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

October, 2005

[Ed note: This Report has been slightly redacted for circulation to registered undertakings on 11 November, 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 is the fourth period for which returns from scheme undertakings are to be evaluated and analysed and for which the Authority is to make a recommendation to the Minister for Health and Children in relation to the commencement or non-commencement of risk equalisation payments. On the first two occasions the Authority recommended that payments not be commenced. On the third and most recent occasion the Authority recommended that payments be commenced. The Tánaiste and Minister for Health and Children chose not to follow this recommendation.

This report sets out the analysis and review of staff. The views set out in it should not be construed as necessarily those of the Authority unless formally adopted by it in its Report.

This Report takes account of the representations received from insurers in response to the Authority's proposed recommendation of 12 September, 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 5 September to take account of the representations of insurers. These changes are also in blue type.

The report is structured as follows:

Section A briefly reviews the 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 the 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 included in risk equalisation 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 12 September, 2005.

Appendices I - IV summarise the arguments for and against risk equalisation that were put forward 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 is 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 in relation to each of these arguments.

Appendix II includes arguments provided by Andersen Consulting.

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

Appendix IV summarises the arguments in the different submissions that the Authority received.

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 Act) and in the Risk Equalisation Scheme, 2003 as amended (the Scheme). The Act states 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 payments ought to be commenced, 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 commencement of risk equalisation payments 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 the commencement of risk equalisation payments 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 payments 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 payments 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

This section attempts to summarise and expand upon the general views of the Authority to date and may be borne in mind when members of the Authority consider this report. The views in this section are not to be construed as the views of the Authority unless and until formally adopted by the Members for purposes of the Report to the Minister under Section 12 of the Health Insurance Authority Act, 1994 (as amended).

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 all of the 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, staff 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 at the time as set out in its Policy Paper, save where the contrary might appear.

1. Theory of Risk Equalisation

Difficulties can arise for a community rated market in the absence of risk equalisation payments. 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, clearly in the best overall interests of health insurance consumers. Furthermore, the Act specifically requires that the Authority has 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 to 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 payments 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 payments would provide greater incentive for insurers to recruit higher risk members.

A community rated system could become destabilised if there were a dramatic shift in the age profile and 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 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, any potential effect that commencing risk equalisation payments might have on the stability of the community rating system cannot be disregarded 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 are no risk equalisation payments and no prospect of risk equalisation payments. 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 a similar basis. In these circumstances the later new entrants may need to either offer a significant discount in price or differentiate itself in some other way such as on the basis of product or service. 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. In particular, if price following existed in the market, the commencement of risk equalisation payments 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 the 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 would 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.

With 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 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 is considered sufficient in terms of providing an incentive for new entrants to enter the market.

Sharing of Efficiencies

The extent to which risk equalisation payments 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 sharing of efficiencies. The fact that the commencement of risk equalisation payments may result in the sharing of efficiencies is a matter of concern to the Authority and will influence its deliberations.

4. Risk Equalisation and Excess Profits

References in this Report to “excess profits” shall, save when the context might specify or 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, either a competitive market must exist after the commencement of risk equalisation payments 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.

It is considered that the ownership of any insurance company in the market is not 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 the commencement risk equalisation payments 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 payments 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 it may be beneficial to have some form of incentive to encourage new entrants to enter the

market. However, 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 is considered sufficient in terms of providing an incentive for new entrants to enter the market.

If uncertainty over any commencement of risk equalisation payments and over the status of VHI is resolved in the short term, the health insurance market in Ireland should still attract some new entrants, but fewer than if risk equalisation payments are not commenced. 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 existence of such differences limits the value of comparisons with international experiences to the deliberations of the Authority 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 January, 2005 to 30 June, 2005. Where appropriate, reference is also made to the previous sets of returns filed with the Authority, for the periods between 1 July, 2003 and 31 December, 2004. Before discussing the analysis we will review the nature of the data received.

Returning Undertakings

Returns were submitted by BUPA Ireland, ESB Staff Medical Provident Fund and Vhi Healthcare. VIVAS Health will not be required to submit a return until January 2006. This return will be in respect of the period July to December 2005. Therefore VIVAS Health are excluded from the calculation of the Market Equalisation Percentage. However, Staff of the Authority consider that the effect of the inclusion or exclusion of VIVAS Health in returns would not have a significant effect on the value of the MEP because of the size of VIVAS Health during the period. On the basis of levy returns, it is estimated that VIVAS Health's total "Insured Persons" would have been less than 2,000, compared to approximately 400,000 for BUPA Ireland, 30,000 for ESB SMPF and 1,500,000 for Vhi Healthcare.

VIVAS Health was invited to submit the information that is normally included in returns on a voluntary basis. They did not so do.

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 January, 2005 and 1 April, 2005). Therefore, the figures would, on average, relate to the middle of February, 2005. 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 January, 2005 to 30 June, 2005. 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 c. 6 months or less (Vhi Healthcare inform us that their claims are settled more quickly). As a result of this time lag 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% 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 December, 2004 and / or July, 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 January, 2005 to 30 June, 2005. 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.

Errors in ESB SMPF's Returns

When reviewing the returns received, Staff of the Authority noticed two separate abnormalities in ESB SMPF's returns. The matters were queried with ESB SMPF who stated that each abnormality related to a separate error in the compilation of the returns filed. They forwarded a corrected return and a report within 7 days, as required by the Scheme.

One of the errors in the return filed by ESB SMPF resulted in a surprisingly high increase in the ratio of benefits included in returns to treatment days included in the returns. The Authority relies on all entities governed by the Scheme undertaking their statutory responsibilities with the appropriate level of care and diligence and it is a matter of concern to Staff of the Authority that neither those compiling the returns, the signatories to the returns nor the accountants preparing the independent accountants report noticed such a stark abnormality in the returns, which were filed with the Authority. The seriousness of the matter was made clear to ESB SMPF.

Inconsistencies in Returns

The obligation for filing returns that are consistent with the Scheme rests solely with the undertakings concerned.

The Authority relies on the statements by the signatories to returns that "*the return ... has been prepared in accordance with [the requirements of the Scheme] and is accurate and complete to the best of our knowledge and belief, having made appropriate enquiries of other directors and officers of [the undertaking]*". The Authority is also conscious of the reports of independent accountants, which state, *inter alia*, that "*the return ... has been prepared in accordance with Article 9 of the Risk Equalisation Scheme, 2003 (S.I. no. 261 of 2003) and is fairly presented in all material respects*". The Authority has regard to these statements when making judgements on the materiality of any inconsistencies in returns.

Definition of Health Services Provider

An inconsistency exists in the returns 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. Information provided by BUPA Ireland with the returns that they filed in January 2005 indicates that they exclude approximately 0.6% of the amount paid in benefits because they believe that the providers of the benefits do not fall within this definition. BUPA Ireland were requested to provide this information again with the returns filed in July 2005 but did not so do. Vhi Healthcare do not exclude any benefits from returns because they believe the providers of the benefits do not come within the definition of a health services provider. *Staff of the Authority do not believe, on the basis of the information available, that the difference of interpretation has any material consequences.*

Amended definition of Settled Claims

There also appears to be an inconsistency in respect of the extent to which insurers include claims paid to individuals serving waiting periods in their returns. The Authority's legal advisers consider that all ambiguity in relation to this matter of "settled claims" was removed by the amendment to the Risk Equalisation Scheme, which, it is considered, makes it clear that such claims should be excluded from returns. Nevertheless, Vhi Healthcare continue to include these claims. The claims, which Vhi Healthcare continues to include, incorrectly in the view of the Authority's legal advisers, only relate to claims made as a result of accidents or injuries to the c. 1% of Vhi Healthcare's membership that is serving waiting periods. *The Authority's actuarial advisers (the UK Government Actuary's Department) have advised that in their view "the effect of VHI not excluding benefits in respect of accidents for those in waiting periods will not materially affect the RE calculations. This is because of the fact that only approximately 1% of the VHI membership is in waiting periods and the cost of claims per person in respect of accidents for these people will be significantly lower than the average cost of claims per person from all relevant sources."*

Corrective Payments

During the Authority's evaluation and analysis of returns it came to the attention of the Authority that Vhi Healthcare treat payments on account made to hospitals and corrections to such payments as "corrective payments". It is not clear to Staff of the Authority how this approach complies with the requirements of the Scheme. However, Vhi Healthcare assert that their approach is compliant with the Scheme and they also assert that, in any event the approach that they adopted would not have a material effect on risk equalisation calculations. In support of their assertions Vhi Healthcare forwarded data based on an approach, which Staff of the Authority consider to be consistent with the

Scheme on 13 October, 2005. When calculations were performed again using the data received on 13 October, the Market Equalisation Percentage remained at 4.2% and the Market Positive Equalisation Adjustment increased by €3,000 to €6,457,000. As the effect of using the data received on 29 July, 2005 is not material, the analysis in this report uses the data set out in the return forwarded by Vhi Healthcare on 29 July, 2005.

Forms to be submitted with Risk Equalisation Returns

The Authority has now finalised forms to be submitted by undertakings along with risk equalisation returns. It is considered that the provision of this further information, in relation to how the figures included in returns from insurers are arrived at, may be helpful when reviewing returns. It is also intended that this breakdown of information would be useful in helping to clarify whether or not insurers are completing returns on a similar basis. In particular, the forms would provide details of insured persons and benefits paid, including those insured persons and benefits paid that are not subject to the Risk Equalisation Scheme. The Authority requested that all undertakings complete these forms and submit them to the Authority. BUPA Ireland did not submit the forms. ESB SMPF stated that they would not be in a position to complete the forms and instead submitted partially completed forms. Vhi Healthcare submitted completed forms. It is intended that, with respect to future returns, all undertakings will be required to submit these forms under sub-article 9 (6) of the Scheme.

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 3.8% (from around 400,000 members to around 415,000 members) in the first half of 2005. During the same period Vhi Healthcare's membership grew by around 0.6% (or around 10,000) to around 1,565,000. ESB SMPF's membership has changed little, while VIVAS Health's membership has increased from c.1,000 to c. 6,500 in the period (if returns were filed the number of insured persons is estimated to be less than 2,000 due mainly to the fact that any returned figures would be based on 1 January and 1 April figures). In terms of share of the open-membership market, BUPA Ireland's market share has increased from 20.5% to 20.9%, VIVAS Health's market share is now 0.3%, while Vhi Healthcare's market share has dropped from 79.4% to 78.7%.

In total, the number of persons with private health insurance in Ireland (including members of undertakings that are not scheme undertakings) has grown from 2.05m to 2.08m or by c. 1.5% in the 6 months to 30 June, 2005.

Vhi Healthcare's lapse rate, which had reduced in the 12 months to December 2004 increased once more, but remains well below the rate for the 12 months to December 2003. Their sales figures, which had declined significantly, from around 85,000 in 2000 to around 57,000 in 2004, increased significantly to around 75,000 for the 12 months to June 2005. These figures exclude additions to existing policies (e.g. births and new members on existing policies). Reliable figures for additions were not provided by Vhi Healthcare for earlier years and so are not included when looking at historic trends. If additions are included, sales to the end of June 2005 total c. 115,000.

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 the 12 months to June 2005 was around 115,000 (including additions to existing policies), while BUPA Ireland's was estimated to be around 70,000 (including additions to existing policies).

Financial Information

In the tables overleaf Gross Underwriting Surplus equals earned premium less incurred claims and less operating expenses.

Vhi Healthcare published their annual accounts for the 12 months to February, 2005. We compare the figures for the 12 months to February, 2005 with previously published results. The claims figures in accounts include a provision for outstanding claims. The accuracy of this provision only becomes known over time as claims are settled. As part of their representations following the Authority's proposed recommendation in March, 2005, BUPA Ireland forwarded updated claims figures for past years, which included updates to these provisions. The Authority requested similar updates from Vhi Healthcare. In the case of Vhi Healthcare, the effect of the adjustments to the outstanding claims provisions varied from reducing claims incurred by €4.2m in the 12 months to February, 2003 to increasing the claims incurred figure by €3.8m (or c. 2%) for the 12 months to February, 2005. The effect of allowing for these adjustments in the table below is to slightly increase the surplus for the 12 months to February 2003, slightly reduce it for the 12 months to February, 2004 and significantly reduce it (by €3.8m) for the 12 months to February, 2005. The figures in each table below include the adjustments to these provisions and this explains why the figures differ significantly from those published in Vhi Healthcare's Annual Reports

	12 months to February 2003	12 months to February 2004	12 months to February 2005
Gross Underwriting Surplus (GUS) adjusted for restated outstanding claims provision	€38.5m	€71.0m	€27.5m
GUS as a % of earned premium adjusted for restated outstanding claims provision	5.6%	8.8%	3.2%
Published Surplus adjusted for restated outstanding claims provision*	€37.4m	€60.3m	-€9.4m
Published Surplus (adjusted for restated outstanding claims provision) as a % of earned premium*	5.4%	7.5%	-1.1%

*When adjusting published surpluses the tax charge was adjusted proportionately.

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.

These figures might also be considered in the context of previously forwarded figures for BUPA Ireland, which were included in the previous report and are included again below.

	2002	2003	2004
Gross Underwriting Surplus adjusted for restated outstanding claims provision	€13.5m	€20.6m	€25.8m
Gross Underwriting Surplus as a % of earned premium adjusted for restated outstanding claims provision	16.6%	17.9%	17.3%

It should be noted that the above figures forwarded by BUPA Ireland as part of their representations in April 2005 differ from the figures published by the Financial Regulator in respect of BUPA Ireland. It is considered appropriate, in the context of the Authority's work, to consider the most up to date figures forwarded to the Authority by BUPA Ireland and it is these figures that are used throughout this report.

Premium increases

Vhi Healthcare announced a rise in premiums of approximately 12.5% from 1 September, 2005. This rise compares to an average annual rise in Vhi Healthcare's premiums of c.8.9% in the years since BUPA Ireland entered the market up to but excluding the 12.5% rise.

New Entrants



The Success of Vhi Healthcare's New Products

In October, 2004, 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. Price Waterhouse Coopers, 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.” In this way Vhi Healthcare could use these products, which may be more competitively priced to retain low risk members and to attract those purchasing insurance for the first time. Vhi Healthcare state, in their annual report that “*Sales of our new Life Stage Choices plans have been particularly encouraging, with total sales from launch date in October to the end of February some 46% over target*”. By the end of June 2005 almost 70,000 people, or over 4% of Vhi Healthcare's membership had these plans, which were launched in October, 2004.

Legal Proceedings

In May, 2005 BUPA Ireland commenced judicial review proceedings against the Authority, the Tánaiste and Minister for Health and Children, the Attorney General and the State. In his grounding affidavit, Mr Martin O'Rourke, Managing Director of BUPA Ireland, made a number of assertions regarding the procedures undertaken by the Authority in relation to its decision in April 2005 to recommend that risk equalisation payments be commenced. The Authority and its advisers carefully reviewed the assertions made by Mr O'Rourke in his affidavit and are satisfied that the Authority at all times acted appropriately and in compliance with the law. For further detail please see Mr O'Rourke's affidavit of 24 May, 2005 and the Chairman of the Authority, Professor Alastair Wood's responding affidavit of 29 June 2005 as well as other notes concerning the proceedings which have been circulated to Members of the Authority.

Following the Tánaiste's decision not to commence risk equalisation payments in June, 2005, BUPA Ireland withdrew its case against the Authority but is continuing proceedings against the other respondents listed above and is challenging, *inter alia*, the consistency of the Risk Equalisation Scheme with the Constitution of Ireland and European Communities Law.

The Tánaiste's decision

In June 2005 the Tánaiste decided not to commence risk equalisation payments. In a letter to the Authority dated 30 June, the Tánaiste stated that she made this decision “*having considered the Authority's Report, representations received on a proposed determination, and the advices of my Department and actuarial advisers*”. The Tánaiste also acknowledged “*the conscientious and exemplary manner in which the Authority has fulfilled its functions under the scheme*”.

In a Dáil debate on 30 June, the Tánaiste also cited the following as reasons for her decision:

- One-off factors in BUPA Ireland's returns.

- Differences in reserving requirements and the commercial status of insurers.
- The number of insurers in the market and the level of competition.
- The growth of Vhi Healthcare's membership and profits following BUPA Ireland's entry to the market.
- The level of the MEP.

All of the above were considered in the Authority's report to the Tánaiste of April 2005 and are considered again in this report.

Changes to Regulations

A number of changes were made to the Regulations governing health insurance in July of this year. The most significant of these changes is that insurers are no longer permitted to refuse to provide contracts to persons over the age of 65 who are not transferring from another contract, although insurers may impose initial waiting periods of up to two years and pre-existing condition waiting periods of up to 10 years in respect of such persons.

After the Authority's recommendation and prior to the change in the Regulations, effected in July 2005, BUPA Ireland had voluntarily commenced accepting members of this older group. BUPA Ireland also offers favourable terms to members of this older group. Under a promotion, BUPA Ireland waive the initial waiting period and offer a free health screening to people over the age of 65. The Authority has asked BUPA Ireland to explain the basis upon which it considers that this promotion complies with the Health Insurance Acts, 1994 to 2003 and related Regulations but has not yet received a reply.

This change did not affect the returns received to date. However, if the change to regulations materially affects the demographic profile of new sales to the various insurers, this could affect trends in the age / sex profiles and the MEP. It should be noted that insurers were never previously prohibited from accepting applicants over the age of 65 but the practice was that such applicants were refused cover.

In the context of any considerations regarding the effect that changes to Open Enrolment Regulations may have, it is worth noting the following:

- If age profiles converge, any risk equalisation payments will reduce to reflect them.
- Any direct financial incentive for selling insurance to older members of the population in a community rated market derives from the existence of risk equalisation payments or the prospect of payments. This is evidenced by the fact that all insurers refused older people prior to the Authority's recommendation to the Tánaiste of April, 2005. Therefore, in the absence of risk equalisation payments or the prospect of them it is not at all clear that insurers would have the incentive to market to older people as BUPA Ireland is currently doing.
- It is not clear for how long BUPA Ireland's promotion for older people will continue.
- The greatest effect of the change in the Open Enrolment regulations may be expected to occur in the initial period following the amendment.

In considering this issue the Authority considers the first two of the above points to be of particular relevance.

In its representations of 3 October, 2005 following the Authority’s proposed recommendation of 12 September, BUPA Ireland argued that the change in the Open Enrolment Regulations described above was not reflected in the Authority’s analysis. Other comments made by BUPA Ireland would appear to indicate that they are not of the view that the change in the Open Enrolment Regulations will have a significant effect. For example, in paragraph 48 of their representations, BUPA Ireland state that:

“The Authority’s own research shows how difficult it is to encourage consumers to switch health insurers, particularly older consumers. Given the regulatory constraints and the practical effect of market inertia insurers have limited scope to persuade greater numbers of policyholders of any particular age bracket to switch to them.”

While in paragraph 23 they state that:

“Such differences [in claims profile] are the unavoidable result of differences in product design, inertia and pricing”.

The relevance of the change to the Open Enrolment Regulations should be considered in the context of these comments by BUPA Ireland and in the context of the listed points made by Staff of the Authority above. Nevertheless, on 7 October, the Authority invited BUPA Ireland to provide details of how the profile of their membership had changed. On 14 October, BUPA Ireland provided the number of “Cell Insured Persons” as defined in the Risk Equalisation Scheme, 2003 (as amended) for each cell as at 1 October, 2005. The details of the changes in age profile since 1 April, 2005 (the previous date for which the Authority has such data) are specified in the table below. We also include data concerning 1 October, 2004 so changes over the last 6 months may be compared with changes over the previous 6 months. Data on Vhi Healthcare’s age profile is also relevant when considering the significance of any change in the rate of convergence of risk profiles and data for Vhi Healthcare as at 1 April, 2005 is included.

Age Group	% in Age Group as at 1 October 2004 BUPA Ireland	% in Age Group as at 1 April, 2005 BUPA Ireland	% in Age Group as at 1 October, 2005 BUPA Ireland	% in Age Group as at 1 April, 2005 Vhi Healthcare
0-17	29.40	29.27	29.03	23.20
18-29	18.99	18.51	18.13	16.70
30-39	23.15	23.10	23.03	15.59
40-49	14.92	15.11	15.18	15.06
50-59	9.59	9.83	9.93	13.29
60-69	3.42	3.62	3.94	9.16
70-79	0.45	0.48	0.65	5.10
80+	0.08	0.08	0.11	1.89
Total Insured Persons	380,385	399,704	427,100	1,503,242

The principal differences in trends appear to relate to the eldest two age groups, although the number of persons insured in these age groups with BUPA Ireland remains small. It is also worth noting that BUPA Ireland's total number of insured persons appears to be increasing at a faster rate once more.

In order to gauge the effect that the change to BUPA Ireland's membership might have on the MEP, their membership as at 1 October, 2005 was analysed along with the returns from Vhi Healthcare and ESB Staff Medical Provident Fund for the period January to June, 2005. For the purposes of the analysis BUPA Ireland's cost of claim per person within each cell for the period January to June 2005 was also used. The result was that the MEP grew from 4.2% to 4.3% so it appears that the MEP may continue to grow despite changes to BUPA Ireland's age profile. It should be noted, however, that the calculations did not allow for a number of factors including:

- Changes to the age profile of other insurers.
- The possible growth in memberships of other insurers.
- The inclusion of VIVAS Health.
- The possible changes to the cost of claims per person in each cell.

The last factor may have a significant effect. While BUPA Ireland waived the initial waiting period for new policyholders over the age of 65, it did not waive the waiting periods in respect of pre-existing conditions. Furthermore, there will be a time lag before any claims made by new older BUPA Ireland policyholders will be settled due to administration procedures etc. Therefore, the claim per person for older people may be significantly reduced for BUPA Ireland, at least in the short term, and this may depress the value of the MEP.

Another significant change to the Risk Equalisation Scheme was the addition of a provision giving legal effect to guidance issued by the Authority in relation to the completion of risk equalisation returns.

Proposed Changes to the Commercial Status of Vhi Healthcare

In her letter to the Authority of 30 June 2005 the Tánaiste stated that *"It is my intention to submit proposals to Government in September concerning VHI's commercial status and related matters"*. At the time of writing it is not clear what these proposals might be. However, the Tánaiste stated in Dáil Éireann on 30 June 2005 that *"I want to bring a memorandum to the Government in September with a view to moving towards full commercialisation of VHI. It will take some years before companies do not have such reserve requirements and are able to meet the requirements of the Irish Financial Services Regulatory Authority which currently requires a reserve of 50%. This is particularly high when compared to the UK, where it is 20%, and Northern Ireland. We should have, at European level, a common figure for health insurers in terms of the reserve requirement. This factor clearly affects competition in the market, in particular that brought to bear by the new entrant."*

Significant changes in returns

The MEP

The MEP (with HSW = 0) has reduced to 4.2%, for the period January to June, 2005. Previous returns for the periods, July to December 2003, January to June 2004 and July to December 2004, gave MEPs of 3.7%, 3.5% and 4.7%, respectively. The latest MEP is in line with the expectations of staff and is consistent with an increasing underlying trend.

In the previous staff report much attention was drawn to the effect that the increase in the average cost per member for BUPA Ireland's over 80s had on the MEP. It was estimated that more than half of the increase in the MEP from 3.5% to 4.7% may have resulted from this increase in costs, which in view of the small number of BUPA Ireland customers over the age of 80, may have resulted from random fluctuation. The average cost per BUPA Ireland member over the age of 80 for the four periods for which returns have been received to date were as outlined in the table below:

	July to Dec 2003	Jan to June 2004	July to Dec 2004	Jan to June 2005
Cost per BUPA over 80	€79	€26	€1,013	€81

When the latest return is included in the analysis it becomes more apparent that both returns in 2004 may have been outliers in respect of the cost per BUPA Ireland member aged 80 or over. Therefore, part of the significant increase in the MEP between the two periods in 2004 may have resulted from a depressed MEP in the first period, due to a low cost for BUPA Ireland's over 80s as well as from an inflated MEP in the second period due to a high cost per member for BUPA Ireland's over 80s. The return of the cost per member for BUPA Ireland's over 80s to a level closer to the average over the four periods resulted in part of the reduction in the MEP for this period.

Another factor in the reduction in the MEP may be seasonality. When the MEP reduced for the period January to June 2004, a factor in the reduction in the MEP 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. In the third period BUPA Ireland's level of hospital bed utilisation per member increased by c.10%, resulting in a value similar to that obtained for the first period. In the latest returns BUPA Ireland's level of hospital bed utilisation per member fell again, by around 10%, with consequent effects on the MEP. Therefore, part of the drop in the MEP would appear to result from seasonality in BUPA Ireland's claims. In this context it is interesting to note that the current MEP, for the period January to June 2005 has increased by 0.7 percentage points since the same period in 2004.

As noted above, the latest returns 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.

ESB SMPF's level of Hospital Bed Utilisation

ESB SMPF's level of hospital bed utilisation per member fell by more than 15% in the latest returns. ESB SMPF's members have consistently had a lower rate of hospital bed utilisation within age and gender cells but the difference between it and other insurers has almost doubled in the latest returns. While this particular period may be an outlier, it may be the case that the continued significantly lower level of hospital bed utilisation by ESB SMPF's population, within age and gender bands, is indicative that their population is significantly healthier than the insured population.

If the Health Status Weight is increased to 0.5, thereby partially equalising differences in hospital bed utilisation within age and gender cells, and risk equalisation payments had been commenced the transfer to ESB SMPF for the six-month period January to June 2005 would reduce from €1.3m to €0.2m. If the Health Status Weight were equal to 1, thereby fully equalising hospital bed utilisation and payments had commenced ESB SMPF would actually have to pay €0.9m into the risk equalisation fund. It should be noted that it is not possible under the Scheme to increase the HSW to 1; the reference to a Health Status Weight equal to 1 is included to illustrate the effect of fully allowing for ESB SMPF's membership's lower level of hospital utilisation within age and gender bands.

The effect on ESB SMPF's transfers of changing the value of the HSW would not have been as dramatic for the other periods. If we look at the effect that increasing the HSW would have had on ESB SMPF's transfers for each of the four periods to date, we will see that the effect of changing the HSW is much greater for this period than for earlier ones. However, if the level of hospital utilisation were fully equalised as well as the age and gender profiles (by increasing the HSW to 1) the total transfer to ESB SMPF over the four periods would drop from c. €4.4m to c. €200,000. The Scheme only permits the Authority to increase the HSW to 0.5. With a HSW equal to 0.5 the total transfer would have been equal to c. €2.3m.

ESB SMPF's transfers:

	Jul-Dec 03	Jan-Jun 04	Jul-Dec 04	Jan - Jun 05	Total
HSW = 0	€1.1m	€0.9m	€1.2m	€1.3m	€4.4m
HSW = 0.5	€0.8m	€0.4m	€0.9m	€0.2m	€2.3m
HSW = 1	€0.4m	€0.0m	€0.6m	- €0.9m	€0.2m

In its Policy Paper, the Authority considered the appropriateness of risk equalisation being applied in a community rated market with open enrolment and lifetime cover. ESB

SMPF is not required to comply with open enrolment in the same way that other insurers are. It is only required to accept members from a sub group of the population.

If ESB SMPF were excluded from risk equalisation for this period, the HSW remained at 0 and payments had been commenced transfers from BUPA Ireland would reduce by €0.2m and transfers to Vhi Healthcare would increase by c. €1.1m.

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 commencing risk equalisation payments.

