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Health Economics
C O N S O R T I U M

THE HEALTH INSURANCE AUTHORITY

Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market

Final Report

YHEC
Office of Health Economics

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Chapter 1: Introduction

1.1 INTRODUCTION

York Health Economics Consortium (YHEC), in conjunction with the Office of Health Economics, were commissioned by The Health Insurance Authority (HIA) to undertake an independent review of the competitiveness of the private health insurance market in Ireland. The HIA was particularly interested in the likely impact on existing and future competition of implementing a risk equalisation scheme.

1.2 TERMS OF REFERENCE

The terms of reference for the study were to examine:

- The extent of competition currently in the Irish market in terms of price, service and product range and the level of innovation, e.g. improvements to existing products, addition of new products etc.;
- How this is being influenced by risk equalisation in terms of the effect risk equalisation would have on business plans and the likelihood of new entrants coming into the market;
- If risk equalisation were introduced, what effect it would have on the above or on insurers leaving the market and what effect this would have on prices, service, product range and innovation;
- The effect on competition of including/not including utilisation in the risk equalisation calculations;
- The effect a change in commercial status of Vhi Healthcare would have on the level of competition.

As part of the investigation of competition, the Authority was interested in examining a broad range of issues:

- An assessment of the amount of competition the Irish market can sustain, based on the size of the market and international evidence;
- The possible effects of an exit of a market player in Ireland, including how this would affect price and service levels, product range and the financial viability of any remaining market players;
- The extent to which current legislation affects competition;
- Possible new entrants and the reasons why they are attracted to the market/reasons why they have not entered;

- The effect of competition on premiums and premium rises, including international evidence, particularly from the above-mentioned markets;
- The effect that a new entrant might have on the market, including the effects on existing private health insurers and the uninsured;
- The degree of bargaining power of insurers and healthcare providers, e.g. hospitals, consultants, etc. in setting reimbursement rates.

1.3 MOTIVATION

In Ireland, the private health insurance industry operates in accordance with the principles of community rating, open enrolment, minimum benefits and lifetime cover. This implies that private health insurance is available to all at affordable prices which are determined by the level of cover, rather than other factors such as an individual's medical history. The Government have set the maintenance of community rating as one of their main objectives in satisfying the best interests of consumers. Another government aim is to achieve competition in the health insurance industry in so far as it is beneficial to consumers.

Against this backdrop, the structure of the industry has changed over the last decade. In particular, in keeping with the Third EU Non-Life Directive, the industry was opened to competition. Thus, the unchallenged monopoly of the incumbent provider of health insurance – Vhi Healthcare (henceforth VHI), a state-owned organisation – was effectively ended when BUPA Ireland entered the Irish market in 1996. Since its launch, BUPA Ireland has established a market share of 15%, most of which came from new subscribers to the industry. Furthermore, private health insurance is also provided by restricted undertakings, whose membership is constrained to employees of particular organisations (e.g. ESB Staff Medical Provident Fund, Prison Officers Medical Aid Society, and St Paul's Garda Medical Aid Society). These schemes account for a small segment of the entire market and are not considered to be in direct competition with BUPA Ireland or VHI.

Given the existing regulatory framework and industry structure, there is a potential threat to the equilibrium of the market. In theory, community rating may incentivise insurers to 'cherry-pick' low risk lives. This may initiate destabilising flows of members. In a simple 2-firm model, the entrant with the greater proportion of low risk lives will be able to charge a lower premium. This will attract further low risk lives away from the incumbent. At the extreme, the high risk profile insurer may earn insufficient premium income to meet its claims costs. Thus, over time, this insurer may become insolvent.

To maintain the community rated system, the Government have proposed the implementation of a risk equalisation scheme. This scheme is designed to eliminate differences in the risk profiles of insurers. It operates by transferring cash from a low risk insurer to a high risk insurer to compensate the latter for its higher claims incidence and, therefore, prevents cherry picking. Many countries with community rated systems have risk equalisation (e.g. Australia).

1.4 METHODOLOGY

One of the main objectives of this research project was to assess the effect of the proposed risk equalisation scheme on the level of existing and future competition in the health insurance market. This objective was satisfied in three distinct, but not mutually exclusive, stages as follows:

- Theoretical background – outlines the economic principles of competition in the private health insurance market and the arguments in favour of, and against, risk equalisation;
- Assessment of the current level of competition – examines the existing level of competition in the industry in accordance with the structure-conduct-performance paradigm by conducting a detailed analysis of publicly available data;
- Evaluation of future competition – discusses potential entry into the industry. To ascertain the potential for competition in the industry, interviews were undertaken with interested parties, including BUPA Ireland and VHI, as well as potential entrants from Ireland and the UK.

International evidence on the effect of risk equalisation in practice is beyond the scope of this report, but is a potentially valuable area for additional research.

The structure of the report is as follows:

- A description of the operation of the Irish health care system is contained in Chapter 2;
- The regulatory framework of the private health insurance industry is outlined in Chapter 3;
- Chapter 4 assesses key parameters in the private health insurance market to assess the level of current competitiveness of the market;
- The theoretical background to risk equalisation is presented in Chapter 5;
- The main findings identified from interviews with existing industry participants and potential entrants are outlined in Chapter 6;
- Our conclusions are reported in Chapter 7.

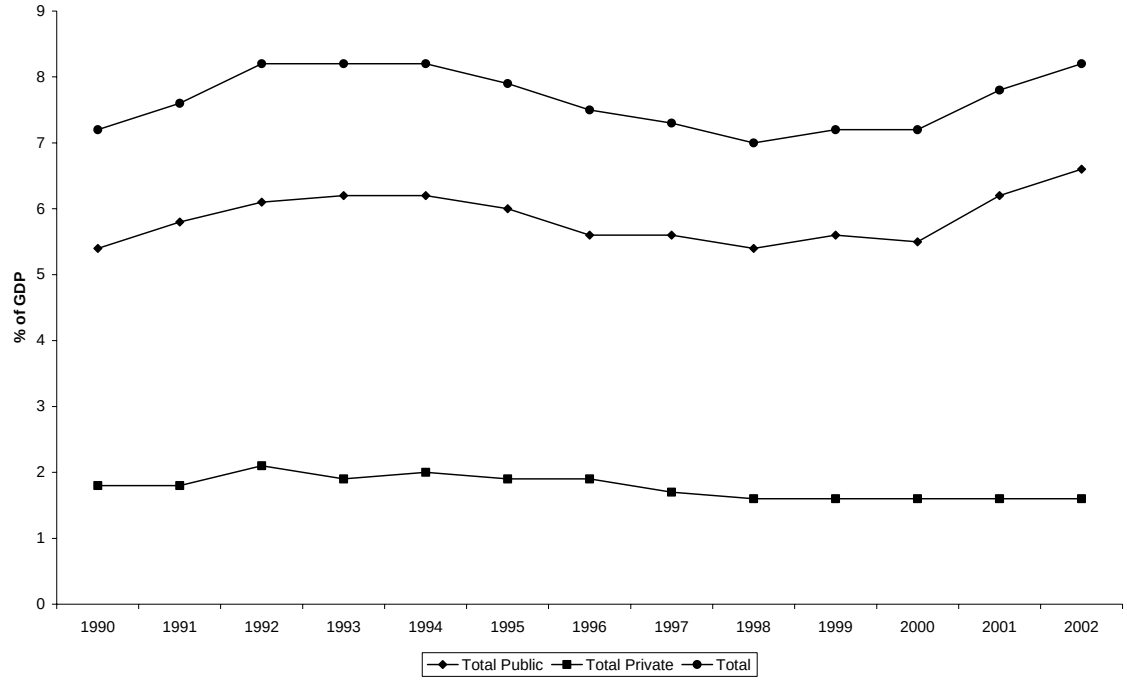
Chapter 2: The Healthcare System

2.1 INTRODUCTION

A key determinant of the competitiveness of the Irish health insurance market is the underlying structure of the healthcare system. The purpose of this Chapter is to provide a brief descriptive overview of the Irish healthcare system as a basis for further research. The development of the market for health insurance, in the presence of this healthcare system, is then described in Chapters 3 and 4.

The Irish healthcare system involves a complex mix of private and public involvement. As shown in Figure 2.1, total expenditure on health amounted to approximately 8% of GDP in 2002. This represents a slight increase on previous years and a return to the levels reported in the early 1990s. The main driver in the variability of total health expenditure is public (government) spending, which accounts for over 80% of the total. The remaining health expenditure comprises private spending, financed by individuals, either directly from their own income or indirectly through private health insurance. Expenditure by this sector, expressed as a percentage of GDP, has been relatively constant since 1998.

Figure 2.1: Health expenditure in Ireland, 1990 to 2002



Note: Public health expenditure is disaggregated into non-capital expenditure (such as net non-capital expenditure reported by the Department of Health and Children, and spending from the European Social Fund and the National Lottery) and capital expenditure (consisting of capital spending reported by the Department of Children and Health and the National Lottery). Private health expenditure includes expenditure by the Voluntary Health Insurance Board (VHI); household and non-household private expenditure and private capital expenditure. The contribution of BUPA Ireland to private health expenditure was not available.

Source: Department of Health and Children, *Health Statistics 2002. Section L: Expenditure Statistics*, 2002.

To provide an insight into the operation of the healthcare system, this Chapter examines the demand for and supply of healthcare.

2.2 DEMAND SIDE

The concept of free access to healthcare has evolved gradually in Ireland during the last century. During the first half of the twentieth century, only a small number of services were provided free of charge to all, irrespective of income. This scheme was extended by the Health Act, 1953, which legislated for free access to hospital services for all but the top 15% of earners. By 1979, all of the population was entitled to free hospital treatment in public wards, although the payment of consultants' fees was dependent on income. Finally, in 1991, eligibility for access to public hospital and consultant services were made available to the entire population, although those with relatively higher incomes had restricted entitlements to services.

Thus, the current system operates on the basis of the allocation of a medical card to those who are entitled to full access to healthcare services. Members of the population who satisfy any of the following criteria are eligible for a medical card:

- Aged 70 years or over;
- The only source of income is one of the following:
  - Old Age Non-Contributory Pension (maximum);
  - Deserted Wife's Allowance;
  - Infectious Diseases (Maintenance) Allowance;
  - Disability Allowance;
  - One-Parent Family Payment (maximum);
  - Widow's/Widower's (Non-Contributory) Pension (maximum);
  - Orphans (Non-contributory) Pension (maximum);
  - Blind Person's Pension (maximum);
  - Supplementary Welfare Allowance.
- Children in foster care;
- Children, under the age of 16 years, whose parents already hold a medical card;
- A full-time student aged between 16 and 25 years and financially dependent on their parents, who already hold a medical card.

In addition to these criteria, entitlement to a medical card may be assessed on the basis of income. Table 2.1 shows the weekly income limits, below which individuals may be entitled to a medical card.

Table 2.1: Weekly income limit (€)[a]

Category	**Income thresholds**	
	Aged under 66 years	**Aged 66 to 69 years**
Single person living alone	138	151
Single person living with family	123	130
Married couple	200	224
Allowance for child aged under 16 years	25	25
Allowance for dependants aged over 16 years (with no income)	26	26

Note: [a] Calculated as gross income less pay related social insurance (PRSI) and health contribution.
Source: *www.oasis.gov.ie/health/health_services_in_Ireland/medical_card.html*, date accessed: 05/08/03.

Medical card holders, who account for approximately 35% of the population, are entitled to the following services free of charge:[1]

- General practitioner (GP) services;
- Prescribed drugs and medicines;
- Public hospital services (both inpatient and outpatient);
- Dental services;
- Optical services;
- Aural services;
- Maternity and infant care services;
- A maternity cash grant of €10.16 on the birth of each child;

[1] Department of Health and Children, *Health Statistics 2002. Section D: Community Health and Welfare Services*, 2002.

- A range of community care and personal social services.

Persons who do not satisfy the above criteria or exceed the income levels reported in Table 2.1 are not entitled to a medical card. However, this category of the population is eligible to receive the following:

- Public hospital services, subject to inpatient and outpatient hospital charges;[2]
- Subsidised prescribed drugs and medicines;[3]
- Maternity and infant care services;
- Free or subsidised community care and personal social services.

People falling into this category are not entitled to free GP services and other medical card entitlements. Roughly 65% of the population fall into this category.[4]

Typically, demand for private healthcare services arises mostly (but not completely) from members of the population who are not entitled to medical cards.[5] As mentioned earlier, these services can be paid for directly from individual's income or indirectly through private health insurance.

In Ireland, like healthcare systems in many other countries, the provision of free healthcare implies that one mechanism for rationing these services is removed, and therefore, demand for many services can exceed supply. This excess demand is evident from the waiting lists for certain elective procedures provided publicly.

2.3 SUPPLY SIDE

The supply side of the Irish healthcare system is characterised by a hierarchical system. The Department of Health and Children, while not directly involved in the provision of healthcare, sets the budgets of the 10 health boards.[6] These health boards are responsible for coordinating the delivery of health and social services in their area. Such services can be provided by private health professionals and service providers, voluntary hospitals and voluntary/community organisations, as well as the health boards themselves.

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[2] Charges are levied for inpatient and outpatient treatment as well as for visits to casualty in a public hospital. Visits to outpatient or casualty departments cost €40 per visit. The charge for inpatient services is €40 per day, up to a maximum of €400 per annum (www.oasis.gov.ie/health/hospitals/hospital_charges.html, date accessed: 05/08/03).

[3] Under the Drugs Payment Scheme, members are entitled to refunds if their monthly bills for prescribed drugs, medicines or appliances are in excess of €70 (www.oasis.gov.ie/health_services_in_Ireland/drugs_payments_scheme.html, date accessed: 02/09/03).

[4] Department of Health and Children (2002b).

[5] In the survey of consumers and non-consumers of private health insurance, entitled *The Private Health Insurance Market in Ireland* (March 2003) commissioned by The Health Insurance Authority (HIA), 5% of the overall sample had both private health insurance cover and a medical card. In total, 16% of medical card holders sampled had private health insurance.

[6] www.oasis.gov.ie/health/health_services_in_Ireland/health_boards.html, date accessed: 11/08/03.

2.3.1 Primary Care

General practitioner (GP) services are supplied by a group of independent professionals. Essentially, there should be no differences in the types of treatment from the GP received by members of the population, irrespective of their entitlement to a medical card. However, the payment method differs between the two groups. GPs are reimbursed for public patients (holders of medical cards) via the General Medical Services (Payments) Board, which is operated by the health boards. The payment schedule for public patients generally involves a capitation fee per person which is weighted by age, gender, and distance from the GP practice. Private patients (those not eligible for a medical card) incur the cost of GP visits on a fee-for-service basis.

There are also public and private dentists and opticians. As with the provision of GP services, there is some overlap between public and private provision of these other primary care services. For example, a private dental or optical practice may receive both public and private patients. In contrast, a public dentist or optician is only permitted to treat public patients.

2.3.2 Consultants

Private patients are required to pay for the services of consultants involved in providing their care, which are generally charged on a fee-for-service basis. Under the existing arrangements, the compensation paid to consultants by private health insurers on behalf of their members are set out in a fee schedule. Essentially, there are two types of agreements between the two parties:

- Full participation – involving amounts accepted as full discharge of the insured person's liability for fees;
- Partial participation – involving a liability for the insured person to receive a balance bill for fees.

The vast majority of consultants have fully participating agreements with insurers.[7]

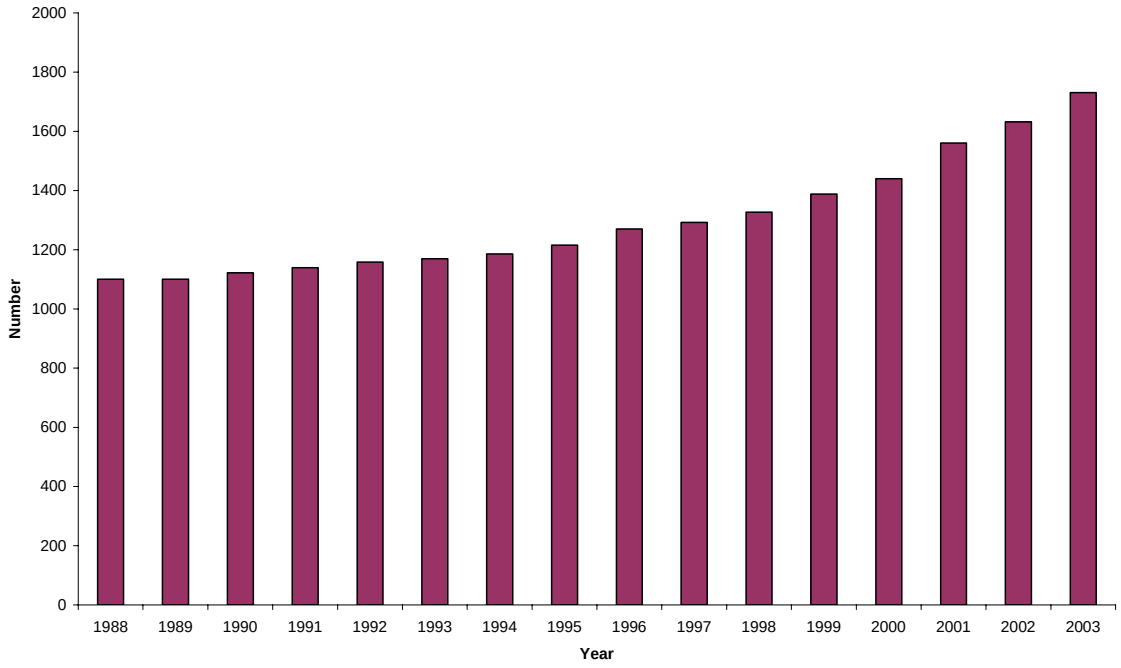
Over the last two decades there has been steady growth in the number of consultant posts (see Figure 2.2). Since 1988, the number of posts has increased by more than 50%. Although the total number of consultant posts was less than 2,000 in 2003, it still exceeded expectations set in 1993.[8] However, in a more recent report by the Commission on Financial Management

[7] The percentage of consultants with arrangements with BUPA Ireland and VHI who are in fully participating schemes is 97% and 99% respectively (see www.bupaireland.ie/ourproducts/essential/consultant.htm, date accessed: 01/08/03 and www.vhihealthcare.com/corporate/student_4.html, date accessed: 02/10/03).

[8] These expectations were calculated as part of a report, entitled Medical Manpower in Acute Hospitals (1993), cited in Comhairle na nOspidéal, *Consultant Staffing*, January 2003.

and Control Systems in the Health Service (2003), evidence suggested that 1,000 additional consultants would be required to satisfy current demand.[9]

Figure 2.2: Number of consultants' posts, 1988 to 2003



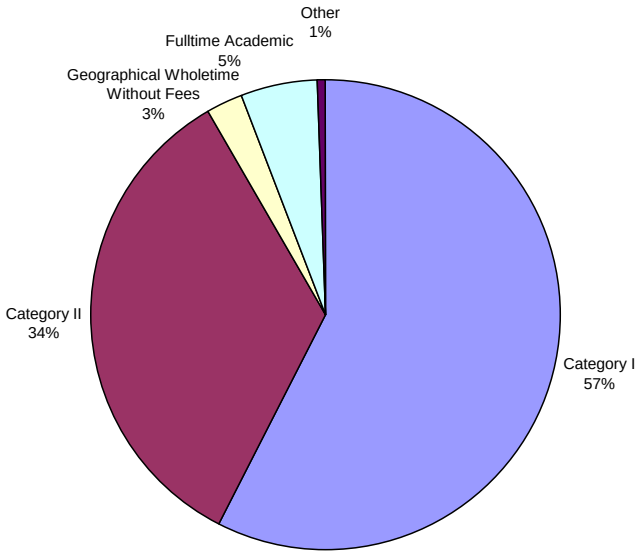
Source: Comhairle na nOspidéal (2003).

In isolation, the absolute number of consultants appears large. However, it is difficult to assess the impact of this stock on their bargaining power. To quote an example put to us, "the only urologist in Galway may be in a stronger bargaining position than 1 of 10 operating in Dublin". Thus, the number of consultants has been disaggregated by contract type, specialty and geographical region. In Ireland, consultants are divided into five categories.[10] One of the main differences between these categories is the flexibility afforded with regard to private practice. For example, consultants under Category I are required to conduct private practice in public hospitals. In contrast, Category II consultants may engage in on- and off-site private practice. According to Figure 2.3, the majority of consultants are employed under Category I contracts.

[9] Commission on Financial Management and Control Systems in the Health Service. *Report of the Commission on Financial Management and Control Systems in the Health Service.* January 2003. This figure also takes into account the impact of the European Union's Working Time Directive (WTD). According to the Commission, more consultants will have to be recruited as a result of implementing the WTD. The Commission argues that this will provide the opportunity to employ consultants to work exclusively in the public sector.

[10] Definitions are described in Comhairle na nOspidéal, *8th Report: December 1995 – December 2000*.

Figure 2.3: Distribution of consultants by contract type, January 2003



Source: Comhairle na nOspidéal (2003).

An estimate of the number of consultants working solely in private practice (i.e. not contracted to public hospitals) is reported in Table 2.2. These figures should be interpreted as a lower bound only as they do not include part-time consultants in private practice (numbering approximately 200); consultants employed under Category II (approximately 600); consultants retired from the public sector, but still operating in the private sector; or private specialists temporarily working in the public sector. According to the figures reported in Table 2.2, it appears that there is scope for consultants in some regions in some specialties to behave like a local monopoly and demand economic rents from insurers.[11] However, this strong bargaining position may be limited if patients are willing to travel to another region to receive treatment, or if there is little demand for these services in the consultant's particular geographical area.

[11] Even if Table 2.2 is adjusted to take account of missing data by multiplying each cell by 5, say, the number of wholly private consultants in some specialties and regions still remains small.

Table 2.2: Number of consultants in wholly private practice

Specialty	ERHA East Coast	ERHA North	ERHA South West	Mid-West	Midland	North East	North West	South East	South	West	Total
Anaesthesia	0	4	0	0	2	0	0	1	8	2	**17**
Medicine	18	12	4	0	2	0	0	2	13	5	**56**
Obstetrics/ Gynaecology	6	0	2	0	2	0	0	2	6	0	**18**
Paediatrics	2	0	0	0	0	0	0	0	4	0	**6**
Pathology	1	2	0	0	0	0	0	0	4	0	**7**
Psychiatry	7	2	11	0	1	0	0	0	2	2	**25**
Radiology	2	0	0	0	1	0	0	1	5	0	**9**
Surgery	15	13	2	3	3	0	0	3	16	5	**60**
Total	**51**	**33**	**19**	**3**	**11**	**0**	**0**	**9**	**58**	**14**	**198**

Note: ERHA, Eastern Regional Health Authority.
Source: Comhairle na nOspidéal (2003).

Estimates suggest that the annual average income for Category II consultants from insurers amounts to €130,000.[12] When this is added to public sector payment, the average total income for a consultant amounts to €280,000. As Table 2.3 shows, anecdotal evidence suggests that this is far greater than the level of remuneration received by consultants in other European countries, and is only exceeded by the levels in the US.

Table 2.3: Annual payments to consultants

Country	Annual payment (€)
Finland	€45,000[a]
UK	€80,808 to €138,873 (max. €205,071)[b]
Denmark	€87,996 to €99,626[c]
New Zealand	€79,712 to > €125,000[d]
France	€83,000[e]
Canada	€162,401 to €213,872[f]
Ireland	€280,000
US	€314,000 to €515,000[g]

Notes: It is not clear if any allowance is made for non-monetary benefits paid to consultants.
[a] Average for a hospital specialist.
[b] Range for consultants' public salaries excluding private practice. Maximum is achievable under a system of merit awards.
[c] Lower bound relates to a consultant. Upper bound relates to a managing consultant.
[d] Lower bound relates to maximum under public hospital salary scale. Upper bound earned by consultants in private practice.
[e] Maximum for public hospital doctors.
[f] Lower bound relates to medical specialists. Upper bound relates to surgical specialists.
[g] Lower bound relates to median earnings of oncologists and anaesthetists. Upper bound relates to median income for cardio-vascular surgeons.
Source: Wren (2003).

[12] Wren, M.-A., *Unhealthy State: Anatomy of a Sick Society,* Dublin, 2003. Additional estimates of the average consultant salary have been estimated by the National Task Force on Medical Staffing to be €133,051. National Task Force on Medical Staffing. *Report of the National Task Force on Medical Staffing.* June 2003.

However, given such apparently attractive levels of reimbursement, it is surprising that one interviewee complained of a scarcity of consultants (see Chapter 6). This indicates that supply-side barriers may make it difficult to operate as a consultant in Ireland. Existing consultants may exploit these barriers and demand higher income. The potential barriers to practising as a medical professional in Ireland were recently identified by a report commissioned by The Competition Authority and are summarised in Table 2.4. The deterrents mainly relate to registration, educational and training requirements, including a fixed number of places at colleges. While these barriers are certainly significant in absolute terms, it is not clear that they are high in comparison with other countries.

Table 2.4: Entry requirements in the medical profession – Summary of key registration, educational and training requirements

Nature of educational/training requirements	Legal or other basis
Registration on the Register of Medical Practitioners is required for all doctors who wish to practise as a registered practitioner in Ireland. Registration must be renewed on an annual basis.	Medical Practitioners Act, 1978.
Only persons with 'registrable' qualifications can apply for Registration on the General Register.	Medical Practitioners Act, 1978.
Only persons with recognised specialist training may apply for registration on the Register of Medical Specialists.	Medical Practitioners Act, 1978.
Limitation on study places available at schools of Medicine	No apparent legal basis. Determined, according to The Irish Medical Organisation (IMO), by Higher Education Authority and Department of Education and Science in consultation with Department of Health and Children.
The process of creation and filling of GMS posts	No apparent legal basis. Determined by the regional health boards in consultation with the IMO.
Process of appointment of hospital consultants	Health Act, 1970. Comhairle na nOspidéal regulates number and type of posts.

Source: Indecon, *Indecon's Assessment of Restrictions in the Supply of Professional Services*, prepared for The Competition Authority by Indecon International Economic Consultants – London Economics, March 2003.

2.3.3 Hospital Services

There are 3 types of hospital in Ireland:

- Health Board Hospitals – operated by the health boards and financed by State funds;
- Public Voluntary Hospitals – some are owned and operated by religious orders. Others are incorporated by charter or statute and work under lay boards of governors. These are financed to a large extent by State funds;
- Private hospitals – operated independently of State funding.

Public hospitals, such as health board and public voluntary hospitals, provide both public and private treatment. However, to ensure equity of access in public hospitals, private patients must generally be kept in private beds, which are designated by the Minister for Health and

Children (the Minister). The distribution of public hospitals by health board is reported in Table 2.5. The highest concentration of hospitals is in Dublin. Similarly, a high proportion of private hospitals are also located in Dublin.

Table 2.5: Breakdown of public hospitals in Ireland by health board

Health Board	**Public hospitals**	
	Number	**%**
Eastern Regional Health Authority	36	27.3
Southern	32	24.2
South Eastern	17	12.9
Western	11	8.3
Mid-Western	10	7.6
North Western	10	7.6
Midland	9	6.8
North Eastern	7	5.3
Total	**132**	**100.0**

Source: *www.doh.ie/contact/hospitals.html*, date accessed: 25/09/03.

Initially, it may seem that the private hospitals, outside Dublin, may have greater control over the charges received from insurers. However, VHI has estimated that approximately 50% of the bed capacity used by its members is in public hospitals.[13] Therefore, the bargaining position of private hospitals is diminished because it is relatively easy to substitute between private and public hospitals.

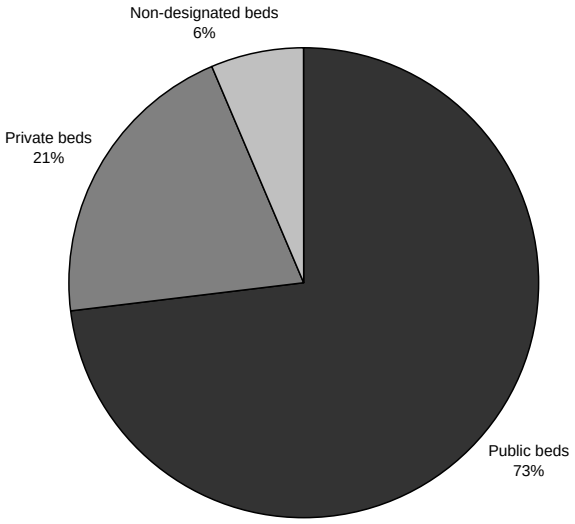
Total bed capacity in public acute hospitals has been estimated at 12,292.[14] The allocation of these beds is reported in Figure 2.4. The majority of beds (73%) are used to accommodate public patients. Non-designated beds (6%) are typically found in areas such as intensive and coronary care. It has been estimated that bed capacity in the acute private hospital sector is roughly equal to the number of private beds in public hospitals.[15] Thus, in 1999, the aggregate bed capacity across both the private and public sectors was approximately 14,800.

[13] Vhi healthcare, *Annual Report and Accounts (Text Only Version)*, 2003.

[14] Department of Health and Children, *White Paper: Private Health Insurance*, 1999, Table 2. More recently, the number of acute hospital beds in public services in 2000 has been estimated as 11,832. Furthermore, it is suggested that 80% of acute hospital beds may be designated as public and the remaining 20% as private (see Department of Health and Children, *Acute Hospital Bed Capacity: A National Review*, 2002).

[15] Department of Health and Children (1999), para. 1.16.

Figure 2.4: Acute Hospital Bed Designation in Public Hospitals, 1999



Source: Department of Health and Children (1999).

Private patients treated in public hospitals are required to pay hospital charges in addition to the public hospital inpatient charges, unless they are in one of the relatively few non-designated beds or a public bed, which are not subject to these charges. (These charges are in addition to the implicit indirect charges paid by private patients through taxation.) The schedule of these charges is reported in Table 2.6. These charges are set by the Minister, who has acknowledged that they do not reflect the real cost of providing care to these patients and are therefore, below the economic cost of these beds. However, it is argued that these charges 'are intended only as a contribution to the cost of care in public hospitals'.[16] As Table 2.6 shows, the daily hospital charges levied on private patients in the first two categories of hospital increased by almost 50% over the period 2001 to 2003. The rate of increase over the entire period was less for health board district hospitals (almost 27%). The largest annual increase took place in 2002, when charges for all types of public hospitals were increased by a uniform rate of 26.5%. The increase in these charges may be driven by a rising cost of treating patients (see Table 2.7).

[16] Department of Health and Children (1999), para. 2.24.

