



**Aviva Health Insurance Ireland (Aviva)**

**Submission to the Health Insurance Authority on Risk Equalisation in the Irish Private  
Health Insurance Market**

**27 August 2010**

<b>INTRODUCTION .....</b>	<b>3</b>
<b>CONSULTATION PROCESS .....</b>	<b>7</b>
<b>Regulatory Impact Analysis .....</b>	<b>9</b>
<b>THE HEALTH INSURANCE MARKET .....</b>	<b>12</b>
<b>The Voluntary Health Insurance Board .....</b>	<b>12</b>
<b>Minimum Benefits .....</b>	<b>15</b>
<b>Lifetime Community Rating .....</b>	<b>15</b>
<b>COMPETITION .....</b>	<b>16</b>
<b>INTERNATIONAL COMPARISONS .....</b>	<b>21</b>
<b>THE SUPREME AND HIGH COURT RULINGS.....</b>	<b>25</b>
<b>BARRINGTON REPORT .....</b>	<b>27</b>
<b>RECOMMENDATIONS.....</b>	<b>29</b>
<b>RESPONSES TO SECTION 4 OF CONSULTATION PAPER .....</b>	<b>31</b>
<b>RESPONSES TO SECTION 5 OF THE CONSULTATION PAPER.....</b>	<b>38</b>
<b>RESPONSES TO SECTION 6 OF THE CONSULTATION PAPER.....</b>	<b>40</b>
<b>RESPONSES TO SECTION 7 OF THE CONSULTATION PAPER.....</b>	<b>41</b>
<b>CONCLUSION.....</b>	<b>42</b>
<b>APPENDIX 1.....</b>	<b>45</b>

## INTRODUCTION

Aviva Health Insurance Limited, hereinafter Aviva, welcomes the opportunity to participate with the Health Insurance Authority hereinafter the HIA in this consultation process. Aviva welcomes and will support any provision that will enhance consumer benefits, enhances patient safety and quality of outcome, fosters competition and promotes a level playing field within the health insurance market for the greater public good. Aviva believes all of these factors in combination with community rating to be key in the support of a stable, affordable and dynamic health insurance market.

Consumer needs should be at the forefront of any proposals put forward by the Authority. Now more than ever the need to ensure affordability for all consumers must be safeguarded. Any measures which are going to artificially raise premiums must be very carefully considered and in particular any alternatives which can avoid such an outcome must be carefully and thoroughly explored.

Aviva is deeply disappointed by the limited nature of the current consultation document and its failure to address key problems within the market.

The consultation document is proposing a scheme that achieves 100% equalisation of insurers' claims costs resulting from age, gender and health status. The proposal to extend the scheme to cover health status is justified by an unproven assertion that within each age band, VHI members are in poorer health than those of Aviva and Quinn Healthcare, without any acknowledgment of the Minister for Health & Children's intention to rebalance the market.

In the absence of structural change, the scheme currently proposed will result in very significantly higher payments to VHI from its competitors than under the previous risk equalisation scheme because:

- The scope of equalisation has been extended to include health status as well as age and gender
- There is no proposal to reduce payments to encourage competition (unlike the old scheme where payments were reduced by 20% to satisfy the Government's objective of encouraging competition)
- There is no provision to guard against over-compensation (unlike the present tax based loss compensation scheme)

Aviva is fully committed to community rating and recognises that a risk equalisation scheme may be a necessary support to achieve stability within a community rated market. However, prior to the implementation of any risk equalisation scheme fundamental structural changes must occur within the market.

For long term stability and a proper competitive environment to be achieved the following key changes must be implemented:

1. The VHI must be fully regulated and authorised by the Financial Regulator;
2. The VHI age profile must be re-balanced;
3. The VHI market share must be reduced.

Once these steps have been achieved, ideally there would be more market participants with approximate market shares and with similar age and gender profiles. These changes would automatically inject more competition into the market, would place all participants on an equal regulatory playing field and spread the burden of older members across the market. A proper functioning competitive market structure should then be in place to the greater benefit of consumers who would have more choice on products but would equally face lesser premium increases than if a risk equalisation scheme were introduced under the current market conditions.

### **Executive Summary**

The Irish Health Insurance Market has been in a constant state of uncertainty since the market opened in 1994. Aviva has lobbied consistently for reform of the marketplace and welcomes the announcement from the government to address this issue. However it is absolutely critical that the scheme implemented works for all parties involved and ultimately provides the best possible solution for the Irish health insurance consumer and a competitive vibrant and stable health insurance market.

### **Consultation Process**

Aviva is deeply disappointed by the current consultation document and would question the nature, extent and content of the current consultation process on risk equalisation (much of which is based on its previous scheme which was struck down by the Supreme Court). Aviva is concerned about the current consultation process in that it is only looking at the issue through a very narrow lens dealing purely with technical questions rather than seeking to find a long term solution to all the problems within the health insurance market. In addition, it is disconcerting that the proposed consultation document has not taken some of the key recommendations received to date into consideration e.g. the Competition Authority Report, the Barrington Report and the Supreme and High Court judgments. The failure to address some of the key distortions within the market means that any recommendations reached in this process will by their very nature be incomplete and, more worryingly, likely to lead to inconsistencies and cause further damage to consumers and insurers.

### **The Health Insurance Market**

There are a number of key issues that need to be addressed prior to the implementation of any risk equalisation scheme. As an absolute minimum, the size, dominance and regulation of the VHI must be addressed. Current practises of the VHI are severely distorting competition and are recognised to provide a huge commercial and economic advantage to this dominant player – to propose any new scheme while these imbalances occur will only exacerbate current difficulties.

Minimum benefits and lifetime community rating also have a part to play in the overall risk equalisation scheme and must be thought through thoroughly to ensure success. The level at which minimum benefits are set should be the level at which risk equalisation operates as this is the basic consumer protection point – any benefits over this level are discretionary add-ons by the consumer and as such should not be taken into account when assessing risk equalisation.

## **Competition**

Aviva aligns with the Minister for Health and Children's ambition to create a market, where competition brings innovation and benefits to consumers. Whilst Aviva are fully supportive of community rating and recognises that a risk equalisation scheme may be necessary to support community rating, it is absolutely critical market reform is implemented prior to the introduction of risk equalisation. The competition authority has identified the key distorting factors, which the HIA must take into consideration. Also, within the risk equalisation scheme, it is necessary to have competition safeguards in place to protect all competitors in the marketplace and to foster healthy competitive practices, which will benefit consumers and entice new entrants. Aviva would request that the Authority, whose key responsibility is to create a stable market all consumers, is that it carry out detailed stress tests of the consequences of its proposals for consumers and insurers in the market. It is absolutely critical to have a complete view of the whole picture, in order for any risk equalisation scheme to be implemented successfully and to ensure all players have the ability to succeed in the marketplace.

## **International Comparisons**

Aviva has researched and examined the competitive positions of the jurisdictions cited by the Authority within its consultation document. Aviva found that none of the jurisdictions mentioned by the Authority in support of risk equalisation had an insurer as dominant as the VHI, had so few competitors as the Irish market and had the net beneficiary of risk equalisation subject to lesser regulatory and solvency requirements than its competitors.

## **The Supreme and High Court Rulings/The Barrington Report**

Both the High Court and the Supreme Court deemed that the previous risk equalisation scheme had serious anti-competitive effects. Also the Barrington report clearly outlined the current marketplace is not one where prospective participants can earn or expect to earn a rate of return on capital employed. Aviva are concerned that the Authority has not undertaken any analysis to identify if any of VHI's competitors can sustain their current proposal. It is apparent to all that the proposed scheme will have severe consequences on VHI's competitors. The Authority absolutely must to review the impact on the competition in light of the Supreme Court and High Court rulings and the Barrington Report findings and ensure the proposed solution promotes a level playing field within the health insurance market for all players.

## **Recommendations**

Aviva fully supports the creation of a vibrant and competitive community rated marketplace and would welcome its arrival. However, this cannot be achieved until fundamental structural changes are implemented within the market. In particular, the dominance, lack of regulation and re-balancing of the VHI must be addressed prior to the implementation of any risk equalisation scheme. A proper functioning competitive market structure should then be in place to the greater benefit of consumers who would have more choice on products but would equally face lesser premium increases than if a risk equalisation scheme were introduced under the current market conditions.

## CONSULTATION PROCESS

Aviva has a number of serious concerns about the current consultation process and in particular the narrow scope of the consultation document. It is apparent from the document published by the HIA that the larger policy questions have already been pre-determined by the HIA and the Department of Health and Children and submissions are purely sought on technical details. In addition, Aviva is surprised and dismayed to note that the Consultation document fails entirely to take into account any considerations on the current operation of the market and the regulatory turbulence that has occurred in recent years or the other reform measures announced by the Minister for Health and Children in May 2010. This is epitomised by the way the Authority has chosen to present its International Comparisons where it has focused purely on risk and not set out any information on the number and size of insurers, their regulatory status, the impact on competition and the impact on premiums. To attempt to set an international benchmark while being blinded to the operation of the market in each jurisdiction is completely misguided and shows the narrow focus that the Authority chooses to have publicly debated.

Perhaps the most notable factor of the Consultation paper is the lack of progression of the HIA in its thinking since its previous consultation on risk equalisation in 2002.