Market Equalisation Percentage

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

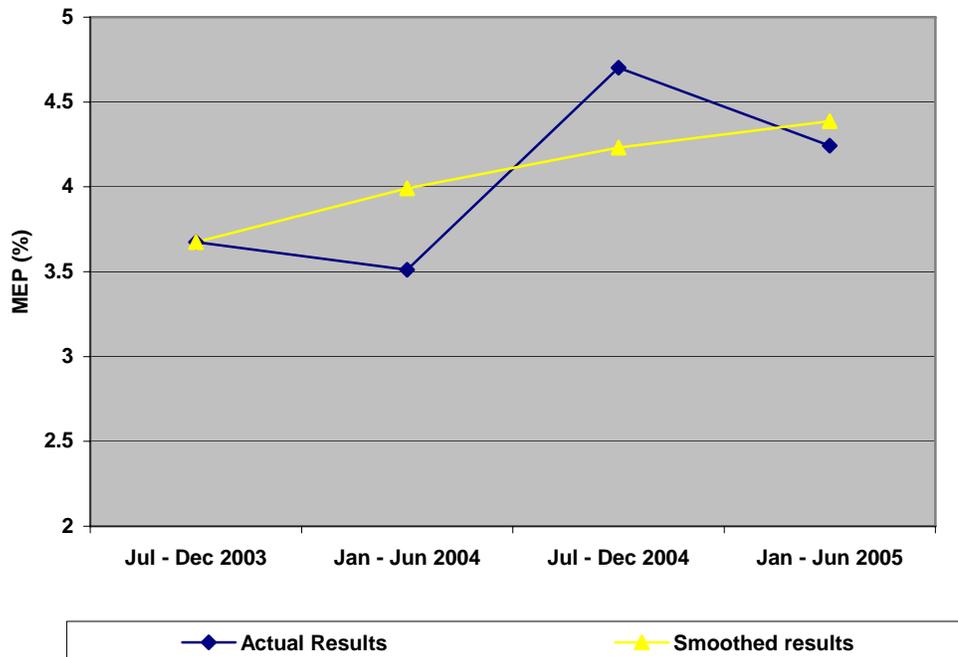
The Health Status Weight (HSW) used when calculating the Market Equalisation Percentage was 0.

The Market Equalisation Percentage for the period 1 January, 2005 to 30 June, 2005 is 4.2%. This is a decrease of 0.5 percentage points from the previous period, 1 July, 2004 to 31 December, 2004. The chart below shows the trend in the MEP, with HSW equal to zero, over the four periods for which returns have been received.

We also plot what the MEP would have been had the costs per person within age and gender cells remained constant throughout the four periods. The constant costs per person were taken as the averages within each cell for each undertaking. By doing this we remove the random fluctuation in the MEP that results from random fluctuation in amount paid in claims. If there is any trend in the amount paid in claims that affects the MEP (such as a trend resulting in the costs for one insurer increasing or reducing at a faster rate than for other insurers) this would also be removed.

This methodology was approved by the Authority's actuarial advisers, the UK Government Actuary's Department, who agreed that it is an appropriate analytical technique.

Market Equalisation Percentage with HSW = 0.0 for the four periods for which returns have been received



Relative Sizes of Insurers and the overall size of the market

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

Company	Insured Persons in RE returns 01/01/05 to 30/06/05	% of total insured persons in scheme undertakings
BUPA Ireland	393,400	20.4%
ESB Staff MPF	28,842	1.5%
Vhi Healthcare	1,502,991	78.1%
Total	1,925,234	100.0%

The figures in the preceding 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-February figures, as they are the average of the figures for 1 January and 1 April. Figures for VIVAS Health are not included in the above table, as they are not required to submit risk equalisation returns until the next period, July to December 2005.

The membership of products that are subject to risk equalisation for each undertaking as at 30 June, 2005 are set out in the table below (VIVAS Health’s relevant products are also included even though they are currently availing of a limited exemption from the Scheme):

Company	Membership of Products Subject to Risk Equalisation @ 30/06/05	% of Total Membership in Scheme Undertakings
BUPA Ireland	416,532	21.0%
ESB Staff MPF	28,939	1.5%
Vhi Healthcare	1,530,060	77.2%
VIVAS Health	6,548	0.3%
Total	1,982,079	100.0%

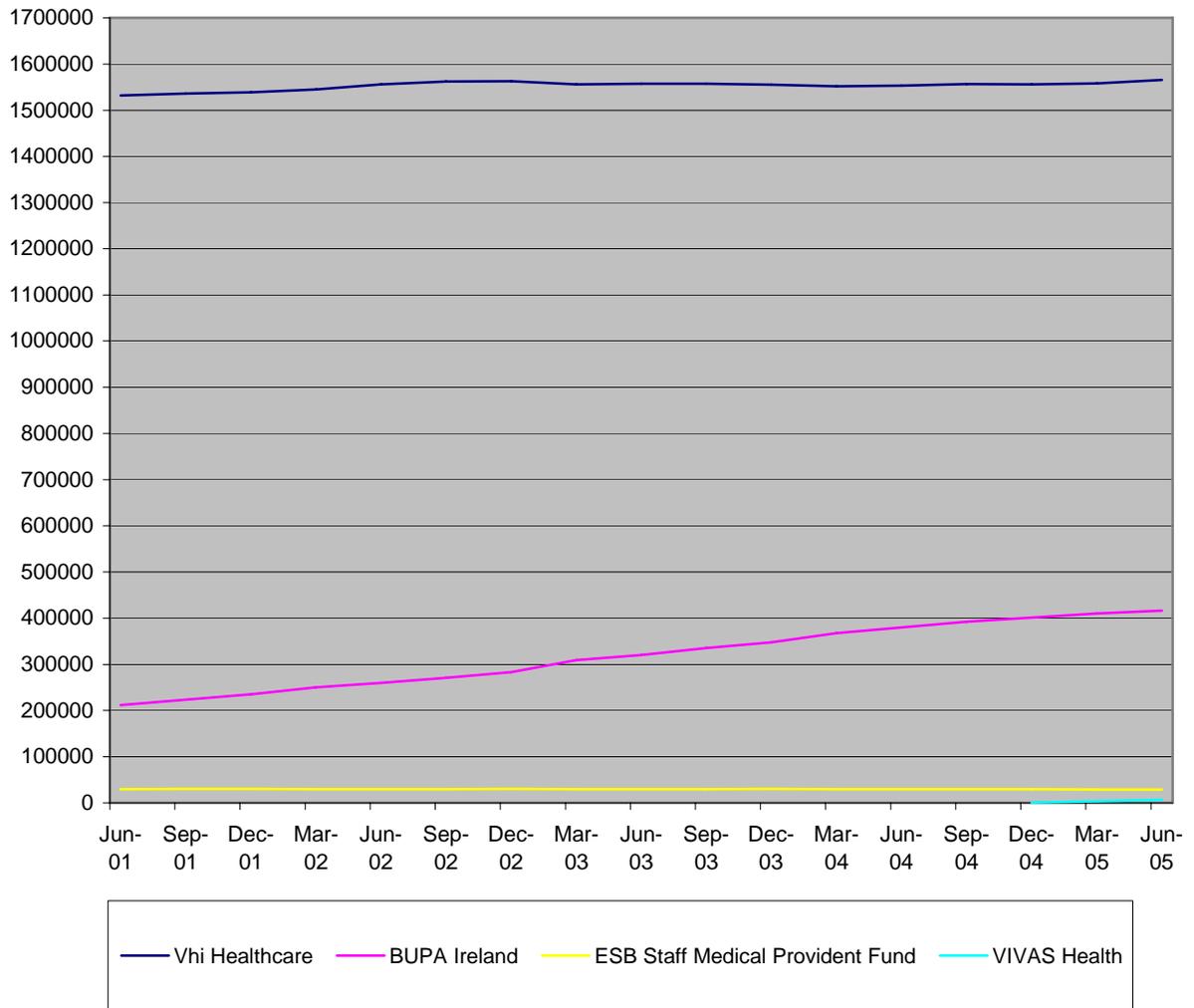
While the membership of products subject to risk equalisation for ESB SMPF has stayed broadly constant since June 2001 and Vhi Healthcare’s membership of products subject to risk equalisation has increased by about 54,500 (or about 3.7%), BUPA Ireland’s membership of products subject to risk equalisation has increased by about 204,000 (or by about 96%).

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

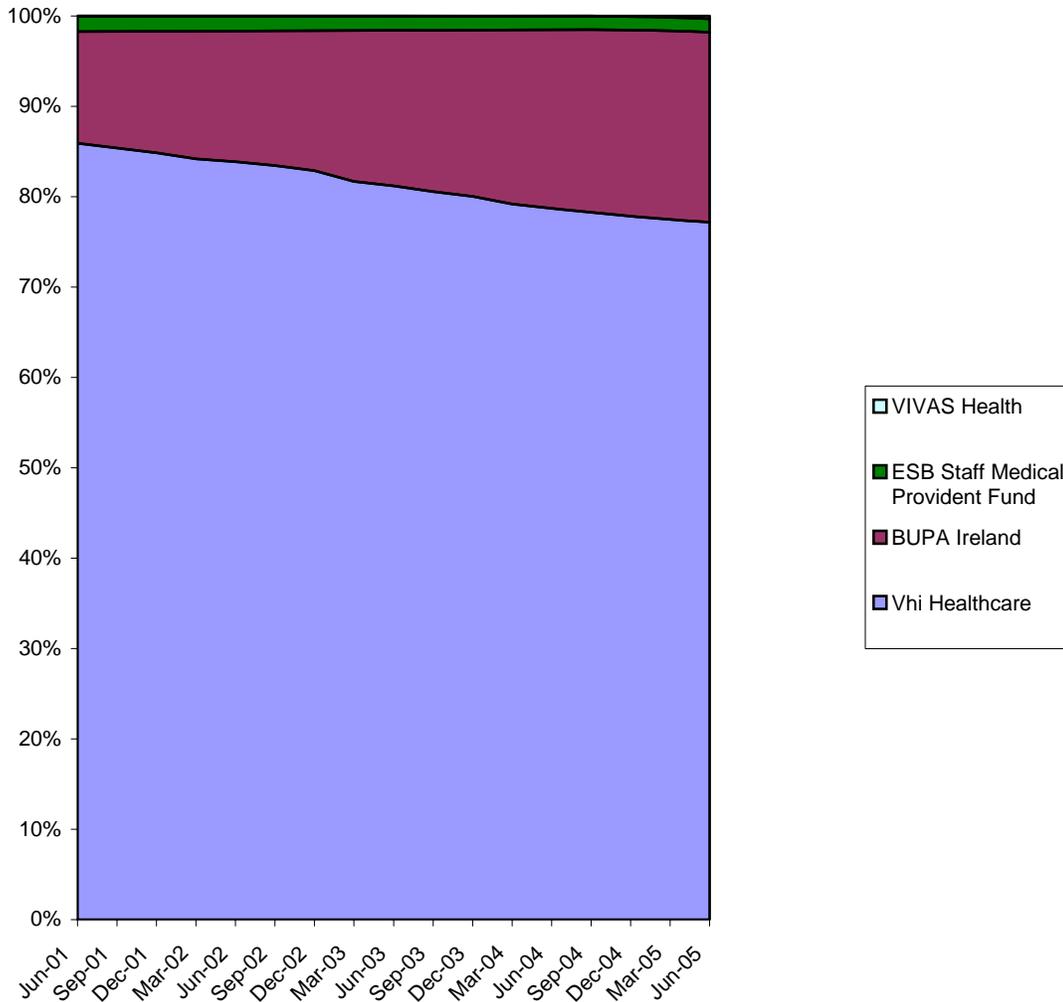
VIVAS Health is a relatively new company and so has not yet attracted significant market share. It is unsurprising then, that its market share is almost indiscernible in the charts overleaf.

As well as the fact that VIVAS Health are not yet required to make risk equalisation returns, another difference between the historic data in the following two charts 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 because a greater proportion of their membership are likely to have taken out insurance for the first time. Also the first chart includes products that are not subject to risk equalisation. BUPA Ireland has no such products whereas Vhi Healthcare and VIVAS Health do.

Total Undertaking Membership Jun 01 - Jun 05

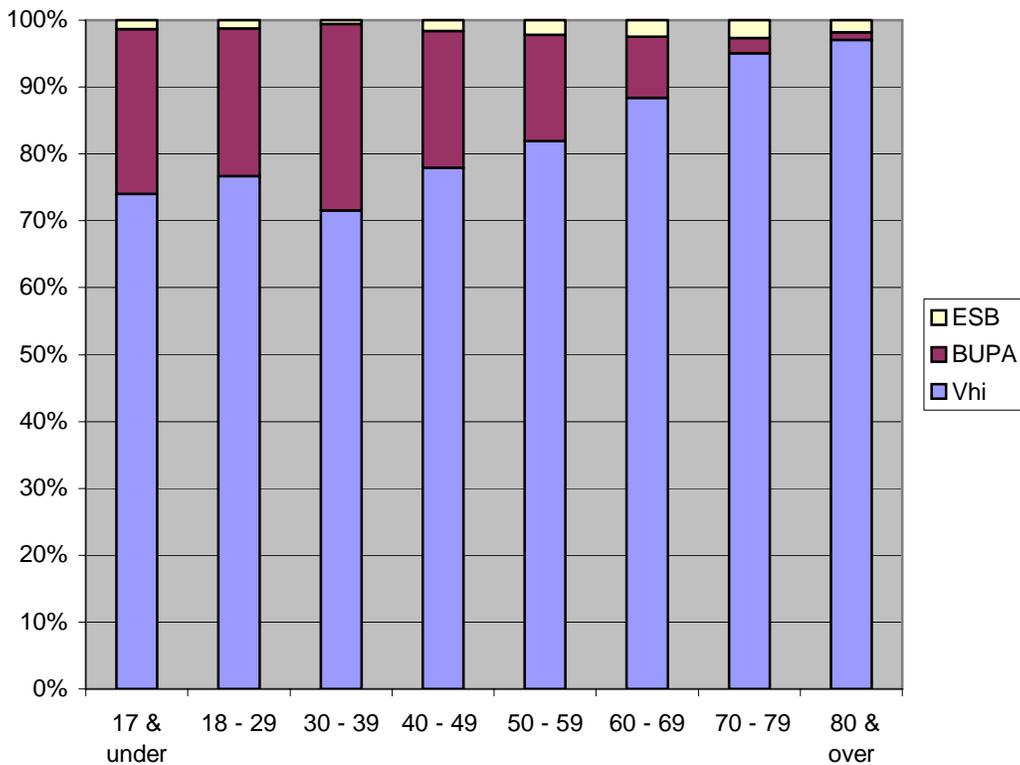


Market Shares (by Membership) for Products Subject to RES - Jun 01 to Jun 05



When looking at market shares in the health insurance market, it is also useful to look at market shares within age bands. This is because it is more beneficial to insurers to have high market shares in younger age groups, where claims are generally lower. The chart overleaf describes the market shares of each of the returning undertakings within age bands.

Market Shares in Each Age Group



The above chart shows that BUPA Ireland’s market share varies from 1% of the over 80 age group to 28% of the 30 to 39 age group.

In the context of the above chart it is interesting to consider comments by some that the commencement of risk equalisation payments would not be appropriate while any insurer has significantly more than 30% of the market. If new entrants continued to acquire market share predominantly in the younger age groups, it is relevant to consider which c. 30% of the market would remain with Vhi Healthcare.

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 1/3rd 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. It does not 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 has a larger proportion of members that have plans that only provide cover in public hospitals than Vhi Healthcare and it also has a larger proportion of members that have plans that include excesses than Vhi Healthcare.

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 1/3rd and each adult as 1, the average equalised benefit per insured person for each insurer, for each set of returns, is outlined in the tables below:

Insurer	Average “Equalised Benefits” per Insured Person			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	€127	€119	€140	€135
ESB SMPF	€240	€222	€249	€263
Vhi Healthcare	€220	€235	€242	€266
Market	€205	€215	€223	€240

Insurer	Average “Equalised Benefits” per Insured Person as a % of the Market Average			
	July–Dec '03	Jan – Jun '04	July- Dec '04	Jan – Jun '05
BUPA Ireland	62%	55%	63%	56%
ESB SMPF	117%	104%	112%	109%
Vhi Healthcare	107%	110%	109%	111%
Market	100%	100%	100%	100%

The above tables show that BUPA Ireland’s average equalised benefit per insured person has decreased significantly, in terms of its percentage of the market average, since the last

period (from 63% of the market average to 56% of the market average). BUPA Ireland's average equalised benefit per insured person, as a percentage of the market average, for the period 1 January, 2005 to 30 June, 2005 is similar to its average equalised benefit per insured person, as a percentage of the market average, for the period 1 January, 2004 to 30 June, 2004. This supports the hypothesis that seasonality exists in BUPA Ireland's returns, as BUPA Ireland have previously stated. The corresponding figures for ESB SMPF also appear to exhibit some signs of seasonality.

Average number of treatment days per member

The differences in the average "equalised benefit per member" is partly due to differences in the average cost per treatment day for each insurer and partly 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 tables below. The figure for ESB SMPF, for January to June 2005, is surprisingly high. When Staff of the Authority queried this with ESB SMPF, they were told that the reason for the increase was that the December 2004 payment to consultants was made in January 2005, with the result that there were seven payments to consultants in the period January to June 2005 and only five in the previous period, July to December 2004. Reference was also made to the 25% increase in the cost of public beds in private hospitals, which would be expected to have an effect across the market.

Insurer	Average Equalised Benefit per Treatment Day			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	€423	€453	€481	€520
ESB SMPF	€549	€546	€586	€744
Vhi Healthcare	€509	€549	€597	€611
Market	€499	€538	€580	€601

Insurer	Average Equalised Benefit per Treatment Day as a % of the Market Average			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	85%	84%	83%	86%
ESB SMPF	110%	101%	101%	124%
Vhi Healthcare	102%	102%	103%	102%
Market	100%	100%	100%	100%

The differences described in the previous four 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. However, 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 tables. 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			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	0.300	0.263	0.290	0.260
ESB SMPF	0.438	0.408	0.425	0.353
Vhi Healthcare	0.432	0.428	0.406	0.436
Market	0.410	0.399	0.384	0.400

The above table displays signs of seasonality for BUPA Ireland and ESB SMPF, although ESB SMPF’s average treatment days per insured person for the period January to June 2005 is somewhat lower than what may have been expected. Vhi Healthcare’s average number of treatment days per insured member has increased considerably since the last period, returning to a level similar to that experienced in the first two periods. As can be seen from the table overleaf, Vhi Healthcare’s average number of treatment days per insured person as a percentage of the market average appears to be increasing.

Insurer	Average Treatment Days Per Insured Person as a % of the Market Average			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	73%	66%	76%	65%
ESB SMPF	107%	102%	111%	88%
Vhi Healthcare	105%	107%	106%	109%
Market	100%	100%	100%	100%

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 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 123% and 107% respectively. Vhi Healthcare’s and ESB SMPF’s indices appear to be increasing as a percentage of the market, while BUPA Ireland’s index is remaining constant, indicating that there has been little change in BUPA Ireland’s relative age / sex profile 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).

Insurer	Age/Sex Risk Profile Index (Percentage of the Market Average)			
	July – Dec '03	Jan – Jun '04	July – Dec '04	Jan – Jun '05
BUPA Ireland	72%	72%	72%	72%
ESB SMPF	118%	120%	120%	123%
Vhi Healthcare	105%	106%	106%	107%
Market	100%	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 four 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	Jan – Jun '05	Average for the 4 periods
BUPA Ireland	95%	86%	105%	87%	93%
ESB SMPF	87%	84%	92%	70%	83%
Vhi Healthcare	100%	100%	100%	100%	100%

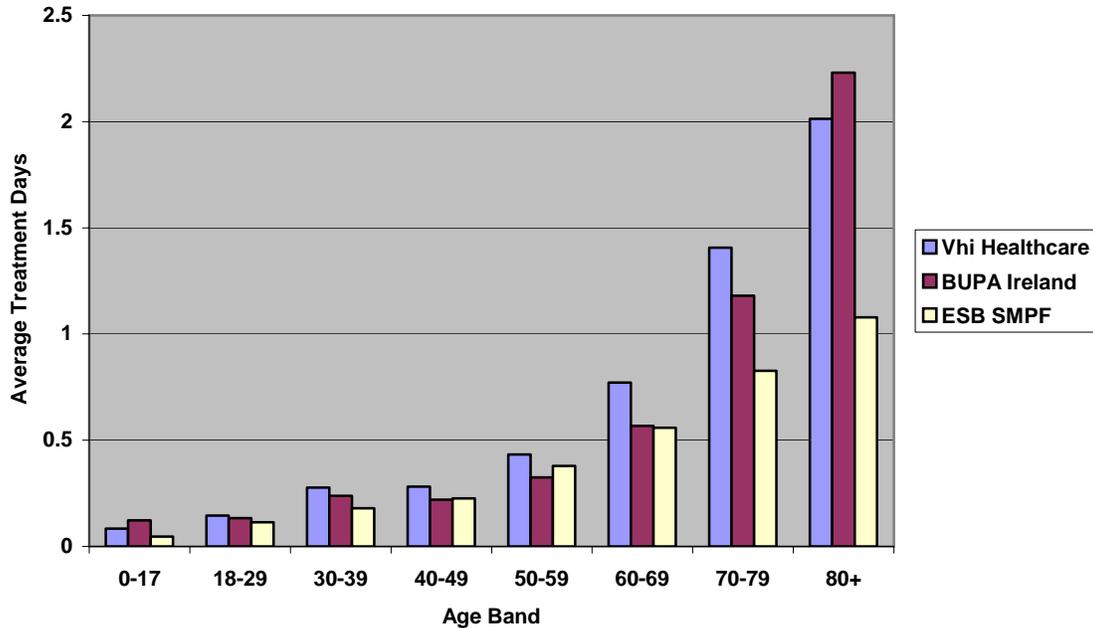
The figures for the period January to June 2005 in the table above indicate that BUPA Ireland's and ESB SMPF's memberships used hospital accommodation less than Vhi Healthcare within each age/sex group. The difference between ESB SMPF and Vhi Healthcare is particularly substantial. The lower Health Status Risk Profile Indices for BUPA Ireland and ESB SMPF may be as a result of these companies having healthier members within each age and gender group but it may also be influenced by differences in contract terms and levels of efficiency. The figures for BUPA Ireland and ESB SMPF appear to exhibit signs of seasonality.

In the previous period, BUPA Ireland had a higher Health Status Risk Profile Index than Vhi Healthcare and one of the significant reasons for this was the increase in treatment days for that period for BUPA Ireland consumers that were 80 years of age or older. This was the only age group for which the level of treatment days for BUPA Ireland customers was considerably higher than for Vhi Healthcare customers. While it is the case that BUPA Ireland's level of treatment days for this age group is still higher than Vhi

Healthcare's for the period January to June 2005, the chart below shows that the difference between the two figures is now relatively small.

ESB SMPF's significantly lower level of average treatment days within age and gender bands, which we referred to earlier can also be clearly seen in the chart below.

Average Treatment Days by Age Band January - June 2005



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 four sets of returns, is included overleaf.

Insurer	% of Market Average “equalised benefit” per Member			
	July – Dec ’03	Jan – Jun ’04	July – Dec ’04	Jan – Jun ’05
BUPA Ireland	62	55	63	56
ESB SMPF	117	104	112	109
Vhi Healthcare	107	110	109	111

Insurer	% of Market Average Treatment Days per Member			
	July – Dec ’03	Jan – Jun ’04	July – Dec ’04	Jan – Jun ’05
BUPA Ireland	73	66	76	65
ESB SMPF	107	102	111	88
Vhi Healthcare	105	107	106	109

Insurer	% of Market Age/Sex Risk Profile Index			
	July – Dec ’03	Jan – Jun ’04	July – Dec ’04	Jan – Jun ’05
BUPA Ireland	72	72	72	72
ESB SMPF	118	120	120	123
Vhi Healthcare	105	106	106	107

While BUPA Ireland’s average claim per member is 44% 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 14% lower than the market cost (see tables on page 35). 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 the previous period, July to December 2004, increasing the HSW to 0.5 would have caused a decrease in the MEP from 4.7% to 4.5%. One reason why the MEP with the HSW = 0.5 was lower than with the HSW = 0 for that period, was the large increase in the level of treatment days included in returns for BUPA Ireland policyholders aged 80 or over for that period.

In the periods July to December 2003 and January to June 2004, changing the HSW to 0.5 increased the MEP. This is once again the case for the period January to June 2005, in that increasing the HSW from 0 to 0.5 would cause an increase in the MEP from 4.2% to 5.3%. It is interesting to note that, with HSW = 0.5, there is a significant increase in the market equalisation percentage between the periods July to December, 2004 (MEP = 4.5%) and January to June, 2005 (MEP = 5.3%).

	Market Equalisation Percentage (%)			
	Jul – Dec '03	Jan – Jun '04	Jul – Dec '04	Jan – Jun '05
HSW = 0.0	3.7	3.5	4.7	4.2
HSW = 0.5	4.0	4.4	4.5	5.3
Difference	0.3	0.9	-0.2	1.0

The difference between the MEP values for HSW = 0 and HSW = 0.5 for each period seems to increase and decrease periodically:

A reason for this periodic widening and narrowing of the gap between the two values could be the apparent seasonal increase and decrease in BUPA Ireland's Cell Claim Value (level of hospital bed utilisation in returns).

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 three periods.

Gender	BUPA Ireland	ESB SMPF	Vhi Healthcare
Male	49%	51%	48%
Female	51%	49%	52%

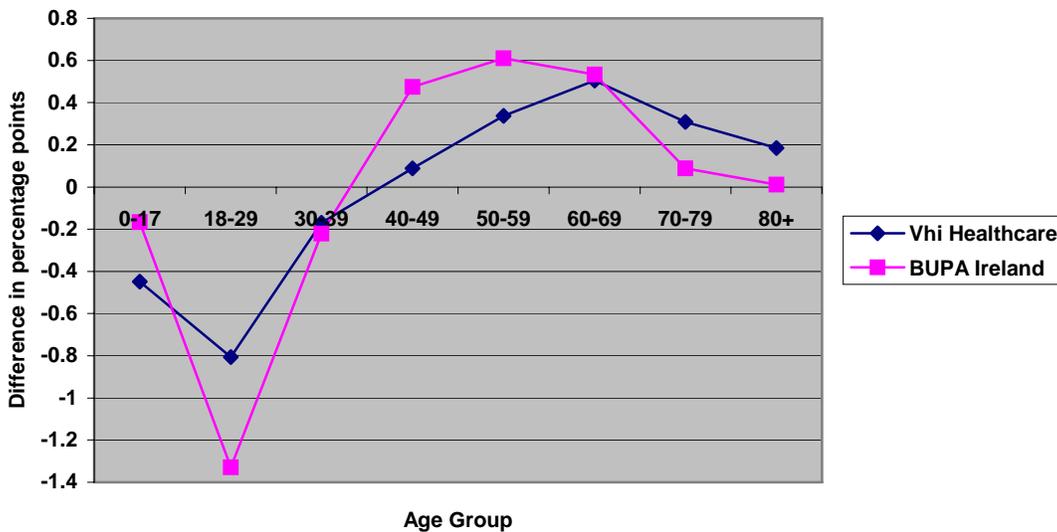
The current age distribution (for the period January to June, 2005) of each insurer's population is shown below. Corresponding figures for the period, July to December, 2003 are shown in brackets.

