



COMPETITION AUTHORITY

COMPETITION IN THE PRIVATE HEALTH INSURANCE MARKET

April 2006

Introduction

VIVAS Insurance Limited trading as VIVAS Health welcomes the opportunity to participate with the Competition Authority in this consultation process. VIVAS Health welcomes any provision that will enhance consumer benefits, enhances patient safety and quality of outcome, fosters competition and promotes a level playing field within the health insurance market, for the greater public good. It is apparent that competition is failing within the market, after 12 years there are only three players and both commercial insurers have been forced to recourse to litigation or complaints to the European Commission about the operation of the market.

Concerns over Consultation Process

VIVAS Health has a number of serious concerns about the nature of this consultation process. In particular, the terms of reference and the involvement of both the Department of Health and Children and the Health Insurance Authority (hereinafter ‘the HIA’) all of which in our opinion may taint the independence and validity of the consultation.

The terms of reference as announced and published by the Competition Authority vary greatly from those announced on 23 December 2005 by the Minister for Health and Children when triggering the risk equalisation subsidy. It was stated in the press release issued on that date that the Competition Authority would be mandated 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 to create greater balance in the share of the market held by competing insurers;”

The 23 December press release gave a direct and specific mandate to both Authorities to develop liberalisation strategies to reduce VHI market dominance. However, the terms of reference as issued make absolutely no reference, remark or comment on market shares or on the need to reduce market dominance. This fundamental change in the nature of the consultation from that announced severely undermines the process and dilutes the impact of the consultation. VIVAS Health requests clarity on why, how and by whom, were the terms of reference changed to exclude a reference to VHI market dominance. This change has both limited the scope and use of the consultation and has once again effectively shielded the VHI from scrutiny. The only conclusion to be drawn by VIVAS Health is that this change is reflective of the continuing Government (and in particular Department of Health and

Children) policy of protectionism and favouritism towards the VHI and as such the consultation has not been engaged in in an independent or fair manner.

VIVAS Health has severe reservations about the involvement of the Department of Health and Children in the setting of the terms of reference. The Department of Health and Children are the parent department of the VHI. They (the DoHC), have given the VHI numerous economic and regulatory advantages over its competitors and thus have given the VHI (the largest provider of health services in the market) a massive effective subsidy . The Department of Health and Children is not only severely conflicted in its role in the health insurance market but has proven that it can and has acted to favour the VHI and help it to consolidate its market share.

The attitude of the Department of Health and Children towards competitors of VHI can be gleaned from their involvement with the Department of Finance in the Consultation on the Consolidation of Financial Services Legislation. The Department of Finance entered into public consultation on the Financial Service Market – to which VIVAS Health, BUPA and the VHI made submissions within the deadlines. The Department of Health and Children however waited to see the responses of VIVAS Health and BUPA and having studied these responses then made a submission a number of weeks after the deadline had elapsed – in this submission the Department of Health and Children sought to discredit the views set out by both VIVAS Health and BUPA but made no mention of the actual comments submitted by VHI. Following protests from VIVAS Health the Department of Health and Children was later forced to retract and amend its submission (a copy of this correspondence is available on request). In light of the actions of the Department of Health and Children in regard to this previous consultation process, the involvement the Department in setting the terms of reference of this current process (in particular as stated above where there is evidence that these have already been fundamentally reduced since their announcement) can only call into question the independence and validity of the consultation process.

VIVAS Health also questions under what legal powers the Minister for Health and Children has referred this issue to the Competition Authority and by corollary the powers therefore of the Competition Authority to investigate the matter.

Similarly, VIVAS Health questions the participation of the HIA in the consultation process. The HIA, like the VHI, is a statutory body also under the aegis of the Department of Health and Children. The HIA must therefore act within the parameters of its functions as set out within the Health Insurance Acts. It must be questioned therefore under what legal base

within its Acts has the HIA the power to engage in this form of consultation and report? In particular, the terms of reference reflect a number of questions that appear to flow directly from HIA staff reports recommending a subsidy to their sister Department of Health and Children statutory body, namely the VHI. The inclusion of such terms by a party which has already pre-determined the answers (in favour of VHI) causes concern over the impartiality of the consultation process. The HIA has already pre-determined a number of issues of competition within the health insurance market through its decision making on risk equalisation subsidies. Thus, we believe that it cannot be expected that the HIA will come to differing conclusions through this consultation process, as if it were to do so then its first analysis was flawed, if not then it cannot act impartially.

VIVAS Health therefore respectfully submits that the matters dealt with in its submission be considered solely by the Competition Authority.

A number of key issues have also been excluded from the terms of reference which should not have been ignored when looking at a comprehensive overview of the market.

In particular, the failure to engage in any international benchmarking of other jurisdictions with community rating and risk equalisation is unfathomable. While it is understood that there are time constraints within the consultation, this issue is crucial to fully understanding the regulatory impact of policies enacted in Ireland. No competition study or report to date commissioned by the State has included any international benchmarking of similar markets. It is questioned why any international benchmarking has been consistently excluded in health insurance by the State. It is suggested that the rationale for exclusion is that the State cannot find any other jurisdiction which has an 80% state owned dominant player that is being afforded preferential regulatory and economic advantages, in addition to a draconian risk equalisation scheme, the likes of which cannot be found in any other jurisdiction.

The timing of this consultation when the State has triggered risk equalisation subsidies is questionable. While VIVAS Health strongly believes that competition in the market cannot be assessed without looking at risk equalisation it does not understand how this will be assessed again impartially by the two bodies who have recommended it. VIVAS Health fears that this Consultation is merely an exercise by the Department of Health and Children to prolong the present status quo while extracting massive subsidises to its own insurer.

Many of the issues contained with the Terms of Reference are the subject of judicial proceedings or being considered by the European Commission. The appropriateness of this consultation while a number of matters are *sub judice* is highly questionable.

