Association of British Insurers 51 Gresham Street, London EC2V 7HQ Tel: 020 7600 3333 Fax: 020 7696 8999

ADDITIONAL SUBMISSION FROM THE ASSOCIATION OF BRITISH INSURERS

Competition Commission investigation on the market of privately funded healthcare services

March 2013

The UK Insurance Industry

1.1 The UK insurance industry is the third largest in the world and the largest in Europe. It is a vital part of the UK economy, managing investments amounting to 26% of the UK's total net worth and contributing £10.4 billion in taxes to the Government. Employing over 290,000 people in the UK alone, the insurance industry is also one of this country's major exporters, with 28% of its net premium income coming from overseas business.

1.2 Insurance helps individuals and businesses protect themselves against the everyday risks they face, enabling people to own homes, travel overseas, provide for a financially secure future and run businesses. Insurance underpins a healthy and prosperous society, enabling businesses and individuals to thrive, safe in the knowledge that problems can be handled and risks carefully managed. Every day, our members pay out £147 million in benefits to pensioners and long-term savers as well as £60 million in general insurance claims.

The ABI

2.1 The ABI is the voice of insurance, representing the general insurance, protection, investment and long-term savings industry. It was formed in 1985 to represent the whole of the industry and today has over 300 members, accounting for some 90% of premiums in the UK.

2.2 The ABI's role is to:

- Be the voice of the UK insurance industry, leading debate and speaking up for insurers.
- Represent the UK insurance industry to government, regulators and policy makers in the UK, EU and internationally, driving effective public policy and regulation.
- Advocate high standards of customer service within the industry and provide useful information to the public about insurance.
- Promote the benefits of insurance to the government, regulators, policy makers and the public.

Introduction

3.1 The ABI welcomes the Competition Commission investigation of the private healthcare market and the need to ensure a competitive and sustainable market for high quality private healthcare. Inefficiency in the provision of private healthcare can increase the cost of private medical insurance making it less affordable for consumers who want to purchase their healthcare privately. Efficient private healthcare services include competition between providers and transparency on the cost and quality of evidence-based treatment choices. The ABI believes the best interests of the privately funded patient are delivered through timely access to appropriate healthcare that is both high quality and value for money.

3.2 Insurers are required by regulation to set out in clear terms the nature of the cover that is in their policies during the sales process. This is regulated by the Financial Services Authority (FSA), and any insurer that fails to satisfy such requirements would face regulatory action.

3.3 Health insurers in the UK are responsive to customer needs and the sector is one that performs well, as evidenced by few FOS complaints (refer annex 1). Since 2007, there have been no more than 652 complaints to the FOS and an upheld rate of no more than 1:2.3 in any one year, against claims paid that totalled £2.501bn-£2.781bn per year. Customers who are fully informed of the cover of a policy should be able to choose the policy that is most suitable for them, at the time they purchase the policy.

3.4 The Competition Commission has received submissions that include statements that are misleading with regard to private medical insurance. The purpose of this paper is to provide clarity on how private medical insurance works when customers want to switch to a new insurer and the corporate market.

Inability to switch insurer without further underwriting

4.1 Submissions from some stakeholders describe how PMI customers are impeded from being able to switch to a new insurer due to a 'lock in effect' with a certain provider. The submission by FIPO states the ability to switch to a new insurer will be 'difficult or non-existent under the same terms and conditions in the presence of pre-existing medical conditions' and, at A.9 of the submission, asserts that policyholders should have the ability to switch policy provider through a "policy portability" model.

4.2 The reality is that insurance is designed to cover customers for unexpected events, rather than highly likely events such as claims on pre-existing conditions. Having said that, insurers have developed models to keep the premium affordable when the customer has pre-existing conditions and is switching to a new insurer:

- Medical History Disregarded - employees get cover that can include pre-existing medical conditions, because the large size of the corporate risk pool balances the small number of employees with an increased risk
- Moratorium underwriting – if the customer does not receive treatment, take medication, ask advice about or have symptoms of a pre-existing condition for a given period of time (usually two years), the medical condition could become eligible for cover
- Fully underwritten – if the customer has a condition that is likely to come back, the insurer can issue a policy but that condition and any condition related to it might not be covered
- Switch terms – where personal medical exclusions remain the same on switching to a new insurer, the overall cover can be different regarding benefits or limits

4.3 The ability to switch to a new insurer on the same underwriting terms is a feature of the UK corporate market where there are sufficient beneficiaries in the risk pool to off-set the risk of anti-selection.[1] The corporate market is competitive with regular pricing reviews and thin margins. The market is intermediated with 'open book' pricing where the intermediary checks the pricing proposed by an insurer. Corporates can switch without further underwriting by taking existing underwriting terms with them. For individual policies it is more likely there will be anti-selection that ultimately increases the cost of insurance for all customers.

