ENSHRINING PORTABILITY OF PRIVATE HEALTH INSURANCE

A REPORT BY
ACCESS ECONOMICS PTY LIMITED

FOR

AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

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ACCESS ECONOMICS

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EXECUTIVE SUMMARY

- In principle, members of private health insurance funds have the right to choose their fund and the right to change funds without penalty (the concept of portability);

- Legislation passed in 1988 sought to ensure portability of private health insurance. In the intervening years there have been major legislative initiatives, in particular the purchaser/provider agreements (contracting) between funds and hospitals/doctors (1995) and Lifetime Health Cover (2000). Lifetime Health Cover (LHC) provides an incentive for people to retain private health insurance cover for the long term. When portability is impaired, LHC is undermined. The portability provisions have not kept pace with all the intervening changes and no longer provide the consumer protection that is required and expected;

- Private health insurance portability has been significantly eroded by the imposition of benefit limitation periods (waiting periods by another name), by the sheer complexity of the legislation (which makes it difficult to interpret and enforce) and by cumbersome health fund administration;

- PHIO data suggests that the level of complaint about portability issues is rising;

- To secure the considerable benefits of competition, markets must be contestable by new sellers and consumers must be able to exercise genuine choice;

- Obstacles to portability include the complexity and lack of clarity of the legislation, the barriers to new entry to the private health insurance market arising from the high degree of regulation of the industry, and the imbalance of information between funds and their members;

- The Federal Government has seen the opportunities to improve the lot of consumers by opening some markets to greater competition (notably in telecommunications and superannuation) but has, to date, moved very cautiously in relation to private health insurance;

- In the interests of PHI fund members, portability should now be firmly enshrined both in legislation and in practice. This report recommends three steps to that end:
  - Building a stronger overriding principle around the concept that a transferring member should never be worse off than a member maintaining continuous membership with one fund and establishing unequivocally that benefit limitation periods are waiting periods;
  - Addressing member frustration at administrative hassles and health fund concern at administrative costs by building an on-line information clearing house for the exchange of data needed for a transfer of membership (implementation as a module of Eclipse may be a possibility); and
  - Making the legislative concept of "broadly comparable benefit" effective by prescribing the broad categories, thereby preventing the funds from using minor differences in benefit entitlements as obstacles to portability.

1. PURPOSE

This report addresses portability of private health fund membership.

Part 2 succinctly states the nature of the problem.

Part 3 explains why portability is important to ensure that Australia has a competitive and efficient private health insurance sector that is responsive to the needs of Australians. It argues the case for portability to be more firmly enshrined in the private health insurance policy, legislative and administrative framework.

Part 4 provides background on policy development and previous endeavours to address consumer concerns (including the review conducted by the Private Health Insurance Ombudsman in 2000).

Part 5 examines the obstacles to enshrining portability and concludes that the intentions of the current legislative provisions are not being realised in a satisfactory manner.

Part 6 draws on the experience in two other sectors of the economy (telecommunications and superannuation) and shows how consumer interests have been advanced by persistent efforts to improve the competitive structures in those areas.

Part 7 suggests several options designed to enshrine portability in private health insurance.

2. WHAT IS THE PROBLEM?

There is compelling evidence of significant and increasing obstacles to portability of private health insurance despite 1988 legislation that sought to achieve it.

This evidence is seen in:

- **a continuing high level of complaints to the Private Health Insurance Ombudsman (PHIO):** Many of these complaints relate to processes and the problems they create when members seek to transfer. While the legislation seeks to enshrine portability, the funds don't have in place the systems that could deliver it in any meaningful way. The complaints that are handled by PHIO are undoubtedly the tip of an iceberg; and
- **uncertainty about the meaning of the legislation which has opened the door to several funds imposing benefit limitation periods upon transferees:** This is entirely against the spirit of the legislation. However, given the complexity of the legislation, there is a range of possible interpretations, most of which operate to the detriment of consumers.

In the years that have passed since the 1988 legislation, there have been very major structural changes in private health insurance. In 1995, the Keating government legislated to allow purchaser/provider agreements (contracts) between funds (as the "purchaser") and hospitals and doctors (as the "providers"). These provisions were amended in late 2000 by the Howard government to permit medical gap cover without contracts. Another very important initiative in 2000 was the introduction of Lifetime Health Cover.

The portability provisions (as amended) are clearly not up to the task in the increasingly complex world of private health insurance. This is an unintended consequence.