While VIVAS Health engages in good faith with the Competition Authority on this consultation process, unfortunately it has severe reservations about the manner in which the consultation has occurred to date and the likely outcome from the process. In particular, with the continuing involvement of the HIA and the Department of Health and Children. Regrettably, VIVAS Health believes that this exercise may yet become another tool for the Department of Health and Children to justify its stance to date on the health insurance market and VIVAS Health holds little trust that any recommendation issued will be balanced, fair or seek to actually promote competition within the market.

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

1. The massive dominance of the state owned VHI and its impact on the health insurance market
2. The consequence of risk equalisation to the health insurance market
3. Commentary on the Terms of Reference issued by the Authority.

1. The massive dominance of the state owned VHI and its impact on the market

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 to any new entrants (and possibly expelling present players).

- 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 increases¹.
- 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. In one year VHI has gained 26% market share in the multi-trip travel insurance market².
- 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.
- The VHI has been allowed act in a financially reckless manner through its pricing arrangements – VHI has been permitted to price premiums in certain knowledge of incurring underwriting losses on the premise that either the State (through its ownership and implicit financial guarantee) or its competitors (through RES) will finance this artificially created deficit and potential insolvency. The compatibility of such a strategy with the provisions of the VHI Acts to break even has not been clarified by either the DoHC or the VHI.

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

¹ See VHI Press Release dated 29 April 2004 and Letter by VHI to the Minister for Health and Children dated 4 July 2005.

² VHI Press Release dated 14 February 2005.

importance which the Authority must consider when looking at competition within the health insurance market.

The present dominance of VHI affects the market in the 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 exceeded 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.
- ❖ In research conducted by VIVAS Health last year with a number of medical consultants, it was made very clear that consultants 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.
- ❖ VHI as a former monopoly and with a huge dominance influence 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 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 there 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 equalisation 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 past has acted as guarantor for a 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 Private 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 as providers.

In addition, VHI's publicly stated policy has been that there is no need for any further private beds. As such it has refused to cover any new private medical facilities and has in the past acted as a capacity blocker. It is understood by VIVAS Health that the VHI has repeatedly informed all new providers that there is no need for their services within the market. VHI also refuse to cover any facility until it has been in operation for a number of months, this completely undermines the viability of new providers in their crucial first months of business – it is noteworthy however that VHI did not seem to apply the same logic when fully branding its own Swift Care clinic. This policy has stifled the natural evolution of private medical facilities in Ireland, both for hospitals and private consultants and has resulted in less consumer choice and availability and an increase in waiting periods for treatment.

2. VHI's dominance and Risk Equalisation

Risk Equalisation is inappropriate in a market that includes a dominant player. VIVAS Health is not aware of any similar health insurance market where risk equalisation is present and the market share of the largest player even approaches VHI's level of dominance. The following table illustrates the market shares of competitors in those national markets where the regulatory environment requires a form of community rating. It illustrates a stark difference between the Irish market structure and the respective structures of the New York, New Jersey and Australian markets.

Market	Market share of largest player	Number of competitors
New York	18%	34
New Jersey	30%	22

Australia	29%	26
Ireland	Approximately 76%	3

Market strength in the Irish health insurance market is concentrated in VHI. The Hefindahl-Hirshman Index³ (a measure of market concentration) for the Irish health insurance market is approximately 6,700. A value in excess of 1,800 indicates a highly concentrated market. This concentration and dominance must of itself be a matter of concern from a competition perspective.

Both risk equalisation and the dominance of VHI have been recognised by a number of bodies, including the Competition Authority itself, as barriers to entry to the Irish health insurance market. There is an urgent need to revise the risk equalisation scheme before irreparable damage is done to competitors of VHI and a liberalisation policy must be put in place to fully open the market with set targets for VHI market share reduction. The present situation cannot be allowed to continue unless the Government wishes to revert to a State monopoly.

³ The index is calculated as 10,000 x sum of squares of market share percentages

VIVAS Health shall now deal with questions posed within the terms of reference individually. A number of the comments are applicable under a number of headings in the terms of reference. It is requested that the Authority look at the VIVAS Health responses to be applicable in any other scenario it deems relevant.

As set out above, VIVAS Health strongly believes that the two main barriers to competition within the Irish health insurance market are:

1. The risk equalisation scheme,
2. The dominance of VHI.

- 1. 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.**

VIVAS Health questions the validity of this first point which appears to flow directly from arguments made by the VHI/HIA to justify the imposition of the risk equalisation subsidy by claiming there are two relevant sub-markets one for younger persons and one for older persons. The HIA has already made a finding in this regard and as such cannot be viewed as an impartial arbiter on this question. This question is indicative of the manipulation of the terms of reference and the watering down of its contents to protect the VHI. While unfortunately not being confident of the outcome from this particular question VIVAS Health does have a number of views on the relevant market and the sub-markets set out therein.

The sub-markets within the health insurance market can be categorised as follows:

1. The division of the market dependent on method of payment
2. The sub-market of consumers tied to the dominant player
3. The sub-market of commercial and non-commercial consumers

- 1. The division of the market dependent on method of payment**

How a consumer pays and access their health insurance can have huge effects on the insurer that they choose

If the consumer is an employee and works within a company which offers paid health insurance, in effect the employer makes the decision on the provider chosen. In smaller companies where there is no annual review of coverage this is often a barrier to entry as

companies tend not to reassess their health insurance coverage and continue with existing relationships – this factor adds considerably to inertia within the market.

Choice can be further reduced when the company has also been offered a range of ancillary products from the incumbent (at a discount). For example they may purchase the business travel insurance policy at a much reduced cost. Should they choose to switch insurers their travel insurance premium rises and they suffer a cost penalty. This in effect locks out other insurers from that market and limits competition.

Another limiting factor within the sub-market of company paid insurance is the issue of employee contracts. A number of employee contracts specifically identify that they are covered for VHI Plan X – with the identification of one specific provider companies are reticent to switch insurers for fear of industrial action.

VHI for historical reasons has a salary deduction mechanism within most companies within the State. This is valuable commercial infrastructure held by a State body. A number of companies are reticent to introduce another line or two lines into their salary deduction mechanisms to cater for other players within the market. This in effect creates a barrier to switching as other insurers are effectively locked out of the system.