Age Group	BUPA Ireland % in each age group	ESB SMPF % in each age group	Vhi Healthcare % in each age group
0-17	29.2 (29.4)	21.9 (22.8)	23.0 (23.5)
18-29	18.4 (19.8)	14.0 (14.9)	16.8 (17.6)
30-39	23.1 (23.4)	6.9 (7.4)	15.6 (15.8)
40-49	15.2 (14.7)	16.1 (16.2)	15.1 (15.0)
50-59	9.9 (9.3)	18.6 (18.3)	13.3 (13.0)
60-69	3.6 (3.1)	13.3 (12.3)	9.2 (8.7)
70-79	0.5 (0.4)	7.4 (6.6)	5.1 (4.8)
80+	0.1 (0.1)	1.9 (1.6)	1.9 (1.7)

The above table shows that Vhi Healthcare has a significantly greater proportion of members in the older age groups than do BUPA Ireland, i.e. Vhi Healthcare have c. 10 times the proportion of members in the 70 – 79 age group and more than 20 times the proportion of members in the over 80 age group.

The chart overleaf 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 January to June, 2005, (denoted by the negative values in the chart overleaf). The proportion of their members in the older age groups (over 40) has increased (denoted by the positive values in the chart overleaf). For example, for Vhi Healthcare the proportion in the 18 – 29 age group has dropped by 0.8 percentage points from 17.6% to 16.8%.

Difference in percentage points in the proportion in each age group between the periods July - Dec 2003 and Jan - June 2005



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 between July to December 2003 and January to June 2005, BUPA Ireland’s proportion of members in the 18 – 29 age group has decreased by between 1.3 and 1.4 percentage points. Despite this fall, however, BUPA Ireland still has a larger proportion of its members in this age group, than does Vhi Healthcare.

Vhi Healthcare inform us that the average age of their membership is 37.1 years at 30 June, 2005, (compared to 36.9 at 31 December, 2004), while BUPA Ireland inform us that the average age of their membership is 30.2 years at 30 June, 2005 (compared to 29.9 at December, 2004). ESB SMPF inform us that the average age of their membership is 41 years (unchanged since December, 2004). From this we calculate the average age of the membership of scheme undertakings (excluding VIVAS Health) to be 35.7. (We can calculate the average age of the open membership market (excluding VIVAS Health) by excluding ESB SMPF. This gives a rounded figure of 35.6).

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 (excluding VIVAS Health) has grown by 1.8 years since BUPA Ireland entered the market, Vhi Healthcare’s average age has increased by 3.2 years, while BUPA Ireland’s average age has increased by 1.8 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 around 0.4 years every year since 1997 in the average age of Vhi Healthcare's membership, although Vhi Healthcare inform us that 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. The lapse figures, however, may include some deaths, (where a death occurred for the policyholder and therefore the policy was cancelled).

Vhi Healthcare Additions and Deletions

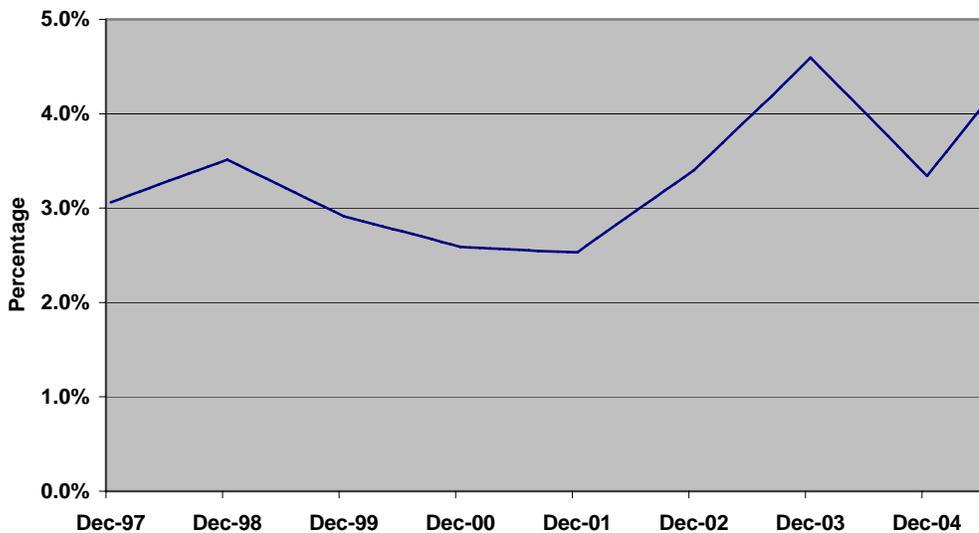
Vhi Healthcare state that it is the difference between additions and deletions that is important rather than the number of additions and deletions "as some members may be counted as both an addition and deletion and perhaps even on multiple occasions." This difference between additions and deletions was about 6,000 in the 12 months up to the end of June 2005 (additions exceeding deletions). In each of the previous four twelve month periods to the end of February 2001, 2002, 2003 and 2004 additions exceeded deletions by less than 6,500.

The analyses of lapses and sales overleaf 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 for the year ending 30 June, 2005 was 31.6 years. This appears to be consistent with the average age of lapsers in the years 1998 to 2003, which were generally estimated to be between 30 and 32 (the figure for the 12 months ending 31 December, 2004 was slightly lower at 29.3). The average age of Vhi Healthcare's lapsers 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 below.

Vhi Healthcare Estimated Annual Lapse Rates 1997 - June 2005



It would not appear to be possible to make a conclusive judgement regarding a trend in Vhi Healthcare's lapse rate. The peak to the end of December 2003 followed Vhi Healthcare's 18% price increase with effect from 1 September, 2002. Also it might be the case that the increase in the lapse rate between 2001 and 2003 was 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). In the first six months of 2005, it appears that Vhi Healthcare's lapse rate has begun to increase again, although it is considered that the lapse rates, when viewed in isolation, would not be indicative of the commencement of a death spiral.

BUPA Ireland's lapse rate for the 12 months ending 30 June, 2005 would appear to be higher than Vhi Healthcare's, although it should be noted that BUPA Ireland's lapse rate figures include members who have left policies which remain in force, whereas Vhi Healthcare's lapse figures do not. BUPA Ireland's higher lapse rate may not be surprising, as BUPA Ireland's membership is younger and would be expected to contain

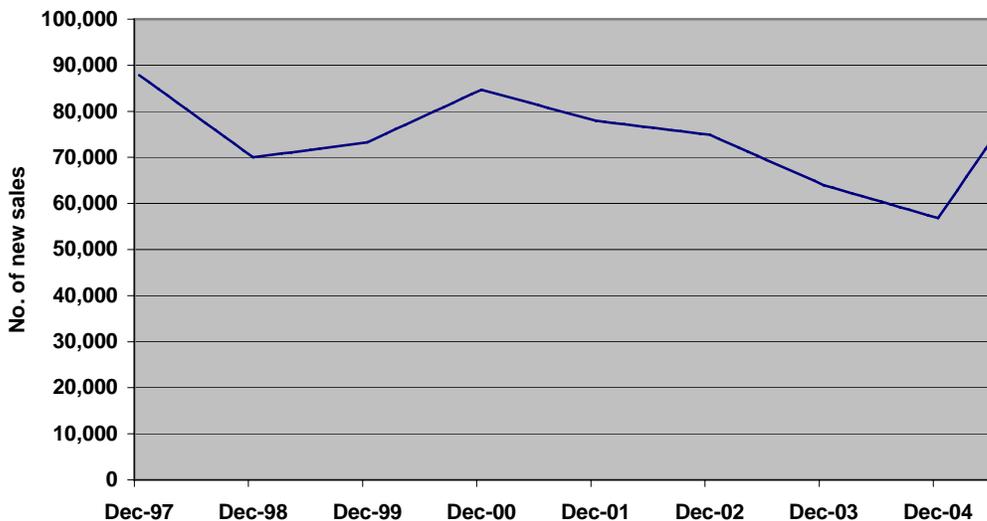
a larger proportion of switchers. The Authority's research has indicated that both of these groups are more likely to cancel a policy than the general population.

ESB SMPF's lapse rate for the 12 month period ending 30 June, 2005 was 3.4% and its average age of lapsers was 37 years.

Sales

Between 1998 and 2004, the average age of those who purchased Vhi Healthcare policies remained reasonably constant, at about 29 years. This has increased slightly for the year ending 30 June, 2005 to 30.9 years (excluding new births and additions). The average age of Vhi Healthcare's new sales 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. If we include additions and new births in calculating the average age of new members then we would expect the average age to reduce. The number of Vhi Healthcare's members under the age of 1 is c. 17,000 and it is considered that this is a good estimate of the number of new births for Vhi Healthcare. If this estimate of new births is allowed for when calculating the average age of new members, then the average age reduces to c. 25.2. However, in this analysis, we are looking at trends in sales figures and how they might affect the stability of the market. New births would be subject to separate trends to other new sales. Vhi Healthcare were unable to supply average age data for their additions and so it is not possible to allow for these in the calculations.

Estimate of new sales for Vhi Healthcare 1997 - June 2005



Based on figures received from Vhi Healthcare, their new sales decreased steadily between December 2000, when they peaked, and December 2004. The level of sales in 2002, however, 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. Vhi Healthcare's sales appear to be increasing since December 2004 and this may be due to the reported success of Vhi Healthcare's new products.

The average age of those who purchased BUPA Ireland policies in the 12 months ending 30 June, 2005 is 25.3 (including members who have joined existing policies, i.e. expansions and births). [The average age of ESB SMPF's new sales in the 12 month period was 17 years.](#)

The Effect of any Risk Equalisation 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 payments been in force for the four 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)	€865	€10,939
Jul – Dec, 2004	(€16,759)	€1,163	€15,596
Jan – Jun, 2005	(€16,454)	€1,290	€15,164
Total for 12 months ending Jun 2005	(€33,213)	€2,453	€30,760

[When considering any trend in the growth of potential risk equalisation transfers, i.e. the Market Positive Equalisation Adjustment \(MPEA\), it should be noted that in addition to the factors that affect the MEP, the MPEA is also affected by inflation in the cost of claims and increases in the amount of claims included in risk equalisation. Therefore, it would be expected that the rate of increase in the MPEA would be greater than that for the MEP.](#)

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 risk equalisation transfers. It would also be expected if the post risk equalisation 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 commencement of risk equalisation payments 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 risk equalisation transfers and if the commencement of risk equalisation payments 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 risk equalisation 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 payments 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 commencement of risk equalisation payments 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 the commencement of risk equalisation payments 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 previously 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. No updated financial information was received from BUPA Ireland with their returns for the period January to June, 2005. [The Authority wished to provide BUPA Ireland with every opportunity to provide the information and, following its initial request in July, made further requests in August, September and again in October following receipt of BUPA Ireland's representations. BUPA Ireland provided the Authority with updated information on 26 October, 2005. At this time the Authority was finalising its report to the Tánaiste \(which must be forwarded by 28 October, 2005\) and the Authority did not consider it possible to consider this information as part of the Authority's deliberations and account is not taken of it in this report.](#) Therefore, the estimate for BUPA Ireland that is included in the financial analysis below is based, in part on the projection for 2005 that was provided by BUPA Ireland to the Authority as part of its representations and which was described by its independent accountants as "highly subjective". This projection includes a deterioration in BUPA Ireland's loss ratio (claims incurred divided by earned premium) between 2004 and 2005 from 69% to 78%.

This accounts largely for the reduction in BUPA Ireland's estimated profits as a percentage of earned premium to about 13%. In the previous three calendar years BUPA Ireland's surplus as a percentage of earned premium ranged from 16.6% to 17.9%.

Vhi Healthcare forwarded a copy of its Annual Report and Accounts 2005, which relates to 1 March, 2004 to 28 February, 2005 as well as management accounts for the four months to the end of June 2005.

ESB SMPF forwarded a copy of their accounts for the year ended 31 December, 2004.

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 30 June, 2005. 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 were 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 €m, which would be equivalent to about a third of Vhi Healthcare's estimated Pre RE Gross Underwriting Surplus.

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. The Unexpired Risk Reserve in effect represents a provision for losses that will be incurred in respect of future periods of insurance cover (in contrast to a provision for a claim that has already been incurred), and therefore, in considering the ongoing viability of the business, it is appropriate to ignore transfers to this reserve.

The figures estimated from the data received have been rounded to the nearest €m in the case of Vhi Healthcare, while those for BUPA Ireland are rounded to the nearest €m. ESB SMPF's are also rounded to the nearest €m. As a result of the small amounts involved for ESB SMPF the rounding might have a significant effect on their estimates, but it is considered that not to round would be spurious.

It should be noted that the estimated surplus for Vhi Healthcare for the year to 30 June 2005 (€25m) is much less than the equivalent surplus shown in their published accounts for the year to 28 February 2005 (€41m). The main reason for this reduction seems to be that the figures provided by Vhi Healthcare indicate a much increased loss ratio (claims as percentage of premiums) in the 4 months to 30 June, 2005, compared with the 4 months to 30 June, 2004. In addition, the surplus in the accounts for the year to 28 February, 2005 is less than that estimated for the year to 31 December, 2004 in the previous staff report (€65m).

Estimates of Insurer's Gross Underwriting Surpluses for the 12 months ending 30 June, 2005 and the effect that risk equalisation would have on such surpluses.

Vhi Healthcare	
Membership	1,565,000
Earned Premium	890m
Claims Incurred	790m
RE Claims Settled	645m
Operating Costs	75m
Pre RE Gross Underwriting Surplus	25m (2.8% of premiums)
RE Transfer	31m (16m for Jul- Dec '04, 15m for Jan – Jun '05)
Post RE Gross Underwriting Surplus	56m (6.3% of premiums)
BUPA Ireland	
Membership	417,000
Earned Premium	163m
Claims Incurred	120m
RE Claims Settled	85m
Operating Costs	21m
Pre RE Gross Underwriting Surplus	22m (about 13% of premiums)
RE Transfer	-33m
Post RE Gross Underwriting Surplus	-11m (a loss of about 7% of premiums)
ESB SMPF	
Membership	30,000
Earned Premium	18m
Claims Incurred	18m
RE Claims Settled	13m
Operating Costs	(Most costs appear to be paid by ESB)
Pre RE Gross Underwriting Surplus	Nil
RE Transfer	2m
Post RE Gross Underwriting Surplus	2m (about 11% 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 payments 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 payments. 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 payments. 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 payments may result in Vhi Healthcare's premiums being increased by about 3.5% (i.e. the annual risk equalisation 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 payments were commenced, in order to make a Gross Underwriting Surplus of 5%, BUPA Ireland would need to increase its premiums by about 12% (assuming the volume of sales is unchanged).

Therefore, based on the above estimates (which assume an 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 12% 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 3.5%) 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 total premiums would be about 1% to 1.5% (or €10m to €15m) lower if risk equalisation payments were commenced.

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's gross underwriting surplus for the 12 months to February 2005, allowing for the restatement of their outstanding claims provision, was around 3.2% of their earned premium for the period, or €27.5m (before transfers to the unexpired risk reserve (URR), tax, and investment income) for the 12 months up to February 28, 2005. This may be compared with the corresponding surplus figure of 8.8% or €71m for the year ended 29 February, 2004. The figure of about €31m per annum that would have resulted in the 12 months to 30 June, 2005 from risk equalisation payments (without phasing) should be viewed in this context.
- In their 2005 accounts Vhi Healthcare states that it "is budgeting for a loss in its current financial year [2005/06]". The budget forwarded by Vhi Healthcare indicates that this loss is projected to be €52m before investment income and tax and

any allocation to or release from the unexpired risk reserve. Part of the deterioration of the results from 2004 to 2006 reflects the working through of the “low” premium increase of 3% implemented in September 2004.

In relation to maintaining low prices, there would clearly be increased competitive pressure on BUPA Ireland following any commencement of risk equalisation payments, however, it would be expected that the competitive pressures on Vhi Healthcare would reduce. In order to maintain a 5% gross underwriting surplus, it has been estimated that BUPA Ireland would need to increase premiums by about 12%. While this is a substantial increase, it would not necessarily leave BUPA Ireland in an uncompetitive position, to the extent that their premiums rates are already below those of Vhi Healthcare for each undertaking’s main plans. It could be argued that that in this context the prices of BUPA Ireland’s plans should be compared with Vhi Healthcare’s newer plans rather than Plan B / Plan B Option. However, if Vhi Healthcare’s newer plans offer better value, it may be that this is achieved by virtue of a more advantageous risk profile than Vhi Healthcare’s traditional plans. Therefore, if risk equalisation payments were commenced, in order to remain profitable, the prices of these plans would need to be increased in the same way that the prices of BUPA Ireland’s plans would. Although it is difficult to make direct price comparisons because products are never identical, the analysis on page 46 of this report shows that, since 1 September, 2005 the price of Vhi Healthcare’s Plan B Option is about 24% higher than that of BUPA Ireland’s Essential Plus (No Excess) plan. [It is also relevant to note that BUPA Ireland referred to “26% savings” between their products and Vhi Healthcare’s products when they appeared before the Joint Oireachtas Committee on Health and Children on 29 September, 2005.](#) The differential will however reduce following BUPA Ireland’s premium rise due from 1 March 2006.

In their representations following the Authority’s previous proposal to commence risk equalisation payments, BUPA Ireland stated that they would withdraw from the Irish market if a decision to commence risk equalisation payments were made. However, this may not be a logical reaction, bearing in mind the investment that BUPA Ireland has made in Ireland, the brand that it has built and the client base that it has developed (over 400,000 members). Nevertheless, given BUPA Ireland’s statements, the possibility of their withdrawal is a factor that the Authority should consider.

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 the commencement of risk equalisation payments. The Authority would need

to weigh the credibility and the effects of BUPA Ireland's and Vhi Healthcare's claims against each other.

Even though there is no convincing evidence that BUPA Ireland would be unable to continue to compete if risk equalisation payments were commenced, 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 42 of this report 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 payments. 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% and 9% of earned premium in 2005 and 2006 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 (after adjusting for the overstatement in the provision for outstanding claims).

[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 text block]



it is relevant to consider that Vhi Healthcare's Plan B was about 29% more expensive than VIVAS Health's I / We Level 2 following Vhi Healthcare's price increase on 1 September but before VIVAS Health's price increase on 10 October. Following VIVAS Health's price increase, Vhi Healthcare's Plan B is now c. 18% more expensive than I / We Level 2. VIVAS Health have also recently introduced a new plan which offers almost identical benefits to Vhi Healthcare's Plan B called the Market Plan. Plan B is c. 22.5% more expensive than the Market Plan.

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 similar, but not identical products, namely BUPA Ireland's Essential Plus (No Excess) and Vhi Healthcare's Plan B Option. When comparing premiums we will consider adult group rates, net of tax relief at source. Since 1 March, 2005 BUPA Ireland's Essential Plus (No Excess) has cost €39.81 per month. Between 1 September, 2004 and 31 August, 2005 Vhi Healthcare's Plan B Option cost €43.93 per month (about 10% more expensive than Essential Plus (No Excess)). On 1 September, 2005 Vhi Healthcare increased the price of Plan B Option by 12.0% and it now costs €49.20 per month (about 24% more expensive than BUPA Ireland's product).

However, if the prices of Vhi Healthcare's new products are compared with similar BUPA Ireland products the price difference is significantly narrower. For example, Plan B Excess was priced similarly to BUPA Ireland's Essential Plus until the price increases on 1 September, when the price of Plan B Excess increased by 12.5%. Similarly we can compare Vhi Healthcare's Company Plan to BUPA Ireland's Essential Plus with an Excess. These products are similar except that BUPA Ireland's product provides full cover in the Galway Clinic and full cover for day treatment, outpatient treatment and treatment for certain heart conditions in the Blackrock Clinic and the Mater Private, while Vhi Healthcare's product does not. Prior to the price increase on 1 September, Vhi Healthcare's Company Plan was 8% cheaper than BUPA Ireland's Essential Plus with an Excess. After the increase on 1 September, the Vhi Healthcare product will be 3% more expensive than the BUPA Ireland product.

The most appropriate products to compare between VIVAS Health and Vhi Healthcare are VIVAS Health's Market Plan and Vhi Healthcare's Plan B, which provide almost identical benefits. Plan B is currently c. 22.5% more expensive than the Market Plan. Prior to VIVAS Health's price increase on 10 October, VIVAS Health's Market Plan did not exist. An appropriate comparison for the period after Vhi Healthcare's price increase on (1 September) and before VIVAS Health's price increase on (10 October) would be between Vhi Healthcare's Plan B and VIVAS Health's I / We Level 2. During this period Plan B was c. 29% more expensive than I / We Level 2; it is currently c. 18% more expensive.

The table below 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 and VIVAS Health's one price increase to date took place on 10 October. ESB SMPF increased their premiums in January, 2005.

Year	BUPA Inflation	Vhi Inflation	VIVAS Inflation	ESB SMPF Inflation	Consumer Price Index
1990 / 1991	n.a.	4.0%	n.a.	13.2%	3.4%
1991 / 1992	n.a.	5.1%	n.a.	19.4%	3.2%
1992 / 1993	n.a.	4.1%	n.a.	5.6%	3.0%
1993 / 1994	n.a.	6.0%	n.a.	3.1%	1.5%
1994 / 1995	n.a.	8.5%	n.a.	13.2%	2.4%
1995 / 1996	n.a.	6.0%	n.a.	5.3%	2.5%
1996 / 1997	n.a.	6.0%	n.a.	6.1%	1.6%
1997 / 1998	9.0%	9.0%	n.a.	6.1%	1.5%
1998 / 1999	9.0%	9.0%	n.a.	5.1%	2.4%
1999 / 2000	9.4%	9.4%	n.a.	8.2%	1.6%
2000 / 2001	6.25%	6.5%	n.a.	5.9%	5.6%
2001 / 2002	9.4%	9.0%	n.a.	7.7%	4.9%
2002 / 2003	14.4%	18.0%	n.a.	12.0%	4.6%
2003 / 2004	8.25%	8.00%	n.a.	8.6%	3.5%
2004 / 2005	6.0%	3.00%	n.a.	10.0%	2.2%
2005 / 2006		12.5%	7.5%*		

* Staff of the Authority were informed by VIVAS Health that their price increase averaged c. 7.5%. Staff of the Authority have yet to confirm this. The increase for VIVAS Health's most popular plans were in excess of 9%

Since BUPA Ireland entered the market their eight premium increases have averaged 8.9% and resulted in a total increase of 98%. Vhi Healthcare's eight increases for the same time period also average 8.9% and resulted in a total increase of 98%. It is interesting to note that these values are the same for both insurers. Vhi Healthcare premiums have increased further, on 1 September 2005, by an average of 12.5%. Vhi Healthcare is of the opinion that their current prices provide a "true community rate" to their members. However, they claim that it would not be sustainable in the absence of risk equalisation payments.

Drivers of premium inflation in health insurance include:

- 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 2004/2005. During this period, premiums per member increased by about 123%, while the cost of claims per member increased by about 96%. This provides an illustration of the effect that factors other than the cost of claims can have on premium inflation.

It is interesting to note that in 2005, for only the second time in eight years, the increase in premium per member is lower than the increase in claims cost per member. The previous time that this was observed (in 2002) may have related to Vhi Healthcare being denied their price increase in 2000, by the Minister for Health and Children.

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%
2005	13.1%	7.9%

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	7.5%	2001-2005
Ireland	9.0% ⁹	1996- 2005
UK	6.7%	1988-2003
USA	10.4%	1998-2004

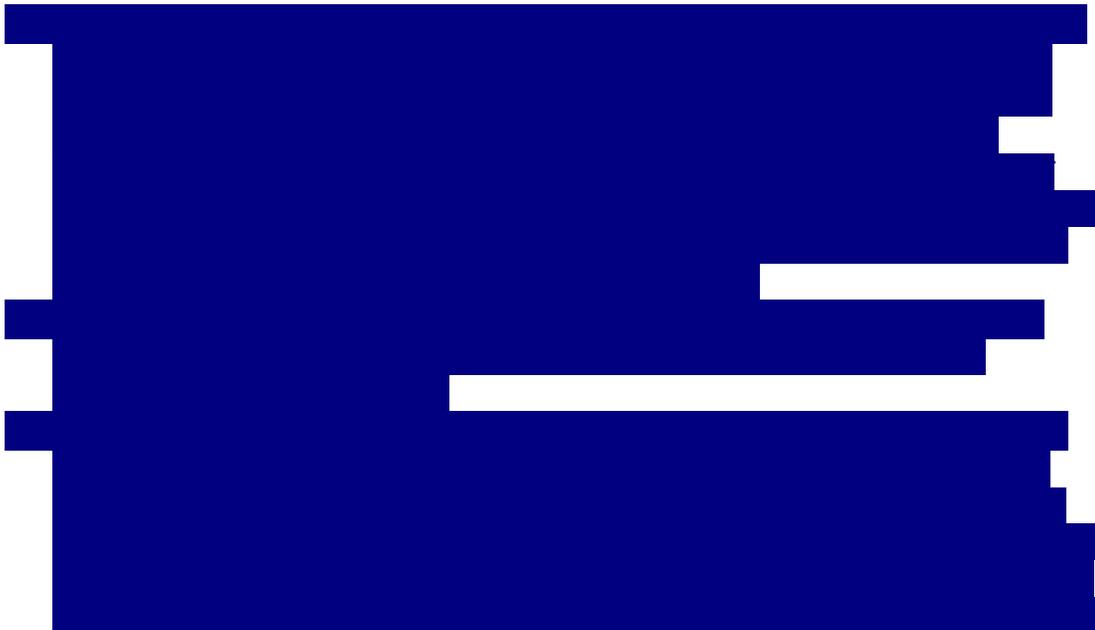
The Number of Insurers in the Market / New Entrants to the Market

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

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.]



⁹ This figure assumes that there will be no further premium increases before the end of 2005.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Possible impediments to entering the Irish market include the following:

- 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

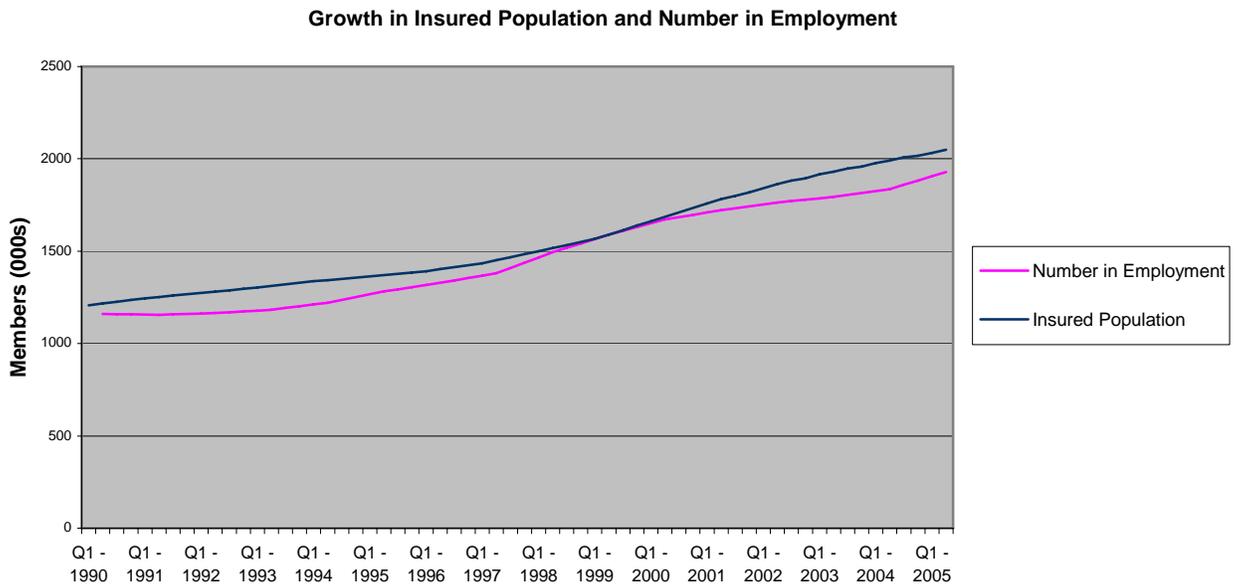
- The lack of certainty in relation to whether risk equalisation payments will be commenced and the implications that such uncertainties have for formulating business plans.

