast majority of treatments take place in private hospitals in Ireland.

Open Enrolment

Open enrolment is the practice whereby all applicants for private health insurance cover are accepted by a private health insurer, regardless of their risk status (subject to prescribed waiting periods). Insurers must comply with the terms of the Open Enrolment Regulations 2005. Insurers may not refuse to provide health insurance cover to anyone, except in very limited circumstances.

Out-Patient Services

Institutional services other than in-patient services provided at, or by persons attached to, a hospital or home and institutional services provided at a laboratory, clinic, health centre or similar premises. Outpatient services but does not include (a) the giving of any drug, medicine or other preparation except where it is administered to the patient direct by a person providing the service or is for psychiatric treatment, or (b) dental, ophthalmic or aural services.

Private Health Insurance (PHI)

Private health insurance can be distinguished, on the one hand, from compulsory social insurance which is deducted from earnings, and other forms of sickness or income protection insurance.

Preferred Provider Networks (PPN)

Preferred Provider Networks are selective networks of medical facilities or practitioners which PHI firms may choose to contract with for the provision of healthcare services.

Primary Healthcare

Primary Healthcare generally involves a visit to a medical professional such as a GP or a Public Health Nurse as a first port of call.

Restricted Membership Undertakings

These are occupation or work-based health insurance schemes, which come within the definition of a health insurance undertaking. Their policies must comply with all of the provisions of the health insurance legislation except that scheme membership is restricted to persons and their dependants of a common vocational, occupational or other group or class.

Risk Equalisation (RE)

Risk equalisation is a process that aims to equitably neutralise differences in insurers' costs due to variations in the health status of their members. Risk equalisation results in cash transfers from insurers with lower risk members to insurers with higher risk members.

Secondary Healthcare

Secondary healthcare is healthcare which involves treatment at a hospital on an in-patient or day-patient basis.

Tertiary Healthcare

Tertiary healthcare involves recuperative, rehabilitative or palliative care in a non-acute hospital setting, often extending over weeks, months or years.

Vhi Healthcare

Vhi Healthcare is the largest provider of PHI in Ireland. It was established under the Voluntary Health Insurance Act 1957, and is owned by the State.

VIVAS Health

VIVAS Health is the newest entrant to the private health insurance market in Ireland, having commenced operations in 2004.

EXECUTIVE SUMMARY

Context of the Report

1. The Competition Authority undertook this analysis of competition in the private health insurance market following a request by the Minister for Health and Children, in a press release of 23rd December 2005, to the Competition Authority and the Health Insurance Authority, to report *"on further measures to encourage competition in the health insurance market and the strategy or strategies which might be adopted in order to create greater balance in the share of the market held by competing insurers"*.

2. The analysis was undertaken in the context that Ireland's public policy objective in private health insurance is intergenerational solidarity – whereby the young subsidise the old by paying the same prices for private health insurance, despite the lower risk they represent to health insurers. The concept of intergenerational solidarity is underpinned by the following principles:

    a. **Community Rating** – unlike all other insurance products in Ireland, health insurers must charge all customers the same price for the same level of cover regardless of age, gender and the current or likely future state of their health.[1]

    b. **Open Enrolment** – all applicants for private health insurance must be accepted by a health insurer.

    c. **Lifetime Cover** - all consumers are guaranteed the right to renew their policies (irrespective of factors such as their claims history).

    d. **Minimum Benefits** – health insurers are required to cover a particular set of treatments and procedures, and to cover all public hospitals.

    e. **Risk Equalisation** – this system aims to neutralise differences in health insurers' costs that arise due to variations in the risk profile of their customer base. Risk equalisation results in cash transfers from health insurers with lower risk profiles to health insurers with higher risk profiles.

3. The Competition Authority does not assess the necessity, proportionality or appropriateness of these principles but their effects on competition are analysed, and measures to promote competition within this framework are identified. The report does not purport to tackle issues in the public health system, or to analyse how it affects the private health insurance market.

4. Since the Minister's request there have been a number of significant developments that may lead to a fundamental change in the structure of the Irish private health insurance market. Specifically, BUPA Ireland announced, on 14th December 2006, its intention to withdraw from the Irish market and has ceased accepting new members. Thus various potential future scenarios exist for the Irish private health insurance market and there is much uncertainty.

[1] Ireland's requirement of Community Rating is "unfunded", meaning that there is no fund built up over the lifetime of an insured person to cover their expected claims cost. Instead, the money contributed by all insured persons is pooled by each health insurer and the cost of claims in any given year is taken from the pools.

5. The Competition Authority concluded in December 2006 that it could best pursue its statutory objective of promoting competition by reporting in an independent capacity, rather than in conjunction with the Health Insurance Authority.

6. It was considered that a separate report could be completed more speedily and that this was desirable due to the increased market uncertainty and change to the original impetus for the report. Nonetheless, much useful work was carried out jointly by both Authorities and much of the analysis and findings contained in this report were informed by the expertise of the Health Insurance Authority.

Key Findings

The Effect of Public Policy on Competition

7. Competition in private health insurance in Ireland is constrained by the combination of it being a voluntary system and founded on the concept of intergenerational solidarity. The legislative and regulatory framework designed to support this decision significantly limits the scope for competition in private health insurance; by definition, community rating, open enrolment, lifetime cover, the Minimum Benefit Regulations and risk equalisation prevent many of the key features of competition in insurance markets[2] from emerging in private health insurance. For example:

   - Health insurers cannot offer discounts to people with healthier lifestyles, such as non-smokers;

   - Health insurers cannot offer discounts to employers who have programmes for promoting employee health, such as free/subsidised health screening;

   - Innovation in private health insurance is limited as health insurers must continue to cover procedures that have been overtaken by more effective and efficient technologies until the Minimum Benefit Regulations are updated; and,

   - Health insurers are constrained in their ability to select the most efficient network of hospitals.

8. Moreover, insurance is all about risk and insurance companies compete through the effective management of risk. As health insurers in Ireland are not allowed to price their products according to the perceived risk presented by each customer, the basis upon which actuaries can assess private health insurance products and customers is fundamentally changed and this limits the basis upon which health insurers compete.

9. The legislative and regulatory limitations imposed on private health insurance in Ireland to enforce intergenerational solidarity thus encourage the prices and products of competing health insurers to converge. One cannot expect to see the kind of competition in private health insurance that consumers are used to in other insurance markets.

[2] Insurance markets here refers to private insurance (e.g. motor insurance and house insurance), rather than public insurance (PRSI).

Factors that Inhibit and Distort Competition in Private Health Insurance

10. The private health insurance market is also characterised by a number of other factors which tend to distort and dampen competition beyond the restrictions imposed by intergenerational solidarity.

11. First, the largest private health insurance provider, Vhi Healthcare, is not prudentially regulated as a health insurance undertaking.[3] This situation arises from Vhi Healthcare's continued exemption under Art. 4(c) of the 1973 EU First Non-Life Insurance Directive.[4] Without this exemption, Vhi Healthcare would have to be regulated by the Financial Regulator and would be legally required to have reserves far greater than its current levels and to establish subsidiary or sister companies for selling its non-health insurance products (such as travel insurance and contact lenses).[5] Thus Vhi Healthcare enjoys a regulatory advantage which allows it to compete in ways not available to other health insurers.

12. Second, there are many barriers to new health insurers entering the Irish market. Some of these barriers to entry relate to the peculiarities of private health insurance and are unavoidable. The current climate of uncertainty regarding Risk Equalisation and BUPA Ireland's stated intention to exit the market also make the Irish private health insurance market less appealing. One barrier to entry is the market position of Vhi Healthcare in terms of its legacy as a State-owned former monopoly and its regulatory advantage. A less significant barrier is the large legacy network of salary deduction schemes that Vhi Healthcare built up as the former incumbent monopoly provider of private health insurance. Inertia on the part of employers makes it difficult for other health insurers to build up a similar network.

13. Third, although the process of switching health insurer is simple and straightforward, some consumers have an incorrect perception that the process is difficult and cumbersome. Certain practices by health insurers also discourage consumers from switching health insurer in response to a more competitive offering, for example tying private health insurance and travel insurance products.

14. Fourth, it is difficult for consumers to compare and contrast private health insurance policies. This makes it difficult for consumers to know which health insurer's product best meets their needs and inhibits competition.

15. Fifth, the Minimum Benefit Regulations, in their current form, hinder innovation in product design and the development of limited cover plans.

Key Recommendations

16. The Competition Authority makes 16 recommendations in this report for promoting competition in the private health insurance market in Ireland. In particular, the Competition Authority recommends:

    - Vhi Healthcare's exemption from prudential regulation should be ended as soon as possible so that it becomes subject to the legal solvency requirements and corporate structuring rules that apply to other health insurers in Ireland;

[3] Vhi Healthcare is regulated by the Financial Regulator in its capacity as an insurance intermediary, for the sale of travel insurance and dental health insurance for example.
[4] The European Commission recently announced that it has decided to *"send Ireland a formal request to submit its observations on the continued legality of the exemption of the Irish Voluntary Health Insurance Board (VHI) from certain EU rules on non-life insurance."* European Commission press release, 24th January 2007.
[5] Vhi Healthcare is currently statutorily prevented from establishing subsidiaries.

- A package of measures should be introduced to provide consumers with useful and timely information to enable them to consider alternative private health insurance products, and to promote consumer awareness of the ease of switching health insurer;

- Vhi Healthcare should discontinue its practice of cancelling its MultiTrip Travel Insurance when its members switch health insurer;

- The Minimum Benefit Regulations should be modernised and the Health Insurance Authority should be allowed to approve limited cover plans, to allow more innovation in the market;

- The Health Insurance Authority should conduct an information campaign to inform employers about how to set up multiple salary deduction mechanisms;

- The Health Insurance Authority should be given wider powers to enforce the Health Insurance Acts and formally assigned the function of promoting the interests of consumers; and,

- The Health Insurance Authority should undertake a full cost benefit analysis of what would be required to move to a prospective Risk Equalisation System and the Minister for Health and Children should clarify the exemptions from Risk Equalisation that apply.

17. These measures will promote competition in private health insurance, within the limits of intergenerational solidarity, regardless of how the market structure evolves.

The Commencement of Risk Equalisation Transfers

18. The Competition Authority finds that once Risk Equalisation transfers commence, the average price of private health insurance will increase regardless of the level of competition in the market. This is because the market is currently distorted by Vhi Healthcare's ability to reduce its level of reserves to compete with BUPA Ireland's and VIVAS Health's prices, which are in turn facilitated by their more favourable risk profiles. The commencement of Risk Equalisation transfers, and the impending requirement on Vhi Healthcare to increase its reserves to meet the Financial Regulator's requirements, will inevitably lead to price increases in private health insurance in Ireland.

19. The commencement of Risk Equalisation transfers is also likely to strengthen Vhi Healthcare's market power and allow it to increase its prices above competitive levels and sustain those prices for a significant length of time.

20. At the time of writing, it is extremely difficult to make predictions about the future of the private health insurance market and competition in the market given the speed at which events are unfolding.

21. Eventually, the uncertainty surrounding Risk Equalisation and BUPA Ireland's declared exit will dissipate. Vhi Healthcare's regulatory advantage will be ended. Thus the likelihood of new health insurers entering the market to compete with Vhi Healthcare will be somewhat improved.

22. Ireland may wish to consider more fundamental measures to promote competition. These measures could involve, for example, one or a combination of: structural solutions (e.g. splitting Vhi Healthcare into a number of competing insurers, and perhaps a one-off "Grey PHI" consisting of consumers over a certain age), privatisation, and a review of intergenerational solidarity and the manner in which that objective is pursued.

23. Whether such fundamental measures are desirable or not depends on the trade-offs between the actual value added by the principles governing private health insurance, which effectively control prices and redistribute risk, against the loss in consumer welfare caused by those same principles which by their nature prevent the emergence of a more normal competitive market.

Private Health Insurance in Ireland – Facts and Figures

24. The entire population of Ireland can avail of public care in public hospitals.[6] The main function of private health insurance in Ireland is to cover private secondary medical care in hospitals.

25. Since access to healthcare is guaranteed under the public health system, the role of private health insurance is to offer consumers a greater choice of treatments and facilities, higher standards of accommodation during treatment, and potentially shorter waiting times for treatment.

26. Around 50% of the population of Ireland has private health insurance – about 2 million people. This is quite a high penetration rate; in the UK, for example, which also has a universal public healthcare system but a *risk-rated* private health insurance market, around 10% of the population have private health insurance. Overall, the demand for private health insurance has increased with Ireland's economic growth.

27. BUPA Ireland entered the Irish private health insurance market in 1997[7] to compete with the State owned Vhi Healthcare, which had held a monopoly position for 40 years. BUPA Ireland steadily grew its market share to 20% in 2004, when VIVAS Health entered the market.

28. By September 2006, VIVAS Health had a market share of 3%, BUPA Ireland had a 22% market share, and Vhi Healthcare had 75% of private health insurance consumers.

29. It remains to be seen how the announcement by BUPA Ireland, in December 2006, that it intends to exit the market will affect relative market shares.

30. Private health insurance prices have been rising. Medical inflation has been running at much higher levels than elsewhere in the economy and this has been passed through to consumers of private health insurance.

[6] There is a daily charge of €60 up to an annual maximum charge of €600. Thirty percent of the population qualify for a medical card and are exempt from the €60 charge.
[7] Technically BUPA Ireland entered in 1996 but it began accepting business in 1997.

How Health Insurers Compete

31. Health insurers compete through product innovation and price competition. When it entered the Irish market in 1997, BUPA Ireland sought to differentiate its products from Vhi Healthcare, for instance by offering cover for alternative therapies. In 2004, VIVAS Health introduced a wide range of options for consumers, with cover for services which Vhi Healthcare and BUPA Ireland do not provide, such as tooth whitening and laser eye surgery. VIVAS Health also introduced some targeted marketing for certain occupational groups (e.g. nurses and teachers).

32. Vhi Healthcare responded to this competition, sometimes pre-emptively, by introducing its own innovations; in particular, complementary products such as travel insurance, dental insurance, and health clinics.[8] These are just some of the product innovations that have been introduced since Vhi Healthcare's monopoly ended in 1997.

33. When BUPA Ireland entered the market, it initially priced its products about 10% below comparable Vhi Healthcare plans. Since then, annual price increases by BUPA Ireland have been very similar in magnitude to Vhi Healthcare's, thereby maintaining this 10% price differential.

34. When VIVAS Health entered the market in October 2004, it initially priced its plans more than 10% below comparable BUPA Ireland products and more than 20% below comparable Vhi Healthcare products. The price differential between VIVAS Health and the other health insurers has increased in the last two years.

35. Competition in the private health insurance market in Ireland has led to the steady decline of Vhi Healthcare's share of the overall market and a corresponding steady gain by BUPA Ireland and later VIVAS Health.

36. As overall demand for private health insurance in Ireland has been growing, Vhi Healthcare's customer base has remained static, despite its declining share of the market.

37. Since BUPA Ireland entered the market approximately 10% of private health insurance consumers have switched health insurer.

38. Switching occurs mainly in the younger age cohorts, with "cost savings" by far the most commonly cited reason for switching. Thus newer health insurers tend to attract younger more profitable customers, and while Vhi Healthcare's overall market share may have been declining, it has retained a higher share of older and thus less profitable consumers. Many consumers have not switched because they are satisfied with their current provider or they see no point in switching.

Vhi Healthcare's Regulatory Advantage

39. Private health insurance is highly regulated, by a complex web of regulations, legislation and regulatory institutions including EU Directives, Irish health insurance legislation, the Minister for Health and Children, the Health Insurance Authority and the Financial Regulator.

[8] Ordinarily the Financial Regulator does not permit health insurance undertakings to sell other insurance products directly but Vhi Healthcare is not regulated by the Financial Regulator and is actually prevented from establishing subsidiaries under its legislative framework.

40. In 1992, the EU enacted the Third Non-Life Insurance Directive which, in effect, prescribed that Ireland must allow any health insurance company which is authorised in another EU Member State to offer health insurance in Ireland.

41. The existing framework of EU Directives and Irish health insurance legislation and regulations has led to each health insurer in Ireland being regulated differently:

    - Vhi Healthcare is exempt from prudential regulation (but must obtain the approval of the Minister for Health and Children in certain aspects of its business);

    - BUPA Ireland is an intermediary for a UK health insurance undertaking (BUPA Insurance Ltd); and,

    - VIVAS Health is the only health insurance undertaking in Ireland regulated as such by the Financial Regulator.

42. This means that the three health insurance providers are competing subject to differing regulatory restraints. For example:

    - Vhi Healthcare is not subject to any solvency requirements;

    - BUPA Ireland's underwriting is subject to UK solvency requirements; and

    - VIVAS Health's solvency requirements are set by the Financial Regulator.

43. This inconsistency distorts competition in private health insurance.

44. The Minister for Health and Children has already indicated her intention to legislate for Vhi Healthcare to be obliged "*to attain the level of reserves necessary to achieve authorisation as an insurer within six years*." The Competition Authority recommends that this timeframe be shortened and Vhi Healthcare's exemption from regulation as a health insurance undertaking removed as soon as possible.

45. The Competition Authority further recommends that this review should consider methods for Vhi Healthcare to build up its reserves to appropriate solvency requirements other than the accumulation of surplus through premium increases.

46. Vhi Healthcare should also be obliged to establish sister companies (or subsidiaries) to carry out its non-health insurance activities, as it would have to do if it was regulated by the Financial Regulator.

The Health Insurance Authority

47. The Health Insurance Authority was established in 2001 and is responsible for monitoring the operation of health insurance legislation, including associated regulations. Its powers of enforcement are very limited, however, and it does not have the explicit function and power of promoting consumers' interests as other sectoral regulators, such as the Financial Regulator, do.

48. If the Health Insurance Authority believes, for example, that a health insurer's product has the potential to undermine community rating, or that the information a health insurer provides to consumers is misleading, it has only the draconian power to de-register the health insurer or sometimes no power at all. The Competition Authority recommends that the Health Insurance Authority be given the powers to:

    - Direct that a health insurer alter its practices or its products to comply with the provisions of the Health Insurance Acts or regulations, and to provide for appropriate sanctions; and

    - Promote the interests of consumers.

49. Giving the Health Insurance Authority these powers will allow it to better protect consumers and promote competition by ensuring that the information consumers receive is accurate and useful, and that private health insurance products available in Ireland comply with the law.

Barriers to New Health Insurers Entering the Market

50. A wide range of obstacles to entering the Irish private health insurance market have been identified by stakeholders and potential entrants:

    - The irretrievable cost of building a trustworthy brand (although this would be less for a recognised provider of other forms of insurance);

    - Private health insurance is a highly regulated and specialised form of insurance and so specialist knowledge is required and commercial freedom limited;

    - Vhi Healthcare's legacy position as a former monopoly and State-owned entity, its regulatory exemptions and large market share;

    - Risk Equalisation and the associated uncertainty around its commencement; and,

    - Access to salary deduction mechanisms.

51. It is clear from the views of potential market entrants that the single greatest barrier to entry is the position of Vhi Healthcare in the market, whereby its legacy advantages are, in part, perpetuated by a favourable regulatory regime.

52. A less significant barrier is the large legacy network of salary deduction schemes that Vhi Healthcare built up as the former incumbent monopoly provider of private health insurance. Inertia on the part of employers makes it difficult for other health insurers to build up a similar network.

53. The Competition Authority recommends that the Health Insurance Authority should conduct a campaign to make employers aware of their ability to set up multiple salary deduction mechanisms.

Barriers to Existing and Future Health Insurers Competing

54. For competition in any sector to work it is important that consumers are able to choose the supplier which offers them the best product or service for their needs. For products such as private health insurance, which involve ongoing contracts, consumers must be able to switch their health insurer when they are offered a more suitable or more competitive product than their existing plan.

55. The actual process of switching health insurer is simple and straightforward. Research indicates that 98% of switchers were "satisfied" or "very satisfied" with the switching process.

56. Switching is inhibited because consumers find it difficult to make comparisons between different private health insurance products in the first instance and because there is an incorrect perception that switching is difficult or may lead to a loss of cover. There is also a certain amount of consumer inertia – 14% of private health insurance consumers surveyed said that they would never switch insurer.

57. The Competition Authority recommends a package of measures to promote better information for consumers to enable them to switch health insurer where appropriate.

    - Health insurers should be obliged to provide prescribed information to consumers regarding the switching process and comparing private health insurance plans, both at point of sale and renewal; and,

    - The Health Insurance Authority should draft a Switching Code for health insurers detailing their duties during the switching process.

58. These recommendations will bring the private health insurance market into line with recent reforms in markets for other financial products such as motor insurance and bank current accounts. They will aid any new health insurers in attracting customers from existing providers.

59. One further market feature that inhibits switching is Vhi Healthcare's practice of linking its private health insurance products to its travel insurance products. If a customer of Vhi Healthcare decides to switch his/her private health insurance to another health insurer, and that customer has also purchased a Vhi MultiTrip travel insurance product, Vhi Healthcare also cancels the travel insurance.

60. This practice forces Vhi Healthcare customers to research alternative travel insurance products as well as alternative private health insurance products when they are considering switching. Switchers who wish to avoid gaps in their travel insurance cover are forced to switch both products at the same time. This practice discourages Vhi Healthcare customers from switching to alternative health insurers by creating unnecessary inconvenience. This should cease immediately.

61. The Minimum Benefit Regulations were established to give consumers a high degree of protection, given the complexities of private health insurance products, by obliging health insurers to cover certain procedures and hospitals.

62. The Regulations ensure that consumers do not inadvertently purchase private health insurance plans with insufficient cover. However, the Regulations also limit the extent to which health insurers can innovate and reduce the scope for the development of "limited cover plans". Limited cover plans are tailored, lower cost plans which, for example, cover a limited set of hospitals or do not offer maternity benefits.

63. The Competition Authority recommends that the system of minimum benefits should be simplified and updated, and that products offering limited cover should be permitted subject to prior regulatory approval by the Health Insurance Authority.

Vhi Healthcare's Buyer Power

64. The three health insurers in Ireland cover about 50 private medical facilities[9] and close to 2,000 hospital consultants. Private hospitals are heavily reliant on custom generated by private health insurers. Other sources of custom for private hospitals are the National Treatment Purchase Fund, restricted membership health insurance schemes or persons who pay for treatment out of their own pockets.

65. At the same time, private health insurance tends to lead to incentives to over-consume private healthcare, because the consumer is no longer paying the true cost of private healthcare. Over-consumption of healthcare pushes up the cost for all consumers. Thus health insurers seek ways to minimise the effect of this tendency towards over-consumption and their negotiating power over the private hospitals and consultants aids them in this regard.

66. With 75% of private health insurance consumers, Vhi Healthcare is by far the largest buyer faced by private hospitals. If BUPA Ireland's stated intention to exit the market results in there being only two health insurers in Ireland Vhi Healthcare's position will be further strengthened.

67. Vhi Healthcare's position affects contractual negotiations between private hospitals and other health insurers; Vhi Healthcare "sets the rules of the game". This does not give Vhi Healthcare a significant advantage in the private health insurance market, however, as other health insurers benefit from being able to replicate Vhi Healthcare's contract arrangements.

68. Vhi Healthcare's position also makes it a "gatekeeper" of significant importance. The OECD has found that *"Providers…. cannot afford not to have a contract with one insurer, given the concentration of the [private health insurance market] and their high dependence on income from privately insured patients".*[10] New private hospitals will find it difficult to prosper without securing Vhi Healthcare's custom. According to the OECD, the Irish private hospital sector is relatively underdeveloped, and most private treatments are still delivered in public facilities, in part because health insurers have not supported private hospital capacity increases.[11]

69. Vhi Healthcare's scale may enable it to negotiate better reimbursement rates, and thus lower premiums for its customers, but the measures taken by Vhi Healthcare to reduce reimbursement costs are those which any economically rational health insurer would be expected to exercise and do not rely exclusively on buyer power. Cost control measures, rather than buyer power, drive real efficiencies in the provision of private hospital services.

70. Financially prudent health insurers exercise caution in deciding which hospital facilities to cover. It is prudent for health insurers to refuse to cover medical facilities where there are justifiable concerns that such facilities would constitute unused surplus capacity; average costs fall as more capacity is used.

71. However, by virtue of its buyer power Vhi Healthcare has a significant influence over the level of private hospital capacity in Ireland. The Minister for Health and Children has recently announced a number of measures which will lead to an increase in the number of private hospitals in Ireland.

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[9] Around half are in-patient hospitals which vary substantially in size; 20% are treatment or addiction centres; and the remaining 30% includes dental clinics, laser eye clinics, cosmetic surgery facilities, imaging facilities, diagnostics, pathology-related testing and respite care.

10 OECD (2004) p.38

[11] OECD (2004a), p.177

Risk Equalisation and Community Rating

72. Risk equalisation is a mechanism that aims to neutralise the effects of differing risk profiles across insurers. It aims to avoid the market instability that can arise if individual health insurers fail to attract a sufficient share of low risk consumers. Risk Equalisation by its nature limits competition.

73. The practice of risk adjustment and reimbursement started more than 30 years ago in the United States. Countries which have introduced a form of risk equalisation or cost reinsurance include Australia, Canada, New Zealand, Germany and the Netherlands.[12]

74. Ireland introduced legislation providing for Risk Equalisation in 1994; the current system came into effect in 2003. Risk Equalisation transfers under the Irish scheme will affect competition, both in terms of price and competition for different market segments.

75. Vhi Healthcare has stated that it cannot survive without Risk Equalisation transfers. BUPA Ireland has always maintained that it cannot make a profit under Risk Equalisation and that it would exit the market if it had to make Risk Equalisation transfers (which is has stated that it will now do). VIVAS Health has never objected to the existence of Risk Equalisation *per se* (though it believes Ireland's particular Risk Equalisation Scheme to be "draconian") and has recently reiterated its commitment to the Irish private health insurance market.

76. BUPA Ireland and VIVAS Health have to date been able to price below Vhi Healthcare due to their more favourable risk profile and hence lower average claims. Prior to BUPA Ireland's declared intention to exit the market, the Competition Authority concluded that the commencement of Risk Equalisation transfers would, in the short run, have likely led to a sharp rise in BUPA Ireland's prices. This effect would tend to lead to a narrowing of the price differential between Vhi Healthcare and BUPA Ireland. This is due to the neutralising effect Risk Equalisation transfers have on risk profile asymmetry; all health insurers will have to carry a share of the cost of all risks.

77. The commencement of Risk Equalisation transfers and the subsequent narrowing of price differentials could have numerous effects. First, BUPA Ireland's most price-sensitive consumers would be likely to discontinue cover completely. Second, switching from Vhi Healthcare would become less likely and, if BUPA Ireland's prices increased by as much as it estimated, switching to Vhi Healthcare would have become more likely. Each of these effects imply a consolidation of Vhi Healthcare's market position.

78. VIVAS Health is exempt from Risk Equalisation transfers until October 2007; the price differential between VIVAS Health and Vhi Healthcare will then also narrow.

79. Overall, price competition will be significantly reduced in the short term and the scope for price competition in the future will remain limited. Risk Equalisation transfers will reduce the competitive pressure on Vhi Healthcare.

[12] Though in many of these countries, private health insurance is mandatory.

80. Risk Equalisation transfers also change health insurers' incentives to compete across different market segments. In the absence of Risk Equalisation transfers, health insurers have an incentive to target low risk customers, typically younger customers, who are more profitable in a community rated market. Risk Equalisation attempts to eliminate advantages from competing for low risk customers only.

81. There is no perfect Risk Equalisation system, however, and health insurers may still try to improve their position by attracting less risky customers. They may succeed because young people generally switch more readily and healthier people may also switch more readily.

82. Nonetheless, Risk Equalisation should improve competition for older and more risky customers, although the considerable inertia of this segment will make it more difficult for other health insurers to attract this custom.

83. Finally, Risk Equalisation discourages new health insurers from entering the Irish market. Though new health insurers are exempt from Risk Equalisation transfers for three years, they are likely to be net contributors to the Risk Equalisation system as they tend to win custom from younger and healthier individuals.

Vhi Healthcare's Market Power

84. Market power allows a health insurer to set prices above competitive levels or reduce the quality of its products below what would be the norm in a competitive market. It can also reinforce barriers to entry and slow down the rate of innovation.

85. Once Risk Equalisation payments commence, Vhi Healthcare's market power will increase significantly. This is the case regardless of whether BUPA Ireland exits the market.

86. Vhi Healthcare's market power stems from a combination of factors:

- Vhi Healthcare's very large share (75%) of a market which has very few health insurers;
- Vhi Healthcare has been able to maintain prices above its competitors for comparable plans, and Risk Equalisation transfers would allow it to profitably raise its prices;
- Though Vhi Healthcare did respond to competition from BUPA Ireland and VIVAS Health by introducing innovations and new products, the commencement of Risk Equalisation transfers will reduce the competitive pressure on Vhi Healthcare to attract and retain price-sensitive consumers;
- The competitive threat from new health insurers entering the market is low due to the high barriers to entry; and,
- Private health insurance customers, including group schemes, have little or no countervailing buyer power when dealing with Vhi Healthcare.

87. Before Risk Equalisation was triggered, Vhi Healthcare had some market power but BUPA Ireland and VIVAS Health imposed a significant competitive constraint on the behaviour of Vhi Healthcare. The commencement of Risk Equalisation transfers will substantially weaken this competitive constraint and increase Vhi Healthcare's market power. Vhi Healthcare is likely to be able to profitably increase its premiums above competitive levels for a sustained period of time.

88. The Competition Authority also finds that once Risk Equalisation transfers commence, the average price of private health insurance will increase regardless of the level of competition in the market. This is because the market is currently distorted by Vhi Healthcare's ability to reduce its level of reserves to compete with BUPA Ireland's and VIVAS Health's prices, which are in turn facilitated by their more favourable risk profiles. The commencement of Risk Equalisation and the impending requirement on Vhi Healthcare to increase its reserves to meet the Financial Regulator's requirements will inevitably lead to price increases in the market.

Potential Further Measures to Promote Competition

89. At the time of writing, it is extremely difficult to make predictions about the future of the private health insurance market and competition in the market given the speed at which changes are occurring.

- Eventually, the uncertainty surrounding Risk Equalisation and BUPA Ireland's declared exit will dissipate;

- The implementation of the Competition Authority's recommendations should reduce barriers to entry and provide more scope for effective competition between health insurers; and,

- The longer VIVAS Health is in the market the more valuable and trusted its brand will become.

90. Regardless of how the structure of the private health insurance market evolves, Ireland may wish to consider more fundamental measures to promote competition. These measures could involve, for example, one or a combination of: structural solutions (i.e splitting Vhi Healthcare into a number of competing insurers, and perhaps a one-off "Grey PHI" consisting of consumers over a certain age), privatisation, and a review of intergenerational solidarity.

91. Whether such fundamental measures are desirable or not depends on the trade-offs between the actual value added by the principles governing private health insurance, which effectively control prices and redistribute risk, against the loss in consumer welfare caused by those same principles which by their nature prevent the emergence of a more normal competitive market.

92. When considering fundamental measures, the following factors must be taken into consideration:

- A structural solution may cause some administrative duplication initially but this would not be major and could certainly be overcome by selling "baby Vhi"s to experienced (health) insurance undertakings;

- Structural solutions may require the destruction of the Vhi Healthcare brand;

- The effect on health insurers' ability to negotiate with private hospitals and hospital consultants;

- All options would need to be researched in terms of their feasibility, legal requirements, costs and benefits to find the most appropriate package of measures;

- Private health insurance is inextricably linked to (perceptions of) Ireland's public health system – any changes to one will affect the other.

LIST OF RECOMMENDATIONS

The Competition Authority makes 16 recommendations to improve competition in the Irish private health insurance market. A number of these recommendations concern the structure and regulation of Vhi Healthcare. The Authority recommends addressing Vhi Healthcare's market position by means of legislative and regulatory measures (Recommendations 1-5).

In a Press Release of December 23rd, 2005, the Minister for Health and Children announced that the recommendations arising from this Report would *"inform the drafting of the Bill that will provide for the conversion of VHI into a PLC"*. Accordingly, dates have not been allocated against each Recommendation, as is the Competition Authority's normal practice. Instead, some Recommendations (1, 2, 3, 6, 7, 9, 10, 12, 13 and 16) are designed to be accommodated as part of the upcoming Bill mentioned in the Minister's Press Release, while others (Recommendations 4 and 5) are contingent on the earlier recommendations.

Recommendation 1 **Require Vhi Healthcare to establish subsidiary or sister companies for activities other than health insurance**	**Action By**
Vhi Healthcare should be obliged to provide non-health insurance services in the same manner as other insurers. Accordingly, the Minister should allow and oblige Vhi Healthcare to establish sister companies (or subsidiaries) to carry out non-health insurance activities.	**Minister for Health and Children**

Recommendation 2 **Reassess the requirements placed on Vhi Healthcare to meet the Financial Regulator's reserve requirements**	**Action By**
Vhi Healthcare's solvency reserve requirements should be reassessed. • The proposed six-year timeframe allowed for Vhi Healthcare to attain the necessary level of reserves to be regulated as an insurance company should be reviewed. • Consideration should also be given to reducing the level of solvency reserves required of Vhi Healthcare prior to the conclusion of the "Solvency 2" process. • Consideration should be given by the Minister to methods of permitting Vhi Healthcare to raise capital by means other than the accumulation of surplus.	**Minister for Health and Children**

Recommendation 3 **Remove the requirement for Vhi Healthcare to seek Ministerial approval for premium increases**	**Action By**
The requirement for Ministerial approval for Vhi Healthcare premium increases under S.3 of the Voluntary Health Insurance (Amendment) Act, 1996 should be abolished.	**Minister for Health and Children**

Recommendation 4 **Regulate Vhi Healthcare as an insurance undertaking once it has reached the required reserves**	**Action By**
Vhi Healthcare should be subject to prudential regulation in its capacity as an insurance undertaking by the Financial Regulator when it has reached the level of reserves required by the Financial Regulator.	**Financial Regulator**

Recommendation 5 **Remove Vhi Healthcare's exemptions from the EU Non-Life Directives**	**Action By**
Vhi Healthcare's exemptions from the First and Third EU Non-Life Directives should be abolished. Once Vhi Healthcare has received authorisation as an insurance company from the Financial Regulator by reaching the required level of reserves, removal of these exemptions by the institutions of the EU should be sought by the Minister for Health and Children.	**Minister for Health and Children**

Recommendation 6 **Provide the Health Insurance Authority with wider powers to enforce the Health Insurance Acts**	**Action By**
Legislation should be brought forward to amend the Health Insurance Acts and provide that the Health Insurance Authority has the power to direct that a health insurer alter its practices or its products to comply with the provisions of the Acts or regulations thereunder; and is granted the power to apply appropriate sanctions.	**Minister for Health and Children**

Recommendation 7 **Assign the Health Insurance Authority the function of promoting the interests of consumers**	**Action By**
Legislation should be brought forward to amend the Health Insurance Acts to assign to the Health Insurance Authority the function of promoting the best interests of consumers.	**Minister for Health and Children**

Recommendation 8 **Employers should be made aware of their ability to set up multiple salary deduction mechanisms**	**Action By**
The Health Insurance Authority should conduct an information campaign to employers who provide employees with the option of paying their health insurance via salary deduction to inform them of the ease with which multiple salary deduction mechanisms can be set up.	**HIA** **2007**

Recommendation 9 **Implement a Switching Code for private health insurance**	**Action By**
The Health Insurance Authority should draft a Switching Code for health insurance which would, in a brief, clear and definitive manner, detail the duties and obligations of health insurers during the switching process, as well as the rights of consumers.	**HIA** **2007**

Recommendation 10 **Provide consumers with prescribed switching information at point of sale and renewal**	**Action By**
Health insurers should be obliged by statute to provide prescribed information to consumers on their rights regarding switching and waiting periods as well as information to facilitate comparison and understanding of products and of their rights as consumers. Following consultation between the Health Insurance Authority, the insurers and others (e.g. National Consumer Agency), a prescribed format of documentation should be drawn up. Each insurer should be responsible for providing this documentation to consumers at point of sale and at renewal time. In the interim period, PHI firms should distribute the HIA's current pamphlet on consumer rights with renewal notices. This pamphlet should be replaced by the 'new' documentation when it is ready.	**HIA** **Health Insurers** **Annually** **Minister for Health and Children**

Recommendation 11 **Vhi Healthcare should cease cancelling travel insurance policies where a customer switches from Vhi Healthcare to another health insurer**	**Action By**
Vhi Healthcare should cease automatically cancelling the Vhi Healthcare MultiTrip travel insurance policies of customers who switch their PHI policy from Vhi Healthcare to another health insurer. Vhi MultiTrip travel insurance policies should remain active until the policy expiry date. Vhi Healthcare should be obliged to cover any claims which fall under the 'travel' element of the insurance policy, while the consumer's new health insurer should be obliged to cover any claims which fall under the consumers' health insurance policy. This recommendation would also apply to other health insurers should they decide to sell travel insurance products which are conditional on having private health insurance with them.	**Vhi Healthcare** **2007**

Recommendation 12 **The Minimum Benefit Regulations should be simplified and updated**	**Action By**
The Minister for Health and Children should amend the *Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996* in order to accomplish the following goals: • Simplify the system of minimum benefits • Remove restrictions on the PHI products which health insurers can offer, while maintaining an obligation to provide a certain minimum level of healthcare cover to any individual covered by a health insurance contract • Remove the fixed minimum monetary values • Specify benefits to be covered in non-monetary terms, if possible	**Minister for Health and Children**

Recommendation 13 **The Health Insurance Authority should be allowed to approve limited-cover plans**	**Action By**
If limited cover plans are found to be feasible and compliant with relevant legislation and with community rating, the Minister should amend the *Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996* to give the Health Insurance Authority responsibility for approving limited-cover plans proposed by health insurers. The key criterion for regulatory authorisation should be whether any such product could undermine community rating in the PHI market.	**Minister for Health and Children**

Recommendation 14 **The likely effect of the Health Status Weight on the scope for price competition in the market should be taken into account when investigating its introduction**	**Action By**
When investigating the introduction of the HSW the HIA, in addition to concluding that the material difference 'wholly or substantially' is attributed to variations in health status rather than efficiencies, should also take into account any likely effect that raising the HSW will have on scope for price competition in the market.	**Health Insurance Authority**

Recommendation 15 **Undertake a cost benefit analysis of moving to a prospective Risk Equalisation system**	**Action By**
Undertake a full cost benefit analysis of what would be required to move to a prospective Risk Equalisation system.	**Health Insurance Authority**

Recommendation 16 **Clarify eligibility for Risk Equalisation payment exemptions**	**Action By**
Legislation should be brought forward clarifying what type of companies are eligible for the limited exemption from the requirement to make returns and otherwise comply with the Risk Equalisation Scheme.	**Minister for Health and Children**

1. PRIVATE HEALTH INSURANCE – A MOVING TARGET

1.1 This report is the Competition Authority's assessment of competition in the private health insurance ("PHI") market in Ireland. It assesses barriers to competition in the market and makes 16 recommendations designed to promote market entry and improve competitive dynamics in PHI.

Request from the Minister for Health and Children

1.2 In December 2005, the Minister for Health and Children asked the Competition Authority and the Health Insurance Authority ("HIA") to:

> *"report to me within six months on further measures to encourage competition in the health insurance market and the strategy or strategies which might be adopted in order to create greater balance in the share of the market held by competing insurers".*

1.5 Following discussions between the Health Insurance Authority and the Competition Authority the following Terms of Reference were agreed between the two Authorities in Spring 2006:

- *"Examine market structure in relation to private health insurance, and identify relevant sub-markets, if they exist. These markets will be analysed from the perspective of restrictions on the degree of rivalry, barriers to entry and barriers to switching private health insurers.*
- *Identify and analyse industry practices, legislation and/or administrative practices in private health insurance in the State that limit the degree of rivalry in the marketplace to the detriment of consumers.*
- *Identify barriers to switching private health insurers, analyse their origin, and, where appropriate, make recommendations to have unnecessary barriers to switching removed.*
- *Identify duties that could be assigned to the Health Insurance Authority under existing legislative provisions and additional functions that might possibly be assigned to the Health Insurance Authority.*
- *Identify and analyse any implications for competition of existing primary and secondary legislation affecting private health insurance.*
- *On the basis of the analysis and conclusions of the joint report of the health insurance market –*
    - *Make recommendations for change to any enactment or administrative practice that is limiting competition in private health insurance in the State to the detriment of consumers.*
    - *Make any other recommendations deemed appropriate."*

1.3 The Competition Authority and the HIA conducted a joint analysis from late Spring 2006 onwards. The analysis was conducted within the framework of Ireland's decision to have PHI available on the basis of intergenerational solidarity, whereby the young subsidise the old. This is supported by Community Rating, Lifetime Cover, Open Enrolment, Minimum Benefit Regulation and Risk Equalisation.

1.4 The Authorities' preliminary recommendations were accordingly designed to promote and facilitate market entry, and increase rivalry between firms who were already in the market.

Recent Developments May Radically Alter the Market Structure

1.6 In the latter stages of the Authorities' work, a number of significant developments took place in the health insurance market.

- On 23rd November 2006, in judicial review proceedings, the High Court dismissed a claim by BUPA Ireland that the scheme of Risk Equalisation introduced by the Minister for Health and Children in November 2005 was unconstitutional. While Mr Justice McKechnie's decision also acknowledged that the scheme involved elements of anti-competitive behaviour, particularly interference with profitability, and made entry less attractive, it upheld the current scheme of Risk Equalisation.

- Following this judgment, BUPA Ireland announced on 14th December 2006 its intention to withdraw from the Irish market and has ceased accepting new members.

- At the time of writing (January 2007) it is unclear what BUPA Ireland's future intentions are. BUPA Ireland has appealed this decision to the Supreme Court. AXA Insurance has confirmed that it is in discussions with the Department of Health and Children with a view to taking over BUPA Ireland's customer book.[13] However BUPA Ireland has indicated that they are keeping open the possibility of re-entering the market should market conditions change.[14]

1.7 These developments indicate that there is still a very high degree of uncertainty in the market, as it is not clear whether BUPA Ireland will, in fact, exit the market and, if it does, whether another insurer will buy its book and take over its position in the market.

The Competition Authority's Decision to Conclude its own Report

1.8 While the two Authorities had substantially completed their analysis and drawn up draft recommendations in December 2006, BUPA Ireland's announcement caused the Competition Authority to reappraise these findings and recommendations.

1.9 The Competition Authority decided in December 2006 to cease working jointly with the Health Insurance Authority and proceeded to conclude the Report on competition in the private health insurance market separately. The Competition Authority took this decision in cognisance of the urgent need to bring the report to a conclusion. The Minister for Health and Children was informed of the Competition Authority's decision in December 2006.

1.10 In her press release of 23rd December, 2005, the Minister for Health and Children asked the Competition Authority and the Health Insurance Authority to report to her within six months. The Authorities quickly became aware that it would not be possible to produce a rigorous analysis and report within this timeframe.

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[13] *Axa in talks to take over from BUPA*, 10th January 2007. Available online at http://www.rte.ie/business/2007/0110/axa.html

[14] *BUPA says no to call for AXA takeover*, 11th January 2007. Available online at http://www.unison.ie/irish_independent/stories.php3?ca=133&si=1751957&issue_id=15086

1.11 Both Authorities also found in the course of their work that the necessity to get the approval of two separate Authority Boards at various stages contributed to a significant lengthening of the drafting process. Compared to Studies of other markets undertaken by the Competition Authority on a sole basis, this added significantly to the time and workload necessary to progress to final drafting.

1.12 Following the announcement by BUPA Ireland in December 2006, the Competition Authority concluded that it was necessary to expedite delivery of the Report, while, at the same time, there was a need to review all the analysis to date in the context of BUPA's stated intention to exit the market by assessing how changes in the private health insurance market might alter structures, incentives and market power in the market.[15] The Competition Authority was also cognisant of the Minister's statement that she expected the Report on competition in private health insurance in mid-January 2007.[16] The simplest means of bringing the Report to a speedy conclusion was to dispense with the dual approach and for the Competition Authority to focus on completing a report alone.

1.13 Nonetheless, much useful work was carried out jointly by both Authorities, and much of the analysis and findings contained in this report was informed by the expertise of the Health Insurance Authority. It is hardly necessary to reiterate that the Competition Authority's decision to conclude this report on an independent basis in no way reflects on the professionalism and expertise of the Health Insurance Authority. The Competition Authority is grateful for the assistance of the Health Insurance Authority, without whose participation and knowledge this report would not have been possible. The Authorities continue to enjoy an excellent working relationship.

Provision of Information by Interested Parties

1.14 The two Authorities undertook a joint public consultation process; in addition, a number of key external stakeholders were consulted. The Competition Authority wishes to express its gratitude to the various individuals, firms, and other bodies who took the time to make submissions during the consultation period, or who otherwise participated during the drafting of this report. This report could not have been completed without the input of these parties. A list of submissions received is contained in Appendix 7.

1.15 This Report makes use of certain data provided to the Competition Authority under summons by BUPA Ireland. In complying with the summons, BUPA Ireland asked the Competition Authority to place on record its objection to the Joint Report and the associated drafting process. BUPA Ireland made no submissions to the Joint Study, and did not participate voluntarily in the process. BUPA Ireland considered that the Joint Report process was not provided for under statute and was outside the scope of the Competition Authority's powers.

1.16 BUPA Ireland also wished to clarify that it had consistently welcomed the Competition Authority's involvement in the private health insurance market. It made clear that its objections were directed at the manner and timing of the process, mandated by the Department of Health and Children, and the involvement of the Health Insurance Authority, together with what it saw as constraints on the terms of reference.

[15] This conclusion is valid notwithstanding AXA Insurance's more recent statement of intent with respect to the health insurance market.
[16] "Government regrets BUPA's decision to leave the Irish market". Available online at http://www.dohc.ie/press/releases/2006/20061214c.html

Structure of the Report

1.17 The structure of the Report is as follows:

- Chapter 2 describes the PHI market in Ireland;
- Chapter 3 assesses how health insurers compete;
- Chapter 4 discusses the regulation of PHI in Ireland and regulatory reform;
- Chapter 5 analyses barriers to entry;
- Chapter 6 analyses ways to improve competition between private health insurers;
- Chapter 7 analyses buyer power;
- Chapter 8 describes Risk Equalisation and considers its effects on competition in the market;
- Chapter 9 examines market power in the PHI market; and,
- Chapter 10 contains concluding comments.

1.18 A number of Appendices are included with supporting material.

2. THE PRIVATE HEALTH INSURANCE MARKET

Summary

2.1 Over two million people in Ireland have voluntary private health insurance (PHI), representing 50% of the population. Demand for health insurance has grown steadily since it first became available in Ireland in the late 1950s. A number of factors have contributed to the growth in demand for health insurance including economic and population growth as well as a negative perception of the public hospital system.

2.2 The PHI market was opened to competition in the mid-1990s and, a new set of regulations was simultaneously introduced. Prior to this, Vhi Healthcare was the sole operator in the market, having been granted a statutory monopoly in 1957. BUPA Ireland began operations in January 1997 and VIVAS Health entered the market in late 2004. In December 2006, Vhi Healthcare had a 75% market share, BUPA Ireland had a 22% share, and VIVAS Health had 3% of the market.

