



Competition in the Private Health Insurance Market

Submission by the Society of Actuaries in Ireland

April 2006

Introduction

The Society of Actuaries in Ireland is the professional body representing the actuarial profession in Ireland.

The Society was invited by the Competition Authority and the Health Insurance Authority to make a submission in relation to their examination of the private health insurance market in Ireland from a competition policy perspective. The Society is happy to make such a submission in the context of the Society's mission to "develop the role and standing of the Actuarial Profession and enhance its reputation, in particular for serving the public interest".

Our submission is necessarily brief given the short time available for submissions to be made. The Society would be happy to discuss the issues raised in our submission in more detail with the Competition Authority and the Health Insurance Authority.

Although the Society has not studied the legal situation, we recognise that a number of issues relating to the operation of the private health insurance market in Ireland are currently the subject of legal proceedings in both the Irish and EU Courts.

It is important to note that the Society's submission necessarily reflects primarily an actuarial perspective. The Society acknowledges that there are wider economic, as well as legal, considerations but has not undertaken any specific studies in this regard.

In 2002, a working group of the Society prepared a detailed report on risk equalisation in the Irish health insurance market. This report (referred to hereafter as "the 2002 report") is published on the Society's website¹. The recommended Society position outlined in Section 13 of the report was adopted in its entirety as, and remains, the Society's position. The 2002 report contains considerable analysis of, and commentary on, the Irish health insurance market, and we recommend a detailed reading of the full report to the Competition Authority and the Health Insurance Authority.

As noted later in our submission, the actual system of risk equalisation that was put in place in 2003 is different in a number of respects from that proposed by the Society in 2002. It is important to emphasise that the Society has not studied or commented on the risk equalisation system as enacted in 2003.

Our comments below follow the order in which issues are raised in the consultation document.

¹ http://www.actuaries.ie/Events%20and%20Papers/Events%202002/2002-05-01_Risk%20Equalisation/Risk_Equalisation_WP_Report_2002.pdf

Market structure and sub-markets: restrictions on the degree of rivalry, barriers to entry, barriers to switching

Sub-markets

There are several sub-markets in the health insurance market which affect competition:

- ***Method of premium payment***

The methods of premium payment in the health insurance market include employer-paid (i.e. health insurance is provided as an employee benefit), salary deduction and direct payment by members. Salary deduction is the predominant method, but a proportion of the market is company-paid.

In company-paid situations, the employer decides which health insurer or insurers to use (in some cases, employees may be offered a choice of insurer). This represents a barrier to entry for new health insurers due to the existing relationships and contracts between employers and incumbent insurers i.e. it is a factor that adds considerably to inertia in the market. It also presents a barrier to switching for individuals. This is exacerbated if employment contracts name a specific insurer or if an employer enters into a multi-year agreement with an insurer.

On the other hand, it can be argued that company-paid schemes provide new insurers with an opportunity to build market share by dealing with a relatively small number of employers.

In salary deduction situations, the employer decides which health insurer(s) may have a salary deduction “slot” on their payroll system. While employees can choose to pay premiums through an alternative mechanism (e.g. personal direct debit), this is at the expense of convenience. Again, this is both a barrier to entry and a barrier to switching.

- ***Insured and non-insured***

Another subdivision of the market is those who are insured and those who are not currently insured. As has been shown by surveys conducted on behalf of the Health Insurance Authority, there is considerable inertia in the insured market. This inertia, which is partially caused by a lack of information, is a barrier to switching and a barrier to entry for new insurers.

- ***Benefit levels***

There are sub-markets for different levels of health insurance benefits, ranging from “minimum benefits” to those that provide more comprehensive cover, access to preferential “hotel” accommodation during hospital treatment and greater benefits in respect of GP and primary care services. As set out in the later section on the implications of legislation, the Society’s view is that the requirement for community rating should apply only up to the level of benefits prescribed for the purposes of risk equalisation. This could increase the scope for competition at higher benefit levels. It

also implies that premiums for benefits which are not subject to risk equalisation – such as benefits for GP services – should not have to be community-rated.

The section on legislation also deals with an issue that has been raised in relation to the consistency of the legislative definition of community rating with the risk equalisation scheme as enacted, in the context of the range of products across the market.