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 payments 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 51% 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.



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 €25,000 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 €25,000 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 payments would be in the best overall interests of health insurance consumers 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 payments:

- 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 payments and the commencement of risk equalisation payments 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. In particular, the Tánaiste stated the following in Dáil Éireann on 30 June:

"I want to bring a memorandum to the Government in September with a view to moving towards full commercialisation of VHI. It will take some years before companies do not have such reserve requirements and are able to meet the requirements of the Irish Financial Services Regulatory Authority which currently requires a reserve of 50%. This is particularly high when compared to the UK, where it is 20%, and Northern Ireland. We should have, at European level, a common figure for health insurers in terms of the reserve requirement. This factor clearly affects competition in the market, in particular that brought to bear by the new entrant."

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 payments.

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 rate has increased once more, although it is still significantly lower than it was in 2003 and there would not appear to be evidence of an increasing trend. Also, having reduced steadily since 2001, Vhi Healthcare’s sales have increased significantly in the 12 months to June 2005. If we look at the sales less lapses statistic we see that this has increased for the second period running. Therefore there would not appear to be evidence of a death spiral in Vhi Healthcare’s sales and lapses figures. However, the turnabout in the trends of Vhi Healthcare’s sales and lapse figures occurred following Vhi Healthcare’s 3% price increase in September 2004. Vhi Healthcare argue that this pricing strategy, while assisting them in maintaining business and winning new business will inevitably lead to financial losses. A price increase of 3% in a year would not appear to be sufficient in the context of medical inflation and there appears to be a worsening in Vhi Healthcare’s financial situation, which could lead to the instability of the market. However, in this context the question arises as to whether Vhi Healthcare would be in a position to address any such financial difficulties that may arise by changing their price strategy once more. Vhi Healthcare argue that to do so would lead to a return to increasing lapse rates and reducing sales and would in effect lead to “commercial suicide”. They say that instead they have been forced to opt for “financial

suicide” by charging a lower premium than they require. If the absence of risk equalisation payments were forcing Vhi Healthcare to opt between commercial suicide and financial suicide it would clearly be a very serious situation. However, it is worth recalling that prior to Vhi Healthcare’s 3% price increase they were making substantial profits. In this context it could be argued that it was possible for them to provide better value, without necessarily placing themselves in immediate financial difficulties. Also other options were open to them in competing with the other insurers in the market such as the very successful introduction of their LifeStage products. Finally there is not yet enough data available to be conclusive with regard to whether the current strategy that they have adopted amounts to “financial suicide as they claim.

It is true that Vhi Healthcare is losing market share but this is not necessarily contrary to the best overall 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 evidence is not conclusive that instability is imminent or will inevitably arise, the absence of risk equalisation payments in a community rated market increases the potential for market instability to arise.

Also, while it is currently not clear whether VIVAS Health 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 made profits of c. 17.3% of earned premium in 2004, before adding investment income, that it did not experience 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. This is at the ultimate expense of the Irish health insurance consumer. If risk equalisation payments were commenced, BUPA Ireland would no longer be able to adopt this strategy. 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 payments 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 health insurance 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 commencement of risk equalisation payments. Therefore, there would 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 health insurance consumers.

If we assume the following:

- Vhi Healthcare cannot maintain their current pricing strategy in the absence of risk equalisation payments and are obliged to increase their premiums if payments are not commenced;
- ESB SMPF pass on the benefit of any transfers that they receive to their members if risk equalisation payments are commenced;
- BUPA Ireland increase premiums, as predicted earlier if risk equalisation payments are commenced,

then we would estimate that the total premium paid would be lower by a factor of around 1.0% to 1.5% 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 payments 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 payments would make the market more attractive to new entrants. However, new entrants that require the absence of risk equalisation payments in order to enable them to compete would be unlikely to enter a market that could commence risk equalisation payments at some time in the future.

Basis for Competition

In the absence of risk equalisation payments, 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 health insurance consumers. Therefore the benefits of competition are more likely to be enjoyed by health insurance consumers in a

competitive community rated market with risk equalisation payments than in a competitive community rated market without risk equalisation payments.

Competition in Different Segments of the Market

In a community rated market without risk equalisation payments 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. In this context it should also be noted that BUPA Ireland announced that it would waive waiting periods for people over the age of 65 in June of 2005 at a time when the Authority had recommended that risk equalisation payments should be commenced and the Tánaiste and Minister for Health and Children had proposed to follow the Authority's recommendation.

It is true that a higher level of competition for younger people can benefit a community rated market, but even if risk equalisation payments were commenced 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 c. €25,000 payment (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 commencement of risk equalisation payments, then any such payment should be viewed in the context of the c. €16.5m payment (for the six-month period) that would have resulted if risk equalisation payments were made.

Intergenerational Solidarity

As noted, BUPA Ireland benefits from the community rated market, in the absence of risk equalisation payments. BUPA Ireland customers also benefit. The new strategy adopted by Vhi Healthcare in relation to the sale of the LifeStage products may mean that these members of Vhi Healthcare also benefit from risk segmentation in a community rated market without risk equalisation payments, as these customers may receive better value for money than those that choose not to move or to continue to purchase Vhi Healthcare's more traditional plans. Such segmentation of risks, whether within a particular insurer or between different insurers in a community rated market without risk equalisation payments reduces the extent to which intergenerational solidarity operates in the market

and is a move towards risk rating. Each member of a plan whose members have a higher risk profile funds a higher proportion of the total risk in the market than do members of plans whose members have a lower risk profile. If risk equalisation payments were commenced, the total risk in the market would be shared more evenly across insured persons in line with the principle of intergenerational solidarity, so that, the premiums of plans whose members have a higher risk profile would not have to increase further to compensate for the absence of risk equalisation payments. It is likely that the premiums of plans whose members have a lower risk profile 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 4.2% in c. 8.5 years. In the past 12 months, the MEP has grown by 0.7 percentage points, although in the past 12 months it has reduced by 0.5 percentage points. The recent volatility in the MEP appears to be largely a result of the volatility / seasonality in the cost of BUPA Ireland's membership in the 80 and over age group. This was discussed in detail in the Authority's Report to the Tánaiste for the previous period. The longer term trend would indicate that the MEP is growing at a rate of around 0.5 percentage points per annum. The view of staff that the long-term trend in the MEP 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 as well as to the relative cost of claims incurred by members within age and gender cells.
- 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 c. 21%.
- Even if some health insurance 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 unless recent changes to regulations extending open enrolment to people over the age of 65 has a significant effect.
- Of the three factors influencing the MEP the cost of claims incurred by members within age and gender cells appears to be the only one that is subject to significant random fluctuation or seasonality. If the variation in this factor over the past four periods is removed, as in Section E, the steady upward influence on the MEP of BUPA Ireland's rising market share can be seen.

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 argue 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.

Pros and Cons of commencing risk equalisation payments

Pros

- The commencement of risk equalisation payments 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 facilitated by the regulatory structure in making excess profits by adopting a strategy of price following.
- The risk of the level of excess profits growing significantly as a result of growing segmentation of risk and price following 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 instability developing would be reduced.
- The commencement of risk equalisation payments could result in a redirection of competition towards areas other than risk profile management, which would be more beneficial to health insurance consumers.
- The possibility that inefficient or profiteering insurers could thrive at the expense of health insurance consumers on the basis of their lower risk profiles would be reduced.
- Uncertainty surrounding whether or not risk equalisation payments will be commenced would be removed.
- The commencement of risk equalisation payments would result in a change to the current situation, where there are huge incentives for insurers to attract younger healthier lives and huge 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 there is no conclusive evidence of market instability. While there is evidence of a worsening financial situation for Vhi Healthcare, the evidence is not conclusive that Vhi Healthcare could not, in the short-term, at least address its worsening financial situation in the absence of risk equalisation payments by increasing prices.

- 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 payments 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 health insurance consumers.
- In any event the lower premiums in the market are likely to increase.
- 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 always deemed it necessary to comment on statements of opinion.

The representations, which were received as hard copies, were retyped verbatim so as to enable Staff of the Authority to insert any comments they may have under each relevant paragraph. Staff of the Authority did not consider it necessary or appropriate to correct misspellings or grammatical errors in the documents received.

BUPA Ireland's Representations:

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

Martin O'Rourke
Managing Director
(Authorised Agent)

3rd October 2005

Mr. Dermot Ryan,
Chief Executive/Registrar
Health Insurance Authority
Canal House
Canal Road
Dublin 6

Re: Risk Equalisation

Dear Dermot,

I enclose the submissions of BUPA Ireland Limited and BUPA Insurance Limited in response to the Authority's letter of 12th September 2005.

We do not wish to request confidential treatment of any aspect of this submission.

I regret that the Authority has not adequately responded to our letter of 16th September 2005 seeking essential information and explanation.

Finally, I should make clear that BUPA Ireland is furnishing these submissions without prejudice to any current or future objections as to 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 rights in respect of the manner in which the Authority has purported to give notice of its proposed recommendation.

Yours sincerely,

Martin O'Rourke

**SUBMISSION BY BUPA IRELAND TO
THE HEALTH INSURANCE AUTHORITY
RE LETTER DATED 12/09/05**

3 October 2005

SUBMISSION

By BUPA Ireland Limited and BUPA Insurance Limited

to

The Health Insurance Authority

in response to

letter dated 12 September

BUPA Ireland
12 Fitzwilliam Square
Dublin 2

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A. INTRODUCTION AND EXECUTIVE SUMMARY

1. This submission is furnished to the Health Insurance Authority (“the Authority”) on the same terms as the parties’ previous submissions dated 5 April 2005¹⁰.
2. Since the recent decision of the Tánaiste and the Minister of Health and Children not to commence the risk equalisation levy, the Irish health insurance market has continued to grow, with no signs of contraction or instability. The Authority’s analysis of the last set of returns reveals that once more, the MEP has fallen. Meanwhile, the European Commission has raised questions about the possible magnitude of the RES levy and its devastating impact on insurers who may be obliged to fund it.

The Authority makes no further comment on the use of the term “levy” by BUPA Ireland beyond stating that the Authority applies applicable legislation including as to provision of risk equalisation payments.

The growth in the market was considered in Section E in this report; subsection “The overall size of the market”. The trend in the MEP was considered in the subsection “Differences in risk profiles and relative sizes of insurers”.

The Authority considers that the threat to the stability of the market is undiminished and that the MEP remains on an upward trend.

The Authority operates in accordance with the legislative provisions, which have not been impugned successfully in any relevant forum.

3. Despite all of this, the Authority is proposing to recommend commencement of the levy. To that end, the Authority repeats previously contradicted and still unsubstantiated claims as to excessive profitability and inflation. In addition, the Authority tentatively introduces new claims, principally that BUPA Ireland enjoys a regulatory advantage, when the Staff Report accompanying its prior recommendation acknowledges the very significant regulatory advantages enjoyed by the VHI. In the same vein, a vague (and unsupported) claim is made in relation to the efficiency of insurers, which presumably (but unjustifiably) is directed at BUPA Ireland. Once again, ample rebuttal for the claim is to be found in the prior Staff Report, which candidly admits that all of the efficiencies achieved by BUPA Ireland in procuring treatment will be passed to the VHI by

¹⁰ BUPA Ireland Limited and BUPA Insurance Limited (“BUPA Ireland”) furnish 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 omissions in compliance or purported compliance with the provisions thereof. In addition, the parties specifically reserve their rights in respect of the manner in which the Authority has purported to give notice of its draft recommendation.

way of RES levy. The Authority still fails to compare like with like and again takes no account of differences in product lines, levels of utilisation of hospital services, or premium income.

The issue of “excessive profitability” is discussed later in this document.

The Authority recognises both the regulatory advantage afforded to BUPA Ireland by virtue of the community rating system and the advantages to Vhi Healthcare as a result of its special regulatory status. Both of these factors have been taken into account by the Authority. The Staff Report does not say that all of BUPA Ireland’s efficiencies will be passed to Vhi Healthcare as a result of the risk equalisation payments. It does however acknowledge that the application of the zero sum adjustment may result in some efficiency sharing. Staff of the Authority consider that any comparisons made in this context to be appropriate.

4. Of equal concern we note that the Authority’s by now reflexive incantation that a ‘community rated’ market is at risk of instability. That misplaced concern is exemplified by the new claims by the Authority as to what it considers to be differences in ‘risk profiles’. Of course, what the Authority is actually referring to is the inevitable and indeed innocuous difference in claims costs between insurers, whose average membership age is actually converging. The apparently innocuous shift from ‘cost’ to ‘risk’ is significant since even the most cursory consideration of risk would require an analysis not just of claims costs, but also off-setting revenues, product design and the related issue of propensity to claim.

BUPA Ireland have not demonstrated that inevitability of differences in claims costs arising should be a factor that the Authority should take into account when reaching its decision. For the reasons set out in the Authority’s proposed recommendation, Staff of the Authority do not consider that the difference in claims costs between insurers is “innocuous”. The analysis of the detailed age data provided to the Authority as part of the returns would not indicate that age profiles have converged to any significant extent over the period for which returns have been made. This matter is considered in Section E of this report, subsection “The age / sex profile of the memberships of insurers”. Staff of the Authority consider that the age profile of an insurer is an important factor in determining its risk profile.

5. It is clear from the proposed recommendation that the authority is heavily influenced by a number of reports that it has interpreted to support the need for risk equalisation. Leaving aside the questionable independence of many of them, almost all are heavily qualified. Even those that are not very old, such as that of the Society of Actuaries, come with the devastating caveat that no legal or economic expertise has been brought to bear. Regrettably, the Authority appears to have proceeded in the same way, with the crucial difference that its view is a *sine qua non* of the Minister of Health and Children proceeding to commence an enormous levy of indeterminate duration.

The reports considered by the Authority have come from experts in a variety of disciplines, including both actuaries and economists. The Authority takes due cognisance of the current relevance of any report and any qualifications in it. The Authority has taken extensive advice, including legal, economic and actuarial and acts in accordance with legislation, which has not been impugned successfully in any relevant forum.

6. In the simplest terms, the Authority is charged with answering a precise regulatory question – Is the commencement of risk equalisation in the best overall interest of health insurance consumers? In doing so, it must consider the maintenance of competition and community rating. Community rating in the form required by Irish law is working well, and there is no evidence of non-compliance by any insurer. In Ireland, insurers offer a menu of contracts which allow individual consumers to ‘self-select’ a policy most closely aligned to their preferences. In a competitive market a multitude of products will emerge and it is that phenomenon, in addition to inertia, that gives rise to differences in claims profiles. However, those differences should not, *per se*, be a source of concern to any regulatory body, including the HIA. Provided that off-setting revenue is available to meet the cost of claims and taking into account the ability to incentivise lower claims costs through product design, a better or worse claims profile (in relative terms) is not a reason for regulatory intervention. It is this simple piece of economic reasoning that has so far eluded the Authority, and which we must commend to the Authority above all else.

The Act specifically refers to having regard to the “application of community rating across the market”. It is open to the Authority to consider the market as a whole. 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”. BUPA Ireland’s analysis seems to ignore the advantage provided to insurers with a lower risk profile in a community rated market.

7. We continue to take grave objection to the Authority’s lack of analysis of the inevitable and dire effects of the levy being commenced, particularly in the absence of an adequate forward looking regulatory impact assessment. BUPA Ireland’s premiums would have to increase enormously, but the Authority simply assumes that our members, representing many of the most price-sensitive customers in the market, will continue to purchase health insurance. It is obvious that these people will be priced out of the market as BUPA Ireland’s business irretrievably contracts. Accordingly, the commencement of risk equalisation carries the double jeopardy of making no sense from a regulatory perspective while being highly regressive in distributional terms by taxing the most cost-sensitive participants in the Irish health insurance market. That is the inevitable outcome of delivering a subsidy to the VHI, an insurer capable of trading profitably, but which has now decided to behave in a way that maximises its

chances of obtaining a subsidy. A clearer example of rent seeking could not be imagined, and should not be facilitated by the Authority.

Staff of the Authority consider that the analysis that has been carried out has been thorough. It is clearly possible that some BUPA Ireland policyholders would leave the health insurance market in response to any premium increases that BUPA Ireland may implement. However, this needs to be seen in the context of considerable inertia among health insurance consumers and the continued expansion in the market when BUPA Ireland increased its premiums by 14.4% and Vhi Healthcare increased its premiums by 18%.

BUPA Ireland has not provided any updated financial data supporting their claims since the Authority's recommendation in April, despite requests for them to do so.

The Authority considered the effect of any risk equalisation transfer on premiums payable by consumers and the effect of payments on the business plans / solvency of insurers, see Section E of this Report.

In the context of the BUPA Ireland's comments, it is worth noting that in 2004 BUPA Ireland's gross underwriting surplus was 17.3% of earned premium, while BUPA Insurance Ltd made a profit of c. 5% of earned premium in the UK in 2002 and 2003. It should therefore be possible for BUPA Ireland to pay for at least some of any risk equalisation payments out of their profits, rather than asking policyholders to fund the full amount.

It is also relevant to note that BUPA Ireland's products are currently significantly cheaper than Vhi Healthcare's, (the Managing Director of BUPA Ireland referred to "26% savings" before the Oireachtas Joint Committee), although the gap is expected to reduce following BUPA Ireland's expected price increase in March 2006.

It is not the Authority's policy that more price sensitive consumers should be subsidised by less price sensitive consumers.

8. The Authority's proposed recommendation is also flawed because it is being made before the ramifications of significant recent charges to the market have been determined, including charges designed to address the dominance and privileged status of the VHI.

The Authority does not consider that it is appropriate to delay its recommendation until more is known of the effect of the new rules on the admission of those over age 65 nor for any proposed changes to the corporate and regulatory status of Vhi Healthcare.

The Authority does not consider that there is evidence that the change in regulations relating to over 65s would significantly reduce differences in risk profiles and even if this was the case, any risk equalisation payments would reduce to reflect this situation. The

other changes in Regulations are also considered in this Report, see, in particular Section D.

9. The Authority has not adequately explained the basis for the proposed recommendation, and the “reasons” it has articulated do not withstand scrutiny. Nevertheless, they will be considered in turn. In addition, the procedures adopted by the Authority are characterised by similar flaws to those identified previously.

The Authority has provided adequate reasons for its proposed recommendation and does not consider that the procedures were flawed.

B. BASIS, CONTEXT AND JUSTIFICATION FOR THE PROPOSED RECOMMENDATION

I. Basis of Proposed Recommendations

10. The Authority’s recommendation appears to be based on the following premises:

- (a) a reaffirmation of its third recommendation, which was overruled by the Tánaiste;
- (b) the alleged upward trend in the MEP and MPEA since the Third Returns;
- (c) the alleged views of “independent experts”;
- (d) the perception that BUPA Ireland enjoys some form of unfair regulatory advantage;
- (e) the perceptions that a different age mix implies a lower risk profile and that claims costs can be equated with risk;
- (f) the levy would prevent unidentified “super-normal profits” in the market;
- (g) the levy would prevent unidentified inefficiencies in the market;
- (h) VHI has more old people and old people cost more;
- (i) BUPA Ireland’s operating surplus is too high;
- (j) risk of “instability”; and
- (k) premium inflation.

The Authority provided the full reasons for its proposed recommendation in its letter of 12 September, 2005 to insurers. It is important to point out that the Authority's proposed recommendation conveyed to insurers on 12 September 2005, was based on a fresh and complete evaluation and analysis of relevant factors and was not merely a reaffirmation of a previous recommendation.

11. Before considering those issues in turn, we will consider developments since the Authority's previous recommendation, which the Authority has failed to properly address in its reasoning.

The Authority did take into account all relevant developments in deciding on its proposed recommendation and forming its reasoning.

II. The Context of the Proposed Recommendation

12. Irish consumers have not suffered without the levy¹¹ nor has it been suggested that they will suffer in the next 6 months without it. Nevertheless, the Authority appears determined to press on, irrespective of the numerous disadvantages, risks and uncertainties.

BUPA Ireland offer no evidence that health insurance consumers have not suffered without risk equalisation. However, the Authority's letter of 12 September, 2005 to insurers, setting out its proposed recommendation, draws attention to a number of areas where risk equalisation payments may benefit health insurance consumers.

13. BUPA Ireland made extremely detailed submissions on the occasion of the last returns in response to a proposed recommendation unsupported by an appropriately rigorous analysis. We request that this submission be read as incorporating those previous representations. The Authority's prior analysis has largely been reiterated despite the intervening events which vindicate those submissions. We are extremely concerned both by the lack of transparency in the Authority's approach, by the absence of any serious attempt by the Authority to re-evaluate the need for the levy in the light of the current evidence, and by the Authority's failure to adequately bring to the Minister's attention serious issues raised in our earlier submissions (including earlier representations made in response to the Authority's proposed recommendation on foot of the First, Second and Third set of Returns under the Scheme) concerning the impact of the then proposed recommendation on competition and on the best interests of consumers.

¹¹ The VHI has increased its premiums, but has repeatedly and publicly confirmed that this was not attributable to the presence or absence of the levy but to rising costs of treatment in public hospitals, a factor ignored in the proposed recommendation.

The Staff Report takes into account the latest information available. The previous representations were considered carefully by the Authority in deciding whether or not to confirm their proposed recommendation in their Report to the Tánaiste of 29 April, 2005. All previous representations made by insurers also informed the Authority's current process. The representations made following the analysis of the returns for the period ended 31 December, 2004 were included in the Report to the Tánaiste of April, 2005.

14. The Authority is legally required to provide coherent reasons for its proposed recommendations, if BUPA Ireland is to be in a position to avail of its rights. The Authority's refusal to do so is exacerbated by its failure to properly respond to our letter of 16 September 2005 seeking essential information. Such information should have been available to and disclosed by the Authority if it had had a reasonable basis for the conclusions expressed in the proposed recommendation. Our letter identified issues for clarification to enable us to exercise our right to make submissions but the Authority has not offered an adequate or substantive response.

The Authority is required to provide reasons for its proposed recommendation. It considers that it did so sufficiently in its letter of 12 September, 2005 to insurers.

15. The proposed recommendation expressly incorporates and reaffirms both its previous recommendation¹² and the Staff Report. We have made clear that we believe that the earlier recommendation and the Staff Report were flawed. The current proposed recommendation is subject (*inter alia*) to the same deficiencies as its predecessor. Throughout the latest recommendation conclusions are asserted without any reference to adequate analysis or evidence, and then subsequently reiterated as if repetition can plug the void created by the fundamental logical, analytical and evidential deficiencies in the content and structure of the proposed recommendation. In fact, the generalised assertions and hypothetical observations and the vague and imprecise language used throughout the recommendation cannot provide an adequate basis for the recommendation. Similar tentative and equivocal analysis characterised the Authority's last recommendations. This is despite the significance of the Authority's statutory function and the irreversible and serious implications of the levy being commenced.

The Authority rejects the allegation that its previous proposed recommendation and Staff Report were flawed. The letter of 12 September, 2005, including the Authority's most recent proposed recommendation, states the reasons fully and the Authority does not consider it was flawed in any way. The proposed recommendation made in September 2005 was based on a fresh and complete evaluation and analysis of relevant factors and was not merely a reaffirmation of a previous recommendation.

¹² On foot of the Third Returns under the Scheme

16. We have already referred to the fall in the figures upon which the Authority previously placed such inappropriate and unfounded reliance. Other recent events also show that it would be wrong to commence the levy but the Authority has failed to adequately address these:

- there has been no “instability” since the rejection of the Authority’s last recommendation. Nor have the other hypothetical “threats” identified in the Authority’s previous recommendation occurred;

One of the criteria considered by the Authority was the risk that instability may arise in the market. The fact that there is a risk of instability does not imply that it is bound to occur in the short-term. The risk is perceived to be undiminished since the previous recommendation.

- the Irish health insurance market continues to grow;

The growth of the market is considered in this Report, section E.

- the long term effect of the arrival of a third company, VIVAS Healthcare, has yet to be determined;

The impact of VIVAS Health has been considered in this Report. It is not possible to be certain of the long-term impact of their entry into the market. There will always be uncertainties in the market and the Authority must apply its judgement.

- the Authority’s analysis does not reflect the ending of limitations or the rights of individuals over 65 to obtain health insurance. This is inconsistent with its (in our view excessive) emphasis on the different age profiles of different insurers and its erroneous conclusion that commencing the levy would increase competition for older consumers. Our 16 September 2005 enquiries as to the Authority’s analysis of the effect of this change have not received a substantive response;

In relation to the above argument the following points are relevant:

- Staff of the Authority are of the view that currently there is not sufficient data available to come to a definitive view on the effect on the risk profiles of the change in regulations obliging insurers to accept applicants over the age of 65 who do not already have insurance. However, Staff of the Authority do not consider that the recent change to the statute will have a significant effect on the risk profiles of insurers. This view is based on the fact that those aged over the age of 65, who do not currently have insurance had chosen not to buy it before they were 65 and it is not clear why a large number of them would change their minds, especially in view of the fact that the

waiting period that may be imposed is longer than for younger people (although BUPA Ireland is currently waiving the initial waiting period for older people) and the fact that there is a financial disincentive (in the absence of risk equalisation) discouraging insurers from marketing to this group.

- BUPA Ireland may point to their recent marketing campaign and the fact that they waive waiting periods in respect of people aged over the age of 65. It is interesting to contrast this with BUPA Ireland's (and all other insurers) approach prior to the Authority's recommendation that risk equalisation payments be commenced, which was to refuse to accept applicants over the age of 65, who are not already insured, even though there was no legal impediment stopping them from accepting such people. It is relevant to consider what the effects of the Authority recommending again that risk equalisation payments not be commenced would be in this context.
- It is worth noting that despite the Authority making it clear before the Oireachtas Joint Committee on Health and Children (at which BUPA Ireland representatives were present) that if an insurer provided evidence of large numbers of people aged over 65 being recruited since the change in regulations the Authority would consider it, no such evidence has been provided.
- Furthermore, this change in the regulations had been long signalled (it was included in the 2001 Act) and therefore there was no reliance on the previous situation, whereby insurers were not obliged to accept newly insured people over the age of 65, in previous recommendations.
- Finally, if risk equalisation payments are commenced and if the change in regulations does have a significant impact on the relative risk profiles of insurers' memberships than any risk equalisation payments would change to reflect this.
- new regulations have been introduced to change the scheme, but the authority has not explained the impact of such changes on its analysis;

The changes in the Scheme are not considered to have a significant impact on the case for and against the commencement of risk equalisation payments.

- the government has pledged to introduce legislation to address deficiencies in the health insurance market, including the commercial status and regulatory exemptions of the VHI with a view to creating a level playing field in terms of solvency requirements, and possibly

taking steps both to privatise the VHI and end the concentration of the market in its hands;

The Authority has considered the possibility of changes in relation to the regulatory status of Vhi Healthcare and this subject is referred to in Sections D (“Proposed Changes to the Commercial Status of Vhi Healthcare”) and E (“The Commercial Status of Insurers”) of the Staff Report, September 2005.

- the Authority apparently now concedes that the levy is not required to address possible “predatory pricing” or “death spiral” issues¹³ as suggested in its last report;

The Authority still considers that the commencement of risk equalisation payments could be used to address possible predatory pricing and a resulting death spiral. However, the available data on premium rises appears to indicate that BUPA Ireland may be adopting a policy closer to price following.

- the Authority acknowledges that the figures on which it relies are subject to random variation;

The Authority has been cognisant of the fact that the data is subject to random variation and perhaps also to seasonality, and has made allowances for such effects in its analysis. The fact that the figures are subject to random variation and possibly seasonality does not, in the Authority’s view, undermine the judgement it has made.