4.4 One of the major factors that people make purchase decisions on is cost. Without the ability to exclude conditions the costs of premiums would rise to a potentially unsustainable level for some customers. If customers were able to switch to a new insurer without further underwriting on pre-existing conditions, customers could buy a lower cost limited policy and then switch to a comprehensive policy when they need to claim. This would deter insurers from offering fully comprehensive products. Such a system would be unsustainable and we are not aware of any market where such a system applies.

4.5 Alternative models in other countries exist where the size of the private medical insurance market forms a large risk pool. In addition, the government of such a country enacts specific regulations to ensure insurers limit their risk of becoming insolvent as a result of insuring a cohort of customers with a high risk of claiming. For example, a risk equalisation model supports the use of a community rating system. This model seeks to compensate insurers with a high demographic risk by spreading the cost of the risk across different insurers. Characteristics of such markets are:

- Government sets out a minimum level of coverage which all policies must provide.

[1] Anti-selection, also known as adverse selection, occurs when there is a high chance the beneficiary will claim but this greater risk is not covered by the insurance rate, terms or conditions.

- In return, Government offers tax relief of 30-50% on health insurance to encourage opt out from the state system.
- In some models, such as in Australia, regulation enables portability of the same level of cover so the insured person can switch to a new insurer, for example for their hospital cover.[2] Pre-existing conditions are not automatically covered under the Australian model. There is a waiting time of up to 12 months for pre-existing conditions to get hospital cover.
- Policy holders are not able to switch policies to extend cover whilst avoiding further underwriting. Insurers must be able to assess the level of risk to ensure the product is financially sustainable.

4.6 Customers benefit from the PMI market practice of offering renewal terms. This practice means customers will remain insured for health conditions they have at that time by choosing to renew their policy with their current insurer. The PMI market practice of offering renewal terms annually, [3] without:

- Re-underwriting health conditions if the customer stays on the same policy or
- Increasing the customer's premium solely because of a claim they make

is a contractual bias in favour of the customer. The customer can choose to accept the terms of renewal or to end the contract at any time but the insurer cannot end the contract. The market principal of offering to renew terms on pre-existing conditions cannot be applied to a new insurer because competition requirements mean different insurers have a different basis for cover, risk appetite, and underwriting approach.

4.7 Customers can claim on their private medical insurance policy as often as they need to. Claims history shows that once a customer makes one claim it is very likely they will make future claims. Offering renewal terms means the customer will remain covered even though their insurer will make material losses in the future by continuing to give cover, at the same level, for customers who have claimed in the past.

Corporate market

5.1 Submissions from some stakeholders argue that the primary concern of a corporate is on the cost of the scheme, particularly in this economic climate. The ABI does not agree with this view. Employers will make commercial decisions based on the value for money of providing private medical insurance to their employees, but these decisions also carefully evaluate the benefit private medical insurance provides to their employees and whether it is of sufficiently high quality.

[2] Australia's Private Health Insurance Act 2007 at http://www.comlaw.gov.au/Details/C2007A00031

[3] The price can change to reflect the cost of healthcare eg new drugs and treatments, the customer's age, the claims of all people in the risk pool, and there might be a change to the benefits associated with a policy. In some cases the price might be subject to a pre-defined No Claims Discount scale. In these cases the customer will still have access to the same level of cover.

Corporates offer private medical insurance to their employees to evidence their commitment to caring for their workforce and as a means to compete with other firms to attract and retain talented staff, retain productivity and reduce sickness absence costs.

5.2 It is a reasonable commercial decision for employers to choose the level of cover they are prepared to fund. The employer chooses the level of cover from a range of options made available by insurers. When employers have chosen to reduce cost, for example by excluding dependents from cover, insurers have provided top-up products that enable individual employees to add to their cover should they choose to.

Association of British Insurers 51 Gresham Street, London EC2V 7HQ Tel: 020 7600 3333 Fax: 020 7696 8999

Annex 1

Claims paid by PMI and complaints on PMI to the Financial Ombudsman Service					
	Claims paid by PMI £bn	Ratio of upheld FOS PMI complaints to PMI customers	Number of upheld FOS PMI complaints	Number of FOS PMI complaints	Per cent of upheld FOS PMI complaints
2011	£2.649	1 : 25,300	221	513	43%
2010	£2.781	1 : 33,500	177	506	35%
2009	£2.679	1 : 29,120	202	652	31%
2008	£2.653	1 : 36,300	170	514	33%
2007	£2.501	1 : 59,940	100	369	<27%