



***Competition in the  
Private Health Insurance Market***

**SUBMISSION BY VHI HEALTHCARE**

***April, 2006***

## SECTION ONE - INTRODUCTION

### Background to the Consultation

In December 2005, the Tánaiste and Minister for Health and Children triggered the risk equalisation scheme with effect from 1<sup>st</sup> January 2006. She said that “risk equalisation is a necessary and appropriate mechanism in a community rated market.” She also announced that the Government had approved the drafting of legislation that will oblige Vhi Healthcare to operate under similar conditions as apply to other insurers in the market including, in particular, obliging it to build up its reserves to the necessary level to receive authorisation as an insurer not later than 2012.

The Tánaiste reiterated her commitment to vigorous competition in the private health insurance market. She asked the Competition Authority and the Health Insurance Authority to report on further measures to encourage competition in the market. Furthermore she mandated the Health Insurance Authority to carry out a major and sustained campaign to heighten consumer awareness of their right to switch without penalty between insurers and to seek the co-operation of employers in facilitating this process.

The Competition Authority and the Health Insurance Authority have been requested to examine the private health insurance market in Ireland from a competition policy perspective and both authorities have now agreed terms of reference for this consultation. The announcement of the consultation process states “Government Health Strategy envisages community rated private health insurance continuing to play a major role in the overall resourcing of private healthcare. “

Vhi Healthcare has compiled this submission on the understanding that community rating supported by risk equalisation now exists within the market following the Tánaiste’s decision in December, which is currently being challenged in the courts by Bupa. However we have referred to the benefits of risk equalisation for competition where appropriate and the evidence presented from the market (e.g. in relation to significant levels of market segmentation across insurers based on age and hence risk profiles) is based upon the absence of risk equalisation for the last ten years.

## Overview

The changes that the Tánaiste announced in December 2005 will have significant implications for the private health insurance market.

Risk equalisation is essential for real and beneficial (i.e. efficient) competition to exist in the health insurance market: The obligations created by community rating are such that the health insurance market is not like any other market for goods and services, or for that matter, any other insurance market. Community rating is a public policy intervention by the State, which, on its own, introduces a tendency for insurers to compete only for better risks (e.g. the relatively young). Risk equalisation is the necessary antidote to this market intervention as it encourages competition across all age groups in the market and ensures that all market participants are incentivised to become more efficient and innovative in terms of cost, product, customer service and provider management. Once introduced, risk equalisation should encourage a more expansive approach to competition, in particular across all age groups, by players in the market. Risk equalisation gives insurers an incentive to compete for the whole market i.e. all age groups. Without it, at least half of Vhi Healthcare's customers are not attractive to new entrants.

The introduction of risk equalisation will now provide certainty about the regulatory structure of the market and may thereby encourage more companies to consider entering the market. New entrants will enter if they believe they can bring sufficient innovation, efficiency, and value for money so that they can make a return.

A factor which must also be noted is the segmentation of the market between individuals and groups. [REDACTED]

[REDACTED]

[REDACTED] Decisions taken by employers at group level are

increasingly centralised in the purchasing function and small price (and/or quality) differences influence decisions. Our competitors are very competitive within the company-paid segment of the market as can be seen from their recent successes in attracting some of the large corporate schemes, which have a significantly better risk profile than the market average. Product offerings must therefore be very competitive and, under the community rating rules, products offered to corporate schemes must also be made available to all consumers in the market. It should be noted that risk equalisation will not completely eliminate the advantages associated with attracting these corporations and their relatively healthy employees.

While surveys have been carried out by the HIA that suggest low levels of switching between insurers, these studies only look at individual behaviours and not the dynamics of the group schemes, where most transfers take place.

According to the latest figures available from the HIA approximately 52% of the population holds private health insurance. Vhi Healthcare has a 78% market share, BUPA has approximately 21% and Vivas, the new entrant, has approximately 1%.

The private health insurance (PHI) market in Ireland is unique. Take-up of PHI is very high and premiums levels are relatively low by international standards. In large part, this has resulted from the community rating of health insurance. Vhi Healthcare can also claim some credit for the high rate of market penetration given that, from its earliest days in 1957, it established robust processes of distribution and customer service while maintaining operating costs at low levels in order to keep premiums down.

### **The Private Health Insurance Market in Ireland**

The market for PHI in Ireland could be defined as the market for payment of the medical costs of the entire population. This includes costs associated with the delivery of primary, secondary (i.e. hospital) and tertiary care (i.e. respite and nursing home care) services. In practice, the PHI market is somewhat smaller for a number of reasons:

- Approximately 30% of the population are entitled to the full costs of such services under the State's Medical Card scheme;
- Payment for services provided is guaranteed to be at least partially financed for all members of the population through the public health system.
- Some consumers will always choose to self-insure rather than to take out a PHI product.

It is therefore more reasonable to assume that the relevant product market is PHI related to secondary (i.e. hospital) care as the proportion of benefits paid for primary care within the entire market is relatively small.

