Portability, switching and competition in the Australian private health insurance market
About PHIAC

The Private Health Insurance Administration Council (PHIAC) is an independent statutory authority that regulates the private health insurance industry. Private health insurance policy is set down by the Australian Government via the Department of Health (DoH).

PHIAC’s statutory objectives are described in the Private Health Insurance Act 2007 (PHI Act). Section 264-5 of the PHI Act instructs PHIAC in performing its role, to “take all reasonable steps” to strike an “appropriate balance” between the three objectives of:

a. fostering an efficient and competitive health insurance industry;

b. protecting the interests of consumers; and

c. ensuring the prudential safety of individual private health insurers.

In order to promote these objectives, PHIAC has undertaken research on competition and other issues within the Australian private health insurance industry. The aim of this research is to support an improved understanding of the Australian private health insurance industry.

It is important to stress that PHIAC is not a policy body. As noted above, policy responsibility for private health insurance is reposed within the DoH as principal adviser to the Minister for Health and the Government. Accordingly, PHIAC does not seek to propose, nor to advance, any particular policy prescription or solution to the matters it examines. It does, however, aspire to provide the factual and contextual basis for a much improved discussion about the important issues that affect private health insurance in Australia. It should not be implied that any view expressed in this research paper is necessarily that of the Minister for Health or the Government.

The Government announced in the 2014-15 Budget that PHIAC will be closed with effect from 1 July 2015. PHIAC’s operations will be merged into, predominantly, the Australian Prudential Regulation Authority, with the remainder of its functions reverting to other agencies.
Preface

Private health insurance is a vital product for many Australians. Around 47 per cent of Australians – or 11.1 million people – hold a health insurance policy which covers them for hospital treatment, while around 55 per cent of the population – or 13.1 million people – are covered for general treatment, which provides cover for dental care, optical services, and many other health services. In addition, around 11.5 per cent of the value of all health services provided in this country is paid for by the private health insurance industry.

This research paper seeks to promote a discussion around the concept and regulation of “portability” and how this affects consumer mobility. Portability is a central idea in the debate about the rights of consumers and the promotion of competition in the PHII industry because it is the mechanism that allows consumers to move from one insurer to another (or within products in the same insurer) without having to re-serve waiting periods. In short, it is the process that enables competitive movement of consumers seeking the best value product for their particular circumstances.

This research paper introduces readers to the key features of the portability system as it has developed in Australia and explains the policy rationale for its introduction. In particular, it points out the critical role an effective portability system must play in creating an environment for effective and fair competitive behaviours between participants in the PHI industry. It also examines some of the most important questions of public policy which have emerged concerning the operation of the portability system within the Private Health Insurance Act 2007. Finally, evidence around consumer behaviour relating to switching insurers is discussed.

There are many factors driving consumer behaviour. However, the focus of this paper is on consumers’ knowledge of their portability requirements and the ease with which the industry fulfils its obligations to provide a convenient transfer process for the consumer who decides that a different policy better meets their needs. Other factors which impact on consumer choice will be examined in future papers.

This research paper draws on stakeholder submissions to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market (Discussion Paper No 2), released by PHIAC in July 2013 as well as submissions received by PHIAC in response to its first discussion paper, Competition in the Australian Private Health Insurance Market, released by PHIAC in November 2012. A variety of other sources were also used, many of which are set out in the bibliography attached to the paper. Overall, the majority of submissions expressed general support for the current regulatory regime on waiting periods and portability rules for hospital cover products, and the current approach of not regulating waiting periods and portability for general treatment products. A number pointed to the need to improve the transfer process from one insurer to another. While some considered that this needs to occur within the existing framework, others considered that the establishment of a centralised electronic system to streamline and standardise the transfer process would be beneficial.

PHIAC acknowledges very helpful conversations with staff of the former Private Health Insurance Ombudsman.  

1 See www.phiac.gov.au. Not all submissions received by PHIAC were approved for public release. PHIAC has preserved confidentiality where it was sought both in this paper and on its website.

2 The functions of the Private Health Insurance Ombudsman have transferred to the Commonwealth Ombudsman with effect from 1 July 2015.
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1. Current Regulatory Framework

1.1 Introduction

A feature of the private health insurance industry is the requirement for consumers to serve waiting periods prior to accessing benefits. If waiting periods had to be re-served when a consumer transfers to another policy, this would form a significant barrier to policyholder mobility and hinder competition in the private health insurance market.

Consequently, Division 78 of the PHI Act\(^3\) prohibits health insurers from re-imposing any waiting period which has already been served when a consumer switches insurers, or switches policies within the same insurer, provided that the new policy is “equivalent” in coverage, or lesser in coverage, compared to the old policy.

These “portability rules” only apply to hospital cover products; they do not extend to the so-called general (also known as ancillary or extra) suite of products offered by insurers. For the rules to be effective, the administrative arrangements which sit behind them and ensure that consumers’ requests to move are dealt with must be efficient.

This chapter explains the approach to waiting periods, the current portability rules, and associated mandated administrative processes. The discussion commences with regulation of waiting periods because the waiting period is what the portability rules address.

1.2 Waiting periods

**Legislative requirements**

Division 75 of the PHI Act sets maximum waiting periods for consumers purchasing a hospital cover policy from a health insurer and not transferring from another health insurer. These are:

- twelve months for hospital treatment or hospital-substitute treatment that is obstetric treatment or treatment of a pre-existing condition;
- two months for hospital treatment or hospital-substitute treatment that is psychiatric care, rehabilitation or palliative care, whether or not for a pre-existing condition; and
- two months for any other hospital treatment or hospital-substitute treatment (that is, not covered by the above two points).

Waiting periods for general treatment cover (excluding hospital-substitute treatments\(^4\)) are not regulated. They are set by individual health insurers, although in practice there is much industry commonality in the waiting periods imposed.

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\(^3\) All legislation referenced in this discussion paper is set out at Attachment 1.

\(^4\) As a technical matter, as defined in the PHI Act (see section 69-10) general treatment includes hospital-substitute treatment.
1 Current Regulatory Framework

Rationale

The waiting period requirements for hospital and hospital substitute cover stem from two prime considerations.