In addition, a number of companies offer a VHI Group Scheme in which their employees can avail of a 10% discount. Due to the lack of consumer knowledge, companies do not realise they can operate the same discount from other providers or choose due to administrative hassles do not want to offer their employees any choice.

2. The sub-market of consumers tied to the dominant player

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. In one year VHI has gained 26% market share (in excess of 200,000 members) in the multi-trip travel insurance market⁴. If a VHI member cancels their health insurance policy they are penalised by VHI and their travel insurance policy is also automatically cancelled with no refund being provided. As most members do not tend to purchase their travel insurance and health insurance policies simultaneously this

⁴ VHI Press Release dated 14 February 2005.

lack of refund acts as a huge disincentive to consumer switching at the time of their VHI renewal.

3. The sub-market of commercial and non-commercial consumers

There are two sub-markets within the health insurance market, those of commercial customers and non-commercial consumers. Commercial consumers have a more ready supply of information via their work places than non-commercial consumers. There is a huge lack of information even about the number of insurers in the market that non-commercial insurers do not know about. No campaign was ever launched by the State to inform the consumer of the various options available e.g. when Esat entered the telecommunications market Eircom was forced to write to each of its clients to inform them that a new provider had entered the market. No similar communication has ever occurred with the VHI consumer base.

VHI members tend to be less informed than other health insurance consumers because they have never changed providers and as such are not aware of their rights and the differing plans offered by other insurers.

2. Identify and analyse industry practise, 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.

The main barriers to rivalry in the market have been cause by the State interference in the market through the granting of numerous economic and regulatory advantages (as highlighted above). The State has consistently raised the barriers to entry of any new insurer who wishes to compete with its own body – not only must all new entrants have to compete with the brand, economies of scale, massive bargaining and purchasing power and loyalty gained by a State monopoly over 50 years it must now also economically subsidise it so that it can attempt to reach normal solvency in 6 years, carry its own solvency margin while loosing all price competition advantage due to risk equalisation. While the State has systematically added more and more costs to new entrants it has done nothing to level the playing field with the VHI.

VIVAS Health as a new entrant into the health insurance market has to bear the following costs:

- Start up costs – legal costs, actuarial costs, employment costs and general start of costs of commencing a business from nothing – including the putting in place of contractual arrangements with all hospitals within the country, IT costs, call centre set up cost and administration costs. These costs must all be recouped prior to any profit being realised by the business.
- Permission from all HSE Hospitals (also controlled by the Department of Health and Children) to allow VIVAS Health entry to those hospitals for direct settlement of VIVAS Health member claims on the same basis as offer to the VHI
- Costs of establishment of contractual relationships with private hospital providers and developing the medical networks to support the health insurance business.
- Regulatory costs – costs associated with receiving an authorisation from two regulators, including attainment of the solvency standard set out by the Financial Regulator for new entrants into the market of at least 4 million euros.
- Ongoing compliance costs – costs associated with the constant solvency reserving and consumer protection compliance with the Financial Regulator.

- Ongoing compliance costs – costs associate with compliance with the HIA and the six monthly cost of producing risk equalisation returns.
- Marketing costs – introducing a new brand and product to the market in particular when faced with a dominant strong State brand.
- Market awareness – informing the public indeed of the existence of a new market entrant.
- Matching of all procedures to be covered by VIVAS Health with the VHI list of procedures as prescribed in the Minimum Benefits legislation

The most beneficial (and largest) cost advantage provided to VHI is the failure by Government to ensure it meets similar solvency criteria as any other non-life insurance undertaking. The Minister for Health and Children announced when implementing subsidies to VHI through the risk equalisation scheme on 23 December 2005 that it was giving VHI until 2012 to reach normal safe prudential solvency criteria. If the Government is committed to creating true competition within the health insurance market then VHI, like all its competitors, must be required to reach normal solvency levels immediately and not at some distant point in the future. It is apparent that the risk equalisation payments rather than being used (as was the intention under the legislation) to equalise risks is being manipulated by Government to make VHI solvent through its competitors money. Why such a prolonged period to reach solvency is necessary has also not been explained by Government (other than the political fallout from large VHI premium increases), in particular as with reinsurance VHI could reach adequate solvency levels at a much faster rate. It is contended that VHI could continue to run off its reserves or maintain these stagnant (using the extra capital to continue to either maintain premiums low or expand into other financial markets) and simply reinsure in the final year to attain solvency. It is also noted that while Government has stated that it will require VHI to be solvent by 2012 this has not been embedded into legislation, it would appear that no milestones to reach solvency have been laid down and as such there is no legal requirement obliging either VHI or Government to fulfil this promise in the future. This continuing uncertainty, in particular in light of VHI new pricing policy, makes it impossible for competitors (and new entrants) to properly asses the risks within the market.

All of these costs must be covered and recouped prior to any profit being made in the business. The risk equalisation scheme does not recognise these cost or take into account market shares prior to subjecting a new entrant to payments. The failure to take these factors into account is a huge disincentive to new entrants.

Industry practise hindering competition:

- The regulatory and economic advantages provided by the Department of Health and Children to the VHI to the detriment of the market.
- The tying of VHI members via its travel insurance policy – hindering their choice of insurer and penalising members who choose to switch by not offering any refund on their travel insurance policy.
- The exemption of VHI from solvency for at least another 6 years – allowing them to continue to sell below costs.
- The exemption of VHI from all consumer protection legislation allowing them to incur lower regulatory costs – including not paying a levy to the Financial Regulator.
- The salary deduction mechanism offered to the VHI only to most companies within the State sector.
- The lack of consumer information on their rights on switching.
- The lack of regulation on the VHI allowing them to indulge in aggressive win back campaigns and dissemination of false information on their competitors – a properly regulated insurance company cannot reference its competitors.
- The use by VHI of its dominance to hinder the development of private medical facilities in the State – this has the effect of hindering the development of new insurance products, preferred provider networks and limits consumer choice. Ireland has not seen the development (and benefits) of PPO's, HMO's etc...that are prevalent in other jurisdictions – the size of the VHI and its stranglehold on the market is a huge barrier to alternative methods to phi entering the market. If there were a number of reimbursement alternatives for the consumer this would add new cost reducing dynamics to the market.
- The use by VHI of its dominance to block any new medical facilities entering the Irish market is keeping medical costs at a higher level than if there were competition within the market. The VHI practise vis-à-vis Consultants has also had a knock-on effect to competition within that market which is affecting all providers.

