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**Staff Report to Members of The Health Insurance Authority in relation to its statutory functions and duties regarding risk equalisation.**

April 2005.

*[Ed note: This Report has been slightly redacted for circulation to registered undertakings on 18 May, 2005. The redaction involved the removal of short sections in accordance with the Authority's policy in relation to the confidentiality of discussions with potential new entrants.]*

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## Introduction

This document was prepared by Staff of The Health Insurance Authority (the Authority) in order to inform the Authority's deliberations on whether or not to recommend that risk equalisation payments be commenced. It is set out in accordance with the format previously used for Staff reports on risk equalisation.

This report takes account of the representations received from insurers in response to the Authority's proposed recommendation of 15 March, 2005. An examination of each of the representations received is included in Section G. In that section the arguments made by insurers are in normal type, while comments in relation to them are in blue type.

Changes were also considered in respect of Sections B to F of the Staff Report of 8 March to take account of the representations of insurers. These changes are also in blue type.

This report is structured as follows:

**Section A** briefly reviews the preliminary views of the Authority as set out in its *Policy Paper on Risk Equalisation in the Irish Private Health Insurance Market*, September 2002 ("Policy Paper").

**Section B** proposes some more detailed views than those outlined in the Policy Paper and also expands on these views. In this section areas of debate in relation to risk equalisation are grouped under 7 headings:

1. The theory of risk equalisation,
2. Risk equalisation and community rating, open enrolment and lifetime cover,
3. Risk equalisation and the facilitation of competition,
4. Risk equalisation and excess profits,
5. Risk equalisation and the dominance of Vhi Healthcare,
6. Risk equalisation and new entrants and
7. Risk equalisation and international experience.

**Section C** raises matters relating to the nature of the data requested in returns and the assumptions adopted by insurers in making these returns that might be pertinent to the Authority's deliberations.

**Section D** considers some developments since the Authority's last decision regarding risk equalisation.

**Section E** reports on the market, providing information that is relevant to the issues that the Authority has stated it considers relevant to its deliberations.

**Section F** sets out the considerations of the Staff of the Authority.

[Section G](#) includes an examination of the representations received in response to the Authority's proposed recommendation of 15 March, 2005.

Appendices I - IV include arguments for and against risk equalisation that were put by the Authority's advisers and by other sources that made submissions to the Authority as part of the risk equalisation consultation process. In each case the arguments are grouped under the same headings and using the same numbering system as are used in Section B in order to facilitate cross-referencing.

**Appendix I** lists the arguments for and against risk equalisation that were listed by the Society of Actuaries in Ireland in its submission to the Authority. We also include the views of the UK Government Actuary's Department ("UK GAD") in relation to each of these arguments.

**Appendix II** includes arguments provided by Andersen Consulting.

**Appendix III** includes findings of the research into competition in the Irish Private Health Insurance market undertaken by York Health Economic Consortium for the Authority.

**Appendix IV** includes arguments in the different submissions that the Authority received, as part of its consultation process.

**Appendix V** outlines the time constraints under which the Authority will be operating and sets out the length of time that the process of commencing risk equalisation payments (if such a decision were taken) would take.

## **Section A. Short review of the Authority's Policy Paper**

The Authority's role in relation to risk equalisation is set out in the Health Insurance Acts, 1994 to 2003 (the Acts) and in the Risk Equalisation Scheme, 2003 (the Scheme). The Acts state that the Authority, when making its Report to the Minister, should in certain circumstances "*include in that report a recommendation by it that the Minister ought or ought not (as it considers appropriate having regard to the best overall interests of health insurance consumers) to exercise the power hereafter mentioned*".

The Act goes on to provide some guidance on the definition of the best overall interests of health insurance consumers. It states "*the best overall interests of health insurance consumers includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings*". In recommending whether or not risk equalisation ought to be implemented, the Authority must therefore have regard to the best overall interests of health insurance consumers. The Act requires the Authority to consider specifically maintaining community rating and facilitating competition in defining the best overall interests of health insurance consumers. When considering whether consumer interests are being served in the market, the Authority will consider all health insurance consumers, i.e. young, old, healthy and less healthy consumers.

The principle of community rating, together with open enrolment and lifetime cover helps to make private health insurance affordable for those who need it most. However, the Authority is aware of the difficulties that can arise for a community rated market, particularly the difficulties that can arise when risk profiles differ significantly between insurers in the market. Two potential difficulties that concern the Authority are described below.

### *Price Following*

An insurer with a significantly lower risk profile might be in a position to charge a considerably lower premium as a result of its lower claim costs. However, it might choose instead to set its premium at a level slightly below the premium of other insurers with higher risk profiles. From the point of view of the insurer with the lower risk profile this could be viewed as a sensible strategy. Setting its price slightly below the prices of other insurers would assist it in attracting a significant proportion of the new entrants to the market and some better risks from the other insurers, but would avoid attracting too many higher risks from the other insurers. This could result in the claim costs of the insurers with the higher risk profiles rising further as they fail to attract or retain sufficient low risk consumers. The insurer with the lower risk profile could again follow these price increases and the process would continue.

The overall market effect would be that all consumers would pay a premium close to the premium required to cover the claims of the insurers with the highest risk profiles and if the risk profiles of these insurers continued to worsen as described above, the premiums for all consumers would continue to rise.

### *Predatory pricing / Death Spiral*

The scenario is that an insurer with a much lower risk profile chooses to charge a significantly lower premium because it experiences lower claim costs. This premium might be significantly lower than the cost of insuring the market as a whole. The average claim of other insurers may increase, as the insurer charging a low premium might primarily attract younger, healthier, more mobile consumers with relatively low claim costs. The other insurers may not be able to reduce premiums to attract the low risk consumers back as their average claim would be too high. These insurers may ultimately be forced out of the market.

Older consumers would have the option, of course, of joining the insurer charging the lower premium, however, many older consumers might be more reluctant to move their insurance. If the insurers with higher risk profiles were driven out of the market, older consumers would join the insurer charging the lower premium. This insurer's average premium would have to rise to cover the higher risk consumers and another insurer with a low risk profile could pursue a predatory pricing strategy. Alternatively the insurer may not be willing to accept all of the high risk consumers and may opt instead to leave the market entirely or another possibility is that confidence in the market might be undermined causing some consumers to opt out of health insurance completely.

In the absence of other mitigating factors, the above scenarios are clearly not in the "best overall interests of health insurance consumers". The potential for them to arise stems directly from a significant difference in risk profiles existing in a community rated market with open enrolment and lifetime cover. The Authority is therefore of the view that the introduction of risk equalisation could be justified in the appropriate circumstances. However, the Authority recognises that intervention may not always be appropriate to address difficulties in the private health insurance market and where intervention is necessary risk equalisation may not be the most appropriate or even an appropriate form of intervention to use.

The Authority will need to be mindful of the likely effectiveness of risk equalisation in addressing any problems existing in the market and any potential harm that the commencement of risk equalisation may cause to the best overall interests of health insurance consumers. In this context the Authority will be particularly mindful of the level of competition existing in the market at the time and of the likely effect that risk equalisation would have on competition in the market.

When considering whether or not risk equalisation should be commenced in the best overall interests of health insurance consumers, the Authority will therefore consider, *inter alia*, matters such as

- the differences in risk profiles between insurers,
- the relative sizes of insurers,
- the age / sex profile of insurers' policyholders,
- the rate of premium inflation,
- the number of insurers in the market / new entrants to the market,
- the effect of any transfer on premiums payable by consumers,

- the overall size of the market,
- the effect of payments on the business plans or solvency of insurers and
- the commercial status of insurers.

## **Section B. Proposed Authority views**

As stated in the introduction, we have grouped the arguments for and against risk equalisation into seven areas of debate. The Authority has already considered some of these areas of debate in its Policy Paper on Risk Equalisation. However, in order to address what appear to the Authority to be the major arguments for and against risk equalisation it is necessary to expand on some of the arguments set out in the Policy Paper. In this section, we set out proposed views that the Authority may consider adopting in relation to each area of debate. These views, wherever possible, reflect the preliminary views of the Authority as set out in its Policy Paper.

### **1. Theory of Risk Equalisation**

Difficulties can arise for a community rated market in the absence of risk equalisation. The commencement of risk equalisation payments is therefore justifiable in the appropriate circumstances.

### **2. Risk Equalisation and Community Rating, Open Enrolment and Lifetime Cover**

Community rating, together with open enrolment and lifetime cover helps to make private health insurance more affordable for those who need it most. The maintenance of these principles is, therefore, in the best overall interests of health insurance consumers. Furthermore, the Act specifically requires that the Authority have regard to the need to maintain community rating across the market for health insurance when deliberating on whether or not to recommend that risk equalisation payments be commenced.

Risk equalisation cannot in itself guarantee the stability of a community rated market, however there are difficulties that can arise for a community rated market that risk equalisation could address in the appropriate circumstances.

### **3. Risk Equalisation and Competition**

The Authority is aware of the many benefits that competition can bring for consumers and considers it entirely appropriate that there is a significant emphasis on the facilitation of competition in the legislation governing risk equalisation. Indeed the legislation specifically states that the facilitation of competition is included in the best overall interests of health insurance consumers to which the Authority must have regard when deliberating on whether or not to recommend that risk equalisation payments be commenced.

When considering the relationship between risk equalisation and competition, the Authority will have regard for the effect of competition within different segments of the market (in particular the segments of the market for older and younger

consumers), the effect of different facets of competition (e.g. price competition, service competition, product competition) and the basis on which companies are in a position to compete (e.g. innovation, efficiency or regulatory advantage). The Authority will also consider the extent to which a risk equalisation scheme can result in the sharing of efficiencies across undertakings.

#### Competition in different segments of the markets

In a community rated market without risk equalisation there is little or no incentive to compete for high risk lives and it has been argued that this benefits community rating by encouraging insurers to recruit low risk lives, which keeps the average cost of claims and therefore premiums down. Risk equalisation would provide greater incentive for insurers to recruit higher risk members.

The Authority is aware that a community rated system could become destabilised if there is a dramatic shift in the age profile and that encouraging competition for higher risk lives could result in such a destabilisation. However, a system that implicitly discourages insurers from competing for older lives in favour of younger lives and thereby encourages them to develop products and services for the younger market could be considered to be counter to the principles of community rating. Furthermore, it is considered that it will always be in the interests of insurers to attract younger policyholders, especially when the low level of switching that exists between insurers is considered. Having said that, we cannot disregard any potential effect that introducing risk equalisation might have on the stability of the community rating system and it would therefore be preferable if unfunded lifetime community rating were introduced as the Authority has already recommended.

#### Different facets of competition

Competition can benefit consumers in a number of different ways including through price competition leading to lower premiums; greater choice of products and product innovation; and improvements in the service provided by competing insurers.

The fiercest price competition is most likely to arise in a community rated market where there is no risk equalisation and no prospect of risk equalisation. This is because such a market would be very attractive to new entrants who could, all things being equal, expect to initially recruit low risk lives and therefore pay a low level of claims. Furthermore, it may be difficult for later new entrants to attract significant membership purely by offering a relatively small discount on the dominant insurer's price, if there were another more developed brand operating on the same basis. In these circumstances the third or subsequent entrant might either offer a significant discount in price or differentiate itself in some other way such as on the basis of product, service or marketing. However, the fierce price competition that might ensue in such circumstances might come at the effective loss of community rating. As noted earlier, insurers with higher claim values may not be able to compete with the significant discounts offered and might lose significant numbers of their lower risk members. The result could be a

destabilising effect on the high-risk insurers and on the community rated market as a whole.

The Authority would not predict that the commencement of risk equalisation payments would result in a significant reduction in premiums but in certain circumstances it could result in a moderation of premium inflation, which could have a very significant effect over time. In particular, if price following existed in the market the introduction of risk equalisation may result in a moderation in the rate of premium inflation by enabling the higher risk insurers to compete on price. However, any commencement of risk equalisation payments, while enabling an insurer with a higher risk profile to compete on price, could have a detrimental impact on the ability of other insurers to compete and might not result in lower prices to the consumer. In this context Vhi Healthcare's market share, the fact that it is exempted from certain requirements of the Non-Life Directives and of the Insurance Acts, as well as the fact that it does not have a commercial mandate, should be noted as they could affect the ability of other insurers to compete with it. When considering the facilitation of competition between undertakings, the Authority will consider the extent to which insurers are in a position to compete both before and after any commencement of risk equalisation payments.

#### Basis for Competition

Insurers can compete with each other on the basis of *inter alia* greater efficiency, quality, innovation, a powerful brand or regulatory advantage. While competition through lower premiums, based on efficiency, quality and innovation are desirable, competition through lower premiums based on the regulatory structure can be undesirable. In particular, insurers with a lower risk profile (whether deliberately or accidentally achieved) should, all other things being equal, be in a position to charge lower premiums in a community rated market than an insurer with a higher risk profile. This can facilitate less efficient insurers and / or insurers taking excess profits that have lower risk profiles in competing with more efficient insurers. Likewise, insurers that do not enjoy excess profits can introduce higher levels of inefficiency.

The Authority has had regard to the effect that a requirement to pay risk equalisation transfers might have on the ability of new entrants to compete, as noted in the section relating to new entrants. The Authority is of the view that, including in the light of, the three year exemption from making / receiving payments as well as the further 6 – 12 month period during which only partial payments are made / received under a risk equalisation scheme, the Irish private health insurance market would retain the potential to attract further new entrants following any commencement of risk equalisation payments.

#### Sharing of Efficiencies

The extent to which risk equalisation may result in the sharing of efficiencies would depend on the type of scheme commenced. As stated in its Policy Paper, the Authority would wish to eliminate any such inappropriate sharing of efficiencies. The fact that risk equalisation may result in the sharing of efficiencies may be a matter of concern to the Authority and will influence its

deliberations. In particular, concerns regarding the proportionality of any scheme commenced would be considered in this regard.

#### **4. Risk Equalisation and Excess Profits**

References in this Report to “excess profits” shall, save when the context might imply otherwise, refer only to that element that is super-normal in economic terms and where that element is facilitated by the regulatory regime.

The Authority recognises that companies have a right to maximise their profits and that, in a competitive market, efforts by companies to maximise profits can serve the best overall interests of health insurance consumers by, for example, improving efficiencies and keeping the cost of healthcare services down. However, it would be a matter of concern to the Authority if the regulatory structure facilitates insurance undertakings in earning excess profits to the detriment of the best overall interests of health insurance consumers. Such a situation can develop as outlined in the section of the Policy Paper that deals with price following. As noted, price following can occur and can lead to consumers being charged excessive amounts to fund the excess profits of insurers if risk profiles vary significantly in a community rated market. Risk equalisation could limit the extent to which price following could occur by sharing the total risk in the market between insurers.

However, the Authority will need to consider the possibility that excess profits may merely be passed from one insurer to another. In order for risk equalisation to result in a benefit for consumers in the context of reducing or removing excess profits, which had arisen by virtue of the regulatory regime, either a competitive market must exist after the introduction of risk equalisation or there must be some other effective mechanism that would be likely to result in a situation in which consumers do not continue to be overcharged.

The Authority’s concerns in relation to excess profits facilitated by the regulatory regime, also apply to other areas affecting the consumer’s value for money such as the regulatory regime supporting relatively inefficient insurers.

#### **5. Risk Equalisation and the Dominance of Vhi Healthcare**

As noted above a lack of competition in the market could affect the extent to which risk equalisation can be effective in serving the best overall interests of health insurance consumers. Currently, there are a number of matters, which could affect the ability of other insurers to compete with Vhi Healthcare. Some of these matters relate to the size and the brand of Vhi Healthcare, others relate to the facts that Vhi Healthcare operates on a non-commercial basis, it is not subject to normal solvency requirements and it is exempted from the Insurance Acts and the Non-Life Directives. The Authority will consider such matters insofar as they affect the extent to which other insurers are able to compete with Vhi Healthcare as well as considering how they affect the other interests of health insurance

consumers, e.g. Vhi Healthcare's non-commercial basis as well as its economies of scale may result in lower premiums being charged to consumers.

The Authority does not consider that the ownership of any insurance company in the market is directly relevant to the argument.

## **6. Risk Equalisation and New Entrants**

The Authority recognises the benefits that new entrants to the private health insurance market could bring for consumers. The Authority also recognises that risk equalisation could impact on the attractiveness of the Irish market to new entrants. Three ways in which risk equalisation could impact on the attractiveness of the Irish market are:

- (i) In time, a new entrant would be likely to be a net contributor to a risk equalisation fund if payments were commenced and therefore a community rated market without risk equalisation would be more attractive to a new entrant than a community rated market with risk equalisation.
- (ii) Lack of certainty with regard to whether or not risk equalisation will be commenced could make it difficult for new entrants to develop business plans.
- (iii) The commencement of risk equalisation payments may be seen by some potential new entrants as an unwelcome increase in Government / regulatory intervention in the market.

The impact of risk equalisation, however, is viewed within the context of other disincentives to new entrants joining the market such as the following:

- The commercial and regulatory status of Vhi Healthcare, the strength of Vhi Healthcare and question marks over its future ownership;
- The regulatory framework;
- The current high level of market penetration and the relatively small market size; and
- A perceived high level of entry costs including reputational risks and potentially risks to other areas of business.

Considering the benefits that new entrants could bring to the market, the Authority recognises that it may be beneficial to have some form of incentive to encourage new entrants to enter the market. However, the Authority is of the view that, including in the light of, the three year exemption from making / receiving payments as well as the further 6 – 12 month period during which only partial payments are made / received under a risk equalisation scheme, the Irish private health insurance market would retain the potential to attract further new entrants following any commencement of risk equalisation payments.

If uncertainty over the final implementation of risk equalisation and over the status of Vhi Healthcare is resolved in the short term, the health insurance market in Ireland should still attract some new entrants, but fewer than if risk equalisation payments are not implemented. With regard to the lack of certainty in relation to risk equalisation, the Authority appreciates that this can cause difficulty when devising business plans. The Authority will bear in mind the importance of not perpetuating this uncertainty unnecessarily.

## **7. Risk Equalisation and International Experience**

Significant differences exist between the private health insurance markets in different jurisdictions. Such differences relate to, *inter alia*, different regulatory regimes, different market structures, the existence of a compulsory health insurance system and services provided by public healthcare systems. The Authority is of the view that the existence of such differences limits the value of comparisons with international experiences to its deliberations in relation to risk equalisation.

## **Section C. Returns made under the Risk Equalisation Scheme, 2003**

The analysis in this report is, to a significant extent, based on the risk equalisation returns received from scheme undertakings for the period 1 July 2004 to 31 December, 2004. Where appropriate, reference is also made to the previous sets of returns filed with the Authority, for the periods 1 July 2003 to 31 December, 2003 and 1 January, 2004 to 30 June, 2004. Before discussing the analysis we will review the nature of the data received.

### Insured Persons and Settlement Dates of Claims

The returns provide information on the number of “Insured Persons” at the beginning of each quarter in the period (i.e., the number of insured persons is provided as at 1 July, 2004 and 1 October, 2004). Therefore, assuming that membership changed linearly between 1 July, 2004 and 1 October, 2004, the figures would, on average, relate to the middle of August. The definition of “Insured Person” excludes those that are serving waiting periods and those that hold policies that are not subject to risk equalisation (e.g. outpatient policies).

The figures for claims included in the returns relate to claims settled in the period 1 July, 2004 to 31 December, 2004. There is a significant time lag between when claims are incurred and when claims are settled. BUPA Ireland inform us that 90% of claims are settled within about 6 months or less (Vhi Healthcare inform us that their claims are settled more quickly). As a result of this time lag, it is reasonable to assume that the period during which claims are incurred is, on average, earlier than the date on which the number of insured persons is counted. This can have an impact when one of the insurers is growing or reducing at a significant rate. We would estimate that in the case of these returns it could cause the returned values of BUPA Ireland’s claims per member and treatment days per member to appear in the region of 2-3% lower than would otherwise be the case.

Furthermore, basing the returns on settled claims gives a significant amount of control to undertakings in deciding whether claims are included in one set of returns or another. For example, an insurer could decide to settle a large number of claims in June, 2004 and / or January, 2005 rather than during the period concerned. Potentially this could have a significant impact on individual returns. However, all claims would have to be settled at some point so that inflating claims in one period in this way would lead to a deflation in claims in another period and vice versa.

### Seasonal Effects on Returns

The returns received by the Authority cover the period 1 July, 2004 to 31 December, 2004. It is possible that there could be seasonal variations in returns due to, for example, holiday seasons in hospitals or in insurers, or seasonal factors in illness trends.

### Inconsistencies in Returns

In the last set of returns received by the Authority, an inconsistency arose, relating to the application of the definition of a health services provider and, in particular, whether the cost of treatment in diagnostic centres should be included in returns.

Data has been provided from BUPA Ireland and Vhi Healthcare in relation to the diagnostic centres, to which payments are made, which are included in or excluded from returns. There is some inconsistency between the centres included for each undertaking. However, the Authority is not in a position to direct which payments should or should not be included in returns. The Scheme would need to be amended accordingly to eliminate this inconsistency. Although it is not thought that this matter would have a significant effect on returns, in its last Report to the Tánaiste and Minister for Health and Children, the Authority recommended that such an amendment be made, in the context of other proposed amendments that had been suggested in its previous Report.

There may also be a minor inconsistency in respect of the extent to which insurers include claims paid to individuals serving waiting periods in their returns. Again, it is considered that this matter would not have a significant impact on the figures included in returns.

With the experience of having analysed the first two sets of returns, the Authority prepared draft forms for collecting further information, in relation to how the figures included in returns from insurers are arrived at, that may be helpful when validating returns. It was intended that this breakdown of information would serve to clarify whether or not insurers are completing returns on a similar basis. In particular, the Authority is interested in a breakdown of total insured persons and total benefits paid, including those insured persons and benefits paid that are not subject to the Risk Equalisation Scheme.

BUPA Ireland submitted the forms with their returns for the period 1 July, 2004 to 31 December, 2004. Vhi Healthcare and ESB SMPF both responded to the request stating they would be unable to provide the information with this set of returns, although Vhi Healthcare have undertaken to submit the forms with the next set of returns.

While the effect of the inconsistencies noted above may not be significant in the context of the Market Equalisation Percentage or in the context of the Authority's current deliberations, they could be significant in the context of any possible future transfers. For example, an inconsistency that affects the MEP by .05 percentage points could equate to a difference in transfers of more than €300,000 p.a. Working a scheme in which there is such uncertainty in relation to the correct level of transfer would pose serious difficulties. These difficulties could be addressed through the amendments in the legislation / regulations that the Authority proposed in previous risk equalisation reports. The Department of Health and Children has recently

indicated that the Tánaiste would be amenable to considering amendments to the Scheme, of the kind suggested by the Authority.

#### Amendment to Returns

The Authority received an amended return from Vhi Healthcare on 28 February, 2005 after a significant part of the analysis set out in this document had been completed. The amended return forwarded by Vhi Healthcare was carefully considered by the Authority and was forwarded to UK GAD in order to ascertain whether the amended return would have a material impact on the analysis set out in this document. It was agreed that the effect was not material. The analysis in this document, therefore, uses the data set out in the return forwarded by Vhi Healthcare on 28 January, 2005. The immateriality of the effect of the amended return is apparent from considering the table below:

	If Vhi Healthcare's Return of 28 January, 2005 is used	If Vhi Healthcare's Return of 28 February, 2005 is used
Value of MEP	4.7%	4.7%
Value of MPEA	€16,759,000	€16,716,000

## **Section D - Some Developments since the Authority's Last Decision on Risk Equalisation**

In this section we will summarise some of the main developments since the Authority's last risk equalisation decision.

### Growth of Insurers:

BUPA Ireland's membership has grown by around 6% (from 380,000 to over 400,000) in the second half of 2004, while Vhi Healthcare and ESB SMPF's memberships have remained relatively stable, with the result that BUPA Ireland increased its share of the open-membership market from 19.7% to 20.5%.

In total, the number of persons with private health insurance has grown from 2.03 million to 2.05m or by about 1% in the 6 months to 31 December, 2004.

Vhi Healthcare's lapse rate, which had increased significantly between 2001 and 2003, has reduced. Their sales numbers, which have declined significantly since 2000, continue to decline.

Sales figures for BUPA Ireland and for Vhi Healthcare are compiled on different bases. For example, additions to existing policies are included with new sales by BUPA Ireland but are not treated as new sales by Vhi Healthcare. This clearly makes it difficult to compare the sales figures received from each insurer. Bearing this in mind, Vhi Healthcare's level of sales in 2004 was estimated to be about 57,000 (excluding additions to existing policies), while BUPA Ireland's was estimated to be about 75,000 (including additions to existing policies). Neither of these figures includes new births. Of course, if risk equalisation were introduced the split of new business could be expected to change as premium rates would be expected to change.

### Financial Information:

In the tables below [Gross Underwriting Surplus equals earned premium less incurred claims and operating expenses.](#)

BUPA Ireland forwarded summaries of their profit and loss accounts for the year 2004. [These figures are updated in BUPA Ireland's representations to allow for overstatements of outstanding claims. The figures in the table below are those included in the representations.](#) We compare the figures for 2004 with those [for earlier years.](#)

	2002	2003	2004
Gross Underwriting Surplus	<del>€3m</del> €4m	<del>€6m</del> €1m	<del>€4m</del> €6m
Gross Underwriting Surplus as a % of earned premium	<del>16.1%</del> 16.6%	<del>13.7</del> 17.9%	<del>16.3</del> 17.3%

These figures might also be considered in the context of previously forwarded figures for Vhi Healthcare, which were included in the previous report. Gross Underwriting Surplus and Published Surplus figures for Vhi Healthcare are shown in the table below.

	12 months to February 2002	12 months to February 2003	12 months to February 2004
Gross Underwriting Surplus (GUS)	€18.3m	€4.3m	€73.3m
GUS as a % of earned premium	3.1%	5.0%	9.1%
Published Surplus	€4.7	€3.8	€62.3m
Published Surplus as a % of earned premium	2.5%	4.9%	7.8%

The difference between the Gross Underwriting Surplus and the Published Surplus figures for Vhi Healthcare is that the former ignores investment income, tax and transfers to the unexpired risk reserve while the latter does not.

Premium increases:

Vhi Healthcare announced a rise in premiums of approximately 3% from 1 September, 2004. This rise compares to an average annual rise in Vhi Healthcare's premiums of about 10% in the years since BUPA Ireland entered the market up to but excluding the 3% rise.

Following Vhi Healthcare's rise in premiums, BUPA Ireland increased their premiums by 6%, from 1 March, 2005.

#### New Entrant:

Since the Authority's last decision on risk equalisation, VIVAS Health entered the market. They began business in October, 2004 and offered similar products to those already available in the market, with prices similar to those of BUPA Ireland. A gap between the premiums for BUPA Ireland's products and VIVAS Health's products has now opened following the 6% increase in BUPA Ireland's premiums on 1 March, 2005.

VIVAS Health have introduced a new way of selling products in the market, namely through intermediaries. Also, Allied Irish Bank (AIB), one of VIVAS Health's major shareholders, refers customers to them, but does not act as an agent or as an intermediary.

VIVAS Health have only recently entered the market. Based on the data available to the Authority, their growth appears to have been quite slow. The new insurer has not yet gained a significant market share. They may have had an impact on the market in other respects, however, in that, in advance of and since VIVAS Health's entry to the market, the other insurers appear to have increased their marketing and altered certain benefits. For example, there has been a notable increase in the level of maternity benefits now available in the market overall. Also, Vhi Healthcare introduced a new range of products, which are cheaper than their traditional plans but do not provide any cover for the Blackrock Clinic nor the Mater Private Hospital. PWC, in a report commissioned by Vhi Healthcare and forwarded to the Authority by them, say that these products "are likely to enable Vhi Healthcare to retain certain members that it might otherwise lose to competitors but at a lower margin."

#### Significant changes in returns:

The MEP (with HSW = 0) has increased considerably to 4.7%, for the period July to December, 2004. Previous returns for the periods, July to December, 2003 and January to June, 2004, gave MEPs of 3.7% and 3.5%, respectively. A factor for the reduction in MEP between the first two periods was that BUPA Ireland's level of hospital bed utilisation per member fell by 12%. BUPA Ireland said that this drop was due to seasonality and a reduction in the average number of days hospitalisation per claim. Since the last period, BUPA Ireland's level of hospital bed utilisation per member has increased by about 10%, resulting in a value similar to that obtained for the first period. The fact that the MEP has increased again for the period July to December, 2004 could be considered to support the possibility of seasonality, however, future returns would need to be analysed in order that more reliable conclusions could be drawn. It is interesting to note that ESB SMPF's returns also exhibit signs of seasonality, whereas Vhi Healthcare's do not.

Another point to note is that the total level of cell equalised claims for BUPA Ireland has risen by 27% between the periods January to June, 2004 and July to December, 2004. This total level of claims changed little between the periods July to December 2003 and January to June 2004.

Further reasons for the rise in the MEP include the growth in BUPA Ireland's market share and a very significant rise in the average cost of benefits for each BUPA Ireland member aged over 80.

Risk equalisation attempts to estimate the claim costs that each insurer would have incurred if they had their own costs and the market's age and gender profile. BUPA Ireland has very few people over the age of 80 (about 0.08% of its membership, with a cost of about €300,000 in this period). Risk equalisation allocates the market share of those aged over 80 (over 1.5% or about 20 times the proportion in BUPA Ireland) to each insurer. Therefore the "risk equalised" cost to BUPA Ireland of those aged over 80 is their own cost multiplied by about 20. Therefore, the contribution that over 80s made to the risk equalisation transfer in this period is about  $20 * 300,000$  (the equalised cost) less 300,000 (BUPA Ireland's original cost), which approximately equals €5.3m (or about 1.5 percentage points of the MEP).

In the previous period, BUPA Ireland only spent about €150,000 on claims for those aged over 80. Therefore, the contribution that over 80s made to the risk equalisation transfer in the previous period was about  $20 * 150,000 - 150,000$  or about €2.8m (or about 0.8 percentage points to the MEP).

Therefore 0.7 percentage points of the rise in the MEP (which was 1.2 percentage points) can be attributed to the increase in costs for the 300 BUPA Ireland policyholders aged over 80.

The sensitivity of the MEP to the settled claims for the less than 300 BUPA Ireland policyholders aged over 80 should be noted. As this is such a small number of policyholders there could be random fluctuations, which could have a significant effect on the MEP. Furthermore, it would be possible for an insurer to manipulate the claim settlement dates for such a small number of policyholders in order to manipulate the MEP.

As mentioned in Section C, basing the returns on settled claims gives some control to undertakings in deciding whether claims are included in one set of returns or another. If this was the case, for example, if an insurer decided to settle a large number of claims in the month before or after, rather than during the period concerned, a pattern such as the one observed over the last three returns periods could arise, i.e. all claims would have to be settled at some point, so that inflating claims in one period would lead to a deflation in claims in another period and vice versa.

#### Review of Health Status Weight.

The figures returned by insurers for the period 1 January, 2004 to 30 June, 2004 indicated that there may be a material difference in the rates of claim for different insurers within age and gender bands. In this context, the Authority decided to consider investigating whether the HSW should be increased, and engaged UK GAD to advise on this matter.

Possible approaches to the investigation have been considered and difficulties associated with each approach have been discussed with UK GAD, Vhi Healthcare

and BUPA Ireland. The Authority awaits a submission from Vhi Healthcare on the matter. The Authority will also contact VIVAS Health in relation to this matter in due course.

#### Publication of Information

In the interests of transparency, a number of reports commissioned by the Authority from independent consultants were attached to the Report to the Tánaiste and Minister for Health and Children, relating to the period 1 January, 2004 to 30 June, 2004, and these were also published on the Authority's website. As has always been the case, summaries of the reports are appended to this document.

## Section E. Issues to be considered

In this section we will consider the “Issues to be Considered” as specified in the Authority’s policy paper in appraising the matters further set out in this section. The “Issues to be Considered” listed in the policy paper were:

- the differences in risk profiles between insurers,
- the relative sizes of insurers,
- the age / sex profile of insurers’ policyholders,
- the rate of premium inflation,
- the number of insurers in the market / new entrants to the market,
- the effect of any transfer on premiums payable by consumers,
- the overall size of the market,
- the effect of payments on the business plans or solvency of insurers and
- the commercial status of insurers.

As well as the above matters, it is proposed that the Authority consider the extent to which efficiencies could be shared if risk equalisation payments were commenced.

### Differences in risk profiles and relative sizes of insurers

Risk equalisation attempts to address problems arising in a community rated market where risk profiles differ significantly between insurers by equitably sharing the risk amongst the insurers in the market. Therefore, if risk profiles do not vary significantly risk equalisation could not be expected to have any significant effect in addressing difficulties that might exist in the market.

Furthermore, if the insurer(s) whose risk profile(s) differ significantly from the market as a whole have a relatively small number of customers, then the effect that risk equalisation could be expected to have in addressing any problems that might arise would be relatively small, although it could have a significant effect on the smaller insurer(s). [In such a case, a smaller insurer may become unviable and the harm to the best overall interests of health insurance consumers resulting from the departure of such an insurer from the market \(in terms of the reduced level of consumer choice and other negative effects on competition\) might be seen to outweigh the benefits of introducing risk equalisation.](#)

### *Market Equalisation Percentage*

The Market Equalisation Percentage (MEP) is approximately equal to the amount that would be transferred if risk equalisation were introduced, expressed as a percentage of the total benefits in the market that are subject to risk equalisation.

**The Health Status Weight used when calculating the Market Equalisation Percentage was 0.**

**The Market Equalisation Percentage, for the period 1 July, 2004 to 31 December, 2004 is 4.7%. This is an increase of 1.2 percentage points from the previous period, 1**

January, 2004 to 30 June, 2004 and an increase of 1 percentage point since the period, 1 July, 2003 to 31 December, 2003.

*Relative Sizes of Insurers and the overall size of the market*

The number of “insured persons”, as defined in the Risk Equalisation Scheme, 2003, in each undertaking are included in the table below:

<b>Company</b>	<b>Insured Persons in RE returns 01/07/04 to 31/12/04</b>	<b>% of total insured persons in scheme undertakings</b>
BUPA Ireland	371,681	19.6%
ESB Staff MPF	29,324	1.5%
Vhi Healthcare	1,499,266	78.9%
<b>Total</b>	<b>1,900,272</b>	<b>100.0%</b>

The figures in the above table do not include people serving waiting periods or members of the insurers who have purchased products that are not subject to risk equalisation. Furthermore, the figures in the above table are effectively based on mid-August figures, assuming that membership changed linearly between 1 July, 2004 and 1 October, 2004, as they are the average of the figures for 1 July and 1 October. The membership of products that are subject to risk equalisation for each undertaking as at 31 December, 2004 are set out in the table below:

<b>Company</b>	<b>Membership of Products Subject to Risk Equalisation @ 31/12/04</b>	<b>% of Total Membership in Scheme Undertakings</b>
BUPA Ireland	401,455	20.6%
ESB Staff MPF	29,486	1.5%
Vhi Healthcare	1,518,279	77.9%
VIVAS Health	1,019	0.1%
<b>Total</b>	<b>1,950,239</b>	<b>100.0%</b>

While the membership of products subject to risk equalisation for ESB SMPF has stayed broadly constant since June 2001 and Vhi Healthcare’s membership of products subject to risk equalisation has increased by about 42,500 (or about 2.9%), BUPA Ireland’s membership of products subject to risk equalisation has increased by about 189,000 (or by about 89%).

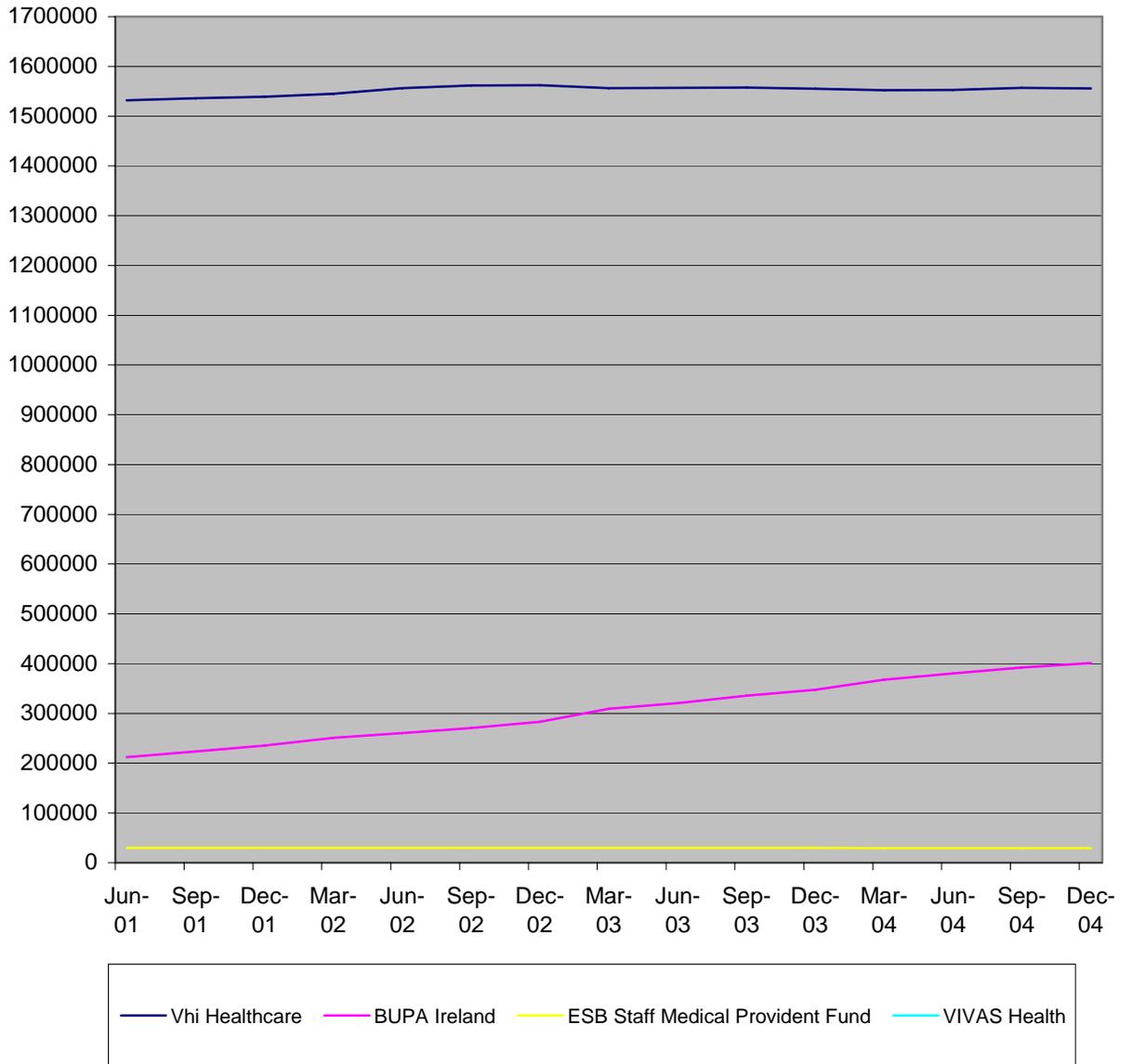
The following charts show the growth in membership figures since June 2001.

As already noted, in Section D, VIVAS Health is a relatively new company and so hasn’t yet made much of an impact, in terms of market share. It is unsurprising then, that its market share is indiscernible in the charts overleaf.

