

# **Irish Congress of Trade Unions**

## **Submission to the Competition Authority / Health Insurance Authority Study on Competition in the Private Health Insurance (PHI) Market**

11 April 2006

## Introduction

Congress welcomes the opportunity to submit our views to the Competition Authority / Health Insurance Authority on their forthcoming study of the effectiveness of the Private Health Insurance (PHI) market. The Irish Congress of Trade Unions represents the interests of nearly 600,000 workers in the Republic of Ireland. The growth of Private Health Insurance has been greatly assisted by the design and development of workplace Health Insurance Schemes which are now commonplace and a feature of many remuneration packages offered employees.

Congress has been gravely concerned in recent years about the nature of the developments and debate emerging through the opening of the Health Insurance market in accordance with the EU Directive, **in particular,**

- (i) the apparent targeting of younger age groups from new entrants/insurers and subsequent exposure of a skewed client grouping among insurers,
- (ii) the partial implementation of regulatory mechanisms and reluctance (up to recently) to introduce the recognised mechanism to give practical application of the principle of *Community Rating* i.e. *Risk Equalisation*, to ensure viable and appropriate coverage of the older age groups
- (iii) the recent court challenge to the *Risk Equalisation* Fund and, by implication, to the principle of *Community Rating* and
- (iv) the impact of unfair competition (in the absence of *Community Rating*) for workers and their families who have subscribed to Private Health Insurance in the absence of a universal affordable Healthcare system for all citizens.

## The development of Private Health Insurance.....Current Situation

It is widely known that 50% of the Irish population pay for Private Health insurance. In their study *The Health Report* (Tussing and Wren 2005) the authors point out that “*two-thirds of the non-medical card population buy private insurance....20% of inpatient beds in public hospitals, 24% of patients who receive elective day treatments and 33% of people who receive elective in-patient treatments in hospital are private.*”

This is a significant market which makes a major contribution to the funding system underpinning our Health Service. People have made this contribution since the 1950s to avail of options in healthcare provision for themselves and their families, within a healthcare system which guarantees universal access **only on a selective** basis i.e. (i) for all the population to A&E services (subject to a low fee), (ii) on an increasingly limited basis to less than a third of

the population who have low levels of earnings/income and (iii) to people aged over seventy years. **It important that this market functions well to protect the investment made by workers and their families on an intergenerational basis, spreading the risk appropriately among the population.**

**Congress endorses the perspectives and comprehensive analysis of the AMICUS/FGS Consulting report<sup>1</sup> which points to the overarching need for stability, including:**

- “The need to keep PHI contributions at an affordable level, or cover will become too expensive for the vast majority of people;
- The need to protect those who have contributed to PHI Schemes throughout a significant portion of their working lives from facing enormous price increases for cover as they reach retirement age and beyond;
- The need to ensure that large number of employees who have traditionally been members of the VHI Schemes are not exposed to any potential failure of the VHI arising from threats to its continued viability caused by unfair market conditions and/or unfair competition.”

Congress believes it is important the effectiveness of competition in this market should not be considered separately to national healthcare policy or the potential / intended role that Private Health Insurance could play in funding healthcare services, within the peculiar mix of public/private funding which operates in Ireland.

Congress has identified a range of concerns with the funding system currently underpinning our Health services<sup>2</sup> which denies access to those service for many people on low incomes; neither covered under the limited access to free healthcare nor in a position to invest in private healthcare.

Recent developments have been little more than corrective in making up lost ground of previous years by extending partial health service cover to a greater number of citizens. The stated Government intention to invest further Private Healthcare, supposedly freeing up publicly funded services is unlikely to be effective where waiting lists are extensive and key aspects of the health services remain in crisis. It is therefore important to develop our current funding system to ensure the principle of equity is placed at the heart of developments, and that we achieve a competition framework which promotes stability and affordable services for all.

---

<sup>1</sup> **Report on Impact of Failure to Commence *Risk Equalisation* Payments in the Private Health Insurance Market in Ireland – AMICUS/FGS Consulting April 2005**

<sup>2</sup> **The Health Agenda - Professor Dale Tussing and Maev Ann Wren, 2005.**

## **Funding the Health Services.....Principles which would underpin Funding System**

The last fundamental review of Health Funding, undertaken in 1989, considered funding issues in the broader context. The *Report of the Commission on Health Funding* argued that our funding system needed to reflect a number of precepts, guiding principles which balanced *efficiency with equity and comprehensiveness*.