2.1 PHIO EVIDENCE

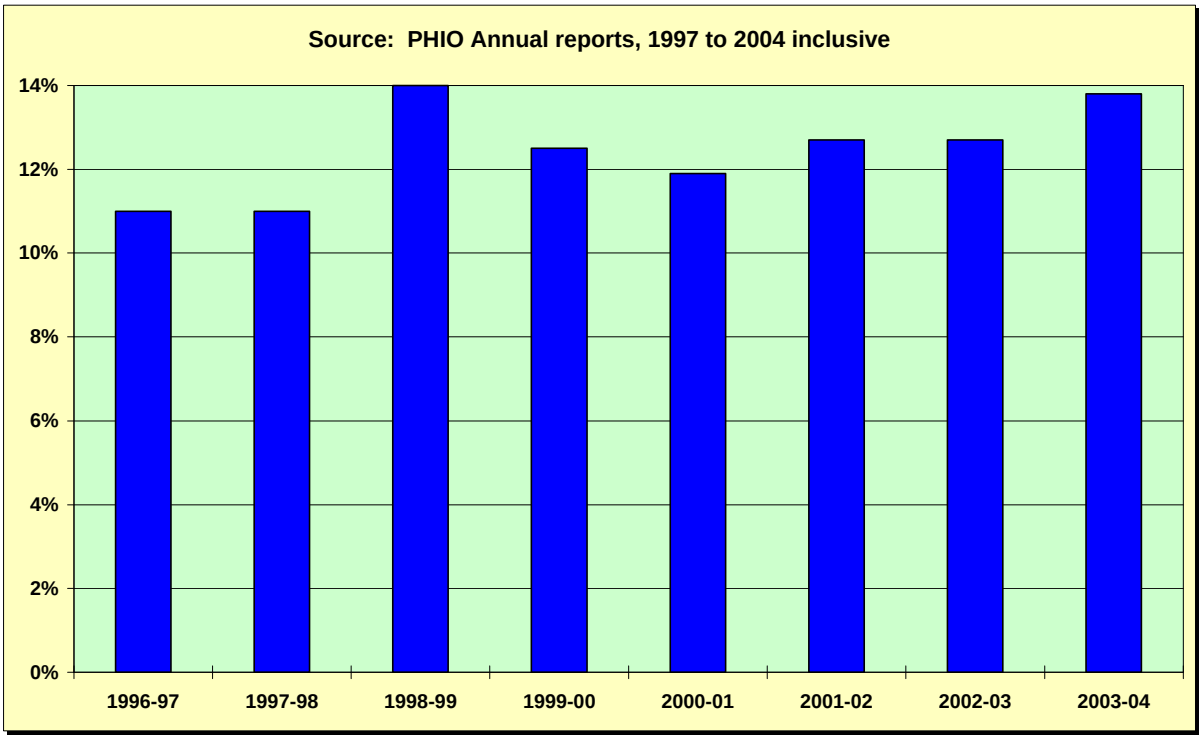
PHIO publishes statistics on complaint issues but has not reported on portability complaints on a regular and consistent basis. Portability of membership is not a complaint category in its own right but is encompassed in the "membership" category. A search of PHIO annual reports reveals that:

- transfer issues comprised 20% of complaints about membership in 1996-97;
- transfer/continuity issues comprised 28% of complaints about membership in 1997-98;
- transfer/continuity issues comprised 24% of complaints about membership in 2000-01; and
- 170 complaints were received about problems in transferring between funds during 2003-04.

We cannot be entirely sure that the PHIO statistics have been compiled on a fully consistent basis over time (for a start, the number of categories of complaint issues has increased from six to nine) but complaints about membership issues have increased as a proportion of all complaints (see Chart 1) and it would appear also that that complaints about problems in transferring between funds have increased as a proportion of membership complaints.

On the face of it, complaints about portability issues have increased by more than sixfold, from an estimated 27 in 1996-97 (the first full year of PHIO operations) to a reported 170 in 2003-04.

CHART 1: MEMBERSHIP COMPLAINTS TO PHIO AS A PERCENTAGE OF THE TOTAL



There is no way of knowing the full extent of member dissatisfaction over portability issues. Some complaints will be resolved without PHIO intervention. Perhaps, over time, PHIO has become better known. But then again, perhaps the mere existence of PHIO provides an incentive for funds to resolve complaints before members seek PHIO assistance. All in all, the level of complaints to PHIO is the key indicator available and there is no respectable argument for overlooking it.

PHIO interpretation of the data is further evidence of the extent of the problem:

> "*Benefit limitation periods ... are waiting periods under another name. They have the effect of imposing additional waiting periods, beyond the standard ones ...*" (PHIO Annual Report 1998)
>
> "*The right to transfer between health funds without having to re-serve waiting periods is a basic consumer protection measure which has been available to health fund members for many years. However, the issue has become increasingly complex in recent years, due to a number of factors, including the difficulties of comparing different tables of cover and the introduction of selective contracting with hospitals*." (PHIO Annual Report 1999)
>
> "*A second area where consumers have consistently faced difficulty is in the area of product portability. The National Health Act as it relates to portability is extremely complex and again it is an area where the interpretation and subsequent application of the provisions by funds has been inconsistent*." (PHIO Annual Report 2001)

> "*There are a number of key issues for the private health insurance industry which have been raised regularly in the Ombudsman's Overview of past year's reports. They have been as much or more of a concern in 2003-04 as they have been in virtually all previous years of this office's existence ... These perennial issues (include) the rights of consumers when changing health funds (portability)...* " (PHIO Annual Report 2004)

One specific issue noted by PHIO relates to the concept of "***broadly comparable benefits***" and how these relate to hospital purchaser provider agreements (HPPAs). As reported by in the PHIO 2004 annual report:

> "*This experience has led a number of funds to question the application of the portability policy in situations arising from the cessation of contracts between hospitals and health funds*."

The "experience" referred to by the Ombudsman was a particular and, in our view, exceptional event—the late 2003 breakdown in negotiations between the BUPA health funds and the Healthscope hospital group. This issue is addressed extensively at pages 6 & 7 of the PHIO 2004 annual report and there is no purpose to be served in hoeing over that ground again here because portability of health fund membership was not the core issue but merely one of the areas of collateral damage.

The fact that this issue has arisen at all would suggest that clauses (lab) and (lba) of Schedule 1 of the Act[1] are not effective in their current form. To the lay reader, these clauses require funds to disregard issues around HPPAs—such as whether or not there is a contract (HPPA) in place with a particular hospital—when determining whether or not a benefit is broadly comparable.