Table 2.6: Charges levied on private patients in public hospitals[a] (€)

Hospital category	Hospital charges								
	Private			Semi-private			Day-care		
	2001[b]	2002[c]	2003[d]	2001[b]	2002[c]	2003[d]	2001[b]	2002[c]	2003[d]
Health board regional hospitals and voluntary and joint board teaching hospitals	238.71	301.97	349	186.65	236.12	273	171.41	216.83	251
Health board county hospitals and voluntary non-teaching hospitals	198.08	250.57	290	159.99	202.39	234	142.21	179.89	208
Health board district hospitals	123.16	155.79	156	105.39	133.32	133	91.42	115.64	116

Notes: [a] Non-designated and public beds are exempt from these charges.
[b] From 1 January 2001.
[c] From 1 August 2002.
[d] From 1 January 2003.

Source: *www.oasis.gov.ie/health/hospitals/hospital_charges.html*, date accessed 05/08/03 and the Department of Health and Children.

The difference between the prices charged for public beds to private patients and the underlying cost of these beds is reported in Table 2.7. There has been an increase in both the price to private patients and the subsidy over the two-year period reported in Table 2.7. It is interesting to note that the increase in the subsidy was proportionately greater than the increase in the private patient charge. Indeed, the subsidy received in 2001 was in excess of 50% of the inpatient daily bed cost for both categories of hospitals.

Table 2.7: Cost per inpatient bed day compared with private patient charges (€), 2000 and 2001

	Cost per inpatient bed day		Private patient charge		Subsidy	
	2000	2001	2000	2001	2000	2001
Group 1 Hospitals	465	546	232	239	233	307
Group 2 Hospitals	347	409	192	197	155	212

Note: Group 1 Hospitals refer to the major academic training hospitals (Beaumont Hospital, Cork University Hospital, James Connolly Memorial Hospital, Mater Hospital, St James' Hospital, St Vincent's Hospital, and University Hospital Galway). Group 2 Hospitals include all non-teaching hospitals.
Source: Commission on Financial Management and Control Systems in the Health Service (2003).

2.4 SUMMARY

The healthcare system in Ireland has been designed to ensure that the population has affordable access to necessary health services. The following aspects characterise the Irish healthcare system:

- Services are provided by both the private and public sectors;
- There are two categories for the eligibility of public services. Members of the population falling into the first category (consisting of medical card holders) are entitled to free access to health services (with some waiting lists for services). Those

in the second category (who are not entitled to a medical card) also have access to public hospital services, but they are charged a standard levy;

- Patients make a conscious choice between public and private hospital care. Therefore, public and private health services are not complementary. As the White Paper notes 'persons availing of private hospital services have always been seen as availing of an alternative service to the public system';[17]
- Over 80% of health expenditure is funded publicly (mostly from taxation). Voluntary private health insurance is available to those who undergo private treatment.

Having outlined the healthcare system, the subsequent Chapters examine the operation and structure of the private health insurance market.

[17] Department of Health and Children (1999), para. 1.32.

Chapter 3: Private Health Insurance in Ireland

3.1 INTRODUCTION

Voluntary health insurance was introduced in Ireland under the Voluntary Health Insurance Act, 1957. The Voluntary Health Insurance Board (VHI), now trading as Vhi Healthcare, a state-owned organisation, was established to provide this insurance. Originally, it was intended that the purpose of this private health insurance was to defray 'the costs … of ... medical, surgical, hospital and other health services' for the 15% of the population who, at that time, were not deemed eligible for public hospital services.[18] However, other members of the population were also free to avail of this insurance. Indeed, in the first decade of its operation, the popularity of this proposal was evident as subscriptions to VHI quickly increased from 23,238 in 1958 to 321,777 in 1968.[19] This upward trend in subscriptions to private health insurance has continued to the present day.

This Chapter reports the legislation which has shaped private health insurance in Ireland and describes the current structure of the industry.

3.2 LEGISLATION

Two pieces of legislation have been key in the evolution of the private health insurance industry in Ireland:

- The Third Non-Life Insurance Directive, 1992, from the European Commission;[20]
- The Health Insurance Act, 1994.

3.2.1 Third Non-Life Directive

Apart from a number of occupational group schemes, from the time of its establishment in 1957, VHI enjoyed a relative monopoly. However, with a view to developing an integrated European market, the European Commission's Third Non-Life Directive sought to abolish such monopolistic positions by July 1st, 1994. This Directive was transposed into Irish legislation through the Health Insurance Act, 1994 and other Acts. Under the 1994 Act, organisations wishing to set up a health insurance business in Ireland were required to register with the Minister. Following this move towards greater competition, the first, and to date the only, entrant to the Irish private health insurance market was BUPA Ireland, a subsidiary of The British United Provident Association (BUPA). The structure of the market

[18] The Voluntary Health Insurance Act, 1957, Section 4, paragraph 1.
[19] Department of Health and Children (1999), Appendix VII.
[20] Official Journal of the European Communities, Council Directive 92/49/EEC of 18 June 1992.

and the conduct and performance of the two industry participants is discussed in greater detail in Chapter 4.

Furthermore, the Directive also included provision for the principles of community rating, open enrolment, lifetime cover and minimum benefits. Under these conditions, the Directive permitted the establishment of a risk equalisation (or 'loss compensation') scheme provided that the aim of such a scheme was 'to protect the general good'.

3.2.2 The Health Insurance Act, 1994

The cornerstones of the Irish health insurance market are set out in the Health Insurance Act, 1994, and related regulations in 1996. These are:

- Community rating;
- Open enrolment;
- Lifetime cover;
- Minimum benefits.

Risk equalisation, another proposed feature of the Irish health insurance market, is discussed in Section 3.3.

Community rating

Unlike other insurance markets operating in Ireland, the health insurance market is unique because an insurer is unable to discriminate between risks by charging different premiums. This community rating system, as set out in the Health Insurance Act, 1994, prohibited health insurers from charging different premiums to different people on any grounds.[21] For example, the same premium will be charged to individuals irrespective of factors such as:

- Age, sex or sexual orientation;
- Current or future health state;
- Utilisation of healthcare services;
- The amount of claims.

Thus, in accordance with the 1994 Act, an insurer is required to charge the same premium for a particular product to all individuals. Yet premiums may differ across insurers. However, there are a small number of exceptions to the principle of community rating:

- The premium charged for children under 18 years must not be greater than half that of an adult for the same level of cover;[22]

[21] The Health Insurance Act, 1994, Section 7.
[22] Instead of this discount, the Health Insurance Act, 1994 and the Health Insurance (Amendment) Act, 2001, allow the premium to be waived.

- Students, aged between 18 and 23 years, who are dependent on the person with whom the insurance contract is effected, may be charged a rate which is discounted by up to 50%;[23]
- Premiums paid by members of a restricted membership undertaking may be reduced if the member is in receipt of a pension;[24]
- Members of group schemes may receive a discount of 10% on premiums.

The purpose of community rating is to ensure that insurance cover is affordable for all. Thus, it requires intercohort altruistic behaviour in that high risk lives are subsidised by low risk lives, who in turn expect to be subsidised in the future. This is most obvious for the intergenerational subsidy from young to old subscribers. With community rating, the premiums paid by older, relatively high risk individuals are kept below their risk-rated level. This is due to the subsidisation from the younger, lower risk group, who pay the same premiums even though they may be in excess of those that would be charged in a market where risk rating is permitted. Moreover, the current system of community rating is unfunded in that premium income is pooled to offset members' claims. Consequently, the private health insurance market in Ireland has been referred to as a 'pay-as-you-go' scheme. In contrast, in a funded model, premium income is accumulated over time to offset expected claims.

Thus, for a sustainable operation of a community rated system, it is imperative to ensure that there are sufficient low risk lives to fund their high risk counterparts. Recent figures indicate that roughly 67% of the Irish population are under the age of 45 years. Thus, ensuring sufficient low risk lives may not be a concern at present. However, as those currently aged under 45 years become older, the associated health risks will increase, which may pose problems regarding future funding under a community rated system.[25]

The age profiles of the entire population and a sample of private health insurance subscribers who participated in a survey are reported in Table 3.1. If it is assumed that the sample of subscribers participating in the HIA survey is similar to the population of people with private health insurance, then the figures reported in Table 3.1 show that the age profiles of the entire population and subscribers are similar.

[23] The Health Insurance Act, 1994 had originally set these age bands as 18 to 21 years. The proposal to subsequently increase this band to 23 years was contained in the White Paper on Private Health Insurance (1999) and enacted in the Health Insurance (Amendment) Act, 2001.

[24] This category was legislated for in the Health Insurance Act, 1994 and the Health Insurance (Amendment) Act, 2001. Restricted membership undertakings offer health insurance to members of a 'common vocational, occupational or other group or class' (The Health Insurance Act, 1994, Part I, Section 1).

[25] According to recent population projections, the number of people aged 45 years or over will be in excess of 2.1 million by 2031 (Central Statistics Office, *Regional Population Projections: 2001-2031*, June 2001). This projection has been calculated on the basis that recent demographic trends continue. This represents an increase of approximately 70% in the number of people in this age category from the 2002 figures (Central Statistics Office, *Census 2002, Volume 2: Ages and Marital Status*, July 2003b).

Table 3.1: Age profile of Irish population and private health insurance subscribers (%)

Age group	Population[a]	Private health insurance subscribers[b]
18 to 24 years	16	14
25 to 44 years	41	43
45 to 54 years	17	18
55 to 64 years	12	14
65 years and over	15	11
Total	**100**	**100**

Notes [a] Figures relate to 2002.
[b] Based on a sample of 476 adult respondents with private health insurance.

Source: Central Statistics Office, *Principal Statistics: Demography and Labour Force, www.cso.ie/principalstats/pristat2.html*, date accessed: 11/08/03; Central Statistics Office (2003b); and HIA (2003b).

Open enrolment and lifetime cover

Open enrolment ensures that an insurer generally cannot refuse membership to any individual, under the age of 65, wishing to initiate cover. Therefore, there is a some ability for insurers to discriminate against those over the age of 65 years. Maximum waiting periods were imposed to minimise adverse selection. This may occur due to the asymmetry of information between the insurer and the individual. For example, an individual may enter into an insurance contract because he knows that he will require this cover shortly. In the absence of these waiting periods, community rating and open enrolment may have provided an incentive to join an insurance scheme later since, due to community rating, the individual would pay the same premium as if he had joined earlier. Thus, by enrolling in a scheme later, the individual would save on the cost of premiums. This problem of adverse selection is particularly acute in a system of community rating, where risk selection is not possible, and could destabilise the system of community rating.

The maximum length of time new members may be required to wait before they are eligible to receive payments under the insurance contract is reported in Table 3.2.

Table 3.2: Maximum waiting periods

Category	Waiting period
Initial waiting period	
Under 55 years	26 weeks[a]
Between 55 and 65 years	52 weeks[b]
Waiting period with pre-existing medical condition	
Under 55 years	5 years
Between 55 and 60 years	7 years
Between 60 and 65 years	10 years
Waiting period with upgrade in cover	
Under 65 years	2 years
Over 65 years	5 years

Notes: [a] The waiting period for maternity benefit is 52 weeks.

[b] The White Paper on Private Health Insurance (1999) recommended that the waiting period should be set at 104 weeks for those aged 65 years or over under lifetime community rating, whereby people in this age category can join an insurance scheme. The waiting period for those in this age group with a pre-existing condition would remain at 10 years.

Source: 'Health Insurance Act, 1994 (Open Enrolment) Regulations, 1996. Statutory Instrument, No. 81 of 1996'.

Waiting periods served with one insurer will be taken into account if the person switches to another insurer at the same level of cover. However, for this stipulation to hold, the period between the termination of the first contract and the commencement of the second, must be less than 13 weeks.[26] Waiting periods of up to 10 years effectively counter, to some extent, open enrolment. This highlights the tensions between community rating and market insurance.

Lifetime cover ensures that once a member has joined a scheme, the insurance company is prohibited from terminating, or refusing to renew, this contract. However, exceptions to this rule are:[27]

- The person has conducted fraud in relation to the insurance contract, which has, or may have, resulted in financial loss for the insurance company;
- The company ceased to operate a health insurance business in the State.

Minimum benefits

To ensure that individuals have sufficient insurance, the legislation requires schemes offered by insurance companies to provide a minimum level of cover. In particular, a minimum level of cover applies to the following:

- Day care and inpatient treatment;
- Hospital outpatient treatment;
- Maternity benefits;
- Convalescence;

[26] 'Health Insurance Act, 1994 (Open Enrolment) Regulations, 1996. Statutory Instrument, No. 81 of 1996'.
[27] 'Health Insurance Act, 1994 (Lifetime Cover) Regulations, 1996. Statutory Instrument, No. 82 of 1996'.

- Psychiatric treatment and substance abuse.

The minimum accommodation level is a semi-private room in a public hospital. Most plans offered by the two largest insurers in the Irish private health insurance market entail benefits considerably in excess of these minimum levels.

Legislative amendments

Several amendments have been made to the Health Insurance Act, 1994. The most noteworthy of these is lifetime community rating or late entry premium loadings.

To ensure that there are sufficient low risk lives to subsidise the increasing number of high risk lives, the Government has decided to amend the current system of community rating. Under the White Paper on Private Health Insurance (1999), it is proposed that a lifetime community rating approach be adopted. Lifetime community rating implies that premiums are set according to the age of entry. For instance, a 35-year-old and a 70-year-old would pay the same premium if they both joined at the age of 25. Premiums charged to those who defer joining a scheme would be increased. Therefore, there is an incentive to obtain health insurance at a younger age, which reduces the problem of adverse selection and strengthens the concept of community rating. Table 3.3 shows the proposed maximum premium loadings according to entry age.

Table 3.3: Late entry premium loadings

Age at joining	Maximum premium loading
Under 35 years	0%
35 to 44 years	10%
45 to 54 years	25%
55 to 64 years	45%
65 years or over	80%

Source: Department of Health and Children (1999).

Ahead of this proposed legislative change, the HIA initiated a consultation process, which invited stakeholders and other interested parties to submit representations on the issue of lifetime community rating.[28] Following this consultation process, the HIA set out its general support for the introduction of lifetime community rating in its submission to the Department of Health and Children.[29]

If lifetime community rating is adopted, the legislation on open enrolment would need to be amended. The proposed revisions would ensure that insurers are no longer permitted to refuse cover to people aged 65 years and over.[30]

[28] HIA, *Consultation Paper: Lifetime Community Rating*, August 2002.
[29] HIA, *Submission to the Department of Health and Children: Lifetime Community Rating*, October 2002.
[30] www.oasis.gov.ie/health/health_insurance/new_rules_on_private_health_insurance.html, date accessed: 12/08/03.

3.3 RISK EQUALISATION

Theoretically, the liberalisation of the private health insurance market in Ireland in conjunction with the tenet of community rating may provide an incentive for new entrants to selectively choose low risk lives (explicitly or implicitly), resulting in potentially lower claims payments, and lower premiums and/or greater profits. All else being equal, this potential for 'cherry-picking' would undermine the system of community rating as more relatively low risk lives would be attracted to the low premiums of the new entrant, thereby leaving the incumbent with a disproportionately high number of high risk lives. (This situation can also occur without direct action by new insurers if older, sicker people are less inclined to change insurer.) As a consequence, the incumbent would have to increase premiums, which would potentially result in another tranche of relatively low-risk members switching from the old to new insurer. To prevent this destabilising impact of competition in the presence of a community rated market, the EU's Third Non-Life Directive permitted Member States to 'protect the general good' through measures including establishing 'loss compensation schemes'.

The objective of such a loss compensation (or risk equalisation) scheme is to facilitate a (direct or indirect) flow of funds between a company with a relatively high risk profile and another with lower risks. For instance, an insurer with a relatively high risk profile, compared to that of the market, would receive funds from another insurer with a relatively low risk profile. If the compensation scheme works perfectly, insurers should be indifferent between low and high risk lives.

Although risk equalisation payments have not yet been implemented in Ireland, a provision for the implementation of such a scheme was included in the Health Insurance Act, 1994. Further regulations were issued in 1996, although these were subsequently revoked. The legislation has subsequently been revised in the Health Insurance (Amendment) Acts, 2001 and 2003. The proposals indicate that the risk equalisation scheme will be overseen by the HIA. In particular, the HIA will be charged with making 'a recommendation' to the Minister as to whether or not risk equalisation payments should be initiated if the Market Equalisation Percentage (MEP) falls between 2% and 10%.[31] In reaching such a recommendation, the HIA must 'hav[e] regard to the best overall interests of health insurance consumers', which involve 'the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings'.[32]

Under the risk equalisation scheme, the value of the MEP may trigger a decision to initiate

[31] The Market Equalisation Percentage (MEP) is equal to the ratio of the total amount of risk equalisation payments to total benefits paid by all health insurers operating in the market.

[32] The Health Insurance (Amendment) Act, 2001, Section 9.

the scheme. There are three scenarios:[33]

- If the ratio of potential risk equalisation payments to total equalised benefits paid by the scheme undertakings (the MEP) is less than 2%, then the risk equalisation scheme will not be initiated.
- If the MEP is between 2% and 10%, the HIA is required to make a recommendation to the Minister regarding whether the risk equalisation scheme should be initiated, having regard to the best overall interests of health insurance consumers. The Minister is not permitted to commence such payments, unless the Authority has recommended such action.
- An MEP in excess of 10% shall prompt the Minister to initiate risk equalisation payments unless, following consultation with the HIA, they are not found to be in the best interests of consumers.

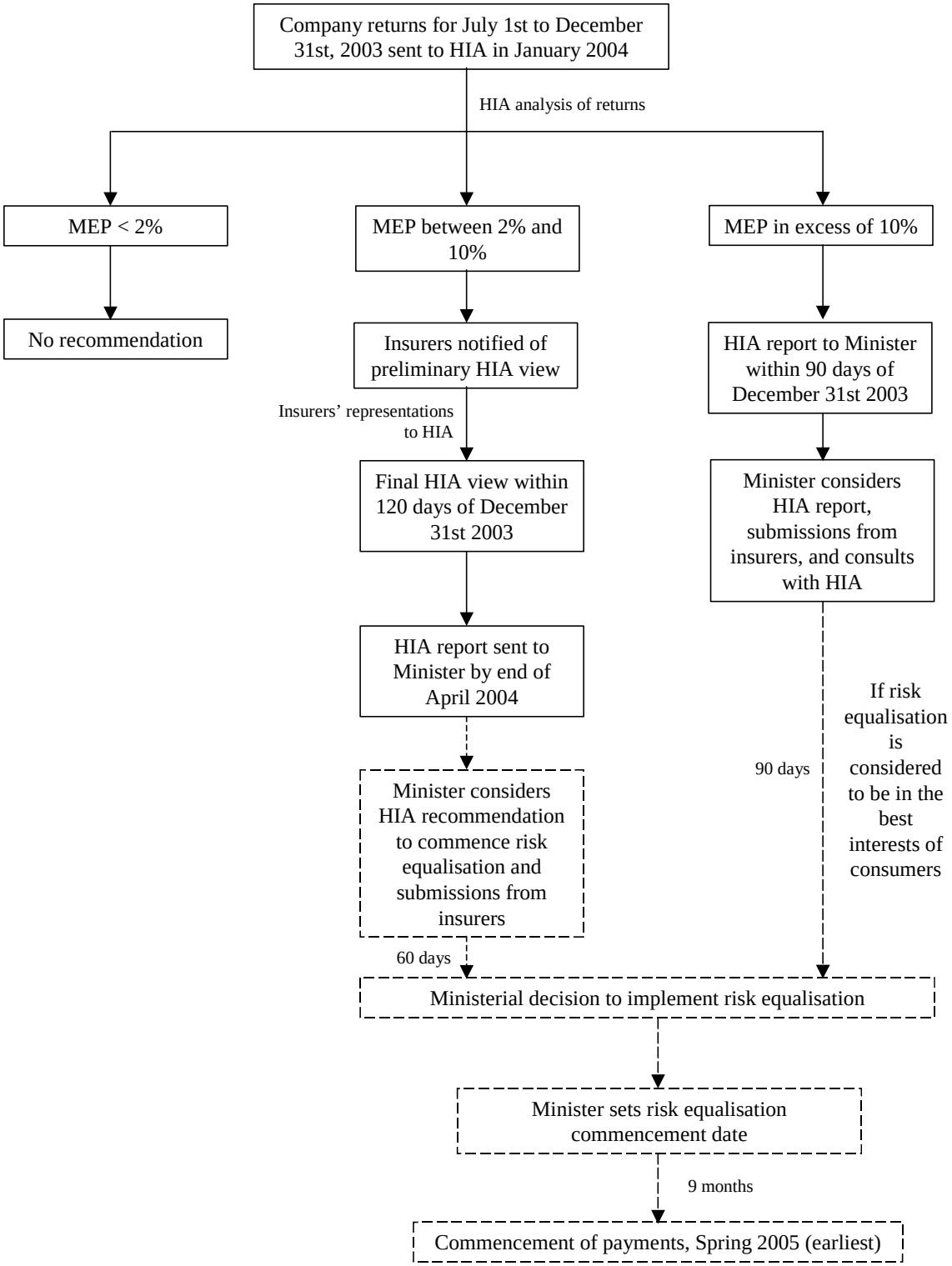
The magnitude of the risk equalisation payments is estimated by comparing claims payments under the insurer's existing profile with that under the market risk profile. In their 'Guide to the Risk Equalisation Scheme, 2003', the HIA have used age and gender as proxies for risk profile, which were recently mandated by regulations. However, the HIA has the discretion to adapt this formula by also including utilisation of healthcare services. The HIA recognises that the inclusion of this measure may provide perverse incentives for insurers.[34]

If a risk equalisation scheme is implemented, the process will not begin before January 2004. The decision to commence a risk equalisation scheme will be made on the basis of companies' returns for the previous 6 months (July to December 2003). Once it has been decided to proceed with a risk equalisation scheme, the magnitude of actual payments will be determined on the basis of returns for the latter half of 2004 (July to December 2004), with transfers made in Spring 2005 at the earliest. The potential timescale is as shown in Figure 3.1.

[33] Under the Health Insurance (Amendment) Act, 2001, a new entrant may be exempt from participating in a risk equalisation scheme for 36 months, with any risk equalisation payments commencing thereafter administered at a discount of 50% for a further 12-month period. In addition, the scheme may not be applicable to restricted membership undertakings under certain conditions. In particular, this exemption applies to restricted membership undertakings that were registered as health insurance undertakings on 1 May 2000 and conducting business in Ireland before 19 November 2001. Restricted membership undertakings were required to formally notify the Minister before 30 September 2003 if they did not wish to participate in a risk equalisation scheme (HIA, *Risk Equalisation: Guide to the Risk Equalisation Scheme, 2003 as prescribed in Statutory Instrument No. 261 of 2003*, July 2003a). Only one restricted undertaking has decided not to participate in such a scheme.

[34] HIA (2003a).

Figure 3.1: Proposed timescale of risk equalisation scheme



Source: The Health Insurance Authority (2003a).

3.4 CONCLUSIONS

This Chapter has shown that the legislation adopted in the Irish private health insurance market is primarily designed to facilitate members of the population in purchasing health insurance on non-discriminatory terms. In a healthcare system where there is excess demand for public services, promoting the use of private services is rational (subject to the overall effects on equity and efficiency). In addition, more recent developments have sought to encourage competition to benefit the insurance consumers, albeit that in practice this has thus far been restricted.

Chapter 4: Structure, Conduct and Performance of the Irish Private Health Insurance Market to Date

4.1 INTRODUCTION

On the basis of the healthcare system and the legislation explained in Chapters 2 and 3 respectively, this Chapter describes the market for private health insurance in Ireland. In particular, it focuses on the structure-conduct-performance paradigm recognised in industrial economics.

4.2 STRUCTURE

Until the advent of competition as set out in the EU's Third Non-Life Insurance Directive, VHI enjoyed a monopolistic position as the sole provider of private health insurance to individuals. However, following liberalisation, BUPA Ireland was established in 1996 and commenced operations in 1997, turning the market into a duopoly. To date, no other firms have actually entered the market, although a number have considered the possibility.

4.2.1 BUPA Ireland

BUPA Ireland was established in June 1996 and is a member of the BUPA group, which was established in the UK in 1947. As a not-for-profit organisation with no shareholders, any surplus earned by BUPA Ireland is reinvested in the company. Recent reports indicate that membership of BUPA Ireland is over 320,000 and it employs over 140 staff.[35] As well as offices in the UK and Ireland, BUPA also has operations in Hong Kong, Spain, Thailand and the Kingdom of Saudi Arabia, in addition to a specialist international division (BUPA International). In the UK, BUPA is a member of the General Insurance Standards Council, which is a voluntary organisation, established to regulate the insurance industry. BUPA is also registered to conduct insurance underwriting business in the UK, and therefore, must satisfy

[35] BUPA Ireland, www.bupaireland.ie/aboutus/index.htm, date accessed: 02/09/03 and BUPA Ireland, *Letter to customers*, dated 22 August 2003, Reference: 6000915100. Limited data is available on BUPA Ireland as its annual report and accounts are merged with those of the BUPA Group.

regulations (including solvency and liquidity requirements) set out by the Financial Services Authority.

4.2.2 VHI

As mentioned previously, VHI was established following the Voluntary Health Insurance Act, 1957, to provide private health insurance predominantly to members of the population who were not entitled to free public health services. VHI is a state-owned body. As such it is restricted from raising equity from capital markets.

There are a number of characteristics which are peculiar to VHI and arise from the legislation surrounding its establishment and subsequent Acts. In particular, the following are noteworthy:

- VHI is operated on a not-for-profit basis. It was originally intended that premium income and other revenues would match claims and other expenses, with any additional surplus set aside as reserves;
- The company is not required to seek authorisation from the Irish Financial Services Regulatory Authority to conduct insurance business. Therefore, it is exempt from solvency requirements. However, this exemption would no longer hold if the corporate structure of VHI were to change (see below);
- Premium increases must be sanctioned by the Minister. While it could be argued that this leaves VHI little discretion over its prices, premium increases have been authorised each year since 1980, apart from 1988, 1992 and 2000;[36]
- VHI is unable to amend existing schemes or provide new schemes without the Minister's consent.

In light of the changing market structure, the Government set out proposals to restructure VHI in the White Paper on Private Health Insurance. These recommendations include the following:

- Allow VHI full commercial freedom;
- Establish VHI as a public limited company;
- Provide €63.5 million to facilitate the restructuring of VHI.

In addition, the Government stated that they did not intend sell VHI immediately. Instead, the Government would welcome third-party investment with the intention of

[36] Based on data from the HIA. It is interesting to note that, although no premium increases were permitted in 1992 and 2000, two such adjustments were authorised in the each of the subsequent years (in January and August of 1993, and February and September 2001).

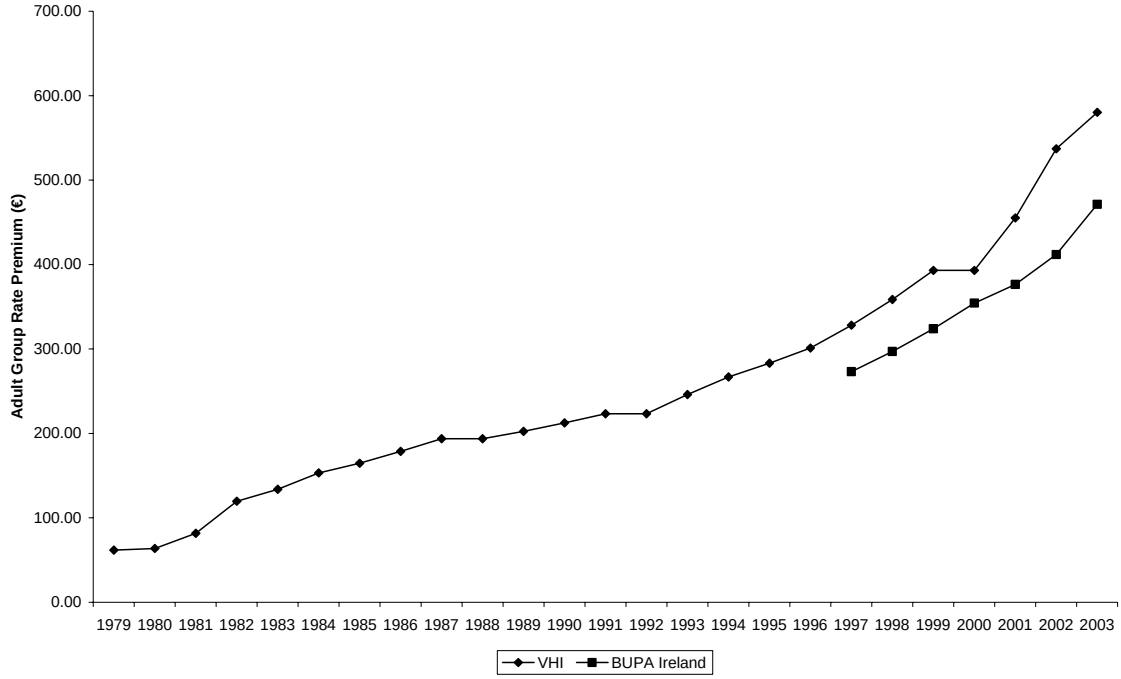
an eventual sale of the Government's stake. However, recent press speculation would suggest that the Government is no longer interested in selling VHI.

4.3 CONDUCT

The variation in premiums, charged by both BUPA Ireland and VHI, is shown in Figure 4.1. This shows that premiums have steadily increased since 1978. In spite of the liberalisation of the market in 1994 and BUPA Ireland's entry in 1996, premiums still continued to increase. It is difficult to draw any definitive conclusions regarding the impact of competition, as it is impossible to evaluate the effect on premiums if VHI had continued in its monopolistic position. However, it is worth noting that the annual increase in VHI's premiums was similar during the periods before and after competition. The mean increase in VHI's premiums prior to the entry of BUPA Ireland in 1996 was 10.2%, compared to 10.0% after 1996. The mean annual increase in VHI's premiums over the period 1990 to 1996 was 5.9%, which is less than half that during the post-1996 period.[37] The post-1996 mean annual VHI premium increase is slightly higher than the average for BUPA Ireland since it commenced operation in 1997 (9.6%). Therefore, it appears that the move from a monopoly to a duopoly has not slowed the growth in VHI's premiums, although in the absence of competition, it is not clear how these would have changed.

[37] The mean VHI premium increase over the period 1980 to 1996 (inclusive) was 10.2%, compared to 10.0% between 1997 and 2003. The mean premium increase for VHI during the period 1990 to 1996 was 5.9%.