### **Related Product Markets**

The following product markets are to some degree linked to the PHI market:

- Cash plans
- Primary care insurance
- Private dental insurance
- Travel insurance
- Provision of Occupational Health Services

In general, we do not believe that any of these new and developing markets has implications for the functioning of the PHI insurance market.

However, with regard to the cash plan market, we believe that impediments to competition in the PHI market are created by virtue of the fact that certain cash plans providers do not need to be registered with the Health Insurance Authority as a health insurance undertaking, or with the Financial Regulator, and are therefore are exempt from the regulatory regime relating to PHI.

## **Vertical integration strategies of insurers**

In addition to the related products and markets identified above, a market for the provision of services relating to the diagnosis and treatment of minor injuries has recently evolved. To meet demand within this market, Vhi Healthcare has been innovative in recently opening a minor injury clinic under the brand name “*Vhi Swiftcare*” at which, persons who require medical treatment for clinically designated conditions not considered to be life threatening can receive diagnosis and treatment.

This is a new market and Vhi Healthcare participates in this market on a stand-alone basis separate to its core business. Patients receive treatment based upon a fee for service system and access to these treatments is available to all i.e. those with private health insurance and those without.

As in the case of the other markets referred to above, we do not believe that this new market has significant implications for the functioning of the PHI market.

## **Community rating**

The PHI market is different to other insurance markets (e.g. car insurance) in that insurers are not allowed charge a price (premium) based upon the individual member's expected level of demand for the service, i.e. a premium that accurately reflects the risks involved. This results from the public policy decision to apply community rating whereby all members must be charged the same premium, irrespective of their risk profile, for the same product or bundle of benefits, as opposed to risk rating.

The consequence of the constraints imposed by community rating is that many of the dynamics of a more standard market are distorted and some unusual economic incentives are introduced. This is particularly true in the absence of risk equalisation.

In particular, there is an incentive for the market to become segmented between the healthy and the ill. In the absence of perfect information on health status this segmentation generally takes place based upon age, although segmentation could also take place based upon other risk factors (e.g. gender). In this regard, the extra marginal

premium gained from every new younger member would be expected to be considerably greater than the administration and claims cost of that member. Conversely, the premium for an older member is expected to be considerably less than the cost of the additional claims and administration associated with that member. This is demonstrated by the fact that, for example, the claims cost of a seventy-year old is more than eight times that of a twenty-year old, although the premium paid by both members under the principle of community rating would be identical.

Insurers have therefore had an incentive to segment the market into low-risk and high-risk groups and to 'cherry-pick' the low risk groups while ignoring the higher risk groups.

Community rating is characterised as risk solidarity, or inter-generational support. Given that community rating is intended to co-exist with competition, this introduces a particular dilemma for public policy makers. Without some form of regulation, community rating by itself would mean that high-risk groups, who are in greatest need of health insurance, could be eventually excluded due to the marketing practices of, and economic incentives confronting, insurers.

Therefore, as a matter of public policy, it has always been regarded as essential to underpin the community rating system with a series of other supportive measures:

- *Open enrolment* to ensure all segments of the market can join;
- *Lifetime cover* to ensure that once a member joins they can continue to be a member even when they become high-risk;
- *Minimum benefits* to ensure that adequate benefits are provided to all risk groups;
- *Risk equalisation* to ensure that individual insurers have a fair risk profile of members and thereby counteract the segmentation strategies of insurers; and
- *Lifetime community rating* to ensure that individuals do not choose only to take out insurance once they become high-risk. This is provided for in legislation but has not yet been introduced.

Without all of these measures, and, in particular, risk equalisation, there is an incentive for real competition to be stifled as insurers seeking to maximise profits will continue to

segment the market thereby leading to an inherent instability within the market (without risk equalisation a community rated market is dynamically unstable). This allows some insurers to make ‘*super-normal*’ profits based upon preferred risk selection rather than on any underlying efficiencies and has the effect that consumers, on average, are paying more than they should for health insurance.<sup>1</sup>

All of the measures referred to are required to ensure proper competition within the market. To date lifetime community rating regulations have not been introduced and risk equalisation transfers have not yet commenced. Once risk equalisation payments have commenced it will take some time for its impact to be seen in the market statistics.

The decision by the Tánaiste in December to implement risk equalisation removes some of the uncertainty for potential entrants. New entrants are exempt from participating in the risk equalisation scheme for a period of three years from the date of their entry to the market. However, such an exemption has the potential to encourage ‘hit and run’ type behaviour whereby insurers enter the market, target healthier lives and then potentially exit the market once their exemption period from risk equalisation expires. They are then free to re-enter the market. Furthermore, the phasing arrangements under which contributing insurers only make payments to the risk equalisation fund at 50% in the first contributing year allows competition to continue based on risk.

### **External factors affecting the market**

It is important to consider the link between the overall health system and the PHI market. It has been noted (and has been shown in relation to the growth in membership of Vhi Healthcare) that the PHI market is directly affected by the perceived state of the health system. Thus, the public health system can be considered economically a “*substitute good*” for private insurance.