It is, of course, not at all unusual for an exceptional event to derail an existing policy. Good public policy requires policy makers to take a deep breath and look beyond the heat and noise of a short term problem.

2.2 AUSTRALIAN UNITY BENEFIT LIMITATIONS

Australian Unity is, to our knowledge, the fund to have moved most recently to impose benefit limitation periods upon transferees. The information they provide indicates that the benefit limitations apply specifically to psychiatric and rehabilitation benefits.

The Australian Unity web site addresses benefit limitations in ***Frequently Asked Questions***, as follows:

> **Q: Will I have to go through the waiting periods again?**
>
> *A: If you join Australian Unity before your current cover expires, or within 30 days of ceasing your membership with your old fund, you will maintain continuity of cover. So you can switch to Australian Unity with the reassurance that you won't have to wait again before you can start making claims on your health cover. However for any benefits you weren't previously covered for, waiting periods may apply.* ***Benefit limitation periods may apply to some conditions in the first 12 months of membership*** *{emphasis added}.*

[1] The relevant sections are reproduced in Appendix A, see page 23 below.

The detailed brochures available for download from the web site provide additional information (extract at Box 1). It is here that we discover some fascinating semantics:

> *Members transferring from an equivalent level of cover with another fund will not have to re-serve waiting periods, however benefit limitation periods do apply.*

The small print at the back of the brochure explains that in the first twelve months of membership with Australian Unity, benefits for psychiatric or rehabilitation are limited to the Basic Hospital Cover Rate (a 'safety-net' rate, which is set at less than 50% of the cost of providing quality private hospital care). In other words, in the view of Australian Unity, a twelve month waiting period for entitlement to full benefits is not a waiting period.

On some readings, the Australian Unity approach is argued to be within the letter of the law, in which case we would conclude that the legislation is failing in its core aim. On other readings, the Australian Unity approach is against the letter of the law, in which case there is a question whether the legislation is being undermined by a permissive policy stance.

BOX 1: AUSTRALIAN UNITY TRANSFER INFORMATION

Switching Funds

Member Get Member – Rewarding you for introducing new members.

Get a friend or a family member to join Australian Unity and receive a $50 gift voucher*, for every new health membership you introduce. If they're joining for the first time or even if they're in another health fund, when they switch to Australian Unity, you get rewarded for recommending us! Ask for a Health Cover Guide and they can transfer to an equivalent level of cover without having to re-serve their waiting periods.

Switching is Easy

It's easy to switch to Australian Unity from your current health fund, just fill in the Application Form and Clearance Request Form on page 16.

*Excludes Healthy Travel Cover. This offer cannot be used in conjunction with any other discount arrangement. Conditions apply.

Waiting periods

Australian Unity gives you immediate cover, except as listed below:

Benefits	Waiting Periods
Pre-existing conditions (including elective procedures eg. vasectomy, cosmetic surgery)	12 months
Extraction of wisdom teeth	6 months
Optical	6 months
St John Ambulance First Aid Course	6 months
Obstetrics/childbirth For Basic Hospital Cover only	9 months
Obstetrics/childbirth For all other tables including Comprehensive Hospital Cover	12 months
Major dental (including dentures, crowns, bridgework, implants)	12 months
Orthodontics	12 months
Orthotics	12 months
Hearing aids	12 months
Blood Glucose Monitors/ Blood Pressure Monitors	12 months
Asthma Pumps/Peak Flow Meters	12 months
TENS Pain Control Machine	12 months
C-PAP machine	12 months
Non-surgical prosthesis	12 months
Psychiatric# (except for Basic Hospital Cover)	12 months
Rehabilitation# (except for Basic Hospital Cover)	12 months

Note: For details of waiting periods, benefit limitation periods and pre-existing conditions, please refer to the Conditions of Benefits, point 6 on page 18. Members transferring from an equivalent level of cover with another fund will not have to re-serve waiting periods, however benefit limitation periods do apply.

#Psychiatric and Rehabilitation are subject to a 12 month benefit limitation period.

Source: Australian Unity HealthCoverGuide at **http://www.australianunity.com.au/**

2.3 PROBLEMS FROM THE OTHER SIDE

One of the arguments sometimes advanced for imposing benefit limitations upon transferring members is that the gaining fund can be disadvantaged because the contribution revenue received from the transferring member may, in the short term, be much less than the benefits paid out. This argument is not at all convincing:

- Given the swings and roundabouts, this effect should be neutral over time with any extra cost from members transferring in offset by members transferring out;
- The reinsurance arrangements are there to overcome any disadvantage experience by funds with an older cohort of members, so if net transfers increase the relative age profile of any fund, this is dealt with by the reinsurance pool.

The funds have argued that the portability arrangements could destabilise them were there any large movement of members. There is no empirical evidence that funds have experienced problems of this nature. However, the reinsurance arrangements are the appropriate tool for dealing with this issue. If there is any substance in the argument that the reinsurance arrangements are not able to resolve such an issue, then it is a matter that should be addressed in the review of the reinsurance arrangements.

3. PORTABILITY MATTERS

Portability of private health fund membership—the ability of members to change insurance providers without financial penalties or other obstacles—is vital to ensuring that Australia has a competitive private health insurance industry.