This is highlighted when examining a previous set of recommendations and promises on reform from the Department of Health and Children on 22 April 2007:

“Summary of measures decided by Government

### *Position of VHI*

- The VHI should become a conventional insurer authorised by the Financial Regulator by the end of 2008. The derogation from solvency requirements which the company enjoys will cease when it is authorised. The Departments of Health and Children and Finance are to report to Government by mid-December on how this is best achieved. **NOT ACHIEVED;**
- The two Departments are to appoint legal and corporate finance advisors to assist in this process. **NOW FURTHER CORPORATE ADVISORS TO BE APPOINTED;**
- A process of consultation should be initiated on how the existing regulatory framework might be changed in the short term to anticipate pending changes at EU level. **NOT ACHIEVED;**
- The immediate publication of a VHI Bill. On enactment it will allow the VHI to establish subsidiaries to operate its ancillary activities such as travel insurance, the Swiftcare clinics etc. This measure will also remove the remaining powers of the Minister in relation to product development, pricing etc. **PRO-VHI MEASURE ACHIEVED IN ADDITION WITH THE REMOVAL OF THE MINISTERIAL PRICE APPROVAL IT HAS ALLOWED VHI ENGAGE IN A PRICING STRATEGY WHICH CLEARLY CANNOT SUSTAIN ITS BUSINESS OR BE IN COMPLIANCE WITH ITS OWN STATUTORY MANDATE ;**

- This Bill will place a statutory obligation on the VHI to take the necessary steps to achieve authorisation in the timeframe set by the Minister. ***NOT ACHIEVED IN PARTICULAR WHEN LOOKING AT VHI ANNAUL REPORT 2009;***
- The VHI will be directed to comply with the Financial Regulator's Consumer Protection Code in the same manner as if it were an undertaking already regulated by the Financial Regulator. ***NOT ACHIEVED.***

### **Pro-Consumer measures**

- That the Minister for Health and Children will ask the appropriate authorities to implement the various recommendations of the Barrington Group that do not require legislation or the making of statutory orders, including ;
- Providing health insurance customers with clear statements of consumers' rights and standardised renewal notices; ***ACHIEVED***
- Requesting companies with payroll deduction schemes to offer at least two companies' products to employees; having group schemes put out to tender on a regular basis. The waiting periods imposed on older people should be reviewed to ensure that they comply with equality legislation. ***NOT ACHIEVED***

### **Risk Equalisation and Community rating**

- The amendment of the Risk Equalisation Scheme to give effect to the Health Insurance Amendment Act, 2007. This abolished the three year exemption from risk equalisation payments for new entrants. The scheme will also be amended to implement some of the recommendations of the Barrington Report. These changes should encourage more competition in the market. To encourage competition and new entrants, and having regard to proportionality, risk equalisation payments will be discounted by 20 per cent. These changes should encourage more competition in the market. ***NOW BEING REVERSED;***
- The circulation of draft Lifetime Community Rating Regulations to insurers for consideration. These are designed to encourage people to take out health insurance at an early age by introducing loadings for later entrants. ***NOT ACHIEVED;***
- The Health Insurance Authority (HIA) initiates a process of consultation with the health insurance industry and private healthcare providers on defining the level of health insurance, which should be subject to community rating. The HIA will also be asked to look at the feasibility of introducing a prospective Risk Equalisation Scheme. ***NO PUBLICATION ON LEVEL OF COMMUNITY RATING AND NOW REVERSAL ON PROSPECTIVE RISK EQUALISATION SCHEME.***

Astoundingly the current consultation document does not consider any of the following factors:

- The distortions in the market being caused by the differing and severely distorted regulatory model applied to undertakings in the market
- No analysis of the proportionality of the proposed risk equalisation schemes to undertakings within the market
- No analysis as to the consequences or impact of the proposed risk equalisation scheme on affordability for consumers of private health insurance;

- No analysis on the impact on competition on undertakings in the market
- No analysis of the benefits of competition in the market;
- No regard to the relative sizes of undertakings in the market;
- No regard to the already recognised high barrier to entry;
- No regard to introducing a policy to drive efficiencies in the health care system; and
- No regard to the need to foster competition or encourage new entrants to the market.

Aviva would in fact contend that the current consultation sets out a more stringent risk equalisation scheme than that previously proposed and which lead to BUPA exiting the market.

It is also apparent from the proposed Consultation document that the HIA has chosen to ignore the recommendations of:

- The Barrington Expert Group Report;
- The Competition Authority finds on the impact of competition of triggering risk equalisation; and
- The High and Supreme Court judgements on the impact on competition and property rights of competitors of the risk equalisation scheme.

### **Regulatory Impact Analysis**

The Authority in its Consultation document requests submissions under the headings of Necessity, Effectiveness, Proportionality, Transparency, Accountability and Consistency as part of its Regulatory Impact Analysis (hereinafter RIA) to use as part of its advice to the Minister.

When considering the implications for competition the Guidelines state that the following questions should be asked about the proposed measure:

- Is it introducing higher switching costs for consumers?

*Aviva: It has been recognised by the Authority (through its Consumer Surveys) that a large amount of inertia remains within the market. As such, the market will not rebalance by itself. In addition, all the Authority Consumer Surveys to date have indicated that the primary reason for switching is still price. As the proposed RES scheme can only raise cost for competitors of VHI it will inevitably have an impact on switching between insurers. The higher costs imposed on competitors of VHI will lead directly to a reduction in switching behaviour.*

- Will there be restrictions on consumer's choice?

*Aviva: As prices will harmonise with the implementation of RES then consumers' choices will diminish. In addition, product structures may change to better suit the risk equalisation criteria hence limiting choice of benefits.*

- Will there be restrictions on firm's choice?

**Aviva:** *The commercial freedom and in particular pricing model will be permanently distorted by this measure. This will have a duplicated effect if the VHI continues its lack of regulation as it will be both a beneficiary of RES payments but will also have the continued freedom to price with total disregard to maintaining solvency levels.*

- Is the regulation likely to restrict entry to the market?

**Aviva:** *It has already been recognised that the current regulatory system results in large barriers to entry, evidence of which is the high market concentration with only two competitors to the dominant incumbent. It can only be assumed that any additional regulatory burdens and in particular the proposed RES scheme with such immense financial consequences to competitors of VHI can only make it close to impossible for any new entrant to put together a viable business model.*

- Is the regulation likely to alter market structure?

**Aviva:** *The proposed RES scheme will fundamentally alter the dynamic in the market with the flow of subsidy payments to VHI from its smaller regulated competitors. At best market shares will stagnant at current levels with switching decreasing between competitors as prices harmonise.*

- Is regulation likely to increase some firm's market power?

**Aviva:** *The Competition Authority found in its report on the Private Health Insurance Market that once risk equalisation payments commenced under the old scheme, most competitive pressures would be removed from the VHI. In addition, it determined that the VHI market power in the health provider market would be enhanced with the flow of payments. As the proposed scheme will have a much greater impact it can only serve to increase the VHI market power. If the VHI were to remain unregulated when the scheme was implemented this would further increase its dominance in all sectors of the market.*

- Is regulation likely to reduce the competitive position of small enterprise relative to large?

**Aviva:** *The Barrington Report determined that:*

*"We believe that the current PMI market is not one where existing and prospective participants can earn or expect to earn a rate of return on capital employed which would be regarded as adequate for the insurance industry."*

*As the two substantially smaller competitors of VHI will be subsidising it, the proposed scheme can only serve to completely eliminate all and any competitive position they may have in the market. This factor will be increased if VHI receives payments prior to authorisation, whereby it will maintain its significant commercial advantage by not being required to comply with any prudential or consumer regulation.*

- Would set up costs be higher for new producers?

*Aviva: Under currently modelling, Aviva cannot foresee how a new entrant would Greenfield into the market if the risk equalisation scheme proposed were in place. The scheme would effectively render the new entrant unprofitable for such a time frame that it could not be viable for any shareholder to decide to invest in the market.*

- Would ongoing costs be higher for new producers?

*Aviva: As only competitors of VHI will be forced to subsidise VHI then ongoing costs will automatically be higher for new producers.*

- Are some firms affected substantially more than others?

*Aviva: The Supreme Court in its judgment on the previous risk equalisation scheme stated:*

*“These were the serious impact on the trading position and trading profitability of BUPA and potentially other undertakings, the potential interference with constitutional property rights and its non competitive effect. Although BUPA argued that the learned trial Judge had underestimated these effects, at least in some respects, the respondents did not challenge those findings although they argued against some of their implications and said they were in any event objectively justified.”*

*Undoubtedly the commercial viability of competitors of VHI will be the only firms affected by this measure. As stated above the trading profitability and the anti-competitive effects will only be experienced by smaller regulated players seeking to compete with VHI.*

Aviva has set out a more detailed response on the RIA at Appendix 1.

## THE HEALTH INSURANCE MARKET

The Irish Health Insurance Market has been in a constant state of uncertainty since the market opened in 1994. However, the past six years have seen an unprecedented turbulence for a market with only three competitors. Five separate sets of litigation have been initiated in the Irish and European Courts against the Government and the HIA based on its previous regulations in the market. The Irish State is currently before the European Court of Justice<sup>1</sup> pending infringement proceedings on foot of a complaint by VIVAS Health (now Aviva) for its failure to apply the provisions of the Non-Life Directives on a non-discriminatory basis in continuing to maintain VHI outside the scope of normal prudential regulation. If this situation is not to be perpetuated then a comprehensive solution to ALL the problems and distortions in the market must be attained.

### The Voluntary Health Insurance Board

The VHI is an insurance anomaly unique to the Irish health insurance market. It is this unique position that VHI retains due to historical circumstances that lead directly to most of the fundamental problems now persisting within the market.

The Barrington Report concluded the following vis-a-vis the VHI:

*“The State owned Vhi has a dominant, favoured and protected position in the Irish PMI market. Vhi has not shown itself to be clearly supportive of an enlargement of the market by new competitors, which would appear to be at odds with government policy. There is also plausible anecdotal evidence that Vhi can do much more to contain the cost of claims, which is by far the major driver of its prices to customers. While Vhi claims that its operating costs as a percentage of revenues are lower than its competitors, the Group believes that this can largely be explained by Vhi’s greater scale and by the fact that the newer competitors are attempting to establish and grow their business. Specifically, Vhi benefits from the following:*

- *A dominant market position resulting from its long history and a reputation (earned mostly in the forty years before competition) for providing an essential service to the Irish PMI consumer;*
- *Consumer perception of its inherent stability resulting from State sponsorship;*
- *Consumer lethargy in moving from their existing provider despite considerable potential cost savings;*
- *The operation of the current Risk Equalization Scheme, which is regarded by its competitors as subsidization of an inefficient competitor;*

---

<sup>1</sup> Case – 82/2010 European Commission v. Ireland

All of these issues are still pertinent today and must be addressed prior to the implementation of any new transition scheme or risk equalisation model. As previously stated, while the Authority may argue that regulation of the VHI does not fall within its terms of reference, it cannot ignore the impact of these distortions on the risk equalisation model, which it is proposing.