- First, if maximum waiting periods were not regulated, then insurers could effectively exclude individuals or groups from membership by setting punitively long waiting periods. This would be inconsistent with the principle of community rating.\(^5\)

- Second, if there were no waiting periods, consumers could potentially ‘hit and run’ by taking out hospital cover, or upgrading to higher cover, only when they knew or suspected they might need hospital treatment (the ‘hit’) and then dropping or downgrading shortly after (the ‘run’). Were this to occur, the treatment costs of members behaving in this way would be borne disproportionately by the insurer’s long term policyholders, and their behaviour would ultimately result in higher premiums for all policyholders.

History

Waiting periods for hospital treatment have been a longstanding feature of the private health insurance regulatory regime. The most important changes since the late 1990s have been the following:

- In 1999: increasing the waiting period for obstetric treatment from 9 to 12 months.

- In 2007: introducing the waiting periods for hospital-substitute treatment. This formed part of the suite of changes made to allow private hospital insurance benefits to be paid for services provided in a wider range of settings.

The policy of not regulating maximum waiting periods for general treatment cover (excluding hospital-substitute treatments) has also been a longstanding feature of the private health insurance regulatory regime.

1.3 Portability

Legislative requirements

The portability arrangements, specified in Division 78 of the PHI Act, ensure that consumers can transfer to a new hospital policy without having to re-serve previously completed waiting periods. These arrangements apply when a policyholder transfers to a new policy with equivalent cover (whether with the current insurer or with a new insurer) from an old policy provided that the transferring policyholder:

- was insured under the old policy at the time they became insured under the new policy; or

- ceased to be insured under the old policy no more than seven days (or such longer time as the new insurer allows) before becoming insured under the new policy; and

- previously held a policy which was a complying health insurance policy; and

- had made full premium payments under the old policy up to the time the person became insured under the new policy.

The key features of the current portability rules are as follows:

- They apply only to hospital treatment and hospital-substitute treatment, and not to general treatment (excluding hospital-substitute treatment).

- If the person is transferring from an old policy to a new policy with equivalent cover, they are only required to serve the balance of any unexpired waiting period under the old policy.

- If the person is transferring to a new policy with a higher level of cover, they will have to serve the entire relevant waiting period for that higher level of coverage.

- Insurers are prohibited from imposing benefit limitation periods (that is, an initial period of membership during which only minimal benefit is paid for particular treatments) for persons transferring to a new policy, either within the one insurer or between insurers.

- If the previous policy imposed higher excesses or co-payments than the new policy, these may be continued under the new policy for a period no longer than the prescribed maximum waiting periods.

\(^5\) This principle means that health insurers are not permitted to discriminate on the basis of health, age (other than age at entry for Lifetime Health Cover), gender, race, sexual orientation, or religion. The practical effect of this principle is that health insurers are unable to substantially price health insurance on the basis of risk.

\(^6\) The ‘hit and run’ phenomenon is at least partly addressed by the introduction of the Lifetime Health Cover measure in 2000.
• The applicability of the portability rules do not alter as the result of:
  - the existence or otherwise of “no gap” or “known gap” agreements between medical providers and either of the insurers the consumer is leaving or joining; and
  - the existence or otherwise of contracts between hospitals and either of the insurers the consumer is leaving or joining.

The above portability arrangements are supported by the legislative requirement on insurers to issue a transfer certificate. Division 99 of the PHI Act (combined with the Private Health Insurance (Complying Product) Rules 2010) specifies this administrative process as follows:

• The old insurer is required to give a transfer certificate to a person ceasing to be insured under a complying health insurance policy, and who does not become insured under another complying health insurance policy of the insurer within 14 days of ceasing insurance.

• The old insurer can provide a transfer certificate to the person leaving, and this person can provide this certificate to the new insurer. If the person does not provide the new insurer with the transfer certificate within 7 days of becoming insured, the new insurer is required to request a transfer certificate from the old insurer within the next 14 days. The old insurer must comply with this request and give the new insurer a transfer certificate within 14 days of receiving the request.7

• An insurer commits an offence if they do not meet these requirements. The penalty is 60 penalty units (which in June 2015 was $10 200) and strict liability applies to any offence (that is, the insurer is deemed legally responsible, irrespective of culpability).

The Private Health Insurance Code of Conduct8 also requires insurers to provide a transfer certificate within 14 days, consistent with the legislative requirement.

**Rationale**

The portability requirements for hospital and hospital substitute cover stem from regulation of maximum waiting periods for hospital or hospital-substitute treatment. They ensure that:

• consumers can move from one health insurer to another health insurer (a first principle of a competitive market), or to move from one policy to another policy offered by the same health insurer, in a convenient way and without the need to re-serve waiting periods; and

• health insurers need to be able to administer this movement in an efficient way.

Portability then seeks to satisfy a core requirement for a competitive market as well as a level of consumer protection.

**History**

The portability rules have evolved over time. Prior to 1988, portability without the imposition of a new waiting period was guaranteed only where a member transferred policies within the same fund and where the transfer arose from the Minister for Health cancelling the registration of a health fund. The portability rules were broadened in 1988 to cover the circumstance of a policyholder changing private health insurers in respect of both hospital and general cover. The rules were further strengthened in 2005 to prevent private health insurers imposing benefit limitation periods on consumers who had transferred from another fund.

In 2007, the portability rules were overhauled when the PHI Act was enacted. The main objective of those changes was to move away from the complex and difficult to administer legislative provisions in the National Health Act 1953 and introduce a much simpler system. This result was an important improvement in implementing the policy principle that any consumer transferring from one product to another, either within or between funds, should not be placed in an adverse position in respect of waiting periods.

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7 This means that the legislation allows a maximum of 35 days for the new insurer to obtain a transfer certificate from the old insurer (that is, the initial 7 days for the person to provide the transfer certificate, and if this does not occur, 14 days for the new insurer to request a transfer certificate, and 14 days for the old insurer to provide the transfer certificate).

8 The Private Health Insurance Code of Conduct is a self-regulatory code to promote informed relationships between health insurers, consumers and intermediaries. The objective of the Code is to maintain and enhance regulatory compliance and service standards across the private health insurance industry. The Private Health Insurance Code of Conduct is available at www.privatehealthcareaustralia.org.au.
2. Competition Aspects

2.1 Introduction

The ability of consumers to move their business to a better value product in a convenient way and at minimal cost is a vital aspect of any competitive market. In other words, the ability of consumers to freely exercise choice is a driver of market-based outcomes.

In regards to private health insurance, consumer choice is best supported by consumer knowledge of product offerings, and lack of regulatory, financial or administrative barriers in shifting their business from one health insurer to another. When this is the case, consumers can determine the most appropriate product that meets their health needs given their particular circumstances.