Two central tenets of competition theory are that the existence of a competitive market depends upon **both**:

- **markets being contestable by new sellers:** A market is held to be perfectly contestable when the costs of entry and exit are zero. In a contestable market, the number of firms and their size is irrelevant. Potential competition is sufficient to ensure that firms in the industry achieve allocative efficiency and earn normal profits. Where there are few barriers to entry, potential entrants are able to enter the industry quickly if abnormal profits are made; **and**
- **the availability and exercise of consumer choice:** If consumers are captive to particular providers or products, or if they are not easily able to substitute away from high-priced firms, the presence of a large number of sellers will not guarantee a competitive market. The keys to consumer choice are knowledge and the lack of institutionalised barriers to shifting their allegiance from one seller to another. If consumers have good knowledge of products and prices, they will be more able to bargain hunt to achieve satisfaction.

3.1 A HIGHLY REGULATED INDUSTRY

Private health insurance in Australia has been characterised by a very high degree of regulation by government. It is worth reflecting for a moment on the rationale for regulation. The customary reasons for regulating an industry are to:

- **combat market failure:** market failure can arise, for example, where the inequality of information between provider and buyer is so large that Government needs to step in to protect the interests of consumers.
- **achieve a range of societal/social objectives which would not be met in an unregulated or less regulated market:** Social objectives include the notions of equity and access, while there may also be economic or financial agendas, such as cost-shifting to the household sector.

There is one principle of which we must never lose sight. The purpose of regulation is to protect the interests of the people. The prudential requirements are a good example. They are designed to support a high level of financial and prudential management so that members are protected from fund failures. **If the regulation is seen to be harming the interests of consumers, then it is time to reconsider it**.

3.2 REGULATION CAN FAIL

There are many examples of the regulation of private health insurance failing to achieve the stated objectives. The justification for community rating, for example, was that it resulted in fairer sharing of the burden of health financing than would have been expected under a risk sharing system. In theory, it provided a framework for people to share their risk without the sick bearing a disproportionate share of the cost. The evidence from the non-regulated insurance sector indicates the financial risk to people with health problems. For example,

patients with diabetes find it very difficult to procure products such as trauma insurance and encounter much higher premiums if they can obtain cover.

Community rating received non-partisan support from the major political parties as well as support from all significant health lobby groups including the AMA and the AHIA. Nonetheless it proved to be unsustainable because consumers did their own self-risk rating and cancelled their memberships (or did not join up) when young, thereby shifting the burden to the older, sicker patients who maintained their own cover. In short, it proved impossible to make community rating work in the context of a voluntary system.

Other elements of the regulatory environment appear quite ineffectual, for example, the regulation of prices.

In Part 5 we address in more detail the obstacles to consumers exercising choice. We show how ineffective regulation has failed to enshrine portability but note also that not all the obstacles to portability arise from regulation.

3.3 REGULATION CAN COST

The Federal Government has accepted that there is a case for reducing the burden of red tape on the funds and has introduced a number of reforms designed to rationalise administrative and compliance processes. This is laudable.

The funds incur considerable costs in complying with the many rules, regulations and reporting requirements. Entry costs are significant and this naturally deters new entrants. The private health insurance market is not easily contested by new players.

Like many other areas of the financial services sector, takeovers and closures have reduced the number of players contesting the private health insurance market. Medibank Private has been able to hold its position as market leader with a market share of almost one quarter. Typically, the six or seven largest funds have commanded well over 80% of the market. In many areas of the country, there are only two or three funds with much in the way of market presence.

3.4 CAN MARKETS BE TRUSTED?

Regulation intended to deal with market failure requires a different mindset to regulation intended to facilitate competition-based reforms. The former is built around the concept that markets need to be corrected, their excesses curbed and their operations retuned to social objectives. The latter envisages that markets can be effective and seeks to remove or ameliorate the factors that impair their operation, in other words to create an environment in which competition generates benefits for consumers without imposing additional costs. Making markets more effective can be a better solution (measured in terms of outcomes for consumers) than relying on regulation.

4. POLICY DEVELOPMENT

The appendices to this report reproduce two key documents regarding portability:

- The legislative support for portability is included in Schedule 1 of the National Health Act 1953 (extract at Appendix A).
- The Private Health Insurance Ombudsman (PHIO) has published a comprehensive consumer guide to portability—***The Right to Change: Portability in Health Insurance*** (Appendix B).

Portability issues appear to have been largely in terms of preventing the funds from imposing new waiting periods on transferring members. This is, however, only one of the avenues by which funds can put stumbling blocks in the way of transfers.

Another arena relates to pre-existing ailments. Any member who encountered difficulties in claiming benefits as a result of pre-existing ailment limitations will be prone to concerns that a transfer to a different fund will result in further difficulties of that nature.

4.1 PRIOR TO 1988

Prior to 1988, the only legislation provision relating to portability was paragraph (l) of Schedule 1 to the National Health Act 1953. This guaranteed portability without the imposition of a new waiting period in extremely limited circumstances, where:

- the member transfers for another health benefits fund conducted by the same organisation; or
- the transfer arises as a result of the Minister cancelling (or considering cancelling) the registration of a health benefits fund.

4.2 1988 AMENDMENT

In 1988, the *Community Services and Health Legislation Act 1988* (No. 79 of 1988) amended the Principal Act (the *National Health Act 1953*) by adding sections (la) to (lf) to Schedule 1. In the intervening years, relatively minor modifications have been made to these sections without altering their thrust.

The explanatory memorandum to the 1988 Act stated that the purpose of the paragraph was to enable contributors to transfer from one RHBO to another:

> "… *without the imposition of a waiting period or with reduced waiting periods where the waiting period has been served in whole or in part*."