2.3 This chapter discusses the role of PHI in Ireland in relation to the public and private hospital system, defines the market for PHI for the purpose of this report, and examines the demand for and the supply of PHI. The chapter provides a description of the main principles underlying the PHI market, namely: community rating, lifetime cover, open enrolment, minimum benefits and risk equalisation.

The Public and Private Hospital System and the Role of Private Health Insurance

2.4 Healthcare can generally be divided into three broad categories:

- Primary healthcare, which refers to healthcare provided by GPs (general practitioner), dentists and other healthcare workers who work as a first port of call for patients;
- Secondary healthcare, which refers mainly to medical treatment carried out in hospitals; and
- Tertiary healthcare, which refers mainly to nursing homes, convalescence etc.

2.5 The healthcare system in Ireland can be divided between public healthcare which is funded by the State and private healthcare which patients must pay for. There are both public and private hospitals. Many public hospitals have a substantial proportion of private beds which, in some cases, are located in separate sections of public hospitals. Patients who are treated publicly in public hospitals tend to have long waiting periods for elective treatments for both adults and children.[17] Patients who are treated privately tend to have shorter waiting periods.

2.6 The entire population is entitled to public care in public hospitals for a daily charge of €60.[18] Medical card holders are exempt from this charge.[19] Public health care provision is much more restricted in primary and tertiary care. Only those with medical cards are entitled to free primary care.

[17] Although waiting periods vary considerably depending on medical and surgical conditions and between adults and children.
[18] Up to an annual maximum charge of €600.
[19] Currently just over 30% of the population is entitled to a medical card.

2.7 Patients who are treated privately either pay for their medical expenses themselves or, if they have PHI, their insurer pays for their treatment on their behalf (if it is covered by their insurance policy).[20] Patients with PHI who require elective treatments can usually gain access to private beds in most of the public hospitals relatively quickly and be treated privately.

2.8 The main function of PHI in Ireland is to cover private secondary medical care in hospitals.[21] The Minimum Benefit Regulations specify the minimum level of cover which a PHI plan must provide.[22] Most PHI plans cover all or part of the fees arising from a hospital in-patient stay (i.e. overnight) and ancillary healthcare services that are medically necessary, such as procedures performed in a day-care or side-room setting. Most PHI policies also cover some level of outpatient treatment[23] and a small degree of primary care.

2.9 PHI provides subscribers with either private or semi-private[24] accommodation in three different categories of hospitals depending on the level of cover held by the subscriber. These three categories of hospitals are:

- Public hospitals (i.e. hospitals that are funded by the State);
- Privately owned and operated hospitals; and
- High-tech private hospitals such as the Galway Clinic, Blackrock Clinic and the Mater Private Hospital.[25]

Defining the Private Health Insurance Market

2.10 Defining the relevant market is typically the starting point in a competition analysis. The purpose is to determine to what extent buyers can substitute between products – in this case between PHI products, or between PHI and other products. Relevant markets have both products and geographic dimensions.

2.11 The relevant market defined for the purpose of this report is open enrolment PHI policies that offer indemnity for in-patient hospital services with varying levels of hospital accommodation in Ireland. This will be referred to as the "PHI market" in this Report. A full discussion of the definition of this market is contained in Appendix 2.

Demand for Private Health Insurance

2.12 Demand for PHI has risen continuously since its introduction in the late 1950s. During the 1980s around 30% of the population had PHI. This has grown to a current level of 50% of the population or some 2 million people. Although the average age of PHI consumers is rising, demand among young people continues to be strong.

2.13 The main determinants of demand for PHI in Ireland are:[26]

- Employment growth;

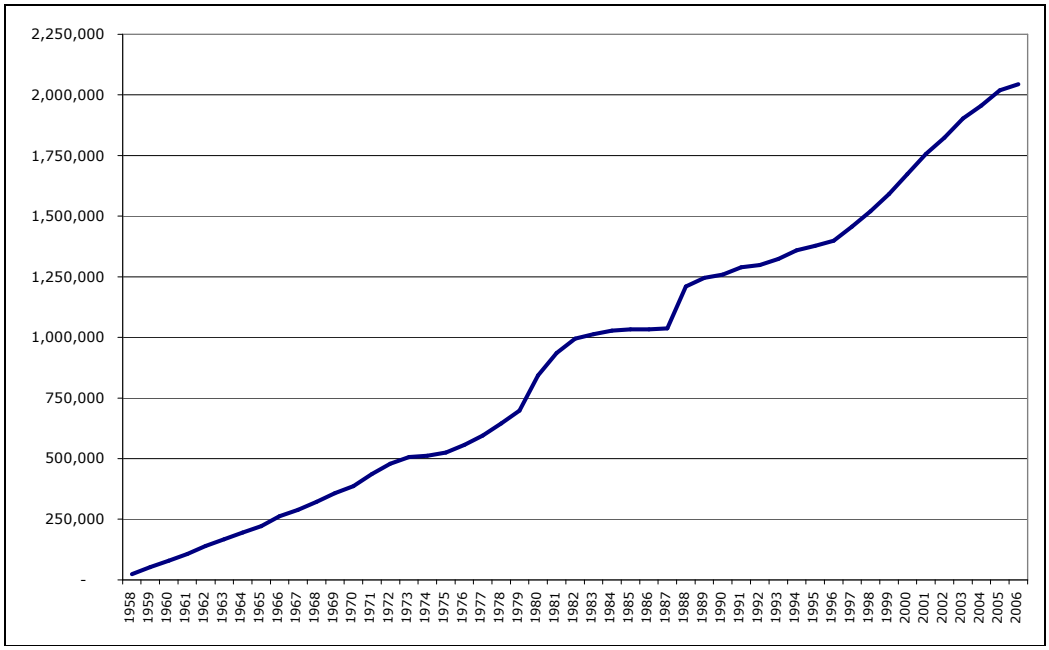
[20] This may be subject to limits depending on the PHI policy.
[21] A health insurance contract is defined by the Health Insurance Act, 1994, as amended by the Health Insurance (Amendment) Act, 2001.
[22] The Minimum Benefit Regulations are discussed in more detail towards the end of this chapter.
[23] Outpatient treatment is treatment provided in a hospital which does not require an overnight stay.
[24] A semi-private room is a room which contains not more than 5 beds.
[25] These high-tech hospitals are only covered on certain PHI policies which tend to be the most expensive policies. See Chapter 3 for a discussion of PHI polices and prices.
[26] Nolan and Wiley (2000).

- Real incomes;
- Price of PHI; and
- Perceptions of the quality of public system care and the length of waiting lists.[27]

2.14 As already stated, the proportion of the population with PHI has risen significantly since the mid-1990s and continues to grow by about 3% per year. This is illustrated in Figure 1 below. The main reasons for this are as follows:

- The economy grew exceptionally rapidly from 1998 to 2001, with accompanying growth in the population and labour force and a fall in unemployment;
- The entry of two new players into the market has caused an increase in product development in the market; and
- Consumer research shows that there was a continued significant perception among the public that the public health services were inadequate and that waiting lists were long.

Figure 1: Growth in Number of People with Private Health Insurance 1958-2006



Source: White Paper 1999; BUPA Ireland Summons; HIA

[27] See, for instance, Watson, D and Williams, J (2001*) "Perceptions of the Quality of Health Care in the public and private sectors in Ireland",* ESRI.

Supply of Private Health Insurance

2.15 There are three companies operating in the PHI market; BUPA Ireland, Vhi Healthcare and VIVAS Health.

- Vhi Healthcare, the State-owned mutual health insurance company, had a monopoly before the PHI market was opened to competition in the mid-1990s.

- BUPA Ireland was the first new entrant into the PHI market in 1997 and is an intermediary that sells health insurance for the Irish branch of BUPA Insurance Ltd.[28]

- VIVAS Health is the newest entrant having commenced operations in October 2004.

Main Principles Underlying the Private Health Insurance Market

2.16 The Irish PHI market is based on the principle of solidarity between insured generations. The health insurance legislation sets out a number of policy concepts that underpin PHI in Ireland; these are community rating, lifetime cover, open enrolment, minimum benefits and risk equalisation. Together, these features attempt to prevent health insurers from setting premiums according to an individual's age, gender or risk profile, and to ensure that PHI is in principle available to and affordable for all those who wish to purchase it.

2.17 **Community rating** means that the level of risk that a particular consumer poses to an insurer does not affect the premium paid. The Government's *White Paper on Private Health Insurance 1999* states that community rating is the *"corner-stone of the Irish health insurance system".* Legislation requires that health insurers cannot charge different premiums to different people for the same level of cover. In other words, everybody must be charged the same premium for the same level of cover, irrespective of age, gender and the current or likely future state of their health. There are some exceptions - children under 18 years of age, students in full time education and members of group schemes can be offered discounts.

2.18 Community rating is designed to benefit consumers who are most likely to make a claim, by helping to ensure that PHI is affordable to those who want it most – the old, the sick and the infirm. It promotes and relies on inter-generational solidarity, which means that younger, healthier people effectively subsidise older people, who have higher claims, in the expectation that they (the younger generation) will themselves be subsidised by future generations. People pay more than is actuarially required in their younger years, but less than actuarially required in their later years.

[28] In December 2006 BUPA Ireland announced its intention to withdraw from the Irish market following the failure of its High Court challenge to the legality of the Risk Equalisation Scheme.

Box 1: Definition of Community Rating

The term community rating is not defined in legislation; its meaning must be construed from the references to it in Section 7 and Section 12 of the Health Insurance Act 1994.

Section 7 allows for a provider to offer a menu of plans with a variety of benefits and can set prices for that policy as it wishes, however it must disregard, amongst other things age, gender and health status. Section 7(1)(c) refers to such a contract as a "community rated health insurance contract".

The precise meaning of community rating was central to the first judicial review brought by BUPA Ireland (the validity proceedings). BUPA Ireland argued that Section 7 implied that community rating was confined to rating **within** a plan, i.e. that each insured person within a given policy must be charged the same premium but otherwise there is no community rating **across** the entire market of insured persons.

In the High Court, on November 23rd 2006, Mr. Justice Liam McKechnie, disagreed with BUPA Ireland's interpretation of community rating. He referred to the term *"community rating across the market for health insurance"* in Section 12(10)(iii) and concluded that for the purposes of the RE Scheme the "community" which must be rated is the community which contains the entire insured population, i.e. the market for private health insurance in Ireland.[29]

Justice McKechnie's ruling accordingly confirmed that community rating applies across every health insurer and every plan, rather than within each plan. The Court's ruling provides clarity on the meaning of community rating; however it is as yet unclear whether this will have a direct effect on setting policy prices. The meaning of Section 7 is unchanged. Insurers can offer a menu of community rated health insurance contracts.

2.19 Community Rating in Ireland takes the form of **Single Rate Community Rating**. This system is unfunded, meaning that there is no fund built up over the lifetime of an insured person to cover their expected claims cost. Instead, the money contributed by insured persons is pooled by each insurer and the cost of claims in any given year taken from the pools.

2.20 The *Health Insurance (Amendment) Act 2001* includes provision for the introduction of a system of **Lifetime Community Rating**; however this has not yet come into force. If lifetime community rating was in place, insurers would be entitled to charge an extra premium to consumers who first join PHI at a particular age (35 years in the current legislation) or who join after a prolonged gap in cover. The main rationale for lifetime community rating is to encourage people to start taking out health insurance at an early age to underpin the future viability of community rating.

2.21 **Lifetime cover** is a system that guarantees all consumers the right to renew their policies annually, regardless of factors such as age, risk status or claims history. The system is governed by the *Lifetime Cover Regulations, 1996*. The effect of this system in Ireland is that private health insurers may not refuse to insure anyone who had PHI at any time during the previous 13 weeks (except in very limited circumstances). This obligation extends to all health insurers and applies to all health insurance products.

[29] Actual Judgment of Mr. Justice McKechnie not yet delivered.

2.22 **Open enrolment** is the practice whereby all applicants for PHI cover must be accepted by a private health insurer, regardless of their risk status. Insurers must comply with the terms of the *Open Enrolment Regulations, 2005*.

2.23 Under the **Minimum Benefit Regulations** all insurance products that provide cover for inpatient hospital treatment must provide a certain minimum level of benefits. The *1999 Government White Paper on Health Insurance* indicates that the purpose of the Minimum Benefit Regulations is:

> *"to maintain inter-generational solidarity within the community rating system;*
>
> *to ensure the continued availability of the type of broad hospital care cover traditionally held as a minimum by the insured population;*
>
> *to ensure that individuals do not significantly under-insure due to lack of proper understanding of the restrictions which, in the absence of a specified minimum entitlement, could apply to some types of policies."*[30]

2.24 The Minimum Benefit Regulations, as amended, were made by the Minister for Health in 1996.[31] They detail the minimum benefits and payments for hospital charges and consultants' fees which health insurers must provide for a range of medical procedures. The regulations incorporate detailed prescriptive schedules of treatments and minimum amounts of cover that insurers are required to offer for each of these treatments. The minimum amounts specified for treatments are in monetary terms. Amounts for hospital accommodation are determined by reference to monetary amounts or proportions of hospital charges. To a great extent they cause the private healthcare market to mirror the public healthcare system.

2.25 The four features of the market described above attempt to prevent insurance companies from setting premiums according to an individual's age, gender and risk profile. As a result premiums are set at a higher rate than that which young or healthier people would have to pay in a 'risk rated' market while premiums for older or less healthy people are lower than they would be in a risk rated market and hence more affordable.[32] This inter-generational transfer from young to old is intended to ensure social solidarity. It provides certainty to individuals that in the event of illness or serious injury, PHI remains affordable. However health insurance markets with community rating and open enrolment can be unstable.

2.26 **Risk equalisation** is the mechanism that seeks to address instability in the market. Risk equalisation is a process that aims to neutralise in an equitable manner differences in insurers' costs that arise due to variations in the health status of their members. It involves monetary transfers from health insurers with lower than average risk profiles to health insurers with higher than average risk profiles, so that the latter are not at a disadvantage vis-à-vis the former in regard to their expected claims costs. New entrants are exempt from risk equalisation payments for the first three years after they commence business and are only subject to half payments in year four. Risk equalisation is discussed in detail in Chapter 8.

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[30] Department of Health and Children (1999), *White Paper on Private Health Insurance,* Available at: http://www.dohc.ie/publications/white_paper_on_private_health_insurance.html

[31] *The Health Insurance Act, 1994 (Minimum Benefit) Regulations*, S.I. No. 83 of 1996

[32] Risk rated premiums take regard of the health status and other relevant risk factors of the individual policy holder; whereas a community rated premium disregards risk status of the individual policy holder.

2.27 Health insurers hold very different views on the necessity and ramifications of the scheme. Vhi Healthcare holds that the Risk Equalisation Scheme is absolutely necessary to provide stability in the market and to ensure that all consumers, in particular high risk consumers, can avail of health insurance at a reasonable cost. Vhi Healthcare further holds that Risk Equalisation is necessary to promote competition across the market, rather than cherry-picking of younger, healthier and ultimately less costly, consumers.

2.28 BUPA Ireland contends on the other hand, that the current Risk Equalisation Scheme damages competition by obliging it to heavily subsidise a rival in the market, ultimately to the extent of forcing it out of the market. BUPA Ireland alleges that the transfers it would be obliged to pay under the Scheme would be far in excess of its expected surpluses over the next three years. In order to avoid making significant losses as a result of the Risk Equalisation transfers, BUPA Ireland has announced its intention to withdraw from the market, although it is allowing for the possibility of market re-entry should market structures change.

2.29 VIVAS Health, as a new entrant, currently holds an exemption from Risk Equalisation payments which is due to expire in late 2007. It has announced its intention to remain in the market despite the imposition of Risk Equalisation. However, in its submission to this Report, VIVAS Health characterised the current Risk Equalisation Scheme as draconian, disproportionate and technically flawed and called for its revision.

2.30 No consensus has been reached by the health insurers on the necessity of the Risk Equalisation Scheme, its proportionality or its technical characteristics. The wide divergence in views indicates that the legitimacy of the Risk Equalisation Scheme is, and is likely to remain, in dispute in the near future.

Conclusion

2.31 Vhi Healthcare had a statutory monopoly of the PHI market until the mid-1990s when the market was opened up to competition, in response to an EU Directive. There are currently three players in the market - BUPA Ireland entered the market ten years ago and VIVAS Health commenced operations more recently, in late 2004. BUPA Ireland recently announced its intention to exit the market. Demand for health insurance continues to grow, with the total number of people insured increasing by approximately 3% p.a.

2.32 The way in which PHI is provided in Ireland is based on a number of fundamental principles namely community rating, lifetime cover, open enrolment, minimum benefits and risk equalisation which have implications on the way insurers can operate. Making PHI subject to the principles that ensure intergenerational solidarity, on a voluntary basis, means that competition will always be limited compared to other insurance products.

3. HOW HEALTH INSURERS COMPETE

Summary

3.1 This chapter examines how the market has changed since it was opened to competition in terms of the products on offer and prices, and how firms in the market compete through product differentiation and price competition and the interaction between the two. The effect of the commencement of Risk Equalisation transfers on how health insurers compete is examined in Chapter 8.

3.2 In December 2006, Vhi Healthcare had a 75% market share, BUPA Ireland had a 22% share, and VIVAS Health had 3% of the market.[33] This chapter examines switching behaviour by consumers, in terms of the reasons why some people switch and some people don't, and seeks to explain how BUPA Ireland and VIVAS Health have grown their market share and why Vhi Healthcare has been losing market share.

3.3 Whiles there are differences in the products and prices of PHI available from the three PHI insurers, there are constraints on what the insurers can offer to consumers as a result of the underlying principles on which the market is based.

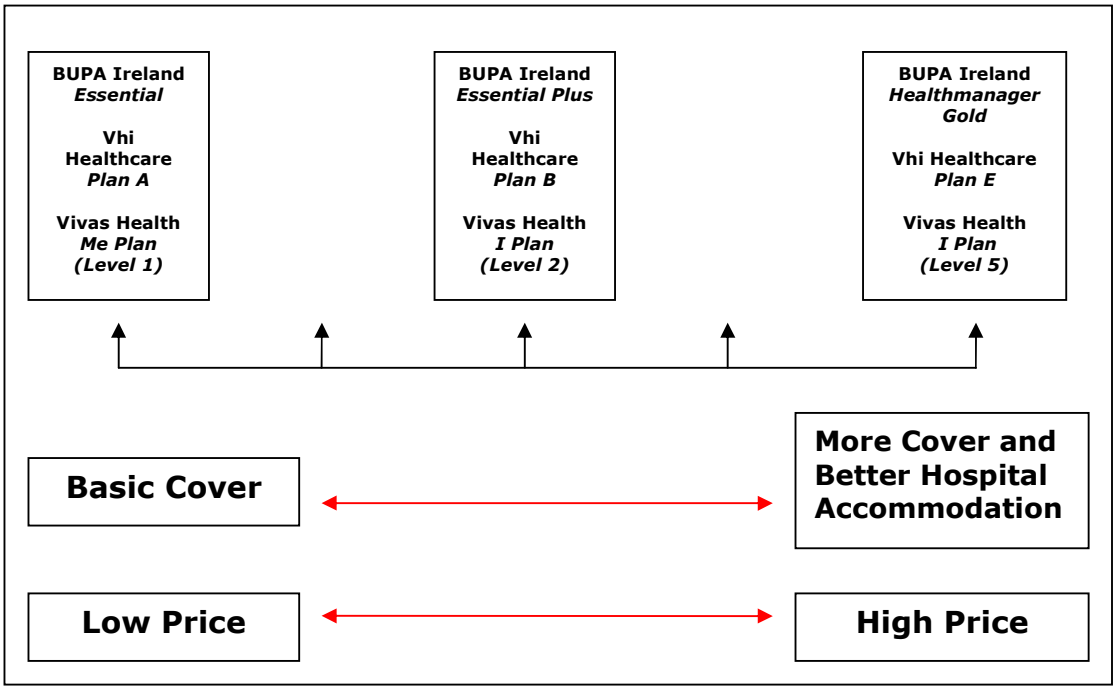
Private Health Insurance: Plans and Prices

3.4 There is a wide variety of PHI policies available, offering various degrees of insurance cover at different prices.[34] PHI policies are differentiated by, amongst other things;

- The freedom of choice with regard to hospital usage (whether the policyholder's choice of hospital is unrestricted, or alternatively limited to specific hospitals);
- The standard of hospital accommodation offered (whether the policyholder is entitled to a private or semi-private room);
- The range and comprehensiveness of treatment covered (some restrict the types of treatment available); and
- Whether or not there are cost excesses (some policies offer reduced rates if the subscriber accepts an excess on the amount payable by the PHI provider).

[33] BUPA Ireland announced its intention to exit the market in December 2006.
[34] Appendix 4 contains a comparison table of the various plans on offer which the HIA publishes on its website.

Figure 2: Private Health Insurance Products in Ireland



3.5 PHI policies range from very low levels of cover to extensive cover as illustrated in Figure 2. The varying levels of cover are reflected in the price. There are over twenty different PHI plans currently on the market which can be broadly grouped into three levels of cover:

- Each of the insurers offer what can be described as a 'basic', low priced plan which provides the specified minimum level of cover required by the Minimum Benefit Regulations but without many extras. The plans which would fall into this category are BUPA Ireland *Essential*, VIVAS Health *Me Level 1*, and Vhi Healthcare *Plan A*. These policies cover semi-private accommodation in public hospitals only with re-imbursement of all consultants' fees and other normal hospital charges while an in-patient or a day patient. These basic plans are not very popular - less than 10% of Vhi Healthcare's subscribers have Plan A.

- By far the most popular plans are those that provide full cover for treatment in a private room in a public hospital and in a semi-private room in all private hospitals, except the Blackrock Clinic and the Mater Private Hospital. These plans also cover all other normal hospital charges and consultants' fees. These plans include BUPA Ireland *Essential Plus*, VIVAS Health *Me Level 2* and Vhi Healthcare *Plan B* and are shown in Table 1 below, along with variations on these products (e.g. with/without excess). A large majority of all PHI consumers are covered by one of these plans.

Table 1: Most Popular PHI Plans and Premiums*

Insurer	Plan	Annual Adult Premium
VIVAS Health	*Me Plan Level 2*	€465.96
BUPA Ireland	*Essential Plus (excess)*	€475.20
VIVAS Health	*I & We Plans Level 2*	€503.04
BUPA Ireland	*Essential Plus (no excess)*	€524.88
Vhi Healthcare	*Plan B Excess*	€541.56
Vhi Healthcare	*Plan B*	€612.60
Vhi Healthcare	*Plan B Option*	€664.20

** These prices are the cost per annum based on the Adult Rate net of the 10% group rate discount and net of tax relief at source and are correct as at 31 December 2006.*

- The top range plans provide full cover for private rooms in private hospitals as well as cover in the high tech private hospitals including the Blackrock Clinic and the Mater Private Hospital. These plans include *BUPA Healthmanager Gold*, *VIVAS Me Plan Level 5* and *Vhi Plan D* and *Plan E* and are the most expensive policies on the market.

3.6 PHI products have developed over time. There has been a gradual tendency to offer greater product variation, mainly in the area of primary care. Other benefits available with some PHI plans include cover overseas, cover for scans, cover with UK hospitals, cover for convalescence and discounts for students in full time education. All PHI plans come with varying levels of outpatient benefits.

Price Competition

3.7 The principle of community rating means that the same price is charged for a PHI plan for all consumers regardless of their age, health status or other characteristics. This limits the degree of price competition that can occur in the market. Health insurers are not permitted to offer discounts to non-smokers, or to those who go for regular health screening, for example.

3.8 In recent years, almost all PHI subscribers have received the 10% discount available to members of a group scheme as each health insurer now offers the 10% discount to members who join on-line through their website or over the phone. As such, the group scheme price (i.e. 90% of the standard adult rate) has effectively become the market price. Group Schemes are discussed in more detail in Box 2.

3.9 Premium increases are driven by a number of factors, some of which are under the control of the health insurers and some of which are not. Factors such as medical inflation and the cost of private beds in public hospitals are beyond the control of insurers, except in so far as they can use their buyer power to keep prices down.

3.10 Vhi Healthcare's prices are subject to the approval of the Minister for Health and Children. Annual price increases tend to take effect in September of a given year. Neither BUPA Ireland nor VIVAS Health require Ministerial approval for their prices.[35] BUPA Ireland's annual price increases tend to take effect in March of a given year while VIVAS Health's annual price increases tend to take effect in October.

[35] All three insurers must however inform the HIA when introducing a new product to ensure that it complies with the requirements of the health insurance legislation.

3.11 Price increases by Vhi Healthcare in the period before 1996 were around 6% p.a. prior to BUPA Ireland's entry, as shown in Table 2 below.

3.12 When BUPA Ireland entered the market, it initially priced its policies about 10% lower than comparable Vhi Healthcare plans. As shown in Table 4 below, annual price increases by BUPA Ireland have been very similar in magnitude to Vhi Healthcare's, thereby maintaining this 10% price differential.

3.13 VIVAS Health entered the market in late 2004. Vivas Health's products were originally priced more than 10% below comparable BUPA Ireland products and more than 20% below comparable Vhi Healthcare products. VIVAS Health has announced two price increases, the first was effective from October 2005 (7.5% increase) and the most recent was effective from October 2006 (6.7% increase). As VIVAS Health's cumulative price increases have been lower than those of either Vhi Healthcare or BUPA Ireland, the price differential between VIVAS Health and the other insurers has increased in the last two years.

Table 2: Vhi Healthcare, BUPA Ireland and VIVAS Health Annual Price Increases

Year	Vhi Healthcare	VIVAS Health	BUPA Ireland
Sep-90	4%		
Sep-91	5.1%		
Sep-92	4.1%		
Sep-93	6%		
Sep-94	8.5%		
Sep-95	6%		
Sep-96	6%		
Sep-97 Mar-98	9%		9%
Sep-98 Mar-99	9%		9%
Sep-99 Mar-00	9.4%		9.4%
Sep-00 Mar-01	6.5%[36]		6.25%
Sep-01 Mar-02	9%		9.4%
Sep-02 Mar-03	18%		14.4%
Sep-03 Mar-04	8%		8.25%
Sep-04 Mar-05	3%		6%
Sep-05 Oct-05 Mar-06	12.5%	7.5%	9.5%
Sep-06 Oct-06	12%	6.7%	

BUPA entered Jan 1997

VIVAS entered Oct 2004

Sources: HIA; www.vhi.ie; www.bupa.ie; www.vivas.ie

[36] Vhi Healthcare's initial request for a 10% price increase in September 2000 was denied, and a 6.5% increase was later granted in February 2001.

3.14 The current situation is that significant price differentials exist between comparable plans offered by Vhi Healthcare, BUPA Ireland and VIVAS Health. The prices for Vhi Healthcare's most popular plans are around 10% more expensive than plans with similar levels of cover from BUPA Ireland and between 10%-20% more expensive than plans with similar levels of cover from VIVAS Health. The price differential between different health insurers plans varies depending on the time of year it is calculated as the three insurers apply annual premium increases at different times of the year.

Product Innovation

3.15 Product innovation is constrained by the existence of the Minimum Benefit Regulations. All PHI plans must meet the standards prescribed in the Minimum Benefit Regulations. As PHI plans must provide coverage for all public hospitals and certain other medical facilities, the Regulations limit innovation in the bundling of PHI packages. All PHI products must include maternity benefits, for example.

3.16 While PHI products have developed over time, the most noticeable changes have occurred in the two years since the entry of VIVAS Health into the market. Since VIVAS Health entered the market, Vhi Healthcare has faced greater competitive pressures and has made many improvements to the quality and range of its own products. There is now greater product variation in the market, such as in the area of primary care.

3.17 Historically Vhi Healthcare had five core plans – *Plan A, Plan B, Plan C, Plan D* and *Plan E*. *Plan D* and *Plan E* were introduced after two new private hospitals opened in Dublin in the late 1980s – the Blackrock Clinic and the Mater Private Hospital.

3.18 On entering the market, BUPA Ireland introduced four products that were broadly comparable to Vhi Healthcare's Plans A to E. Unlike Vhi Healthcare, BUPA Ireland offered cover for alternative therapies. BUPA Ireland's *Health Manager* Plan was a new addition to the market, offering enhanced outpatient/GP/alternative practitioners/consultant benefits, with no excess, as well in-patient cover. The plan provided for a 50% payback on outpatient bills up to £500 with 75% payback over this sum. BUPA Ireland has introduced some product variations over the years, including claim excesses on its popular *Essential* plan. Vhi Healthcare subsequently introduced these "excess" products.

3.19 Some of Vhi Healthcare's product developments in recent years are:

- The introduction of a new product called *HealthSteps* in February 2002 which covers everyday healthcare costs such as GP visits and dentist visits and can be purchased on a standalone basis or as an add-on to traditional hospital plans; and
- The launch of a new product called *Global* in 2003 which provides health insurance for Irish residents staying for extended periods abroad.

3.20 In addition, Vhi Healthcare has launched other products that are related to PHI:

- Launch of an annual travel insurance product which acts as an add-on to the benefits offered in Vhi Healthcare's PHI policies in February 2004;

- First provider in Ireland of dental insurance as of May 2004 in association with DeCare;
- *Vhi Get Fit*, an online interactive fitness programme, in partnership with eDiets Europe, a subsidiary of eDiets.com;
- *Vhi Swiftcare Clinics*, with medical expertise provided by The Well, a multidisciplinary medical partnership which provides a range of medical, healthcare and lifestyle services to individual and corporate clients;
- An online shop selling a wide range of healthcare, personal well-being and fitness products; and
- A renewal and billing IT system which it developed in-house and is now selling to other insurance firms.

3.21 VIVAS Health entered the market in late 2004 and introduced a wide range of options for consumers with varying levels of cover. One range of products ("*Me*" products and "*Smart*" plan) offer basic hospital cover but relatively minimal ancillary benefits. VIVAS Health also introduced some targeted marketing for certain occupational groups (e.g. nurses and teachers). VIVAS Health appears to be trying to differentiate itself by offering its members services which Vhi Healthcare and BUPA Ireland do not, such as tooth whitening and laser eye surgery. It has also joined with AIB to offer its members annual travel insurance as an add-on to the benefits offered in PHI policies. This offer is available to anyone who has PHI - not just those with VIVAS Healthcare PHI policies. VIVAS Health also offers all its customers the option of adding on cover for everyday health expenses (e.g. GP visits) called *day-to-day* cover. In November 2006, VIVAS Health also announced that it would be offering a tailored health insurance product to Hibernian Insurance customers, in partnership with Hibernian.[37]

3.22 At the same time that VIVAS Health entered the market, Vhi Healthcare launched a new range of PHI policies called *Lifestage Choices*. There are three products in the range – *First Plan, Family Plan* and *Forward Plan*, with an additional *Plus* option for each. These plans are designed specifically for the varying healthcare needs of people at different life stages as well as the standard levels of hospital cover. These plans offer greater cover for everyday health related expenses than Plans A to E.

3.23 On the basis of these factors, it is clear that the entry of VIVAS Health and the knowledge that it was due to enter the market, encouraged Vhi Healthcare to improve its offering to its existing members and invest more in attracting new members. The level of choice available to consumers has noticeably improved since the market was opened to competition, indicating that BUPA Ireland and VIVAS Health exert competitive pressures on Vhi Healthcare. This has been to the benefit of all consumers in the market.

[37] "*Hibernian Direct links with VIVAS Health to offer Health Insurance*". November 6th, 2006. Available online at http://thelink.assurelink.ie/e_article000702620.cfm?x=b8vybW0,b45M2mW3,w

The Interaction between Price and Non-Price Competition – Strategic Product Design

3.24 While insurers cannot price their policies differently on the basis of age, gender, health status or any other risk factors, they can, to a degree, design products which, by offering different levels of cover, are attractive to different market segments. In other words, non-price and price competition interact in the PHI market. Non-price competition refers to firms competing on factors other than price such as product design, quality of service etc. Non-price competition based on strategically designed products can stimulate price competition for market segments.

3.25 Thus, for example, a health insurer can design a low cost, basic cover PHI product that is attractive to younger and healthier consumers who wish to purchase PHI but expect never to make a claim, and a high cost, wide cover PHI product that is attractive to older and less healthy consumers who expect to make a claim sometime and wish to have maximum cover and maximum comfort when unwell.

3.26 The idea behind a health insurer strategically designing products to attract certain customers is to get consumers to self select a product that is priced closer to the risk they represent to the health insurer. Take for example Vhi Healthcare *Lifestage Choices*. There are three principle products in Lifestage Choices; firstly there is '*First Plan'* which is aimed at single people; secondly is '*Family Plan'* designed for people with children or those that are thinking of starting a family; and, lastly there is '*Forward Plan'* designed for the elderly with benefits like enhanced convalescence care and health screening.

3.27 The existence of community rating and risk equalisation add a further dimension to this interaction. Community rating makes younger and healthier PHI consumers in general more profitable than older and less healthy consumers. This makes it more profitable for each health insurer to attract young and healthy consumers, no matter which PHI product they purchase. Risk equalisation is intended to remove this incentive and make all consumers equally attractive to health insurers. The actual effect depends on a number of factors and is discussed in more detail in Chapter 8.

3.28 Advertising is also occasionally targeted at specific groups to encourage self-selection. VIVAS Health has advertised a special offer on its website in summer 2005 and summer 2006, whereby it offered 50% off all premiums for children on their hospital plans, which applies to all children under the age of 18 and also to students and apprentices up to age 23.[38] VIVAS Health also offers PHI products which are tailored specifically to Teachers and Nurses. Vhi Healthcare regularly advertises in trade and professional publications, such as *InTouch*, the newsletter of the INTO. All three PHI firms engage in sponsorship of a wide range of sporting, fitness and lifestyle activities.

[38] VIVAS Health Press Release, "VIVAS Health announces 50% off premiums for children – First-ever price cuts in Irish Health Insurance sector". Available online at http://www.vivashealth.ie/pressrelease250705.html

Box 2: Group Schemes and Group Scheme Discount[39]

Group schemes are a widespread feature of the PHI market. Most group schemes are work-based, while others are vocational (e.g. teachers) or locally based (e.g. credit unions). Members of group schemes pay their premium through a variety of methods such as via salary deduction in a work-based scheme, or via direct debit. Some companies offer subsidised or free PHI to their employees as part of their benefit package, with employees paying a top-up via salary deduction or direct debit.

Work-based group schemes where employers deduct PHI premia for employees directly from their salary were a very common way for people to pay their PHI premiums. People were encouraged to pay their premium in this way as Vhi Healthcare gave a discount for members who joined as part of a group scheme. This discount was 10% when the Health Insurance Act was passed in 1994 and so a 10% group scheme discount was incorporated into the legislation as the maximum discount that could be offered on an adult PHI premium.

For Vhi Healthcare, work-based group schemes continue to be an important means of collecting premium revenue, having built up a large network of salary deduction schemes in Irish companies over time. A large majority of Vhi's members avail of their health insurance through the mechanism of work based group schemes and pay their premiums via salary deduction. Of those PHI subscribers who avail of their health insurance through work based group schemes, approximately one-quarter benefit from their employer paying all or part of their health insurance policy premium.

Neither BUPA nor VIVAS have extensive salary deduction collection mechanisms in place. It is uncommon for their members to pay their premiums directly from their salary. Members tend to pay by direct debit payments. Adding a second or third health insurer to a salary deduction mechanism is not difficult but involves time and expense.

In recent years, almost all new PHI subscribers have availed of the 10% group scheme discount as the three insurers offer the 10% discount to members who join on-line through their website or over the phone. As such, the group scheme price (i.e. 90% of the standard adult rate) has effectively become the market price.

Vhi Healthcare's legacy of access to this distribution channel available to gives it an advantage over other health insurers.

How Market Shares have Evolved[40]

Market Shares by Total Membership Numbers

3.29 Between 1957 and 1996, when Vhi Healthcare had a statutory monopoly, it grew in size to well over one million members, with an average annual increase in its total membership of 13% over this period. Growth in Vhi Healthcare's total membership slowed considerably after its monopoly ended to about 1% p.a. between 1997 and 2005. Its total membership has remained static, at around 1.5 million members over the last five years.

[39] This information is based on research carried out by the Competition Authority in the preparation of this Report.
[40] The data contained in this section was obtained from a number of sources; the 1999 White Paper, the HIA and data obtained from Vhi Healthcare, VIVAS Health and BUPA Ireland (under summons).

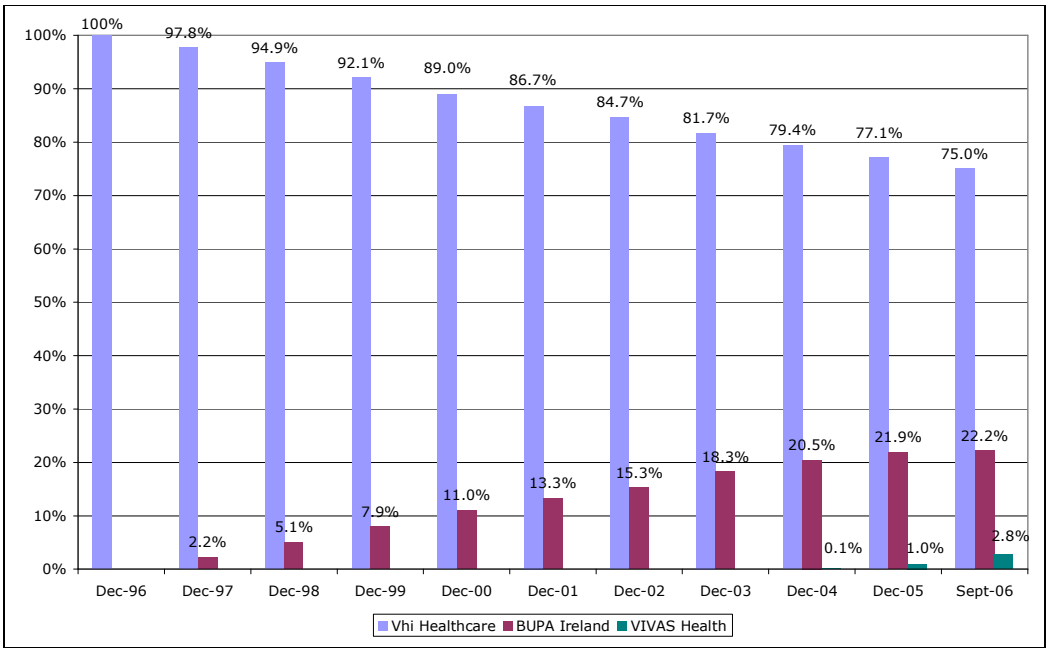
3.30 Since its market entry in late 1996, BUPA Ireland has built up its membership numbers. From a market share of 13.3% at the end of 2001 (235,000 members), it grew to 22% of the market by September 2006, doubling its total membership in this five year period to 459,000 members.

3.31 Vhi Healthcare and BUPA Ireland were the only two health insurers for a period of nearly 8 years as there was no further entry until late 2004 when VIVAS Health commenced operations.

3.32 Within one year of entry, by the end of 2005, VIVAS Health had a market share of 1% or 20,000 members, and had achieved a 3% market share by September 2006.

3.33 With the entry of BUPA Ireland, and later VIVAS Health, Vhi Healthcare's 100% market share fell from 87% (end of 2001) to 77% (end of 2005), to 75% (September 2006), as shown in the graph below.

Figure 3: Market Shares in PHI, 1996 - September 2006*



* All figures are for full year January to December except in the case of 2006 which is for the period January to September.
Sources: White Paper 1999, HIA, BUPA Ireland Summons.

Market Shares by New Sales of PHI

3.34 The preceding analysis looked at market shares on the basis of total membership numbers. It is also useful to consider other measures of market shares.

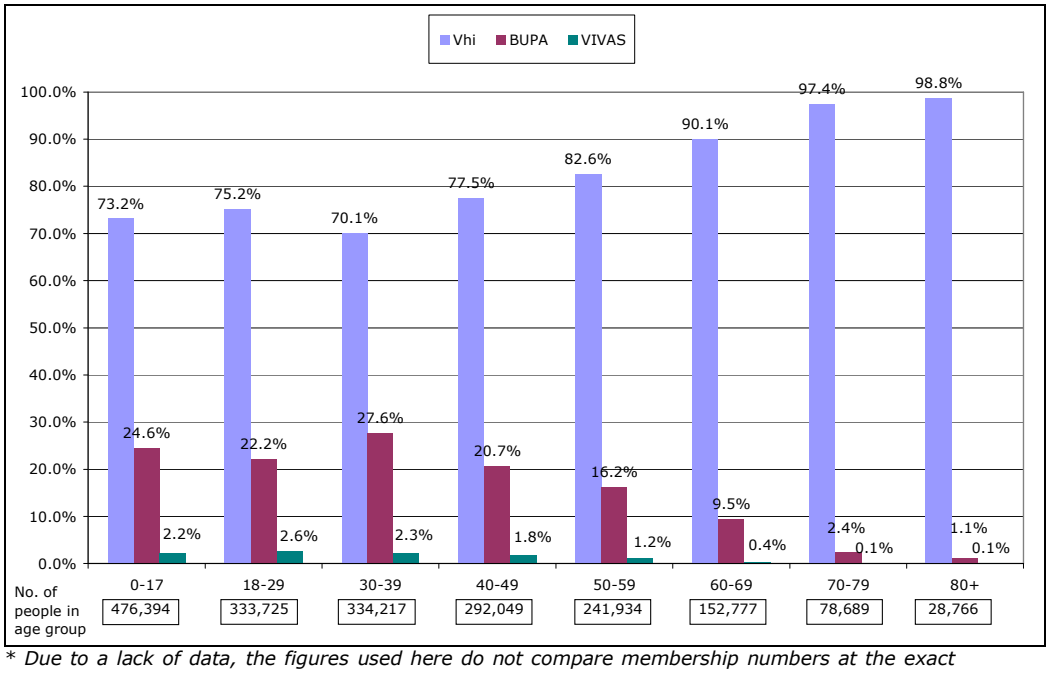
3.35 The market is growing by approximately 3% per annum and all three insurers have successfully attracted new members in recent years. For example, new sales of PHI in the twelve months to June 2005 amounted to approximately 191,000 members, with Vhi Healthcare gaining about 115,000 (60%), BUPA Ireland about 70,000 (37%) and VIVAS Health about 6,000 (3%), according to data from the HIA.[41]

Market Shares by Different Age Categories

3.36 Market shares in the PHI market can also be considered on the basis of different age categories of members. Examining market shares in this way reveals how different age groups are distributed among the three insurers. Claims costs are highly correlated to age. In a community rated market, therefore, younger people are more attractive to insurers than older people.

3.37 Vhi Healthcare's market share is greater in the older, less profitable age cohorts. As shown in Figure 4 below, in the 0-17 age group Vhi Healthcare has 73% of the market while BUPA Ireland has nearly 25% and VIVAS Health has just over 2%. Vhi Healthcare's lowest market share is in the 30-39 age group at around 70% compared to 28% for BUPA Ireland and 2% for VIVAS Health. Vhi Healthcare's market share increases significantly for people over 60 and in the 80+ age group, it is almost 100%.

Figure 4: Market Share by Age Groups*



** Due to a lack of data, the figures used here do not compare membership numbers at the exact same point in time. In the case of BUPA Ireland and Vhi Healthcare, the data refers to April 2005. This data was obtained from* HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation. In the case of VIVAS Health, the data refers to June 2006 and this data was obtained by the Competition Authority from VIVAS Health directly.*

[41] It is important to note that the three health insurers define 'new sales' in different ways. Both BUPA Ireland and VIVAS Health consider a new sale to include additions to existing policies and births. However, in the case of Vhi Healthcare new sales exclude births. Therefore, if births were included in the above figures, this would increase the number of Vhi Healthcare's new sales. VIVAS Health's new sales figure is for the period from late October 2004 to June 2005, as it only entered the market in October 2004. HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*

3.38 The significant difference in the age profile of the three insurers is largely due to the different times at which they entered the market. Vhi Healthcare has almost all PHI consumers over the age of 70. These people are likely to have joined Vhi Healthcare many years ago and have chosen to remain with Vhi Healthcare. The majority of BUPA Ireland and VIVAS Health's members are in younger age groups. This is not unusual. The most mobile people in the market are young people who are taking out health insurance for the first time. These people are attracted to BUPA Ireland and VIVAS Health by their lower prices. As BUPA Ireland and VIVAS Health do not have large numbers of old members this allows them to keep their premiums low because claims cost increase significantly as subscribers age.

Joiners, Leavers and Switchers

3.39 Aggregate membership data for each of the health insurers conceals two-way flows of members who are joining, leaving or switching between the three insurers. Table 3 below shows the annual change in membership numbers by insurer annually between 2002 and 2005, and the nine months to September 2006.

3.40 Until December 2006, Vhi Healthcare's total membership was static, hovering around 1.5 million over the last five years. However, there is a considerable two-way membership flow in terms of new members joining and other members leaving. Vhi Healthcare was losing significant numbers of members, particularly those in younger age groups, some of whom were switching to BUPA Ireland and VIVAS Health, and some who chose to cease buying health insurance altogether. Due to its older age profile, Vhi Healthcare was also losing members as a result of death. Vhi Healthcare's losses in membership were being counterbalanced to some extent by a significant level of new sales. Vhi Healthcare was succeeding in recruiting a substantial proportion of newly insured consumers and a large number of newly born children became subscribers on their parent's Vhi Healthcare policy each year. However, the growth in Vhi Healthcare's membership was falling short of the number of leavers.

3.41 As shown in Table 3 below, the net change in Vhi Healthcare's total membership was very small in 2004 and 2005, and in the nine month period to September 2006 it was negative, indicating that the number of new members joining (including babies) was 6,000 less than the number of leavers/deaths. The number of new members joining Vhi Healthcare has not changed dramatically over the last three years, averaging approximately 65,000 per annum.[42]

[42] HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*

Table 3: Net Change in Membership Numbers by Insurer and in the Total Market between year ending December 2002 and the 9 month period to September 2006

	Vhi Healthcare	BUPA Ireland	VIVAS Health	Total Market
Dec-02	23,611	47,603	-	**71,214**
Dec-03	-7,628	64,719	-	**57,091**
Dec-04	837	53,742	1,019	**55,598**
Dec-05	1,047	40,845	19,073	**60,965**
Sept-06	-6,065	16,857	37,258	**48,050***

* This figure refers to a 9 month period, not a 12-month period. Figures for the end of 2006 were not available at the time of publication.
Source: Calculated from HIA Data

3.42 Although BUPA Ireland was also experiencing some lapses of policies up until December 2006, the number of new members was significantly higher than the number of leavers and, as a result, BUPA Ireland's total membership was growing strongly. After 10 years in the Irish PHI market, BUPA Ireland was also gaining members each year from newly born children becoming subscribers on their parent's BUPA Ireland policy. As shown in Table 3, BUPA Ireland's total membership increased by over 53,000 in 2004, by a further 40,000 in 2005 and by a further 17,000 in the nine months to September 2006. In the twelve months to the end of June 2005, BUPA Ireland gained approximately 70,000 new members[43] but appears to have lost approximately 35,000 to result in a net gain of 40,845 members in 2005. However, growth in BUPA Ireland membership ceased as of December 14th 2006, when it announced that it would no longer accept new members, and would not renew the policies of existing customers after January 2007.

