COMPETITION AUTHORITY CONSULTATION ON GUIDANCE IN RESPECT OF COLLECTIVE NEGOTIATIONS RELATING TO THE SETTING OF MEDICAL FEES

March 2006

Introduction

VIVAS Insurance Limited trading as VIVAS Health welcomes the opportunity to participate in this consultation process. VIVAS Health welcomes any provision that will enhance consumer benefits, protection, fosters competition and promotes a safe and quality assured outcome.

However, the Consultation document produced by the Authority fails to recognise two issues which have a serious impact on medical fees:

- The health insurance regulatory regime;
- The massive dominance of the state owned VHI.

Specific elements of the nature of health insurance regulation must be considered by the Authority when implementing any new Guidance. VIVAS Health as the newest entrant to the health insurance market in Ireland would also severely disagree with some of the propositions put forward by the Authority about the market and the opportunities for new entrants.

A number of the questions posed by the Authority in the course of its consultation, relating to how medical practitioners organise themselves and/or dealing with medical processes will not be dealt with by VIVAS Health. VIVAS Health does not believe it is appropriate or proper for it to deal with these matters and has reservations about the leading nature of the questions posed.

VIVAS Health shall set out its views vis-à-vis:

1. The health insurance regulatory regime and its impact on medical fees
2. The massive dominance of the state owned VHI and its impact on medical fees
3. Commentary on certain assertions put forward by the Authority vis-à-vis new entrants and the operation of the current market.

VIVAS Health shall also answer the questions posed by the Authority to the extent applicable to the nature of its business.

1. The health insurance regulatory regime and its impact on medical fees

When considering the issue of medical fees and the present situation, the historical context must be viewed. VHI was until 1996 a monopoly player within the health insurance market. Therefore, the only two purchasers of medical practitioner services were, the public health system and the VHI – which in effect were both emanations of the State. As the VHI had a near monopoly on health insurance it could in effect set prices for procedures as it wished and should a medical practitioner decide not to agree to these fees in effect they would lose all insured private patients and their practice could suffer greatly. It is not unusual therefore, in the face of such a monopoly (the VHI) for medical practitioners to react accordingly and to group under their industry association to heighten their negotiating power. Similarly, private hospitals have had little negotiating power against the VHI due to their near total dependence in the past on coverage by the VHI for their viability. This is evidenced by the VHI disaster recovery plan in the late 1980's where VHI paid much lower rates to private hospitals in order to stabilize its financial position, leading to an abuse of dominance action in Deane v. VHI[1].

The Health Insurance Act, 1994 (hereinafter "the Act") was put in place when the health insurance market was opened to competition by virtue of the Third Non-Life Directive[2]. The Act enshrined into legislation what had previously been the practise of VHI. In addition, S.I. 83/1996 Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 (hereinafter "the Minimum Benefit Regulations) primarily encompasses what used to be the benefits within VHI Plan A. The extent therefore of the regulatory capture by the VHI cannot be underestimated.

The Minimum Benefit Regulations act as a price setting mechanism and in effect restrict competition both from a pricing and a product perspective. As every health insurance product must contain minimum benefits (e.g. all males purchase maternity benefits), the scope for an insurer to create a specific product around a preferred provider network is impossible. The system must still be capable of providing the minimum benefit should the consumer choose to opt out of the network. In addition, the pricing of health insurance products must factor minimum benefit payments.

The risk equalization scheme (RES) which has been implemented by the Minister for Health and Children must also be considered by the Authority and the impact this will have on the

[1] High Court Judgment of 22 April 1993, by Keane J. and Supreme Court Judgment of 28 July 1994.
[2] Council Directive No. 92/49/EEC

market. Risk equalization payments shall mean a convergence in prices for all competitors of VHI (in effect a harmonization and price setting of health insurance premiums by the Health Insurance Authority). The capability therefore of competitors of the state owned VHI to a perceived consumer reduction in services by entering into preferred provider networks while paying the same premium as VHI is not feasible. In addition, with the increased likelihood of VHI gaining further market share with the introduction of risk equalization and a loss in competitive pressure[3] it shall be in a position to further leverage its dominance.