- the European Commission has been publicly reported as having queried the proportionality of a levy which would be in excess of the payer’s operating profits. This is a strong signal to the Authority that it must exercise its discretion to propose commencement in conformity with EC law;

No communication or ruling has been conveyed by the European Commission to the Authority to the effect that it has not acted in accordance with EU law. The Authority continues to operate its mandate in accordance with the provisions of applicable law, which have not been successfully impugned in any relevant forum.

- the latest research commissioned by the Authority has not suggested any market instability. To the contrary it demonstrates the absence of any basis for regulatory intervention; and

As already mentioned, the Authority has not suggested that market instability exists now. However, it considers that the risk of market instability arising is undiminished. To wait until market instability is imminent or will inevitably arise may be too late to intervene.

¹³ At least this seems to be the gist of its remarks on the issue - the Authority fails to state its position clearly.

- the Financial Regulator has published its most recent report on the insurance industry, which do not support any contention that BUPA Ireland's profits can be regarded as excessive.

It appears that BUPA Ireland considers that the indications in the IFSRA Insurance Review that Non-Life Insurers in Ireland made profits of 18.4% of earned premium in 2004 is evidence that their profits in 2004 of 17.3% of earned premium were not excessive. However, Staff of the Authority and the Authority's actuarial advisers agree that comparisons with general insurers writing other classes of business, whether in Ireland or elsewhere is less appropriate than comparisons with other health insurers. One particularly relevant point in this context is the volatility in the results for the insurers writing other classes of business. In particular, the table below is relevant in describing the relative volatility of the returns for BUPA Ireland and Non-Life Insurance business in Ireland.

	Underwriting Profit as a percentage of earned premium for BUPA Ireland	Underwriting Profit as a percentage of earned premium for Non-Life Insurance business in Ireland.
2004	17.3%	18.4%
2003	17.9%	11.9%
2002	16.6%	-1.4% (a loss)
2001	21.2%	-14.9% (a loss)
Direct Unweighted Average	18.25%	3.5%

A more appropriate comparison would be with other health insurers, including with BUPA Insurance Limited. BUPA Insurance Limited's operating profit was just over 5% of earned premium in 2003 and just under 5% of earned premium in 2002. We also include details of US Insurers overleaf:

US Insurers

Insurer	Time Period	Net Income	Revenue	Net Income as a % of Revenue
		\$m	\$m	
UnitedHealth Group	Q2 2005	809	11,100	7.3%
	Q1 2005	779	10,890	7.2%
	Q3 2004	698	9,860	7.1%
	Q2 2004	596	8,700	6.9%
	Q1 2004	554	8,100	6.8%
Highmark BC/BS	2004	339.4	8,900	3.8%
	2003	105.8	8,600	1.2%
Aetna	Q2 2005	409.7	5,500	7.4%
	Q1 2005	424	5,430	7.8%
	Q4 2004	300.7	5,200	5.8%
	2003	933.8	18,000	5.2%
Blue Cross / Blue Shield	2003	6100	182,700	3.3%
Anthem	2003	935.2	20,400	4.6%
WellPoint	Q1 2004	611.7	11,000	5.6%
	2003	774	16,700	4.6%

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. It is also 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 16.6% and 21.2%.

17. The Authority's current proposal appears driven by its evident concern to reaffirm its previous recommendation and its reflexive commitment to commencement of the levy rather than by an independent analysis of the current position or any assessment of the significance of these important changes. Indeed, the proposed recommendation engages in acrobatics in an attempt to downplay inconvenient facts, rewriting its earlier recommendation in the process¹⁴.

¹⁴ To avoid facing the impact of the declining MEP and MPEA on its earlier reasoning, the Authority continues to assert an analysis premised on "an upward trend" despite all evidence to the contrary. This is discussed in Section C1 below.

The Authority rejects the suggestion that it is simply reaffirming its previous recommendation. In particular, it is satisfied that it has adequately reconsidered the matter in the light of current circumstances.

The clear implication in this paragraph is that the motive of the Authority, in making its proposed recommendation, was one of self justification for inappropriate reasons outside its statutory remit, and this is rejected entirely by the Authority.

18. Despite the fact that it can review the situation at six monthly intervals, the Authority continues to show unseemly and inexplicable haste in recommending the levy immediately, rather than allowing for sufficient time to elapse so as to evaluate the impact of recent developments and so as to build up a sufficient body of data to avoid the impact of seasonality, random variations, anomalies or the other acknowledged distorting factors. It also seems to ignore the fact that once the levy is commenced, short of revocation of the Scheme, payments will go on in perpetuity.

The Authority is satisfied that there is adequate information on which to base a decision. In particular, it considers that the data is sufficient to support the view that the MEP is on an upward trend. Furthermore, if a decision were to be deferred in order to build up a greater body of data, the Authority would need to bear in mind the potential adverse effects of this, for example in increasing the risk of market instability.

The Authority rejects the allegation of “unseemly and inexplicable haste in recommending the levy immediately”. The conduct of the statutory process is prescribed by the Health Insurance Acts. As to the allegation that, on foot of that process, the Authority would seek to recommend at an unduly early stage in the development of the market the commencement of risk equalisation payments, the Authority rejects that. The Authority made its proposed recommendation for the bona fide factors already stated by it in its letter of 12 September, 2005 to insurers. All relevant factors have been fully and properly considered by the Authority.

19. It would be entirely inappropriate in the light of the recent developments and in advance of the pending legal and commercial developments, for the Authority to recommend commencement now, nor has any adequate justification for such haste. The proposal is particularly irresponsible given (*inter alia*) the major areas of uncertainty, the fact that it is based on data which it has acknowledged to be subject to seasonal and random variations(not all of which are identified or acknowledged by the Authority), and because such intervention is proposed before the effect of recent developments can be fully measured.

As already noted, the Authority is satisfied that there is adequate information on which to base a decision.

20. We also object to the proposed recommendation on the basis of the inconsistent approach adopted by the Authority, frequently making conclusions or considering matters without any analysis or evidence or in respect of issues beyond its remit, while ignoring highly material matters on other occasions, including developments noted above. The Authority ignores matters which are clearly highly relevant to its assessment of the statutory criteria and repeatedly bases its recommendation on perceived policy goals which are far removed from the issues delegated to it for assessment.

Staff of the Authority are satisfied that the analysis carried out was adequate and meaningful.

Here, as elsewhere, e.g. paragraph 15, BUPA Ireland makes allegations of such a sweeping and general nature, and lacking in specificity, as to make it practically impossible for the Authority to consider them.

III Justification for proposed recommendation

21. BUPA Ireland has consistently mentioned and demonstrated that risk equalisation is not a necessary or logical feature of the Irish health insurance market. As such, we can perceive of no situation where the commencement of the levy would be warranted. The Authority has sometimes indicated that it is not for it to call into question why provision has been made for risk equalisation, but in this proposed recommendation, and in its last recommendation, the Authority has clearly asserted the need for risk equalisation in policy terms, which in turn appears to weigh heavily upon its proposed recommendation to commence the levy. While we doubt that this is a valid way for any regulator to proceed, it necessarily requires BUPA Ireland to once more address the claims that risk equalisation (or for that matter its commencement) is objectively necessary as a matter of public policy.

The Authority's assessment of the need, or otherwise, for the commencement of risk equalisation payments has been assessed in accordance with the requirements of legislation, in particular having "regard to the best overall interests of health insurance consumers".

22. Ireland operates a system of community rating which prevents insurers engaging in "risk rated pricing". That is not in any way affected by the fact that the Authority makes its recommendation with reference to the need to maintain community rating "across the market". Otherwise, that would permit the Authority to use risk equalisation to attempt to achieve a form of community rating not required by law. It is for the Oireachtas, not the Authority to decide on the appropriate form of community rating. If one accepts, however misguided, that risk equalisation was introduced to support community rating, then that can

only be to support the form of community rating currently on the statute books. Regulation must not be used as a backdoor method of amending primary legislation.

The Act specifically refers to having regard to the “application of community rating across the market”. It is open to the Authority to consider the market as a whole.

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”.

23. The abiding theme in the Authority’s proposed recommendation and its prior recommendation is that somehow, a “community rated” market is not stable. The apparent source of that instability is inevitable differences in claims profiles. However, such differences are the unavoidable result of differences in product design, inertia and pricing. As it happens, those age profiles are gradually, but steadily converging as BUPA Ireland’s existing members get older, and as it attracts more older customers. In statistical terms, the market may have already passed the point where the difference in the average age of members was greatest. As those ages converge even further, any concern (which for reasons stated below are misconceived) must surely lessen. The Authority’s latest research demonstrate the continue convergence the age profiles of the VHI or BUPA Ireland and the proposed recommendation clearly requires re-evaluation on this ground alone. Moreover, the convergence is not captured in the MEP which could increase by reason of a range of factors unconnected with any difference in “risk” profiles.

The Authority’s analysis is concerned with differences in risk profiles. This will be related to the claims profile, but that will be affected by other factors such as product design. The aim of risk equalisation payments is to offset differences in risk profile, and with an HSW of zero, this focuses on risk differences due to the age and gender profiles of each insurer’s membership.

In the longer term, it will be expected that the age profiles of BUPA Ireland and Vhi Healthcare should gradually converge. However because any convergence is expected to be gradual, it is still expected that the MEP will continue on an upward trend, at least in the short to medium term, if risk equalisation payments are not commenced. This is because of the expectation of continued growth in the market shares of newer entrants.

Even if the age profiles of the insurers start to converge more rapidly, the impact of the difference in profiles can still grow in the context of the market as a whole if the sizes of the insurers also converge. This is, in effect, what is being measured by the MEP.

Any change in risk profiles of insurers would be reflected in the value of any risk equalisation payments, should payments be commenced.

24. It is important to emphasise that only a difference in risk profile might warrant regulatory consideration where it arose inevitably from the operation of legal requirements. However, RES does not measure risk, it measures differences in the claims costs profiles. Significantly, the Health Insurance Acts, in providing for the adoption of a risk equalisation scheme, makes reference to “the nature and distribution of insured risks among undertakings”. Therefore, it is inconceivable that as part of its analysis, the Authority would not consider risk in all of its dimensions, in addition to calculating the MEP in accordance with the scheme. To date the Authority has failed to do so. The consequences of this failure are very serious for BUPA Ireland. It repeatedly faces claims that it enjoys a superior risk profile to the VHI, when all that can be fairly said is that BUPA Ireland has a less favourable claims cost profile than the VHI. A less favourable claims cost profile does not mean that VHI has an unfair proportion of risk. In the insurance context, risk is the complex interaction of revenue, claims cost and propensity to claim (which in turn is affected by product design). One insurer may have a higher proportion of older people than another, but if it is in a position to recover sufficient premiums to cover likely claims costs, then in no way can it be said to be disadvantaged. Regrettably, the Authority refuses to consider any of these issues, most especially the issue of off-setting revenues, so as to arrive at an informed view of risks.

The references in the legislation to “conditions specified in the Scheme related to the nature and distribution of insured risks amongst the registered undertakings” relate to the value of the MEP.

Age and gender are clearly two key determinants of the insurers’ risk profiles, and with an HSW of zero, it is differences in the age and gender profiles that risk equalisation seeks to address. It therefore seems entirely appropriate to focus on age and gender for the purpose of the analysis. BUPA Ireland refer to whether an insurer has, or has not, been disadvantaged. However, this is not the criterion that the Authority must adopt, which is the “best overall interests of health insurance consumers”.

The Authority also considered the range of other matters outlined in this Report and did not confine itself to deliberations in relation to the MEP.

C. RESPONSE TO THE DISCERNIBLE REASONS FOR PROPOSED RECOMMENDATION

I. “Upward Trend” in the MEP and MPEA

25. The Authority goes to great lengths to avoid the fact that the recent fall in the Market Positive Equalisation Adjustments (“MPEA”) and the Market Equalisation Percentage (“MEP”) undermines its analysis. The Third Recommendation was based on the assertion of an “upward trend” in those figures but the Authority fails to accept that the fall in those figures undermines

its central premise. Instead, it embarks on extraordinary manoeuvres to adjust the figures and show that “*down*” is “*up*”. These extend to retrospective adjustments to earlier results and a novel (although unexplained) attempt to “*smooth*” the figures, a process never before evidenced in the Authority’s reasoning and which the Authority has failed to explain, despite our request that it should do so.

The Authority does not consider that there is any discrepancy between their expectation that the MEP is on an upward trend, and the latest fall in the MEP. Indeed the Authority’s choice of the word “trend” following the analysis of the returns for the period ended 31 December, 2004 implied that there would be occasions when the MEP might fall. It is not the case that a variable with an upward trend must increase in every period.

While the Authority has never previously smoothed the MEP figures in its Report, it is not a novel approach to attempt to smooth figures that are subject to random variation and/or seasonality, with a view to *inter alia* discerning underlying trends. Moreover, the approach adopted was clearly explained in the Authority’s letter of 12 September, 2005 to insurers.

The Authority’s view that the trend in the MEP is upward is based on the following.

- The MEP has increased from 0% to 4.2% 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.
- If a comparison is made of consistent periods in the calendar year, it is seen that 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. Similarly, the MEP has grown from 3.5% in the first half of 2004 to 4.2% in the first half of 2005.
- 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, in particular because of variations in the amount paid by BUPA Ireland in respect of settled claims, especially 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.

26. The Authority now seems to be arguing that it always knew that the MEP should have been 4.0% last time round, not 4.7% as quoted in its provisional and final recommendation, and that it expected that the figure would be 4.2% this time round, (a prediction that does not appear from the documents themselves). The Authority has failed to indicate the “true” MEP this time round, i.e. allowing for anomalies and “random variations”, nor has it indicated the extent of the predicted future “trend”.

These points have largely been covered above. The “true” level of the MEP is as defined in the legislation, although this will be subject to some random and seasonal variation which was the reason for calculating a “smoothed” value with a view to removing this variation.

27. Our previous submissions¹⁵ noted that the Authority attached undue significance to these figures. The current returns bear this out. The Authority still attaches far too much weight to the supposed upward trends, but this is now even more indefensible given the decline in the figures. Appendix 1 shows the cartwheels performed by the Authority to avoid the evidence of the latest returns. The Authority argues that there is still an upward trend in the MEP, despite its fall, because it actually should have been lower last time round (once allowance was made for the anomaly of our high payments to some over 80 patients). However, this allowance was **not** actually made by the Authority at the time in the reasons for its recommendations, even though the Staff Report had noted the anomaly.

The MEP and MPEA relate to the value of the transfers and so if they are large and are passed on to consumers, they are relevant with respect to the best overall interests of health insurance consumers. The MEP/MPEA is only one of a number of factors that the Authority considers in deciding whether or not to recommend the commencement of risk equalisation payments.

The points about the upward trend have already been answered.

It is not correct that the Authority did not make allowances for random variation in the cost of BUPA Ireland’s policyholders aged over 80, in its Report to the Tánaiste of April 2005. In particular, see Section D, subsection “Significant Changes in returns”, of the Staff Report incorporated therein, in which it was stated “0.7 percentage points of the rise in the MEP can be attributed to the increase in costs for the 300 BUPA Ireland policyholders aged over 80... as this is such a small number of policyholders this could be subject to random fluctuations which could have a significant effect on the MEP”.

As in the discharge of its other functions, the Authority has bona fide discharged its duties in accordance with the applicable legislation.

¹⁵ In response to the proposed recommendation dated 15 March 2005 on foot of the Third Returns under the RES (submissions dated 5 April 2005).

28. Even leaving aside the fact that the current results belie the predictions underlying its analysis, the HIA still attaches unwarranted significance to the two figures¹⁶:

- (a) it ignores the fact that the MPEA will increase irrespective of any differences between insurers due to external factors (such as medical inflation);

While the MPEA will be affected by medical inflation, the MEP should not be.

- (b) although (retrospectively) allowing for one major anomaly applicable to the last returns, the Authority fails to allow for anomalies affecting the current figures;

Staff of the Authority seek to identify any material anomalies that affect the figures; however no such anomalies have been found for the latest set of returns, nor do BUPA Ireland identify any. The calculation of smoothed figures is also considered helpful in determining whether there are any significant anomalies in the current set of returns.

- (c) although now casually mentioning that the figures are affected by “*random variations*” and despite our request for clarification¹⁷, the Authority does not quantify their effect; nor does it consider their impact on its prediction of an “upward trend”;

It is not possible to fully determine the level of random variation and therefore it is not possible to quantify its effect with certainty, nor does the Authority do so in its last Report to the Tánaiste. The Authority does not consider that random variations affect their view that the MEP is on an upward trend.

- (d) the Authority ignores the impact of the changing size of the market on the figures;

The Authority does recognise the effect of the changing size of the market, although the MEP would be unchanged if the market increased uniformly for all insurers. The increasing market share of newer entrants (in the context of an increasing overall market) is a fundamental point in the Authority’s view that the MEP is on an upward trend.

- (e) the Authority ignores the impact of the propensity of different market segments to avail of hospital services with varying intensity and the impact of such differences on the calculations;

Although there are many factors that will affect the insurers’ risk profiles, the risk equalisation calculations with an HSW of zero only seek to remove the effect of differences in age and sex profile, and this is therefore the focus of the analysis.

¹⁶ See our submissions on the Third Returns paragraphs 51 to 59 in particular.

¹⁷ By letter dated 16 September 2005.

- (f) the Authority ignores the extent to which the changes in the figures reflects changing medical technology and treatment patterns and with some treatments having changed fundamentally, along with the duration of any associated hospitalisation; and

Medical technology and treatment patterns will influence the risk equalisation calculations, but this will be a second order effect, since, as already mentioned, the calculations aim primarily at equalising the effect of differences in age and sex profiles.

- (g) the Authority also ignores the fact that the MPEA will increase as BUPA Ireland's market share increases, irrespective of any change in age/gender profiles.

This is a reason for the Authority's view of an upward trend in the MEP. Growth in the MEP and MPEA for whatever reason is important because, as mentioned above, if payments are commenced and the resulting transfers are large and are passed on to consumers, they are relevant with respect to the best overall interests of health insurance consumers. The Authority notes that medical inflation, as well as the growth in the overall market, affects the value of the MPEA. For the avoidance of doubt, this point is being made more explicit in the main body of this report.

29. The figures prove little and certainly do not demonstrate any case for intervention. However, the Authority's reliance on the "upward trend" in these figures is misplaced for an even more fundamental reason – the statutory criteria are the best interests of consumers rather than any fluctuations in these statistics.

The MEP and MPEA relate to the value of the transfers and so if they are large and are passed on to consumers, they are relevant with respect to the best overall interests of health insurance consumers. The MEP and MPEA are also an indication of the significance of the difference in risk profiles and are therefore relevant when considering the regulatory advantage held by insurers with lower risk profiles and the effects that this might have on competition in the market, the risk of instability arising and other matters affecting the best overall interests of health insurance consumers as outlined in this Report.

In this context, the Authority has a right to determine what is in the best overall interests of health insurance consumers.

30. The returns to date do not show an upward trend. They do show that:

- there is insufficient data to discern meaningful trends. The Authority itself admitted this previously¹⁸ but now appears determined to ignore its earlier reservations although they have been borne out by subsequent events;

¹⁸ From page 8 of the Authority's report dated 28 April 2004. This point was reiterated verbatim in the Authority's report of 27 October 2004.

More data is available now than was the case in 2004. The Authority considers that there is now sufficient data to determine a meaningful trend.

- it is irrational to predict “trends” given the limited information available, including the fact that in two of the four returns the MEP fell;

The Authority considers that the information available is sufficient. The existence of an upward trend does not rule out the possibility of occasional falls, particularly where there is seasonality in the data.

- it is irrational to determine trends when a single factor, such as BUPA Ireland’s payments for members over 80 years, can have such a distortive effect;

The analysis carried out by the Staff of the Authority seeks to identify the effect of distortions. The fact that the distorting effects were recognised meant that appropriate account could be taken of them in the Authority’s deliberations. Furthermore, the upward trend in the MEP is primarily linked to the growth in BUPA Ireland’s market share and this is not likely to be affected by random or seasonal variation.

- it is inappropriate for the Authority to discount the significance of a fall in the MEP and MPEA by attempting to discount the distortive effect of the over-80’s on the last occasion, when it did not adopt that approach in the recommendation at the time, even though the Staff Report had noted the anomaly;

The latest fall in the MEP does not affect the Authority’s view that the MEP is on an upward trend. When the distortion affecting the over 80s age group was identified this was taken into account in the Authority’s deliberations and the view was still that there was an upward trend.

- it is irrational to predict trends given the Authorities own acknowledgement of “seasonal fluctuations” and “random variations” or to assume that such “random variations” and “seasonal variations” are immaterial without any analysis of the impact of such factors on the figures on which the Authority essentially bases its recommendation (even leaving aside the suitability of using these as indicators in the first place); and

The upward trend in the MEP is primarily linked to the growth in BUPA Ireland’s market share and this is not likely to be affected by random or seasonal variation. The Authority recognises the possible effects of random variation and seasonality and is cognisant of these when deliberating on whether or not risk equalisation payments should be commenced.

- it is inappropriate to recommend a levy when the payment figure would be seriously skewed by acknowledged anomalies, seasonal and random variations and other distorting factors.

It is true that random and seasonal variation would affect the payments actually made under the Risk Equalisation Scheme. However, these variations are a function of the underlying insurance business to which the insurers are already subject. In addition, the random and seasonal variation should cancel out in the longer term.

31. The bizarre attempt to “smooth” the figures appears to be a desperate attempt to shore up a discredited analysis. The Authority has failed to give a meaningful explanation as to what it has done and why. The deficiencies in its approach in this regard are identified in Appendix 2.

The Authority considers that the smoothed values of the MEP are a useful method of attempting to remove the effect of random and seasonal variation in order to indicate the underlying movement in the MEP. The approach was also approved by the Authority’s actuarial advisers, the UK Government Actuary’s Department.

II. Independent Experts’ Reports

32. The Authority tries to rely on the views of “many other independent experts, that Risk Equalisation payments are normally appropriate in a community rated market with open enrolment and lifetime cover”. Such reports are of little relevance because Irish law does **not** provide for a “community rated market” but rather for the community rating of individual products. The Authority has ignored the extent to which such reports were based on theoretical models of **community rated markets** fundamentally different to the **community rated product model** provided for under Irish law.

BUPA Ireland seem to ignore that the Act refers to having regard to the “application of community rating across the market”, which suggests that risk equalisation should be considered in the light of the market as a whole. BUPA Ireland is not correct in stating that the Authority relies on the expert reports referred to. Rather it uses its judgement to guide it to those areas of these reports which are relevant to the performance of its functions. Furthermore, the reports referred to were specifically prepared in the context of the Irish market, rather than some unrelated theoretical market. Where reference is made to the reports the Authority would take the view that those reports are still relevant.

33. In any event, we do not accept the existence of a consensus supporting the levy in the current circumstances and note that much the same body of historic opinion did not prevent the Authority from advising *against* commencement on two earlier occasions. Furthermore, the Authority has ignored significant opinions to

the opposite effect, including views expressed by former Minister, Mr Des O'Malley, by Professor Ray Kinsella, by economist Sean Barrett, and by the Director of Consumer Affairs. The Authority's (selective) reference to such opinions is an abrogation of the Authority's duty to form its own views and suggests a preconception on the part of the Authority that the imposition of the levy is only a question of timing. Any such approach would be entirely inconsistent with its statutory requirements. The Authority's simplistic reference to the reports also entirely fails to take account of the reservations, qualifications and countervailing factors expressed in those reports. Specifically:

- both the Competition Authority and the report of the Advisory Group on Risk Equalisation ("the Harvey Report") acknowledged that risk equalisation is a barrier to entry in the Irish market;
- the Harvey Report stated that the RES "...*should not result in any health insurer having to share profits which it has made as a result of its own efficiencies and cost controls*" and that "*it is imperative that the need to protect the stability of the market does not dampen the will to promote effective competition*". Moreover, the Harvey Report itself relies on a number of submissions claiming that risk equalisation was necessary to underpin community rating but neither they nor the Harvey Report provides any analytical support for this claim;
- The Society of Actuaries admitted that it had not undertaken any economic assessment of the impact of risk equalisation;
- Mercer, who we understand to be the original architects of the Risk Equalisation Scheme 1996, a fact which may of itself influence their thinking on this matter, recognised as recently as 27 June 2005 that the market is more attractive to new entrants without provision for risk equalisation. Mercer determined that they could not advise the Minister to commence risk equalisation payments at that time, and there is no reason to suggest that their views have subsequently altered in that regard.

The Authority accepts that there are conflicting opinions about the appropriateness of risk equalisation, and it has taken all formal submissions it has received into account in reaching its proposed recommendation. The Authority is satisfied that the submissions received cover a wide area of expertise (including actuarial and economic) and does not consider that the fact that the Society of Actuaries may not have included economic analysis or indeed that the Competition Authority may not have undertaken actuarial analysis to be particularly surprising. The Authority's letter of 12 September, 2005 to insurers includes the reasons for the proposed recommendations and the Authority strongly disagrees with the suggestion that it had any preconceptions as to the appropriateness of commencing risk equalisation payments.

The Authority took due account of the potential disadvantages of commencing risk equalisation payments, in particular the impact on competition and the possible sharing of efficiencies.

34. Secondly, it is impossible to treat such reports as an up to date analysis of the current Irish market or a recommendation that the levy is now required. The Authority has ignored the time elapsed since the publication of the documents it cites. Its analysis should have been based on rather more contemporary information, and on the basis of expert research and up to date analyses of the short medium and long-term impact on the levy. However, the Authority has not referred to any such analysis of the effects on the Irish market of the imposition of the levy over the next 3 to 5 years. Instead, the Authority relies on selective references to past reports, underscoring the absence of any proper prospective analysis of implications of the levy in the current market. The Authority has not undertaken any up to date analysis of the effects on consumers if the levy was to be imposed in the current environment. Since the proposed recommendation was published, the Authority has published a report in September 2005 from Insight Statistical Consulting commissioned by the Authority. That report reinforces these submissions (and indeed our earlier submissions) by demonstrating the continued growth and stability of the market, the continued high level of consumer satisfaction, the continued effect of inertia on switching behaviour but also the slightly increased propensity of older customers to switch insurers and the continued narrowing of the age gap between the VHI and BUPA. These findings and the findings of the earlier Annual Report themselves demonstrated the inappropriateness and prematurity of the proposed recommendation.

The reports were prepared over the period since 2002. BUPA Ireland do not indicate how these reports have become out dated in that time. The Authority would in any case be cognisant of the current value of any report. Furthermore, this Report considers the prospective impact of commencing risk equalisation payments, while recognising that any future projections are subject to considerable uncertainty.

The Authority does not consider that the report from Insight Statistical Consulting in any way undermines the Authority's reasons for its proposed recommendation. Indeed in relation to matters such as the growth in the market and the age gap between insurers the Authority has more detailed and relevant information available to it from returns, which was considered before its proposed recommendation.

III. “Regulatory Advantage”/Competition for Older, Higher Risk Customers

35. The Authority advances the extraordinary suggestions that BUPA Ireland enjoys a “*regulatory advantage*” and that the levy could “*level the playing field*”. The Authority has, again, lost sight of the statutory criteria but its reasoning is flawed for other reasons as well. BUPA Ireland has no such “advantage”.

Staff of the Authority consider that the regulatory advantage to which the Authority refers in its letter of 12 September currently enjoyed by BUPA Ireland is clear. In a community rated market, an insurer's price for each contract will normally be struck with reference to the expected claims profile of the holders of that contract, which will be heavily influenced by the age and gender profile of those members. Clearly in the absence of risk equalisation, an insurer with significantly lower risk profile will be in a position to, *inter alia*, adopt strategies outlined in the Authority's Policy Paper of 2002 and numerous other Authority documents, which have been made available to insurers. This constitutes an advantage, which they would not have if the market was not community rated and which would be significantly reduced if risk equalisation payments were commenced.