Figure 4.1: Premiums, 1978 to 2003[a]



Note: [a] Adult group premium of BUPA Ireland's Essential Plus (with excess) and VHI's Plan B. Does not include tax relief at source. Two distinct price increases were authorised during 1993 (January and August) and 2001 (February and September). For these years, the later premium was taken.

Source: HIA.

Two possible interpretations of the historic patterns of premiums shown in Figure 4.1 are predatory pricing and Stackelberg competition.

4.3.1 Predatory Pricing

The first explanation, predatory pricing, would arise if either BUPA Ireland or VHI set their price substantially lower than those currently in the market. This may initiate a price war between the two rivals and could potentially increase the market share of the relatively cheaper firm. While this may deter entry by a potential additional competitor if it is perceived as a credible threat, the lowest-priced rival may incur significant losses if prices are set below average cost. In this case, this strategy may not be sustainable in the long run.

If the hypothesis of predatory pricing is correct, then given that VHI is a not-for-profit organisation, the premium charged by VHI is the break-even premium. If the premium charged by BUPA Ireland is below break-even level, then ceteris paribus BUPA Ireland may be incurring losses by undercutting VHI. As mentioned previously, the motivation for this strategy is to win market share from the incumbent. Evidence from a survey conducted on behalf of the HIA suggests that only 6% of

consumers with private health insurance sampled have switched from one insurance company to another.[38] Furthermore, 34% of BUPA Ireland customers participating in the survey were switchers. Thus, if this is a fair representation of the population of consumers with private health insurance, the majority of BUPA Ireland's subscribers may be attributed to new business rather than a redistribution of existing subscribers from VHI. The age distribution of consumers that have switched insurers is reported in Table 4.1. Almost half of those switching were aged between 25 and 34 years. Lower proportions of switching consumers were found in older age groups. This suggests that younger, low risk consumers are more mobile than older, high risk consumers.

Table 4.1: Age profile of consumers who have switched insurance companies

Current age of consumers	% of consumers who have switched insurers[a]
18 to 24 years	8
25 to 34 years	49
35 to 44 years	20
45 to 54 years	19
55 to 64 years	4
Over 65 years	–

Note: [a] Based on a sample of 29 respondents.
Source: HIA (2003b).

Only 12% of non-switchers have seriously considered changing insurance companies. Table 4.2 reports the percentage in each age cohort of those have considered switching, but have not done so. These results suggest that respondents aged between 35 and 44 years are more likely to consider changing their private health insurance provider. However, the difference in the distribution of non-switchers across the age groups is not as marked as that reported in Table 4.1. Interestingly, no respondents aged over 65 years have actually switched or considered doing so (see Tables 4.1 and 4.2).

Table 4.2: Respondents who have considered switching, by age category

Age category	% in each age cohort who have considered switching[a]
18 to 24 years	5
25 to 34 years	13
35 to 44 years	19
45 to 54 years	15
55 to 64 years	13
Over 65 years	–
Total	**12**

Note: [a] Based on a sample of 447 respondents who have not switched private health insurers.
Source: HIA (2003b).

[38] HIA (2003b).

The barriers to changing insurance company are reported in Table 4.3. Two of the most important factors that deterred consumers from moving to another company were satisfaction with the service provided by the existing company and insufficient cost savings.

Table 4.3: Barriers to switching

Reason	% of non-switchers
Satisfied with current provider	27
No significant cost savings	17
Been with existing provider for a long time	14
Level of cover no better	13
Too much hassle/paperwork	12
Could not be bothered	12
Concerned that coverage would not be the same	11
Prefer to stay with an Irish company	10
Range of products/services no better	7
Concerned about waiting periods	5
Too difficult to compare plans	4
Feel loyal to my current provider	4
Other insurer would not want me/too high of a risk	4
Looked after by work/employer	3
Still considering it/have not made up my mind	3
Did not know that I could switch	2
Just joined current provider	2
Too expensive	1
Lack of information	0
Don't know	7
No choice/Not my decision	6

Note: Based on a sample of 447 non-switchers.
Source: HIA (2003b).

However, the evidence in Figure 4.1 also supports an alternative explanation for the deviation in the premiums of the two rivals, which does not relate to such an aggressive pricing strategy as predatory pricing. Instead, this interpretation relates to the differences in risk profiles. As the incumbent, it may be more likely that VHI has a relatively high risk profile compared to that of BUPA Ireland since the former has built up its customer base over a longer time period. For instance, members may have joined shortly after VHI was first established in 1957 and may still be with the company. This difference in risk profile would allow BUPA Ireland to charge a lower premium. Given the inherent difficulties of measuring risk, age is often used as a proxy. The age breakdown of BUPA Ireland and VHI members, who participated in the HIA survey is reported in Table 4.4. The average age of BUPA Ireland members, 38 years, is lower than that for VHI members. This is driven by the difference in the proportion of members of both companies in the 55 to 64 years age group (8% of BUPA Ireland members versus 16% of VHI members) and in the 65 years and over

category (3% versus 12%, respectively), which are statistically significant.[39] (It should be noted that because claims rise substantially with age, average age alone is not a good comparator of risk profiles.)

Table 4.4: Age breakdown of BUPA Ireland and VHI members

Age group	BUPA Ireland customers (%)	VHI members (%)
18 to 24 years	14	14
25 to 34 years	34	22
35 to 44 years	24	19
45 to 54 years	18	18
55 to 64 years	8	16
65 years or over	3	12
Average age (years)	38	44

Note: Based on 65 BUPA Ireland customers and 386 VHI members.
Source: HIA (2003b).

In addition to the older age profile, the HIA survey also found that the propensity to claim was greater among VHI members compared to BUPA Ireland members – 40% of VHI members sampled had made a claim in the last 3 years compared to 27% of BUPA Ireland customers. The higher claims incidence associated with VHI members is consistent with its older age profile since, as Table 4.5 shows, the probability of making a claim increases with age.

Table 4.5: Claims experience of respondents with private health insurance by age group (%)

Age group	% within each age group who have made a claim
18 to 24 years	16
25 to 34 years	39
35 to 44 years	63
45 to 54 years	65
55 to 64 years	70
65 years or over	84
Total	55

Note: Based on 476 respondents who answered that they had private health insurance.
Source: HIA (2003b).

In the absence of data on the profits earned by BUPA Ireland or the risk profiles for the two companies, it is not possible to make a definite conclusion about the two conjectures of predatory pricing or price following. However, the trend of rising premiums suggests that the two rivals are not participating in a price war.

[39] The 95% confidence interval for the difference in proportions in the 55 to 64 years age groups is –0.1554 to –0.0046. Similarly, the 95% confidence interval for the difference in proportions in the 65 years and over age group is –0.1426 to –0.0374.

4.3.2 Stackelberg Competition

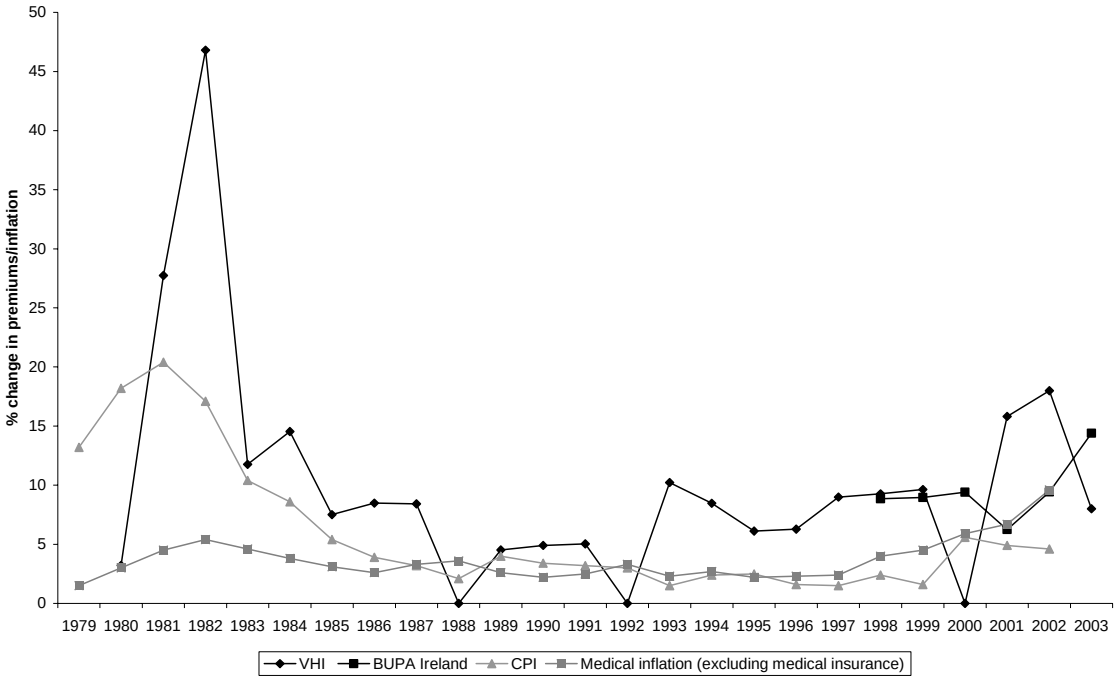
The second interpretation of Figure 4.1 suggests that the private health insurance market may be characterised by Stackelberg competition. This implies that the incumbent (in this case VHI) sets the price (subject to approval by the Minister), while the entrant (BUPA Ireland) follows by charging a similar, albeit marginally lower, price. This theory is supported by the statistically significantly positive correlation between the premiums of the two companies.[40] Apart from this price following strategy, other factors such as an increase in the price of private beds or medical inflation, which affect all participants in the industry, may also explain the positive association between premiums. The stability of a Stackelberg model depends on the potential threat of entry. For example, if a third company was considering entering, one or both of the existing firms may have an incentive to cut prices, thereby reducing the possible profitability of the market for the new entrant.

Figure 4.2 demonstrates the increase in premiums relative to inflation over the period 1979 to 2003. Generally, premiums are increasing at a faster rate than general and medical inflation. In the VHI Annual Report, the Chief Executive of VHI has attributed the recent significant increases in premiums, in excess of medical inflation, to the operation of the community rated system in the absence of risk equalisation.[41] By this argument, the premiums of VHI must increase to offset its relatively high risk profile. Therefore, the compensation received under a risk equalisation scheme would permit VHI to charge lower premiums, although BUPA Ireland's reaction may be to increase premiums. Thus, following any implementation of a risk equalisation scheme, there may be convergence of premiums across insurers.

[40] The Spearman's correlation coefficient between BUPA Ireland's and VHI's premiums is 0.991, which is statistically significant at the 0.01 level. A correlation coefficient is a parameter between -1 and 1, which measures the linear relationship between two variables. A correlation coefficient of 1 would imply a perfect (positive) linear relationship.

[41] Vhi Healthcare (2003).

Figure 4.2: Increase in premiums and inflation, 1979 to 2003



Note: Inflation is measured by the Consumer Price Index, CPI. Medical inflation excludes medical insurance.
Source: HIA and Central Statistics Office.

At their 2003 level, BUPA Ireland and VHI premiums amounted to approximately 2% of the annual average industrial wage.[42]

4.3.3 Regulation

As mentioned previously, the HIA was established on February 1st, 2001 in accordance with the provisions of the Health Insurance Act, 1994 and the Health Insurance (Amendment) Act, 2001. The HIA is responsible for the regulation of private health insurance in Ireland. In particular, its functions, as set out in the Health Insurance Act, 1994 and the Health Insurance (Amendment) Act, 2001, are:

- To manage and administer any [risk equalisation] schemes, and to establish and maintain the fund for these schemes;
- To maintain the Register;
- To evaluate and analyse returns;
- To prepare and furnish to the Minister, at such intervals as may be prescribed, a report in relation to:

[42] Based on a preliminary estimate for June 2003 of €540.27 per week across all industries (Central Statistics Office, *Industrial Earnings and Hours Worked*, June 2003). Premium data relates to the adult group rates, excluding tax relief at source, of BUPA Ireland's Essential Plus (with excess) in March 2003 and VHI's Plan B in September 2003.

- Such an evaluation and analysis in so far as it relates to returns made to it in a prescribed period;
- Matters concerning the carrying on of health insurance business and developments in relation to health insurance generally that the Authority considers ought to be included in the report as a result of that evaluation and analysis;

If it appears to the Authority from such an evaluation and analysis that conditions specified in the scheme related to the nature and distribution of insured risks amongst the registered undertakings are fulfilled, include in that report a recommendation by it that the Minister ought or ought not (as it considers appropriate having regard to the best overall interests of health insurance consumers) to exercise the power hereafter mentioned in this subsection. The provision of a scheme shall require the Authority, if it appears to the Authority that a recommendation of the kind referred to in that provision is required to be included in a report under that provision, to:

- Give notice to each registered undertaking of the fact that it proposes to include such a recommendation in the report, the nature of that proposed recommendation and the reasons therefore,
- Invite, by means of that notice, the undertaking to make, within 21 days from the date of the service of the notice on the undertaking, representations to the Authority in relation to the nature of the recommendation that, in the undertaking's opinion, ought to be included in the report, and
- Take into account any such representations made to it within that period before finally deciding what the nature of the said recommendation ought to be.

- A risk equalisation scheme may provide:
  - For the establishment and maintenance by the Authority of a fund into which all moneys paid to the Authority under the scheme shall be paid and out of which all moneys paid by the Authority under the scheme shall be paid;
  - For the keeping by the Authority of specified accounts in relation to the scheme and the furnishing of copies of those accounts, as audited by the Comptroller and Auditor General, and copies of the report of the Comptroller and Auditor General thereon to the Minister at specified times;
- To advise the Minister either at his or her request or on its own initiative on matters relating to the functions of the Minister under this Act, the functions of the Authority and health insurance generally;
- To monitor the operation of this Act and the carrying on of health insurance business and developments in relation to health insurance generally.

4.4 PERFORMANCE

This Section focuses on the performance of the industry and its participants.

4.4.1 Membership

Almost 50% of the population of Ireland has private health insurance.[43] The vast majority of coverage is supplied by BUPA Ireland and VHI. Recent estimates indicate that the membership of BUPA Ireland is over 320,000.[44] VHI's share of total membership stood at over 80% in 2002.[45] The temporal pattern of VHI's membership is reported in Figure 4.3. The number of people with private health insurance supplied by VHI has been generally increasing steadily since 1958, apart from a slight decline in 1986. The rate of growth in VHI's membership has remained relatively unchanged over the last decade, despite BUPA Ireland's entry into the Irish market. For instance, the mean annual increase in VHI subscribers over the period 1990 to 1996 was approximately 1.7%, compared to 1.6% since 1997.[46] This rate of growth has been slower than that experienced by the market (2.3% and 3.9% respectively).[47] The fact that BUPA Ireland's entry into the market did not lead to a fall in VHI's membership is consistent with the low number of consumers switching between the two insurers reported in Section 4.2.1. The upward trend in membership continued over the period shown in Figure 4.3 notwithstanding increases in the cost of cover (see Figure 4.1). This suggests that the demand for private health insurance is relatively inelastic – demand is not very sensitive to changes in price.[48]

It is also worth noting that over the last quarter of a century, the largest increase in VHI membership (16%) occurred in 1988. One possible explanation for this increase in subscriptions was the sharp fall in the number of acute hospital beds in 1987/88. It is also worth noting that no premium increase took place in 1988, although this seems

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[43] HIA, *Annual Report and Accounts*, 2002.

[44] BUPA Ireland (2003). A time series of BUPA Ireland's membership since it entered the market was not available.

[45] Vhi Healthcare (2003).

[46] Department of Health and Children (1999); Vhi Healthcare (2003); and HIA.

[47] Department of Health and Children (1999) and the HIA, *Annual Report and Accounts*, 2001 and 2002;

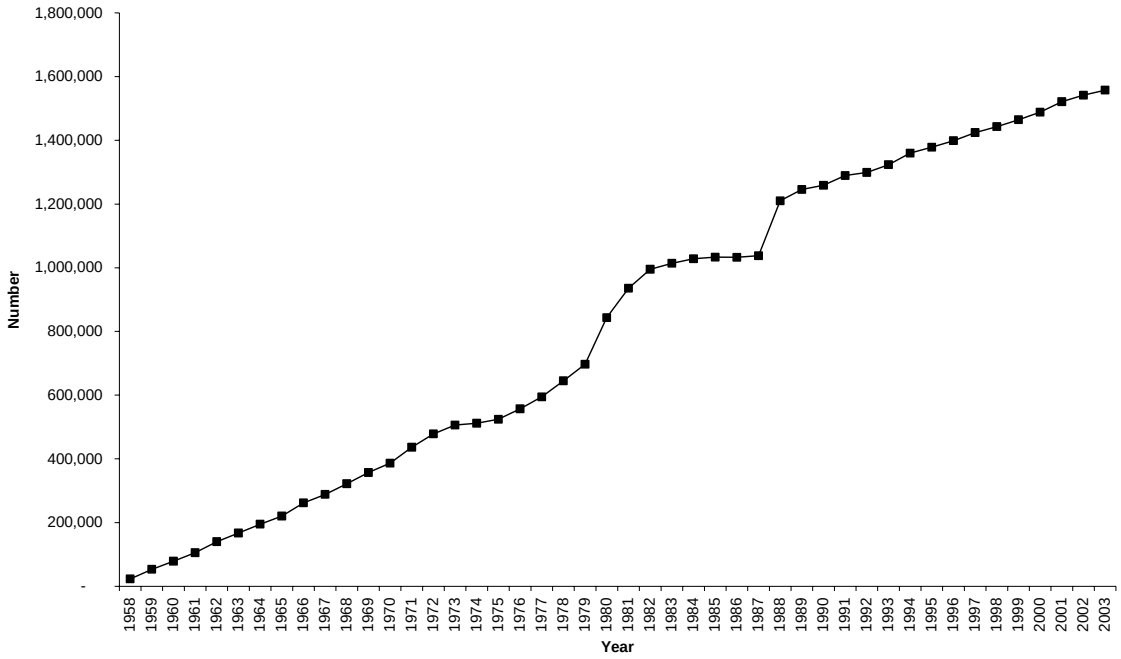
[48] Indeed, the positive correlation between premium and membership suggest that the demand curve for private health insurance is upward sloping. The estimated equation for VHI's demand curve is:

membership = 835,968.65 + 1,562.593*premium
(19.3) *(10.4)* $n = 24, R^2 = 0.824$.

This implies that membership would increase by 1,563 consumers if premiums were to increase by one euro. Similarly, if the premium was set at 0, VHI's membership would be equal to 835,969. However, caution should be exercised in interpreting these results for a number of reasons. First, the sample size is relatively small. Second, the direction of causality is ambiguous – premiums may be influenced by the number of subscribers, but the reverse may also be true. Finally, the model presented above is simplistic and does not take account of other factors, such as income, which may have a positive effect on demand, even in the presence of rising premiums.

to be an issue of timing since there were increases in December 1987 and February 1989. It is worth noting that such a substantial increase in membership was not observed in the other two years (1992 or 2000), when premiums remained constant.[49]

Figure 4.3: VHI's membership, 1958 to 2003



Sources: Department of Health and Children (1999); Vhi Healthcare (2003); and HIA.

Given the ongoing increases in premiums in real terms and the access to alternative public services, it is interesting to ask why almost 50% of the Irish population take out private health insurance? A number of surveys have been undertaken which may contain possible answers to this question. The results of the first, undertaken by the Economic and Social Research Institute in 1999 are reported in Harmon and Nolan (2001) and Nolan and Wiley (2000).[50] The second was commissioned by the HIA (2003).[51] The overall results of both surveys are generally consistent. In particular, one of the predominant reasons for purchasing private health insurance cover is to ensure quick and superior treatment. However, the perception that private services involve a higher standard of care defies the governmental objective to ensure that

[49] It is important to note that VHI did not request the Minister to grant an increase in its premiums in 1992. Instead, this observation seems to be explained by the timing of increases. Price increases took place in September 1991 and January 1993. Conversely, the Minister refused to allow VHI increase premiums in September 2000 due to the general economic climate, in particular high inflation. However, rather than an outright refusal, the premium increase was postponed to February 2001, although this increase was less than that requested.

[50] Harmon C. and Nolan B. Health Insurance and Health Services Utilization in Ireland. *Health Economics.* 2001; 10: 135-145. Nolan B. and Wiley M. *Private Practice in Irish Public Hospitals*. ESRI, 2000.

[51] HIA (2003b).

there is no difference between public and private healthcare services.[52] The results of both surveys are reported in Tables 4.6 and 4.7.

Table 4.6: Reasons for having health insurance (%)[a]

Reason[b]	**% answering 'very important'**	**% answering 'very' or 'quite important'**
Fear of large medical or hospital bills	88.5	98.4
Being sure of getting into hospital quickly when you need treatment	86.4	98.6
Being sure of getting good treatment in hospital	77.4	95.9
Being able to arrange hospital treatment when it suits you	68.7	95.7
Being sure of getting consultant care	67.5	96.0
Being able to choose your own consultant	52.7	88.9
Being able to have a private or semi-private room in hospital	27.8	65.2
Being able to get into private hospitals	27.2	63.3

Notes: [a] Respondents were chosen at random. In total, 2,620 individuals participated in the survey. Approximately 43% of participants answered that they had private health insurance cover. The results presented in Table 4.6 do not distinguish between those with or without private health insurance.

[b] Respondents were asked to classify the reasons as very, quite or not at all important. Reasons are ranked according to the percentage who answered 'very important'.

Source: Harmon and Nolan (2001) and Nolan and Wiley (2000).

[52] For example, an explanatory note entitled 'GP services to medical card holders' states that 'Doctors must treat medical card patients in the same way as they treat private patients' (www.oasis.gov.ie/health/gp_services/GPs_and_medical_card_holders.html, date accessed: 12/08/03).

Table 4.7: Attitudes to private health insurance (%)[a]

Statement[b]	Agree strongly	Agree slightly	Neither	Disagree slightly	Disagree strongly	Don't know
Private health insurance is a necessity not a luxury						
Consumers	72	22	0	4	2	0
Non-consumers	25	30	12	14	13	7
I will always have private health insurance						
Consumers	57	30	5	1	1	5
Private health insurance provides peace of mind						
Consumers	68	27	2	2	1	1
Non-consumers	28	41	10	7	5	9
Having private health insurance means always getting a better level of health care service						
Consumers	38	40	5	10	5	3
Non-consumers	31	33	8	11	8	10
Having private health insurance means you can skip the queues						
Consumers	29	43	8	10	8	2
Non-consumers	42	35	5	7	5	7
There is no need for private health insurance in Ireland, public services are adequate						
Consumers	4	4	6	24	58	4
Non-consumers	7	17	11	26	32	7
Only old people and sick people need private health insurance						
Consumers	2	7	8	17	62	4
Non-consumers	2	9	12	20	50	7
Private health insurance is only for the wealthy						
Consumers	7	17	12	26	35	3
Non-consumers	29	26	11	16	14	4
People who can afford to pay for private health insurance have a responsibility to pay for it and not rely on public health services						
Consumers	35	27	12	17	8	1
Non-consumers	37	29	11	10	8	5

Notes: [a] A sample of 1,001 subjects participated in the survey. Of these, 47% answered that they had private health insurance.

[b] Respondents were asked if they agreed or disagreed with the above statements.

Source: HIA (2003b).

The fact that Table 4.7 shows that private health insurance is perceived as a necessity and also that the majority of subscribers thought they would always have health insurance may indicate that the price elasticity of demand for private health insurance is quite low. Related to the issue of the sensitivity of demand to changes in premiums, respondents were asked what level of premium increases would prompt them to discontinue their insurance cover. The results are reported in Table 4.8. A premium increase of 10% would result in 8% of those surveyed discontinuing cover. However, as shown in Figures 4.1 and 4.2, in reality, past premium increases of this amount (and even greater, as shown in Figure 4.1) did not prompt corresponding

declines in membership (see Figure 4.2). It is also interesting to note that the demand for private health insurance seems to be less responsive to increases in premiums for those aged over 65 years. For example, compared to this group, a slightly larger proportion of the younger age groups are willing to discontinue cover following increases of 20% or 30% in premiums. In addition, the same survey found that 44% of those with private health insurance thought that recent increases in premiums were justified, given increases in the costs of treatment and advice. These findings may be associated with the anticipated utilisation of healthcare – older people may believe that they are more likely to require these services and, therefore, are more generally hesitant to discontinue cover. The reduced mobility of subscribers in this age group may also be related to a lack of knowledge about switching or competing plans.

Table 4.8: Premium increases leading to discontinuation of cover

Amount of premium increase	Total (%)	Age groups (%)					
		18 to 24	25 to 34	35 to 44	45 to 54	55 to 65	Over 65
10%	8	10	11	7	9	8	–
20%	22	21	22	21	26	24	20
30%	24	22	20	28	27	24	19
40%	15	17	9	15	14	14	27
50%	10	7	13	13	9	9	3
60%	4	2	3	4	5	4	3
70%	1	–	3	2	–	–	–
80%	1	–	–	1	2	1	–
90%	0	–	1	–	–	1	–
100%	1	–	–	1	1	1	–
No increase/No % specified	15	21	20	9	6	13	27
Average	32.5	29.5	32	34	32	34	33

Note: Based on a sample of 476 respondents with private health insurance.
Source: HIA (2003b).

Furthermore, the research commissioned by the HIA found that 85% of consumers were satisfied with the overall value for money of private health insurance. Moreover, there were no significant differences in the answers of BUPA Ireland and VHI members sampled, even though the premiums paid by the latter are relatively higher according to the survey (€435 for VHI members and €327 for BUPA Ireland consumers). However, there was a difference between consumers and non-consumers who were asked if they agreed with the statement that 'private health insurance is good value for money'. Over half of consumers (55%) agreed with this statement compared with only 14% of non-consumers. This indicates that the cost of private health insurance is an important determinant of whether to purchase cover. Indeed, this is confirmed in Table 4.9, which shows that the lack of affordability is one of the main reasons for not having insurance cover.

Table 4.9: Reasons for not having private health insurance (%)[a]

Reason	Main reason	Other reason	Any mention
Too expensive/premiums too high/cannot afford it	42	23	64
Have a medical card	25	17	42
Have not thought about it	14	12	26
Healthy/do not require it	5	11	16
Satisfied with public services	5	21	26
Will get it when older	4	9	12
Do not approve of it	2	3	5
Other	4	4	8
Don't know	1	18	19

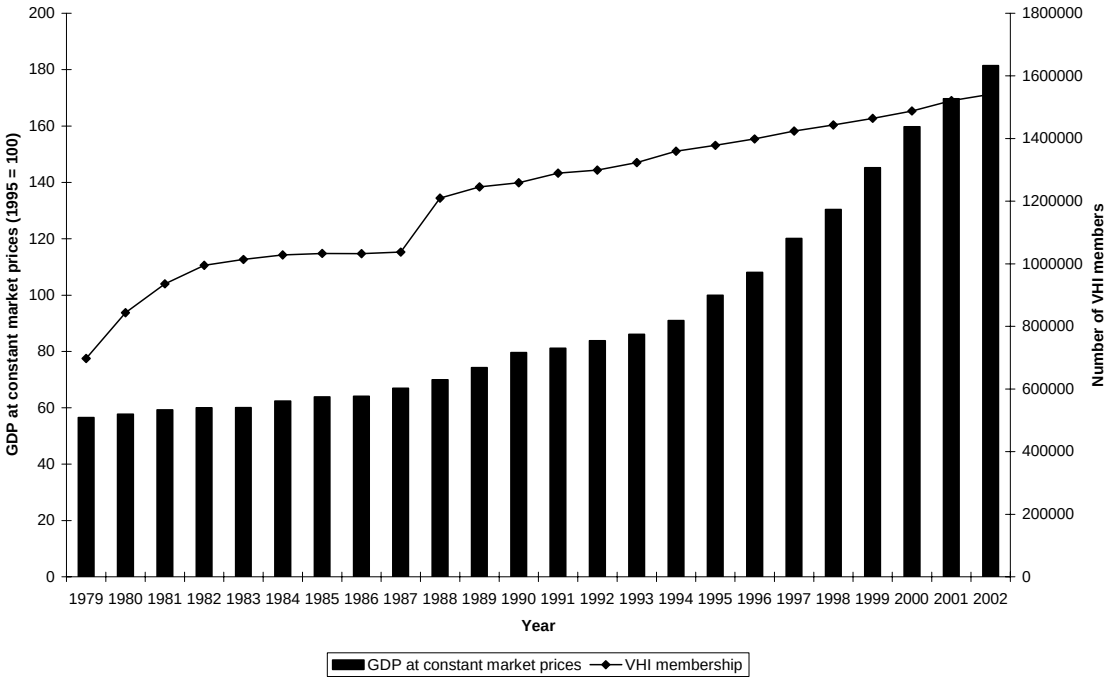
Note: [a] Based on a sub-sample of 479 respondents who never had private health insurance.
Source: HIA (2003b).

A factor which may contribute to the affordability of health insurance is the tax relief on premiums. The original motivation for this was to provide incentives for individuals to purchase private health insurance. Currently, the tax relief on premiums is at the standard rate of tax (20%).[53] This tax relief is administered at source so that subscribers pay the discounted premium and the insurance company subsequently claims the tax back from the Government. The main argument against this scheme is that the increasing premiums of recent years have not discouraged the demand for private health insurance. However, while this point is recognised in the White Paper on Private Health Insurance, it argues that some State intervention is necessary particularly if healthcare costs increase substantially, thereby increasing the price of private health insurance. It has been estimated that abolition of this tax relief would result in a 25% increase in premiums.[54] Consequently, the White Paper states 'there are no plans to alter the available relief in respect of health insurance premiums'.[55]

In addition, the strong performance of the Irish economy has increased income for many and thereby made private health insurance more attractive. The positive association between VHI's membership and GDP is shown in Figure 4.4.

[53] Department of Health and Children (1999), para. 2.18.
[54] Tax relief at the standard 20% rate of tax implies that subscribers are currently paying 80% of the value of premiums. If this tax relied was abolished, subscribers would incur 100% of the cost of premiums, which represents an increase of 25%.
[55] Department of Health and Children (1999), para. 2.21.

Figure 4.4: Relationship between VHI membership and GDP, 1979 to 2002



Note: For the index of GDP at constant market prices, 1995 = 100.

Source: Department of Health and Children (1999); Vhi Healthcare (2003); HIA; and Central Statistics Office, *National Income and Expenditure 2002*, August 2003.