Market structure

According to the 2002 report (paragraph 8.5), “*the main barriers to entry into the Irish market are seen to be (i) the size of the market, given the market penetration of existing providers, (ii) the investment required, taken in the context of (i), (iii) the dominant position of the VHI, accentuated by its ownership structure, its regulatory position and its [then] lack of a commercial mandate, and (iv) the uncertainty in regard to risk equalisation. Having no risk equalisation, or having a light form of risk equalisation, would increase the attractiveness of the market from the viewpoint of a new entrant – the benefit could, of course, be excessive and unfair to existing participants.*”

VHI, with its origins as a protected State monopoly and a market share that is currently almost 80%, enjoys economies of scale, and infrastructural advantages such as greater access to salary deduction, although it may be argued in relation to such economies of scale that an offsetting factor is that there are certain cost advantages for new insurers such as in relation to being able to follow previously negotiated provider contracts. In addition, the VHI brand may carry an associated perception of state guarantee.

VHI is exempt from holding a solvency margin which has the effect of reducing its costs. The six year transition to the application of solvency standards to the organisation that has been proposed would allow it to retain this advantage for some time. On the other hand, the requirement to strengthen VHI’s solvency position by the end of the transition period will mean that during the transition period VHI’s premium rates will have to increase at a greater rate than would otherwise have been the case.

These advantages will arguably make it difficult for newer insurers to compete with VHI on price once risk equalisation has the effect of “equalising away” the advantage enjoyed by newer insurers in relation to the risk profile of their customers.

Consequently, positive pro-competitive measures are likely to be necessary to combat market inertia. We note, for example, that in other markets (e.g. telecoms, electricity), the relevant regulators’ statutory objectives include the promotion of competition, and that such regulators may adopt specific measures to address the issue of market dominance.

Industry practices, legislation, administrative practices that limit rivalry to the detriment of consumers

Certain aspects of the Minimum Benefit Regulations limit the scope for product innovation. For example, the requirement, under the Minimum Benefit Regulations, that health insurers must cover all public hospitals represents a significant restriction in relation to insurers’

ability to vary their product design and to control claims costs, as it rules out the possibility of lower cost plans based on preferred provider networks.

We understand also that there is very limited scope for insurers to negotiate the pricing of private treatment in public hospitals; rather, the prices are determined by the Department of Health and Children and/or the Health Service Executive. This limits the scope for insurers to compete on costs.

The lack of price competition amongst private health care providers further limits the scope for competition between health insurers.

Barriers to switching & recommendations to remove barriers

The lack of consumer knowledge and understanding of the options available is a significant barrier to switching. In particular, we believe that many consumers do not understand that, under the statutory open enrolment provisions, they are entitled to switch insurers without the application of underwriting conditions (i.e. there are no waiting periods for pre-existing medical conditions). Consideration could be given to ways in which to raise consumer awareness in this regard. For example, health insurers could be required to include a prominent statement in the renewal notices issued to their policyholders in relation explaining their right to switch insurers without penalty in relation to existing levels of cover. In addition, the Health Insurance Authority could undertake an advertising campaign to highlight the potential to switch insurers.

The functions of the Health Insurance Authority

Health insurers are required to deal with two regulatory authorities – the Financial Regulator and the Health Insurance Authority – in relation to different aspects of the overall regulatory regime, with both authorities having a mandate in relation to consumer protection. As insurers would undoubtedly prefer to deal with a single regulator, this may represent an additional barrier to entry, and consideration might therefore be given to some restructuring of the regulatory regime.

Implications for competition of existing primary and secondary legislation affecting private health insurance

Given the short time available for preparation of this submission, it is not possible to provide a full commentary on the existing legislation. We have concentrated on the issues relating to community rating and risk equalisation.

Community rating

Section 7.4 of the Society's 2002 report notes that:

- it does not make sense to require community rating of benefits above the level of benefits prescribed for the purposes of the risk equalisation scheme, and
- it is hard to justify community rating on “general good” grounds for benefits above the prescribed level.

The 2002 report goes on to state that this would argue for allowing the normal pricing of a voluntary market to apply for benefits above the prescribed level.

The system of community rating that is in place is different to the approach proposed in the 2002 report. If this latter approach were adopted, it could increase the scope for competition.

We are also aware that there is currently a debate in relation to the consistency of the legislative definition of community rating with risk equalisation. This issue is addressed below under the risk equalisation heading.