This chapter explores competition issues relating to waiting periods, portability, and consumer mobility in the private health insurance industry.

2.2 Waiting periods and competition

Hospital cover

The first issue to consider is whether regulation of waiting periods in respect of hospital cover has a positive or negative influence on competition.

It is not difficult to see a mixture of competing forces at work here.

- On the one hand, the regulation of maximum waiting periods clearly does somewhat impede competition, as it reduces the scope for insurers to compete on the basis of product differentiation and price by extending the waiting periods for different hospital treatments. As a result, in respect of waiting periods, an insurer’s ability to compete is confined to reducing or waiving the waiting periods as part of a marketing strategy directed at attracting more policyholders. The two month waiting period is sometimes waived, while the twelve month waiting period is generally not waived or reduced because of the potential cost to the insurer.

- On the other hand, regulation of waiting periods for hospital treatment and hospital-substitute treatment establishes a degree of uniformity across the industry. Generally, specified maximum waiting periods makes it easier for consumers to compare products by removing one of the possible variables. This is a positive influence on competition in the private health insurance market as it enhances the capacity for consumers to consider their health insurance options.

Where the balance should lie between these two competing views is difficult to assess. Policy makers, to date, appear to have placed greater weight on the desirability of certainty and consistency across the industry in respect of hospital and hospital-substitute cover. Another factor is that regulating maximum waiting periods for hospital cover is consistent with the policy intent of promoting access to private hospital services as a means of relieving demand on public hospitals.

There is also arguably a consumer protection element to regulating maximum waiting periods for hospital cover as this protects consumers from products with excessive waiting periods (this is, exceeding 12 months). However, regulation of maximum waiting periods comes at the cost of higher than otherwise
hospital cover premiums for all consumers due to insurers inability to offer products with waiting periods longer than 12 months.  

Most industry stakeholders who made a submission to Discussion Paper No 2 consider that the regulated maximum waiting periods for hospital treatment are either neutral or a positive for competition. There was strong support for the continued regulation of maximum waiting periods for hospital treatment.

However, an industry stakeholder questioned whether there could be a case for:
- increasing the waiting period for some hospital treatments (such as Cochlear implants) to allow greater product innovation and make certain products more affordable;
- removing the regulatory maximum waiting periods for hospital substitute treatments given that the waiting periods for chronic disease management programs are unregulated; and
- clarifying the meaning of a ‘pre-existing condition’.

In addition, one industry stakeholder did present the alternative view that waiting periods for hospital treatments should not be regulated. This reflects the view that regulated waiting periods hinder competition in the industry. Market dynamics in general treatment products where insurers waive waiting periods is an example of how competition emerges in the absence of regulation. It is also argued that one of the consequences of regulated waiting periods for hospital treatment is the reliance on products with restrictions and exclusions to lower the price in order to make the product more affordable for consumers (particularly young consumers). In contrast, if waiting periods were not regulated, insurers could offer longer waiting periods instead of exclusions/restrictions which would reduce their benefit outlays and enable them to lower the price of hospital cover products.

### General treatment

The second key issue is whether the Government should regulate waiting periods for general treatment products. The waiting periods for general treatment products vary between insurers but typically they are as follows:
- Two months for lower cost items such as general dental services, physiotherapy, occupational therapy, speech therapy and health screening services where no Medicare benefit is payable.
- Six months for optical items.
- Twelve months for major dental procedures such as crowns and bridges.
- Between one and three years for certain higher cost general treatments such as orthodontics, hearing aids, breathing appliances, laser eye surgery, and blood glucose monitors

Broadly, the merit or otherwise of regulatory restrictions on waiting periods for general treatment cover, in respect of their positive and negative influence on competition, are the same as outlined for hospital cover.

For general treatment (excluding hospital-substitute cover), the current policy settings appear, on balance, to place greater weight on increasing the scope for insurers to compete via product differentiation, and less weight on consumer protection through constraining the length of waiting period. For instance, health insurers can set longer waiting periods for high cost general treatments to protect themselves against the ‘hit and run’ phenomenon, and thereby reduce their outlays which allows them to set lower premiums. This reflects competitive pressures at work and insurers setting premiums on general treatment products taking account of risk to the insurer.

In the current environment, the preference for not regulating waiting periods for general treatment products and regulating maximum waiting periods for hospital cover products can be supported by:
- the practice of many insurers waiving all or some waiting periods on general treatments as part of a marketing strategy directed at attracting more policyholders while waiting periods for hospital treatment are rarely waived; and

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9 Confidential submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market.
10 Confidential submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market.
11 Confidential submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market.
• the fact that general treatment services are often used on a predictable basis and the cost per service is more affordable for most people, whereas hospital treatments are less predictable and the costs per hospital episode are much higher.

The vast majority of industry stakeholders who made a submission to Discussion Paper No 2 considered that the waiting periods for general treatment services should remain unregulated. This reflects the above considerations, and the view that there is already a strong incentive to keep waiting periods low in order to compete for customers. The fact that some or all waiting periods are often waived for general treatment services also suggests the market is operating a competitive way.

The exception was a submission which argued that regulating waiting periods for general treatment services combined with portability rules would enhance competition in this segment of the market and there are advantages in having consistency with the way hospital products are regulated. Another submission noted that if waiting periods of general treatment services were regulated, there is a risk insurers would seek to differentiate themselves in the market by using exclusions and restrictions in general treatment products instead of varying waiting periods to differentiate themselves.

### 2.3 Industry characteristics impacting on consumer choice

There are specific industry characteristics impacting on consumers’ ability to identify their preferred product.

**Complexity**

A perceived characteristic of the private health insurance industry is that products are complex and difficult to compare. There is wide variation in prices, coverage (restrictions and exclusions), rates of benefit payment (known gap and no gap arrangements), inconsistent naming of top, medium and basic products across health insurers, waiting periods in the case of general treatment products, co-payments, excess payments, benefit limitation periods for certain treatments, and insurer provided health services (such as call centre advice). This complexity is further compounded by the combining of the purchase of hospital and general insurance products. The result is that consumers’ ability to identify what is the best value offering for them, and to exercise their right to switch health insurance providers, is challenging to say the least.

The Government has sought to address this issue by establishing the industry-supported website [www.privatehealth.gov.au](http://www.privatehealth.gov.au). This website enables consumers to compare products offered by different health insurers. It is becoming more widely known amongst consumers as illustrated by its 899 841 unique visitors in 2013-14, a 45 per cent increase on the previous year. This continues the very strong growth since 2010-11.