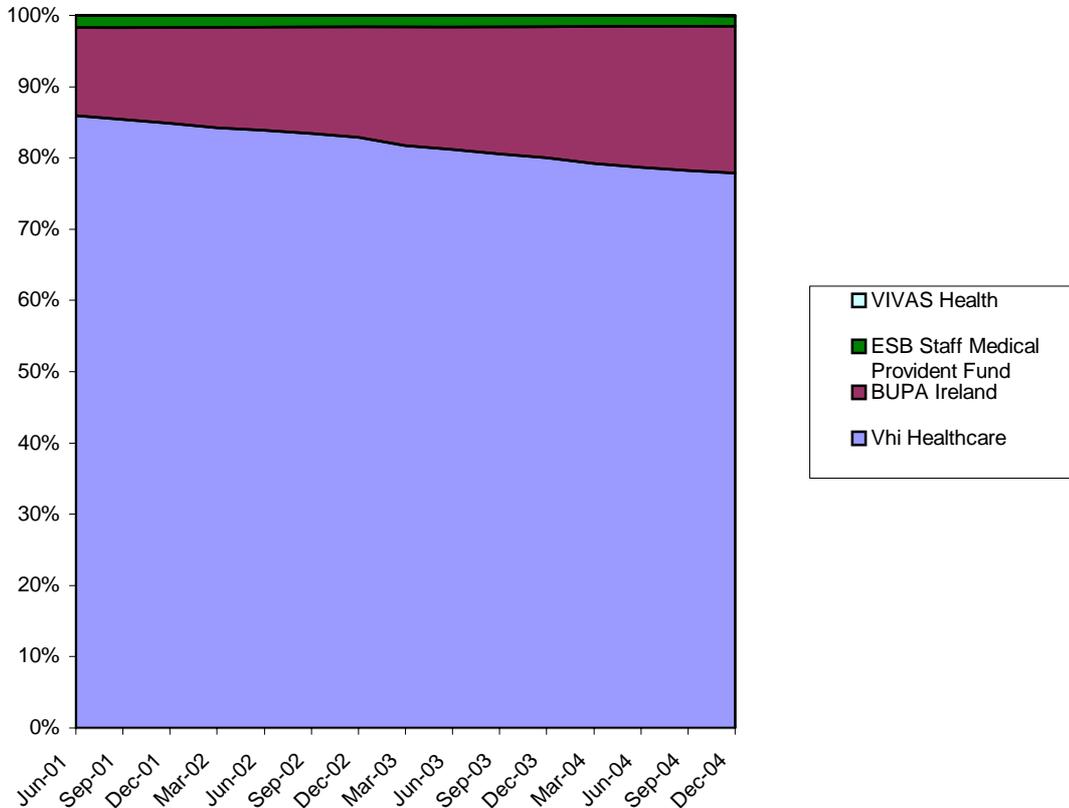
As noted, the main difference between the historic data in the charts below and the figures in risk equalisation returns is that figures in the returns do not include persons serving initial waiting periods. BUPA Ireland would be expected to have a greater

proportion of people serving initial waiting periods as a greater proportion of their membership are likely to have taken out insurance for the first time.

**Total Undertaking Membership Jun 01 - Dec 04**



**Market Shares (by Membership) for Products  
Subject to RES - Jun 01 to Dec 04**



*Risk profiles*

It is difficult to correctly and accurately compare the risk profiles of different insurers due to difficulties in separating out the effects of different levels of efficiency and insurance products. In order to compare risk profiles we will use the following techniques:

1. Average Claim per member.
2. Average Treatment Days per member.
3. An index based on the Age/Sex Risk Profile of each insurer (complementary to this index, we will also gauge the significance of variations in treatment days not captured by the Age/Sex Risk Profile Index by calculating a Health Status Risk Profile Index.)

In each case we will note the disadvantages of the index being used. Also, where appropriate, when calculating indices we will treat each insured child as 1/3<sup>rd</sup> of an insured adult to reflect the fact that they are not charged a full premium.

### *Average claim per member*

Comparing the average equalised benefit per insured person of each insurer may not be completely reliable. The main advantage of this method is its simplicity. It does not, however, allow for the fact that one insurer might be more efficient than another or one insurer may sell more of a product that provides less benefits or provide a different level of cover (by, for example, applying different excesses, exclusions or waiting periods). In this context it is worth noting that BUPA Ireland sells a larger proportion of plans that only provide cover in public hospitals and it also sells a larger proportion of plans that include excesses than Vhi Healthcare sells.

The risk equalisation returns provide us with the “equalised benefit” for each insurer. The “equalised benefit” is the total claim for the period that is subject to risk equalisation. Counting each child as 1/3<sup>rd</sup> and each adult as 1, the average equalised benefit per insured person for each insurer, for each set of returns, is outlined in the table below:

Insurer	Average “Equalised Benefit” per Insured Person			% of the Market Average		
	July – Dec '03	Jan – Jun '04	July – Dec '04	July– Dec '03	Jan – Jun '04	July- Dec '04
BUPA Ireland	€127	€119	<b>€140</b>	62%	55%	<b>63%</b>
ESB SMPF	€240	€222	<b>€249</b>	117%	104%	<b>112%</b>
Vhi Healthcare	€220	€235	<b>€242</b>	107%	110%	<b>109%</b>
Market	€205	€215	<b>€223</b>	100%	100%	<b>100%</b>

The above table shows that BUPA Ireland’s equalised benefit per insured person has increased significantly since the last period (from 55% of the market average to 63% of the market average). For BUPA Ireland, the equalised benefit per insured person for the period 1 July, 2004 to 31 December, 2004 is similar to the equalised benefit per insured person for the period 1 July, 2003 to 31 December, 2003. This supports the hypothesis that seasonality exists in the returns. The figures for ESB SMPF also appear to exhibit signs of seasonality.

### *Average number of treatment days per member*

The differences in the average “equalised benefit per member” are partly due to differences in the average cost per treatment day for each insurer and partly due to differences in the average number of treatment days per insured person for each insurer.

The average “equalised benefit” (or claim subject to risk equalisation) per treatment day for each insurer, for each set of returns, is as set out in the table overleaf:

Insurer	Average Equalised Benefit per Treatment Day			% of the Market Average		
	July – Dec '03	Jan – Jun '04	July – Dec '04	July – Dec '03	Jan – Jun '04	July – Dec '04
BUPA Ireland	€423	€453	<b>€481</b>	85%	84%	<b>83%</b>
ESB SMPF	€549	€546	<b>€586</b>	110%	101%	<b>101%</b>
Vhi Healthcare	€509	€549	<b>€597</b>	102%	102%	<b>103%</b>
Market	€499	€538	<b>€580</b>	100%	100%	<b>100%</b>

The differences described in the previous two tables would to some extent result from factors other than differences in risk profile. Such factors would include differences in products and levels of efficiency. In order to compare risk profiles it would be better to compare the average number of treatment days per insured person. Comparing the average number of treatment days per insured person is not ideal either. It does not separate out differences in efficiency or all differences in the level of cover. For example, greater efficiency might be reflected in the ability of one insurer to provide less intrusive surgery requiring a shorter hospital stay. Nevertheless, it would seem likely that the distortions arising from these sources might be less serious than they would be in the case of the average equalised benefit per insured person.

The reliability of the average treatment days per member also relies on the assumption that the “value” (in terms of the underlying healthcare cost) of each treatment day is the same for each insurer. In practice, it is possible that this assumption will not be borne out. For example, if the cost of a treatment day varied by age of the patient and each insurer’s membership had different age profiles, then a comparison of the number of treatment days per member would not fully capture the differences in the risk profiles of the insurers.

The average number of treatment days per member for each insurer, for each set of returns, is set out in the following table. Again, each insured child counts as 1/3 when counting the number of insured persons in order to allow for the fact that children are not charged a full premium.

Insurer	Average Treatment Days Per Insured Person			% of the Market Average		
	July – Dec '03	Jan – Jun '04	July – Dec '04	July – Dec '03	Jan – Jun '04	July – Dec '04
BUPA Ireland	0.300	0.263	<b>0.290</b>	73%	66%	<b>76%</b>
ESB SMPF	0.438	0.408	<b>0.425</b>	107%	102%	<b>111%</b>
Vhi Healthcare	0.432	0.428	<b>0.406</b>	105%	107%	<b>106%</b>
Market	0.410	0.399	<b>0.384</b>	100%	100%	<b>100%</b>

The above table displays signs of seasonality for BUPA Ireland and ESB SMPF. The average number of treatment days per insured person has dropped considerably for Vhi Healthcare.

### *Age/Sex Risk Profile Index*

Another approach is to compare the risk profiles based on the age/sex profile of each insurer. We do this by applying a “risk weighting” to each member of the insured population. This weighting will be based on the age/sex of the insured person. We can then compare the average weighting for each insurer. We refer to this average weighting as the age/sex risk profile index.

The difficulty with this approach lies in finding an appropriate weight for each age/sex combination. One weight that may be considered appropriate, is the market average number of treatment days for each age/sex group. Thus each insurer is using the same weights.

The use of the number of treatment days as the basis for setting the risk weights is not without its disadvantages. As already mentioned, the number of treatment days will not provide a pure measure of risk, since it could include an element of efficiency and other factors. Also, as noted earlier, it does not take account of differences in the value of treatment days. However, this is probably not as great of a concern when it is only being used to calculate an age/sex index.

The Age/Sex Risk Profile Index for BUPA Ireland is equal to 72% of the market rate, while those of ESB Staff Medical Provident Fund and Vhi Healthcare are 120% and 106% respectively. These figures have changed little since the previous periods, indicating that there has been little change in the relative age / sex profiles of the insurers over the periods. Note that it is not considered necessary to adjust for children by counting each child as 1/3 (in the calculation of this index).

<b>Insurer</b>	<b>Age/Sex Risk Profile Index (Percentage of the Market Average)</b>		
	<b>July – Dec '03</b>	<b>Jan – Jun '04</b>	<b>July – Dec '04</b>
BUPA Ireland	72%	72%	72%
ESB SMPF	118%	120%	120%
Vhi Healthcare	105%	106%	106%
Market	100%	100%	100%

### *Health Status Risk Profile Index*

Of course the Age/Sex Risk Profile Index ignores differences in risk profiles due to other factors, i.e. it ignores whether insurers’ risk profiles vary within age/sex bands due to factors such as social class. In order to gauge the significance of variations of risk profile within age/sex bands we calculate an overall index of the health status risk profile (ignoring the effect of differences in the age/sex distributions of the memberships). We call this index the Health Status Risk Profile Index.

The Health Status Risk Profile Index is calculated by estimating the average number of treatment days that each insurer would have if they all had the same standard age

sex profile and their own level of treatment days for each age/sex group. The standard age/sex profile that we use is the profile for the market as a whole.

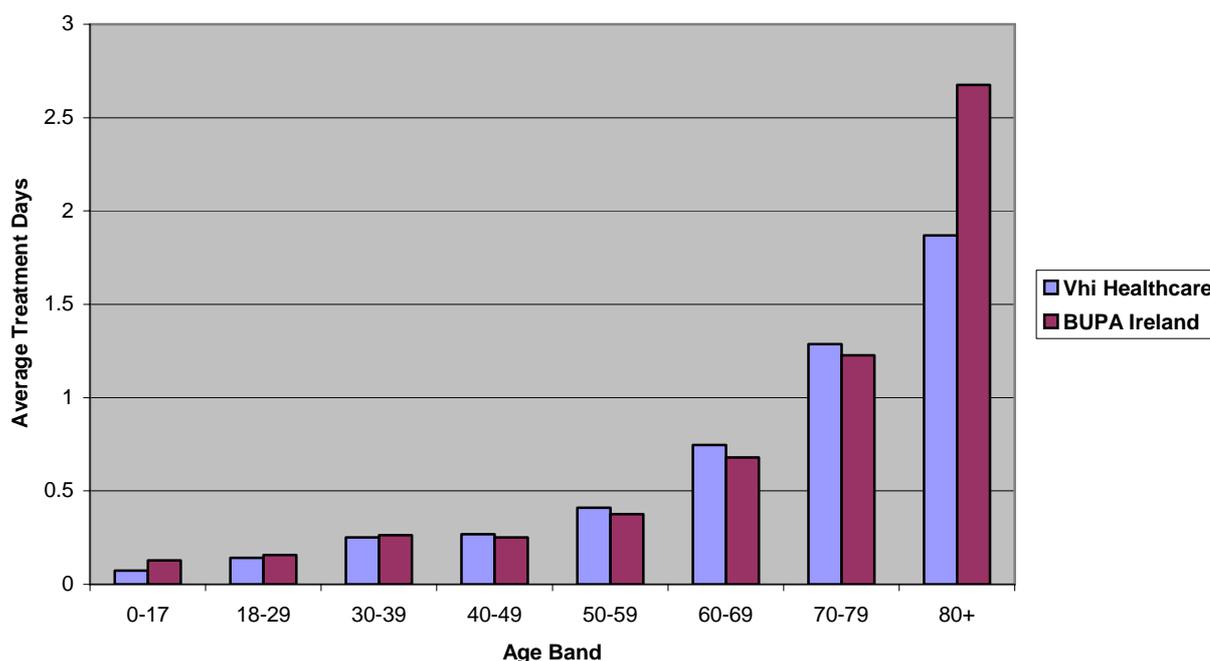
As we aim to ignore the effect of the age and sex profile with this index, there is no need to adjust for the number of children. The table below shows the relative values of the Health Status Risk Profile Index for the three periods for which returns have been received.

Insurer	Health Status Risk Profile Index (Percentage of Vhi Healthcare's index)			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Average for the 3 periods
BUPA Ireland	95%	86%	105%	95%
ESB SMPF	87%	84%	92%	88%
Vhi Healthcare	100%	100%	100%	100%

This index, viewed in isolation for this period, would indicate that BUPA Ireland's membership is less healthy than the memberships of other insurers. This differs from the situation in previous periods (and explains why the MEP with a HSW of 0.5 is lower than the MEP with a HSW equal to 0, when the reverse was previously the case).

One of the significant causes for this reversal appears to be the increase in treatment days for BUPA Ireland consumers that are 80 years of age or older (this matter was already discussed in detail in Part C). It can be seen from the chart below that this is the only age group for which the level of treatment days per person for BUPA Ireland customers is considerably higher (in absolute terms) than for Vhi Healthcare customers.

Average Treatment Days by Age Band July - Dec 2004



### Summary of Risk Profile Comparison

While the Health Status Weight is 0, risk equalisation will not equalise the difference in risk profile suggested by the differences in the Health Status Index. A summary of the other measures of the risk profile of the three insurers, for the three sets of returns, is included below.

Insurer	% of Market Average “equalised benefit” per Member			% of Market Average Treatment Days per Member			% of Market Age/Sex Risk Profile Index		
	July – Dec '03	Jan – Jun '04	<b>July – Dec '04</b>	July – Dec '03	Jan – Jun '04	<b>July – Dec '04</b>	July – Dec '03	Jan – Jun '04	<b>July – Dec '04</b>
BUPA Ireland	62	55	<b>63</b>	73	66	<b>76</b>	72	72	<b>72</b>
ESB SMPF	117	104	<b>112</b>	107	102	<b>111</b>	118	120	<b>120</b>
Vhi Healthcare	107	110	<b>109</b>	105	107	<b>106</b>	105	106	<b>106</b>

While BUPA Ireland’s average claim per member is 37% lower than the market, this appears to be due in part to the fact that BUPA Ireland’s average cost per treatment day is about 17% lower than the market cost (see table at top of page 27). Differences in cost per treatment day may be due to matters such as differences in efficiency, differences in products, or differences in health status, e.g. cost per treatment day may vary with the age of the patient.

The Authority may consider it appropriate that risk equalisation calculations take account of differences in health status due to factors other than age and gender. The mechanism in the Scheme that enables the Authority to do this is the Health Status Weight. With a Health Status Weight equal to 0 (as is currently the case), the aim of the calculations is to equalise age and gender profiles across the market and not to equalise individual insurers costs within each age and gender cell. If the Health Status Weight is increased to 0.5, two sets of calculations will be performed. One will aim only to equalise age and gender and the other will aim to also equalise the level of utilisation of hospital services (measured by treatment days per member) within each cell. The transfers between insurers would then be calculated as the average of the transfers found using each calculation. This would partially equalise differences in health status due to factors other than age / gender but it might also result in the sharing of efficiencies between insurers, which could have consequences for insurers’ incentives to reduce medical costs. In deciding whether to increase the HSW, the Authority will take into account whether the resulting changes to the risk equalisation payments are proportional to the benefit of calculating the payments in this way. In this period increasing the HSW to 0.5 would cause a decrease in the MEP from 4.7% to 4.5%. In the other two periods, changing the HSW to 0.5 increased the MEP. It is interesting to note that, with HSW = 0.5, there is little change in the market equalisation percentage between the periods 1 January, 2004 to 30 June, 2004 (MEP = 4.4%) and 1 July, 2004 to 31 December, 2004 (MEP = 4.5%).

As noted previously, one reason for the fact that the MEP with the HSW = 0.5 is now lower than with the HSW = 0 is the large increase in the level of treatment days included in returns for BUPA Ireland policyholders aged 80 or over.

	Market Equalisation Percentage		
	Jul – Dec '03	Jan – Jun '04	<b>Jul – Dec '04</b>
HSW = 0.0	3.7	3.5	<b>4.7</b>
HSW = 0.5	4.0	4.4	<b>4.5</b>

If we concentrate only on the differences in the Age / Sex risk profile we find that the market index for BUPA Ireland is 28% lower than the market and 32% (as a percentage of Vhi Healthcare's index value) lower than Vhi Healthcare's. With the HSW equal to zero, the risk equalisation calculations only aim to adjust for the effect of differences in the age and sex profiles of the insurers.

#### The age / sex profile of the memberships of insurers

Central to the predatory pricing and price following models is the theory that the risk profile(s) of some insurer(s) is so much higher than the risk profile(s) of other insurer(s) that the former are unable to compete effectively to attract or retain sufficient low risk lives. This causes their risk profiles to rise further. Such a failure to attract lower risk lives would cause the risk profile of some insurers to rise inexorably and this would be apparent from an analysis of changes in the age / sex profiles of the memberships of insurers (particularly those with higher risk profiles).

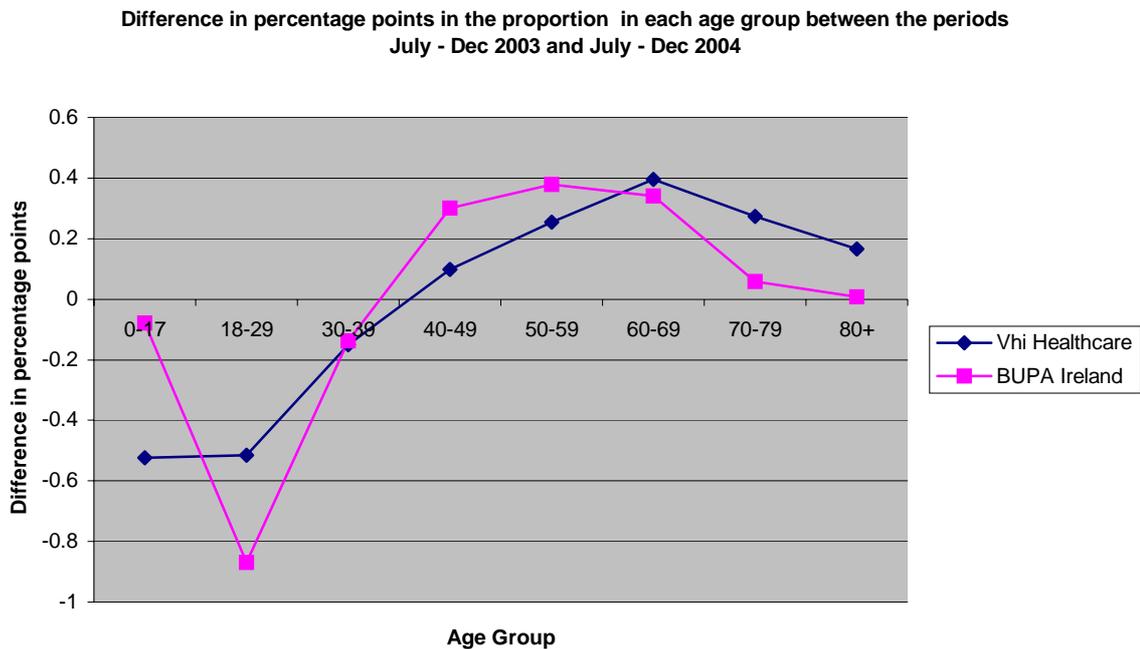
The current gender distribution of the three insurers is set out in the table below. The proportions in each gender for each insurer are unchanged from the previous two periods.

<b>Gender</b>	<b>BUPA Ireland</b>	<b>ESB SMPF</b>	<b>Vhi Healthcare</b>
Male	49%	51%	48%
Female	51%	49%	52%

The current age distribution (for the period July to December, 2004) of each insurer's population is shown overleaf. Corresponding figures for the period, July to December, 2003 are shown in brackets.

Age Group	BUPA Ireland % in each age group	ESB SMPF % in each age group	Vhi Healthcare % in each age group
0-17	<b>29.3</b> (29.4)	<b>22.0</b> (22.8)	<b>23.0</b> (23.5)
18-29	<b>18.9</b> (19.8)	<b>14.9</b> (14.9)	<b>17.1</b> (17.6)
30-39	<b>23.2</b> (23.4)	<b>6.9</b> (7.4)	<b>15.6</b> (15.8)
40-49	<b>15.0</b> (14.7)	<b>16.1</b> (16.2)	<b>15.1</b> (15.0)
50-59	<b>9.6</b> (9.3)	<b>18.4</b> (18.3)	<b>13.2</b> (13.0)
60-69	<b>3.5</b> (3.1)	<b>12.9</b> (12.3)	<b>9.1</b> (8.7)
70-79	<b>0.5</b> (0.4)	<b>7.1</b> (6.6)	<b>5.1</b> (4.8)
80+	<b>0.1</b> (0.1)	<b>1.8</b> (1.6)	<b>1.9</b> (1.7)

The chart below indicates a general ageing of BUPA Ireland and Vhi Healthcare's populations. The percentage of each insurer's members in the younger age groups (under 40) has decreased, between the periods July to December, 2003 and July to December, 2004, (denoted by the negative values in the chart below). The proportion of their members in the older age groups (over 40) has increased (denoted by the positive values in the chart below). For example, for BUPA Ireland the proportion in the 18 – 29 age group has dropped by 0.9 percentage points from 19.8% to 18.9%.



The 18 – 29 age group is one of the key profit-making groups. In July to December, 2003, BUPA Ireland had a higher proportion of its members (about 19.8%) in this group than did Vhi Healthcare (about 17.6%). It is interesting to note that a year later, (July to December, 2004), BUPA Ireland's proportion of members in the 18 – 29 age group has decreased by about 0.9 percentage points. Despite this fall, however, BUPA Ireland still has a larger proportion of its members in this age group, than does Vhi Healthcare.

In each of the other age groups BUPA Ireland is essentially maintaining or increasing its risk profile advantage over Vhi Healthcare. However, it should be noted that the changes in the proportions in these age groups are quite small.

Vhi Healthcare inform us that the average age of their membership is 36.9 years at 31 December, 2004, (compared to 36.2 at 31 December, 2003), while BUPA Ireland inform us that the average age of their membership is 29.9 at December 2004 (compared to 29.6 at December, 2003). ESB SMPF inform us that the average age of their membership is 41. From this we calculate the average age of the market as a whole to be 35.5. (We can calculate the average age of the open membership market by excluding ESB SMPF. This gives a rounded figure of 35.5).

The rise in Vhi Healthcare's average age (0.7 in one year) is surprising because during 2003 (when their average age grew by 0.4) the combined effect of their lapses and sales figures would have been expected to have caused a higher increase in the average age than in 2004 when they had considerably lower lapses. When the matter was queried with Vhi Healthcare, however, assurance was given that the average age figures supplied were correct and consistent, although Vhi Healthcare could not provide an explanation as to why the growth in the average age was greater in 2004 than in 2003.

Vhi Healthcare inform us that the average age of their membership was 33.9 when BUPA Ireland entered the market. Therefore, it would appear that while the average age of the members of open-membership undertakings has grown by 1.6 years since BUPA Ireland entered the market, Vhi Healthcare's average age has increased by 3 years, while BUPA Ireland's average age has increased by 1.5 years since the end of 1997.

Staff were unable to find data concerning death spirals in other jurisdictions that would be useful when analysing the situation in Ireland.

It may be worth considering the growth in the average age in Australia, which is a community rated market with risk equalisation and lifetime community rating. The average age of the insured population in Australia has grown by 0.4 years every year since the introduction of lifetime community rating (risk equalisation was already in place). This compares to an increase of 0.4 years every year since 1997 in the average age of Vhi Healthcare's membership, although the rate of growth in Vhi Healthcare's average age was considerably higher in 2004.

In order to ascertain whether the rise in Vhi Healthcare's average age is indicative of a "death spiral", we should consider the following matters:

1. Is the rate of lapsing from Vhi Healthcare increasing and what is the age profile of those that are lapsing?
2. Is the rate of new entrants to Vhi Healthcare decreasing and what is the age profile of new entrants?

It is also relevant to consider whether Vhi Healthcare is under financial strain as a result of their risk profile, in the context of the regulatory structure. This matter is considered later.

Before considering the level of lapses and sales it is worth noting that comparisons between the figures provided by each insurer may be of limited value as they may not be produced on a similar basis. Therefore, we concentrate on the trends over time of the Vhi Healthcare figures, which Vhi Healthcare have stated are compiled on a consistent basis. These sales and lapse figures are the number of members that have joined and left Vhi Healthcare as a result of new policies being purchased and old policies being cancelled. They do not include people who join existing policies or people who leave policies when others remain on the policies. Vhi Healthcare refer to these as additions and deletions to existing policies. Nor do the figures include births. However, the lapse figures may include some deaths.

#### Vhi Healthcare Additions and Deletions

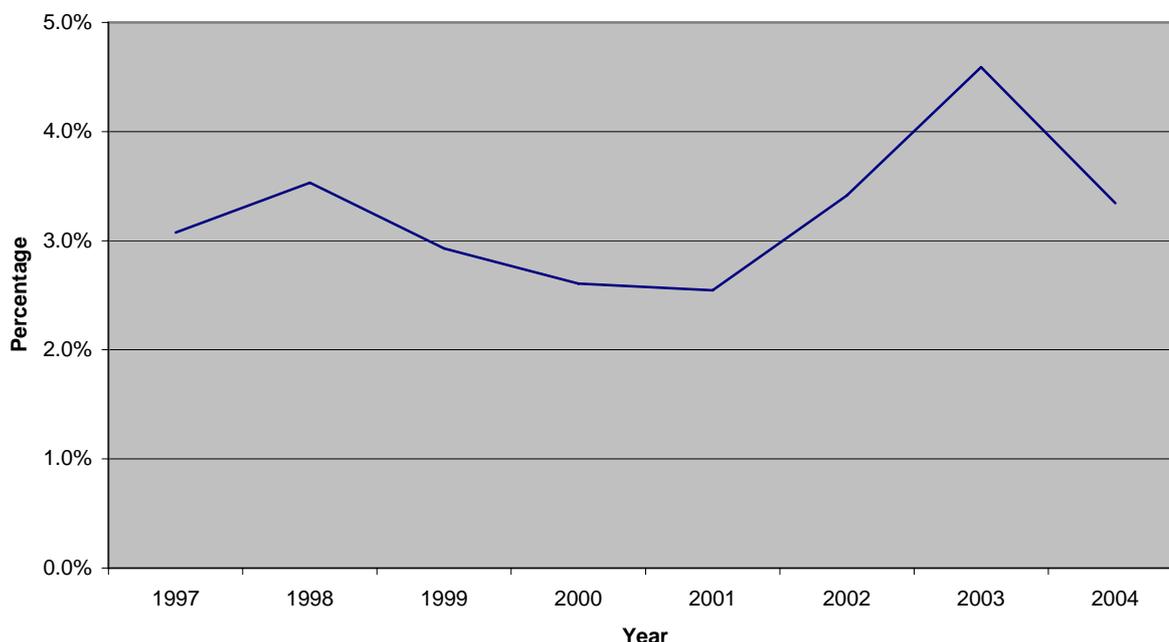
Vhi Healthcare state that it is the difference between additions and deletions that is important rather than the number of additions and deletions “as some members may be counted as both an addition and deletion and perhaps even on multiple occasions.” This difference between additions and deletions was about 2,000 in the 12 months up to February, 2004 (additions exceeding deletions). In the previous three twelve month periods additions exceeded deletions by between 4,500 and 6,500.

The analyses of lapses and sales below are based on data provided by registered undertakings. Analyses in relation to Vhi Healthcare do not include additions and deletions. Therefore, care should be taken when attempting to compare these figures with the sales and lapses of companies (such as BUPA Ireland) that include additions to policies as sales and deletions from policies as lapses.

#### *Lapses*

The average age of Vhi Healthcare’s lapsers during the 12 months ending 31 December, 2004 was 29.3. This appears to be slightly lower than the average age of lapsers in the years 1998 to 2003, which were generally estimated to be around 30 to 32. This average age is considerably lower than the average age of Vhi Healthcare’s membership and therefore a high rate of lapses could place a strain on Vhi Healthcare’s risk profile and costs. Estimates of Vhi Healthcare’s lapse rates since 1997 are shown in the chart overleaf.

Vhi Healthcare Estimated Annual Lapse Rates 1997 to 2004



It would appear that Vhi Healthcare's lapse rate began to increase significantly in 2001. However, between 1997 and 2002 there did not appear to be any discernible pattern in the rate of change of Vhi Healthcare's lapse rates. Furthermore, about 25% of the members that Vhi Healthcare lost in 2003 resulted from the loss of four major group Schemes following Vhi Healthcare's 18% price increase. Also it might be the case that the increase in the lapse rate since 2001 is in part related to factors other than the absence of risk equalisation. For example, the rise could have been due to changing economic conditions. In 2004, the lapse rate reduced significantly once more and returned to the level that it was at in 2002 (and in 1998). Therefore, it is considered that, the lapse rates, viewed in isolation, would not be indicative of the commencement of a death spiral.

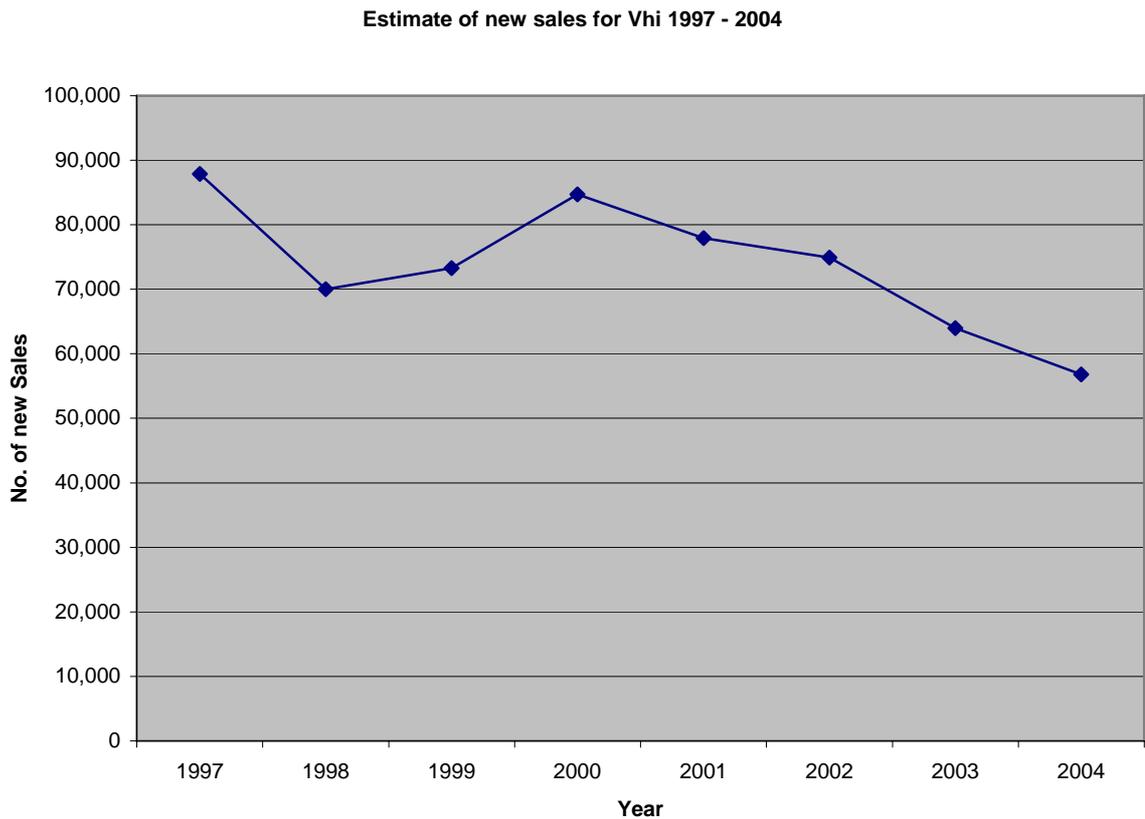
It is worth noting that some of the lapse figures received from Vhi Healthcare for the purposes of this analysis, are not consistent with figures in a report by PWC, commissioned by Vhi Healthcare and forwarded by them to the Authority.

BUPA Ireland's lapse rate over the 12 months ending 31 December, 2004 would appear to be higher than Vhi Healthcare's, although it should be noted that the lapse figures provided are not prepared on a similar basis by the two insurers. BUPA Ireland's higher lapse rate may not be surprising, as BUPA Ireland's membership is younger and contains a larger proportion of switchers. The Authority's research has indicated that both of these groups are more likely to cancel a policy than the general population.

ESB SMPF's lapse rate over the 12 months ending 31 December, 2004 was about 3% and its average age of lapsers was 29 years.

### Sales

The average age of those who purchase Vhi Healthcare policies has remained reasonably constant, at about 29 years, since 1998. This average age is considerably lower than the average age of Vhi Healthcare's membership and therefore any significant reduction in sales could place a strain on Vhi Healthcare's risk profile and costs. Estimates of Vhi Healthcare's sales figures since 1997 are shown in the chart below.



Based on figures received from Vhi Healthcare, their new sales have decreased steadily since 2000, when they peaked, although the level of sales in 2002 was higher than in 1998 and 1999. Sales only dipped below the 1998 level after Vhi Healthcare increased its prices by 18% in September, 2002. However, Vhi Healthcare's sales have continued to reduce in 2004 and this may be a matter for concern.

The average age of those who purchased BUPA Ireland policies in 2004 is 25.3 including new borns (27.7 excluding new borns) and the average age of those who purchased ESB SMPF policies in 2004 is 20 years.

The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers

The transfers that would have resulted had risk equalisation been in force for the three periods analysed to date (with a HSW=0) are set out in the table below:

	BUPA Ireland (‘000s)	ESB SMPF (‘000s)	Vhi Healthcare (‘000s)
Jul – Dec, 2003	(€1,644)	€1,084	€10,561
Jan – Jun, 2004	(€1,804)	€65	€10,939
Jul – Dec, 2004	(€16,759)	€1,163	€15,596
<b>Total for 12 months ending Dec 2004</b>	<b>(€28,563)</b>	<b>€2,028</b>	<b>€26,535</b>

Risk equalisation transfers could affect premiums in a number of ways:

- The premiums of the payers might increase. This would be expected if the profits being made by the payers would not cover the RE transfers. It would also be expected if the post RE market was not competitive or if there were no other pressures or incentives to maintain or achieve low prices. This effect might be mitigated to some extent if the introduction of RE enabled the payee to compete with the payer on price, forcing the payer to achieve greater efficiencies.
- The premiums of the payers might reduce. This could occur if the profits being made by the payer exceeded the level of RE transfers and if the introduction of RE enabled the payee to compete with the payer on price.
- The premiums of the payee might reduce. This would be dependant on the market post RE being competitive or the existence of some other pressure or incentive to maintain or achieve low prices.
- The payee might choose not to reduce premiums or as Vhi Healthcare claim to have done, may have already allowed for the receipt of risk equalisation transfers in their premium rates, in which case the commencement of risk equalisation transfers would not be expected to affect premiums immediately. However, if risk equalisation payments are not commenced, such an insurer may not be able to maintain the lower premiums indefinitely.

An insight into the Business Plans and the financial circumstances of insurers would provide an insight into how insurers might react after any introduction of RE transfers and how the best overall interests of health insurance consumers would be affected.

The Authority asked Scheme undertakings for financial information in order to assist the analysis of the effect that risk equalisation might have on their cashflows. Such an analysis would inform the Authority’s deliberations on how the commencement of risk equalisation payments might affect premiums and the business plans / solvency of insurers.

BUPA Ireland provided details of their 2004 profit and loss accounts and also a summary of their forecasts of their profit and loss accounts for the calendar years 2005 – 2007.

Vhi Healthcare referred the Authority to its published annual accounts covering the period 1 March 2003 to 28 February 2004.

ESB SMPF previously forwarded a copy of their accounts for 2003.

Based on the data provided, we have attempted to analyse how full risk equalisation payments would have affected the profit and loss accounts for all three undertakings for the 12 months up to 31 December, 2004. It should be noted that a number of assumptions needed to be made when estimating the Earned Premium, Claims Incurred and Operating Costs figures. These assumptions may not hold true (indeed, the insurers themselves would have difficulty estimating future cashflows even though they would have access to much more data). Furthermore, small discrepancies in estimating Earned Premium or Claims Incurred could have a very large effect on the estimates of surplus. For example, if there is an error of 1% in estimating the earned premium for Vhi Healthcare, this would result in the estimate of the Gross Underwriting Surplus for Vhi Healthcare being incorrect by about €9m, which equals about 14% of Vhi Healthcare's estimated Pre RE Gross Underwriting Surplus.

In relation to the estimates below, it should be noted that forecasts of Vhi Healthcare's surplus, which were produced by Vhi Healthcare management and used in a report by PWC, were forwarded to the Authority and that these forecasts differ significantly from the estimate below. Vhi Healthcare estimate a surplus of €35m for the 12 months to the end of February, 2005, while a surplus of €65m is estimated below for the twelve months to the end of December 2004. However, the Vhi Healthcare forecasts are not consistent in some respects with accounts published in previous annual reports and Staff consider, (and UK GAD are in agreement), that it is more appropriate to consider the estimate below.

It should also be noted that, in the analysis, investment income (which would add to the surpluses enjoyed by insurers), as well as transfers to reserves, such as Vhi Healthcare's "Unexpired Risk Reserve", and tax, (both of which would reduce an insurer's surplus), are ignored.

Monetary figures for Vhi Healthcare are estimated by Staff of the Authority and rounded to the nearest €m. BUPA Ireland's monetary figures were provided by the insurer and (except in the case of operating expenses) are to be filed with the Financial Services Authority. Subsequently, as part of their representations, BUPA Ireland forwarded updated financial information. It is this updated information that is included below. Figures are rounded to the nearest €100,000. ESB SMPF's monetary figures are estimated by the Authority and rounded to the nearest €m. Because of the small amounts involved for ESB SMPF rounding might have a significant effect on the estimates. However, it is considered not to round would be spurious.

*Estimates of Insurer's Gross Underwriting Surpluses for the 12 months ending 31 December, 2004 and the Effect that Risk Equalisation Would Have on Such Surpluses.*

<b>Vhi Healthcare</b>	
Membership	1,556,000
Earned Premium	865m
Claims Incurred	725m
RE Claims Settled	605m
Operating Costs	75m
Pre RE Gross Underwriting Surplus	65m (7.5% of premiums)
RE Transfer	26.5m (11m for Jan- Jun '04, 15.5m for July – Dec '04)
Post RE Gross Underwriting Surplus	91.5m (10.6% of premiums)
<b>BUPA Ireland</b>	
Membership	401,000
Earned Premium	149.2m
Claims Incurred	<del>105m</del> 103.5m
RE Claims Settled	74.6m
Operating Costs	19.9m
Pre RE Gross Underwriting Surplus	<del>24m</del> 25.8m (about <del>16.1%</del> 17.3% of premiums)
RE Transfer	-28.6m
Post RE Gross Underwriting Surplus	<del>4.5m</del> -2.8m (a loss of about <del>3.0%</del> 1.9% of premiums)
<b>ESB SMPF</b>	
Membership	30,000
Earned Premium	18m
Claims Incurred	17m
RE Claims Settled	12m
Operating Costs	(Most costs appear to be paid by ESB)
Pre RE Gross Underwriting Surplus	1m (about 5.6% of premiums)
RE Transfer	2m
Post RE Gross Underwriting Surplus	3m (about 16.7% of premiums)

Vhi Healthcare states that it has already passed the risk equalisation transfer on to consumers (through the lower than normal rise in premiums last year). Therefore, it is not likely that there would be any reduction in Vhi Healthcare's premiums as a result of the commencement of risk equalisation transfers other than the effect that might result if increases in transfers were used to slow down premium inflation. However, Vhi Healthcare also argue that as a result of this lower than normal price increase they will have financial difficulties in the absence of risk equalisation. If they do have financial difficulties, it is possible that they may increase premiums in order to gain the amount that they would otherwise receive from risk equalisation. The issue of

whether such an increase might be required is an issue that we return to below. For the time being we will assume that it may be required and that as a consequence the absence of risk equalisation transfers may result in Vhi Healthcare's premiums being increased by about 3% (i.e. the annual RE transfer as a percentage of premium) in the future.

ESB SMPF have stated that they have not taken a decision on whether transfers should be used to lower premiums (or slow down premium inflation). If we assume that ESB SMPF pass on the full benefit of risk equalisation payments to their members it would result in a reduction of about 11% in ESB SMPF's premium.

If risk equalisation were introduced, in order to make a Gross Underwriting Surplus of 5%, BUPA Ireland would need to increase its premiums by about 7%.