The core difficulties that must be addressed within the VHI are as follows:

**1. It must be subject to prudential regulation by the Financial Regulatory in a similar fashion to all other insurance undertakings in the market.**

The lack of regulation of the VHI by the Financial Regulation has lead directly to:

- The VHI running down its reserves and forcing the Irish State (and all citizens whether they have health insurance or otherwise) to rescue it with a huge capital injection; the VHI dampening its premiums by raiding the solvency reserves set aside for the protection of its consumers;
- Ignore all the consumer protections set out by the Financial Regulator.

The discriminatory nature of the current lack of regulation has been recognised by the European Commission and has lead directly to the Irish State being brought before the European Court of Justice<sup>2</sup>. At its most basic the current lack of regulation allows the VHI to engage in commercial practices which neither of its competitors can replicate i.e. VHI currently operates its insurance intermediary authorisation, its Swiftcare Clinics, its chronic disease management and its EOP/EAP programmes all within the one corporate structure.

In addition, and more damaging to the market is the VHI stated position of dampening its premium increases by using its reserves. While the VHI alleges it cannot compete with its competitors due to its older age profile it still appears to release new benefits or have special offers which Aviva (with its propoerted younger age profile) cannot compete with. This in effect will also have a knock on impact on the VHI claims ratio as if it continues to engage in such tactics this will automatically not only make it loss making but also show that its claims costs far exceed its premium income. This continued pricing activity must be reviewed in light of any proposed risk transfers as risk equalisation should not be used as a mechanism to facilitate below cost pricing.

The VHI in August 2010 are offering Free Kids on its Parent and Kids Plans and on its One Plan+. VHI has approximately 340,000 children for which it must pay a levy of €55 per child. In addition, average claims cost for a child are generally €147<sup>3</sup>. Hence, the VHI could potentially lose approximately €69 million with this offer, after having already declared losses of €41 million for 2009 and stating they are under a statutory obligation to ensure that its income at least matches its expenditure. Furthermore, the free kids offer means that the VHI are not collecting any levy payments for these members and hence these younger members are not making any contribution to the cost of insuring its older

---

<sup>2</sup> Case – 82/2010 European Commission v. Ireland

<sup>3</sup> Source: HIA Consultation Document on Risk Equalisation dated June 2010

members. In fact, this offer in effect means that the VHI's older members and the competition through the levy are subsidizing the VHI kids. The costs of competing with these loss making practices impact competitiveness and distort market behaviours, as such these factors must be taken into account and reflected in any risk equalisation scheme. These activities (and the commercial advantage gained) are only possible because of the lack of regulation by the Financial Regulator of the VHI.

The cost of capital advantage gained by VHI through its lack of regulation must also be addressed and reflected within the risk equalisation scheme, in particular if RES were to be implemented at any time prior to VHI attaining regulation.

The Authority cannot seek to implement any risk equalisation until a level regulatory playing field is put in place for all health insurers within the market.

## **2. The size and dominance of VHI**

The sheer size of VHI is causing a distortion to competition in both the health insurance and health care markets. The VHI retains in excess of 60% market share arising from its historical monopoly position. To have such a large player within any market and in particular one with such a lack of competitors is of itself problematic. All aspects of regulation are altered by the size of VHI and it has been widely recognised by the Competition Authority, Barrington Report and Health Insurance Authority Report on Competition that the size of VHI acts as a barrier to entry. In particular the Barrington Report concluded that:

*“The Group, which was appointed by the Minister primarily because of the uncertainties that currently exist in the Irish PMI market, has concluded that the main reason for such uncertainties is the hugely dominant position of Vhi and the manner in which Vhi has used this State-supported and dominant position. It is unlikely that new participants in the Irish PMI market will ever achieve an adequate rate of return while Vhi’s position remains so dominant.”*

The size of VHI also has an impact when looking at the scheme itself any changes it implements within its claims management or health provider negotiation will have a huge effect on the size of the risk equalisation subsidy which its competitors must pay. The dominance of the VHI also means that it can effectively set all the rates within the market and that it will set the average claims cost within the market – as such its inefficiencies will then be compensated by its competitors.

When looking at the risk equalisation scheme the proportionality of payments and the commercial impact of the scheme is dramatically altered by the size of VHI. If there were five competitors in the market with a more even balance of market shares and older members the impact on any one competitor of risk equalisation payments would not be as significant. This would mean that the market would be more stable in the longer term and allow all undertakings to engage in meaningful competition both for members and within the health provider arena.

## **Minimum Benefits**

Minimum Benefits set out the basic package of benefits deemed as a minimum for consumer protection. As such, it can only be determined that any benefits in excess of this minimum constitute a luxury that is purchased at the discretion of the consumer. Risk equalisation should therefore only apply at the level of minimum benefit as any benefit in excess of this level is an add-on by the consumer.

While it is understood that the policy goal within the new proposal on minimum benefits (see Expert Group Report July 2010) is to promote coverage of primary care and chronic disease management (CDM) this must also be considered in light of risk equalisation to avoid penalising insurers who incentivise members to participate in step down community care facilities rather than hospital services and who engage in chronic disease management plans to remain maintain the health of their members.

In particular, if an insurer were to receive a greater cost benefit or commercial advantage through increasing risk equalisation this would need to be addressed. A situation should not occur whereby it is more favourable for an insurer to increase all costs in the market in order to force competitor subsidies and premium increases in order to maintain or gain market share – in particular if losses can be absorbed due to lack of regulation. The efficiencies of competitors should not be penalised.

If the policy goal within the proposed minimum benefit legislation, and the wider policy objectives of the Department of Health and Children, to move patients to treatment within the community and chronic disease management is to be achieved then the consideration of health status within the risk equalisation scheme would need to be fundamentally reviewed.

It would also be essential that the concept of reward for healthy behaviours should be considered, as international evidence would suggest that particularly in the light of CDM programs that such rewards are proven to be immensely effective.

## **Lifetime Community Rating**

The legislative provisions for lifetime community rating have been on the statute books since 2001 and yet to date no regulations have ever been enacted. Lifetime Community Rating will have an impact on the structure and age profiles of the market.

Community rating relies on younger customers being attracted to the market as their premiums contribute to the costs of claims from older people. The introduction of Lifetime Community Rating should attract and retain younger people in the market which will make health insurance more affordable for all – which is particularly important in the current economic environment.

## COMPETITION

The Minister for Health and Children stated in her announcement on 27 May 2010 that the Minister wishes to create a market where competition brought innovation and benefits to consumers. In addition, she also that she would be investigating the re-balancing of older members in order to achieve the same basic commercial incentives for all players within the market and to allow all players make reasonable profits. As such, Government policy would appear to be to reach a position whereby competition can flourish for all market participants and not solely of the dominant player. As previously stated, Aviva is fully supportive of community rating and recognises that a risk equalisation scheme may be necessary in order to support community rating, however, the implementation of risk equalisation under current market conditions will cause huge damage to the market and drive consumers out of the market.

While the Authority cited a number of reports as a support for the previous risk equalisation scheme the contrast with the lack of any mention of either the Competition Authority Report, the Barrington Report or even the Authority's own report all of which dealt with competition issues is stark.

The Competition Authority in its Report of 2007 highlighted a number of damaging consequences to competition that would accrue from the previous risk equalisation scheme. As the current proposal from the Authority is to introduce a risk equalisation of greater magnitude it is worth reiterating the conclusions set forth by the Competition Authority.

Firstly, the Competition Authority found that the following factors were inhibiting and distorting competition in the market:

1. That the VHI was not regulated and as such could compete in ways not available to other health insurers.
2. The climate of uncertainty due to regulatory challenges within the market.
3. The market position of VHI in terms of its legacy as State-owned former monopoly and its network of salary deduction schemes.
4. The lack of consumer awareness of their switching rights.
5. The difficulty for consumers to compare and contrast the various products in the market.
6. The Minimum Benefit regulations, which hinder product innovation.

Secondly, in so far as the commencement of risk equalisation transfers was concerned, the Competition Authority concluded it would have the following effects on the market:

- A. The average price of health insurance will increase;
- B. Transfers will strengthen VHI market power and allow it to increase its prices above competitive levels and sustain those prices for a significant length of time;
- C. Price sensitive consumers would be likely to discontinue cover completely;
- D. Switching from VHI would become less likely and if competitors prices increased switching back to VHI would become more likely;
- E. VHI would consolidate its market position both in the health insurance market but also in the health care provider market; and

- F. If the uncertainty around risk equalisation was removed and VHI regulatory advantage removed the likelihood of new entrants might improve.

The HIA must take these far reaching competition considerations into account and do some analysis of what will occur if the market structure has not changed and risk equalisation (or similarly the transitional scheme) are put in place. This result must then be assessed against what may be achieved if structural changes happened and a cost benefit analysis of the various positions. In particular, the impact of affordability must be stress tested by the Authority, the entire market will destabilise if premiums rise to such a level that the most price-sensitive members are forced to exit the market and the cost for new younger members becomes prohibitive – purely to subsidise VHI. Similarly, the cost to corporate schemes must be considered when regarding Ireland as a prime location for foreign direct investment.

The Competition Authority also suggested more fundamental measures to promote competition rather than imposing behaviour remedies such as the risk equalisation scheme. The measures cited by the Competition Authority were structural solutions such as the splitting of the VHI, perhaps a once-off “Grey PHI”, privatisation and a review of intergenerational solidarity and the manner in which that objective is to be pursued. Structural remedies are always less damaging to competition than trying to put in place behaviour solutions. Both Irish and European competition law put an onus on the State to put in place a remedy for a service of general economic interest which is the least detrimental to competition, as such the HIA is under a legal obligation to consider other methodologies and then determine which has the least impact on the competitive landscape.

In addition, the Competition Authority highlighted the historical advantage that the VHI has vis-a-vis its competitors both in terms of its brand but also due to its far reaching network of salary deduction schemes and the tying of products by the VHI. This leveraging of the VHI dominance from one financial market into another must be reviewed and remedied if a proper competitive environment is to be achieved.