More generally, the internet makes it far easier to obtain information on products and pricing offered by health insurers than in the past, when this information had to be obtained by approaching each insurer. Furthermore, the increasing role of insurance brokers and intermediaries in recent times is making product and pricing information more accessible. These factors facilitate portability in today’s market environment, acting to mitigate the effects of complexity.

**Community rating**

Another characteristic of the private health insurance industry is that the industry is subject to the community rating principle. This principle aids portability because insurers cannot exercise discretion over who they attract or retain as policyholders and, in turn, are not able to risk-rate their products. Arguably, community rating and portability rules for hospital cover make private health insurance one of the easiest products for consumers to switch between.

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13 Catholic Health Australia’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.
16 The website [www.privatehealth.gov.au](http://www.privatehealth.gov.au) was created in the late 2000’s to help consumers make informed choices about private health insurance. Since then, the PHIO has ensured the information available is up-to-date, collated, analysed, and user-friendly.
17 Private Health Insurance Ombudsman Annual Report 2013-14, pages 43 and 44.
18 For example, perhaps around 20 per cent of consumers are purchasing private health insurance via an intermediary in 2013 compared with 12 per cent in 2012 (see Health Care & Insurance Australia 2013, IPSOS, pages 281-282).
19 Bupa’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.
In contrast, the general insurance industry is able to risk-rate their products and can exercise discretion through their charging or product availability frameworks, if they are not interested in the business of a particular potential policyholder. Such behaviours limiting switching do not occur in the private health insurance industry.

**Growth market**

In recent years, the Australian private health insurance industry has experienced aggregate growth in policyholders of around 3 per cent per annum.\(^{20}\) As a result, if a health insurer is seeking to grow its membership base at a rate above 3 per cent per annum, a component of this growth will need to be achieved by enticing consumers to switch from other health insurers. Another possible consequence of moderate growth around 3 per cent per annum is that the larger health insurers are very active in the advertising market.\(^{21}\) This is further supported by a number of insurers offering extended premium-free periods to consumers who switch to their fund, and waiving waiting periods in respect of general treatments.

Industry sources suggest that in 2011-12 between a quarter to a third of new policyholders joining a health fund were consumers switching from other health insurers.\(^{22}\) The 2013 IPSOS Report into health care and insurance in Australia found that 46 per cent of new total new joins to a health fund had changed funds in the two years preceding the survey.\(^{23}\)

### 2.4 Switching in the Private Health Insurance Industry

**Where switching could be important**

As mentioned, the ability of consumers to switch insurers in order to access a more preferred product (one with a better price or service offering) in an efficient manner is a cornerstone of a competitive market. From the point of view of protecting the interests of consumers, switching could also be important in three specific circumstances.

- **First**, health insurers are able to alter the terms of their products, for example by adding exclusions or restrictions. These changes can be done at any time, so long as the insured persons are informed of any change in a reasonable time before it takes effect.\(^{24}\) If and when this occurs, this may provide an incentive for the consumer to consider transferring to another insurer (or to another product with the same insurer) and it is important in these circumstances that portability arrangements work efficiently.
- **Second**, the ability for consumers to transfer to another health insurer may also be affected by the supply side of the market. If a consumer wishes to undergo treatment at a private hospital which does not have a contract with their insurer, then the consumer may wish to transfer to another fund (one which has a contract) so as to avoid additional out of pocket costs. These additional costs (the difference between the default benefits paid by the fund and the actual hospital charge) can be substantial. The ease and timing of the transfer to another health insurer may be even more critical in these instances as the consumer may only become aware of the issue at the time they are arranging their admission.\(^{25}\)
- **Third**, also on the supply side of the market, the need for an efficient transfer process arises in the case where a policyholder wishes to transfer their membership so as to take advantage of ‘no gap’ or ‘known gap’ agreements between an insurer (but not the consumer’s current insurer) and a provider whose services they wish to access.\(^{26}\) This issue can arise in respect of both hospital and general treatment cover.

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20 PHIA data.  
21 As an illustration of this point, industry spending on advertising has more than doubled in the last six years to around $100 million in 2013.  
22 Some insurers made this point in their applications for an increase in premiums to apply from 1 April 2013.  
23 Health Care & Insurance Australia 2013, IPSOS, page 299.  
24 PHI Act, paragraph 93-20(2)(c).  
25 However, from the perspective of the health insurer the policyholder is moving to, this could be a negative because this insurer has to bear the cost of the hospital treatment even though the consumer has been a policyholder with this insurer for a very short period of time. This issue is discussed further at the end of this paper.  
26 Transferring insurers at point of treatment could be problematic for consumers. The decision to transfer should be based on a range of factors rather than simply based on one admission. As mentioned in the above footnote, there is also an issue for the insurer gaining the new policyholder in having to bear the cost of claims while the consumer has paid very little premium to the new insurer. This issue is discussed further at the end of this paper.
Evidence of switching

The limited evidence available suggests that only a minority of consumers transfer their membership to another health insurer. This is reflected in PHIAC’s data on the level of retention (see Figure 1) and transfers from one health fund to another in respect of hospital treatment and combined (hospital and general treatment) coverage (see Figure 2).

Some key observations include:

- **Figure 1** shows that the two-year retention level for insurers has been declining since March 2008, from 91 per cent to 87 per cent in March 2015 for the not-for-profits and from 88 per cent to 81 per cent for the ‘for-profit insurers’, with the decline accelerating since March 2012. This declining trend could be the result of an increase in lapses and/or consumers switching. If it is the latter, and given that the market size is increasing overall, then this could be an indicator of an increase in market dynamics in recent years.

- **Figure 2** shows that transfers of hospital and combined cover policies have been rising since March 2008. Most notably, there has been a significant acceleration of transfers for the ‘for-profit’ insurers since March 2010. However, the numbers are small at around 3.7 per cent of the total number of hospital and combined policies in March 2015.

The 2013 IPSOS Report found that only about 6 per cent of the sample reported that they switched their health insurer in the last two years, compared with 4 per cent in 2011 IPSOS Report. Furthermore, 4 per cent indicated that they are very likely to switch health funds in the next 12 months, compared with 2 per cent in the 2011 IPSOS Report. While these findings suggest that consumers have a high propensity

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27 A chart showing the split between open and restricted insurers is very similar, with open insurers matching for-profit insurers and not-for-profit insurers matching restricted insurers.