Therefore, based on the above estimates (which assume a HSW equal to 0) and assuming that

- There is no change in the number of policies in force for each insurer,
- Vhi Healthcare would need to increase their premiums if transfers are not commenced,
- ESB SMPF pass on the full benefit of risk equalisation transfers to its members, and
- BUPA Ireland needs to increase its premiums by about 7% to have a 5% gross underwriting surplus, (BUPA Ireland may seek a higher level of profitability, which would require a higher increase in premium)

the difference between a situation in which risk equalisation payments are not commenced (in which Vhi Healthcare would have to increase their premiums by about 3%) and one in which transfers are commenced (and BUPA Ireland would need to increase their premiums but ESB SMPF would be able to reduce theirs) is that premiums would be about 1.5% to 2% (or €15m to €20m) lower if risk equalisation were introduced.

We said that we would return to the issue of whether the 3% increase in premiums announced by Vhi Healthcare is sustainable in the absence of risk equalisation payments.

- Vhi Healthcare published a gross underwriting surplus of 9.1%, or €73m (before transfers to the unexpired risk reserve, tax, and investment income) for the 12 months up to February 29, 2004. The about €26.5m per annum that would have resulted in the 12 months to 31 December, 2004 from risk equalisation (without phasing) could be viewed in this context.
- Increases in private health insurance premiums take a long time to work through. The 18% increase of Vhi Healthcare's premiums in 2002 is still working through the system and will have a significant effect on Vhi Healthcare's published accounts for 2005. Therefore, if we assume that recent trends in terms of membership, claims growth and growth in expenses continue, it is likely that Vhi Healthcare will publish a significant surplus in 2005. Mr Vincent Sheridan has stated in a press statement published on the Vhi Healthcare website that "In the current year we are looking toward a reduced but nonetheless satisfactory surplus".

- It is difficult to project Vhi Healthcare’s surpluses any further as it will depend on the level of premium increases in future years. Vhi Healthcare state that the financial outlook for the 12 months to 28 February, 2006 and thereafter “is quite negative, however, unless a Risk Equalisation Fund is introduced into the Irish health insurance market.” They go on to say that the price increase from 1 September, 2004 “provides a true community rated price to our members ... [which] is not sustainable without risk equalisation”.

In relation to maintaining low prices, there would clearly be increased competitive pressure on BUPA Ireland following any introduction of risk equalisation payments, however, it would be expected that the competitive pressures on Vhi Healthcare would reduce. Based on the figures available for 2004 (the only full year for which BUPA Ireland finances and risk equalisation figures are available) it would appear that BUPA Ireland would remain in a position to price itself competitively in relation to the market.

It has previously been suggested that BUPA Ireland might be driven from the market by the introduction of risk equalisation, although based on the Authority’s analysis, this would not appear to be a logical reaction. Considering the investment that BUPA Ireland has made in Ireland, the brand that it has built and the client base that it has developed (401,000 members), it would appear that continuing to compete with Vhi Healthcare would be a more logical reaction. Furthermore, when BUPA Ireland entered the market, the Irish legislative regime to give effect to a risk equalisation scheme had already been enacted. However, it should be noted that, in their representations, BUPA Ireland are adamant that they would withdraw from the Irish market if a decision to commence risk equalisation was confirmed. In this context the possibility of BUPA Ireland withdrawing from the market should be considered.

The withdrawal of BUPA Ireland could have negative consequences for consumers in relation to reduced consumer choice and reduced competitive pressure in the market. However, the following should also be noted:

- Withdrawal by BUPA Ireland need not necessarily result in a reduction in competition (another insurer could purchase the BUPA Ireland Business).
- If an insurer cannot compete with other insurers when it has the market risk profile, then it could be argued that it is either introducing inefficiencies into the market or that it has unrealistic profit requirements.
- Vhi Healthcare are equally adamant that their business is not viable without risk equalisation. The Authority would need to weigh the credibility and the effects of BUPA Ireland’s and Vhi Healthcare’s claims against each other.

While it would appear to Staff of the Authority that BUPA Ireland would be in a position to continue to compete with Vhi Healthcare if risk equalisation were introduced, it may not be able to continue to grow at the rate that it has to date or to challenge Vhi Healthcare’s dominance in the short to medium term.

The analysis in the table on page 40 would not indicate that the solvency of either insurer would be put at immediate risk by a decision to commence or not to

commence risk equalisation. Vhi Healthcare argue that their current pricing strategy is unsustainable, but even if this is true they will be able to change it.

If risk equalisation payments are not commenced the financial estimates forwarded to the Authority by BUPA Ireland would indicate that they plan to make gross underwriting surpluses of around 10%, 9% and 8% of earned premium in 2005, 2006 and 2007 respectively. Previous forecasts received from BUPA Ireland indicated that they expected to make a gross underwriting surplus of 13% of earned premium in 2004. This compares to an actual gross underwriting surplus of 17.3% of earned premium for 2004.

*[Ed Note: This section refers to a business plan forwarded to IFSRA and the Authority prior to the commencement of operations by VIVAS Health and considered by the Authority in the context of its deliberations. Consistent with the Authority's policy regarding the confidentiality of discussions with potential new entrants, it has been redacted from the copy of the Report forwarded to registered undertakings.]*

[Redacted content]

## The Rate of Premium Inflation

Before discussing the rate of premium inflation it would be informative to note the current level of price difference in the market. We will compare two similar, but not identical products, namely Vhi Healthcare's Plan B Option and BUPA Ireland's Essential Plus (No Excess). When comparing premiums we will consider adult group rates, net of tax relief at source. From 1 September, 2004 Plan B Option has cost €43.93 per month. Between 1 September, 2004 and 29 February, 2005 Essential Plus (No Excess) cost €37.56 (almost 15% cheaper than Vhi Healthcare's product). On 1 March, 2005 BUPA Ireland increased the price of Essential Plus (No Excess) and it now costs €39.81 per month (about 9% cheaper than Plan B Option).

The following table shows the rates of increase in premiums in the Irish market since 1990. The Vhi Healthcare increases generally take place on 1 September, while the BUPA Ireland increases generally take place on 1 March. ESB SMPF increased their premiums in January, 2005.

<b>Year</b>	<b>BUPA Inflation</b>	<b>Vhi Inflation</b>	<b>ESB SMPF Inflation</b>	<b>Consumer Price Index</b>
1990 / 1991	n.a.	4.0%	13.2%	3.4%
1991 / 1992	n.a.	5.1%	19.4%	3.2%
1992 / 1993	n.a.	4.1%	5.6%	3.0%
1993 / 1994	n.a.	6.0%	3.1%	1.5%
1994 / 1995	n.a.	8.5%	13.2%	2.4%
1995 / 1996	n.a.	6.0%	5.3%	2.5%
1996 / 1997	n.a.	6.0%	6.1%	1.6%
1997 / 1998	9.0%	9.0%	6.1%	1.5%
1998 / 1999	9.0%	9.0%	5.1%	2.4%
1999 / 2000	9.4%	9.4%	8.2%	1.6%
2000 / 2001	6.25%	6.25%	5.9%	5.6%
2001 / 2002	9.4%	9.0%	7.7%	4.9%
2002 / 2003	14.4%	18.0%	12.0%	4.6%
2003 / 2004	8.25%	8.00%	8.6%	3.5%
2004 / 2005	6.0%	3.00%	10.0%	2.2%

Since BUPA Ireland entered the market their eight premium increases (including the increase at 1 March, 2005) have averaged 9% and resulted in a total increase of 98%. Vhi Healthcare's eight increases also average 9% and resulted in a total increase of 98%. It is interesting to note that these values are the same for both insurers. Vhi Healthcare is of the opinion that the premium charged from 1 September, 2004 provides a "true community rate" to their members. However, they claim that it is not sustainable in the absence of risk equalisation transfers.

Drivers of premium inflation in health insurance are:

- Increases in the costs of procedures. The main drivers of increases in the costs of procedures include remuneration levels of healthcare professionals and the cost of hospital accommodation, including public hospital accommodation.

- Increases in the volume of claims. The volume of claims can increase as a result of changes in the risk profile of the population insured or changes in the public awareness and demand for healthcare. It has been argued that a significant driver of the demand for healthcare is the level of supply.
- More expensive treatments replacing older technology and treatments.
- Changes in the levels of efficiency and profit making of insurers as well as changes in reserving strategy.

The table below compares the rates of increase in Vhi Healthcare's premiums per member with the rates of increase in their cost of claim per member calculated from their annual reports for 1996/1997 to 2003/2004. During this period premiums per member increased by about 106%, while the cost of claims per member increased by about 73%. This provides an illustration of the effect that factors other than the cost of claims can have on premium inflation.

Year	Vhi Healthcare Increase in Claims Cost Per Member	Vhi Healthcare Increase in Premium Per Member
1998	5.0%	6.9%
1999	7.9%	11.0%
2000	1.6%	10.6%
2001	9.1%	9.6%
2002	9.0%	7.4%
2003	13.2%	14.1%
2004	11.8%	17.1%

#### *Comparisons with overseas inflation*

Comparisons with overseas rates of premium inflation are difficult and of limited value. This is because the economic conditions (particularly the general rate of inflation), the types of products being sold, the regulatory systems being operated and the initial prices of products differ significantly between different countries. Also, rises in particular costs (such as the nurses pay rise and the rises in the cost of public beds) could have significant effects in Ireland even though they might not reflect international trends. Nevertheless, while the premium inflation rates in Ireland do appear to be on the high side when compared internationally, they do not stand out. The following table illustrates the premium inflation rates in some other countries.

Country	Inflation Rate	Period
Australia	7.1%	2001-2003
<b>Ireland</b>	<b>8.9%</b>	<b>1997- 2004</b>
UK	6.7%	1988-2003
USA	10.4%	1998-2004

#### The Number of Insurers in the Market / New Entrants to the Market.

The market benefits from new insurers entering the market if, for example, these new entrants introduce greater efficiencies, more choice or more innovation.

#### *The entry of VIVAS Health*

VIVAS Health entered the Irish private health insurance market in October 2004 to become the third open-membership insurer in the market. The products offered by VIVAS Health are similar to products that were already available in the market. At the time they were launched, the premiums for these products were similar to the premiums of BUPA Ireland's products. A gap between the premiums for BUPA Ireland's products and VIVAS Health's products has now opened following the 6% increase in BUPA Ireland's premiums on 1 March, 2005.

At the time of the launch of VIVAS Health, Vhi Healthcare introduced a new range of products, which are marketed similarly to those marketed by VIVAS Health (i.e., they are marketed to people at different stages of life). These products are cheaper than the traditional Vhi Healthcare products (A-E, A-E Option, with or without Healthsteps) as they do not provide any cover in the Blackrock Clinic or Mater Private hospitals. It is also implied in a report produced by Price Waterhouse Coopers for Vhi Healthcare that one purpose for the launch of these products was to launch "new market segmenting PMI products". It may be that this would benefit Vhi Healthcare as it would be preferable for them to sell cheaper products to younger people than for the younger people to move to different insurers.

Also, both Vhi Healthcare and BUPA Ireland have significantly increased the level of maternity benefit offered following VIVAS Health's entry to the market.

#### *Potential New Entrants*

There currently appears to be a significant amount of interest from companies considering entering the private health insurance market. The Authority is aware that at least four parties are considering or have recently considered entering the Irish private health insurance market.

*[Ed note: In order to protect the identity and business plans of organisations that are not registered undertakings and that have approached the Authority in confidence, the following section of the report has been removed. This approach is consistent with the Authority's policy in relation to contacts from potential new entrants.]*

*The section describes how these organisations come from a range of backgrounds / corporate structures and propose(d) to adopt a varied range of strategies.]*



[REDACTED]

*Possible impediments to entering the Irish market are:*

- The possible privatisation of Vhi Healthcare, which could lead potential new entrants to await an opportunity to buy Vhi Healthcare;
- The market strength and brand of Vhi Healthcare;
- The fact that BUPA Ireland also has a well established brand and is part of a large international group;
- The non-commercial status of Vhi Healthcare;
- The fear that Vhi Healthcare might be protected by the State;
- The lack of available information on experiences of new entrants in the Irish private health insurance market on which to base business plans; and
- The lack of certainty in relation to whether risk equalisation payments will be commenced and the implications that such uncertainties have for formulating business plans.

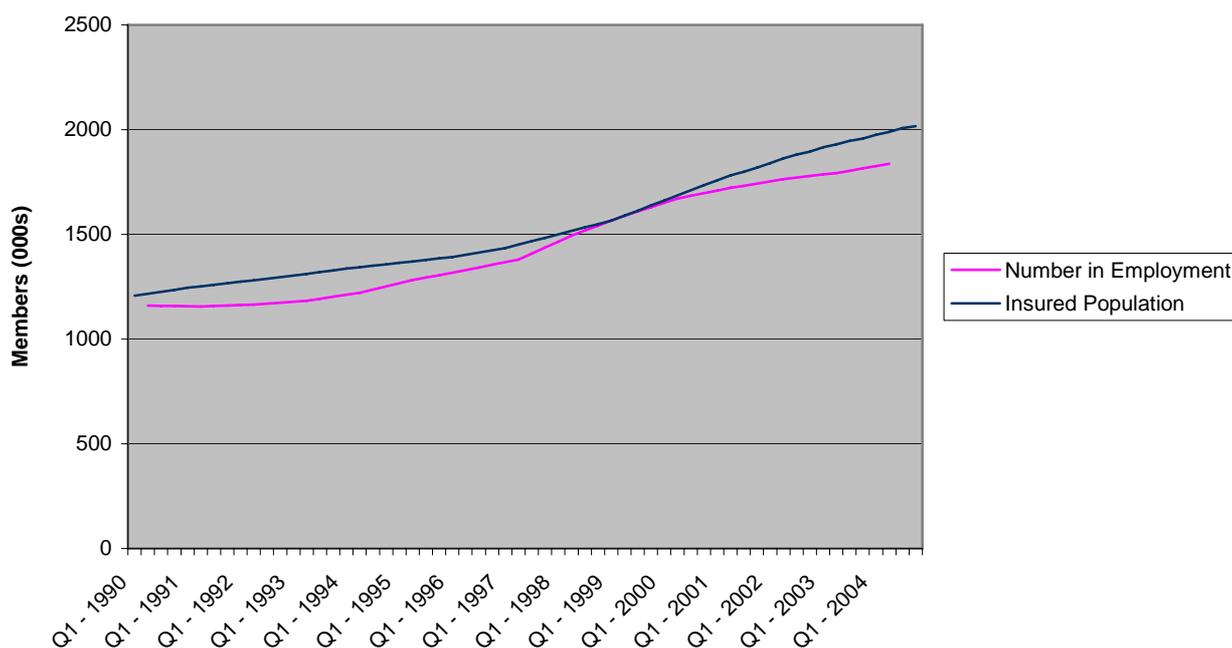
Furthermore, a community rated market without risk equalisation would be more attractive to a new entrant (who would be likely to be a contributor to a scheme) than a community rated market with risk equalisation. This effect is counterbalanced, to some extent, by the 3 year limited exemption and subsequent 6 –12 month phase-in period.

It is worth bearing in mind that the Authority’s research into competition in the Irish market points out that new entrants that would require the absence of risk equalisation to enable them to compete (on the basis of a more advantageous risk profile) because they are either less efficient or require more profit than the insurers in the market, may be increasing the level of profit or inefficiency in the market.

### The Overall Size of the Market

Approximately 50% of the Irish population currently have private health insurance. The graph below shows how the number of insured people and numbers in employment have increased since 1990.

**Growth in Insured Population and Number in Employment**



*Notes on chart:*

1. Seasonal changes in the number in employment are smoothed out.
2. The insured population excludes holders of Vhi Healthcare’s Plan P.
3. The figures for the insured population are taken from the White Paper on Private Health Insurance (1999) as well as from data held by the Health Insurance Authority. Figures for 1999 and 2000 are estimates.
4. Until 2001, only annual figures were available for the insured population, figures for other quarters are calculated by interpolation.

It is clear that there has been strong growth in the number insured since 1990. The above chart shows the correlation between the growth in the insured population and

the growth in the labour force. The growth in the insured population is particularly strong since BUPA Ireland entered the market (growth of around 75,000 p.a. in the years since BUPA Ireland entered, as opposed to growth of around 30,000 p.a. in the previous years). However, the growth in the labour force is also particularly strong over this period (growth of around 65,000 p.a. in the years after BUPA Ireland entered the market as opposed to around 30,000 p.a. in the period before BUPA Ireland's entry). It is therefore difficult to ascertain how much of the growth in the market is due to economic conditions and how much resulted from the entry of BUPA Ireland.

It is likely that the strong growth in the market was at least, in some part, related to the entry of BUPA Ireland and the investment that it made in sales and marketing, as well as the increased investment in sales and marketing made by Vhi Healthcare since 1997. It will be interesting to see whether the entry of VIVAS Health to the market will have any noticeable effect on the future market size.

#### The Zero Sum Adjustment and its Effect on the Sharing of Efficiencies

There is the potential in the Risk Equalisation Scheme for a limited sharing of efficiencies between undertakings even when only age / sex profiles are equalised. This possibility results from the application of the Zero Sum Adjustment, which aims to ensure that transfers to the risk equalisation fund equal transfers from the fund (i.e. to ensure the system is self-financing). In the circumstances of these returns, if full risk equalisation payments were being made, BUPA Ireland would be required to pay about €500,000 more than it would have had to pay if the transfer had been purely based on its own level of efficiencies and on its own health status within age and sex groups. This extra €500,000 could be viewed as a sharing of BUPA Ireland's advantages in terms of efficiencies and in terms of a better health status of members within age / sex groups.

#### The Commercial Status of Insurers

The commercial status of insurers is relevant to whether or not the commencement of risk equalisation would be in the best overall interests of insurers insofar as it impacts on the level of competition existing in the market and the likelihood of new entrants entering the market.

Vhi Healthcare is the major player in the market. The Tánaiste and Minister for Health and Children has ultimate responsibility for Vhi Healthcare and is also ultimately responsible for legislative decisions in the private health insurance market, although The Health Insurance Authority also has significant responsibilities in relation to the regulation of the market. Vhi Healthcare is exempted from the requirements of the Third Non-Life Directive and the Insurance Acts and, therefore, is not required to maintain solvency reserves. Furthermore, Vhi Healthcare is operated on a non-commercial basis and is not required to achieve rates of return.

Therefore, the commercial status of Vhi Healthcare raises two points that may be relevant to any decision relating to the possible commencement of risk equalisation:

- Firstly, commercial insurers, who are mandated to achieve rates of return and must maintain solvency reserves, may find it difficult to compete with Vhi Healthcare after any commencement of risk equalisation and the introduction of risk equalisation might, therefore, remove some competitive pressures from Vhi Healthcare. An example of Vhi Healthcare's willingness to take advantage of its regulatory position is evident from its stated policy of keeping premiums low (they claim at a true community rate) by running down reserves. Their stated willingness and ability to run down reserves, which other insurers could not do (due to statutory minimums) gives the Vhi Healthcare pricing advantages. Vhi Healthcare's regulatory position has also facilitated its expansion into travel insurance, dental insurance, global insurance and an on-line retail service on differing terms than those required of other insurance companies.
- Secondly, it has been argued that, because of its status, regulatory decisions will favour Vhi Healthcare. If potential new entrants to the market were to accept this argument it could dissuade them from entering the market.

It should also be noted that while the non-commercial basis that Vhi Healthcare is mandated to operate on might make it more difficult for other insurers to compete with it, the fact that it is not mandated to make profits might in itself be in the best overall interests of health insurance consumers by having a depressing effect on premium rates.

However, as has been noted by BUPA Ireland, the commercial status of an insurer does not necessarily determine its incentives in the market, and might not, therefore, indicate how such an insurer might react to transfer payments.

There are currently proposals to change the corporate status of Vhi Healthcare and this may result in changes to some of the matters discussed above.

BUPA Ireland is part of a large international provident association. Despite the fact that BUPA Ireland does not have shareholders, it is likely that it will still have goals in terms of achieving rates of return. Surpluses would then benefit BUPA policyholders, though not necessarily BUPA Ireland policyholders.

VIVAS Health is mostly owned by AIB Bank (a public limited company) and investment company, IIU.

## Section F. Staff Review

### Maintenance of Community Rating:

The Authority is required by the Health Insurance Acts 1994 to 2003 to have regard to “the need to maintain the application of community rating across the market for health insurance” when considering the best overall interests of health insurance consumers. In a separate section the Acts state that “community rating” should be construed in accordance with health insurance contracts that charge the same premium as all other such contracts effected by that undertaking. This narrow interpretation of the term community rating does not appear to require that intergenerational solidarity operates across the market. We have received legal advice to the effect that the Authority may take a wider interpretation of the term “community rating” to include intergenerational solidarity. In any case the Authority may take the view that intergenerational solidarity across the market would lead to a more equitable distribution of costs and would, therefore in itself be in the best overall interests of health insurance consumers. Therefore, we will consider intergenerational solidarity in a separate section, in this section we will consider whether the Irish community rated market can remain stable and continue to operate in the absence of risk equalisation.

### *The Stability of the Market*

We have already discussed how the absence of risk equalisation in a community rated market can increase the potential for one or more insurers in the market to enter into a “death spiral”. In previous reports, while we drew attention to the fact that there were some indications that Vhi Healthcare was beginning to lose more of the better risks, we stated that Staff were of the view that there did not appear to be convincing evidence that a death spiral had either commenced, was imminent or would inevitably arise. Since the last report Vhi Healthcare’s lapse rates have reduced, however, their level of sales also continues to fall. While their falling sales figures are a matter of concern, the fact that the sales are now, once more greater than lapses, would lead us to the view that there is still a lack of evidence that a death spiral is imminent or will inevitably arise. Furthermore, Vhi Healthcare’s published profits would indicate that it has some room to manoeuvre in averting such a crisis. Indeed its recent 3% price increase might be a move in this direction and it will be interesting to see how future sales and lapse figures are affected.

It is true that Vhi Healthcare is losing market share but this is not necessarily contrary to the interests of health insurance consumers. It is also true that their average age is growing faster than the market’s average but this would be expected given that any new insurer that is taking market share and attracting many people who are getting insurance for the first time would be expected to have a younger average age.

However, it should be noted that, while there is a lack of convincing evidence that a death spiral is imminent or will inevitably arise, the absence of risk equalisation in a community rated market increases the potential for a death spiral to commence.

Also, while the Authority's review of VIVAS Health products and premiums would not indicate that they intend to compete aggressively on price, if BUPA Ireland or VIVAS Health (or another new entrant) were to adopt such a strategy it could have serious consequences for the stability of the market.

### The Facilitation of Competition between Undertakings

#### *Different Facets of Competition*

It is evident from the fact that BUPA Ireland states that it is making operating profits of about 17.3% of earned premium, before adding investment income, that it is not experiencing competitive pressures in the area of price. BUPA Ireland appears content to follow the price increases of Vhi Healthcare and to continue making very large profits. Such a tactic is facilitated by BUPA Ireland's advantageous risk profile and the current regulatory structure of the market. This is ultimately funded by the Irish consumer. If risk equalisation payments were commenced, the extent to which a price following strategy would be facilitated by the regulatory structure would be greatly reduced. Furthermore, while the level of excess profits currently being achieved may still be considered low in the context of the total premium paid in the market, it is growing and the continued absence of risk equalisation would allow this situation to worsen.

It should also be noted that a review of VIVAS Health's products and premiums would indicate that they will adopt a similar position to BUPA Ireland and look likely to also benefit from excess profits at the expense of consumers.

The dominant position of Vhi Healthcare must also be considered in this context. It would appear that the competitive pressures on Vhi Healthcare would decrease as a result of the introduction of risk equalisation payments. Therefore, there may be a reliance on the non-commercial status of Vhi Healthcare, statements by Vhi Healthcare executive and its Board as well as the willingness and ability of this and future Ministers for Health and Children to ensure that the benefits of risk equalisation payments are passed on to consumers.

It is estimated that, if Vhi Healthcare are obliged to increase their premiums to make up for the absence of risk equalisation and if ESB SMPF pass on the benefit of their transfers and allowing for an increase of BUPA Ireland's premiums, as predicted earlier, the total premium paid would be lower by a factor of around 1.5% to 2% in a market with risk equalisation payments than it would in a market without risk equalisation payments. This assumes that Vhi Healthcare's statement that the 3% announced price increase from 1 September, 2004 "provides a true community rated price to our members ... [which] is not sustainable without risk equalisation" is correct.

The level of price competition could increase significantly in the absence of risk equalisation if a new insurer were to enter the market and use its risk profile advantage to compete aggressively on price, although this does not appear to be the case in respect of VIVAS Health. As noted above such a development would lead to an increased risk of a death spiral developing.

While competition appears to have benefited the quality of customer service provision and product innovation in the market, scope for further innovation would appear to remain. The advent of further new entrants to the market could increase the level of innovation and the absence of risk equalisation would make the market more attractive to new entrants. However, new entrants that require the absence of risk equalisation in order to enable them to compete would be unlikely to enter a market that could introduce risk equalisation at some time in the future.

#### *Basis for Competition*

In the absence of risk equalisation, insurers in a community rated market are likely to concentrate on competing on the basis of risk profile management, i.e. securing competitive advantage through securing a better risk profile than competitors, rather than securing competitive advantage by driving costs down, being innovative, offering better quality service etc. Competition on the basis of securing a better risk profile would not appear to be particularly beneficial to consumers. Therefore the benefits of competition are more likely to be enjoyed by consumers in a competitive community rated market with risk equalisation than in a competitive community rated market without risk equalisation.

#### *Competition in Different Segments of the Market*

In a community rated market without risk equalisation there is little or no incentive for insurers to compete for older persons. In these circumstances one would expect competitive pressures to be directed at acquiring younger lives, with very limited effort being put in to addressing issues specifically related to the older members of the community. Examples of this phenomenon include the large increase in maternity benefits, 10% discount for people who purchase insurance on-line and the selective waiving of waiting periods for low risk lives. It is true that a higher level of competition for younger people can benefit a community rated market, but even if risk equalisation were introduced it would remain in the interests of insurers to attract younger lives. It is considered that the benefits that would accrue to older lives by providing insurers with an incentive to compete for them would outweigh any negative effect resulting from a reduction in the incentive to attract younger lives. In any case, the aim of maintaining a lower risk community is more appropriately achieved through the introduction of unfunded lifetime community rating.

#### *The sharing of efficiencies*

Part of the about €500,000 (for the six-month period) that BUPA Ireland would have to make as a result of the Zero Sum Adjustment could result in a sharing of efficiencies. However, if the Authority is of the view that risks should be shared across the market through the implementation of risk equalisation then any such extra payment should be viewed in the context of the about €16.8m payment (for the six-month period) that would result from differences in the age / sex profile of members.

## Intergenerational Solidarity

As noted, BUPA Ireland benefits from the community rated market, in the absence of risk equalisation. BUPA Ireland customers also benefit. Each member of Vhi Healthcare and ESB SMPF currently funds a higher proportion of the total risk in the market than each member of BUPA Ireland funds. If risk equalisation were introduced, the total risk in the market would be shared more evenly across insured persons in line with the principle of intergenerational solidarity, so that, Vhi Healthcare would not have to increase their premiums further to compensate for the absence of risk equalisation. It is likely that BUPA Ireland's premiums would increase as their members fund a greater amount of risk.

## The rise of the Market Equalisation Percentage

The MEP has risen from 0 (before BUPA Ireland commenced business) to 4.7% in about 8 years. In one year, the MEP has grown by 1 percentage point. The increase over this 12 month period, however may be due to random fluctuations or variation in the time taken to settle claims. It would appear that, since BUPA Ireland entered the market the MEP has grown at an average rate of just over 0.5 percentage points p.a. ~~It would appear that the MEP is growing at a rate of 0.5 to 1 percentage point per year.~~ The view that the trend is upward is also based on the following analysis:

- The MEP is linked to the relative market shares of different insurers and to the relative risk profiles of the insurers in the market.
- BUPA Ireland's market share has grown steadily every quarter since 2001. Prior to this date available data is limited, but BUPA Ireland's share of the membership with insurers that are currently subject to risk equalisation grew from 0% to over 12% between 1997 and mid 2001. Its market share has since grown steadily to about 20%.
- Even if some consumers that would in the past have joined BUPA Ireland now join VIVAS Health, causing a slow down in the growth of BUPA Ireland's market share, the MEP is likely to continue to grow.
- There is no reason to believe that BUPA Ireland's risk profile relative to Vhi Healthcare's will change significantly for many years.

Therefore, we would expect the growth in the MEP to continue as BUPA Ireland's market share grows and we would not expect the counter effect of BUPA Ireland acquiring an older population to be significant for many years. BUPA Ireland argues that the rate of growth in the MEP might relate to the growth in the overall market. To the extent that the growth in BUPA Ireland's market share is related to the growth in the market, this argument may be valid. The growth in BUPA Ireland's market share has occurred in the context of a growing market. It may be the case that if the overall market ceased to grow then so too might BUPA Ireland's share of the market and the MEP, although it is also possible that BUPA Ireland's market share would continue to grow even in a declining market. For example, some consumers might move from Vhi Healthcare to cheaper policies with BUPA Ireland rather than leave the market.

In the main the above analysis considers the trend in the MEP in the absence of risk equalisation payments. If risk equalisation payments are commenced the consequent changes in premium rates would be likely to have an impact on the relative growth in insurers' memberships and, therefore, the trend in the MEP would be expected to be different.

## **Pros and Cons of Introducing Risk Equalisation**

### Pros

- The introduction of risk equalisation could result in the level of premium charged being lower than it would otherwise be if the benefit of transfers is passed on to consumers.
- The competitive pressure on BUPA Ireland would be increased and they would no longer be in a position to engage in price following.
- The risk of the level of excess profits growing significantly as a result of price following, facilitated by the regulatory structure, would be reduced.
- The costs of the different levels of risk in the market would be more equitably distributed throughout the market in accordance with the principle of intergenerational solidarity.
- The risk of a death spiral developing would be reduced.
- The introduction of risk equalisation could result in a redirection of competition towards areas other than risk profile management, which would be more beneficial to consumers.
- The possibility that inefficient or profiteering insurers could thrive at the expense of consumers on the basis of their lower risk profiles would be reduced.
- Uncertainty surrounding whether or not risk equalisation will be introduced would be removed.
- The introduction of risk equalisation would result in a change to the current situation, where there are significant incentives for insurers to attract younger healthier lives and significant disincentives against attracting older less healthy lives to one in which the incentivisation for insurers would be shared more evenly across all lives in the community.

### Cons

- Currently the market appears to be stable, in that it is not clear, from the evidence available, that instability is imminent or will inevitably arise as result of the absence of risk equalisation. While the previous sentence reflects the view of Staff, Vhi Healthcare state that their solvency is threatened. They have provided forecasts to support this statement; however, the bases for these forecasts have not been provided.
- According to the data received by the Authority from BUPA Ireland it would appear that the level of excess premium being charged as a result of the absence of risk equalisation would currently not appear to be significant, in the context of the overall premium paid in the market.
- The competitive pressures on Vhi Healthcare would be reduced.

- Vhi Healthcare may require tighter regulation in order to ensure that it operates on a non-commercial basis and that it does not abuse a dominant position.
- Premiums in the market could increase if the insurers receiving transfers do not pass the benefit on to consumers.
- In any event the lower premiums in the market are likely to increase.
- It could result in some limited sharing of efficiencies.
- Further information could be available with later returns, which could inform considerations.
- An anomaly exists in the Scheme in relation to health services providers, which may have an impact on competition between such providers.
- The market would become less attractive to new entrants.

## **Section G: Examination of Representations from Insurers.**

In this section comments are included in respect of representations, where appropriate, but bearing in mind that arguments and/or statements of opinion by registered undertakings may be repeated. In these circumstances, we have not deemed it necessary to comment each time the argument is made. Also, we have not deemed it necessary to comment on statements of opinion.

### **BUPA Ireland's Representations:**

Received from BUPA Ireland, Martin O'Rourke, *Managing Director*

5 April 2005

Dear Dermot

### **Proposed Recommendation in relation to Risk Equalisation**

I enclose the submissions on behalf of BUPA Ireland in respect of the Authority's proposed recommendation to the Minister in relation to Risk Equalisation.

Please note that certain sections of the submissions are commercially sensitive and legally confidential. I would be happy to identify these for you on request. Meanwhile I should be obliged for your confirmation that they will not be divulged to any other party without our consent.

I should draw your attention to the fact that BUPA Ireland's ability to respond has been limited by two factors. The first is timing, in that the Authority's delivery of its notification on 15 March 2005 meant that the statutory 21 day consultation period was interrupted by two holiday periods (St. Patrick's Day and the Easter vacation). This reduced the effective time available to BUPA Ireland to exercise its statutory right to respond to the draft recommendation. Secondly, although the Authority has twice confirmed to BUPA Ireland that its 15 March letter contains all the reasons for the Authority's decision. That letter canvasses a range of issues but generally fails to explain the conclusion the Authority seeks to draw from such issues, or the evidential and analytical basis for any such conclusion. In short, the letter does not provide an adequate explanation of the reasons for the proposed recommendation. BUPA Ireland regrets that the Authority has not provided the additional clarification and documents requested in our letters of 23 March, 30 March and 31 March and reserves the right to make such additional submissions as may be appropriate once such information and documentation is forthcoming.

Finally, I should make clear that BUPA Ireland is furnishing these submissions without prejudice to any current or future objections concerning the validity of any aspect of the Risk Equalisation regime or of any act or omission in compliance or purported compliance with the provisions thereof. In addition, BUPA Ireland

specifically reserves its rights in respect of the manner in which the Authority has purported to give notice of its draft recommendation.

In the circumstances we repeat our request and look forward to hearing from you as a matter of urgency.

Yours sincerely

*Martin*

## A. EXECUTIVE SUMMARY

### **BUPA Ireland submits that the Authority should reverse its proposed recommendation for the following reasons:**

- The commencement of Risk Equalisation would be a catastrophic intervention in the market. The effect of this recommendation, if adopted, would be to confiscate efficiently earned profits, inevitably driving BUPA Ireland from the market for the benefit of the VHI. BUPA Ireland would be most concerned if the VHI's profitability was confused with the welfare of the market.

The profitability of insurers was considered in this Report (Section B.4, Section D “Financial Information”, Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”). This was considered relevant to the effect that risk equalisation might have on the solvency and business plans of insurers and on the premiums paid by consumers. Any risks to the solvency of insurers, which would affect the stability of the market and which emanate from the regulatory structure (i.e. a community rated market without risk equalisation) were considered to be relevant to the Authority's deliberations.

With regard to the reference to “efficiently earned profits”, on the basis of the data available it would appear that BUPA Ireland's level of profits relate substantially to the age and gender profile of its membership and to price following.

- The Authority cannot and has not justified its proposed recommendation on the basis that Risk Equalisation will facilitate competition. Since the arrival of BUPA Ireland into the market, consumers, and in particular the less well-off, have benefited greatly from competition. The commencement of Risk Equalisation payments would mean that, annually, BUPA Ireland would pay over to VHI a sum that is double its operating profits.

The impact of the introduction of risk equalisation on competition is unclear, for example the competitive pressures on Vhi Healthcare might reduce but the competitive pressure on BUPA Ireland might increase. The Authority, however, considered in its proposed recommendation that *“the Authority's previously expressed concern as to a possible reduction in competitive pressure if risk equalisation payments are commenced has now diminished. The Authority is now of the view that the benefits to health insurance consumers, which would accrue from the commencement of risk equalisation payments would outweigh any countervailing factors.”* As BUPA Ireland acknowledge, the proposed recommendation was not justified solely on the basis that competition would be facilitated.

- Even if BUPA Ireland could remain in the market and increase its premiums to cover the costs of Risk Equalisation, its products would be uncompetitive. Such increases would hit customers for BUPA Ireland's lower priced packages

the hardest. There is a very strong possibility that these customers would opt out of private health insurance altogether, thereby depriving those individuals of the benefits of private health insurance;

Analysis carried out by Staff of the Authority does not show evidence that BUPA Ireland would be obliged, as a result of risk equalisation payments, to increase its premiums, to such an extent that its products would be uncompetitive. (Refer to Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”)

It is possible that increases in BUPA Ireland’s premiums will cause some people to leave the health insurance market. However, in this context it is worth noting that BUPA Ireland continued to grow following the 14.4% increase in their premiums in March 2003. Furthermore, consumers now have the option of switching to VIVAS Health (or, as has always been an option, Vhi Healthcare) rather than leaving the market altogether.

- **In any event, BUPA Ireland would not ever plan to remain in the market under these circumstances. Our analysis shows that the commencement of risk equalization would render the business commercially unviable under any pricing scenario.**

This matter is considered earlier in the Report (Refer to Section E, “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”. The consideration reflects the comment in BUPA Ireland’s representations but applies further analysis to the issue. We repeat this analysis here, for convenience:

It has previously been suggested that BUPA Ireland might be driven from the market by the introduction of risk equalisation, although based on the Authority’s analysis, this would not appear to be a logical reaction. Considering the investment that BUPA Ireland has made in Ireland, the brand that it has built and the client base that it has developed (401,000 members), it would appear that continuing to compete with Vhi Healthcare would be a more logical reaction. Furthermore, when BUPA Ireland entered the market, the Irish legislative regime to give effect to a risk equalisation scheme had already been enacted. However, it should be noted that, in their representations, BUPA Ireland are adamant that they would withdraw from the Irish market if a decision to commence risk equalisation was confirmed. In this context the possibility of BUPA Ireland withdrawing from the market should be considered.

The withdrawal of BUPA Ireland could have negative consequences for consumers in relation to reduced consumer choice and reduced competitive pressure in the market. However, the following should also be noted:

- Withdrawal by BUPA Ireland need not necessarily result in a reduction in competition (another insurer could purchase the BUPA Ireland Business).
- If an insurer cannot compete with other insurers when it has the market risk profile, then it could be argued that it is either introducing inefficiencies into the market or that it has unrealistic profit requirements.

Vhi Healthcare are equally adamant that their business is not viable without risk equalisation. The Authority would need to weigh the credibility and the effects of BUPA Ireland's and Vhi Healthcare's claims against each other.

- The Health Insurance Acts 1994 - 2003 stipulate that the Health Insurance Authority can only recommend its introduction where this is in "*the best overall interests of health insurance consumers*". In this, the Authority must consider, reason and properly articulate why the introduction of Risk Equalisation would (a) maintain the application of the community rating across the Irish health insurance market, and (b) facilitate competition between undertakings. BUPA Ireland submits that the Authority has neither properly reasoned nor articulated (as it must) why Risk Equalisation should now be introduced, nor could it do so based on the evidence and analysis before it.

Firstly, it is appropriate to clarify that the Acts state the Authority must "have regard to" the best overall interests of health insurance consumers (Refer to Health Insurance (Amendment) Act 2001 9(4)(c)).

The Authority has had regard to the "best overall interests of health insurance consumers" and is satisfied that its recommendation is grounded exclusively on that basis. The Authority is satisfied that reasons were sufficiently set forth in the proposed recommendation but for the avoidance of doubt, has now set them forth more fully in this Report.

- In terms of the Authority's reliance on nine previously identified factors, we were not in a position to ascertain the extent to which the Authority is relying on them. Moreover, it is not even clear what significance the Authority attaches to changes in any of those factors. For example, the Authority is unclear as to whether an increase in the number of insurers strengthens or weakens any claim for the commencement of Risk Equalisation.

The Authority provided full reasons for its proposed recommendation in its letter dated 15 March, 2005. There is no obligation on the Authority to link these reasons to the nine factors. Rather, it is the function of the Authority to weigh these factors carefully and collectively in making a balanced judgment.

- "Community rating" is expressly defined by the Acts. The maintenance of community rating, as so defined, is not under any threat. All health insurers in the Irish market, apply community rating as defined. The Authority is not justified in recommending the introduction of Risk Equalisation to allegedly guard against a threat to community rating that does not (and may never) exist.

An unstable community rated market may not be viable. If a community rated market is more likely to become unstable in the absence of risk equalisation then, in order to maintain community rating across the market for health insurance, it may be appropriate to commence risk equalisation payments. In any event the definition of the best overall interests of health insurance consumers is not an exhaustive definition

and it is open to the Authority to consider that the maintenance of a stable market is in itself in the best overall interests of health insurance consumers.

It could also be argued that the wording “across the market” implies an interpretation different from that contended for by BUPA.

- If there was an immediate threat to community rating, the Authority must clearly identify it, and identify how Risk Equalisation is the only available intervention to prevent it. In a previous recommendation, the Authority indicated that, all else being equal, it would only propose commencement if the risk of instability was inevitable. Now, despite no material change in relevant circumstances, the Authority is proposing commencement.

There are three points to be made in relation to the above paragraph.

