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Dear Mr Ryan

Risk Equalisation Consultation Process

I refer to your letter dated 14 June 2002 concerning the risk equalisation consultation process and I apologise for the delay in replying.

I have reviewed the replies that you have had to the consultation document and also revisited some of the papers that I looked at previously including, in particular, the report of the Advisory Group on Risk Equalisation.

In addressing the questions that you have raised, the approach that I have taken is to try to assess whether, in the light of all the information available, both in the replies to the consultation document and from all the other documents on this issue, it would be appropriate to introduce a risk equalisation (RE) scheme now. In trying to form this view one would then be forced to confront the different arguments for and against the introduction of the scheme and give them due weight in coming to a decision. As a by-product, an insight to the criteria that are to be used would then emerge. For these purposes I am assuming that if a RE calculation were to be carried out the market equalisation percentage would exceed the 2% threshold set out in article 8(4) of the regulations, which would require a recommendation from the HIA to the Minister on whether or not the RE scheme should be commenced.

The arguments for and against an RE scheme and other considerations were well presented in the submission from the Society of Actuaries (SoA) and I have attached them as an appendix for convenience. I have tried to summarise what they said but there is quite a lot of it. I find it hard to quarrel with much of what the SoA say.



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It would be fair to say that the great majority of opinion supported the commencement of a RE scheme, the only two opponents being BUPA (unsurprisingly) and, from the consultation document replies, Professor Ray Kinsella.

Although I do not have any definitive evidence, it seems to be tacitly accepted by all that BUPA are making windfall profits of significant amounts because they have chosen, sensibly from their viewpoint, to charge similar premiums to VHI but have younger lower risk lives and therefore much lower claims costs. These windfall profits are presumed to exist despite the fact that BUPA may not have the economies of scale of VHI, although this latter factor may be offset by the support that BUPA Ireland might get from their parent company in the UK. This appears to be a classic example of what many papers on community rating regard as “cream skimming” when there is not a RE scheme in place. It seems unlikely that if RE is introduced, BUPA will be able to increase their premiums significantly so that they are in excess of VHI’s in order to maintain profits and therefore will need to compete more directly with a well established monopoly state owned enterprise.

Disregarding any other effects that BUPA’s entry to the market may have had the implication is that consumers are paying more than they would have to if there was a RE scheme and that this is directly benefiting BUPA. In my view, BUPA are not entitled to keep these profits as a reward for entering the market, risky as this may have been for them in competing with a well established state owned monopoly. It is not the role of a RE scheme to offset these disadvantages.

However, having said that BUPA customers certainly will not gain and may see an increase in their premium as a result of introducing an RE scheme. Nor is it clear that VHI policyholders are worse off because of the lack of an RE scheme. There are three reasons for this.

- (i) The market has expanded significantly and BUPA are not perceived to be cherry picking VHI’s customers to a large extent. To substantiate a claim that VHI customers are worse off one would need to take the view that if BUPA had not entered the market then VHI would have signed up all the new entrants that BUPA has signed up. It is difficult for me to take a view on that from here but this seems very unlikely.
- (ii) It appears that the effect of introducing RE would be to transfer money to VHI so that it could afford to charge premiums of the order of 3% less than it might otherwise do. This is a comparatively small figure (although it applies to a lot of customers) and in the context of the large and continuing increases that have taken place each year in the level of health insurance premiums and the control exercised over the level of VHI premiums by the minister it may not be easy to demonstrate that VHI customers would have benefited from RE payments by having premiums 3% less than they otherwise would have been.
- (iii) There appears to be some debate about the level of competition that actually exists in the market now that BUPA are an active player but even if one takes the view that competition is still far from perfect it seems likely that there have been some benefits from competition that will offset to some degree the theoretically lower premiums that RE would allow VHI customers.

Although the theoretical arguments for introducing an RE scheme appear to be widely accepted, one must look at the context of the Irish market to see whether in practical terms it is necessary or desirable to introduce it now.