Furthermore, since the Competition Authority Report in 2007 the market has changed again with the aggressive pricing mechanism put in place by VHI, which has further deteriorated their trading position. The extent to which the VHI has issued loss leading plans in order to retain market share funded through reserves must also be considered in the context of distortions to competition within the market. The VHI within its press release of 1 July 2010 state:

**“Vhi Healthcare Legal Obligations**

*Vhi Healthcare has to ensure that it has a viable business by fully adapting to the economic, regulatory and competitive environment in which it operates. It has to ensure that its income at least matches its expenditure in 2011 and has received legal advice that it must achieve this. In this regard the Board of Vhi Healthcare is in the process of examining the different options to meet these legal obligations.”*

The VHI has eroded its solvency position year on year by failing to ensure that at least its expenditure matches its income year on year and has breached this obligation in 2009 by declaring a loss of over €40 million. Risk equalisation should not be used as a mechanism to rectify previous breaches of its corporate and statutory obligations.

In a market where competition is already recognised to be distorted by the lack of regulation and dominance of the VHI it is nonsensical to put in place any measures, which would exacerbate this situation.

The Authority has clear guidance from the Competition Authority as to what will occur to affordability and the competitive position of competitors of VHI and health care providers if their recommendations are implemented. These consequences must be examined, reviewed and then the results communicated to all stakeholders when putting forward any new form of risk equalisation.

### **Competition Safeguards within the Previous Risk Equalisation scheme**

The previous risk equalisation scheme had some basic minimal provisions to help competition in the market, all of which now appear to have been removed by the Authority. Firstly, the previous scheme did not trigger automatically but only after analysis by the Authority on the risk profiles and an assessment on the stability of the market and the need to foster competition. The current processes already presuppose automatic transfers occurring with no recommendations, analysis or determinations. As such, if we were to apply the current scheme to 2007, the VHI made a profit of in excess of €70 million would have received in excess of €100 million from its competitors, similarly, in 2008 when the VHI made €112 million in profits it would have again received in excess of €100 million from its competitors (notably the VHI profitability in 2007/2008 was gained WITHOUT any risk equalisation transfer and with substantially the same age profile which it now claims is making it unprofitable). As such consumers would merely be subsidising greater profits within the VHI – there is no mechanism or provision within the current proposal to address such a situation. The Authority cannot possibly contend that it is credible for commercial undertakings to participate in a scheme which could lead to such outcome. In particular, there would seem to be little motivation for a commercial entity to remain in a market where it will lose market share and have no return on capital while subsidising a large, unregulated and potentially profitable competitor. The Authority under the previous scheme had made the determination that BUPA Ireland would not exit the market under such conditions and such assessment was proved to be incorrect. Even the current levy scheme has provisions against overcompensation of the VHI – but again these have not been reflected in any part of the consultation documentation. There is no transparency of the review by the HIA of the overcompensation of the VHI which would allow competitors assess the accuracy of the levy. In addition, it is not clear what factors are considered by the HIA i.e. does the HIA account for the deliberate loss caused by the VHI kid's free offer which does not even include the recuperation of the costs of the levy? The Authority must within the parameters of any risk equalisation scheme taken into the consequences under competition law and seek to ensure that safeguards are put in place so that the risk equalisation scheme does not bolster the dominance of VHI in the market.

Allied to the above and problematic to both schemes is the fact that the monies received by VHI under risk equalisation are not ring-fenced for any purpose – as such Aviva monies could be used for VHI to open new Swiftcare Clinics, run underpriced plans (which VHI would then get compensated for under risk equalisation) or purely expand its existing business lines.

It should be observed that the Authority under the previous scheme had an obligation when considering risk equalisation to foster competition within the market – this provision has now been removed and no explanation has been provided as to why this provision is no longer relevant.

Similarly, there was a three and a half year exemption for new entrants into the market – this was seen as a core provision to help attract new players and this provision has been removed. The Minister subsequently removed the exemption and stated in a Press Release dated 26 April 2007 that:

*‘Secondly, they also provide for a discount of 20 per cent in the amount of risk equalisation payments due to be made. This is a proportionate response to the removal of the three-year exemption, to encourage competition. The reduction will be in the order of €10 million, less than 1 per cent of VHI’s premium income and about €6 per VHI member’*

The Authority does not appear to have had any consideration to the above or to put any measures in place to encourage competition. In fact, the current proposals by the Authority would appear to be in direct contradiction to the above and entirely biased in one direction.

While great reliance is placed by the Authority vis-a-vis undertakings competing for older members there is no remedy put forward by the Authority on how best to overcome the recognised inertia within this age cohort. Why has the Authority not explored the possibility of allowing insurers to incentivise switching in this older age cohort i.e. through premium reductions this may have allowed some movement in the market and be far less prejudicial than the proposed risk equalisation scheme but has again not be considered. Similarly, the Authority has claimed that products are being marketed to particular segments of the market, why has the Authority not requested that all advertising state that all standard procedures for older members are also covered in the cheaper plans?

The Authority is at pains to state that older members are more costly to the VHI, however, there is no analysis given as to what premium VHI receives for these allegedly older members or how long that older member has been paying health insurance to the VHI. If costs are equalised within the proposed scheme then why is premium not also assessed – if an older member is paying for Plan E should this extra premium accruing to the VHI not also be a factor. In addition, if older members are on higher level plans which lead to higher utilisation why consumers on lower plans should compensate for this. Also if a 70 year old has been paying VHI for health insurance over 50 years is this member really unprofitable for the lifetime of their membership?

Rather than consider what will occur in market without a risk equalisation scheme as stated in the Consultation document what the Authority should consider is what will occur to all competitors in the market if their current proposals are put in place. This analysis must be carried out immediately and in consultation with all stakeholders in the market and the Competition Authority. Similarly, the Authority as stated above should also consider the implications of putting in place structural remedies to address the core problems in the market.

A fundamental policy decision must be taken as to what kind of health insurance market we want within Ireland – quite apparently if the ambition is to maintain the VHI dominance and to freeze market shares and prevent new entrants then a robust risk equalisation scheme

which does not take any market or competitive factors into account is the optimal solution. While the Authority may claim that such decisions go beyond the scope of its function Aviva would argue that such is not the case – the Authority must act to sustain the market and all consumers and as such is under a core obligation to consider all options on how these can be achieved. The proof of the failure of market policy to date, despite the protestations of how profitable the market is for all other than VHI, is that there are still only three players in a market with a larger premium income to motor insurance, quite apparently something is not functioning correctly and more of the same policy decisions will not remedy this.

## INTERNATIONAL COMPARISONS

The Authority has provided a number of international comparisons in order to bolster its argument on the need for health status within the new proposed risk equalisation scheme. However, similar to its review of the Irish market it failed entirely to give an overview of the market, how competition functions within the market and the size and number of undertakings within each market. Aviva has re-assessed each of the jurisdictions cited by the HIA and found that no market had a dominant undertaking the size of VHI, no market with risk equalisation moved payments to an unregulated undertaking like VHI, no market had so few players as the Irish market. As such, the view set out by the HIA on purely the technical aspects of a risk equalisation schemes fails to give the context in which those scheme operate none of which have the huge distortions present within the Irish market.

On the specific nature of the issues of health status, Aviva uncovered that although health status may often be found to be a factor assessed in determining RES payments, schemes in different jurisdictions may be fundamentally different in their scale and effect, and are often heavily modified according to the particular contours of the local market, i.e. competitive markets will see strong schemes, whilst in other markets, no RES exists for luxury benefits.

Indeed, it was uncovered that the particular health factors considered in determining RES payments were as different among markets as the markets themselves and that the degree of variance between these markets was such that many, if not all, could not be seen as any real guide as to the form of scheme which should occur within Ireland.

As outlined below, none of those markets reviewed by the HIA could be seen as analogous to Ireland in terms of market penetration, number of competitors, age-share of competitors, and regulatory standards.

	<b>Netherlands</b>
Size of market	Mandatory – covering all legal residents, <sup>4</sup> with limited exception
Number of competitors	Five largest account for almost 90 percent share, <sup>5</sup> however, as of 2006 there was 33 players then competing (this has since been subject to considerable consolidation in the period since. <sup>6</sup>

---

<sup>4</sup> Sarah Thomson and Elias Mossialos: “*Private health insurance in the European Union*” – report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities, June 24<sup>th</sup>, 2009, p.261. Report available at <http://ec.europa.eu/social/main.jsp?catId=754&langId=en>

<sup>5</sup> Robert E. Leu, *et al*: “The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets”, Commonwealth Fund pub. no. 1220, 2009, page 20. Report available at [www.commonwealthfund.org](http://www.commonwealthfund.org).

See also “*Private health insurance in the European Union*”, page 272.

<sup>6</sup> *Ibid.*.

Size of competitors	Three largest competitors accounted for 65 percent share in 2006 – this has since further consolidated in the period since. <sup>7</sup>
Regulatory status of competitors	All governed on equal footing, primarily by the 2006 Health Insurance Act.
Nature / effect of RES scheme	Complex scheme paid into by government and employers and drawn on by insurers. Mixed prospective and reactive elements.
Nature of system of health provision	Primary channel of health spending. This covers some 52 percent of all health costs and includes Ambulatory and hospital care. Outpatient pharmaceuticals, maternity care, etc. Long term care (accounting for 42 percent of health spending) is provided through public funds and complementary health insurance (above the ordinary health insurance minimum) covers various other treatment standards and expenses, accounts for 6 percent of medical expenses, and sees 92 percent market penetration. The complementary, i.e. non-basic system does not appear to be subject to RES.

	<b>Australia</b>
Size of market	44.5 percent of the general population as of 2009
Number of competitors	37 insurers, including 13 restricted membership. Most are mutual but the greater part of the market is controlled by “for profit” providers
Size of competitors	Largest, 28.59percent; next 15.72percent, third 9.75percent. Six insurers account for 77.8 percent share (or 84.5percent when taking into account common ownership) <sup>8</sup>
Regulatory status of competitors	All regulated in common, primarily under the Private Health Insurance Act 2007, and delegated rules.
Nature / effect of RES scheme	Only nine insurers in the market are for profit but competition is strong. RES exists as a Multi-tiered “pool” - an age based pool that shares <ul style="list-style-type: none"> <li>• the costs of treatment for people aged 55 and above</li> <li>• a high cost claimants pool—that shares the costs of claims greater than \$50,000</li> <li>• the transfer of money between insurers and the RETF, based on the experience and relative risk of their health benefits fund membership base.</li> </ul>
Nature of system of health provision	Similar to Ireland – arguably quasi supplementary to state coverage / quasi replacement.