3.43 VIVAS Health's membership is also growing strongly. Its total membership grew by 19,000 in 2005 and by a further 37,000 in the nine months to September 2006. The growth in VIVAS Health's membership was by far the strongest of the three insurers in the nine month period to September 2006 – almost double BUPA Ireland's membership growth.

3.44 Since 2003, the increase in the total market, as shown in the final column of Table 3, has been driven by growth in BUPA Ireland and VIVAS Health's membership.

[43] HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*

Switching by Private Health Insurance Customers

3.45 The most recent in-depth survey of PHI consumers was undertaken in 2005 by the HIA.[44] This survey provides evidence on switching patterns and behaviour in the PHI market. It found that 10% of consumers had switched health insurer in the ten years since BUPA Ireland had entered the market.[45] The fieldwork for the HIA's survey was carried out between March and April 2005, eight years after the entry of BUPA Ireland but less than 6 months after VIVAS Health entered the market. Therefore, the survey would not have taken account of the effect of VIVAS Health's entry on switching in the market and whether and to what extent switching has occurred from Vhi Healthcare or from BUPA Ireland. Therefore the 10% switching rate is likely to underestimate the level of switching that has occurred in the market. No survey has been carried out which examines switching in the market with three players.

3.46 Using the 10% switching level implies that approximately 200,000 people have switched insurers (based on a total market of 2 million). BUPA Ireland's membership is around 450,000 members. Therefore we can estimate that switchers account for approximately 50% of BUPA Ireland's total membership, with the remaining 50% being 'new sales'. Therefore market share growth for BUPA Ireland has come from an equal combination of new sales and switchers.

3.47 It is not possible to determine whether VIVAS Health's members are predominantly switchers or new sales, as we do not have sufficient data at this point in time and no survey of switching behaviour has been undertaken with three players in the market.

3.48 Based on the results of the survey, it is generally younger people who switch. Over two-thirds of switchers are aged between 25-44 (34% plus 31%), while only 1% of switchers are aged 65 or older.

Table 4: Age at which switchers changed insurers[46]

Age cohort	Switchers	All non-switchers
18-24	9%	13%
25-34	34%	19%
35-44	31%	22%
45-54	15%	18%
55-64	10%	15%
65+	1%	14%

[44] *The Private Health Insurance Market in Ireland – A Market Review* Available online at http://www.hia.ie/docs/consumer-research/PHI-A-Market-Review-Final-Report-Incl-Appendix%20A-220905.pdf

[45] A previous survey carried out in 2003 by the HIA found that 6% of survey respondents had switched health insurer. This indicates that the level of switching is increasing.

[46] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*, p.36.

Why Consumers Switch

3.49 According to the HIA's research, by far the most commonly cited reason why people switch health insurer is to save money. It follows that those people who have switched are the more price-sensitive consumers. During the period between 1997 and 2004 when Vhi Healthcare and BUPA Ireland were the only insurers in the market, the scope for consumers to discriminate between the two firms on the basis of price was relatively static as BUPA Ireland maintained a similar pricing policy to Vhi Healthcare with a 10% price differential. As VIVAS Health offers the potential for greater savings, this is likely to have increased the rate of switching in the market.

Table 5: Main Reasons for Switching[47]

Why did you decide to change insurers? What was the main factor that led you to change your health insurer?	Main Factor
New insurer was cheaper/ Cost savings	48%
Level of cover was better	12%
New insurer had a better product/ service range	8%
Group scheme switched	8%

3.50 Of those consumers who had switched insurer, 98% professed themselves to be either "very satisfied" or "satisfied" with both the changeover process and their new insurer. This indicates that people who were motivated enough to switch health insurer found the switching process simple and straightforward.

Why Consumers Do Not Switch

3.51 By far the most common reason why people have not switched is because they are satisfied with their current provider (36%), as shown in the table below.

[47] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*, p.36.

Table 6: Main Reasons for Not Switching[48]

Why have you not switched your PHI provider?	BUPA customers	VHI customers	Overall
Satisfied with current provider	32%	35%	36%
Levels of cover no better	15%	16%	15%
Not my decision	15%	13%	14%
No significant cost savings	15%	13%	13%
Been with existing provider for a long time	2%	14%	13%
Too much hassle/paperwork	9%	12%	12%
Couldn't be bothered	13%	9%	9%
Felt loyal to their provider	4%	8%	8%

3.52 The survey results do not suggest that brand loyalty is a very important factor in the market as only 8% of customers felt loyal to their provider and other factors are considerably more important. However, the survey does suggest that an important factor in discouraging people from switching is having been with their current provider for a long time. This is not an unusual factor given that health insurance has "experience good" elements. That is, a consumer can only judge it's try worth after he/she has actually used the product. Thus a consumer who has had a positive experience of making a claim on a PHI policy will be more inclined to stay with that insurer rather than switching insurer.

3.53 To summarise, the reasons why many people do not switch insurer are due to consumer inertia, apathy and satisfaction with their current provider, rather than the switching process being difficult or cumbersome.

Conclusion

3.54 Price competition in PHI in Ireland is limited by community rating. It has been facilitated by the ability of new entrants to price below Vhi Healthcare for similar levels of cover due to their lower claims costs as a result of having younger members on average.

3.55 Product innovation is limited by the Minimum Benefit Regulations. Within that restriction, product innovation across the market as a whole has been particularly noticeable since the entry of VIVAS Health.

3.56 In terms of market shares, at December 2006, Vhi Healthcare had 75% of the total market, BUPA Ireland had 22% and VIVAS Health had 3%. There is a significant amount of movement occurring in the market with people taking out private health insurance for the first time, people switching health insurer, people choosing not to renew their health insurance and people leaving the market through death.

[48] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*, pp.41, 101, 123. Fieldwork was carried out in March and April of 2005, and multiple responses to questions were permitted.

3.57 The overall trend was a movement away from Vhi Healthcare to BUPA Ireland and VIVAS Health such that Vhi Healthcare's total membership has been stagnant in recent years while BUPA Ireland's and particularly VIVAS Health's were growing strongly. The recent changes to the market are likely to have a significant impact on market dynamics going forward however it is too soon to determine how market shares will be affected.

3.58 It emerges on the basis of survey responses that those consumers who have switched did so to save money. However many consumers, particularly older customers, are far less price sensitive and display inertia and even apathy when it comes to the issue of switching. Although the process of switching is not considered to be cumbersome and people may be aware that they could save money by switching many people, particularly older people, do not act on these factors and tend to remain with their current provider as they express a high degree of satisfaction with their current provider.

4. REGULATION OF PRIVATE HEALTH INSURANCE

Summary

4.1 This chapter examines the various ways in which PHI firms in the Irish market are regulated. The main sources of regulation of PHI in Ireland are the EU Non-Life Insurance Directives, the Voluntary Health Insurance Acts, the Insurance Acts, the Central Bank and Financial Services Authority of Ireland Acts, the Health Insurance Acts, the Health Insurance Authority (HIA) and the Financial Regulator. The chapter demonstrates how the various European and Irish laws have resulted in the three insurers being regulated differently with consequent effects on market behaviour and competition. The chapter examines each of the three open enrolment insurers in turn in terms of how they are regulated and concludes by examining the role of the HIA in regulating the market.

4.2 The three open enrolment health insurers operate under three different prudential insurance regulation regimes.

- BUPA Ireland is an agent for an insurance undertaking authorised in the UK by the UK Financial Services Regulator;
- VIVAS Health is regulated as an insurance undertaking by the Financial Regulator; and
- Vhi Healthcare is exempt from regulation as an insurance undertaking by virtue of the *VHI Act 1957*, as amended, and the EU Non-Life Insurance Directives.

4.3 Although regulated differently under prudential insurance regulations, the open enrolment health insurers are regulated in exactly the same manner under health insurance legislation, notably the Health Insurance Acts, 1994-2003, by the Health Insurance Authority (HIA). Various restricted membership schemes are also regulated under the health insurance legislation.

4.4 Aspects of Vhi Healthcare's exemption from prudential regulation as an insurer offer it a competitive advantage. In particular, Vhi Healthcare's exemption from EU solvency requirements has allowed it to ignore prudential solvency practice and follow pricing practices that would not ordinarily be available to an insurer, thus distorting competition. However, aspects of the VHI Acts restrict its room for commercial innovation.

4.5 The varied prudential regulatory regimes to which the PHI firms are subject create an unbalanced regulatory environment. Competition in the PHI market will be improved by ensuring that all players in the market fall under the same prudential regulatory regime, subject to the requirements of EU legislation.[49] Vhi Healthcare must become subject to the same regulatory regime as its competitors. The remainder of this chapter details the ways in which this goal should be accomplished.

4.6 The chapter contains a number of recommendations directed at the HIA to improve their enforcement powers and enable them to promote consumer interests fully.

4.7 The effects of Risk Equalisation on the market are discussed in Chapter 8.

[49] Whereby PHI firms may be authorised as insurance undertakings in their home Member State and operate in other Member States.

EU Non-Life Directives

4.8 Prior to 1 July 1994, the provision of PHI in Ireland was subject to the terms of the *Voluntary Health Insurance Act, 1957*. This Act established the Voluntary Health Insurance Board (now Vhi Healthcare) and required other bodies engaged in the business of health insurance to be licensed by the Minister for Health. Under this system, Vhi Healthcare developed as a virtual monopoly because membership of the other PHI schemes available was confined to individuals sharing a common vocational or occupational group and their dependants. These schemes are referred to as ***restricted membership schemes***, the largest of which are the St. Paul's Garda Medical Aid Society, the Prison Officers' Medical Aid Society and the ESB Medical Provident Fund.[50]

4.9 The EU has enacted three Directives governing the provision and authorisation of non-life insurance, including private health insurance. These non-life Directives were passed in 1973, 1988 and 1992. The Government is obliged to conform with the EU Non-Life Insurance Directives when regulating health insurance in the State.

4.10 The **Third Non-Life Directive** was adopted in 1992. It provides that any non-life insurance company which is authorised to transact insurance business in an EU Member State must be allowed to transact the same classes of business in any other Member State. The Directive also recognises that an EU Member State may adopt and maintain specific legal provisions to protect the general good.

4.11 In 1994, in response to the Third Non-Life Directive, the Health Insurance Act 1994 was enacted and was amended by the *Health Insurance (Amendment) Act 2001* and *Health Insurance (Amendment) Act 2003* (collectively referred to as the Health Insurance Acts).[51] The Health Insurance Acts opened the Irish PHI market to competition and provided for the regulation of the industry.

The Health Insurance Authority

4.12 The Government established a separate regulatory authority, the **Health Insurance Authority** (HIA), on 1st February 2001. Prior to the establishment of the HIA, the Department of Health and Children carried out the health insurance regulatory functions that had been created under the 1994 Act. Under the terms of its statute, the HIA is independent in the exercise of its functions.

4.13 Insurance companies who offer PHI must be registered with the Health Insurance Authority and comply with the provisions of the Health Insurance Acts, including associated Regulations made thereunder. The principal functions of the HIA as provided for in the Health Insurance Acts are:

- To evaluate and analyse returns made to it under the Risk Equalisation Scheme 2003[52] and to prepare and furnish a report to the Minister for Health and Children in relation to this evaluation and analysis;

[50] Approximately 100,000 people are currently insured with the restricted membership schemes.
[51] A full list of Statutory Instruments that have been made pursuant to the Health Insurance Acts are available on the HIA's website, www.hia.ie
[52] S.I. 261 of 2003

- To carry out its role in relation to the Minister's decision whether or not risk equalisation should be commenced. If risk equalisation is commenced, to manage and administer the process and establish and maintain the risk equalisation fund;
- To maintain the Register of Health Benefits Undertakings;
- To advise the Minister at his or her request or on its own initiative on matters relating to the functions of the Minister under this Act, the functions of the Authority and health insurance generally; and
- To monitor the operation of the Act and the carrying on of health insurance business and developments in relation to health insurance.

4.14 The following three sections examine each of the three PHI providers in turn in terms of how they are regulated.

Regulation of BUPA Ireland

4.15 The BUPA Ireland Group has two companies that operate in the Irish PHI market:

- BUPA Insurance Ltd. is a UK health insurance undertaking authorised and supervised by the UK Financial Services Authority (FSA). By virtue of the Third Non-Life Directive, it operates in Ireland on a freedom of service basis, subject to meeting the FSA's capital and solvency requirements. BUPA Insurance's Irish branch is regulated by the FSA, but it must submit annual statistical returns to the Financial Regulator, and it is covered by the Financial Regulator's conduct of business rules.

- BUPA Ireland Ltd., an Irish-incorporated subsidiary of BUPA Insurance Ltd., operates the Irish branch of BUPA Insurance. BUPA Ireland is also authorised by the Financial Regulator as a multi-agency intermediary, but is a *de facto* tied agent of BUPA Insurance. The Financial Regulator's conduct of business and solvency rules apply to BUPA Ireland and it is also covered by the Financial Services Ombudsman scheme. Since it is not authorised as an insurance undertaking by the Financial Regulator, it cannot underwrite insurance. However, as an intermediary authorised by the Financial Regulator, it could, without the need for amendments to its authorisation, intermediate in insurance other than PHI. BUPA Ireland also sells non-insurance products, in particular, occupational health services and Employee Assistance Programmes.

4.16 BUPA Insurance Ltd, which is the underwriting company for BUPA Ireland, is, as an insurance undertaking, authorised in the UK and subject to the FSA's solvency regime.

Regulation of VIVAS Health

4.17 VIVAS Insurance Ltd., trading as VIVAS Health, is authorised as an insurance undertaking by the Financial Regulator, and is subject to its capital and solvency regime, and its conduct of business rules. VIVAS Health is also subject to the Financial Services Ombudsman Scheme. VIVAS Health is required to submit annual returns, audited accounts and quarterly management accounts to the Financial Regulator. The terms of its authorisation require VIVAS Health to underwrite only Non-Life Insurance Classes 1 and 2 (accident and sickness insurance).[53] VIVAS Health would require an amendment to its authorisation to allow it to underwrite other forms of insurance.

4.18 VIVAS Health does not engage in insurance intermediation. As an insurance undertaking, VIVAS Health falls outside the scope of the Investment Intermediaries Act, 1995. Accordingly, it can engage in insurance intermediation once it has informed the Financial Regulator.[54]

4.19 Under the European Communities (Non-Life Insurance) Framework Regulations, 1994, VIVAS Health cannot sell non-insurance products to consumers. Art. 7 of the Regulations states that undertakings shall:

> *"limit its operations to the business of insurance and to operations directly arising therefrom, to the exclusion of all other commercial business……..."*

As a result, should an insurance undertaking wish to engage in non-insurance related activities, it must be part of a structure whereby sister companies or subsidiaries carry on this business.

4.20 Unlike Vhi Healthcare and BUPA Ireland, both of which offer, for example, occupational health and Employee Assistance Programmes, VIVAS Health is, in its current form, legally prevented from offering these services or acting as a referral agent for such services. However, the shareholders of VIVAS Health could rearrange the ownership structure of VIVAS Health so that related companies with the same holding company could sell non-insurance products to consumers. An example is the sale of BUPA Ireland's non-PHI products such as occupational health and Employee Assistance Programmes, which are, in fact, the products of sister companies.

4.21 VIVAS Health is the only PHI firm which is regulated in its entirety by both the Financial Regulator and the HIA. Because it is a relatively new entrant to the market, VIVAS Health is required by the Financial Regulator to have solvency cover equivalent to 200% of the required EU minimum solvency margin and a solvency ratio of 40%. Both of these requirements will decline after 3 years.[55]

Regulation of Vhi Healthcare

4.22 The EU Non-Life Insurance Directives, the Voluntary Health Insurance Act 1957 and the Voluntary Health Insurance (Amendment) Acts, 1996 and 1998, govern the regulation and operations of Vhi Healthcare. Vhi is exempt under Art. 4(c) from the 1973 EU First Non-Life Directive. Vhi Healthcare holds exemptions from the following requirements of the First Non-Life Directive (as amended):

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[53] Annex A to the First Non-Life Directive lists 18 classes of non-life insurance. Class 10, for example, refers to motor vehicle liability.
[54] Communication from the Financial Regulator, September 6th, 2006
[55] The Financial Regulator is currently working towards a regime where capital requirements will be proportionate to risk, as part of the EU *Solvency 2* Project.

- Receiving official authorisation from the competent authorities prior to commencement of operations (Art. 6);
- Taking the form of an incorporated company limited by shares or by guarantee or unlimited (Art. 8);
- Limiting its operations to the business of insurance, excluding all other commercial business (Art. 8(1)(b));
- Possessing a minimum guarantee fund (Art. 8(1)(d)) or establishing and retaining a minimum guarantee fund (Art. 17b);
- Providing a scheme of operations and proof of solvency margin to the competent authorities when seeking authorisation to extend business to other classes of insurance (Art. 8(2));
- Submitting to financial supervision (Arts. 13, 19 and 22); and
- Retaining a solvency margin at least equal to that provided for in the Directive (Art. 16).

4.23 Vhi Healthcare also enjoys exemptions from the following requirements of the Third Non-Life Directive:

- Inform competent authorities of any proposals to take a qualifying holding in an insurance undertaking (Art. 15); and
- Require equalisation reserves to be denominated in assets of specified forms (Art. 21).

4.24 Due to its exemption under Art. 4(c) from the 1973 EU First Non-Life Directive, Vhi Healthcare is exempt from regulation by the Financial Regulator as an insurance undertaking. This allows it to operate in ways that its competitors cannot as regards its corporate governance, structure and prudential obligations. Neither BUPA Ireland nor VIVAS Health are exempt from the requirements of the Directive.

4.25 Vhi Healthcare is authorised by the Financial Regulator as a multi-agency intermediary, and may intermediate in insurance other than PHI underwritten by other firms. It has broker arrangements in place with DeCare Dental and Europ Assistance for the provision of dental and travel insurance respectively. Vhi Healthcare may also sell non-insurance products. For example, Vhi Healthcare's online shop sells products as diverse as foot spas and rugby jerseys.[56] Vhi Healthcare is required to be solvent only in its capacity as an insurance intermediary.

4.26 Vhi Healthcare's health insurance and intermediary businesses are both covered by the Financial Services Ombudsman.

4.27 As a statutory body, Vhi Healthcare can only operate in a manner permitted in its governing legislation. For instance,

- It is not allowed to establish subsidiary or sister companies;
- It is statutorily restricted as regards its financing;
- It is only allowed to underwrite health insurance contracts;
- It can only engage in other health related insurance activities on an agency basis; and,

[56] Since Vhi Healthcare is exempted from the EU Non-Life Directives, it is thereby also exempted from the relevant Irish enabling legislation, Art.7(2)(a) of the *European Communities (Non-Life Insurance) Framework Regulations, 1994.*

- It must notify the Minister for Health and Children of price increases in its health insurance products[57] and the Minister has the power to reject a price increase.[58]

4.28 Under the *Voluntary Health Insurance Act 1957*, Vhi Healthcare is restricted in terms of the categories of business which it is allowed to provide.[59] The *Voluntary Health Insurance (Amendment) Act 1996* extended the types of health insurance schemes that Vhi Healthcare could offer. The *Voluntary Health Insurance (Amendment) Act 1998* permitted Vhi Healthcare to act as an agent for an international health plan. This allowed it to add medical cover while travelling abroad as an additional benefit to its core PHI product. The *Health Insurance (Amendment) Act 2001* allowed Vhi Healthcare to provide health related services, but only with the consent of the Minister.

4.29 The following table, adapted from the Financial Regulator's submission, indicates the variations in the way PHI firms are regulated:

Table 7: Regulation of Private Health Insurers[60]

	Vhi		**BUPA**		**VIVAS**
	PHI	Insurance Intermediary	PHI	Insurance Intermediary	PHI
Do the Financial Regulator's Conduct of Business Rules apply to the company?	**No**	**Yes**	**Yes**	**Yes**	**Yes**
Is the firm required to meet EU insurance capital and solvency requirements?	**N/A**[61]	**N/A**	**Yes**[62]	**N/A**	**Yes**
Is the firm required to meet the Financial Regulator's intermediary solvency requirements?	**No**	**Yes**	**No**	**Yes**	**N/A**
Does the firm require the Financial Regulator's approval to appoint directors and managers?	**No**	**Yes**	**No**	**Yes**	**Yes**

[57] S.2(2) of the Voluntary Health Insurance (Amendment) Act, 1996 states that *"The Board may, with the consent of the Minister, make and carry out a scheme amending or revoking a scheme under this section including a scheme under this subsection."*
[58] Since 1996, the Minister has exercised the power to reject a proposed Vhi Healthcare price increase once.
[59] Section 4 of the Act provides for the provision of *"schemes of voluntary health insurance subject to the consent of the Minister in regard to the scope and extent of the benefits"*.
[60] Separate columns record PHI firms' insurance undertaking businesses and their intermediary businesses.
[61] Due to its exemptions from EU Directives, this requirement is not applicable to Vhi Healthcare
[62] The UK Financial Services Authority establishes the capital and solvency standards that BUPA Insurance is required to meet.

Benefits to Vhi Healthcare of Directive Exemptions

4.30 Vhi Healthcare's exemption from the EU Non-Life Directives means that it does not need to divert capital into retaining solvency margins or a minimum guarantee fund. It can engage in commercial strategies which are not available to other insurers, such as running down reserve levels to minimise premium increases.[63] According to its 2006 *Annual Report*, Vhi Healthcare held reserves of just under €220m, and held a solvency margin level of 23%. It aims for a target solvency margin level of 40% - which is the level required by the Financial Regulator.

Establishment of Associated Companies

4.31 Consumers may value the ability to purchase multiple products from a single supplier for a variety of reasons.[64] Vhi Healthcare is not obliged to establish subsidiaries or sister companies for non-insurance activities. Were other PHI firms to provide non-insurance products they would face a more rigorous regulatory regime, as well as the extra expense of setting up associated companies. Where one market participant is able to offer consumers multiple product deals on more advantageous terms, competition is distorted. If this significantly diminishes effective competition, multiple product providers face reduced pressure to create efficiencies and pass on cost savings to their customers.

4.32 Vhi Healthcare has launched the following non-insurance products and services since 2004:

- Vhi Get Fit, an online interactive fitness programme, in partnership with eDiets Europe, a subsidiary of eDiets.com;
- Vhi Swiftcare Clinics, with medical expertise provided by The Well, a multidisciplinary medical partnership which provides a range of medical, healthcare and lifestyle services to individual and corporate clients;
- An online shop selling a wide range of healthcare, personal well-being and fitness products; and
- A Renewal and Billing IT system which it developed in-house and is now selling to other insurance firms.

4.33 Vhi Healthcare has stated that it wishes to be in a position to establish subsidiaries, sister companies or joint ventures, as it considers this to be a more efficient way of organising its business.

4.34 PHI firms should be regulated according to the same principles in the provision of non-insurance services. This requires ending Vhi Healthcare's exemption from the Third Non-Life Directive. It also means both allowing and obliging Vhi Healthcare to establish appropriate corporate structures for non-PHI products and services which it wishes to offer. This would maximise transparency and remove the competitive advantage Vhi Healthcare gains from its multi-agency intermediary status.

[63] Vhi Healthcare's 2006 *Annual Report* states that it finances the cost of community rating from its reserves.
[64] E.g. brand loyalty, perceived lowering of transaction costs, or the ability to use a "one-stop shop" facility.

Solvency Margins

4.35 In her press release of 23rd December 2005, the Minister for Health and Children announced that the Government had approved the drafting of a Bill to amend the existing Voluntary Health Insurance Acts. This Bill would, among other things, oblige Vhi Healthcare *"to attain the level of reserves necessary to achieve authorisation as an insurer within six years."* In other words, Vhi Healthcare would be given until 2012 to meet the solvency standards which other PHI firms are currently required to meet.

4.36 This is a positive step. All current and potential market participants should be regulated consistently with regard to reserve and solvency requirements. This will mean that consumers can be confident that PHI firms are in compliance with high standards of prudential regulation and will ensure that all firms face the same compliance costs. Requiring Vhi Healthcare to meet appropriate reserve levels will remove this distortion of competition in the market over a period of time, as all PHI firms will face a similar regulatory burden. In its submission, Vhi Healthcare *"supports the view that there should be a level playing field for all insurers in the market and it accepts the need for it to meet normal commercial solvency requirements in the same way as other insurers."*[65]

4.37 The timeframe announced by the Minister for Health and Children in December 2005 within which Vhi Healthcare must attain the necessary level of reserves seems generous. Accordingly, in the interests of transparency and accountability, the length of this timeframe should be independently reviewed and shortened, if appropriate. Vhi Healthcare should also give consideration to other suitable methods of meeting the solvency requirements (e.g. reinsurance or subordinated debt) which could be completed over shorter time periods.

Other Benefits Enjoyed by Vhi Healthcare

4.38 Vhi Healthcare is not subject to the Financial Regulator's conduct of business rules, except where it is acting as an insurance intermediary, nor does it pay an insurance undertaking levy to the Financial Regulator.[66] The levies required of non-life insurance companies, which are determined according to gross premium income, far exceed the levies required of intermediaries. Intermediaries may be charged a maximum levy of €18,000 per annum.[67] Thus, Vhi Healthcare is exempt from the costs other health insurers have to pay as a result of being regulated by the Financial Regulator (or the equivalent body in other EU countries).

Recommendations

4.39 Competition is unlikely to flourish where new entrants are subject to a greater regulatory burden than a former monopoly incumbent. In order for a fully competitive market to emerge, Vhi Healthcare's exemptions from the First and Third EU Non-Life Directives should be removed. The exemptions serve as a barrier to rivalry with other market participants, and also as a barrier to entry. The Authority is aware of two potential entrants who decided not to enter the Irish PHI market, citing as one of their reasons the commercial status of Vhi Healthcare. Therefore, it is desirable to remove these exemptions in the best interests of competition.

[65] Vhi Healthcare submission at p.32

[66] It pays other levies in its capacity as a multi-agency intermediary to the Financial Regulator as well as levies to the Financial Services Ombudsman.

[67] The levy calculation structure is detailed in the Financial Regulator's *2006 Guide to Industry Funding*, available online at http://www.ifsra.ie/data/pub_files/2006%20Guide%20to%20Industry%20Funding.pdf#search=%22%22insurance%20undertaking%22%20levy%22

There may be a short-term correction on Vhi Healthcare premiums, which is worthy of consideration when addressing the manner and timing of the ending of the Non-Life Directive exemptions for Vhi Healthcare. It should also be noted that, since Vhi Healthcare's exemption is enshrined in EU legislation, it must be removed at EU level.

4.40 Vhi Healthcare would be unlikely to receive authorisation as an insurance company from the Financial Regulator if it were to immediately become subject to regulation in its current form. Vhi Healthcare must alter its structure and financing by establishing subsidiaries or sister companies and meeting appropriate solvency margins before its exemptions are removed. Provision must also be made for its regulation as an insurance undertaking by the Financial Regulator.

4.41 Although Vhi Healthcare enjoys a number of benefits, it is also constrained in certain aspects of its behaviour. S.3(1) of the Voluntary Health Insurance (Amendment) Act 1996 obliges Vhi Healthcare to seek approval from the Minister for any price increase. The Minister for Health and Children has announced that the forthcoming Bill to amend the Voluntary Health Insurance Acts will *"give commercial freedom on products and pricing to Vhi Healthcare"*. This is understood to mean that the Minister for Health and Children would no longer be responsible for approving Vhi Healthcare price increases. The competitive environment would be enhanced if Vhi Healthcare received greater commercial freedom to act in the same manner as other PHI providers.

Recommendation 1 **Require Vhi Healthcare to establish subsidiary or sister companies for activities other than health insurance**	**Action By**
Vhi Healthcare should be obliged to provide non-health insurance services in the same manner as other insurers. Accordingly, the Minister should allow and oblige Vhi Healthcare to establish sister companies (or subsidiaries) to carry out non-health insurance activities.	**Minister for Health and Children**

Recommendation 2 **Reassess the requirements placed on Vhi Healthcare to meet the Financial Regulator's reserve requirements**	**Action By**
Vhi Healthcare's solvency reserve requirements should be reassessed. • The proposed six-year timeframe allowed for Vhi Healthcare to attain the necessary level of reserves to be regulated as an insurance company should be reviewed. • Consideration should also be given to reducing the level of solvency reserves required of Vhi Healthcare prior to the conclusion of the "Solvency 2" process. • Consideration should be given by the Minister to methods of permitting Vhi Healthcare to raise capital by means other than the accumulation of surplus.	**Minister for Health and Children**

Recommendation 3 **Remove the requirement for Vhi Healthcare to seek Ministerial approval for premium increases**	**Action By**
The requirement for Ministerial approval for Vhi Healthcare premium increases under S.3 of the Voluntary Health Insurance (Amendment) Act, 1996 should be abolished.	**Minister for Health and Children**

Recommendation 4 **Regulate Vhi Healthcare as an insurance undertaking once it has reached the required reserves**	**Action By**
Vhi Healthcare should be subject to prudential regulation in its capacity as an insurance undertaking by the Financial Regulator when it has reached the level of reserves required by the Financial Regulator.	**Financial Regulator**

Recommendation 5 **Remove Vhi Healthcare's exemptions from the EU Non-Life Directives**	**Action By**
Vhi Healthcare's exemptions from the First and Third EU Non-Life Directives should be abolished. Once Vhi Healthcare has received authorisation as an insurance company from the Financial Regulator by reaching the required level of reserves, removal of these exemptions by the institutions of the EU should be sought by the Minister for Health and Children.	**Minister for Health and Children**

Role of the Health Insurance Authority

4.42 As part of the consultation process for this Report, submissions were invited on *"duties that could be assigned to the Health Insurance Authority under existing legislative provisions and additional functions that might possibly be assigned to The Health Insurance Authority."* A number of respondents made suggestions as to the role and structure of the Health Insurance Authority (HIA).

Enforcement

4.43 As discussed earlier in this chapter, the HIA is responsible for monitoring the operation of health insurance legislation, including associated regulations. However, its powers of enforcement are very limited. Effectively, the HIA's only power of enforcement against an insurance undertaking is to direct the removal of that undertaking from the Register of health insurers. The final decision is then for the High Court to confirm or deny the removal of the insurer. This would be a draconian step for the HIA to take. To promote more effective regulation, the HIA should also have the lesser power to direct an insurance undertaking to comply with the legislation and be given the power to impose sanctions which are proportionate to the misdemeanour in question, in particular where breaches of health insurance legislation have occurred.

4.44 Various models of sectoral regulation and enforcement are available. The HIA should be granted a limited power of enforcement for the HIA against a body corporate such that the limited power would be likely to achieve effective enforcement of the Health Insurance Acts in most situations without having to consider the draconian power to direct the removal of a health insurance undertaking from the register of undertakings.

Recommendation 6 **Provide the Health Insurance Authority with wider powers to enforce the Health Insurance Acts**	**Action By**
Legislation should be brought forward to amend the Health Insurance Acts and provide that the Health Insurance Authority has the power to direct that a health insurer alter its practices or its products to comply with the provisions of the Acts or regulations thereunder; and is granted the power to apply appropriate sanctions.	**Minister for Health and Children**

Promoting Consumer Interests

4.45 The explicit statutory functions of the HIA are quite limited, especially in respect of consumer information and protection. The HIA's governing legislation gives it no specific role in protecting or promoting the interests of PHI consumers. This Report makes a number of recommendations for actions by the HIA connected with the consumer, for instance, drafting a switching Code for Health Insurers (see Chapter 6). The HIA's role as regards consumer protection should be confirmed and strengthened by an explicit amendment to its powers with regard to consumer interests.

4.46 An explicit amendment to the HIA's functions with regard to consumer interests or consumer protection or both would benefit competition by ensuring that consumers have better information on their statutory rights under the health insurance legislation and accurate information on health insurance products.

Recommendation 7 **Assign the Health Insurance Authority the function of promoting the interests of consumers**	**Action By**
Legislation should be brought forward to amend the Health Insurance Acts to assign to the Health Insurance Authority the function of promoting the best interests of consumers.	**Minister for Health and Children**

Conclusion

4.47 Numerous examples of regulatory asymmetries exist in the PHI market. This chapter provides a number of recommendations to address these issues and provide for symmetric regulation of all players in the market. Competition in the PHI market will be improved by ensuring that all health insurers in the market fall under the same prudential regulatory regime.

5. BARRIERS TO ENTRY

Summary

5.1 Barriers to entry arise where there are obstacles to be overcome which have significant, irretrievable costs associated with them and where it is more difficult for a new firm to enter a market than it was for the existing firms. Barriers to entry limit the choices available to consumers and harm competition by protecting market participants from the pressure to innovate and generate efficiencies in order to retain and grow market share. Broadly speaking, barriers to entry fall into two categories:

- **Structural barriers** arise as a consequence of the market structure, such as very high sunk costs or government regulation; and
- **Strategic barriers** are erected by firms already in the market. These barriers are intentionally created or enhanced by incumbent firms in the market, possibly for the purpose of deterring entry.

5.2 Respondents to the consultation process for this report identified the following key barriers to entry to the Irish PHI market:

- The size of Vhi Healthcare;
- Vhi Healthcare first-mover advantage;
- Costs of market entry;
- Access to salary deduction mechanisms;
- Legislation and the associated regulatory regime[68];
- Solvency requirements; and,
- The particular scheme of Risk Equalisation in place in Ireland.[69]

5.3 Of these barriers to entry, Vhi Healthcare's position in the market and the way in which the Irish PHI market is regulated are seen to be the two most significant. BUPA Ireland's stated intention to withdraw from the market leaves open the possibility that the magnitude of these barriers will only increase, making the Irish PHI market even less attractive to potential entrants than it already is.

5.4 This chapter describes how these factors act as barriers to entry. Many of the barriers identified will be mitigated by the recommendations in Chapter 4 regarding the legislative and regulatory framework of PHI in Ireland. The sunk costs of entering the PHI market, such as advertising, brand building and dealing with regulators are inevitable and unavoidable. Access to salary deduction mechanisms in companies to insurers other than Vhi Healthcare could be improved by way of an information campaign to employers.

[68] This issue was discussed in detail in Chapter 4.
[69] The impact of RE as a barrier to entry is addressed in Chapter 8. Both the 1998 Harvey Report and the November 2006 High Court judgement on the legality of the RE Scheme accepted RE was a barrier to entry.

Interviews with Possible New Entrants

5.5 The Health Insurance Authority conducted interviews with possible new entrants a few years ago in connection with a previous study on the health insurance market.[70] The interviewees were senior executives from companies operating in other insurance sectors in Ireland. The object of the interviews was firstly to enquire as to their views on entering the health insurance market and their reasons for not entering; the interviews were also conducted in the context of Risk Equalisation and competition in the PHI market.

5.6 Interviewees considered there to be numerous barriers to entry to the PHI market. The most prominent of these perceived barriers included:

- The market power of Vhi Healthcare;
- Vhi Healthcare's state ownership and its lack of a clear commercial mandate;[71]
- Vhi Healthcare's exemptions from certain Irish and EU regulations;
- PHI is a highly specialised market which requires particular skills and knowledge;
- PHI is a highly regulated market which limits the commercial freedom of PHI firms;
- Major uncertainties in the health insurance market such as:
    i. The future of Risk Equalisation and its ultimate implementation;[72] and
    ii. The future of Vhi Healthcare and the timing and precise details of its future legal form, its regulation and the possibility of its future privatisation.

5.7 It is clear from the views of potential market entrants that the single greatest barrier to entry is the position of Vhi Healthcare on the market, whereby its legacy advantages are, in part, perpetuated by a favourable regulatory regime.

Market Uncertainty

5.8 Potential entrants value certainty in markets as this allows them to attempt accurate assessments of what strategies should be employed on entering the market, what competitive constraints will arise, what the potential for growth and development is, and, ultimately, whether entry would be profitable. The Irish PHI market is still characterised by uncertainty. This uncertainty takes two main forms.

[70] *"Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market"* York Health Economics Consortium, 2003.
[71] Vhi Healthcare is a state-controlled statutory mutual health insurance body.
[72] BUPA Ireland has announced its intention to appeal the recent High Court ruling to the Supreme Court.

5.9 First, the validity and legality of the current RE Scheme is still being assessed in a number of proceedings. Although the High Court held the RE Scheme to be valid in November 2006, this decision has since been appealed by BUPA Ireland to the Supreme Court. A further judicial review is outstanding at the High Court[73]. BUPA Ireland has also brought a case to the European Court of First Instance alleging that RE constitutes a state aid, and the European Commission is also scrutinising the PHI market and has not ruled out commencing infringement proceedings against the State.[74] Until potential entrants have absolute certainty on whether or not they will be liable to incur RE transfers after the expiry of the exemption period, it is unlikely that *de novo* market entry will occur.

5.10 Second, it is not clear whether BUPA Ireland will in fact exit the market. Although it had announced that it would do so in December 2006, it stated shortly thereafter that it would welcome any proposal from the Government to alter the RE scheme or solvency requirements. More recently, BUPA Ireland refused to enter talks with AXA Insurance regarding the purchase of BUPA Ireland's book as it wanted to keep alive the possibility of re-entering the market, should market structures change. As long as there is uncertainty as to whether BUPA Ireland will remain in the market, potential entrants are not likely to enter the market. This is for two main reasons:

- Potential entrants may wait to see whether BUPA Ireland's customer book comes up for sale, allowing for rapid acquisition of market share, rather than slow development through organic growth; and,

- BUPA Ireland has repeatedly stated that changes to market structures would be required for it to remain in the market. Potential entrants are unlikely to enter the market until it is clear whether market structures, particularly the RE Scheme and solvency requirements, will be changed in order to facilitate BUPA Ireland's remaining in the market.

Solvency Guidelines for Health Insurers[75]

5.11 In certain circumstances, the Financial Regulator imposes increased solvency requirements on new entrants to the insurance market as there is a higher risk of failure in the start-up phase than when the insurer is more established. Irish insurance solvency standards are higher than the current minimum EU standards. This could create a market distortion, as insurance companies from other EU Member States who are regulated in those states are entitled to underwrite insurance business in Ireland, including health insurance, under more favourable solvency criteria. The Financial Regulator has stated that *"most (insurance) companies maintain solvency levels well in excess of our requirements and we are not the only Member State to require companies to maintain solvency levels in excess of the required minimum".*[76]

[73] BUPA Ireland took a second Judicial Review which was granted on 30th January 2006. Relief was sought in respect of the HIA's recommendation made on 27th October 2005 that the Minister exercise her power to commence risk equalisation payments and in respect of the Minister's determination to commence payments from 1st January 2006. The relief was sought in respect of the steps taken by the HIA in making its recommendation, the substance of the HIA's recommendation, the steps taken in the making of the Minister's determination and the substance of the Minister's determination.
[74] *"EU has insurance market concerns".* December 14th, 2006. Available online at http://www.rte.ie/business/2006/1214/bupa2.html
[75] Solvency margins do not constitute a barrier to entry since they are not sunk costs of entry. Solvency margins are retained funds which revert to a firm if it decides to exit the PHI market.
[76] Letter from the Financial Regulator to the Competition Authority, September 2006.

5.12 A review of EU regulatory standards, *Solvency 2*, is now under way,[77] which focuses on capital requirements, supervisory practices and transparency through improved reporting by companies. This will introduce a more risk-based approach to capital requirements. Companies that can demonstrate that they are managing and providing for risks in a prudent manner will benefit from lower capital requirements. At present, the Financial Regulator requires the same solvency reserve provisions for all non-life insurance companies.[78] As *Solvency 2* standards are expected to address the issues involved in allowing different solvency requirements for subsectors of the insurance sector that may have a different risk profile than the average in the non-life insurance sector, the Competition Authority considers it appropriate to await the outcome of the *Solvency 2* process.

Investment and Set-up Costs

5.13 Set-up costs are barriers to entry to a market when they are "sunk", i.e. they cannot be recouped should the entrant subsequently decide to exit the market. In the Irish PHI market, the key sunk cost of entry is developing and establishing a brand. However, this sunk cost is only incurred where a firm establishes itself *ab initio* rather than relying on an already well-known brand. Successfully establishing a brand is important in the PHI market, given the strong brands that currently exist in the market. In particular, Vhi Healthcare is synonymous with health insurance in Ireland having built its brand awareness among the public over the past half-century, and may carry with it a perception of a State guarantee.

5.14 Other potential sunk costs could include the costs of regulatory authorisation and the costs of investing in a complicated IT system. However, an IT system would only constitute a sunk cost if it could not be sold to another firm or used for billing or claims management purposes in another insurance market. Furthermore, there is a well developed market for third party administration services in insurance so that a new insurer would not necessarily need to incur the full cost of developing IT administration systems. With regard to the costs of gaining regulatory authorisation these costs are unlikely to be significant enough to deter firms from entering the market.

Vhi Healthcare First Mover Advantages

5.15 Vhi Healthcare has clear first mover advantages which can raise barriers to entry and disadvantage new or potential entrants. Among the elements contributing to this barrier to entry are the following:

- The Vhi Healthcare brand;
- The Minimum Benefit Regulations which have resulted in Vhi Healthcare's product design essentially becoming the industry standard;
- Vhi Healthcare's salary deduction mechanisms for paying PHI premiums; and
- Vhi Healthcare's procurement relationships with private hospitals.[79]

[77] For further information, please see http://ec.europa.eu/internal_market/insurance/solvency2/index_en.htm
[78] New non-life insurance companies are required to have a solvency margin twice that of the EU minimum for their first three years of operation.
[79] Procurement relationships are addressed in Chapter 7.

5.16 Each of these factors are discussed in more detail below, except for Vhi's procurement relationships with private hospitals which is discussed in detail in Chapter 7.

The Vhi Healthcare Brand

5.17 Vhi Healthcare has significant first-mover brand advantages. In this context Vhi Healthcare's status as a former statutory monopoly is important. Vhi Healthcare has had a forty-year headstart on its rivals which has allowed it to develop a very strong brand that has become synonymous with health insurance. This is reflected in the results of the HIA's 2003 *Consumer Survey* in which respondents described Vhi Healthcare as "secure", "reliable" "familiar" and "Irish".

5.18 PHI has "experience good" elements. That is, a consumer can only judge it's true worth after he/she has actually used the product. Thus a consumer who has had a positive experience of making a claim on a PHI policy will be confident that the health insurer will deliver on the product if they need to make another claim in the future. As a result consumers will be less willing to experiment with a new brand if a tried and tested insurer already exists.

5.19 Vhi Healthcare's long-established brand which is synonymous with health insurance in Ireland gives it a significant advantage over its competitors and potential entrants. New entrants would have to invest considerable sums in establishing their own brand to effectively compete. The costs would be lower for a company that operates in another market and is able to leverage their existing brand in a related market.

5.20 BUPA Ireland's market entry ended Vhi Healthcare's monopoly. After 10 years in the Irish PHI market it had established a reputation and trusted brand.

Minimum Benefit Regulations and Product Design

5.21 The Minimum Benefit Regulations, which determine the core elements of every PHI policy sold in Ireland, were based on Vhi Healthcare's basic product at the time. While the Regulations constrain all PHI provider's ability to innovate and compete on product design, the regulations also cemented Vhi Healthcare's products as standard in the minds of consumers. Any alternative provider is expected by most consumers to provide at least the same level of cover as a comparable Vhi Healthcare product. Accordingly, alternative PHI providers are constrained to design their products to resemble, to some degree, established plans offered by Vhi Healthcare.

5.22 Thus, new entrants are constrained in the alternatives they can offer PHI consumers and the extent to which they can differentiate themselves from existing PHI providers. This constraint also makes it more difficult for existing PHI providers to compete with Vhi Healthcare.

5.23 Chapter 6 contains recommendations regarding the Minimum Benefit Regulations which will minimise the effect of this barrier to entry.

Salary Deduction Mechanisms

5.24 Salary deduction schemes, whereby consumers pay their PHI policy premia through their employer by deducting it directly from their payslip, are one means of collecting premium revenue for health insurers. Consumers benefit from the facility of not having to set up a direct debit to pay for their PHI.

5.25 In order to provide consumers with a convenient means of paying their premiums, new entrants to the market may wish to access company salary deduction mechanisms as a distribution channel. As the former incumbent monopoly provider, Vhi Healthcare has built up a large legacy network of salary deduction schemes. Certain insurers see this avenue as a necessity in order to compete effectively in this sector of the market.[80] However, inertia on the part of companies makes this difficult for other health insurers. Where health insurers are unable to access this functionality, a means of paying for health insurance premiums is, in effect, foreclosed to them.

5.26 In order for a health insurer to offer their customers the ability to pay their premium through a salary deduction mechanism that customer's employer must add a deduction facility to its payroll system. However, companies may be unwilling to go to this trouble, particularly if this involves cumbersome payroll rearrangements. New entrants may have to persuade employers to amend their payroll system to add their insurance company to the employer's salary deduction mechanism.

5.27 Vhi Healthcare therefore enjoys a continuing advantage over other health insurers in terms of their widespread salary deduction network. To the extent that such a network is necessary to compete in this sector, this presents as a barrier to entry.

5.28 It would not be appropriate to force companies with salary deduction mechanisms to adjust them to recognise all PHI providers in Ireland. Promoting behavioural change on the part of companies offering, or considering offering, salary deduction mechanisms could help ameliorate this barrier to entry. Companies need to know that they can offer multiple salary deduction mechanisms for PHI to their employees, and that this is, in most cases, a relatively simple exercise, particularly given the functionality of modern payroll management software suites. The HIA is well-placed to advise businesses of this fact given its role in the market.

Recommendation 8 **Employers should be made aware of their ability to set up multiple salary deduction mechanisms**	**Action By**
The Health Insurance Authority should conduct an information campaign to employers who provide employees with the option of paying their health insurance via salary deduction to inform them of the ease with which multiple salary deduction mechanisms can be set up.	**HIA** **2007**

[80] The Competition Authority's enquiries found that some health insurers see this as a barrier to entering a market and expanding market share but others do not see it as a problem as members of group schemes can pay their premiums in a variety of other ways (most commonly via direct debit) rather than via their payroll.

Conclusion

5.29 A wide range of barriers to entry to the Irish PHI market has been identified by respondents to the consultation process and by potential entrants to the market. The most significant of these barriers are considered to be Vhi Healthcare's position in the market and associated first-mover and legacy RE advantages; the legislative and regulatory environment; and Risk Equalisation. Competition will not work where high barriers to entry persist; therefore measures must be taken to either remove or reduce the magnitude of these barriers.

5.30 Recommendations have already been made earlier in this report to address the regulatory and legislative environment in which PHI firms operate. The removal of Vhi Healthcare's first-mover advantages and its attendant position in the market can be partly and incrementally addressed by means of regulation. Risk equalisation is examined in Chapter 8.

5.31 An information campaign to employers by the HIA will help reduce the negative effects of Vhi Healthcare's legacy network of salary deduction schemes.

5.32 Barriers to entry that involve sunk costs – such as advertising campaigns to build or leverage a brand, or resources spent on gaining regulatory approval – are inevitable and unavoidable.