Legislation hindering competition:

- The risk equalisation scheme
- The minimum benefit regulations

- The Voluntary Health Insurance Acts
- The failure to implement the Lifetime Community Rating regulations

These are dealt with in further detail later in the submission.

3. Identify barriers to switching private health insurers, analyse their origin, and, where appropriate, make recommendations to have unnecessary barriers to switching removed.

A number of barriers to switching have already been identified above, however in addition the following should be considered:

- Non-participation by consultants with new entrants – consumers have an expectation set by the VHI of full coverage and direct settlement. However, in a number of instances consultants and groups thereof have refused to fully participate with VIVAS Health (unless a much greater fee than that paid by VHI is offered) – this means that consumers cannot be guaranteed the perceived same cover as VHI leading to uncertainty.
- VHI holds the majority of data on health insurance consumers. VIVAS Health has found that in instances where benefits are limited based on previous claims i.e. psychiatric claims some medical providers will not directly settle but ask for VIVAS Health members to pay at the commencement of treatment. This is because VIVAS Health cannot confirm the number of days already claimed under another insurer. VHI which has this information will be in a better position in most instances to give the hospital assurances, as such its members are not required to pay.
- Lack of consumer information and access to older consumers who are locked into VHI.
- The tying of consumers by VHI.
- The salary deduction mechanism operated by VHI.

4. 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.

VIVAS Health questions why this is included within a consultation document on competition within the health insurance market. If the purpose of this consultation document is foster competition then VIVAS Health believes that the real question should be:

“What form of Regulator would most benefit the consumer, foster competition and create a level playing field within the market?”

The question should not pre-determine the continuation of a Regulator the existence of which is of itself is a barrier to entry and competition.

VIVAS Health is the only insurer in the market that has had to undergo two sets of authorisation in Ireland, that must pay two sets of Irish regulatory levies and must abide by two sets of Irish consumer regulation. Having to deal with two Regulators at all times has added cost, difficulty and complication to many processes and appears to run contrary to Government policy to create one Single Financial Regulator. VIVAS Health would strongly recommend the immediate dissolution of the HIA and the transfer of its function to the Financial Regulator. This would streamline compliance and regulation, remove the conflict of interest with the Minister for Health and Children acting as Regulator and regulated and would prevent regulatory overlap and contradiction.

VIVAS Health shall set out below, why its experience with the HIA has led it to conclude that the proper management of health insurance rests with the Financial Regulator and how the existence of two regulators in itself is acting as a barrier to entry.

Authorisation Process

VIVAS Health was the first undertaking to undergo the dual authorisation process through both the Financial Regulator and the HIA. VIVAS Health found the process of authorisation by the HIA enormously cumbersome, that it involved a huge duplication of work and at times found the process enforced by the HIA to be at odds with the provisions of the Third Non-Life Directive.

The Third Non-Life Directive established a single authorisation process for insurance undertakings in Europe. However, it has been the experience of VIVAS Health that the requirement to register with the HIA is in many aspects a duplication of the authorisation

process undergone with the Financial Regulator and not compatible with this legal requirement. While Recital 23 of the Third Non-Life Directive permits Member States to require systematic notification of the general and special policy conditions in order to verify that such contracts comply with the legislative requirements in relation to health insurance, such verification is stated not to be a prior condition for the marketing of the products. This verification process is set out within the Health Insurance Acts.

Section 14 of the **Health Insurance Acts, 1994-2003** sets out the legislative parameters for registration of health insurance companies on the Register of Health Benefit Undertakings. This provision was commenced in 1994. The regulations under-pinning Section 14 were commenced in March 1996.

Section 14 (3) states that:

“Upon the establishment of the Register, the following undertakings shall be entered in it:

- (a) an undertaking duly authorised pursuant to the Council Directives to carry on health insurance in the State, and*
- (b) the Voluntary Health Insurance Board.”*

Section 14 of the Health Insurance Acts was commenced on 1 July 1994. However the Third Non-Life Directive was not transposed and commenced until 28 November 1994, hence it was not possible for there to have been any other health insurance company operating that could have availed of this registration other than VHI. Consequently, VHI was automatically placed upon the Register without any further verification or notification being necessary.

In relation to new undertakings entering the market **Section 14(5)** states:

“The Minister may by regulations provide for the registration of undertakings (other than those specified in subsections (3) and (4)) of such classes as may be specified upon and subject to such terms and conditions as may be specified including (but without prejudice to the generality of the foregoing) –

- (a) in the case of a restricted membership undertaking, terms and conditions requiring it to satisfy specified financial criteria and to effect not less than a specified number of health insurance contracts within a specified period, and*
- (b) in the case of any other undertaking, a term or condition requiring the undertaking to be the holder of an authorisation (within the meaning of the Insurance Act, 1989) for the time being in force to carry on non-life insurance business (within the meaning aforesaid).*

The relevant provision within the **Health Insurance Act, 1994 (Registration) Regulations, 1996**⁵ state in **Article 8** thereof:

“An undertaking other than a restricted membership undertaking shall be registered upon application if it is the holder of an authorisation (within the meaning of the European Communities (Non-Life Insurance) Framework Regulations, 1994 (S.I. No. 359 of 1994) for the time being in force to carry on non-life insurance business and complies with the provisions of the Health Insurance Act, 1994.”

Therefore, an extra condition to that applied to VHI was attached to new entrants, who must now comply with the Health Insurance Act.