<sup>7</sup> *Private health insurance in the European Union*, page 40.

<sup>8</sup> Private Health Insurance Administration Council (PHIAC): “*Operations of the Private Health Insurers Annual Report*” 2008–09, PHIAC, Canberra, page 13. Report available at <http://www.phiac.gov.au/resources/file/264-152009.pdf>.

	<b>Belgium</b>
Size of market	73 percent of the general population.
Number of competitors	33 commercial insurers, 60 mutual associations. <sup>9</sup>
Size of competitors	Largest 4 competitors accounted for some 78 percent share as of 2006, <sup>10</sup> largest competitor accounts for 30.8percent <sup>11</sup>
Regulatory status of competitors	Differing regulation depending on nature of company – government has been brought to ECJ for allowing differing solvency levels.
Nature / effect of RES scheme	<p>Two systems – statutory insurance and complementary insurance for what’s not in your minimum entitlement. In the later market, both private and mutual’s compete.</p> <p>Complementary element only accounts for 5.37percent of total health expenditure and only 22percent of private expenditure (rest by households).</p> <p>Largely, complementary insurance is consumed by those less than 70, with 75 percent of all those covered insured through group contracts.</p>

	<b>South Africa</b>
	<p>Although 42.3 percent of all health expenditure is channelled through PMI,<sup>12</sup> only 15.9 percent of the general population market<sup>13</sup> enjoy coverage. No ready information could be found in order to assess the extent of competition or benefits available under relevant policies. To that end, it was not felt appropriate to compare this market with the more advanced, in terms of penetration, markets already reviewed. It may be worthwhile to note that no RES payments have been made under the South African scheme as of present.<sup>14</sup></p>

<sup>9</sup> “Private health insurance in the European Union”, page 38. Figures valid as of 2007.

<sup>10</sup> Ibid, page 40.

<sup>11</sup> Ibid, page 160.

<sup>12</sup> Ibid, page 27.

<sup>13</sup> Denis Drechsler and Johannes P. Jütting: “Private Health Insurance in Low and Middle-Income Countries” OECD Development Centre, March 2005, page 3. Report available at [http://hc.wharton.upenn.edu/impactconference/drechsler\\_031005.pdf](http://hc.wharton.upenn.edu/impactconference/drechsler_031005.pdf)

<sup>14</sup> Heather McLeod & Pieter Grobler: “Risk equalisation and voluntary health insurance: The South Africa experience” in *Health Policy*, 9 July 2010. Report available at: <http://www.sciencedirect.com/science/article/B6V8X-50GTR37-1/2/aaed1951bd02e376fb540cf3d6eca2bc>

	<b>Israel</b>
Size of market	Universal – must have coverage by law with limited exception.
Number of competitors	Four
Size of competitors	Largest – 54 percent (former only open-enrolment player)
Regulatory status of competitors	Seemingly identical
Nature / effect of RES scheme	
	Health Insurance is the primary means through which health spending is funnelled (although subsidised).

	<b>Medicare (US)</b>
<p>Consideration of risk transfers previously used in the Medicare system was not seen to be adequate in light of recent reforms and often differing policy objectives when compared with the seeming rationale for such a scheme in the Irish market.</p>	

## THE SUPREME AND HIGH COURT RULINGS

While the ultimate determination by the Supreme Court<sup>15</sup> was that the previous risk equalisation scheme should be struck down for an issue of interpretation, which lead to a constitutional breach, the Supreme Court rather than dismiss the grounds of appeal on competition grounds chose merely not to deal with these. As such, the competition grounds of appeal set forth by BUPA Ireland still remain open for determination by the Supreme Court.

In particular, the Chief Justice made reference to the highly damaging consequences, which the previous risk equalisation scheme would have on undertakings in the market:

*“Leaving aside the constitutional issue as such, it is nonetheless evident that the scheme in question, established pursuant to the provisions of s. 12, would have serious effects on the trading profitability of BUPA and inevitably have implications for any undertaking considering entering the market in the future. I would add that BUPA have in this appeal argued that on the basis of the evidence tendered in the High Court the learned trial Judge was bound to conclude, and ought to have, that the impact on BUPA’s profitability was far greater than that which he found. Again it is not necessary to resolve that issue since I am drawing attention to the actual and potential implications of a serious dimension, on the basis of the findings in the judgment of the High Court, which the scheme in question nonetheless has for BUPA and potentially for other undertakings. These are matters to be taken into account when interpreting s. 12 in the light of the provisions of s. 2 and s. 7 since the form of Community Rating is an essential element to the Risk Equalisation Scheme.”*

Similarly, the Chief Justice later in the judgment went on to reiterate that:

*“Earlier in the judgment I referred to the impact which the scheme, with its concomitant component of community rating, would or potentially would have on undertakings which recently entered or would enter the private health insurance market. These were the serious impact on the trading position and trading profitability of BUPA and potentially other undertakings, the potential interference with constitutional property rights and its non competitive effect. Although BUPA argued that the learned trial Judge had underestimated these effects, at least in some respects, the respondents did not challenge those findings although they argued against some of their implications and said they were in any event objectively justified. Justified or not, from any point of view a scheme based on community rating across the entire market has actual and potentially serious implications for undertakings in the market.”*

Therefore, indisputably and as determined by both the High and Supreme Court the previous risk equalisation scheme has serious anti-competitive effects. In addition, as stated above the Irish State did not challenge the findings that the scheme itself would leave BUPA unprofitable.

---

<sup>15</sup> BUPA Ireland v. The Health Insurance Authority and Others, Supreme Court judgment dated 17 July 2008.

This judgment was given against the background of a scheme that had some element towards competition (as state above) and also was set at a lower level to the current proposals set forth by the Authority. The Authority would appear to have ignored the judgement of the Court vis-a-vis both competition law but also the infringement of the Aviva constitutional rights in its entirety when setting forth the new risk equalisation scheme. The Authority cannot deny the severity of the consequences of the risk equalisation scheme on competitors of VHI and yet it has chosen not to set forth any provisions to ameliorate this fundamental breach of the property rights of competitors of VHI.

Neither has the Authority chosen to do any analysis as to whether the business model of either of the VHI competitors can sustain their proposal for risk equalisation.

## **BARRINGTON REPORT**

On 17 January 2007 The Minister for Health and Children announced that she had appointed a three person group comprising Colm Barrington (chair), Seamus Creedon and Dorothea Dowling (the Barrington Group) to carry out a business appraisal of the private medical insurance (PMI) market in Ireland and to report back to her on the subject by 31 March 2007. The Minister's announcement included the following terms of reference for the Group:

*“To examine whether, having regard to all aspects of the current health insurance market in Ireland (structure, size, regulatory framework, etc.) and the need to maintain community rating, it is possible for current and prospective participants in the health insurance market to earn a rate of return on capital employed which would be regarded as adequate for the insurance industry.*

*To make whatever recommendations it considers appropriate in the light of its findings.”*

In the context of RES this report dealt specifically with the previous scheme but as previously stated as the current consultation by the Authority recommends an even more severe form of risk equalisation then its conclusions are equally if not more pertinent.

Its primary conclusion was that:

*“We believe that the current PMI market is not one where existing and prospective participants can earn or expect to earn a rate of return on capital employed which would be regarded as adequate for the insurance industry.”*

This key determination has not been refuted and is of central importance when looking to implement any future risk equalisation scheme. The Authority has not clarified whether it has examined this question and stresses tested its current proposals against this conclusion. If there is a policy consideration to keep competitors of VHI in the market it would be assumed that a necessary pre-requisite would be to assess whether the new risk equalisation model has changed to enable an adequate rate of return on capital. If the Authority believes that such a consideration is not necessary then in the interest of transparency and to enable clarity for market participants it should set out its reasoning as to why it either disagrees with the Barrington conclusion (setting forth its analysis on this) or state clearly why it chooses to ignore such a determination. This would give clarity to competitors of VHI as to policy considerations taken into account by the Authority and in particular as to whether the Authority wishes to retain any competition in the market.

On the issue of risk equalisation itself, the Barrington Report stated:

*“A simpler, more limited, transparent and, possibly, prospective form of Risk Equalization should be introduced which would not be regarded as a subsidy to Vhi.”*

It would appear from the current proposals that the Authority has chosen to entirely ignore the aforementioned statement. However, when looking at the two conclusions set out above by the Barrington Group it is apparent that their determination was that no competitor of VHI could survive under the old risk equalisation scheme and regulations. To date, none of the structural remedies cited by the Barrington Group have been implemented that would alleviate this situation. The Authority is therefore under a clear obligation to assess the commercial repercussions to all competitors of its risk equalisation proposals. In addition,

the Authority has a clear mandate to all consumers in the market to ensure the market remains stable and affordable.

The Authority therefore has clear knowledge from the Barrington Report and the Competition Authority Report of the impact to both consumers and undertakings of a new risk equalisation scheme and the disproportionate impact that its proposals will have on competitors of VHI. This must form part of the determination on risk equalisation if nothing else to see if the market can survive the measures set out by the Authority.

## **RECOMMENDATIONS**

Aviva recognises that the current distortions cannot persist within the market. Aviva would welcome the opportunity to work in conjunction with the Authority and the Department of Health and Children to find a long term viable solution to protect community rating and ensure a vibrant and competitive health insurance market can be achieved. Aviva would set out the following recommendations for consideration and debate.

### Pre-Conditions to the Initiation of any Risk Equalisation Scheme

Prior to the initiation of any new risk equalisation scheme the following should be in place:

- The same regulatory regime should apply to insurers in the market;
- Life-time community rating should be in place;
- The VHI age profile must be re-balanced and its market share reduced to no greater than 30%.

Once these steps have been achieved, ideally there would be more market participants with approximate market shares and with similar age and gender profiles.

### Market metrics prior to triggering any new Risk Equalisation Scheme

Once the aforementioned pre-conditions have been put in place then the market should be assessed under the following metrics prior to initiation of any payments:

- The market concentration should be assessed to ensure it is within reasonable parameters;
- An agreed measure of market instability should be apparent within the market e.g. a large number of consumers exiting the market in a single year or large imbalances in claims;
- Clarity on timelines, size of payments and length of time the scheme shall be in operation so that stability and investment decisions can be made; and
- Any payments due under the Scheme should be proportional and spread across the market e.g. there should be an even balance of undertakings receiving and making payments into the scheme. No payment should be of such a size to cause any undertaking to become unviable.