In particular, the possibility that the introduction of an RE scheme may lead to BUPA withdrawing from the market needs to be considered, with potential adverse effects for both BUPA customers and the market as a whole. However, the likelihood of this occurring is unknown.

Of the arguments in favour of introducing RE set out in 1.1 to 1.11 in the Appendix my views are (using the same numbering)

- 1.1 Community rating does **not** guarantee lifelong affordable healthcare (whatever that means). Nothing is guaranteed in the future and the demographic ageing of the population will place a lot of strain on community rated health care, as it will on the public sector provision, even if young people continue to take out private health care. Patently community rating has worked without RE for the last 5 years. Thus I do not find these arguments compelling.
- 1.2 I agree that there is little incentive for BUPA to compete for higher risk customers. Given VHI's position, it is not clear to me that this is true for them. In any event, given my view that in the longer term demographic problems will emerge for community rated private health care it is a moot point whether it is a good idea for companies to exacerbate this potential problem by seeking to attract older lives.
- 1.3 It does not appear that in the short term at least that RE is an essential accompaniment to community rating as community rating has survived for 5 years without it.
- 1.4 Community rating itself is based on the concept that the young and healthy support the old and sick and as discussed above RE would appear to have little effect on this in Ireland in the short term at least.
- 1.5 I agree that BUPA are in a position to earn excess profits and that this is an unattractive feature of the current market.
- 1.6 We have seen that RE is not a necessary adjunct to community rating at the moment.
- 1.7 I agree that RE is likely to encourage competition across high risk as well as low risk lives, although as noted above it is not clear whether this is good for community rating. It is good for the elderly lives though, particularly in the short term.
- 1.8 I am not really in a position to comment on the effects in other countries, as I have not looked at this. Generally speaking though, I take the view that what happens in one country is not always a very good indicator of what will happen in another because of all the differences that will exist between the countries.
- 1.9 I have some sympathy with the view that in normal circumstances RE will not deter new entrants who should really compete in a normal way.

1.10 As above, although this argument is superficially correct and it is regrettable to think that BUPA may be making excess profits at the expense of the Irish consumer, I am not persuaded that the introduction of RE would make a perceptible difference to VHI customers. It might of course make a large difference to BUPA profits. We should remember in this that BUPA is a mutual company and any excess profits will not go to shareholders although they may go outside Ireland.

1.11 I would agree with this as a theoretical argument but do not think it has much force in the Irish situation.

I do not find any of the above arguments for the introduction of RE compelling even before considering the arguments against, which I do below (again using the same numbering as in the Appendix)

2.1 I do not think that RE is an unjustified interference in the market, in the appropriate circumstances.

2.2 It is rather a sweeping statement to say that limited competition in the market has significantly stabilised the market and this has happened in the absence of RE, nor is it clear what 'stabilised the market' means in this context.

2.3 It is not clear to me why RE kills competition, removes incentives to compete, or why prospective new entrants see it as a barrier to competition.

2.4 I agree that lack of competition and the dominant position of VHI with no commercial mandate means that new entrants need an incentive to enter the market. Whether that incentive should be the lack of an RE scheme is another matter.

2.5 I do not think that community rating, lifetime cover, open enrolment and minimum benefits are necessarily sufficient to achieve government aims without RE.

2.6 I think that from a political point of view it is unfortunate that arguments that the real purpose of RE is to protect VHI and, indirectly, the governments interest in VHI and that the government has not taken sufficient action to dismantle a monopoly can be made. It is, perhaps, also unfortunate that HIA itself reports to the same minister.

2.7 I am not sure that I agree that RE as proposed does not encourage preventative health measures and discourages cost containment.

2.8 I have not been through the mathematics of whether insurers with the same risk profile could have transfers under the scheme. It depends on the scheme and it is not clear how big any effect would be; I think that this is a bit academic.