6. ENCOURAGING COMPETITION BETWEEN PRIVATE HEALTH INSURERS

Summary

6.1 How health insurers compete with one another in Ireland is greatly limited by the choices Ireland has made with regard to intergenerational solidarity in PHI. Community rating and the Minimum Benefit Regulations hugely constrain price competition and innovation in the PHI market. For example, health insurers cannot offer discounts to non-smokers, nor can they choose which treatments to cover.

6.2 Within these restrictions, rivalry between health insurers is best promoted by ensuring that the potential for innovation is not overly-restricted and that consumers are not inhibited from switching health insurer in response to new PHI policies which better suit their needs.

6.3 Competition is hindered if consumers find it difficult to switch between competing firms. It is vital that firms can attract customers on the merits of their products and services if consumers are to benefit from competition. In particular, firms will not compete vigorously for consumers who already have a contract with another provider if the cost of attracting those consumers is significantly higher than the cost of attracting consumers that are new to the market.

6.4 Although the process of switching health insurer is simple and straightforward, some consumers have an incorrect perception that the process is difficult and cumbersome. Certain practices by health insurers also make it less likely that consumers will switch in response to better offers from other PHI firms.

6.5 To promote a more competitive PHI market, consumers need to be made aware that it is easy to switch health insurer. They also need the necessary information on competing products to decide whether there are better products available to meet their needs, and they need to have confidence that the switching process will occur smoothly and efficiently. Health insurers need to be free to offer new and innovative PHI products. Accordingly, the Competition Authority makes a range of recommendations in this chapter to promote competition between PHI firms and facilitate switching amongst consumers. Specifically,

- A Switching Code should be developed by the health insurers and the HIA to promote consumer confidence in the switching process;
- Consumers should be provided with useful information on comparing PHI products and the switching process;
- Vhi Healthcare should cease its practice of cancelling travel insurance policies when its PHI customers cancel their PHI policies;
- The Minimum Benefit Regulations should be modernised to minimise their negative effect on competition and innovation in PHI; and
- The HIA should be allowed to approve limited-cover plans to allow more innovation in PHI.

6.6 Efforts to promote switching are important in the long run as they reduce barriers to entry by making it easier for new health insurers to build their business and expand to compete effectively with existing health insurers.

Switching Costs and their Effects

6.7 Switching costs are the monetary and non-monetary costs incurred by consumers when they move from one supplier to another. Switching costs make competition less likely because they make it more difficult for consumers to switch from one supplier to another in response to a cheaper price, new products, or better customer care.

6.8 In markets characterised by high switching costs, price competition, non-price competition and innovation are all less common because suppliers do not need to put as much effort into retaining their existing customers. In general, prices tend to be higher where switching costs, real or perceived, are present than when they are absent.[81]

6.9 Switching costs can be broken down into:

- Transaction costs - the time and money costs incurred by consumers in switching.
- Psychological costs - where consumers who were initially indifferent between producers develop a preference for a particular brand simply because they have become used to it, and perceive a cost of switching to other brands.[82]

6.10 Rational consumers will not consider switching until they can confidently expect that the benefits of switching will exceed the varied costs of switching. The best way to ensure that consumers are not unnecessarily restricted from switching health insurer is to lower switching costs, such that consumers will be more willing to switch in response to a competing product which better suits their preferences.

6.11 Switching costs have two distinct impacts on suppliers.

- First, switching costs make consumers less likely to react to price increases than they otherwise would be as a higher price increase will be required for them to determine that it is worthwhile paying the switching costs.
- Second, because consumers in markets with high switching costs are considered to be "locked in" once they have chosen a particular supplier, intense competition generally only occurs for consumers who are new to the market, such as students, graduates and individuals starting their first job.

6.12 Markets characterised by ongoing contractual relationships between customers and providers often display signs of customer inertia (e.g. banking, utilities) unless steps are taken to promote switching. This is because the customer may perceive significant transaction costs involved in switching, even if there are none.

[81] See, e.g., Klemperer, P. (1987) *Markets with Consumer Switching Costs.* Quart. J. Econ., pp.375-294; Klemperer, P. (1988) *Welfare Effects of Entry Into Markets with Switching Costs*. J. Ind. Econ., pp.159-165; Klemperer, P. (1995) *Competition when Consumers have Switching Costs: An Overview with Applications to Industrial Organisation, Macroeconomics and Industrial Trade*. Rev. Econ. Studies, pp.515-539.
[82] Klemperer (1995), p.518.

6.13 The ability to switch promotes competition by allowing consumers to easily reward with their custom those firms who react best to changing consumer demands. High switching costs create barriers to entry, as consumers will be unwilling to transfer their business from established market players to new providers.[83]

Search Costs and their Effects

6.14 Search costs, which can be distinguished from switching costs, are defined as follows:

> *"Search costs are the total costs spent by a consumer in identifying and interpreting a firm's product and price offering, regardless of whether the consumer buys the product from that firm or not.*
>
> *Switching costs are the total costs incurred by a fully informed consumer through deciding to change suppliers that would not have been incurred by remaining with the current supplier."*[84]

6.15 While switching costs are only incurred upon deciding to switch, search costs may be incurred numerous times, and are incurred regardless of whether a consumer decides to switch. This means that the search activity of consumers will be inhibited more by high search costs, which are an inevitable outcome of searching, than by high switching costs, which only arise following a decision to switch. Firms can increase search costs through obfuscation strategies such as complex tariff structures which consumers find difficult to compare.

6.16 Both search and switching costs can be reduced if consumers have ready access to simple, understandable, high-quality price and product information. Where an industry is unable or unwilling to provide this information, it may fall to an industry regulator or a consumer advocacy agency to do so. To take the case of mobile phone pricing plans, ComReg launched a consumer information website, www.callcosts.ie, in November 2005. This website allows users to input their mobile phone usage statistics and then determines the most suitable pricing plan for them, based on their patterns of usage.

6.17 The Financial Regulator has also been proactive in providing consumers with straightforward information on frequently-complex retail financial products and services through its websites, www.financialregulator.ie and www.itsyourmoney.ie. The cost surveys which the Regulator issues on a regular basis are designed to facilitate consumers by making it easier to compare the costs and features of various financial products.

Switching Costs and Search Costs in the PHI Market

6.18 In the PHI market switching costs are made up of:

- Transaction costs (the time and money costs incurred by consumers in switching) - which are low, as switching can be accomplished easily in a matter of minutes, by means of two phone calls or online; and
- Psychological costs - which are high as consumers incorrectly perceive switching to be costly and have a tendency not to switch regardless of the alternatives available.

[83] Klemperer (1995), p.535.
[84] Wilson, C. (2006). "Markets with Search and Switching Costs". *Centre for Competition Policy Working Paper 06-10.* Available online at http://www.ccp.uea.ac.uk/public_files/workingpapers/CCP06-10.pdf

6.19 Search costs in the PHI market are high as PHI products have many components and are difficult to compare.

6.20 There are strong similarities in switching dynamics in PHI markets across OECD member states. Generally speaking, in Ireland, Australia, Germany, Switzerland and the Netherlands, switching is not extensive, and is more common among younger, healthier population cohorts.[85] Propensity to switch is affected by similar factors, particularly lack of comparative information and low consumer sensitivity.

6.21 The HIA *Market Review* suggests that PHI is a market characterised by inertia. Among those respondents who had not switched PHI insurer, 13% indicated that they had not switched because they had been with their existing provider for a long time, 8% felt loyal to their provider, and 9% simply couldn't be bothered. In contrast, fewer consumers had not switched because of perceived barriers to switching, namely, too much hassle (12%), the difficulty of comparing plans (4%), the expense involved (3%) or lack of information (2%). 14% of respondents indicated that they would <u>never</u> consider switching health insurer.

6.22 This indicates that switching has not occurred because of consumer inertia and apathy, as well as barriers to switching. High levels of inertia and apathy can be indicative of the existence of high search costs. There is little point in considering switching health insurer if the cost, in terms of time and money, of researching and comparing PHI products is high relative to potential gains.

6.23 There is evidence that Irish consumers of PHI have difficulty understanding and comparing competing PHI products. Numerous submissions received during the consultation period stated that information was presented in a complex manner which consumers found difficult to interpret. Whether this applies to all PHI customers, or just a segment, and whether the difficulties of comparison are real or imagined, these perceptions inhibit competition by raising consumers' search costs. In addition, consumer apathy about switching may be an indicator that search costs are perceived to be too high for consumers to engage in searches.

6.24 In the Irish PHI market, switching *per se* is not difficult, yet consumers are reluctant to switch for other reasons such as: satisfaction with their current provider, inertia, or the (incorrect) assumption that significant amounts of paperwork would be involved. As the HIA's *Market Review* showed, very few PHI consumers had ever considered switching, despite the fact that less than 1% of consumers were unaware that they could switch, and only 24% of consumers disagree or strongly disagree that there is adequate information to compare plans from different insurers.

Measures to Facilitate Switching between Health Insurers

A. A Switching Code to Promote Switching

6.25 One way to reduce switching costs is to create a single, standardised mechanism for switching which is accepted by suppliers in the market. A Switching Code typically sets out, at a minimum, the steps which a consumer must take, the responsibilities of the "old" and the "new" supplier, information required to complete a switch, and the timescale for completing this process. A Switching Code is a useful way of promoting awareness of switching, and facilitating switching for those who wish to do so.

[85] OECD (2004a), p.203.

6.26 A PHI Switching Code, agreed by the industry and approved by the HIA, would help convince consumers that switching is easy and simple, rendering the perceptions of consumers more receptive to the idea of switching. It would also deal with any minor problems that may currently exist in the switching process and in "winback" strategies used by health insurers to hold on to customers and discourage them from switching.

6.27 A PHI Switching Code should be a short, succinct and simple document explaining how easy it is to switch and setting out protocols indicating:

- What consumers must do in order to switch;
- Ensuring that consumers receive their renewal notices one month in advance of renewal date;
- What steps the health insurers will take to switch the consumer; and,
- What behaviour is permissible by PHI firms trying to win back customers who are considering switching.

6.28 These agreed protocols could cover, among other things, the operation of sales and business retention, particularly over the phone. When consumers wish to switch away from firms, they may be passed to dedicated Customer Retention Teams, also known as win-back teams, who are tasked with persuading individuals not to switch. While this is a legitimate business activity, the danger of misleading information being used as part of retention strategies must be avoided. A Switching Code could be useful in setting out standards which sales and retention teams must abide by. A useful template for such standards is Section 4 of the Carrier Pre-Selection (CPS) Code of Practice agreed by the telecoms industry. [86]

6.29 Switching Codes have been successfully implemented in industries traditionally characterised by low levels of switching, such as banking. Prior to the introduction of a Switching Code, switching current accounts was a tedious, cumbersome process characterised by errors and failure to complete transactions during the changeover period. Accordingly, there was a clear need to introduce a mechanism to make account switching more convenient. In Ireland, 17,000 consumers used the Irish Bankers Federation (IBF) Switching Code to switch bank accounts from February 2005 to January 2006. Moreover, an estimated further 31,000 customers switched banks, but without using the Switching Code. Experience shows that switching codes not only promote switching and awareness of switching, they also promote more intense competition between market players.

Recommendation 9 **Implement a Switching Code for private health insurance**	**Action By**
The Health Insurance Authority should draft a Switching Code for health insurance which would, in a brief, clear and definitive manner, detail the duties and obligations of health insurers during the switching process, as well as the rights of consumers.	**HIA** **2007**

[86] Available online at http://www.eircomwholesale.ie/dynamic/pdf/cpscopumv1.1.pdf

B. Provide More Information to Consumers

6.30 Informed consumers make better decisions about the products and services which best suit their needs and desires. Without useful, accessible information, consumers are unable to accurately assess the merits of competing products. Provision of clear comparative product and pricing information can promote switching by reducing consumer search costs.

6.31 The HIA has a role to play in reducing search costs by disseminating information on competing price plans to consumers, as part of the mandate given to it by the Minister for Health and Children to *"carry out a major and sustained campaign focused on heightening consumer awareness of their right to switch without penalty between insurers and to seek the cooperation of employers in facilitating this process"*.[87]

6.32 Less than half of PHI consumers feel there is sufficient information to allow for useful comparisons of PHI plans. Greater attention therefore needs to be paid to providing actual and potential consumers of PHI with simple, comprehensible and accessible information about PHI plans offered by each of the PHI firms operating in the Irish market. The HIA publishes on its website a consumer guide, *Understanding and Comparing Private Health Insurance Products*[88] designed to help consumers compare the benefits provided by various PHI schemes. The publication of such data, similar in format to the cost surveys published regularly by the Financial Regulator, needs to be advertised widely.

6.33 While the HIA has promoted awareness of personal consumers' right to switch, less information on switching is readily available to corporate customers, specifically employer-paid group schemes, who make purchasing decisions on behalf of their employees.

6.34 The provision of renewal notices by insurers facilitates switching as it provides consumers with all the information they require to seek quotes from competing insurers on one simple form.

Recommendation 10 **Provide consumers with prescribed switching information at point of sale and renewal**	**Action By**
Health insurers should be obliged by statute to provide prescribed information to consumers on their rights regarding switching and waiting periods as well as information to facilitate comparison and understanding of products and of their rights as consumers. Following consultation between the Health Insurance Authority, the insurers and others (e.g. National Consumer Agency), a prescribed format of documentation should be drawn up. Each insurer should be responsible for providing this documentation to consumers at point of sale and at renewal time. In the interim period, PHI firms should distribute the HIA's current pamphlet on consumer rights with renewal notices. This pamphlet should be replaced by the 'new' documentation when it is ready.	**HIA** **Health Insurers** **Annually** **Minister for Health and Children**

[87] *Tánaiste announces introduction of risk equalisation and measures to achieve greater competition in the private health insurance market*. Available online at http://www.dohc.ie/press/releases/2005/20051223.html
[88] Available online at http://www.hia.ie/docs/pcaci/Comparison-Table-8-January-2007.pdf

C. Renewal Notices for Employer-Paid/Subsidised Group Schemes

6.35 Consideration should be given to means of facilitating switching in employer-paid or employer-subsidised group schemes. To give an example, an employer could offer a number of PHI plans to its employees but restrict switching to two or three occasions per annum. This form of group scheme provision during specified "open seasons" is used in the US by the federal government in its capacity as an employer, and by numerous corporations. The creation of "open seasons" for switching has two main benefits:

- Firstly, employer and PHI firms' administrative costs would be reduced, as the cost of facilitating switching would occur only twice or three times a year, rather than randomly throughout the year. This would make the provision of multiple plans more attractive to employers.

- Secondly, the establishment of set switching periods would provide PHI firms with a set-piece opportunity to strongly encourage switching during these periods and would allow group scheme members to compare and contrast PHI plans during the switching period. This would promote competition between PHI firms at the corporate level and promote transparency between competing plans.

D. Cease Tying Private Health Insurance and Travel Insurance Policies

6.36 In February 2004 Vhi Healthcare entered the worldwide multi-trip travel insurance market. It did this by way of offering a new innovation to the travel insurance market in Ireland – an annual travel insurance product which was available as an "add-on" to a consumer's PHI policy. This product is only available to Vhi Healthcare PHI customers. By May 2006 Vhi Healthcare held an estimated 35% share of the worldwide multi-trip travel insurance market in Ireland.[89]

6.37 Vhi Healthcare's success in this related market caused other insurers to begin underwriting worldwide multi-trip travel insurance as an add-on to PHI products, as well as the regular worldwide multi-trip product. For example, AIB and ACE offer such products in competition with Vhi Healthcare, though their products are not tied to any one health insurer and are available to all PHI consumers.

6.38 Vhi Healthcare offers Vhi-brand MultiTrip Travel Insurance to individuals, couples and families, as well as Group Business Travel Insurance for sale online. Neither BUPA Ireland nor VIVAS Health offers an own-brand travel insurance product.[90] Vhi Healthcare is therefore currently in the unique position of offering an own-brand travel insurance proposition as an insurance intermediary, underwritten by Europ Assistance.

[89] Vhi Healthcare Press Release, May 31st 2006. Available online at https://www.vhi.ie/press/310506.jsp

[90] Any insurance undertaking wishing to expand its insurance operations beyond the scope of its authorisation may apply to the Financial Regulator to seek an extension of classes to enable it to underwrite the insurance business.

6.39 Vhi Healthcare travel insurance is only available to Vhi Healthcare members. If Vhi Healthcare members cancel their PHI policy, their Vhi MultiTrip travel insurance policy (if they have one) is automatically cancelled without refund.[91] However, where a company decides to switch its PHI Group Scheme from Vhi Healthcare to another health insurer, it may keep its Business Travel Insurance policy, but the cost of the travel insurance policy will increase.[92]

6.40 Vhi Healthcare's cancellation policy can act as a barrier to switching. Barriers to switching arise where the costs of switching exceed the savings from switching. Consumers are unlikely to switch if the savings generated by moving to another health insurer and another travel insurance provider fail to exceed the value of the remaining travel insurance premium.[93]

6.41 In this respect, it is worthy of note that, as of December 2006, both AIB's and ACE's standard add-on worldwide multi-trip travel insurance products were cheaper than the alternative Vhi Healthcare product. Economically rational customers would be expected to switch to other similar offerings where non-trivial cost savings can be made. Where this does not occur, the market mechanism may not be working properly, due to inertia, barriers to switching, or lack of consumer information. Consumers need the information which indicates to them that other products offer better value, and they also need to be aware of the costs, if any, of switching.

6.42 Switching would be facilitated, and consumers would benefit, if the link between Vhi Healthcare's multi-trip travel insurance product and its PHI products were broken, such that consumers could keep their multi-trip travel insurance if they switched to another health insurer.

6.43 Vhi Healthcare should be obliged to ensure that its travel insurance policy is not contingent on its PHI policy. If consumers knew they were free to switch health insurer without losing their travel insurance, this would reduce the barriers to switching. The Competition Authority is not suggesting that Vhi Healthcare should be obliged to keep offering travel insurance to non-PHI customers in perpetuity. It should only be obliged to keep open a MultiTrip policy until the next renewal date.

6.44 In certain circumstances tying and bundling may enhance efficiency, and such practices are common in competitive markets. If the customer decides not to purchase the bundled or tied product, the supplier does not make the cost saving arising from the tie or bundle. If a Vhi Healthcare customer wishes to switch health insurer, Vhi Healthcare should be permitted, as it does with its Business Travel Insurance product, to increase the price of Multitrip insurance to reflect the increased average cost of (less efficiently) selling the non-bundled product.

[91] Vhi Healthcare Multi Trip Travel Insurance Policy Document, p.33. Available online at http://www.vhi.ie/pdf/products/multitrip_terms.pdf

[92] Vhi Healthcare Group Business Travel Policy Document, p.4. Available online at http://www.vhi.ie/pdf/products/businesstravelterms.pdf

[93] As the potential savings from switching to another provider increase, Vhi Healthcare's cancellation policy becomes less of a barrier to switching.

Recommendation 11 **Vhi Healthcare should cease cancelling travel insurance policies where a customer switches from Vhi Healthcare to another health insurer**	**Action By**
Vhi Healthcare should cease automatically cancelling the Vhi Healthcare MultiTrip travel insurance policies of customers who switch their PHI policy from Vhi Healthcare to another health insurer. Vhi MultiTrip travel insurance policies should remain active until the policy expiry date. Vhi Healthcare should be obliged to cover any claims which fall under the 'travel' element of the insurance policy, while the consumer's new health insurer should be obliged to cover any claims which fall under the consumers' health insurance policy. This recommendation would also apply to other health insurers should they decide to sell travel insurance products which are conditional on having private health insurance with them.	**Vhi Healthcare** **2007**

6.45 Care needs to be taken in implementing this recommendation. If a consumer ceases to hold any PHI policy, but continues to hold Vhi MultiTrip insurance, they will not be covered for the sum originally insured under their PHI policy, and will be personally liable. Consumers should be made aware before cancelling their PHI policy that failure to secure another PHI policy may leave them liable to such expenses for the remainder of their Vhi MultiTrip policy.

E. Amend the Minimum Benefit Regulations and Allow Limited Cover Plans

6.46 The Minimum Benefit Regulations were established to afford consumers a high degree of protection by ensuring that all PHI plans provide cover for all public hospitals and treatment in certain facilities for "prescribed health services".[94] This is a legitimate goal given the complexities of the PHI market. However the Minimum Benefit Regulations limit innovation and restrict competition by obliging PHI firms to cover certain procedures and hospitals. This limits the extent to which PHI firms can innovate in the development of products and services.

6.47 The Minimum Benefit Regulations should be modernised so that they provide protection for consumers without unnecessarily limiting competition and innovation in PHI.

[94] This includes the vast bulk of medical illnesses and conditions requiring medical treatment.

Recommendation 12 **The Minimum Benefit Regulations should be simplified and updated**	**Action By**
The Minister for Health and Children should amend the *Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996* in order to accomplish the following goals: • Simplify the system of minimum benefits • Remove restrictions on the PHI products which health insurers can offer, while maintaining an obligation to provide a certain minimum level of healthcare cover to any individual covered by a health insurance contract • Remove the fixed minimum monetary values • Specify benefits to be covered in non-monetary terms, if possible	**Minister for Health and Children**

6.48 The Minimum Benefit Regulations prevent the development of limited-cover plans. Limited-cover plans would allow PHI firms to offer tailored, lower-cost PHI plans by agreeing reimbursement terms with a limited number of selected hospitals or consultants, permitting PHI firms to exercise a greater degree of control over claims costs.

6.49 The development of limited-cover options could benefit three groups of stakeholders:

- Consumers, who could choose from a wider range of PHI plans;
- Private health insurers who would have a greater ability to control claims costs by limiting the facilities which they will cover; and,
- Private Hospitals as coverage of private hospitals could become more attractive for PHI firms if they were relieved of the burden of covering all public hospitals.

6.50 The development of limited-cover options would have to be done within the constraint of community rating. They would also have to be clearly marketed as such, so that consumers would know that any limited-cover plans they purchase offer partial healthcare coverage.

Recommendation 13 **The Health Insurance Authority should be allowed to approve limited-cover plans**	**Action By**
If limited cover plans are found to be feasible and compliant with relevant legislation and with community rating, the Minister should amend the *Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996* to give the Health Insurance Authority responsibility for approving limited-cover plans proposed by health insurers. The key criterion for regulatory authorisation should be whether any such product could undermine community rating in the PHI market.	**Minister for Health and Children**

Conclusion

6.51 How health insurers compete with one another in Ireland is greatly limited by the choices Ireland has made with regard to intergenerational solidarity in PHI. Community rating and the Minimum Benefit Regulations hugely constrain price competition and innovation in the PHI market. For example, health insurers cannot offer discounts to non-smokers, nor can they choose which treatments to cover.

6.52 Within these restrictions, competition between health insurers is best promoted by ensuring that the potential for innovation is not overly-restricted and that consumers are not inhibited from switching health insurer in response to new PHI policies which better suit their needs. It is vital that firms can attract customers on the merits of their products and services if consumers are to benefit from competition.

6.53 Although the process of switching health insurer in Ireland is relatively straightforward, difficulties in comparing PHI products and the mistaken perception that switching health insurer is costly reduce the likelihood of PHI consumers switching health insurer in response to a better (value) product. The Competition Authority makes a number of recommendations to facilitate switching and thereby address the switching costs and search costs which exist in the Irish PHI market.

6.54 Efforts to promote switching are important in the long run as they reduce barriers to entry by making it easier for new health insurers to build their business and expand to compete effectively with existing health insurers.

7. HEALTH INSURER BUYER POWER

Summary

7.1 Competition problems tend not to arise where there are many sellers and many buyers in a market. Competition is likely to weaken as markets become more concentrated, either on the demand side or the supply side. Private hospitals in Ireland face a market with few health insurers buying their services. Although this theoretically places all PHI firms in a strong bargaining position relative to private hospitals, the fact that Vhi Healthcare holds by far the largest share of the PHI market means that it holds the strongest bargaining position.

7.2 PHI, by its nature, tends to lead to over-consumption of private healthcare because the PHI consumer is no longer paying the true cost of private healthcare. Thus health insurers seek ways to minimise the effect of this tendency and buyer power aids them in this regard.

7.3 This chapter takes a step-by-step approach to the issue of buyer power. First, buyer power is defined and explained. Then, the effects of buyer power are assessed – does buyer power harm the market? Having set out the theoretical basis for looking at buyer power, the relationship between private hospitals and PHI firms, particularly Vhi Healthcare, is examined.

7.4 This shows that Vhi Healthcare exhibits a high level of buyer power with respect to private hospitals. The chapter concludes that Vhi Healthcare's buyer power does not give it a distinct advantage in selling PHI as other PHI providers can replicate Vhi Healthcare's contractual arrangements with private hospitals. It does however have a limiting effect on competition in private medical services.

What is Buyer Power?

7.5 Buyer power refers to scenarios where a few strong buyers can exert power over sellers. The OECD has defined buyer power as follows: *"a retailer is defined to have buyer power if, in relation to at least one supplier, it can credibly threaten to impose a long term opportunity cost (i.e. harmful or withheld benefit) which, were the threat carried out, would be significantly disproportionate to any resulting long term opportunity cost to itself"*.[95]

7.6 Using this definition, any PHI firm could theoretically have buyer power with respect to private hospitals. However, what is of key importance for a competition analysis is the disparity in buyer power between PHI firms.

7.7 Buyer power is more likely in concentrated markets. The OECD has found that *"market concentration in the insurance industry and private hospitals' dependence on income from private enrolees has allowed insurers to exercise strong contractual power over private hospitals"*.[96]

[95] It continues: *"By disproportionate, we intend a difference in relative rather than absolute opportunity cost, e.g. Retailer A has buyer power over Supplier B if a decision to de-list B's product could cause A's profit to decline by 0.1% and B's to decline by 10%"* OECD, quoted in Davies et al, (2002) p.28.
[96] OECD (2004) p.35.

7.8 Concentrated markets have few, rather than many, participants. Concentration can occur on either the buyer's side or the seller's side of the market. For example, an oligopoly is a market where there are few sellers, but many buyers, while an oligopsony is a market in which there are many sellers, but few buyers. Buyer power is often a feature of oligopsonies, as many sellers compete against each other to sell their products to a limited number of buyers.

When is Buyer Power Good or Bad?

7.9 Buyer power can have positive or negative effects depending on the structure of the related (upstream and downstream) markets. For example, it can be pro-competitive and pro-consumer if it does not increase the buyers' own *selling* power. One positive effect of buyer power is that it can promote both price and non-price competition among suppliers. PHI firms take advantage of the amassed buying power of their members to negotiate better deals with medical facilities than any one consumer could on his or her own.

7.10 Buyer power can harm competition where one buyer or a few buyers obtain such strength that a supplier becomes dependent on the buyer(s) for his continued participation in the market, or where it becomes a necessary requirement for entry to the market. Buyer power *may* be beneficial where it offers countervailing power to suppliers with strong selling power, and where it faces price competition in its own end market.[97] Where strong seller power does not arise, buyer power may not be beneficial and can harm the final consumer of the *buyer's* products.

7.11 In determining buyer power, much depends on the relative importance to each party of its business with the other. Buyer power in a market with few buyers can reduce consumer benefits.[98] It can also harm competition in the upstream market by creating a barrier to entry to that market and threatening the long-term viability of suppliers.

7.12 Where buyer power is unequal between buyers this can magnify differences in downstream competitive positions.[99] In a market with few buyers, one of which is much bigger than the others, the greater the power exerted by the main buyer, the greater its ability to reduce the price it pays. This may lead to lower prices to downstream customers in the short run (assuming cost savings are passed on to consumers), but at the cost of a number of negative effects in the medium to long term which damage consumer welfare. Possible negative effects include:

- Lessening competition in the long run by reducing the incentive for new private hospitals to enter the market;
- Reducing the ability of private hospitals to innovate in service delivery and patient care;
- Reducing the prices suppliers receive, making it more difficult for them to finance new investment in staff, facilities, training and technology; and,
- Reducing the quality of care in the long-term due to investment opportunities foregone.

[97] Clarke, Davies, Dobson and Waterson, (2002) p.22.
[98] Economists call this a "deadweight loss".
[99] Dobson, Waterson and Chu (1998), p.6.

Do Private Health Insurers have Buyer Power?

7.13 In order to determine the likelihood of buyer power, it is necessary to assess the different categories of private healthcare buyers. Private bed in-patient stays are paid for by:

- The patients themselves ("self-payers");
- The open enrolment health insurers;
- The restricted membership schemes (ESB, Gardaí, Prison Officers); and,
- The State, funding the National Treatment Purchase Fund ("NTPF").

7.14 Self-payers, the NTPF and the restricted membership schemes all contribute small proportions to the overall demand for private healthcare.

- Given the cost of surgical procedures, relatively few patients pay for their own treatment.[100] Self-payers therefore provide a relatively small proportion of total demand for private hospitals.
- The NTPF was established in 2002 to expedite procedures for individuals on long-term public waiting lists. In 2005, it paid for the treatment of 18,197 patients.[101] 16 private hospitals in Ireland participate in the NTPF.[102] 90% of NTPF referrals are to private hospitals, and 95% of these are to private hospitals in Ireland. This suggests that the NTPF paid for the treatment of approximately 15,500[103] patients in Irish private hospitals in 2005, a very small (<1%) proportion of total patients treated.
- Between them, the restricted membership schemes account for approximately 100,000 individuals. By corollary, there are over 2 million people with PHI and thus the 3 health insurers contribute the lion's share of demand for private hospital in-patient services.

7.15 It is clear, therefore, that private hospitals are heavily reliant on custom generated by PHI rather than self-payers, the NTPF or restricted membership schemes. This suggests that open enrolment PHI firms hold buyer power in relation to private hospitals.

7.16 PHI providers cover about 50 private medical facilities and close to 2,000 hospital consultants. PHI providers buy services from hospital consultants and private medical facilities and sell PHI to consumers. Half of the population are PHI consumers. So, there are many private medical facilities, relative to the number of PHI providers, and there are very many PHI consumers, relative to the number of PHI providers.

[100] OECD (2004) p.35
[101] NTPF Annual Report (2005), p.5. Available online at http://www.ntpf.ie/news/NTPF%20Ann.Report%202005.pdf
[102] These are the Bon Secours hospitals in Dublin, Cork, Tralee and Galway, the Blackrock and Galway Clinics, Garden Hill, Sligo (St. Joseph's), Barringtons Hospital, Limerick, Aut Even, Kilkenny, Clane General Hospital, St. Francis Hospital, Ballinderry, Shanakiel Private Hospital, Cork and Northbrook Clinic, Mount Carmel, St. Vincent's Private Hospital and the Mater Private Hospital, all in Dublin.
[103] 90% of 18,197 = 16,377; 95% of 16,377 = 15,558.

7.17 The Irish PHI market is highly concentrated. There are three health insurers; Vhi Healthcare with 75% of the market, BUPA Ireland with 22% and VIVAS Health with 3%. If BUPA Ireland proceeds to exit the market, and another company does not purchase its book, this will increase market concentration, leaving private hospitals and hospital consultants with two rather than three PHI providers' custom, Vhi Healthcare and VIVAS Health. This will accordingly increase the buyer power of the remaining health insurers.

Provider Negotiations

7.18 Of the three health insurers, Vhi Healthcare is in the best position to leverage its buyer power. This is because its customer base of over 1.5 million individuals and market share of 75% allows it to act as a "gatekeeper" of significant importance. Private hospitals are therefore likely to agree terms with Vhi Healthcare to ensure access to the widest possible pool of consumers. If a private hospital fails to do so, 75% of the PHI market will be foreclosed to it. This gives Vhi Healthcare a position of considerable power among buyers, as having Vhi Healthcare as a client is necessary to enter the private hospital market.

7.19 The OECD has found that *"Providers…. cannot afford not to have a contract with one insurer, given the concentration of the PHI market and their high dependence on income from privately insured patients".*[104] New entrants to the private hospital market will find it difficult to prosper without securing Vhi Healthcare coverage. Only two of the 26 private hospitals offering in-patient facilities are covered by BUPA Ireland and VIVAS Health, but not Vhi Healthcare. Over 90% of private in-patient hospitals have coverage in place with Vhi Healthcare.

7.20 Should BUPA Ireland exit the market, it is inevitable that Vhi Healthcare's share of the market will increase, making it even more necessary for private facilities to conclude terms with Vhi Healthcare. Private hospital operators acknowledge that market exit will lead to increased strength on the part of Vhi Healthcare. The chairman of Euro Care International, which operates the Whitfield Private Clinic in Waterford, stated following BUPA Ireland's announcement that *"VHI is capable of driving a hard bargain. They're good operators and they know their business very well," he says. "They now can drive a harder bargain than before."* The impact of BUPA Ireland's market exit, he added, would make it harder to attract investors.[105]

Is Private Health Insurer Buyer Power Problematic?

7.21 Vhi Healthcare's position as the largest health insurer affects contractual negotiations between private hospitals and other health insurers. First, it gives Vhi Healthcare bargaining strength to drive down the fees charged by hospital consultants and private hospitals. In its submission to this report, Vhi Healthcare states that other health insurers avoid entry costs and free-ride by replicating Vhi Healthcare's provider contract arrangements, thereby securing a second mover advantage.[106] The OECD has also stated that Vhi Healthcare negotiates reimbursement levels which are followed by BUPA Ireland.[107]

[104] OECD (2004) p.38.
[105] "Exit of Bupa creating uncertainty in private health sector". *Irish Times*, December 27th, 2006.
[106] Vhi Healthcare submission at p.24.
[107] OECD (2004) p.35.

7.22 On the other hand, VIVAS Health has stated that rates negotiated with medical facilities by Vhi Healthcare effectively act as price floors.[108] Therefore, Vhi Healthcare's buyer power may be undermining competition upstream between private facilities, and exaggerating the difference in competitive positions between competing health insurers downstream.

7.23 It is clear from these submissions that, by virtue of its size and long-standing position in the market, Vhi Healthcare has established the "rules of the game" with respect to provider contracts. Vhi Healthcare claims that this allows other health insurers a second-mover advantage, while VIVAS Health claims that Vhi Healthcare provider negotiations set an effective price floor for reimbursement rates for other health insurers. Either way, Vhi Healthcare exercises leadership in the negotiation of provider contracts which causes other health insurers to alter their patterns of behaviour in the market. These firms constrict their behaviour voluntarily, by following Vhi Healthcare's provider negotiation model, or involuntarily, due to the effective price floor established by Vhi Healthcare, as VIVAS Health submits.

7.24 Vhi Healthcare's buyer power vis-à-vis private hospitals, gives it some advantage in the PHI market; though its competitors can to a large extent replicate the terms and conditions agreed by Vhi Healthcare with private medical facilities they may still have to pay more for identical procedures. This does not necessarily harm consumers of PHI however. Consumer harm is more likely to arise if Vhi Healthcare's buyer power causes the private hospital sector to be underdeveloped and slow to innovate, such that there is an undersupply of private medical services in Ireland.

Countervailing Efficiencies

7.25 Analysis of buyer power must balance the potential anti-competitive effects of buyer power against efficiency benefits which may arise. The exercise of buyer power in the Irish PHI market may generate efficiencies. Premium increases may be limited due to bargaining power, although price increases have nonetheless continued to be significant in recent years. It is unclear that other efficiencies are generated.

7.26 Vhi Healthcare has promoted the increased use of relatively more efficient day-care and side-room procedures and is on record as stating that *"in our negotiations (we) insist that internal efficiencies, rather than price, be the first point of focus for hospital management".*[109] However, the promotion of day-care and side-room procedures arises not from the exercise of buyer power, but from the cost control which any economically rational health insurer would be expected to exercise. Even so, the OECD has found that, due to their limited exposure to the cost of care, Irish PHI firms' efforts to control costs are still focusing more on reimbursement levels than on ways of improving productive efficiency, such as managing volumes or promoting cost-efficiency of care.[110] The OECD has concluded that health insurers need to better manage expenditure growth in order to secure affordability and value for money.[111] It is apparent that cost control measures, rather than buyer power, generate efficiencies in the provision of private hospital services.[112]

[108] VIVAS Health submission, p.7.
[109] *"VHI's sole purpose is to serve its members",* Irish Times, August 2nd, 2005.
[110] OECD (2004a), p.210.
[111] OECD (2004), p.47.
[112] Indeed, inefficiency is more likely to occur as firms tend towards oligopoly or monopoly positions in the market.

7.27 Demand management by health insurers, whereby PHI customers are incentivised to go to certain facilities (because the health insurer has secured a more expert service and/or a better price for that procedure in that facility) are not common in Ireland. To an extent, their introduction is inhibited by the Minimum Benefit Regulations.

Capacity Management

7.28 Three submissions claim that Vhi Healthcare has a policy of managing capacity in the provision of private healthcare services. A further submission claims that Vhi Healthcare has refused approval to facilities on the ground that they represented surplus capacity.[113]

7.29 Of the 50 private medical facilities covered by health insurers in Ireland, around half are in-patient hospitals which vary substantially in size, 20% are treatment or addiction centres and the remaining 30% includes dental clinics, laser eye clinics, cosmetic surgery facilities, imaging facilities, diagnostics, pathology-related testing and respite care.[114] There are around 15 private hospitals outside of Co Dublin. Apart from Dublin, Galway is the only county to have more than one major private hospital. The Irish private hospital sector is relatively underdeveloped, and most private treatments are still delivered in public facilities, in part because, according to the OECD, health insurers have not supported increases in private hospital capacity.[115]

7.30 Financially prudent health insurers will exercise caution in deciding which facilities to cover. It is prudent for health insurers to refuse coverage for medical facilities where there are justifiable concerns that such facilities would constitute unused surplus capacity. This is because, where capacity is not being fully utilised, the average fixed cost per patient to the health insurer is high. Average cost as a whole falls as more capacity is used.

7.31 Capacity management (such as tendering for private hospital facilities by PHI firms) and payment policies have a role to play where a competitive private hospital market is supplying services to a competitive PHI market. If health insurers did not carefully manage capacity and provider payment negotiations, the costs of unused private hospital capacity would fall on all PHI consumers, potentially increasing the cost of PHI, although access and technology would have improved. Where a health insurer of Vhi Healthcare's relative size and influence in the market engages in these practices, the effects on the private hospital market are much more significant than if a smaller health insurer were to engage in similar practices.

7.32 Vhi Healthcare buyer power may therefore keep premiums low for consumers in the short-term. However, in the medium to long term, allowing any one health insurer to effectively determine the appropriate levels of private hospital capacity in the market could undermine competition in private medical facilities.

[113] Vhi Healthcare denies these claims.
[114] A full list of facilities covered by Irish health insurers is included in Appendix 3.
[115] OECD (2004a), p.177.

Supplier-Induced Demand

7.33 Consumers of PHI do not directly pay the full cost of each private medical treatment they consume, as this is met by their health insurer. Thus PHI consumers have a tendency to over-consume medical procedures (compared to the cost of providing them).[116] Over-consumption of medical treatments by PHI consumers pushes up the cost of providing PHI and so health insurers try to avoid this situation. For example, Vhi Healthcare has made certain procedures subject to a limited number of claims per customer where there was evidence of over-consumption. Such a situation would be aggravated if the suppliers of private medical services prescribed over-consumption of their services. In general, consultants charge a fee per visit and have an incentive to encourage over-consumption to increase their overall fees per patient. This phenomenon is called "Supplier-induced demand." [117] Conversely, efforts to discourage supplier-induced-demand may indirectly discourage over-consumption by PHI customers.

7.34 The Chief Executive of Vhi Healthcare recently warned that new private hospitals would lead to increased healthcare costs for patients.[118] He went on to state that while, in the short term, increased competition could help reduce prices, in the longer term, supplier-induced demand would drive up the cost of PHI.

7.35 No generally accepted theory of supplier-induced demand has yet been formulated. Some studies conclude that, where it arises, its effect is small, both in absolute terms and relative to other influences on the provision of medical services, and can be controlled by well-targeted cost containment measures.[119] Other studies suggest that it is a significant effect and would be measurably greater if it were not for the actions of health insurers to counteract it.[120] Given the controversy surrounding supplier-induced demand, there should be no fundamental assumption that new private hospitals will lead to large supplier-induced demand effects.

7.36 Vhi Healthcare's submission assumes that competition between private hospitals will not reduce healthcare costs, and that PHI cost control measures will fail to prevent significant supplier-induced demand. Given the increasing focus of health insurers on limiting costs, for instance by moving towards day-patient and side-room procedures,[121] measures are being put in place to promote cost efficiencies. Vhi Healthcare, for example, pays set prices for a range of procedures, services and accommodation, and covers day-care radiotherapy treatments.[122]

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[116] This is exacerbated by the fact that health insurers do not pay the full cost of private beds in public hospitals.

[117] Supplier-induced demand is the economic theory that suppliers can induce unnecessary demand from consumers. Theories of supplier-induced demand are often applied to healthcare markets where suppliers (e.g. doctors) are much more knowledgeable about the service in question (medical care) than their patients. It is argued that this is especially likely where patients have PHI and therefore do not bear the full costs of treatment.

[118] *"Glut of private hospitals 'will increase healthcare costs"* Irish Medical Times, June 24th, 2005. Available online at http://www.imt.ie/displayarticle.asp?AID=8433&NS=1&CAT=18&SID=1

[119] E.g. Bickerdyke et al. (2002), p.xiv .

[120] E.g. Richardson J and Peacock S, "Reconsidering theories and evidence of supplier-induced demand", Centre for Health Economics, Research Paper 2006 (13), Monash University, Business and Economics

[121] In its submission, Vhi Healthcare states at p.14 that more than 65% of all cases are treated on a day care basis.

[122] *Vhi Healthcare Annual Report 2004*, p.11.

7.37 Private hospitals are currently constrained in what they can charge PHI firms. Although eventually 1,000 beds will be moved out of the public system into the private system, private hospitals will still be under competitive constraints, as they will have to compete against other existing private hospitals, as well as eleven new entrants.[123] Indeed, given that private hospitals tend to specialise in elective, rather than non-elective and A&E procedures, competition should become more intense among private hospitals in the provision of these services.

7.38 Cost-control strategies include annual budget and reimbursement limits, price freezes, predetermined length-of-stay agreements, and designation of procedures for day or side-room treatment.[124] While these measures are not predicated on the assumption that supplier-induced demand exists,[125] they can facilitate demand management by reducing the scope for demand inducement.[126] In a situation where health insurers, most notably Vhi Healthcare, have buyer power, controlling costs related to private hospital procedures can have knock-on effects, as the OECD recognises.[127]

Impact of New Hospitals and the Potential Development of Preferred Provider Networks

7.39 In July 2005, the Minister for Health and Children announced plans to construct eleven new private hospitals on the campuses of public hospitals in order to release 1,000 beds in public hospitals for public patients.[128] The Minister for Health and Children stated that this move would promote greater competition in the supply of hospital services.[129] When complete, this will have a significant effect on health insurers by altering the cost base of in-patient beds. The Minister for Finance also announced in the 2006 Budget that the price of public hospital in-patient beds would increase by 25% to more closely reflect their economic costs.

7.40 One submission to the Competition Authority notes that new private hospitals *"may result in insurers covering different hospitals to each other to a much larger extent than is currently the case"*. Other submissions support this statement. Health insurers could reduce their transaction and administrative costs by concluding direct settlement arrangements with a limited number of facilities.

7.41 Selective contracting mechanisms such as Preferred Provider Networks (PPNs) are, however, uncommon in most OECD Member States, for various reasons including regulatory requirements, reimbursement practices and the desire not to restrict individual choice of provider. Consumers expect that health insurers will provide widespread coverage. This may mean that health insurers face limited incentives to provide limited coverage options, as consumers may perceive PPNs to be inferior products, compared to general-coverage plans.

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[123] The Minister for Health and Children has recently announced plans for the development of private hospitals on the grounds of public hospitals.
[124] OECD (2004) p.35.
[125] Indeed, such policies support other objectives, such as cost containment or quality control.
[126] Bickerdyke et al (2002), p.91.
[127] In its 2004 Report, the OECD noted that *"Vhi imposed cost containment practices that, in the view of hospitals, hampered productivity improvements".*
[128] "Tánaiste announces plans for 1,000 new public hospital beds over 5 years". http://www.dohc.ie/press/releases/2005/20050714a.html
[129] Greater competition could also potentially be promoted by making more use of cross-border trade in private hospital services. The health insurers currently cover 5 hospitals in Northern Ireland, while the NTPF pays for treatments in 2 medical facilities in Northern Ireland, and a further 3 facilities in England.

7.42 However, the emergence of PPNs will facilitate competition and consumer welfare by encouraging private hospitals to compete vigorously with each other, by promoting innovation in the delivery of medical services, and by allowing consumers a greater degree of choice in the PHI packages they wish to subscribe to, consistent with community rating. However, in order for PPNs to contribute to consumer welfare, two factors are necessary:

- More private hospitals need to be constructed; and
- More health insurers need to enter the market.

7.43 While the first requirement is underway, there is uncertainty regarding the second requirement.[130] For this reason, the emergence of PPNs may be more likely to emerge in the medium-term rather than the short-term. However, once this dynamic process occurs, health insurers and their customers will benefit from competition to provide services between private hospitals.

Conclusion

7.44 It is clear that health insurers in the market are able to exert buyer power with respect to private medical facilities. However, the degree of buyer power held by each firm varies widely, and is vested mainly in Vhi Healthcare. If BUPA Ireland exits the market, and its business is not taken over by another company, Vhi Healthcare's buyer power will inevitably increase.

7.45 Vhi Healthcare buyer power may have some short term benefit for consumers, in so far as its control of the capacity of private hospitals keeps down the price of private medical services without allowing Vhi Healthcare a significant advantage over competing health insurers. On the downside, its high share of PHI consumers makes it a gatekeeper to the private hospital sector which could cause capacity to be too constrained and may lead to a lack of innovation in private medical facilities.

7.46 Recent developments in the private hospital sector can be expected to increase capacity, thus counteracting the potential negative effects of Vhi Healthcare's buyer power.

[130] Chapter 5 discusses barriers to entry in greater detail.

8. RISK EQUALISATION

Summary

8.1 The purpose of this chapter is to analyse how Risk Equalisation ("RE") affects competition in the Irish private health insurance (PHI) market. Importantly, the chapter does not examine the necessity, appropriateness or proportionality of RE. Three recommendations arise from the analysis and are directed to the Health Insurance Authority (HIA) and the Department of Health and Children. The recommendations are designed to ensure, to the maximum extent possible, given the existence of the current Risk Equalisation Scheme ("RE Scheme"), that competition in the PHI market is encouraged.

8.2 The chapter is structured as follows:

- The first section provides a brief discussion of the rationale for RE. This section is not intended to be a re-justification for the introduction of RE in Ireland, or even a definitive statement of the rationale for RE, but rather to simply present the issues as we understand them for the purposes of providing background and context for subsequent sections.
- The second section highlights issues from the experiences of other countries that have systems of risk equalisation and is based on a more extensive overview provided in Appendix 6. The principal lesson that emerges is that Ireland is an outlier with respect to market structure. Of the countries reviewed, none have markets as concentrated as the Irish PHI market. The implication is that comparisons of the effects of RE in other countries are of limited value.
- The third section analyses how RE affects competition in the PHI market with specific reference to price competition, non-price competition, efficiencies and barriers to entry. RE tends to limit the scope for price competition and weakens incentives to seek efficiencies.
- The fourth section considers RE as a factor discouraging entry to the Irish PHI market and finds that the RE Scheme itself and the uncertainty in the market surrounding the RE Scheme are barriers to entry.
- The fifth section discusses issues relating to the operation and mechanics of the RE Scheme with specific reference to the Health Status Weight, the Zero Sum Adjustment, the nature of the RE Scheme, the three year exemption for new entrants and the termination of the RE Scheme. The most important finding here is that the use of a health status risk adjustor, in the form currently provided for in legislation will substantially weaken health insurers' incentives to seek efficiencies and reduce significantly any remaining scope for price competition in the Irish PHI market.
- The chapter concludes with the main finding that RE will consolidate Vhi Healthcare's market position and strengthen its market power in the Irish PHI market.