The HIA survey identified some respondents without private health insurance. Of these 525 individuals, 42% said that they were likely to get it in the future while almost a third answered that they will never purchase cover.[56] It is interesting to note the demographic differences between the two groups. The likelihood of purchasing private health insurance was greater among those aged less than 35 years of age, in the upper and lower middle classes, and in employment or education. In contrast, those who stated that they were unlikely to obtain health insurance were aged 45 years or older, in the working class, homemakers, retired or unemployed. Apparently, the characteristics of those without private health insurance are similar to those who are entitled to medical cards, although the incomes of these two groups may differ.

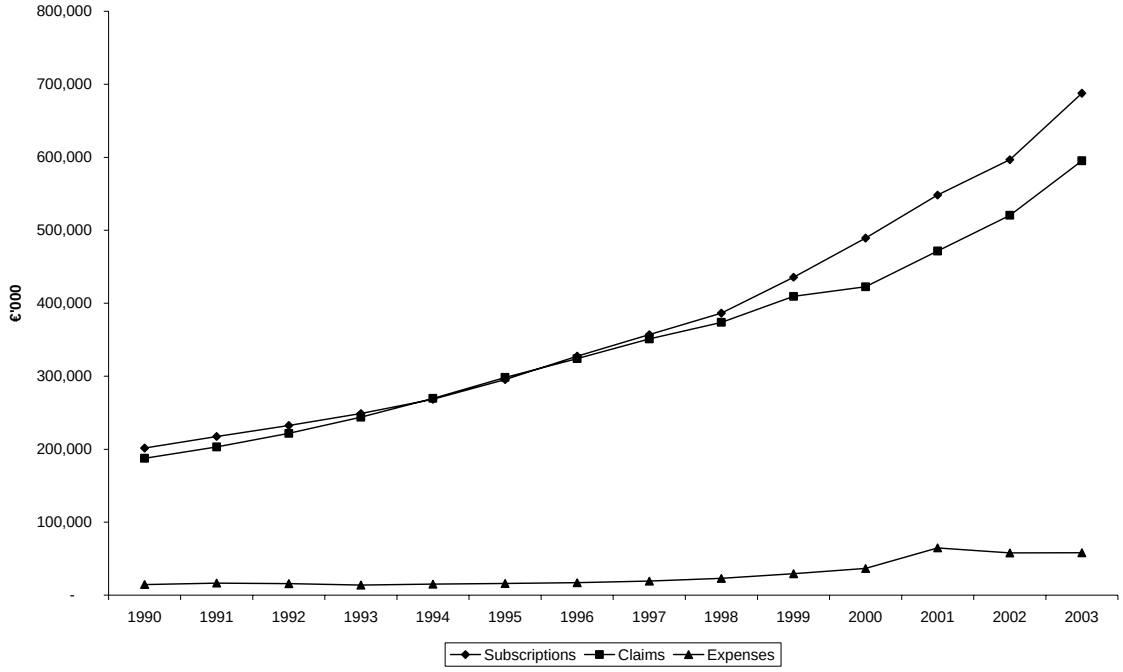
4.4.2 Financial Performance

The financial records of BUPA Ireland are not in the public domain. Therefore, the figures reported in Figure 4.5 relate to VHI only. The results show that earnings from premiums generally exceeded claims costs, with both indicators increasing over time. In addition, operating expenses increased until 2001, after which they declined,

[56] HIA (2003b).

although they were still above 1999 levels. It may be argued that this increase in operating expenses may be a consequence of the liberalisation of the private health insurance market. For example, VHI's advertising and marketing expenses may have escalated in the face of competition and the abolition of its monopoly position. Indeed, this hypothesis is corroborated by the fact that between 1990 and 1996, expenses increased by 18%, which is substantially lower than the 200% increase over the 7-year period since BUPA Ireland's entry into the market in 1997.[57] Controlling for membership, the average expense per member increased from €13.50 in 1997 to €37.30 in 2003.

Figure 4.5: VHI's financial performance, 1990 to 2003 (€'000)

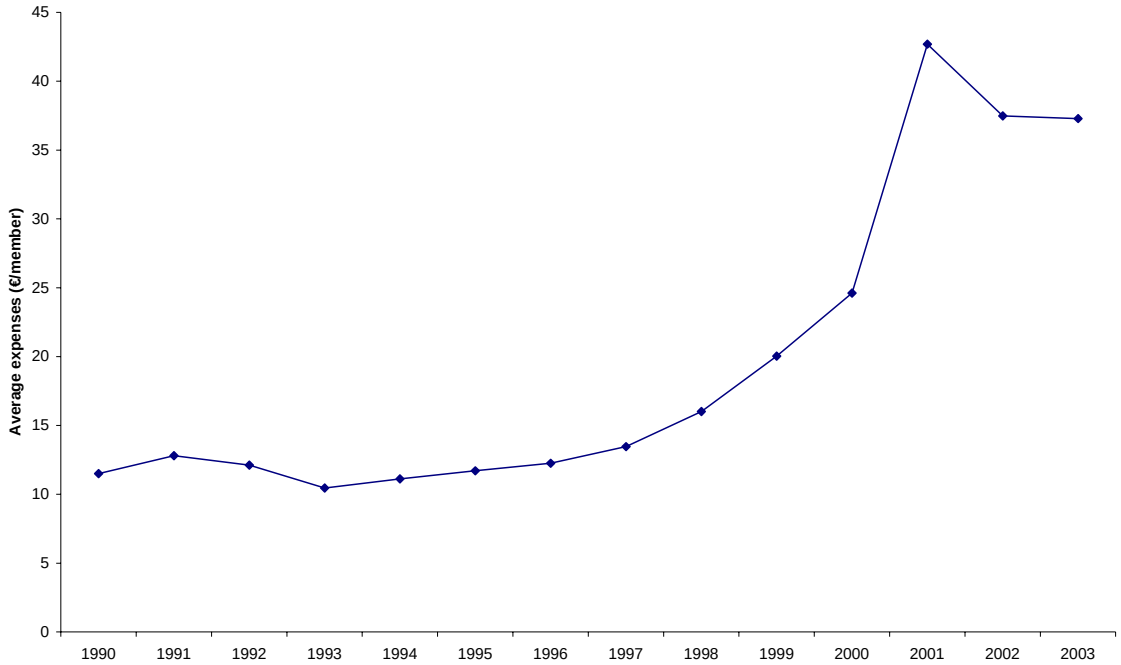


Note: Conversion rate: €1 = £0.787564.
Source: Department of Health and Children (1999); Vhi Healthcare (2003); and Central Bank of Ireland (euro conversion rate).

The average expense per member is demonstrated in Figure 4.6. There appears to have been an increase in the average expense in recent years. However, in addition to the possibility of greater operating expenses associated with an increasing membership, this upward trend may also be driven by other factors such as the introduction of competition. Because the impact of increasing subscriptions cannot be isolated, it is not possible to draw definitive conclusions from Figure 4.6 about economies or diseconomies of scale.

[57] Department of Health and Children (1999) and Vhi Healthcare (2003).

Figure 4.6: VHI's operating expenses per member, 1990 to 2003



Source: Department of Health and Children (1999); Vhi Healthcare (2003); and HIA.

4.4.3 Health Insurance Products

One argument in favour of competition is that it offers the consumer greater choice. This may be evident as rival firms may have an incentive to diversify their product, rather than compete on price (especially if products are homogeneous). As Table 4.10 shows, there are some differences between the products offered by BUPA Ireland and VHI.[58] Indeed, even within the characteristics reported in Table 4.10, variations arise in the size of benefits amounts. The plans are described in more detail in Appendix A.

A comparison of VHI's current Plan C Option and that offered in November 1997 shows that there is little difference between the two schemes.[59] In particular, benefits such as full cover for specified heart procedures in the Blackrock Clinic and the Mater Private Hospital; maternity benefits; cover abroad and reduced student rates, are offered in both versions of Plan C Option. However, the plans currently offered by VHI may differ from those offered prior to the introduction of competition. Discussions with one of the insurers would suggest that, since the introduction of

[58] VHI also offers schemes which cover 'everyday' medical expenses (HealthSteps); public hospital inpatient charges (Plan P); and healthcare costs of those living abroad (Global). Further details of these are contained in Appendix A.

[59] VHI, 'Some Extra 'Options' for Plan C Members', November 1997 and www.vhihealthcare.com/info/products/planc_option/index.jsp, date accessed: 01/08/03.

competition, there have been more product innovations targeted at younger people, such as maternity benefits, alternative medicine and primary care.[60]

This completes our assessment of the current market for private health insurance in Ireland.

[60] For example, there is no mention of alternative medicine in *A Guide to Plans A B C D E: Rules. Applicable to new registrations or renewals on/or after 1st March 1997,* produced by VHI.

Table 4.10: Summary of attributes of health insurance products

	Accommodation	Maternity	Outpatient[a]	Convalescence	Cover while abroad	Student discount	Specified heart procedures	Additional features
BUPA Ireland								
Essential	Semi-private room in BUPA Ireland's public participating hospitals	Y	Y	Y	Y	N	Y	UK cover
Essential Plus (with inpatient excess)	Private room in a public hospital or semi-private room in private hospital. Includes a €63 excess per claim for private hospitals.	Y	Y	Y	Y	N	Y	UK cover
Essential Plus (no inpatient excess)	Private room in a public hospital or semi-private room in private hospital.	Y	Y	Y	Y	N	Y	UK cover
HealthManager Starter	Private room in a public hospital or private room in certain BUPA Ireland participating private hospitals	Y	Y	Y	Y	Y	Y	UK cover
HealthManager	Private room in BUPA Ireland participating private hospitals.	Y	Y	Y	Y	Y	Y	UK cover, Health Line
Gold	Private room at all BUPA Ireland participating hospitals.	Y	Y	Y	Y	N	N/A[b]	UK cover
VHI								
Plan A	Semi-private room in a public hospital	Y	Y	Y	Y	N	N	Health information Nurse Line
Plan A Option	Semi-private room in a public hospital	Y	Y	Y	Y	Y	Y	Health information Nurse Line
Plan B	Private room in a public hospital or a semi-private room in a private hospital	Y	Y	Y	Y	N	N	Health information Nurse Line
Plan B Option	Private room in a public hospital or a semi-private room in a private hospital	Y	Y	Y	Y	Y	Y	Health information Nurse Line
Plan C	Private room in either a public or private hospital	Y	Y	Y	Y	N	N	Health information Nurse Line
Plan C Option	Private room in either a public or private hospital	Y	Y	Y	Y	Y	Y	Health information Nurse Line
Plan D	Private room in a private or public hospital, or semi-private room in either the Blackrock Clinic or Mater Private Hospital	Y	Y	Y	Y	N	N/A	Health information Nurse Line
Plan D Option	Private room in a private or public hospital, or semi-private room in either the Blackrock Clinic or Mater Private Hospital	Y	Y	Y	Y	Y	N/A	Health information Nurse Line
Plan E	Private room in a public or private hospital	Y	Y	Y	Y	N	N/A	Health information Nurse Line
Plan E Option	Private room in a public or private hospital	Y	Y	Y	Y	Y	N/A	Health information Nurse Line

Notes: [a] While all plans offer outpatient cover, there is some variance in the level of these benefits across plans. For example, certain outpatient expenses must exceed specified amounts before a subscriber can submit a claim. Members of BUPA Ireland's Essential plan cannot claim benefits greater than €6,400 less an excess of €250. The level of excess is increased to €470 for members with dependants. The same annual limit applies to members of Essential Plus and Gold, although the level of excess is set at €220 per member, and €440 and €380 (respectively) per member with dependants. The HealthManager Starter and HealthManager plans are not subject to any excesses. Instead, BUPA Ireland will pay half of the annual costs for outpatient treatment up to a maximum of €7,650 under these plans. For VHI's Plans A to E, these annual excesses are set at €310 for an adult and €500 for a family. This threshold is slightly lower for the option plans. The level of annual excess on Plan A Option is €250 for an adult and €470 for a family. The other Option plans have annual excesses of €220 for an adult and €380 for a family. According to VHI's Table of Benefits, the maximum outpatient payable by VHI is €3,200 per year. This is increased to an annual limit of €6,400 for the Option plans. Further details of the plans are specified in Appendix A. Both BUPA Ireland and VHI have schedules of allowable expenses which permit a certain amount to be offset against certain medical expenses over the excess. In calculating a claim for outpatient expenses, these allowable expenses are used, rather than the actual cost incurred by the subscriber. For example, consider a scenario a health insurance plan with an excess for outpatient expenses of €500 and an allowable expense of €25 for GP visits, even though the actual cost of a visit to the GP is €50. In this case, the patient would have to visit the GP over 20 times in one year to be eligible to submit a claim.

[b] N/A, not applicable. This denotes that specified heart procedures are implicitly covered in these plans because they include cover for Blackrock Clinic.

Source: BUPA Ireland, *www.bupaireland.ie/ourproducts/index.htm* and Vhi Healthcare, *www.vhihealthcare.com/products/index/html*.

Chapter 5: Economic Principles of the Private Health Insurance Market

5.1 INTRODUCTION

The purpose of this chapter is to set out the economic principles underlying assessment of competition, and in particular of the ease of entry by new competitors. It provides a preliminary statement of factors which may have a significant effect on the degree of competition in the Irish health insurance market. Reference is also made to the impact of including utilisation in, or excluding it from, the risk equalisation formula.

This chapter is structured as follows. Section 5.2 sets out the background by defining the policy parameters governing the health insurance market in Ireland, and summarises their economic implications. Sections 5.3 and 5.4 then describe the framework of competition economics and relate that to the case of the Irish health insurance market. Section 5.3 sets out the factors which determine whether businesses will want to operate in a market. Section 5.4 then considers the barriers that may prevent them entering that market should they wish to do so.

5.2 BACKGROUND TO THE ECONOMICS OF THE HEALTH INSURANCE MARKET

In considering whether to recommend commencement of risk equalisation, the HIA is required to have regard to the "best overall interests of health insurance consumers" (the Health Insurance (Amendment) Act, 2001). These best overall interests are in turn specified by the 2001 Act to include references to the need to maintain "the application of community rating across the market for health insurance and to facilitate competition between undertakings".

We understand the Government's objectives for the health insurance market to include:

- Social solidarity;
- Promotion of consumer interests – low prices and high quality – through competition;
- Minimum reliance on public expenditure consistent with the first two objectives.

We take as given that, in pursuit of the first and third of these objectives, the health insurance market in Ireland will continue to be subject to:

- Community rating; with
- Open enrolment and lifetime cover.

Risk-related setting of health insurance premiums and barring of, or removal of cover from, high-risk consumers are thereby legally prevented. It would, at least in principle, be possible for social solidarity to be achieved without community rating, by a system of government subsidy to individuals, or to insurers in respect of individuals, so as to enable everyone to afford risk-related health insurance premiums. For example, Zweifel and Breuer (2002) have proposed the introduction of such an arrangement in Germany.[61] However, such an approach would entail a substantial increase in public expenditure compared with a self-financing community rated health insurance system. We assume for the purposes of this project that a government subsidy based approach would be ruled out by the Government on these grounds.[62]

Given community rating and open enrolment, the problem of selection arises. The economics of adverse selection and cream skimming will not be restated at this point, other than to note three points:

- That implementation of a risk equalisation scheme is common in circumstances of community rating combined with open enrolment. Parkin and McLeod (2001) found 16 countries, other than Ireland, with risk equalisation in place, and only one country with community rating but not risk equalisation, namely South Africa.[63] However, this finding should be treated with caution because it is not clear that a consistent definition of risk equalisation was used in the cross-country comparison. Furthermore, Ireland is included in this total, even though such a scheme has not yet been implemented. All of the 16 countries use age in the risk equalisation formula, and nearly all use gender. Three are identified as including a utilisation element in the formula. Inclusion of utilisation is thus an option worthy of serious consideration, but it is not widely used;
- Even if open enrolment suggests that cream skimming by insurers would be illegal, there remain several ways in which insurers could attempt to attract a disproportionate number of lower risk consumers. There is a clear incentive to do so, in order to keep the claims costs down and hence the profits earned from community rated premiums up. Such measures include: targeted marketing (e.g. advertising in media aimed at the young and healthy); structuring insurance plans to appeal most to the healthiest (e.g. lower premiums in return for higher deductibles or

[61] Zweifel P. and Breuer M. Weiterentwicklung des deutschen Gesundheitssystems. Kurzfassung des Züricher Modells (Further development of the German health system. Summary of the Zurich model) in *Das Gesundheitssystem zukunftsfähig machen* (Making the health system fit for the future) by the Verband Forschender Arzneimittelhersteller (VFA): Berlin; 2002, available at *www.vfa.de/zuerichermodell*.

[62] The project terms of reference do not include consideration of alternatives to community rating.

[63] Parkin N. and McLeod H. Risk equalisation methodologies: an international perspective, University of Cape Town, 2001; CARE Monograph No.3; Centre for Actuarial Research (CARE).

co-payments); and offering lower premiums in return for using service providers who follow strict protocols or other utilisation management techniques (Van de Ven and Ellis, 2000);[64]

- Even if different risk profiles emerge by chance rather than design, there is a case for risk equalisation. Without equalisation a 'higher risk' insurer (one whose profile of consumers contains above average proportions of the old and sick) would have to raise premiums and, in a competitive market, could be driven out of business even if more efficient and providing higher quality services than the lower risk insurer. In a less competitive market, the higher risk insurer might not be driven out of business if the lower risk insurer chooses to price follow and raise prices. But the result of that would be inefficiently high premiums throughout the market. This would mean windfall profits for the lower risk insurer obtained at the expense of consumers.

The second government objective listed above refers to the need to facilitate competition. It is important to note that competition is not an end in itself, however. Competition is generally put forward as the best way of protecting consumers' interests: ensuring that they are supplied with the quality of services they want at prices that reflect efficient production. But as the Competition Authority puts it: "Deviations in public policy away from this principle are, however, acceptable to the Competition Authority if they address a clear market failure or public policy objective that cannot be addressed in a manner that is less restrictive of competition".[65]

It is also the case that not all forms of competition are necessarily beneficial to consumers. Rivalry among insurers on the basis of lower prices and/or more or higher quality products benefits consumers. Overall, competition between insurers that increases the total uptake of private health insurance by young people could benefit existing consumers to the extent that new low risk members are distributed in proportion to existing higher risk members. But competition between insurers for these younger members may not benefit existing consumers with insurers who have a higher risk profile. If new insurers recruit young people at an artificially low premium, based on their lower risk profile, there is no gain to consumers with other insurers (in the absence of risk equalisation).

5.3 IS THE MARKET ATTRACTIVE?

Health insurance in Ireland is a national, rather than international, market. The characteristics of the Irish health care system are not replicated as a whole anywhere else. Furthermore, patients are likely to expect to be able to receive health care fairly locally to their homes, except in small numbers of extreme cases, without overseas travel.

[64] Van de Ven W.P.M.M. and Ellis R.P. Risk adjustment in competitive health plan markets. Chapter 14 in *Handbook of Health Economics.* Volume 1, edited by Culyer A.J. and Newhouse J.P., Elsevier, 2000, pp.755-845.

[65] The Competition Authority. *Submission to The Health Insurance Authority – Risk equalisation in the private health insurance market in Ireland*. March 2002.

The attractiveness of the Irish market will determine to what extent businesses wish to invest in it. Factors affecting a market's attractiveness can be grouped under five headings (in the manner of the Porter model):[66]

- The existing intensity of rivalry in the market. The more intense the rivalry the lower the prospective profitability of being in that market;
- The existence of substitute products. Good substitutes being available implies less scope for profits;
- Buyers' power. Greater consumer power implies less scope for producers to extract rent (profit);
- Suppliers' power. The more powerful are suppliers, the less profit is likely to be available to those they supply;
- New entry.

The actions and attitudes of the Government have the potential to affect any or all of these groups of factors.

The following sections consider the first four groups of factors in turn. Barriers to new entry are discussed in Section 5.4.

Market size – whether it is large enough to attract new entrants – is clearly an important issue. But it is not a matter of absolute scale. Rather the concern is with market size relative to the minimum efficient scale of production. This is discussed in Section 5.4 below.

5.3.1 Existing Level of Rivalry

When viewing the intensity of competition in a market, a potential investor or new entrant is likely to take account of the following factors, bearing in mind that less intense rivalry is attractive as it leaves greater scope for profit:

- Number of competitors. The higher the number, the greater the likely degree of competition, other things being equal;
- Size distribution of competitors. Rivalry is likely to be greater, the more equal in size are the major companies in the market. Conversely, where firm sizes are very different there will be a greater (but not certain) tendency for market leaders to emerge, whose behaviour, e.g. with respect to prices, the smaller firms may tend to follow rather than try and challenge;
- Homogeneity of competitors. If firms in the market have similar cost structures and organisational types, tacit coordination between them is easier and more likely, so that rivalry may be less intense and the scope for profits greater;

[66] Porter M. *Competitive strategy*. New York, 1980.

- The scale of market-specific investment required. If large outlays are required to obtain assets – fixed capital, highly trained labour, reputation – in order to operate in the market and if those assets could not readily be reused in other markets then the market will be comparatively unattractive. Large investment in market-specific assets are a barrier to exit should the going get tough;
- Stability of demand in the market. The more stable the market, the more attractive it is. If demand fluctuates widely over time this is likely to encourage greater rivalry because it: makes tacit coordination between firms more difficult; offers more opportunities for increasing market share by grabbing extra demand when the market is growing; and leads to more stubborn defence of market share whenever the market periodically shrinks.

The open market for health insurance in Ireland contains only two organisations – BUPA Ireland and VHI – which are of uneven size: BUPA Ireland 14% of insureds, VHI 86%.[67] In the absence of data on the cost and organisational structure on BUPA Ireland, it was not possible to judge mutual homogeneity or heterogeneity of the two insurers, but there appears in any case to be no coordination between them. There do not appear to be any large, market-specific, fixed assets needed in the health insurance market.[68] (For example, with modern systems, an internet and call-centre operation in England could be readily extended to the Irish market or similar facilities and experienced staff acquired in Ireland from similar service sectors.) Appropriately skilled and experienced managers could be 'poached' from rivals if required, but may not be necessary to firms already experienced in operating insurance businesses with large numbers of individual members. A reputation as a reliable and claimant-friendly insurer may be a costly-to-acquire asset but should be largely achieved by appropriate non-health insurers from Ireland and by major health insurers from outside Ireland with an established brand. Demand for health insurance in Ireland has been stable and growing for many years.

Overall, on the basis of the existing level of rivalry, the Irish health insurance market looks quite attractive to potential new investors as the rivalry is not so intense as to preclude profitable operation. The one caveat concerns the dominant market position currently held by VHI. The large majority of consumers are content with the level of service they currently receive, in most cases from VHI, and as at November/December 2002, only 6% of private health insurance consumers in Ireland had ever switched insurer, mostly from VHI to BUPA Ireland (HIA, 2003b). This suggests that potential new entrants could find it hard to win custom away from the dominant incumbent. Instead they may have to expect to rely on trying to win the business of new entrants into the health insurance market. These will be predominantly younger people entering employment or reaching income levels at which health insurance looks attractive. Therefore, the subsequent effects of risk equalisation are of potentially greater importance.

[67] HIA (2003b).
[68] Fixed assets are defined as assets which are not variable in supply in the short term, such as land.

5.3.2 Substitute Products

One substitute for health insurance in Ireland, for those whose incomes are high enough to exclude them from holding a medical card is to fully self-insure and meet all costs of private health care out of their own pocket. This is unlikely to appeal to risk averse individuals. The other alternative is to use the public system and pay smaller charges, potentially after a longer wait.

5.3.3 Buyers' Power

A substantial majority of consumers are part of group schemes, although there are size asymmetries across groups. Group schemes receive discounted premiums. According to the Health Insurance Act, 1994, the size of the discount is fixed at 10% for all groups, irrespective of their size. Therefore, it is unlikely that larger group schemes can exercise greater bargaining power in negotiations with insurers over premiums. Consequently, the health insurance market does not appear likely to demonstrate substantial buyer power. Greater standardisation of products puts more power in the hands of consumers as it reduces switching costs. Some standardisation is imposed by the minimum benefits requirement in the Irish health insurance market, but there is nonetheless quite a wide range of insurance plans on offer from BUPA Ireland and VHI. In addition, the principles of open enrolment and lifetime cover may also strengthen the position of purchasers of private health insurance. Overall, however, the degree of buyer power, if any, is unlikely to be a deterrent to a firm considering investment in this market.

5.3.4 Suppliers' Power

Physicians and hospitals are the most significant suppliers of relevance. As a group they undoubtedly have market power. It is unclear, however, what is the extent of competition between them, which would reduce their power when bargaining with health insurers over the prices and terms according to which they offer their services to the insurers' consumers.[69] However, unless the entry of new insurers stimulated new investment, competing insurers may not achieve significant cost reductions. Equally, since VHI has faced legal challenges, from providers to the use of its dominant market power, it cannot be assumed that the absence of competing insurers leads to lower prices. A related supplier power issue concerns Enterprise Liability. This could lead private practitioners to insure their work in private hospitals separately, leading to cost increases by all private suppliers. It would be difficult for health insurers to resist these rises so, until resolved, enterprise liability issues may affect a potential entrant's view of the risk of suppliers raising prices.

[69] We understand that the Competition Authority is currently conducting a preliminary investigation into the contracts between health insurers and the Irish Hospital Consultants Association.

5.3.5 The Role of Government

The role taken by the Government can affect any or all of the factors just described and thereby can have a major effect on the expected profitability of a market. The main aspects of relevance are: government regulation of the industry and uncertainty around how regulation – including competition laws – may be applied or changed; and more generally the extent to which potential investors in the market perceive it as being subject to political "interference".

The health insurance market is subject to considerable regulation. It can be argued this is no more than in many other countries' private health insurance markets. However there are some particular features of the Irish market which are exceptional:

- The status of VHI as a state-owned body. This clearly introduces the scope for major fears among potential investors in the health insurance market that they will not be competing on a completely fair basis as long as VHI remains publicly owned. The state cannot allow VHI to fail and will ultimately ensure its financial stability, even if that damages the interests of private sector competitors;
- Uncertainty concerning the position of VHI. The Government has indicated a desire to restructure VHI. Uncertainty over the timing and exact nature of any change in VHI's status may well make the Irish health insurance market unattractive. It may also encourage a policy of watchful waiting among firms interested in the Irish health insurance market. Acquiring some or all of VHI would provide a quick way to achieve significant market share without the cost, delay and uncertainty of starting from scratch. Furthermore, why enter the market now if doing so might preclude you from buying VHI when it is put up for sale, on the grounds that competition laws would discourage mergers between existing firms in the market that control large percentages of that market;
- Uncertainty over the implementation of risk equalisation. This could have a large impact on a new entrant to the market who, as explained above, is likely to find itself with a relatively low-risk profile of consumers. If risk equalisation is implemented they may have to transfer large sums to VHI. This has a major impact on expected profits. The uncertainty is increased by the degree of discretion that current arrangements give to the Minister. The uncertainty was until recently exacerbated by the lack of clarity over the exact form of the equalisation formula, and specifically whether it would just be based on age and gender of consumers or also on their history of health care utilisation. This ambiguity was clarified by recent regulations that specified that at least initially, the formula will be a function of age and gender. All of these uncertainties are mitigated to some extent by the option that new entrants to the market have to opt out of risk equalisation for the first three years they are in the market and the gradual phasing of payment thereafter. Nevertheless, considerable uncertainty about the profitability of the market remains; and these are

all uncertainties (concerning the method of implementing a risk equalisation scheme) that could be removed;

- The political importance of private health insurance premiums, given high levels of membership, and government oversight of premiums. This could mean that at times, VHI premium increases could be kept low, disadvantaging competitors, to meet other objectives e.g. inflation. For instance, the Minister refused to grant VHI a premium increase in 2000 as part of government objectives to combat excessively high inflation (see Chapter 4, Sections 4.3 and 4.4).

Potential new entrants to the Irish health insurance market have identified the existence of risk equalisation (as distinct from uncertainty about it) as a major barrier to entry. The Competition Authority agrees that this is the case:

> "Risk equalisation is a barrier to entry into the Irish private health insurance market. Many large EU health insurance firms have explicitly stated that this is the case." [70]

However, as the Competition Authority goes on to make clear, this is not necessarily an objection to risk equalisation. Risk equalisation will reduce the expected profits of new entrants because, as explained above, they can be expected to recruit disproportionate numbers of relatively low risk consumers because new consumers to the market and switchers from existing insurers will be disproportionately from the younger age groups. Anything that reduces expected profits is a discouragement to firms thinking of entering the market. However, new entry is only socially beneficial if the new entrants are more efficient than the incumbents. Ability to attract low risks is not a sign of efficiency and is not in itself socially advantageous. Thus, although risk equalisation reduces the attractiveness of the health insurance market it may only discourage those firms that expect to be less efficient than the incumbents, and so, other things being equal, may be a matter of less concern. But until the implementation of risk equalisation is clear, the potential introduction of such a scheme will affect perceived profits for new entrants.

Thus, there are numerous factors which could affect the attractiveness of the health insurance market in Ireland. Overall, the main sources of damage to that attractiveness appear likely to stem from the dominant market position of VHI; its current status and uncertainties about its future ownership, financial performance and premiums; and uncertainty about risk equalisation.

The following section describes possible barriers to entry that exist however commercially attractive a market is or might become.

[70] The Competition Authority (2002).

5.4 BARRIERS TO ENTRY

Three groups of factors can act as impediments to market entry:

- Expectations of incumbents' reactions – whether they will cut prices;
- Large incumbent advantages;
- Substantial exit costs.

5.4.1 Expectations of Falling Prices

Of central importance are factors affecting a potential new entrant's expectations concerning the likely reactions of the incumbent firms to entry. Expectations about whether incumbents are likely to cut prices to levels that would make the market unprofitable for a new entrant depend on:

- Whether entry requires investment in substantial market-specific assets. This includes marketing and other costs needed to establish a profile and good reputation in the market, not merely physical assets. The incumbents will already have incurred those sunk costs and can be expected, if necessary, to reduce prices to levels at which they fail to cover those costs rather than exit the market;
- Minimum efficient scale (MES) relative to the size of the potential market. The MES is the smallest scale at which a producer can achieve minimum average costs. The larger is the MES, the greater is the expected difference between the pre- and post-entry price in the market, and hence the greater is the deterrent to new entry;
- Excess capacity in the market. The more excess capacity there is, the more credible is the threat of a price cut by incumbents in response to new entry;
- Aggressive reputation of incumbents.

We have already considered asset specificity in Section 5.3.1 above, and it is not necessarily the case that large scale investment in market-specific assets is inevitable for entry into the Irish health insurance market.