Some significant perspectives highlighted in that Report include:

*“Healthcare is regarded as a measure of the equity and efficiency of a society’s social system, its funding has to reconcile these two concerns.*

### ***The basis for choosing a funding model.....***

*....the Commission believes that the sharing of risk must be compulsory since it is unacceptable for healthcare to be denied those who neglect to provide for the contingency of illness.*

*... in addition to the implications for efficiency there are also implications for equity and comprehensiveness contained in the funding model.....*

***The Commission considers two precepts to be fundamental; Firstly, that the necessary health services should be available to all person on the basis of their need for such services and not their ability to pay for them, and, secondly, that the costs of such services should be shared on the principle of proportionately greater contributions from those of greater means.***

*The Commission believes that such principles must be given the greatest practical expression in the provision of health services, since we believe that society holds the value of good health to be antecedent to the effects of other social services”.*

The Commission also referred to the appropriate contribution of the Private Health Insurance to the overall funding of the Health Services and, to the principle of *Community Rating* which involves cross-subsidisation from the younger and healthier members of the community, who over-pay in relation to their risk levels, to the older and less healthy members who under pay. This cross-subsidisation is an important reflection of the principle of solidarity. The opposite of *Community Rating* is risk-rating under which older and ‘riskier’ customers pay higher premiums.

In its treatment of the case for insurance through private schemes the Commission balanced the argument for potential improvements in *efficiency, control of costs and consumer choice* against the criteria of *costs-effectiveness, equity and comprehensiveness*. The Commission drew particular attention to the fact that a system based on private health insurance does not necessarily perform well against the criterion of :

- (i) *cost effectiveness* – the effective control of costs in private healthcare was not supported by evidence,
- (ii) *choice* – in the context of providing a basic level or ‘necessary’ healthcare service there are difficulties with a *consumer* making **informed** decisions about healthcare *wants* and an appropriate *level /range of cover*
- (iii) *comprehensiveness* - that a safety net would also be needed (provided by the State) for those who could not / could not insure themselves or insured themselves at a level below a basic acceptable service or,
- (iv) *equity* – that “*any shift towards risk-rated insurance would involve a significant redistribution of income towards younger age-groups and in general, towards those with a lower likelihood of illness. While the subsidisation of older age-groups by the younger ones under community-rating is sometimes questioned there is a tendency to overlook the fact that this is in fact, a form of compulsory inter-temporal insurance; the younger groups are, effectively, contributing towards the greater likely cost of their own healthcare when older. This form of redistribution spreads over time those costs which fewer individuals might be able to afford if they were less evenly distributed*”.

Finally, the Commission believed that “*one of the principle disadvantages of the competitive insurance approach is that it would be extremely difficult to enforce Community-rating by competing insurers. In these circumstances older age groups and poor-risk categories could be left without insurance cover except at prohibitive rates*”.

In fact, the Commission report doubles as a foresight exercise. In the intervening period, the National Health Strategy *Quality and Fairness; A Health Service for You* was developed based on the principles of equity and access to health services based on need and not ability to pay. Significant efforts were made to address the funding concerns raised as the EU requirement to open the PHI market was implemented. The mechanism of *Risk Equalisation* was devised to give effect to *Community Rating*, though its introduction was not implemented until recent

months giving opportunities to exploit an overtly unfair marketplace by targeting younger lower risk groups. The Health Insurance Authority (HIA) was established as a regulator of the PHI market.

In the context of these developments, while the precepts and guiding principles underpinning health policy remain intact as an acceptable basis for the development of our Health Services, the predicted challenges and difficulties of a greater Private Health Insurance funding base without offsetting measures to protect *Community Rating* have given rise to serious difficulties.

### **Analysis of the AMICUS/FGS study**

Among other studies, the FGS report updates this analysis in so far as it examines as it examines :

- the kind of PHI Market which has evolved,
- the devices and structures to regulate the market
- how the market operated in practice and the implications for employees,
- how BUPA fared as a new entrant and the VHI fared since the ending of the monopoly
- how the Consumer has benefited.

In terms of the kind of market which has evolved; its regulatory devices and structures, the Report notes some **key considerations and lessons** which resonate against the Commission analysis over fifteen years ago, including:

- The introduction of competition in the PHI market was and remains an EU requirement
- Government policy is to maintain the *Community Rating* System of PHI cover
- Government recognised, in putting the legislation in place, that *Community Rating* could not operate without *Risk Equalisation*.
- For most, especially PAYE employees and those in retirement, PHI cover is not affordable without *Community Rating*
- *Risk Equalisation* and the Independent Regulator were put in place to prevent unfair competition and to ensure stability in the market
- It was never envisaged that *Community Rating* would operate in the Irish PHI market without *Risk Equalisation* (other than for a short period of time to allow new entrant settle into the market and build up a reserve to meet such payments).

The FGS report points to problems with the operation of the market and serious implications. The key findings of the Report include the following:

- The PHI market is highly unusual and contravenes many of the commonly held norms of market behaviour. Clever regulation is needed and is not evidenced to date. The way regulation has operated to date is illogical and works against the interests of employees and former employees;
- BUPA has done exceptionally well and has benefited enormously from the failure to complete the market by introducing *Risk Equalisation*.
- The PHI market is inherently unstable. Employees and former employees cannot afford for the VHI to fail as a result of such instability;
- There is little evidence that competition as currently operated has benefited consumers to any substantial degree
- The current state of play is not sustainable. The major losers from any failure by Government to act will be employees and former employees.