While there are long waiting lists, cost cutting (and consequently less medical cards being awarded) and other budgetary pressures on the public system, PHI membership has shown an increase.

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<sup>1</sup> For further information in relation to these topics please see the submissions of Vhi Healthcare in relation

In addition, the membership of insurers is affected by economic cycles. Recent strong economic performance has meant that many employers are now routinely providing subsidised private insurance as an employee benefit.

The state of the public health system, together with employers' willingness to fund PHI have registered in customer research as the main reasons why people purchase PHI (see the Amárach study for the HIA). Given the high penetration of PHI to date, it seems unlikely in the short to medium term that PHI penetration levels will continue to increase at recent levels. An increase in the size of the population may lead to an increase in membership levels, even at static penetration levels, although the propensity for immigrant foreign nationals to take up PHI appears to be low to date.

We have already made the point that these studies focus on individual behaviour while most transfers take place at the group scheme or corporate level.

## SECTION TWO – THE MARKET

### Market Structure

Until 1997 PHI was provided exclusively by Vhi Healthcare with the exception of some services that were provided through the closed occupational schemes of the ESB, Prison Officers and the Garda Síochána. This effectively resulted in one “community” operating within the market. Since the introduction of competition in the private health insurance market in 1997, separate and distinct “communities” (i.e. each insurer’s members being a community in itself) have operated within the market and they have invariably been of widely different absolute sizes and with widely different risk profiles. The introduction of risk equalisation transfers will now ensure that there will, in effect, be one market community and the inter-generational solidarity principle that underpins the market will thereby be supported.

Approximately 52% of the population have private health insurance as compared with approximately 11% in the UK, which is a risk rated system. By international standards this is very significant and is one of the highest for a “voluntary” market within the world.

Currently, three insurers operate within the market and they have widely different risk profiles. While Vivas Health is relatively new to the market membership, information for Bupa is available from the Staff Reports of the Health Insurance Authority.

### Relative market shares

Vhi Healthcare currently has the largest market share within all age groups. However, it is important to point out that it is estimated that a significantly higher proportion of members within older age groups are members of Vhi Healthcare, as compared with younger age groups.

**Figure 1 was here**

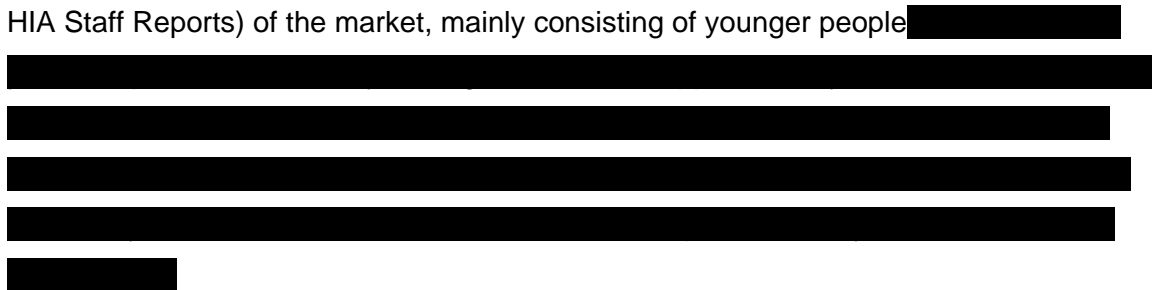
Relative risk profiles

In terms of the membership profile of each insurer, significantly more of Bupa's membership is aged 39 years or less as compared to Vhi Healthcare. (Figure 2)

**Figure 2 was here**

Market shares over time

It is also important to analyse the transition of membership over time. Bupa entered the market in 1997 and since then has gained a membership of approximately 22% (source HIA Staff Reports) of the market, mainly consisting of younger people



### Relative market shares and risk profiles by premium income

Total premiums within the PHI market in the year 2004 were in excess of €1,000 million (source HIA Annual Report, 2004). Given that the average premium rates for Vhi Healthcare are somewhat higher than its competitors, it is estimated that approximately 85% of the premium went to Vhi Healthcare. This results from a number of factors including the fact that more Vhi Healthcare members choose higher plans compared to its competitors' members, average premium rates for the same level of cover are higher for Vhi Healthcare compared to its competitors (as a direct result of Vhi Healthcare's relatively poor risk profile, i.e. older customers), and the fact that there are proportionally less children (and consequently higher average premiums) within Vhi Healthcare's membership as compared with its competitors.

### **Market Performance**

It could be expected that new entrants would be attracted into a market where existing firms were inefficient. In addition, it could be expected that an inefficient insurer would have considerably higher levels of administration costs and provider costs compared to other insurers. From the perspective of administration costs, financial performance, provider efficiency and the actual relative level of premiums, an indication of the relative performance of the market can be made.

### Administration costs and efficiency

Vhi Healthcare's administration costs are significantly lower than many other health insurers throughout the world. Its administration costs in the financial year ending 28<sup>th</sup> February 2005 represented 8.6% of earned premium. This compares most favourably with that of United Kingdom insurers. For example, the Bupa group, in the United Kingdom, has an administration ratio of over 17% per annum. In the United States health insurers generally have administration ratios of more than 12%.