It is also unclear to what extent there are economies of scale in this market. BUPA Ireland has cited economies of scale in overhead costs as being available to VHI, and thereby representing a competitive disadvantage it has to struggle with.[71] Similarly, BUPA Ireland may be able to exploit synergies with its UK business. We have no information at this stage about this matter. However, if economies of scale are so great that minimum average cost can only be achieved if the market is supplied by a single firm then an interesting consequence is that the socially desirable policy may be to have a regulated monopoly (e.g. in the manner of regulated network utilities) rather than competing, inefficiently small, firms.

[71] BUPA Ireland, *Private health insurance briefing document*, 2000.

We do not expect this to be the case, but it is a logical consequence of a belief in the existence of large economies of scale.

Excess capacity does not seem to be relevant to the health insurance market, where physical operational capacity can be expanded or contracted fairly rapidly.

It is difficult to judge how aggressive BUPA Ireland or VHI might in fact be in respect of price cutting to compete with a new entrant but we are not aware that either organisation has a reputation for competing aggressively on price (see Chapter 4, Section 4.3).

Thus, overall it seems unlikely that expectations of falling prices are likely to be great.

5.4.2 Incumbent Advantages

New entrants may find themselves at a disadvantage if incumbents enjoy 'first mover advantages', such as:

- Precommitment contracts with suppliers or customers, which have the effect of excluding new entrants from supplies of key inputs or from access to substantial parts of the market for a period of time. Precommitment contracts are unlikely to be relevant in the Irish health insurance market;
- Licences and patents. Again these are not relevant in the Irish health insurance market;
- Learning curve effects. These apply most to capital intensive industries, and so not to health insurance;
- Pioneering brand advantages. These are important for so-called "experience goods", i.e. products whose characteristics can only be judged once they have been purchased and used (as opposed to "search goods" which can be judged simply by inspection, prior to purchase). Health insurance arguably has "experience good" elements. If a tried and trusted supplier of health insurance already exists, consumers will be less willing to experiment with a new brand. Uncertainty about a new insurer inclines them to stay with the old and satisfactory brand they know. VHI and to a lesser extent (given its shorter history in Ireland) BUPA Ireland appear to be trusted suppliers of health insurance services in Ireland. This was evident in the qualitative assessment undertaken as part of the HIA survey (HIA, 2003b). In focus groups, BUPA Ireland was considered 'innovative, young, vibrant, cheaper and efficient', although the fact that it was not an Irish company was mentioned as a negative aspect. The views of VHI related to 'familiarity, security, reliability and Irish', but some participants also viewed it as a 'rip-off, monopoly, inefficient and old fashioned'. The presence of these strong brands is a barrier which any new entrant would have to overcome.

5.4.3 Exit Costs

Entry carries with it some probability of failure. If exit costs are low, failure is not a great problem: 'hit and run' entry is then possible. However, if exit costs are high then failure will be costly. High exit costs discourage entry. The main determinant of exit costs is the extent and specificity of the capital required. As already discussed this does not appear likely to be an insurmountable problem in health insurance. Failure may also affect reputation in other insurance markets, however. Furthermore, the duration of contracts between insurance providers and their members is one year. Thus, this facilitates exit as an insurer may withdraw from the market with relatively little notice.

A related concern is that, under open enrolment and lifetime cover, exit by one insurer means its members could transfer to other providers. In an extreme case, this could affect the risk profile of another insurer and their position under risk equalisation. As a result, exit of one firm need not be immediately beneficial to others in the market.

5.5 SUMMARY

This Chapter has provided an economic framework for considering the degree of competition and ease of entry into the health insurance market in Ireland. The following Chapter builds on these principles using the views of existing industry participants, commentators and regulators and potential new entrants.

Chapter 6: Views on Existing and Future Competition in the Irish Private Health Insurance Market

6.1. INTRODUCTION

In this Chapter, Porter's 5 forces of competition are revisited to ascertain the level of existing competition and the scope for future competition on the basis of discussions with interested parties. As outlined in Chapter 5, the competitiveness (or more generally, contestability) of an industry is determined by the interaction of:

- The existing level of rivalry;
- The closeness of substitute products;
- Buyers' power;
- Suppliers' power;
- New entry.

Views were sought from existing industry participants, regulators and commentators in Ireland, and also potential new entrants. The positions of these parties were established from interviews and also the published submissions sent to the HIA on the issue of risk equalisation. All interviews were conducted on a confidential basis. Consequently, no comments have been attributed to individual organisations, apart from those that have already been publicised (e.g. in submissions to the HIA). The types of organisations participating in these interviews are described in Section 6.2.

The conclusions reached on the basis of this empirical analysis confirms the largely theoretical results in Chapter 5 and the data analysed in Chapter 4. A number of interviewees stated that the apparent level of competition in the industry was minimal. Moreover, the scope for future competition was limited by various barriers to entry, perceived not only by new entrants, but also existing industry participants. Interestingly, these barriers were related to the existing industry structure and also the current and proposed regulatory framework. In particular, community rating and risk equalisation were identified as having a significant impact on the level of existing and future competition. The arguments put forward by the interested parties under each of Porter's 5 categories are outlined in the following sections.

6.2. SAMPLE OF INTERVIEWEES

Two rounds of interviews were conducted to ascertain opinions from interested parties. The first series of interviews was held during August 2003, in person, with existing stakeholders, industry commentators and regulators in Ireland. In particular, representatives from the following organisations were interviewed:

- Current providers:
  - BUPA Ireland;
  - VHI;
- Regulators:
  - Department of Health and Children;
  - The Competition Authority;
- Representatives from the following independent organisations with extensive knowledge on the Irish health care system and private health insurance:
  - The Economic and Social Research Institute;
  - The Centre for Insurance Studies, University College, Dublin.

The second tranche of interviews involved companies or individuals from both Ireland and the UK who may be, or have been, interested in entering the private health insurance market in Ireland. The HIA conducted all interviews, except one, with potential Irish entrants in person in Ireland. YHEC interviewed the remaining Irish party and potential UK entrants by telephone. This sample, referred to as potential entrants, consisted of organisations with differing backgrounds:

- New Irish companies;
- Irish companies considering adding private health insurance to their business portfolio;
- UK private health insurers with established brands in Ireland, which are not directly related to private health insurance;
- UK private health insurers with no existing operations in Ireland.

From a list of approximately 20 UK companies approached, only 6 agreed to be interviewed. The following explanations were offered by some who declined to participate:

- Business is restricted to the UK;
- The selling and underwriting of private health insurance products is conducted by different companies. Therefore, if the distributor were to enter the Irish market, it would require an underwriter;
- Current business is underwritten by BUPA, which is already operating in Ireland, and also no branch network exists in Ireland.
- No longer sells private health insurance products in the UK.

In total, thirteen Irish and UK organisations were interviewed. These parties were at differing stages in their entry decision process:

- Two commented that they were currently considering entry;
- Another interviewee was considering Ireland as part of an expansion programme in Europe;
- Seven companies decided against entry on the basis of past research;
- One company has informally considered entering the market, but no further progress has been made on this issue to date because this company is currently focussing on its core business;
- One further company had not considered entering the market;
- Entering the Irish market was not an option for the final company because they wanted their business to be focussed on the UK market.

Those who have decided against entry at the moment, or who had not (formally) considered entering as yet, did not rule out revisiting this issue if there was a change in the existing industry or regulatory structure (e.g. the structure of VHI or the implementation of a risk equalisation scheme).

Subsequent sections in this chapter examine:

- The existing level of rivalry;
- Substitute products and buyers' power;
- Suppliers' power;
- New entry.

6.3 EXISTING LEVEL OF RIVALRY

The private health insurance market in Ireland consists of only 2 firms, with unequal size and market share. A cursory examination of the number of firms in the industry may suggest that there are not enough firms in the industry to realise the benefits to consumers from competition. However, according to the theory of contestability, market structure alone does not determine the extent of competition in an industry. Efficiency gains may be achieved even in a one-firm industry if the threat of entry is credible (e.g. the sunk costs associated with entry are zero). The current extent of competition in the Irish private health insurance industry are assessed under the following headings:

- Price competition;
- Product innovation.

The impact of the regulatory framework on the level of existing rivalry in the industry is examined in Section 6.3.3. The dominant position of VHI was also identified as an impediment to existing and future competition, and is discussed in Section 6.6.3.

6.3.1 Price Competition

One outcome of a contestable market is that efficiency gains may be passed on to consumers in the form of lower prices. The introduction of competition in the private health insurance market in Ireland, following the Third EU Non-Life Directive, has introduced some price competition as BUPA Ireland's premiums have been consistently lower than those of VHI for a similar level of cover (see Chapter 4, Section 4.3). For example, according to BUPA Ireland's submission, in 1996 members required at least Plan D, at a current cost of €860.70, to be fully covered for heart surgery. This level of benefit was subsequently provided under BUPA Ireland's Essential product at a lower cost of €297.64.[72] If BUPA Ireland has made full provision for risk equalisation, its lower prices should be indicative of greater efficiency. If not, they may reflect the younger age of its membership.

Although premiums have continued to grow, even after the introduction of competition (see Chapter 4), it is not possible to determine their temporal pattern if the market had not been liberalised. However, discussions with interested parties in Ireland identified a number of characteristics in the market which may have inhibited the rate of growth of premiums:

- Insurers may exert their bargaining power in negotiating with suppliers;
- The operation of the community rated system ensures that premiums are lower than those paid in a risk-rated model for some subscribers (e.g. older subscribers may be expected to pay a higher premium in a risk rated rather than a community rated market);
- The Government has set the price of private beds in public hospitals below their full economic cost;
- There may be cross subsidisation from the public sector if private patients are treated in public beds;
- The age profile of the market is quite young.

Although competition may have suppressed price rises, premiums may still be at inefficiently high levels. For instance, VHI has estimated that due to its relatively high risk profile, its premiums are 3% higher to cover its corresponding higher claims incidence.[73] Therefore, if the current system of community rating was supported by a risk equalisation scheme, then VHI's premiums may fall, but those of BUPA Ireland may increase, reflecting the payments

[72] BUPA Ireland, *BUPA Ireland's Reply to the HIA Consultation Paper "Risk Equalisation in the Private Health Insurance Market in Ireland"*, April 2002.

[73] Vhi Healthcare, *Equality, Efficiency and Fairness – The Case for Effective Risk Equalisation. A Vhi Healthcare submission to The Health Insurance Authority*, March 2002.

it would have to make under the scheme (this is also discussed in Section 6.3.3). As VHI have a larger market share, the benefits of lower premiums to VHI members may offset the higher premiums paid by members of BUPA Ireland.

According to VHI, any incentive for 'real competition' is allayed by the 'windfall profits' earned by (new entrant) low risk insurers. By this argument, the profits earned in a community rated system in the absence of risk equalisation are greater than those that would be gained by competing on a level playing field, which would be created following the implementation of risk equalisation. VHI has estimated that BUPA Ireland's profit margin for 2002 amounted to approximately €29 million from a premium income of €53 million. This cannot be independently verified.

6.3.2 Product Innovation

In a competitive environment, firms have an incentive to develop new products to win market share. A wider range of products provides consumers with greater choice. However, this improved product choice may not always be beneficial to all consumers. In the absence of risk equalisation, VHI maintained that competition in a community rating setting has created product distortions. Under these circumstances, insurers have an incentive to develop products targeted at low risk lives because of the typically lower claims costs associated with this group. VHI argued that BUPA Ireland has introduced new benefits, designed to attract 'the young and healthy'. These changes have prompted VHI to follow by modifying its products to retain these members. This has implications for the viability of community rating in the absence of risk equalisation (see Section 6.3.3).

6.3.3 Sustainability of a Community Rated Equilibrium in the Absence of Risk Equalisation

In principle, community rating, in conjunction with open enrolment and lifetime cover, could undermine an incumbent in the short run if its profile is skewed towards high risk lives. This could ultimately lead to the downfall of the market in the long run if the high risk lives of the incumbent are transferred to the other health insurer (assuming no other competitors), who then has to increase its premiums significantly at short notice. Therefore, a community rating equilibrium cannot be sustained in the absence of risk equalisation because insurers have an incentive to attract low risk lives. A situation may arise whereby an incumbent insurer faced with competition from a new entrant has a disproportionately greater number of high risk lives, and consequently, claims. Indeed, this insurer may become insolvent over time. To protect the existing community rated system in the Irish market, a risk equalisation scheme has been developed.

This conclusion is consistent with that reached by the Advisory Group on the Risk Equalisation Scheme (1998).[74] Due to the 'unduly unstable' nature of the community rated system, the Advisory Group deduced that 'risk equalisation is essential to underpin community rating'. The Group recommended a move to unfunded lifetime community rating, which may diminish the inherent instability of the current single rate system by reducing the reliance on 'a continuing flow of new young members'.

VHI also argued for risk equalisation to ensure the maintenance of a community rated system and, therefore, affordable private health insurance. According to their submission, because the age distribution of members is not equal between the insurers, an organisation with a disproportionately higher percentage of old lives has a higher claims incidence, which will force it to charge a higher premium.[75] Other providers, with a comparatively younger risk profile, may undercut this premium and/or earn 'windfall profits'. Any price differentials may prompt flows of customers from the high risk insurer to the relatively low risk insurer, or competitors could track its prices and earn an increased rate of profit.

Contrary to these views, BUPA Ireland (2002) argued that 'the continuance and preservation of community rating as specified is in no way dependent on the presence or otherwise of risk equalisation', rather that the operation of a community rated system is protected by legislation.[76] Under the Health Insurance Act, 1994, it is prohibited to offer private health insurance contracts that are not community rated. Moreover, competition, encouraged in the absence of risk equalisation (see Section 6.6.4), would result in a 'more stable market'. BUPA Ireland claimed that, instead of destabilising the market, competition has actually had a stabilising impact because it has not prompted flows of customers from VHI to BUPA Ireland, and it has increased consumer confidence in private health insurance.

By BUPA Ireland's arguments, therefore, the operation of a community rated system, in the absence of risk equalisation has not as yet destabilised the market, despite claims from VHI that product innovation has been targeted at low risk lives. Furthermore, BUPA Ireland argued that the negative effect on current and future competition may be mitigated if 'it can be clearly shown, using published and objective criteria, that risk equalisation will only be recommended to the Minister if it is demonstrated to be in the consumers' interest'. BUPA Ireland proposed the following criteria as the basis for such intervention:

- Downsizing of the market;
- Exit of old age policyholders;
- Threatened financial collapse or exit of one or more material insurers.

[74] Advisory Group on the Risk Equalisation Scheme, *Report of the Advisory Group on the Risk Equalisation Scheme: The Minister for Health and Children's independent review of the Risk Equalisation Scheme*, April 1998.
[75] Vhi Healthcare (2002).
[76] BUPA Ireland (2002).

However, BUPA Ireland concluded that '"risk equalisation" has no role in private medical insurance in Ireland nor has it been demonstrated to have a role'.

6.4 SUBSTITUTE PRODUCTS AND BUYERS' POWER

In the absence of switching costs, if there is a wide range of close substitutes for a given product, the demand for that product will be more elastic and therefore a firm's ability to charge a higher price for it may be limited. As discussed in Chapter 5, there are few perfect substitutes for private health insurance. One interviewee identified cash plans as a close, albeit imperfect, substitute for private health insurance. These cash plans provide benefits to patients, such as a fixed amount for every night spent in hospital, but do not cover the cost of hospital treatment. As such, cash plans may be categorised either as a substitute for or complement to private health insurance. Discussions with interviewees suggested that the demand for cash plans, as a substitute for private health insurance, is increasing.

No interviewees expressed particular concerns regarding the power of consumers. This implies that the issue of buyers' power is not particularly important, as suggested in Chapter 5.

6.5. SUPPLIERS' POWER

The beneficial effects of competitive behaviour among health insurers may be negated if suppliers exercise substantial bargaining power. In Ireland, the supply of private health services is controlled by consultants, private hospitals and the Government. One interviewee claimed that substantial supply side reform was required. In particular, this stakeholder blamed current shortages on the apparent lack of competition between consultants. A potential entrant also remarked on the strong position of consultants and another viewed the Irish Hospital Consultants Association as a powerful organisation. Another participant said that they were happy with the existing level of capacity in private hospitals.

Another interviewee voiced concerns over the strong position of the Government in setting the price of private beds in public hospitals. It was stated that there was no scope for negotiation with the Government over this issue. While it is within the Government's power to increase this price, it is not clear if this will actually happen as it is influenced by other factors such as meeting inflation targets.

Therefore, it seems that there are mixed views on the degree of suppliers' power.

6.6. NEW ENTRY

In principle, the apparently minimal level of rivalry between BUPA Ireland and VHI should be conducive to new entrants. However, since the liberalisation of the industry, no firms, other than BUPA Ireland, have entered the market. Discussions with potential entrants identified a number of factors which may discourage entry:

- Entry costs;
- The future size of the market;
- Large incumbent advantages;
- Risk equalisation and the regulatory framework;
- The degree of government intervention;
- Exit costs.

6.6.1 Entry Costs

The perceived level of investment required to break into the Irish private health insurance market differed according to the circumstances of the potential entrants. For instance, capital expenditure would be considerably greater for those starting from scratch. In contrast, those who already sell non-health insurance services in Ireland or offered private health insurance in the UK may benefit from economies of scale or scope, or synergies. This may lower the minimum efficient scale and, therefore, barriers to entry, for these organisations. One interviewee, from a company that had no experience in providing private health insurance in the UK, mentioned an additional entry cost in recruiting staff (possibly from BUPA Ireland, VHI or from abroad) with the appropriate skills to write private health insurance products.

6.6.2 The Future Size of the Market

Interviewees in Ireland commented on the steady ongoing increase in subscribers to private health insurance in Ireland (as shown in Chapter 4). They mentioned a number of possible explanations for the consistently increasing demand for private health insurance during recent years. One is the recent strength of the Irish economy. The resulting increase in disposable income implied that affordability thresholds have been lowered.

Both existing stakeholders and potential entrants, however, questioned the scope for the continuance of recent growth in the demand for private health insurance. Given the current high level of market penetration and the Government's proposals to increase public hospital capacity, new business may be limited. In addition, the concentration of business in relatively inexpensive products also raised issues about potential profitability. There are a number of possible explanations for the sustainability of these types of products. The first suggests that the level of efficiency of existing incumbents diminishes the opportunity for new entrants to earn a reasonable rate of return. Alternatively, the second interpretation

means that one or all incumbents may be receiving subsidies. Another potential entrant, that considered entering the market when it was liberalised, decided against it partly because it would not have been profitable.

Thus, for some potential entrants, the current and, especially, future size and profitability of the market were seen as disincentives to enter.

6.6.3 Large Incumbent Advantages

Most potential new entrants considered the dominance of VHI as a barrier to entry. While one UK insurer acknowledged that this was a disadvantage, it commented that this situation was no different to the structure of the industry in the UK, where BUPA have a large market share. According to the interviewees that have considered entry, VHI's strong position has conferred a number of advantages, such as:

- Preferential terms in negotiations with suppliers;
- A strong brand and reputation (evident from its large customer base and the small number of members that have switched from VHI to BUPA Ireland).

BUPA Ireland contended that due to its size, VHI may exploit significant economies of scale, which would put any new small entrant at a competitive disadvantage.[77] For instance, a large organisation, like VHI, may use its size to attain favourable rates and arrangements with suppliers. Higher costs, in addition to any risk equalisation payments, may prohibit the entrant from earning a reasonable rate of return or generating a surplus. In addition to its size, the government ownership of VHI and its exemption from minimum solvency requirements has compounded its competitive advantage vis-à-vis any new entrant.

In contrast VHI maintained that insurers with a low risk profile may exploit a competitive advantage by negotiating high ('uneconomic') rates 'to secure agreements' with suppliers. This may place insurers with a disproportionately greater number of older and sicker members in a weaker bargaining position with service providers. While this strategy may increase the cost of claims for the low risk insurer, the provider with the high risk profile is likely to experience a significant increase in the overall cost of its claims, due to its greater claims incidence. VHI claimed that BUPA Ireland has already adopted this behaviour and paid 'above the odds' for 'radiotherapy benefits and the daily rates paid to certain key hospitals such as the Blackrock Clinic and St Patrick's hospital'. Once again, this cannot be independently verified. However, the suppliers' bargaining power to demand a higher price from VHI would be diminished if there were excess capacity for their services.

[77] One possible implication of this is that if there are significant economies of scale, then it may be more efficient for the industry to be supplied by one firm, which is regulated to ensure that gains are passed onto members. However, BUPA Ireland did not allude to this.

A number of entrants also mentioned the level of investment required to create a brand to rival VHI's household name as a disincentive to enter. For example, a new entrant may have to spend more on advertising than the incumbent to increase its profile. The magnitude of this investment depends on the following company attributes:

- Penetration in Ireland;
- Type of existing operations.

Thus, the cost of establishing a brand is likely to be greatest for an entrant starting from scratch. An established company would still have to incur significant, albeit slightly lower, expenditure to develop a health brand that would appeal to the Irish market and/or credibility as a provider of private health insurance. There was a general consensus that being an Irish company or brand was an advantage. This was evident by the success of the marketing strategy adopted by BUPA in promoting their BUPA Ireland brand and establishing their main office in Fermoy, Cork. One potential entrant commented that investment in brand recognition was not as important as establishing a good reputation.

In addition to its size and strong reputation, the status of VHI as a government-owned, not-for-profit organisation, may also deter entry. Unlike a commercial company that must reimburse shareholders, any profits made by VHI may be reinvested in the business, thereby benefiting members through lower premiums and/or greater benefits. Furthermore, as a state-owned organisation, it is unlikely that the Government will allow VHI to fail. There is no scope for such backing in a private company. Most potential entrants mentioned that they would reconsider the entry decision if VHI were to be restructured, or indeed privatised. A number of interviewees would consider purchasing part of VHI as a route to enter the Irish market. Indeed, VHI claimed that a change in its not-for-profit status would make it a more attractive acquisition.

One interviewee mentioned that for a potential entrant, the advantage in buying VHI lies in its established distribution network and customer base. Thus, a company with established operations in Ireland will place a lower price on VHI than another bidder who is new to the Irish market. Also related to the privatisation of VHI, issues were raised regarding the appropriate method of divestiture – entirely or in part. One interviewee commented that VHI should be sold in parts, as a market share of 80% is unsustainable in the long term.

VHI has recognised that the uncertainty surrounding its future structure and ownership, arising from the White Paper (1999), may deter immediate prospective entry. While there is an opportunity in future to acquire a segment of VHI, potential entrants will withhold entry into the Irish market until the uncertainty regarding the future of VHI is resolved. By entering the market before this stage, they may be prohibited from acquiring some, or all, of VHI on anti-competitive grounds. Future changes to the regulatory environment were also seen by one potential entrant as a barrier to the acquisition of VHI. In addition, VHI argued

that a change in its status from a non-profit to a commercial organisation may also encourage entry since potential rivals would then be competing on a more level playing field with VHI.

6.6.4 Risk Equalisation and the Regulatory Framework

Views of industry participants, commentators and regulators

A number of interviewees saw risk equalisation as a barrier to entry. BUPA Ireland's opposition to a risk equalisation scheme was based on the premise that 'consumers' best interests' are satisfied through competition. Consequently, it followed from BUPA Ireland's argument that if risk equalisation is 'likely to be damaging to competition' then such a scheme is not likely to be beneficial to consumers and, therefore, 'should be regarded very much as a last resort'. The impact of the possible introduction of a risk equalisation scheme, it claimed, has been to discourage 'further new competition'. If new entrants are to make payments under a proposed risk equalisation scheme, due to their expected lower risk profile, the profitability of entering the market will be reduced, thereby making entry less attractive. However, as discussed in Section 6.3, contestability is not solely dependent on the number of firms operating in an industry. BUPA Ireland blamed the lack of entry into the Irish market since its liberalisation in 1997 on the threat of risk equalisation. Furthermore, it is argued that risk equalisation will also have a detrimental effect on the existing level of competition in the private health insurance market. BUPA Ireland claimed that the magnitude of payments it would be liable to pay under such a scheme are likely to make its operation 'commercially unviable'. Therefore, there would be an incentive for BUPA Ireland to increase operational efficiency if it were to remain in the market after the initiation of a risk equalisation scheme, assuming that the VHI does not receive subsidies from the Government.

It should be noted that BUPA Ireland's case implies that it wishes to encourage new entrants as a means of achieving greater competition ('further competition from new entrants should be encouraged'). This seems counterintuitive as BUPA Ireland may lose business to the new rival. However, the losses encountered by BUPA Ireland under competition may be less than those potentially incurred under a risk equalisation scheme. Under the latter, BUPA Ireland may be required to make payments due to its low risk profile. In addition to this direct cost, these payments will also limit BUPA Ireland's ability to react to a new rival if entry occurs. This is further compounded by the 3-year exemption from risk equalisation payments received by new entrants. Therefore, BUPA Ireland is potentially in a better position to compete on equal terms with new entrants (and at an advantage over VHI) if risk equalisation is not implemented.

The view of risk equalisation as a barrier to entry has been supported by both the Competition Authority (2002) and the Advisory Group on the Risk Equalisation Scheme (1998). However, both organisations acknowledged that there is a trade-off between the objectives of maintaining community rating and increasing competition. They concluded that risk

equalisation is necessary to ensure the continued operation of community rating. In addition, the Advisory Group suggested that the risk equalisation scheme should be designed to minimise this adverse impact on competition. Under such circumstances, a barrier to entry is beneficial because it inhibits unsustainable competition.

Unlike BUPA Ireland, VHI did not view the implementation of risk equalisation as a barrier to entry. Instead it argued that new entrants, who would be expected to attract a low risk profile, will still be able to gain an advantage even under a risk equalisation scheme, due to the imperfect nature of such an instrument. In addition, it claimed that the proposed 3-year period of exemption will allow new entrants to 'find their feet' (e.g. cover start-up costs). In VHI's opinion, BUPA Ireland contradicted its own argument that risk equalisation is a barrier to entry, as it entered the market knowing of the threat of risk equalisation.[78]

Similarly, the Society of Actuaries (2002) argued that risk equalisation is 'a logical concomitant to a voluntary health insurance system based in community rating, open enrolment and lifetime cover'.[79] Instead of damaging competition and market stability, the Society reasoned that the introduction of a risk equalisation scheme may dissolve uncertainty surrounding the issue and may in fact foster these factors.

Views of potential entrants

Seven companies that have actively or informally considered entering the Irish market cited the possible introduction of risk equalisation as a factor which influenced their decision against entry at this stage. Risk equalisation was a major deterrent to one interviewee, considering entry at the time of liberalisation of the market. However, although risk equalisation made the market less attractive, two companies perceived risk equalisation as essential in a community rated system – one of these companies referred to it as a 'necessary evil'. A number of objections to risk equalisation were raised by potential new entrants, including:

- A reduction in the profitability of entering the market;
- Rewarding inefficient incumbents.[80]

In addition, a mutual-type, not-for-profit organisation also added that such payments may penalise their existing members in other countries because risk equalisation payments would be made at the expense of lower premiums and/or greater benefits.

[78] VHI, *Ensuring Lifelong Affordable Health Insurance in Ireland: Why Risk Equalisation is Essential in a Community Rated Health Insurance Market*.
[79] Society of Actuaries in Ireland, *Report of Working Group on Risk Equalisation*, April 2002.
[80] If under the risk equalisation scheme, an incumbent were compensated in full for its claims, then its incentive to be efficient would be removed.

The 3-year exemption for new entrants from risk equalisation was said to be insufficient to attract new competitors. One company pointed out that this 3-year opt-out clause was irrelevant for an organisation that entered the market now, since the incumbents are not currently subject to risk equalisation payments until such a scheme has been initiated. Thus, the exemption period should also coincide with the commencement of a risk equalisation scheme. Yet, as BUPA Ireland acknowledged in its submission, this 3-year period 'is of no relevance in assessing the viability of a business plan. The practicality would be that just as the business plan might show signs of moving towards a profit, the company would become commercially unviable due to having to share hard won gains (if any) with a competitor through the RES [Risk Equalisation Scheme] payments'. It could be argued that the risk equalisation scheme encourages new entrants to attain efficiency gains to offset these risk equalisation payments and remain profitable. Two interviewees raised the point that the proposed 3-year exemption was less than the effective 6-year immunity from risk equalisation payments implicitly given to BUPA Ireland and that new entrants could make a case for a longer exemption. Only two interviewees thought that the 3-year exemption may be of some help to new entrants.

One company, that accepted risk equalisation as inevitable, pointed out that entry to the market would be attractive in the period immediately following the commencement of risk equalisation payments. This comment is related to the fact that some incumbents' ability to react to entry by cutting premiums will be limited after making risk equalisation payments. For example, a new entrant could enjoy an advantage over BUPA Ireland for 4 years (comprising the 3-year exemption followed by the phasing of risk equalisation payments over the next 12 months).

The current uncertainty surrounding the implementation of a risk equalisation scheme was also seen as a deterrent to entry. For instance, one organisation did mention that further clarification was required regarding the proposed timescale for the scheme and the nature of risk equalisation payments.

All potential entrants said that they would reconsider their decision not to enter the Irish market if there is a change regarding the implementation of the risk equalisation scheme.

6.6.5 The Degree of Government Intervention

The attitude of potential entrants towards the barriers created by government intervention was mixed. Some argued that, given the current situation, the potential to exercise bargaining power as a private health insurer would be limited. However, others argued that the impact of any change in government policy would be the same for all insurers and, therefore, had little influence over their decision to enter the Irish market. One UK insurer added that the current level of prices of private beds in public hospitals was acceptable, although it would be optimal for these prices to be set by the market. This interviewee argued for the withdrawal

of government control of these prices on the grounds that the costs of claims would increase if prices were set too high in order to generate revenue for the health service because:

- Hospitals have no incentive to minimise costs;
- Private hospitals may use the price of private beds in public hospitals as a benchmark for their charges.

A number of stakeholders in Ireland mentioned the uncertainty surrounding the potential impact of government initiatives to increase both public and private hospital capacity on the demand for private health insurance. Increasing the capacity in public hospitals may reduce the demand for private health insurance among existing and future subscribers. Furthermore, increasing private hospital capacity may create additional demand for services from existing and new subscribers, and consequently may increase the claims incidence of insurers.

6.6.6 Exit Costs

A number of organisations already operating in Ireland also alluded to the reputational impact of entering the market. While the tangible financial costs of exiting the industry due to later failure may be insignificant, the detriment to a company's reputation may be considerable. The damage to a company's reputation following an unsuccessful expansion into the private health insurance market may be compounded if there are negative spillovers to other products offered by the same company.