[3] As stated by the Staff Report of the Health Insurance Authority dated October 2005.

2. The massive dominance of the state owned VHI and its impact on medical fees

The VHI presently holds in excess of 76% of the health insurance market in Ireland. VHI is the largest single insurance undertaking within Ireland with in excess of 1.56 million members. In addition, VHI is subject to numerous economic and regulatory advantages provided by the State which its competitors cannot avail of. These economic and regulatory advantages include *inter alia*:

- The VHI has been granted a massive subsidy by the Minister for Health and Children in the form of risk equalisation which will have the effect of:
    i. Reducing any competitive pressure it may face;
    ii. Reducing the market share of its competitors while increasing its own;
    iii. Subsidising its own inefficiencies;
    iv. Price fixing health insurance premiums through convergence;
    v. Increasing its own profit margin while eliminating its competitors profits;
    vi. Foreclosing the market (and possibly expelling present players) to any new entrants.
- No requirement to carry any solvency. This in effect provides VHI with free capital that it can use as it wishes – its competitors by contrast must set aside 40% of their capital as reserves. The VHI has been permitted by the State to use these reserves to engage in two below cost premium increases[4].
- The VHI is exempt from all the Financial Regulator's consumer and prudential regulation – hence providing VHI with a much lower cost of compliance.
- The VHI has been granted an authorisation by the State to act as an intermediary through the same statutory body as is purporting to act as an insurance undertaking. No other insurance undertaking within the European Union can do this simultaneously and using its economies of scale in one market to fund its entrance into a secondary market.
- The VHI has been permitted by the State to leverage its dominant position within the health insurance market into a number of secondary financial services markets, in particular that of travel insurance by tying both products.

[4] See VHI Press Release dated 29 April 2004 and Letter by VHI to the Minister for Health and Children dated 4 July 2005.

In one year VHI has gained 26% market share in the multi-trip travel insurance market[5].

- The VHI has been permitted by the State to vertically integrate and become a health care provider (through the opening of the Swift care clinic) – no other insurance undertaking within the European Union could replicate the VHI model. How and to what extent the level of cross-subsidisation by the VHI of this clinic is unknown.

It is apparent from the above that the State is heavily invested in the protection and facilitation of the VHI in its consolidation of market share. The ramifications of any increase in market dominance and the possible exit of other market competitors is of critical importance which the Authority must consider when looking at the criteria for the setting of medical fees.

The present dominance of VHI affect the market in a following ways:

- The VHI holds all the bargaining power when negotiating with hospitals and medical practitioners. As VHI is their primary supplier of business, hospital and medical practitioners are very reluctant to fall out of contract. It has also been the experience of VIVAS Health when negotiating with these parties that they are extremely reluctant to give any insurer better rates than VHI as should VHI discover this then they would force the private hospital or medical practitioner to also lower their rates.
- VHI Cash Limits – VHI imposes cash limits upon certain hospitals whereby the VHI provides the hospital with a certain fund for the year, once this fund is exceed then one of two scenarios occur. Firstly, the hospital receives no fee whatsoever for any further VHI members within its hospital or secondly, VHI pays a much reduced rate for any subsequent members treated. This has a knock-on effect to medical fees as hospitals are encouraged to limit capacity to avoid exceeding the cash limit and incur loss.
- Following research conduct by VIVAS Health last year with a number of consultants. It was made very clear that they considered the VHI fee rate as the minimum rate that they would accept from any insurer. It was stated that while they would agree higher rates for the same procedures with VIVAS Health they could not and would not agree a lower fee rate as they would fear that VHI would force them to also drop their rates. Due to the dominant position of VHI they could not afford to fall out of participation with VHI for setting this subsequent lower rate.

[5] VHI Press Release dated 14 February 2005.