Rationale for Risk Equalisation

8.3 As discussed in Chapter 2, public policy toward the PHI market is underpinned by a number of social objectives. The Irish PHI market is based on the principle of solidarity between insured generations and public policy measures have endeavoured to ensure that this principle is upheld by four main mechanisms: Community Rating; Open Enrolment; Lifetime Cover; and Minimum Benefits.[131] Together, these features attempt to prevent insurance companies from setting premiums according to an individual's age, gender or any other risk characteristics, ensuring that PHI is in principle available to and affordable for those who wish to purchase it.

8.4 Health insurance markets with community rating and open enrolment may be subject to two forms of instability.[132]

- First, there may be overall market instability when the market as a whole fails to secure a continuing stream of young entrants (**Adverse Selection**).
- Second, instability can result from the failure of an individual health insurer to attract a sufficient share of 'preferred' new entrants. **Risk Selection** by health insurers, deliberate or otherwise, can contribute to this form of instability.

Adverse Selection

8.5 The first source of instability, adverse selection, refers to a market process that arises due to an asymmetry of information between the insurer and the insured. Insured individuals or policyholders typically have more information on their health status, actual and potential, than insurance providers. Community rating in Ireland, which takes the form of Single Rate Community Rating, requires that the same premium must be charged to each policy holder for a given level of cover, regardless of risk they present. PHI is therefore better value for high risk individuals. One implication is that healthier individuals may forgo PHI and this tends to reduce the size of the pool of healthier policyholders available to health insurers, leading to a rise in premiums. This may induce more relatively healthy policyholders to forgo PHI. This iterative process may continue with premiums escalating. Ultimately, the market for low risk individuals may disappear altogether leaving only an insured pool of high risk individuals paying what essentially amounts to a risk rated premium. Thus intergenerational solidarity is lost.

8.6 The feature of open enrolment in the Irish PHI market compounds the problem of adverse selection. Open enrolment ensures that no individual is refused cover if they wish to purchase it. However, this feature incentivises low risk consumers to postpone purchasing so as to minimise the length of time they are subsidising the higher risks. With open enrolment and community rating low risks can return (i.e., when they become higher risk) to the market at a later date at no extra cost.

[131] These four principles are discussed in some detail in Chapter 2.
[132] The Society of Actuaries in Ireland (2002), *Report of the Working Group on Risk Equalisation,* para. 7.2.

8.7 The Harvey Report[133] identified three other classes of community rating and recommended the introduction of Unfunded Lifetime Community Rating.[134] In a lifetime community rated system, premiums rise with age at entry. For a given level of cover, all policyholders who entered the market at the same age pay the same premiums.[135] The premium rate for each age at entry is set with the objective of ensuring that policyholders entering at that age pay higher payments than actuarially required in their earlier years of insurance and lower payments than actuarially required in their later years of insurance. This system would address the problem of adverse selection by encouraging young, low risk policy holders to enter the market while maintaining open enrolment and lifetime cover. Similar to single rate community rating, lifetime community rating is a 'pay as you go' system;[136] hence there is an intergenerational transfer.

8.8 The Government indicated in the 1999 White Paper on Private Health insurance its intention to introduce the principle of lifetime community rating.[137] Section 7A of the Principal Act makes provisions for the introduction of lifetime community rating and late entry premium loadings; however, it has not yet been commenced.[138]

Risk Selection

8.9 It is the second source of instability that RE attempts to address. The practice of "risk selection" by health insurers, often referred to as "cherry picking", is the method by which health insurers select (preferred) risks. In Ireland health insurers cannot price policies according to risk. However, health insurers can strategically design and market their policies in such a way as to attract healthier individuals. For example, health insurers can invest heavily in promoting policies whose features appeal to particular age categories.

8.10 A firm that has been successful in attracting low risks will be able to charge a lower premium. In turn, lower premiums attract more policyholders. Survey results show that young, healthier individuals generally switch for a lower premium.[139] Therefore new health insurers can, in the presence of inertia among consumers with other health insurers use a combination of product design and pricing to gain market share and earn profits.

[133] Advisory Group on the Risk Equalisation Scheme (1998), *The Minister for Health and Children's independent review of the Risk Equalisation Scheme*, pp. 18-24.
[134] The other forms of community rating identified were Funded Lifetime Community Rating, Unfunded Lifetime Community Rating and Yearly Community Rating.
[135] For example, for a given level of cover, an 80 year old and a 45 year old that purchased health insurance for the first time at age 25 pay the same premium, however a 45 year old purchasing cover for the first time will pay a higher premium than a 25 year old purchasing cover for the first time.
[136] A 'pay as you go' insurance system refers to an unfunded system in which contributors to the system pay the expenses for the current recipients, no reserves are accumulated and all contributions are paid out in the same period. Current premiums are used to pay current claims in that year and so the higher than actuarially required premiums for the young subsidise the lower than actuarially required premiums of the old.
[137] Department of Health and Children (1999), *White Paper on Private Health Insurance,* p. 33.
[138] Section 7A of the Principal Act, as amended by the Health Insurance (Amendment) Act, 2001 Section 6.
[139] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*. Switching is discussed further in Chapters 3 and 6.

8.11 However, this can be unstable. Take the following two possibilities:[140]

- To maximise profits, the new entrant could "price follow" by setting its prices slightly below the incumbent. The new entrant would attract those inclined to switch, who are generally good risks, and new policyholders attracted into the market by the lower premium. The incumbent may increase its premium to cover its increased average claim costs, as its risk profile worsens due to the switching of low risks to the new entrant. The entrant can follow the premium increase, thus maintaining the price differential. The overall market result is that all policyholders are paying premiums close to the cost of covering claims for the highest risk profiles.
- To maximise market share, the new entrant could price significantly lower than the incumbent to reflect its lower risk pool. The significant price difference will encourage more switching than in the 'price following' scenario. With a significant price differential, higher risk individuals may also be inclined to move. However, due to consumer inertia in the older age groups the majority of switching will be by younger and healthier individuals. The incumbent health insurer left with the higher risk profile may not be able to lower premiums to attract back the lower risk individuals due to its higher average claim cost, in fact it may have to increase premiums; in the extreme case the incumbent health insurer may become insolvent and driven out of the market - this process has been referred to as the 'death spiral'.

8.12 The two scenarios lead to an unstable market, the latter being more unstable than the former. In these scenarios there is only competition for 'good' risks and this will lead to a divergence in risk profiles between the two health insurers. For example, assuming there are only two health insurers, one insurer could end up insuring all the high risk and the other all the low risk.

8.13 The principle of intergenerational solidarity fails if there are significant differences between the risk profiles of health insurers. RE aims to address this asymmetry by neutralising claim cost differences and promoting competition across the market, i.e., for both low risk and high risk profiles. In principle therefore, risk equalisation aims to neutralise the asymmetry so that a health insurer with a relatively high risk profile and high expected claims costs is, *ceteris paribus*, not at a disadvantage vis à vis other health insurers with relatively low risk profiles and low expected claims costs. This results in monetary transfers from health insurers with healthier than average risk profiles to those with less favourable risk profiles.[141]

[140] HIA (October 2005), *Letter from HIA to Tánaiste and Minister for Health and Children,* pp. 5-6. Available at: http://www.hia.ie/docs/risk-equalisation/RE-Letter-to-Tanaiste-27-10-05.pdf

[141] The Irish RE Scheme has a triggering mechanism, whereby the scheme cannot commence until the Market Equalisation Percentage ("MEP"), i.e., the difference in risk profiles between insurers, reaches a certain threshold – 2%. Once it reaches this threshold it cannot be triggered until the HIA and the Minister for Health and Children decide whether the RE Scheme should commence. The procedure to be followed varies depending on the value of the MEP; this process is explained in detail in Appendix 5.

International Experience

8.14 The practice of RE (or cost reinsurance/reimbursement) started more than thirty years ago in the United States in the context of Medicare (publicly provided health insurance for the elderly).[142] Countries which have introduced a form of RE or cost reimbursement include, among others, Australia, Canada, New Zealand, Israel, Colombia, the US and in Europe, Belgium, the Czech Republic, Finland, Germany, the Netherlands, Norway, and Switzerland. In general, these countries have introduced some form of risk compensation in order to entrench community rating and open enrolment.

8.15 It is difficult to find perfectly comparable markets to the Irish PHI market.[143] However, countries that have markets that incorporate the concept of community rating and that have some form of RE Scheme or other risk compensation schemes are informative, for example Australia, the Netherlands and Switzerland. Based on a review of these countries, which is contained in Appendix 6, it is possible to draw some useful conclusions.

8.16 First, economic research suggests that the most efficient strategy to avoid risk selection is a 'good' risk equalisation scheme. A RE Scheme, however, cannot explain all variations in expected health expenditures across individuals because some variation is inherently random and, therefore, unpredictable. For this reason, in some case RE Schemes are often complemented by "reinsurance schemes": they provide health insurance companies with a form of insurance (*re-insurance*) against possible large losses due to unexpected high claims by their policyholders. These schemes reimburse insurers for their actual costs and accordingly incentives for efficiency and cost containment are weak; however, reinsurance schemes, unlike RE Schemes, create weaker incentives to risk select. Therefore, RE and reinsurance schemes create different incentives for risk selection, efficiency and cost containment but they can also be used to complement each other. In Australia, a reform is in progress that aims to replace the pure reinsurance scheme with a RE Scheme.

8.17 Second, experience in the Netherlands and Switzerland suggests that RE Schemes based on demographic factors only are inadequate for predicting health expenditures. Since 2002, the Dutch scheme has employed health status indicators in the RE formulae.[144] According to economic studies (and also the US experience), this move is expected to increase the accuracy of the scheme and, therefore, to reduce though not completely remove the incentives for risk selection. However, such schemes tend to be highly complicated to manage and require the use of extensive data.

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[142] Editoral; *Risk adjustment in Europe;* Health Policy65 (2003) 1-3.

[143] In general international comparisons are useful but care is needed to ensure that they are undertaken in a meaningful manner. An in-depth review of all the existing schemes, which goes into the merits of the actual different methodologies or risk equalisation formulae, is beyond the scope of this report. For a description and comparison of the risk equalisation formulae in some countries, see McLeod, Heather and Parkin, Neilm (2001), *Risk Equalisation Methodologies: an International Perspective, CARE Monograph No. 3*, University of Cape Town, South Africa. For an international comparison with a more European focus, see van de Ven et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries,* Health Policy Vol. 65: pp. 75-98.

[144] These health status adjusters are "Diagnostic Cost Groups" (DCGs), that are computed from hospital diagnoses and "Pharmacy based Cost Groups" (PCGs), computed from outpatient prescription drugs. Empirical literature found that demographic adjusters based on age and gender are able to predict only a maximum of 5 to 7 percent of total expenses while health-based adjusters are able to predict almost 17 percent of total expenses (see van de Ven, van Vliet et al. (2004), *Health-Adjusted Premium Subsidies In The Netherlands*, *Health Affairs* 23: pp. 45-55). It is important to note that only 25 to 30 percent of total expenses can be predicted in prospective risk adjustment models (see van de Ven and Ellis (2000), *Risk Adjustment in competitive health plan markets*. In: Culyer AJ, Newhouse JP (ed), *Handbook of Health Economics.* Amsterdam, Elsevier North Holland, pp. 755-845.). Therefore, 70 to 75 percent of healthcare expenses are random and cannot be predicted – neither by the risk adjustment mechanism nor by information available to insurers. So, this share of total expenses is irrelevant for neutralising incentives for risk selection.

8.18 Third, among health status adjusters, those based on diagnostic information are increasingly used in countries with more advanced RE Schemes. However, whether the inclusion of these kinds of risk adjustors will entirely eliminate risk selection remains to be seen.

8.19 Finally, none of the countries researched have health insurers with comparable market share to that of Vhi Healthcare or similar problems in terms of encouraging competition in their private health insurance markets. In Switzerland and the Netherlands, the top four health insurers account for approximately 50% of the market, while in Australia the top 6 health insurers account for 76.7%. This is in contrast to Ireland where the largest health insurer, Vhi Healthcare, has approximately 75% of the market. If BUPA Ireland's stated intention to exit the market results in there being only two health insurers in Ireland, the market will become even more concentrated.

The Effect of Risk Equalisation on Competition

8.20 The following subsections look at rivalry in the PHI market and consider the likely effect that RE and the commencement of RE transfers will have on price competition, non-price competition and efficiencies.

Price Competition

8.21 The introduction of RE transfers would likely have resulted in substantial price convergence, i.e., a narrowing of price differentials, between BUPA Ireland and Vhi Healthcare. BUPA Ireland's more favourable risk profile and lower average claims costs enabled them to price below Vhi Healthcare. In an RE environment, the differences in health insurers' claims costs due to asymmetry of risk profiles is neutralised.

8.22 With the commencement of RE transfers, all health insurers that have surpassed their three year exemption will have to carry a share of the costs of all risks and this will tend to increase the costs for those health insurers with a greater proportion of low risk policyholders, and premiums will increase accordingly.

8.23 With regard to BUPA Ireland, the HIA attempted to estimate the likely increase in premiums due to the commencement of RE transfers. The HIA states that:[145]

"In relation to maintaining low prices, there would clearly be increased competitive pressure on BUPA Ireland following any commencement of RE payments, however, it would be expected that the competitive pressure on Vhi would reduce. In order to maintain a 5% gross underwriting surplus, it has been estimated that BUPA Ireland would need to increase premiums by about 12%. While this is a substantial increase, it would not necessarily leave BUPA Ireland in an uncompetitive position" [146]

[145] HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, pp. 52-53.
[146] The figures used for BUPA Ireland in the HIA's October 2005 report are the projections for 2005 provided by BUPA Ireland as part of its representations.

8.24 Comparing prices of health insurers' products is increasingly difficult to perform given the new products introduced in recent years. The HIA's report in October 2005 presented some price differentials for the most popular plans offered by Vhi Healthcare, BUPA Ireland and VIVAS Health.[147] Table 8 below presents the price differentials between Vhi Healthcare and BUPA Ireland as they were between March 2005 and the time of writing. Table 9 presents the same differentials adjusted for a 12%[148] premium rise by BUPA Ireland and assumes that Vhi Healthcare holds its premiums constant.[149] In the period after Vhi Healthcare has increased its prices, and before BUPA Ireland increase its prices, price differentials reduced to 10%. In the period following BUPA Ireland's price increase, price differentials reduce to 0.4%; essentially during this period prices converge.

Table 8: Price differentials without RE between Vhi Healthcare Plan B Option and BUPA Ireland Essential Plus (no excess)[150]

Period	Vhi Healthcare	BUPA Ireland	Differential
March 2005 - Sept 2005	100 (€43.93 per month)	90.6 (€39.81 per month)	9.4%
Sept 2005 - March 2006	100 (€49.20 per month)	80.9 (€39.81 per month)	19.1%
Post March 2006	100 (€49.20 per month)	88.9 (€43.74 per month)	11.1%

Table 9: Estimated price differentials with RE between Vhi Healthcare Plan B Option and BUPA Ireland Essential Plus (no excess)[151]

Period	Vhi Healthcare	BUPA Ireland	Differential
Sept 2005 - March 2006	100	90.6	9.4%
Post March 2006	100	99.6	0.4%

[147] The RE Scheme in Ireland determines transfers by reference to the most popular benefit level.

[148] BUPA Ireland argue that, in calculating this figure, the HIA did not take into consideration the price sensitivity of PHI consumers. BUPA Ireland, in its October 2005 representation to the HIA, argues that its members represent some of the most price-sensitive customers in the market and will thus be priced out of the market by a 12% price increase, implying that the number of policy holders in the market will decrease (holding the number of policy holders with other insurers constant). By taking this price sensitivity into account, and assuming a 20% fall in membership in 2006 and a 11% premium increase in 2006 (rather than the HIA's estimate of a 12% price increase) on top of a 9% increase due to medical costs inflation (i.e., an overall 20% premium increase), plus Health Status Weight = 0, then according to BUPA Ireland, the total price increase in 2006 required to break even over these three years would be 34.7%, assuming still only a 20% fall in membership. This suggests that BUPA Ireland's price if it stayed in the market could surpass Vhi Healthcare's.

[149] With regard to the likely effect of the commencement of RE on Vhi Healthcare premiums, it states in the HIA October 2005 report that: *"Vhi Healthcare states that it has already passed the risk equalisation transfer on to consumers (through the lower than normal rise in premiums last year). Therefore it is not likely that there would be any reduction in Vhi healthcare's premiums as a result of the commencement of risk equalisation payments other than the effect that might result if increases in transfers were used to slow down premium inflation."* HIA (October 2005), Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation, p. 50.

[150] Based on figures for adult group rates, net of tax relief at source. These figures are from: HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 54.

[151] Based on figures for adult group rates, net of tax relief at source. These figures are from: HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 54.

8.25 Insight Statistical Consulting was commissioned by the HIA in 2005 to conduct a comprehensive research study of the Irish PHI market ("The Market Review"). As discussed in Chapter 3, cost savings are the biggest determinant of a consumer's decision to switch. Of those who have switched, cost savings was by far the most commonly cited reason for switching. The HIA's Market Review 2005 concluded that a cost saving of at least 20% would be required in order to encourage at least half of all consumers to switch. Three quarters of non-switchers said they would switch if cost savings of 30% were realised.[152]

8.26 The commencement of RE transfers and the subsequent narrowing of price differentials between BUPA Ireland and Vhi Healthcare could have had numerous effects.

- First, BUPA Ireland's most price sensitive consumers would likely discontinue cover.[153]
- Second, switching from Vhi Healthcare would become less likely and, if BUPA Ireland's prices increased by as much as it estimated, switching to Vhi Healthcare would become more likely.

Each of these effects implies a consolidation of Vhi Healthcare's market position.

8.27 BUPA Ireland's exit would render this analysis largely academic. The short term effects are now entirely uncertain. However, VIVAS Health has a more favourable risk profile than Vhi Healthcare and so can price below Vhi Healthcare. VIVAS Health is exempt from the RE Scheme until October 2007 (three years after it first commenced business), and in the subsequent year it will be only liable for half payments. Once VIVAS Health's three year exemption is up a similar effect to that which was predicted for BUPA Ireland is likely to occur. When VIVAS Health becomes liable under the RE Scheme the price differential between it and Vhi Healthcare will also narrow.

8.28 The general conclusion that can be drawn from the above discussion is that RE limits the extent to which health insurers can compete on price and tends to promote a convergence of prices across the market. Given the price differentials required to induce switching by PHI consumers, RE and the commencement of RE transfers would substantially reduce the level of switching in the market. The implication is that RE would tend to consolidate the position of Vhi Healthcare and substantially augment its current market power. This raises the possibility that once RE payments commence, Vhi Healthcare will likely be able to profitably raise its premiums above current levels.

8.29 Indeed, once RE transfers commence, Vhi Healthcare's incentives will fundamentally change. When considering whether to raise prices, Vhi Healthcare balances two effects;

- First, an increase in premiums would reduce profitability because some customers will switch, and because the share of sales it captures may be reduced – this is the marginal cost of a premium rise; and

[152] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review,* p. 46.
[153] Evidence presented in the Market Review shows that there is a direct relationship between price increases and propensity to discontinue cover. According to the survey, approximately 7% of the policyholders interviewed will discontinue cover if annual premiums rise by 10%; if the increase is of the magnitude of 20%, a percentage of 27% of all interviewed customers said they would discontinue cover. These percentages are higher for the age groups of 18-24 and 25-34; the age cohorts where BUPA Ireland has strong membership. If premium rose by 10% then 10% of the 18-24 age group and 4% of the 25-34 age group would discontinue cover; if the premium increase was 20% this increase to 35% and 29% respectively. HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review,* p. 70. Available at: http://www.hia.ie/publications/consumer-research/index.html

- Second, an increase in premiums would increase profitability because those customers that stay with Vhi Healthcare will be paying more – this is the marginal benefit of a premium rise.

8.30 Vhi Healthcare will raise prices until the marginal cost equals the marginal benefit. Without RE, the first effect is exaggerated because switchers and new sales tend to be the most profitable customer segments – this tends to constrain price increases. However, with RE, all customers are to a significant extent 'average customers' because of the neutralising effect of RE transfers.[154] Therefore, the marginal costs of a premium increase is reduced implying that Vhi Healthcare could profitably raise prices by a greater amount in an RE environment than it otherwise could.

Non-price Competition

8.31 As discussed in Chapter 3, firms compete in many dimensions including price, quality, service or combinations of these and other factors which consumers value. A health insurer's incentive to compete in any dimension is determined by the competitive environment it faces. In the PHI market non-price and price competition interact. Legislation allows for a provider to offer a menu of plans with a variety of benefits and to set prices for that policy as it wishes. However, health insurers may not charge different prices on the basis of age, gender, health status or any other risk factors.[155]

8.32 In the Irish PHI market health insurers can design products, based on levels of cover, to attract different market segments. By getting consumers to self-select a PHI plan that best reflects their risk health insurers can to some extent, price discriminate between different market segments. Non-price competition based on strategically designed products can stimulate price competition for market segments. For our purposes here however, we are interested in how the introduction of RE and the commencement of RE transfers would likely affect an insurer's incentives to pursue this 'stratification strategy'.

8.33 Without RE health insurers have an incentive to risk select, i.e. to target younger and less risky consumers, and there is little incentive to compete for relatively bad risks, i.e. older or chronically ill consumers. BUPA Ireland states that:[156]

"It is not surprising that BUPA Ireland's average age profile among its customer base as a whole should be somewhat younger than the incumbent's as a result of market inertia….BUPA Ireland has certainly identified that first time purchasers of private health insurance represent an opportunity to grow our business but we have also always welcomed applications of older people or indeed any segment of the community"

[154] RE aims to neutralise the advantage/disadvantage of having a 'good'/'bad' risk profile, essentially all customers become the same – 'average customers'; the profitable and unprofitable customers in a non-RE environment balance out in an RE - environment and so all consumers have an 'average' profitability. However, due to the 'imperfect' nature of the RE Scheme, the neutralising effect will not be complete.
[155] The concept of community rating is discussed in some detail in Chapter 2.
[156] O'Rourke, M (September 2005), *Third Affidavit of Martin O'Rourke,* 2005/532JR BUPA IRELAND LIMITED and BUPA INSURANCE LIMITED –and- HEALTH INSURANCE AUTHORITY, MINISTER FOR HEALTH AND CHILDREN, IRELAND and THE ATTORNEY GENERAL para. 9 & 14.

8.34 As discussed in Chapter 3, health insurers are increasingly using product design and benefits to attract certain types of customers. RE changes health insurers' incentives to compete across different market segments. In principle RE attempts to encourage competition for all segments of the market, or put differently, RE attempts to eliminate advantages from competing for young risks only. The OECD review of the PHI market in Ireland says that the introduction of RE in Ireland is "*likely to improve fair competition across insurers by reducing the appeal of competition based on risk selection*".[157]

8.35 The Irish RE Scheme adjusts for age and gender only and RE transfers are calculated on the basis that all health insurers have the market proportion of policyholders in each age and gender category. This may still leave some scope for risk selection as it does not totally account for differences in health risks.[158]

8.36 Nonetheless, once the RE Scheme is implemented, health insurers will have a new incentive to compete for older and, therefore, higher risk categories. This is because having a customer base that has a risk profile closer to that of the overall market will tend to reduce a health insurer's liability under the RE Scheme. Thus, while health insurers will likely continue with the stratification strategy, it may emerge that product types designed for older and higher risk customer categories will be priced more competitively. However, because of the higher level of inertia among, and higher acquisition costs for older age cohorts, Vhi Healthcare is likely to retain a large share of older cohorts and thus it will prove difficult for other health insurers to compete for this segment.

Efficiencies

8.37 RE may affect private health insurers' incentives to seek cost efficiencies. A health insurer's costs may be decomposed into two elements: non-claims costs (e.g. administration costs, marketing, regulatory compliance costs and other costs of operation) and claims costs. The magnitude of non-claims costs will not be directly affected by RE. However, to the extent that the introduction of RE affects the market power of health insurers, incentives to minimise non-claims costs may be affected. The impact of RE on health insurers' market power is discussed later in this chapter.

8.38 In contrast to non-claims costs, claims costs are directly affected by RE. The principal determinants of the claims costs that a health insurer faces are the risk profile of its customer base and efficiency of claims management.

8.39 We deal first with the risk profile of a health insurer's customer base as a determinant of claims costs. The main objective of RE is to neutralise the effects of differing risk profiles so that in principle, a health insurer with a relatively high risk profile and high expected claims costs is, *ceteris paribus*, not at a disadvantage vis à vis other health insurers with relatively low risk profiles and low expected claims costs. In effect, RE implies a sharing of risks across the PHI market. The question arises as to how RE affects an insurer's incentives to contain claims costs.

8.40 At this stage it is useful to introduce an illustrative example. Consider a market with 1,000 PHI customers, 60% who are 'Old' and 40% who are 'Young' (we abstract from gender). There are two health insurers: Insurer A who has 80% of the market and Insurer B who has the remaining 20%.

[157] Colombo, F. and Tapay, N. (2004), *Private Health Insurance in Ireland. A Case Study, OECD Health Working Paper No. 10,* p. 4.
[158] The current RE Scheme in Ireland does include a Health Status Weight (HSW); this is currently set at zero and thus has no effect. However, the HIA can introduce the HSW up to a maximum of 0.5. This is discussed later in this chapter.

8.41 To establish a 'base case scenario', Case 1, we first assume that each health insurer has the same costs associated with its Young and Old customers and that each health insurer has the market risk profile, i.e., Insurer A has 480 Old customers (60% of its customer base) and 320 Young customers (40% of its customer base) while Insurer B has 120 Old customers (60% of its customer base) and 90 Young customers (40% of its customer base). Table 10 below illustrates the calculation of RE transfers for Case 1. When all health insurers have the same risk profile there will be no monetary transfer under the RE Scheme, irrespective of their market shares, as each health insurer's risk profile is identical to the market risk profile. It is clear that even when health insurers have different costs, but the market risk profile, no transfers are required.

Table 10: Case 1 - Base case scenario

	Old		**Young**		**Pre-equal. Total costs**	**Post-equal. Total costs before ZSA[159]**	**Post-equal. Total costs after ZSA**	**RE transfer**
Insurer	Number	Cost (€)	Number	Cost (€)	(€000)	(€000)	(€000)	(€000)
A	480	500	320	100	272	272		0
B	120	500	90	100	68	68		0

8.42 Table 11 illustrates Case 2 where health insurers have different risk profiles but the same costs. Pre equalisation (i.e., before transfers are calculated and effected) Insurer A would have a breakeven premium of €340 and Insurer B would have a breakeven premium of €260; thus the breakeven differential is €80.[160] When the risk profile between health insurers differs, and health insurers have the same costs, RE transfers neutralise the effects of differing risk profiles. For a given age group, if the proportion of the health insurer's customer base within that group is less than that of the overall market, that health insurer will be liable to make a payment into the fund for that group and *vice versa*. In Case 2 the health insurer has the same costs for young and old customers and so the RE transfer purely relates to the different risk profiles between health insurers resulting in a RE transfer of €12,800 and a convergence in breakeven premiums to €324.

Table 11: Case 2 - Insurers have the different risk profiles, but same costs

	Old		**Young**		**Pre-equal. Total costs**	**Post-equal. Total costs before ZSA**	**Post-equal. Total costs after ZSA**	**RE transfer**
Insurer	Number	Cost (€)	Number	Cost (€)	(€000)	(€000)	(€000)	(€000)
A	480	500	320	100	272	259.2	259.2	-12.8
B	80	500	120	100	52	64.8	64.8	+12.8

[159] ZSA refers to Zero Sum Adjustment and is discussed in more detail later in this chapter.
[160] An insurer's breakeven price/premium is the premium by which total earned premiums are equal to total claim costs for that insurer and, therefore, profits are nil (other costs, such as operating expenses, are assumed to be nil). The breakeven premium is not the premium necessarily charged to the customer.

8.43 Table 12, Case 3, illustrates the effect that cost differences have on RE transfers. Cost differences can for our purposes here be interpreted as arising from differing levels of efficiency. So for example, we develop Case 2 by adjusting Insurer A's claims costs for Old customers by assuming that Insurer A has 10% higher claims cost for its older customers. As can be seen from Case 3 this results in higher RE transfers to Insurer A; Insurer A is partially compensated for being inefficient in claims cost management, for example, at the expense of Insurer B. However, it should be noted that the increase in claims costs is not entirely offset by the increase in RE transfer payments. The implication is that Insurer A's incentive to contain costs for the group of consumers where it has a greater proportion than that of the overall market, in this case Old customers, is weakened, but not eliminated.

8.44 It is worth noting here the effect on breakeven premiums. Insurer A's breakeven premium before RE transfers is €370 while Insurer B's is €260 (as before). Insurer A's breakeven premium before RE transfers has increased because of inefficiency. After the application of the RE Scheme, breakeven premiums are €354 and €326 for Insurer A and Insurer B respectively; the breakeven price differential has narrowed to €28. The implication is that there remains scope for price competition based on seeking cost efficiencies that are passed on to consumers.

Table 12: Case 3 - Case 2 but Insurer A has 10% higher claim costs for old customers

	Old		**Young**		**Pre-equal. Total costs**	**Post-equal. Total costs before ZSA**	**Post-equal. Total costs after ZSA**	**RE transfer**
Insurer	Number	Cost (€)	Number	Cost (€)	(€000)	(€000)	(€000)	(€000)
A	480	550	320	100	296	281.6	282.9	-13.1
B	80	500	120	100	52	64.8	65.1	+13.1

8.45 Table 13, Case 4, illustrates a similar effect that cost differences have on RE transfers. In this case, Insurer A's greater costs arise with respect to young customers. Insurer A's proportion of young members is below the market average. In this scenario the RE transfer to Insurer A is reduced relative to Case 2. The implication is that Insurer A has stronger incentives to reduce costs associated with customer groups for which it is underrepresented, in this case, young customers.

8.46 Again is useful to consider breakeven premiums. Before RE transfers are effected, Insurer A and Insurer B's breakeven premiums are €344 and €260 respectively, while after transfers they are €328 and €324 respectively.

Table 13: Case 4 - Case 2 but Insurer A has 10% higher claim costs for young customers

	Old		Young		Pre-equal. Total costs	Post-equal. Total costs before ZSA	Post-equal. Total costs after ZSA	RE transfer
Insurer	Number	Cost (€)	Number	Cost (€)	(€000)	(€000)	(€000)	(€000)
A	480	500	320	110	275.2	262.72	262.46	-12.7
B	80	500	120	100	52	64.8	64.73	+12.7

8.47 Insurer B's incentives are opposite to those of Insurer A because it is underrepresented in the older age category and overrepresented in the younger age category. That is, Insurer B's incentives to contain costs for its young customers would be weakened and incentives to contain costs for its old customers would be strengthened. To the extent that health insurers can separate the management of claims costs between groups of consumers; a health insurer's incentive to contain costs, in the presence of RE, for its age and gender cohorts that are below the market average may be stronger, but incentives to contain costs for its age and gender cohorts that are above the market average may be weakened.

8.48 Table 14, Case 5, illustrates the case where Insurer A is less efficient than Insurer B in both age categories. When Insurer A is inefficient across both groups of consumers the RE transfers it receives increases at a cost to Insurer B. This overall effect arises, for example, because of the greater importance of the older age category in terms of their contribution to costs, i.e., there are more of them and, individually, they are more expensive. The implication is that overall incentives to contain costs are reduced and inefficiencies/efficiencies achieved by a health insurer are, to some extent, shared with other health insurers in the market via the RE transfer.

Table 14: Case 5 - Case 2 but Insurer A has 10% higher claim costs for old and young customers

	Old		Young		Pre-equal. Total costs	Post-equal. Total costs before ZSA	Post-equal. Total costs after ZSA	RE transfer
Insurer	Number	Cost (€)	Number	Cost (€)	(€000)	(€000)	(€000)	(€000)
A	480	550	320	110	299.2	285.12	286.163	-13.037
B	80	500	120	100	52	64.8	65.037	+13.037

8.49 Three further points are worth stressing about this example.

- First, the mechanism by which efficiencies are shared across health insurers is through the Zero Sum Adjustment. This issue is discussed later in this chapter when the mechanics of the RE Scheme are examined.

- Second, as the example demonstrates, there remains scope for price competition based on seeking efficiencies that are passed on to consumers in the form of lower premiums. Whether this actually occurs depends on the market power of the health insurers. We return to the issue of market power later in this chapter and again in Chapter 9.
- Finally, the above examples are presented mainly to demonstrate the efficiencies sharing and incentives points. The example ignores the effects that price sensitive customers have on the calculations. Specifically the example assumes that neither health insurer loses customers because of a rise in premiums due to the RE transfer.

Barriers to Entry

8.50 Entry and the threat of entry exerts competitive pressure on existing health insurers. Anything that restricts or discourages entry can hinder competition in the market. RE and the uncertainty surrounding RE are barriers to entry. The following subsections deal with each of these issues in turn.

Risk Equalisation as a Barrier to Entry

8.51 RE is a barrier to entry into the Irish PHI market. New entrants tend to pick up less risky customers and hence are likely to become net contributors under a RE Scheme. Therefore a market without RE payments is more attractive to a new entrant. RE may also affect the types of firms that enter the PHI market.

8.52 The Harvey Report states that "*The Advisory Group accepts that risk equalisation on its own is a barrier to new entrants to the market.*"[161]

8.53 In the reading of the High Court judgement on November 23rd 2006, Mr. Justice Liam McKechnie concluded that the RE Scheme made entry less attractive and that it involved some elements of anti-competitive behaviour.[162]

8.54 Two health insurers have entered the Irish market since it opened to competition in 1994. BUPA Ireland entered in 1997 and VIVAS Health entered in 2004. In both instances, at the time of entry, RE was on the statute books, although it had not been triggered. BUPA Ireland (May 2005) argues that RE was viewed to be a 'reserve power' and thus they believed that it would not be enacted as they could not see any basis for such a reserve power to be called upon.[163] It is worth noting that evidence of past entry does not lead us directly to the conclusion that entry barriers are low.

8.55 The HIA states that there appears to be a significant amount of interest in entering the Irish PHI market:

"The Authority is aware that at least four parties are considering or have recently considered entering the Irish private health insurance market". [164]

[161] Advisory Group on the Risk Equalisation Scheme (1998), The Minister for Health and Children's independent review of the Risk Equalisation Scheme, p. 40.
[162] *Judicial Review,* 2005/532JR BUPA IRELAND LIMITED and BUPA INSURANCE LIMITED –and- HEALTH INSURANCE AUTHORITY, MINISTER FOR HEALTH AND CHILDREN, IRELAND and THE ATTORNEY GENERAL.
[163] O'Rourke, M (May 2005), *Grounding Affidavit of Martin O'Rourke,* 2005/532JR BUPA IRELAND LIMITED and BUPA INSURANCE LIMITED –and- HEALTH INSURANCE AUTHORITY, MINISTER FOR HEALTH AND CHILDREN, IRELAND and THE ATTORNEY GENERAL para. 42.
[164] HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 57.

8.56 York Health Economics Consortium (YHEC), in conjunction with the Office of Health Economics, were commissioned by the HIA to undertake an independent review of the competitiveness of the Irish PHI market. Their report: *Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market*, ("The York Report") states that seven of eleven companies that have actively or informally considered entering the Irish market cited the possible commencement of RE as a factor that influenced their decision not to enter the market. They reasoned that RE would reduce profitability and reward inefficient incumbents.[165]

8.57 CRA International (2005), in an expert report prepared for the Department of Health and Children, argues that community rating without RE is an invitation to inefficient firms to enter the market since their inefficiency could be masked by the profits available from a good risk profile. RE is designed to stop this happening and so makes entry less easy. It argues that in the absence of RE, it is the incumbent that faces a cost that entrants do not; the cost of incurring the bad risks. In the absence of RE it is the entrant that can make excess profits.[166]

8.58 RE is a regulatory measure that imposes large sunk costs on contributors in the RE Scheme. New entrants and potential entrants are likely to be net contributors to the RE Scheme as they tend to pick up younger and healthier individuals as described in the earlier sections.

8.59 RE makes the Irish PHI market less attractive for new entrants. There is asymmetric legislation in place which aims to minimise the effect of RE as a factor inhibiting entry. This legislation is in place to encourage entry by giving potential entrants time, i.e., three years, to become established in the market. The three year exemption is discussed later in this chapter.

8.60 Finally, there are other factors in the market that also inhibit entry. Barriers to entry are discussed in some detail in Chapter 5.

Uncertainty Surrounding Risk Equalisation

8.61 Lack of certainty over the RE Scheme and the magnitude of RE payments is a barrier to entry. This uncertainty can affect both health insurers and policyholders. Health insurers find it difficult to predict and understand RE payments, and volatility in payments may have significant effects on small health insurers.

8.62 There are two main sources of uncertainty surrounding RE. First, uncertainty arises with respect to the scheme itself, principally its legality. Legal proceedings have been ongoing both in Europe and Ireland. In 2003 the European Commission approved the Irish RE Scheme; prior to this there was uncertainty as to the future of the RE Scheme in Ireland. BUPA Ireland lobbied against its introduction and is currently appealing the European Commission's decision. In 2005, after the HIA first recommended the initiation of RE payments, BUPA Ireland initiated proceedings in the High Court concerning the validity of the relevant provisions of the Health Insurance Acts 1994-2003 and the Risk Equalisation Scheme 2003-2005 ("the validity proceedings"). After the Minister for Health and Children announced a commencement date for RE payments BUPA Ireland initiated a second set of proceedings ("the judicial review proceedings").

[165] York Health Economics Consortium (2003), *Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market*, p. 75.
[166] Walker; Dr. Mike, (2005), *Expert Report on Risk Equalisation*; CRA International, para. 95-100.

8.63 The second source of uncertainty relates to how the RE Scheme works in terms of the magnitude of a health insurer's potential liability under the scheme. The retrospective nature of the RE Scheme and the potential for random fluctuations to affect payments raises uncertainties for players in the market as it may cause difficulties for health insurers in predicting and planning for future payments. Volatility of payments is likely to affect new and small entrants disproportionately and this may affect potential entrants' decision to enter. These issues are discussed further later in this chapter.

8.64 Prior to entry firms must formulate business plans. Uncertainty over factors that will affect profitability makes investment less attractive. Three of six potential entrants interviewed by the HIA stated that the uncertainty surrounding RE is unattractive. One potential entrant said that RE is difficult to understand, and that uncertainty about RE is nearly a bigger barrier than the actual details of the RE Scheme.

8.65 BUPA Ireland's recent announcement that it is to exit the Irish PHI market creates additional uncertainty. In the current environment it would be very difficult for a potential entrant to formulate realistic business plans because of the multitude of unknown variables. This would likely severely affect the ability of a potential entrant to secure financial support. Entrants are likely to adopt a 'wait and see' approach. Until the uncertainty over RE and the way in which it operates is removed it is highly unlikely that any new entry will occur.

Mechanics of the Risk Equalisation Scheme

8.66 According to the three health insurers in Ireland, many of the issues in relation to the mechanics of the scheme are regarded as of only second order importance.[167] BUPA Ireland for example has fundamental objections to the system and would regard any recommendations that relate to the mechanics of the RE Scheme as 'tinkering'. On the other hand, while Vhi Healthcare would have some strong views on the Health Status Weight for example, it would regard many of the other issues as unimportant. In contrast VIVAS Health would have strong views on many of the issues outlined below.

The Health Status Weight

Issue

8.67 The way RE payments are calculated affects health insurers' incentives. The RE Scheme in Ireland at present compensates for age and gender but not for health status. There is however a provision in legislation for the HIA to introduce a Health Status Weight ('HSW'). The introduction of this health status risk adjustor may reduce risk selection but may also reduce incentives to seek efficiencies.

Analysis

8.68 RE attempts to neutralise the effects of differing risk profiles on health insurers' claims costs. At present this is done by taking account of the age and gender profile of a health insurer's customer base and comparing that to the age and gender profile of the total population of PHI consumers. Stated differently, under the current RE Scheme age and gender are the only 'risk factors' or 'risk adjustors' used to calculate risk equalisation transfers. Although strongly correlated with health risks, these two demographic factors are not necessarily good predictors of the risk profile of the insured population.

[167] Based on meetings conducted by the Competition Authority with VIVAS Health, and the HIA with Vhi Healthcare, and a summons hearing held by the Competition Authority with BUPA Ireland.

8.69 In legislation there is a third risk adjustor that may be introduced, so called health status. Under the scheme, health status is calculated on the basis of 'utilisation'. That is, health status is incorporated by using the extent to which, on average and within a given age and gender group, customers utilise healthcare services, measured as number of nights spent in hospital. Legislation allows for only partial incorporation of this health status risk adjustor. This is achieved by weighting the calculations so that a so called Health Status Weight (HSW) = 1 implies complete incorporation, and a HSW = 0.5 implies partial incorporation. A HSW = 0.5 is the maximum level of the HSW allowed under Irish legislation.

8.70 The main concern with increasing the HSW from zero as it currently stands, to a half is that any efficiencies that a health insurer achieves in respect of reducing the extent to which their membership uses healthcare services will be shared with other health insurers. Thus a RE Scheme compensating for health status in the form proposed in Ireland could be seen to have cost-reinsurance features and inadequate incentives to cost containment.

8.71 At this point an illustrative example is useful. To remain consistent we start from the point we began at in the example discussed under the *Efficiencies* subsection earlier in this chapter. Insurer A has a market share of 80% with 60% of its customer base consisting of 'Old' customers and 40% 'Young'. Insurer B has a market share of 20% with 40% of its customer base consisting of 'Old' customers and 60% 'Young'. We assume throughout this example that health insurers have the same cost per day in hospital for Young and Old policyholders (€50) and that differences in costs arise due to utilisation of hospital services in terms of number of nights.

8.72 Table 15, Case 6, establishes the base case scenario where both health insurers utilise hospital services to the same extent for both young and old, i.e., an average of 2 nights for Young customers and 10 nights for Old customers for both health insurers. Further RE calculations are based only on an age risk adjustor (we continue to abstract from gender) and the health status risk adjustor is not included. The resulting transfers are identical to Case 2 described earlier. This is because we have simply broken average cost per age group/cell down into its two factors: cell average cost per night and cell average number of nights.

Table 15: Case 6 - Base case scenario

	Old			**Young**			**Pre-costs**	**Post-costs before ZSA**	**Post-after ZSA**	**RE**
Insurer	No.	Cost (€)	Nights	No.	Cost (€)	Nights	(€000)	(€000)	(€000)	(€000)
A	480	50	10	320	50	2	272	259.2		-12.8
B	80	50	10	120	50	2	52	64.8		+12.8

8.73 Table 16, Case 7, illustrates RE calculations for the case where Insurer A's Old members, due to inefficiencies in claims management, spend on average 10% more time in hospital than Insurer B. An RE Scheme that does not adjust for utilisation of hospital services produces the same result as Case 3 from earlier, i.e., the RE transfer from Insurer B to Insurer A is €13,090 and breakeven premiums are €354 and €325 for Insurer A and B respectively.

Table 16: Case 7 - No HSW adjustment

	Old			Young			Pre-costs	Post-costs before ZSA	Post-after ZSA	RE
Insurer	No.	Cost (€)	Nights	No.	Cost (€)	Nights	(€000)	(€000)	(€000)	(€000)
A	480	50	11	320	50	2	296	281.6	282.9	-13.1
B	80	50	10	120	50	2	52	64.8	65.1	+13.1

8.74 Table 17, Case 8 repeats the calculations from Case 7, except now the health status risk adjustor is incorporated. Introducing the health status weight significantly affects transfers. The situation where health status is fully incorporated (HSW = 1) leads to transfers of €17,600 from Insurer B to Insurer A and a breakeven premium of €348 for both health insurers. In other words, the inclusion of the risk adjustor based on utilisation in terms of market average number nights spent in hospital entirely neutralises any advantage to Insurer B of more efficient claims management. The situation where the health status risk adjustor is only partially incorporated (HSW = 0.5), as allowed for in legislation, leads to a partial sharing of efficiencies. In this case the transfer from Insurer B to Insurer A is €15,355 and the breakeven premiums for Insurer A and Insurer B are €351 and €337 respectively.

Table 17: Case 8 - Health Status Adjustment (HSW = 1 and HSW = 0.5)

	Old			Young			RE Transfer HSW =0	Re Transfer HSW = 1	RE Transfer HSW = 0.5
Insurer	No.	Cost (€)	Nights	No.	Cost (€)	Nights	(€000)	(€000)	(€000)
A	480	50	11	320	50	2	-13.1	-17.6	-15.35
B	80	50	10	120	50	2	+13.1	+17.6	+15.35

8.75 A number of further points about this example are worth stressing.

- First, the introduction of the health status risk adjustor as allowed for in legislation introduces a degree of efficiency sharing far over and above that which currently exists via the Zero Sum Adjustment. The Zero Sum Adjustment is discussed in the following subsection.
- Second, the inclusion of the additional risk adjustor substantially removes scope for price competition based on seeking efficiencies and passing them on to consumers in the form of lower premiums.

- Finally, we have interpreted for the sake of argument that the additional nights in hospital spent by Insurer A's Old customers is due to inefficiency. The additional nights required on average by Insurer A's customers may be due to genuine risk factors. The essential point is that 'utilisation' as measured by number of nights in hospital is unable to distinguish between inefficiency and health related factors.

8.76 If, on any occasion, the HIA decides to alter the value of the HSW from its current value of zero, it must notify the registered undertakings subject to the RE Scheme. The HSW can then be incorporated into the RE Scheme six months from the date of notification. The HSW can only be introduced once certain criteria are met. The Risk Equalisation Scheme, 2003 states:[168]

"health status weight" and "HSW" means a percentage which on the risk equalisation commencement day shall be 0%, and thereafter shall be such a percentage as the Authority may from time to time determine for the purposes of calculations under this schedule, provided that the Authority shall not make such a determination unless

i. the Authority has observed from its analysis of returns carried out pursuant to Article 10(2) of Part IV that there are material differences in claims experience within prescribed age and gender cells as between scheme undertakings, and

ii. the Authority has carried out an investigation into the reasons for such material differences, and

iii. as a result of such investigation the Authority has concluded that the said material differences are wholly or substantially attributable to variations as between scheme undertakings in the health status of covered persons rather than in the respective efficiency levels of those undertakings;

and that accordingly the Authority considers that the making of such a determination is in the best overall interests of health insurance consumers".

