

Competition Authority
Health Insurance Authority

Public Consultation

Competition in the Private Health Insurance Market

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1. Introduction and Background

Until 1987, private health insurance (PHI) in Ireland was provided (ignoring firm-sponsored schemes not open to the public) by a State-owned statutory monopoly, the Voluntary Health Insurance Board, now Vhi Healthcare. The legislation required, and still does require,

- open enrolment, and
- community rating.

Under **open enrolment**, no customer can be refused cover. Age or adverse health status may not be used to screen potential clients. Once enrolled, a customer may not be dropped for any reason (other than non-payment).

Under **community rating**, all must be charged the same premium for a particular product, irrespective of health status or personal characteristics which could be indicators of health status, such as age or gender. There may not be a 'no-claims bonus', for example. This means that health insurance premiums quoted to potential clients in Ireland cannot be risk-rated in any way, as they are in conventional insurance markets. Thus PHI insurers are passive takers of risk, unable to manage the claims potential of their book through screening applicants or through differential pricing.

This combination of open enrolment and community rating has important consequences for the operation of the market, and in particular for competition. It also gives rise to the system of risk equalisation payments provided for in the Irish legislation, recently activated by the Minister for Health and Children on the advice of the Health Insurance Authority. PHI in Ireland is, from the consumer perspective, a voluntary top-up to the tax-financed and universal State health system, which is free at the point of use. PHI entitles subscribers to choice, priority admission to hospital care and other additional benefits specified in the plans offered by insurers. The principal risk covered is hospitalisation costs.

Approximately 50% of the population (up from 35% as recently as 1990), drawn largely from the middle and upper income groups, have chosen to pay for PHI, which is marketed principally through places of employment. PHI premiums in Ireland equate to about 7% of total health expenditures, underlining the supplementary nature of the system. The voluntary nature of the system provides the opportunity for insurers to target their marketing, for example through the use of distribution channels likely to yield younger customers. This is the only form of risk management open to them.

Community rating means that, while insurers may price a particular package of cover at whatever level they wish (subject to Ministerial approval in Vhi's case), they must then charge the same price to all who choose that package. If premiums could be risk-rated, they would rise steeply with age. Elderly people would pay premiums 7 or 8 times those charged to younger age groups. For this reason, the Irish legislation provides for risk equalisation payments between insurers, to reflect differences in risk profile in their

customer base, since these cannot be dealt with through risk-rated pricing as in a normal insurance market. With motor insurance for example, a new entrant that attracted mainly younger drivers would experience higher claims, but would offset the cost through higher premiums. In PHI, the entrant attracting younger customers would experience *below-average* claims, the incumbent(s) with an older age-profile consequently *above-average* claims. Entrants can price below the incumbent without risk of loss, since they are operating off a lower cost curve. Without a balancing mechanism such as risk equalisation payments, a PHI market with open enrolment and community rating will be unstable, particularly where, as in the Irish case, an incumbent has an inherited book of higher-risk clients. This risk of instability is exacerbated to the degree that client recruitment by entrants is concentrated in younger, and hence lower-risk, age groups. This is also a feature of the Irish PHI market, given the pace of labour force growth and the importance of place-of-employment as a distribution channel. Even without deliberate targeted marketing, entrants will tend to recruit clients with a risk profile below the market average. If the market displays customer inertia, for example if older clients are slow to switch insurers, a pattern where the incumbent is perforce operating off a higher cost curve than the entrants can persist indefinitely.

While the open enrolment and community rating requirements find their justification in social policy, they create an anomalous market. Market stability requires arrangements that offset the variations in claims cost faced by the players, since differential risk-related pricing (the solution in normal insurance markets) is prohibited.

The largest player in the Irish PHI market is the former State monopoly, Vhi Healthcare, which is understood to have just under 80% of members. There are two further players, the UK company BUPA, understood to have about 20%, and a recent Irish-based entrant, Vivas, understood to have a low single figure percentage.

The Minister for Health and Children has recently accepted the advice of the Health Insurance Authority to trigger the risk equalisation scheme provided for in the legislation. This will see regular payments from BUPA to Vhi Healthcare based on the age and gender profile, but not health status profile, of the companies' client base. The most recent entrant, Vivas, will not be required to participate in the risk equalisation scheme until it has been three years in business, a provision of the legislation.