In Australia and South Africa, both of which operate community rating and where the PHI market environment is similar to Ireland, administration ratios are generally in excess of 12%.<sup>2</sup>

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<sup>2</sup> Source: Various. South Africa survey of insurers carried out by Medical Benefits Council and Australia direct from insurers.

While this difference in administration costs between Bupa and Vhi Healthcare is quite significant, the difference is less pronounced based upon administration costs per member. However, these figures still indicate that Vhi Healthcare's administration costs are less than those of Bupa.

Such comparisons clearly indicate that Vhi Healthcare is a relatively efficient organisation. There may therefore be little scope for competition in relation to administrative costs.

#### Provider costs and efficiency

Given the differing natures of health systems it is difficult to compare the relative efficiency of the market in terms of provider reimbursement.

Vhi Healthcare aspires to and meets internationally recognised '*best practices*' in relation to provider and claims management. More than 65% of all cases are now treated on a day case basis, reimbursement is based upon resource intensity and utilisation reviews take place in respect of claims.

The direct payment arrangements, which Vhi Healthcare has in place with providers, are hugely beneficial to consumers and take the financial worry out of medical treatment, particularly where there is full cover for the services concerned, which is the case in relation to many in-patient treatments.

### International comparison of premiums

Health insurance premiums in Ireland are significantly lower than those in most other countries. In this context it is necessary to have regard to the underlying benefits provided; the health system operating in each country; the differing demographic profiles of the countries and the relative wealth of the country. Measuring the level of premiums as a percentage of the average industrial salary based upon a standardised age structure and benefit package provides a mechanism to compare such premiums.

The indicative table below, which is based upon data from 2001, shows that Vhi Healthcare premiums are significantly cheaper than those applicable in the other selected countries. This may indicate that there is limited scope for consumers to gain price reductions from additional competition if a 'fair' risk profile is held by all insurers.

**Table 1: Comparison of Premiums between countries**

<b>Country</b>	<b>Indicative secondary care premium</b>	<b>Average salary</b>	<b>Premium as % of average salary</b>
Australia <sup>3</sup>	€578	€26,699	2.2%
Germany <sup>4</sup>	€3,338	€31,472	10.6%
Ireland <sup>5</sup>	€475	€26,522	1.8%
Netherlands <sup>6</sup>	€2,426	€30,327	8.0%
Spain <sup>7</sup>	€490	€19,307	2.5%
United Kingdom <sup>8</sup>	€1110	€31,289	3.5%
United States <sup>9</sup>	€2,625	€24,162	10.9%

<sup>3</sup> Sources: Medibank Private, Mercer HR

<sup>4</sup> Source: Destatis, MercerHR

<sup>5</sup> Source: Vhi Healthcare internal data, Central Statistics Office

<sup>6</sup> Source: Mercer HR

<sup>7</sup> Source: Sanitas, Mercer HR

<sup>8</sup> Source: Laing & Buisson, MercerHR

<sup>9</sup> Source: Kaiser Permanente, MercerHR

### Financial performance of insurers

Given the relatively efficient administrative and provider arrangements already referred to, it is also useful to consider the financial performance of the industry. The low level of profit made by Vhi Healthcare, in keeping with its not-for-profit status, supports the view that the organisation is relatively efficient in delivering benefits to its members. In the financial year 2004/2005 Vhi Healthcare made an operating surplus of 1.4%. This was somewhat lower than the previous years. (The average of the previous five years was 4.1%, which is still lower than its target level of 5%.)

Given that premiums are increasing faster than average surplus levels, the result of such historically low operating surpluses is that Vhi Healthcare has been unable to reach what might be considered commercial solvency levels.<sup>10</sup> This is largely based upon the historic public policy objective that Vhi Healthcare should only “breakeven” which is supported by the “not-for-profit” provision in its governing legislation.

A further explanation for the historically low profit margins is that the underlying market is only marginally profitable and therefore it might be expected to be highly concentrated among a small number of insurers. It is difficult to confirm this view. However, profitability and concentration numbers from the United Kingdom (1.2% profit margin for 2001 from Laing with the top three insurers holding a 71% market share (no more current data is available), the Netherlands and Australia suggests that this is possible. The higher level of medical inflation and the low absolute levels of health insurance premiums in Ireland together with the low profit margins for PHI generally may make it unattractive to insurers.