8.77 The HIA's (April 2005) *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation* states that:[169]

"The figures returned by insurers for the period 1 January, 2004 to 30 June, 2004 indicated that there may be a material difference in the rates of claim for different insurers within age and gender bands. In this context, the Authority decided to consider investigating whether the HSW should be increased, and engaged UK GAD to advise on this matter."

8.78 However, to date, the HIA has not done a complete analysis of the issues surrounding the HSW. At present there is no proposal to increase the HSW to 0.5 in the RE Scheme.

[168] Statutory Instruments SI. No. 261/2003: Risk Equalisation Scheme, 2003 Second Schedule: Risk Equalisation Calculations, Section 1.
[169] HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 20.

8.79 Vhi Healthcare, in its representations to the HIA in April 2005, stated that it was convinced that the maximum permissible HSW should be used in the RE calculations.[170] Vhi Healthcare believes that age and gender are inadequate measures of the relative risk profile of health insurers and that, in the current system, health insurers have an incentive to attract better risks and are being rewarded for having a more favourable risk profile. With the HSW set at zero, as is currently the case, a health insurer's own average cost for each age and gender group is used for the purpose of calculating transfers, implying that contributing health insurers who have a lower average cost in a given age and gender group gain an advantage. Vhi Healthcare claims that the bulk of this lower average cost arises from differences in health status.[171]

Recommendation

8.80 The HIA cannot decide to increase the HSW unless an investigation is carried out into the reasons why there are material differences in claims experience within prescribed age and gender groups between health insurers and the HIA is confident that all or the majority of the material difference arises due to variations in the health status of covered persons between undertakings rather than the efficiency levels of those undertakings. The HIA must consider that the decision is *'in the best overall interests of health insurance consumers'.* When making its determination as to what is in the best interests of consumers the HIA should also be mindful of the effect that raising the HSW from zero to a half would have on the scope for price competition.

Recommendation 14 **The likely effect of the Health Status Weight on the scope for price competition in the market should be taken into account when investigating its introduction**	**Action By**
When investigating the introduction of the HSW the HIA, in addition to concluding that the material difference 'wholly or substantially' is attributed to variations in health status rather than efficiencies, should also take into account any likely effect that raising the HSW will have on scope for price competition in the market.	Health Insurance Authority

The Zero Sum Adjustment

Issue

8.81 The Zero Sum Adjustment ("ZSA") is a factor applied at the end of the RE calculation to ensure that the RE Scheme is self-financing, i.e., so that the transfers to health insurers equals the transfers from health insurers. However, the application of this factor may result in some sharing of efficiencies between health insurers.

[170] Vhi Healthcare's representation. HIA (April 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 135.
[171] Vhi Healthcare (2006), *Assessment of the adequacy of the risk equalisation scheme (RES).*

Analysis

8.82 The need for the ZSA arises as the average claim per person in each age and gender group will vary from health insurer to health insurer. This means that the net payments and receipts will not balance as theoretically members costs would be deducted from one health insurer at a different cost from that at which they were added to the cost of another health insurer. The application of the ZSA is explained in Appendix 5. The ZSA can positively or negatively impact either the payer or payee.

8.83 The HIA recognises that there are a number of reasons for the variations in the claims per person from health insurer to health insurer, including:[172]

- *"Differences in health status of policyholders;*
- *Differences in efficiency;*
- *Differences in contract terms (e.g. excesses or greater reliance on public hospitals); and,*
- *Seasonal and or timing effects (e.g. where an insurer's membership is growing rapidly, a larger proportion of its "Insured Persons" may be subject to pre-existing condition waiting periods thereby reducing the average claim)."*

8.84 The ZSA can therefore be considered as redistributing some of the combined effect of these factors. The HIA states that it is not possible to produce a definitive breakdown of the ZSA into the elements relating to health status and to other factors. The HIA state:[173]

"In the circumstances of these returns, if full risk equalisation payments were being made, BUPA Ireland would be required to pay about €925,000 more than it would have had to pay if the transfer had been purely based on its own level of efficiencies and on its own health status within age and sex groups. This extra €925,000 could be viewed as a sharing of BUPA Ireland's advantages in terms of efficiencies and in terms of a better health status of members within age / sex groups."

8.85 Mercer Human Resource Consulting, in their advice to An Tánaiste, concur that although a €0.9m portion of the transfer, due to the ZSA, relates to efficiency differentials and to risk differentials not captured by the age and gender basis currently applied, any transfer that took account of health status in addition to age and gender would have resulted in a significantly higher transfer. The example illustrated through Case 6 to Case 9 in the discussion of the HSW in the previous subsection demonstrates this point.

8.86 VIVAS Health, in its submission, states that:[174]

"… the "Zero Sum Adjuster" has the effect of sharing health status as has been acknowledged by the Department of Health's actuarial adviser. This Health Status Adjustment "by the back door", whether intentional or not, lacks transparency and must lead to a sharing of efficiencies which undermines competition."

[172] Correspondence between the HIA and the Department of Health and Children regarding the Zero Sum Adjustment (November 2005).
[173] HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 60. Available at: http://www.hia.ie/publications/riskequalisation/index.html
[174] VIVAS Health (2006), *Competition Authority: Competition in the Private Health Insurance Market,* p. 29.

8.87 Table 18 shows the value of the ZSA for RE calculations corresponding to the period January to June 2005. With a HSW equal to zero, the ZSA factor accounts for approximately 5.6% of the overall payment required by BUPA Ireland. If the HSW is fully incorporated (i.e., equal to one) then the ZSA reduces to €320,000. This indicates that for this period approximately 65% of the ZSA reflects differences in HSW; with approximately 35% of the ZSA or 1.3% of the total RE transfer being a redistribution of differences in efficiencies, contract terms and seasonal/timing effects, assuming the HSW fully captures differences in the health status of policy holders.

8.88 Two points about these calculations need to be stressed. First, the calculations are only indicative and tend to vary considerably from period to period. Second, as recognised in the previous subsection, a RE Scheme that compensates for health status uses the extent to which a health insurer's customer base uses healthcare services, hence, any efficiencies it has achieved in respect of reducing the extent to which its membership uses healthcare services will be included in the calculation of payments. Thus the 1.3% attributed to efficiency is likely to underestimate the true value.

Table 18: Zero Sum Adjustment as a Percentage of Transfer January-June 2005[175]

HSW	Transfers (€m)	ZSA (€000)	ZSA as % of transfer
0	16.5	925	5.6
0.5	20.5	625	3.05
1	24.5	320	1.3

Recommendation

8.89 Empirically it appears that any sharing of inefficiency via the ZSA is currently on a small scale. The incorporation of the ZSA is a relatively small trade-off for having a self-financing system. Although it may incorporate some degree of differences in health status and sharing of efficiencies, if the HSW were to be incorporated to its capped level, thereby possibly involving further sharing of efficiencies, the payments in the period January to June 2005 would be approximately 25% higher. Accordingly the Competition Authority does not make any recommendation in relation to the ZSA.

Nature of the Risk Equalisation Scheme (Retrospective v. Prospective)

Issue

8.90 The current RE Scheme in Ireland is retrospective in nature. It has been argued that a retrospective system creates a certain amount of uncertainty that makes planning difficult. Predictability is critically important for smaller competitors. It is argued that a prospective system would be more predictive for health insurers, more transparent and less susceptible to volatility.

[175] Correspondence between the HIA and the Department of Health and Children regarding the Zero Sum Adjustment (November 2005).

Analysis

8.91 RE can be done either retrospectively or prospectively.

- A **Retrospective System** calculates payments at the end of a period using information from that period; for example, in Ireland, to calculate RE payments a health insurer's claims are recalculated at the end of a period using the market age and gender distribution but using a health insurer's own average claim per member for that period.
- A **Prospective System** calculates payments at the beginning of a period using information from prior periods. The Society of Actuaries in Ireland state that under a prospective scheme:

  "the Health Insurance Authority would publish a set of age and gender premium rates for the minimum level of benefits required under community rating. The Authority would also calculate a community premium rate based on market age and gender data. Insurers would make payments to or receive payments from a risk equalisation fund based on the difference between the age and gender premium rates and the community premium rates."[176]

8.92 The Society of Actuaries in Ireland (2002) is in favour of a prospective RE Scheme as it possesses some advantages over a retrospective system; it contends that a prospective system is: [177]

"… more predictive for insurers and might also be considered more transparent because it more clearly shows the subsidy paid or received from each age and gender cell. In addition, it does not suffer from the potential weakness of the retrospective scheme where an insurer may have small exposure in a particular age and gender cell resulting in volatile average claims per member for that cell."

8.93 VIVAS Health, in its submission, refers to the Society of Actuaries in Ireland's Report stating that the RE Scheme should be prospective in nature rather than the current retrospective system. They argue that the current retrospective system makes it difficult to manage, to plan for and difficult to understand. Moreover, a prospective system would be more predictable for health insurers, more transparent and less susceptible to volatility. VIVAS Health notes that predictability is critically important to smaller competitors and the imposition of a retrospective system showed little regard for the concerns of prospective new entrants at the time.

8.94 Internationally there has been a general preference for retrospective compared to prospective models, the latter being more complicated to manage. However a number of countries have moved to or are investigating a move to a prospective system. The principal attraction of prospective models is that they help health insurers to more accurately set their premiums based on the payments that they expect to receive/give to the central fund. van de Ven *et al.* state: [178]

"An argument for preferring prospective models is that insurers ex-ante want to know the amount of premium subsidies that they receive, which can help them to accurately set the premium they ask from their enrolees. Another argument in favour of prospective models is that only prospective information can be used for selection. In addition, prospective models provide insurers with more incentives for effective preventive care than retrospective models."

[176] The Society of Actuaries in Ireland (2002), *Report of the Working Group on Risk Equalisation*, para. 11.3.
[177] Ibid, para. 11.3.
[178] van de Ven et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries*, Health Policy Vol. 65: p. 80.

Recommendation

8.95 As described above, a prospective system can be more predictive for health insurers, more transparent and less susceptible to volatility. These factors ensure greater certainty for health insurers and may enable entry and planning to a greater degree than a retrospective system. However, the likely costs associated with implementing a prospective system would not be trivial. The HIA should undertake a full cost benefit analysis on what would be required to move to a prospective system.

Recommendation 15 **Undertake a cost benefit analysis of moving to a prospective Risk Equalisation system**	**Action By**
Undertake a full cost benefit analysis of what would be required to move to a prospective Risk Equalisation system.	**Health Insurance Authority**

The Three Year Exemption from Risk Equalisation Transfers

Issue

8.96 New entrants to the PHI market are exempt from RE transfers for the first three years after commencing business and are subject to half payments in year four. It is not clear whether the relevant legislation applies to new entrants that purchase a book from an existing player in the market or new entrants with, for example, a strong brand in other related markets such as retail financial markets.

Analysis

8.97 The White Paper states that:[179]

"In recognition of the value, in terms of enhanced competition, which new entrants serving the market as a whole are in a position to bring to consumers, and having regard to administrative and information systems requirements placed by risk equalisation on a new insurer, the Government have decided that, prior to commencing trading, an insurer entering the health insurance market would be given the choice of availing of a temporary exemption from participation in the risk equalisation scheme."

8.98 The period of exemption envisaged in the White Paper was 18 months. This was increased and later appeared in the legislation as a three year exemption, with an additional 6-12 month period during which only partial payments are made/received.[180]

8.99 Section 12B (1) of the Principal Act states:[181]

"Neither—

i. the requirement of any scheme to make a return or returns, in so far as the return or returns would relate to the period of 6 months beginning on the date referred to hereafter in this section, nor

ii. the other provisions of any scheme, in respect of the period of 36 months beginning on that date,

[179] Department of Health and Children (1999), *White Paper on Private Health Insurance,* p. 48.
[180] HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 10. Available at: http://www.hia.ie/publications/riskequalisation/index.html
[181] Section 12B of the Principal Act, as amended by the Health Insurance (Amendment) Act, 2001, Section 10.

shall apply to an undertaking (other than a restricted membership undertaking) if, before the date on which it commences the carrying on of a health insurance business ('the commencement date'), it serves a notice on the Authority or, if the establishment day is subsequent to the commencement date, the Minister, stating that it does not wish—

iii. that requirement to make a return or returns relating to the period of 6 months beginning on the commencement date, and

iv. the other provisions of any scheme, in respect of the period of 36 months beginning on the commencement date,

to apply to it."

8.100 Section 12B(3) states:

"As respects 2 or more registered undertakings which are associated companies of one another, only one of those undertakings may serve a notice under and in accordance with subsection (1)"

8.101 Section 12B(4) of the Principal Act states that section 432 and other relevant provisions of Part 13 of the Taxes Consolidation Act 1997 shall apply when considering whether companies are associated. Section 432 of the Taxes Consolidation Act 1997 states that:

"… a company shall be treated as another company's associated company at a particular time if, at that time or at any time within one year previously, one of the 2 companies has control of the other company, or both companies are under the control of the same person or persons."

8.102 Vhi Healthcare, in its submission, argues that the three and a half year exemption should not apply in a situation where a new entrant purchases an existing insurer which participates in the RE Scheme, for example, BUPA Ireland's business. Vhi Healthcare states that from a legal perspective it is unclear as to what would happen in such a situation.[182]

8.103 One submission to the Competition Authority argued that the market would offer a more neutral balance of incentives if the three-year exemption from RE were scrapped.[183] Vhi Healthcare, in a submission to the Competition Authority, states: [184]

"… such an exemption has the potential to encourage 'hit and run' type behaviour whereby insurers enter the market, target healthier lives and then potentially exit the market once their exemption period from risk equalisation expires."

8.104 One of VIVAS Health's recommendations, in its submission to the Competition Authority, is to: [185]

"Change the risk equalisation scheme to ensure that an undertaking is not forced to hand over profits until it reaches a certain market share. Risk Equalisation could then apply only to business in excess of that minimum market share."

8.105 In interviews held by the HIA with potential entrants in August 2003 three interviewees stated that the three year exemption was not sufficient given the longer period of immunity BUPA Ireland has enjoyed. One interviewee thought the exemption would be of some help. Another interviewee stated that the benefits of a three year exemption are limited as long as incumbents are not subject to payments.

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[182] Vhi Healthcare (2006), *Competition in the Private Health Insurance Market,* p. 15.
[183] McCarthy, Colm (2006), *Competition in the Private Health Insurance Market.*
[184] Vhi Healthcare (2006), *Competition in the Private Health Insurance Market: Submission by Vhi Healthcare,* p. 8.
[185] VIVAS Health (2006), *Competition Authority: Competition in the Private Health Insurance Market,* p. 32.

Recommendation

8.106 Asymmetric regulation that favours new entrants may be appropriate in markets where there are barriers to entry. The three year exemption is justified as it overcomes to some extent, RE, and other factors, as barriers to entry. However, currently there is some ambiguity as to who is eligible for this limited exemption. The Department of Health and Children should clarify whether or not an insurer who enters the market for PHI by purchasing an existing health insurer or share of an existing health insurer whose risk profile is subject to RE, will be eligible for the three year exemption. Moreover, the Department of Health and Children should be mindful of regulatory gaming when providing clarification.

Recommendation 16 **Clarify eligibility for Risk Equalisation payment exemptions**	**Action By**
Legislation should be brought forward clarifying what type of companies are eligible for the limited exemption from the requirement to make returns and otherwise comply with the Risk Equalisation Scheme.	**Minister for Health and Children**

Termination of the Risk Equalisation Scheme

Issue

8.107 By legislation, the decision of the Minister for Health and Children to implement RE payments in December 2005 cannot be reversed. Termination of the scheme would require approval by the Oireachtas.

Analysis

8.108 The Department of Health and Children states that: [186]

> *"The Oireachtas has at all material times the prerogative to abrogate or annul the scheme or amend the statutory regime. Furthermore, there is a statutory obligation on the Minister to present the Annual Reports of the Authority to the Houses of the Oireachtas every twelve months following any commencement of the payments provisions. These reports are required to evaluate the operation of the scheme "with respect to its effects on the interests of health insurance consumers" (s33 of the Health Insurance Acts)".*

[186] Barrett, P (October 2005), *Second Affidavit of Patrick Barrett,* 2005/532JR BUPA IRELAND LIMITED and BUPA INSURANCE LIMITED –and- HEALTH INSURANCE AUTHORITY, MINISTER FOR HEALTH AND CHILDREN, IRELAND and THE ATTORNEY GENERAL para. 41.

8.109 BUPA Ireland states that:[187]

> *"the provision for the Health Insurance Authority to make annual reports to the Minister in no way cures the absence of a mechanism to suspend payments. Firstly, the imposition of levies potentially in excess of operating profits could well force insurers to exit the market immediately so as to avoid rapidly escalating Risk Equalisation liabilities. The vague prospect of the issue being looked at in the context of an annual review does not address this risk. Furthermore, a general ongoing annual reporting obligation (which might or might not trigger a political intervention) falls far short of a specific and transparent procedure designed to ensure that levy payments could only continue for such time as they remained necessary and proportionate. Thirdly, the lack of a clear and defined procedure for the suspension of levy payments in appropriate circumstances is a fundamental flaw."*

8.110 The fact that there are no provisions for RE transfers to cease instils stability into the market. If risk differentials reduce, transfers under the RE Scheme will decrease and hence the financial burden associated with the RE Scheme will decrease. VIVAS Health, in its submission to the Competition Authority, states:[188]

> *"The more companies and the more evenly spread market shares are the lesser the burden of risk equalisation becomes."*

Recommendation

8.111 No specific recommendations arise from this analysis. A RE Scheme that can easily be turned on and off would create uncertainty in the market; hence the RE Scheme should not have a termination clause other than that currently in existence in the legislation.

Conclusion

8.112 As stressed at the outset of the chapter, the analysis of RE in this report only relates to the effects of the scheme on competition in the market and does not seek to answer the question of whether or not the current RE Scheme is necessary, proportionate or appropriate.

8.113 The immediate effect of the commencement of RE transfers to Vhi Healthcare (which BUPA Ireland must pay, regardless of whether it exits, and VIVAS Health will soon have to pay) will be to increase the average price of PHI. This is true regardless of the cost-cutting measures one would expect a health insurer to seek out in a competitive market, as the commencement of RE transfers will represent a significant adjustment to the cost bases of the health insurers.

8.114 The effect of the commencement of RE on competition will be to limit price competition, consolidate the market position of Vhi Healthcare, and inhibit and discourage entry. The overall effect is that the RE Scheme will tend to substantially strengthen Vhi Healthcare's market power and limit significantly the competitive constraint that other health insurers can place on its behaviour.

[187] O'Rourke, M (September 2005), *Third Affidavit of Martin O'Rourke,* 2005/532JR BUPA IRELAND LIMITED and BUPA INSURANCE LIMITED –and- HEALTH INSURANCE AUTHORITY, MINISTER FOR HEALTH AND CHILDREN, IRELAND and THE ATTORNEY GENERAL para. 44.
[188] VIVAS Health (2006), *Competition Authority: Competition in the Private Health Insurance Market,* p. 34.

9. MARKET POWER

Summary

9.1 This chapter discusses market power in the health insurance market before RE was triggered and after it was triggered assuming RE transfers commenced. Currently, in the absence of RE transfers, Vhi Healthcare does not have market power that would allow it to price its PHI products above competitive levels for a significant period, however this will change once RE transfers commence.

9.2 In addition, depending on Vhi Healthcare's ability to successfully get consumers to select PHI products that most closely correspond to their risk, the protection that older members in particular currently have from Vhi Healthcare's ability to exercise market power may be substantially diminished. Further, as discussed in preceding chapters, there are many barriers to entry into the PHI market, and therefore there is no serious threat of entry to the market in the near future to significantly constrain Vhi Healthcare's ability to exercise market power.

9.3 It is extremely difficult to make predictions about the future of the PHI market and competition in the market given the speed at which changes are occurring. Eventually, the uncertainty surrounding RE and BUPA Ireland's declared exit will dissipate and Vhi Healthcare's regulatory advantages will be ended, thus making more credible the threat of new PHI providers entering the market to compete with Vhi Healthcare. Whether or when this would be enough to provide a significant competitive constraint on Vhi Healthcare is not yet clear, and thus Vhi Healthcare's significant market power may continue indefinitely.

9.4 If BUPA Ireland's declared exit from the market results in there being only two PHI providers in Ireland, the analysis that follows does not substantially change.

What is Market Power?

9.5 Market power arises when a firm does not face effective competitive pressure such that it is able to increase its profits by pursuing either of the following strategies:

- **Raise its prices** above competitive levels for a significant period of time; or
- **Reduce the quality** of its products below competitive levels (by reducing service standards, innovation or other costly dimensions of quality) for a significant period of time thereby lowering costs so that even in the absence of a price increase, greater profits are earned per unit sold.[189]

9.6 More succinctly, market power is the ability of a firm to raise price, adjusted for quality, above the competitive level. [190] The remainder of this discussion will refer to the ability of a firm with market power to raise price above the competitive level on the understanding that the discussion could also be phrased in terms of reducing quality.

[189] Customers can be thought of as paying higher prices for a given level of quality, service or innovation, thus deriving poorer value for money than competition would deliver.
[190] Market power can be distinguished from the concept of dominance. Dominance is a legal concept rather than an economic concept. The nearest concept in economics is that of substantial market power. Dominance (a legal concept) involves the possession of substantial market power (an economic concept). A firm must

9.7 Market power is not absolute – it is a matter of degree. The degree of market power will depend on the circumstances of each case. It is common for a firm to hold some degree of market power, especially in a market with few firms. Our concern is whether a firm holds substantial market power.

9.8 A firm will have substantial market power if it does not face effective competitive constraints. A competitive constraint is something that prevents a firm from profitably sustaining prices above competitive levels. To assess whether a firm has substantial market power, it is necessary to consider whether and to what extent a firm faces competitive constraints.

What are Competitive Constraints?

9.9 A firm can face the following competitive constraints:

- **Existing competitors and switching behaviour of customers** - If a firm faces competitors which customers could easily switch to if the firm attempted to raise and sustain their prices above the competitive level, and if customers are sensitive to changes in prices, it is less likely to be profitable for the firm to increase their prices. These circumstances will weaken the potential market power of a firm. Conversely, if a firm does not face competitors which customers could easily switch to (e.g. they are locked in through contracts) if they attempted to raise/sustain prices above competitive levels (e.g. if the competitors were capacity constrained and were unable to meet an increase in demand), or if customers were not sensitive to changes in price it is more likely to be profitable for the firm to increase their prices. These circumstances will strengthen the potential market power of a firm. It is more likely to be profitable for a firm to increase their prices if they do not face these competitive constraints and therefore their market power is strengthened.

- **Likelihood of New Entrants** - If it is easy for companies to enter the market (i.e. entry barriers are low), it is less likely that a firm will be able to profitably sustain prices above the competitive level as doing so would attract new entry which would then drive the price down – if not immediately, then in the long term. High barriers to entry will strengthen the potential market power of a firm.

- **Countervailing Buyer Power** – If a firm sells its products to buyers who have a strong negotiating position, due to their size or strategic importance to the firm, it is less likely that the firm will be able to profitably raise its prices above the competitive level. Strong buyer power can mitigate market power. Conversely, it is more likely to be profitable for a firm to increase its prices if it sells to buyers that have a weak or limited negotiating position.

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have substantial market power to be dominant. The European Court of Justice has defined a dominant market position as: *"a position of economic strength enjoyed by an undertaking which enables it to prevent effective competition being maintained on the relevant market by affording it the power to behave to an appreciable extent independently of its competitors, customers and ultimately of consumers."* Case 27/76 *United Brands v Commission* [1978] ECR 207. This definition has been used in other cases.

Assessing Market Power

9.10 An assessment of market power entails examining the competitive constraints which exist in a particular market by looking at the following issues:

- **Existing competitors and switching behaviour of customers:** When assessing whether market power exists, we look at the market shares of all firms in the market, how market shares have changed over time and switching behaviour of customers. This gives us some indication of the competitive constraint from existing competitors, whether they have been able to expand operations to meet demand, and whether customers are willing and able to switch in response to a price increase. Evidence that a firm enjoys substantial market power may include the following:
    - The firm has enjoyed a high and stable market share;[191]
    - Customers are not sensitive to price increases due to, for example, inertia, brand loyalty, switching costs or satisfaction with their current provider; and,
    - There are barriers to expansion (such as capacity constraints or lack of access to upstream inputs or essential facilities) which prevent existing competitors from meeting an increase in demand.
- **Likelihood of New Entry:** When assessing whether market power exists, we must look at how easy or difficult it is for a new firm to enter the market. Are there major obstacles which a new entrant would have to overcome? Do new entrants face costs which incumbents do not? The main objective of entry analysis is to determine whether the threat of new entry is strong enough to prevent or deter the exercise of market power by a firm within a reasonable period of time. Without high barriers to entry substantial market power will seldom, if ever, be found. It is worth noting that evidence of past entry does not lead us directly to the conclusion that entry barriers are low, for example because the conditions in a market can change.
- **Countervailing Buyer Power:** This involves an assessment of the size and negotiating position of a firm's customers and their ability to form buyer groups in order to enhance their negotiating position. It is also necessary to determine whether a firm sells to a large buyer(s) who may have a strong negotiating position with the firm should it attempt to raise prices above competitive levels.

9.11 Evidence about the behaviour and financial performance of firms is also relevant in a market power analysis. Where there is direct evidence that, over the long term, prices substantially exceed relevant costs or profits substantially exceed competitive levels, this may point to market power. However, it is worth noting that a firm exercising market power need not necessarily be profitable.

[191] Precise market share thresholds for defining market power do not exist. There are no market share thresholds for defining dominance under Article 82 of the EU Treaty or Section 5 of the Competition Act 2002. Under Irish law, it is for the courts, not the Competition Authority, to determine whether a firm is dominant.

9.12 Economic regulation is a further relevant factor when assessing market power in industry sectors where, for example, prices and/or service levels are subject to controls by the government or a sectoral regulator. Economic regulation have the effect of limiting the extent to which a firm can exploit their market power. Inappropriate regulation can enhance a firm's market power.

Effects of Market Power on Competition

9.13 Firms with market power have the potential to harm consumers and the competitive process by:

- Raising prices above the level that would exist in a competitive market;
- Reducing quality below the level that would exist in a competitive market;
- Weakening existing competition;
- Raising barriers to entry; or
- Slowing innovation.

Market Power Assessment before RE was triggered in December 2005

9.14 Before the RE Scheme was triggered by the Minister in December 2005, Vhi Healthcare had some degree of market power, however the degree of market power it had was not significant and did not raise competition concerns.[192]

9.15 The factors which pointed to Vhi Healthcare possessing some market power were:

- Nine years after the market was opened to competition Vhi Healthcare still had a very high market share (77% at December 2005);
- Structural barriers to entry into the PHI market were very high; and,
- Vhi Healthcare's customers had very limited countervailing negotiating power.[193]

9.16 On the other hand, Vhi Healthcare faced a number of competitive constraints which limited the degree of market power it held and any further widening of the price differential which existed. These competitive constraints were:

- BUPA Ireland and VIVAS Health's more favourable risk profile which enabled them to price below Vhi Healthcare (risk profile asymmetry);
- The price sensitivity of switchers and potential new customers; and,
- The principle of community rating.

[192] However this situation was unsustainable, as discussed in more detail later.

[193] Buyers of PHI are made of up of two main groups – individuals/families, and corporate buyers who pay for health insurance on behalf of their employees or members. Individual consumers of PHI are not in a position to exert any bargaining or buyer power vis-à-vis Vhi Healthcare. As the largest employer-paid group schemes account for more than 1% of Vhi's total membership, no group scheme may be large enough to be able to influence Vhi Healthcare's pricing decisions due to the size of the scheme in proportion to Vhi Healthcare's total membership.

9.17 In combination, these three constraints limited Vhi Healthcare's market power in the following manner:

- **Risk Profile Asymmetry**: First, BUPA Ireland's and VIVAS Health's more favourable risk profile meant that their average claims costs per customer were lower than that of Vhi Healthcare. This enabled them to set their prices below Vhi Healthcare for plans with comparable levels of cover. The price differential between Vhi Healthcare and BUPA Ireland for comparable plans was in the order of 10 – 20%. Neither firm was required to compensate Vhi Healthcare for its legacy of older customers as the RE Scheme had not been triggered.

- **Switchers/New Sales**: Second, the presence of BUPA Ireland and VIVAS Health imposed a competitive constraint on the behaviour of Vhi Healthcare by offering alternatives to existing and potential customers. Due to the price sensitivity of likely switchers and potential new consumers of PHI, if Vhi Healthcare had attempted to increase prices above the existing level, so that the differential between it and its competitors widened, it would have accelerated the rate at which its market share was declining. This would have happened because:

  (i) existing price sensitive customers would have switched away from Vhi Healthcare;

  (ii) Vhi Healthcare would have won a lower proportion of sales to new PHI consumers.

  In terms of profitability, the impact of these two effects was exaggerated because switchers and new sales tended to be less risky, i.e., further price increases would likely have caused Vhi Healthcare's most profitable customer segment to shrink. As such, Vhi Healthcare could not act entirely independently of its competitors when setting its prices.

  BUPA Ireland and VIVAS Health's members have accumulated from two main sources: switchers and new sales. These two groups of consumers are price sensitive consumers and so were attracted to insurers with lower premiums. In addition, survey evidence shows that young, healthy consumers make up the majority of likely switchers and new sales. Both of these groups are very attractive to insurers as they tend to be highly profitable customers.

- **Community Rating**: Third, the behaviour of switchers and potential new customers combined with the principle of community rating ensured that Vhi Healthcare could not raise prices for less mobile, and typically riskier, customer segments. In effect, because Vhi Healthcare could not perfectly price discriminate between risks and has to offer the same level of cover to all customers for the same premium, less mobile customer segments (who tend to be older) enjoyed a degree of protection from Vhi Healthcare's market power because of the disciplining effect imposed by more mobile customer segments, i.e. switchers and potential new customers.

9.18 To summarise, any further widening of the price differential which existed between Vhi Healthcare and BUPA Ireland/VIVAS Health was constrained by these three factors which limited Vhi Healthcare's market power. Therefore before the developments in the market that occurred in 2006, Vhi Healthcare had some degree of market power however it was not substantial. In the absence of RE transfers the level of market power would not be substantial. Competition in the market from BUPA Ireland and VIVAS Health imposed a strong competitive constraint on Vhi Healthcare as they were able to price below Vhi Healthcare due to their cost advantage. Vhi Healthcare could not profitably sustain prices above competitive levels as consumers (individuals and employer-paid group schemes) could switch to alternative providers in response to differences in prices. As these consumers tended to be young this made price rises unprofitable.

9.19 If BUPA Ireland had won its High Court case the situation as described above would have continued. However this situation was unsustainable. The market could not have continued to operate in this manner indefinitely. Vhi Healthcare's financial position has become increasingly tenuous. While BUPA Ireland and VIVAS Health would have been able to continue pricing below Vhi due to their more favourable risk profile, the question of Vhi Healthcare's financial viability would have to have been addressed. If Vhi Healthcare had increased its prices this may have resulted in a death spiral with more and more of its younger members leaving to join BUPA Ireland or VIVAS Health. If Vhi Healthcare had continued to run down its reserves to limit price increases and thereby limit the number of young members switching to BUPA Ireland and VIVAS Health, Vhi Healthcare would not have been able to meet the solvency requirements set by the Financial Regulator and therefore delayed the time at which Vhi Healthcare could be regulated as an insurance company by the Financial Regulator.

Market Power Assessment after RE was triggered in December 2005

9.20 In December 2005, the Minister triggered the RE Scheme. The first RE payment from BUPA Ireland to Vhi Healthcare was scheduled to happen in July 2006. To date, no transfers have occurred as BUPA Ireland initiated High Court proceedings and a stay was put on any transfers (however BUPA Ireland's RE transfers have been accumulating since January 2006). BUPA Ireland's case was rejected in the High Court; BUPA Ireland are appealing this decision. Although BUPA Ireland had stated that it would exit the market if it was forced to make RE payments to Vhi Healthcare, the Competition Authority considered it important to make an assessment of the PHI market on the following assumptions: BUPA Ireland would remain in the market[194] and pay RE transfers and, once VIVAS Health's period of exemption expired, it too would commence making payments to Vhi Healthcare. The effects of this market outcome on competition are discussed in detail in Chapter 8.

9.21 The following analysis therefore considers how the triggering of RE would likely have affected market power, in particular the market power of Vhi Healthcare, had certain events not occurred – such as BUPA Ireland appealing the case, and a stay being put on RE transfers, and BUPA Ireland announcing that it would exit the market.

[194] The analysis is the same if BUPA Ireland's business is continued by another firm, assuming that any buyer of BUPA's business would not be granted a three year exemption from RE payments.

Risk Profile Asymmetry

9.22 The triggering of RE means that all health insurers have to share the costs of all risks in the market. VIVAS Health will continue to enjoy an exemption from the RE Scheme until late 2007 from which time they will also become liable for RE transfers. As discussed in Chapter 8, RE transfers would likely lead to an initial jump in BUPA Ireland's prices. As a result prices would be expected to initially converge to the current Vhi Healthcare level as BUPA Ireland (and later VIVAS Health) increase their premiums. Thus RE transfers would result in an increase in the market price level.[195] This would have two initial effects:

- First, assuming that the most price sensitive consumers in the market are currently members of either BUPA Ireland or VIVAS Health, some of BUPA Ireland's and VIVAS Health's customers may exit the market completely, tending to increase Vhi Healthcare's market share.
- Second, the rate of switching from Vhi Healthcare to VIVAS Health and BUPA Ireland would likely fall as the 10 - 20% price savings available from switching from Vhi Healthcare to VIVAS Health and BUPA Ireland would no longer exist or be substantially diminished.[196]

New Sales/Switchers

9.23 The behaviour of price sensitive switchers and potential new customers has acted as a competitive constraint on Vhi Healthcare. Switchers and potential new customers tend to be less risky and have lower associated average claims costs. The potential loss of switchers and potential new customers to BUPA Ireland and/or VIVAS Health, due to a further rise in premiums, was therefore likely to be unprofitable for Vhi Healthcare.

9.24 Based on patterns to date, two observations can be made. Vhi Healthcare was able to maintain a 10-20% price differential over the past decade, despite this Vhi Healthcare won the majority of new sales. This suggests that were BUPA Ireland and later VIVAS Health to increase their premiums to the current Vhi Healthcare level to fund RE transfers, Vhi Healthcare could:

1. Raise its premiums (possibly by so much as to ensure that the current price differential is restored) without fear of significant switching by its customers; or,
2. Raise its premiums and continue to win the majority of new sales (or possibly an even greater proportion of new sales if, for example, it was to increase its premiums by an amount that ensured that the differential was less than that which prevails at present).

[195] The new static price equilibrium is not necessarily the competitive price level but should instead be considered an upper bound. In reality the competitive price is likely to be lower. In particular, RE will affect each insurer's costs. Prior to RE, BUPA Ireland and VIVAS Health, due to the more favourable risk profile of their customer base, have lower average claims costs than Vhi Healthcare. Once RE transfers commence, BUPA Ireland's and VIVAS Health's average claims costs will tend to rise while Vhi Healthcare's will tend to fall.

[196] In response to increasing prices by BUPA Ireland and VIVAS Health, customers may downgrade their cover but remain with the same insurer to negate the effect of a price increase. If this occurs, it will not have a substantial effect. It may reduce insurers' premium income but not significantly as the majority of customers are on plans for which there is not a suitable downgrade available (VIVAS Level 2 or BUPA Essential); it will have a minimal effect on RE transfers as transfers are based on age/gender and claims costs which is already limited by 'Maximum Equalised Payments'.

9.25 Finally and crucially, with RE transfers taking place, Vhi Healthcare would be less concerned about the loss of less risky switchers or potential new customers because, to a significant degree, all customers are 'average customers' because of the neutralising effect of the RE Scheme.[197] Therefore, the marginal costs of a premium increase is reduced implying that Vhi Healthcare would be able to profitably raise prices by a greater amount than it can at present when in receipt of RE transfers.

9.26 The overall effect of Vhi Healthcare receiving RE transfers and the increase in prices by BUPA Ireland and later VIVAS Health is that the competitive constraints on Vhi Healthcare would be weakened and its ability to profitably increase prices above competitive levels for a sustained period of time is likely to be significantly strengthened.

Community Rating

9.27 Vhi Healthcare who has the majority of older and riskier customers has an incentive to design products which encourage people to choose plans which best reflect their risk profile. With Vhi Healthcare receiving RE transfers, this would weaken Vhi Healthcare's incentives to pursue product stratification strategies, but it would not eliminate them. Vhi Healthcare, when it is in receipt of RE transfers, would no longer face the same level of competitive constraints on its pricing behaviour as it currently does.

- First, the implementation of the RE Scheme would not wholly eliminate the incentive for an insurer to design products which target low-risk customer categories because RE only partially compensates an insurer for an unfavourable risk profile. This means that Vhi Healthcare would continue to target low risk customers.

- Second, in order to reduce their RE liabilities, there would be an incentive for BUPA Ireland and VIVAS Health to attract older customers from Vhi Healthcare rather than only focusing on younger age groups. However, the effectiveness of such a strategy would likely be limited due to the significantly higher acquisition costs and apparent less mobile nature of older customer segments. This means that it would be likely that BUPA Ireland and VIVAS Health would continue to have a greater incentive to target product development at younger age groups.

9.28 If Vhi Healthcare could successfully group its members with similar risk profiles into particular products when in receipt of RE transfers, the principle of community rating would be less effective in protecting less mobile customers from the market power of Vhi Healthcare. The protection that Vhi Healthcare's older members in particular had from Vhi Healthcare's ability to exercise market power due to the disciplining effect of the switching behaviour of younger, more price sensitive members would be diminished. To the extent that Vhi Healthcare can successfully group members with similar risk profiles into particular plans, any competitive constraint that the price sensitive consumers placed on Vhi Healthcare's pricing strategies for price insensitive consumers is diminished with RE and hence Vhi Healthcare could raise prices for these consumers.

[197] RE aims to neutralise the advantage/disadvantage of having a 'good'/'bad' risk profile, essentially all customers become the same – 'average customers'; the profitable and unprofitable customers in a non-RE environment balance out in an RE- environment and so all consumers have an 'average' profitability. As noted in Chapter 8, because of the 'imperfect' nature of the RE Scheme, the effects are not completely neutralised.

9.29 It is not possible to be conclusive about the effect that the 'community rated health insurance contract' principle on which the market is based would have on the level of market power possessed by Vhi Healthcare when it is in receipt of RE transfers. Whether or not Vhi Healthcare would be able to exert market power over its older members depends on whether Vhi Healthcare can isolate older and therefore riskier members into different plans to its younger members and whether it is more profitable for BUPA Ireland and VIVAS Health to invest in encouraging older Vhi Healthcare members to switch to them.

9.30 To summarise, before RE was triggered, BUPA Ireland and VIVAS Health imposed a strong competitive constraint on the behaviour of Vhi Healthcare due to a combination of three factors:

(i) the favourable risk profile enjoyed by its competitors which allowed them to compete strongly on price;

(ii) switchers and new sales who are the most price sensitive consumers; and

(iii) the principle of community rating.

9.31 The commencement of RE transfers from BUPA Ireland and later VIVAS Health to Vhi Healthcare would affect factors (i) and (ii). This would result in the overall competitive constraints imposed on Vhi Healthcare being significantly weakened. Depending on Vhi Healthcare's ability to successfully pursue market stratification strategies, the protection that older members in particular currently have from Vhi Healthcare's ability to exercise market power may be substantially diminished. Further, as discussed in preceding chapters, there are many barriers to entry into the PHI market, and therefore the threat of entry would not provide a significant competitive constraint on Vhi Healthcare.

9.32 Overall, the analysis strongly suggests that in an RE transfers environment, Vhi Healthcare would have substantial market power and would likely be able to profitably increase its premiums above current levels, and possibly to such an extent as to restore current price differentials.

9.33 BUPA Ireland, and later VIVAS Health, would have to amend their respective pricing strategies to take account of the RE transfers they were required to pay. Vhi Healthcare, when in receipt of RE transfers, would then be in a position to build up its reserves and enable it to be regulated as a prudential insurance company by the Financial Regulator. At this point in time, all three firms would be operating in the market under the same regulatory conditions. The market would stabilise and the level of uncertainty in the market would decrease. The potential for entry into the market at that time would be dependent on the level of competition that has developed between the three firms operating in the market. All of these events would, *in the long term*, enhance the competitive constraint on Vhi Healthcare from existing PHI providers and make the Irish PHI market more attractive to new entrants. Whether or when this would be enough to provide a significant competitive constraint on Vhi Healthcare is not yet clear, and thus Vhi Healthcare's significant market power may continue indefinitely.

Market Power Assessment if VIVAS Health is the only Competitor to Vhi Healthcare

9.34 In December 2006, BUPA Ireland announced that it was exiting the market. BUPA Ireland always maintained that it would not stay in the market if RE was triggered. VIVAS Health, on the other hand, have always maintained that they will remain in the market when they become liable for RE payments.

9.35 The immediate effect of BUPA Ireland's announcement on VIVAS Health and Vhi Healthcare depends on the decisions made by BUPA Ireland's customers – whether they stop buying PHI or switch and to whom they switch.

9.36 By not renewing the policies of existing customers after February 2007 and not taking on new customers since December 2006, BUPA Ireland is effectively minimising the RE liabilities it will owe upon exiting the market. As a result the RE transfers to Vhi Healthcare for periods post-BUPA Ireland's announced exit will start to decline. The exact date when payments from BUPA Ireland to Vhi Healthcare will have to be made remains unclear.

9.37 Overall, Vhi Healthcare's market power is likely to be substantial regardless of whether BUPA Ireland exits the market or its business, is taken over by another company. Obviously, if VIVAS Health remains the only competitor to Vhi Healthcare there would be even less of a competitive constraint on Vhi Healthcare.

Conclusion

9.38 Before RE was triggered, BUPA Ireland and VIVAS Health imposed a strong competitive constraint on the behaviour of Vhi Healthcare due to a combination of three factors:

(i) the favourable risk profile enjoyed by its competitors which allowed them to compete strongly on price;

(ii) switchers and new sales who are the most price sensitive consumers; and

(iii) the principle of community rating.

9.39 The commencement of RE transfers, from BUPA Ireland and later VIVAS Health, to Vhi Healthcare would affect factors (i) and (ii). This would result in the overall competitive constraints imposed on Vhi Healthcare being significantly weakened. In addition, depending on Vhi Healthcare's ability to successfully pursue market stratification strategies, the protection that older members in particular currently have from Vhi Healthcare's ability to exercise market power may be substantially diminished. Further, as discussed in preceding chapters, there are many barriers to entry into the PHI market, and therefore there is no serious threat of entry to the market in the near future to significantly constrain Vhi Healthcare.

9.40 Thus Vhi Healthcare is likely to have substantial market power once it receives RE transfers from other health insurers. This market power would allow it to price its PHI policies above competitive levels without losing a significant amount of business or encouraging entry into the market.

9.41 As the uncertainty regarding RE and the uncertainty surrounding BUPA Ireland's declared market exit dissipate, the threat of entry will be stronger. Whether or when this would be enough to provide a significant competitive constraint on Vhi Healthcare is not yet clear.

9.42 If BUPA Ireland's declared exit from the market results in there being only two PHI providers in Ireland, Vhi Healthcare would face only one competitor in the market and thus even less competitive constraint.

10. CONCLUSION

Competition in Private Health Insurance is Highly Constrained

10.1 Competition in private health insurance ("PHI") in Ireland is constrained by the combination of it being a voluntary system and founded on the concept of intergenerational solidarity. The legislative and regulatory framework designed to support this decision significantly limits the scope for competition in private health insurance; by definition, community rating, open enrolment, lifetime cover, the Minimum Benefit Regulations and risk equalisation prevent many of the key features of competition in insurance markets[198] from emerging in private health insurance. For example:

- Health insurers cannot offer discounts to people with healthier lifestyles, such as non-smokers;
- Health insurers cannot offer discounts to employers who have programmes for promoting employee health, such as free/subsidised health screening;
- Innovation in private health insurance is limited as health insurers must continue to cover procedures that have been overtaken by more effective and efficient technologies until the Minimum Benefit Regulations are updated; and,
- Health insurers are constrained in their ability to select the most efficient network of hospitals.

10.2 This stands in contrast to other insurance markets that Irish consumers are used to. For example:

- Mortgage protection insurers offer discounts to non-smokers;
- House insurers offer discounts to households with alarms; and
- Motor insurers are unimpeded in the repairs that they cover and which supplier they use to provide repairs.

10.3 Moreover, insurance is all about risk and insurance companies compete through the effective management of risk. As health insurers in Ireland are not allowed to price their products according to the perceived risk presented by each customer, the basis upon which actuaries can assess private health insurance products and customers is fundamentally changed and this limits the basis upon which health insurers compete.

10.4 The legislative and regulatory limitations imposed on private health insurance in Ireland to enforce intergenerational solidarity thus encourage the prices and products of competing health insurers to converge. One cannot expect to see the kind of competition in private health insurance that consumers are used to in other insurance markets.

10.5 It is within these major constraints on competition that the Competition Authority makes recommendations to maximise competition in PHI.

[198] Insurance markets here refers to private insurance (e.g. motor insurance and house insurance), rather than public insurance (PRSI).

Recommendations to Promote Competition

10.6 The private health insurance market is also characterised by a number of other factors which tend to distort and dampen competition beyond the restrictions imposed by intergenerational solidarity.

10.7 First, the largest private health insurance provider, Vhi Healthcare, is not prudentially regulated as a health insurance undertaking.[199] This situation arises from Vhi Healthcare's continued exemption under Art. 4(c) of the 1973 EU First Non-Life Insurance Directive.[200] Without this exemption, Vhi Healthcare would have to be regulated by the Financial Regulator and would be legally required to have reserves far greater than its current levels and to establish subsidiary or sister companies for selling its non-health insurance products (such as travel insurance and contact lenses).[201] Thus Vhi Healthcare enjoys a regulatory advantage which allows it to compete in ways not available to other health insurers.

10.8 Second, there are many barriers to new health insurers entering the Irish market. Some of these barriers to entry relate to the peculiarities of private health insurance and are unavoidable. The current climate of uncertainty regarding Risk Equalisation and BUPA Ireland's stated intention to exit the market also make the Irish private health insurance market less appealing. One barrier to entry is the market position of Vhi Healthcare in terms of its legacy as a State-owned former monopoly and its regulatory advantage. A less significant barrier is the large legacy network of salary deduction schemes that Vhi Healthcare built up as the former incumbent monopoly provider of private health insurance. Inertia on the part of employers makes it difficult for other health insurers to build up a similar network.

10.9 Third, although the process of switching health insurer is simple and straightforward, some consumers have an incorrect perception that the process is difficult and cumbersome. Certain practices by health insurers also discourage consumers from switching health insurer in response to a more competitive offering, for example tying private health insurance and travel insurance products.

10.10 Fourth, it is difficult for consumers to compare and contrast private health insurance policies. This makes it difficult for consumers to know which health insurer's product best meets their needs and inhibits competition.

10.11 Fifth, the Minimum Benefit Regulations, in their current form, hinder innovation in product design and the development of limited cover plans.