BUPA Insurance entered the Irish health insurance market in June 1996 and was the first new undertaking to be placed upon the Register. As the Health Insurance Authority was not established at that time, the Register was held by the Minister for Health and Children. The Registration process undergone by BUPA consisted in BUPA sending in a letter requesting registration. The Department of Health then confirmed with the United Kingdom regulatory authority in relation to their being properly authorised as an insurance company. Once this was verified they were placed upon the Register. No further documentation was required to be notified and no products were reviewed in advance.

Since, BUPA entered the market, neither Section 14 or the underpinning regulations on Registration have been amended. The only change has been that the HIA has taken over a number of the functions previously carried out by the Minister for Health.

For VIVAS Health to be placed upon the register, the HIA requested an enormous amount of information about business plans, process and distribution networks all of which clearly fall outside their jurisdiction and which the HIA do not appear to have a legal base to ask for. The HIA asked to approve all VIVAS Health policy documentation, while this would appear contrary to the Third Non-Life Directive. In addition in a number of disputes with the HIA, the HIA objected to wording used by VIVAS Health although other competitors in the market were operating under similar terms. Furthermore on a number of occasions during the authorisation process VIVAS Health was informed by the HIA that its authorisation was not a priority as the HIA had other work involving the implementation of risk equalisation to focus

⁵ S.I. No. 80/1996

on. This highlights the attitude from the beginning of the HIA towards new entrants, their authorisation being secondary to the implementation of subsidies towards the VHI.

Hence the registration requirements have now been interpreted by the HIA to require the provision of detailed information in relation to every aspect of VIVAS Health's business. Requests were made by the HIA for all policy documents, all products, all sales processes, all third party agreements, a copy of the Financial Regulator application and all service provider contracts. In addition, a list of questions was furnished by the HIA to VIVAS Health of matters it wanted dealt with. Much of the requested information has already been submitted to the Financial Regulator in relation to its authorisation process. For example, the Financial Regulator requested a copy of our third party administration agreement, to review that we have not outsourced too much of our business and that we are the actual insurance company carrying on the business, in addition the HIA have requested the same contract "in order to ensure that it is your organisation that would be carrying on health insurance business". On at least one occasion during the authorisation process, conflicting guidance was given by the two Regulators.

Again, it would appear that a differing and more stringent set of criteria are being applied by the HIA to new entrants than those applied to either VHI or BUPA, even though the legislation has remained the same. This dual authorisation process creates complexity of regulation to new entrants in the health insurance market which was not undergone by the present incumbents. The HIA has unilaterally ascribed to itself an authorisation process which previously did not exist. This is indicative of the HIA actions since its establishment which has involved a consistent assigning of more powers and functions (in many instances without a statutory base). The assignment of more powers has been a consistent feature of HIA consultation processes albeit that two of its commercial insurers have repeatedly called through various consultations for its incorporation within the Financial Regulator. VIVAS Health can offer copies of correspondence that outline the long, protracted and duplication of work caused by the HIA re-interpretation of its statutory functions. This dual authorisation which does not appear to be in accordance with the spirit of the Third Non-Life Directive or Government Policy on Better Regulation and the existence of two regulators is another barrier and obstacle to entry for any new competitors.

VIVAS Health Experience since Authorisation by the HIA

The first decision taken on risk equalisation post the entry of VIVAS Health into the market was triggering of payments under the risk equalisation scheme. This ensured that VIVAS Health only received the bare statutory minimum exemption of from payments – albeit that

VHI had enjoyed an exemption of over 40 years and BUPA had received an 8 year exemption. Such a decision by the Regulator within 5 months of entry of a new player on the market sends a very clear signal to all new competitors of the priority that the Regulator gives to competition and new entrants in the market.

Within its Staff Report of April 2005 (only 6 months after the entry of VIVAS Health to the market) the HIA alleged that:

“It should be noted that a review of VIVAS Health’s products and premiums would indicate that they will adopt a similar position to BUPA Ireland and look likely to also benefit from excess profits at the expense of the consumers⁶.”

and

“The level of price competition could increase significantly in the absence of risk equalisation if a new insurer were to enter the market and use its risk profile advantage to compete aggressively on price, although this does not appear to be the case in respect of VIVAS Health. As noted above such a development would lead to an increased risk of a death spiral developing.⁷”

These exact same comments were repeated by the HIA in its Staff Report on Risk Equalisation in October 2005.

The attitude of the HIA to new entrants is clearly perceived above, although they only had 6 months of information it was already determined that the VIVAS Health business would be to the detriment of consumers while simultaneously stating that if VIVAS Health was aggressively pricing it would cause a death spiral. Hence the independent regulator had already condemned the new entrant and was prepared to criticise it regardless of what actions it took.

In addition, since VIVAS Health has been present in the market it has twice been threatened with legal proceedings by the HIA. The first for comments made during a presentation before the Joint Oireachtas Committee for Health and Children in September 2005. While this debate was supposed to be an open forum for discussion the HIA threatened legal action and issued solicitors letters over a comment made by Oliver Tattan when asked to express an opinion on whether he believed the HIA were biased. His response to said question being:

“It is clear the regulator has a bias because he has recommended that risk equalisation be implemented since we entered the market.”

⁶ P.51 April 2005 HIA Staff Report

⁷ Ibid 2.

The HIA alleged that VIVAS Health was trying to damage the reputation of one of its staff through the use of the pronoun “he” and that the statements were incorrect. The HIA demanded that VIVAS Health withdraw the comments and correct public record or they would take all further action as may be advised. VIVAS Health corrected the record to mention “it” rather than “he” and pointed out to the HIA that the statement was in fact correct. No response has been received to date from the HIA on the letter issued by VIVAS Health. This behaviour is indicative of the attitude of the HIA to negative comments from new entrants and the regulatory bullying to avoid any such criticism occurring.

Secondly, the HIA have threatened legal proceedings against VIVAS Health vis-à-vis the provision of an independent accountants report with its risk equalisation returns. VIVAS Health was unable to comply with the request, having approached two leading firms of Chartered Accountants to provide said returns as it would appear that there is a legal flaw with the underlying regulations. Although the HIA has legal powers to regulate health insurance undertakings it does not appear to have legal powers to prescribe and regulate accountants. VIVAS Health as the newest entrant to the market feels the HIA is hostile to its business and that it is being unilaterally bullied within the market.