6.7 SUMMARY

Since the Health Insurance Act, 1994, liberated the private health insurance market in Ireland and ended VHI's monopoly, only one company, BUPA Ireland, has entered the market to date. The behaviour between these two organisations has increased competition, but only to a limited extent. Discussions with these participants, industry commentators, regulators and potential entrants identified a number of factors that contribute to the low level of existing competition and the limited scope for future competition, such as:

- The status of VHI;
- The prospect of risk equalisation;
- The increasing demand for cash plans as substitutes to private health insurance;
- The degree of government intervention in the supply of health services;
- The entry and exit costs.

In addition, two interviewees raised the issue of the degree of independent regulation of the industry, given the perceived links between the HIA and the Department of Health and Children.

Indeed, considering these deterrents to entry, three UK insurers commented that it was comparatively easier to enter other markets which are more 'liberal and flexible', such as Spain, Portugal or Italy. Interestingly, despite the differences in the regulatory structures in the UK and Irish markets, only one UK insurer commented that it would have to develop a new product for the Irish market and also expressed concern that it would not be able to select risks, which had been a successful business strategy in its UK operations.

Nevertheless, while almost all potential entrants had decided against entry, the interviewees did not completely rule it out in the future. Indeed, changes in the existing regulatory framework (e.g. risk equalisation) or the structure of the industry (e.g. the structure of VHI) would prompt entrants to reconsider their decision.

Chapter 7: Conclusions

7.1 INTRODUCTION

In this Chapter, we present our conclusions from our review of the current market for private health insurance in Ireland and our investigations of the level of interest in future market entry. We have set out our findings in the same order as the key issues identified in the HIA's invitation to tender for this work. A summary of our key conclusions is set out in Section 7.11.

The terms of reference for the study are to examine:

- The extent of competition currently in the Irish market in terms of price, service and product range and the level of innovation, e.g. improvements to existing products, addition of new products etc.;
- How this is being influenced by risk equalisation in terms of the effect risk equalisation would have on business plans and the likelihood of new entrants coming into the market;
- If risk equalisation were introduced, what effect it would have on the above or on insurers leaving the market and what effect this would have on prices, service, product range and innovation;
- The effect on competition of including/not including utilisation in the risk equalisation calculations;
- The effect a change in the commercial status of Vhi Healthcare would have on the level of competition;
- An assessment of the amount of competition the Irish market can sustain, based on the size of the market and international evidence;
- The possible effects of an exit of a market player in Ireland, including how this would affect price and service levels, product range and the financial viability of any remaining market players (*);
- The extent to which current legislation affects competition;
- Possible new entrants and the reasons why they are attracted to the market/reasons why they have not entered (*);
- The effect of competition on premiums and premium rises, including international evidence, particularly from the above-mentioned markets;
- The effect that a new entrant might have on the market, including the effects on existing private health insurers and the uninsured;
- The degree of bargaining power of insurers and healthcare providers, e.g. hospitals, consultants, etc. in setting reimbursement rates.

It should be noted that these terms of reference include several duplicated items, noted by an asterisk above, and we have commented only once on these in the discussion that follows.

7.2 THE EXISTING LEVEL OF COMPETITION

There has clearly been an increase in competition, following the entry of BUPA Ireland to the market. However, the removal of the VHI monopoly has not led to obviously fierce competition on premiums, with BUPA Ireland premiums apparently following VHI premiums to some extent. In a market with a dominant player, and one where all firms have limited control over supplier costs, (the costs of private health care providers) two strategies could be followed, aggressive price competition or price following behaviour. Price following has some advantages as it allows the new entrant to avoid strong competition with the existing insurer. Stronger price competition could be successful in attracting additional customers but at a lower premium per member. If lower prices by the entrant led to retaliatory pricing by VHI then the benefits of price-cutting would be offset. In comparison, price following is less competitive and generates fewer new members for the entrant but at a price that is more favourable. (We return to this issue in our discussion of further new entrants and their effects.)

There are similarities in plans between BUPA Ireland and VHI, though this is partly a result of the position of VHI as the current dominant player (so that its plans define product markets within which BUPA Ireland then competes) and also the result of a need for comparability, since consumers need to able to compare products as well as premiums.

Some aspects of market regulation have also limited differences in products. For example, some of BUPA Ireland's early innovations were judged as inappropriate for the market. That is, the regulation of the market potentially reduced the extent of innovation and is likely to continue to do so. Risk equalisation also becomes much more complex in an environment where plans differ in e.g. the level of deductible or co-payment, two key features of health insurance plans in competitive insurance markets.

There have been some innovations in the range of services covered or the extent to which particular complex procedures are covered in individual plans. For example, BUPA Ireland's inclusion of access to some cardiac surgery services appears to have encouraged a response from VHI, giving an additional potential service in lower priced plans. There have also been innovations in access to alternative medicine. Given the overall regulation of the market, we would expect to see other innovations of this kind in a more competitive market but only to a limited degree.

The fundamental product on offer in private health insurance in Ireland is rapid access, at low cost, to private inpatient care. This was borne out by the HIA survey (HIA, 2003b) which

found that of those with private health insurance in the sample, 76% valued hospital treatment the most, with the next most important element being hospital accommodation (11%). Innovations around this basic offering of private inpatient care, while of some value to consumers, are likely to be less attractive. This may explain the domination of some lower cost plans in the current market. Extra benefits in higher cost plans are not attracting customers from the basic plans in large numbers. However, this may reflect the relatively young age of new entrants and the lower attraction to them of additional items in plans, given their overall low risk, but this too is likely to remain a feature of the market for some time.

7.3 RISK EQUALISATION AND MARKET ENTRY

From our interviews with potential entrants, we are satisfied that the current position on risk equalisation in the Irish health insurance market is deterring entry. This is for three reasons:

- Although one of the statutory functions of the HIA is to implement the process for determining risk equalisation payments, until payments begin, there will continue to be some uncertainty about the size of payments;
- Once there are clear precedents, which indicate definitively to potential entrants both the calculation and real monetary cost of risk equalisation, risk equalisation is a continuing deterrent to entry, relative to a situation in which it did not exist, as it is likely to reduce the profits of new entrants, though this need not make new entry unviable.
- Currently, there is still uncertainty over how the risk equalisation scheme will be implemented. Therefore, any potential new entrant cannot be sure of what payments they might make. New entrants may also make a claim for exemption from risk equalisation for the same time period as has been enjoyed by BUPA Ireland. Unless they know that this will definitely not be granted, their business planning must cover the scenarios with and without such a long exemption. As a result, new entrants are more likely to adopt a "wait and see" approach. This does not mean that no new entrants will come forward but rather that some potential new entrants, uncertain of their gains or with a business plan offering only limited projected profits, will be less inclined to enter the market now.

However, it should be noted that, as discussed elsewhere, we are satisfied that competition from new entrants, in the absence of risk equalisation, would not necessarily be beneficial for the market. Competition through lower premiums, based on efficiency, quality and innovation are desirable. Competition through lower premiums based on the ability (whether deliberately or accidentally achieved) to recruit younger members is socially undesirable. New insurers would, in our assessment, inevitably attract lower risk, younger members. (Any future moves to impose penalties on those first taking up private health insurance at an older age would reinforce this tendency. For example, the proposed late entry loadings under

lifetime community rating would encourage people to purchase health insurance at a younger age. However, this impact will not be immediate as there will be a grace period during which older people may commence subscriptions without being penalised.)

The recruitment by new insurers of younger consumers is a consequence of attitudes by old and young:

- Older people with health insurance will not choose new insurers in large numbers due to inertia, brand loyalty to VHI and also perceived difficulties in transferring between schemes. Whatever the principles that underpin lifetime membership, the reality is that transfers between schemes are hedged around with conditions which, by their length alone, may deter many members from changing schemes. For example, paperwork and hassle were noted in the HIA consumer survey (2003b) as deterrents to changing insurer and contract documentation is very long (see e.g. BUPA Ireland's website, www.bupaireland.ie/memberinfo/contractdetails.htm, which includes schemes rule of over 50 pages). It also raises questions about cover following a change of plan or insurer that could discourage some consumers e.g. due to waiting periods;
- Younger individuals considering taking out private insurance for the first time, due to increased earnings, new family responsibilities or a move away from a parental policy, will be younger than average current members and more likely to shop around for their health insurance.

New insurers with lower risk memberships will be able to set premiums below VHI. This situation would continue for a considerable time, until the new schemes' early members aged, until the difference in premiums led older, sicker VHI members to transfer or until VHI lost sufficient younger members, due to higher premiums, as to become unviable. During this period, and in the absence of risk equalisation:

- New entrant insurers would gain windfall profits from lower premiums at the expense of higher premiums for those who stayed loyal to VHI;
- New consumers insuring with new entrants would obtain lower premiums by avoiding their share of the cost of older insured people, effectively sidestepping community rating.

We have considered the suggestion that the recruitment of low risk groups by new entrants could be contained by appropriate "conduct of business" regulations. We do not accept this argument, however, as we believe that the low rate of switching between BUPA Ireland and VHI is evidence of considerable inertia on the part of the existing insured population and new consumers are likely to be younger consumers. In our view, any new entrant is almost bound to recruit a lower risk, younger population. Even a dedicated marketing strategy to the oldest and sickest in the population of insured people may not achieve much switching and this is

probably the last target group in the sights of either existing insurers or potential new entrants. In consequence, new entry without risk equalisation would, in our view, have the effects forecast for it in previous reports by groups in Ireland that have examined this issue (see Chapter 6).

Lastly, we note that the current attitude of potential new entrant insurers to risk equalisation is closely linked, in our view, to the perception that they would immediately benefit from a lower risk membership. If this were not the case, risk equalisation could be seen as encouraging market entry as insurers would be reinsured, by risk equalisation, against the risk of recruiting high-risk members. That is, risk equalisation offers some protection to insurers but only in situations where they cannot predict whether they will recruit members with above or below average risks. It is the strong likelihood that new entrants will recruit lower risks that removes this benefit from risk equalisation and makes it appear as an additional charge on successful new entrants.

7.4 EFFECT OF IMPLEMENTATION OF RISK EQUALISATION

Implementation of risk equalisation payments will affect the current market players and potential new entrants.

The effect of risk equalisation on existing insurers is difficult to assess. It seems unlikely that VHI will change its position, since it would be a beneficiary for the short to medium term. BUPA Ireland may see the reduced surpluses that it generates as a justification for leaving the Irish market. However, this may not be a concern, for the reasons set out below.

Firstly, if BUPA Ireland cannot make satisfactory profits in the health insurance market with risk equalisation, then it may be introducing inefficiency into the market, such that its withdrawal would be in the long-term interests of consumers. For example, if VHI enjoys substantial economies of scale, the most efficient form of market provision would be a regulated monopoly, as one producer would achieve lower costs than many producers, each of a sub-optimal size. However, a priori this is inconsistent with the objectives of market liberalisation set out in the Third Non-Life Directive.

More simply, if risk equalisation is a key requirement of community rating, the continuing principle on which the Irish private health insurance market is based, then community rating must be put before any benefits from competition, not least because, in our assessment, these benefits will mainly accrue to younger, fitter new purchasers of health insurance, not older, sicker, members of existing schemes. The whole purpose of current market regulation is to spread the cost of older, sicker groups across younger, fitter groups. Without risk equalisation, community rating is effectively being applied to two separate communities, consumers in VHI and those in BUPA Ireland. Equal premiums within an insurer ensure no

discrimination against high-risk elderly people within each insurer but without risk equalisation payments between the two insurers, community rating overall effectively breaks down. If risk equalisation is not implemented, older, sicker people will face higher premiums while younger, fitter people will enjoy lower premiums. Whether this leads ultimately to VHI failing is less significant than the basic discrepancy in premiums. It can be argued that differences in premiums will eventually lead older, sicker members of existing schemes to move to new insurers. But if they are forced to move in this way, not because of dissatisfaction with their current insurer but because of inevitable differences in the risk profile of VHI and new entrants, this can hardly be described as a benefit of greater competition and choice in the market.

Secondly, BUPA Ireland should have been aware of the Government's plans for risk equalisation when it entered the market. Its business planning could easily have taken some versions of risk equalisation into account. In consequence, this is not a new development, which, of itself, should turn around BUPA Ireland's attitude, and so market exit by BUPA Ireland is only likely if it has based its plans on a continuing ability to keep the gains from a younger membership. Furthermore, in economic terms, bygones are bygones. If BUPA Ireland is unable to compete with risk equalisation payments taking place, and if VHI is not being unduly protected or subsidised as a result of its public ownership, then BUPA Ireland would appear not to be able to provide value for money when bearing the community risk rather than the risks of its younger members alone. (If VHI is inefficient then it is still not the case that BUPA Ireland has a strong case to keep any gains from a younger membership. These could be used through risk equalisation to reduce VHI costs while at the same time other means, e.g. a review of efficiency and constraints on premium increases, are used to remove any identified inefficiencies in VHI.)

Thirdly, the wider BUPA organisation is not a profit-seeking company with shareholders but a provident organisation. This would, in our view, make it less rather than more likely to pull out of the Irish market as it potentially faces fewer commercial pressures for profits. Given the proximity of the UK to Ireland and a shared language, there could also be some negative publicity for BUPA in withdrawing from the Irish market. (We have no direct knowledge of the commercial targets or relationship between BUPA and BUPA Ireland and this comment is based purely on our expectations of the behaviour of a provident in the face of the implementation of risk equalisation.)

Lastly, BUPA Ireland, or any future market entrant, would be more likely to try to sell a going concern than to simply close their business. If the brand name and membership are attractive to other entrants, then exit by an insurer need not mean a reduction in the number of competing insurers but a change in the ownership of insurers. Only in extreme circumstances would it be plausible that an insurer would leave the market without an attempted sale of its business, though a buyer for the business cannot be guaranteed.

The effects on potential new entrants include:

- Greater clarity on risk equalisation, so that its impact on a new entrant can be calculated with less uncertainty;
- Confirmation that profits from the recruitment of lower risk, younger consumers would not be available and that, overall, profits would be smaller as a result of risk equalisation (albeit in order to support the key principle of community rating).

Once risk equalisation payments have been made, this would reduce the uncertainty over their status and could, in practice, increase willingness to enter the market. Once the basis of payment is clear, it would be easier for potential entrants to develop their business plans. However, in our view the implementation of a scheme and greater precision over its costs to new entrants with low risk memberships would not stimulate a large number of new entrants. This is because other factors, noted in subsequent sections, are deterring entry and will continue to do so, whatever happens with risk equalisation. Of these, the commercial status and market dominance of VHI is the most important, though the size of the potential profits to be had is also important. (The status of VHI is considered in Section 7.6.)

Any new entrant to the health insurance market is likely to face similar costs for patient care, after adjustments for risk equalisation. As such, they will not be able to reduce the costs of treatment for their members unless they can successfully introduce elements of managed care such as better management of chronic disease to slow its progression. Unless they can manage claims downwards by introducing different clinical management policies, new insurers can only make profits through the efficiency of marketing, claims management and processing or other elements not directly related to the services provided by health care providers to insured members. That is, profit may have to be made on the administrative margin, not on total turnover including payment for treatment. This may mean that the market is of limited attraction due to the margins at which VHI has operated and the impact of risk equalisation.

There may be scope for new insurers to reduce administrative costs. But where cost reductions are only focused on administrative aspects of total expenditure, not the cost of treatment itself, any new entrant is competing for additional profits within a relatively small margin, proxied by the administrative margins of VHI. It follows that new entrants who wish to make higher profits than VHI would need to make significant reductions in administrative costs. If administrative costs are less than ten per cent, for example, a cut in administrative costs of a quarter would only add 2.5 per cent of turnover to profits. However, it may be that administrative costs can be reduced and that new entrants can make profits in excess of VHI. (By way of illustration, we note newspaper reports of a potential entrant to the health insurance market in Ireland, focusing on the Internet and with links to a claims processing system in the UK. This would clearly offer one way of reducing the cost of premium collection and claims management.)

If in the future firms left the market, then, unless there are genuine economies of scale in administration, premium costs may be expected to rise faster, rather than slower, unless there were a significant number of other health insurers in the market at that time. The reason for this is that a firm may have greater control over its premiums if it operates as a monopoly, rather than in a competitive setting. However, the evidence presented in Section 4.3 of Chapter 4 was not supportive of this hypothesis because it showed that the rate of premium increase for VHI was largely unaffected by BUPA Ireland's entry into the market. This may reflect the role of the Government in controlling the premiums charged by VHI. Similarly, exit would be likely to reduce the range of products offered, other things remaining equal.

7.5 UTILISATION IN RISK EQUALISATION

The way in which risk equalisation payments are calculated will have implications for the extent to which they provide incentives for health insurers to control their costs.

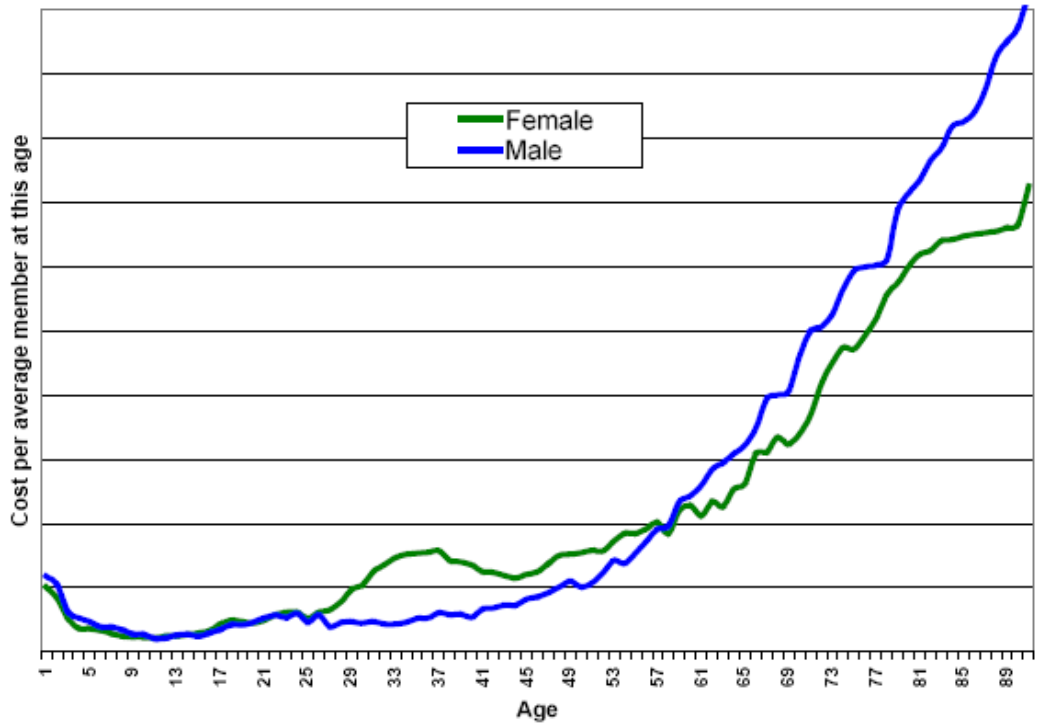
The costs of a health insurer can be summarised as the cost, for each age and sex group, of their utilisation of health services by their members and the cost per unit of these services. Utilisation is crudely measured by nights spent in hospital and the costs for each age and sex group are equivalent to an average number of nights in hospital at the average cost per night of the private beds provided.

Risk equalisation payments are intended to offset the effects on any one insurer of having a different risk profile from the market as a whole. The calculation of risk equalisation payments is based on a comparison of what the insurer spent on claims with what it would have spent on claims if its members were similar in their risk profile to the market as a whole.

The use of health services and claims for health care are strongly associated with age and sex (see Figure 7.1). (Elderly people, and women in certain age groups, have higher utilisation of health care than younger people and males in the same age groups.) Since risk equalisation is designed to offset the effects of differences between insurers in the risk profile of their members, age and sex clearly needs to be included in any risk equalisation calculations. However, as we do not know exactly the risks faced by individuals within each age and sex group, the adjustments may need to take account of differential utilisation of services, from one insurer to another, within an age and sex group. That is, adjusting for the age and sex profile of the insurer may not fully take account of differences in the real risk profile of the insurer's members. Risk, and utilisation of services, may differ for reasons other than the age and sex of the membership, e.g. due to recruitment of members in particular occupational or disease sub-groups. Utilisation may also be reduced by the case management used by the insurer, e.g. recommending low cost interventions initially to patients that reduce their ultimate use of expensive procedures. Where higher utilisation reflects higher clinical risks within age and sex groups, there is a case for adjustment payments that take these higher risks

into account. Where utilisation is affected by the insurer's actions, there is a case for not calculating risk equalisation payments that adjust for utilisation. Hence the debate over utilisation, within age and sex groups, as a reflection of each insurer's risk and a factor that the risk equalisation process should address.

Figure 7.1: Average health expenditure per person, by age



Source: Vhi Healthcare (2002).

7.5.1 Age and Sex Adjustment Only

Age and sex adjustment is used here as short-hand for a system of risk equalisation which combines the market proportions of members in each age and sex group with the insurer's own levels of utilisation and cost of services. Risk equalisation payments are calculated by comparing the insurer's actual and adjusted claims expenditure. Adjusted expenditure includes adjustment for age and sex only, at this stage.

Actual claims expenditure is what the insurer spent on health care for its members. Age and sex adjusted expenditure is the expenditure that would have occurred if:

- The insurer had the market average proportions of members in each age and sex group;
- These members had the insurer's own levels of utilisation of services and cost of each unit of service (e.g. hospital bed night).

If age and sex adjustment to the market profile is used, the following steps are required:

- The average cost of each member of each age and sex group to the insurer is calculated;
- This average cost for each group is then multiplied by the proportion of the total market membership in each age and sex group and by the insurer's own total membership. This provides an estimate of what the insurer would pay in claims if its members had exactly the same age and sex structure as the market as a whole;
- The estimated cost of claims is then compared with the actual cost of claims to calculate the risk adjustment payment for age and sex. This may leave the insurer gaining or losing, depending on whether they tend to have older or younger members.

There are several tensions in this approach.

At its simplest, the risk equalisation approach works out what an insurer would have spent with a different membership. Under age/sex adjustment, this is the membership with an age and sex profile that matches the market. This is equivalent to working out the cost of transferring members between insurers (notionally) to achieve the same market profile by age and sex in each insurer, with their total membership unchanged. But if the adjustment calculations include each insurer's own utilisation and cost per unit, within each age and sex group, then any given age and sex group will have a different notional cost per member in each insurer. In consequence, the net payments and receipts in risk equalisation will not balance. Notionally, members' costs would be deducted from one insurer at a different cost from that at which they were added to the cost of another insurer.

The consequence is that some adjustment will be needed, so that age and sex adjustment has to become, to some degree at least, age, sex, utilisation and cost-based adjustment. That is, under most foreseeable circumstances, some standardised figure for utilisation and cost will be needed for each age and sex group, for calculations across all insurers. This ensures that payments and receipts for risk equalisation balance. Notional transfers of members would be taking place at the same utilisation and unit cost per member in each age and sex group.

The only situation in which it is possible for the calculations to include the insurer's own utilisation and cost is when there is a central fund, which would pay out or receive funds when calculated payments and receipts differed. It would be feasible to set up such a balancing fund. However, it is difficult to see insurers accepting this situation, particularly when payments out by insurers with a lower risk age and sex profile exceeded receipts by insurers with higher risk age and sex profiles.

7.5.2 The Effects of Adjusting for Insurer Utilisation

We compare here the effects of moving from age and sex-based adjusted expenditure, using each insurer's own utilisation and cost per unit, to the use of age, sex and utilisation-adjusted expenditure, based on the market age and sex profile and average market utilisation in each age and sex group. (As noted above, some move to standard utilisation and cost figures would be needed to balance payments and receipts even without full use of the market average level of utilisation but this is ignored here and the calculations using the market age and sex profile, with or without the market utilisation in each age and sex group are compared..)

Each insurer would be in one of four positions when the two methods are compared. The examples below assume for simplicity that an insurer has utilisation in every age and sex group that is consistently above or below the market rate (though these positions would be more complicated once differences in relative utilisation between age and sex groups are allowed):

- Lower risk profile, lower utilisation, net payer of risk equalisation payments. The insurer would make higher payments if these were based on the market average utilisation in each age and sex group, as this would increase its adjusted expenditure to a higher level than use of its own, lower utilisation. This insurer pays out according to the gap between adjusted expenditure and (lower) actual claims expenditure. An increase in the former increases the risk equalisation payment and reduces the gains for the insurer from having lower utilisation, which is assumed to reflect differences in risk that should be adjusted for;
- Lower risk profile, higher utilisation, net payer of risk equalisation payments. The insurer would pay less in risk equalisation payments if these were based on the market average utilisation in each age and sex group, as this would reduce its adjusted expenditure and reduce the gap between this and the actual (lower) claims expenditure. This would reduce its payments out under risk equalisation;
- Higher risk profile, lower utilisation, net recipient of risk equalisation payments. The insurer would receive less from risk equalisation if the market level of utilisation in each age/sex group were used. This would tend to increase the age/sex-adjusted level of expenditure, reducing the gap between adjusted expenditure and (higher) actual claims expenditure. As this gap decreases, so its receipts under risk equalisation would decrease;
- Higher risk profile, higher utilisation, net recipient of risk equalisation payments. The insurer would receive more from risk equalisation payments if these were based on the market rate of utilisation in each age and sex group. Lower market utilisation rates will reduce its level of age/sex-adjusted expenditure. This would in turn increase the gap between its (higher) actual expenditure and its age/sex-adjusted expenditure and so increase the payment due under risk equalisation.

In summary, if the insurer's own utilisation is used to calculate risk equalisation payments (and ignoring the issue that this could leave payments and receipts unbalanced), then high utilisation insurers would generally lose and low utilisation insurers would generally gain. Conversely, if the market average utilisation level is used to calculate risk equalisation payments, high utilisation insurers gain and low utilisation insurers lose. This is because the adjusted expenditure is based on the market average. For high utilisation insurers, the gap between actual expenditure and adjusted expenditure increases for high risk insurers, increasing the payments they receive under risk equalisation, while the gap between actual expenditure and adjusted expenditure for low risk, high utilisation insurers falls, so they pay out less in risk equalisation payments.

The reverse is true for low utilisation insurers, who lose out when their risk equalisation payments are based on adjusted expenditure using the market average utilisation. For high risk, low utilisation insurers, adjusted expenditure is higher using the market rates of utilisation so the gap between actual expenditure and adjusted expenditure is smaller. They receive a smaller risk adjustment payment. Low risk, low utilisation insurers have a higher adjusted expenditure when market rates of utilisation are used so they must pay out more in risk equalisation payments.

The result of including the market rate of utilisation for each age and sex group is to compensate insurers to some extent for higher utilisation. This effectively assumes that utilisation is not within the control of insurers and that their risk equalisation payments should take some account of this. The effect is to increase payments by, or reduce payments to, lower utilisation insurers. This perversely lowers the incentive towards efficiency and management downwards of utilisation by each insurer. The adjustment using market average levels of utilisation in each age and sex group effectively treats lower utilisation as due to patient characteristics and therefore something that risk equalisation should adjust for. However, in practice the difference due to including the market levels of utilisation, in place of insurers' own utilisation, might not be as great as might appear.

As noted earlier, some adjustment will be required to balance payments and receipts under risk equalisation, even if the insurer's own utilisation is the preferred basis for calculating risk equalisation payments. Even if the adjustment does not go as far as to use the market average utilisation in each age and sex group, it is likely to go some way towards it, so bringing about some of the effects noted above when market utilisation is used to calculate risk adjustment payments.

Furthermore, in the current market, and that likely to operate for the coming years at least, the utilisation figures used may have only a limited impact, due to the relative sizes of insurers and the regulations for risk equalisation. Since VHI is currently so much bigger than BUPA and has an older population mix than BUPA, its gains from risk equalisation:

- Will be small relative to its total claims costs, so that receipt of risk equalisation payments will be unlikely to have a major effect in reducing VHI premiums;
- Since VHI dominates BUPA in many age and sex groups, whether the VHI rates of utilisation and cost per bed night or market rates are used as a starting point, the effects will be very similar. VHI is so big that the market averages will be made up of 85 per cent of the VHI rates, on average, and will be even closer to VHI levels for age and sex groups in which VHI has an even bigger market share;
- Current risk equalisation regulations allow for only a 50 per cent weight to be used for utilisation, reducing the impacts summarised in this section.

It follows that, overall, whether own insurer or market levels of utilisation are used, the effect on VHI will be similar. In consequence, the effect will have to be similar on BUPA, unless payments and receipts under risk equalisation differ with the introduction of a balancing fund. The issue is only likely to be important if there are large differences in utilisation between insurers, considered below.

7.5.3 To Use Insurer or Market Utilisation?

If utilisation at market rates is used in risk adjustment calculations, the effect is to assume that actual rates of utilisation reflect the risks of ill health and insurers with above average utilisation by their members should receive an offset through risk equalisation payments.

Use of the company's own rate of utilisation to calculate risk adjustment payments assumes that members of different insurers' schemes do not differ in their underlying ill health, even after adjustment for age and sex. As a result, each insurer is seen as not deserving compensation for the higher utilisation of its members.

The practical difference between adjusting for age and sex or age, sex and market rates of utilisation will be reduced, to some extent, by any adjustment process that equates payments with receipts under risk equalisation. That is, use of an insurer's own utilisation rates and costs per bed night is not possible exactly (unless these equal the market rate). Some adjustment will always be needed and this will move the calculation towards the use of the market averages, inevitably, in order to balance payments and receipts across all insurers.

In order to decide whether differences in utilisation within age and sex groups should be taken into account in calculating risk adjustment payments, the absolute levels of these in each company should be researched in greater detail. One potential ameliorating factor should also be noted. When the differences in utilisation and cost per bed night are large between companies, use of market averages will effectively protect to some degree insurers with higher costs and higher utilisation. But if the difference in utilisation and cost per unit of health care is large, it is unlikely to be due mainly to the policies of the insurer, in our view. That is, we would not expect either the management of the use of services or the

negotiating skills of the insurer in obtaining lower prices from providers to differ between insurers by more than a limited margin, for several reasons:

- Insurers can and do recruit staff from each other so approaches to patient case management or long term disease management are not likely to remain within one insurer;
- Aspects of patient case management may form part of the marketing used by insurers and so enter the public domain, e.g. access to pre-surgical case management advice and support;
- Other aspects of patient case management may be gleaned by insurers from providers or from their own research on their competitors;
- Reduced claims due to disease management are most likely to occur over the long term so, at least for a period of years after an insurer enters the market, we would not expect to see it achieve major reductions in utilisation through disease management.