- BUPA Ireland’s views in relation to what the Authority must do regarding establishing the immediacy of a threat etc. is not borne out by the legislation.
- BUPA Ireland is misrepresenting the Authority’s previously stated views. The Authority previously stated *“If the Authority considered that such a threat were imminent or would inevitably arise it would, all else being equal, commence risk equalisation payments in order to maintain community rating”*. The Authority did not state that these would be the only circumstances in which it would recommend that payments be commenced.
- There has been a material change in the relevant circumstances as outlined in the proposed recommendation.
  - In so far as any change in the MEP is being relied upon by the Authority, there is no proper analysis of why the MEP has increased e.g. due to increased hospital charges, or increases in the number of consumers in the market. Seasonality in the data is also ignored, as are possible discrepancies in returns filed by the insurers.

It would appear that the growth in the MEP is related to the growth in BUPA Ireland’s market share. If the trend in BUPA Ireland’s market share continues to be upward and there is no significant change in the age and gender profiles of insurers then the trend in the MEP will be upward. The following points are relevant.

- The MEP has increased from 0% to 4.7% since the entry of BUPA Ireland.
- The growth in BUPA Ireland’s market share has been consistent, at least since 2001 (prior to that data is limited). If BUPA Ireland continues to grow as in the past and there is no significant change in age/gender profiles then the MEP will continue to grow.
- There is no evidence that significant changes are occurring with regard

to the relative age and gender profiles of insurers.

- The MEP has grown from 3.7% in respect of the second half of 2003 to 4.7% in respect of the second half of 2004.
- It is unlikely that any of the above factors would be significantly affected by seasonality, however other fluctuations may have some impact on the values of the MEP at different points in time.
- There is volatility in the value of the MEP, largely resulting from variations in the amount paid by BUPA Ireland in respect of settled claims, particularly in the over 80s age group. However, an analysis that is based on the growth of BUPA Ireland and the relative age and gender profiles of insurers should not be affected by this.

The Authority has worked to achieve consistency in returns across the market and to gauge the extent of any inconsistencies that may exist. The Authority is not aware of any material discrepancies in returns filed.

- o Even if the VHI receives payments, it has absolutely no economic incentive to pass these on to consumers. Therefore, the commencement of Risk Equalisation will not result in an average reduction in premiums paid by consumers. In fact, the opposite will result with the reconstitution of the State monopoly.

The possibility that risk equalisation payments will not result in lower premiums for Vhi Healthcare than would otherwise be the case was considered. (Refer to Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”). In this context such benefits were described as potential. It may be worth noting that Vhi Healthcare state that it has already passed the risk equalisation transfer on to consumers (through the lower than normal rise in premiums last year). The question therefore becomes whether Vhi Healthcare could maintain this lower price and remain solvent in the absence of risk equalisation.

- In its analysis the Authority has made a number of fundamental errors and has been inconsistent with its previously stated approach. As will be demonstrated, for example: it is not open to the Authority to base its decision on the *"possibility"* of a *"threat to market stability"* or on any other conjectured or theoretical future problems; an increase in the MEP of 1.2% does not equate to an imminent or inevitable threat to market stability (if that is the appropriate standard, which is not the case).

The MEP is only one of a number of factors considered by the Authority.

Imminence / inevitability of instability is not and never was a prerequisite for the commencement of risk equalisation payments.

One of the concerns of the Authority has been to identify threats to market stability, assess how imminent or realistic such threats might be and consider the timeliness of market intervention so as to preclude such a threat materialising in such a way as to prejudice “the best overall interests of health insurance consumers”. This is part of the range of considerations entertained by the Authority in accordance with the legislation. The Authority is satisfied that it was open to it to do so.

## **B. THE CURRENT STATE OF THE IRISH HEALTH INSURANCE MARKET**

1. The arrival of BUPA Ireland in 1996 did not have adverse effects on VHI nor on consumers, nor on the market for health insurance in Ireland, which had been predicted in certain quarters. The doomsday scenarios traditionally advanced as a justification for Risk Equalisation have never materialised, nor is there any evidence that they are likely to do so now. On the contrary, the element of competition succeeded in providing the incentive for VHI to adapt and improve. The introduction of competition has clearly been beneficial in this regard. Over the last 9 years:

Vhi Healthcare do not concur that the entry of BUPA Ireland did not have adverse effects on them.

The doomsday scenarios referred to by BUPA Ireland are understood to refer to:

- Earning of excessive profits by insurers with lower risk profiles that price follow, being facilitated by the regulatory structure.
- Instability resulting from the growing significance of risk profile differences.

Staff are of the view that there is evidence of the former and that the possibility of the latter arising is increasing.

- (a) the total number of individuals availing of private health insurance in Ireland has grown by over 40%.
- (b) Over 550,000 more Irish citizens now avail of health insurance.
- (c) The proportion of Irish residents covered by health insurance has increased from 34% to 49% of the population.

The growth in the market was considered earlier in the Report. (Section E “The Overall Size of the Market”).

- d) The range and extent of cover available to Irish consumers has significantly improved.  
Currently, there are at least forty different products on offer in the market, with a myriad of possible add-ons.
- (e) The quality of customer service offered has notably improved since an element of choice was offered in the Irish market.

The benefits of competition (including its effects on competition and customer

service) were considered earlier in the Report. See in particular:

- Section B “Risk Equalisation and Competition”.
- Section D “New Entrants”.
- Section E “The Number of Insurers in the Market / New Entrants to the Market”.
- Section F “The facilitation of competition”.

2. These figures tell their own story. Established sound market theory as to responsible regulatory practice posits, quite correctly, that there should be no intervention in the market unless there is a market failure. The evidence here does not support the suggestion that the market can possibly be characterised as "unstable" or as requiring radical regulatory intervention.<sup>1</sup>

These are the views of BUPA Ireland. Also, it is not clear what is meant by “market failure”. It is unclear whether BUPA Ireland considers the facilitation, by the regulatory regime, of large profits at the expense of consumers or an increased possibility of instability to constitute “market failure”. Waiting to intervene only when the market is already displaying clear evidence of an existing threat to stability could be too late to have confidence of fully avoiding the consequences of such a threat.

3. One interesting feature of the competitive environment, which again undermines the case for Risk Equalisation to protect the VHI, is that the VHI's business has not suffered as a result of the introduction of an element of competition. The VHI is now one of the most profitable insurers in Ireland. It is far more profitable and financially secure now than it was prior to the arrival of BUPA Ireland.

- Its current reserves of €278m (or more) compare to a figure of just €87.7m in 1997.
- It is making record profits of €73m to February 2004<sup>2</sup>.
- In the year to February 2004, it reported a pretax return on capital of over 30% as against 3% in 1997.<sup>3</sup>
- It now has over 1.55 million members, c. 200,00 more than it did before BUPA Ireland's arrival
- It enjoys an annual premium income in excess of €800 million compared to about €356 million in 1997

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<sup>1</sup> See – “Towards Better Regulation”, Department of the Taoiseach

<sup>2</sup> Prior to investment income, tax and unexpired risk reserve.

<sup>3</sup> Prior to unexpired risk reserve and disregarding tax.

Again, Vhi Healthcare may argue that its business has suffered as a result of the introduction of an element of competition in the absence of risk equalisation.

The points relating to the financial strength and security of Vhi Healthcare were considered earlier, in Section E.

In relation to the fourth bullet point, it is true that Vhi Healthcare now has over 1.55 million members, but this is actually about 150,000 more than it did before BUPA Ireland's arrival, rather than the figure given above.

4. Accordingly it is hard to see how a case could possibly be advanced in support of the proposition that the Authority would be entitled to consider that Risk Equalisation payments were required in favour of the VHI. That is so despite its attempts to assert an imminent financial crisis.

The Authority does not make its decision "in favour of the VHI" or of any other registered undertakings. The Authority has regard for the best overall interests of health insurance consumers.

## **C. THE RELATIONSHIP BETWEEN RISK EQUALISATION AND COMMUNITY RATING**

5. Obviously, the need for Risk Equalisation payments has to be assessed against the background of the notion of community rating that is applied in a particular market. With community rating as applied under Irish law, the requirement for such payments is not at all apparent when insurers are permitted to reflect differences in the risk characteristics of the group of customers who choose a particular policy in the corresponding premium.

BUPA Ireland appears to be looking at community rating across a subset of the market. The Act refers to having regard to the “application of community rating across the market” – this suggests that it is at least open to the Authority to consider the market as a whole.

Regardless of this point, an unstable community rated market may not be viable. If a community rated market is more likely to become unstable in the absence of risk equalisation then, in order to maintain community rating across the market for health insurance, it may be appropriate to commence risk equalisation payments. In any event the definition of the best overall interests of health insurance consumers is not an exhaustive definition and it is open to the Authority to consider that the maintenance of a stable market is in itself within the definition of “the best overall interests of health insurance consumers”.

6. Irish law requires that everyone pays the same premium for contracts that are similar (or identical) in terms of the benefits they offer, which contracts must at least cover the minimum benefits (which are hugely exceeded in the market), with provision for renewals provided that the insurer continues to offer the product in question. Insurers can offer different contracts, and charge different premiums, without any restrictions on the extent to which the differences in prices can reflect differences in the risk profile of the subgroup of customers who choose a particular policy. There is no obligation to price individual policies on the basis of the community risk profile rather than the risk profile of the group of customers who choose the policy. In that sense insurers are free to adjust prices to take account of the risks that they face. Seen in this light, the justification for commencing risk equalisation payments is non-existent.

7. In Ireland's case there is no requirement to have cross-subsidies across policies (even though the 'profitability' of policies, and thus the extent to which they contribute to an insurer's fixed and common costs, may differ across policies). In Ireland's case, there is no requirement for subsidies, and community rating (to the extent that it is shorthand for compliance with existing legal obligations) could be maintained even if

one insurer had most of the customers with the greatest propensity to make claims. There is no reason to expect that the ability of competitors systematically to target particular groups of customers differs materially nor that differences in risk profiles would result in threats to the maintenance of community rating.

The Authority is aware of the definition of community rating in the legislation (although the Authority's legal advisers indicate that the Authority would have more flexibility than BUPA Ireland would suggest). Even without recourse to this flexibility it is worth noting again that an unstable community rated market may not be viable. If a community rated market is more likely to become unstable in the absence of risk equalisation then, in order to maintain community rating across the market for health insurance, it may be appropriate to commence risk equalisation payments. In any event, the definition of the best overall interests of health insurance consumers is not an exhaustive definition and it is open to the Authority to consider that the maintenance of a stable market is in itself in the best overall interests of health insurance consumers.

It is also open to the Authority to consider that the concept of intergenerational solidarity is within the definition of "the best overall interests of health insurance consumers".

#### **D. THE ROLE OF THE AUTHORITY - STATUTORY CRITERIA FOR RISK EQUALISATION**

8. The only relevant consideration for the Authority in determining whether to recommend commencement of Risk Equalisation is whether Risk Equalisation is in the "*best overall interests of health insurance consumers*". The "best overall interest of health insurance consumers" is defined<sup>4</sup> as including "*the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings*". Although the Risk Equalisation Scheme refer to changes in the MEP, the legislation makes clear that the best interests of the consumer is the criterion. Changes in the MEP or MPEA do not of themselves demonstrate that the commencement of Risk Equalisation would meet the criterion.

9. The powers and functions provided for in the Acts and the Scheme must be exercised by the Authority in accordance with both Irish and European law. This requires, inter alia, (a) fair procedures and (b) appropriate consultation in respect of any proposed recommendation, including the reasons and basis for any such proposed recommendation. It also extends to a requirement that any proposed regulatory intervention must be shown to be necessary, justified and proportionate.

The Authority acknowledges that its proposed regulatory interaction must be objectively necessary and proportionate. This has been a paramount element of the deliberations of the Authority.

10. To discharge its statutory functions, the Authority must identify a basis for ascertaining the best overall interests of health insurance consumers. The starting point of that analysis must be that, more often than not, consumer interest is best served by allowing free and unfettered competition, minimising distortions such as subsidies. Free and unfettered competition drives price towards marginal cost, improves efficiency and product variety, and ultimately allows more consumers to avail of an increasing array of health insurance products. Certainly, as demonstrated earlier, that has been the experience of Irish consumers of health insurance products since BUPA Ireland entered the market. Competition is already restricted by provisions such as Minimum Benefit and Open Enrolment. However, the commencement of Risk Equalisation would remove meaningful competition in the Irish health insurance market, which could not be justified on the basis of any compelling social policy such as the best interests of health insurance consumers, or the protection of community rating.

The benefits of competition were considered by Staff of the Authority. (Refer to Section B.3). The argument that Vhi Healthcare is currently "fettered" in competing

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<sup>4</sup> Section 12(10)(a)(iii)

with BUPA Ireland by the existence of a community rated market without risk equalisation is also relevant.

11. The commencement of Risk Equalisation, which would require a much smaller insurance provider to pay a subsidy representing twice its current profits to the dominant Irish supplier, is clearly a fundamental change to the market and a barrier to normal competition. There should be a strong presumption against such a result and in favour of competition for several reasons, including the following:

The commencement of risk equalisation payments would not constitute a subsidy. The Authority is in agreement with the Society of Actuaries in Ireland that risk equalisation is a logical concomitant to community rating. The absence of risk equalisation in a community rated market gives a regulatory advantage to insurers with lower risk profiles. Risk equalisation aims to considerably reduce this advantage. While it may be argued that in the particular circumstances of the Irish private health insurance market it may be in the best overall interests of health insurance consumers to afford some form of advantage to new entrants in order to facilitate competition, it is not the case that risk equalisation payments would be a subsidy. Risk equalisation payments aim to considerably reduce the regulatory advantage held by those insurers with significantly lower risk profiles. The Authority must have regard to whether such a regulatory advantage (i.e. the advantage currently held by insurers with lower risk profiles) is harmful to the best overall interests of health insurance consumers by, for example, reducing the competitive pressure on insurers with lower risk profiles or impacting negatively on the maintenance of community rating across the market.

It is accepted that the commencement of risk equalisation payments would be a significant change and that it could have an uncertain effect on competition. In the context of BUPA Ireland's claim that the change would be fundamental, it may be noted that risk equalisation schemes have been legislated for in Ireland for a number of years, including prior to BUPA Ireland's entry to the market. Staff considered the possible effects on competition in depth (Refer to Section F). It is worth noting in the context of BUPA Ireland's comments that the risk equalisation payment that would have accrued for 2004 was about €28.6m, while BUPA Ireland made more than €25.8m in profit (before investment income and tax) in the same year.

- the desirability of increasing consumer choice and fostering an environment in which a number of different providers operate.

This was considered (Refer to Section B.3, Section B.6, Section E "The Number of Insurers in the Market / New Entrants to the Market") and Section F "The Facilitation of Competition").

- the avoidance of a situation in which one company's dominance of the market is reinforced with an 80% market share.

Abuse of dominance would be an issue more than dominance itself. The Authority considered market shares and the impact that risk equalisation might have on the ability of insurers to compete with each other (Refer to Section E: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”).

- the introduction of competition across throughout the economy is central to Irish economic policy

Competition is also central to the Authority’s deliberations (throughout this Report).

- Ireland operates a sophisticated system of competition law reflecting a deliberate legislative choice by the Oireachtas that unrestricted competition is in the best overall interests of health insurance consumers

The Health Insurance Acts and Risk Equalisation Scheme are a deliberate legislative choice by the Oireachtas.

- the provision of private medical insurance has been liberalised under EC law, and although Member States may regulate for the common good, the guiding principle is that competition best serves the interest of consumers
- The need to "facilitate competition" is expressly mentioned as one of the factors to be considered by the Authority in ascertaining the best overall interests of health insurance consumers

These issues have either not been addressed by the Authority in its draft recommendation or have been referred to in the most cursory and superficial manner. There is no evidence in the draft recommendation (or as far as BUPA Ireland is aware, elsewhere) of any meaningful analysis of the application of these considerations. To the extent (and we were unable to clarify this) that reliance was placed by the Authority on the York Report, there is attached, as Annex, a letter from Dotecon, Economic Consultants, demonstrating that the contents of that Report would not provide economic justification for the Authority's proposed recommendation.

The benefits of competition were considered, but not in isolation. Consideration of competition is evident in a number of sections in the Report and also the York Report.

12. The Authority must also have due regard to the fact that the provision of health insurance is already heavily regulated in Ireland. There is a panoply of

legislative safeguards in place to preserve community rating and to protect consumers. These include the Health Insurance Acts and regulations thereunder, including in particular the provisions dealing with Minimum Benefit, Lifetime Cover and Open Enrolment. The Authority must consider why further regulatory intervention is required to maintain the statutory objective of advancing the interests of health insurance consumers, or whether the existing legal safeguards sufficiently achieve this aim. Even if the Authority considered that further regulatory intervention was required (and in BUPA Ireland's submission there is no basis for such an opinion) the Authority must also consider, by way of combining with its statutory obligation, whether the commencement of Risk Equalisation was the appropriate way to remedy any market failure. In making its Report to the Minister, the Authority may propose alternatives to commencement, and in this case, it should do so.

The Authority's proposed recommendation was made in full knowledge of the regulatory structure. The provision of health insurance is regulated in terms of community rating. It is because of this regulation that risk equalisation payments may be required.

No "alternatives to commencement" have been proposed by BUPA Ireland.

13. The Authority is also required to consider (as part of the best overall interests of health insurance consumers) the "need to maintain the application of community rating". Section 7 of the 1994 Act defines "community rating": Irish insurers generally cannot charge different premiums depending on the individual's risk profile but must (subject to very limited exceptions) charge the same premium to all individuals availing of the same products for the same periods. The position as regards community rating in that sense is clear. As far as BUPA Ireland is aware, all Irish insurers are complying with that requirement and the Authority has not advanced evidence to the contrary. It is difficult to see how the introduction of Risk Equalisation could possibly be justified by reference to a need to maintain community rating, in circumstances in which there is no evidence to suggest that community rating is not already being adhered to. Given the existing statutory protection of community rating and the absence of any significant issue as to the effectiveness of those measures, it is impossible to see any basis upon which Risk Equalisation could be justified as a proportionate measure by reference to a perceived need to maintain community rating. The obvious way to maintain community rating is by enforcing existing legal requirements. The use of Risk Equalisation payments for this purpose would be ineffective, disproportionate and indeed irrational. We make further submissions in relation to the unsuitability of Risk Equalisation to moderate or ensure compliance with community rating in Section D below.

This point has already been addressed.

14. Although it is difficult to see how the Authority could attribute any meaning to "community rating", other than that expressly provided for in the Acts( and despite any argument that the VHI has made), the same conclusion would be reached even if the related concepts of "open enrolment" and "minimum benefit" were deemed to be included in the concept of community rating. There is no logical connection between the commencement of Risk Equalisation payments and the objective of compliance with the Minimum Benefit, Lifetime Cover and Open Enrolment Regulations. **Compliance with those requirements is a matter of legal fact.** We note that the Authority has no powers of enforcement in that regard. **The statutory objective is being and will continue to be maintained in the absence of Risk Equalisation**<sup>5</sup>. Therefore it is difficult to see any basis on which it is contended that there is any actual or perceived threat to community rating which could or should be addressed by the commencement of Risk Equalisation. Risk Equalisation has not been demonstrated to be either necessary or proportionate in circumstances in which those requirements were being adequately addressed already by law.

[This point has already been addressed.](#)

15. **The Authority has not asked the relevant statutory question:** namely, how would Risk Equalisation benefit consumers given that its introduction cannot be justified by reference to the need to maintain community rating. Given its inevitable anti-competitive consequences, specifically, the removal of BUPA Ireland from the market which would reduce competition in the market and the welfare loss for consumers, it is entirely disproportionate to any notional benefit that might be derived by the VHI. As we will demonstrate, even if there was a windfall gain for the VHI, its customers would receive nothing.

[The Authority has described in the reasons for its proposed recommendation how risk equalisation could benefit consumers. See also Section F – Pros of commencing risk equalisation payments.](#)

[Furthermore, in its letter of 15 March, 2005, Vhi Healthcare again stated that “all funds received from risk equalisation will be applied for the benefit of consumers. Our target surplus of 5% \(of premium income\) will not change.”](#)

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<sup>5</sup> Although, the VHI has a policy of targeting younger consumers, that of course is not prohibited by law.

## **E. ANALYSIS OF NINE FACTORS RELIED ON BY THE AUTHORITY**

16. The Authority clearly acknowledges<sup>6</sup> that the introduction of Risk Equalisation Payments might be appropriate only under certain circumstances, and may cause harm so that it might not be in the best overall interests of health insurance consumers. The Authority has set out nine factors which it would, inter alia, consider when deciding whether to recommend commencement of Risk Equalisation payments<sup>7</sup>. The nine factors are:-

- the differences in risk profiles between insurers,
- the relative sizes of insurers,
- the age/sex profile of insurers' policyholders,
- the rate of premium inflation,
- the number of insurers in the market / new entrants to the market,
- the effect of any transfer on premiums payable by consumers,
- the overall size of the market,
- the effect of payments on the business plans or solvency of insurers and
- the commercial status of insurers.

17. Generally, the Authority does not specify how each of these criteria are used in the assessment of the relative costs and benefits of commencing Risk Equalisation. Further, the Authority gives no indication of how these factors would be measured, nor how any particular finding would be interpreted (e.g. whether high premium inflation would render a recommendation in favour of commencement of Risk Equalisation more or less likely, what would be considered to be a critical threshold value for each criterion, or why that particular measure would be appropriate to consider). Although the Authority has stated that it will consider these factors, it is difficult to reconcile them to the analysis in its letter dated 15 March 2005. It is not clear if the Authority has taken them into account in its analysis, or whether it has considered them in arriving at its decision to recommend commencement of Risk Equalisation. However, if that is the case, then it was incumbent upon the Authority in order to allow for the making of representations to confirm this, explaining its

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<sup>6</sup> HIA Guide to Risk Equalisation, page 13.

<sup>7</sup> Authority Policy Paper, "Risk Equalisation in the Private Health Insurance Market in Ireland", September 2002, and reiterated in the Authority's Report to the Minister dated 27 October 2004.

reasoning in relation to each of these factors, and affording the insurers the opportunity to analyse their application. In this section, we will comment on the relevance of each of these matters and how they should be appropriately measured in terms of the purported analysis by the Authority as to whether it would recommend the commencement of Risk Equalisation.

The Authority is required to provide reasons for its proposed recommendation. It considers that it did so sufficiently in its proposed recommendation but, for the avoidance of doubt, has done so more fully in this Report.

### **Factors 1 and 3: Differences in risk profiles between insurers / the age/sex profile of insurers' policyholders:**

18. These two criteria cannot be considered as being separate; rather, the age/sex profile of an insurer's policyholders is partly reflected in the corresponding risk profile. The age and gender profiles are (if not exclusively) clearly correlated with the risk profile. An appropriate measurement of differences in risk profiles between insurers would consider such underlying determinants of risk rather than simply measuring differences in the cost of claims. However, the Authority does not appear to have conducted and has refused to confirm whether it undertook any analysis other than that based on the MPEA and MEP figures. Indeed, to the extent that differences in claims costs are related to differences in the range of benefits provided, the MEP gives a distorted picture of the need for, and the likely magnitude, of payments.

The Authority received advice from UK GAD on how these matters would best be analysed. This advice was followed in the analysis in Section E, and throughout the rest of the Report, where appropriate.

The Authority does not use the MEP alone as the sole indicator of risk profile differences. (Section E: “Differences in risk profile and relative sizes of insurers” and Section E: “The Age / Sex profile of the memberships of insurers”.)

19. The Authority has not established the difference in risk profile between insurers. Apart from the blunt instrument of central expenditure on health services, the Authority does not provide any indication as to what measures it would use/has used for establishing differences in the risk profile of insurers other than those accounted for by age and gender. It is not obvious what would constitute appropriate measures of such differences in risk profiles although it is clear that utilisation of health services (as would be reflected, for example, in the use of a Health Status Weight when calculating MEP and payments) is not a good measure because it includes differences in efficiency amongst insurers.

BUPA Ireland comment that “The age and gender profiles are (if not exclusively) clearly correlated with the risk profile”. It is clear from an analysis of age and gender differences and from Staff of the Authority’s other analyses that there is a difference in risk profiles (see Section E: “Differences in risk profile and relative sizes of insurers” and Section E: The Age / Sex profile of the memberships of insurers”.)

20. Another issue is how the Authority would interpret/has interpreted differences in the risk profiles of different insurers, having regard to the different market segments, and how this should affect its recommendation. For example, it is not clear what difference the Authority would consider to be acceptable, or whether it would consider a snapshot view or long-term trends (and, in the latter case, how many observations it would require).

The analysis is multi-factorial. There is no one level of acceptable risk difference. Snapshots and trends are considered insofar as the data will allow.

21. The Authority's explicit reference to differences in risk profiles (and the particular consideration of the age/sex profile of insurers, which is also part of calculating the MEP) indicates that the Authority is aware of the shortcomings of the MEP as a measure. However, we have not been able, for the purpose of making representations, to discover whether and if so, what, other factors have been relied upon to assess differences in risk profile.

The Authority is required to provide reasons for its proposed recommendation. It considers that it did so sufficiently in its proposed recommendation but, for the avoidance of doubt, has done so more fully in this Report.

22. What is unclear, is whether in accordance with its stated policy, the Authority has taken difference in risk profiles into account in formulating its recommendation, and, if so, the conclusion reached and the evidential basis for any such conclusion.

The Authority is required to provide reasons for its proposed recommendation. It considers that it did so sufficiently in its proposed recommendation but, for the avoidance of doubt, has done so more fully in this Report.

23. In any event the Authority does not appear to have conducted a meaningful risk profile analysis, but rather to have focused on the profile of claims payments. Accordingly there is no basis upon which the commencement of Risk Equalisation could be justified in this instance on the basis of these factors.

Staff are satisfied that the analyses proposed by UK GAD and included in this Report are meaningful.

## **Factors 2 and 8: The relative sizes of insurers and the effect of payments on the business plans or solvency of insurers**

24. The relative sizes of insurers is relevant when considering the potential risk to community rating, and the prospective impact of Risk Equalisation, and the potential impact on competition. These issues are at the core of assessing the relative costs and benefits of Risk Equalisation. With insurers of significantly different size such as VHI and BUPA Ireland, the impact of differences in risk profiles would be limited, and the impact of payments might be significant. Risk Equalisation payments require, transfers from one insurer to another, which may have very different impact on the business plans of insurers, and in an extreme case such as this, may have an impact on the solvency of insurers. For example, if a relatively small insurer has to make payments under a Risk Equalisation scheme, such payments may represent a large proportion of its costs whereas to a large insurer in receipt of these same payments, such payments may only represent a very small proportion of revenue. e.g. approximately 4% per customer that VHI might get under the current proposals, albeit that we consider that this will not occur.

These matters were considered (see Section E: “Differences in risk profile and relative sizes of insurers”). This section was updated in light of BUPA Ireland’s above comments in order to increase the emphasis on this point.

25. The question of proportionality arises if the relative sizes of insurers (as in the case in Ireland) are such that Risk Equalisation payments would undermine the viability of the contributing insurer towards insolvency without delivering any benefit for consumers. The effect of payments on insurer's business plans is only a relevant consideration to the effect that it relates to the best interest of health insurance consumers, with all that that entails. Accordingly, if the Authority's decision to recommend (or not to recommend) Risk Equalisation Payments was likely to lead to an insurer's insolvency then that could be a relevant consideration, to the extent it would reduce the degree of competition in the market. In that regard, we note the derogation from requirement exclusively enjoyed by the VHI.

These matters were considered (Section E: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”). The view stated is that it would not appear that the solvency of any insurer would be immediately threatened by the commencement / non-commencement of risk equalisation. For example, BUPA Ireland could increase premiums if necessary.

26. In so far as solvency is concerned, it is worth noting that in a competitive market, entry and exit of insurers, small or large, would be observed. Inefficient

insurers may be forced out of business by entry of more efficient insurers to the long term benefit of the consumers. The Authority would have to apply sophisticated analysis of cost and revenues of individual insurers to determine to what extent potential insolvency is due to general inefficiency in operations as much as the Risk Equalisation payments.

The level of analysis and the type of analyses that Staff of the Authority should undertake is a matter for the Authority but Staff are satisfied that it has been done to an appropriate level.

Having a favourable risk profile is not the same as being efficient. Risk equalisation essentially takes away the favourable risk profile, and if an insurer is then at a loss, it could be due to inefficiency.

No satisfactory evidence has been provided that would persuade Staff of the Authority to significantly revise its analysis in Section E: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”. In particular, the financial analysis provided by BUPA Ireland would appear to have a number of deficiencies.

27. Applying these considerations to the present case, it is clear that they militate against the proposed recommendation due to the impact of the proposed recommendation on BUPA Ireland, its customers, and on health insurance consumers generally. See Section G in particular.

Clearly BUPA Ireland claim that the effect that the commencement of risk equalisation payments would have on their viability is much greater than the effect hypothesised earlier in this Report. (Section E.: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”). However Staff of the Authority do not agree with the financial analysis on which BUPA Ireland’s claim is based (see the comments on Section G of BUPA Ireland’s representations later in this section).

#### **Factor 4: Rate of premium inflation**

28. It is unclear why the Authority considers the rate of premium inflation to be relevant to the consideration of the relative cost and benefits of Risk Equalisation payments or to the consideration of when it may be appropriate to commence such payments. Premium inflation, and any change in the rate of inflation, may be attributable to a number of factors such as:

- increase in underlying medical costs (with all insurers' costs and premium

being necessarily driven to a large degree by increasing costs of treatment in public hospitals)

- reduced efficiency of insurers and lack of competitive pressure
- changes in demographic profile of the insured community (e.g. exit of low risk customers)

The relationship between premium inflation and the best overall interests of health insurance consumers is self-evident. The Authority has previously outlined the relationship between price following and predatory pricing and premium inflation. Both price following and predatory pricing are facilitated by a community rated market without risk equalisation.

The first and the third of BUPA Ireland's suggested causes of premium inflation relate to cost. It is difficult to see how increased costs would be pushing BUPA Ireland's premium inflation when the gap between their costs and revenue and their increasing profits are considered. It is more likely that BUPA Ireland's premium inflation relates to the second suggested cause (i.e. a lack of competitive pressure) and perhaps to price following facilitated by the regulatory regime.

29. It is difficult to see how the Authority can make any meaningful conclusion as to premium inflation without a detailed analysis of each of these factors. Equally the fact of premium increases cannot of itself justify the introduction of Risk Equalisation in the absence of an analysis of the effect of the commencement of Risk Equalisation payments on premiums.

Staff are satisfied that the analysis included in the Report is meaningful. (Section E: "The Rate of Premium Inflation") Again, it is a multi-factorial issue and the Authority has not drawn a conclusion on the basis of premium increases alone.

30. The Authority has also referred to "price following" as an issue. However, price following can only arise if the market is not sufficiently competitive, and the Authority has not shown how commencement of Risk Equalisation would affect the likelihood of price following.

Full reasons were provided. The relationship between community rating, risk equalisation and price following were discussed in Section A, Section B.3, and Section F.)

31. It is worth noting that the commencement of Risk Equalisation Payments in itself is likely to result in, or contribute to, premium inflation: more price sensitive consumers (and in particular, BUPA Ireland customers) will decide not to take

previously affordable policies aimed at them because the premiums on those policies have been increased by BUPA Ireland in response to the need to make Risk Equalisation payments. Thus, it would be more appropriate to consider the likely impact of Risk Equalisation Payments on future premium inflation rather than the existing or historic rate of premium inflation.

This was considered in Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”. It was also considered in the “Cons” section of “Pros and Cons of Introducing Risk Equalisation” in Section F.

It is noted in the analysis in Section E that it is not possible to forecast the effect of commencing payments on premiums with any level of certainty and that the analysis only reflects Staff of the Authority’s view of what might happen.

It is considered that overall premium inflation might be lower if risk equalisation payments are commenced, than would otherwise be the case. Premiums should only rise for those insurers making payments (currently covering about 20% of the market).

Furthermore, BUPA Ireland argue that the premium rates for their products (which are lower priced than Vhi Healthcare’s) would increase. Firstly VIVAS Health’s premiums might not increase for about 2-3 years, so consumers would have the option to move to VIVAS Health rather than leave the market. Even if we restrict our analysis to BUPA Ireland and Vhi Healthcare, according to the analysis of Staff of the Authority the increase in BUPA Ireland’s premiums might be about 6%. According to BUPA Ireland’s analysis, in relation to which Staff of the Authority have many reservations, the new lower premiums (between Vhi Healthcare and BUPA Ireland) would be those for Vhi Healthcare’s products. According to BUPA Ireland’s analysis, these premiums would be about 6% - 7% higher than BUPA Ireland’s premiums should be if risk equalisation payments are not commenced. Therefore, on the basis of either analysis BUPA Ireland customers would be able to obtain cover for a 6% to 7% increase in premium or perhaps cheaper with VIVAS Health.

The effect that such a once-off increase in premium rates (for a minority of consumers) might have on the stability of the market could be considered in the context of the continued growth in the market following BUPA Ireland’s premium increase of 14.4% and Vhi Healthcare’s premium increase of 18%. It could also be considered in the context of the higher level of ongoing premium inflation that could result from price following.

32. In any event the lack of significant premium increases over the last year makes it difficult to comprehend how this factor could justify the current proposal to commence Risk Equalisation. Furthermore, the arrival of a new entrant should be a more effective solution to any perceived price following phenomenon than the

introduction of Risk Equalisation. In that sense, the Authority has failed to give proper consideration to the market based remedies that it has apprehended, albeit mistakenly.

Premium increases over the last 8 years were considered (Refer to Section E “The Rate of Premium Inflation”). It is considered that by introducing risk equalisation, premium increases could be moderated, as the extent to which insurers with lower risk profiles are facilitated in price following would be reduced.

BUPA Ireland’s profits, as a percentage of earned premium, continued to be high when compared with the profits of BUPA Insurance Limited in the UK and other insurers. High profits are, of course, perfectly acceptable, but excessive profits facilitated by the regulatory structure, and which may be to the detriment of the best overall interests of health insurance consumers, need to be examined.

The effect that new entrants could have on price following strategies was considered (See, in particular, Section B.3 “Risk Equalisation and Competition” – “Different Facets of Competition”.) It should be noted that the effect would be minimal if the new entrant(s) also decide to engage in price following. Furthermore, if a new entrant were not to engage in price following, this could lead to an increased risk of instability developing.

It was noted in the “Cons” section of “Pros and Cons of Introducing Risk Equalisation” in Section F that the introduction of risk equalisation may reduce competitive pressures on Vhi Healthcare.

#### **Factor 5: The number of insurers in the market/new entrants to the market**

33. It is unclear why the number of insurers in the market in itself would be relevant to the decision to recommend commencement of Risk Equalisation Payments, without a clearer understanding of how the Authority would analyse the impact of Risk Equalisation Payments on competition.

The number of insurers in the market is considered an indicator of the level of competition in the market. This factor was not considered in isolation. Risk equalisation could impact on competition in many ways and the overall impact is not certain. The fact that there is a third insurer in the market means the market is now more competitive and more capable of withstanding any harm that risk equalisation might cause in respect of competition. (Refer to Section E “The Number of Insurers in the Market / New Entrants to the Market”)

34. For example, if the Authority believed that – through some unspecified mechanism – Risk Equalisation Payments were a remedy for price following, the

justification for commencement of Risk Equalisation Payments would be reduced if more insurers were present in the market, because it would be more difficult to maintain price following in any case. On the other hand, if the Authority believed that more competitors implied more pressure towards optimal pricing, then a higher number of competitors should make a recommendation for commencement of Risk Equalisation Payments more unlikely.

The effect that new entrants could have on price following strategies was considered (See, in particular, Section B.3 “Risk Equalisation and Competition” – “Different Facets of Competition”.) It should be noted that the effect would be minimal if the new entrant(s) also decide to engage in price following. Furthermore, if a new entrant were not to engage in price following, this could lead to an increased risk of instability developing.

35. In summary, it is unclear how the Authority would assess the number of competitors and new entrants, without an understanding of the view that the Authority would take on the impact of more competitors on the costs and benefits of Risk Equalisation. There is no evidence that the new entrant would be an adequate substitute in the event of the withdrawal of BUPA Ireland from the market. Its current market penetration is insignificant and it is difficult to see how it could be expected to survive once it became subject to the regime in less than 3 years. Furthermore, BUPA Ireland has clearly grown the market since its arrival, and it would be a mistake to assume that customers who had chosen BUPA Ireland would necessarily transfer to either of the other insurers in the event of BUPA Ireland’s withdrawal. Given the more price sensitive profile of BUPA Ireland consumers as opposed to the VHI in particular, faced with very substantial price increases a significant number might be expected to allow their cover to lapse if their chosen insurer was forced to withdraw from the market.

Staff of the Authority would not view VIVAS Health as a replacement for BUPA Ireland. The possibility of the withdrawal of BUPA Ireland from the market is considered in Section E: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”.

In relation to the last sentence of paragraph 35, the comments following paragraph 31 are relevant.

36. To the extent that these factors can be applied they undermine the case for Risk Equalisation. On the one hand the arrival of a new entrant offers a more satisfactory non-interventionist solution to any perceived price following issue. On the other hand, it would be unrealistic for the Authority to regard a fledgling entrant as an effective alternative for BUPA Ireland, or as evidence that the VHI was under any real competitive pressure.

The arrival of a new entrant does not offer a solution to price following if it, itself, price follows. If the new entrant chooses not to price follow there could be a threat to the stability of the market. (See, in particular, Section B.3 “Risk Equalisation and Competition” – “Different Facets of Competition”).

**Factors 6 and 7: The effect of any transfer on premiums payable by consumers/the overall size of the market**

37. It is again unclear how the Authority would go about assessing these effects. There is no coherent or consistent model of how competition with or without Risk Equalisation Payments would affect premiums payable by consumers. As is demonstrated herein, the effect on premiums of any transfer would be to render BUPA Ireland unviable, thus depriving the market of meaningful competition and depriving its customers of their chosen insurer and depriving Irish health insurance customers generally.

Staff are satisfied with its analysis of how premiums might change with the introduction of risk equalisation. (Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”). This analysis has also been reviewed by UK GAD.

Staff of the Authority do not consider it unrealistic to assume BUPA Ireland will remain viable and therefore remain in the market. . (Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”).

The Authority is aware, however, that it cannot rule out the possibility of BUPA Ireland exiting the market if risk equalisation is introduced, just as it cannot ignore Vhi Healthcare’s claim that if risk equalisation is not commenced, it will become financially unviable. The Authority has considered these two claims.

If risk equalisation payments are commenced and BUPA Ireland are unable to compete with Vhi Healthcare, this could be for other reasons, for example, inefficiencies or unrealistic profit requirements.

38. More importantly, the Authority does seem to consider the overall size of the market, rather than the impact that commencement of Risk Equalisation Payments would have on this size through its effect on premiums payable by consumers. As noted above, Risk Equalisation Payments (even if they were perfectly calculated) are likely to result in higher average premiums, and will price less well-off customers out of the market. The Authority does not seem to have any view on the magnitude of

this effect (based on the price responsiveness of demand), nor on the impact that such a pricing off of good risks would have on overall costs and premiums.

The comments following paragraph 31 of BUPA Ireland's submission are relevant.

Furthermore, it is not the Authority's policy that less price conscious consumers should subsidise more price conscious consumers.

Staff of the Authority consider that the appropriate mechanism for encouraging good risks to take out health insurance is Lifetime Community Rating.

### **Factor 9: Commercial status of insurers**

39. As noted previously, the commercial status of individual insurers is not a relevant consideration for the Authority except to the extent it is relevant to the best interests of health insurance consumers of health insurance in general. Care is required in considering the impact on competition as a result of the introduction of Risk Equalisation. The commercial status of an insurer does not necessarily determine its incentives in the market, and might not therefore indicate how such an insurer would respond to transfer payments. In any event as appears from Section G the consequence of this proposal would be to jeopardize the status of BUPA Ireland without delivery of any meaningful benefit to consumers. Such a result would not be in consumers' interests because of the reduction in competition and in consumer choice. The VHI's public protestations that absent Risk Equalisation it would be put into a loss making situation are self serving and disingenuous. The VHI is in a dominant position in the market. It is the price maker in terms of setting premiums. It was open to the VHI to charge more appropriate premiums if required. If it fails to do so then it only has itself to blame. The supposed financial pressure on the VHI is not an appropriate or material consideration for the Authority to consider (because it has not been demonstrated to be related to the statutory criteria of the best interests of health insurance consumers). In addition, it is in any event both highly exaggerated and self inflicted. The VHI's deliberate pricing decisions are a transparent attempt to create a self-perpetuating prophecy, engineering a situation where Risk Equalisation might be seen to be required, albeit based on a misconstruction of the statutory standard. The welfare of the VHI should not be equated with market stability.

Staff do not dispute that the commercial status of an insurer does not necessarily determine its incentives in the market, and might not therefore indicate how such an insurer would respond to transfer payments.

Staff of the Authority considered Vhi Healthcare's claims that it would face financial pressure were risk equalisation not to be introduced, in the same way as it has considered BUPA Ireland's claims that its company would become unviable were risk

equalisation payments to be commenced. The two claims were given the appropriate level of consideration. (Section E: “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”).