The views as expressed to VIVAS Health by the HIA on competition are very unsettling to a new entrant. The HIA has publicly stated excess profits to be a bad thing within the market – albeit this criticism has only be levelled at commercial players and no comment was made in 2004 when VHI made in excess of €60 million in profits. The HIA has often recanted the VHI view that there are two markets in health insurance one for old members and one for young members – disregarding entirely the 40 years of premiums received by VHI for those older members. The HIA has taken no account of the start up costs involved in commencing a health insurance company or when profitability is likely to occur when deciding to recommend that the VHI receive a massive subsidy. The HIA being of the view that all that is necessary is for a new entrant to operate massive price increases to fund risk equalisation without taking into account the likely impact this will have upon a new business. The HIA has equated consumer benefit with a VHI consumer benefit which will invariably lead to a conclusion in favour of VHI.

The distortive interpretation of competition law implemented by the HIA is evidenced when looking at its definitions of price following and predatory pricing. The HIA have formulated a definition of predatory pricing entirely outside the spectrum of normal competition law, unrelated to dominant undertakings and shoe-horned as a mechanism to implement risk equalisation. It is evident from all the HIA papers to date that a new entrant can only ever be

either price following or predatory pricing both of which will lead to risk equalisation – no explanation or clarification of what level of pricing will not incur these labels has ever been provided by the HIA.

The Financial Regulator

VIVAS Health has found all dealing with the Financial Regulator (who has a long experience in dealing with non-life insurance undertakings) at all times to be professional and impartial. However, the Financial Regulator has undertaken in the past year a number of Consultations on changes that it is proposing within the market. While VIVAS Health welcomes these consultations it has highlighted the danger of having two regulators within the one market. For example, a number of the proposals put forward under CP 10 – Consultation on the New Consumer Protection Code were contradictory to health insurance practise e.g. one of the recommendations would have forbidden direct settlement with hospitals. These would have had a tremendous impact on the VIVAS Health business in particular as VHI would not have been subject to the same prohibition – giving VHI yet another huge commercial advantage over its competitors.

Similarly, the numerous Consultations and Guidance issued to VIVAS Health by the Financial Regulator is constantly raising its costs of compliance. While VIVAS Health favours any measures put in place to benefit consumers and to help with the proper regulation of insurance undertakings the knock on effect that this has on the health insurance market must be considered. VHI with over 1.6 million consumers is exempt from a plethora of legislation and consumer protection measures, ranging from company law requirements to consumer information and codes of practise to the need to guarantee its financial position through proper reserving for the benefit of its consumers. A form of ad hoc regulation has occurred vis-à-vis VHI whereby it is opted in and out of regulation as it feels – for example VHI was prescribed as subject to the jurisdiction of the Financial Services Ombudsman albeit that it is not subject to any of the consumer regulation or protections which the Financial Services Ombudsman looks at issued by the Financial Regulator.

Recommendation:

In light of all of the above and due to the VIVAS Health experience with two regulators it would strongly endorse the immediate abolition of the HIA and the transfer of its functions to the Financial Regulator. The Financial Regulator could then become a true Single Regulator for financial services and this would eliminate duplication and contradictory regulation that is presently occurring within the market. The Financial Regulator already has a broad consumer

and prudential mandate with powers of enforcement and as such it would be the optimum regulator to oversee the entirety of the market.

If the Government is to provide VHI with 6 years to enter into solvency (a point which is strongly disputed by VIVAS Health as set out above) and hence receive an authorisation under the Third Non-Life Directive – there is nothing preventing Government from exempting VHI purely from this prudential requirement while making VHI subject to all consumer regulation and health insurance regulation from the Financial Regulator.

5. Identify and analyse any implications for competition of existing primary and secondary legislation affecting private health insurance.

Risk equalisation

It is not denied by any party that the present risk equalisation scheme will have a profound affect on competition within the health insurance market. Prior to looking into risk equalisation its evolution and genesis must be considered. Risk equalisation was conceived at a time when VHI was a monopoly player within the market and where there was no data or information as to what would occur in Ireland once competition was permitted in health insurance. It was developed in a vacuum based on theoretical fears (fanned by VHI) of the market collapsing and VHI entering into a death spiral. Based purely on academic possibilities it was embedded in legislation in 1994 by the Department of Health as a reserve power.

Since BUPA entered the market in 1996, VHI has been predicting its financial collapse and calling for the urgent implementation of risk equalisation. This is despite the fact that VHI's financial position has grown in strength since competition entered the market and made in excess of €65 million in profits in 2004. In 2001, what had been a reserve power for the implementation of risk equalisation was replaced with a far more draconian scheme – ignoring the lack of market instability or putative death spiral. Despite the public opposition by BUPA of risk equalisation since its entry into the market in 1996, its numerous communications and submissions on risk equalisation a report and scheme were produced which in no way reflected the views of the only other competitor to VHI. There appears to have been no effort made to reach a negotiated settlement on the issue, or to attempt any other alternatives prior to the implementation of risk equalisation. Position have become entirely polarised within the market and have lead to costly and lengthy litigation being perceived as the only solution.

Risk equalisation has now been implemented at a time where there is no market instability and no death spiral, even the academic need originally used to justify risk equalisation is not present in the market. It appears that risk equalisation is now viewed as a weapon against price following and excess profits (which can be dealt with through a number of other remedies (none of which appear to have been considered)) rather than its true original purpose. The motivation and justification for risk equalisation at this time must therefore be questioned, in particular when it occurs just as a new entrant seeks to bring further competition to the State insurer.

VIVAS Health shall deal with risk equalisation under two primary headings, firstly the disproportional nature of the present scheme and secondly the technical flaws within the scheme.

Proportionality

The risk equalisation scheme is disproportional to the matter that it is attempting to control. This is apparent when one notes that the implied payments under RE from the second largest undertaking in the market (BUPA Ireland) exceed that undertaking's profits by some margin. While it can be argued that BUPA Ireland can increase premiums to address this shortfall, it is not clear whether BUPA's customers (many of whom were never customers of VHI) would accept such an increase – there is a significant probability that a very significant proportion will choose to cease insurance cover entirely.