This leads us to the view that, where utilisation differences are large between insurers for the same age and sex groups, they are likely to reflect real differences in the risk of illness or the use of specific types of provider and so the market average for these values should be used in risk equalisation calculations.

Conversely, when the differences are smaller, it may be appropriate to use the insurer's own levels of utilisation of services and the cost per bed night of services provided. But, since the differences between insurers are smaller, the effect of using market averages in place of the companies' own values for these two elements in the calculation will be small in these circumstances.

When the market is comprised of a large insurer, VHI, and one or more (in future) smaller insurers, a particular concern will be that the utilisation experience of the smaller companies may be based on a very small sample of members in some age/sex groups. As a result, it could be unreliable, either well above or below the real average risk level, by chance. This issue is well understood and is already addressed in the risk equalisation regulations.

As noted earlier, in the current environment, it may not make a significant difference for the calculation of VHI's receipt of payment under risk equalisation whether its own or the market average rate of utilisation is used, as the latter will largely reflect the VHI experience. Where an insurer making net payments under risk equalisation wishes to argue that its utilisation has been successfully managed downwards and that its risk equalisation calculations should be based on its own utilisation figures, to some extent, rather than market rates, we suggest that the HIA seek additional data on the characteristics of members in age and sex groups with low utilisation. This could include identifying e.g. patients with a history of diabetes or heart disease. The onus might be put on the low-utilisation insurers to demonstrate that this is due to their successful management of patients and not to chance recruitment of healthier people,

particularly when the number of their members in each age and sex group is low compared to the total market. However, it may be necessary to collect additional information on each insurer's members in future if this comparison of risks is to be carried out as the current, non-risk rated system, reduces the need for detailed health data on members.

7.6 STATUS OF VHI

If it chooses to restructure VHI, the Government has a number of options available to it. For example, the ownership structure of the company may change through privatisation. Alternatively, restrictions placed on the company may be removed through commercialisation, which does not involve a change in ownership. We would expect that a change in the status of VHI, to a privately owned mutual or profit-making company, would have significant effects on the market. This is confirmed by our interviews with potential entrants and our economic analysis. New entrants are likely to prefer to be competing with a non-government, commercial company as this would be seen as a level playing field. While VHI is linked tightly to the Government, new entrants will be concerned that its commercial decisions may be influenced by factors such as the relative timing of premium increases and elections or the general economic situation. Ministers have delayed increases in premiums by VHI in the past, for example. If VHI were supported when adopting policies preferred by Government, rather than developed from commercial calculations, this could put potential new entrants at risk of e.g. being unable to raise premiums in the face of rising costs.

VHI have indicated that they have a competitive approach already but we would expect that a commercially free VHI would develop further in this regard and would be driven by shareholder or member value, in line with new entrants.

New entry could also take the form of partial or complete purchase of VHI if it became a mutual or a limited company. The opportunity to buy a part of VHI is attractive to potential new entrant insurers but, because of VHI's size, existing firms may be prohibited from purchasing it, in whole or in part, by competition law, because this could be seen as not encouraging sufficient competition. As a result, until the commercial position of VHI is clear, potential new entrants may prefer to wait and decide whether to enter by acquisition of a part or all of VHI, rather than incur the costs of building a brand independently. Such clarification would also remove uncertainty over the kind of competition a new entrant would face, which is currently deterring potential entrants.

Overall, we would expect that the commercialisation and/or privatisation of VHI would contribute to a more competitive market, both directly and indirectly, particularly if VHI was transformed into several commercial companies, not just one, available for acquisition and investment by new entrants. In the long run, however, these investors might expect a higher rate of return from VHI than it currently provides and so the effects of increased competition

may be offset by the desire for higher profits. In the absence of a non-commercial player in the market, the price limiting impact of its presence would be lost. On the other hand, commercial companies might be able to operate the business at lower costs than a former government agency, leading to lower premiums for consumers from future commercial owners of VHI or a private sector VHI itself.

We note that our comments here are based on an assessment of the economics of the market and the attitudes of potential entrants. We accept that the ***politics*** of a change in VHI's status may not be simple, because of the current place occupied by VHI in the hearts and minds of its members. VHI appears to have many of the attributes of a public healthcare system, rather than a commercial entity, in the eyes of its subscribers and so there may be resistance to a change in its status to that of a profit-making company or possibly even to mutual status, for example.

7.7 THE SIZE OF THE MARKET AND NUMBER OF FIRMS

It is difficult to assess how many companies could be supported by the Irish health insurance market. We also did not carry out detailed research internationally, as this was excluded from the final research brief. It is possible to observe that in some European countries there are many insurers operating within a risk equalisation or social solidarity framework, e.g. over 400 sickness funds operate in Germany. Australia has a large number of insurers in a very similar market to that in Ireland, with substantial numbers of people covered by a community rated form of voluntary, supplementary health insurance. Also, the UK health insurance market, with a relatively small total number of consumers, has many more insurers, though some of these insurers in practice use products devised in association with the market leaders. But these observations need to be viewed cautiously.

A key problem in comparing countries of a similar size with Ireland is that their health care funding is heavily linked to their history and direct comparisons cannot be drawn:

- Many European countries have compulsory health insurance, operated by sickness funds, for all or all those in employment or all those below a high-income threshold. These are effectively public systems of health care support and the sickness funds do not necessarily operate on commercial principles;
- Premiums for health care in Europe are typically linked to income and so, in spite of the involvement of independent sickness funds, much of the system is effectively in the public sector, raising and redistributing levies on income or payroll, with little real price competition.
- For historical reasons, e.g. whether sick funds began with a local, regional or occupational focus, the number of sick funds in different European countries varies considerably;

- Where insurance companies are taking on those above a given income threshold, they are effectively guaranteed a market so the market situation overall is again less comparable with Ireland.

As indicated in recent press reports, an insurer could enter the market in partnership with firms carrying out claims management of similar kinds in the UK and using the Internet as a tool for rapid entry. This would appear to give low set-up costs. It may not generate a large business but if large costs are not incurred for market entry, a satisfactory rate of return may be achievable. The success of any entry of this kind would also send important signals to other potential entrants and a market with more competitors could then develop.

Potentially, current uncertainty over risk equalisation and the future of VHI is a barrier to entry and, once greater clarity emerges, we might expect a diversity of large and small firms to enter the market. Market entry and the number of firms would then depend on economies of scale and the fixed costs of establishing a presence in the market. For an insurer planning on a long-term commitment, building an identity need not have high costs, e.g. using the Internet as a marketing and sales tool. As a result, it may be possible for a wide range of sizes of firm to enter the market and make some profits.

Over time, if it is the case that having fewer firms providing health insurance is more efficient, due to economies of scale for example, the market will consolidate. But the exact number of companies at that stage cannot be predicted, in particular, as the number could be heavily influenced by any decisions made to change VHI into a purely commercial entity either as a whole or after break-up into several companies.

As shown in Section 4.4.1 in Chapter 4, the level of penetration in the private health insurance market in Ireland is already quite high, with almost 50% of the population subscribing to such schemes. We would expect the future growth of the market to be determined by demand and supply factors such as population, GDP, the number of insurers or product innovation. Indeed, there may be potential for further growth as 42% of those in the HIA survey who do not already have private health insurance, stated that they were likely to get it. However, the importance of this group should not be overstated since there may be a divergence between what respondents said they will do and what they actually do in practice.

Lastly, the effects of medical cost inflation should be noted. Premiums for private health insurance have grown in real terms and can be expected to continue to grow. As a result, all insurers may face some loss of members as premiums rise, in real terms, to cover rising costs.

7.8 CURRENT LEGISLATION AND COMPETITION

To a considerable degree, this point has been addressed in earlier discussions.

The Irish health insurance market is heavily controlled, relative to a free market. However, all insurance markets in developed countries are subject to a range of legislation, because of the nature of the product sold and the need for prudent management of consumers' funds.

The legislation in place in the Irish health insurance market, beyond that for reasons of financial prudence and general consumer protection, is there to sustain a set of principles of social solidarity that underpin private health care in Ireland. (We note that this use of the term social solidarity is unusual in that the term is more often applied to schemes which offer support for the whole population or the less well-off, rather than schemes which only offer direct benefits to those who can afford to join them.)

If, over time, the legislation was removed so that the market moved to one in which conventional risk-rated insurance was sold, we would expect that more firms would enter the market in the short term. These firms would be likely to have particular approaches to risk selection. There would potentially be much greater diversity of plans.

However, we would expect this to be a short-term situation. Over the longer term, as the membership of different companies became more balanced, we would expect to see some firms leave the market, due to the rising costs of medical care and their effects on premiums and profits, but typically with others taking over their business or merging to absorb them.

If the legislation remains in place, the market that will develop has effectively been discussed in earlier sections.

7.9 THE EFFECTS OF A NEW ENTRANT

While VHI remains a dominant provider in the market, new entrants face a choice of strategies:

- Shadow VHI prices from below, so that customers always save by choosing the new entrant but prices remain largely set by the dominant player;
- Compete more strongly on premiums, to challenge BUPA Ireland for new members and potential switchers.

Shadowing of the dominant supplier is more likely to be effective when there are only a few firms in the market. If more insurers enter, it is increasingly likely that they will look at their premiums as a way of generating a larger market share. In price shadowing, they would be

more likely to get only a proportionate share of the market and, with more firms involved, this will be a smaller share. It follows that if more firms enter the market, price competition is not guaranteed but looks increasingly likely. The strategy adopted by new entrants will be influenced by their expectations of incumbents' reactions to their entry. For instance, existing insurers may accommodate entry or behave aggressively towards new rivals.

However, the effects of risk equalisation must be considered alongside the entry of new insurers. If risk equalisation is not implemented and risk equalisation payments not made, this will affect both entry and pricing. But risk equalisation is government policy so it is important to consider its effects on the behaviour of new entrants and consequently we consider here the position with or without risk equalisation in future.

If it were to become clear that risk equalisation payments will never take place, we would expect more insurers to enter the market. Some of these are likely to be much more aggressive in competing on premiums as these new insurers, with predominantly younger members, would be well placed to charge lower premiums. We have noted elsewhere that the effect of this would be to end community rating, with separate communities effectively developing with each insurer. Effective segregation of risks is a sensible policy for insurers in all insurance markets and those seeking low premiums will need to address this in detail. Therefore, in our assessment, the most vigorous price competition can only come at the cost of the loss of effective community rating.

If risk equalisation payments take place, price competition will be much less. New entrants will effectively have to carry a share of all risks and so will need to plan for the future cost of risk equalisation payments. This need not mean that price competition disappears. At present, with only two players in the market, there has been little test of the relative efficiency of the premium collection and payments systems of VHI. It is possible that new entrants could compete very effectively on premium levels by using different mechanisms, as indicated in recent press reports of a new entrant. For example, VHI currently has offices around Ireland where members can call in to discuss their concerns. This may be an overhead that new insurers can ignore as it may be less important for younger members making fewer claims and potentially with less time available for office-based communication with VHI.

We would not expect to see premiums fall in a market with more insurers and with risk equalisation payments firmly established. This is because the rate of medical cost inflation continues to be significantly higher than the consumer price index (CPI). We would not expect a new insurer to be able to resist this pressure to any great extent, particularly if they were a small player. That is, the going rate for medical services is likely to be set by the bigger insurers and by other market factors (e.g. decisions on investment in new hospitals and on consultant recruitment in Ireland – see Section 7.10). In consequence, there is a limit to the effect of competition in the insurance market on the charges for care in the provider

market. (It is possible to conceive of models of care delivery based overseas, where patients are treated at significantly lower costs. The difficulty with this approach is that the price of care is linked to the distance travelled. Unless patients are prepared to travel a relatively long way, e.g. Greece, India, South Africa, the cost of treatment is unlikely to be lower. While overseas treatment can be acceptable to some patients, we would doubt that this model will develop to challenge existing suppliers of private treatment in Ireland, particularly given the relatively low cost of private beds in public hospitals.)

Given limited scope for lower provider prices due to competition in the insurance market, we would expect some moderation of premiums due to greater pressure on premium collection and claims management costs by each insurer. Greater competition among insurers may lead to product innovation such as improved disease management for e.g. chronic patients. However, much of the treatment provided privately in Ireland is surgical and this is potentially less amenable to reduced utilisation by tighter disease management techniques, except in the long run. That is, while action now to prevent patients with chronic chest disease from having a medical admission to hospital this winter is feasible, action now to prevent the need for hip or heart surgery would be unlikely to yield benefits for many years. However, intense rivalry between insurers may encourage technological innovation which may result in improved surgical techniques. Conversely, alternative theories suggest that the incentive to innovate may be actually greater under a concentrated market structure. According to this hypothesis, there is a positive correlation between innovation and the degree of concentration in an industry because there are economies of scale in innovation and also because a concentrated industry allows firms to appropriate the returns on their innovations.[81] Empirical evidence suggests that, in general, the relationship between innovation and concentration is non-linear – initially increasing with the level of concentration and declining thereafter. In the concentrated private health insurance market in Ireland, there has been some product innovation but it is not possible to conclusively assess whether this level of innovation would have been higher or lower if there had been greater competition in the market.

It follows from this that, as noted earlier, competition would mainly be around the administrative margins of health insurance and so the effective turnover from which profits can be generated will be limited. As a result, we would expect only limited moderation of premiums. Over time, if a new insurer with a different approach began to dominate the market, they may be able to exert greater downward pressure on medical inflation but we think this is unlikely and could be in conflict with restraints on market power under competition legislation.

[81] For a general discussion of the impact of market structure on innovation see Chapter 12 of Martin, S. *Industrial Economics: Economic Analysis and Public Policy*. New York, 1994. One of the main proponents of the theory that the incentive to innovate is greater in concentrated industries was Schumpeter (Schumpeter J. A. *Capitalism, Socialism and Democracy.* New York, 1942).

7.10 COMPETITION IN THE PROVIDER MARKET

We have not seen detailed data on provider performance or on price negotiations between providers and insurers. The current market position of providers was discussed with the two insurers in the market at present. Our assessment of the providers below covers:

- Private beds;
- Consultants.

Hospital supply to the private sector in Ireland is comprised of private hospitals and private beds in public hospitals. The latter are potentially widely available at a lower cost than private hospitals and so, while the cost per bed day is restrained by the Government, we would expect private hospitals to have only limited scope for raising prices. These beds in private hospitals also provide the capacity to treat a significant proportion of private patients though the available published data do not allow us to analyse this in detail.

There are about 145 hospital admissions for inpatient care in Ireland, per 1,000 population per year. We would expect the rate of admission for privately insured people to be below this rate, because of their age and socio-economic status. ESRI data suggests that there are around 170,000 private hospital admissions per year and estimates of private insured populations indicate that there are approximately 1.7 million members.[82] However, VHI had 170,000 inpatient claims in 2002 so total claims are likely to be higher. Allowing for BUPA Ireland patients, we assume 200,000 private inpatients per year. There are approximately 11,800 acute hospital beds in public hospitals in Ireland and 20% of these can be used for private care. At a 75% level of occupancy and with a length of stay of 6.5 days (the public hospital average), these private beds in public hospitals could treat around 90,000 patients a year, close to half of the total private inpatient activity.

In practice, fewer patients could be treated in public hospitals if these hospitals are operating at high rates of occupancy so that beds cannot be guaranteed to be available. Nonetheless, the extent of capacity in public hospitals, as a share of the total market, remains quite large.

In a provider market where close to half the total demand is or can be met from capacity that is available at a relatively low price, the private patient daily charge in public hospitals, the market power of other providers is inevitably limited. However, it is not eliminated. The rest of the demand still has to be met. Limited evidence from insurers suggests that in meeting this demand, the differential charged by the private sector is significant and in some cases may be up to 100% greater than the cost of a private bed in a public hospital.

[82] The Economic and Social Research Institute, *Activity in Acute Public Hospitals in Ireland 1990 – 1999*, March 2002.

The supply of private beds in Ireland varies by geographic area and it is possible that some private hospitals are able to use this to increase their charges for private patients. However, the relative proximity of hospitals in Dublin and other major cities for many patients means that local market power of this kind will be more limited than in a more geographically dispersed country.

In our discussions, the two current Irish insurers did not indicate any major concerns with the current level of hospital capacity or the ability of providers to extract higher charges. However, VHI is on record as having concerns about the construction of additional private hospitals.

New private facilities could lead to an increased rate of utilisation of hospitals by insured people or, at the discretion of consultants, a shift in patients from private beds in public hospitals. For example, a shared room in a new private hospital might well be attractive to a patient compared to a private room in a relatively old public hospital building. (This is put forward as an example and not a criticism of current private beds in public hospitals.) This would mean that the costs to insurers would rise, due to the difference in prices between private beds in public hospitals and entirely private hospitals. Given that about half of all private patients could be treated in public hospitals, the scale of the transfer over time could be relatively large and its cost implications relatively significant for insurers. In consequence, the future development of private hospital bed capacity in Ireland is likely to be a significant factor in the appraisal of the market by new entrants. This appraisal could lead to the development of policies which reduce the risk of transfer of activity to private hospitals, or the cost to the insurer, by greater use of co-payments or other means.

The supply of consultants in Ireland is determined by government medical staffing policy, though there are a small number of consultants working exclusively in the private sector. One of the current insurers noted in discussion with us its concern that the number of consultants was relatively low and that this inevitably increased their market power to some extent. This aspect of supply is clearly outside the control of insurers and, to a considerable degree, outside the control of private hospitals. These hospitals could recruit their own medical staff – for local contractual reasons a large private hospital in Cork is staffed by independent specialists rather than public hospital consultants – but that model could be financially risky for new consultants. Overall, the public hospital consultant in Ireland and countries such as the UK and Australia is the dominant provider for private patients.

The Government in Ireland has made commitments in the recent past to substantial expansion of consultant numbers. The medical staffing of the public system is examined in greater detail in the recently published report of the National Task Force on Medical Staffing (the Hanly report).[83]

[83] National Task Force on Medical Staffing. *Report of the National Task Force on Medical Staffing.* June 2003.

It should be noted that expansion of consultant numbers could have a similar effect on insurers to expansion of private hospital capacity. While fewer consultants may have greater market power, more consultants could increase the amount of private treatment provided. For example, currently consultants may manage excess demand from private patients by a policy of watchful waiting. This need not require a formal waiting list but the suggestion to patients that their condition is not yet ready for surgery. Additional consultants may reduce the amount of watchful waiting and increase total activity. In addition, in many clinical areas the threshold for diagnostic procedures is not well defined. As a result, an increase in the number of consultants could lead to an increase in the total number of procedures carried out, e.g. in endoscopy or cardiology. These would have a smaller impact on total costs but could contribute to a faster rate of premium increases over time.

7.11 OVERALL SUMMARY CONCLUSION

Our overall conclusions from this study are:

- Risk equalisation is one of several factors which are deterring potential entrants to the Irish health insurance market;

- The main other deterrent at present is the non-commercial status of VHI and the uncertainty over its future status;

- If uncertainty over the final implementation of risk equalisation (that is, the establishment of precedents for the calculation and actual transfer of risk equalisation payments) and over the status of VHI is resolved in the short term, the health insurance market in Ireland should still attract some new entrants, but fewer than if risk equalisation payments are not implemented;

- There is no satisfactory case for the non-implementation of risk equalisation payments as long as there is a fundamental commitment to community rating;

- Without risk equalisation payments, the benefits of new entry are limited in that lower prices and higher profits for insurers could be achieved for some but older people with health insurance, less inclined to move between insurers, would lose from the absence of full risk equalisation;

- Losses to elderly people in higher premiums would exactly offset gains to younger people in lower premiums in an efficient market, without risk equalisation but with limited shifting between insurers. Alternatively, younger consumers might gain less and new entrant insurers gain more in higher profits, again at the expense of older members of established insurance schemes;

- Only if premium differences encouraged wholesale movement between insurers at older ages would this be avoided. The market would achieve risk equalisation. In our view, this will in practice take a longer, rather than a shorter time, particularly if new entrant insurers use some of the gains from a lower risk membership to increase profits rather than compete aggressively on premiums charged;

- We do not accept that community rating can be implemented by business regulation rules as we regard the recruitment of younger, lower risk members by new entrants as virtually inevitable;

- The potential sale of VHI, in whole or in part, represents a significant opportunity for new entrants to the insurance market. Since existing insurers may face limits on their purchase of some or all of VHI, a policy of "wait and see" on VHI is potentially leading to deferral of entry by some interested in offering health insurance in Ireland, whether risk equalisation payments take place or not.

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APPENDIX A

Health Insurance Products

A.1 DETAILS OF BUPA IRELAND'S ESSENTIAL AND ESSENTIAL PLUS PRODUCTS

Type of benefit	Essential	Essential Plus
Hospital Cover	• Full cover for a semi-private room in public participating hospitals • Cover for certain types of heart surgery at the Blackrock Clinic and Mater Private Hospital	• Full cover for hospital charges for private rooms in public hospitals • Full cover for hospital charges for semi-private rooms in private hospitals (excluding the Blackrock Clinic and Mater Private Hospital) • An excess of €63 per claim may be levied for private hospitals, however this may be waived by paying a higher level of subscription • Full cover for day-case treatment, outpatient surgery and certain types of major heart surgery in the Blackrock Clinic and Mater Private Hospital
Consultant Cover	• Cover for consultants while in a participating hospital[a] • Cover for GP fees for procedures performed in a participating hospital day surgery or doctor's surgery	• Cover for consultants while in a participating hospital[a] • Cover for GP fees for procedures performed in a participating hospital day surgery or doctor's surgery
Outpatient Cover	Annual benefit and limit per member - €6,400 less excess of €250 Annual benefit and limit per member with dependants - €6,400 less excess of €470 The following benefits are not subject to excess: • Charges for radiotherapy and chemotherapy by participating hospitals and consultants who participate in the Full Cover Scheme are refunded in full[b] • MRI scans at approved centres • Breast prosthesis • Hairpiece following cancer treatment • Child Home Nursing Care – up to 28 days per year for up to €40 per day The following benefits are subject to an annual limit and excess: • Radiologist fees for consultants in the Full Cover Scheme – a full refund[b] • Pathologist fees – up to €20 per referral • Radiology, pathology and other diagnostic tests – full	Annual benefit and limit per member - €6,400 less excess of €220 Annual benefit and limit per member with dependants - €6,400 less excess of €440 The following benefits are not subject to excess: • Charges for radiotherapy and chemotherapy by participating hospitals and consultants who participate in the Full Cover Scheme are refunded in full[b] • MRI scans at approved centres • Breast prosthesis • Hairpiece following cancer treatment • Child Home Nursing Care – up to 28 days per year for up to €40 per day The following benefits are subject to an annual limit and excess: • Radiologist fees for consultants in the Full Cover Scheme – a full refund[b] • Pathologist fees – up to €20 per referral • Radiology, pathology and other diagnostic tests – full

	refund for participating hospitals and charges at BUPA Ireland approved diagnostic centres • Public hospital casualty charges - €20 for each episode • Physiotherapy – up to €20 per consultation • GP – up to €20 per consultation • Approved alternative practitioners therapies – acupuncture, homeopathy, chiropractic and osteopathy – up to €20 per consultation • Speech therapy, chiropodist, occupational therapy, dietician - €20 per visit for up to 12 visits combined each year • Optical tests - €20 per year for one test per year • Certain medical and surgical appliances – full refund for appliances on BUPA Ireland's approved list • Consultants' fees – up to €51 per consultation • Consultants' fees - €385 towards routine outpatient maternity consultations each year • Home Nursing following inpatient treatment (on consultant referral) – up to €40 per day for up to 40 days per year • Women's cancer screening (at approved centres) - €30 per year • Blood test for prostrate cancer screening (at approved centres) - €20 per year • Dental - €20 per year • Emergency dental treatment for, and which immediately follows (i.e. within 5 days), a dental injury caused by an accidental external impact – up to €510 per accident for restorative treatment provided by a dentist	refund for participating hospitals and charges at BUPA Ireland approved diagnostic centres • Public hospital casualty charges - €20 for each episode • Physiotherapy – up to €20 per consultation • GP – up to €20 per consultation • Approved alternative practitioners therapies – acupuncture, homeopathy, chiropractic and osteopathy – up to €20 per consultation • Speech therapy, chiropodist, occupational therapy, dietician - €20 per visit for up to 12 visits combined each year • Optical tests - €20 per year for one test per year • Certain medical and surgical appliances – full refund for appliances on BUPA Ireland's approved list • Consultants' fees – up to €51 per consultation • Consultants' fees - €385 towards routine outpatient maternity consultations each year • Home Nursing following inpatient treatment (on consultant referral) – up to €40 per day for up to 40 days per year • Women's cancer screening (at approved centres) - €30 per year • Blood test for prostrate cancer screening (at approved centres) - €20 per year • Dental - €20 per year • Emergency dental treatment for, and which immediately follows (i.e. within 5 days), a dental injury caused by an accidental external impact – up to €510 per accident for restorative treatment provided by a dentist • Dexa scanning for osteoporosis screening • BUPA Ireland executive health check – up to €20 per year
Maternity	• Hospital charges – up to 3 nights accommodation, up to a maximum of €1,050 • Consultants fees involved in a normal delivery (i.e. gynaecologist, paediatrician, pathologist radiologist and	• Hospital charges – up to 3 nights accommodation, up to a maximum of €1,150 • Consultants fees involved in a normal delivery (i.e. gynaecologist, paediatrician, pathologist radiologist and

	anesthetist) - €705.85 • Home birth grant - €1,050	anesthetist) - €705.85 • Home birth grant - €1,150
Convalescence	• Following a hospital stay, €26 per day towards convalescence in any state registered nursing home for up to 14 days	• Following a hospital stay, €51 per day towards convalescence in any state registered nursing home for up to 14 days
UK Cover	• Cover for treatment in UK participating hospitals for inpatient treatment certified by BUPA Ireland's Medical Advisor as unavailable in Ireland	• Cover for treatment in UK participating hospitals for inpatient treatment certified by BUPA Ireland's Medical Advisor as unavailable in Ireland
Emergency treatment abroad	• Access to a 24-hour helpline • Cover for treatment of up to €55,000 per episode or repatriation to Ireland if local treatment is not available	• Access to a 24-hour helpline • Cover for treatment of up to €55,000 per episode or repatriation to Ireland if local treatment is not available
Family policy	–	–
Healthline	–	–
Annual cost (subscription rates per person, net of the standard rate of income tax)	*Discounted Group Rate*: Adult rate - €272.39 Child/student rate - €87.97 *Individual rate*: Adult rate - €302.66 Child/student rate - €97.74	***Including excess of €63 per claim in private hospitals***: *Discounted Group Rate*: Adult rate - €377.04 Child/student rate - €131.42 *Individual rate*: Adult rate - €418.93 Child/student rate - €146.02 ***Excluding inpatient excess***: *Discounted Group Rate*: Adult rate - €416.38 Child/student rate - €148.64 *Individual rate*: Adult rate - €462.64 Child/student rate - €165.16

Note: [a] Depending on whether or not the consultant is participating in BUPA Ireland's Full Cover Scheme. If this is the case, the consultant has agreed to accept BUPA Ireland's fees in full settlement for treatment performed at one of BUPA Ireland's participating hospitals or in an outpatient surgery facility. If the consultant is not fully participating, BUPA Ireland will pay their fees in accordance with the rate shown as the standard rate in the Schedule of Benefits.

[b] Full refund means that BUPA Ireland will pay charges for the treatment up to the amount shown for that treatment in the BUPA Ireland Schedule of Benefits for those consultants participating in the BUPA Ireland's Full Cover Scheme.

Source: BUPA Ireland, *www.bupaireland.ie/ourproducts/index.htm*, dates accessed: 07/08/03 and 20/10/03.