36. The Authority has not addressed observations by its staff in the April 2005 Staff Report, which are directly relevant to the question of perceived "*regulatory advantages*," and which categorically identify the VHI as the only insurer enjoying regulatory advantages over other insurers.

"VHI Healthcare is exempted from the requirements of non-life directive in 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 pressure from VHI Healthcare. An example of VHI Healthcare's willingness to take advantage of its regulatory position is evidence from its stated policy of keeping premiums low (they claim it through community rate) or 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 different 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."

BUPA Ireland raises the separate but important issue of the regulatory advantages enjoyed by Vhi Healthcare. This was considered in the Staff Report (see sections B.5 and E "Commercial status of insurers").

The advantages held by insurers who have lower risk profiles in a community rated market were also referred to throughout the Authority's April Report.

37. It is not clear what “*advantage*” BUPA Ireland is supposed to have, but there are references to the (predictable) fact that VHI has proportionally more old people and the Authority notes old people tend, on average, to generate greater claims costs. Such an age differential did not lead the Authority to recommend commencement on two earlier occasions, and it has failed to explain its change of position, now, as the gap actually continues to narrow. The Authority does not deal with the fact that the average age of our new customers is, we believe, greater than the corresponding figure for the VHI. In any event, the Authority is implying an unfair criticism of BUPA Ireland for facts not of our making, beyond our control, and not to our advantage. Far from amounting to a regulatory advantage, differences in claims profile are an inevitable market outcome, which as we have repeatedly outlined do not warrant regulatory interference.

Staff of the Authority accept that in the current structure of the market it is likely that the age profile of BUPA policyholders will be lower than that for Vhi Healthcare. The Authority is not criticising BUPA Ireland for this difference. However, the Authority is concerned that where differences in age profiles exist, there can be detrimental effects on the best overall interests of consumers including the facilitation of competition in a community rated market and the maintenance of community rating as outlined by it in its proposed recommendation and other documents, e.g. its Policy Paper of 2002.

As already discussed, the Authority considers that the MEP is on an upward trend. This view is based partly on the expectation of continued growth in BUPA Ireland's market share, which will be only partially offset by any narrowing of the age profiles between the insurers.

38. Our age profile is an inevitable fact of life for a new entrant. It reflects our comparatively brief time in the market, our product mix and market inertia. When we launched in Ireland, our ability to build a customer base depended on growing the market, primarily by attracting first time buyers of health insurance. Having been here for less than a decade it is not surprising that our age profile should be somewhat younger than the VHI, which has been here for a half century. Moreover, by underpricing its higher plans (purchased by older people), VHI has been able to lock BUPA Ireland out of this market segment. Inevitably, BUPA Ireland's plans have had the most success in attracting the most price sensitive customers, who tend to be younger.

The Authority is not criticising BUPA Ireland for having a younger age profile. However, differences in age profile have implications for the best overall interests of health insurance consumers in a community rated market, which was the reason for enacting the risk equalisation scheme. As required by the legislation, the Authority must

consider whether to recommend the commencement of risk equalisation payments, having regard to the best overall interests of health insurance consumers.

39. The Authority's own research shows that:

- (a) existing health insurance customers remain slow to switch insurers;
- (b) the rate of switching is about 1% per annum;
- (c) older people are generally more reluctant to change insurers but evidence is beginning to emerge of a slightly greater willingness for consumers in this group to switch; and
- (d) even a significant difference in premiums might not be sufficient to persuade significant numbers to switch insurers. Although VHI premiums remain higher, switching has been very low. Such inertia represents a significant barrier to new entrants¹⁹.

None of these points changes the position whereby BUPA Ireland does have a younger age profile than Vhi Healthcare.

40. It is absurd to suggest that the VHI is under a "disadvantage". It still benefits from the effective monopoly it enjoyed until 1996, giving it the best established brand with a loyal following of some 1.56m subscribers representing circa 80% of the market. It has reserves of €386 million according to its last annual accounts in 2005 (i.e. its general reserves of €282 million plus other technical provisions of €104 million). The VHI is free to match our products and prices with new more competitive offerings if it chooses. In reality, the VHI has the pre-eminent position in the Irish market still and would not seek to change places with BUPA Ireland (i.e. exchange our respective customer bases in their entirety, including their respective premium income as well as their age and gender profiles).

This does not mention the impact of having a higher age profile and the Authority considers that this is a disadvantage to Vhi Healthcare as a result of having to operate in a community rated market.

The Authority's consideration of any advantages held by any insurer in the market is in the context of the best overall interests of consumers and the regulatory structure of the market. In this context, the relevant advantages to Vhi Healthcare that BUPA Ireland refer to are considered in this Report.

¹⁹ Insight Statistical Consulting's September 2005 Report for the Authority confirms earlier work by Amárach on all of these issues.

41. The Authority ignores the fact that there cannot be a “level playing field” given our comparative “disadvantages” through

- (1) not having been in the Irish market as long;
- (2) never having been a monopoly;
- (3) not having such a well established brand in Ireland or anything approaching the value of the incumbent’s goodwill here, more particularly its huge, long established and loyal customer base;
- (4) not having its 50 years experience in the Irish market (or the benefit of premiums over that period by its long-established customer base);
- (5) not having the incumbent’s greater resources and financial power in Ireland;
- (6) not having any exemption from solvency requirements;
- (7) not having the incumbent’s dominant position in the market;
- (8) our limited access to nearly 80% of the market due to market inertia;
- (9) deriving a significantly lower average premium per member;
- (10) lacking the VHI’s economies of scale.

These points were considered in the Staff Report. However, in practice, many of these “disadvantages” are the same point - that BUPA Ireland is smaller and less established in the Irish market than Vhi Healthcare. BUPA Ireland presumably derives advantage as part of a major multinational. It is not clear that having a lower average premium per member is necessarily a disadvantage since it will depend on a wide range of other factors, including the terms of the policies sold, the age profiles etc.

BUPA Ireland was aware of a number of these “disadvantages” prior to its entry to the market and also the Government’s legislative provisions for risk equalisation.

42. The Authority’s references to the claims costs for older people are misleading because the Authority still fails to consider countervailing factors benefiting the VHI, such as its significant higher average premium income, its dominant position, its even greater market penetration in terms of the more expensive products which give rise to both higher premiums, and disproportionately higher claims costs due to the increased frequency and intensity of claims by customers availing of those plans, **irrespective of age and gender.**

These are factors that the Authority has considered. It is not clear what significant advantage Vhi Healthcare might derive from having a large penetration of the market for more expensive products (assuming this is true), if it is the case that such products have disproportionately high claims costs. It should be noted that with an HSW of zero, the risk equalisation calculations do not attempt to equalise the effect of differences in the propensities to claim that are unrelated to age and gender differences.

43. It is unlikely that, absent BUPA Ireland, the VHI would have introduced the innovations and extensions to cover which it eventually introduced in response to the competitive pressure from BUPA Ireland. Nor is there any evidence that, but for BUPA Ireland, the VHI would have itself attracted the hundreds of thousands of first time buyers who have chosen to avail of lower premium increases and better cover. Nor would the VHI have reduced its rate of premium increases but for competition. The VHI's history as a monopolist suggests the reverse, as does the fact that even with competition, it charges higher premiums than we do. Without competition, the VHI might well have a similar number of customers, and a broadly similar age and gender profile, as now. It would probably be charging higher premiums, particularly for the low priced plans. It would still offer less extensive cover, just as it did during its time as a monopoly.

The advantages of competition are recognised in this report, see in particular Section B "Risk Equalisation and Competition". However it is worth noting that the arguments above relate to past events and are largely conjectural. The criterion that needs to be applied is how the commencement of risk equalisation payments might affect the best overall interests of health insurance consumers.

The growth in the market following BUPA Ireland's entry to the market has also been considered, see in particular Section E "The Overall size of the Market". The increase in the labour force since BUPA Ireland entered the market and the correlation between this growth and the growth of the health insurance market is also considered in this subsection.

Again it is important to note that the Authority's consideration of any advantages held by any insurer in the market is in the context of the best overall interests of consumers and the regulatory structure of the market.

44. The fact that we have grown the market by attracting first time buyers of cheaper health insurance products and have developed our own customer base does not imply a "regulatory" advantage which somehow requires us to subsidise the VHI with its long established brand and massive market share, much less the ESB employees scheme. It is irrational to penalise BUPA Ireland either for the age/gender profile of the VHI's existing customers or for the fact that, as a new entrant, we inevitably attract a lower age profile initially, a situation which will change over time, a trend already apparent from the Authority's own research.

Just having a younger age profile does not imply a regulatory advantage – it is the interaction of this with the regulatory requirement for a community rated market that creates the advantage. Risk equalisation payments are neither a subsidy nor a penalty – they are legislatively prescribed payments designed to correct a regulatory distortion in the market in the best overall interests of health insurance consumers.

45. The Authority also hints that BUPA Ireland benefits from the absence of effective competition other than the VHI. However, research has shown that the main obstacle stopping other potential new entrants is the threat of the levy. If it is being suggested that we obtain a regulatory advantage because the levy provisions deter new entrants, then it would be both perverse and unfair for BUPA Ireland to be criticised and penalised for the consequences of a measure not of our making, of doubtful validity and which we have consistently opposed. It does not make sense to recommend the commencement of the levy on this basis. Furthermore, the solution to any such “advantage” arising from the lack of new entrants would not be to impose the levy for the benefit of the incumbent but rather to take measures which would encourage further entry. The levy would have the opposite effect.

It is not being suggested that BUPA Ireland enjoys a regulatory advantage because the risk equalisation scheme discourages new market entrants. The interaction between new entrants and risk equalisation is a complex matter and the Authority gives this consideration. See in particular Appendix 3 part 6 for the views of York Health Economic Consortium in relation to this matter.

The reference to the alleged “doubtful validity” of the legislation is noted. As stated previously, the Authority operates all applicable legislation, none of which has been impugned successfully in any relevant forum and all of which enjoys, inter alia, the benefit of presumption of constitutionality applicable to all legislation whose enactment postdates the Constitution of Ireland 1937.

46. The Authority assumes that our different age/gender mix implies excess profits but ignores the reality that our major competitor is charging higher premiums than we are. The Authority wrongly equates age distribution and claims costs with risk, ignoring other, equally material elements of the underwriter’s assessment of risk, including the profitability of its current products, with its age/gender mix. The recommendation expresses concern about the “*level of competitive pressure on insurers with memberships with favourable risk profiles*”. This observation is flawed because it treats claims costs as a proxy for risk profiles without considering other equally relevant underwriting data such as the relative size of the undertaking, and the level of premiums being charged. The assertion that the levy will be beneficial in terms of competitive pressure on insurers with memberships with favourable risk profiles, i.e. BUPA Ireland, is bizarre because a

levy in excess of BUPA Ireland's operating profits would clearly render BUPA Ireland uncompetitive. Secondly, nowhere in the draft report is there any meaningful analysis of the need for competitive pressure to be exerted on the VHI with its high prices and dominant market position. Thirdly, the Staff Report acknowledged that the levy would force us to increase our premiums although it seriously underestimated the extent to which we would need to do so²⁰. In fact, as the Staff Report recognised, the levy would clearly relieve any competitive pressure on the VHI and would thus be contrary to the best interests of its own consumers and indeed consumers as a whole.

BUPA Ireland would of course have been aware that there was provision for risk equalisation payments in Ireland when they entered the Irish health insurance market.

While there will be a range of factors that affect each insurer's risk profile, the age and gender profile will figure significantly amongst these and, with a HSW equal to zero, if payments were to be commenced, it is the age and gender profile that the Scheme would endeavour to equalise and that the Authority is specifically required, by statute, to analyse. The significant size of the risk equalisation contributions (with an HSW of zero) demonstrates the importance of differences in the age and gender profiles.

The commencement of risk equalisation payments would increase competitive pressure on BUPA Ireland since it would no longer be able to rely on a younger age profile in order to achieve profitability. BUPA Ireland has not demonstrated that the payments would render their operation uncompetitive. However, if BUPA Ireland is unable to compete on this basis, it might suggest that it is inefficient or has unrealistically high profitability requirements.

In this Report it is estimated that BUPA Ireland would need to increase its premiums by about 12% in order to achieve a gross underwriting surplus of 5%. It is recognised that this is an indicative calculation only since the estimates are subject to significant uncertainty, but the Staff of the Authority consider that these calculations still provide a useful measure. In this context, it is worth noting that BUPA Ireland, in their presentation to the Joint Committee on Health and Children on 29 September, 2005 referred to savings of 26% compared with Vhi Healthcare's premiums.

In reaching its proposed recommendation, the Authority has considered the possible weakening of competitive pressures on Vhi Healthcare as a result of commencing risk equalisation payments.

BUPA Ireland has previously acknowledged inertia among consumers in the market. This inertia has been previously borne out by the continued growth of the market and in

²⁰ Due to unrealistic assumptions, such as an implicit assumption that our present and future customers would accept the increase, on top of any other increases which might be required and that an increase would have immediate effect for the entirety of the relevant financial period, and due to a failure to allow for significant factors such as the accruals necessary to address levy liabilities and the fact that our levy liabilities would be likely to increase rapidly outstripping our probable profits.

BUPA Ireland's market share, following the 14.4% and 18% premium increases by BUPA Ireland and Vhi Healthcare respectively in 2002/2003.

47. There is no suggestion that older people are finding it difficult to find insurances or that they are being priced out of the market. Indeed this seems unlikely, however, given the relatively small number of consumers who have switched from the VHI despite its higher premiums. The ability of older consumers to obtain insurance has been enhanced as a result of our lower premiums. The Authority refers to the desirability of competition for older members as a justification for the levy but fails to consider the extent to which this policy goal has been addressed by the recent legislation.

The Authority has not stated that older policyholders find it hard to obtain insurance or are being priced out of the market. However, in a community rated market without risk equalisation there is a greater incentive for an insurer to sell its policies to younger people rather than older people and there is therefore a greater incentive for insurers to compete for younger people. This situation is not affected by recent amendments to legislation. The comment that Vhi Healthcare have higher premiums is somewhat at odds with the comment in paragraph 38 that Vhi Healthcare underprice the plans purchased by older people.

48. BUPA Ireland has programmes aimed at older policyholders, a fact apparently overlooked by the Authority. These include the appointment of Ronnie Delaney as its effective "Ambassador to the Aged", promotions aimed at older consumers, including a free health check for older consumers worth circa €500. Given the legal restraint of product community rating rules, it is difficult to see what else we could do to encourage older customers, and the Authority has not indicated what it has in mind. The Authority's own research shows how difficult it is to encourage consumers to switch health insurers, particularly older consumers. Given the regulatory constraints and the practical effect of market inertia insurers have limited scope to persuade greater numbers of policyholders of any particular age bracket to switch to them.

The Authority notes the existence of these programmes, although BUPA Ireland's own comments seem to indicate that they believe they may have limited impact in changing the age profile. However, it is important to point out that risk equalisation is not designed to correct any action (or inaction) by any of the insurers. It is rather a mechanism for correcting a distortion created by the regulatory regime of community rating. Therefore, the introduction of programmes to encourage the purchase of health insurance by older policyholders does not directly affect the case for and against the commencement of risk equalisation payments and the Authority does not consider it appropriate to delay any recommendation until these programmes have taken effect. If BUPA Ireland's programmes aimed at older members succeed in bringing its age profile much closer to Vhi Healthcare, then the amount of their risk equalisation contribution should reduce.

IV. Prevention of “Supernormal” Profits

49. The proposed recommendation repeatedly hints that the levy might prevent possible “supernormal” profits and encourage insurers to be competitive. This seems strange since the levy would be paid to the more expensive insurers. The Authority has previously stated that the levy was not intended as a form of price regulation²¹, but now the Authority proposes to operate it as such. Any such approach is flawed – the solution to supernormal profits if they exist (which we dispute) would be greater competition (which is being prevented by risk equalisation), whereas the levy would have the opposite effect. The proposed recommendation does not explain how the Authority determines “supernormal profits” or whether the Authority has actually concluded that “supernormal profits” are in fact being earned in the Irish market. Furthermore, the Authority wrongly assumes that if there are supernormal profits being earned, RES will remove them and no more. Having made provision for risk equalisation supposedly as a reserve power the Oireachtas would surely be surprised to discover that risk equalisation is being turned into a profit confiscation and redistribution mechanism.

This paragraph seems to ignore the link between age profiles and profitability. The Authority agrees that competition would help address supernormal profits which are facilitated by the regulatory regime and impact negatively on the best overall interests of consumers and it considers that the commencement of risk equalisation payments would serve to enhance the effectiveness of competition in the market. The Risk Equalisation Scheme is not a “profit confiscation” mechanism but is intended to enhance the best overall interests of health insurance consumers, which are clearly influenced by any existence of such supernormal profits.

50. Although it does not include any economics based analysis of BUPA Ireland’s profitability, or of the impact of a levy on future profitability, the Authority does advance a crude calculation that BUPA Ireland succeeded in “*making an operating surplus of circa 17.3% of earned premiums in 2004*”, which it compares to BUPA’s profits of circa 5% of earned premium in the United Kingdom, observing that “profits are ultimately funded by customers”. The Authority seems to attach some importance to the latter comment since it is actually articulated twice in the recommendation but it is difficult to see the relevance of the rather trite observation, since, as the Authority should understand, the profits of any commercial enterprise are ultimately funded by its customers. To the extent that profitability of insurers is being compared, account should be taken of the extent to which the insurer’s products are directed at different market sectors, and also any start-up losses incurred on new business ventures (such as travel and dental) would need to be excluded. While BUPA

²¹ Staff Report page 106.

Ireland believes that any such analysis is of very little relevance it challenges the Authority's suggestion that BUPA Ireland's operating surplus is unusually high. This claim is not borne out by an examination of the Financial Regulator's Insurance Statistical Review 2004, published just after the proposed recommendation.

It is true that profits are ultimately funded by consumers, and therefore any profits over and above those required to encourage the insurer to enter the insurance market would be an unnecessary drain on consumers. Staff of the Authority recognise that there are many factors that influence an insurer's profitability, but consider that BUPA Ireland's estimated surplus of 17.3% of earned premium is significant in the context of BUPA Insurance Limited's profits of about 5% of earned premium in 2002 and 2003.

Comments made in respect of paragraph 16 in relation to comparisons of profitability are also relevant.

In the context of the discussion of profitability, it is important to note that the Authority is only concerned with supernormal profits to the extent that they are facilitated by the regulatory regime and impact negatively on the best overall interests of consumers.

Despite requests, the Authority has not received updated financial information for this period from BUPA Ireland.

51. We do not accept that it is appropriate to compare BUPA Ireland's small, comparatively newly established, business to our large, long established business in the UK. The comparisons drawn by the Authority are commercially naïve, failing to allow for the fundamentally different business dynamics and the fact that newly established health insurers' claims patterns are likely to be lower initially but to progressively increase, as indeed is happening to us in Ireland. Our Irish business is in a fundamentally different market position to that of our UK parent, or, indeed, the VHI and comparisons of percentage profits are misleading given the different scale of BUPA Ireland as compared to BUPA in the UK, or indeed as compared to the VHI. The Authority fails to consider the fact that 5% in the context of the VHI's operations, or BUPA's UK business, may be a far more attractive return than a higher percentage of a much smaller volume in the context of BUPA Ireland's much smaller business. The reality is that, insofar as the difference between premiums and claims are concerned, the actual contribution per BUPA Ireland member is lower than that of their counterparts in the UK.

An expanding insurer may have a different profitability profile from a stable, long established company. For example, claims might be reduced as a result of waiting periods and underwriting (although formal underwriting is not possible in the Irish market and in any case is not so relevant to group business), but on the other hand acquisition expenses might depress profits. Nevertheless, Staff of the Authority still

consider that the comparison of profitability is relevant and appropriate, particularly given the large difference between BUPA's profits in Ireland and the UK. The review of the profitability of US health insurers included earlier (see paragraph 16) also suggests that BUPA Ireland's surplus is considerably in excess of what might be expected (although there are issues in making fully consistent comparisons).

In the previous paragraph, BUPA Ireland make reference to the higher costs for newly established businesses and they also previously referred to the disadvantages of the lack of economies of scale, which would be expected to reduce the profits of newly established businesses.

52. The allegation of excess profits is also meaningless in the absence of any meaningful analysis of the relationship between recent increases in the various insurers' premiums and claims inflation. Moreover, since the VHI is on record as to its intention not to raise its prices to the level required to cover claims costs and to run down its cash reserves to the point of bankruptcy, and yet, even with this stated policy of uneconomic pricing its premiums are still significantly higher than ours, it is difficult to see any credible basis on which our profits can be described as "excessive".

Staff of the Authority are satisfied that the analysis that has been carried out has been meaningful.

The fact that BUPA Ireland believes that Vhi Healthcare (with lower operating expenses as a proportion of earned premium than BUPA Ireland) is priced "uneconomically", despite being "significantly" more expensive than BUPA Ireland, which is making large profits, is an indication of the extent of the regulatory advantage held by BUPA Ireland by virtue of its lower risk profile.

V. Inefficiencies

53. The proposed recommendation suggests that the levy may prevent inefficiencies. Once again this does not provide a coherent reason for the proposal. The Authority has not indicated whether such inefficiencies actually exist nor, if so, their extent, the reasons for such inefficiencies or how the levy would prevent them. Nor has it identified the insurers responsible for such inefficiencies.

It is not for the Authority to prescribe the level of efficiency that an insurer should reach. However the Authority is concerned that the regulatory regime may facilitate more inefficient insurers competing with more efficient insurers by virtue of the fact that they have a lower risk profile in a community rated market.

As was stated in the Authority's letter of 12 September, 2005 to the insurers, "the regulatory advantage afforded to insurers with significantly lower risk profiles could also

facilitate inefficient insurers in competing with insurers with high risk profiles.” This would not generally be in the best overall interests of health insurance consumers and therefore the Authority considers that it is appropriate to take measures that help avoid such inefficiencies arising.

54. If the references to inefficiencies are aimed at BUPA Ireland, they are factually flawed. For example, the Authority’s own recent Staff Report noted that our average cost per treatment day is about 17% lower than the market cost, and that this may be due (inter alia) to better efficiencies. In addition, the Staff Report observed that the levy would share the benefits of our efficiencies with less efficient companies like the VHI:

“If full risk equalisation payments were being made, BUPA Ireland would be required to pay about €500,000 more than it would have 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” and “Part of the €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 the sharing of efficiencies.”

For the period ended 30 June 2005, BUPA Ireland’s average cost per treatment day (as estimated from the risk equalisation returns) is about 14% lower than for the market as a whole. However, it is difficult to draw firm conclusions from this, as the average cost will depend on factors other than pure efficiency, for example contract terms and the treatments being offered.

The “Zero Sum Adjustment” may result in the sharing of efficiencies and differences in health status (other than those related to age and gender) between insurers (see Section E “The Zero Sum Adjustment and its Effect on the Sharing of Efficiencies”). For the period ended 30 June, 2005, if risk equalisation payments had been commenced, BUPA Ireland’s full risk equalisation contribution would be about €25,000 more than it would have been if the transfer had been purely based on its own level of efficiencies and its own health status within age and gender groups.

55. The Authority ignores the fact that the levy would discourage greater efficiency in the healthcare sector, instead recommending the levy in circumstances where its own research shows that it could discourage efficiencies by removing the competitive pressure on the VHI to introduce efficiencies and by forcing BUPA Ireland to share the benefits of its efficiencies with its larger competitor and the ESB employees scheme. To put it another way, BUPA Ireland and its customers reduce claims costs through insurance products. Their customers may choose to pay a lower premium and to forego certain non-essential treatment or to undertake

it on a more cost-effective basis or to bear some treatment costs themselves by way of excesses, thus incentivising more efficient claiming behaviour, a factor ignored by the RES.

In reaching its proposed recommendation, the Authority has had regard to the possible reduction in competitive pressure on Vhi Healthcare as a result of commencing risk equalisation payments. It is not the intention of the Risk Equalisation Scheme to equalise the efficiencies between insurers, for example those relating to differing contract terms, such as excesses, although, as already mentioned, there may be some sharing of efficiencies through the Zero Sum Adjustment.

56. By contrast, commencing the levy would blunt the incentives for the VHI to reduce costs and force new entrants to share their efficiencies thereby reducing the incentives to achieve these efficiencies in the first place.

The Authority has considered the reduced level of competitive pressure on Vhi Healthcare and the possible limited sharing of efficiencies.

57. The Authority's flippant comment that our inability to pay suggests that we must have been operating inefficiently is as ill considered as it is offensive to BUPA Ireland, and its circa 430,000 customers and 234 staff. It is also at odds with the evidence referred to above. It is nonsense to suggest that we must be inefficient if we are not able to pay a levy greater than our profits, in favour of a competitor four times our size, charging premiums higher than we do. It is unfair for the Authority to make such assertions without having regard to the impact of premium income for the different products or the other factors referred to above.

The Authority's view is shared by York Health Economics Consortium, who stated the following:

“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.”

VI. “Instability”

58. The Authority refers to *“the risk of instability arising”* and advocates the levy as a pre-emptive strike. The Authority does not suggest that the market is unstable, or likely to become so in the foreseeable future. Nor, despite repeated requests, does it say what it means by *“instability”* or why the levy is needed now.

It is considered that the Authority's Policy Paper, which was referred to in the Authority's letter of 12 September, 2005 to the insurers provides an adequate indication of what is meant by the term "instability".

59. In fact, competition offers the best way to ensure a flourishing health insurance market for the benefit of consumers. The number of health insurance consumers has grown very significantly since 1995, a phenomenon attributable largely to the competitive dynamic brought to the market by BUPA Ireland, and attendant expansion and improvement in the VHI's plans. The VHI's reserves have increased by circa €300 million during the same period. Although the Authority now seems to accept that no "death spiral" is imminent, it still proposes the levy to forestall possible "instability". Once again, the Authority's recommendation is flawed. There is no evidence that any "risk" of "instability" has increased since the Third Returns. The numbers of consumers availing of health insurance continues to increase, albeit slower than previously, and according to the most recent reports commissioned by the Authority, currently stands at 52% of the population. The market is operating satisfactorily without intervention. The experiences of the last 6 months, and indeed, the last decade, show there is no need for the levy to prevent "instability".

The Authority has not stated that the risk of instability has increased. The Authority stated in its proposed recommendation that it was its view that the *"risk of market instability arising in the community rated market in the absence of risk equalisation payments is undiminished since the Authority made its recommendation to the Tánaiste in April, 2005."*

60. VHI's premiums have gone up, but that reflects rising healthcare costs, not the absence of the levy. The VHI complains about falling profits but this reflects its pricing policy and is not a reason for intervention. The Authority has failed to carry out any meaningful analysis as to the adequacy or otherwise of recent VHI price increases, in particular its 3% increase in 2004, and the amount of revenue foregone by virtue of its failure to set premiums so as to adequately cover rising medical costs. In any event, the profitability of the VHI is not the issue. The statutory criteria are the best interest of consumers, not those of the VHI. In reality, the VHI was in a far worse financial position a decade ago and was required to trade out of its difficulties without a subsidy or intervention. It is perfectly able to do so today. It can set premiums commensurate with the risk associated with the customers who will choose particular product. Last year, the VHI, in an extraordinary outburst, expressed its determination not to increase its premiums in the absence of the levy and, according to the Irish Times *"warned the Government it is prepared to go bankrupt rather than charge the premium increases it needs to survive"* and that it would *"run down its cash reserves by refusing to charge the extra premium needed to cover the additional costs of its*

older customer base”²². It is most disappointing that this strategy now appears to be paying dividends in terms of its impact on the Authority’s thinking.