A key reason for the disproportionality is that risk equalisation addresses only one of the competitive differences between insurance companies. In the Irish market as it is currently structured, there is a range of advantages and disadvantages that affect the different players in the market:

- Newer entrants to the market (currently BUPA Ireland and VIVAS Health) will tend to pick up younger customers as there is a higher level of inertia associated with older customers. This does not imply active risk selection. The experience over time for all insurers should be similar.
- VHI was previously a protected monopoly. It retains a dominant status with approximately a 76% market share. This market share gives VHI very considerable market power in terms of brand, rate setting, infrastructural advantages such as dominant access to salary deduction, as well as economies of scale that are derived from its former state monopoly status
- VHI's brand carries an associated perception of state guarantee. VHI's exemption from solvency requirements may be construed as implying an actual state guarantee that the organisation cannot be allowed to become insolvent.
- VHI is exempted from carrying a solvency margin which has the effect of substantially reducing the costs of the business. A 6 year transition to application of solvency standards to the organisation has been proposed. This would allow the organisation to continue to carry this advantage for some time.
- VHI is exempted from other regulations that would apply to the insurance companies that it competes with or could compete with. For example, VHI is permitted to act as

an insurance agent at the same time that it acts as an insurance company. This allows the organisation to create lock ins of its members using a mechanism that is not available to its competitors

Risk equalisation is an attempt to equalise the first of these differences, but does not in any way address the other differences – most notably the competitive advantages that VHI derives from its dominant position in the market.

While all companies in the market attempt to compete on many dimensions: price, benefits, service, cost control, etc. it is apparent that price is a critically important dimension and is likely to remain so as the market continues to evolve (albeit in a manner that is constrained by other aspects of regulation such as minimum benefits). In this scenario, “equalising away” the primary advantage of the newer entrants that (to a certain extent) allows those companies to compete on price inevitably leads to a disproportionate outcome in relation to profitability.

A consequence of this imbalance is that it is very likely that the imposition of risk equalisation will have the effect of consolidating the inertia within the market. This is because if price differentials are lessened or reversed, the remaining advantages of the dominant player will be substantial and dominance reduction will likely cease and may be reversed. The implication is that market shares will move much more slowly or may reverse with the advent of risk equalisation. The triggering of risk equalisation will consolidate the market share of the dominant player.

The proportionality of risk equalisation payments has also never been determined or benchmarked against international equivalents. It is noteworthy that in Australia (which has in excess of 20 health insurers) only the over 65's and chronically ill are subject to risk equalisation.

Risk Equalisation – technical aspects of the scheme

In considering its views of the technical aspect of the risk equalisation scheme as currently constructed, and the effect on competition, VIVAS Health has referred to the 2002 report of the Working Group on Risk Equalisation of the Society of Actuaries in Ireland.

In its 2002 report, the Working Group considered the appropriate nature of a risk equalisation scheme in the context of the “official objectives” of risk equalisation. These objectives included preservation of the stability of community rating and facilitation of competition.

Certain criteria were to be met by the scheme including equalisation of risk profiles, equity, non equalisation of benefit levels and predictability.

In the context of these objectives, the Working Group examined the criteria and determined the view of the group as to the appropriateness of the criteria and in turn the implications of the criteria for the form of risk equalisation that should have been adopted. In relation to these matters, the following points are noted from the report of the Working Group as they relate to the interaction between risk equalisation and competition:

The Working Group identified that the scheme should not be such that “preferred” new entrants are disincentivised from entering the market. The actual scheme does not take account of this need, as companies attracting completely new entrants to the market (as BUPA has successfully done and as VIVAS Health are now also doing) do not benefit from any differentiation between these customers and the customers that are switchers between companies. There does not appear to be an objective logic for penalising newer insurance companies in relation to business that is new to the market and that in many cases would have remained in the uninsured population in the absence of competition.

In relation to the matter of equity, the group concurred that there should not be sharing of efficiencies between health insurers. This would imply that the relevant factors for RE calculations should not go beyond age and gender (while the group was not definitive on this matter, it did list several reasons why health status should not be included as a factor). In fact, there remains a reserve power vested with the HIA to recommend the introduction of health status as a factor. This is a further disincentive to competition because introduction of this factor will bring further pricing pressure on smaller insurers. It should also be pointed out that 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.

Also on the matter of equity, the group strongly suggested that the chosen scheme should be designed to have the lowest level of interference in the insurance market and should be as transparent as possible. The actual scheme, however, is a very “strong” form of risk equalisation, and its retrospective nature makes it difficult to manage, to plan for and difficult to understand for external parties.

The group stated that “it is also hard to see how community rating can be justified on “general good” grounds for benefits above the prescribed level”. In fact, while there is some top-slicing of benefits, the effect of the top slicing is to equalise claims payments for benefits well in excess of “the prescribed level” (which was interpreted as Plan B) in many cases.

The group very specifically recommended that the system of risk equalisation should be prospective in nature and explained in some detail how a system would work. The group pointed out that a prospective basis would be more predictive for insurers and more transparent. A predictive scheme was also identified as being much less susceptible to volatility (the actual experience is that BUPA Ireland have experienced extreme volatility of putative payments in some age bands due to the retrospective system). Predictability is critically important to smaller competitors and it might be contended that the imposition of a retrospective system showed little regard for the concerns of prospective new entrants at the time.

Minimum Benefit Regulations

The Minimum Benefit regulations are a prime example of the regulatory capture of the VHI. The Minimum Benefit regulations in effect codified the benefits contained within VHI Plan A at the time. Hence, while VHI was automatically compliant every new insurer was imposed with the obligation to meet this standard. In addition, as the Minimum Benefit regulation lays down the minimum benefits possible it in effect harmonised all products within the market to follow those of the VHI. This historic product model based on VHI products continues, if one looks at the HIA product comparisons these are all founded to fit VHI plans rather than any innovations within the market.