### **Conclusion as to the nine factors adopted by the Authority**

40. In summary, some of the criteria listed by the Authority could, in principle, cover some factors that one would wish to analyse in depth in order to make a recommendation as to whether to commence Risk Equalisation payments, based on a careful assessment of costs and benefits. However, without any understanding of how the Authority has used these criteria, how it has measured them and of how it has interpreted its findings, BUPA Ireland cannot properly consider, assess and respond to the Authority’s analysis.

41. The list itself, as presented, lacks any guidance as to how the Authority would link each of the factors to the assessment of the relative costs and benefits of Risk Equalisation Payments, which the Authority would have to undertake in order to discharge its statutory obligations. For example, while the Authority would consider the impact of Risk Equalisation Payments on premiums, it is not clear whether (and how) it would consider the resultant impact on the overall take-up of insurance.

The factors were considered both individually and collectively as part of the decision-making process.

42. Further, the list is lacking other factors that should be considered. For example, given the potential distortions in the MEP measure (which would tend to overstate the need for Risk Equalisation Payments if differences in claims costs are to some extent driven by differences in the range of benefits offered by different policies, combined with a tendency of high-risk customers to opt for more comprehensive policies), one would want to look in more detail on the structure of claims costs, and try to strip out those differences that are driven by differences in benefits. Similarly, given that the Act permits insurers to price different policies taking account of the extent of customer self-selection, one must consider the extent to which differences in claims cost are compensated by differences in premium revenue. The Authority does not seem to consider either of these factors. Neither does the Authority inquire into consumer preferences considering the evolution in the variety of products.

Staff are satisfied with the factors they have considered. Comparison of age / sex profiles, for example, is not influenced by product structure / premiums. The relevance of inquiring into consumer preferences considering the evolution in the variety of products is not articulated by BUPA Ireland.

43. Finally, the list of factors which the Authority has identified as relevant to any decision on the introduction of Risk Equalisation appears inconsistent with the reasons actually identified by the Authority in its 15 March 2005 letter, which purported to set out the reasons for the proposed recommendations.

The factors are not inconsistent with the reasons identified. In any case, they cannot be expected to be exactly the same as one is a set of factors and the other is a set of reasons.

44. However, to the extent that the nine factors may be relevant, the draft recommendation cannot be deemed an appropriate measure in the best interest of consumers. Viewed as a whole, the 9 factors would not justify a departure from the status quo. In particular, according to the approach, which the Authority itself mandated as appropriate, the following considerations militate against the imposition of Risk Equalisation: -

- (a) the effect of the payments on business plans on insurers' solvency (and thus on competition and consumer choice);
- (b) the fact that there are only three insurers on the Irish market, one of which is a new entrant which has yet to establish a firm market presence,
- (c) the insignificance of any difference in claims distribution viewed in the context of the size of the market as a whole (in terms of premium income and numbers insured) ;
- (d) the fact that the benefits of any levy would be at best insignificant whereas they would remove competition from the market.

Points (a) and (b) have already been addressed.

With regards to point (c), Staff do not agree that differences in claims distribution are insignificant.

With regards to point (d), Staff have considered all effects of any transfers and the effect on competition (throughout this Report).

## **F. RESPONSE TO "REASONS" IN THE AUTHORITY'S LETTER DATED 15 MARCH 2005**

### **F.1. The standard applied by the Authority**

45. Before considering the five reasons advanced by the Authority, a fundamental issue arises.

46. The Authority has not applied the appropriate test to determine whether Risk Equalisation is required. The Authority's reliance throughout its letter on expressions such as "threat of", "could" and "might" and other such tentative terms reveal that there is no basis for the Authority's decision to the Minister to recommend Risk Equalisation based on information which emerges from the third set of returns. Such terminology underscores the absence of evidence of actual instability. Nor is any

“live” or “current” issue identified which could justify such intervention. The Authority does not even identify the perceived “threat” as probable, let alone inevitable. On the contrary, it categorises the issues in terms of “the possibility of a threat” to market stability which it believes may ultimately impact on community rating.

The emergence of a threat would not be in the best overall interests of health insurance consumers. It is considered that to wait until a threat has materialised may be too late.

47. This is not sufficient to establish that the statutory criteria have been satisfied, and this very language reveals that the Authority has failed to apply the correct statutory criteria. The Authority is not entitled to propose the implementation of a radical measure with far reaching consequences for consumers and for existing insurers on the basis of speculation that hypothetical problems *may* arise in future.

It is unreasonable to suggest that a decision, which by nature must be based on possible market developments, can be made without hypothesising to some extent, albeit on an objective, reasoned basis.

48. Given the efficacy of markets in achieving consumer welfare, the Authority should only recommend the introduction of a market interference of the magnitude of Risk Equalisation on the basis of clear and compelling evidence that it is absolutely necessary, proportionate and objectively justified. The Authority must also demonstrate that the benefits of Risk Equalisation outweigh its negative consequences, and that actual rather than hypothetical problems have arisen which require immediate intervention, which cannot be resolved by other, less intrusive and more appropriate, measures, which it could and should address by means of its periodic reports to the Minister for Health and Children. In addition, it is always open to the VHI to revert to rationality in setting its prices.

It is noted that BUPA Ireland does not suggest any “less intrusive or more appropriate measures”.

49. It is clear that no basis for Risk Equalisation can be asserted once the standards which the Authority itself has previously articulated are applied. For example, in its report on the second set of returns, the Authority indicated that it would recommend commencement if market instability was “*imminent*” or would “*inevitably arise*”. Whilst BUPA Ireland does not accept that “*market instability*” is an appropriate measure as to whether Risk Equalisation should commence<sup>8</sup>, the Authority is now proposing to recommend the introduction of Risk Equalisation when it is clear that there is no threat to market stability which could conceivably be described as “*imminent*” or “*inevitable*”.

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<sup>8</sup> In its submissions to the Authority dated 23 March 2004 (on the Authority’s second proposed recommendation), BUPA Ireland, although agreeing with the conclusion not to recommend commencement, expressed reservations about the Authority’s approach based on identifying a threat to market stability. We pointed out that “instability has not been defined for the market” and ‘a “threat” to stability is too amorphous to justify intervention in the market”.

The Authority's previous indication does not mean it would not recommend commencement under other circumstances that it deemed to be appropriate.

50. These submissions will now consider each of the 5 "reasons" advanced by the Authority in support of its draft recommendation, explaining why they are misconceived. The conclusions reached by the Authority on all of these issues are unreasonable, and irrespective of the degree of reliance on each of these factors, the Authority appears to have failed to discharge its statutory functions.

Staff of the Authority disagree.

## **F.2. The MEP and MPEA**

51. The Authority's first Point combines a variety of points which will be considered in turn. The key issue was the increase in the MPEA and MEP.

*"The MPEA has increased significantly from €11.8m to €16.7m since the previous report. ... This increase is reflected in the value of the MEP, which has increased significantly from 3.5% to 4.7%..... The growth in the MEP reflects the growth in the MPEA as a proportion of claims subject to Risk Equalisation.*

*As a result, the potential benefits, for example, by way of any possible average reduction in the premiums paid by consumer across the market, which could accrue to individual health consumers directly from the transfer of funds, would also appear to have increased. While it could be argued that, when viewed in relation to the number of health insurance consumers and the level of premium paid in the market (just over €1bn in 2004), the MPEA remains small the Authority considers the increase to be significant and is of the view that the underlying trend is upward. Furthermore, in the Authority's view this trend is likely to continue in the absence of Risk Equalisation Payments commencing".*

52. The Authority appears to be placing too much reliance on the MEP and MPEA figures or rather on a perceived trend in those numbers. This is not only incorrect in principle, it is inconsistent with the Authority's previous approach to the issue for the reasons explained below. In and of themselves, the MEP and MPEA reveal little and the Authority is mistaken in its apparent assumption that the figures or increases or trends themselves could justify Risk Equalisation. Furthermore, not only is there an insufficient factual basis for the Authority to predict trends, the Authority is wrong in principle in proposing Risk Equalisation on the basis of the speculation as to future trends when the current position does not justify intervention. Furthermore the Authority's reliance on comparison of the returns and on perceived trends in MPEA and MEP is also flawed because the Authority has failed to demonstrate that the different companies data is being prepared on a "like" for "like" basis because it has not quantified the effect of seasonality and because the Authority does not have sufficient data to reach meaningful conclusions. We will deal with each of these points in detail.

The MEP and MPEA relate to the value of the transfers and so if they are large and passed on to consumers, they are relevant with respect to the best overall interests of health insurance consumers.

Staff of the Authority do not consider that there is evidence that the growth in the BUPA Ireland market share, which is the main driver behind the trend of the increasing MEP would be significantly affected by seasonality.

Staff have always endeavoured to ensure consistency in returns and other data received from insurers. Staff are currently working with the Department of Health and Children in relation to proposed amendments to the Scheme, to remove certain items that have previously led to differences in interpretation.

See Section C, above.

53. There is a degree of circularity in the Authority's analysis with its simultaneous observations that the MPEA increase is reflected in the MEP and that the MEP increase is reflected in the MPEA. The Authority's reference to both figures also gives the impression that they are two independent grounds for its conclusion, whereas there is clearly a relationship between the two figures. However, the Authority has erred in placing any weight upon the MPEA figure without taking any account of the extent to which the change to the MPEA was due to factors unrelated to the claims distribution between insurers, such as the increasing public hospital charges, and increases in the total number of consumers. These two factors alone could lead to an inevitable increase in the MPEA even if the MEP remained constant.

It was not the Authority's intention to give the impression that the MEP and MPEA are two independent grounds for its conclusion.

Staff of the Authority considered the MPEA in terms of premiums paid / claims in the market and, therefore, issues such as increasing public hospital charges and increases in the total number of consumers do not arise as these would affect all factors.

54. The Authority's proposal is inconsistent with its earlier approach. When considering the first set of returns, the Authority did not consider market instability to be inevitable at an MEP of 3.7%. As remains the case today the values of the MPEA and MEP were low in the context of the overall premium paid and the number of customers in the market<sup>9</sup>. However, the Authority is now prepared to recommend the commencement of Risk Equalisation where the MEP has only risen to 4.7%, without sufficiently analysing the possible reasons for this small increase (e.g. seasonality of claims), and without demonstrating how such a marginal increase necessitates radical market intervention.

Staff of the Authority consider that the change in the MEP, (from 3.7% to 4.7%) is significant.

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<sup>9</sup> From the Authority's Recommendation on the first set of returns dated 5 March 2004.

This Report details the Staff's analysis of the possible reasons for the increase in the MEP. As well as seasonality of claims, the growth in BUPA Ireland's market share is also considered to be a factor. (See Section D "Significant changes in Returns").

55. The weight placed by the Authority on these figures is inconsistent with its analysis of the figures in respect of previous periods, and even harder to comprehend in circumstances in which the Authority has itself acknowledged the MPEA to be relatively small in the context of the number of consumers and the amount of premium paid. The Authority's comments that "*While it could be argued that, when viewed in relation to the number of health insurance consumers and the level of premium paid in the market (just over €1bn in 2004), the MPEA remains small, the Authority considers the increase to be significant and is of the view that the underlying trend is upward*". This passage effectively acknowledges two reasons why commencement of Risk Equalisation is not justified, (1) the MPEA is insignificant in the context of the level of premium paid in the market as a whole and in relation to the number of health insurance consumers; (2) it follows from these acknowledgements that the Health Authority must recognise that even if the Risk Equalisation was to be utilised by VHI by way of a reduction of premiums, which is inconceivable, the effect would be insignificant, and would have no material impact on the competitiveness of VHI's pricing. By contrast, the impact of imposing a levy on BUPA Ireland corresponding to nearly twice its annual profits makes it unviable.

Staff of the Authority do not accept that the effect of the MPEA would be insignificant.

Staff of the Authority have considered the effect that risk equalisation payments may have on premiums and price competitiveness. (Section E "The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers").

56. The suggestion that Risk Equalisation was necessary because "*this trend is likely to continue in the absence of Risk Equalisation Payments commencing*" suggests that the Authority was applying the wrong test. MEP and MPEA figures, or increases or trends therein are not and cannot be justification for introduction of Risk Equalisation. **The only justification is the interests of the consumer, and (other than its vague and unsubstantiated references to "stability") the Authority has failed to demonstrate the relationship between the proposed measure and the best interests of the consumer.** It has not attempted to quantify the probable increase in the figures, or to demonstrate why any such trend needs to be countered by Risk Equalisation so as to protect the interests of the consumer.

Stability is an important issue for health insurance consumers. Staff consider that the relationship between the proposed measure (the MPEA) and the best overall interests of health insurance consumers, includes the potential benefit for consumers that any percentage reduction in premiums would bring (Section E "The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers").

57. The Authority will not have any valid basis upon which to postulate the existence of a trend in the MEP, until many more sets of returns are available providing a statistically meaningful sample. That is not to say that the Authority could not perform its statutory function until then, but absent any evidence that would raise concerns (which based on the information before us is not the case), BUPA Ireland submits that it is not reasonable to infer a trend from three data points, particularly when, as here, the MEP fell in the second set of returns, and now appears to have risen. Of course, while there are three data points, 3.7% followed by 3.5%, followed by 4.7% based on the first, second and third returns respectively, the Authority can make only two actual observations in deducing a “trend”, namely (1) that the MEP fell once and (2) then increased. No meaningful inferences about the existence of trends can be drawn in these circumstances. The Authority admitted in its second report to the Minister that further returns would be required in order to meaningfully assess the data, particularly in the context of seasonality<sup>10</sup>. The proposed recommendation is entirely at odds with the Authority’s declaration in that regard. Any forecasts prepared by the Authority on the basis of MEP and MPEA are subject to the same flaws.

The Authority did not “admit... that further returns would be required in order to meaningfully assess the data...”.

Staff of the Authority did not infer a trend from only three data points. It would appear that the growth in the MEP is related to the growth in BUPA Ireland’s market share. If the trend in BUPA Ireland’s market share continues to be upward and there is no significant change in the age and gender profiles of insurers then the trend in the MEP will be upward. The following points are relevant.

- The MEP has increased from 0% to 4.7% since the entry of BUPA Ireland.
- The growth in BUPA Ireland’s market share has been consistent, at least since 2001 (prior to that data is limited). If BUPA Ireland continues to grow as in the past and there is no significant change in age/gender profiles then the MEP will continue to grow.
- There is no evidence that significant changes are occurring with regard to the relative age and gender profiles of insurers.
- The MEP has grown from 3.7% in respect of the second half of 2003 to 4.7% in respect of the second half of 2004.
- It is unlikely that any of the above factors would be significantly affected by seasonality, however other fluctuations may have some impact on the values of the MEP at different points in time.
- There is volatility in the value of the MEP, largely resulting from variations in the amount paid by BUPA Ireland in respect of settled claims, particularly in the over 80s age group. However, an analysis

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<sup>10</sup> To quote the Authority at page 11 of its report dated 27 October 2004: “Furthermore, there appears to be some seasonality in the data of at least certain undertakings disclosed in the returns. In this context, the Authority recognises that over time further data (including more returns), which may provide a more complete picture, will become available and inform future deliberations”.

that is based on the growth of BUPA Ireland and the relative age and gender profiles of insurers should not be affected by this.

The Authority has worked to achieve consistent returns across insurers and to gauge the extent of any inconsistencies that may exist. The Authority is not aware of any material discrepancies in returns filed.

58. Any attempts by the Authority to discern a trend may also suffer from a lack of uniformity in filed returns. As the Authority is aware, differences in statutory interpretation arose concerning the correct interpretation of the Risk Equalisation Scheme. On several of those issues, BUPA Ireland, because of the ultimate immateriality of the issue, or because no alternative interpretation was compelling, deferred to the view of the Authority on the matter in question. However, in respect of fixed price procedures, the Authority ultimately amended previously issued guidance. Consequently, it seems that earlier returns have not been filed on a uniform basis. Therefore, independently of the extremely limited information on which the Authority has obviously formed its views, the Authority's conclusions become wholly unreliable in the face of these likely inconsistencies in returned data.<sup>11</sup> As far as BUPA Ireland is aware, the Authority has not analysed the effect and the data effecting such differences of approach between insurers and between the two various sets of returns. Clearly the integrity of any comparisons of the data depends on their having been prepared on a like for like basis.

The Authority had consideration for possible inconsistencies in the data returned. (Section C "Inconsistencies in Returns"). Any perceived differences were not considered to be of significant magnitude.

In respect of Fixed Price Procedures, it would be expected that the effect of the change in the Authority's guidance would have been to slightly increase the level of claims included in returns by Vhi Healthcare and ESB SMPF. The change in guidance was consistent with the approach adopted by BUPA Ireland in the first set of returns and therefore there would be no inconsistency in BUPA Ireland's returns resulting from this change in guidance.

Staff of the Authority considered the effect that this change in guidance might have been expected to have on the calculation of the MEP and the MPEA. The considerations were based on data provided by Vhi Healthcare (the change in guidance would not have affected BUPA Ireland's returns and ESB SMPFs returns would not be expected to have a significant effect).

It is estimated that the effect of the change in guidance on the MEP, would have been to reduce the MEP based on returns received after the change in guidance. Therefore, it is estimated that, if the change in guidance had not occurred, the increase in the

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<sup>11</sup> In its report to the Minister, provided to BUPA Ireland by letter of 14 May 2003, the Authority mentioned differences in interpretation that had arisen between insurers in respect of the first set of returns. The Authority recommended to the Minister that the definition of statutory terms, several of which had been the subject of discussions between BUPA Ireland and the Authority, including that of "fixed price procedures", would benefit from clarification. To date, these recommendations have not been acted upon by the Department.

MEP would have been more pronounced. However, it is not expected that the difference would have been material in terms of the Authority's deliberations, (perhaps 0.1 percentage points in the value of the MEP).

Because the MPEA is based primarily on BUPA Ireland's claims, in relation to which the change in guidance did not result in inconsistency, it is considered that the effect of the change would have been of second order through the Zero Sum Adjustment. Therefore, it is considered that, if the change in guidance had not been made, the trend in the increase of the MPEA would have been very slightly (in the view of Staff immaterially) affected.

59. In any event, the calculation of the MEP (and its trend, even if one could be inferred from a small number of observations) is entirely insufficient to establish that there is a rationale for commencement of Risk Equalisation Payments. This is because the MEP is calculated solely with reference to claim payments, without taking account of the risks severed from particular policies.

The Authority did not use the MEP alone, as a measure of risk profile.

### **F.3 "Pass through" to consumers**

The final point with regard to MEP and MPEA raised in the Authority's first Point was its contention that

*"the potential benefits, for example by way of any possible average reduction in the premiums paid by consumer across the market, which could accrue to individual health consumers directly from the transfer of funds, would also appear to have increased"*

60. Notwithstanding the use of language such as "potential"; possible; and "could" which is based on conjecture. The Authority appears to have assumed that consumers would benefit from an average reduction in premiums by virtue of Risk Equalisation being commenced, apparently without quantifying any such benefit. Again, BUPA Ireland wishes to raise its concern about a proposed recommendation being made on the basis of what could happen, as opposed to what would in all probability happen. In fact, it is unlikely that the benefit of Risk Equalisation payments will be passed through to VHI customers.

The possibility that risk equalisation payments will not result in lower premiums for Vhi Healthcare than would otherwise be the case, was considered by Staff of the Authority. (Refer to Section E "The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers"). In this context such benefits were described as potential. It may be worth noting that Vhi Healthcare state that it has already passed the risk equalisation transfer on to consumers (through the lower than normal rise in premiums last year).

61. **In response to the last recommendation of the Authority, the VHI asserted that the Authority was not entitled to inquire into the likelihood that**

**consumers would actually benefit from the commencement of Risk Equalisation.**

VHI would see to it that such “pass through” occurred. The VHI objection is not surprising since the VHI does not have any incentive to effect a pass through, especially considering that if Risk Equalisation was commenced, its principal rival, BUPA Ireland would not be able to exert the same competitive constraint on the VHI as it has done to-date. For its part, BUPA Ireland considers an adequate analysis of “pass through” to be appropriate and indeed essential for the Authority.

[This matter was considered in Section E: The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers.](#)

62. Unlike cost saving which may sometimes accrue to consumers by virtue of competitive pressures, in this case, a zero sum game will occur. The gain to VHI would be directly offset by a cost to BUPA Ireland and a welfare loss for all consumers. BUPA Ireland would no longer be viable, and would not be in the market, thereby relieving legitimate competitive pressure on VHI, and making it less likely that VHI will pass on anything to consumers. VHI has no incentive to pass on Risk Equalisation payments to consumers, and any statement by the VHI that it would do so cannot be an influencing factor on the Authority. Furthermore, even if Risk Equalisation were to lead to an equalisation of premiums over different customer types, more price sensitive customers would be priced out of the market, ultimately increasing the average premium for all insured, and reducing the number of consumers able to avail of the benefits of private health insurance. The Authority does not appear to have addressed this issue.

[BUPA Ireland has the option of reducing its profits. Therefore, premium reductions potentially brought about by risk equalisation payments, would not necessarily require BUPA Ireland to increase its premiums to entirely compensate for the level of transfers. It is not considered that competitive pressure would disappear if risk equalisation payments were commenced.](#)

[The comments following paragraph 31 of BUPA Ireland’s representations, \(and in particular, the fact that VIVAS Health is now in the market\), are relevant.](#)

[It is not the Authority’s policy that more price sensitive consumers should be subsidised by less price sensitive consumers.](#)

63. In fact, given its forays into new markets and its non-adherence to standard accounting convention, the VHI has both the incentive and the opportunity to deprive consumers of any possible benefit of commencement. There is every likelihood that it will simply be availed of by the VHI as part of its warchest and used to subsidise new risk rated products such as travel and dental insurance. Its public utterances suggest that the VHI will not pass on the benefit of any levy to consumers. In its most recent annual report, the VHI indicated that instead of pursuing the price adjustments which were appropriate in the absence of Risk Equalisation, it would forego the required increase, and instead price as if Risk Equalisation had been commenced. The VHI claims that it is already offering a ‘community rate’ at its own expense. BUPA Ireland does not accept that the Authority is entitled to place weight on such

disingenuous statements by the VHI, which are clearly designed to generate a controversy and increase the pressure for Risk Equalisation to be commenced. VHI can present any number as the ‘required increase’ while asserting that in practice it will not increase premiums to that level so as to replicate what it claims would occur if Risk Equalisation was commenced. Given the evidently self-serving nature of such claims by VHI, the Authority is not be entitled to be swayed in VHI’s favour by these assertions. However, the Authority can and should take account of the fact that this declaration by VHI itself suggests that, if it is to be believed the VHI’s consumers stand to gain nothing extra from the commencement of Risk Equalisation because VHI is already supposedly providing the same rates as if Risk Equalisation has already been commenced.

Staff acknowledge and have already considered the uncertainty regarding whether or not Vhi Healthcare will pass (or has already passed) on the benefit of risk equalisation to consumers. (Refer to Section E “The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers”).

It has also been considered that if risk equalisation is not introduced, Vhi Healthcare may have to (significantly) increase their premiums again.

#### **F.4 Risk of Instability**

64. The Authority’s second Point was as follows:

*“ ... the Authority is cognisant of the possibility of instability arising in a community rated market, which would threaten the maintenance of community rating across the market, and that in certain circumstances the commencement of Risk Equalisation Payments might be appropriate in order to address such instability.*

*The Authority previously stated that if it considered, based on the information available to it, that such a threat emanating from the regulatory regime were imminent or would inevitably arise, it would, all else being equal, recommend the commencement of Risk Equalisation payments in order to maintain community rating. In its previous report the Authority did not consider that such a report was imminent or would inevitably arise. However, it recognised that such a threat is a possibility that the Authority must take very seriously.*

*Specifically, as part of its deliberations the Authority considered analyses of certain trends in the market, including trends in the values of the MEP and MPEA, the level of lapses and sales for different insurers, the growth in the memberships of different insurers, the total growth in the market, the risk profiles of insurers as well as other matters details in its Policy Paper (see, in particular, Section 3). In doing so it aimed, among other things, to ascertain whether there is a possibility of a threat to the stability of the market arising which should be addressed at this stage by the immediate commencement of Risk Equalisation Payments.*

*The possibility of a threat to the stability of the community rated market arising that would warrant the immediate commencement of Risk Equalisation Payments was also considered in the context of the financial position of the insurers. In particular, in assessing whether such a threat to individual insurers exists, which could lead to instability in the private health insurance market as a whole, levels of profitability were considered relevant. In this context the Authority considered both publicly available information (annual report for VHI Healthcare, returns to the UK Financial Services Authority by BUPA Insurance Limited) and other financial information provided to the Authority on a confidential basis by scheme undertakings.*

*In the light of the increase in the MEP and the MPEA and in the underlying trend of these figures, the Authority is of the view, based on the data available to it, that the likelihood of threat to the stability of the community rated market arising in the absence of Risk Equalisation has increased [Our underlining for emphasis]. The Authority further considers that a threat to the stability of the market, in itself, would be counter to the best overall interests of consumers and the stability of the community rated market and the best overall interests of consumers would be best protected by acting before such a threat arises.”*

65. This passage makes a number of points, none of which provides a credible justification for the proposed measure. The following paragraphs will explain why the reliance on a perceived threat of *instability* is not a sufficient basis for Risk Equalisation. In the last part of the passage, the Authority refers to a miscellany of issues such as lapses, but the Authority is not entitled to rely on such matters without explaining their significance or the basis for the Authority’s conclusions and without demonstrating how these matters render Risk Equalisation appropriate in the best interests of consumers.

The emergence of a threat would not be in the best overall interests of health insurance consumers. It is considered that to wait until a threat has materialised may be too late.

66. Firstly, there is repeated reference to the risk of “*instability*” without adequately explaining what is meant by such instability or the basis on which such instability or its significance is measured. Previously, BUPA Ireland has attempted, without success, to have the Authority clarify what “*instability*” means.

It is considered that the Authority’s Policy Paper, which was referred to in the reasons provided to insurers in this context provides an adequate indication of what is meant by the term “*instability*”.

67. Secondly, on any other interpretation “*instability*” would not of itself justify the measure unless it was demonstrably in the consumers’ best interests that it be avoided and that this measure was an appropriate, indeed the most appropriate means of securing the goal. The proposed recommendation has not meaningfully addressed these issues, but simply assumes firstly the existence of a stability issue, without defining it or showing how it relates to consumers and without showing why it

necessitates the introduction of Risk Equalisation, so as to protect the interests of consumers.

Again, Staff of the Authority consider these points to have been adequately addressed in its Policy Paper.

68. The Authority has attempted to assert that such “*instability*” might threaten community rating, but it has entirely failed to show how that could conceivably happen given that community rating is required by law; there is no evidence that it is not being complied with and if there was an issue in that regard then the appropriate response would seem to be to enforce the existing provisions rather than introduce an entirely different measure with no obvious connection to the regulatory objective.

The Authority’s Policy Paper addresses this issue.

69. Thirdly, for the reasons outlined in Section B above, it is impossible to describe the present market as unstable, nor has the Authority suggested otherwise. Indeed the language used by the Authority reveals that there is no current instability nor even any current threat of such instability. Accordingly the third set of returns does not provide any basis for the Authority’s proposed recommendation.

Staff of the Authority consider that the possibility of a threat of instability has increased and this is a matter of concern. To wait for a threat to the stability of the market to materialise, may be too late.

70. Fourthly, as outlined above, the “*possibility of a threat to the stability of the market arising*” cannot meet the requirements of establishing that the introduction of Risk Equalisation is appropriate in the best interests of consumers. The Authority is misconceived in its current attempt to recommend the introduction of Risk Equalisation in the absence of market instability by relying on, in the Authority’s memorable phrase, the “*possibility of a threat*” to market stability. The introduction of Risk Equalisation can not be justified, as the Authority has sought to do, as a measure designed to preempt a speculative problem. There is no rational basis upon which the Authority can conclude that Risk Equalisation should be introduced because “*the best overall interests of consumers would be best protected by acting before such a threat arises*”. Given that the Authority is tasked by law with reviewing the matter every six months, it is fully capable of dealing with problem if it actually materialises, rather than doing so preemptively on the basis of speculation that a threat may arise sometime.

Waiting to only intervene when a threat to the stability of the market has materialised, may be too late.

71. Finally, as part of this passage the Authority mentions a potpourri of issues, such as levels of lapses<sup>12</sup> and sales for different insurers, the growth in the membership of different insurers, the total growth in the market, the risk profiles of insurers, as well as other matters detailed in its policy paper, but entirely fails to elaborate the conclusions that it seeks to draw in relation to those issues or their role in the Authority's analysis or the evidence on which any such analysis is based. If the Authority is seeking to rely on any of those factors as reasons to introduce Risk Equalisation then it should say so and clearly explain its reasoning in that regard. Its failure to do so is contrary to the statutory requirements placed upon the Authority to explain the reasons for its decision and makes it impossible for BUPA Ireland to respond adequately to arguments which the Authority has failed to articulate fully. The same issue arises with regard to the Authority's assertion that it has referred to various information, some publicly available, some furnished in confidence. If the Authority is relying on any such information and drawing conclusions from it in support of its recommendation then once again it is incumbent on it to say so and explain its reasons in that regard. Its failure to do so is at odds with its statutory obligations in this regard.

The reasons provided in the proposed recommendation are sufficient. The underlying details, in relation to matters such as lapses, are confidential to the undertakings.

#### **F.5 Premium Inflation and Price Following**

72. The Authority's third Point was as follows:

***“The Authority notes that premium increases in the market since 1997 have averaged c.9% p.a. While this rate of increase appears to have slowed dramatically of late with a 3% in VHI Healthcare's (September 2004) and a 6% increase in BUPA Ireland's premiums (March 2005), the Authority also notes that in 2002/2003 VHI Healthcare increased their premiums by 18%, while BUPA Ireland increased their premium by 14.4%. In this context and in the context of the ratios between claims incurred and premiums earned, the Authority is concerned about the level of competitive pressure on each insurer in the market.***

***It would appear from the growth in membership of the insurers and from other data provided by the insurers that sales are now more evenly spread between the two***

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<sup>12</sup> As the Authority is aware, BUPA Ireland previously expressed concern at the Authority's reference to lapses, specifically noting that: “care is required in interpreting data to ensure that consumers who switch between providers of private medical insurance are not erroneously treated as lapsed members..... There may be idiosyncratic reasons explaining lapses for reasons that are entirely unconnected with how the market is functioning generally. Clearly, the Authority considers the issue of sales and lapses to be relevant for the purposes of its analysis, given that they are linked, and having regard to the risk that erroneous inferences might be drawn from a consideration of data concerning these issues, we would welcome further elaboration by the Authority of its view on these matters.”

*main insurers than was previously the case. Furthermore, there has been a new entrant to the market, which may further increase the level of competition.*

*Against this background, the Authority's previously expressed concern as to a possible reduction in competitive pressure if Risk Equalisation Payments are commenced has now diminished. The Authority is of the view that the benefits to health insurance consumers, which would accrue from the commencement of Risk Equalisation Payments would outweigh any countervailing factors.*

*The Authority also sees merit in arguments that the commencement of Risk Equalisation Payments could potentially benefit competition in the market in some ways, for example, by increasing competition for older policyholders."*

73. The following paragraphs explain why these points once again fail to withstand scrutiny. The Authority has not taken into account the reason for premium increases, misinterpreting the reasons for increases. Further, the recent fall in the rate of premium and arrival of a new entrant then to suggest that no action is required in respect of premium inflation. In any event the Authority is not entitled to simply assume that Risk Equalisation will reduce premiums. Furthermore, the draft recommendation is inconsistent to all previously when premiums were rising more quickly.

Staff are concerned with the effect that price following appears to be having on the rate of premium increases.

74. It is difficult to see how the premium increases dating back to 1997, and particularly those in 2002/2003 could justify the introduction of Risk Equalisation given that no such recommendation was made on the First or Second sets of returns and, as the Authority itself acknowledges the rate of premium increase has been slowing.

The rate of premium increases are relevant in that they indicate price following and lack of competition. The rate of premium inflation remains a matter of concern, despite the most recent increases. This matter is not viewed in isolation, but is viewed in conjunction with other matters, which have changed significantly.

Furthermore the reduced premium inflation may indicate that competitive pressures on Vhi Healthcare have increased. This may lessen concerns in relation to any reduction in competitive pressures on Vhi Healthcare resulting from the commencement of risk equalisation payments.

75. BUPA Ireland does not accept that the rate of premium increase has been as similar as the Authority's comments would suggest, the timing of each insurer's annual increase being entirely different, and the Authority has not compared "like" for "like" in this regard<sup>13</sup>.

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<sup>13</sup> For example, the increase asserted for BUPA Ireland is based on its increases up to March 2005, which increase incorporates the 25% increase in public hospital bed charges introduced on 1 January 2005. The VHI's September 2004 increase has obviously not incorporated this.

Section E “The Rate of Premium Inflation” shows how, since BUPA Ireland entered the market, its eight premium increases have averaged around 9% and resulted in a total increase of 98%, the same figures as those for Vhi Healthcare.

If like is not being compared with like, then the fact that the rates of premium increase for both Vhi Healthcare and BUPA Ireland are so similar, would be more suggestive that price following, rather than claims costs, is driving premium inflation in the case of BUPA Ireland.

76. More importantly, the Authority has mistakenly attributed the premium increases to a lack of competitive pressure, without considering the range of factors which could explain the alleged phenomenon. In particular, it has ignored the reality that both insurers’ premium requirements are driven by the same input costs, and with both insurers facing increases in public hospital charges the order of between 174-274%<sup>14</sup> approximately over the last 8 years it is inevitable that the insurers should increase premiums in order to pass these rising input costs onto their customers.<sup>15</sup>

Staff of the Authority agree that increases in public hospital charges will affect both Vhi Healthcare and BUPA Ireland. However it would appear that there is a lack of competitive pressure on BUPA Ireland emanating from its lower risk profile in a community rated market and there is a concern that the present regulatory structure is facilitating the making of large profits to the detriment of the best overall interests of health insurance consumers by allowing insurers with a preferential risk profile to engage in price following.

77. Furthermore, it is odd that, having chosen not to recommend Risk Equalisation when the level of premium increase was relatively high, the Authority should seek to do so on this basis when the rate of increase is slowing, and when, on its analysis, a new entrant is likely to introduce a further element of competition and pressure to keep premiums competitive. These factors, and the suggestion that new entrants are now evenly spread between the VHI and BUPA Ireland all suggest that perceived concern about premium increases do not provide a plausible justification for Risk Equalisation but the Authority has, inexplicably, reached the opposite conclusion.

The rate of premium increase in the market appears to be slowing recently because of Vhi Healthcare’s lower than normal rise in premiums last year (thereby, allegedly, passing the risk equalisation transfer on to consumers). The fact that BUPA Ireland’s rate of premium increase is similar to Vhi Healthcare’s may suggest price following.

Staff of the Authority have considered that if risk equalisation is not introduced, Vhi Healthcare may have to (significantly) increase their premiums again.

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<sup>14</sup> *These increases are calculated using regional hospital rates in the period January 1997 – January 2005, and taking all three types of hospital accommodation (private, semi-private and day case) given that the increases have varied over time, particularly the day case rate which has shown a much greater increase (274%) as its usage has increased.*

<sup>15</sup> *That is from 1 January 1997 to 1 January 1995 inclusive*

78. The implication that premium levels are too high, and that somehow Risk Equalisation would address this, also ignores the fact that VHI is on record as claiming that its premiums are being set at the levels which would be applicable if it was benefiting from Risk Equalisation payments. BUPA Ireland's premiums are inevitably heavily influenced by the VHI's, since, to remain competitive, BUPA Ireland must set its premiums significantly below that of the dominant incumbent, which it has consistently done.

The Authority has not ignored Vhi Healthcare's statement regarding the setting of its premiums. (Refer to Section E "The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers").

79. The Authority's analysis appears to be ambivalent if not contradictory on the issue of price following, simultaneously describing it later in the letter as a reason not to introduce Risk Equalisation (because the "*threat to the stability of a community rated market might be avoided...where price following exists*") and to introduce it because "*the higher premium inflation that would result from an uncompetitive market in which price following exists...might also increase the possibility of a threat to the stability of the market*"). In either case, however, and without providing any evidence to the effect that price following exists, the Authority implies that premium (and the levels of their increases) are excessive, and that therefore Risk Equalisation should be commenced. **Of course, in economic terms, the relevant counterfactual is what those premiums would be without meaningful competition because BUPA Ireland could not remain in the market following the introduction of Risk Equalisation.** The Authority's analysis does not take into account, either adequately or at all, of how the market would change if Risk Equalisation Payments were commenced. The Authority appears to assume that many features of the existing market especially those relating to the competitive constraints faced by VHI, will remain constant, or at least, not be weakened by the commencement of Risk Equalisation. For the reasons expanded upon below, that cannot be the case

Staff of the Authority refute BUPA Ireland's comments regarding the sections of the Authority's letter referred to here. The Authority considers the sections to have been taken out of context. In particular the removal of the words "for a time" and "circumstances in which" completely alter the meaning of the quoted section.

Staff have considered how the market would change if risk equalisation payments were commenced. The potential weakening of competitive pressures on Vhi Healthcare are recognised in this Report. (Section E and Section F).

80. Clearly, the best overall interest of consumers would not be served if either BUPA Ireland or VHI were charging vastly inflated premium (thus consistently earning returns significantly beyond their cost of capital). Given that BUPA Ireland's prices are consistently below those of the VHI and the greater economies of scale enjoyed by the VHI, it is difficult to understand how it could ever be said to be earning excessive profits. Moreover, as the financial data provided by BUPA Ireland

to the Authority demonstrates, BUPA Ireland’s profitability is precisely what one would expect from a relatively small well-managed business.

Staff of the Authority are of the view that BUPA Ireland is currently earning an very high return on capital (required solvency capital = €67m, according to the representations, while operating profit in 2004 exceeded €25m). BUPA Ireland seems to be ignoring the effect of differences in risk profile, which is central to the concept of risk equalisation. Its profits also appear very high when viewed as a percentage of earned premium and compared with the profits of BUPA Insurance Limited in the UK.

81. Of course, all of this begs the question as to what analysis the Authority in fact conducted with a view to assessing whether there is excess profitability in the market, not least because the Authority itself represented that it would take this very issue into account in its deliberations. Other sectoral regulators, both in Ireland and elsewhere, have calculated profitability using detailed economic models, which include the use of detailed cost-of-capital calculations. For the Authority to have done so in respect of BUPA Ireland would have required intensive consultation and dialogue with BUPA Ireland. That has not occurred.

Profits of about €25.8m (before investment income and tax), where required solvency capital is about €67m and premiums are about €150m would appear to be very high. The Authority analysed the “extensive financial data” referred to below. BUPA Ireland’s operating profit of about 17.3% of earned premium may also be considered in the context of the figures below from the US market. BUPA Insurance Limited’s (the UK Company) operating profit in 2003 was just over 5% of premium and in 2002 was just under 5%. The Authority is, of course, mindful of the issues involved in drawing inferences from cross border comparisons resulting from, for example, differences in accounting standards and in statistics quoted.

**US Insurers:**

Insurer	Time Period	Net Income	Revenue	Net Income as a % of Revenue
		\$m	\$m	
United Health Group	Q1 2005	779	10890	7.2%
	Q4 2004			
	Q3 2004	698	9860	7.1%
	Q2 2004	596	8700	6.9%
	Q1 2004	554	8100	6.8%
Highmark BC/BS	2004	339.4	8900	3.8%
	2003	105.8	8600	1.2%
Aetna	Q4 2004	300.7	5200	5.8%
	2003	933.8	18000	5.2%
Blue Cross/Blue Shield	2003	6100	182700	3.3%
	2002	4000		
Anthem	2003	935.2	20400	4.6%
WellPoint	2003	774	16700	4.6%

*Source Modern Healthcare-Daily Doses – various dates*

It should be noted that the profits of an insurance company may be cyclical / volatile and concentrating on one year's profits may be misleading. However, BUPA Ireland has provided the Authority with figures relating to its operating profit for the years 2001 to 2004 and during these years its operating profit varied between 16.5% and 21% of earned premium.

82. BUPA Ireland has already provided the Authority with extensive financial data concerning its business in Ireland, and specifically, its profitability<sup>16</sup>, but has never been asked for any of the data necessary for an economics based appraisal of profitability. If the Authority recommends commencement, and that is accepted by the Minister, then assuming the MEP remains constant (although the Authority considers that it will rise), BUPA Ireland is faced with making an annual and increasing payment to the Authority of €33.4 million. The phasing provision of the Risk Equalisation Scheme does not mitigate that effect in any way, since the liability for Risk Equalisation Scheme payments must be accrued from the date of commencement of the Scheme. As Section G demonstrates, Risk Equalisation would render BUPA Ireland's business unviable.