2.9 I agree that RE ignores the economies of scale of VHI and that possibly a loss making company could subsidise (if that is the correct word) a profit making company but that does not seem to be a reason not to have RE. It is not the primary purpose of RE to address issues of market dominant positions.

2.10 I agree that the market does not appear unstable currently and in the absence of a major change in circumstances it is not obvious why the market should destabilise in the short term. Whether RE would stabilise an otherwise unstable



market is not clear and would depend on the circumstances. It is certainly not a panacea for all ills and is essentially mostly useful where one company in a market cannot attract sufficient new entrants. Even then one would need to ask why one company could not if other companies could.

2.11 I cannot comment on whether RE succeeded or not in Australia, but it is unlikely to be highly relevant.

2.12 The argument that risk selection and cherry picking are illegal and customers can transfer if they want and thus the market is self regulating seems disingenuous. Companies can cherry pick, perhaps to a reasonably large degree, by their marketing and sales strategies to ensure that they get the lives they want, even if they have to accept some lives that they do not want because of open enrolment. Of course it is open for all companies to do this, including VHI. It is also unlikely that the older lives at VHI would want to transfer to BUPA because the reduction in premium is unlikely to be significant and inertia will play a large part.

2.13 It may be true that an insurer practising overt risk selection could be dealt with under consumer protection legislation but in effect all companies are doing is targeting their marketing which I assume is unlikely to be against the law.

2.14 The fact that all insurers have to be licenced does not seem relevant to the argument.

2.15 I do not agree that RE is necessarily a disproportionate response to a hypothetical threat; or that it is incompatible with diversity of choice and product design and disregards consumers' choice. Again this is too sweeping a statement.

2.16 I do not agree that RE, if used at all, should only be used after market failure.

Again, none of the arguments against RE seem to be compelling in the Irish market. One argument not included in the list is that once RE is introduced the situation would be more certain and that may be helpful to the market but again I do not find this argument very strong. Thus the decision on whether to introduce RE is a finely balanced one.

In coming to their view

- a) HIA must take account of the "best overall interests of health insurance consumers" when making recommendations to the minister (S12(4)(c) of Health Insurance Act 1994 inserted by S9 Health Insurance (Amendment) Act 2001)
- b) The phrase is not defined but it must take account of the new S12 (10) (a)(iii) which says that the "best overall interests of health insurance consumers includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings"
- c) Community rating and facilitating competition are major factors to be considered for assessing the "best overall interests of health insurance consumers" but are not exhaustive.

My view is that at this moment in time it is not necessary to introduce RE. Although I do not think it is necessary to introduce the scheme now, it may be necessary at some



future point and HIA would take this decision in the light of the factors mentioned in 4 below. My main reasons for not introducing RE now are

- a) It is not clear that the introduction of RE would benefit VHI customers significantly. It would also not help BUPA customers and may harm them depending on what action BUPA took in response, including the possibility that BUPA withdraws from the market.
- b) The position of VHI as a state owned dominant market player. From outside Ireland this will be viewed as protecting VHI.
- c) The fact that BUPA has a comparatively small market share.
- d) The market is currently stable.
- e) If BUPA is making excess profits I would expect them at least to be taxed, although I do not know what the tax position of health insurers in Ireland is.

In coming to these views I have not assessed whether or not an RE scheme would be in accordance with the EU non life directives or in accordance with EU competition policy and if HIA do not have legal advice on this they may wish to obtain some before finally coming to a view.

In the light of the discussions above, I now set out my views on the specific questions that you asked at the end of your letter

1. The HIA should have in mind the factors that it will consider when making recommendations to the minister but should not commit itself to a particular formula or set of criteria.
2. I see little merit in defining too closely the criteria that the HIA may use. Markets evolve and change over time and the HIA should not limit its room for manoeuvre. This is particularly the case since the decision to introduce the scheme is a once only decision, which cannot be reversed. That is not to say that HIA may not list some of the factors that it will take into account.
3. I think that the responses and other material available on RE are sufficient for the HIA to come to a view.
4. As stated above I do not think that the HIA should be too prescriptive in formulating criteria. Obviously it will have to have regard to the requirements of the law as an overarching criterion. In my view the factors that HIA will want to consider are such things as the governance of VHI, the relative market share of VHI and BUPA, the overall size of the market, the entry of a new insurer, the market equalisation percentage, the age/sex structure of the various companies, the effect of any transfer on the premiums payable by customers, the level of premiums under contracts, the effect of any payments on the business plans and solvency of the insurers.
5. I see no objection in principle to the criteria being in the public domain but, as set out above, they are deliberately imprecise.