10.12 The Competition Authority makes 16 recommendations in this report for promoting competition in the private health insurance market in Ireland. In particular, the Competition Authority recommends:

- Vhi Healthcare's exemption from prudential regulation should be ended as soon as possible so that it becomes subject to the legal solvency requirements and corporate structuring rules that apply to other health insurers in Ireland;

[199] Vhi Healthcare is regulated by the Financial Regulator in its capacity as an insurance intermediary, for the sale of travel insurance and dental health insurance for example.
[200] The European Commission recently announced that it has decided to *"send Ireland a formal request to submit its observations on the continued legality of the exemption of the Irish Voluntary Health Insurance Board (VHI) from certain EU rules on non-life insurance."* European Commission press release, 24th January 2007.
[201] Vhi Healthcare is currently statutorily prevented from establishing subsidiaries.

- A package of measures should be introduced to provide consumers with useful and timely information to enable them to consider alternative private health insurance products, and to promote consumer awareness of the ease of switching health insurer;

- Vhi Healthcare should discontinue its practice of cancelling its MultiTrip Travel Insurance when its members switch health insurer;

- The Minimum Benefit Regulations should be modernised and the Health Insurance Authority should be allowed to approve limited cover plans, to allow more innovation in the market;

- The Health Insurance Authority should conduct an information campaign to inform employers about how to set up multiple salary deduction mechanisms;

- The Health Insurance Authority should be given wider powers to enforce the Health Insurance Acts and formally assigned the function of promoting the interests of consumers; and,

- The Health Insurance Authority should undertake a full cost benefit analysis of what would be required to move to a prospective Risk Equalisation System and the Minister for Health and Children should clarify the exemptions from Risk Equalisation that apply.

10.13 These measures will promote competition in private health insurance, within the limits of intergenerational solidarity, regardless of how the market structure evolves.

Potential further measures to promote competition

10.14 The Competition Authority finds that once Risk Equalisation transfers commence, the average price of private health insurance will increase regardless of the level of competition in the market. This is because the market is currently distorted by Vhi Healthcare's ability to reduce its level of reserves to compete with BUPA Ireland's and VIVAS Health's prices, which are in turn facilitated by their more favourable risk profiles. The commencement of Risk Equalisation transfers, and the impending requirement on Vhi Healthcare to increase its reserves to meet the Financial Regulator's requirements, will inevitably lead to price increases in private health insurance in Ireland.

10.15 The commencement of Risk Equalisation transfers is also likely to strengthen Vhi Healthcare's market power and allow it to increase its prices above competitive levels and sustain those prices for a significant length of time.

10.16 At the time of writing, it is extremely difficult to make predictions about the future of the private health insurance market and competition in the market given the speed at which events are unfolding.

10.17 Eventually, the uncertainty surrounding Risk Equalisation and BUPA Ireland's declared exit will dissipate. Vhi Healthcare's regulatory advantage will be ended. Thus the likelihood of new health insurers entering the market to compete with Vhi Healthcare will be somewhat improved.

10.18 Ireland may wish to consider more fundamental measures to promote competition. These measures could involve, for example, one or a combination of: structural solutions (e.g. splitting Vhi Healthcare into a number of competing insurers, and perhaps a one-off "Grey PHI" consisting of consumers over a certain age), privatisation, and a review of intergenerational solidarity and the manner in which that objective is pursued.

10.19 Whether such fundamental measures are desirable or not depends on the trade-offs between the actual value added by the principles governing private health insurance, which effectively control prices and redistribute risk, against the loss in consumer welfare caused by those same principles which by their nature prevent the emergence of a more normal competitive market.

APPENDIX 1: METHODOLOGY OF ANALYSING COMPETITION

The following section outlines the method of competition analysis used in this Report. It starts with a discussion of market power and how relevant markets are defined, goes on to look at market structure and the role and measurement of market concentration, and then discusses the main sources of competition - new entry and rivalry among existing competitors.

Market Power

The economic analysis of competition is based on the concept of market power. Market power is the ability profitably to maintain prices above competitive levels for a significant period of time. The exercise of market power results in prices that fail to reflect the social costs of production, and this leads to resource misallocation and economic inefficiency. In addition to the ability profitably to raise prices, a firm with market power may also be able to increase its profits by manipulating the quality of the goods or services it provides. By reducing quality, a producer can lower its costs so that even in the absence of a price increase, greater profits are earned per unit sold. In practice, when assessing whether market power has been exercised, analysts consider quality adjusted price levels where possible.

The analysis of competition and the exercise of market power for a competition review typically involve several separate analytical steps. These steps include the definition of relevant markets, the analysis of market structure, the analysis of rivalry, and the analysis of the magnitude of any barriers to entry for new participants or to expansion by existing participants.

Market Definition

The analysis of competition and the exercise of market power typically begin with market definition. Market definition provides a conceptual framework for organising information relevant to the overall analysis. It involves identifying the product or group of products comprising a relevant market, as well as the geographical scope of the relevant market, based on an analysis of substitutability. The relevant market includes those products that are close substitutes for each other. As close substitutes, the products within a market are prime sources of competition for one another. Those outside a particular market may provide competition in future by means of new entry or product repositioning.

Relevant markets have both product and geographic components. With regard to the product component, substitutability is looked at first from the standpoint of buyers (demand-side). This is often done by examining the characteristics of the product, but can also be done using econometric (statistical) analysis where suitable data are available. A useful conceptual approach to measuring substitutability is to ask how buyers would respond to a **S**mall but **S**ignificant **N**ontransitory **I**ncrease in **P**rice ("**SSNIP**"). If a SSNIP of 5% or 10% for one product would result in many consumers switching to a different product, then both products would be in the relevant market and the producers of each would be viewed as direct competitors. Conversely, if very few consumers would switch to the second product, it would not be in the same market, and the producers of each would not be direct competitors with regard to those products.

Supply side substitutability measures the extent to which an existing product that is not currently a good substitute for consumers could be made a close substitute with only relatively minor modifications. For example, suppose A4 and A3 paper are not close substitutes for buyers. However, if a producer of A3 paper could easily cut its paper to a smaller size, then both should be considered to be in the same market.[202] Products should only be included as supply substitutes if producers are capable of switching production quickly between them and would actually do so. Otherwise, their impact can be considered under entry or product repositioning.

A market definition generally includes reference to a geographic area. A similar methodology is used to define this relevant geographic area. On the demand side, the analysis asks whether products in another area are close substitutes for buyers in the area of interest. For example, if there were a price increase of 5% in area 1, would buyers switch to products in area 2? If so, the second area is in the relevant market. On the supply side, the question is whether a supplier outside the area could quickly begin to supply within the area. If so, the area would also be included. Here the question is not whether the buyers would switch but whether sellers from other regions would begin to sell in the geographic area of interest.

Evidence used in defining the relevant geographic market includes:

- Whether buyers have previously bought, or would consider buying, substitute products, or would buy the original products from a new area;
- Whether sellers base business decisions on the prospect of buyer substitution between products, or whether suppliers in alternative locations are willing and able to meet demand;
- The costs and timing of switching products and how quickly buyers could react to a price increase; and
- The level of transport costs relative to the price of the product.

The definition of the market indicates the product or group of products and the geographical scope of the relevant market. When this exercise is being carried out for a particular purpose, e.g., a merger analysis, a competition case or a study of the market, some market definition questions may be left open if the competitive analysis does not depend upon these questions. However, the market definition exercise provides a basis for a detailed competition analysis.

Market Structure

The next stage in the analysis of competition involves a description of the structure of supply on the relevant market. This may include:

- Market concentration, including the number of firms, and their market shares;
- The stability of market shares over time and level of entry and exit;
- The level of vertical integration (i.e., the extent to which suppliers are involved in several levels of the supply chain);
- Cost and technology factors such as innovation, and research and development intensity; and
- Product differentiation.

[202] This example is taken from the European Commission *Notice on the Definition of the Relevant Market for the Purposes of Community Competition Law*. OJ [1997] C 372/5.

A concentrated market has a small number of firms with large market shares, while an unconcentrated market has a large number of firms, each with a small market share. Market concentration may be measured, for example, by the number of firms in the market or by concentration ratios. A concentration ratio is the total market share held by the firms with the largest market shares. For example, the 4-firm concentration ratio is the sum of the market shares of the largest four firms. Another widely used measure of market concentration is the Herfindahl Hirschman Index ("HHI").[203] The HHI takes account of both the number and relative sizes of firms in the market.

The HHI and other measures of concentration are commonly calculated on three different bases:

- Volume as measured by the number of units supplied;
- Capacity as measured by the maximum possible volume; or
- Value as measured by revenue.

In insurance markets, the usual measure is the third measure above, as shown by premium income. The most recent data available are used to calculate market shares. Historic data may also be used, especially if there is volatility in market shares.

A high market share is generally correlated with market power in the sense that the two often appear together, but inference cannot be drawn. A firm might have a high market share because it is efficient and customer focused and has succeeded in winning customer demand by competition on the merits in the market. Conversely, a company with much lower market share might have considerable market power if its rivals are unable to expand sales due to capacity constraints. Each case must be considered on its merits when determining whether suppliers have market power. For this reason, concentration in a market is at best indicative of a potential problem with competition.

Competition: Entry and Rivalry

Entry and rivalry are the drivers of competition in markets. Entry refers to the ability of new suppliers to sell in the market. Equally important is the ability of existing suppliers to expand. Rivalry refers to competition between existing suppliers. Rivalry in price is common, but suppliers may also compete in quality, variety, innovation and other variables.

Entry to a sector can constrain price rises and induce existing suppliers to behave more competitively. A successful entrant has a positive effect in terms of choice and value for buyers because otherwise buyers would not be able to switch from the existing suppliers.[204]

[203] The HHI is calculated by adding the sum of the squares of the market shares of each current competitor. This measure gives proportionately greater weight to the market shares of the larger firms. It will vary between 10,000 (one firm) and 0 (very large number of firms, each with a very low market share). The HHI is used in this Study simply to describe the level of concentration, with markets described as follows:

(a) If the HHI is less than 1000, the market is unconcentrated;
(b) If the HHI is between 1000 and 1800, the market is moderately concentrated; and
(c) If the HHI is above 1800, the market is highly concentrated.

These are commonly used categories for the HHI in competition analysis.

[204] Even the threat of entry, provided it is credible, may have a positive effect on competition. How credible the entry threat is will depend on how quickly the entrant could succeed in the market, and the efficiency of the entrant relative to existing suppliers. The competitive effect of entry will vary, or even be non-existent, depending on the magnitude of barriers to entry.

Barriers to entry arise from various sources. Regulation that imposes costs or conditions on entrants that are not imposed, or are imposed to a lesser extent, on existing suppliers can be an insurmountable barrier to entry. Regulation that delays entry can diminish the competitive threat posed by an entrant. Action by existing suppliers that raises the costs of entry or delays entry also dampens its impact. This can happen if incumbents control the inputs, assets or technology necessary for the production or supply of relevant products, can set market standards, or can increase customer switching costs (discussed further below). For example, exclusive distribution agreements may foreclose the market to rivals by cutting off their options to gain distribution for their goods. Other barriers to entry can arise naturally in a market. For example, first mover advantage could in certain circumstances be a barrier to entry. Similarly, some customer searching or switching costs may arise naturally, and not because of action by existing suppliers.

High fixed costs can be, but are not necessarily, a barrier to entry.[205] There are two important scenarios, however, in which fixed costs can constitute a barrier to entry:

- Where the entrant must bear fixed costs that the incumbent(s) did not have to bear; and

- Where fixed costs are sunk (i.e. committed to the market and irrecoverable if the entrant subsequently leaves) and the incumbents have first mover advantages.

Consumer search or switching costs can be barriers to entry because they make it more difficult for a new supplier to attract customers away from existing suppliers. These can arise naturally, or because of actions of existing suppliers. An example of a natural barrier to entry would be supply that involves a personal relationship. In contrast, some customer switching costs arise from the behaviour of suppliers in the market. Examples include long-term contracts, exclusive supply or distribution, lack of information provision by existing suppliers, or loyalty programmes.

A critical factor is whether barriers to entry or switching costs result from or are increased by the actions of the incumbent firms, or whether they are natural in the sense of arising regardless of incumbent behaviour. If they arise in part or in whole from incumbent behaviour, they need to be analysed more carefully. In many cases, practices that have the effect of increasing barriers to entry or switching costs can at the same time have advantages for consumers. For example, long-term contracts may offer customers greater security. Any recommendations targeted against such behaviour should be based on a weighing of the pros and cons in terms of consumer benefit.

The analysis of competition generally involves examining all of the above factors, and balancing the pro-competitive and anti-competitive aspects. Not all impediments to competition can be addressed. Some may have strong efficiency rationales so that prohibiting the underlying conduct could do more harm than good. Others may simply be natural features of the market that cannot be removed. Conversely, certain impediments can be shown to be clearly anti-competitive. This is particularly true of regulation or concerted industry action that makes entry or rivalry more difficult.

[205] The Competition Authority (2002), *Notice in Respect of Guidelines for Merger Analysis*, Decision No. N.02/004, in Section 5 gives some examples of where barriers to entry might be considered high. These Guidelines can be accessed on the Authority's website, www.tca.ie

APPENDIX 2: MARKET DEFINITION

Summary

Defining a relevant market is a process undertaken to identify the product or group of products that are close substitutes for each other and the geographical area in which the relevant market exists.

For the purpose of this Report, the relevant market is open enrolment PHI policies that offer indemnity for in-patient hospital services with varying levels of hospital accommodation in Ireland. This is referred to as 'the market for PHI' in this Report.

This Appendix considers the market for PHI. Defining the relevant market is typically the starting point in a competition analysis. Relevant markets have both product and geographic components. The analysis in this Appendix seeks to determine to what extent buyers can substitute between PHI products, or between PHI and other products.

The Relevant Product Market for Private Health Insurance

The relevant product market defined for the purpose of this Report is open enrolment PHI policies that offer indemnity for in-patient hospital services with varying levels of hospital accommodation.

The relevant product market is the set of products or services that buyers consider to be close substitutes for each other in terms of the ability and willingness of customers to switch among products in response to changes in relative prices.

A number of narrower niche markets comprised of groups of buyers which share common characteristics may exist within the relevant product market for PHI. These niche markets may be distinguished by the characteristics of buyers such as age, gender, claims history, life stage, social class, whether they are members of group schemes, and if so, the type of group scheme they are part of.

It is not necessary for the purpose of this Report to precisely define narrower niche markets as it would not impact the analysis of rivalry or barriers to entry in subsequent chapters, nor would it impact the recommendations that follow.

Demand-side Substitution

Substitutability is looked at first from the standpoint of buyers which is referred to as demand-side substitution. Assessment of demand side substitution entails a determination of the range of products viewed as sufficiently close substitutes by consumers to be considered part of the same market. This is often done by examining the characteristics of the product. Another useful conceptual approach to measuring substitutability is to ask how buyers would respond to a **S**mall but **S**ignificant **N**ontransitory **I**ncrease in **P**rice ("**SSNIP**"). This section begins by assessing the characteristics of the PHI product and compares it to other potential substitutes. On the basis of the analysis that follows it is clear that from a demand perspective there is no suitable alternative to a PHI policy.

PHI is a clearly identifiable insurance product designed to cover specific risks, primarily the risk of having to incur the costs of a private in-patient stay in hospital. Although the terms and conditions of PHI products and the level of cover they offer vary, PHI plans have a number of common features which means that there is a high degree of substitutability on the demand side between different PHI policies.[206] These common features are:

- Minimum Benefits: All PHI plans must cover a list of specified medical procedures to comply with the Minimum Benefit Regulations.[207] This means that PHI policies only differ in terms of how many additional extras they offer on top of the specified minimum benefits.

- Open enrolment: All PHI plans are available to all members of the population. There are no restrictions on who can take out a PHI policy. Insurers cannot choose who they want to cover.

- Community Rating: Private health insurers cannot price discriminate, in other words, they cannot charge different prices to different customers for the same policy. PHI policies are not specific to individual consumers or businesses.[208]

Are Related Insurance Products (Health Cash Plans, Serious Illness Insurance and Income Protection Insurance) a substitute for PHI?

There are a number of insurance products available to consumers which relate to at least some elements of private acute healthcare, and might therefore be considered as substitutes for PHI. These related products are:

- Health cash plans;

- Serious illness insurance; and

- Income protection insurance.

However, none of these three products are effective substitutes for PHI from the consumer's perspective. A consumer who wishes to manage the risk associated with getting sick or being in an accident and requiring treatment in a private hospital cannot substitute a health cash plan, critical illness insurance or income protection insurance for a PHI plan should the price of a PHI policy increase. Consumer surveys have found that many people hold multiple health insurance-related products. Thus, from a demand perspective, PHI and the aforementioned related healthcare products are not substitutes.

[206] There may be narrower niche product markets based on gradations of cover, but for the purpose of the Report it is not necessary to establish this, as the analysis that follows would remain the same.
[207] For further discussion of Minimum Benefits, Open Enrolment and Community Rating, please see Chapter 2.
[208] In situations where an employer purchases health insurance as part of the employee benefit package they offer, there are no differences in the PHI polices which are available to these companies (or the price the company pays) compared to an individual consumer.

Table 19: Key features of Related Health Insurance Products

Product Type	Key features	Proportion of PHI holders with this product[209]
Health Cash Plans	Payments towards primary care medical costs and daily cash payments for in-patient hospital stays.	21%
Serious/Critical Illness insurance	Lump-sum cash payment if subscriber is diagnosed with a specific illness or disability covered by the policy (e.g. cancer or stroke) for which the long-term incapacitating effects are not normally covered by PHI.	33%
Income Protection Insurance/ Permanent Health Insurance	Provides a regular income if a subscriber becomes unable to work as a result of physical or mental ill-health.	31%

Are the PHI Policies Offered by Restricted Membership Undertakings a substitute for PHI?

In addition to the three main open enrolment PHI providers, PHI is also provided by 'restricted' undertakings, so-called because their membership is restricted to employees of particular organisations and their family members. The main restricted schemes are the ESB Staff Medical Provident Fund, the Prison Officers Medical Aid Society, and St Paul's Garda Medical Aid Society.

The PHI plans offered by restricted undertakings are only available to a very specific group of people (i.e. ESB staff, prison officers or members of the Gardai respectively and their family members). They are not available to the general public. The policies offered through the three largest restricted schemes are similar to the most popular policies offered by the open enrolment providers. It is highly likely that a large majority of the members of these schemes would subscribe to an open-enrolment health insurer if their particular restricted scheme was not available to them. Therefore, there is asymmetric substitutability.[210] Nevertheless, these schemes do not exert any competitive discipline on the three main PHI providers as they are not available to the general public. For this reason, the restricted membership schemes are not considered to be in direct competition with open enrolment PHI plans and as such are excluded from the relevant product market.

Is the Public Healthcare System a substitute for PHI?

All consumers have a choice as to whether or not to purchase PHI. PHI is voluntary unlike some other types of insurance which are compulsory, for instance third-party motor insurance is obligatory.

A possible alternative to taking out PHI is to:

- Rely solely on public healthcare services; or

[209] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*

[210] Those people who are eligible to take out insurance under the restricted schemes have the option of taking out a policy with any of the three main open enrolment insurers, so for these people, the products would be substitutable.

- Utilise public healthcare services where appropriate and available, and pay for private healthcare services directly as the need arises (or possibly use other insurance products).

Half of the population does not currently hold PHI. The main reasons why people choose not to take out PHI are:

- It is considered too expensive;
- It is considered unnecessary as the person has a medical card which entitles them to a wide range of healthcare services free of charge;[211] or
- It is considered unnecessary given the person's personal characteristics (e.g. young and healthy), or
- The consumer considers the public healthcare service to be adequate to their needs.

From the results of the HIA's 2005 consumer survey,[212] 90% of people with PHI and 51% of people who do not have PHI do not believe that the public healthcare service offers an adequate service and so PHI is considered necessary to gain access to private healthcare services.

- Only 12% agree/strongly agree that there is no need for PHI, and that the public services are adequate.
- Only 13% of those who have PHI say that if the public services were improved they would discontinue PHI cover.

Therefore, most people do not see the public healthcare system as an alternative to PHI. They see PHI as a necessity, not a luxury, which brings peace of mind.[213]

For the purpose of this Report, the public healthcare service is not regarded as a substitute for PHI. While it might be conceivable that a certain percentage of the population might decide to forgo PHI and rely solely on the public healthcare services (or pay privately if they so wished) in response to a permanent small price increase in PHI premiums, this is unlikely to be on a sufficient scale to render that price increase unprofitable by a hypothetical monopolist, given the responses from consumer surveys.

- Relying on the public healthcare system is not a practical substitute for many people as there is uncertainty regarding future healthcare needs and associated treatment requirements and costs.
- Certain treatments are not available through the public healthcare system and those who do not have PHI can only access these treatments by paying for them privately.
- For most elective treatments, there are shorter waiting times for those who have PHI.

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[211] About 30% of the population holds a medical card. Medical card holders are entitled to the following services free of charge: General Practitioner (GP) services; prescribed drugs and medicines; public hospital services (both inpatient and outpatient); dental services; optical services; aural services; maternity and infant care services; a maternity cash grant of €10.16 on the birth of each child; a range of community care and personal social services. Department of Health and Children, *Health Statistics 2002. Section D: Community Health and Welfare Services, 2005.*

[212] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*

[213] 69% agree/strongly agree that PHI is a necessity not a luxury. 65% agree/strongly agree that having PHI means always getting a better level of healthcare service. 79% agree/strongly agree that PHI provides peace of mind.

The SSNIP test for the PHI Market

The following section applies a SSNIP test to the PHI market. This is a useful conceptual approach to measuring demand side substitutability by asking how buyers would respond to a **S**mall but **S**ignificant **N**ontransitory **I**ncrease in **P**rice ("**SSNIP**"). If a SSNIP of 5% or 10% for one product would result in many consumers switching to a different product, then both products would be in the relevant market and the producers of each would be viewed as direct competitors. Conversely, if very few consumers would switch to the second product, it would not be in the same market, and the producers of each would not be direct competitors with regard to those products.

The 2005 consumer survey commissioned by the HIA assessed the likely responses of PHI customers to an increase in the price of PHI.[214] 7% of consumers stated that if the price of PHI rose by 10% they would discontinue cover.[215]

Table 20 below shows that it would be profitable for a hypothetical monopolist to increase premiums by 10%. Data on premiums and claims were obtained from the returns made by the health insurers to the HIA.[216] The table shows what the level of profits would be following a 10% price increase and an anticipated 7% fall in sales volume. As the 'new' gross profit [ ] is greater than the original profit [ ], this indicates that a unilateral price rise by private health insurers would be profitable. Any constraint that might exist from the consumer's ability to fall back on the public healthcare system in Ireland, or to avail of alternative healthcare funding options such as health cash plans, is not an effective competitive constraint on PHI providers. Therefore we can conclude that PHI is a relevant market.[217]

Table 20: Effect of a 10% price increase on profits (€ million)[218]

		Assume 10% price increase occurs		
		Scenario A	**Scenario B**	**Scenario C**
	Original	**No change in no. of members or claims**	**7% lost customers and claims fall by 7%** [219]	**7% lost customers but no change in claims**
Premiums	[ ]	[ ]	[ ]	[ ]
Claims	[ ]	[ ]	[ ]	[ ]
Gross Profit	[ ]	[ ]	[ ]	[ ]
Change in Gross Profit		[ ]	[ ]	[ ]

Similar results can be obtained by using the results from earlier surveys.

[214] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review*

[215] The results of this survey are comparable to other economic studies of the elasticity of demand (i.e. the responsiveness of consumers in terms of quantity demanded to changes in prices) for PHI which have also found that the demand for PHI is highly inelastic, indicating that few consumers refrain from purchasing PHI in response to an increase in its price (e.g. Nolan and Wiley, 2000).

[216] This data is confidential.

[217] When carrying out a SSNIP test, one should bear in mind the cellophane fallacy problem. The test assumes the 10% price increase is from the competitive price, however, this may not be the case and the results may be distorted.

[218] Based on data obtained from levy returns made by Vhi Healthcare and BUPA Ireland to the HIA for year end June 2005. VIVAS Health is excluded from this analysis. As VIVAS Health only commenced operations in October 2004 their exclusion does not affect the overall results.

[219] It is arguable that claim costs would fall less than pro rata if the cancelled subscriptions were predominantly among those with good health and lower anticipated claims (this is a likely scenario). However, on the survey results cited here the price rise would be attractive even if total claims were unaffected, as indicated in the last column of the table.

- In the survey commissioned by the HIA and conducted in November/December 2002 by Amárach Consulting it was found that 8% of consumers would discontinue cover if PHI premiums increased by 10%.[220]

- Nolan and Wiley commissioned a survey in 1999 which asked consumers how likely they would be to renounce insurance entirely if the price of PHI increased by 10%, on a 5 point scale from very likely to most unlikely.[221] The survey found that 7.8% of customers would be very likely to give up insurance. Assuming that all 7.8% of customers who said "very likely" would renounce insurance, and using the same financial data in Table 20 above, once again the 'new' profit is higher than current profits. As it would be profitable for a hypothetical monopolist to increase premium by 10%, these survey results also indicate that PHI is a relevant market.

To summarise the issue of demand-side substitutability, PHI is a clearly identifiable insurance product designed to cover specific risks, primarily the risk of getting sick or being involved in an accident and thereby incurring the costs of a private in-patient hospital stay. As discussed above:

- All PHI policies form part of the same product market due to their common features;

- Other health insurance related products (such as health cash plans, critical illness insurance and income protection insurance) are not substitutes for PHI;

- The public health service is not an adequate substitute for PHI; and

- The restricted membership schemes are not part of the relevant market.

Supply-side Substitution

Supply-side substitutability is important in defining the relevant market. It examines whether suppliers of other products can switch production to the relevant product immediately in response to a small but significant non-transitory change in the price (in the range of 5%-10%) charged by the hypothetical monopolist, without incurring significant sunk costs or risks. When these conditions are met, the additional production that is put on the market will have a disciplining effect on the competitive behaviour of the existing market players.

If an insurer is authorised to write PHI, the authorisation covers all types of buyers and PHI policies. It is not necessary for PHI providers to gain approval from the HIA, or any other regulatory body, before introducing a new PHI plan.[222] Thus, there are no regulatory barriers preventing entry into different types of PHI policies for insurers that already sell PHI. Furthermore, the assets and capabilities required to provide one PHI plan can be used to provide other plans. IT systems such as claims management and billing systems can be used to support different types of PHI policies. Therefore, although PHI products differ in terms of the benefits each offers to consumers, which may result in narrower niche markets based on gradations of cover, there is a high degree of substitutability on the supply side. The supply side of the market is sufficiently flexible to justify defining one wide relevant market for PHI products.

[220] HIA (2003), *The Private Health Insurance Market in Ireland*
[221] Nolan and Wiley (2000)
[222] All PHI plans must comply with the health insurance legislation as detailed in Chapter 3.

Can suppliers of related products such as health cash plans, serious illness cover and income protection insurance easily offer PHI?

Identifying effective supply substitutes in the PHI market involves an assessment of the various facilities and resources needed for a supplier of other related insurance products, to switch to providing PHI in the short term.

From a supply perspective, PHI and the aforementioned related health insurance related products (i.e. health cash plans, serious illness cover and income protection insurance) are not substitutable. Given the characteristics of these products, suppliers cannot quickly move from one to another. PHI is subject to a particular set of regulations and legislation, as described in Chapter 2 and Chapter 4, which must be compiled with. Authorisation by the Financial Regulator and registration with the HIA is necessary before a firm can supply PHI to consumers. Given that a provider of a related health insurance product would not be able to move costlessly and immediately to providing PHI in response to a small but permanent price change, for the purposes of this Report suppliers of other insurance products are not considered to be part of the same market as PHI.

Summary of the Relevant Product Market for PHI

The conclusion that PHI is a product market is supported by decisions of the European Commission and UK Competition Commission relating to different European national markets.

- In the mergers of AXA & UAP[223] and Allianz & Vereinte,[224] the European Commission found that PHI represents a relevant market.

- The UK Competition Commission also took a similar view in its assessment of the merger of BUPA and Community Hospitals Group:

> *"As regards the [private medical insurance] policies themselves, most of those in the personal sector are readily substitutable and we consider that they fall within the same market. There are product differences between personal and corporate policies (the latter tend to be specific to particular requirements) but there is, nonetheless, a high degree of substitutability on the supply side. For that reason we consider that both types form part of the same economic market. All the parties that gave evidence to us agreed. We regard other forms of insurance products such as cash plans, income protection and critical illness policies as complementary to PMI rather than as substitutes. Accordingly, we do not regard them as part of the PMI [private medical insurance] market."*[225]

The Relevant Geographic Market for Private Health Insurance

For the purposes of this Report, the relevant geographic market applicable to the relevant product market is the State.

Relevant geographic markets are defined according to the ability and willingness of customers to switch among suppliers in different areas in response to changes in relative prices (demand side substitutability) and the ability and willingness of suppliers to supply customers in different areas in response to changes in relative prices (supply side substitutability). The principles applied in defining the geographic market are the same as those for the product market.

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[223] Available at http://ec.europa.eu/comm/competition/mergers/cases/decisions/m1033_fr.pdf
[224] Available at http://ec.europa.eu/comm/competition/mergers/cases/decisions/m812_de.pdf
[225] "British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger". Available at: http://www.competition-commission.org.uk/rep_pub/reports/2000/449BUPA.htm#full

Demand-side substitution

When examining substitution from a demand-side perspective, the geographic market definition starts by looking at a relatively narrow area and identifies whether enough customers would switch to suppliers located in other areas in response to a small but permanent price increase in the relevant product/service in the original area, which would make such a price increase unprofitable.

The market evidence indicates that customers in Ireland can and do buy health insurance from the three PHI providers who operate on a nationwide basis, regardless of whether the provider has an office in their locality. This has been facilitated by the ability to sell insurance over the Internet and over the phone and the fact that face-to-face contact is not necessary.

Irish consumers cannot purchase PHI from overseas health insurers who do not operate in the Irish market as the health insurance sold by these firms foes not comply with Irish health insurance legislation.

Supply-side substitution

The three PHI providers operate on a nationwide basis, i.e. their PHI products are available to consumers throughout Ireland and they are priced on the basis of standard national tariffs. Insurers do not limit their operations to only serving particular areas and PHI subscription rates do not vary significantly across different parts of the country.[226]

It is possible for insurers based anywhere in the State to serve customers in any other part of the State. PHI products can be bought and sold over the phone, by post, on the Internet, through local offices and through intermediaries (in the case of VIVAS Health only). Given the experience of VIVAS Health, the most recent entrant into the market, it is clear that multiple physical locations are not necessary to sell PHI. VIVAS Health operate a call centre in addition to selling policies on-line. This means that once an insurer has established itself and is selling PHI policies, there do not appear to be any substantial impediments to that insurer selling PHI policies anywhere in the country. Thus, the relevant geographic market is at least as broad as the State.

If the scope of the geographic market is at least national, then the question arises as to whether the geographic market is international for the relevant product market. Where firms in other territories can switch to supplying the area in question seamlessly and immediately in response to small and permanent changes in relative prices in that area, the geographic market will need to be widened to include those neighbouring territories. Insurers in other markets who wish to sell PHI in Ireland to Irish consumers must be authorised by the Financial Regulator and registered with the HIA. Their PHI plans must comply with Irish health insurance legislation in terms of community rating, open enrolment, minimum benefit regulation etc. As a result, there is no cross-border trade in the PHI market in Ireland. [227]

While geographical substitution within the State by existing PHI providers is straightforward, this is not the case when supplying PHI to Irish consumers directly from abroad - even from other parts of the Single European Market. Therefore, due to the regulatory requirements in place, the geographic market for PHI is defined to be the State.

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[226] HIA (2005), *The Private Health Insurance Market in Ireland – A Market Review.* PHI ownership in Ireland: Dublin 33%, Rest of Leinster 27%, Munster 27%, Connaught/Ulster 14%.

[227] Vhi Healthcare states the following on its website: *"Vhi Healthcare's plans are intended for people resident in Ireland and only people resident in Ireland are eligible to join."*

Summary of the Relevant Geographic Market for PHI

The conclusion that the geographic market for PHI is the State is supported by decisions of the European Commission and UK Competition Commission relating to different European national markets.

- In the mergers of AXA & UAP and Allianz & Vereinte, the European Commission found that the relevant geographic market for PHI is national.

- The UK Competition Commission took a similar view in its assessment of the merger of BUPA and Community Hospitals Group:

> *"As regards the geographical market, we consider that the PMI market is national. Subscription rates do not vary according to locality, and insurers look for the widest possible geographic coverage."*

Conclusion

Market definition is based upon substitution possibilities. For the purposes of this Report, the relevant market is open enrolment PHI policies that offer indemnity for in-patient hospital services with varying levels of hospital accommodation and the geographic extent of competition for PHI is the State.

PHI is a distinct product market with different risk and market characteristics and a unique regulatory framework. In terms of the product market, demand-side substitution is possible across different types of PHI policies. PHI products are not substitutable with other related health insurance products in response to relative price changes and the public healthcare system is not an adequate substitute for PHI. Supply is readily substitutable between different PHI products but not between PHI and other related health insurance products as suppliers cannot quickly move from one to the other. This leads to the definition of a relatively broad relevant product market. It is not necessary for the purposes of this Report to detail more precise narrower product niche markets which may exist as it would not alter the analyses or recommendations that follow.

The geographic scope of the market is national as the regulations in place make it impossible for a supplier in another area to seamlessly and immediately supply the Irish market in response to small and permanent changes in prices.

APPENDIX 3: HOSPITAL COVERAGE BY HEALTH INSURER

County	Hospital	Status	VHI	BUPA	VIVAS	NTPF
Antrim	Royal Victoria Hospital	Public	Y	Y	Y	N
	Ulster Independent Clinic	Private	Y	Y	Y	N
Cavan	Cavan General Hospital	Public	Y	Y	Y	N
Clare	Bushypark Treatment Centre	Private	Y	Y	Y	N
	Ennis General Hospital	Public	Y	Y	Y	N
	Cahercalla Community Hospital	Private	Y	Y	Y	N
Cork	Cork University Hospital	Public	Y	Y	Y	N
	Erinville Hospital	Public	Y	Y	Y	N
	Bantry General Hospital	Public	Y	Y	Y	N
	St Patrick's Marymount Hospice	Public	Y	Y	Y	N
	Mallow General Hospital	Public	Y	Y	Y	N
	Mercy University Hospital	Public	Y	Y	Y	N
	South Infirmary/ Victoria Hospital	Public	Y	Y	Y	N
	St. Finbarr's Maternity Hospital	Public	Y	Y	Y	N
	St. Mary's Orthopaedic Hospital	Public	Y	Y	Y	N
	Millbrook Hospital	Private	Y	N	Y	N
	Shanakiel Hospital	Private	Y	Y	Y	Y
	Tabor Lodge	Private	Y	Y	Y	N
	Smiles Cosmetic Dental Clinic	Private	N	N	Y	N
	Bon Secours Hospital	Private	Y	Y	Y	Y
	Shandon Street Hospital	Private	Y	N	Y	N
Derry	Altnagelvin Hospital	Public	Y	Y	Y	N
	North West Independent Hospital	Private	Y	Y	Y	N
Donegal	Letterkenny General Hospital	Public	Y	Y	Y	N
Down	Daisy Hill Hospital	Public	Y	Y	Y	N
Dublin	Blackrock Clinic	Private	Y	Y	Y	Y
	Auralia Clinic	Private	N	N	Y	N
	Charlemont Clinic	Private	Y	N	Y	N
	Claymon Laboratories	Private	Y	N	Y	N
	Beacon Clinic	Private	N	N	Y	N
	Bon Secours Hospital	Private	Y	Y	Y	Y
	Mater Private Hospital	Private	Y	Y	Y	Y
	Mount Carmel Hospital	Private	Y	Y	Y	Y
	M.S. Care Clinic, Rathgar	Private	Y	Y	Y	N
	Northbrook Clinic	Private	Y	Y	Y	Y
	Rutland Centre	Private	Y	Y	Y	N
	St. Patrick's Hospital	Private	Y	Y	Y	N
	St. Vincent's Private Hospital	Private	Y	Y	Y	Y
	Hampstead Private Hospital	Private	Y	N	Y	N
	Highfield Private Hospital	Private	Y	N	Y	N
	St. Edmundsbury Private Hospital	Private	Y	Y	Y	N
	St. John of God Hospital	Private	Y	N	Y	N
	Northwood Imaging at TLC Centre	Private	Y	N	Y	N
	Optilase Laser Eye Clinics	Private	N	N	Y	N
	Smiles Cosmetic Dental Clinics	Private	N	N	Y	N

	Stanhope Centre	Private	Y	N	N	N
	Beaumont Hospital	Public	Y	Y	Y	N
	Cappagh National Orthopaedic Hospital	Public	Y	Y	Y	N
	Connolly Memorial Hospital	Public	Y	Y	Y	N
	Coombe Women's Hospital	Public	Y	Y	Y	N
	Incorporated Orthopaedic Hospital, Clontarf	Public	Y	N	Y	N
	Mater Misericordiae Hospital	Public	Y	Y	Y	N
	National Maternity Hospital, Holles st.	Public	Y	Y	Y	N
	Our Lady's Hospice	Public	Y	Y	Y	N
	Our Lady's Hospital for Sick Children	Public	Y	Y	Y	N
	Peamount Hospital	Public	Y	Y	Y	N
	Rotunda Hospital	Public	Y	Y	Y	N
	Royal Victoria Eye and Ear Hospital	Public	Y	Y	Y	N
	St. Colmcille's Hospital	Public	Y	Y	Y	N
	St. James' Hospital	Public	Y	Y	Y	N
	St Joseph's Hospital	Public	Y	Y	Y	N
	St. Luke's Hospital	Public	Y	Y	Y	N
	St. Michael's Hospital	Public	Y	Y	Y	N
	The Adelaide and Meath Hospital	Public	Y	Y	Y	N
	The Children's University Hospital	Public	Y	Y	Y	N
	St. Vincent's Hospital, Fairview	Public	Y	Y	Y	N
	St. Vincent's University Hospital	Public	Y	Y	Y	N
Galway	Portiuncula Hospital	Public	Y	Y	Y	N
	Merlin Park Regional Hospital	Public	Y	Y	Y	N
	University College Hospital	Public	Y	Y	Y	N
	Cuan Mhuire, Coolarne	Private	N	N	Y	N
	Bon Secours Hospital	Private	Y	Y	Y	Y
	Galway Clinic	Private	Y	Y	Y	Y
Kerry	Bon Secours Hospital	Private	Y	Y	Y	Y
	Talbot Grove Centre	Private	Y	N	Y	N
	Kerry General Hospital	Public	Y	Y	Y	N
Kildare	Clane General Hospital	Private	Y	Y	Y	Y
	Naas General Hospital	Public	Y	Y	Y	N
	Cuan Mhuire, Athy	Private	N	N	Y	N
Kilkenny	Aislinn Treatment Centre	Private	Y	Y	Y	N
	Aut Even Hospital	Private	Y	Y	Y	Y
	Lourdes Orthopaedic Hospital	Public	Y	Y	Y	N
	St. Luke's General Hospital	Public	Y	Y	Y	N
Laois	Midland Regional Hospital, Portlaoise	Public	Y	Y	Y	N
Leitrim	Our Lady's Hospital	Public	Y	Y	Y	N
Limerick	Cuan Mhuire, Bruree	Private	Y	N	Y	N
	Barrington's Hospital	Private	Y	Y	Y	Y
	St. John's Hospital	Public	Y	Y	Y	N
	Milford Hospice	Public	Y	N	N	N
	Mid-Western Regional Hospital	Public	Y	Y	Y	N
	Mid-Western Regional Maternity	Public	Y	Y	Y	N

	Hospital					
	Mid-Western Regional Orthopaedic Hospital	Public	Y	Y	Y	N
Louth	Louth Hospital	Public	Y	Y	Y	N
	Drogheda Cottage Hospital	Public	Y	N	Y	N
	Our Lady of Lourdes Hospital	Public	Y	Y	Y	N
Mayo	Hope House	Private	Y	Y	Y	N
	Mayo General Hospital	Public	Y	Y	Y	N
Meath	Our Lady's Hospital	Public	Y	Y	Y	N
Monaghan	Monaghan General Hospital	Public	Y	Y	Y	N
Offaly	Midland Regional Hospital, Tullamore	Public	Y	Y	Y	N
Roscommon	Roscommon County Hospital	Public	Y	Y	Y	N
Sligo	St Joseph's, Garden Hill	Private	Y	Y	Y	Y
	Sligo General Hospital	Public	Y	Y	Y	N
Tipperary	Aiseiri Centre	Private	Y	Y	Y	N
	Nenagh General Hospital	Public	Y	Y	Y	N
	Our Lady's General Hospital	Public	Y	Y	Y	N
	South Tipperary General Hospital	Public	Y	Y	Y	N
Waterford	Waterford Regional Hospital	Public	Y	Y	Y	N
Westmeath	St. Francis' Private Hospital	Private	Y	Y	Y	Y
	Midland Regional Hospital, Mullingar	Public	Y	Y	Y	N
Wexford	Aiseiri Centre	Private	Y	Y	Y	N
	Wexford General Hospital	Public	Y	Y	Y	N
	Ely House	Public	Y	Y	Y	N
Wicklow	Forest Treatment Centre	Private	Y	Y	N	N

Sources:

Vhi Healthcare http://www.vhi.ie/pdf/products/memhbook.pdf

BUPA Ireland http://www.bupa.ie/hospitals/textonly_healthmanagergold.html

VIVAS Health http://www.vivashealth.ie/documents/me_brochure.pdf

NTPF http://www.ntpf.ie/where/hospitals.asp

APPENDIX 4: HIA PRODUCT COMPARISON

This Product Comparison is updated on a regular basis by the HIA.

Understanding and Comparing Private Health Insurance Products

Research carried out by The Health Insurance Authority ("the HIA") indicates that Irish consumers have difficulty understanding and comparing health insurance products. The HIA publishes this document in order to address this difficulty by providing details of the main benefits provided by health insurance products in a simple, brief format that facilitates the comparison of these main benefits. It is a brief guide to the main costs and benefits of the private health insurance products sold by BUPA Ireland, Vhi Healthcare, and Vivas Health.

This document does not purport to provide full product details and should not be confused with full contractual terms and conditions, which are available from the insurers. In particular, in order to avoid overcomplicating this document some potential differences between insurers and their products are not discussed, e.g. levels of customer service, number of hospitals in which cover is provided, number of consultants providing cover. The HIA provides this information on a necessarily summary basis in order to be of assistance but without liability on its part or that of its officers. You are advised in all circumstances to discuss your requirements with insurers and to review carefully the terms and conditions of the contracts.

Furthermore, the cover referred to in this document is subject to the terms and conditions of the contracts. In particular, there are circumstances during which cover may not be provided, such as during waiting periods or where other exclusions apply. Again you are advised to discuss these matters with the insurers and to review carefully the terms and conditions of the contracts.

Please note that the details and costs included in this document apply to the products as at 1 September, 2006

Contact details:

The Health Insurance Authority
Address: The Health Insurance Authority
Canal House
Canal Road
Dublin 6
Telephone: (01) 4060080 Fax: (01) 4060081
Email: info@hia.ie
Internet: www.hia.ie

BUPA Ireland
Customer Helpline: 1890 700 890 (lo-call)
Mon – Fri: 8.00am – 8.30pm
Saturday: 10.00am – 3.30pm

Fax: (025) 42122
Email: betteroff@bupaireland.ie
Internet: www.bupaireland.ie

Vhi Healthcare
Customer Service: 1850 44 44 44 (CallSave)
Mon – Fri: 8.00am – 8.00pm
Saturday: 9.00am – 2.00pm

Fax: (056) 61741
Email: info@vhi.ie
Internet: www.vhi.ie

VIVAS Health
Customer Service: 1850 717 717 (CallSave)
Mon – Fri: 8.00am – 8.00pm

Fax: (01) 2937995
Email: support@vivashealth.ie
Internet: www.vivashealth.ie

Table 1: Hospital Accommodation – BUPA Ireland, Vhi Healthcare, and VIVAS Health

The main benefit of most private health insurance products in Ireland is the level of hospital accommodation/hospital treatment. For many plans, more than 90% of the value of claims relate to hospital accommodation and treatments although other products concentrate on out-patient benefits.

Table 1 sets out the levels of hospital accommodation offered by BUPA Ireland, Vhi Healthcare, and Vivas Health for each of their products and the cost per month on Adult Group rate. The Adult Group rate is a 10% discount on full price and may be obtained if you take out health insurance as part of a group.

Table 2: Outpatient, Overseas, Psychiatric Hospital, and Maternity Benefits – BUPA Ireland, Vhi Healthcare, and VIVAS Health

Table 2 indicates which products provide significant outpatient benefits as well as the level of psychiatric hospital and maternity benefits. Of course insurers may offer more benefits than those listed and you should contact the insurers for full product details and terms and conditions.

Table 1: Hospital Accommodation – BUPA Ireland, Vhi Healthcare, and VIVAS Health

Price Increases: BUPA Ireland tend to increase prices on 1 March for all contracts with renewal dates after that date. Vhi Healthcare tend to increase prices on 1 September for all contracts with renewal dates after that date. VIVAS Health increased its prices in October 2005. The prices in Table 1 incorporate all price increases up to 1 September, 2006.

Cost per month based on Adult Group Rate (net of tax relief at source)	Product	Public Hospitals		Private Hospitals (excluding Blackrock Clinic and The Mater Private)		Blackrock Clinic and The Mater Private	
		Semi-private Room	Private Room	Semi-private Room	Private Room	Semi-private Room	Private Room
BUPA IRELAND							
€27.61	Essential	✓					
€39.60	Essential Plus with Excess	✓	✓	€80 excess			
€43.74	Essential Plus	✓	✓	✓			
€41.91	HealthManager Starter	✓	✓	A very limited number of private hospitals are covered			
€59.97	HealthManager	✓	✓	€126 excess	€126 excess		
€150.40	HealthManager Gold	✓	✓	✓	✓	✓	✓
VHI HEALTHCARE							
€35.24 / €37.71	Plan A / Plan A Option	✓					
€43.08/ €43.94	First Plan / Family Plan	✓	✓				
€37.20 / €44.99	Company Plan / Company Plan +	✓	✓	€75 excess*			
€45.13	Plan B Excess	✓	✓	€75 excess			
€51.05 / €55.35	Plan B / Plan B Option	✓	✓	✓			
€53.50 / €54.37	First Plan Plus / Family Plan Plus	✓	✓	✓*			
€78.83 / €83.25	Plan C / Plan C Option	✓	✓	✓	✓		
€83.54	Forward Plan	✓	✓	✓	✓		
€101.45 / €106.24	Plan D / Plan D Option	✓	✓	✓	✓	✓	
€151.59 / €156.34	Plan E / Plan E Option	✓	✓	✓	✓	✓	✓
€9..92	HealthSteps Silver	These products do not provide cover for hospital accommodation					
€15.33	HealthSteps Gold						
€4.09	Plan P	Covers charges incurred as a public patient – this plan does not provide cover for private healthcare					
VIVAS HEALTH							
€23.83	Me Level 1	✓					
€27.00	I & We Level 1	✓					
€35.58	Me Level 2	✓	✓	✓			
€38.42	I & We Level 2	✓	✓	✓			
€38.58	Teachers / Nurses Plan	✓	✓	✓			
€32.67	Smart Plan	✓	✓	✓			
€37.04	Market Plan	✓	✓	✓			
€55.75	I & We Level 3	✓	✓	✓	✓		
€55.92	Teacher / Nurses Plan Plus	✓	✓	✓	✓		
€84.00	I & We Level 4	✓	✓	✓	✓	✓	
€116.83	I & We Level 5	✓	✓	✓	✓	✓	✓
€9.66	Day to Day: Teachers/ Nurses	These products do not provide cover for hospital accommodation. Tchrs/ Nurses Day to Day plans can only be purchased with Tchrs/ Nurses Plan & Tchrs / Nurses Plan Plus Level A products can be purchased with a hospital plan at a saving of €1.50 - €1.75 per month. Day to Day 50 can be purchased with a hospital plan at a saving of €2.57 per month					
€10.25	Day-to-day: Me Level A						
€11.33	Day-to-day: I & We Level A						
€17.23	Day to Day 50						

* Cover in the Galway Clinic is limited

Notes

- Please note that even if your policy covers a particular level of accommodation, if that level of accommodation is not available you might be required to stay in a lower level of accommodation. You should also note that semi-private rooms can accommodate up to 5 people.
- Many products offer full or significant cover for the Blackrock Clinic and Mater Private Hospitals in respect of day treatment, outpatient treatment and treatment for certain heart conditions. If this is important to you, you should discuss it with the insurers.
- Vhi Healthcare's Company plans and VIVAS Health's Teachers/ Nurses Plans are available to all consumers and not just companies/ teachers/ nurses.
- The excesses referred to in the table above are paid either once per medical condition or once per claim.
- Subject to availability, it is generally possible to stay in a higher level of accommodation than you have cover for if you pay part of the charges, either as a percentage of the charges or as an excess per night in hospital. Contact the insurers for more information.