Staff of the Authority are satisfied with their analysis and would not agree with BUPA Ireland's analysis in Section G of its representations. A review of BUPA Ireland's analysis, prepared by UK GAD, is included later in this document.

83. Given that the Risk Equalisation Scheme payment will eliminate all of BUPA Ireland's projected profits and more, it is incumbent on the Authority to explain how it considers that BUPA Ireland can remain in the market, and even if it could, what sort of competitive constraint it would be for the VHI? Given the price elasticity of demand, in response to any substantial increase in BUPA Ireland's prices, its customers are likely to leave it en masse. Paradoxically, the measure is actually likely to provoke precisely the sort of instability that the Authority appears to wish to guard against if indeed the Authority considers the difficulty of efficient competition existing as "*instability*". **The Authority is solving a theoretical "possibility of a threat" of a problem by creating an immediate one.**

With regard to the price elasticity of demand of BUPA Ireland's policyholders, the 14.4 % price increase in March 2003 did not prevent the continued growth of BUPA Ireland.

The Authority's analysis in Section E would not indicate that BUPA Ireland would need to increase its premiums to the extent implied. Furthermore, it indicates that BUPA Ireland's prices could be maintained at a competitive level.

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<sup>16</sup> In response to requests from the Authority, on 12 February 2004 BUPA Ireland provided the Authority with its financial results for 2001-2003 in table form, as well as a table of its projected financial results for 2004-2006. On 5 February 2005, BUPA Ireland furnished information to the Authority in tabular form of the number of its new sales in 2004, its total number of lapses in 2004 and its projected results for 2005-2007.

84. The inappropriateness of the Authority's assumptions that the benefits of Risk Equalisation would be passed on to consumers has been dealt with above. The final justification advanced by the Authority, that the commencement of Risk Equalisation will increase competition for older policy holders, is incomprehensible and we are unable to comment on this suggestion with clarification from the Authority as to how it asserts such competition could arise, the likelihood of that happening in practice and the evidence or analysis underlying this suggestion. The Authority has failed to address the more obvious scenario, namely the increase in the cost to the less affluent consumers effectively required to further subsidise the more expensive VHI plans, leading to a reduction in the size of the health insurance market and a vicious circle with the increasing claims costs being spread over a shrinking market. Again, this looks more like "instability" that the Authority should guard against.

Staff have taken account of the fact that older members are unlikely to switch. (Refer to Section B.3). The introduction of risk equalisation, however, may reduce disincentives for insurers to target older consumers, who may be new to the market.

Staff of the Authority consider that the introduction of lifetime community rating is an appropriate measure to encourage young consumers to purchase private health insurance.

## **F.6 Competition for Members**

85. The final Point advanced by the Authority in support of the Authority is as follows:

*"In the points above, the Authority has discussed the direct benefits that could flow from the introduction of Risk Equalisation Payments, and the impact of Risk Equalisation Payments on the maintenance of a community rated market and on the facilitation of competition. The Authority recognises that these matters are interlinked. The Authority sees merit in the argument that circumstances in which a threat to the stability of a community rated market without Risk Equalisation might be avoided for a time are circumstances where price following exists. However, price following could lead to excessive inflation of health insurance premiums to the benefit of one or more insurers and to the detriment of consumers. In this context, the Authority notes that both VHI Healthcare and BUPA Ireland premiums have increased by the same proportion, 98%, since BUPA Ireland entered the market. Of course a higher premium inflation would result from an uncompetitive market in which price following exists (and which would be facilitated by the regulatory regime in the absence of Risk Equalisation) might also increase the possibility of a threat to the stability of the market. This threat might arise from any increasing difficulties that consumers might have in being able to afford higher health insurance premiums in future. For example, a threat may arise if younger people either choose not to purchase health insurance or allow their policies to lapse to a greater extent than older persons.*

*The Authorities recommendation is made in the context of the evidence available to it.*

***It may also be noted that the proposed commencement of Risk Equalisation Payments will have the consequential effect of removing any uncertainty concerning when and if Risk Equalisation Payments may commence, which might currently affect the market.”***

86. Once again the Authority has failed to advance appropriate reasons for the introduction of Risk Equalisation. Most of the points have been addressed above<sup>17</sup> but the Authority also makes assumptions which are totally unsupported by its earlier reasoning. For example, the passage asserts without defining or quantifying what “benefits” *could* flow from the introduction of Risk Equalisation payments. Once again, the possibility of benefits is insufficient, the Authority cannot make a recommendation of this nature based on benefits which it has not even been able to characterise as, at the very least, probable. Likewise, the Authority is incorrect in its apparent assumption that in its earlier reasons it has, other than by means of blanket, unsubstantiated assertions, made any attempt to discuss the impact of Risk Equalisation on the maintenance of a community rated market and the facilitation of competition. The Authority has eschewed any real analysis of any of those issues, and this is another reason why its proposal is flawed.

[Staff of the Authority have already articulated the benefits that could flow from the introduction of risk equalisation payments, such as the potential effect of transfers on premiums.](#)

87. Quite apart from issues of methodology, it is by no means apparent that Risk Equalisation may be used as a form of price regulation. The reasons advanced to justify Risk Equalisation are constantly changing, however, one recent argument that has been advanced is the supposed need to maintain community rating, a policy goal apparently removed from price resolution. Furthermore, even if Risk Equalisation could be permissibly used for that purpose, it may not be adopted in a manner that is contrary to Community Law. Since the Authority’s affirmative recommendation is essential for the Minister to proceed where the MEP is between 2% and 10%, the

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<sup>17</sup> For example, the Authority has asserted in its proposed recommendation that BUPA Ireland’s prices (taking its Essential Scheme) had risen 98% since its launch in January 1997, and that VHI’s equivalent prices (on VHI’s Plan A) had risen 100%. This does not compare like with like. The 98% increase asserted for BUPA Ireland is based on its increases up to March 2005, which increase incorporates the 25% increase in public hospital bed charges introduced on 1 January 2005. The VHI’s price (on which the Authority’s asserted 100% price increase is based) has not incorporated this increase as yet, and it is appropriate that the Authority take into account that VHI will have to increase its price to absorb the public hospital bed charges increase.

*It appears that BUPA Ireland’s Essential Scheme and VHI’s Plan A have been compared by the Authority because they are the only two directly comparable products, both having existed from 1 January 1997 to date. However, BUPA Ireland has many more products on the market (for example, its HealthManager range), which account for the majority of its sales. As these products are priced differently from other insurers’ products on the market, they cannot be compared, yet they are significant in terms of BUPA Ireland’s profile and the analysis of its cost effectiveness in the market.*

Authority is bound to respect Article 10 of the Treaty on European Union. Risk Equalisation Payments would wipe out all of BUPA Ireland's profits. It is therefore presumptively disproportionate, and accordingly, the Authority must exercise its discretion by recommending that it not be commenced.

It is not the Authority's intention to recommend risk equalisation as a form of price regulation. As outlined earlier, a community rated market without risk equalisation can reduce the level of competitive pressure on new entrants and facilitate price following to the detriment of the best overall interests of health insurance consumers..

With regard to the assertion that risk equalisation would wipe out all of BUPA Ireland's profits, BUPA Ireland could increase its premiums to allow profits to be made. If an insurer cannot make a profit when it has a risk profile equal to that of the market, it may be that the insurer is either uncompetitive or inefficient.

88. The Authority raises the possibility that price following could lead to excessive premium inflation to the benefit of one or more insurer and the detriment of consumers. The Authority does not suggest that such a phenomenon is actually happening, nor does BUPA Ireland accept there is any basis for any such contention. The mere "possibility" of such a phenomenon may not be relied upon to introduce Risk Equalisation.

Evidence from premium inflation rates and relative risk profiles would suggest that price following might be occurring.

89. The Authority also contends that premium inflation might threaten the stability of the market. Once again this hypothetical future scenario cannot justify the Authority's current recommendation.

For reasons outlined previously, Staff of the Authority consider it perfectly reasonable to contend that premium inflation might threaten the stability of the market. This argument was also made by the Former Members of the Advisory Group on the Risk Equalisation Scheme.

90. The same is true of the possibility of stability problems if young people chose not to purchase/renew health insurance. The Authority is not suggesting that this is a problem at present and therefore it cannot justify the proposed recommendation. In any event the flaw in the Authority's reasoning becomes more apparent when regard is had to its failure to take account of the extent to which the commencement of Risk Equalisation, and the premiums increases which that is likely to provoke, will lead to a reduction in the numbers of younger persons (or more precisely, less well off) availing of private health insurance. The issue identified by the Authority is far more likely to arise in practice if Risk Equalisation is introduced.

If young people were inclined not to purchase or renew private health insurance policies due to premium inflation, then it could be asserted that premium inflation could lead to instability.

Comments under paragraph 31 are relevant.

91. Finally, it is impossible to see any rational basis for the Authority's final justification for its decision to recommend Risk Equalisation. The Authority cannot legitimise its proposed recommendation on the basis that the introduction now of Risk Equalisation payments will remove any uncertainty in the market as to when and how Risk Equalisation payments might commence. **Furthermore, the articulation of this as justification for the introduction of Risk Equalisation implies a misconception that the introduction of Risk Equalisation is inevitable and that the only issue is one of timing. The function of the Authority is to reach a conclusion as to whether Risk Equalisation should be introduced at all.** Only if the answer to that question was yes, and on the basis of the then current returns, rather than some perceived possible future threat, would the Authority be entitled to decide whether immediate instruction was appropriate to address legitimate regulatory goals. The justification is not "*uncertainty*" as to when Risk Equalisation might be triggered.

The Authority is aware of what its function is.

Staff of the Authority Note that the Society of Actuaries in Ireland recommended the commencement of risk equalisation on the basis that it would remove uncertainty in relation to the matter. This is clearly not an irrelevant detail. However, it should be noted that this point was not included in the Authority's letter to insurers as a reason. It was included as a "consequence".

G. **FINANCIAL EFFECTS OF COMMENCEMENT OF RISK EQUALISATION**

**Level of competition in the market and the commencement of Risk Equalisation**

92. For the purposes of 'pass through' to consumers, the Authority appears to have assumed that despite facing an annual Risk Equalisation payment of €33.4 million and rising, BUPA Ireland could remain in the market exerting the same competitive discipline on the VHI as before. The precise financial effects of the commencement of Risk Equalisation are described in greater detail in this Section. However, in summary terms, given the size of the price increase that would be required to cover the cost of Risk Equalisation, and considering the price elasticity of demand particularly of BUPA Ireland customers, it is impossible to see how any efficient competitor of the VHI could survive which obviously cannot be in the best interests of health insurance consumers.

Staff of the Authority estimated the effect on BUPA Ireland's finances in Section E of this Report under the heading "The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers". BUPA Ireland's differing analysis is considered overleaf.

With regard to the price elasticity of demand of BUPA Ireland's policyholders, we would again refer to the continued growth of BUPA Ireland following its 14.4% price increase in March, 2003.

93. The Authority also expresses the view that now that Vivas has entered the market, the adverse competitive consequences of commencing Risk Equalisation have somehow lessened. This assumes that BUPA Ireland can stay in the market exerting the same competitive pressure if Risk Equalisation commences. The Authority's analysis necessarily assumes that a fledgling competitor such as Vivas which has yet to establish itself in the market, would be in a position to meet at least all of the demand currently satisfied by BUPA Ireland, a wholly unrealistic possibility for several years. Moreover, it is difficult to see how Vivas can be expected to survive in the medium term, with any exemption from Risk Equalisation payments due to expire within three years, it is probable that Vivas would be unable to survive due to the same Risk Equalisation constraints as those currently proposed for BUPA Ireland.

As noted in the "Cons" section of "Pros and Cons of Introducing Risk Equalisation" in Section F, the commencement of payments could reduce the competitive pressure on Vhi Healthcare. The entry of VIVAS Health has the potential to increase competitive pressure on all other insurers, particularly in light of VIVAS Health's limited exemption from making (or receiving) payments under the Scheme.

94. The Authority has failed (to our knowledge) to undertake a meaningful analysis of the impact of Risk Equalisation Payments on BUPA Ireland's viability in the Irish market and if it has done so it has not provided it to BUPA Ireland. The following table illustrates the negative impact on BUPA Ireland customers

(and also demonstrates the relatively small benefit to VHI customers). It should be noted that this analysis assumes that the VHI would pass the benefit of any levy to its customers, although this is unlikely to be the case, and also assumes price elasticity of demand, namely that BUPA Ireland's customers will remain with it despite substantial increases. Of course, this is not a likely scenario at all especially considering the extent of price sensitivity of consumers as demonstrated in research carried out for the Authority by Amárach:-

As noted under paragraph 92, the Authority did undertake a meaningful analysis.

<b>NEGATIVE IMPACT OF RES</b>			
<b>PRICE INCREASE IMPACT (BUPA IRELAND)</b>		<b>PRICE INCREASE IMPACT (VHI)</b>	
<b>RES Payment</b>	€3,400,000*	<b>RES Receipt</b>	€3,400,000
<b>Average Number of Members (2004)</b>	374,000	<b>Average Number of members</b>	1,560,000
<b>RES Levy per member</b>	€89	<b>RES receipt per member</b>	€1
<b>Average revenue per Member</b>	€99	<b>Average Revenue per member</b>	€14
<b>Price Increase required</b>	22%	<b>Potential price reduction</b>	4%

\* Most recent six monthly RES calculation x 2. Assumes HSW=0.

The analysis in the above table is not considered to be meaningful for the following reasons:

- The RES payment in respect of 2004 would have been about €28.6m from BUPA Ireland.
- Not all of this transfer would have gone to Vhi Healthcare.
- The price increase assumes that BUPA Ireland wishes to maintain its current level of profit (about 17.3% of premium), which is far in excess of BUPA Insurance Limited in the UK and Vhi Healthcare (even though BUPA Ireland say that Vhi Healthcare is one of the most profitable insurers in Ireland).

Therefore the analysis by Staff of the Authority is considered to be superior.

95. The impact on BUPA Ireland's competitiveness can be demonstrated by reference to the example of the impact of the introduction of Risk Equalisation Payments on the current pricing of a typical family policy solely for presentation purpose, we assume that there is a reduction in VHI prices. As we explain below,

for economic reasons no such reductions will occur, not at least because VHI have no incentive to do so under a zero sum scenario if Risk Equalisation commences:-

Staff of the Authority do not agree with the analysis in the table below because

- It is based on the above table.
- It assumes that Vhi Healthcare's premium will reduce further, when Vhi Healthcare state that they have already allowed for risk equalisation transfers.
- It does not allow for the fact that Vhi Healthcare's premiums are due to increase again in September.

	<b>CURRENT PRICE</b>	<b>RES IMPACT</b>	<b>NEW PRICE</b>
<b>VHI Plan B Option</b>	€1,441	-4%	€1,383
<b>BUPA Ireland Essential Plus</b>	€1,297	+22%	€1,582
<b>BUPA Ireland cheapest (dearer)</b>	10% cheaper		(14%) dearer

(This table assumes that HSW = 0)

96. The following table analyses what would be the impact of Risk Equalisation Payments on the historic operating profit of BUPA Ireland and VHI respectively for the years from 2002 to 2004, and it also projects the impact going forward. It demonstrates that absent Risk Equalisation, both BUPA Ireland and VHI are successful and profit making. The effect of Risk Equalisation Payments is to inflate VHI's profits, but also to transform BUPA Ireland's operating profit into an unsustainable operating loss for each of the years in question. This would render BUPA Ireland's products uncompetitive and its business unviable:-

Staff do not agree with the analysis below, for the following reasons:

- The figures for operating profit do not match those in the Annex.
- The figures seem to assume no change in premiums, which is unrealistic.
- The RE transfer figure for 2004 is incorrect. It should be €28.6m.
- It is unclear how BUPA Ireland arrived at RE transfer figures for 2002, 2003, 2005 and 2006.

Corporation tax is payable on the above profits at a composite UK and Irish tax rate of 25% approximately. In addition, the capital required for regulatory solvency capital purposes to support the business currently totals €67m. The proposed introduction of Risk Equalisation Payments with a potential full year charge of €40m+ renders the business commercially unviable under any pricing scenario.

	<b>BUPA Ireland</b>			<b>VHI Healthcare</b>		
<i>€m.</i>	<b>Operating profit<sup>18</sup></b>	<b>RES payment</b>	<b>Operating Loss</b>	<b>Operating profit<sup>19</sup></b>	<b>RES receipts</b>	<b>Operating profit</b>
<b>2002</b>	13.1	(17.0)	(3.9)	18.3	12.2	30.5
<b>2003</b>	15.7	(25.7)	(10.0)	34.3	17.0	51.3
<b>2004</b>	24.3	(32.7)	(8.4)	73.3	25.7	99.0
<b>2005</b>	17.3 <sup>20</sup>	(42.5)	(25.2)	N/a	32.7	
<b>2006</b>	17.3	(49.7)	(32.4)	N/a	42.5	
<b>2007</b>				N/a	49.7	

As noted, BUPA Ireland has not provided a meaningful analysis to arrive at this conclusion.

Any temporary benefit from phasing relief in the 12 months following introduction of Risk Equalisation would be ignored as being irrelevant to longer term decision

<sup>18</sup> Before tax and investment income (no unexpired risk reserve)

<sup>19</sup> Before tax, investment income and unexpired risk reserve.

<sup>20</sup> *The planned reduction in 2005 reflects the decision to limit 2005 premium increases to 6.6% despite a 25% increase in public hospital bed costs.*

making.

97. It would be unrealistic for any regulator to expect BUPA Ireland to remain in the market while losses of such magnitude were being sustained. Accordingly, **the inevitable consequence of the implementation of Risk Equalisation would be to force BUPA Ireland out of the market**, reducing competition, and reducing the choice available to the consumer.

This was considered by Staff of the Authority. However this Report has been amended in order to take account of BUPA Ireland's statements.

98. Accordingly, the commencement of Risk Equalisation would operate against the overall interest of consumers as it would do nothing to ensure compliance with existing regulatory obligations or the maintenance of community rating. In the circumstances it seems inconceivable that commencement could be in the best overall interests of consumers. The contrary is the more likely result of a radical intervention which could seriously impact on premium levels, render the dominant insurer's only real competitor unviable, effectively eliminating competition in the Irish health insurance market

This is the view of BUPA Ireland.

The UK Government Actuaries Department were commissioned to review the financial analysis included with BUPA Ireland's representations. Their review follows.

“



Government Actuary's Department  
www.gad.gov.uk

Your Reference :  
Our Reference :

Liam Sloyan  
Health Insurance Authority  
Canal House  
Canal Road  
Dublin 6

**DIRECT (GTN)**  
**(020) 7211 2688**

**FAX (GTN)**  
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**E MAIL**  
**david.lewis@gad.gov.uk**

15 April 2005

Dear Liam

**Financial analysis in section G of BUPA Ireland's submission in response to the Authority's letter of 15 March 2005**

You asked us to write with our comments on the financial analysis contained in section G of BUPA Ireland's submission in response to the Authority's letter dated 15 March 2005. This section contains a brief review of the impact risk equalisation might have on premium levels and on profitability.

Our comments on BUPA's analysis are as follows:

Tables on premium changes on page 32 [Ed: The page number refers to original BUPA Ireland representations. The tables appear on pages 110 and 111 of this Report]

1. BUPA has taken the risk equalisation payment as €33.4 million, which they say is twice the payment for the period ended 31 December 2004. It may have been more appropriate, particularly given any seasonal effects in the data and the use of the average number of members over 2004 as a whole, to take the sum of the payments for the periods ended 30 June 2004 and 31 December 2004, which would give €28.6 million.
2. They have assumed that all of the payment from BUPA Ireland is paid to Vhi. In practice a part of this would be received by ESB.

3. It is not clear to us how BUPA obtained the figures for the average number of members in 2004.
4. The average revenue per member for BUPA seems to be calculated as €149.2 million (being the earned premium they report for 2004 in Annex 2 to the submission) divided by 374,000.
5. It is implicit in BUPA's calculations that they wish to maintain the same level of profitability. In contrast, for the staff report it was assumed that BUPA's profit would reduce to 4% of premiums (from 16% currently). If this adjustment is made, and the risk equalisation payment is reduced to €28.6 million, the BUPA analysis and that in the staff report are consistent. The 22% required premium increase quoted by BUPA reduces to 19% if the risk equalisation payment is taken as €28.6 million; 12% of this increase could then be assumed to be absorbed by lower profits, leaving a required increase of 7%, which is also the figure quoted in the staff report. It can be noted that if there is no change in Vhi premiums, a 7% increase for BUPA would mean that their Essential Plus policy would still be cheaper than the Vhi Plan B Option policy.
6. It is not clear how they obtained the average revenue per member for Vhi, although it may be €803 million (being the earned premium reported by Vhi for the year ended 29 February 2004) divided by 1,560,000; this gives a figure of €15 (rather than €14). If this is true, the premium figure does not relate to the same period as the risk equalisation payment or the number of members. Nevertheless the estimated premium reduction of 4% is similar to the figure of 3% given in the staff report (although in that case it was assumed that this had already been reflected in Vhi's premium rates).
7. In the comparison of the premiums for Vhi Plan B and BUPA Ireland's Essential Plus, there is no reference to the fact that these premium rates increase at different times. The Vhi premium is due to increase on 1 September 2005, whereas the BUPA premium would not rise until 1 March 2006. This could substantially change the comparison of the premiums from 1 September 2005.
8. BUPA assume that Vhi make a reduction in their premium to reflect risk equalisation, which clearly makes the comparison less favourable to BUPA. However, this ignores Vhi's statement that it has in effect already passed on the benefit of risk equalisation, in which case you would not expect any further immediate reduction in their premium.

Table on effect on operating profit on page 33 [Ed: The page number refers to original BUPA Ireland representations. The table appears on page 112 of this Report]

1. The letter from KPMG attached as Annex 2 to the submission indicates that the operating profit figures in the table in page 33 [Ed: Page 112 of this report] have not been audited by KPMG: they simply confirm that the figures for 2002 to 2004 are the same as those presented to the BUPA Board in management accounts and those for 2005 and 2006 are the same as those included in BUPA's budgets for those years. KPMG states that they have only carried out a limited review of the management

accounts and have done no work on the budgeted figures, which they comment "... is by its nature highly speculative".

2. There is no information available on the assumptions underlying the budgeted figures and therefore it is impossible to judge their appropriateness for the purpose to which they are used.

3. Annex 3 to the submission gives restated profit figures to allow for the overprovision for claims. No allowance or mention of this was made in the table on page 33 [Ed: Page 112 of this report] which will therefore understate profitability.

4. The operating profit figures after risk equalisation assume no change in premiums, and this does not seem reasonable for future years. Also, it has been assumed that there is no change in the numbers of policyholders.

5. It is not clear how the risk equalisation payment for 2004 has been calculated. The sum of the payments for the periods ended 30 June 2004 and 31 December 2004 is €28.6 million, whereas BUPA has shown a figure of €2.7 million, which again tends to overstate the loss.

6. It is unclear how they have obtained the risk equalisation payments for other years. Although we have made no calculations to estimate this, the estimated risk equalisation payments for future years appear high.

7. It has again been assumed that the whole of the risk equalisation payment is applied to Vhi. In practice, a part of it would be received by ESB.

8. The years do not correspond exactly: for BUPA they are years ended 31 December and for Vhi they are years ended 28 February. BUPA has assumed that the risk equalisation payment for 2004 would be all allocated to the Vhi accounts for the year ended 28 February 2005.

If you have any further questions, please give me a call.

Yours sincerely

A handwritten signature in black ink that reads "D. Lewis". The signature is written in a cursive style with a large, looped initial 'D'.

David Lewis"



# GAD

Government Actuary's Department

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**[david.lewis@gad.gov.uk](mailto:david.lewis@gad.gov.uk)**

28 April 2005

Dear Liam,

I refer to our letter dated 15 April 2005 responding to your commission to review the financial analysis included with BUPA Ireland's representations. We understand that this letter is now to be included in the staff report to the Authority and may therefore be in the public domain.

Please note that GAD's consideration of the financial analysis included with BUPA Ireland's representations has been based on our understanding of the requirements and purposes of the Authority in its consideration of whether or not to recommend the commencement of risk equalisation payments. We are therefore unable to provide any assurance as to the suitability of our comments for any other purposes of the Authority, nor for any purposes of a third party.

I would be grateful if you could arrange for a copy of this letter to go with our letter dated 15 April 2005 in the staff report.

Yours sincerely

David Lewis

## **H. CONCLUSION**

99. In conclusion, BUPA Ireland does not consider that the Authority has properly demonstrated any cogent or reasonable case for the introduction of Risk Equalisation as being in the best overall interests of health insurance consumers, nor could it do so based on any rational analysis or available evidence. To the contrary, the evidence is that the introduction of Risk Equalisation will not influence adherence to community rating, and will have an adverse influence on the current healthy competitive environment. BUPA Ireland requests that the Authority reconsider and reverse its current proposed recommendation based on the above submissions.

100. Not only has the Authority failed to meet the standards set down by law even the method purported to do so was inadequate. Most fundamentally, despite being required by statute to communicate to BUPA Ireland the reasons for its proposed recommendations, the Authority has largely failed to do so in any meaningful or coherent manner and has essentially dismissed BUPA Ireland's requests for information and documents. It has entirely failed to clarify the basis upon which the Authority is purporting to make its draft recommendations. The Authority's approach is contrary to its statutory responsibilities and the dictates of natural justice, constitutional fairness, and fair procedures. The effect of the supply of inadequate reasons and the refusal to elaborate on the same is to prejudice BUPA Ireland's ability to exercise its statutory right to make submissions in respect of the draft recommendations. BUPA Ireland reserves its rights in respect of the prejudice sustained thereby.

101. The Authority's approach is contrary to the requirements of Constitutional fairness, natural justice, fair procedures and regulatory obligations. For the reasons referred to above the Authority should abandon its proposed recommendation.

[These points have already been addressed.](#)

## Annex 1 To BUPA Ireland Submissions



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Mr Martin O'Rourke  
Managing Director  
BUPA Ireland  
12 Fitzwilliam Square  
Dublin 2

Dear Martin,

You have asked us to consider to what extent the report titled 'Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market', prepared by the York Health Economics Consortium in conjunction with the Office of Health Economics for the Health Insurance Authority in 2003 (the York report), provides support for a recommendation to commence risk equalisation payments under the Risk Equalisation Scheme 2003.

Based on our review of the document, and on advice from Irish counsel with regard to the obligations on health insurers under Irish law, our view is that the York report does not provide robust support for any recommendation to commence risk equalisation payments; we set out the reasons for our view in more detail below.

Although the report concludes that there is a good case for such payments, these conclusions are not based on robust and reliable analysis of the effects of risk equalisation payments on competition, and the relative costs and benefits of such payments. Rather, they are informed by a distorted view of the benefits of competition, and a flawed assessment of the likely effects of risk equalisation payments. Therefore, we do not believe that the conclusions presented in the York report provide any guidance on whether risk equalisation payments are in the best overall interest of consumers, taking account of their impact on the maintenance of community rating and on the promotion of competition.

More specifically, the main conclusions drawn in the York report are that:

- risk equalisation is one of several factors deterring entry into the Irish health insurance market (with the non-commercial status of VHI, and the uncertainty over its future status, being the other main entry deterrent);
- if uncertainty over the final implementation of risk equalisation is resolved, the market should still attract some new entrants, though fewer than if risk equalisation payments were not implemented;
- there is no satisfactory case for the non-implementation of risk equalisation payments as long as there is a fundamental commitment to community rating;
- without risk equalisation, the benefits of new entry are limited in that older people with health insurance, who would be less inclined to move between insurers, would lose (and, at best, these losses would exactly be offset by gains to younger people, but alternatively such gains would be smaller and new entrants would benefit in the form of profits);

- because new entrants will inevitably recruit younger, lower risk members, rather than an average risk profile, community rating cannot be implemented by business regulation.<sup>21</sup>

However, these conclusions are not supported by any analysis of the threat to community rating (as, based on advice from Irish counsel, we understand it to be defined under Irish law) from competition or the relative costs and benefits of risk equalisation payments in light of their impact on the level and structure of premiums, and on the effectiveness of competition. Rather, the conclusions in the York report appear to be based on the following flawed or mistaken assumptions:

- *Any competition that leads to differences in risk profiles across insurers threatens community rating.* This ignores that community rating as we understand it to be defined under Irish law, based on advice from Irish counsel, only prevents insurers from charging different prices for the same policy (which, together with the open enrolment provision, ensures that insurers cannot discriminate against particular customers based on their individual risks, and therefore that access to private health insurance is not denied to those who need it most). Community rating allows insurers to offer different policies and discriminate prices based on self-selection of customers. Given that all insurers have to comply with these obligations, the ability of new entrants or competitors to 'cherry-pick' customers and "to selectively choose low risk lives"<sup>22</sup> is limited, and in any case replicable by all market participants, including the incumbent.<sup>23</sup> Thus, community rating as set out under Irish law - namely a prohibition on discrimination by the insurer between individual customers based on their likely risk characteristics - is sustainable in a competitive market.
- *New entry, and competition, is "only socially beneficial if the new entrants are more efficient than the incumbents".*<sup>24</sup> This naively assumes that the alternative to competition is a perfectly regulated monopoly (where regulation achieves allocative, productive and dynamic efficiency, and requires the incumbent monopolist to set community-rated premiums), and ignores the benefits that can be obtained from competition bringing prices closer to costs even in cases where new entry results in an overall increase in costs when compared to the more realistic alternative of imperfect regulation, and the incentives created by competition for innovation and the development of new products.
- *"[C]ompetition from new entrants in the absence of risk equalisation would not necessarily be beneficial for the market"*<sup>25</sup> *because it might be driven by the ability of new entrants to attract younger customers and thus only lead to higher premiums for high-risk older customers.* This ignores that risk equalisation in itself has a detrimental impact on average premiums as it will (a) price out of the market the more price-sensitive customers (reducing the size of the market), (b) undermine the incentives to reduce costs (which, contrary to the assertion in the York report, are not limited to administrative costs but also cover other cost drivers such as improved health management, better incentives to negotiate down supplier costs etc.) and (c) weaken the incentives for innovation.
- *Risk equalisation would only discourage entry that is driven by the new entrant's ability to attract lower risks rather than any cost advantages.* This ignores that, in the presence of customer switching costs, even a more efficient entrant might find it difficult to operate profitably without enjoying some compensating benefits (such as a lower risk profile)

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<sup>21</sup> The recommendations are summarised on pp 97-98 of the York report.

<sup>22</sup> Page 23 of the York Report

<sup>23</sup> In other words there is no pool of customers that would only be available for a new entrant, but not for the incumbent. Any differentiation of products, which a new entrant might use in order to attract particular customers, can be replicated by the incumbent and will have the same effect.

<sup>24</sup> Page 56 of the York Report

<sup>25</sup> Page 77 of the York Report

when competing with an incumbent who is protected by customer inertia. Thus, even if the absence of risk equalisation provides some advantages to new entrants, these may be necessary in order to compensate for incumbency advantages, and without such compensation efficient entry would be discouraged. In this context, it is worth pointing out that market research commissioned by the Health Insurance Authority found that a "cost saving of at least 26% would be required to encourage significant numbers of consumers to switch."<sup>26</sup>

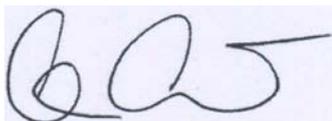
- *Uncertainty about the prospect of risk equalisation payments has a stronger entry deterrence effect than these payments themselves.* The claim that a possible downside faced by a new entrant would have a stronger impact than the same downside occurring with certainty is clearly incompatible with any notion of rational decision making. Triggering risk equalisation payments would in any case generate further uncertainty about the measurement and method of calculation of those payments.
- *In any case, "community rating must be put before any benefits from competition, not least because ... these benefits will mainly accrue to younger, fitter new purchasers of health insurance, not older, sicker members of existing schemes."*<sup>27</sup> Apart from the fact that the claim that competition benefits would only be experienced by some customers is unsubstantiated, this seems to directly contradict advice to us to the effect that under Irish law the Health Insurance Authority is required to act in the best overall interests of health insurance consumers, which is defined none-exhaustively with reference to **both** maintaining community rating and promoting competition.

Thus, as pointed out above, in our view the conclusions presented in the York report are unsupported. In particular:

- The report fails to take account of the meaning of community rating as we understand it to be defined under Irish law;
- It is based on the claim that community rating has to be given priority over competition, which on the basis of advice from Irish counsel we understand to be mistaken;
- it ignores or misrepresents the benefits from competition, and implicitly favours a regulated monopoly over competition without taking account of the fact that any form of regulation is likely to be imperfect;
- It fails to analyse the impact of risk equalisation on competition and the level of premiums;
- It misstates the potential effect of risk equalisation on entry incentives, at least implicitly claiming that the only entry that would be discouraged would be socially undesirable.

I trust that this letter addresses your question. We would be happy to provide a detailed assessment of the York report in due course should this be required.

Sincerely,



Dr Christian Koboldt  
Director

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<sup>26</sup> "The Private Health Insurance Market in Ireland", Amarach Consulting, March 2003, p 4.

<sup>27</sup> Page 79 of the York Report.

YORK  
**Health Economics**  
CONSORTIUM

18 April 2005

*Director: Dr Peter A West*

Brian Turner  
Head of Research/Technical Services  
The Health Insurance Authority  
Canal House,  
Canal Road,  
Dublin 6, IRELAND.

Dear Brian,

**RE. A JOINT RESPONSE FROM YHEC AND OHE CONSULTING TO  
LETTER FROM DR CHRISTIAN KOBOLDT, DIRECTOR OF DOTECON**

Following your message of 13 April 2005, York Health Economics Consortium (YHEC) and OHE Consulting are pleased to have this opportunity to respond to the points raised by Dr Koboldt in his letter to Mr Martin O'Rourke dated 5 April 2005, and to clarify the arguments set out in our report 'Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market' (2003).<sup>1</sup>

YHEC, in conjunction with OHE Consulting, were commissioned to undertake an independent review of competition in the market for private health insurance in Ireland, with particular regard to the likely impact of introducing risk equalisation. This research took account of the views of a number of stakeholders, including existing insurers, potential entrants, and representatives from the Competition Authority and the Department of Health and Children. The research team came to the project with no prior opinion on the impact of risk equalisation on competition in the private health insurance market in Ireland, and is confident that it has no conflict of interest.

We would now like to address the specific points raised by Dr Koboldt.

/ Continued .....

<sup>1</sup> York Health Economics Consortium (YHEC) and Office of Health Economics (OHE), 'Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market'. November 2003.

- *Any competition that leads to differences in risk profiles across insurers threatens community rating.*

We agree that, as Dr Koboldt states '[c]ommunity rating allows insurers to offer different policies and discriminate prices based on self-selection of customers'. At the extreme, however, this may effectively become *de facto* risk rating as insurers may offer products with different combinations of premia, coverage, deductibles and co-payments to segment the market and attract members with particular characteristics. This is at variance with the basis for the implementation of community rating, namely 'inter-generational solidarity'.<sup>2</sup> In the absence of risk equalisation, other regulatory intervention might well be required to prevent this threat to community rating.

- *New entry, and competition, "is only socially beneficial if the new entrants are more efficient than the incumbents".*

We do not 'assume that the alternative to competition is a perfectly regulated monopoly' as stated by Dr Koboldt.<sup>3</sup> Rather our point refers to the losses in social welfare that would arise in the event of entry by an inefficient insurer. If such an entrant has a lower risk profile, then it will be able to charge a lower premium to attract additional business. However, a movement of members from a more efficient to a less efficient firm represents a social welfare loss.

- *"[C]ompetition from new entrants in the absence of risk equalisation would not necessarily be beneficial for the market" because it might be driven by the ability of new entrants to attract younger customers and thus only lead to higher premiums for high-risk older customers.*

We agree that risk equalisation is likely to raise average premium levels because by supporting community rating it will discourage some price sensitive low risks (young/healthy) from buying insurance and will retain some price sensitive high risk (elderly/ill) who would no longer insure if their

/ Continued .....

<sup>2</sup> Health Insurance Authority. Consultation Paper on Lifetime Community Rating. August 2002, p. 2.

<sup>3</sup> Dr Christian Koboldt, letter dated 5 April 2005.

premia were not subsidised by lower risk insurees. That is what community rating plus risk equalisation is for: providing a mechanism to keep elderly/ill people insured, by requiring young/healthy people to pay for some of the first group's costs.

Dr Koboldt's argues that risk equalisation will 'undermine the incentives to reduce costs' and 'weaken the incentives for innovation'. In contrast, we maintain that the incentive for insurers to be efficient and innovative could even be stronger with risk equalisation than without, as efficiency and innovation are then the only source of profit, rather than selection of lower risk insurees.

- *Risk equalisation would only discourage entry that is driven by the new entrant's ability to attract lower risks rather than any cost advantages.*

Dr Koboldt argues that 'in the presence of customer switching costs, even a more efficient entrant might find it difficult to operate profitably without enjoying some compensating benefits when competing with an incumbent who is protected by customer inertia'. We acknowledge that the presence of switching costs is likely to discourage some switching even to a more efficient new entrant, but only up to a point. Firms will enter the market if their efficiency gains are sufficiently high to offset switching costs and encourage members to move from the incumbent(s). However, if the efficiency improvement offered by a new entrant is less than the costs of switching, then by definition this type of entry would not be in those consumers' interests.

- *Uncertainty about the prospect of risk equalisation payments has a stronger entry deterrence effect than these payments themselves.*

This is not a direct quote from our report. We did not say this and it is not our view. Dr Koboldt appears to have misunderstood the arguments made in our report in relation to the uncertainty surrounding the implementation of a risk equalisation scheme. Dr Koboldt argues that it is not the case that 'a possible downside faced by a new entrant would have a stronger impact than the same downside occurring with certainty'. We agree. But we stand

/ Continued .....

by our view that in a world characterised by risk aversion, any uncertain cost with an expected value of €X represents a greater barrier to entry than a certain cost of €X. Consider the following example: The probability that risk equalisation will be introduced is 0.5. If risk equalisation is introduced, then the insurer surmises that there are two possible means of calculating the payment which both have equal probabilities, but the magnitude of payments under the first scheme is €10,000 and €20,000 under the second scheme. In this case, the expected value of payments is €7,500  $0.5*((0.5*€10,000)+(0.5*€20,000))$ . Due to risk aversion, the insurer would prefer to face a certain payment of €7,500. In this more subtle analysis of decision making under uncertainty, a risk averse insurance provider would prefer to face the certain risk equalisation scheme payment of €7,500 to the uncertainty of facing payments of zero, €10,000 or €20,000. On a more minor point, Dr Koboldt then states '[t]riggering risk equalisation payments would in any case *further* uncertainty about the measurement and method of calculation of those payments' (emphasis added). We agree that there will inevitably be some uncertainty about the operation of the scheme (arising as a result of changes in legislation, the structure of the market, or the political regime), but we feel that once the scheme has been adopted, it is likely that the degree of uncertainty will fall compared to the situation before risk equalisation has been implemented.

- *In any case, “community rating must be put before any benefits from competition, not least because ... these benefits will mainly accrue to younger, fitter new purchasers of health insurance, not older, sicker members of existing schemes”.*

The motivation for this point relates to the apparent mutual incompatibility between community rating and competition under the existing market conditions. The findings from our review, and from standard economic theory suggest, that it is difficult to promote competition within the existing market without putting community rating at risk (this is due to the likely unsustainability of equilibrium). This has also been recognised by the Competition Authority, which acknowledged ‘the over-riding importance attached to the public policy objective of maintaining community rating’.<sup>4</sup>

/Continued .....

<sup>4</sup> The Competition Authority, ‘Submission to the Health Insurance Authority – Risk Equalisation in the Private Health Insurance Market in Ireland’.

However, we acknowledge that the research team is not in a position to prioritise community rating over competition in achieving the best overall interests of consumers.

Finally, we would like to highlight that our conclusion that ‘there is no satisfactory case for the non-implementation of risk equalisation payments as long as there is a fundamental commitment to community rating’ is consistent with that reached by both the Competition Authority and the European Commission.<sup>5</sup> This argument is also supported by the fact that ‘a risk equalisation scheme is common in circumstances of community rating combined with open enrolment’, as evident by the adoption of risk equalisation in 16 out of 18 countries where there is community rating.<sup>6</sup>

Thus we maintain the conclusion of our review that the introduction of risk equalisation will probably prove to be a deterrent to entry, but is likely to be necessary to protect the tenet of community rating.