I trust that you find the above remarks helpful and I would be happy to discuss any aspect of them with you. As I mentioned to Liam I am out of the office next week but



should be back the following week. If you want to follow up anything in my absence please contact Aidan Smith in the first instance.

Liam mentioned on the phone that the question of late entry premiums is next on the agenda and it seems to me, without having gone into it in any detail, that introducing this would be a good idea.

Yours sincerely

A handwritten signature in blue ink that reads "D. Lewis". The letter "D" is enclosed in a circle.

David Lewis



APPENDIX

1. Excluding legal argument over RE, which was outside the SoA terms of reference, the SoA summarises the arguments for RE (without necessarily agreeing with them) as
 - 1.1 Community rating guarantees lifelong affordable healthcare and it cannot work without RE.
 - 1.2 The only way of facilitating competition between insurers over all categories of people is by equalising risk profiles, otherwise there is no incentive to compete for higher risk categories.
 - 1.3 RE is an essential accompaniment to community rating – if premiums cannot reflect risk then risks must be equalised.
 - 1.4 RE sustains community rating by ensuring that the young and healthy support the old and sick.
 - 1.5 As a new entrant BUPA has the automatic benefit of a better risk profile to VHI and is thus able to earn excess profits.
 - 1.6 The claim that RE is a subsidy is unsustainable; it is a necessary adjunct to community rating.
 - 1.7 Far from being anti competitive RE is essential to real competition.
 - 1.8 Other countries show that without community rating older people do not insure and if RE is not applied community rating does not survive.
 - 1.9 RE will not deter new entrants to the market who will compete in the normal way.
 - 1.10 Without RE customers are paying for the excess profits of BUPA.
 - 1.11 RE is not interfering in the market but is a mechanism to maintain a level playing field in a market that already has other constraints.
2. The SoA summarises the arguments against RE (without necessarily agreeing with them) as
 - 2.1 RE is an unjustified interference in the market, which should be left to find its own level.
 - 2.2 Limited competition in the market has significantly stabilised the market and this has happened in the absence of RE.
 - 2.3 RE kills competition, removes incentives to compete, prospective new entrants see it as a barrier to competition.
 - 2.4 Lack of competition and the dominant position of VHI with no commercial mandate means that new entrants need an incentive to enter the market.
 - 2.5 Community rating, lifetime cover, open enrolment and minimum benefits are sufficient to achieve government aims without RE.



- 2.6 The real purpose of RE is to protect VHI and, indirectly, the governments interest in VHI; the government has not taken sufficient action to dismantle a monopoly.
 - 2.7 RE as proposed does not encourage preventative health measures and discourages cost containment.
 - 2.8 Even if insurers have the same risk profile the RE scheme may require transfers.
 - 2.9 RE ignores the economies of scale of VHI; possibly a loss making company could subsidise a profit making company.
 - 2.10 No evidence of instability in the market and no evidence that RE would solve such a problem.
 - 2.11 RE failed in Australia.
 - 2.12 Risk selection and cherry picking are illegal and customers can transfer if they want; thus the market is self regulating.
 - 2.13 An insurer practising risk selection could be dealt with under consumer protection legislation.
 - 2.14 All insurers have to be licenced, protecting the market from fly by night operators.
 - 2.15 RE is a disproportionate response to a hypothetical threat; it is incompatible with diversity of choice and product design and disregards consumers' choice.
 - 2.16 RE, if used at all, should only be used after market failure.
3. The official objectives of RE as stated to the Advisory Group by the Department of Health and Children are
 - 3.1 Preserve community rating in a competitive environment
 - 3.2 Subject to 3.1 to facilitate competition
 - 3.3 Satisfy the general good principle of the 3rd NL directive
 - 3.4 To be self financing and
 - 3.5 To meet as far as possible the following
 - 3.5.1. Equalisation of risk profiles – eliminate incentives to select preferred risks
 - 3.5.2. Equity between insurers without anyone having to share profits made as a result of its own efficiencies and cost controls
 - 3.5.3. RE should not contain any disincentive to prevent insurers seeking to maximise efficiency and cost controls
 - 3.5.4. RE should not equalise different benefit levels