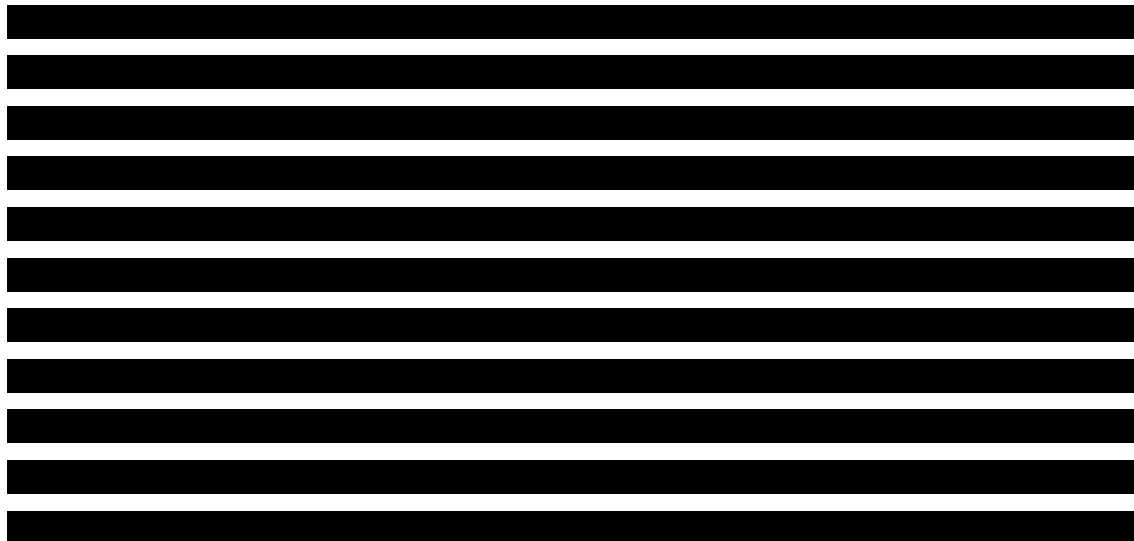
Any analysis of profitability must make reference, at least in passing, to the super-normal profits that Bupa has made since its entry to the market, in the absence of risk equalisation. Risk equalisation should remove the existence of windfall profits. Vhi Healthcare's target profit is 5% of premium income, although this may have to be higher over the next five years in order to achieve the target solvency level set by Government. A return of 5% of premium income would provide a return of 12.5% on capital employed

if capital employed was at the 40% solvency level currently required by the Financial Regulator.

### **Market Segmentation**

Higher average costs per person for older people (as compared with younger age groups), together with the legislative requirement of community rating, mean that insurers have had an incentive to operate a preferred risk selection strategy particularly in the absence of risk equalisation. While the introduction of risk equalisation will ameliorate the advantage in getting younger healthier lives, it will not remove it entirely given that risk equalisation is calculated using only two risk factors and that there is evidence that switchers are relatively healthier than the market average. Such a strategy means, in effect, dividing the market into segments and targeting only those within the lower risk groups.

The best indication of this incentive is shown in the relative profitability for insurers in respect of younger members as compared with older age groups.



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<sup>10</sup> Solvency in an insurance context refers to the excess of assets over liabilities. Regulators, given the uncertain nature of insurance business insist that insurers hold a minimum level of solvency. Typically commercial solvency would be considered to be twice the minimum solvency level.

This is shown by calculating a notional community rate (zero excess profit) for a group of insured members and comparing this with the equivalent risk premium that would be charged for members within each age group.

## **SECTION THREE: COMPETITION & RIVALRY**

Competition within a market, whether it is segmented or not, is largely based upon price. However, there is also competition in relation to service, providers and product benefit.

### **Price competition**

There is some evidence (see HIA Staff Report, October 2005) to suggest that Bupa has adopted a sustained price following strategy in the absence of risk equalisation in order to maximise their profits. Apart from maximising profitability, a price following strategy has also had the attraction for Bupa that it was the approach least likely to trigger risk equalisation.

The Vivas pricing strategy is that they charge prices slightly below those of Bupa. It is unclear, as of yet, whether such a strategy can be considered to be sustained price following. Our expectation is that Vivas will use their price advantage over the next two years to maximise membership numbers i.e. adopt a deep discount strategy. Given the exemption period from risk equalisation they, like all other new entrants, will be at a significant commercial advantage until they are required to participate in the risk equalisation scheme.

One pricing area in which Vivas has been innovative is in relation to child premiums. At various points since their launch they have aggressively cut their prices for children. An example of this is the 'Back to School' offer they introduced in August 2005 and also in January 2006.

### **Impact of medical inflation**

Medical inflation has a growing impact on demand for PHI. Recent premium increases have ranged from 3% to 18% per annum. Such increases have resulted from a number of factors including increasing utilisation and increases in provider costs.

In an international context, similar levels of medical inflation have been experienced<sup>11</sup> but they are nonetheless a continued potential source of concern for the market. There is evidence of PHI consumers choosing to self-insure rather than maintain their PHI given the extent of premium increases.

### **Price transparency**

Given the application of community rating the price of each product is reasonably straightforward for a consumer to determine. However, given the potential complexity of the medical treatments under-pinning each product, it may be difficult for a consumer to compare the relative cost of the products provided by different insurers.