Levels of profitability and pricing strategies were amongst the factors that were considered in assessing the risk of market instability.

The Authority would take issue with the third and subsequent sentences dealing with the profitability of Vhi Healthcare. Specifically, the standard prescribed in law is not that of the profitability of any one insurer, but rather the permissible features in the Health Insurance Acts (the best overall interests of health insurance consumers) to which the Authority has had careful regard.

61. The Authority should heed the observation in its own Staff Report that:

“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 pressure from VHI Healthcare. An example of VHI Healthcare’s willingness to take advantage of its regulatory position is evidenced from its stated policy of keeping premiums low (they claim it through community rate) or 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.”

This is an issue that has been taken into account by the Authority.

Coincidentally, this extract from the Staff Report shows the very “forward regulatory impact assessment” of which BUPA alleges a lack in the process undertaken by the Authority both in the previous Staff Report and in the processing of the current set of returns, as set out in the Authority’s letter to insurers of 12 September, 2005.

62. Nevertheless, the Authority suggests that one of the reasons for its proposed recommendation is that, although VHI retains a circa 80% market share and continues to grow and to attract new subscribers, BUPA Ireland and VIVAS Health are attracting “*a significant proportion of the total sales in the market*”. This is scarcely surprising in circumstances in which the VHI’s premiums are higher than BUPA Ireland, however, it is not a legitimate reason for the Authority to recommend the levy. It is predictable in a competitive environment that more of the new subscribers are likely to be attracted to the more competitive products. The Authority’s approach to this issue and its concern for “stability” appears to be directed to a perception that its function is associated with the preservation of the

²² Irish Times 30 April 2004.

incumbent's position rather than to encouraging competition or to the best interests of consumers.

The fact that more favourable risk profiles facilitate lower prices which in turn attract the better risks is precisely what the Authority hypothesised in its Policy Paper of 2002 and which contributed to concerns in relation to the best overall interests of health insurance consumers.

The distribution of new sales is relevant in assessing how risk equalisation payments might affect competition. The Authority rejects any suggestion that it considers "... its function is associated with the preservation of the incumbent's position...".

VII. Premium Inflation/Price Following

63. The suggestion that the levy is desirable to prevent price following appears driven by ideological dogma rather than considered reasoning, let alone evidence. The Authority has suggest that "*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*". However, the Authority fails to take due account of the price differential between BUPA Ireland and VHI premiums, which are generally higher. The Authority ignores the actual savings which BUPA Ireland offers consumers. For example, in November 1996 a family of 2 adults and 2 children selecting basic entry level products would have saved €44 per annum with BUPA Ireland. Today that gap has increased to €236. These figures are based on group rates, before tax relief.

Just because BUPA Ireland's premium rates are lower does not mean that price following is not occurring. If BUPA Ireland's premiums are set by reference to Vhi Healthcare's premiums (even if somewhat lower) rather than by reference to the underlying risk and if this situation is maintained over a long period, then it would suggest that price following is happening. The increase in the price differential between BUPA Ireland and Vhi Healthcare relates to the inflation in both sets of prices and to the fact that BUPA Ireland's prices have not yet been increased following the 12.5% increase in Vhi Healthcare's prices in September 2005.

64. The Authority has essentially repeated its mantra from its third recommendation without taking account of intervening developments including the VHI's recent 12.5% price increases which have not been mirrored by BUPA Ireland.²³ In fact, there is no basis for asserting "price following" as defined by the Authority

²³ BUPA Ireland normally would not review its premiums until March 2006. At that time the premium increase, if any, may be greater than or less than that of the VHI. (A decrease in premium seems unlikely given spiraling healthcare costs).

itself.²⁴ The assertion of price following is also flawed in the absence of a rigorous analysis of the key drivers behind premium increases for all Irish health insurance providers. The VHI has publicly stated that its recent premium increases are **not** attributable to the presence or absence of Risk Equalisation payments:

“The single biggest factor contributing to (the most recent) price increases is the increased costs of private beds in public hospitals. In January 2005 the Department of Health and Children added 25% to the cost of a private bed in a public hospital and the direct impact of this adds €47.5million or 6% to our costs. During the 3 year period from January 2003 to January 2005 the cost of a private bed in a public hospital increased by 109%. Other cost drivers contributing to the spiralling costs of healthcare are new technology developments in drugs and prosthesis, new facilities, new diagnostic procedures, and aging population, increased consumption of healthcare as well as a society which that demands top quality healthcare. These all amount to an average premium rate increase of 12.5% from 1 September 2005, without any reference to the absence of Risk Equalisation.”²⁵

Given that BUPA Ireland has not yet announced its March 2006 increase, it is hardly surprising that Vhi Healthcare’s 12.5% premium increase in 2005 has “not been mirrored by BUPA Ireland”.

65. The Authority has failed to take any meaningful account of these factors, many of which were identified long ago in the work of the advisory group on Risk Equalisation as being the primary drivers of premium inflation and which are still identified by both the VHI and BUPA Ireland as the primary causes of current premium increases. It is most disconcerting that despite BUPA Ireland having pointed out the overwhelming effects of medical inflation and the abundance of evidence on this topic in response to the Authority’s last proposed recommendation, the Authority continues to eschew any form of rigorous analysis of the issue, and instead recycles what has already been comprehensively rebutted.

The Authority recognises that there are many factors that might drive premium inflation and that many of these will affect Vhi Healthcare and BUPA Ireland in a similar way. However, given the different portfolio of business of Vhi Healthcare and BUPA Ireland, and the differences in the ratios of incurred claims to earned premiums, the historically

²⁴ The September 2002 policy paper explained that price following was when an insurer with a significantly lower risk profile chose “to set its premium at a level slightly below the premium of other insurers with higher risk profiles”. Given the significant gap, between the VHI’s premiums and ours, this would not be a fair characterisation of the current position. It would be unfair to describe BUPA Ireland as having chosen “to set its premium at a level slightly below the premium of other insurers”.

²⁵ Irish Times 8 September 2005.

similar levels of premium inflation might imply price following and a lack of competition.

Representations from all relevant registered undertakings have been considered and the Authority does not consider that its analysis has been “comprehensively rebutted”.

66. The Authority has ignored its own earlier observation that intervention may not always be appropriate to address “difficulties” in the health insurance market and that even where intervention is necessary risk equalisation may not be the appropriate or even an appropriate form of intervention to use. Notwithstanding these statements the Authority appears determined to recommend the levy, despite the fact that such intervention is manifestly not necessary, and that such a solution is not an appropriate solution, let alone “the most appropriate” intervention. While BUPA Ireland vigorously rejects the assertion of price following, it appears irrational to deal with any such perceived concern by imposing a levy on BUPA Ireland, with its lower premiums, in favour of the entity whose higher premiums it is supposedly following. There would be other more appropriate solutions to any such perceived issue, the most appropriate being to encourage greater competition by correctly determining that commencing the levy has no connection with the maintenance of community rating.

The Authority’s proposed recommendation is not inconsistent with the comments in its Policy Paper referred to by BUPA Ireland. The Policy Paper also explained the difficulties that can arise in a community rated market without risk equalisation as a result of the facilitation by the regulatory structure of insurers making excess profits by adopting a strategy of price following. If risk equalisation payments were commenced, the extent to which insurers with lower risk profiles would be facilitated in this way would be reduced.

67. The Authority also suggests the levy because price following might lead to “increasing difficulties” for consumers in being able to afford higher health insurance premiums. The Authority observed that “*for example a threat may arise if younger people either choose not to purchase insurance or allow their policies to lapse to a greater extent than older persons*”. It is not clear whether the Authority is stating that a levy is needed now to deal with such a situation or whether it is making a theoretical observation that sometimes a levy might be required for this reason. In any event, while the increasing VHI premiums may discourage some consumers, especially those less likely to need health services²⁶, the fact that its customers have not already switched *en masse* despite its consistently higher prices suggests a high degree of inertia. By contrast, a huge element of BUPA Ireland’s success has resulted from the fact that its lower premiums have attracted first time buyers of health insurance. BUPA Ireland has offered competitive products at significant lower premiums resulting in the

²⁶ See for example Jill Kerby’s Article, Irish Times 1 September 2005.

growth of the insurance market. Accordingly, any recommendation of the levy would also be misguided if it was premised on the need to avoid younger people dropping out of the health insurance market. The levy would be counterproductive in that regard. By increasing the premiums for first time buyers currently attracted by our lower prices, the Authority could deter first time buyers, creating a real market problem rather than the theoretical issue it mentions.

The Authority is concerned that an uncompetitive health insurance market could lead to unnecessarily high premiums and eventually to an unstable market because consumers would have difficulty in affording premiums. Although the commencement of risk equalisation payments would be likely to increase BUPA Ireland's premiums, it has been estimated in this Report that overall premiums might come down (provided the benefit of the transfers are passed on to consumers). Also, by creating a more competitive ongoing environment, future rates of premium increase might be contained for all consumers.

VIII. Impact of the Levy

68. It has been repeatedly acknowledged, most recently in the Staff Report²⁷ that “*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*”. The Staff Report added that it “*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 income 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*”. (Emphasis added). The current proposed recommendation has not been justified by reference to a rigorous prospective regulatory impact assessment in accordance with the principles laid down by the Irish Government.

This is a selective quotation. The Staff Report (Section B.3) goes on to explain that where there is fierce price competition without risk equalisation payments, this “... might come at the effective loss of community rating” and “the result might be a destabilising effect ... on the community rated market as a whole”. The Authority has had regard to the principles enshrined in the Department of the Taoiseach Paper, entitled “Better Regulation” insofar as is consistent with applicable legislation.

69. The Staff Report acknowledged that the levy would **not** reduce premiums but, at best, it **might** slow their increase in certain ill defined circumstances (which are in our view inapplicable in any event). It is difficult to fathom how the rate of increase might be slowed since the Authority's own analysis assumed a significant increase in BUPA's premiums to fund the levy. In such circumstances

²⁷ Page 9

the VHI (facing less competition from BUPA Ireland) would have no incentive to pass any of the levy payments to consumers. Even without risk equalisation, the VHI has maintained premium levels higher than its competitors. There is no evidence of any analysis of the impact of the levy based on meaningful projections reflecting the likely impact of the levy “over time”. The Staff Report does not even define the period it had in mind, much less link it to meaningful projections based on realistic forward looking assumptions as to developments over the next 3 to 5 years at least. The suggestion that the Authority does not consider that the levy payments would “*constitute unfair payments*” appears to ignore the statutory criteria in favour of an unspecified judgment as to what is equitable.

The April report to the Tánaiste says “the Authority would not predict ... a significant reduction in premiums ...” Later in the Report there is analysis of the effect that any risk equalisation payments might have on premiums based on certain assumptions (see Section E “The Effect of any Risk Equalisation Transfer on Premiums Payable by Consumers and the effect of Payments on the Business Plans/Solvency of Insurers”). This analysis was considered by the Authority. Risk equalisation payments might moderate future premium inflation by resulting in an increase in competitive pressure on insurers with lower risk profiles and in particular by reducing the extent to which the regulatory regime facilitates insurers in making excess profits counter to the best overall interests of consumers by engaging in price following. The inflationary effects of such “Price Following Strategies” are clearly described in the Authority’s Policy Paper of 2002. Staff of the Authority consider that the analysis carried out is adequate.

The possibility that insurers receiving risk equalisation payments may not pass these payments on to consumers was considered in this report. See, in particular, Section E, “The Effect of any Risk Equalisation Transfer on Premiums Payable by Consumers and the Effect of Payments on the Business Plans / Solvency of Consumers” and Section F, subsection “Pros and Cons of commencing risk equalisation payments”.

With regard to the Authority’s comments in respect of any risk equalisation payments not constituting “unfair payments”, the Authority came to this view on the basis that those with lower risk profiles benefit from a regulatory advantage in a community rated market without risk equalisation and that risk equalisation payments would merely seek to reduce such regulatory advantage. This was clearly outlined in the Authority’s letter of 12 September, 2005 to insurers. Moreover, such payments are not considered mutually exclusive from or inconsistent with the statutorily prescribed criteria. Furthermore, the Authority rejects the assertion that it ignored the statutory criteria “in favour of an unspecified judgement as to what is equitable”.

70. The absence of any provision for review of the levy once started increases the need for the Authority, to at least examine the probable prospective effect of the levy before recommending commencement, analysing its likely prospective impact over the next three to five years at least. We believe that, even allowing

for differences of opinions given the inherent subjectivity of future forecasting, on any reasonable analysis, it is clear that the commencement of the levy would rapidly render the business of BUPA Ireland unviable. The Authority has disagreed, but it has never advanced a meaningful analysis based on forward projections. In particular, the following variables need to be considered in order to determine whether our business would be able to sustain the levy going forward:

- (a) BUPA Ireland's projected profit levels going forward;
- (b) the premium increases that would be required to fund the levy (in addition to increases required to deal with rising medical costs);
- (c) the time required for such premium increases to flow through in any particular accounting period;
- (d) the impact of such premium increases on our ability not only to grow the market by attracting new customers, but even to retain existing customers (price elasticity);
- (e) the impact of any loss of customers due to such premium increases on our profitability and our ability to pay the levy;
- (f) the probable amount of the liability, including necessary accruals, in respect of levy liabilities both now and at the end of the initial phasing arrangements²⁸; and
- (g) the extent of any probable change in the amounts of the levy payments projected by the Authority over the next three to five years.

Staff of the Authority are satisfied that the analysis carried out is meaningful. It can also be noted that any longer term projections would be highly speculative. Claims that risk equalisation payments would render BUPA Ireland unviable need to be set alongside similar comments that Vhi Healthcare would be unviable without risk equalisation payments.

The Staff Report (section E "The Effect of any Risk Equalisation Transfer on Premiums Payable by consumers and the Effect of Payments on the Business Plans/Solvency of Insurers") states that "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".

²⁸ The Authority's limited analyses appear, inter alia, to have overlooked the need to accrue against levy liabilities, rather than dealing with payments on a cashflow basis.

The Authority's view is shared by York Health Economics Consortium, who stated the following:

“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.”

71. If the Authority had undertaken a meaningful prospective analysis, and even allowing some scope for differing assumptions, the inevitable conclusion of any realistic assessment would have been that the deficit would mount rapidly and our financial position would quickly become unviable.

BUPA Ireland have not demonstrated that this is the “inevitable conclusion” and have not provided any updated financial information in support of their arguments, despite requests. The comments made above in respect of paragraph 70 also apply.

The Authority has been conscious that, an amendment to the Scheme would be required in order to cease risk equalisation payments if they are commenced and also recognises that the Scheme provides the Authority with an ongoing role in advising the Minister for Health and Children in relation to the operation of the Scheme.

72. The claim that such a substantial levy would not be unfair is also at odds with the views expressed by the European Commission in a letter from the Internal Market division of the European Commission to the Irish Government which is reported to have communicated the Commission's view that *“a requirement to pay under the RES an amount so significant that it would force an operator to exit the market would seem to discourage other operators from entering the market and does, in any event, seem disproportionate.”*²⁹

No communication or ruling has been conveyed by the European Commission to the Authority to the effect that it has not acted in accordance with EU law. The Authority continues to operate its mandate in accordance with the provisions of applicable law, which has not been impugned successfully in any forum.

73. The assumption on page 80 of the April 2005 Staff Report that *“premiums should only rise for those insurers making payments (currently covering about 20% of the market)”* is also flawed. Firstly, it ignores the absence of any serious competitive pressure on VHI to maintain low premiums if the levy forced us to

²⁹ Report in the Irish Times entitled “Brussels supports BUPA case over risk scheme” dated 17 August 2005.

increase our rates. Secondly, it ignores the effect of premium increases on the hundreds of thousands of first time buyers of health insurance attracted by our lower premiums, and does not consider whether they would accept an increase. Since these consumers were generally not previous VHI customers, and the VHI's premiums are higher than ours, it is illogical to suggest that all such consumers would remain in the market, if our premiums were to increase. Thirdly, the suggestion that premium increases would only affect "around 20% of the market" ignores the inevitable effect of forcing an increase on the most competitively priced insurer and the extent to which this would inevitably lead to a lessening in competition throughout the market as a whole.

The Authority took into account the possible weakening of competitive pressure on Vhi Healthcare as a result of the commencement of risk equalisation payments. See Section F of this report as well as Section E. It is clearly possible that some BUPA Ireland policyholders would leave the health insurance market in response to the any premium increases that BUPA Ireland may implement. However, this needs to be seen in the context of considerable inertia among health insurance consumers and the continued expansion in the market when BUPA Ireland increased its premiums by 14.4% and Vhi Healthcare increased its premiums by 18%.

74. Finally, if the Authority is concerned that consumers are paying too much by way of health insurance premiums, its solution demonstrates the Authority's confused decision-making. The 80% of health insurance consumers availing of VHI's products are paying more by way of premium than with BUPA Ireland's products. However, the solution is in their own hands. They can switch insurers to avail of lower premiums. Regulatory intervention by way of the imposition of a levy would be heavy handed and unnecessary. It is illogical to impose a levy which would increase the premiums for the group of Irish consumers who have chosen less expensive products so as to benefit the majority who have stayed with the more expensive incumbent.

The fact that BUPA Ireland believes that Vhi Healthcare (with lower operating expenses as a proportion of earned premium than BUPA Ireland) is not priced economically, despite being "significantly" more expensive than BUPA Ireland, which is making large profits is an indication of the extent of the regulatory advantage held by BUPA Ireland by virtue of its lower risk profile.

It is not the policy of the Authority that the regulatory regime should result in less price sensitive consumers supporting more price sensitive consumers and perhaps large profits amongst the insurers of more price sensitive consumers.

75. We find it difficult to foresee any circumstances in which the commencement of the levy could be in the best interests of consumers in the circumstances of the Irish market. Nevertheless, throughout its proposed recommendation, the

Authority appears to have proceeded on the assumption that in the event of any perceived issue or problem the commencement of the levy would be the necessary and appropriate response, indeed the only possible solution and that the sooner it was introduced the better. In doing so, the Authority has consistently failed to adequately analyse the extent to which the levy would be likely to address a perceived issue, or make matters worse, or to lead to other problems. The Authority also appears to have failed to seriously consider whether any such issues could be more effectively and appropriately tackled by other means, such as by invoking its statutory power to make recommendations to the Minister on matters pertaining to the health insurance market in Ireland. The levy has not been shown to be necessary or proportionate in the absence of such an analysis. In so doing the Authority has failed to comply with the statutory obligation placed upon it and has also ignored its own observation that “*Where intervention is necessary risk equalisation may not be the most appropriate or even an appropriate form of intervention to use.*”³⁰

The Authority rejects any suggestion that it sees risk equalisation payments as the appropriate response to every issue or problem that may arise in the health insurance market.

The possible effect of any risk equalisation payments on the premiums payable by consumers was considered in Section E of this Report.

IX. Uncertainty

76. The suggestion that the commencement of the levy would be beneficial because it would have the “*consequential effect of removing any uncertainty concerning when and if Risk Equalisation payments may commence*” is bizarre. Firstly, the commencement of the levy in the current circumstances would clearly not bring “*certainty*” given the outstanding legal challenges to the validity of the Risk Equalisation provisions. Secondly, the achievement of “*certainty*” is not a rational or coherent reason for a regulatory decision of this magnitude.

This paragraph omits the obligation on the Authority to apply the Irish statutes as they stand enacted and which statutes have not been successfully impugned before any relevant forum.

77. In reality the commencement of the levy would harm competition and the best interests of consumers (and, indeed, the maintenance of community rating) by rendering the business of BUPA Ireland unviable and precipitating a contraction in the Irish health insurance market. Commencement of the levy would also further reduce the likelihood of other companies entering the market. The

³⁰ The Authority’s Policy Paper on Risk Equalisation, 2002.

Authority also ignores the fact that the possibility of an event cannot have a worse entry deterrent effect than the “certainty” of its occurrence. In the circumstances such “certainty” cannot seriously be advanced as a rational justification for the commencement of the levy.

Staff of the Authority note that the Society of Actuaries in Ireland recommended the commencement of risk equalisation payments 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.

D. CONCLUSION

78. BUPA Ireland welcomes new competition and measures designed to encourage further competition in the Irish market. Indeed one of the reasons we strenuously oppose the imposition of the commencement of the risk equalisation levy is because it would continue to stifle competition in the Irish market. We are prepared to compete on the merits for customers, and not for regulatory rents such as the levy.

The benefits of competition are recognised in this Report and the possible effects that the commencement of risk equalisation payments may have on competition are considered throughout this Report.

79. BUPA Ireland is extremely concerned that the Authority is, once more, proposing to recommend commencement to the Minister. As before, much of the Authority’s analysis is tentative in nature, and replete with oblique conjecture, as illustrated by its discussion of possible excess profitability and inefficiency, both of which are contradicted by the Authority’s own prior analysis.

The sweeping criticisms in this paragraph are rejected including by reference to material in this Report in the analysis of the BUPA submission.

80. It is most dispiriting that, in addition to facing an incoherent proposed recommendation for a second time, the Authority has repeated its refusal to explain or disclose essential elements of its analysis. As an insurer which is mindful of efficiency and cost, we cannot indefinitely commit to engaging in a regulatory process where all relevant information and explanation is not shared with us, where the most fundamental legal and economic errors appear to be repeated and where, despite our expenditure of significant resources the Authority’s output is as unaffected as if we had chosen never to attempt to avail ourselves of our statutory rights.

The Authority provided the full reasons for its proposed recommendation in its letter of 12 September and gives full consideration to all representations received under the statutory process.

81. BUPA Ireland considers the case against the commencement of risk equalisation to be compelling. The market is stable and product innovation, not least by BUPA Ireland, continues apace. The MEP has fallen and no amount of retrospective adjustments can alter that fact. Differences in claims costs and age profiles are a feature of the market, but that is the inevitable and unremarkable outcome of differences in product offerings, and the well documented inertia phenomenon. More importantly, those differences are off-set by differences in premiums and size and the gap between the average age of the two major insurers continues to shrink. Community rating is operating effectively and the existing legislative framework operates well in delivering that protection for consumers while at the same time delivering the benefits of competition especially to those previously priced out of the market. To reverse those welfare gains for society at this stage is folly. Far from being the logical concomitant of community rating, commencement of risk equalisation would lead to significant contraction of the market as well the loss of all of attendant benefits of competition. Accordingly, we urge the Authority to reverse its proposed recommendation.

These points have been covered above.

APPENDIX 1

The Authority's Re-writing of its Earlier Recommendation

A. The Authority has embarked on a contrived and contorted attempt to justify the reaffirmation of its earlier recommendation, which was premised on a predication of market trends which has not been borne out by the most recent data.

B. In its last recommendation the Health Insurance Authority stated:

“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 Authority considers the increase to be significant and is of the view that the underlying trend is upwards. Furthermore, in the Authority's view this trend is likely to continue in the absence of Risk Equalisation payments commencing.”
(Emphasis added)

C. The Authority also insisted that

“While there may be some seasonality in the data being included in returns received under the Scheme, the Authority is satisfied that the underlying trend in the MEP and the MPEA is upward and is likely to so continue. Furthermore the Authority considers that the basis for this view would not be materially affected by any seasonality in the data.”
(Emphasis added)

D. Our submissions vigorously took issue with the attempt to discern a “trend” based on three data points, on one of which the MEP actually fell (a criticism reinforced by the current results). However, the Authority maintained that “the underlying trend is upwards”.

E. In reality, the MPEA has dropped to €16.45m. The MEP has also slipped, to 4.2%.

F. The proposed recommendation attempts to downplay the disconnect between current results and its earlier predications:

“The MPEA changed little since the previous report (it has reduced from €16.7m to €16.5m). ...The MEP has reduced from 4.7% to 4.2%. In its April 2005 Report to the Tánaiste the Authority stated that it considered that 0.7% of the MEP (4.7% for the period July to December 2004) could

be attributed to the increase in costs for BUPA Ireland's policyholders aged 80 or over and that this increase may have been significantly affected by random variation. Therefore the MEP for the period January to June 2005 is in line with the Authority's views of an underlying trend of increase in the MEP. Indeed, if the effect of variation in the claims per member within age and gender cells as smoothed in order to remove any random effects in this variation then "the smoothed MEP" for the four periods to date would have been 3.7%, 4.0%, 4.2% and 4.4%... The Authority is also of the view that the factors in the April 2005 report, already circulated, on which it based its view of the trend of increase in the MEP still apply.

While there maybe some seasonality and random variation in the data being included in returns received under the Scheme, the Authority is satisfied that the underlying trend in the MEP and MPEA is upward and is likely to so continue. Furthermore, the Authority considers that the basis for this view would not be materially affected by any seasonality or random variation in the data.

In the context of any possible seasonal variation affecting returns, it is appropriate to consider the change in the MPEA over the two 12 month periods ending June 2004 and June 2005. Between these two periods the total MPEA increased from €23.4m to €33.2m. The Authority noted the alteration in the MEP as well as a small change in the MPEA, which are both fully consistent with the Authority's expectations at the time of its previous reports."

- G. This is a disingenuous attempt to retrospectively alter the basis for the Authority's last recommendation to the Minister.
- H. The Staff Report had indeed noted that the large BUPA Ireland payments to the over 80 group influenced the increase in the MEP on the last occasion and was responsible for 0.7% of the increase in the MEP on that occasion. However, it is simply not true for the Authority to suggest that this means that the current falling figures bear out its previous finding of an "upward trend". Such an interpretation is at odds with the contemporaneous documents.
- I. Notwithstanding the acknowledgement in the Staff Report of the over-80s payments, the Authority on the last occasion repeatedly emphasised and asserted a supposed upward trend in MEP and MPEA figures, and did not adjust those figures in its recommendation to exclude that element of the increase in the MEP and the MPEA attributable to the over 80s payments.
- J. The Authority recommended commencement on the basis of a supposed upward trend in the MEP and MPEA figures without allowing for the

anomalies mentioned in the Staff Report. The Authority now appears to be reinterpreting its previous reasoning, **after the event**, in order to disguise the fact that events have refuted its predictions.

The Authority does not consider that there is any discrepancy between their expectation that the MEP is on an upward trend, and the latest fall in the MEP. Indeed the Authority's choice of the word "trend" following the analysis of the returns for the period ended 31 December, 2004 implied that there would be occasions when the MEP might fall. It is not the case that a variable with an upward trend must increase in every period.

APPENDIX 2

Smoothing

The Authority's "smoothing" of the figures in its latest return is a departure from its previous practice and from the procedures actually provided for in the Scheme. It is difficult to see the basis of the new procedure in circumstances in which the Scheme itself actually included provisions supposedly designed to deal with distorting anomalies. The result of this rewriting of the rules has been to inflate the current figures, but we do not accept the smoothed figures or the importance the Authority attaches to either the actual or smoothed figures.

The Authority has failed to explain why it followed this novel procedure or the methodology involved, despite our request for clarification. The terminology it employs is not referable to the language of the Scheme and the Authority has not explained its departure in this regard.

For example, the report does not explain in clear terms how exactly the "smoothing" has been undertaken, how they have indexed the figures for inflation or other escalation. It is unclear why the Authority has sought to average a figure which would clearly be distorted by escalation/inflation rather than averaging a figure less subject to such distortions, like bednight counts per member, which would be less susceptible to such distortions than monetary values

The Authority has not indicated whether it believes that RES payments should be made under the smoothed MEP or the actual figure – this would have a significant impact on any such liability.

The Authority has not explained why it is only departing from one aspect of the regulatory formula without re-examining other aspects which are patently flawed, such as the failure to take account of premium revenues or of overheads. Nor is there any comparative analysis of the extent to which different products are aimed at similar market sectors, or of the respective revenue overheads, claims costs, product cover and age profiles associated with such corresponding products.