3.5.5. RE should be practical

3.5.6. RE should be predictable

4. SoA think 3.1 to 3.4 are fine but not some of 3.5

4.1 RE will not help instability where there is a lack of young preferred new entrants in the market. Other instability arises from a market disruption because one insurer cannot attract enough young preferred new entrants. This is unlikely at present and therefore the stability argument alone would not currently justify RE.

4.2 RE is a transfer between policyholders not insurers because at its simplest community rating is a subsidy given by younger policyholders to older policyholders. Community rating is not equitable in the short term (although it may be in the longer term) because in normal voluntary markets premiums reflect risk. Community rating interferes with this, where some pay more than they should and some pay less. The real justification for RE is not stability but it is an equitable mechanism to execute the transfer from the young to the old.

4.3 Community rating above the minimum benefit level does not make sense. SoA suggest normal rating for benefits above the minimum level

5. Some market considerations are

5.1 Main relevance of the public/private mix is the potential instability in the numbers buying healthcare

5.2 The extent of regulation in Ireland is not exceptional by international standards and RE would not make it so.

5.3 The structure of a health care system and extent of competition between health providers are major determinants of health care costs. In Ireland the vast majority of claims costs are outside the immediate control of insurers. The perception is that VHI were quite successful in containing provider costs in the face of an uncompetitive provider sector. A competitive health insurance system should be as least as effective.

5.4 Barriers to entry are, among other things

5.4.1. The Infrastructure that is needed.

5.4.2. 3rd party claims management services if available may reduce entry costs.

5.4.3. If the insurer needs to provide its own care facilities costs are significantly increased.

5.4.4. If healthcare providers are heterogeneous and not closely organised there is more opportunity for product differentiation as an entry strategy.

5.4.5. If a provider can pick his own risks entry becomes less risky

5.4.6. Distribution structures may be important.



- 5.4.7. Nature of cover needed is critical and depends on what the state provides.
 - 5.4.8. If market is cyclical there may be times when it is easier to enter
 - 5.4.9. Availability of reinsurance is vital.
 - 5.4.10. Regulatory and capital requirements.
 - 5.4.11. Behaviour of current market participants.
- 5.5 SoA view on main barriers to entry are
- 5.5.1. The size of the market and current penetration levels
 - 5.5.2. The investment required in the context of 5.5.1 above
 - 5.5.3. The dominant position of VHI, its ownership structure, its regulatory position and its lack of a commercial mandate
 - 5.5.4. Uncertainty regarding RE.
 - 5.5.5. Having no or light RE increases the attractiveness of the market to a new entrant - the benefit could be excessive and unfair to existing participants.
- 5.6 Customer inertia is very strong. However, this is as likely to be positive to a new entrant who will not want the high cost customers.
- 5.7 Competition for young members or employer schemes will be strongest without RE but without RE there will be no competition for high risk subscribers.
- 5.8 It is unrealistic to expect more than a few competing health insurers in a small market and even if there were some more would there be sufficient competition?
- 5.9 SoA thinks that the market has benefited considerably from the limited competition from BUPA but competition is not always a good thing e.g. insurers bidding up health provider costs where the providers are not in a competitive market.
- 5.10 VHI has 85% of the market built up over 45 years and BUPA has 15% built up over 7(?) years. VHI is not regulated as an insurer and is ultimately owned and regulated by the Minister, who, for example, has final control over pricing. BUPA is a branch and is regulated by the FSA in the UK. Thus in neither case is the market transparent.
- 5.11 SoA view is that market is not competitive. There is little real evidence of price competition and one might expect this from the market dynamics. VHI's prices are in effect set to cover costs plus a margin. The market incentive for BUPA is to be a price follower. Without RE it is not sensible for BUPA to charge prices that would encourage VHI high risk members to move.
- 5.12 Competitive focus in practice is on securing new entrants and it is important for the market and both insurers that they secure adequate new entrants.