The second reading speech was rather more fulsome:

> "…*The National Health Act is also amended to allow contributors to health insurance who wish to transfer from one health benefits organisation to another because of factors such as lower contribution rates and other benefits, to do so without having to face difficulties through the imposition of new waiting periods. These measures improve the freedom of choice for that half of Australia's population which currently has private health insurance. Members will be able to transfer from one organisation to another without the imposition of waiting periods, or with reduced waiting periods where part or whole of the waiting period has been served in the previous organisation*."

The current provisions, (l) and (la) to (lf), are reproduced in the extract from Schedule 1 at Appendix A.

4.3 PHIO REVIEW IN 2000

The office of the Private Health Insurance Ombudsman (PHIO) undertook a review of the portability provisions during 2000. PHIO reported that the review was prompted by continuing problems associated with varying interpretations of the provisions by the funds.

PHIO concluded that:

> "… *the provisions fail because there is a dispute on what constitutes a broadly comparable benefit and the effect of different components within products to establish beyond doubt the relevant part of the relevant benefit*."

Following consultation around a draft report, in December 2000 PHIO released a final report of the review reflecting the "agreed position". This comprised 27 recommendations covering:

- Contracting arrangements between funds and providers (8 recommendations);
- Exclusionary products (3 recommendations);
- Benefit limitations (4 recommendations);
- Front end deductible products (3 recommendations);
- Hospital versus ancillary products (2 recommendations);
- Loyalty bonuses (1 recommendation);
- The timing of portability (2 recommendations); and
- Consumer literature on portability (4 recommendations).

In other words, PHIO pursued a practical, product-based approach rather than focussing on issues of principle. That approach seems in retrospect to have been entirely appropriate in the search for a voluntary and consensus solution.

4.4 ASSESSMENT OF THE 2000 REVIEW

The PHIO review was a very genuine attempt to find a solution by consensus, one that would be implemented voluntarily. This was an endeavour worth trying. If the industry had stuck by the spirit of what was agreed at that time, it is arguable that portability issues would not be continuing to generate concern. The fact that they remain of concern suggests that a self-regulatory solution is not a promising option for the future.

Stated simply:

- the 1988 legislation sought to enshrine portability by legislative requirement ***and it failed*** because the provisions are not sufficiently compelling; and
- the 2000 review sought to enshrine portability by consensus and voluntary adherence to modes of operation and codes of conduct ***and it failed*** because the industry has chosen not to comply with the recommendations; therefore
- it is timely to take another look at the options which may include strengthening the regulations to make them effective.

4.5 SUBSEQUENT PHIO PROCESSES

Since the review in 2000, the PHIO has continued to address the problems raised with it by consumers and has continued to have dialogue with the industry. The papers generated in that consultation process are not on the public record.

5. OBSTACLES TO PORTABILITY

The three main obstacles to portability of private health insurance are:

5.1 INEFFECTIVE PORTABILITY PROVISIONS

As told in Part 4, the 1988 legislation sought to enshrine portability by legislative requirement. It failed because:

- the provisions are not sufficiently compelling;
- a key concept, that of a ***broadly comparable benefit***, is not explicitly defined in the legislation (although the legislation does, in several places, indicate issues that are not to be considered in establishing what is broadly comparable). As such, this key concept is open to wide and sometime mischievous interpretation; and
- the very complexity of the legislation makes it difficult to administer.

5.2 A GENERAL FRAMEWORK OF PROTECTION

The 1988 amendments need to be seen in the wider legislative context. The high level of regulation of private health insurance funds itself builds substantial barriers to new entry and walls of protection around the existing players. As discussed in part 3, the justification for regulation can include measures to combat market failure. Competition-based economic reforms require an entirely different mindset. They seek to create industry conditions under which market processes can be effective in delivering significant benefits to consumers. That is, they seek to correct market failure at source, rather than compensate for it.

The portability provisions are the “odd men out”.

5.3 INFORMATION IMBALANCE

Private health insurance products are by nature very complex. Private health funds are adept at promoting their good news. The bad news (in the form of benefit limitations, complex administration of claims, unspoken rule changes) often catch members out. Consumers are poor readers of “small print”. Very few members would be able to describe, in any detail, the benefit entitlements and limitations of their existing cover, let alone compare their existing cover with that of a competing fund. In short, there is a substantial imbalance of information between the funds and the fund members and this mitigates against successful bargain-hunting activity.

6. LESSONS FROM OTHER SECTORS

Portability issues have been particularly important and at times controversial, in two other sectors of the economy, telecommunications and superannuation. A thrust of policy has been to revitalise these industries through competition-based reforms. The essential or underlying issues in portability are the same whatever the sector—the scope for competition-based reforms to produce better outcomes for consumers. Better outcomes include both quality improvements and real price reductions.

There is value in considering what has happened and what is continuing to happen, in these two sectors (in neither case could it be claimed that the potential for competition-based reform is exhausted). Before they were subjected to the reforms, neither stood as a paragon of virtue. Indeed, one could have argued that going back a decade or two, private health insurance showed more signs of competition than either. In recent years, we have seen some giant strides in both areas and now both sectors are arguably well ahead of private health insurance in using competition as a spur to healthy growth.