- VHI as a former monopoly and with a huge dominance influences and sets the standards for price, extent of cover and benefits within health insurance. VHI as a state owned statutory body is perceived to be the safe option that will cover all procedures required. Hence, consumers are influenced and have come to expect (from competitors) that they must at least match the VHI product offering. Any suggestion therefore that preferred provider networks could be entered into by new entrants is nonsensical and is not sustained by consumer research. Similarly, a limitation on the number of consultants participating with a new undertaking is viewed with suspicion by consumers. Consumers have also come to expect that their shall be direct settlement – if the VHI is direct settling with most consultants and hospitals but a new entrant is only offering a limited range the market will not accept such a restriction. As stated above with the payment of the risk equalization subsidy which will price fix all premiums it is highly unlikely that consumers will pay the same for what they perceive to be less hospitals and consultants.

The lack of regulation to which VHI is subject also has ramifications for the medical providers. It has been known that VHI in the passed acted as guarantor for loan for private hospitals in exchange for priorities on sale, and has made capital grants available to private hospitals. It was reported that VHI acted as a guarantor for Mount Carmel Hospital in exchange for first rights to purchase the hospital. This huge financial and economic interference (which a properly regulated insurance company could not use) acts as a further tie and distortion of the relationship between the VHI as an insurer and the hospital providers. In addition, VHI stated public policy has been that there is no need for any further private beds, as such has refused to cover any new private medical facilities and has in the past acted as a capacity blocker. This policy has stifled the natural evolution of private medical facilities in Ireland, both for hospitals and private consultant and has resulted in many of the problems that are now present in the Irish health care system.

Any comparisons made therefore with either the U.K. market or the U.S. market must be viewed against the level and extent of competition within their health insurance markets. The United Kingdom has in excess of 20 health insurance companies, and the company with the highest market share has approximately 40%. In the United States the number of insurers is much greater and no single insurer has the dominance of VHI.

The Incidence Of Medical Partnerships

Question 1: How widespread are partnerships amongst doctors satisfying all fo the criteria listed in paragraphs 2.11 and 2.12 in Ireland? Roughly what percentage of (i) consultants and (ii) GPs are engaged in partnerships of this kind? How significant a percentage of (i) consultants and (ii) GPs are involved in any single partnership?
No Comment.

Question 2: How widespread are partnerships amongst doctors just sharing offices and overheads but not sharing commercial risks or profits in Ireland? Roughly what percentage of (i) consultants and (ii) GPs are engaged in "administrative" partnerships of this kind?
No Comment – irrelevant and largely hindered by VHI dominance.

Question 3: Are partnerships more prevalent amongst certain specialities of consultants in private practice? If so, what specialities and why?
No Comment.

Question 4: Do (or could) partnerships exist amongst consultants of differing specialities? If so, please give specific examples.
No Comment – irrelevant and largely hindered by VHI dominance.

Question 5: Are partnerships amongst doctors in general reduced to written agreements or do they also incorporate other types of co-operation? Please explain.
No Comment.

Question 6: Are partnerships amongst doctors in general formed with the express intent of fixing prices or is the setting of prices generally necessary to realise efficiencies arising from such partnerships? Please explain.
No Comment. VIVAS Health does not believe it appropriate to make any assumptions in relation to the rationale behind which doctors may form partnerships. In particular, where a judgment must be made on a possible criminal activity.

Medical Ethics and Fee Setting

Question 7: Are there circumstances where a body formed to promote medical professional standards and ethics must discuss or recommend fees, quantity of services

offered or other commercial terms to its members as part of this mandate? If so, please give specific examples.

No comment.

Question 8: Please identify instances when the prohibited fee setting mechanisms identified in paragraphs 3.1 to 3.7 in your view satisfy the provisions of Section 4(5) of the Competition Act.

No comment.

Question 9: Please set out how these practices satisfy each of the conditions of Section 4(5) of the Competition Act.

No comment.

Fee setting by the payor

Question 10: Is fee setting by the payor a feasible model for the determination of consultants fees in Ireland? If not, what steps can be taken to improve its operation to make it more effective?