### **Non-price competition**

#### Service

Undoubtedly there is already a considerable level of competition in relation to the provision of service within the industry. Large corporations require their insurer of choice to provide administration facilities to the highest standards of information technology sophistication (e.g. web-enabled functionality). Evidence of the degree to which insurers believe service provision to be an important part of the business can be seen in the fact that both Vhi Healthcare and Bupa have won a number of domestic and international awards for the service provided to their customers.

#### Provider coverage

Competition relating to provider coverage results from the ability of insurers to reach agreements with different providers. There has been some limited evidence of this in the market. For example, Vhi Healthcare covers St. John of Gods psychiatric hospital while Bupa does not. However, most of the provider competition at present relates to the rates paid to institutions.

In this regard Bupa, which has a preferred risk profile, has the ability to pay rates above that of Vhi Healthcare in order to secure agreements partly because of their limited volume of claims.

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<sup>11</sup> See Australia, United States (e.g. Calpers) and continental Europe.

Bupa and other insurers entering the PHI market benefit from the prices, which Vhi Healthcare, with its longer standing in the market, is able to negotiate with providers of hospital services. Bupa and others can seek similar prices to those negotiated by Vhi Healthcare. However, as a result of their younger membership, and lower resulting claims costs, they can obtain a competitive advantage over Vhi Healthcare by agreeing a higher price with a provider in circumstances where Vhi Healthcare is unable to reach agreement with a provider on price. Vhi Healthcare prudently considers itself to be constrained by competition legislation to a much greater degree than its competitors and regards itself as requiring objective justifications for its actions in dealing with providers. Other players and new entrants are not subject to these restrictions.

It is quite likely that future provider competition will be based on the underlying reimbursement methods, rather than the level of reimbursement for a given method. This is because new entrants may seek to contain costs relative to their competitors to compete within the market (e.g. preferred provider networks etc.).

A large number of new private facilities are due to come on stream in the near future. This will represent a significant challenge for all insurers and may result in insurers covering different hospitals to each other to a much larger extent than is currently the case.

### **Product Competition**

Historically, all the products in the market mainly provided benefits for hospital (i.e. secondary care) treatments. The products were largely differentiated based upon the benefits provided for hospital accommodation. The products also provided some level of benefits for primary care services. In recent times insurers are now providing the option of purchasing primary care benefits as part of their main hospital care products to consumers. Although there are some differences in the hospital benefits provided by both insurers, the focus by and large is the same.

In recent years the number of products offered within the market has dramatically increased. This has resulted from decisions by insurers to provide benefits that are more tailored to the individual health needs of members.

The risk profiles of the membership of products are significantly different. Members on average choose higher-level plans that provide better benefits as they get older (and, in general, wealthier). This is seen in the membership profile of Vhi Healthcare, since the level of benefit increases the age profile becomes older (see below).

**Table: 2 Average Age profile of Vhi Healthcare members by product**

Plan	Average age at 1 <sup>st</sup> January 2006	
	Standard	Options
A & A Options	████	████
B & B Options	████	████
C & C Options	████	████
D & D Options	████	████
E & E Options	████	████

Source: Internal Vhi data, Ignores LifeStage Plans<sup>12</sup>

This suggests that there has been an incentive for an insurer to risk segment and thus provide less access to and/or a higher price for higher cost hospital accommodation in order to attract the lower risk segment the absence of risk equalisation. The introduction of risk equalisation will reduce this incentive but, as previously mentioned, is unlikely to completely remove it.

A recent development in the market has been the introduction of excess plans, which do not provide full indemnity for the insured person. One of the aims of these products is to make health insurance cheaper and they can be used by insurers to attract better risks that are more price sensitive than relatively poorer risks.

<sup>12</sup> There are currently about █████ members holding Vhi Healthcare's Lifestage Plans but it is too early to determine their average age by each of the respective plans

## SECTION FOUR: BARRIERS TO ENTRY

It has been suggested that there are a number of barriers that discourage new entrants from entering the market. Many of these alleged barriers (e.g. risk equalisation) do not really exist or, insofar as they do, they are 'natural barriers' and therefore part of the underlying structure of the market environment.

### **Low profit margins**

The return on health insurance business is generally low as compared with other industries except in the case of the excess profits that can be made by new insurers in the absence of risk equalisation to date, or because they will get a derogation from it for a period of time.

### **Start-up costs**

On entering the market the main sunk cost would relate to development of an administration and claims processing system together with a brand. Given that likely new entrants are large-sized multinational insurers or financiers together with large 'bancassurers' it is possible that they may already have in place the necessary systems. Even if they do not, capital taxation allowances, access to capital and the grace period of three years for new entrants before becoming subject to risk equalisation mean that financing such costs should not be a major issue.

### **Cost of entry**

The requirement to have a certain level of start-up capital (minimum solvency level) may be considered to be additional cost of entry to the market. However, as noted in the Competition Authority's study on the Non-Life Insurance market, such costs are required for prudential management purposes. The comments made within that report largely equally apply to the PHI market. The important thing is to ensure that solvency requirements should not be excessive, or go beyond that required for prudential purposes.