Yours sincerely,

**PETER WEST**  
**Director**

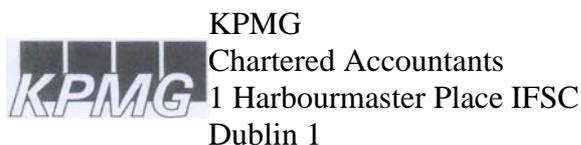
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<sup>5</sup> YHEC and OHE (2003), p. 97. The Competition Authority stated ‘given the over-riding importance attached to the public policy objective of maintaining community rating, some system of risk equalisation is likely to be necessary to support the principle of community rating’ (see ‘Submission to the Health Insurance Authority – Risk Equalisation in the Private Health Insurance Market in Ireland’).

The European Commission concluded that ‘the RES [Risk Equalisation Scheme] is necessary for the stability of a community rated health insurance market’ (see ‘Risk equalisation scheme in the Irish health insurance market’, State Aid N 46/2003 – Ireland, May 2003).

<sup>6</sup> YHEC and OHE (2003) p. 50. Figures are based on a study by Parkin and McLeod, entitled ‘Risk equalisation methodologies: an international perspective’ (University of Cape Town, 2001, CARE Monograph No. 3).

## Annex 2 to BUPA Ireland's Representations



Ireland

Private and confidential

The Directors  
BUPA Ireland Limited  
12 Fitzwilliam Square  
Dublin 2

05 April 2005

Dear Sirs

In accordance with the terms of our engagement letter dated 5 April 2005, we have carried out the agreed upon procedures specified below in respect of certain information included in Schedule of Appendix 1 to this letter ("the Schedule"). We understand this information may be included in the submission to be made by BUPA Ireland Limited to the Health Insurance Authority ("the HIA"). The Directors of BUPA Ireland are responsible for the preparation of the Schedule.

The agreed upon procedures do not constitute an audit and have the limited scope described below.

We confirm that, on the basis of our work, the items of financial information identified in the attached annotated copy of the Schedule have been accurately extracted from their respective sources, as indicated by us on the Schedule, using the convention set out below:

- Agreed the operating profit for the year ended 31 December 2002 to the management accounts for BUPA Ireland considered by the board of BUPA Ireland Limited on the 24 April 2004.

- Agreed the operating profit for the year ended 31 December 2003 to the management accounts for BUPA Ireland considered by the board of BUPA Ireland Limited on the 24 June 2004.
- Agreed the operating profit for the year ended 31 December 2004 to the management accounts for BUPA Ireland Limited circulated to the board of BUPA Ireland Limited on the 4 April 2005.
- Agreed the budgeted operating profit for the year 31 December 2005 to the budgeted financial information considered by the board of BUPA Ireland Limited 2 December 2004.
- Agreed the budgeted operating profit for the year 31 December 2005 to the budgeted financial information considered by the Board of BUPA Ireland Limited 25 September 2004.

For the avoidance of doubt operating profit includes earned premiums less medical costs (including the outstanding claims provision) and other operating costs. It should be noted that the outstanding claims provision is calculated on an accruals basis at each period end in accordance with accounting convention and is by its nature an accounting estimate which is subject to judgement.

We confirm that we have carried out a limited review of the management accounts which included limited review procedures in respect of the outstanding claims provision for each of the periods ending 31 December 2002, 2003 and 2004 for group reporting purposes and to group materiality guidelines. We have not carried out a full scope audit of the financial information included in the management accounts.

We make no comment on, and have performed no work in respect of the budgeted financial information for the years ending 31 December 2005 and 2006. It should be noted that any prospective financial information is by its nature highly subjective.

Apart from the agreed upon procedures set out above, for the purposes of this letter, we make no representations regarding the appropriateness or the sufficiency of the above procedures for your purposes.

This letter is for your information only and is not to be quoted or referred to, in whole or in part, without our prior written consent.

Yours faithfully

KPMG

	<b>Actual 2002 €m</b>	<b>Actual 2003 €m</b>	<b>Actual 2004 €m</b>	<b>Budgeted 2005 €m</b>	<b>Budgeted 2006 €m</b>
Earned premium	81.5	115.0	149.2	175.8	200.5
Medical costs	(54.6)	(82.4)	(105.0)	(136.4)	(159.8)
Underwriting surplus	26.9	32.6	44.2	39.4	40.7
Administration costs	(13.8)	(16.9)	(19.9)	(22.1)	(23.4)
<b>Operating profit</b>	<b>13.1</b>	<b>15.7</b>	<b>24.3</b>	<b>17.3</b>	<b>17.3</b>

### Annex 3 to BUPA Ireland Representations

The following table shows the operating profit for the years ended December 2001 to 2004, as already reported to the Board of BUPA Ireland (see Schedule 2) and subsequently furnished to HIA. At the end of each year, provisions were made for the outstanding claims (OCP).

We have restated that those results, using the claims paid data to March 2005, to show what the results would have been had there been no over or under provision of outstanding claims in each year. With the passage of time therefore, this gives a more certain reflection of operating performance of the business.

	2001 €m	2002 €m	2003 €m	2004 €m
Earned premium	61.9	81.5	115.0	149.2
Medical costs	(39.1)	(54.6)	(82.4)	(105.0)
Underwriting surplus	22.8	26.9	32.6	44.2
Administration costs	(11.8)	(13.8)	(16.9)	(19.9)
<b>Operating profit ~ reported</b>	<b>11.0</b>	<b>13.1</b>	<b>15.7</b>	<b>24.3</b>
Overprovision of OCP	2.1	0.4	4.9	1.5
<b>Operating profit ~ restated</b>	<b>13.1</b>	<b>13.5</b>	<b>20.6</b>	<b>25.8</b>

Having restated the results with benefit of this hindsight, the level of profit in any year would not have been significantly different, with the possible exception of 2003, which is explained below.

Claims were settled at an accelerated rate in the second half of 2003 by comparison to the equivalent period in 2002, which caused us to have a higher OCP in 2003 than would otherwise have been the case. (This could be due to a number of reasons including, for example, the claims submission patterns to the dominant insurer.) The degree to which this acceleration did not reflect an underlying increase in claims activity did not become apparent until after the year end when the accounts were finalised. Furthermore, as part of our OCP, we made specific provision for potential payments to hospitals which, whilst they were the best estimate of the liability at that time, subsequently proved to be overstated. In making our OCP estimate at the end of 2003, we also had regard to our OCP experience in 2002, which left uncomfortably little room for unexpected claims incidents.

There is always uncertainty in estimate of claims outstanding. This is even more so the case in a readily growing business with no significant historical date (e.g. in 2001, our membership grew by almost 30%). Our auditors performed a limited review of the OCP each year and no changes to the provision were ever suggested – see Schedule 2 to this submission. Indeed, good accounting practice (and regulation) require us to be prudent in making such provisions, particularly with such a rapidly growing business. We are satisfied that we have discharged our duties responsibly in this regard.

Whilst the FSA Return can be useful for understanding history, the transfer of BUPA's insurance business from one BUPA company to another in 2001 did have an impact on the 2001 and 2002 Returns as per discussions and correspondence on this

matter with the Authority in April 2004. This schedule has been provided as an aid to interpretation.

## **Vhi Healthcare's Representations:**

Received from Vhi Healthcare, Vincent Sheridan, *Chief Executive Officer*

5 April 2005

Dear Dermot

Thank you for your letter of 15<sup>th</sup> March 2005.

As you can imagine your letter conveying the proposed recommendation of the Authority was received with a great deal of relief in our office. On a personal level I was concerned that I had failed to sufficiently impress on the Authority the urgent and essential need for the activation of Risk Equalisation in order to ensure the stability not only of Vhi Healthcare but of the health insurance market in Ireland.

I do not intend to resubmit or even summarise the detailed representations and reports we have presented to the Authority to date, in furtherance of our case for Risk Equalisation. These remain a matter of record. There are, however, a number of points which I believe are relevant at this juncture:

1. The absence of Risk Equalisation has resulted in financial damage to Vhi Healthcare. The long process laid down in legislation for transfers to commence following a positive recommendation from the Authority will further delay the progress of financial recovery. As already advised we will incur losses in the current year. Our recovery will not be helped by the very large increases in the cost of medical care which our members will have to cover over the next few years.

Although risk equalisation would have helped Vhi Healthcare, all other things being equal, Vhi Healthcare has not yet experienced severe financial difficulties. The losses in the current year (if incurred) are partly due to Vhi Healthcare's own pricing decisions.

2. It is appropriate, I believe, to repeat at this point the undertaking we have already given to the Authority that all funds received from Risk Equalisation will be applied for the benefit of consumers. Our target surplus (of 5% of Premium Income) will not change.

This assertion is, and will be, difficult – if not impossible – to verify.

3. The activation of Risk Equalisation will facilitate meaningful discussion on other issues within the private health insurance market. One of these relates to the future corporate structure and perhaps even ownership of Vhi Healthcare. Primarily our interface on these issues will be with the Department of Health & Children but we would also welcome any views the Authority may have on

the matter. There are other anomalies within the market, not least on the regulatory side, which can begin to be addressed when Risk Equalisation is activated. We would also like to engage with the Authority on other issues impacting on the effective operation of Community Rating, e.g. price review dates; premium renewal dates etc.

Staff of the Authority consider that the ownership of any insurer is not directly relevant to its decision in relation to risk equalisation. However, Vhi Healthcare's non-commercial status and exemptions from the Insurance Acts were taken into account insofar as they affect other insurers' ability to compete with Vhi Healthcare and insofar as they affect the best overall interests of health insurance consumers (See Section B5 and Section F "The Commercial Status of Insurers").

4. It is our belief that the activation of Risk Equalisation should facilitate a new era of healthy competition within the health insurance market provided our competitors (as the York report succinctly put it) have not based their plans on a continuing ability to keep the gains from a younger membership. Genuine competition and product innovation across all membership age brackets would be a very positive development for consumers. Risk Equalisation can only facilitate this.

The Authority is supportive of competition in all segments of the market and, while not specifically concerned about insurers maximising profits, (unless excess profits are being facilitated by the regulatory structure), would be concerned if, in doing so, insurers acted contrary to the best overall interests of health insurance consumers (Sections B3, B4 and F – The Facilitation of Competition between Undertakings).

5. While it is not part of our brief to argue the case for new entrants (and we have never accepted that there is any need for such a unique honeymoon period and we intend to raise this issue with you in the future) it is relevant to note that the effective 3.5 years exemption permitted in the Act is of little value unless it is unique to those that have just established.

VIVAS Health would not appear to concur with Vhi Healthcare's view in relation to this matter.

6. In relation to the material increase in the MPEA in the six months to 31<sup>st</sup> December 2004 we were more surprised at the low level recorded for previous review periods than we are at the level now reported. One would have thought that this measure would follow a relatively smooth curve. We do not have access to the analysis required to rationalise on this point but we are naturally concerned if any manipulation of figures included in Returns as between one period and another has taken place. The most recent information (contained in your letter of 31<sup>st</sup> March) regarding the complete change that HSW has on the

value of the MEP adds to our concern under this heading. This will become a particularly important issue when the Risk Equalisation fund is activated.

Seasonality in returns is possible. While it might be possible for an insurer to manipulate the timing of claims, this should only be a matter of timing, i.e. increasing the number of claims settled in one period should lead to a corresponding reduction in the number of claims settled in another period, and vice versa (Section D – Significant Changes in Returns).

7. We do not have available the information upon the basis of which the Authority has formed the view that the underlying trend of the MPEA is likely to be upwards, particularly in the absence of Risk Equalisation, but we agree with the Authority's conclusion. We would point out however that, irrespective of whether the underlying trend of the MPEA is upward, the existence of any appreciable value for the MPEA over any reasonable period of time indicates a potentially significant cost to affected insurers resulting from the divergence of risk profiles. The Authority has tended to measure the importance of the size of the MPEA/MEP by reference to the effect that transfers to an insurer are likely to have on the premiums payable by individual insurance consumers. We submit however that the major financial significance of the transfers potentially made as a result of the MPEA/MEP is their cumulative value over a period of time rather than the difference in the value of a potential value of a transfer measured by reference to changes in the MPEA/MEP from one calculation period to the next. The potential long term and incremental effects upon an insurer of having to themselves bear the costs of a poor risk profile are much more likely to have an effect upon its ability to charge reasonable (let alone 'competitive') premiums than the effect upon consumers of their insurer not obtaining a transfer of funds by reference to the measurement of the MPEA/MEP on a specific occasion. Another major potential effect of such transfers is to disincentivise insurers from risk selection. This is recognised in the reasons underlying the decision of the Authority as set out in your letter.

We suggest that the Authority should expand upon its reasons as expressed with reference to the MPEA/MEP so as to take account of the chronic cost to affected insurers indicated by the ongoing existence of an appreciable MPEA/MEP, and the potential incentive to competition provided by such transfers.

The reason for Staff of the Authority's assertion that the MEP is on an upward trend is based on BUPA Ireland's growth in market share (Section F – The Rise of the Market Equalisation Percentage).

It is appropriate to consider the MPEA in relation to premiums, as transfers could either be used to sustain lower premiums or, (in the event of no transfers), higher premiums could be used in attempting to alleviate the financial consequences to the insurer.

8. We remain seriously hampered in commenting upon any reasoning expressed by the Authority on the basis of ‘market stability’ because the Authority has still not explained what exactly it means by the term. In my previous correspondence I explained what we inferred the Authority’s meaning to be. The Authority’s renewed reference at this point in its letter to the different analyses that it has been considering when reviewing ‘market stability’ seems to support the inferences we drew. They also seem to be supported by the contents of the final set of reasons as set out in your letter of the 15<sup>th</sup> March.

As you will know from their report, of which I sent you a copy, DKM Economic Consultants consider that ‘market stability’ can only be measured by assessing the dynamics that can be recognised as likely to affect a market over a substantial period of time – rather than by measuring what is happening in the market at a particular point of time. The Authority’s final set of reasons appear to take account of this when they recognise that, where ‘price following’ exists (as it manifestly now does), this may for a time avoid the consequences of instability actually present in the market, indicated by an inflation of health insurance premiums to the benefit of one or more insurers but to the cost of consumers; - this in turn may be expected to ultimately result in consumers, particularly younger consumers, being driven from the market for insurance. Vhi supports that view. The Authority has previously looked to measure ‘market stability’ as reflected also in or affecting the conduct of undertakings as well as that of consumers. Undertakings will clearly be affected by the inflation that the Authority has recognised. The premiums that will have to be charged by the insurer with a deteriorating risk profile (community-rated by reference to that ageing community) will inevitably drive away all business which regards itself as unfairly rated at that level, and a responsible insurer would be likely to have to plan an orderly run-down of its business to commence before such a trend become the subject of public comment or disquiet.

We submit that when referring, as the Authority has done in its recommendations to date, to potential instability in a community-rated market, it should expand upon its reasons by noting that market stability may also legitimately require to be assured by reference to the dynamics inherent in the market in the long term and that these dynamics now clearly include the inflation in premiums resulting from ‘price following’.

Staff of the Authority are satisfied that its interpretation of the term ‘market stability’ is sufficiently explained in its Policy Paper on Risk Equalisation. The Authority is mindful of longer term dynamics in the market.

9. We believe that apart from affecting the ‘stability’ of the community-rated market, what the Authority rightly refers to as ‘*excessive inflation of health insurance premiums to the benefit of one or more insurers and to the detriment of consumers*’ should be explicitly recognised as imperilling ‘*the application of community rating across the market*’. That is what happens when, as it is expressed in the Andersen Report (page 71), there is a ‘*situation*

*where an incumbent insurer is obliged to set its premium rate by reference to the incumbent's higher risk population rather than to the population as a whole'. Both the Andersen and York Consortium Reports consider that, that as a matter of economic judgment, Risk Equalisation should be introduced once it is clear that this situation has arisen. The York Consortium Report suggests that Risk Equalisation is essential so as to avoid such a situation arising.*

Staff of the Authority have considered both the Andersen and YHEC Reports in its deliberations, but is not bound to act according to their conclusions.

10. It has always been our contention that the price following strategy adopted by our competitor has had the effect that competition has led to a material increase in the cost of health insurance in the Irish market. We therefore concur with the points made in relation to price following by the Authority. Risk Equalisation will effectively transfer the windfall profits achieved through the practice of price following back to the market for the benefit of consumers. This process will clearly help the creation of a stable market. It is worth pointing out that the positive intervention of Risk Equalisation could not be more appropriate than at a time when the market is facing quite severe cost drivers. The Authority can be assured that our pricing policy will continue to be driven by the cost of providing benefits and of the need to ensure financial stability (other than to the extent of carrying the entire community risk within the market).

We had hoped to attach the FSA Returns for BUPA Insurance Limited for the year to 31<sup>st</sup> December 2004 to demonstrate that the enormous windfall profits generated in previous years have continued in 2004. However, changes with regard to the filing of returns in the UK mean that the geographical breakdown of premiums and claims must now be obtained directly from the company. Unfortunately we understand that BUPA Insurance Limited is reluctant to release the returns and it will be at least the end of April before the information becomes available.

It is impossible to know what the impact on premiums would have been, had competition not been introduced into the market. Furthermore, as stated earlier, it is, and will remain, difficult – if not impossible – to verify this assertion in relation to Vhi Healthcare's pricing.

11. The single biggest benefit that will flow from the activation of Risk Equalisation is that it will facilitate the application of community rated prices across the market. Thus the future of Community Rating will be more assured (assuming the Authority recommend to the Tánaiste as indicated in your letter of March 15<sup>th</sup> 2005) than at any time since competition entered this market. We remain convinced that the maximum permissible Health Status Weighting

should be included in the calculation of the MEP and look forward to further discussion on this subject with you.

The issue of the HSW is separate from the decision in relation to whether to recommend that the Minister ought or ought not introduce risk equalisation payments. However, Staff of the Authority are mindful of the impact of the HSW.

Please do not hesitate to contact me for further information or if additional issues should arise in the course of the finalisation of the Authority's recommendation to the Tánaiste.

Kind regards.

Yours sincerely

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Vincent Sheridan  
Chief Executive

## **VIVAS Health's Representations**

Received from VIVAS Health, Oliver Tattan, *Chief Executive Officer*

5 April 2005

Dear Dermot

I refer to your letter dated 15 March and the contents set out therein:

VIVAS Health strongly disagrees with the Authority's proposed recommendation that risk equalisation payments commence. The position of VIVAS Health is explained in this letter. In summary:

- The Authority has failed to take into account the position of VIVAS Health as the 3<sup>rd</sup> entrant to the market (and the only health insurance company that is regulated as such by IFSRA)
- The Authority has not provided any evidence of the need for commencement of payments; indeed the situation appears to be little different from six months ago
- The Authority's assertion that an upward trend is emerging in MEP is based on extremely scanty evidence and is fundamentally unsatisfactory
- The Authority appears to have acted ultra vires in some aspects of forming its opinion
- Commencement of payments is counter to the promotion of competition, and is a reward to the VHI for reckless behaviour
- The reasoning of the Authority that risk equalisation can lead to a more competitive market is patently flawed.
- Risk equalisation payments would be an extraordinary burden on the market while VHI remains a protected and unregulated arm of the State

There are valid arguments that risk equalisation payments may be required in the long term to sustain community rating. However, the market is demonstrably not at that stage yet, and we have not seen any analysis that implies this need. Risk Equalisation should only be used when the Irish consumer can avail of a proper competitive health insurance market, where all competitors are operating on a level playing field and market shares are more evenly balanced.

### **Introduction**

VIVAS Health entered the health insurance market in October 2004 and is the only health insurance provider in the market regulated and authorised as an insurance company by the Irish Financial Services Regulatory Authority. I would like to commence by stating that it is with great dismay that I see the Health Insurance Authority ("the Authority") seeking to recommend the implementation of risk equalisation at the first opportunity available after the entrance of a new player into the market. It is apparent that protection of the state owned VHI from real

competition is of greater importance than the flourishing of a dynamic and competitive health insurance market.

The fact that this recommendation has been taken at this time is not a direct consequence of the entry of VIVAS Health to the market. The Authority has a statutory obligation to make a recommendation on a six-monthly basis.

The Authority had stated in its Policy Paper (in September, 2002) that the number of insurers in the market / new entrants to the market would be considered as part of its deliberations.

Competition and the liberalisation of markets has been one of the primary factors for the economic growth in Ireland over the previous years. Consumers across the economy have benefited from the entrance of new players opening competition and challenging the status quo of established and often state owned companies. As stated by the Competition Authority in its Annual Report 2004;

*“Opponents of reform follow a predictable pattern of economic NIMBYism. Everybody supports competition, but then says competition should not be allowed in their own back yard. These vested interests constantly argue that “we are special” or disingenuously that “we are only protecting consumers” or, scare mongering that “the skies will fall in if this regulation is removed”. None of these claims are supported by any credible evidence.”*

The Authority through its recommendation on risk equalisation would appear to be following the pattern of Government protectionism of state resources under the guise of consumer protection.

As stated within the Authority’s own policy paper<sup>28</sup>:

*“The Authority will be particularly mindful of the level of competition existing in the market at the time and of the likely effect that risk equalisation would have on competition in the market.”*

However, it is apparent from the entirety of the recommendation of the Authority that neither the level of competition nor the effect of this recommendation on a new entrant to the market was considered. In fact, no reference or consideration of the VIVAS Health position at all is present in the recommendation of the Authority.

The Authority has a statutory obligation to have regard to the best overall interests of health insurance consumers when making its decision on whether or not to recommend the introduction of risk equalisation payments. This includes a reference to “the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings”. Staff of the Authority carefully considered the level of competition and also the effect of its recommendation on the business plans and solvency of insurers in coming to its decision. See Sections B3, B6, D – New Entrant, E – The Number of Insurers in the

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<sup>28</sup> Health Insurance Authority – Policy Paper on Risk Equalisation in the Private Health Insurance Market in Ireland. September 2002.

## Market / New Entrants to the Market and F – The Facilitation of Competition between Undertakings.

In its submission to the Authority's risk equalisation consultation process, the Competition Authority stated that "*Given the overriding importance attached to...community rating, some system of risk equalisation is likely to be necessary.*" The Competition Authority later clarified that they believe a reserve power is absolutely necessary and that it was likely that the conditions would arise that The Health Insurance Authority would need to recommend the commencement of a scheme.

Positive market dynamics are already evident from the entry of VIVAS Health to the market:

- a range of different and innovative new products – including for the first time the tailoring of products to suit consumer needs
- the creation of a wide distribution channel: dissemination of information to consumers via intermediaries.
- the first to cover new facilities as they enter the market e.g. VIVAS Health was the first to reach agreement with the Galway clinic
- more hospitals and treatment centres for scans are covered by VIVAS Health than any other insurer
- the introduction of entirely new benefits previously unheard of in the Irish market e.g. post natal domestic support

As noted the benefits of new entrants / increased competition are considered by Staff of the Authority.

Flexible business models must be allowed to flourish to ensure the optimum benefit from competition is gained by consumers. None of these competitive indicators were considered by the Authority.

### **Reasons of the Authority**

I will turn now to the particulars set out within the proposed recommendation of the Authority. I note that the reasons given by the Authority for the implementation of risk equalisation, with the exception of the change in MEP, are exactly the same as those provided by the Authority for not triggering risk equalisation in its two previous decisions. In fact the similarity of the rationale provided by the Authority is such that the reasons provided in its letter of 15 March are meaningless.

While the arguments are consistent, there have been significant changes.

#### 1. Substantiation of Reasons provided by the Authority

The Risk Equalisation legislation provides a wide range of MEP values from 2-10% to avoid fluctuations inadvertently triggering risk equalisation and recognising that any six month measurement based on claims paid is inherently subject to fluctuations. This statutory discretion allowed the Authority adequate time to accumulate extensive market information prior to introducing a highly draconian market restriction measure which cannot be reversed should the assessment of the Authority prove to be detrimental to the market. No evidence is set out by the Authority to substantiate the change in opinion which has led to the recommendation against triggering risk equalisation transforming into reasons for triggering risk equalisation within a six month period. The failure to provide evidence to substantiate the reasons given for risk equalisation would appear to indicate that the recommendation is based more on theoretical possibilities rather than substantive market indicators.

The decision was not based on theoretical possibilities, rather on the Authority's assessment of the potential threat to the market. For examples of this assessment see Section E – The Age/Sex Profile of the Memberships of Insurers and Section F – Maintenance of Community Rating. The reasons for the Authority's changed recommendation are clearly articulated in its letter to insurers of 15 March, 2005.

In particular, clarity is sought from the Authority on the following:

- How the Authority reached the conclusion that the underlying trend of MPEA is upward when the previous two MPEA were 3.7% and then 3.5% respectively. The fact that the MPEA is now 4.7% is not evidence of a trend without any further returns occurring to substantiate this. Further, on a simple rational analysis, a movement in the MEP between two adjacent periods (in this case from 3.5% to 4.7%) must logically be driven by predominantly random factors including variation in claims within age bands and movement in claims settlement patterns and not by substantial change in the relative mix of ages between insurers. We note also that the MEP with full Health Status Weighting (HSW) appears to be on a downward rather than an upward trend.

Staff of the Authority did not infer a trend from only three data points. It would appear that the growth in the MEP is related to the growth in BUPA Ireland's market share. If the trend in BUPA Ireland's market share continues to be upward and there is no significant change in the age and gender profiles of insurers then the trend in the MEP will be upward. The following points are relevant.

- The MEP has increased from 0% to 4.7% since the entry of BUPA Ireland.
- The growth in BUPA Ireland's market share has been consistent, at least since 2001 (prior to that data is limited). If BUPA Ireland continues to grow as in the past and there is no significant change in age/gender profiles then the MEP will continue to grow.
- There is no evidence that significant changes are occurring with regard to the relative age and gender profiles of insurers.
- The MEP has grown from 3.7% in respect of the second half of 2003 to 4.7% in respect of the second half of 2004.

- It is unlikely that any of the above factors would be significantly affected by seasonality, however other fluctuations may have some impact on the values of the MEP at different points in time.
- There is volatility in the value of the MEP, largely resulting from variations in the amount paid by BUPA Ireland in respect of settled claims, particularly in the over 80s age group. However, an analysis that is based on the growth of BUPA Ireland and the relative age and gender profiles of insurers should not be affected by this.

The Authority has worked to achieve consistent returns across insurers and to gauge the extent of any inconsistencies that may exist. The Authority is not aware of any material discrepancies in returns filed.

- What evidence is there to suggest that any premium reductions for all consumers in the market through the triggering of risk equalisation would occur? It is apparent that the only possible reduction in premiums if any would not accrue to all consumers but only VHI consumers – who according to the VHI following their previous price increase of 3% are now already being charged a community rated premium.

Staff of the Authority have not suggested that all consumers in the market will benefit from premium reductions. However, based on their assumptions and calculations, they believe that the average premium in the market will be reduced (see Section E – The Effect of any Transfer on Premiums Payable by Consumers and the Effect of any Payments on the Business Plans / Solvency of Insurers). Furthermore, there can never be absolute certainty about premium rises/falls, and if absolute certainty were needed then risk equalisation might never be introduced, even if it were warranted. Vhi Healthcare has said that charging a true community rated premium is not sustainable in the absence of risk equalisation.

- What has occurred in the past six months since the Authority stated that: *“the potential benefits, by way of any possible percentage reduction in premiums, which could accrue to individual health insurance consumers directly from the transfer of funds, would appear to be small.”*<sup>29</sup>?  
How has this position now changed?

The MPEA / MEP have increased so the potential effect on premiums has also increased. In its letter to insurers of 15 March, while the Authority recognises that the potential benefits in terms of any possible average reduction in premiums might be argued to be small, relative to the overall size of the market, the Authority stated that it considers the increase in this figure to be significant. Furthermore, it is unclear at what level VIVAS Health would consider the potential benefits to be large enough for them to be given to consumers.

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<sup>29</sup> Page 10 – Report of The Health Insurance Authority to the Tanaiste and Minister for Health and Children pursuant to Article 10 of the Risk Equalisation Scheme, 2003 for the period 1 January, 2004 to 30 June, 2004.

- What factual evidence of market instability and in particular any triggers of instability (as set out by the paper commissioned by the Authority from Arthur Andersen) are present within the market that were not present six months ago?

The Authority is mindful of the issues raised in the Arthur Andersen Report but is not bound by its recommendations. The Authority considers that the likelihood of a threat to the stability of the community rated market arising in the absence of risk equalisation has increased. For examples of the assessment on which this statement was based, see Section E – The Age/Sex Profile of the Memberships of Insurers and Section F – Maintenance of Community Rating.

- What evidence does the Authority have that the implementation of risk equalisation at this point will benefit the overall interests of health insurance consumers which it did not have six months previously?

The reasons for the Authority's changed recommendation are clearly articulated in its letter to insurers of 15 March, 2005.

## 2. Validity of Reasons Provided by the Authority

The vires of the Authority taking into account premiums prior to its establishment and present risk equalisation mandate is questioned. In addition, and without prejudice to the above, the validity of the claim by the Authority that premiums may reduce with the implementation of risk equalisation is questioned.

### **The York Health Economic Consortium Report Titled “Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market”**

commissioned by the Authority itself states at page 29:

*“It is difficult to draw any definitive conclusions regarding the impact of competition, as it is impossible to evaluate the effect on premiums if VHI had continued in its monopolistic position. However, it is worth noting that the annual increase in VHI's premiums was similar during the periods before and after competition.”*

The pricing structures implemented by independent commercial entities fall strictly within the remit of the economic arrangements of each business. A correlation in price increases by health insurers is to be expected as they will be subject to a number of similar input costs e.g. the Department of Health and Children raising the costs of hospital beds by 25%. In this context, the extent to which price following has occurred since the Authority was entrusted with its mandate has been low. The Authority should perhaps look at other markets dominated by state players i.e. electricity, transport, gas, post to see how pricing has occurred across the economy rather than making inferences from only one sector.

Staff of the Authority are of the view that there is much evidence of price following. Arguments that the cost bases of the different insurers are the same are undermined by the following:

- BUPA Ireland’s argument that comparing price increases between BUPA Ireland and Vhi Healthcare is not comparing like with like
- BUPA Ireland’s loss ratio and resulting profitability, which would imply that it is experiencing little competitive pressure
- The cost bases of Vhi Healthcare and BUPA Ireland would appear to differ to the extent that the loss ratio (claims divided by premium earned) is significantly lower for BUPA Ireland than for Vhi Healthcare.

Inflation across the economy was considered by the Authority insofar as the consumer price index was included in its analysis. (See Section E “The Rate of Premium Inflation”).

Staff would not agree that a review of inflation in electricity, transport, gas and post prices, in particular, would be useful. The cost drivers in these sectors would be very different and in some cases would appear to relate largely to oil prices or could be related to previous under-investment. If the purpose of such a review is to persuade the Authority of the benefits of competition, the Authority is already aware of these benefits, as is clear from the centrality of consideration of competition to the Authority’s analysis.

It is unlikely that net contributors to risk equalisation shall reduce premiums, and as evidenced above, VHI when acting as a monopoly did not reduce its premiums, it is questioned what evidence or rationale is used by the Authority to contend therefore that premiums would reduce.

Staff of the Authority considered how premiums might change in the event of the introduction of risk equalisation payments (see Section E – The Effect of any Transfer on Premiums Payable by Consumers and the Effect of any Payments on the Business Plans / Solvency of Insurers). By necessity, this consideration required the making of assumptions.

In addition, the research commissioned by the Authority from **Amárach Consulting** entitled “**The Private Health Insurance Market in Ireland**” in March 2003 highlighted that only 6% of persons have switched provider in the market place, of which over 50% were under 34. In addition, it was found that cost was the primary motivation for switching. Only another 12% of people have seriously considered switching, the vast majority of whom were under 50. 16% stated they would never switch, of which 46% represented the over 65s. The average amount cited to encourage a person to switch was found to be 26%, however, this rose to over 37% in the over 65s.

Based, therefore, on the research carried out by the Authority itself, in order to have more competition in relation to older policyholders, competitors of the state owned VHI would require a price differential of over 37% for persons over 65 to even begin to consider switching. Therefore, the claim by the Authority in the recommendation that risk equalisation payments could potentially benefit competition in the market in some ways by increasing competition for older consumers is unfounded. In fact the more likely result is that competitors of VHI will have higher premiums due to risk equalisation payments and will therefore be less likely to attract older consumers who

are already very reticent towards switching. The only possible conclusion, therefore, is that risk equalisation will only assist VHI in retaining its market dominance.

Although there may be a low level of switching by older consumers, competition may still improve for older consumers who are new entrants to the market. In particular, the extent to which significant disincentives against recruiting older consumers exist would reduce. Switching among younger consumers may still take place.

### 3. Ultra vires considerations by the Authority

The overall claim by the Authority that the best overall interests of consumers will benefit from the implementation of risk equalisation is questioned. Throughout the recommendation the Authority has taken into account a number of irrelevant factors while failing in its statutory mandate to consider pertinent details. In particular, the absence of any consideration of the position of VIVAS Health is apparent. While the Authority has sought to look at the premiums charged by VHI and BUPA no regard was taken of the competitive pricing put in place by the new market entrant. Similarly, while concern over the financial position of VHI and BUPA was expressed no regard to the financial position and or solvency of VIVAS Health is evidenced. The increase in VHI profitability and huge increase in its membership base since the introduction of competition into the market, leading to VHI declaring €60 million in profits in the last year before VHI started its policy of running down reserves, does not appear to have been relevant to the Authority. It is curious that the Authority sought to entirely ignore the position of the only private for profit health insurer in the market.

The possible effect of predatory pricing by the dominant state player, VHI, to consolidate its market share and push new entrants out of the market has not been developed by the Authority. The danger of VHI which is not subject to any solvency requirements, and which has a number of structural advantages from being a state monopoly for nearly 40 years, to run off reserves in an anti-competitive manner or as a tool to trigger risk equalisation is heightened. This is evidenced by the publicly stated policy of VHI<sup>30</sup> to run off reserves and put itself into a state of financial difficulty unless risk equalisation is triggered. The Authority does not appear to have taken the motivation behind the present supposed financial difficulty into account, but has rewarded VHI for placing itself in a potentially precarious financial situation<sup>31</sup>. If the VHI financial stability is problematic, regulation under the Non-Life Directives would preclude behaviour that could prejudice its consumers like the reckless running off of reserves.

It is suggested that the Authority should regard the commercial status and relative market shares of the insurers concerned when making a recommendation on competition. It is well established that more efficiencies and competition occur with the introduction of more private competitors to a state monopoly or statutory body.

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<sup>30</sup> Please see VHI Annual Report 2003

<sup>31</sup> VHI Press Release of 16 March 2005 – where VHI CEO states “We will shortly report significantly reduced profits for the year to 28 February 2005 and may lose money in the current financial year.”

No ultra vires issues are evident in this text and none are accepted.

Staff of the Authority took account of the entry of VIVAS Health into the market (see Section D – New Entrant and Section E – The Number of Insurers in the Market / New Entrants to the Market). Also, see below.

Staff of the Authority also took account of the sizes of Vhi Healthcare and BUPA Ireland, as well as their financial positions (see Section D – Growth of Insurers, Section D – Financial Information, Section E – Differences in Risk Profile and Relative Sizes of Insurers and Section E – The Effect of any Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Insurers). *[Ed Note: This section refers to a business plan forwarded to IFSRA and the Authority prior to the commencement of operations by VIVAS Health and considered by the Authority in the context of VIVAS Health’s comments above. Consistent with the Authority’s policy regarding the confidentiality of discussions with potential new entrants, it has been redacted from the copy of the Report forwarded to registered undertakings.]*

The commercial status of insurers, including the regulatory status of Vhi Healthcare is considered in Section E – “The Commercial Status of Insurers.” This subsection was further amended to take account of VIVAS Health’s arguments that Vhi Healthcare is willing and able to take advantage of its regulatory position in order to compete unfairly.

#### 4. Lack of Proportionality

The implementation of risk equalisation at the present moment is not proportional to either the alleged threat to the stability of the market, nor in the best interest of health insurance consumers. The detrimental effect to competition in the market, as recognised by the recommendation of the Authority itself outweighs any theoretical and unsubstantiated benefits that consumers may accrue.

The report by the **Competition Authority** on “**Competition Issues in the Non-Life Insurance Market**” found that:

*“Greater competition in the insurance market would make a huge difference to individuals and the Irish economy.”*

While this statement was made in relation to motor, employer liability and public liability it is equally if not more relevant to the health insurance market which has a huge concentration of market dominance with a state player. The implementation of risk equalisation at a time when the state owned player has approximately an 80% market share and the negative effects this would have on other lesser players is not a balanced approach to any alleged benefits to consumers. Risk equalisation will remove the incentive from VHI to compete for business as it will be subsidised regardless. The negative effect this consequence may have on the market would not appear to have been assessed by the Authority.

Other non-life insurance markets in Ireland are quite different from the health insurance market (for example, these other markets referred to by the Competition Authority are risk rated). It is therefore difficult to draw parallels between the findings of the Competition Authority's Report into these markets and developments in the Irish health insurance market.

In its submission to the Authority's risk equalisation consultation process, the Competition Authority stated that "*Given the overriding importance attached to... community rating, some system of risk equalisation is likely to be necessary.*" The Competition Authority later clarified that they believe a reserve power is absolutely necessary and that it was likely that the conditions would arise that The Health Insurance Authority would need to recommend the commencement of a scheme.

### **The Position of VIVAS Health**

It is contended that there is no material evidence before the Authority upon which to base its recommendation and as such that such a recommendation is unreasonable in the present circumstances. The negative impact on the profitability, property rights and right to earn a livelihood of VIVAS Health has not been considered by the Authority. The effect of the implementation of risk equalisation has entirely focused on the repercussions on the previous duopoly to the exclusion of all other entities affected. The Authority is under a statutory mandate to consider the best interests of all consumers within the health insurance market; this must include VIVAS Health members. As a registered undertaking under the Health Insurance legislation the Authority is under a statutory responsibility to assess and consider VIVAS Health. While VIVAS Health is presently exempt from risk equalisation payments, a recommendation to implement risk equalisation will have an immediate impact on the VIVAS Health business model vis-à-vis pricing, reserving and solvency planning, none of which were taken into account by the Authority.

The Report of Staff of the Authority takes account of the entry of VIVAS Health into the market (see Section D – New Entrant and Section E – The Number of Insurers in the Market / New Entrants to the Market). The Report was amended further in order to explicitly take account of the effect of risk equalisation payments on VIVAS Health's financial position. *[Ed Note: This section refers to a business plan forwarded to IFSRA and the Authority prior to the commencement of operations by VIVAS Health and considered by the Authority in the context of VIVAS Health's comments above. Consistent with the Authority's policy regarding the confidentiality of discussions with potential new entrants, it has been redacted from the copy of the Report forwarded to registered undertakings.]*

[REDACTED]

[REDACTED]

[REDACTED]

As previously stated, the only likely effect of risk equalisation is the consolidation and possible increase of the state owned VHI market share. This would be at variance with the spirit of the stated policy provision within the Third Non-Life Directive to abolish the monopoly rights enjoyed by state undertakings. Other, less prejudicial instruments to competition law could have been utilised by the Authority other than the implementation of risk equalisation.

VIVAS Health have not established that the introduction of risk equalisation would consolidate Vhi Healthcare's market share. In order to maintain its market share, Vhi Healthcare would need to recruit about 80% of new business. It is accepted (see Section F) that the competitive pressure on Vhi Healthcare would reduce. It is also unclear – and not offered by VIVAS Health – what “other less prejudicial instruments” could have been utilised by the Authority.

### **Competition**

The recommendation to implement risk equalisation also fails to remedy any of the other problems within the health insurance market. Under this heading, the biggest hindrance to competition is the dominant position of VHI. Effective competition cannot occur in any market where one undertaking has an 80% market share – there is no motivation with this concentration for the dominant player to compete fairly (much less when they are afforded other special state protections).

It is not claimed that the commencement of risk equalisation is a panacea, nor could any one measure be expected to be. That does not, however, stop the Authority from coming to the view that the commencement of risk equalisation is on balance in the best overall interests of health insurance consumers. The other points regarding dominance, competitive pressure of Vhi Healthcare, other regulatory advantages have already been discussed.

The Department of Health and Children, which is also the Department, which oversees the Authority, has permitted the VHI to engage in a number of activities, which would be prohibited to any other regulated insurance company. It has facilitated the expansion of the VHI market to include travel insurance, dental insurance, global insurance and an on-line retail outlet on differing and more favourable terms than those required of regulated insurance companies. The VHI has also been allowed to run off its reserves to the possible financial detriment of its own consumers. This uneven playing field, which allows VHI to act with impunity and without prudential regulation, is only compounded by the implementation of risk

equalisation. Risk equalisation cannot encourage a healthy and competitive market without a level playing field first being implemented for all undertakings and a positive policy initiative by Government to reduce VHI dominance.

The Department of Health and Children does not oversee the Authority in the carrying out of its functions. The Authority is entirely independent of the Department in terms of its decision-making. Furthermore, Staff of the Authority considered the status of Vhi Healthcare as a statutory body (see Section E – The Commercial Status of Insurers). The points above are discussed in the Report.