- 5.13 The other benefit of competition has been on customer service and product flexibility, which benefits may be underestimated.
- 5.14 The market has grown since 1994, much against expectations. In future, growth may be governed by the standard of public health care and the value perceived by the customer of private health care as well as the general level of prosperity.
- 5.15 The market is potentially unstable with or without RE because of the high levels of penetration; this is despite the fact that people are entitled to public health care. This position could be affected by changes in the relative attractiveness of public and private health care. Growth in private care could in part be due to a public perception that public care is getting relatively worse as well as the growing economy and more employers offering private health care. However, one could take the view, unsurprisingly given the buoyant economic conditions, that the health care market has been quite stable since 1994. Nor does there seem any obvious reason for this to change.
- 5.16 However, if some combination of circumstances led to an overall reduction of, say, 5% pa for 3 or 4 years in the total numbers purchasing health care then the effect on an insurer with a poorer risk profile could be totally disproportionate to the reduction in the market size. Spiralling down could happen quickly.
- 5.17 Another possible development could be a new entrant charging much lower prices reflecting lower risk members. Again rapid detrimental effects could arise.
- 5.18 Two major areas of uncertainty over the market have been RE and the future structure and ownership of VHI and these have probably been barriers to entry. Would BUPA have entered the market if RE had applied from 94/95?
- 5.19 So far as can be established medical inflation and health insurance premiums have outpaced general inflation but without any noticeable effect on the market. Can this continue?
6. The minister decides the commencement of RE. It appears that there is no mechanism to stop RE once it is in. The definition of consumer interest is crucial in any recommendation by HIA.
7. The AG method of RE in the HIA consultation document has the significant merit that it does not share claims costs so that insurers benefit if they control claims costs.
8. A prospective method of RE might be better.
9. The inclusion of health status in a RE scheme increases risk equalisation. Arguments against it are
- 9.1 It is more difficult to get the information.
- 9.2 The system may benefit where it is attractive to insurers to attract new healthy lives.

- 9.3 It is more difficult for an insurer to maintain a superior health mix over time than an age/sex mix.
10. RE could work currently without a health status parameter.
11. Not clear why the introduction of RE is linked to market factors of maintaining stability and facilitating competition. Even in a stable market RE could be viewed as required. Introducing RE would only destabilise the market if it caused an insurer to exit the market.
12. HIA has to make its recommendations in the best overall interests of health insurance consumers. Apart from the possibility that BUPA exits the market if RE were introduced, which would not be in the interests of consumers or a rational reaction by BUPA, SoA do not think that there will be a near term effect on the interests of consumers one way or another. In the longer term SoA believe that the interests of consumers would be served by the introduction now of a limited form of RE, both in terms of intrinsic market effects and by establishing certainty on the issue.
13. SOA position is
- 13.1 RE is a logical result of community rating and other imposed market requirements. Its introduction would not cause market instability or inhibit competition and would bring certainty.
- 13.2 The form of RE should encourage competition and new entrants.
- 13.3 RE based on AG should be introduced, preferably a prospective scheme.
- 13.4 Obligatory system of unfunded lifetime community rating as in the SoA Jan 2001 submission should be introduced.
- 13.5 VHI position should be regularised.