## **Provider negotiations**

There is evidence to suggest that both Bupa and Vivas largely replicate the provider contract arrangements (but not necessarily all the rates) of Vhi Healthcare. Smaller restricted membership undertakings do likewise. In general, there is an incentive for smaller new entrants to do this given the complex nature of provider reimbursement arrangements. In so doing significant entry costs can be avoided by an entrant insurer. Furthermore, ‘free-riding’ on the economies of scale generated by a larger insurer will secure significantly better provider reimbursement rates. This ‘free-riding’ principle allows new entrants to continue to enjoy cost advantages into the future and is perhaps symptomatic of ‘second-mover’ advantages in the market.

## **Uncertainty of commercial and corporate status of Vhi Healthcare**

Uncertainty relating to Vhi Healthcare’s commercial status may be a possible barrier to entry. If it is perceived that Vhi Healthcare may be privatised in the future (be it medium term or long term) some potential entrants may decide not to enter because of their potential interest in acquiring Vhi Healthcare combined with the possible competition implications of attempting to do so if they were an existing insurer in the market. There are currently no plans to privatise Vhi Healthcare.

## **Uncertainty relating to risk equalisation and overall regulatory structure**

The continued uncertainty (pending the outcome of a number of court cases) relating to whether risk equalisation will be implemented in full and whether transfers will ultimately take place between insurers means that prospective insurers do still not know the full *‘rules of the game.’*

Vivas entered the market when Vhi Healthcare had a larger market share and in full knowledge of the legislation relating to risk equalisation. It must therefore be assumed that they did not perceive this as a major barrier to market entry or to competition.

In fact, the certainty of the three-year period of grace from risk equalisation payments means that new entrants can actively target less risky individuals for a period of at least

three years without having to compensate insurers with a higher risk profile. This has the potential to encourage a spate of 'hit and run' entrants who enter for the period of three years and subsequently exit (or reduce their role within) the market once risk equalisation applies to them. They could then possibly re-enter the market.

### **Impact of barriers to entry on competition**

Much industrial organisation theory has considered the impact of barriers to entry on industry structure. In considering the impact of any such barriers to entry the post-entry competition position is fundamental to determining their effect.

Given that profit margins are so low in the PHI market, it is conceivable that even in the absence of any perceived barriers to entry that exist, the market structure would not in fact be any different.

### **Other factors affecting future levels of competition**

#### Impact of risk equalisation

The introduction of risk equalisation will not discourage efficient competition but will in fact do the opposite. It will encourage efficient competition across all age groups based on efficiencies, rather than on preferred risk selection.

As indicated above, the three-year exemption may not be in the best interests of the market as it may encourage 'hit and runs'.

The European Commission has confirmed that risk equalisation is not a state aid but is a corrective mechanism to adjust for differing risk profiles between insurers in order to support community rating.

#### Number of insurers

All industrial economics theory suggests that it is not the number of companies within the market that determines competition within a market but the relative efficiency of each insurer within the market. Thus having ten new entrants to the PHI market would only

be advantageous if consumers were going to benefit in terms of lower premiums for the same level of benefits as currently provided. There is no benefit to consumers in having additional players in the market simply for the sake of it.

## SECTION FIVE: LEVEL OF SWITCHING WITHIN THE MARKET

The reported levels of switching vary considerably. For example, both the Amárach and Insight reports suggest switching is at a low level at less than 3%. Both of these surveys use sample studies with a reasonably small sample size. Vhi Healthcare's own experience is somewhat different. We have already made the point that these studies focus on individual behaviour while most transfers take place at the group scheme or corporate level. Given our large database we can track reasonably easily the numbers and the profile of customers who have transferred to our competitors.

Our data indicates that ██████ customers have left Vhi Healthcare and joined our competitors since competition came to the market in 1997. This equates to a switching rate of between ██████ of Vhi Healthcare's membership over the period. The vast majority of these are within the younger and most profitable segment of the market. Older people do not tend to switch as readily.

In 2005 alone, we estimate that ██████ members left Vhi Healthcare and, of these, some ██████ transferred to our competitors. This equates to a switching rate of approximately ██████ of our membership.

### **Switching costs**

In theory at least the costs of switching health insurer are low. Under health insurance legislation members are entitled to switch between insurers. Subject to transferring to an equivalent level of cover with a new insurer within 13 weeks of cancelling with a previous insurer, no initial or pre-existing waiting periods can be applied by a new insurer. This means the new insurer must pay claims subject to usual product rules.

### **Switching process**

The process for a consumer to switch insurer is reasonably straightforward.

### Individual customers

Members need only contact their insurer and confirm that they would like to switch insurer. The insurer will facilitate this process usually within one working day. The new insurer will contact the previous insurer to confirm the person's details and the expiration of their waiting period.

### Business customers

The decision to switch must be made by the employer, who is paying the cost of the premium. It is not unreasonable that employers would make this choice in circumstances where they are paying premiums for their employees. Vhi Healthcare encounters stiff competition from its competitors in this particular arena, which ultimately benefits consumers as a whole since prices are required to be community rated.