### Operations of a new Risk Equalisation Scheme

Once the structural changes to the market have occurred and more competitors are present in the market then Aviva would recommend the following form of risk equalisation scheme to help support a vibrant and competitive community rated market:

- A fully prospective risk equalisation scheme based on 80% of age and gender to recognise that insurers should retain some incentive to compete for younger lives in order to support community rating;
- Risk equalisation should only be set at the of minimum benefits – any coverage over this level should not be equalised;
- A scheme that is fully transparent;
- An annual review to determine if the scheme is still required or should be suspended or amended; and
- A scheme that is consistent with the principles of accrual accounting so that insurers can correctly reflect the impact of the scheme in their accounts.

- A scheme where any change to rules or parameters are announced at least a year in advance to allow insurers to assess the impact on their financial plans and effectively implement any changes to their product or pricing strategy resulting from changes to the scheme.
- A scheme that incentivises insurers to engage in activities aimed at promoting the health of their customers
- Any proposed scheme must be cognisant of the prudential and consumer requirements set out by the Financial Regulator and allow undertaking time to ensure compliance with these requirements.

For the avoidance of doubt Aviva does not endorse either an increase in the current levy scheme, or the implementation of any risk equalisation scheme until and when the market has undergone structural changes. In particular, Aviva would stress all commentary above is prefaced with the need firstly to engage in fundamental reform of the market.

## RESPONSES TO SECTION 4 OF CONSULTATION PAPER

**Please note that all answers in this section are based on the assumption that the market will undergo fundamental structural reform through the regulation, rebalancing and market share reduction of the VHI prior to the implementation of any form of risk equalisation.**

### Section 4

#### 4.1 What are your views on using underlying risk factors in a risk equalisation scheme?

As stated previously, in the context of a competitive and balanced market, Aviva supports a prospective scheme that partially adjusts risk on the basis of age and gender.

In a balanced market, the financial transfers between insurers under the scheme would be relatively small. Any additional overall benefit from requiring these transfers to be technically more accurate when reflecting risk differences (such as including health status) would not be worth the additional cost.

The particular disadvantage of a very complex scheme is the associated lack of transparency. A scheme that produces transfers that are difficult to understand and predict is unlikely to gain support across the market, as there will be suspicions that it is being manipulated by rival companies.

Aviva does not support the introduction of a health status measure in a risk equalisation scheme as we do not accept the unproven assertion in the consultation paper that within each age band, VHI members are, on average, in poorer health than those of Aviva and Quinn Healthcare. It is noted the only consequence of including health status now for the first time within the risk equalisation scheme is to increase the levy of subsidy payments to an ever more insolvent VHI.

#### 4.2 What underlying risk factors should be used?

Age and Gender of the market at the start of the financial year.

Aviva favours a prospective scheme as it is important to both insurers and the market that insurance companies can properly forecast future costs in order to price their policies and establish appropriate reserves.

Both currently and in particular following the introduction of Solvency II, any additional uncertainty about future costs will have a direct impact on the capital required to support insurance company's liabilities. Part of the cost of holding this capital will ultimately be passed on to policyholders.

In addition, the way the rules are defined and drafted should be consistent with the principles of accounting, allowing insurers to accrue for the cost or benefit of the scheme. This is in contrast with the current tax based loss compensation scheme (levy and age related tax relief), where the insurer is liable for the full annual levy in respect of each person who enters into a contract during the year, even if they cancel the contract after paying only one monthly premium.

4.3 What data should be collected from undertakings in respect of underlying risk factors?

Age and Gender at the start of the financial year.

Only data that is collected from customers when they apply for or renew their Health Insurance policy should be used for risk equalisation.

Customers will see it as an unnecessary intrusion into their privacy to provide additional information that they know will make no difference to their being offered cover or that has any impact on the price that they are charged. Any data collected solely for the purpose of risk equalisation is very unlikely to be reliable, so if used, would undermine the scheme as a whole. As a result, even if there are other credible risk factors that are predictive of claims costs, we do not believe it is practical to use anything other than age and gender given that the market is community rated.

4.4 Should underlying risk factors be fully or partially equalized?

Once the interests of older (and sicker) members are protected (i.e. that they have the same rights as other members, that their contractual benefits are paid, and that their benefits are not diluted from what they expect), community rating best is supported when all of the competitors in the market target their activities at ensuring that younger (and healthier) people are attracted to enter and stay in the health insurance market in order to maintain a stable sustainable market for all. In the context of a balanced market, partial equalisation would provide an incentive for insurers to support the market in this way.

Age and Gender should equalised to encourage competition and support community rating. Aviva's view is that 80% equalisation of differences in claims costs due to age and gender is appropriate.

4.5 What are your views on the difficulties of collection and auditing data?

Age and gender is relatively easy to collect and audit.

Audit is central to ensuring confidence that the data provided by each insurer is consistent and compliant with regulation. Difficulties in collecting and auditing data will arise if the scheme is overly complex.

4.6 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?

It will be impossible to establish the confidence of each of the insurers in a risk equalisation scheme where VHI is the only company in the market to benefit from the scheme. It is therefore imperative there is a relatively even balance of customers between companies in the market before either a “transitional” or “robust” risk adjustment scheme is introduced.

A scheme that produces transfers that are difficult to understand and predict is unlikely to gain support across the market, as there will be suspicions that it is being manipulated by rival companies.

- 4.7 Would a risk equalisation system based on underlying risk factors (in addition to age and gender) be sufficiently effective in supporting community rating?

Once the interests of older (and sicker) members are protected (i.e. that they have the same rights as other members, that their contractual benefits are paid, and that their benefits are not diluted from what they expect), community rating best is supported when all of the competitors in the market target their activities at ensuring that younger (and healthier) people are attracted to enter and stay in the health insurance market in order to maintain a stable sustainable market for all. Any scheme that removes the incentive to attract young and healthy members will no longer be effective in supporting community rating.

- 4.8 What are your views on using diagnosis related risk factors in a risk equalisation scheme?

Aviva does not support the introduction of a health status measure in a risk equalisation scheme as we do not accept the unproven assertion in the consultation paper that within each age band, VHI members are, on average, in poorer health than those of Aviva and Quinn Healthcare. Additionally, after the market shares of older customers are rebalanced, our view is that the introduction of a health status measure will be unnecessary.

Notwithstanding this comment, we do not believe that it would be feasible to base an Irish risk equalisation system on diagnosis related risk factors given the very significant challenges in collecting data and ensuring it was treated consistently by all hospitals and insurers.

- 4.9 What diagnosis related risk factors should be used?

Diagnosis related factors should not be used.

- 4.10 What data should be collected from undertakings in respect of diagnosis related factors?

No data should be collected

4.11 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?

There are very significant issues related to the collection of diagnosis related data in Ireland that mean it would be impractical for use in a risk equalisation system.

Such a system will require:

- Data on health status to be collected at point of admission to market,
- Ongoing data collection and retention.
- Coding of claims for all Public and Private sources
- Training of the coders
- Updating of codes
- Addition of Codes

With the exception of the HSE PCRS system there is no repository for this data at the moment . A further issue will be the portability of data between the Public and Private hospitals and within insurers and the institution of a Unique Patient Identifier (UHI) for all members of the public to ensure portability of data, possibly using the U.S. Hospital Information and Portability (HIPA) Act model . This latter point would require legislation and Data Protection approval.

In respect of the former points a substantial investment in staff and IT systems would be required.

Further the concept of miscoding would require multiple bodies e.g. hospital, consultant and insurers to be involved in the coding and validation thereof in view of the cost effects of any errors of coding. The key role of the medical professional in the coding and response to coding question cannot be underestimated.

4.12 Do issues arise for private and public hospitals?

Should the DRG or ICD 10AM system be implemented, it will impose significant issues in terms of the coding staff to be available, the use of coding software and implementation of sophisticated IT systems (including grouper software) to be able to record such results. If the coding is not 100% consistent with will lead to incorrect charges which could cause commercial harm to insurers. Currently the system of ICD10AM coding is in use within the HSE system, but is not in use in any private hospital.

The implementation and use of such a system would require significant investment in training of staff, the recruitment of staff with specialist skills and investment in IT systems by the coders involved.

A further issue will be rationalisation of coding between the insurers and the health providers (hospitals) and their confirmation with the data input by consultants a significant investment in the training of all parties to the health insurance market is required. Failure to do this on a planned organised and integrated manner will mean that certain parties will not code and thus will leave the matter of coding to the insurers which may leave the system open to manipulation.

It would appear at this stage that HSE has made investment in certain of their hospitals to provide such functionality it may or may not be able to extend the system within the current fiscal restraints.

A full review of all patients files by HSE and private hospitals prior to billing could result in further patient payment delays, with potential effects on the current system of direct settlement which would appear to be in the patients financial interest. Form an insurer's point, these delays could increase the level of reserving required for IBNR and distort the results of any insurer.

In relation to private hospital providers many would not have the skills, capacity or financial availability to install such systems and would be seen that such a move would concentrate the financial resources within small number of larger private hospitals whilst closing smaller hospitals who are unable to invest in the level of technology required. Again, points in relation to staff availability and training would be required.

As stated above there is also a need that the universal health insurance (UHI) indicator be created, so that patients who switch between insurers can have the health status tracked.

- 4.13 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?

It would be particularly difficult to ensure that diagnosis related data was being treated consistently by hospitals and insurers. We cannot see how these difficulties could be overcome in a way that would make diagnosis related factors a feasible basis for a risk equalisation scheme in Ireland. Insurers would effectively have little to no control over the source and hence ability to check the accuracy of the data.

- 4.14 Should the differences in costs between diagnosis related risk factors be fully or partially equalized?

Aviva does not support the use of diagnosis related factors in a risk equalisation scheme.

- 4.15 Would a risk equalisation system based on diagnosis related risk factors be sufficiently effective in supporting community rating in the best interests of consumers?

Refer to 4.7.

4.16 Should insurers provide the data at a DRG level or at a DRG level category?

Neither option is appropriate.