High Court cases have been initiated by BUPA challenging the various decisions of the Minister and the regulator regarding risk equalisation, and also challenging the legislation on which these were based. These cases are ongoing.

The Minister for Health and Children has requested the Competition Authority and the Health Insurance Authority jointly to initiate a study of the Irish PHI market from a competition policy perspective, a public consultation process has been announced and submissions have been invited. The two authorities intend to report to the Minister by the end of September 2006. In this context, this submission has been independently prepared by the author. It should be noted that it has been prepared at the request of Vhi Healthcare.

2. Market Structure – Rivalry

Without risk equalisation payments, the optimal market strategy for an entrant to a formerly monopoly PHI market, with open enrolment and community rating, is clear. It should

- Price a little below the incumbent, enough to give an edge in the younger client-recruitment age-groups but not so far below the incumbent as to attract its older and higher-risk clients.
- Follow the incumbent up the price curve as the latter is forced to reflect the worsening relative risk profile in premiums. Not to do so risks becoming too attractive to unprofitable clients
- Resist the introduction of risk equalisation.

Provided overall market share can be controlled, the entrant can expect strong profitability under this strategy. (An alternative strategy of steep price-cutting and rapid market-share gain is less attractive, since the entrant could quickly begin to ascend the claims cost curve). But eventually, the incumbent is likely to fail or risk equalisation is likely to be introduced. Without risk equalisation, the market will see rivalry only for part of the market. The entrant has no commercial incentive to strive for market share amongst the older clients, although it must accept any who seek cover. It is likely that overall market pricing will be higher without risk equalisation – the entrant has incentives to play price-follower behind an incumbent forced to increase prices in response to steadily-worsening risk profile and consequent higher claims.

It follows that the inspection of market share numbers, or the computation of concentration ratios or Herfindahl indices, is of limited interest in a PHI market like the Irish one. It is a presumption of these measures that each customer is equally valuable to each supplier, and that all of the market will consequently be contested by each player. Clearly, in the Irish PHI market, there is a substantial body of customers who are unremunerative, and whose business will not be attractive unless some system of risk-equalisation is implemented which renders the entire market potentially profitable for entrants and incumbents alike.

At present, Vhi has roughly 4 clients in all age groups for each BUPA client. But it has roughly 12 clients aged over 70 for each BUPA client aged over 70. As a result, the Health Insurance Authority has recommended the triggering of risk equalisation at both of the last six-monthly reviews. While the Minister declined its advice on the first occasion, she has accepted it on the second, and the risk equalisation payments from BUPA to Vhi are set to commence, unless of course the High Court proceedings set her decision aside.

Once a risk equalisation scheme that compensates for age/gender composition in the client base is introduced, the incentives to established players in the market are altered. If the risk equalisation scheme fully offsets the age/gender-related differences in claims costs that they face, each player (aside from entrants enjoying the three-year grace period) now has an incentive to compete for customers across the age and gender profile. Thus a market with risk equalisation can be expected to display greater rivalry than a market without.

The risk equalisation payments now being implemented in Ireland compensate for age and gender, but not for health status. Thus two companies, with identical age/gender profiles, could have a different claims cost experience if one of the companies happened to have less healthy clients. With open enrolment and a ban on no-claims bonuses or other surrogates for risk selection, the most plausible source of differing health status weights is a tendency for clients with a record of claims to feel more secure with their established insurer. If the less healthy are less likely to switch, the competitive disadvantage of an incumbent with an older client base can survive (at a lower level) the introduction of a risk equalisation scheme extending only to age/gender compensation. On the other hand, a scheme fully compensating for health status as well as age/gender could come to be seen as having cost-reimbursement features and inadequate incentives to cost control.

The incentives for a recent entrant such as BUPA under risk equalisation are altered. There is no longer a reason to avoid older clients *per se*, although a strategy to somehow selectively attract lower-risk clients within each age/gender group will still be rewarding in the absence of health-status weighting in the risk equalisation payments. To the extent that the incumbent has the higher-risk clients within each group, market arrangements discouraging switching are in the interest of the entrants, where the risk equalisation scheme is confined to age/gender, but not health status, compensation.

3. Market Structure - Barriers to Entry

The Irish legislation accords new entrants a three-year holiday from risk equalisation, dating from the point of market entry. Vivas are currently beneficiaries of this provision. BUPA, due to the deferment of the risk equalisation scheme, have been beneficiaries since they first entered the market in 1997, but are liable for risk equalisation payments from 2006 onwards, unless they succeed in the courts in having the scheme deferred.