The Authority cannot undertake some comparative exercises but ignore other, more relevant, avenues on the basis that it has limited data available – it is the Authority's responsibility to seek additional data where appropriate.

The reason for calculating a "smoothed" series of values was to attempt to remove the effect of random and seasonal variation and thereby illustrate any underlying trend more clearly. The approach adopted was approved by the UK Government Actuary's Department.

The Authority's letter of 12 September, 2005 to insurers did explain how the smoothed values were calculated. The smoothed figures also smooth the effect of inflation but this should have less effect on the MEP (which is a percentage not a monetary value).

There is no suggestion that the risk equalisation payments should be calculated using the smoothed approach.

Vhi Healthcare's Representations:

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

Office of the Chief Executive

3rd October 2005

Mr Dermot Ryan
Chief Executive / Registrar
The Health Insurance Authority
Canal House
Canal Road
Dublin 6

Re: Risk Equalisation

Dear Dermot

Thank you for your letter of 12th September. Vhi Healthcare welcomes the proposed recommendation of the Authority that Risk Equalisation be introduced and we strongly urge the Authority to make a final recommendation to the Minister on the same terms.

I would make the following additional comments to the points which we have previously put forward:

1. The Authority's analysis in relation to the trend of the MEP is entirely consistent with our own analysis and we concur with the view that the marginal decrease in the period July to December 2004 was affected by random variation. One of the two reasons provided by the Tánaiste for rejection of the previous recommendation of the Authority, i.e. that "*deferring a decision would allow time for further corroboration of trends both in risk profile and competition in the market*", now appears to us to be fully addressed. The trend is clearly upwards. Thus the dynamic instability within the market which was clearly envisaged in the reports prepared by York Health Economic Consortium and DKM (among others) has become more evident in recent months.

It is assumed that the reference to “July to December 2004” should be to “January to June 2005”. The reduction in the MEP from 4.7% to 4.2% in the latest period may also have been a result of seasonality. In any case, rather than looking at individual periods it is more useful to also consider other matters, such as the rise of the MEP over longer periods and this was the approach taken in the Staff Report.

The Authority has not stated that there is instability in the market, although it is of the view that there is a risk that such instability could arise.

2. The second reason provided by the Minister for her decision not to introduce Risk Equalisation, relating to the commercial structure of Vhi Healthcare, was addressed in my letter of 30th August. We understand that this issue is being actively considered by the Department of Health and Children. I would reiterate that while Vhi Healthcare is in favour of the removal of its current derogation from solvency requirements, it clearly cannot become subject to normal solvency requirements until Risk Equalisation is in place.

The issue of the commercial status of the insurers is considered in the Staff Report (see Section B.5 and Section E, “Commercial status of insurers”).

3. The fact that Vhi Healthcare has a large market share is continuously raised by our competitors as a reason not to introduce Risk Equalisation. The health insurance market cannot be described as a “free market”, or properly compared to any other market for the provision of services. This is because insurers are required to operate within the constraints imposed by community rating, which is an intervention in the market. In a community rated market, a smaller market share of better risks is much more profitable than a large market share, as we have previously demonstrated. As we have outlined in detail in previous correspondence, Vhi is being financially crippled by the burden created by Community Rating in the absence of Risk Equalisation. The introduction of Risk Equalisation would create an incentive for insurers to compete for business right across the market.

Vhi Healthcare’s market share is relevant to the extent that it may affect the ability of insurers to compete effectively. The Authority recognises that community rating offers a regulatory advantage to insurers with significantly lower risk profiles. Although this may affect relative profitability, this is only relevant where the differences are such that they affect the best overall interests of health insurance consumers. It has not been established that “Vhi is being financially crippled” by community rating without risk equalisation, although it is acknowledged that there is a greater risk of instability arising in a community rated market without risk equalisation, as previously articulated.

4. We strongly agree with the Authority's analysis that the regulatory advantage being afforded to insurers with a lower risk profile (such as BUPA Ireland) does not benefit the best overall interests of health insurance consumers. Rather, it facilitates such insurers to make windfall profits at the expense of health insurance consumers generally, as we have consistently pointed out.

The Authority considered a number of factors in determining whether the commencement of risk equalisation payments would be likely to be in the best overall interests of health insurance consumers. The analysis of the regulatory advantage that some insurers may enjoy through the application of community rating was just one of those factors.

5. We now call up on the Authority to apply Health Status Weight as an additional factor for the purpose of its evaluation and analysis in respect of future returns, having regard to the material differences in claims experience as between insurers.

This is an issue for the Authority that is currently under review and is separate from the decision on whether or not to recommend the commencement of risk equalisation payments.

I am readily available to provide any further information you may require.

Kind regards.

Yours sincerely

Vincent Sheridan
Chief Executive

VIVAS Health's Representations

Received from VIVAS Health, Oliver Tattan, *Chief Executive Officer*

Mr. Dermot Ryan

Chief Executive/Registrar
The Health Insurance Authority
Canal House
Canal Road
Dublin 6.

3 October 2005

Dear Mr. Ryan,

I refer to your letter dated 12 September 2005.

VIVAS Health was disappointed and dismayed to read the recommendation of the Authority which failed to take account of any of the previous comments made by VIVAS Health.

This is not correct, as evidenced by the Authority's Report to the Tánaiste of April 2005. The Authority gave careful consideration to the representations from all insurers that were received in response to the previous proposed recommendation.

As a new entrant into the health insurance market VIVAS Health cannot continually be dragged through a round of consultation lasting 3 months every 6 months. This consultation process is lengthy, futile and costly to VIVAS Health in particular where there is no evidence that previous comments have been considered. This form of continual regulatory interference in a new business is not suitable and was not endured by either of our competitors.

The consultation procedure is prescribed by statute enacted by the Oireachtas and it is a matter for VIVAS Health to determine how it will respond to it. As already noted, VIVAS Health's previous comments were properly considered.

VIVAS Health notes that:

1. The MEP has reduced to 4.2% rather than risen as previously stated by the Authority in its previous recommendation.

The letter dated March 2005 to insurers setting out the Authority's previous proposed recommendation stated that "... in the Authority's view this [upward] trend [in the MEP] is likely to continue in the absence of risk equalisation payments commencing".

Although the MEP has reduced for the period ended 30 June 2005, this is in line with the Authority's view of an underlying trend of increase in the MEP, as was conveyed in its letter of 12 September, 2005 to insurers.

2. The Authority has cited independent experts as supporting risk equalisation, but has not set out the many caveats included in the opinions of these experts.

The Authority cited these experts as supporting the principle of risk equalisation payments in a community rated market. It is acknowledged that there are practical issues to consider, which is done in this Report.

3. The Authority cites independent experts that in the majority gave a view prior to the commencement of the regulations.

Although some of the experts' reports were before the introduction of the risk equalisation scheme, the Authority considers that those reports remain relevant. Indeed the reports were generally prepared in the context of risk equalisation proposals in the Irish private health insurance market.

4. The Authority has not taken into account any of the previous submissions made by VIVAS Health.

The Authority did give due consideration to the previous representations made by VIVAS Health and took account of them, as evidenced by the Authority's Report to the Tánaiste of April 2005.

5. The Authority has not taken into account any competition implications.

The Authority takes very seriously the potential implications for competition and this is mentioned throughout the Staff Report. See in particular, Section F, subsection "The Facilitation of Competition between Undertakings".

6. The Authority has not considered market share of the undertakings or the market concentration.

Market share and concentration have been considered (for example see section B.5 and section E "Relative sizes of insurers and the overall size of the market", as well as the analysis of lapse rates and new sales patterns.)

7. The Authority has not considered the impact of risk equalisation on VIVAS Health.

The Staff Report considers the potential impact on VIVAS Health (see, in particular, Section E “the effect of any risk equalisation transfer on premiums payable by consumers and the effect of payments on the business plans/solvency of insurers”).

8. The Authority does not take into account the regulatory advantages afforded to the state undertaking.

The Staff Report gives consideration to the commercial status of insurers and their regulatory requirements (see for example section B.5 and Section E “Commercial status of insurers”).

9. The Authority has not provided any evidence of market instability – other than that purposefully caused by the State undertaking.

The Authority considers that there is a continuing risk of market instability arising and that the best overall interests of health insurance consumers may be best protected by acting to address this risk.

10. The Authority has used as part of its recommendation a Staff Report not made available to consultation.

The Authority did not refer to its Staff Report in its proposed recommendation. Its letter of 12 September, 2005 to insurers outlined the proposed recommendation and the full reasons for it.

It is noted that the Authority has twice presented before the Oireachtas Joint Committee on Health and Children with its sister Department of Health and Children statutory body VHI.

These meetings were part of the normal practice of Parliamentary oversight. The Authority has never made a joint presentation to the Committee with Vhi Healthcare or with any other insurer and the sequence and timing of appearances by the Authority were determined by the Committee alone.

The views and comments expressed by the Authority during the representation on 22 September make it apparent to VIVAS Health that only the protection of VHI is relevant to the Authority. The representations put forward by the Authority and the answers provided to various questions failed to give a balanced or objective view.

Staff of the Authority reject these assertions and point out that they are totally without foundation and unsupported by the facts or any evidence.

That the Authority should state that the advent of a new competitor was a factor in implementing risk equalisation shows the lack of commitment that the Authority has in its mandate to foster competition.

In considering the best overall interests of health insurance consumers, the Authority is required to have regard to the need to facilitate competition. The Authority has given careful consideration to the impact that risk equalisation payments might have on competition. New entrants to the health insurance market may act to increase the level of competition and this is deemed relevant in the Authority's consideration of the need to facilitate competition.

Yours sincerely,

Oliver Tattan
CEO

Letter to VIVAS Health in response to its letter of 3 October, 2005:

The Authority considered it necessary to write to VIVAS Health in response to its letter of 3 October, 2005, in order to correct the record in relation to a number of items.

6 October, 2005

Mr Oliver Tattan
Chief Executive Officer
VIVAS Health
Paramount Court
Corrig Road
Sandyford
Dublin 18

Dear Mr Tattan,

I refer to your letter of 3rd October 2005 setting out your submissions in response to my letter of 12th September, conveying the Authority's proposed recommendation as to the commencement of risk equalisation payments.

The substantive content of your submission will receive careful consideration. However, at the outset, I wish to deal with a number of points made by you.

Firstly, it is not the case that the Authority has failed to take account of previous comments made by VIVAS Health. It is clear from the Report to the Tánaiste of 29 April, 2005, a copy of which was forwarded to you, that this is so.

Secondly, the consultation procedure is prescribed by statute enacted by the Oireachtas and it is a matter for VIVAS Health to determine how it will respond to it. The staff of the Authority had many discussions with you and your colleagues prior to the commencement of business by VIVAS Health in the Irish market and you and your colleagues were fully aware of the provisions of the Risk Equalisation Scheme, 2003. Indeed the business plan which VIVAS Health submitted to the Irish Financial Services Regulatory Authority in January 2004, (and which you also provided to the Authority), recognised fully the nature of the statutory regime and its possible commercial implications for VIVAS Health. It is unfortunate that you consider the regulatory process provided for by statute to be "futile".

Thirdly, your comments that "*the Authority has twice presented before the Oireachtas Joint Committee ... with its sister Department of Health and Children statutory body VHI*" and "*only the protection of the VHI is relevant to the Authority*" appear to call into question the independence and integrity of the Authority. This is a most serious allegation which we challenge in the strongest possible terms.

Your suggestion that the Authority appeared *with* Vhi Healthcare before the Oireachtas Joint Committee – the implication being that this was somehow a joint and co-ordinated venture – is misleading and disingenuous. While it is true that on two occasions the Authority has appeared before the Joint Committee this year when Vhi Healthcare has also appeared, nothing can be read into this. The Authority was invited by the Joint Committee to appear before it and duly did so. The Authority did not appear on a joint platform with Vhi Healthcare. On both occasions Vhi Healthcare made their presentation to the Committee after the Authority had concluded its appearance before the Committee. The Authority had no hand or part in arranging the timing of either its or Vhi Healthcare's appearance before the Joint Committee. To my knowledge, all arrangements were made solely by the Joint Committee.

The Authority has consistently maintained that it is appropriate for other undertakings to also appear before the Joint Committee to express their views. The Authority is pleased that BUPA Ireland, Vhi Healthcare and VIVAS Health have all been afforded two opportunities to appear before the Joint Committee.

Furthermore, it is not the case that "*only the protection of VHI is relevant to the Authority*". The Authority's mandate in relation to competition is as stated in the Health Insurance Acts and it has always strived to fulfil this. The Authority discharges its duties diligently in accordance with the Health Insurance Acts, the provisions of which are applied evenly to all market participants. The Authority, in appearing before the Oireachtas Joint Committee, was assiduous in maintaining its impartiality and any suggestion by you that the contrary is true is *entirely* without substance. We reserve the right to pursue this most serious allegation further through whatever channels we deem necessary.

Finally, I note that during your own appearance before the Joint Committee on 29th September you seem to have misled the Committee in relation to the actions of the Authority. Specifically, you stated that "... [*s*]ince [*VIVAS Health*] entered the market all the recommendations have been that [*risk equalisation*] should be implemented...". This is patently incorrect. The first recommendation of the Authority made after VIVAS Health's entry to the market was in fact that risk equalisation payments should not be commenced. Your comments were used to support your serious claim that the Authority lacked objectivity and independence. I expect that you will be seeking to correct the record of the Joint Committee in this regard.

Yours sincerely,

Dermot Ryan
Chief Executive / Registrar

Appendix I: Review of Arguments for and Against Risk Equalisation by the UK Government Actuary's Department. (Source: Report to the Authority dated 29 July, 2002).

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. (Source: Paper prepared for The Health Insurance Authority workshop of 2 May, 2002)

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. Source: “Assessment of Risk Equalisation and Competition in the Irish Health Insurance Market”, November 2003.

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. This consultation process took place in 2002.

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 may not 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 c. 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

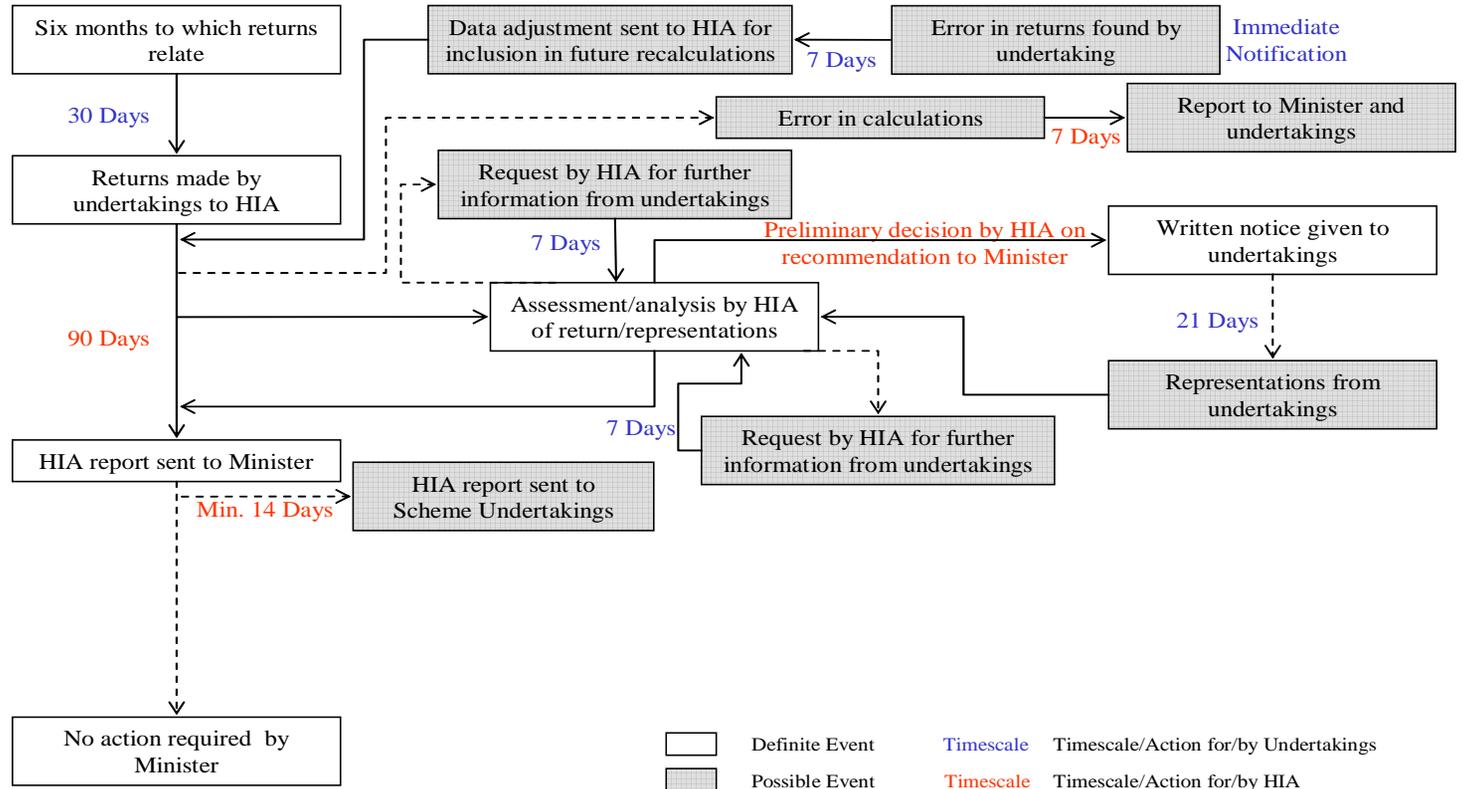
- RE has been recognised in Australia as being “crucially important to ensure the consumer interest is protected”.
- In 2001 it was recognised that the RE scheme existing in Australia was not sufficient and it therefore had to be strengthened.

Appendix V

Risk Equalisation Timelines

Possible Timetable Under Risk Equalisation Regulations

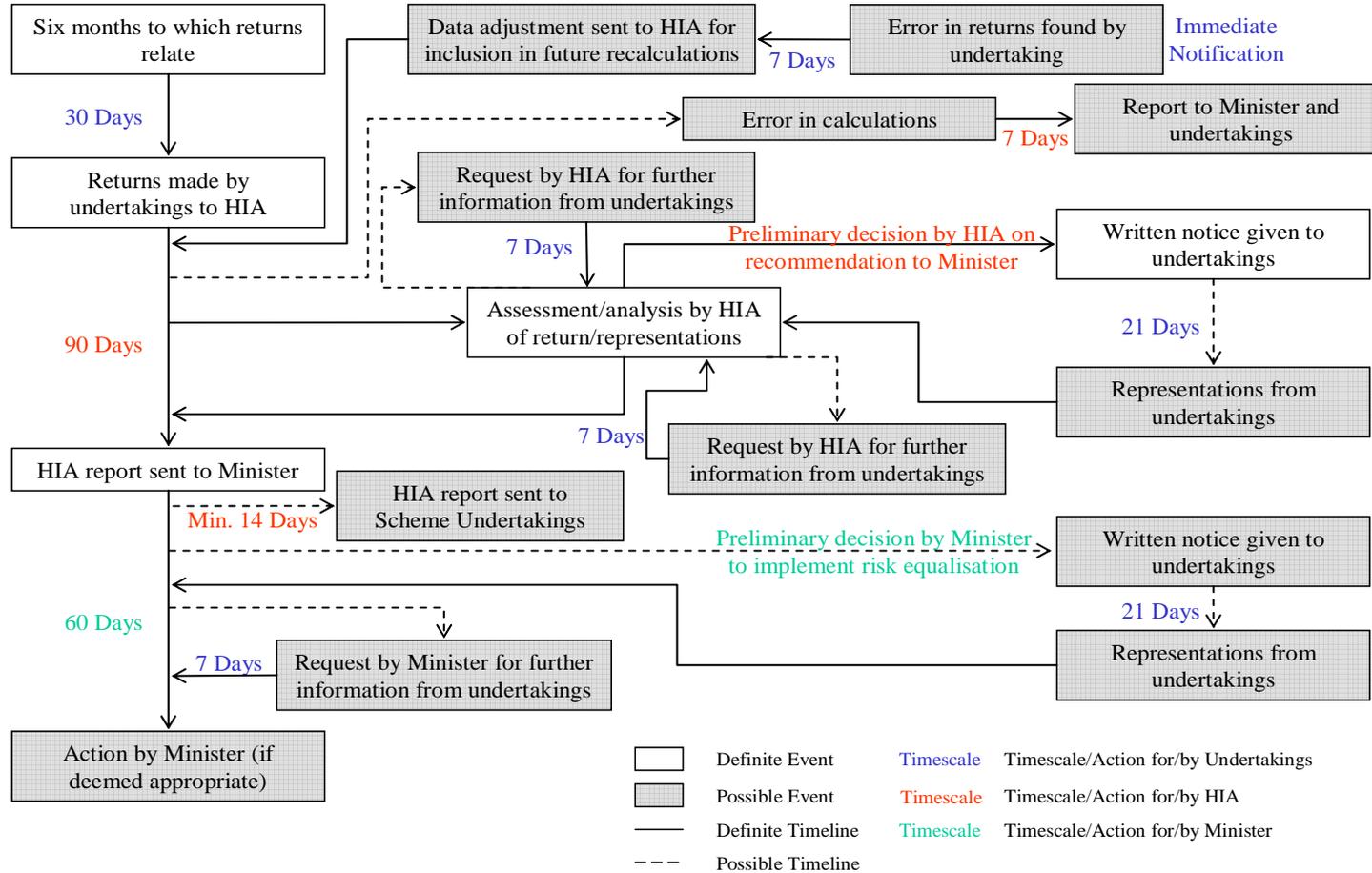
Assumptions: Market Equalisation Percentage of 2% - 10% and RE Not Recommended



- Definite Event
- Possible Event
- Definite Timeline
- - - Possible Timeline
- Timescale Timescale/Action for/by Undertakings
- Timescale Timescale/Action for/by HIA
- Timescale Timescale/Action for/by Minister

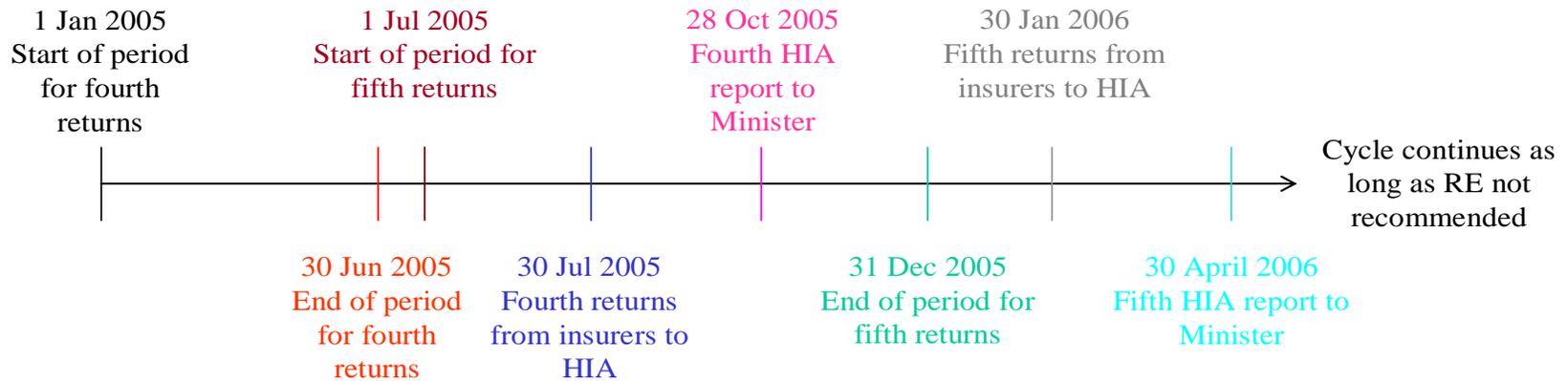
Possible Timetable Under Risk Equalisation Regulations

Assumptions: Market Equalisation Percentage of 2% - 10% and RE Recommended



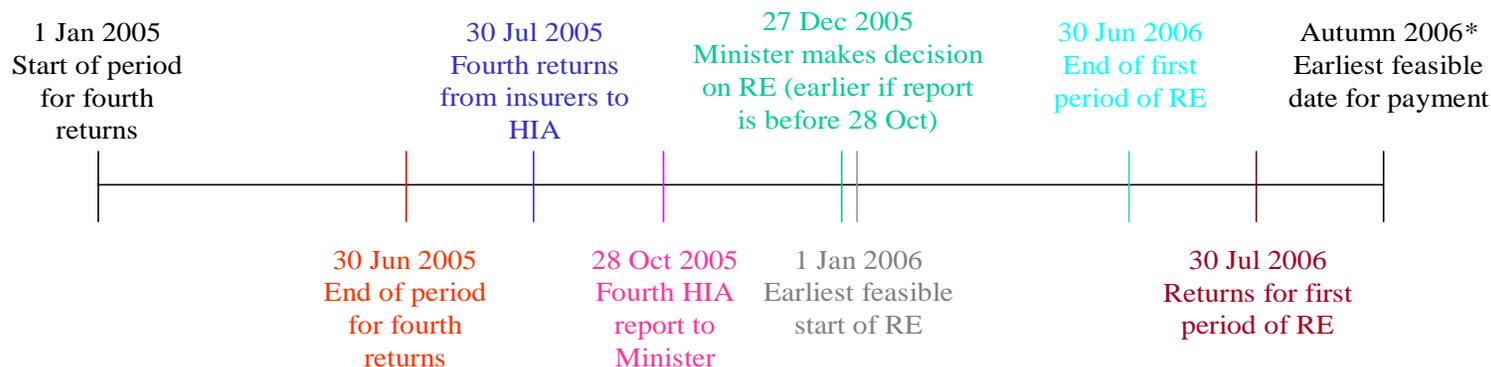
Possible Timeline Under Risk Equalisation Regulations

Assumptions: Market Equalisation Percentage of 2% - 10% and RE Not Recommended

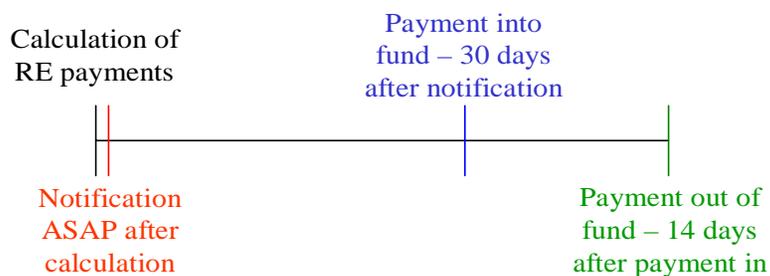


Possible Timeline Under Risk Equalisation Regulations

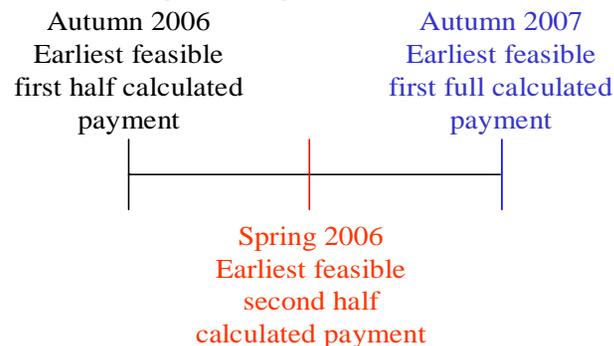
Assumptions: Market Equalisation Percentage of 2% - 10% and RE Recommended/Implemented



* Payment Procedure



* Phasing Arrangements



Note: Phasing arrangements are listed for existing scheme undertakings. Different phasing arrangements apply to new entrants.