Table 2: Outpatient, Overseas, Psychiatric Hospital, and Maternity Benefits - BUPA Ireland, Vhi Healthcare, and VIVAS Health

Benefits		BUPA IRELAND		VHI HEALTHCARE					VIVAS HEALTH			
		Essential, Essential Plus	HealthManager Starter, HealthManager, HealthManager Gold	Plans A –E, A – E Options, Plan B Excess	HealthSteps Silver and Gold	First Plan, First Plan Plus, Family Plan Family Plan Plus Forward Plan	Company Plan	Company Plan Plus	Me Plan (Both Levels)	I / We plans Teachers / Nurses Plans All levels	Market Plan Smart Plan	All Day to Day products
Outpatient Cover		Very Limited	Significant	Very Limited	Significant	Significant	Very Limited	Significant	Very Limited	Very Limited	Very Limited	Significant
Cover for Accident and Emergency Healthcare Abroad		Up to €55,000*	HM & HMG up to €65,000* (**not** covered by HM Starter)	Plan A- B: Up to €65,000* Plan C-E and A-E Options: Up to €100,000*	These benefits are not covered	Up to €100,000*	Up to €100,000*	Up to €100,000*	Up to €55,000*	Level 1: Up to €55,000* Levels 2-5: Up to €100,000*	Market: up to €65,000 * Smart: up to €100,000*	These benefits are not covered
Psychiatric Hospital Cover		Up to 100 days	Up to 100 days	Up to 180 days		Up to 100 days	Up to 100 days	Up to 100 days	Up to 100 days	Up to 180 days	Up to 180 days	
MATERNITY	Assistance with Doctors fees while in Hospital	Up to €790.11	Up to €790.11	Up to €790.11		Up to €790.11	Up to €790.11	Up to €790.11	295.86	Up to €790	Up to €790	
	Assistance with Private Hospital Accommodation	Essential: Up to €1,700 Essential Plus: Up to €2,800	HM Starter: Up to €2,600 HM: Up to €2,900 HM Gold: Up to €3,200	A / A Option: Up to €1,510 B / B Option: Up to €2,100 C / C Option: Up to €2,200 D / D Option: Up to €2,300 E / E Option: Up to €2,400		Family: Up to €2,500 First and Forward: Up to €1,510	Up to €2,250	Up to €2,250	€ 380.93	Level 1: €1,600 Tch/ Nrs: €2,700 Tch/ Nrs+:€2,700 Level 2 : €2,700 Level 3: €2,700 Level 4: €2,800 Level 5: €3,000	Smart: up to €2,260 Market: up to €2,100	
	Assistance with Home Births								These benefits not covered			
	Post-natal home help	This benefit is not covered	This benefit is not covered	This benefit is not covered		This benefit is not covered	This benefit is not covered	This benefit is not covered		Up to €100 per day for 3 days	This benefit is not covered	

Notes on Outpatient Cover

- Within BUPA Ireland's products, HealthManager Gold provides more outpatient benefits than HealthManager, which in turn provides more outpatient benefits than HealthManager Starter.
- Within Vhi Healthcare's products HealthSteps Gold provides more outpatient benefits than HealthSteps Silver, Company Plan Plus and the LifeStage Choices Plans (i.e. First Plan, First Plan Plus, Family Plan, Family Plan Plus and Forward Plan).
- Within Vivas Health's Day-to-Day products, Level B provides more benefits than Level A.

Note on Accident and Emergency Healthcare Abroad

- * These products providing cover for accident and emergency healthcare abroad also provide cover for the cost of repatriation if medically necessary, as well as allowances towards expenses incurred by a companion remaining with and/or travelling with a member being repatriated.

Notes on Maternity Cover

- For many products maternity cover is only provided for a maximum hospital stay of three nights.
- Other maternity benefits are provided by some products, including enhanced outpatient benefits in respect of postnatal care. If you are interested in these benefits please contact the insurers.

Other Benefits

- Other benefits are provided by some health insurance products, e.g.:
  - Cover with UK hospitals
  - Cover for treatment abroad where treatment is not available in Ireland
  - Cover for convalescence
  - Discounts for students in full time education, and children
  - Health information
  - Cover for alternative practitioners therapies
  - Cover for MRI scans, health screens, PET scans, and PET CT scans

  If you are interested in these benefits please contact the insurers

APPENDIX 5: THE RISK EQUALISATION SCHEME

The Risk Equalisation Scheme

Under the Risk Equalisation Scheme (RE Scheme) health insurers are required to submit returns to the HIA every six months. The HIA analyses these returns and under certain circumstances recommends to the Minister of Health and Children whether or not RE transfers should commence. The steps used to calculate RE payments are outlined later in this Appendix.

The procedure to be followed varies depending on the level of difference in risk profiles between insurers. This is defined by, i.e., the Market Equalisation Percentage ("MEP"). The higher the MEP, the greater the difference in the risk profiles of health insurers. Table 21 below presents the MEPs and the payments that would have been made if RE had commenced from when the current RE Scheme came into effect on 1st July 1st, 2003. It is the view of the HIA that the longer term trend of the MEP is upward and its analysis indicates that the MEP is growing at a rate of around 0.5 percentage points per annum.[228]

Table 21: Market Equalisation Percentage and Associated RE Transfer[229]

Period	MEP	BUPA Ireland (€'000s)	ESB SMPF (€'000s)	Vhi Healthcare (€'000's)	VIVAS Health (€'000's)
July – Dec 2003	3.7%	(11,644)	1,084	10,561	n/a
Jan – June 2004	3.5%	(11,804)	865	10,939	n/a
July – Dec 2004	4.7%	(16,759)	1,163	15,596	n/a
Jan – June 2005	4.2%	(16,454)	1,290	15,164	n/a
July – Dec 2005	5.1%	(20,633)	1,305	19,955	(627)

The HIA must report the MEP to the Minister for Health and Children. However, a recommendation to the Minister by the HIA on whether RE payments should be commenced depends on the value of the MEP.

1. If the MEP is below 2% the HIA does not have to make a recommendation to the Minister and RE payments will not commence under any circumstance.

[228] HIA (October 2005), *Staff Report to Members of the Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation*, p. 66
[229] ibid; pp. 41 & 47, and; HIA (April 2006), *Summary of Report of The Health Insurance Authority to the Tánaiste and Minister for Health and Children, in accordance with Section 10 of the Risk Equalisation Scheme, 2003 (as amended), for the period July to December, 2005,* p. 2.

2. If the MEP is between 2% and 10%, the HIA, having regard to the best overall interests of the health insurance customers, must make a recommendation to the Minister on whether or not RE payments should be commenced. Initially the HIA must come to a preliminary view and give notice to the insurers of the recommendation it intends to make. The insurers are given 21 days to make representations. After considering these representations the HIA is required to come to a formal view and forward a report to the Minister within 120 days of the end of the period to which the returns relate. If the recommendation is not to commence RE, then the Minister cannot commence it. If the recommendation is to commence RE then the Minister has 60 days to decide whether payments are commenced or not; during this period the Minister is obliged to consider representations from insurers.
3. If the MEP is greater than 10%, the HIA has 90 days, from the end of the period to which the returns relate, to report to the Minister; a recommendation by the HIA is not required. The Minister has a further 90 days after the report by the HIA to decide whether the implementation of RE is in the best overall interests of consumers. During this period the Minister is required to consult with the HIA. If the Minister wishes to commence RE, the Minister is obliged to consider representations by the insurers prior to making a final decision. If the decision is to initiate RE payments the Minister must issue a 'commencement date'.

The HIA, when deliberating on whether or not the commencement of RE payments is in the best overall interests of health insurance consumers, considers matters such as:[230]

- *"The differences in risk profiles between insurers,*
- *The relative sizes of insurers,*
- *The age / sex profile of insurers' policyholders,*
- *The rate of premium inflation,*
- *The number of insurers in the market / new entrants to the market,*
- *The effect of any transfer on premiums payable by consumers,*
- *The overall size of the market,*
- *The effect of payments on the business plans or solvency of insurers; and,*
- *The commercial status of insurers."*

Prior to 2005 there had been no recommendation to commence RE payments. In both April and October 2005 the HIA recommended the commencement of payments to the Minister for Health and Children. On the first occasion the Minister decided against implementation and on the second occasion the Minister decided to implement payments which would commence on January 1st 2006.

Risk Adjusters and Equalised Benefits

Every six months (January and July) the HIA receive the necessary information for the computation of RE transfers from the health insurers. For each health insurer, this information includes:

- The risk profile of the insured population, i.e., the number of insured persons for each age-gender "band" or cell, as defined by the HIA regulations,[231] and,

[230] HIA (2002), *Policy Paper: Risk equalisation in the Private Health Insurance Market in Ireland*, p.6.

- The average claim costs per person for each age-gender cell.

Currently under the RE Scheme age and gender are the only 'risk factors' or 'risk adjustors' used to calculate RE transfers. Although strongly correlated with health risks, these two demographic factors are not necessarily good predictors of the risk profile of the insured population; the HIA can, under certain circumstances, introduce a Health Status Weight ("HSW"); the HSW is discussed in Chapter 8.

In terms of claim costs, it should be noted that all insurance contracts and claims irrespective of the level of cover provided are included in the RE Scheme; however, an upper limit has been placed on daily rates of benefits which can be taken into account for the purpose of determining RE transfers. The claim costs that may be included for the purposes of the RE Scheme are referred to as 'equalised benefits'. The amount of equalised benefits is effectively capped at €550[232] per in-patient day and has been chosen to correspond approximately with the most common levels of cover in the market. Equalised benefits include only claims in respect of in-hospital care (e.g., claims relating to nursing home services, ambulance services, outpatient care) and exclude certain categories of treatment (e.g., claims relating to cosmetic, fertility, dental or preventative care services). The equalised benefits currently recognised by the legislation are approximately those provided by Vhi Healthcare under its Plan B.

The Calculation of Risk Equalisation Transfers

In this section the steps used in determining a health insurer's payment under the RE Scheme will be explained.

The first step in determining a health insurer's payment under the RE Scheme is to calculate pre-equalisation costs. For each age and gender cell, a health insurer's claims costs are calculated. When equalised benefits are summed up over age and gender cells this yields a health insurer's pre-equalisation costs.

Step 1: Pre-Equalisation Costs

Each undertaking's pre-equalisation claim costs can be expressed as the sum over all age and gender cells of:

(Undertaking membership) * (Undertaking proportion in cell) * (undertaking cost per person in cell)

The second step involves calculating a health insurer's post-equalisation costs. Post-equalisation costs are the costs that a health insurer would have incurred if, for each age and gender cell, it had the same proportion as the overall market population. So, for a given age and gender cell, if the proportion of the health insurer's customer base within that cell is less than that of the overall market, that health insurer will be liable to make a payment into the fund for that cell and *vice versa*. An insurer's liability under the RE Scheme is approximately equal to the difference between pre and post-equalisation costs.

Step 2: Post-Equalisation Costs before Zero Sum Adjustment

Substituting the "*(Undertaking proportion in cell)*" with "*(Market proportion in cell)*" in the first formula to give:

(Undertaking membership) * (Market proportion in cell) * (Undertaking cost per person in cell)

[231] There are eight age bands (age 17 and under, age 18-29, 30-39, 40-49, 50-59, 60-69,70-79, age 80 and over) for each gender type.
[232] Statutory Instruments SI. No. 261/2003: Risk Equalisation Scheme, 2003 First Schedule: Maximum Equalised Payments in Respect of Settled Claims Relating to Prescribed Health Services Section 1.

After estimating the costs undertakings would have incurred if they had the same risk profile as the overall market, the Zero Sum Adjustment ("ZSA") factor is applied. The ZSA guarantees that the RE Scheme is self-financing by making the calculated transfers for the overall market sum to zero. In other words, calculated transfers in the "RE fund" (from payers) may not be exactly equal to transfers out (to payees); one reason being that undertaking's cost per person in each cell is likely to be different among undertakings.

Step 3: Post-Equalisation Costs after Zero Sum Adjustment

(Undertakings Post-Equalisation Costs before Zero Sum Adjustment) * [(Total Pre-Equalisation Costs of the Market) / Total Post-Equalisation Costs of the Market)]

The RE transfer to and from each undertaking is calculated as being equal to the difference between the "Post-Equalisation Costs after Zero Sum Adjustment" and the actual benefits paid by undertakings.

Step 4: The RE Transfer

(Post-Equalisation Costs after Zero Sum Adjustment) – (Pre-Equalisation Costs)

This 'simple' version of the calculation can potentially be complicated by including an additional risk adjustor, i.e., "cell utilisation". Cell utilisation or 'market cell utilisation', is intended to be a proxy for health status. The HIA state in its *Guide to Risk Equalisation Scheme, 2003* that:[233]

> *"If the Authority considers that the age and gender profiles of the insurers' populations do not adequately reflect the underlying risk profiles, it is open to the Authority to take account of the extent to which an insurer's population uses Healthcare services in attempting to measure the level of risk that each insurer has."*

In the simple version of the calculation described above a health insurer's post equalisation costs are, for each age and gender cell, based on that health insurer's own experience of costs within that cell, i.e., the average number of nights in hospital multiplied by the average cost per night in hospital – this is effectively a health insurer's cell utilisation rate. However, for the purposes of the new calculation, for a given age and gender cell, average cell utilisation across the entire insured population is used instead of a health insurer's individual cell utilisation rate. As noted in the *Guide to Risk Equalisation Scheme, 2003*:[234]

> *"The main disadvantage of incorporating the extent to which an insurer's population uses Healthcare services is that it may result in insurers sharing efficiencies that they achieved in respect of reducing the extent to which their memberships use Healthcare services."*

In their calculations the HIA include a Health Status Weight ("HSW"). The HSW is intended to allow a mix of the two types of calculation described above. The HIA has discretion over the HSW factor; it is currently set at zero, implying that the RE calculations will initially be based on age and gender only, i.e., the 'simple' calculation above. The calculations performed on the health status basis, i.e., using average market cell utilisation, will for the moment have no effect on the overall result. The HIA can only increase the HSW from 0 to a maximum of 0.5 and is required to conduct an investigation beforehand to ensure that differences in costs are due to differences in health status rather than difference in efficiencies.

[233] HIA (2003), *Guide to the Risk Equalisation Scheme, 2003 as prescribed in Statutory Instrument No. 261 of 2003*, p.14.
[234] Ibid.

New Entrants

New entrants are exempt from RE payments to and from the fund for the first three years after they commence business and are only subject to half payments in year four.

Restricted Membership Undertakings

There is an allowance in the Risk Equalisation Scheme, 2003, for restricted membership undertakings to opt out of the RE Scheme if they were registered as health insurance undertakings on May 1st, 2000, and if they were carrying on business in the State before the commencement of section 9 of the Health Insurance (Amendment) Act, 2001, (November 19th, 2001). In order to opt out of the RE Scheme, a restricted membership undertaking had to serve a notice on the Minister stating that it does not wish the RE Scheme to apply to it on or before September 30th, 2003.[235]

[235] HIA (2003), *Guide to the Risk Equalisation Scheme, 2003 as prescribed in Statutory Instrument No. 261 of 2003,* p.11. ESB Staff Medical Provident Fund are the only restricted membership undertaking not to have opted out of the RE Scheme.

APPENDIX 6: RISK EQUALISATION – AN INTERNATIONAL COMPARISON

Introduction

This appendix considers the experiences of some other countries that have a comparable health insurance market to that in Ireland, i.e., markets that incorporate the concept of community rating and that have some class of RE scheme or other risk compensation schemes. While it is difficult to find perfectly comparable markets, a detailed consideration of the growing body of international research and experience in this area can be informative. [236]

The countries selected for consideration below are Australia, the Netherlands and Switzerland. This selection is based on several criteria, including regulatory regimes, the interaction of public and private considerations, different market structures and health insurance market reforms that have been undertaken. This review is not limited to "private" health insurance markets and the reasons for this are discussed below.

The next section provides an overview of different types of RE arrangements and health insurance systems. The following section briefly analyses the experiences of Australia, the Netherlands and Switzerland separately. This analysis will, where possible, focus on the following themes: the rationale for RE; the nature of the RE scheme; types of risk adjusters employed; and the effects that RE schemes can have on competition. The final section attempts to draw some conclusions.

Overview

The practice of RE and reinsurance (or cost reimbursement) started more than thirty years ago in the US in the context of Medicare (publicly provided health insurance for the elderly). In the 1990s RE was implemented in the health insurance markets of many other countries, in particular in Europe. [237]

Countries which have introduced a form of RE or cost reimbursement include, among others, Australia, Canada, New Zealand, Israel, Colombia, the US and in Europe, Belgium, the Czech Republic, Finland, Germany, the Netherlands, Norway, and Switzerland. In general, these countries have introduced some form of risk compensation in order to entrench community rating and open enrolment.

In Ireland, a RE Scheme exists in the 'private' health insurance market. Internationally, various schemes compensating for risks, either in the form of RE or in the form of reimbursement (or reinsurance) schemes, have been introduced in public and/or PHI markets. The following subsections describe the different types of risk compensation schemes and whether they have been introduced in the context of private or public health insurance provision.

Different types of Risk Compensation Schemes

Risk compensation schemes can take different forms. In a RE scheme, the health expenditures of health insurers that have different risk profiles are compared with expenditures that would arise if health insurers had the same risk profile, e.g., the average risk profile of the overall insured population, and are compensated accordingly. Equalisation can be centrally determined in a fund (i.e., the central fund) on the basis of a formula adjusted by predictors of healthcare expenditures (e.g., demographic factors such as age and gender, and/or other health status indicators) and this can be done either prospectively or retrospectively or through a mix of both.

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[236] In general international comparisons are useful but care is needed to ensure that they are undertaken in a meaningful manner. An in-depth review of all the existing schemes, which goes into the merits of the actual different methodologies or RE formulae, is beyond the scope of this report. For a description and comparison of the RE formulae in some countries, see McLeod, Heather and Parkin, Neilm (2001), *Risk Equalisation Methodologies: an International Perspective*, CARE Monograph No. 3, University of Cape Town, South Africa. For an international comparison with a more European focus, see van de Ven et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries*, Health Policy Vol. 65: pp. 75-98.

[237] Editoral; *Risk adjustment in Europe;* Health Policy65 (2003) 1-3.

There are other forms of risk compensation schemes which are, in general, of a simpler form than RE schemes. These schemes provide insurance companies with a form of insurance against possible large losses due to unexpected high claims by their policyholders and, for this reason, are often labelled "reinsurance schemes" (or "reimbursement", "risk sharing", "cost-sharing", "cost-pooling" schemes).[238]

The main difference between a RE scheme and a reinsurance scheme is that the former cannot explain all variations in expected health expenditures across individuals because some variation is inherently random and, therefore, unpredictable. In addition, a RE scheme should not seek to explain all the variation because otherwise it would, in effect, be a reinsurance scheme and there would be no incentive to minimise claims costs.

Reinsurance schemes typically involve some arrangement between health insurers and a central fund. Payments under reinsurance schemes tend to be collected into the central fund through a levy, tax or surcharge applied on premiums paid by the entire insured population (including sometimes policy holders not eligible for the scheme). The following are some examples of reinsurance schemes:[239]

- *Proportional:* The central fund retrospectively reimburses each health insurer a fixed percentage of all its acceptable costs;[240]
- *Outlier:* The central fund retrospectively reimburses each health insurer a certain percentage of the acceptable expenses per enrolee only as far as they are above a certain annual threshold;
- *High-risks:* Each health insurer is allowed, for each contract period, to designate, ex-ante, a specified percentage of its members for whom the central fund retrospectively reimburses all or some acceptable expenses; and,
- *Condition-specific:* The central fund retrospectively compensates the health insurers some prospectively determined payment dependent on the occurrence of certain medical problems.

RE and reinsurance schemes create different incentives for risk selection, efficiency and cost containment. Reinsurance schemes typically create weaker incentives to risk select, seek efficiencies and contain costs than RE schemes. The reason is that reinsurance schemes retrospectively reimburse health insurers for their actual costs. Reinsurance schemes are often used to complement risk equalisation schemes: the former reduces the incentives for risk selection which are not completely neutralised by RE schemes.

Private v. Public Heath Insurance Market

In Ireland, the RE Scheme applies to the 'private' health insurance market. As recognised by the OECD, the distinction between private and public health insurance markets is not clear-cut and varies according to criteria chosen. For example:[241]

- *Nature of the Providers*: One possible criterion is the nature of the health insurance providers. Based on this criterion, there are private markets that are dominated by government-owned health insurers like in Australia and Ireland and, conversely, there exist countries where private institutions can administer and provide public health cover, e.g., the Netherlands (until 2006).

[238] For the remainder of this Section, the term "reinsurance" refers to all schemes that are not RE Schemes.
[239] van de Ven et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries*, Health Policy Vol. 65: pp. 75-98.
[240] That is, the cost of the set of services and intensity of treatment that it is decided to be acceptable for subsidisation.
[241] OECD (2004), *Private Health Insurance in OECD Countries*, p. 29, Box 2.1.

- *Nature of Regulation*: There are countries where private markets are regulated in a manner very similar to public heath insurance, e.g., Australia, Ireland and Switzerland. Switzerland is an extreme example where there is no public health insurance but individuals are required to purchase basic heath insurance from private health insurers at community-rated premiums. Since 2006 the Netherlands have introduced a universal basic health insurance system where public and private carriers can compete against each other.
- *Source of Financing*: The source of financing of health insurance can also be used as a criterion for distinguishing public and private systems. In some public systems, the risk equalisation fund is funded by 'social contributions', which are calculated as share of income in the form of a payroll tax contributed to by employers, employees or both. The Dutch public system contributions consist of a combination of an income-dependent contribution paid by employers and employees that is uniform for all health insurers and a community rated premium, which differs between health insurers and is financed only by the insured.[242]
- *Voluntary v. Mandatory Health Insurance*: In countries with a universal health insurance package that can be offered by private and/or public health insurers (non-profit and for-profit), e.g., the Netherlands since January 2006 and Switzerland (only non-profit), the distinction between social and private health plans no longer makes sense.

It follows that, on the one hand, a distinction based on one criterion only, e.g., the nature of the providers, can considerably restrict the scope for comparison of RE schemes across countries. On the other hand, one can also question the 'private' nature of the Irish health insurance market. For instance, the market structure, public policy context and regulatory set-up of the Irish PHI appear to have much in common with 'public' health insurance markets.

Selecting Comparable Countries

The table in Annex 1 presents an overview of RE and reinsurance schemes that are used in Australia, Belgium, Germany, Israel, the Netherlands and Switzerland. Australia is often citied as the country that is most similar to the Irish system and this is why we have chosen it for further discussion. The remainder have been chosen for consideration for analysis as these countries were part of a comparative study undertaken by the Risk Adjustment Network (RAN).[243] From Annex 1 it emerges that Australia, the Netherlands and Switzerland can be identified as the most comparable to Ireland for the reasons described below.[244]

First, RE schemes have been employed in the public health insurance markets of, for instance, Belgium, Germany, Israel and the Netherlands (before 2006). Since January 2006, the Dutch system has been extensively reformed. In particular, the distinction between 'private' and 'public' has been abolished and a universal basic health cover has been introduced to which the pre-existing RE scheme has been extended.

[242] This feature has been extended to the new system put into effect since January 2006.
[243] The risk-equalisation systems implemented in public health insurance markets of five European countries (Belgium, Germany, Israel, the Netherlands and Switzerland) have been comparatively studied and monitored by the 'Risk Adjustment Network' (RAN); the RAN is made up of some university research centres around Europe. RAN published their comparative analysis in the journal *Health Policy* (vol. 65, 2003). In particular, see the article of van de Ven et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries*, Health Policy Vol. 65: pp, 75-98. The same volume (65) also reports specific articles for each country. The comparative study is based on the year 2000 but an update of the comparative study by the same authors is available by the Erasmus University, Rotterdam.
[244] In the US, some states have compulsory or voluntary RE or reimbursement schemes for high-risk. These countries are not included in our overview and could be the subject of further research.

Second, countries where the RE scheme is funded through premium revenue are more comparable to the Irish system. This feature is important when looking at the impact of RE on premium or price competition among health insurers. In other countries with a public RE scheme, social contributions are often too small to be of any relevance to consumer switching behaviour or health insurers' incentive to risk select. The systems in Australia and Switzerland are funded through premium revenue. The Netherlands is an interesting case as the RE scheme is half funded through social contributions and half through community rated premiums paid by consumers.

Third, Australia is often cited as having the closest comparable system to that in Ireland. As in Ireland, the Australian system applies to the private market, where the state-owned health insurer has a substantial market share. However, the Australian scheme is better characterised as a scheme incorporating reinsurance for high-risk; this scheme has been criticised and is now under review.[245]

Finally, Switzerland is unique in the sense that there is a PHI market where all consumers are required to buy basic health cover for which a RE scheme exists. Therefore, the main difference with Ireland is that the purchase of health insurance is compulsory, at least for basic cover.

The next section provides a more detailed description of the RE schemes operated in these countries, and their impact on competition among health insurers.

Risk Equalisation in Australia, the Netherlands and Switzerland

Australia

The Australian Private Health Insurance Market[246]

PHI, characterised by the principles of community rating and open enrolment, plays a prominent role in the Australian healthcare system. 43 health insurers operate in the Australian PHI market, of which 6 are for-profit. In 2002, the government-owned health insurer, Medibank Private Limited, had a market share of 30% (by earned income). The CR6, the concentration ratio for the top six companies, was 76.7%, while the membership of the top three health insurers was 57% of the privately insured population. Therefore, while the Australian health insurance market is structurally similar to that of Ireland, in that it is relatively concentrated with the state-owned provider having the largest share of the market, it is not ideally comparable. The Irish market is far more concentrated with only three providers and the state-owned provider having the vast majority.

After the introduction of the Medicare (the public health insurance system) in Australia, the level of PHI membership dropped drastically, from 50% in 1984 down to 30% in 1998. Several measures were introduced to halt and reverse this declining trend, including lifetime community rating legislation. As a result of these measures, the proportion of the population holding PHI policies rose to 45% in 2001.

[245] Reimbursement schemes seem to prevail in PHI markets of, for instance, Australia, Germany and the Netherlands until 2006. In these markets, there exist forms of reimbursement for high risks, funded by surcharges on premiums paid by all the insured population. For instance, in the Netherlands until 2006, access to private health cover for high-risk individuals within those not eligible for public cover was facilitated by the creation of the "WTZ scheme", a regulated niche of the Dutch primary private market that provides standardised PHI policies at regulated prices to eligible high-risk individuals. Premiums for WTZ packages are subject to community rating and open enrolment but also to a cap. This cap is above the average premium levels in the PHI market. (Non-WTZ premiums can also consider risk factors.) A pooling scheme for WTZ policies pools costs exceeding WTZ premiums and divides and spreads these costs through surcharges imposed on all privately insured. Also, there is a compensation scheme between public and private insurance where the privately insured used to pay a contribution to compensate for the higher proportion of the elderly in the public insurance market. In the PHI market in Germany, premiums for the standard benefit package are capped to average costs in the public coverage system. Insurers offering the standard package and compulsory long-term care participate in cost-sharing schemes.

[246] For an overview, see Colombo, F. and Tapay, N. (2003), *Private Health Insurance in Australia. A Case Study, OECD Health Working Paper* No. 8. In addition, see the less recent but more comprehensive report of The Industry Commission (1997), *Private Health Insurance*, Report no. 57, Australian Government Publishing Services, Canberra.

The Australian Reinsurance Scheme

Currently, Australia does not have a RE scheme in the PHI market; the system is a cost-based reimbursement or reinsurance scheme. In order to preserve the community rating principle, all health insurers transfer the hospital related expenditures incurred for: (i) the over 65 year olds; and (ii) those in hospital over 35 days, into a common pool (the so-called 'Reinsurance Trust Fund'). Each health insurer receives or pays to the pool the difference between the benefits it paid during the period (four months) and a share of the total benefits paid by all health insurers during the same period.[247] The share is computed as the proportion of health insurer's total members over total members with PHI in the state.[248] The scheme has been the subject of several criticisms, including:

- The two risk adjusters, age and hospitalization, exclude important predictive factors, (e.g., differences in health expenditures between men and women) and consequently have relatively poor predictive power – this leaves health insurers with strong incentives to risk select;
- Health insurers can have incentives to keep the patients more than 35 days, encouraging the use of long duration and more expensive hospital procedures and discouraging the use of preventive care – in this way, incentives to contain costs are weakened;
- Health insurers have no incentives to contain the costs associated with the over 65s and those requiring hospitals stays over 35 days, as they are reimbursed out of the reinsurance pool based on the actual costs incurred from these two groups; and,
- The scheme pools only the hospital costs, discouraging the development and use of out-of-hospital healthcare.

Given the above concerns, there has been a move to introduce a prospective-based RE system in the Australian health insurance markets. An expert group has been appointed to assess alternative RE models. Their report is due to be submitted to the Australian Government by December 2006.

The Netherlands

The Reform of the Dutch Health Insurance Market[249]

In January 2006, a new insurance regime was introduced, abolishing the former distinction between public and private health plans. Now, there exists a new universal mandatory health insurance scheme that permits any non-profit or for-profit health insurer, meeting certain standards, to offer basic health insurance coverage.

Basic health insurance is financed partly by income-related contributions from employers, employees, pensioners and the self-employed and partly by a community-rated premium that is determined by health insurers and paid directly by consumers. Consumers can switch insurers during annual open enrolment periods. The Health Insurance Act (2005) describes the basic cover in terms of functions of care. The insurance contracts can determine who delivers the care, where, and under what conditions; therefore there is ample room for differentiating the insurance plans by health insurers and consumers. Similar to group schemes in Ireland, the Dutch Health Insurance Act makes provisions for health insurers to give a premium rebate to policyholders who belong to a 'group'. It is estimated that 44% of the population has

[247] The benefits refer to those paid to members over 65 years of age or to those with more than 35 days in hospital.

[248] There is a reimbursement scheme within each state of Australia. A Private Health Insurance Administration Council (PHIAC) is responsible for collecting the 'reinsurance levy', through which a redistribution occurs from those health insurers with low proportion of these groups to those with higher proportion of these groups based on total actual hospital costs incurred by these high-cost groups. Each quarter PHIAC calculates each insurer's contribution to the fund and is responsible for monitoring and reporting on the effectiveness of the levy.

[249] For more information on the new health insurance system, see the publication of The Ministry for Health, Welfare and Sport, *Health Insurance in the Netherlands – the new health insurance system from 2006*. Available at http://www.minvws.nl/images/health-insurance-in-nl_tcm11-74566.pdf

such a group contract. [250] There are about 30 health insurance companies operating in the new Dutch health insurance market with half of the market accounted for by four main health insurers.

The Dutch Risk Equalisation Scheme and its Development

An RE scheme was introduced into the public health system in the 1990s, when the Dutch Government allowed consumers free choice of health insurers. The rationale for an RE scheme was to prevent risk selection. Under the new reform, the old RE system has been kept in place and extended to the former private health insurers.

Since its introduction, the Dutch adopted a prospective RE scheme. The prospective payments are set by the government through a so-called 'macro-budget', which is an ex-ante projection of the total expected healthcare expenditure for the coming year. From the macro-budget, the government derives an 'administrative premium', which is supposed to be the break-even price of the average individual health plan. The new reform has modified this prospective system by introducing a mixed (retrospective and prospective) system where prospective expenditures are adjusted for the changes in risk profile of health insurers that occur during the year. Some ex-post reimbursement (or reinsurance) schemes are also in place.

In 1992 the risk adjusters used were age, gender and historical expenditures. Further refinements were introduced in subsequent years. In 1995 'region' and 'disability status' were added. In 1999, 'employment status' and 'social security status' were introduced. However, the major refinement came in 2002 when two morbidity-based adjusters were included in the formula. These adjusters are "Diagnostic Cost Groups" (DCGs), that are computed from hospital diagnoses and "Pharmacy based Cost Groups" (PCGs), computed from outpatient prescription drugs. Although the introduction of health status indicators such as DCGs and PCGs is likely to improve the predictive accuracy of the Dutch risk adjustment mechanism, incentives for risk selection will not be completely neutralized.[251] From 2007, the scheme might be further improved by adding multiple PCGs per person, multiyear DCGs rather than one-year DCGs, indicators of mental health, and indicators of disability and functional restrictions.

Douven (2004) studied the performance of the Dutch RE scheme for the period 1991-2001.[252] At the beginning of the 1990s prospective risk adjustment could explain about 20% of the variation in healthcare expenditure differentials between health insurers, this figure rose to 55% in 2001. The remaining expenditure differentials among health insurers can be structural and/or random. Douven's findings suggest that differences among health insurers are more structural than random. One structural factor may be related to errors in predicting the so-called 'macro budget'.[253]

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[250] van de Ven et al. (2006), *Risk adjustment and risk selection in Europe: six years later*, report Erasmus University Rotterdam, 12 June 2006, submitted for publication in the *Health Policy*.

[251] Empirical literature found that demographic adjusters based on age and gender are able to predict only a maximum of 5 to 7 percent of total expenses while health-based adjusters are able to predict almost 17 percent of total expenses (see van de Ven, van Vliet et al. (2004), *Health-Adjusted Premium Subsidies In The Netherlands*, *Health Affairs* 23: pp. 45-55). It is important to note that only 25 to 30 percent of total expenses can be predicted in prospective risk adjustment models (see van de Ven and Ellis (2000), *Risk Adjustment in competitive health plan markets*. In: Culyer AJ, Newhouse JP (ed), *Handbook of Health Economics.* Amsterdam, Elsevier North Holland, pp. 755-845.). Therefore, 70 to 75 percent of healthcare expenses are random and cannot be predicted – neither by the risk adjustment mechanism nor by information available to insurers. So, this share of total expenses is irrelevant for neutralizing incentives for risk selection.

[252] Douven, R., (2004), *Risk adjustment in the Netherlands: An analysis of insurers' healthcare expenditures*, CPB Discussion Paper 39.

[253] If this projection turns out to be too low ex-post, then it favours insurers with a population of relatively good health risks. During the sample period Douven found evidence that the ex-ante projection set by the government turned out to be structurally too low. Hence, this might explain why some insurers had structurally lower healthcare expenditures.

Premium Competition in the Dutch Health Insurance Market

Douven and Schut (2006) showed that competition did not play a major role in premium setting by health plans during the period 1996-2004.[254] Instead, they observed in most years that the average premium was only somewhat higher than the administrative premium. The legally specified minimum and maximum levels of financial reserves seem to be the most important drivers of health plans pricing behaviour, together with the government forecast of the following year's healthcare expenditure and the adjusted forecast by the health insurers' association. However, this seems to have changed in the first months of 2006 for two main reasons:

- First, the Dutch Government decided to reimburse health insurers for incorrect prediction of the macro budget. This implies that health insurers did not have to take into account the possibility of an incorrect forecast by the government and could use the focal point of the government's administrative premium as a correct starting point for premium setting. Furthermore, the expected payments under the RE scheme are adjusted retrospectively to account for variation in risk profile of health insurers within the year.
- Second, the threat of a substantial loss of customers seems to have had a profound impact on health insurers' pricing behaviour. Under the new reform, enrolees of the former private and public health insurers were invited to choose a new health insurance contract for basic insurance. This has encouraged substantial consumer switching. At the end of February 2006, about 25 percent of the people had switched providers.

Hence, in 2006 for the first time, health insurers started charging lower premiums for individual contracts, than the administrative premium calculated by the government, because they were expecting many customers to reconsider their health plan choice. Whether this is a temporary effect due to the 'shock' associated with the extensive reform of the health insurance sector or whether competition will have a lasting impact on health plan pricing behaviour remains to be seen.[255]

An issue that is becoming increasingly important under the new regime is risk selection. Under the new regime, health insurers have new tools for risk selection. First, health insurers have flexibility in defining the precise entitlements of their insured, which is an effective tool for risk selection.[256] In addition, health insurers are allowed to sell basic health insurance and any other insurance, e.g. supplementary health insurance, sick leave insurance, and car insurance. This kind of scope for product design can be used effectively as a risk selection mechanism. Finally, premium rebates for group contracts can also be an instrument for risk selection.

Switzerland

The Swiss Health Insurance System[257]

Due to market segmentation, as a result of risk selection, a retrospective RE system was introduced in Switzerland in 1993 to support a solidarity rationale. The RE formula takes into account age, gender and region or canton and payments are calculated for every region separately. The health insurance system in Switzerland is separated into basic insurance which provides coverage for 'compulsory benefits' and supplementary voluntary insurance.

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[254] Douven and Schut, (2006), *Health plan pricing behaviour and managed competition*, CPB Discussion Paper 61.

[255] Fierce competition in the individual and group health insurance markets is likely to generate losses that have to be financed out of the financial reserves because insurers cannot compensate the expected losses on group contracts by cross-subsidisation from individual contracts. Consequently, the health insurers association already warned in the press that most health plans would incur substantial losses in 2006, which could result in an 18 percent premium increase in 2007.

[256] Defining the health cover in terms of 'minimum benefits' has the advantage of providing insurers with more flexibility in designing plans that fit consumers' preferences and in introducing product innovation. The drawback is that this flexibility can result in an effective instrument for risk selection. On the other hand, defining health cover as a 'standardised package' reduces the scope for insurers to personalise plans and inhibits product innovation.

[257] Beck, K, Spycher, S, Holly A, Gardiol, L., (2003), *Risk adjustment in Switzerland*, Health Policy 65, pp. 63-74.

In the basic health insurance market, community rating and open enrolment restrictions apply. Health insurers operating on this side of the market must not pursue profits and must maintain statutory reserves. There is premium competition among health insurers which is combined with a retrospective risk equalisation scheme.

In the supplementary health insurance market health insurers may pursue profits and have almost complete freedom in their choice of product offerings and in setting premiums. Most health insurers operate on both the basic and supplementary sides of the market through subsidiary companies.

In 2000, there were 100 health insurers in the Swiss basic health insurance market. Not all of them are operating in each of the 26 regions but on average there are 40-60 health insurers per region. Depending on the region, each health insurer can have a different market position and risk profile. For instance, in 2000 the biggest health insurer had a market share of 22% in the biggest canton (Zurich), while its market share in the biggest French speaking canton (Waadt) was only 11%.[258] Overall, the market share of the four largest health insurers is about 50%.[259]

Competition and Risk Selection in the Swiss Market

To date there has been no competition analysis of the Swiss PHI market that we are aware of. However, analysis of the first 10 years of the RE scheme revealed that risk selection is the most effective strategy to gain market share. Moreover, the expected profits from risk selection are thought to be very high due to the limited effectiveness of the RE scheme (based only on age, gender and region) and the absence of an ex-post reimbursement or reinsurance scheme to complement the imperfections of the RE scheme. In addition, the comprehensive nature of the basic package, which includes expensive care like home healthcare and nursing home care, provides further incentives to risk select.

There is increasing evidence of the various mechanisms that health insurers have for risk selection. Supplementary insurance onto basic insurance is a very powerful tool for risk selection. It is estimated that about 70% of Swiss inhabitants have at least one supplementary insurance contract. The ability to risk select also arises from exclusive contract offers with high deductibles, selective advertising and the selection of the most profitable regions.[260]

There is an ongoing political discussion about including prior hospitalisation and pharmaceutical cost groups as adjusters in the RE scheme and the parliament is considering a reform of the scheme to include these risk adjusters. This is considered to be an important improvement.

The current RE system was envisaged for the period 1995-2005 but in 2004 the national parliament decided to prolong the RE system until 2010. In 1993, the legislator expected that the consumer mobility would eventually lead to a convergence of the risk profiles of the health insurers in such a way that after 13 years the RE scheme would no longer be necessary.[261] However, this convergence of risk profiles did not materialise even when the Swiss government attempted to facilitate consumer switching.[262]

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[258] Ibid. p. 66.

[259] van de Ven et al. (2006), *Risk adjustment and risk selection in Europe: six years later*, report Erasmus University Rotterdam, 12 June 2006, submitted for publication in the Health Policy.

[260] Insurers can enter into the market in new regions, especially those with higher proportion of young people (and, typically, more keen to move) and establish themselves on a cheap level. Furthermore, insurers having a high proportion of old enrolees can exit the market in a canton and hand over its insured to other companies operating in the canton.

[261] In the case of no RE, even if consumer mobility would perfectly equalise the risk profile of all insurers, the incentives for risk selection will continue to exist.

[262] For instance, on several occasions the Swiss government provided all households with information about possibilities for changing insurance providers and published an overview of premiums (hard copy and internet). Low mobility was probably due, among other things, to the fact that many insured people did not want to change their basic insurance because the supplementary insurance with the new insurers would have cost a lot more. (Legally, however, basic and supplementary cover can be purchased from two different companies). Furthermore, mobility has not increased substantially even in the presence of big differences in premiums (69% in the canton of Zurich in 2000).

Conclusion

In light of this limited review of international experience, it is possible to draw some useful conclusions. First, economic research suggests that the most efficient strategy to avoid risk selection is a 'good' RE scheme. A RE scheme, however, cannot explain all variations in expected health expenditures across individuals because some variation is inherently random and, therefore, unpredictable. In addition, a RE scheme should not seek to explain all the variation because otherwise it would, in effect, be a cost reimbursement or reinsurance scheme and there would be no incentive to minimise claims costs.

Second, experience in the Netherlands and Switzerland suggests that RE schemes based on demographic factors only are inadequate for predicting health expenditures. Since 2002, the Dutch scheme has employed health status indicators in the RE formulae. According to economic studies (and also the US experience), this move is expected to increase the accuracy of the scheme and, therefore, to reduce the incentives for risk selection. However, such schemes tend to be highly complicated to manage and require the use of extensive data.

Third, among health status adjusters, those based on diagnostic information are increasingly used in countries with more advanced RE schemes. However, whether the inclusion of these kinds of risk adjustors will entirely eliminate risk selection remains to be seen.

Fourth, RE schemes can be complemented by reinsurance schemes (often limited to the costs of high-risk and/or old persons) as they can help reduce incentives for risk selection that remain in the presence of RE. However, reinsurance schemes tend to reduce health insurers' incentives for efficiency and cost containment. This is the case in Australia, where reform is in progress that aims to replace the pure reinsurance scheme with a RE scheme. In Germany, an expert group advised the Government to replace the current system with a mixture of a retrospective and prospective model, to make a trade off between risk selection and efficiency.[263]

Finally, none of the countries chosen for analysis above have health insurers with comparable market share to that of Vhi Healthcare or similar problems in terms of encouraging competition in their PHI markets. In Switzerland and the Netherlands, the top four health insurers account for approximately 50% of the market, while in Australia the top 6 health insurers account for 76.7%. This is in contrast to Ireland where the largest health insurer, Vhi Healthcare, has approximately 75% of the market.

[263] IGES/ Lauterbach/ Wasem (2004), *Klassifikationsmodelle für Versicherte im Risikostrukturausgleich. Untersuchung zur Auswahl geeigneter Gruppenbildungen, Gewichtungsfaktoren und Klassifikationsmerkmale für einen direkt morbiditätsorientierten Risikostrukturausgleich in der gesetzlichen Krankenversicherung*.

Annex 1: Overview of RE Scheme in Selected Countries (Source(s): van de Ven et al., (2003) and (2006)

	Australia	Belgium	Germany	Ireland	Israel	Netherlands	Switzer - land
Is RE scheme applied: public or private health insurance market?	No RE scheme	Yes, public	Yes, public	Yes, private	Yes, public	Before 2006: public After 2006: there is no longer distinction between private and public	Yes, private
Are there reinsurance schemes in public or private health insurance market	Private	Public, in combination with RES	Public: introduced in 2002	No	Public	Until 2006 in private; Since 2006: in the market for 'basic' cover	No
Community rating premiums or income-related contributions?	Community rating premiums	Both	Income-related contributions	Community rating premiums	Income-related contributions	Both	Community rating premiums
RE scheme: Prospective or Retrospective ?	Proposal to set up a prospective RES	Retrospective	Retrospective Proposal to introduce a mixed scheme	Retrospective	Prospective	Before 2006: prospective Since 2006: mixed	Retrospective
Risk adjusters include…	Age and hospitali-sation	• Age/gender • Disability • Income • Employment status • Mortality • Family composition • Social status • Urbanization • Diagnosis of invalidity • Eligibility of social exemption • Chronic illness	• Age/gender • Disability • Entitlement for sick leave payments • Income	Age and gender	age	• Age/gender • Pharmacy-based Cost Groups • Diagnostic Cost Groups	• Age/gender • Region

APPENDIX 7: LIST OF SUBMISSIONS

The Financial Regulator

Mr. Séan Hennessy

Dr. Séan Barrett, Trinity College Dublin

Harlequin Healthcare

Westfield Health

International Investment and Underwriting (IIU)

Vhi Healthcare

Cornmarket Group

Mr. John Maher, Waterford Institute of Technology

Dr. Bryan Kenny, Consultant Radiologist

Goodbody Economic Consultants

Dr. James Sheehan

Mr. Joseph Sheehan

Prof. Patrick McNutt on behalf of Adare Hospital and Clinic

Dillon Eustace Solicitors

MRI Ireland

ICTU

Amicus Trade Union

The National Council on Ageing and Older People

Prof. Ray Kinsella, University College Dublin

VIVAS Health

Mr. Colm McCarthy, on behalf of Vhi Healthcare

The Society of Actuaries in Ireland

The National Consumer Agency

The Irish Medical Organisation

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