28 It should be noted that PHIAC’s statistics on transfers of hospital and combined policies underestimate the actual level of transfers occurring in the industry (see St Lukes Health’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 6). In addition, discussions with other insurers support this view. Consequently, PHIAC is examining ways to improve the methodology used to collect statistics on transfers.

29 Health Care & Insurance Australia 2013, IPSOS, page 300.

30 Health Care & Insurance Australia 2013, IPSOS, page 322.
Figure 2: Transfers into a fund: Hospital and combined (hospital and general treatment) cover (a)

Source: PHIAC data.

(a) This figure shows the average number of transfers from one fund to another as a per cent of policyholders in the 12 months to the end of the March quarter. The series has been amended to exclude a spike in September 2011 arising from the transfer of Manchester Unity to Hospitals Contribution Fund.

...to remain with their current insurer, there is an upward trend in those which have switched and those likely to switch.

While the level of switching appears to be low in the private health insurance industry, campaigns such as the recent ‘One Big Switch’ campaign in 2013 – a campaign inviting consumers to consider changing their health fund – which attracted over 100,000 registrations.

It may be informative to examine the experience in other countries with regard to portability. Box 1 summarises the findings of a study of the experience in Switzerland (see page 15).

The level of switching in the most comparable industry – general insurance (which includes liability and property insurance) – also appears to be low at the retail level. The general insurance industry includes features which discourage switching, including bundling of products, cross-selling other services (such as road side assistance), and loyalty and no-claim bonuses.

Price dispersion supports switching

An indicator of a market being competitive is a narrow dispersion of prices of similar products offered by different firms. In contrast, the private health insurance market is characterised by a significant dispersion of prices of similar products. As an illustration, Figure 3 shows the price dispersion of top hospital products (with no excess or co-payment) covering two adults with dependants offered by the larger open private health insurers at the national level. The dispersion is wider if restricted insurers are included, as some of these insurers offer cheaper products than the open funds. The price dispersion in other segments of the hospital product market is similar. Given this price dispersion of hospital products and given that price has been identified as the primary reason for consumers switching insurers (see below), it is perhaps surprising that there is not more evidence of consumers willing to move from one insurer to another in search of what they consider to be better value for their “PHI dollar”.  

31 The number of registrants that actually switched insurers as a result of this campaign is not publicly available.
2 Competition Aspects

Reasons why consumers may not switch

Notwithstanding this price dispersion, the low level of switching in the Australian private health insurance market may reflect a number of factors.

- There could be a general level of consumer satisfaction with current insurers. This view is supported by consumer surveys and by the low level of complaints received by the Private Health Insurance Ombudsman. A special consideration in the case of the private health insurance market is that about a quarter of the total market is held by restricted health insurers. Consumers in this segment of the market may have a greater sense of belonging and loyalty to their insurer.

- It may be that insurers have been adopting aggressive marketing strategies directed at retaining their existing customer base. This may reflect the view that it is cheaper to retain an existing policyholder than to attract a new policyholder from another insurer or from the pool of consumers who do not currently have private health insurance.

- Some consumers may adopt a ‘set and forget’ approach and do not expend the effort needed to review their options. This may be particularly relevant to those consumers purchasing basic hospital products to avoid the Medicare Levy Surcharge. These consumers may be less concerned with the level of coverage or who it is with, so they may tend to make little effort to look elsewhere once a decision has been made.

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33 For example, the 2013 IPSOS found that, in responding to a question “why haven’t you shopped around for private health insurance” 51 per cent responded they were happy with their current fund - see page 326, Health Care & Insurance Australia 2013, IPSOS. Another example is that a survey undertaken by hirmaa found that 98 per cent of consumers are satisfied with their fund (see Australian Health Service Alliance’s and hirmaa’s submission to Discussion Paper No 1, Competition in the Private Health Insurance Market, available at www.phiac.com.au).

34 As an illustration, the Private Health Insurance Ombudsman received in total around 3,400 complaints in 2013-14. This represents a tiny proportion of both claims made and the number of policyholders. In 2013-14, complaints about membership and transfer certificates were also small totaling 218 and 106 respectively.

35 This view is supported by the retention index for restricted insurers being around 92 per cent versus 85 per cent for unrestricted insurers.

36 Confidential submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market.


38 For example, the 2013 IPSOS report found that 30 per cent of respondents to their survey indicated they were either too lazy/apathetic or had no time/too busy to shop around for private health insurance - see page 326, Health Care & Insurance Australia 2013, IPSOS.

An alternative way to look at this issue is that purchasing private health insurance is a significant decision and often a long term one for many consumers, so they are not enticed by short term differences such as a price difference or benefit change. Related to this point, one industry stakeholder argues that the low level of switching is a symptom of regulation in the sense that regulation creates the perception amongst many consumers that health insurance products are “expensive and homogenous”; that is, all insurers are expensive as stimulated by the publicity around the annual increase in premiums, and the products are the same in terms of services covered, waiting periods, marketing offers and discounts so there is little value in switching insurers.

Health insurers are expanding into health related businesses (such as dental, optical, hospitals, medical clinics) and providing health related services (such as chronic disease management plans, preventive health programs and health advice services). This may be part of a consumer retention strategy and strengthening the brand.

As mentioned above, health insurance products are complex and difficult to compare. Further there is a wide range of choice. As with the Swiss experience referred to in Box 1, Australian consumers may feel daunted by the degree of choice and the relatively high search costs associated with assessing alternative options.

The lack of consumer knowledge of the portability rules may be important in explaining the low level of switching. As an illustration of this point, the 2013 IPSOS Report found that 31 per cent of respondents indicated that they may have made a switch had they known that there would be no consequences in terms of waiting periods and benefits.

Following on from this point, the current transfer certificate administrative process may represent a significant barrier to consumers switching. This is discussed in detail below.

**Box 1 – Choice, Switching and Price Competition in the Swiss Private Health Insurance Market**

A study on the rate of switching in the Swiss private health insurance market by Frank and Lamiraud (2008) showed very similar patterns of switching behaviour in Switzerland as there is in Australia, given similar portability rules.

There are three main regulatory features of the Swiss private health insurance market:

- An individual mandate requires all residents to have private health insurance coverage.
- Health insurance companies must offer a standardised health insurance product which is very comprehensive covering out and in patient care and services such as nursing home care.
- Premiums are community rated.