Fee setting by the payor must be assessed against the composition of the market. The consequences of a 76% single market player and only two other regulated Health Insurance competitors within a market must be investigated when putting forward any fee model. Informal research carried out by VIVAS Health suggested that medical practitioners view the state owned undertaking fees as the minimum fee they will accept from any insurer in the market. Lower fees will result in medical practitioners falling out of participation with other insurers as there is a lesser dependency on their business. The fear from medical practitioners being that if lower fees are accepted that this will only result in the dominant undertaking using this to lower their fees in the future.

In order to gain the maximum efficiency from this model a more competitive health insurance market is required. The dominance of the State undertaking must be reduced, hence reducing the dependence by medical practitioners and hospitals on one single commercial supplier. With a number of health insurers within the market, with a more equal distribution of market

shares a payor setting model will operate more effectively and will result in more competition in the setting of fees.

Question 11: Are there any valid reasons for a representative organisation such as the IHCA to play a role in fee setting in this model in such a way that does not breach the Competition Act? If so, please explain what role the representative organisation would play in this model and why this does not breach the Competition Act.

The historical background to this alleged practise must be looked at. At a time where a monopoly was in operation in health insurance and a massive dominant player is present, it is not unusual that in an effort to redress the huge imbalance in bargaining power the IHCA should have intervened in the setting of fees.

Question 12: What efficiencies, if any, are forgone by the payor setting the fees compared to the payor entering into collective negotiations with a representative body of consultants?

The payor setting the fee model in the current market can only ever favour the dominant state undertaking. It is likely that competing insurers will be forced to push up their costs, resulting in further economic advantage being provided to the State undertaking. At best competing insurers will pay an amount similar to the state enterprise.

<u>The messenger model</u>

Question 13: Would the messenger model (or some variation) work in Ireland to cover negotiations between private health insurers and consultants? If not, why not?

There are presently in excess of 2400 Consultants in Ireland and an even greater number of G.P's. Market practise has been to ensure coverage of as many if not all Consultants. It is not believed that a messenger model is viable with such a number of medical practitioners. In addition, due to the size of the VHI, the preference for medical practitioners will always be to negotiate firstly with the State undertaking and then with other insurers. Medical practitioners will more readily agree to fall out of participation with other insurers due to the lack of patient volumes which they will drive. This will have a direct commercial impact on these insurers as patients expect not to have to balance bill and will be more inclined to revert back to the dominant state undertaking. It is to be expected that the dominant state undertaking will

capitalise on the fact that other insurers do not have the same level of coverage or full settlement as it does.

Question 14: Could a messenger model be used in negotiations between doctors and other payors? If not, why not?

No Comment.

Question 15: Is a messenger model necessary to achieve efficiencies in contracting between doctors and payors? If so, please specify the efficiencies achieved.

The only entity likely to achieve or gain efficiencies would be the dominant state undertaking.

Question 16: If a messenger model could work in Ireland, who should be the messenger? Is it appropriate for representative bodies or specialty groups to be permitted to act as messenger or would such bodies be conflicted? What measures, if any, can be taken to prevent conflicts of interest arising?

No comment.

Question 17: Who should engage and pay the messenger?

Any costs to the insurer will be more acutely borne by new entrants and smaller insurers against the state undertaking.

<u>Feasibility and extent of purchasing bundled hospital/consultant services</u>

Question 18: Why do health insurers infrequently purchase services as a bundle including consultant's fees from hospitals?

Private Hospitals do not employ consultants (with the exception of Private Psychiatric hospitals) and as such cannot negotiate bundled hospital services without consultant consent. It is understood that Consultants have been reticent to enter into bundled service arrangements with hospitals as it could interfer with their status as merely acting on a consultancy basis (for tax purposes) and in addition it would fetter their right to freely negotiate with insurers. There is also a fear that the cash limits imposed by the State insurer would also apply to medical services and as such Consultants could see themselves in a situation where they were

being paid either greatly reduced or no fee for a procedure. As previously stated above the capacity to negotiate such bundled services would always be dominated by the State undertaking.