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 be innovative in its product is severely restricted. This in effect limits competition between insurers on product.

The Minimum Benefit regulations also hinder the development of preferred provider networks by insurers as all insurers must cover all public hospitals and a certain level of treatments within private hospitals. As the Minister for Health and Children unilaterally sets the prices for beds within public hospital without negotiation there is no capacity for cost control in this area and this must be factored into premium setting e.g. in January 2005 3 months after VIVAS Health entered the market the Minister implemented a 25% rise in

hospital bed costs (the highest increase in recent history which coincided with VIVAS Health entry into the market!). The Minimum Benefit Regulations are adding to the premiums that insurers must charge.

If the Minimum Benefit regulations were to be amended to allow for the exclusion of public hospitals, the development of preferred provider networks and a specialisation of products then premiums would reduce to the benefit of consumers.

The Voluntary Health Insurance Acts

The Voluntary Health Insurance Acts and in particular the amendments made via the Health Insurance Acts are severely limiting competition within the market. The powers provided to the VHI through these Acts to engage in ancillary activities on more economically favourable terms to those of its competitors are entirely distorting the market. In particular, the failure to specify any solvency requirements via the Acts and to allow VHI to run off its reserves through below cost premiums is impacting the ability of all insurers to compete. It is questioned how the pricing policy engaged in by VHI since September 2004 (a month prior to the entry of VIVAS Health to the market) which aims to put VHI into a financial loss can be reconciled with the VHI statutory obligation to break even.

Lifetime Community Rating Regulations

The failure to implement these Regulations by the Department of Health and Children is hindering the level of competition within the market. When similar regulations were implemented in Australia the market grew by approximately 15%. This type of lifetime community rating will bring further stability to the market by penalising those who choose to wait to take out health insurance. In addition, it will add another factor of competition on premium to insurers within the market.

- 6. 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 recommendation deemed appropriate.**

Recommendations

How to attract new entrants –removal of barriers to entry:

- 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.
- Restructure risk equalisation so that the financial cost is proportionate to the matter it addresses.
- Put in place a clear policy to completely open the market to all players and create a level regulatory playing field.
- Introduce a liberalisation policy with targets to reduce VHI market dominance.

The VHI

Short Term policy solutions:

- The VHI Board can be given a Ministerial direction to strategically start reducing market dominance and allow the market to open properly.
- The VHI as a state emanation must follow the Government's obligation to foster competition. The VHI should be obliged by Government to communicate to its membership that there are now two other insurers within the market place and that they have the possibility to switch to these undertakings without any waiting periods (in accordance with health insurance legislation). In fairness to all parties, this communication should be to members of all ages and risk profiles which will act as an actual and appropriate means of true risk equalisation.
- VHI should be prohibited by the Minister from tying in its members through different financial services. This would give all consumers free choice to shop around between all insurers without the penalty of losing any other coverage they may have purchased with VHI.

- VHI must open and give access to other insurance undertakings to the salary deduction mechanisms it has in place in most companies in Ireland. Salary deduction mechanisms are a State infrastructure and as such should be open to all insurers. An independent body must be established to open all salary deduction mechanisms.
- VHI must be subject to immediate prudential regulation by the Financial Regulator – giving the VHI until 2012 to achieve this objective is not reasonable in light of current market circumstances – why VHI has been given such a prolonged period of time to enter solvency has not be clarified.

Structural changes to VHI:

- Splitting of VHI – breaking VHI into a number of smaller companies would automatically reduce dominance. Once split some parts of VHI could be retained in State ownership, some in private ownership or co-ownership with the State. A split would have to include a separate stand alone intermediary company to resell non-health related products. The Government must decide whether it wishes to have a state company engaging in such activities.
- Selling off part of VHI book- with cross-section of age profiles – this would both reduce dominance and spread risk.

Regulation

- A liberalisation policy must be put in place by the Minister for the health insurance market. The key objective in such policy being to foster competition and properly open the market for all competitors. Such a policy could follow models laid down for the opening of public utility companies with set targets embedded in legislation for market reduction and the opening of infrastructure held by the State company.
- A Code of Conduct for switchers must be implemented (and policed by the appropriate regulatory body) to allow for ease of switching and to prevent aggressive “win back” policies being implemented.
- A single regulator for health insurance should be provided – the Financial Regulator should act as sole regulator dealing with all aspects of health insurance. This would reduce the regulatory burden of having to interact (and pay levies to) two separate Regulators.
- A level playing field must be put in place vis-à-vis ancillary activities in which VHI wishes to engage. VHI must be made subject to the same regulatory parameters as other non-life insurance undertakings. To this effect VHI must not be permitted to

engage in selling other ancillary products without establishing the proper corporate structure (and inherent costs) that this requires.

- VHI must be placed under fiscally proven corporate governance rules to prevent it from implementing below cost premiums leading to its own financial instability. Increased transparency in its accounts are required to ensure that it does not cross-subsidise its products to leverage its dominant position in health insurance into other financial services sectors.
- The VHI should be regulated by the Financial Regulator – compliance with all consumer and prudential regulation must be required.
- Implementation of life-time community rating. This is already provided for in primary legislation but has not been implemented. This would ensure proper intergenerational support by encouraging members to purchase health insurance earlier.

Risk Equalisation

- The present operation of the risk equalisation scheme cannot be sustained. The scheme should be suspended and a new form of risk equalisation must be introduced that takes account of
 - Proportionality of payments.
 - the need to encourage new entrants
 - VHI's dominance, and
- A new risk equalisation scheme similar to that contained in other countries should be implemented. The new scheme would only commence once market shares were more evenly spread. Any payments must be proportional and not such as will wipe out profitability or require massive increased premiums to subsidise another company. The more companies and the more evenly spread market shares are the lesser the burden of risk equalisation becomes. There are several examples internationally of alternative approaches that take account of proportionality, for example applying risk equalisation only to the oldest members in the system and only to chronic illnesses.
- Criteria relevant to actual market instability should be set down in primary legislation. The effect on competition in the market must also be closely observed.