The study found that despite low portability costs, low search costs, a relatively homogenous product and a wide dispersion of premiums offered by health insurers, switching behaviour based on premium charges in the Swiss private health insurance market was low (around 3 per cent per annum) and is not driving premiums to converge to around the same level as economic theory would suggest. The authors concluded that Swiss consumers are not acting as economic agents, because the consumer is overwhelmed by too much choice.

40 HBF submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.
41 Confidential submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market.
42 Health insurers may have other motivations for investing in health related businesses and providing health related services including diversifying the business and reducing future benefit payments.
43 Health Care & Insurance Australia 2013, IPSOS, page 311. In support of this point, the Department of Health and Ageing receives considerable correspondence indicating that consumers are not aware of the portability rules and the ability to transfer hospital coverage without penalty.
In general terms, industry stakeholders consider that complexity of product, satisfaction with existing insurer and consumers not regularly reviewing their options seem to be the main factors explaining the low level of switching. As one industry stakeholder noted, the low level of switching is not as a result of a lack of effort by insurers, brokers and the Government who have devoted considerable resources into encouraging switching.

2.5 Competition issues and switching

PHIAC’s Discussion Paper 1 described competition in the private health insurance industry as a mixed story. This view may also apply to switching. In particular, the low level of switching in the private health insurance industry could suggest that competitive forces may be compromised. However, it is important to recognise that there is no particular level of switching which would indicate that the market is strongly competitive. In this respect, it has been noted by a number of respondents to Discussion Paper 2 that switching in the private health insurance industry creates inefficiencies due to the associated administrative costs, including payments to intermediaries.

An alternative view is that insurers are devoting considerable resources to retaining existing policyholders. Arguably, the low level of switching shows that insurers have been successful in looking after existing policyholders, and insurers have been behaving aggressively to protect their existing policyholder base in the face of strong competition. Reflecting these considerations, many industry stakeholders consider that the threat of consumers switching, combined with the ability to do so at minimal cost and in a convenient way, is sufficient to drive strong competition in the industry. In addition, many insurers consider that the increasing role of insurance brokers in recent times is expected to result in an increase in switching between health insurers in the years ahead. However, insurance brokers contend that the majority of the business they write is for first time purchasers and that encouragement of churn to increase revenue would be to their strategic detriment as it would damage their relationship with their client funds.

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44 The Government’s contribution is establishing and maintaining the comparison website www.privatehealth.gov.au.
45 Hirmaa’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.
46 Health Care & Insurance Australia 2013, IPSOS, page 301.
48 As BUPA’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market notes, these payments are in the order of 20 to 40 per cent of the consumer’s first year premium.
49 See footnote 19 on the growth in advertising in the industry.
50 Submissions to Discussion Paper No. 1, Competition in the Australian Private Health Insurance - KPMG submission page 16, Latrobe Health Services submission page 3 and Teachers Union Health Fund submission page 6.
2.6 Effectiveness of portability rules

The current policy approach in respect to portability is fundamentally a response to the regulation of waiting periods for hospital and hospital-substitute treatment benefits.

None of the submissions to the Discussion Paper No 2 expanded on the difficulty for the insurer the person is moving to may have in determining any residual waiting period to be served, whether a waiting period need be served for treatments not previously covered and whether to continue higher excesses or co-payments under the policy with an insurer the person is leaving. This leads to the assumption that the systems insurers have in place adequately meet these data requirements.

Some submissions did express concern that variations in product benefits are not fully taken into account when determining whether a ‘like-for-like’ transfer has occurred. Subsection 78(15) of the PHI Act prohibits consideration of the additional benefits that may accrue to a policyholder as result of agreements that an insurer may have with a hospital or medical provider. The result is that should a consumer transfer to an insurer which pays higher benefits (through their agreements with providers) than the old insurer for the same treatment, the consumer is not required to serve any additional waiting period with the new insurer.

Some stakeholders noted that, in practice, it is difficult to determine ‘like-for-like’ at the benefit level and any change may add too much complexity to the transfer process. Other industry stakeholders submitted that the inability of the insurer the consumer is joining to take into account the lower benefit levels provided by the insurer the consumer is leaving results in the portability rules not working effectively, and the gaining insurer and its policyholders need to be protected from the increased benefit costs that may be incurred.

This may be particularly important when an insurer and a hospital group fail to renegotiate a renewal of their agreement. If an insurer goes out of contract with a hospital or hospital group, there is an incentive for consumers to switch from this insurer to an insurer who is in contract and so obtain treatment without the significant out-of-pocket expenses they would incur if they remained with the first mentioned insurer. It would be important that any amendment to the portability arrangements (to protect the gaining insurer) would need to ensure that the consumer remains protected and able to utilise their cover without disadvantage.

As we have seen, waiting periods for general treatment cover (excluding hospital substitute treatment) are not regulated, and there are no portability rules in respect of these policies. This is a potential negative influence on competition as consumers may have to re-serve waiting periods for general treatment if they switch funds. However, in practice, many insurers waive the requirement to serve waiting periods for many, if not all, general treatment services if the consumer is transferring from another health insurer. This suggests that the market in some areas is operating in ways which enhance portability. For this reason, the vast majority of industry stakeholders who made a submission to Discussion Paper No 2 consider that there is no public policy case for introducing portability rules for general treatment products.

2.7 Administrative processes supporting portability

Once a consumer has elected to transfer their hospital treatment insurance policy to another fund, the insurer the policyholder is leaving is required under Division 99 of the PHI Act to provide a transfer certificate. This certificate provides evidence to the new insurer of waiting periods already served.

The timeliness and ease (from the consumer’s point of view) with which this administrative process is conducted has an impact on the extent to which consumers are able to exercise choice and maximise their outcomes. If this process is not working well, then the competitiveness of the market is compromised. In the past, representations made by some insurers suggest that the ease of transfer has been impeded by:

- attempts by the insurer the policyholder is leaving to convince them not to transfer to another insurer;
- the lack of commercial incentive for the insurer the policyholder is leaving to process the transfer certificate in a timely manner; and
- the insurer the policyholder is leaving imposing process conditions on the insurer the person is joining such as requiring a hard copy of the request for a transfer certificate rather than a more convenient electronic version.