4.17 How would you adjust the DRG approach in order to avoid a bias towards hospitalization where effective treatments outside of hospital are available and to allow for the rewarding of appropriate use of preventative medicine/treatments?

We cannot see a way in which an approach that is focused on categorisation of hospital based treatment can allow for preventative medicine. A system based on diagnosis related factors would remove the incentive for insurers to manage claims by measures aimed at improving the health of their customers so reducing the need for a hospital stay.

4.18 What are your views on using resource usage related risk factors in a risk equalisation scheme?

Aviva does not support the introduction of a health status measure in a risk equalisation scheme as we do not accept the unproven assertion in the consultation paper that within each age band, VHI members are, on average, in poorer health than those of Aviva and Quinn Healthcare. Additionally, after the market shares of older customers are rebalanced, our view is that the introduction of a health status measure will be unnecessary.

Notwithstanding this comment, we do not support the use of resource usage related factors as it would undermine the incentive for insurers:

- to manage claims by measures aimed at improving the health of their customers so reducing the need for (or length of) a hospital stay
- to negotiate favourable terms with providers as any benefit would be shared with competitors

VHI has a significantly higher proportion of members on higher benefit plans than the rest of the market, so collects the associated higher premiums. Basing risk equalisation on resource usage would unfairly result in competitors paying the risk transfers associated with these higher benefits without being able to collect the premiums.

4.19 What resource usage factors should be used?

Resource usage factors should not be used.

4.20 What data should be collected from undertakings in respect of resource usage factors?

No data should be collected

- 4.21 Should the differences in costs between different resource usage risk factors be fully or partially equalized?

Resource usage factors should not be used.

- 4.22 Would a risk equalisation system based resource usage risk factors be sufficiently effective in supporting community rating?

Refer to 4.7.

- 4.23 This consultation paper has suggested some possible measure of health status (underlying risk factors, DRGs, hospital utilization etc) that could be used in addition to age and gender. Are there other measures that might be adopted?

As stated above, Aviva does not support the introduction of a health status measure in a risk equalisation scheme.

- 4.24 Is it necessary to use more than one health status measure in a risk equalisation system, in order to ensure that it is effective in supporting community rating?

As stated above, Aviva does not support the introduction of any health status measures in a risk equalisation scheme.

## RESPONSES TO SECTION 5 OF THE CONSULTATION PAPER

**Please note that all answers in this section are based on the assumption that the market will undergo fundamental structural reform through the regulation, rebalancing and market share reduction of the VHI prior to the implementation of any form of risk equalisation.**

5.1 - To what extent should costs incurred providing primary care preventive treatment/care and care in the community be included in the system?

It would be desirable that such costs be allowed for within the costs of a risk equalisation scheme should one be implemented. Such costs are integral part of the continuum of treatment of a patient. Thus any RES scheme would need to be adapted to allow for the cost of the treatment based on proven outcomes. In addition, if the policy objective is to incentivize consumers to remain healthy then this should be supported by a risk equalisation scheme that rewards insurers who help their members achieve this goal. As such, insurers should not be penalised through the risk equalisation scheme by helping to improve members' health or by encouraging the use of primary care/community care rather than inpatient treatment.

However to do this, this would require the creation of agreed international pathways and local agreement with the ICGP, Medical Council and for those to be implemented within the current care system in Ireland. Thus 100% of costs included in this would need to be allowed for but based on agreed pathways, expected interventions and based on a system of quality measure outcomes which could be measured similar to the UK QOFF point's reimbursement for GPs. However it would be advisable to limit to the major chronic diseases only, as these would be the highest cost users of resources.

5.2 – How should the limits be set as to exclude what may be regarded as luxury benefits?

If the minimum benefit regulation sets out the basic minimum consumer protection then any product in excess of minimum benefit is by its own definition a luxury product. As such risk equalisation should be set at the same level as minimum benefits. The fact that the majority of the population purchase extra benefits or upgrades in accommodation is not a justification to set risk equalisation at this level.

The sole criteria of inclusion of cost must be based on clinical necessity, proven efficacy of treatment and outcomes. The definition "Luxury" is not a specific indicator of patient medical necessity. Thus once again pathways set out in 5.1 would require to be established which would indicate the level of treatments that are clinically reputable with proven outcomes. Thus treatments that have no clinical outcomes should be excluded.

However, the exclusion of certain treatments, which have a psychological benefit to the patient, would be a dangerous precedent as the use of many such Complementary and Alternative treatments (where properly regulated) have been shown in literature to have positive outcomes on members of all health statuses.

Question 5.3 – Should fixed price procedures be subject to different limits than other forms of treatment? How should fixed price procedures be defined?

The concept of Fixed Price Procedures (FPP) relates to the decision of VHI in the 1980's to cover certain selected procedures performed at the Blackrock Clinic and the Mater Private Hospital as an agreed length of stay for an agreed price. In addition higher rates of reimbursement were paid by VHI to their member who held plans, which did not fully cover these 2 facilities. The procedures at that stage were Cardio-Thoracic surgery, Complex Orthopaedics, Neurosurgery, Spinal Fusion and chemotherapy – which were not generally available in other private hospitals. This was part of the cover arrangements for these private hospitals requested by the Department of Health and Children to protect the VHI from increased claims costs of 2 new high cost hospitals.

This definition and cover is an anomaly, with these procedures now being performed at a range of other private hospitals. It has also been superseded by a range of newer complex procedures.

Thus there is no need for need for such a list as it undermines the choice of members as to the level of cover they may choose (for high technology hospitals) and restricts competition in the provision of certain new procedures. It is preferable for insurer / provider negotiations on new and existing high cost procedures to be performed without the imposition of legislation rates which may bear no reference to international cost comparators, patient safety or the capital and running costs for a procedure

## **RESPONSES TO SECTION 6 OF THE CONSULTATION PAPER**

**Please note that all answers in this section are based on the assumption that the market will undergo fundamental structural reform through the regulation, rebalancing and market share reduction of the VHI prior to the implementation of any form of risk equalisation.**

### 6.1 What are views of stakeholders in relation to this approach?

Aviva would strongly object to the imposition of a transitional arrangement and would question the necessity of putting in place such a scheme. This would in effect mean that Aviva would have to comply with three differing sets of schemes over a three year period and adapt its systems and operations accordingly. This would appear to be an unjustified expense for the sake of a transitional arrangement. If the Authority questions the data received and wishes to review such then this should be built as a safeguard into the proposed risk equalisation scheme rather than putting in place another set of compliance requirements. Regulatory and commercial certainty for market participants cannot be guaranteed if the regulatory position changes on an annual basis.

The Authority must have faith in the validity of its proposed scheme rather than seeking to road test this through some transitional arrangement. Furthermore, the Authority must be confident of the legality of its proposals and this cannot be evaded by seeking to hide behind a transitional tax arrangement. If there are competition and regulatory problems with the risk equalisation scheme then these should be addressed rather than muddied through a tax arrangement.

### 6.2 What type of data would be necessary under this approach in order to assess the extent to which differences in claims costs for each age group between insurers arise from health status differences or from other causes?

As stated above Aviva does not agree with the necessity for any measure on health status.

### 6.3 Would it be possible to adapt this kind of approach when designing a robust system? How would this be done?

Once structural market change has occurred and a risk equalisation scheme is put in place there is a need to ensure that all costs with the market are properly accounted for. In addition, should any undertaking be purposefully engaging in activities which would create a loss making scenario these should not be factored into any determination of risk equalisation. Similarly, there should be a safeguard within the proposed risk equalisation scheme to ensure that no undertaking receives overcompensation from the scheme.

## **RESPONSES TO SECTION 7 OF THE CONSULTATION PAPER**

**Please note that all answers in this section are based on the assumption that the market will undergo fundamental structural reform through the regulation, rebalancing and market share reduction of the VHI prior to the implementation of any form of risk equalisation.**

Question 7. 1 – Should the system include special provisions for new entrants? How should these provisions be framed?

As set out above under the Section on Recommendations if structural remedies were put in place prior to the initiation of any risk equalisation scheme then automatically there could be at least five competitors in the market. Once this has been achieved then the competition safeguards as set out in the Aviva proposal for risk equalisation could be implemented to encourage new entrants and foster competition.

Question 7.2 – Should the risk equalisation transfers take into account the amount of lifetime community rating loadings that an insurer receives and if so, how should the transfers incorporate these loadings?

Loadings to the premiums of older persons, new to the health insurance market will support the claims costs of these customers so to avoid double counting they should be allowed for in the risk equalisation scheme. However, this should be subject to a materiality threshold as it is expected that these loadings will only be significant in the medium term.

Question 7.3 How should the new risk equalisation scheme take account of changes in minimum benefit regulation?

If the minimum benefit regulation sets out the basic minimum consumer protection then any product in excess of minimum benefit is by its own definition a luxury product. As such risk equalisation should be set at the same level as minimum benefits. The fact that the majority of the population to purchase extra benefits or upgrades in accommodation is not a justification to set risk equalisation at this level. In Holland and Germany there is one plan which is set out by legislation and it is this plan that is subject to risk equalisation – there is not a two tier level where consumer protection is set below the level for risk equalisation.

In addition, if primary care and chronic disease management are specified within minimum benefits insurers cannot then be penalised through the risk equalisation scheme for encouraging healthy behaviours in its members and also encouraging the use of cheaper facilities.

7.4 Should the risk equalisation calculations of the authority be published?

In the interest of transparency Aviva would support a completely transparent risk equalisation scheme including the publication and justification for any determinations reached by the appropriate regulatory authority on risk equalisation.

## **CONCLUSION**

Aviva believes it is premature to design any risk equalisation scheme without firstly carrying out the other reform measures announced by the Minister for Health and Children in May 2010. In particular, in the interest of achieving a long term vibrant community rated competitive market the dominance, lack of regulation and re-balancing of the VHI must be addressed.

In addition, the Authority should have due regard to the recommendations and conclusions reached by the:

- Competition Authority Report;
- The Barrington Report;
- The High and Supreme Court judgments.

Aviva would welcome the opportunity to meet with the Authority to discuss the submission and how best to achieve an affordable, consumer orientated and competitive health insurance market.