6.1 TELECOMMUNICATIONS

Telecommunications in Australia were provided in years past by two government-owned and operated business enterprises—Telecom Australia and OTC. Although notionally independent, OTC was effectively the international arm of Telecom. The competition-based economic reforms of the telecommunications sector involved the following elements:

- Privatisation of the industry (by degrees, noting that Telstra still remains at this stage with 51% Federal Government ownership); and
- Progressively allowing elements of the telecommunications market to be contested:
  - Giving business, then residential, consumers the choice of equipment (PABXs, handsets) supplier and shifting control over technical equipment standards from Telecom to an independent authority;
  - Initially other firms were allowed to compete for STD and international calls, while later full service telephone retailers were allowed to operate. These companies sometimes exist as resellers of wholesale services provided by Telstra but in other cases they have they own backbones (eg AAPT);
  - The introduction of an access and interconnection regime to ensure entrants were able to make use of the services on incumbents' facilities and to connect new networks to existing networks;
  - Implementing formal processes for fixed and mobile phone number "portability" that allow customers to switch between telecommunications companies without having to change their number; and
  - Opening the door to new telecommunications technologies (cable, satellite).

As a result of these reforms, it is now relatively easy for a consumer to switch telephone companies in response to better price and service offers and telecommunications companies have to compete to keep and build market share.

While the pace of reform in telecommunications may have seemed rapid, it would appear that there is quite a lot more to come. We point to:

- Opening the mobile phone networks to all (at present, the mobile phone companies do not allow their users to select their network at will, although it is technically possible and permitted in a number of overseas countries);
- Rapid technology-based extension in the sort of services that can be provided (eg, hand held devices providing mobile phone, access to e-mail and Internet, etc);
- Increased portability of telephone numbers (in the age of computer-based telecommunication networks, there is much greater technical capacity, although the experience from abroad is that the telecommunications providers will claim any number of technical difficulties in seeking to delay what will most likely be inevitable); and
- Further rapid change with increasing use of Internet-based telephone services.

On any measure, the telecommunications industry has gone through rapid change. This is a worldwide phenomenon, by no means limited to Australia. It is quite evident that Telstra does not enjoy competition and is not happy to relinquish its dominant market share. Despite the foot dragging, the sector now shows strong evidence of competition. Significant parts of the market are contestable and consumers have greater choice of products and providers than ever before.

Telecommunications shows how the two central tenets of competition policy—contestable markets and consumer choice—are two sides of the one coin.

6.2 SUPERANNUATION

Superannuation is more of a latecomer to competition-policy based reforms. The SG (occupational-based superannuation) reforms in the second half of the 1980s were driven in part by a desire on the part of government to reduce the potential budgetary impact of government-funded age pensions. In that sense, the SG arrangements were the first policy response to the intergenerational pressures of an ageing Australia. There were, however, other dimensions at play. It was seen that Australians were retiring earlier and living longer. If people wanted adequate retirement incomes, then greater efforts were needed to boost community savings. The SG was one way to pursue that objective.

The SG arrangements also provided a spur for new players to enter the industry, in particular the low-cost "industry funds", sponsored by unions and employer groups. These funds provided strong competition for the existing "full fee" retail funds and have achieved very rapid growth in their funds under management. Other players also joined the fray. For example, the major banks all offered relatively low-cost (at the time) superannuation products.

Prior to the introduction of the SG there was only limited superannuation coverage in the private sector. Public sector superannuation schemes were, however, the norm. Some firms had superannuation schemes which they managed. However, the funds were generally for white collar employees and often included a defined benefit section, so if the firm failed, the benefits of the defined benefit section members could vanish with it.

The early focus of policy was to improve the prudential supervision of the industry and to firmly establish the principle that contributory superannuation schemes needed to be seen as funds owned by, and managed in trust for, the sole purpose of providing retirement incomes to members.

Later on, the focus started to widen to embrace competition-based reforms. Those have taken two main directions:

- The first, which was **market driven**, was for funds to **offer members choice in regard to their investment portfolios**. It is now commonplace for members to have a range of investment choices if they do not wish to rely on the default ('Trustees') choice; and
- The second, which was **policy driven**, was to **offer members choice of superannuation fund**. Mooted for quite a long time, the proposal was long delayed in the Parliament as key players (including influential unions) feared the loss of control. Choice of fund will finally become reality from July 2005 (although it has been in place in Western Australia for a number of years).

The superannuation industry could hardly be described as a large fan of choice of fund. Every competition-based reform provokes "concerns" at possible adverse outcomes. In this case, concerns included arguments that choice of fund might increase fees and charges (given the administrative cost of choice) and the need for a complementary consumer protection regime.

6.3 THE SKY HAS NOT FALLEN

The first lesson we can learn from these industries is that despite the various portents of doom, the sky has not fallen as a result of competition-based reforms. On the contrary, the industries are more vibrant and provide their clients with better products and better value for money than ever before.

The second lesson is the point noted above—that the two central tenets of competition policy—contestable markets and consumer choice—are two sides of the one coin. A market is not contestable if consumers are not genuinely free to choose. Consumers don't have choice if other players are not able to contest the market.

The third lesson is that it is possible to construct efficient transfer systems where the consumer can go to just one party, the new provider and provide all necessary authorisations for the membership/services/funds, as the case may be, to be transferred. The administrative obstacles to transferring can be reduced with the right structures in place.

7. WAYS FORWARD

There are several options which, if implemented as a package, would conclusively enshrine portability of private health fund membership. That said, each element could be implemented on its own and would take us at least part way down the best avenues to advance the issue. The options are discussed in the following sections. In our view, there are no mutually incompatible elements.