The dominance of VHI has also been prejudicial to the evolution of the health services in general. The dynamics of the VHI as a previous state monopoly have led to the creation of competition and market anomalies to the prejudice of private health care providers. No natural competition between hospitals, clinics or consultants as preferred insurance providers with the resultant competitive price agreements can occur with a dominant state player. VHI has also distorted the evolution of new healthcare facilities in its reticence to approve new facilities, which would increase capacity as evidenced by the lack of new hospital and clinics which have emerged over the years. This dynamic is only beginning to be reversed by the VIVAS Health philosophy of attempting cover of all new supply side facilities thereby providing them with their first institutional customers and reducing the risk of the investment.

The relative sizes of insurers and the evolution of same were taken into account. VIVAS Health have not established why the manner in which Vhi Healthcare chooses to deal with health services providers is a matter for the Authority in its deliberations on risk equalisation.

Neither does the recommendation of the Authority take into account the numerous advantages that VHI holds as an old state monopoly, from brand recognition, operational and purchasing economies of scale and access to salary deduction networks across the country (from which other insurers are locked out). The use of only one blunt regulatory tool by the Authority to the detriment of commercial enterprise and consumers without taking any steps to create a level playing field or encourage competition would appear to ignore entirely the competition mandate of the Authority.

These matters affect the competitive pressures that insurers are under, and the effect that the commencement or non-commencement of risk equalisation would have on such pressures, and as such were considered by the Authority through its consideration of the facilitation of competition and in the Report of the York Health Economics Consortium. Furthermore it is not unusual for companies that were the first, second or third entrants into a market to accrue advantages over later entrants. On the other hand it is unusual that, in health insurance, later entrants may (at least for a time) take advantage of advantageous risk profiles in a community rated market. Incidentally, other insurers are not “locked out” from salary deduction networks. It is a matter for each employer to decide (perhaps in consultation with staff), which salary deductions it facilitates.

Finally, any commencement of risk equalisation payments would not preclude the Authority from seeking to address some other matters raised by VIVAS Health in other ways.

## Conclusion

The recommendation by the Authority errs in fact as to the object it seeks to achieve. There is an apparent failure by the Authority to take into account any consumers other than those of BUPA Ireland and the state owned VHI. A call is made on the Authority to supply the substantive evidence upon which its reasoning is based and in particular which supports the allegation that there is a threat of market stability and a proven trend in relation to MEP.

Clarity is sought on how the MEP has jumped from a downward decline of 3.7% to 3.5% to now 4.7%. The rapid rise in differential would appear anomalous without either seasonality or other factors having affected the returns. It is requested that the Authority investigate the returns made and seek information from hospitals in relation to previous claims history to ensure that claims in the previous six months have been consistent with the this time period in other years. An analysis of the rate of claims and periods of payments, and claims trends over the past years from hospitals should be carried out by the Authority to ensure this rise in claims experience is generally consistent and not due to other factors.

The interpretation of information by the Authority is consistently qualified by the phrase “*based on the information available.*” As the Authority has been provided with a wide statutory discretion within which to make its decision, it is difficult to understand why the Authority is in such haste to recommend risk equalisation rather than take more time to gather more comprehensive information. The Authority has a statutory decision in relation to whether or not to recommend risk equalisation payments when the MEP is between 2 – 10%. At 4.7% the MEP is still within the lower end of the range for recommendation.

As stated, the Authority has a statutory decision to make, in terms of recommending whether or not risk equalisation payments should be commenced, when the MEP is between 2-10%.

The Authority is therefore requested to change its recommendation that risk equalisation be implemented, as there is no evidence that such a recommendation would be in the best overall interests of health insurance consumers while maintaining community rating and facilitating competition.

Kind sincerely,

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Oliver Tattan  
Chief Executive Officer  
VIVAS Health

## **Appendix I: Review of Arguments for and Against Risk Equalisation by the UK Government Actuary's Department.**

### **Arguments for Risk Equalisation**

#### **1. Theory of Risk Equalisation**

1.1 RE is not interfering in the market but is a mechanism to maintain a level playing field in a market that already has other constraints.

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

#### **2. Risk equalisation and Community Rating, Lifetime Cover and Open Enrolment.**

2.1 Community rating guarantees lifelong affordable healthcare and it cannot work without RE.

**GAD:** "Community rating does **not** guarantee lifelong affordable healthcare (whatever that means). Nothing is guaranteed in the future and the demographic ageing of the population will place a lot of strain on community rated health care, as it will on the public sector provision, even if young people continue to take out private health care. Patently community rating has worked without RE for the last 5 years. Thus I do not find these arguments compelling."

2.2 RE is an essential accompaniment to community rating – if premiums cannot reflect risk then risks must be equalised.

**GAD:** "It does not appear that in the short term at least that RE is an essential accompaniment to community rating as community rating has survived for 5 years without it."

2.3 RE sustains community rating by ensuring that the young and healthy support the old and sick.

**GAD:** "Community rating itself is based on the concept that the young and healthy support the old and sick and as discussed above RE would appear to have little effect on this in Ireland in the short term at least."

2.4 The claim that RE is a subsidy is unsustainable; it is a necessary adjunct to community rating.

**GAD:** "We have seen that RE is not a necessary adjunct to community rating at the moment."

### **3. Risk Equalisation and Competition**

3.1 The only way of facilitating competition between insurers over all categories of people is by equalising risk profiles, otherwise there is no incentive to compete for higher risk categories.

**GAD:** “I agree that there is little incentive for BUPA to compete for higher risk customers. Given Vhi’s position, it is not clear to me that this is true for them. In any event, given my view that in the longer term demographic problems will emerge for community rated private health care it is a moot point whether it is a good idea for companies to exacerbate this potential problem by seeking to attract older lives.”

3.2 Far from being anti competitive RE is essential to real competition.

**GAD:** “I agree that RE is likely to encourage competition across high risk as well as low risk lives, although as noted above it is not clear whether this is good for community rating. It is good for the elderly lives though, particularly in the short term.”

### **4. Risk Equalisation and Excess Profits**

4.1 As a new entrant BUPA has the automatic benefit of a better risk profile to VHI and is thus able to earn excess profits.

**GAD:** “I agree that BUPA are in a position to earn excess profits and that this is an unattractive feature of the current market.”

4.2 Without RE customers are paying for the excess profits of BUPA.

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

### **5. Risk Equalisation and the Dominance of Vhi Healthcare**

The Society of Actuaries did not include any arguments in favour of the introduction of risk equalisation in relation to this matter.

### **6. Risk Equalisation and New Entrants**

6.1 RE will not deter new entrants to the market who will compete in the normal way.

**GAD:** “I have some sympathy with the view that in normal circumstances RE will not deter new entrants who should really compete in a normal way.”

## **7. Risk Equalisation and International Experience**

7.1 Other countries show that without community rating older people do not insure and if RE is not applied community rating does not survive.

**GAD:** “I am not really in a position to comment on the effects in other countries, as I have not looked at this. Generally speaking though, I take the view that what happens in one country is not always a very good indicator of what will happen in another because of all the differences that will exist between the countries.”

### **Arguments against Risk Equalisation**

#### **1. Theory of Risk Equalisation**

1.1 RE is an unjustified interference in the market, which should be left to find its own level.

**GAD:** “I do not think that RE is an unjustified interference in the market, in the appropriate circumstances.”

1.2 No evidence of instability in the market and no evidence that RE would solve such a problem.

**GAD:** “I agree that the market does not appear unstable currently and in the absence of a major change in circumstances it is not obvious why the market should destabilise in the short term. Whether RE would stabilise an otherwise unstable market is not clear and would depend on the circumstances. It is certainly not a panacea for all ills and is essentially mostly useful where one company in a market cannot attract sufficient new entrants. Even then one would need to ask why one company could not if other companies could.”

1.3 Even if insurers have the same risk profile the RE scheme may require transfers.

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

1.4 RE, if used at all, should only be used after market failure.

**GAD:** “I do not agree that RE, if used at all, should only be used after market failure.”

## **2. Risk equalisation and Community Rating, Open Enrolment and Lifetime Cover.**

2.1 Community rating, lifetime cover, open enrolment and minimum benefits are sufficient to achieve government aims without RE.

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

2.2 Risk selection and cherry picking are illegal and customers can transfer if they want; thus the market is self-regulating.

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

2.3 An insurer practising risk selection could be dealt with under consumer protection legislation.

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

2.4 All insurers have to be licensed, protecting the market from fly by night operators.

**GAD:** “The fact that all insurers have to be licensed does not seem relevant to the argument.”

## **3. Risk Equalisation and Competition**

3.1 Limited competition in the market has significantly stabilised the market and this has happened in the absence of RE.

**GAD:** “It is rather a sweeping statement to say that limited competition in the market has significantly stabilised the market and this has happened in the

absence of RE, nor is it clear what ‘stabilised the market’ means in this context.”

3.2 RE kills competition, removes incentives to compete, prospective new entrants see it as a barrier to competition.

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

3.3 RE as proposed does not encourage preventative health measures and discourages cost containment.

**GAD:** “I am not sure that I agree that RE as proposed does not encourage preventative health measures and discourages cost containment.”

3.4 RE is a disproportionate response to a hypothetical threat; it is incompatible with diversity of choice and product design and disregards consumers’ choice.

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

#### **4. Risk Equalisation and Excess Profits**

The Society of Actuaries did not include any arguments against risk equalisation in relation to this matter.

#### **5. Risk Equalisation and the Dominance of Vhi Healthcare**

5.1 The real purpose of RE is to protect VHI and, indirectly, the governments interest in VHI; the government has not taken sufficient action to dismantle a monopoly.

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

## **6. Risk Equalisation and New Entrants**

6.1 Lack of competition and the dominant position of VHI with no commercial mandate means that new entrants need an incentive to enter the market.

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

## **7. Risk Equalisation and International Experience**

7.1 RE failed in Australia.

**GAD:** “I cannot comment on whether RE succeeded or not in Australia, but it is unlikely to be highly relevant.”

## **Appendix II: Review of Comments Made by Arthur Andersen Consulting in Relation to the Arguments For and Against Risk Equalisation**

Arthur Andersen stated that the scope of their work had not been such that they were required to express a professional opinion on the validity of any ideas to the effect of risk equalisation. However they did present an interventionist and a non-interventionist case to the Authority. We include comments from each of these cases here.

### **2. Risk Equalisation and Community Rating, Open Enrolment and Lifetime Cover.**

#### Andersen Interventionist Case

- A fall in volume of those in the age group 19 –29 or a rise in the volume in the age group 60+ could cause a rapid deterioration in finances. A loss of 10,000 new members was estimated to result in a price rise of 0.4% in the community rated premium.
- Vhi Healthcare has been successful in attracting new business in the key income zone (age 19 to 29) but this is not expected to continue due to a slowdown in market growth.

#### Andersen Non-interventionist Case

- The only way that RE can help consumers is by addressing a destructive spiral of market exit and entry caused by predatory behaviour.
- RE addresses predatory behaviour by
  - making insurers with a much higher risk profile viable and keeping them in the market or
  - presence of RE could prevent anyone from attempting a predatory strategy.

### **4. Risk Equalisation and Excess Profits**

#### Andersen Interventionist Case

- BUPA has attracted a significantly younger profile of members, which enables them to make windfall profits and increases prices for Vhi's members.
- Andersen, in proposing the interventionist case estimated that the absence of RE means that prices are at least 2.4% higher than required.
- A Market Equalisation Percentage of 4.5% indicates that one insurer's claim size is less than 60% of the average claims of other insurers. RE should be implemented at this point because it allows for a wide scope of difference in average claims, which is more than sufficient allowance for start up expenses and normal profit making.

### Andersen Non-interventionist Case

- A large difference in risk profiles should provide insurers with higher risk profiles with a large incentive to cut prices and go after the members of other insurers.
- If risk equalisation has any effect on the premium setting decision of the insurer with the higher risk profile it will be to lower its incentive to attract new members and there is therefore no reason for it to reduce premiums and pass the transfer on to consumers.

## **Appendix III: Review of Comments made by York Health Economics Consortium in relation to Risk Equalisation.**

### **1. Theory of Risk Equalisation.**

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

### **2. Risk Equalisation and Community Rating, Open Enrolment and Lifetime Cover.**

- The recruitment of younger, lower risk members by new entrants is virtually inevitable - do not accept that community rating can be implemented by business regulation rules.
- Without risk equalisation, community rating is effectively being applied to two separate communities, consumers in VHI and those in BUPA Ireland.
- Older people with health insurance, less inclined to move between insurers, would lose from the absence of full risk equalisation.

### **3. Risk Equalisation and Competition.**

- There has clearly been an increase in competition, following the entry of BUPA Ireland to the market. However, the removal of the VHI monopoly has not led to obviously fierce competition on premiums, with BUPA Ireland premiums apparently following VHI premiums to some extent.
- Competition from new entrants, in the absence of risk equalisation, would not necessarily be beneficial for the market. Competition through lower premiums, based on efficiency, quality and innovation are desirable. Competition through lower premiums based on the ability (whether deliberately or accidentally achieved) to recruit younger members is socially undesirable.
- Market exit by BUPA Ireland is only likely if it has based its business plan on a continuing ability to keep the gains from a younger membership. If BUPA Ireland is unable to compete with risk equalisation payments taking place, and if VHI is not being unduly protected or subsidised as a result of its public ownership, then BUPA Ireland would appear not to be able to provide value for money when bearing the community risk rather than the risks of its younger members alone.
- Exit by an insurer need not mean a reduction in the number of competing insurers but a change in the ownership of insurers, e.g. BUPA might try to sell its business to another insurer rather than just closing its book.
- The most vigorous price competition can only come at the cost of the loss of effective community rating.
- If risk equalisation payments take place, price competition will be much less.
- The regulation of the market has potentially reduced the extent of innovation, and is likely to continue to do so. A more competitive market would only lead to a limited increase in the degree of innovation.
- If economies of scale are so great that minimum average cost can only be achieved if the market is supplied by a single firm then an interesting consequence is that the socially desirable policy may be to have a regulated

monopoly (e.g. in the manner of regulated network utilities) rather than competing, inefficiently small, firms. One producer would achieve lower costs than many producers, each of a sub-optimal size. However, a priori this is inconsistent with the objectives of market liberalisation set out in the Third Non-Life Directive.

- If Risk Equalisation payments are commenced, it is unlikely that VHI will change its behaviour, since it would be a beneficiary for the short to medium term. BUPA Ireland may see the reduced surpluses that are generated as a justification for leaving the Irish market.
- The wider BUPA organisation is not a profit-seeking company with shareholders but a provident organisation. It would be less rather than more likely to pull out of the Irish market as it potentially faces fewer commercial pressures for profits. There could also be some negative publicity for BUPA in withdrawing from the Irish market.

#### **4. Risk Equalisation and Excess Profits.**

- If it were to become clear that risk equalisation payments will never take place, more insurers would be expected to enter the market and be much more aggressive in competing on premiums.
- Premiums would not be expected to fall in a market with more insurers and with risk equalisation payments firmly established.
- Expect only limited moderation of premiums.

#### **5. Risk Equalisation and the Dominance of Vhi Healthcare.**

- A change in the status of VHI, to a privately owned mutual or profit-making company, would have significant effects on the market.
- New entrants are likely to prefer to be competing with a non-government, commercial company, as this would be seen as a level playing field.
- Commercialisation and/or privatisation of VHI would contribute to a more competitive market, both directly and indirectly, particularly if VHI was transformed into several commercial companies, not just one, available for acquisition and investment by new entrants.
- The commercial status and market dominance of VHI is the most important factor that is deterring market entry, though the size of the potential profits to be had is also important.
- Similarities in plans between BUPA Ireland and VHI are partly a result of the position of VHI as the current dominant player and also the result of a need for comparability.
- VHI have indicated that they have a competitive approach already but we would expect that a commercially free VHI would develop further in this regard and would be driven by shareholder or member value, in line with new entrants.
- Because of VHI's size, existing firms may be prohibited from purchasing it, in whole or in part, by competition law, because this could be seen as not encouraging sufficient competition. Until the commercial position of VHI is clear, potential new entrants may prefer to wait and decide whether to enter by

acquisition of a part or all of VHI, rather than incur the costs of building a brand independently and have to compete with such a dominant player.

- In the absence of a non-commercial player in the market, such as VHI under government control, the price limiting impact of its presence would be lost.
- Shadowing of the dominant supplier is more likely to be effective when there are only a few firms in the market.

## **6. Risk Equalisation and New Entrants.**

- The current position on risk equalisation in the Irish health insurance market is deterring entry.
  - until risk equalisation payments begin, there will continue to be some uncertainty about the size of payments.
  - risk equalisation is a continuing deterrent to entry, relative to a situation in which it did not exist, as it is likely to reduce the profits of new entrants.
  - new entrants are more likely to adopt a “wait and see” approach. Some potential new entrants, uncertain of their gains or with a business plan offering only limited projected profits, will be less inclined to enter the market now.
- Any new entrant is almost bound to recruit a lower risk, younger population.
- The current attitude of potential new entrant insurers to risk equalisation is closely linked to the perception that they would immediately benefit from a lower risk membership.
- The implementation of a scheme and greater precision over its costs to new entrants with low risk memberships would not stimulate a large number of new entrants.
- If uncertainty over the final implementation of risk equalisation and over the status of VHI is resolved in the short term, the health insurance market in Ireland should still attract some new entrants, but fewer than if risk equalisation payments are not implemented
- It is possible that new entrants could compete very effectively on premium levels by using different mechanisms e.g. VHI currently has offices around Ireland where members can call in to discuss their concerns. A new insurer could exclusively use telesales activities to reduce these overheads.

## **Appendix IV: Review of views expressed in submissions and other communications with the Authority during the Consultation Process on Risk Equalisation in the Private Health Insurance Market in Ireland.**

### **1. Theory of Risk Equalisation**

#### BUPA Ireland's Comments:

Circumstances where RE might be needed are as follows“...*Risk equalisation has no role to play in Ireland in protecting consumer interests.*”

- Proposed measures of market stability:
  - When consumers stop buying insurance due to market features,
  - When old age policyholders exit the market in significant numbers and
  - When an insurer is threatened with financial collapse.
- Does instability threaten the interests of health insurance consumers?  
Intervention should be as a last resort, implemented only in exceptional circumstances and where other interventions will not work.
- HIA should publish basis of recommendations but no aggregate data unless sufficient number of competitors.

#### The Competition Authority's Comments:

- “*Given the overriding importance attached to...community rating, some system of risk equalisation is likely to be necessary.*” The Competition Authority later clarified that they believe a reserve power is absolutely necessary and implementation at some stage is likely to be necessary.

#### Professor Ray Kinsella's Comments

- “*It is difficult to see any circumstances in which risk equalisation should be implemented.....*”
- “*In all instances in which the arguments for implementing risk equalisation have been advanced...there are less damaging, more proportionate and more easily enforceable alternatives.*”
- Other forms of intervention can ensure market stability “*specifically Conduct of Business arrangements*”.
- RE would “*almost certainly have a profoundly negative effect on the consumer*”.

#### Vhi Healthcare's Comments

- Community rating is the distortion, not RE.

#### The Society of Actuaries in Ireland's Comments

- Instability can come from
  - the market failing to secure young new members (RE cannot help) or
  - failure of an insurer to attract sufficient good risks (unlikely)
 therefore, “*can be argued that the stability argument alone would not justify risk equalisation*”
- “*We believe that the longer term interests of the consumer and of the market would be served by the introduction of a limited form of risk equalisation now, both in terms of the intrinsic market effects and by establishing certainty on the issue*”
 

Reasons

  - “*The real justification for risk equalisation ... is as an equitable mechanism to execute this transfer*”, (i.e. the transfer of the subsidy from younger policyholders to older policyholders).
  - “*Either risk equalisation is a concomitant of community rating etc. or it is not.... Why there should be linkages to ex post market outcomes is not clear*” - conclude that it is a concomitant

## **2. Risk Equalisation and Community Rating, Open Enrolment and Lifetime Cover**

### BUPA Ireland’s Comments:

- Community rating is protected by legislation and does not need RE.
- Community rating should not be an objective in itself but a public policy instrument to shape the market.
- True community rating does not exist. This is price as a % of salary or fixed entry level price.
- Pre-existing conditions, waiting periods, group discounts etc. impede community rating.
- RE results in a subsidy from low cover plans to high cover plans.
- Inability to differentiate by price will cause prices to rise.

### *Predatory pricing*

- Could only be a temporary strategy.
- Current prices cannot be significantly undercut/not a reality.
- Existing insurers must find ways to respond.
- People will not necessarily opt for cheapest price.
- Inertia means people would be slow to move.
- Renewals mean business doesn’t transfer quickly.
- Might not adversely affect consumers.

### *Large movement of older people to one insurer*

- Must reassess the business plan.
- Reassess control on cancer treatments, heart treatments etc.
- Redesign plans.
- Design new plans.
- Vhi membership has aged but profitability has increased.
- “not a pricing problem, just a lot of work”.

#### *Insurer going out of business*

- Sustained losses by one insurer is a sign of instability but may mean the insurer has to change.
- DETE has experience of when to intervene (e.g. PMPA, ICI).
- HIA must investigate reasons why losses are arising.
- Consumers could benefit from an inefficient insurer going out of business.
- Thresholds cannot be used - no insurer on brink of collapse in 1998.
- There are examples of companies adapting to changing situations.

#### Former Members of the Advisory Group's Comments:

- Unfunded liability emphasises the need for stability.
- A predatory spiral can cause serious instability very quickly.

#### Vhi Healthcare's Comments:

- The low risk community has become separated from the high risk community - subsidisation removed ("*communities rating*").
- Open enrolment is not sufficient protection for the high risk community.
- Community rating should not provide a reason to transfer insurers.
- Few new benefits have arisen for the high risk community.

#### *Insurer going out of business*

- Vhi's business is not sustainable without RE.
- Need for RE has been masked by economic boom.
- Dramatic slowdown in young new members will cause rapid deterioration in Vhi finances.
- "*cash in cash out*" business increases speed of deterioration.
- Stability is insurers not being in financial difficulty and prices increasing at a reasonable rate.

#### The Irish Medical Organisation's Comments:

- Preferred risk selection may lead to "*a spiraling of costs with a rapid deterioration in the financial position of those insurers with poorer risk profiles*".
- Without RE, open enrolment is unenforceable.
- RE should be at statutory minimum levels rather than level of plan most subscribed.

#### The Society of Actuaries in Ireland's Comments:

- Important for overall market stability that insurers have an incentive to attract new low risk members.
- RE would not cause market instability.

### **3. Risk Equalisation and Competition**

#### BUPA Ireland's Comments:

- Competition makes the market more stable.
- Stability is brought about by efficient practices and good management.
- RE encourages claims, hospitalisation and payments to consultants.

#### The Competition Authority's Comments:

- Competition is the best protector of consumer interests.
- *“Any risk equalisation scheme should be as supportive of competition as can be practically achieved”.*

#### The Irish Medical Organisation's Comments:

- RE *“must not penalise efficiency and compensate inefficient operators”.*

#### Professor Ray Kinsella's Comments:

- RE would be damaging to competition and market development.
- The argument that a new insurer will attract younger members assumes the incumbent is unable or unwilling to respond.
- Consumer interests are best captured by considering impact on insurers.

#### Vhi Healthcare's Comments:

- BUPA has not attracted new people to the market - feature of economic boom.
- Community rating without RE favours one competitor over another.
- Absence of RE has caused BUPA to overpay providers. They can make uneconomic deals to gain a marketing advantage because they do not incur claims.
- Consumer's interest is served by *“delivery of equity between all consumers regardless of where they purchase their private health insurance”.*
- BUPA has been able to make benefit improvements due to windfall profits. Lines between high cover plans and low cover plans have become blurred. Plan B is more expensive than it should be due to benefit improvements.
- Cherry picking will happen because the regulatory system encourages it.
- Believe in facilitating real competition, not preferred risk selection!

#### The Society of Actuaries in Ireland's Comments:

- With regard to competition - *“There is little evidence of price competition and the market dynamics would not lead one to expect otherwise.”*

- For new insurers the market incentive is to be a price follower - do not want to attract other insurer's high risk lives.
- RE would not inhibit competition.

The Former Members of the Advisory Group's Comments:

- The greatest threat to stability is medical inflation.
- Medical inflation is best dealt with by increasing competition.
- However, effective competition cannot exist in a market with community rating without RE, because
  - The new competitor will either make windfall profits by setting their price just below that of the incumbent or cause instability by setting a very low price; and
  - The incumbent will not be in a position to compete on price.

**4. Risk Equalisation and Excess Profits**

BUPA Ireland's Comments:

- If a company is making windfall profits, competitors must go after those profits - it's a sign to compete.
- Others cannot sit back and accept the situation - must change their products/prices to win this business.
- An insurer cannot "allow itself" be left with a high risk profile.
- Cannot restrict profit margins of companies, not competition if everyone is making the same profit margin.
- BUPA is not making windfall profits and RE would make BUPA's business unviable.

VHI Healthcare's Comments:

- Vhi's average claim is about 3.5 times BUPA's - most meaningful criterion to use rather than the Market Equalisation Percentage and associated thresholds. Vhi does not favour thresholds.
- BUPA windfall profits have taken €60m from the system giving a 3% price increase.
- BUPA's underwriting profit margin is more than 50%
- Adamant that RE transfers to Vhi would lower prices. Government controlled pricing reinforces this. Profit margin unchanged. Will always price to maximise volume.

**5. Risk Equalisation and the Dominance of Vhi Healthcare**

BUPA Ireland's Comments:

- The leading company has large advantages of scale in overheads, revenue per member, negotiating power and brand.

#### The Competition Authority's Comments

- The relationship between Vhi Healthcare and the Department of Health and Children is one of a number of issues that makes the market unattractive to potential entrants.

#### The Society of Actuaries in Ireland's Comments:

- The Dominant position of Vhi, its ownership, regulatory position and lack of commercial mandate comprises a barrier to market entry.
- Recommend removal of Vhi from Dept of Health, a commercial mandate and reserves compliant with DET&E standards.

#### Vhi Healthcare's Comments:

- A change of status for Vhi Healthcare from non-profit to commercial status would in itself make the market environment more appealing to potential entrants.

## **6. Risk Equalisation and New Entrants**

#### The Competition Authority's Comments:

- *“Risk equalisation, or the prospect of it is just one of a range of issues makes the health insurance market unattractive to new entrants.”* Other issues include:
  - The Irish market appears to be mature in terms of the proportion of the population with health insurance.
  - The relationship between Vhi Healthcare and the Department of Health and Children.

#### Professor Ray Kinsella's Comments:

- The possibility of RE prevents new competition entering .
- Use of a *“minimum four player”* indicator would reduce uncertainty and encourage market entry.

#### The Society Of Actuaries in Ireland's Comments:

- Many barriers to entry in the Irish market:
  - Size of market,

- Investment required relative to size of market,
- Dominant position of Vhi, its ownership, regulatory position and lack of commercial mandate
- Uncertainty regarding RE
- Uncertainty in Relation to RE should be eliminated.

#### Vhi Healthcare's Comments

- None of the reasons why new entrants have been reluctant to enter the Irish market to date relate to RE. The three main reasons are:
  - Vhi Healthcare is perceived to be in play,
  - Vhi Healthcare's non-profit status and
  - Lack of certainty regarding Regulations.

### **7. Risk Equalisation and International Experience**

#### BUPA Ireland's Comments

- There are no international comparisons that support the idea risk equalisation in Ireland would support a competitive environment.

#### Vhi Healthcare's Comments

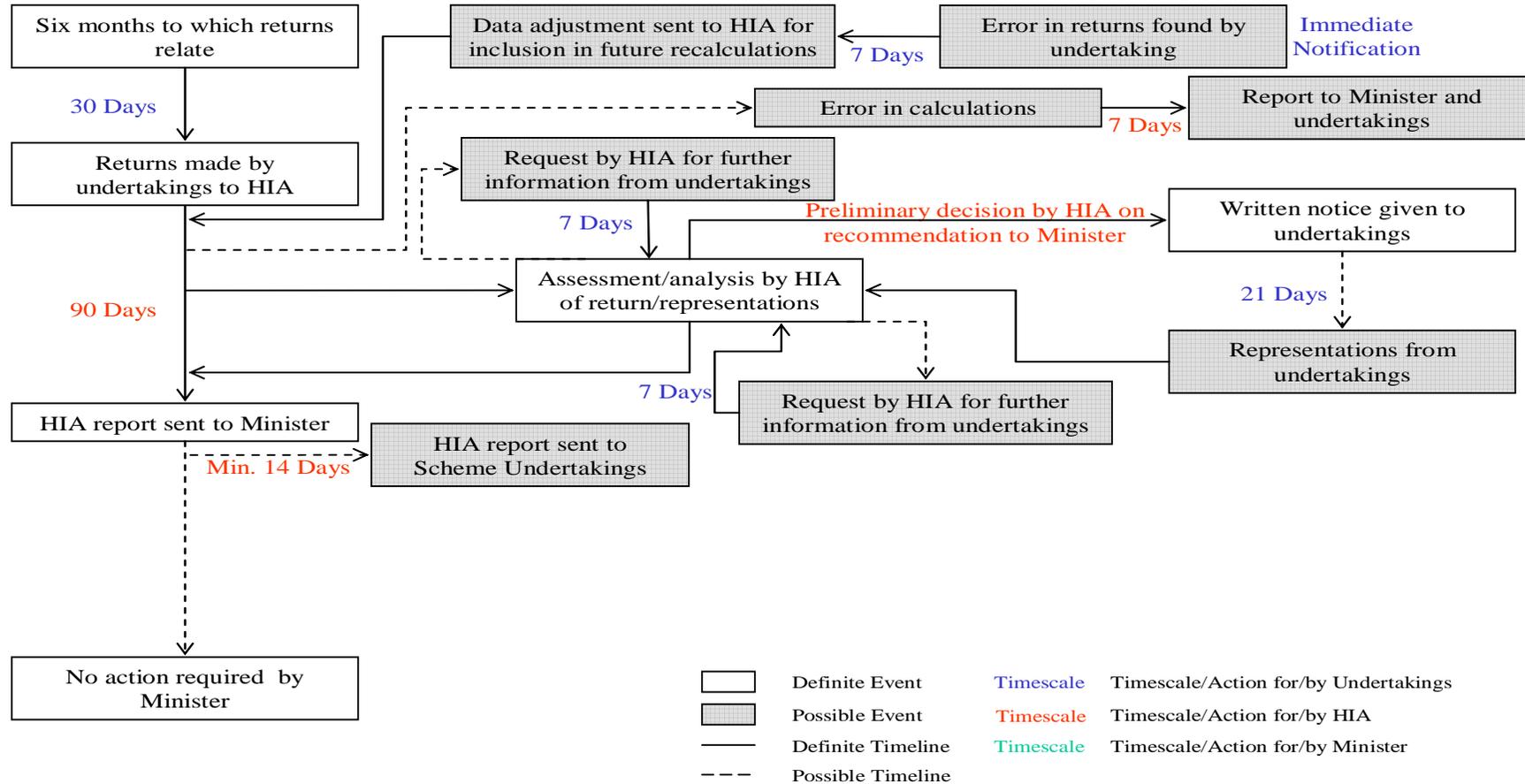
- RE has been recognised in Australia as being “crucially important to ensure the consumer interest is protected”.
- In 2001 it was recognised that the RE scheme existing in Australia was not sufficient and it therefore had to be strengthened

# Appendix V

## Risk Equalisation Timelines

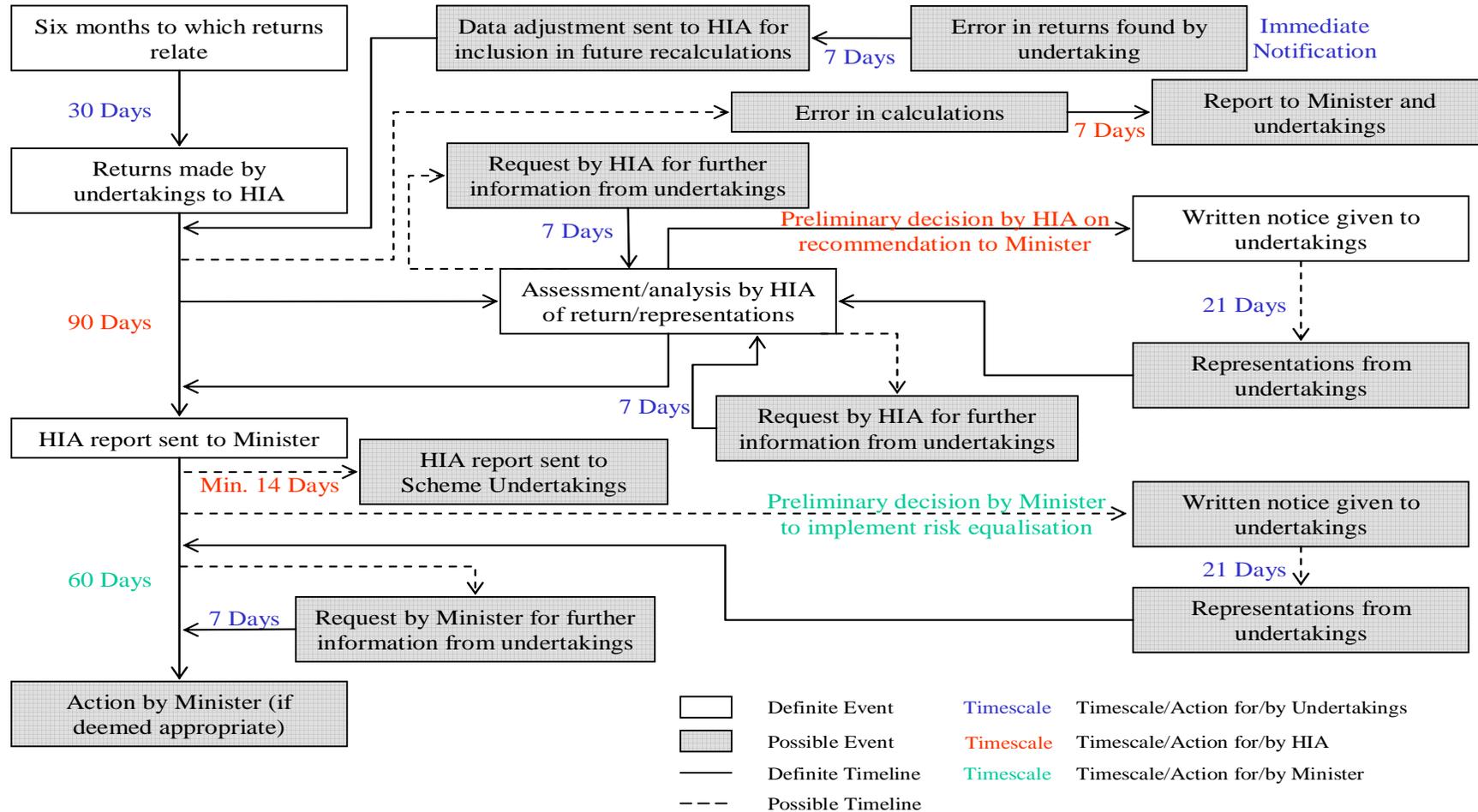
## Possible Timetable Under Risk Equalisation Regulations

Assumptions: Market Equalisation Percentage of 2% - 10% and RE Not Recommended



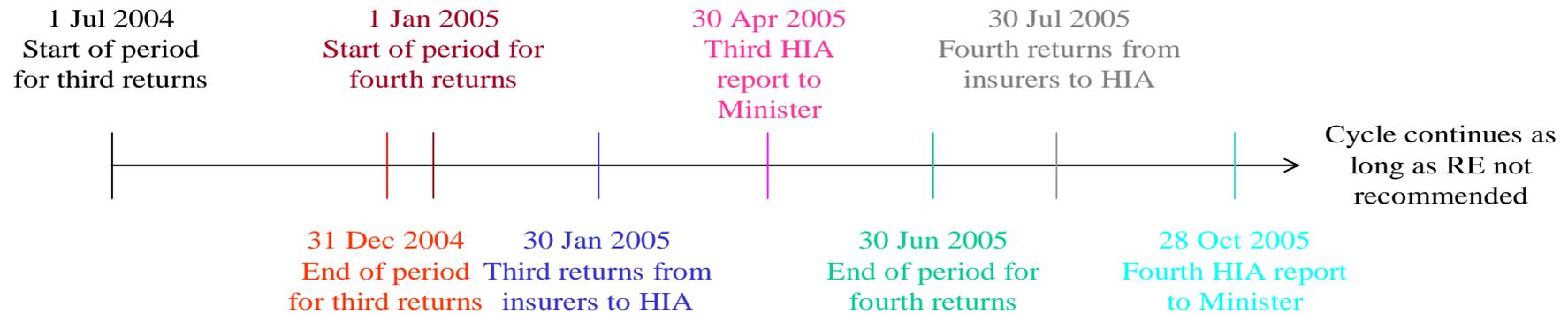
## Possible Timetable Under Risk Equalisation Regulations

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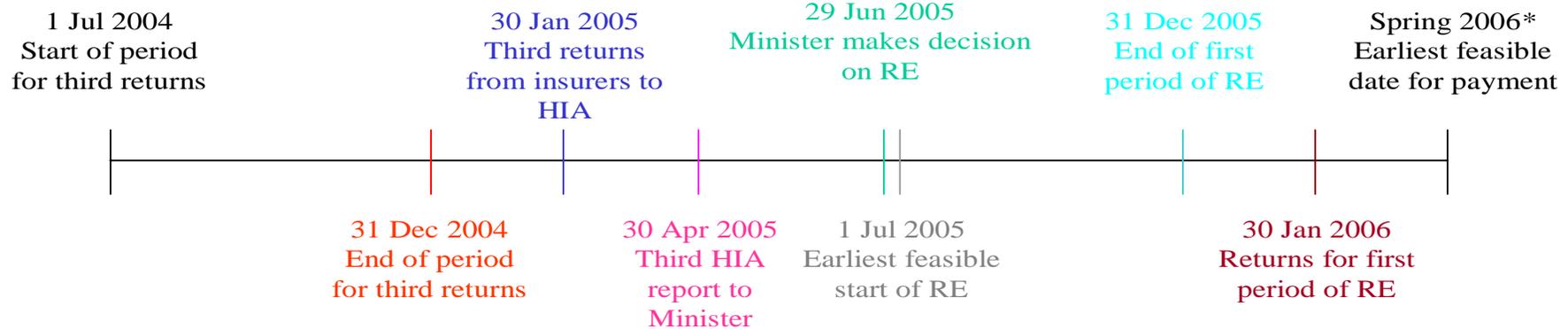
## Possible Timeline Under Risk Equalisation Regulations

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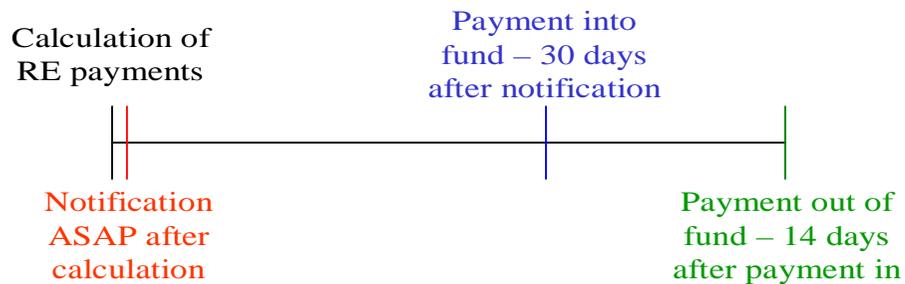


## Possible Timeline Under Risk Equalisation Regulations

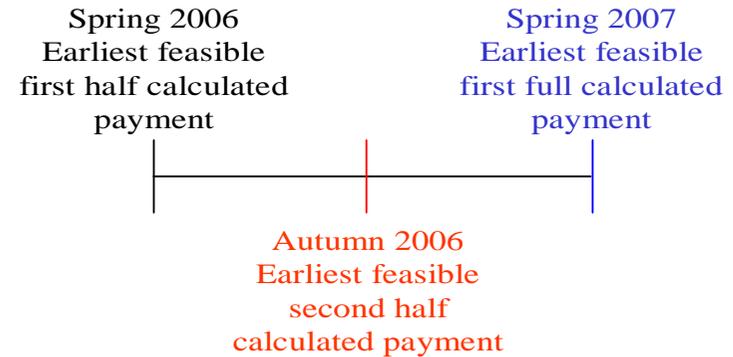
Assumptions: Market Equalisation Percentage of 2% - 10% and RE Recommended/Implemented



### \* Payment Procedure



### \* Phasing Arrangements



**Note:** Phasing arrangements are listed for existing scheme undertakings. Different phasing arrangements apply to new entrants.