### Salary deduction schemes

Not all salary deduction schemes are accessible to all insurers largely for reasons relating to the transaction costs for the employer of administering schemes for multiple insurers. However it is important to understand that employees can still join any insurer and secure the 10% group discount. For example, they could join through the internet, or a credit union, where the 10% discount is also available.

### **Reasons for switching**

A number of reasons have been identified as to why people switch insurers:

1. Price related reasons;
2. Administration and service reasons;
3. Insufficient benefits.

**Table 3: Reasons for leaving insurer**

<b>Cause of leaving</b>	<b>Percentage</b>
Cost	■
Service	■
Not meeting needs	■
Change of job	■
Paying for years / No claims	■
Dissatisfaction with claims handling	■

*Source: Vhi market research*

### **Barriers to switching**

There are a number of reasons why the level of switching remains low at older age levels. The main reason seems to relate to various forms of customer inertia. However it is possible that inertia may also be explained by consumer satisfaction.

It is also the case that to date i.e. prior to the introduction of risk equalisation, distribution, marketing and product design initiatives have been focused on the younger age groups.

In the PHI market the main reason for customer inertia among older members appears to be the lack of appreciation by consumers of the fact they can actually switch insurers. For example, existing claimants may fear they are not covered with their new insurer, will have to serve additional waiting periods and so on.

Furthermore, because of the nature of the services provided, older members may trust their existing insurer, particularly if they have had a positive claims experience. This trust and resulting loyalty may also relate to the brand strength of that insurer perhaps arising from their long standing in the market, corporate culture or the like.

As indicated above, there is also clear evidence that Bupa has followed Vhi Healthcare's pricing since it entered the market. If Bupa had charged a lower premium, as it could have afforded to do, it is possible that more of Vhi Healthcare's

middle-aged and older members would have switched to Bupa if there was a significant price differential. As indicated previously, Vivas may pursue a deeper discount strategy.

We believe that the HIA has a role to play in educating consumers, particularly in the older age groups, in relation to switching.

## SECTION SIX: LEGISLATION

The Health Insurance Acts 1994 – 2001 and the regulations made thereunder impose, in the public interest, a number of constraints on the manner in which health insurers may carry on their business. This distinguishes health insurance from any other type of insurance sold in Ireland.

The main feature of the legislation is that insurers are obliged to offer health insurance on a community rated basis, which requires them to charge the same premium for the same benefits. This principle is supported by rules requiring insurers to provide open enrolment (they cannot refuse to provide insurance to any person), lifetime cover (they cannot refuse to renew a contract with any person) and minimum benefits (a minimum level of cover must be provided under all contracts).

The legislation also provides for a risk equalisation scheme to underpin community rating by equalising risks between health insurance undertakings. The absence of risk equalisation in the market to date has meant that competition has been focused on younger, healthier risks. It is expected that competition will extend across all age categories when risk equalisation is implemented.

Before the Health Insurance (Amendment) Act 2001 was introduced, the Department of Health and Children had proposed that it would permit primary care health insurance products to be risk rated in order to encourage innovation in this area. As the legislation progressed through the Houses of the Oireachtas it was amended to provide that such products should be community rated in the same way as hospital plans. While consumers might have benefited from product innovation in this area, it is difficult to argue that it is not ultimately in the best interests of consumers that such products should be community rated.

The legislative requirements referred to above limit to some degree the extent to which insurers can devise truly unique products and how they carry on their business generally. Vhi Healthcare acknowledges however that the constraints under which it is required to operate are justified in the public interest and are in the best interests of consumers.

Vhi Healthcare supports the view that there should be a level playing field for all insurers in the market and it accepts the need for it to meet normal commercial solvency requirements in the same way as other insurers. The pricing decisions that Vhi Healthcare will have to face over the next 5 years will limit the competitive initiatives that it can pursue. It should be noted in this context that BUPA will enjoy a significant advantage in this area due to the lower solvency requirements imposed on health insurers in the UK.

In our view the appropriate level of solvency for PHI insurers set by the Financial Regulator requires further consideration. The required solvency level should be no greater than that which is necessary for prudential purposes. Due to the short-term nature of health insurance business and the relatively small size of claims, a similar solvency requirement to other types of non-life insurance is not appropriate. Lower solvency levels for health insurance business exist in other EU countries, as compared with other types of non-life insurance.

Vhi Healthcare also supports the view that lifetime community rating should be introduced to further support the principle of community rating. However, in our view it would be essential to give consumers clear advance notice of its introduction and allow a window of opportunity, possibly six to twelve months, for uninsured persons to take out insurance before the new premium loadings are introduced. This was the approach taken when lifetime community rating was introduced in Australia.

## **SECTION SEVEN: CONCLUSION**

Vhi Healthcare strongly advocates a competitive market for health insurance in Ireland. There should be a clear and fair regulatory framework applicable to all existing and potential market players. Clearly consumers should not be required to pay more for health insurance in order to provide the appearance of competition.

We would be glad to meet with the Authorities to discuss these issues further and to comment on any proposals made by other interested parties.