7.1 A STRONGER OVERRIDING PRINCIPLE

The current "overriding principle" in the portability provisions has been stated succinctly by the Private Health Insurance Ombudsman (PHIO), as follows:

> "*The overriding principle which underpins the portability provisions or 'right to change' is that any member transferring from one product to another, either within a fund or between funds, will never be placed in a more adverse position than a new member entering that product for the first time.*"

As noted in part 2, the portability provisions pre-date Lifetime Health Cover (LHC). LHC is a major plank in the policy framework, the objective being to encourage people to take up private health insurance early and to maintain continuous cover. It is more likely that the objectives for LHC will be achieved if the private health insurance sector is competitive and efficient. In turn, that outcome is more likely if the portability provisions are fully effective.

There is a strong case for enhancing the overriding principle underpinning portability (and consequently revising the legislative provisions that give effect to it) so that it is fully consistent with the policy intent of LHC. **The enhanced principle should explicitly address both waiting periods and pre-existing ailments**.

We propose a new set of overriding principles as follows:

> "*The overriding principles which underpin the portability provisions or 'right to change' are that:*
>
> *1) any member transferring between funds will never be placed in a more adverse position as a result of the inter-fund transfer than a member maintaining continuous cover with one fund;*
>
> 2) *any member transferring from one product to another will retain full access to pre-existing entitlements and will never be placed in a more adverse position – in access to any additional benefits – than a new member entering that product for the first time. This applies whether or not the member is maintaining continuous cover with one fund or concurrently transferring between funds;*
>
> 3) *a benefit limitation period is a waiting period as defined in the Act*;
>
> 4) *the existence or otherwise of an HPPA between any fund and any hospital is not a matter to be taken into account in determining whether benefit entitlements are comparable or additional, as would appear to be the intent of current clauses (lab) and (lba) of Schedule 1 of the National Health Act 1953*;
>
> *and, without limiting the generality of 1) and 2),*
>
> 5) *any member will never experience any increase in waiting period/deferred benefit entitlement as a result of transferring between funds; and*

6) *any member will never experience any extension of pre-existing ailment limitations on entitlements as a result of transferring between funds."*

We make the following observations:

- When a member is transferring from one fund to another ***and taking up a broadly comparable product***, it is fundamental that pursuant to funds' rules and procedures relating to portability, he or she should not be placed in a more adverse position than a member remaining in the same fund or product. If the provisions do not assure this outcome, they do not assure portability. We suggest that sub-clause 1 is not some pie-in-the-sky "gold standard". It is the only acceptable standard. To illustrate, if a transferring member has "served out" the waiting period for eligibility for benefits before transferring, no new waiting period should apply.
- Sometimes, the incentive to transfer to another fund will arise because the other fund offers a product that the member finds more suitable or attractive than the alternatives on offer in the old fund. For example, the member may have previously declined to take out medical gap cover with the old fund but decides to upgrade to the medical gap cover inclusion offered by another fund. The medical gap cover benefits are then unambiguously additional benefits and, if the waiting period regime itself is accepted as necessary, then it would not be unreasonable for the transferring member to be subject to the same waiting periods as new members **in determining access to those additional benefits**. But it would be against the spirit of the portability provisions to apply waiting periods to hospital benefits where the benefit entitlement has not been altered by the change of fund or product.
- The proposed new principle does not have any hidden traps for funds in cases where a member chooses to transfer from one private health insurance product to a different product offering greater or lesser benefits. This is the case whether or not the member is maintaining continuous cover with one fund or concurrently transferring between funds. A decision to transfer to a lower level of cover is an eyes-open decision and a member should not expect to gain any extra benefit by concurrently downgrading cover and transferring between funds. Similarly, a decision to transfer to a higher level of cover is an eyes-open decision and fund information will, we trust, make clear when waiting periods apply to the additional benefits only.

The following hypothetical examples illustrate how the proposed new principle would work in practice.

Mr A has top level cover (PremierPlus) with Fund Q and has satisfied all waiting period requirements. He transfers to top level cover (Premium Hospital and Premium Extras) with Fund R.	Mr A would enjoy exactly the same entitlement as an existing post-waiting periods Fund R member with Premium Hospital and Premium Extras cover. **He would not encounter any new waiting period or benefit limitation period as a result of transferring between funds**. Fund Q and Fund R may not have contracts with exactly the same hospitals in each area but this will not affect the continuity of Mr A's benefit entitlements (the same applies to Mrs B, Ms C and Mr D).

Mrs B has top level cover (PremierPlus) with Fund T and has satisfied all waiting period requirements. She transfers to a cheaper product (Budget Hospital and Premium Extras) with Fund V.	Mrs B would enjoy exactly the same entitlement as an existing post-waiting periods Fund V member with Budget Hospital and Premium Extras cover. **She would not encounter any new waiting period or benefit limitation period as a result of transferring between funds**. She has voluntarily chosen an exclusionary product and is no longer entitled to the additional benefits of her previous top level cover product.
Ms C has an exclusionary policy with Fund W and is only part way through her waiting period for full benefit entitlement. She transfers to a broadly equivalent exclusionary product with Fund X.	Ms C would serve out the balance of her waiting period with Fund X before becoming entitled to the benefit entitlements of the product she has chosen. **The waiting period clock would not restart**. Once she had served out her original waiting period, her entitlement to benefits would be the same as any long standing member of the same Fund X exclusionary product.
Mr D has an exclusionary policy with Fund Y and has satisfied all waiting period requirements. He transfers to top level cover (Premium Hospital and Premium Extras) with Fund Z.	Mr D would enjoy exactly the same entitlement as an existing post-waiting periods Fund Z member with an exclusionary policy. In respect of those entitlements, **he would not encounter any new waiting period or benefit limitation period as a result of transferring between funds**. He has voluntarily chosen to upgrade his cover and would be subject to the same waiting period or benefit limitation period restrictions — in relation to the additional benefits only — as an existing Fund Z member who chose to upgrade similarly from an exclusionary product to a top-level product.