Risk equalisation

Whilst recognising that there are individual actuaries who hold different views, the Society’s position in relation to risk equalisation is as set out in the 2002 report, and subsequently restated in a briefing statement dated April 2005.

It should be pointed out that the actual system of risk equalisation that was put in place in 2003 is different in a number of respects from that proposed by the Society in 2002. Key differences as they relate to competition in the health insurance market are:

- The current risk equalisation scheme is retrospective in nature. The 2002 report indicated a preference for a prospective scheme, pointing out that such a scheme would be more predictive for insurers and might also be considered more transparent; a predictive scheme was also identified as being much less susceptible to volatility (see paragraph 11.3 of the report). We note that predictability is of critical important to smaller competitors.
- The 2002 report identified difficulties with the inclusion of a “utilisation parameter” in the risk equalisation scheme (see paragraphs 11.2 and 11.4 of the report). Although the risk equalisation scheme as implemented in December 2005 is based on age and gender only, the Health Insurance Authority is vested with the power to recommend the incorporation of a health status weighting at a future date. Moreover, the “zero sum adjuster” incorporated in the scheme has the effect of partially equalising differences in health status/utilisation.
- The 2002 report highlighted the need to incentivise health insurers to attract young “preferred” new entrants into the market, in order to reduce the risk of market instability (see paragraph 7.2 of the report). However, the system of “unfunded lifetime community rating” recommended by the Society has not been introduced.
- The 2002 report expressed difficulty with the approach provided for in the Health Insurance Act 2001 in relation to the introduction of risk equalisation i.e. that its commencement would be linked to “market factors” (see paragraph 12.2). It put forward the view, in paragraph 12.4, that “*the longer term interests of the consumer and of the market would be served by the introduction of a limited form of risk equalisation now, both in terms of the intrinsic market effects and by establishing certainty on the issue*”.

It is important to emphasise that the Society has not yet undertaken any further specific studies in this area since 2002, and is therefore not in a position to assess the implications for competition of the statutory risk equalisation scheme introduced in 2003 beyond the comments made above. The Society has not studied the mathematical / financial outcomes of the scheme – as the relevant data is not in the public domain – and cannot therefore comment on the impact of the scheme on market incentives.

The Society is aware that certain issues that are fundamental to the operation of community rating and risk equalisation are currently the subject of legal proceedings. These include:

- An argument that the legislative definition of community rating is inconsistent with the risk equalisation scheme as enacted, in that the legislation requires community rating within products (i.e. all persons pay the same price for the same product) whereas risk equalisation applies across the market rather than within products. The counter-argument is that the legislature intended community rating and risk equalisation to apply across the market (up to the prescribed benefit maxima). The Society recognises that the legal outcome in this regard will have potentially far-reaching implications for the operation of the private health insurance market.
- An argument that the prescribed maximum level of benefits for the purposes of the risk equalisation scheme is such that a very high proportion of total benefits is equalised and that this is hard to justify on “general good” grounds. The Society is not in a position to assess the merits of this argument as it does not have access to the data on which the risk equalisation calculations are based.

The current position of the Society, as outlined in a briefing statement dated April 2005², is as follows:

- *Risk equalisation is a logical concomitant to a voluntary health insurance system based on community rating, open enrolment and lifetime cover.*
- *Given the structure of the Irish market, it would be reasonable for the form of a risk equalisation scheme to encourage competition and new competing insurers.*
- *A risk equalisation scheme based on age and gender should be introduced, preferably on a prospective basis. This would go some distance towards sharing of risk profiles between insurers but would also favour new entrants to the market and would avoid the ambiguities and complexities of incorporating a utilisation parameter in the scheme.*
- *An obligatory system of unfunded lifetime community rating on the basis recommended in the Society’s submission to the Health Insurance Authority in January 2001 should be introduced.*
- *The transparency of the market would be greatly improved if the corporate status of the VHI were resolved in a manner that broke the link with the Minister for Health and Children and the VHI were given a commercial mandate. The Financial Regulator could then assume prudential regulation in accordance with normal insurance standards.*

² http://www.actuaries.ie/Press%20Office/Briefing%20Statements/050425-BS_Risk_Equalisation.pdf

As noted previously, we recommend a detailed reading of the full 2002 report to the Competition Authority and the Health Insurance Authority.

We would be happy to discuss the issues raised in our submission in more detail with the Competition Authority and the Health Insurance Authority.