VIVAS Health is supportive of the idea of bundled services. It is a worthwhile proposal in that insurers, consultants and hospitals can work together to promote efficient, safe and quality patient treatment protocols and outcomes.

Question 19: Could direct contracting with hospitals on the basis that the hospitals discharge the consultant's fees provide an alternative to the present Schedule of Benefits? If not, why not?

The Minimum Benefits Regulation place a legal obligation on the insurer (rather than the hospital) to ensure payment of medical benefits. In addition, agreement by consultants with the hospital would be required to enable the hospital to contract on their behalf and to collect fees on their behalf. It is understood that no such agreements are presently in place between hospitals and consultants.

Other permitted fee setting mechanisms?

Question 20: Are there other feasible fee setting mechanism to those outlined in section 4 of the Consultation Document that could be used to set fees but are consistent with competition law?

A number of solutions would be possible once the dominance of the VHI were greatly reduced and the health insurance market in Ireland was acting on a more competitive commercial basis.

Rotas

Question 21: Do you agree with the above characterisation of medical rotas? If not, please furnish your views?

No comment.

Question 22: Are there circumstances which require doctors involved in a rota to agree fees between them? If so, why is such agreement on prices indispensable to the primary

object of the rota which is to achieve sustainable working hours and facilitate continuous access to health care?

No comment.

Question 23: Under what circumstances, if any, can doctors collectively decide to withdraw from a rota?

No comment.

Other permitted practices?

Question 24: Are there other important and widespread collective practices among doctors that are not likely to come within the scope of Section 4(1) of the Competition Act? Please give reasons for your views?

Issues such as new methods of treatment, new procedures, new technologies, altered methods of patient treatment will all require significant interaction between doctors (groups of doctors) and insurers.

Participation rates and balance billing

Question 25: Is the present system of striving for full-cover schemes and using balanced billing arrangements unduly restrictive on competition and are they indispensable to producing the Schedule of Benefits? If not, why?

Full cover schemes and direct settlement are established market practise. Direct settlement in particular is of huge advantage to the consumer who does not have to pay possibly very large claims directly and then seek reimbursement from the insurer. Direct settlement is also of benefit to the insurer in that all claims are presented on a regular basis from hospitals including all consultant invoices.

The assertion put forward by the Authority that new entrants do not have to offer full-cover schemes or could engage in preferred provider networks and gain cheaper rates is not a valid proposition and would be contrary to consumer research conducted by VIVAS Health. As previously stated health insurance consumers expect as a minimum the level of coverage they receive from the state insurer. In addition, consumers value direct settlement which provides consumers with piece of mind.

Preferred provider networks at present with a dominant undertaking cannot occur from both an insurance and Consultant perspective. VHI as the dominant undertaking would be in a prime position to select the top consultants in any one field or any one hospital and tie them exclusively to VHI e.g. locking out competitors from a specific high profile private hospital by entering preferred provider contracts with all the Consultants operating in these hospitals. As VHI drive the majority of patient volume for most Consultants in Ireland, it is unlikely that any Consultant would refuse to enter into a preferred relationship with VHI. The impact on other Consultants would mean a massive reduction in their practise as no VHI members would be driven through their rooms. Even if both VIVAS Health and/or BUPA were to cover these Consultants it could not match the 80% short fall in volumes.

The VHI through its size and manipulation of preferred provider networks could therefore cause sever economic problems to private medical facilities, Consultants and its competitors.

Question 26: In how many/what proportion of cases are patients referred to consultants through A&E? Can A&E be used as a gatekeeper in some circumstances?
Not known.

Question 27: How feasible is it for GP's to have a private health insurer's list of preferred consultants and to select a consultant on behalf of their patients from that list? Can GP's be used as gatekeepers in some circumstances?

As stated above VIVAS Health does not believe it is feasible in light of the present market conditions for preferred consultant networks. However, if the market were to change and consumer expectations vis-à-vis their health insurance needs and providers then it would be feasible for GP's to have the list of preferred providers.

Question 28: How feasible is it for consumers/patients to have their private health insurer's list of preferred consultants and to select a consultant from that list?