A.2 DETAILS OF BUPA IRELAND'S HEALTHMANAGER STARTER AND HEALTHMANAGER PRODUCTS

Type of benefit	HealthManager Starter	HealthManager
Hospital Cover	• Generous cover for a private room in all public hospitals • Cover for a private room in certain BUPA Ireland participating private hospitals • Full cover for certain essential heart surgeries at the Blackrock Clinic	• Generous cover for a private room in BUPA Ireland participating private hospitals • Full hospital cover for certain essential heart surgeries in the Blackrock Clinic and Mater Private Hospital • An amount of €126 per claim will be deducted if treatment is received in certain private hospitals
Consultant Cover	• Cover for consultants while in a participating hospital[a] • Cover for GP fees for procedures performed in a participating hospital day surgery or doctor's surgery	• Cover for consultants while in a participating hospital[a] • Cover for GP fees for procedures performed in a participating hospital day surgery or doctor's surgery
Outpatient Cover	BUPA Ireland will pay half the costs incurred for the following charges for outpatient treatment up to a total of €7,650 each year: • GP fees other than for routine maternity • Fees for approved alternative practitioner therapists – acupuncture, homeopathy, chiropractic and osteopathy • The cost of a BUPA Ireland executive health check at a BUPA Ireland approved centre every two years • The cost of one non-emergency dental treatment each year, up to a maximum of €20 • Charges for women's cancer screening at approved centres • Consultant fees (excluding maternity) • Charges for blood tests for prostate cancer screening • Physiotherapy fees • Hospital fees for radiology and pathology • The cost of certain medical and surgical appliances on BUPA Ireland's approved list • The cost of home nursing (on consultant referral) following inpatient treatment, up to a maximum of €762 per year • The cost of emergency dental treatment, restorative treatment only, by a dentist for and which immediately follows (i.e. within 5 days), a dental injury caused by an	BUPA Ireland will pay half the costs incurred for the following charges for outpatient treatment up to a total of €7,650 each year: • GP fees other than for routine maternity • Fees for approved alternative practitioner therapists – acupuncture, homeopathy, chiropractic and osteopathy • The cost of a BUPA Ireland executive health check at a BUPA Ireland approved centre every two years • The cost of one non-emergency dental treatment each year, up to a maximum of €20 • Charges for women's cancer screening at approved centres • Consultant fees (excluding maternity) • Charges for blood tests for prostate cancer screening • Physiotherapy fees • Hospital fees for radiology and pathology • The cost of certain medical and surgical appliances on BUPA Ireland's approved list • The cost of home nursing (on consultant referral) following inpatient treatment, up to a maximum of €762 per year • The cost of emergency dental treatment, restorative treatment only, by a dentist for and which immediately follows (i.e. within 5 days), a dental injury caused by an

	accidental external impact, up to a maximum of €510 each year • Fees for visits to a Chiropodist, occupational therapist or dietician for up to 5 visits combined each year • The cost of one optical test each year • Speech therapy – up to 8 visits per annum • The cost of child counselling by an approved therapist, up to a maximum of 8 visits each year. BUPA Ireland will also pay: • €200 towards routine outpatient maternity consultations each year • Full cost of breast prosthesis (following inpatient treatment) • Full cost of a hairpiece (following cancer treatment) • Full cost of an MRI scan carried out at a BUPA Ireland approved centre[b]	accidental external impact, up to a maximum of €510 each year • Fees for visits to a Chiropodist, occupational therapist or dietician for up to 5 visits combined each year • The cost of one optical test each year • Speech therapy – up to 8 visits per annum • The cost of child counselling by an approved therapist, up to a maximum of 8 visits each year. BUPA Ireland will also pay: • €385 towards routine outpatient maternity consultations each year • Full cost of breast prosthesis (following inpatient treatment) • Full cost of a hairpiece (following cancer treatment) • Full cost of an MRI scan carried out at a BUPA Ireland approved centre[b] If total treatment costs covered under this heading exceed €630 in the membership year, BUPA Ireland will pay 75% of any further charges that are covered under this benefit incurred during the same year
Maternity	• Hospital charges – up to a maximum of €1,150 • Consultants fees involved in a normal delivery (i.e. gynaecologist, paediatrician, pathologist radiologist and anesthetist) - €705.85 • New born children are covered free in the year of their birth until the next renewal date	• Hospital charges –up to a maximum of €1,250 • Consultants fees involved in a normal delivery (i.e. gynaecologist, paediatrician, pathologist radiologist and anesthetist) - €705.85 • Home birth grant - €1,250 • New born children are covered free in the year of their birth until the next renewal date • Post-natal benefits include up to €385 towards charges for the following treatments, provided they are incurred within 3 months of the birth of a child: - GP fees - Fees for approved alternative practitioner therapists' fees - The cost of one dental examination - The cost of one optical test carried out by a

		practitioner with the FAOI qualification - Charges for physiotherapy by a participating therapist - Charges for chiropody by a participating therapist - Nutritionist services provided by a member of the Irish Nutrition and Dietetic Institute - Counselling by a participating therapist for postnatal depression - Midwifery services provided by a qualified midwife - Up to €39 for a maternity bra
Convalescence	• Following a hospital stay, €58 per day towards convalescence in any state registered nursing home for up to 14 days	• Following a hospital stay, €58 per day towards convalescence in any state registered nursing home for up to 14 days
UK Cover	• Cover for treatment in UK participating hospitals for inpatient treatment certified by BUPA Ireland's Medical Advisor as unavailable in Ireland	• Cover for treatment in UK participating hospitals for inpatient treatment certified by BUPA Ireland's Medical Advisor as unavailable in Ireland
Emergency treatment abroad	–	• Access to a 24-hour helpline • Cover for treatment of up to €65,000 per episode or repatriation to Ireland if local treatment is not available
Family policy	• A family policy will charge for up to 3 children. Additional children will be covered free of charge. • Family members aged between 18 and 21 in full time education will be charged at a child rate as part of a family policy	• A family policy will charge for up to 3 children. Additional children will be covered free of charge. • Family members aged between 18 and 21 in full time education will be charged at a child rate as part of a family policy
Healthline		• Access to a information line, staffed by qualified nurses, for provision of advice on questions related to health issues
Annual cost (subscription rates per person, net of the standard rate of income tax)	*Discounted Group Rate*: Adult rate - €399.00 Child/student rate - €146.62 *Individual rate*: Adult rate - €443.33 Child/student rate - €162.91	*Discounted Group Rate*: Adult rate - €570.93 Child/student rate - €209.79 *Individual rate*: Adult rate - €634.37 Child/student rate - €233.10

Note: FAOI, Fellowship of the Association of Optometrists, Ireland.

[a] Depending on whether or not the consultant is participating in BUPA Ireland's Full Cover Scheme. If this is the case, the consultant has agreed to accept BUPA Ireland's fees in full settlement for treatment performed at one of BUPA Ireland's participating hospitals or in an outpatient surgery facility. If the consultant is not fully participating, BUPA Ireland will pay their fees in accordance with the rate shown as the standard rate in the Schedule of Benefits.

[b] Full refund means that BUPA Ireland will pay charges for the treatment up to the amount shown for that treatment in the BUPA Ireland Schedule of Benefits for those consultants participating in BUPA ireland's Full Cover Scheme.

Source: BUPA Ireland, *www.bupaireland.ie/ourproducts/index.htm*, dates accessed: 07/08/03 and 20/10/03.

A.3 DETAILS OF BUPA IRELAND'S GOLD PRODUCT

Type of benefit	Gold
Hospital Cover	• Full cover for a private room in all BUPA Ireland participating hospitals
Consultant Cover	• Cover for consultants while in a participating hospital[a] • Cover for GP fees for procedures performed in a participating hospital day surgery or doctor's surgery
Outpatient Cover	Annual benefit and limit per member - €6,400 less excess of €220 Annual benefit and limit per member with dependants - €6,400 less excess of €380 The following benefits are not subject to outpatient excess: • Charges for radiotherapy and chemotherapy by participating hospitals and Consultants who participate in the Full Cover Scheme[b] • Consultant fees for up to 2 consultations related to a stay in hospital for inpatient treatment provided by the consultant – up to €65 per consultation • Child Home Nursing Care available for 7 consecutive days of inpatient treatment and on consultant referral – up to €40 per day for up to 28 days each year • Breast prosthesis • Hairpiece following cancer treatment • MRI scans at BUPA Ireland approved centres The following benefits are subject to an annual limit and excess: • Radiologist fees for consultants in the Full Cover Scheme – full refund[b] • Pathologist fees – up to €20 per referral • Radiology, pathology and other diagnostic tests at participating hospitals at BUPA Ireland approved diagnostic centres – full refund • Public Hospital casualty charges - €20 per episode • Physiotherapy – up to €20 per consultation • GP – up to €20 per consultation • Approved alternative practitioners therapies – acupuncture, homeopathy, chiropractic and osteopathy – up to €20 per consultation • Certain medical and surgical appliances (on BUPA Ireland's approved list) • Consultants fees – up to €51 per consultation • Consultants' fees - €385 towards routine outpatient maternity consultations each year • Home Nursing following inpatient treatment (on consultant referral) – up to €40 per day for up to 40 days per year • Women's cancer screening (at approved centres) - €30 per year • Blood test for prostrate cancer screening (at approved centres) - €20 per year • Dental - €20 per year • Emergency dental treatment for, and which immediately follows (i.e. within 5 days), a dental injury caused by accidental external

	impact – up to €510 per accident for restorative treatment provided by a dentist • Dexa scanning for osteoporosis screening • BUPA Ireland executive health check – up to €90 per year • Speech therapy/chiropody/occupational therapy/dietician – up to €20 per visit for up to 12 visits combined each year • Optical tests - €20 per year for one test per year
Maternity	• Hospital charges – 3 nights accommodation up to a maximum of €1,524 • Consultants fees involved in a normal delivery (i.e. gynaecologist, paediatrician, pathologist radiologist and anesthetist) - €705.85 • Home birth grant - €1,524
Convalescence	• Following a hospital stay, €58 per day towards convalescence in any state registered nursing home for up to 14 days
UK Cover	• Cover for treatment in UK participating hospitals for inpatient treatment certified by BUPA Ireland's Medical Advisor as unavailable in Ireland
Emergency treatment abroad	• Access to a 24-hour helpline • Cost of emergency local treatment up to €55,000 per episode or repatriation to Ireland if appropriate local treatment is not available
Family policy	–
Healthline	–
Annual cost (subscription rates per person, net of the standard rate of income tax)	Discounted Group Rate: Adult rate - €1,350.77 Child/student rate - €439.63 Individual rate: Adult rate - €1,500.86 Child/student rate - €488.48

Note: [a] Depending on whether or not the consultant is participating in BUPA Ireland's Full Cover Scheme. If this is the case, the consultant has agreed to accept BUPA Ireland's fees in full settlement for treatment performed at one of BUPA Ireland's participating hospitals or in an outpatient surgery facility. If the consultant is not fully participating, BUPA Ireland will pay their fees in accordance with the rate shown as the standard rate in the Schedule of Benefits.

[b] Full refund means that BUPA Ireland will pay charges for the treatment up to the amount shown for that treatment in the BUPA Ireland Schedule of Benefits for those consultants participating in BUPA Ireland's Full Cover Scheme.

Source: BUPA Ireland, *www.bupaireland.ie/ourproducts/index.htm*, dates accessed: 07/08/03 and 20/10/03.

A.4 DETAILS OF VHI'S PLANS A AND A OPTION

Type of benefit	Plan A	Plan A Option
Hospital care	• Full cover for semi-private accommodation in a public hospital	• Full cover for a semi-private room in a public hospital • Full cover for 50 heart procedures in the Blackrock Clinic and Mater Private Hospital
Maternity and baby	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €255 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €385 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year. • Newborn baby is covered free of charge under existing VHI policy until next renewal date • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission
Cover While Abroad	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed

	medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €100. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €65,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline	medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €1,000. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €100,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline
MRI Scans	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.
Outpatient Cover	• Annual excess for an adult - €310 • Annual excess for a family - €500 Allowable expenses include: • GP visits - €13 per visit • Specialist Consultations - €39 per visit • Physiotherapy - €13 per visit • Home Nursing - €20 per day for up to 42 days • Emergency Dental Treatment immediately following an accident – up to €320 for each accident	• Annual excess for an adult - €250 • Annual excess for a family - €470 Allowable expenses include: • GP visits - €20 per visit • Specialist Consultations - €51 per visit • Physiotherapy - €13 per visit • Home Nursing - €39 per day up to a maximum of €780 • Emergency Dental Treatment immediately following an accident – up to €455 for each accident

	• Pre- and Post- Natal Care – up to €255 in the year of birth • Public Hospital Outpatient Charge - €13 per episode of care • Alternative Medicine - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses	• Pre- and Post- Natal Care – up to €385 in the year of birth • Public Hospital Outpatient Charge - €20 per episode of care • Alternative Medicine - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses • Eye Testing – Up to €20 every 2 years when carried out by an FAOI practitioner or by an Ophthalmic Surgeon or Ophthalmic Physician registered with VHI • Dental Check-up - €20 per annum in excess of any social welfare benefit paid
Convalescence	• Maximum daily benefit of €45 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes	• Maximum daily benefit of €45 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes
Health Info Online	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services
NurseLine	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle

	issues	issues
Patient Assistance Service	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.
Student Discounts	–	• Reduced rates for students in full-time education
Annual Cost (based on group rates, net of 20% tax)	Adult - €326.28 Child - €108.74	Adult - €355.08 Child - €122.49 Student - €149.42

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*, dates accessed: 11/09/03 and 20/10/03.

A.5 DETAILS OF VHI'S PLANS B AND B OPTION

Type of benefit	Plan B	Plan B Option
Hospital care	• Full cover for a private room in a public hospital • Cover for a semi-private room in a private hospital (excluding the Blackrock Clinic and Mater Private Hospital)	• Full cover for a private room in a public hospital • Cover for a semi-private room in a private hospital (excluding the Blackrock Clinic and Mater Private Hospital) • Full cover for 50 heart procedures in the Blackrock Clinic and Mater Private Hospital
Maternity and baby	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €255 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,150 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,150 of costs incurred • Pre- and post-natal care up to €385 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year. • Newborn baby is covered free of charge under existing VHI policy until next renewal date • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission
Cover While Abroad	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored

	• Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €100. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €65,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline	• Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €1,000. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €100,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline
MRI Scans	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.
Outpatient Cover	• Annual excess for an adult - €310 • Annual excess for a family - €500 Allowable expenses include: • GP visits - €13 per visit • Specialist Consultations - €39 per visit • Physiotherapy - €13 per visit • Home Nursing - €20 per day for up to 42 days	• Annual excess for an adult - €220 • Annual excess for a family - €380 Allowable expenses include: • GP visits - €20 per visit • Specialist Consultations - €51 per visit • Physiotherapy - €13 per visit • Home Nursing - €39 per day up to a maximum of €780

	• Emergency Dental Treatment immediately following an accident – up to €320 for each accident • Pre- and Post- Natal Care – up to €255 in the year of birth • Public Hospital Outpatient Charge - €13 per episode of care • Alternative Medicine - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses	• Emergency Dental Treatment immediately following an accident – up to €455 for each accident • Pre- and Post- Natal Care – up to €385 in the year of birth • Public Hospital Outpatient Charge - €20 per episode of care • Alternative Medicine - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses • Eye Testing – Up to €20 every 2 years when carried out by an FAOI practitioner or by an Ophthalmic Surgeon or Ophthalmic Physician registered with VHI • Dental Check-up - €20 per annum in excess of any social welfare benefit paid
Convalescence	• Maximum daily benefit of €51 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes	• Maximum daily benefit of €51 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes
Health Info Online	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services

NurseLine	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle issues	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle issues
Patient Assistance Service	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.
Student Discounts	–	• Reduced rates for students in full-time education
Annual Cost (based on group rates, net of 20% tax)	Adult - €466.31 Child - €169.72	Adult - €514.29 Child - €188.57 Student - €215.50

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*, dates accessed: 11/09/03 and 20/10/03.

A.6 DETAILS OF VHI'S PLANS C AND C OPTION

Type of benefit	Plan C	Plan C Option
Hospital care	• Private room in a public or private hospital (excluding the Blackrock Clinic and Mater Private Hospital)	• Private room in a public or private hospital (excluding the Blackrock Clinic and Mater Private Hospital) • Full cover for 50 heart procedures in the Blackrock Clinic and Mater Private Hospital
Maternity and baby	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €255 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,250 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,150 of costs incurred • Pre- and post-natal care up to €385 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year. • Newborn baby is covered free of charge under existing VHI policy until next renewal date • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission
Cover While Abroad	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home

	• Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €100. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €65,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline	• Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €1,000. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €100,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline
MRI Scans	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.
Outpatient Cover	• Annual excess for an adult - €310 • Annual excess for a family - €500 Allowable expenses include: • GP visits - €13 per visit • Specialist Consultations - €39 per visit • Physiotherapy - €13 per visit • Home Nursing - €20 per day for up to 42 days • Emergency Dental Treatment immediately following an	• Annual excess for an adult - €220 • Annual excess for a family - €380 Allowable expenses include: • GP visits - €20 per visit • Specialist Consultations - €51 per visit • Physiotherapy - €13 per visit • Home Nursing - €39 per day up to a maximum of €780 • Emergency Dental Treatment immediately following an

	accident – up to €320 for each accident • Pre- and Post- Natal Care – up to €255 in the year of birth • Public Hospital Outpatient Charge - €13 per episode of care • Alternative Medicine - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses	accident – up to €455 for each accident • Pre- and Post- Natal Care – up to €385 in the year of birth • Public Hospital Outpatient Charge - €20 per episode of care • Alternative Medicine - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses • Eye Testing – Up to €20 every 2 years when carried out by an FAOI practitioner or by an Ophthalmic Surgeon or Ophthalmic Physician registered with VHI • Dental Check-up - €20 per annum in excess of any social welfare benefit paid
Convalescence	• Maximum daily benefit of €58 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes	• Maximum daily benefit of €58 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes
Health Info Online	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services
NurseLine	• Free access to a confidential telephone help line, staffed by	• Free access to a confidential telephone help line, staffed by

	trained nurses, who provide advice on health and lifestyle issues	trained nurses, who provide advice on health and lifestyle issues
Patient Assistance Service	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.
Student Discounts	–	• Reduced rates for students in full-time education
Annual Cost (based on group rates, net of 20% tax)	Adult - €720.07 Child - €279.30	Adult - €798.37 Child - €318.37 Student - €345.28

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*, dates accessed: 11/09/03 and 20/10/03.

A.7 DETAILS OF VHI'S PLANS D AND D OPTION

Type of benefit	Plan D	Plan D Option
Hospital care	• Private accommodation in a public or private hospital (excluding the Blackrock Clinic and Mater Private Hospital) • Semi-private room in the Blackrock Clinic and Mater Private Hospital	• Private accommodation in a public or private hospital (excluding the Blackrock Clinic and Mater Private Hospital) • Semi-private room in the Blackrock Clinic and Mater Private Hospital
Maternity and baby	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €255 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,350 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,150 of costs incurred • Pre- and post-natal care up to €385 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year. • Newborn baby is covered free of charge under existing VHI policy until next renewal date • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission
Cover While Abroad	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home

	• Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €100. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €65,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline	• Cover for return to Ireland if further treatment is deemed medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €1,000. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €100,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline
MRI Scans	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.
Outpatient Cover	• Annual excess for an adult - €310 • Annual excess for a family - €500 Allowable expenses include: • GP visits - €13 per visit • Specialist Consultations - €39 per visit • Physiotherapy - €13 per visit • Home Nursing - €20 per day for up to 42 days • Emergency Dental Treatment immediately following an	• Annual excess for an adult - €220 • Annual excess for a family - €380 Allowable expenses include: • GP visits - €20 per visit • Specialist Consultations - €51 per visit • Physiotherapy - €13 per visit • Home Nursing - €39 per day up to a maximum of €780 • Emergency Dental Treatment immediately following an

	accident – up to €320 for each accident • Pre- and Post- Natal Care – up to €255 in the year of birth • Public Hospital Outpatient Charge - €13 per episode of care • Alternative Medicine - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses	accident – up to €455 for each accident • Pre- and Post- Natal Care – up to €385 in the year of birth • Public Hospital Outpatient Charge - €20 per episode of care • Alternative Medicine - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses • Eye Testing – Up to €20 every 2 years when carried out by an FAOI practitioner or by an Ophthalmic Surgeon or Ophthalmic Physician registered with VHI • Dental Check-up - €20 per annum in excess of any social welfare benefit paid
Convalescence	• Maximum daily benefit of €64 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes	• Maximum daily benefit of €64 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes
Health Info Online	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services
NurseLine	• Free access to a confidential telephone help line, staffed by	• Free access to a confidential telephone help line, staffed by

	trained nurses, who provide advice on health and lifestyle issues	trained nurses, who provide advice on health and lifestyle issues
Patient Assistance Service	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.
Student Discounts	–	• Reduced rates for students in full-time education
Annual Cost (based on group rates, net of 20% tax)	Adult - €881.52 Child - €349.40	Adult - €969.75 Child - €386.14 Student - €413.06

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*, dates accessed: 11/09/03 and 20/10/03.

A.8 DETAILS OF VHI'S PLANS E AND E OPTION

Type of benefit	Plan E	Plan E Option
Hospital care	• Private accommodation in a public or private hospital • Private accommodation in the Blackrock Clinic and Mater Private Hospital	• Private accommodation in a public or private hospital • Private accommodation in the Blackrock Clinic and Mater Private Hospital
Maternity and baby	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,050 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,050 of costs incurred • Pre- and post-natal care up to €255 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission	• Public hospital accommodation – 3 days full cover • Private hospital accommodation – 3 days cover up to a maximum of €1,450 • Combined benefit of €705.85 available towards doctors' fees (e.g. gynaecologist/obstetrician, paediatrician, anaesthetist (epidural)) • Cover for a Caesarean Section • Home Births – up to €1,150 of costs incurred • Pre- and post-natal care up to €385 (subject to an outpatient excess) • Child Home Nursing – up to €100 per day for nursing care at home following hospitalisation for at least 7 days. To receive this benefit, treatment must commence within 2 weeks of discharge and is available for a maximum of 14 days per year. • Newborn baby is covered free of charge under existing VHI policy until next renewal date • To be eligible for these benefits, the duration of insurance coverage must be at least 52 weeks prior to hospital admission
Cover While Abroad	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed	• A 24-hour emergency telephone service • Medical advice and information • Provision of a prescription if forgotten • Referral to an appropriate doctor and/or hospital • If episode involves hospitalisation, local medical experts will be contacted and care will be monitored • Assistance in making contact with doctor and family at home • Cover for return to Ireland if further treatment is deemed

	medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €100. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €65,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline	medically necessary following hospitalisation • Costs of repatriation to Ireland up to €2 million if medically necessary • Travel expenses of a companion on repatriation up to €1,000. A further €955 is provided for a companion at the time the illness strikes and remains during the hospital episode • Cost of all eligible inpatient hospital charges up to a maximum of €100,000 during first 180 days of travel abroad • Normal pregnancy, travel against medical advice, and travel for the purpose of receiving treatment are not covered • Outpatient expenses are subject to excesses and may be included as part of the annual outpatient claim • Repatriation will not occur in the event of conditions arising from drinking alcohol or taking drugs; deliberate injury; any nervous or mental condition; injuries caused during mountaineering, motor competitions or professional sports; injuries received while breaking the law; injuries caused by air travel unless such travel is with a licensed aircraft operated by an airline
MRI Scans	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.	The following conditions must be satisfied for benefits to be payable: • Referral must be made by a specialist Consultant • Scan is performed in a VHI-approved centre • Scan is used to detect or rule out certain conditions Full cover for outpatient and inpatient MRI Scans is provided in some centres. However, other outpatient scans may be subject to excesses.
Outpatient Cover	• Annual excess for an adult - €310 • Annual excess for a family - €500 Allowable expenses include: • GP visits - €13 per visit • Specialist Consultations - €39 per visit • Physiotherapy - €13 per visit • Home Nursing - €20 per day for up to 42 days • Emergency Dental Treatment immediately following an accident – up to €320 for each accident	• Annual excess for an adult - €220 • Annual excess for a family - €380 Allowable expenses include: • GP visits - €20 per visit • Specialist Consultations - €51 per visit • Physiotherapy - €13 per visit • Home Nursing - €39 per day up to a maximum of €780 • Emergency Dental Treatment immediately following an accident – up to €455 for each accident

	• Pre- and Post- Natal Care – up to €255 in the year of birth • Public Hospital Outpatient Charge - €13 per episode of care • Alternative Medicine - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €13 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses	• Pre- and Post- Natal Care – up to €385 in the year of birth • Public Hospital Outpatient Charge - €20 per episode of care • Alternative Medicine - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Speech Therapy, Occupational Therapy, Dietetics and Chiropody - €20 per visit for a maximum of 12 combined visits where treatment is provided by a registered practitioner • Outpatient Pathology (Consultants' fees) - €20 per referral • Outpatient Radiology (Consultants' fees) – Benefit varies depending on type of treatment received • Outpatient Pathology (e.g. blood tests) and Radiology or other diagnostic tests (e.g. MRI scans) – Agreed charges in an approved outpatient centre • Certain approved medical and surgical expenses • Eye Testing – Up to €20 every 2 years when carried out by an FAOI practitioner or by an Ophthalmic Surgeon or Ophthalmic Physician registered with VHI • Dental Check-up - €20 per annum in excess of any social welfare benefit paid
Convalescence	• Maximum daily benefit of €70 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes	• Maximum daily benefit of €70 up to a maximum of 2 weeks immediately following a hospital stay if deemed medically necessary and in one of the VHI-approved Convalescence Homes
Health Info Online	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services	Free access to services including: • Personalised weekly e-mail updates on health news • 24-hour access to health professionals • Professional advice from experts • Customised programmes (e.g. weight loss and stress management) • Advice on travel • Interactive services
NurseLine	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle	• Free access to a confidential telephone help line, staffed by trained nurses, who provide advice on health and lifestyle

	issues	issues
Patient Assistance Service	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.	• Provides assistance to members who are experiencing undue delays for admission to hospital for certain elective procedures. It offers information on alternative options to expedite treatment.
Student Discounts	–	• Reduced rates for students in full-time education
Annual Cost (based on group rates, net of 20% tax)	Adult - €1,316.53 Child - €537.16	Adult - €1,414.60 Child - €569.79 Student - €595.91

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*, dates accessed: 11/09/03 and 20/10/03.

A.9 HEALTHSTEPS

- Cover for every day expenses
- All members are entitled to discounted gym membership
- No waiting periods for people aged under 45 years
- No medical examinations
- Access to HealthLines
- Adult group rate for HealthSteps Silver – 36 cents a day

Benefits under HealthSteps

Benefit cover	**HealthSteps Silver**		**HealthSteps Gold**	
	Benefit	**Frequency**	**Benefit**	**Frequency**
GP visits	€20.00	Unlimited visits	€30.00	Unlimited visits
Dental visits	€15.00	Unlimited visits	€25.00	Unlimited visits
Physiotherapy	€15.00	Unlimited visits	€20.00	Unlimited visits
Consultants visits	€40.00	Unlimited visits	€60.00	Unlimited visits
Eye tests	€20.00	Every 2 years	€25.00	Every 2 years
Glasses/lenses	€35.00	Every 2 years	€70.00	Every 2 years
Screening	€40.00	Every 2 years	€80.00	Every 2 years
GP procedures	Excluded		Agreed charges	Unlimited
Pathology – professional fees	Excluded		€40.00	Unlimited
Radiology – professional fees	Excluded		€60.00	Unlimited
Radiology/pathology – technical charges	Excluded		Agreed charges	Unlimited
Acupuncturists	€15.00	Maximum of €180.00 per year	€20.00	Maximum of €240.00 per year
Chiropractic	€15.00		€20.00	
Chiropodists	€15.00		€20.00	
Speech therapists	€15.00		€20.00	
Oesteopaths	€15.00		€20.00	
Occupational therapists	€15.00		€20.00	

Source: Vhi Healthcare, *www.vhihealthcare.com/products/index/html*.

A.10 GLOBAL

- Cover for medical expenses for Irish residents moving or living abroad for more than 6 months and who intend to return to live in Ireland at a future date
- Details of cover depend on geographical area – Europe only; worldwide (excluding North America and Canada); worldwide
- Short term cover is also provided for emergency medical treatment if subscriber intends to travel outside geographical area
- Two levels of cover – standard and comprehensive
- Free access to helplines
- Free access to a information service providing medical information
- Provision of other services including informing relatives; replacing lost passport, tickets or credit cards; arranging for a translator; and follow-up on lost luggage
- Additional cover may be obtained for incidences relating to travel; or haxardous sports and activities

Premiums for Standard Cover (€)

Age	Area 1 - Europe	Area 2 – Worldwide (excluding North America and Canada)	Area 3 – Worldwide
Under 19 years	299.12	318.21	882.47
19 to 21 years	361.43	384.50	1,130.07
22 to 24 years	492.30	523.72	1,472.90
25 to 29 years	542.00	629.79	2,006.19
30 to 34 years	635.63	676.20	2,133.16
35 to 39 years	704.17	749.12	2,285.53
40 to 44 years	760.26	808.79	2,399.80
45 to 49 years	884.89	941.37	2,704.54
50 to 54 years	990.83	1,054.07	3,015.63
55 to 59 years	1,109.08	1,233.07	3,244.18
60 to 64 years	1,470.66	1,564.54	4,678.98
65 to 69 years	1,911.86	2,346.48	5,943.01
70 to 74 years	2,716.60	2,919.13	7,137.20
75 to 79 years	3,785.09	4,651.05	10,803.57
80 years and over	4,072.12	5,237.67	12,165.36

Notes: Corporate Group Rates are available upon request. A 5% discount applies to Annual Direct Debit Payments, in advance.

Source: Vhi Healthcare, *New Horizons with Global.*

Premiums for Comprehensive Cover (€)

Age	Area 1 - Europe	Area 2 – Worldwide (excluding North America and Canada)	Area 3 – Worldwide
Under 19 years	491.76	508.82	1,320.53
19 to 21 years	584.02	636.03	1,390.36
22 to 24 years	719.59	790.01	2,317.27
25 to 29 years	951.64	964.08	3,015.63
30 to 34 years	982.65	1,024.34	3,244.18
35 to 39 years	1,060.72	1,138.15	3,555.27
40 to 44 years	1,225.52	1,285.45	3,707.64
45 to 49 years	1,534.54	1,499.69	4,183.79
50 to 54 years	1,623.73	1,613.50	4,558.36
55 to 59 years	2,124.06	2,035.29	5,250.37
60 to 64 years	2,823.48	2,577.59	7,304.80
65 to 69 years	3,854.38	3,910.79	8,324.40
70 to 74 years	4,336.79	4,504.40	9,337.02
75 to 79 years	6,389.96	6,969.59	13,247.81
80 years and over	6,916.98	7,828.57	14,895.93

Notes: Corporate Group Rates are available upon request. A 5% discount applies to Annual Direct Debit Payments, in advance.

Source: Vhi Healthcare, *New Horizons with Global.*

Additional Cover for Extra Premium for Optional Extra Benefits (for Both Standard and Comprehensive Cover)

Additional benefits	Extra premium (€)
Travel benefits	80
Hazardous sports and activities	65

Source: Vhi Healthcare, *New Horizons with Global.*

Benefits under Global

Details of cover	Europe and Worldwide (excluding North America and Canada)		Worldwide	
	Standard	**Comprehensive**	**Standard**	**Comprehensive**
Emergency evacuation/ repatriation	Up to €1,300,000			
Overall medical limit per person per insured event This includes the following benefits:	Up to €650,000	Up to €1 million	Up to €650,000	Up to €1 million
Hospital cover, day care and emergency/casualty room	Full cover			
Pre-hospitalisation consultations (prior to hospital admission)	Full cover			
Post hospital consultations (following hospital stay)	Up to €1,950	Up to €2,600 (including consultations and treatment)	Up to €1,950	Up to €2,600 (including consultations and treatment)
Emergency dental treatment	Up to €800			
Maternity complications (medically necessary caesarean section)	Full cover			
Normal maternity	No cover	Up to €1,020	No cover	Up to €1,020
Home nursing	No cover	Up to €1,300	No cover	Up to €1,300
Psychiatric inpatient treatment	No cover	30 day limit per year	No cover	30 days limit per year
Outpatient cover per person per year	Not applicable	Up to €3,000	€500	Up to €5,000
This includes the following benefits:				
GP fees	No cover	Full cover	Full cover	Full cover
Consultations	No cover	Full cover	Full cover	Full cover
Prescribed drugs	No cover	Full cover	Full cover	Full cover
Oncology, radiotherapy	No cover	Full cover	Full cover	Full cover
X-rays & medical scanning	No cover	Full cover	Full cover	Full cover
Physiotherapy	No cover	Full cover	Full cover	Full cover
Medical appliances	No cover	Full cover	Full cover	Full cover
Excess per insured outpatient event	Not applicable	€44	€44	€44

Source: Vhi Healthcare, *New Horizons with Global.*

A.11 PLAN P

- Plan P provides benefit for the €33 daily public hospital inpatient levy, subject to a maximum payment of €330.
- It does not cover any outpatient treatment.
- Full benefit is available after an 8-week no payment period.
- Membership of Plan P is independent of age or current health state.