Congress believes it is important to capture these developments in the study of the PHI underway. **The FGS report clearly provides a valuable insight into the type of market development which should be avoided and now needs to be rebalanced as soon as possible .**

Congress acknowledged and welcomed the recent, though long-overdue, decision to introduce *Risk Equalisation* as a fair and practical way of deterring new entrants from avoiding risk and cherry picking low risk (younger age group markets). *Community Rating* and *Risk Equalisation* has the potential to ensure the provision of insurance for all age groups, levelling the playing field, given the age profile and higher risks/higher claims associated with a significant proportion of the membership of the VHI.

**Congress is particularly anxious that the solidaristic and practical policy of *Community Rating* achieved through the mechanism of *Risk Equalisation* underpins competition in the Private Health Insurance market.** This view has also been supported by the OECD comments in a Health Working Paper 2004 which states:

*“Opponents of Risk Equalisation find it incompatible with principles of competition and believe it will discourage insurer’s efforts at containing cost. They also indicate that RE seeks to prevent a threat to the market that in their view, is only hypothetical at the moment. In the absence of such a scheme, however, there is the potential that insurers could compete on the basis of attracting a more healthy pool of clients. In fact, there are some differences in the age and health status profiles of enrolees of the two insurer. Thus the two insurers are not currently operating or playing upon a ‘level playing field’.*

*With respect to the impact of such a scheme on competition many experts believe that **Risk Equalisation is a necessary buttress for fair competition with a community-rated environment.** In the absence of adequate Risk Equalisation within an individual market subject to Community Rating and open enrolment, there will be large incentives for risk selection and potential adverse effects on equity and market efficiency”*

In the absence of *Risk Equalisation* there is clear evidence of risk selection. A strategic approach has been developed by new entrants, where younger age groups have been targeted, a development which has fuelled fears among the middle and older age groups about the continuing viability of their investment with the VHI over many years, with some justification! It appears that BUPA has gained about 20% share of the market benefiting from the decision to delay *Risk Equalisation*. It is believed to have made extraordinary profits of up to €100m, a profitability rate of three to four times higher than its profitability in the UK.

### **Applying the analysis to the Study of Competition in Private Health Insurance**

Within current funding arrangements Congress believes the goal of the open market and new regulatory framework is to ensure an affordable, effective and fair contribution by PHI towards funding comprehensive healthcare provision for all. The challenge is to avoid risk selection, cherry picking and to assure efficient markets.

Congress strongly endorses current Irish Law which requires health insurers to provide **open enrolment, Community Rating and lifetime cover**, requirements approved by the EU. This legislation provides safeguards for the guiding principles referred to in the Commission report.

Within current funding arrangements, Congress believes the role of the Health Insurance Authority needs to be more effective in ensuring the operation of fair competition. Measures

need to be developed to address the now skewed, unstable and unsustainable marketplace which threatens the viability of the investment made by workers and their families including the effective operation of the *Risk Equalisation Fund*.

In summary, Congress believes the study to be undertaken by the Competition Authority / Health Insurance Authority should **adopt a framework of analysis which acknowledges:**

1. the precepts and guiding principles underpinning the Irish Health service and that the criteria of *equity*, *cost effectiveness* and the contribution of PHI market towards comprehensive health service funding is taken into account.
2. that *Community Rating* and *Risk Equalisation* are necessary to underpin private healthcare funding systems, on the basis of ensuring equity in so far as they spread risk and costs among society and protect the principle of solidarity and intergenerational investment. In their absence older age groups and poor-risk categories could be left without insurance cover except at prohibitive rates.
3. the operation of a fair and competitive Private Health Insurance market is predicated on effective use of a *Risk Equalisation Fund*. In that context, the study needs to explore competitive practices in the context of a *Community Rating* environment where the *Risk Equalisation* mechanism **is operating. This is clearly difficult where the decision to introduce the Fund has only just been made, has been challenged in court and where the PHI market developments have favoured new entrants in the absence of *Risk Equalisation*.**
4. the operation of a fair and competitive Private Health Insurance market needs to take account of the inherent dynamic and complexity of the Irish PHI market in its study of the operation of sub-markets within a community-rated, risk equalised environment, in particular the need to:
  - provide competitive, affordable healthcare insurance cover for **all** citizens who wish to invest,
  - protect those who have contributed to PHI Schemes throughout a significant portion of their working lives from facing enormous price increases for cover as they reach retirement age and beyond and,
  - ensure that large number of employees who have traditionally been members of the VHI Schemes are not exposed to any potential failure of the VHI arising from threats to its continued viability caused by unfair market conditions and/or unfair competition.