51 Doctor’s Health Fund’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.
53 A confidential submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market noted that an emerging issue is the ability for insurers (for tactical reasons) to go out of contract with hospital where they have substantial ongoing claims costs.
Anecdotal evidence suggests that, in the past, these factors may have resulted in the issuing of transfer certificates taking around 30 days instead of the legislated 14 days after the insurer the person is leaving receives a request for a transfer certificate from the insurer the person is joining.54 The industry has responded to these concerns by amending the Private Health Insurance Code of Conduct which now includes a requirement that insurers provide a transfer certificate within 14 days after receiving the request to issue the transfer certificate, consistent with the legislative requirement. This amendment took effect from 1 July 2012. Further, in October 2012, an industry working party agreed on a process for handling transfer certificate requests, including a standard form and electronic transfer. Submissions from industry stakeholders to Discussion Paper No 2 indicate that while the administrative process has improved since the changes to the Private Health Insurance Code of Conduct were made in July/October 2012, it continues to present challenges.55 Some of the points made include the following:

- The administrative process does not represent a barrier to consumers seeking to change insurers. 56 One submission noted that as the transfer process has already occurred before the transfer certificate request can be made, any logistical concerns with the issue of the transfer certificate do not necessarily impact on the consumer’s decision to transfer.57

- However, some consumers may become disenchanted with the insurer they are joining if the process is not handled efficiently, particularly if delays result in the consumer making payments to both the old and new insurer notwithstanding that the additional payment is later refunded.

- The lack of a standardised industry wide system of processing transfer certificates has resulted in each individual insurer developing their own unique process. This results in poor quality data and a reliance on the good will between the two insurers for the process to function.58

- Incorrect information on the transfer request can cause delays.59 There can also be issues where there is more than one person on the policy. This delays generating a transfer certificate as the insurer is unable to identify the policyholder.

- Attempts by the insurer the person is leaving should not be seen as ploys to delay the process. Instead, these attempts to ‘win back’ consumers should be seen as fostering competition and should not be discouraged.60

There are mixed views on how to improve the current system. Many industry stakeholders consider that there could be merit in developing a centralised electronic system to streamline and to standardise the process. The industry is slowly moving in the direction of an electronic system with the changes implemented in October 2012. However, implementation of a centralised system would represent a major change and is likely to be far from simple. It may require an independent third party to run the system and a standardised system of numbering policyholders throughout the whole industry. It is not likely to be as straightforward as telephone number portability61 and may indeed be as complex as full account portability in the banking industry.62 The costs of establishing a centralised system could be material and these would most likely need to be borne by policyholders.

As a more practical alternative, some considered that the current system could be further improved by allowing electronic authorisation and strengthening the Private Health Insurance Code of Conduct.63 In addition, some industry stakeholders consider that the solution lies in the regulators enforcing compliance with the current 14 day legislative requirement.64

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54 A confidential submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market indicated that over a period of around 4 months to mid-September 2013 82 per cent of transfer certificates sent were greater than 1.5 days old.


56 Medibank Private’s submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.


58 Medibank Private’s submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.

59 In particular, the insurer the person is joining is only permitted to request a transfer certificate 7 days after the consumer has actually transferred to the new insurer (provided the consumer has not already provided a certificate). BUPA’s submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market, page 2.

60 BUPA’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 3.

61 See the Australian Communications and Media Authority’s website: www.acma.gov.au.

62 For information on account portability in the banking industry, see Fraser, BW, Banking Services Switching Arrangements, July 2011.

63 Wayne Cooper’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 5.

64 Hima’s to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 5.
Looking forward, industry stakeholders are concerned that complexity of the regulatory system is significantly increasing with changes to the private health insurance rebate (means testing, removal of Lifetime Health Cover surcharges, and indexation). In addition, switching is likely to increase in the years ahead as a result of the increased presence of insurance brokers, and the increased propensity of consumers to review their policy choices in the light of higher premiums and the reduction in the private health insurance tax rebate as a result of indexation. As a result, there is a risk that the transfer process may become more difficult for insurers to administer. If this is the case, the opinion was expressed that there may be a need to completely re-think the transfer process and legislative timeframes in order to maintain the integrity of portability in the industry in the years ahead. This may create an environment where a centralised electronic system will need to be developed in order for the market to operate in a way that facilitates consumer mobility. In fact, as at May 2015, the industry is moving in this direction.

### 2.8 Costs incurred by the acquiring insurer

As we have seen, a potential issue in the portability context is that the insurer gaining the new policyholder may have to bear significant costs soon after the person joins the insurer even though the person has been a policyholder with this insurer for a very short period of time. The transfer may well occur immediately prior to hospital treatment, perhaps in circumstances where the hospital is out of contract with a particular insurer and the person seeks to avoid significant out-of-pocket expenses. Another example is where a person transfers to a new insurer with a pre-existing condition (such as pregnancy) which requires admission within a comparatively short period (say within 6 months). There is also the possibility that a person may transfer to a particular insurer prior to treatment in order to take advantage of a ‘gap’ or ‘known gap’ agreement the insurer may have with a particular medical provider.

Stakeholders who made submissions to Discussion paper No 2 had differing views on whether there is a case for government intervention to protect the acquiring insurer against a significant increase in costs. Some considered that there is a need for government intervention. However, it was noted that designing and implementing any intervention would present challenges and any intervention should be limited. Other stakeholders consider that there is no case for intervention. They note that risk equalisation provides some protection to insurers and insurers have the option of amending product benefits to protect themselves. This may suggest that there is a need for more stakeholder discussion on this issue.

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65 TUH’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 4
66 The Doctor’s Health Fund’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 4
67 Catholic Health’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 4
68 BUPA’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 5
69 HBF’s submission to Discussion Paper No 2 Portability, Switching and Competition in the Australian Private Health Insurance Market, page 4
Division 75—Waiting period requirements

75-1 Waiting period requirements
(1) An insurance policy meets the waiting period requirements in this Division if the waiting period that applies to a person who did not transfer to the policy is no longer than:

(a) for a benefit for hospital treatment or hospitalsubstitute treatment that is obstetric treatment or treatment for a preexisting condition (other than treatment covered by paragraph (b)) —12 months; and

(b) for a benefit for hospital treatment or hospitalsubstitute treatment that is psychiatric care, rehabilitation or palliative care (whether or not for a preexisting condition) —2 months; and

(c) for any other benefit for hospital treatment or hospitalsubstitute treatment —2 months.