There is thus a significant *incentive to entry* under current Irish arrangements, and its impact needs to be assessed. It could promote inefficient entry, particularly if exit costs are low, with no competition benefits.

There has however also been a potential barrier, in the form of requirements (by the Financial Regulator) for high levels of regulatory capital. It is understood that Vivas was required to meet an initial solvency ratio at 50% of premiums, a high figure for a non-life insurer and particularly for one unlikely, given the nature of the likely client recruitment profile, to face an early adverse claims experience. It is not clear that such a high solvency ratio is appropriate, and this is a potential barrier to entry which the Competition Authority/Health Insurance Authority review might address.

The market would offer a more neutral balance of entry incentives if the three-year exemption from risk equalisation were scrapped, and if all market participants faced the same regulatory requirements as regards solvency, that is, the required ratio of regulatory capital to business written.

4. Market Structure – Barriers to Switching

Markets characterised by an ongoing contractual relationship between customer and provider have often been found to display customer inertia. The customer perceives significant transaction costs in moving to a different supplier, and is not likely to do so unless a sufficient gap opens up in price or service quality. Customer inertia is believed to characterise a wide range of contractual consumer markets, including

- Motor and Home Insurance
- Retail Banking
- Mobile and other Telecoms Services
- Retail Gas and Electricity
- Cable and Satellite TV

Where there are artificial barriers to switching, for example in the case of suppliers who contrive to make it awkward for the switching customer, it is likely that rivalry in the marketplace is impeded, and regulatory authorities will feel that it is legitimate to intervene. In the PHI market, where the customer makes a periodic payment to the supplier, a degree of inertia is to be expected, since there is an element of transaction cost in setting up arrangements with a new supplier. But in addition, there would appear to be a tendency for customers with a record of claims, particularly those suffering a long-term illness, to display greater reluctance to switch, possibly in the (mistaken) belief that a new supplier will be unwilling to take them on, or to service their claims with the same promptness as their current provider. If they have outstanding claims with the current supplier, they may worry about the status of these claims should they switch.

It is easy to see that a pattern of this kind will result in a large incumbent such as Vhi Healthcare experiencing a stronger degree of inertia amongst clients with a recurring claims volume than amongst the generality of customers. To the extent that this happens, the incumbent will have a higher claims-to-premiums ratio than its rivals, *even with a risk equalisation scheme which compensates for age and gender*. From a regulatory perspective, it is important to ensure that customers can be confident about their entitlement to switch supplier, regardless of claims record: this is the policy intention in a competitive PHI market with open enrolment and community rating.

5. Functions of the Health Insurance Authority

The Health Insurance Authority is a distinct statutory body reporting to the Department of Health and Children and charged with oversight of the PHI business. Its principal policy task has until now been the assessment of the timing of the introduction of risk equalisation. There are two further matters to which the Authority might now turn its attention.

Solvency Requirements in the PHI Business

At present, only Vivas of the three players in the Irish market is regulated by the Irish Financial Regulator. Vhi Healthcare is a statutory corporation while BUPA is subject to the regulatory regime in the United Kingdom. This has given rise to a situation where conditions of competitive equality, for example as regards regulatory capital requirements, between the players in the Irish market are difficult to achieve. Vivas has complained that its solvency requirements were placed at too high a level.

There is a role here for the Health Insurance Authority, as the industry regulator, to consider how competitive equality can be achieved. In particular, the HIA might consider, in conjunction with the Financial Services Regulator, whether a study could be initiated into the appropriate solvency requirements for companies writing PHI business in Ireland.

The Promotion of Customer Mobility

The promotion of switching between suppliers could, in tandem with the introduction of risk equalisation, help to increase effective competition between suppliers. The HIA could consider the launch of a public information campaign, designed in particular to allay the fears of 'reluctant switchers', dissuaded from switching not by the transactions costs but by inaccurate perceptions of possible risks due to their claims records. It could also undertake market research into the actual switching behaviour of Irish PHI customers and the sources of reluctance to change suppliers.

In addition, protocols could be established, in consultation with the industry, to handle the logistics of switching. The treatment of outstanding claims against the 'old' supplier would be one important component. Switching codes have been developed in other industries, for example in retail banking, and could provide a template for what is required in the Irish PHI market.