## **APPENDIX 1 – REGULATORY IMPACT ANALYSIS**

Under the Revised RIA Guidelines of June 2009 a set recommended process for the implementation of RIA is set out. Within these recommendations, it is stated that consultation with key stakeholders should start as early as possible a draft RIA should be used as the basis for the consultation. However, the current consultation document by the Authority would not appear to have followed this best practise as no draft RIA is attached.

Furthermore, the RIA should evolve as the consultation process proceeds and be published for stakeholders to assess and review. To merely, state that the RIA principles will form part of advice from the HIA to the Minister does not seem to fulfil these basic criteria.

An RIA must consider a number of policy options and then set out the benefits, costs and impacts of all options. In addition, the Guidelines require that at least three options be considered within the RIA. As previously stated above, Aviva would submit that the current consultation process initiated by the HIA firstly does not consider any alternatives to the proposed risk equalisation scheme and secondly does not even quantify the costs, benefits and impact of those options on any undertaking other than VHI.

The Guidelines state that alternatives to regulation must be considered, alternative forms of regulation should be considered and alternative implementation options should be considered, none of these factors have been reflected in the current consultation.

Also notable is the absence of any set of performance indicators of the RES scheme; there is no consideration or detailed analysis of what will occur to premiums and the impact this will have on consumers. The HIA must as a matter of urgency carry out detailed consumer research on the amount of price elasticity in the market prior to make any recommendations that could cause permanent damage to all undertakings in the market.

The RIA guidelines also state that an impact analysis must be considered under the following headings:

- a) National Competitiveness
- b) Compliance Burden
- c) Whether there is a significant policy change in an economic market, including consumer and competition impacts
- d) Impact on Socially excluded or vulnerable groups
- e) The environment
- f) The rights of citizens
- g) North-South and East-West Relations

While not all the headings set out above would be of relevance in the current consultation, the following would appear to be fundamental in relation to any consultation on the risk equalisation scheme:

### **a) National Competitiveness**

Analysis must be carried out about the added cost burden to both insurers in the market but also to the cost of employers funding health insurance for their

employees. This additional cost burden must then be viewed against the challenges currently experienced in national competitiveness.

Aviva: An increase of 20% on health insurance premiums will cause an unnecessary inflationary rise in costs to both employers and individuals which will have a direct impact on national competitiveness within Ireland.

#### **b) Compliance Burden**

Detailed analysis of the additional costs of compliance for all stakeholders impacted by the proposals must be set out. These additional compliance costs must be viewed in light of the cumulative effect that compliance already has for undertakings, in particular, where the largest insurer bears no cost of compliance from the Financial Regulator. The relative impact of the costs vis-a-vis the relative size of insurers must also be measured. The costs to health care providers who will also have to assist in any of the proposals must be quantified and the consequences of where these additional costs will be funded must be assessed.

Aviva: The cost of implementation of the proposed risk equalisation scheme will add approximately an additional 10% administrative compliance burden across the entire health care market.

#### **c) Whether there is a significant policy change in an economic market, including consumer and competition impacts**

Guidelines 4.55 and 4.56 of the RIA state:

“Greater competition stimulates innovation and efficiency among businesses, contributes to lower prices of goods and services for consumers and enhances overall national competitiveness.”

#### **d) Impact on Socially excluded or vulnerable groups**

Thorough analysis and research needs to be conducted by the Authority on the impact of the proposed scheme on both affordability (for all policyholders in the market not only VHI members) and the likelihood of a further contraction in the overall market size. In addition, this must be balanced with the cost of these additional persons now seeking recourse to the public health system. In order for the health insurance market to function there is a need for a continuous stream of new members to the market; however, no analysis has been carried out of the pricing point at which such members will choose not to purchase health insurance. RES will inevitably lead to premium increases to competitors of VHI, in addition, the Competition Authority in its report found that RES payments would remove VHI pricing competition as such as an economic entity it would seek to maximise its pricing potential. No competitive analysis on this issue has to date been published by the HIA.

### **Proportionality**

The test for proportionality set out within the RIA guidelines is: Are we satisfied that the advantages outweigh the disadvantages of the regulation? Is there a smarter way of achieving the same goal?

While the HIA has examined the impact on VHI of its older age profiles and its alleged unhealthier members no analysis has been done of the impact of the proposed scheme on competitors and how proportional this measure is to the damage it may cause to commercial undertakings. Similarly, no balancing of the various consumers' rights has been considered and in particular the affordability crisis that may ensue.

While it is contended that the VHI carries the burden of cost on the older member, there is no assessment of the premium levels which these older members pay i.e. is a 65 year old on Plan E truly unprofitable? It is suggested that the HIA make inquiries with private hospitals about the profitability or otherwise of this segment of members.

The entire premise of the consultation paper relies on the average claims costs of VHI versus its competitors. However, the Department of Health and Children as the owners of the VHI are currently investigating the claims costs of the VHI and have commissioned a report to understand the large claims increased experienced only by the VHI in the last two years. Aviva would therefore question the implementation of a consultation process based on data that is subject to investigation and which may prove to be unreliable.

The HIA has also failed entirely to consider any options other than the implementation of risk equalisation or explored the possibility that other changes with a lesser impact on competition and consumers could be instigated. For example, the Minister in her announcement in May 2010, stated that she would be:

*“investigating which actions that can be taken to achieve a much more even balance of older customers between the health insurance companies in the market.”*

Quite apparently any such measure will have a huge impact on the proportionality or otherwise of the risk equalisation scheme. That no consideration is given to this question and how it might impact on the proposal is indicative of the narrow investigation of the market conducted by the HIA. While it may be stated that this matter is one for the Department of Health and Children this only shows the fragmented approach to policy making within the health insurance market and enhances the uncertainty of regulation for insurers. If no one body has full overview and responsibility for all features within the market then invariably regulatory distortions will arise in particular in a market where so many factors are inextricably intertwined. For the HIA or the Department of Health to merely state that it cannot engage in a matter because it is the responsibility of the other makes for bad regulation and fragmentation of policy making.

The RIA guidelines state that the more significant the impact the deeper the analysis that is required of any measure. It is undeniable that both the previous RES scheme and the proposed harsher scheme will have a profound effect on the market and in particular on competitors of the VHI. More importantly this RES scheme will have substantial repercussions for consumers both in terms of affordability and choice.

### **Transparency**

The RIA Guidelines set out the test for transparency: have we consulted with stakeholders prior to regulating? Is the regulation in this area clear and accessible to all? Is it supported by good explanatory material?

As previously stated, Aviva does not believe there has been adequate or proper consultation on the fundamental policy issues being determined at present. In particular, the consultation issued by the HIA cannot be considered adequate as it has already predetermined the larger policy questions and is now only seeking advise on technical details on how best to implement these policy questions. In addition, to date the HIA has never set forth any other policy option other than the subsidisation of VHI through RES.

The present consultation also fails to be clear in that from its recommendations it is impossible for Aviva to determine the size of the subsidy it will be required to pay to VHI and hence creates a high uncertainty for its financial planning and for its future projections for regulatory capital. Additionally, as the consultation fails to detail or clarify how the other reforms in the market will operate it makes it practically impossible for any competitor of VHI to each any determination on what impact it will have on its future viability.

The explanatory material set out by the HIA does not allow for any verification of the information set out or clarity as to how certain fundamental matters were determined.

### **Necessity**

The RIA Guidelines set out the test for necessity:– is the regulation necessary? Can we reduce red tape in this area? Are the rules and structures that govern this area still valid?

The policy decision to introduce the last risk equalisation scheme lead to litigation by all parties both in Ireland and in Europe. In addition, it ultimately led to the exit of one player from the market. There must now be a fundamental re-examination of whether the continued validity of this policy under current market conditions in light of the inherent contentiousness that it causes – a proportional and reasonable solution for all players in the market must be considered. Failure to reach a consensus with all stakeholders to finally determine a long term solution that brings stability to the market can only have the same repercussions.

### **Effectiveness**

The RIA Guidelines set out the test for effectiveness:– is the regulation properly targeted? Is it going to be properly complied with and enforced?

The HIA must fundamentally analyse the consequences to consumers and all undertakings in the market of its proposals. Future projections on both affordability and an impact analysis of the commercial and regulatory impact of RES in the forthcoming years must be carried out for all undertakings and not merely the VHI.

### **Accountability**

The RIA Guidelines set out the test for accountability:– is it clear under the regulation precisely who is responsible to whom and for what? Is there an effective appeals process?

One of the deep-seated problems prevailing in the health insurance market is that no one over-arching body has accountability and responsibility for overseeing the market as a whole. The HIA will only deal with select matters in the health insurance market from an undertaking and consumer perspective. The Department of Health and Children has responsibility for some policy issues on health insurance, has responsibility as shareholder of VHI but with apparently limited powers of intervention. The Department of Health and Children is also the reporting department of the HIA and also the ultimate Department for all the public hospitals, which provide services to health insurers. The Financial Regulator

regulated two out of three undertakings in the market from a prudential and also consumer mandate. Finally, the Competition Authority has a role vis-a-vis competition policy in the market. In many instances it is very difficult to determine who is responsible for what within the market and where (if anywhere) to seek redress for problems.

### **Consistency**

The RIA Guidelines set out the test for consistency: – will the regulation give rise to anomalies and inconsistencies given the other regulations that are already in place in this area? Are we applying best practise developed in one area when regulating other areas?

As stated previously the narrow scope of this consultation with its complete failure to examine the other aspects of the health insurance market means that this proposal can only but create anomalies. At its most basic the proposal to purely set out to equalise claims in order to ensure a level playing field while not taking into account the huge distortion by the failure of VHI to operate under normal prudential regulation is a massive anomaly. One cannot seek to equalise purely one side of the equation without seeking also to equalise the other. The huge discrepancies in regulatory treatment have never been more apparent than in recent times when one can juxtaposition the treatment of the Financial Regulator over the Quinn Insurance Company against the treatment of the equally (if not more so) insolvent VHI. While it may be argued that such matters fall outside the remit of the HIA this only highlights the accountability issue set out above.

When looking at the treatment in other markets of other former state monopolies i.e. utilities – in each of these markets structures have been put in place to encourage and facilitate competition with direct mandates to reduce market shares. However, to date all policy steps implemented in the health insurance market have been diametrically opposed to the best practise for utilities.