(2) The Private Health Insurance (Complying Product) Rules may modify the requirements in subsection (1) in relation to all or particular kinds of private health insurers, benefits or insured persons. To the extent the Rules do so, the waiting period requirements in this Division are taken to be met if the conditions in the Rules are met.

Note: If a private health insurer provides an insured person with, or arranges for an insured person to be provided with, treatment, it is treated as a benefit for the purposes of this Division (see subsection 695(3)).

75-5 Meaning of waiting period
The waiting period that applies to a person for a benefit under an insurance policy is the period:

(a) starting at the time the person becomes insured under the policy; and

(b) ending at the time specified in the policy; during which the person is not entitled to the benefit.

75-10 Meaning of transfers
A person transfers to a policy (the new policy) from another policy (the old policy) if:

(a) either:

(i) the person is insured under the old policy at the time the person becomes insured under the new policy; or

(ii) the person ceased to be insured under the old policy no more than 7 days, or a longer number of days allowed by the new policy’s insurer for this purpose, before becoming insured under the new policy; and

(b) the old policy is a complying health insurance policy; and

(c) the person’s premium payments under the old policy were up to date at the time the person became insured under the new policy.

Note: See section 991 about transfer certificates.
75-15 Meaning of preexisting condition

[1] A person insured under an insurance policy has a preexisting condition if:

(a) the person has an ailment, illness or condition; and

(b) in the opinion of a *medical practitioner appointed by the insurer that issued the policy, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy.

[2] In forming an opinion for the purposes of paragraph (1)(b), the *medical practitioner must have regard to any information in relation to the ailment, illness or condition that the medical practitioner who treated the ailment, illness or condition gives him or her.

[3] if:

(a) a private health insurer replaces a *complying health insurance product with another complying health insurance product; and

(b) a person who was insured under a policy that was in the replaced *product is *transferred by the insurer to a policy that is in the replacement product;

the reference in paragraph (1)(b) to the day on which the person became insured under the policy is taken to be a reference to the day on which the person became insured under the replaced policy.

Division 78—Portability requirements

78-1 Portability requirements

[1] An insurance policy meets the portability requirements in this Division if the policy meets the requirements in subsections (2), (3) and (4).

[2] An insurance policy meets the requirement in this subsection if the *waiting period that applies to a person who *transferred to the policy (the new policy) from another policy (the old policy) is no longer than:

(a) for a benefit for *hospital treatment or *hospitalsubstitute treatment that was not *covered under the old policy—the balance of any unexpired waiting period for that benefit that applied to the person under the old policy.

(b) for a benefit for hospital treatment or hospitalsubstitute treatment that was covered under the old policy—the balance of any unexpired waiting period for that benefit that applied to the person under the old policy.

[3] An insurance policy meets the requirement in this subsection if the policy does not impose on a person who *transferred to the policy any period (other than a *waiting period allowed under subsection (2)) during which the amount of a benefit in relation to any particular *hospital treatment or *hospitalsubstitute treatment is less than the amount the person would be eligible for during any other period.

[4] An insurance policy meets the requirement in this subsection if, in relation to a benefit for *hospital treatment or *hospitalsubstitute treatment:

(a) that was *covered under the old policy; and

(b) in respect of which a higher excess or higher copayment applied under the old policy than

is the case under the new policy;

any period during which the higher excess or higher copayment continues to apply under the new policy to a person who *transferred to the policy is no longer than the *waiting period allowed under section 751 for a benefit for that treatment.

[5] In working out:

(a) for the purposes of subsection (2) or (4), whether a treatment was *covered under an old policy; or

(b) for the purposes of subsection (3), whether the amount of a benefit under a new policy during a period is less than the amount it would be during another period;

disregard the existence or otherwise of contracts between the insurer in relation to either of the policies and particular *health care providers or groups of health care providers.

(6) The Private Health Insurance (Complying Product) Rules may modify the requirements in this section in relation to all or particular kinds of private health insurers, benefits or insured persons. To the extent the Rules do so, the portability requirements in this Division are taken to be met if the conditions in the Rules are met.

Note: If a private health insurer provides an insured person with, or arranges for an insured person to be provided with, treatment, it is treated as a benefit for the purposes of this Division (see subsection 695(3)).
Division 99—Transfer certificates

99-1 Transfer certificates

Certificate for the insured person

(1) A private health insurer (the old insurer) must, if a person ceases to be insured under a *complying health insurance policy of the insurer and does not become insured under another policy of the insurer, give the person a certificate under this subsection:

(a) in the *approved form; and

(b) within the period set out in the Private Health Insurance (Complying Product) Rules.

Certificate for the new insurer

(2) A private health insurer (the new insurer) must request a certificate from an old insurer if:

(a) a person who is or has been insured under a *complying health insurance policy of the old insurer *transfers to a complying health insurance policy of the new insurer; and

(b) the person does not give the new insurer the certificate the old insurer gave the person under subsection (1) within 7 days of becoming insured by the new insurer.

The request must be made:

(c) in the *approved form; and

(d) within the period set out in the Private Health Insurance (Complying Product) Rules.

(2A) A private health insurer must not request a certificate except in the circumstances set out in subsection (2).

(3) If a certificate is requested by the new insurer (whether or not the request is in the *approved form or made within the period mentioned in paragraph (2)(d)), the old insurer must give the new insurer a certificate:

(a) in the approved form; and

(b) within the period set out in the Private Health Insurance (Complying Product) Rules.

Offence

(4) A private health insurer commits an offence if:

(a) the insurer is required to do a thing under subsection (1), (2) or (3); and

(b) the insurer does not do the thing.

Penalty: 60 penalty units.

(5) Strict liability applies to subsection (4).

Note: For strict liability, see section 6.1 of the Criminal Code.
Abbreviations and acronyms

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<td>PHI</td>
<td>Private Health Insurance</td>
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<td>PHIAC</td>
<td>Private Health Insurance Administration Council</td>
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<td>PHIO</td>
<td>Private Health Insurance Ombudsman</td>
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Submissions received

The following organisations submitted a submission to Discussion Paper No 2, Portability, Switching and Competition in the Australian Private Health Insurance Market. These submissions are available at [www.phi.ac.gov.au](http://www.phi.ac.gov.au). There were also 5 organisations which submitted a confidential submission.

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<td>Australian Physiotherapy Association</td>
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<td>Bupa Australia Pty Ltd</td>
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<td>St Lukes Health</td>
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<td>11</td>
<td>Wayne Cooper, Independent Auditor for the Code Compliance Committee</td>
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