The feasibility or otherwise of such a suggestion will depend on the education of the public from a health care perspective and vis-à-vis their own needs. The extent to which a consumer may choose a Consultant without medical advice is also questioned. While certain Consultants may be qualified to do the same procedure, some would have more experience in a sub-specialty within a medical discipline or have completed extensive research on specialist

medical issues than others. How a consumer will be able to tailor their own medical condition to the medical expertise of the Consultant will then be of consequence.

Question 29: What are the main advantages/disadvantage of having selective networks of doctors from the point of view of the payor and the consumer/patient?

In a market with a number of properly regulated insurers efficiencies can be gained through selective networks of doctors. If consumers can be educated to understand that selective networks of doctors could work in their favour, either through cheaper insurance costs or quicker supply of services it would be seen as beneficial.

Question 30: What factors are inhibiting selective networks from emerging in Ireland? What measures could be taken to address these factors?

As previously stated, the size of VHI, the consumers perspective of the health insurance market and the necessity to price for all facilities because of the Minimum Benefit regulation are all inhibiting selective networks from emerging. In particular, the need to offer full coverage to all public hospitals (the prices of which are set by the Minister for Health and Children) fetters any possible selective network. As all consumers are fully covered under the public system for public hospital coverage there should be no requirement for private insurers to also offer coverage (unless they so choose). Such of course of action would result in less funding going to the public hospitals.

Question 31: How necessary is freedom of choice of consultant? While in certain instances the number of specialists may be limited, for many standard procedures a commensurate level of skill is attained by many consultant doctors.

The market has developed along these lines with consumer expectation that they can see any consultant they wish.

Question 32: Is an increase in consultant numbers a pre-requisite to selective providers' networks emerging?

Yes, an increase in both consultants and private medical facilities is required to have selective provider networks. This increase would have to be in the context of an addition to the numbers of health insurers and a reduction in VHI dominance.

Codes and Descriptions

Question 33: Can discussions on codes and descriptions of procedures (i) amongst consultants and (ii) between speciality groups and private health insurers occur without requiring discussions on fees or other commercial terms and conditions? Please explain.

This can occur without discussions on commercial terms. However, further information will be required by the insurer vis-à-vis types of new treatments, drugs costs, length of stays etc…in order for the insurer to be able to decide on whether it will cover a certain treatment and the costs it will need to factor into its premium pricing.

Question 34: If you answer yes to the above question, please outline how this separation works in practise? What precautions can be put in place to ensure that such discussions do not breach the Competition Act?

No comment.

Question 35: If your answer is no, please outline why this is not possible? At what point would discussions on codes and descriptions for procedures directly or indirectly impact on price or other commercial terms?

No comment.

Ground rules for consultant services

Question 36: Do you believe that discussions on Ground Rules (i) amongst consultants and (ii) between speciality groups and private health insurers can take place without requiring discussions on fees or other commercial terms and without limiting innovation and choice in such services?

No comment.

Question 37: If you answer yes to the above question, please outline how this occurs in practice? What precautions can be put in place to ensure that such discussions do not breach the Competition Act?

No comment.

Question 38: If not, please outline why this is not possible? At what point would discussions on Ground Rules directly or indirectly impact on price or other commercial terms or on innovation and consumer choice?

No comment.

Question 39: To what extent do discussions on Ground Rules determine treatment volumes by consultants?

No comment.

Other permitted practices under the Schedule of Benefits?

Question 40: Are there other discussions that typically take place between consultants and private health insurers in the settling of the Schedule of Benefits, which on the fact of it do not impact on fees or other terms and conditions of trade and are thus unlikely to raise issues under the Competition Acts?

Discussions with individual consultants and/or a team of medical advisors can occur vis-à-vis new and emerging treatments and the likely costs. Insurers must be able to access expert medical opinion for a group of advisors on what is occurring the various medical fields and the likely cost impact. An insurer cannot be expected to come to a reasoned decision on new treatments without first investigating and gathering details on how best to price these treatments, based on cost inputs, patient safety and expected quality of outcome.