7.2 A SIMPLER INTER-FUND TRANSFER MECHANISM

Under current arrangements, member transfers impose quite onerous clerical impositions on the funds. The "gaining fund" needs to write to the "losing fund" to ascertain LHC status, whether or not the member is financial with the "losing fund", as well as details of the product used (for purposes of determining issues such as waiting periods). Until this information has been obtained, the "gaining fund" is not able to determine the premium that should apply. For example, LHC status is necessary information for purposes of determining whether the member first joined a health fund after the age of 30 and is subject to the LHC premium surcharge.

PHIO has reported that a number of the complaints lodged about portability issues relate to processing problems such as lost correspondence, fund delays in replying, etc.

A reduced level of complaints about portability issues will be one measure of success in enshrining portability. There can be no doubt that improved processes have the potential to reduce the level of complaints. The December 2000 PHIO report on the review of portability arrangements contained 27 recommendations. Some of these addressed points of principle and interpretation but many were concerned with issues of process.

Unlike changing a telephone service (changing retail provider or changing from PSTN to ADSL), there is no required engineering step (such as recoding a telephone exchange computer or changing a card in the exchange) before a member can be transferred. There is a need for an exchange of information. The information that needs to be shared is quite specific:

- member name and membership number;
- fund name;
- product code/description;
- date joined/waiting period remaining;
- LHC status; and
- a financial/non-financial flag.

The next step is to determine the best way to allow highly automated on-line and real time sharing of this data. One option would be a centralised database administered by the Private Health Insurance Administration Council (PHIAC). This would require replicating data on a regular basis. It would, however, fall short of a true real time solution and it would generate an ongoing administrative cost.

We suggest that a superior solution would be an information clearing house. Each fund would keep the necessary information in a consistent form and enable it to be exchanged on request from other funds – a bit like overnight settlements in payment systems where financial institutions exchange transactions data in consistent formats.

Processes would need to take account of privacy legislation requirements. Any member making enquiries of a "bidding fund" would have to authorise the retrieval of his or her details from the existing fund. This is little different to what is required now to support the paper trail approach. A "bidding fund" would have to certify that it had received the requisite member request.

The same clearing house system could then to used to "close the books" if a member does decide to transfer to another fund. The "gaining fund" would notify the "losing fund" on behalf of the member through the clearing house. The "losing fund" would then cease any automatic payment arrangement and refund any excess contributions after a modest administrative fee. The transferring member should not have to fill in multiple forms and advise multiple parties. As we have shown in Part 6, transfers can be achieved with one-stop shopping in telecommunications and superannuation. It is every bit as achievable in private health insurance.

What outcomes might be expected?

- First and foremost, there would be a direct benefit to consumers, who would be better informed. Obviously, better informed consumers make better quality decisions. With on-line real-time access to the pertinent data, a bidding fund would be able to provide a prospectively transferring member with accurate information on premiums and any residual waiting periods (if applicable). Given the consumer focus of this proposal, we would see considerable merit in PHIO involvement in the design of the system. It is important that consideration be given to all of the various interests of consumers.
- Second, the clearing house system would generate significant administrative cost savings for the funds compared with the current paper trail systems. That, in turn, benefits the members indirectly.

Is there a "turnkey solution"? The **Eclipse** project, which is now in the process of being implemented, has many of the features which are required for a clearing house system to work. The first stage of Eclipse allows for on-line verification of health fund details which implies a significant, if not full, overlap of the information needed when a member transfers between funds. The private fund coverage of Eclipse is steadily increasing and is expected to reach 100% when Medibank Private becomes a participant by end-2006/early 2007. There is, of course, a need to consult the partners in the Eclipse project and to tease out the technical questions. Without pre-empting that, we note the possibility that a cost-effective way to implement the clearing house solution could be to add an additional module to Eclipse.

7.3 PRODUCT CATEGORISATION

One of the sticking points noted by the PHIO is the problems that arise in determining whether or not products provide a "***broadly comparable benefit***". The notion of a "***broadly comparable benefit***" is introduced by subparagraph (la) (iii) of Schedule 1 to the *National Health Act 1953*. The legislation does not define the term but various subparagraphs set exclusions—issues which are not to be considered in determining whether or not a benefit is broadly comparable. In short, we don't really know what it is but we have some pointers to what it is not.

Private health insurance funds compete (to the extent that they compete) by means of both price and non-price competition.

- Price competition includes loyalty discounts which, strictly speaking, violate the community rating principles but which are tolerated in policy nonetheless.
- Non-price competition includes various strategies to build brand loyalty (advertising which includes sponsoring sporting events, etc) and strategies to differentiate one fund's products from those of its competitors.

Health insurance is a complex product often poorly understood by the consumer. It is an every day experience that members discover the limitations on their benefit entitlements when their claims are rejected. Fund advertising naturally emphasises all the subtle differences between products which might increase their consumer appeal. Funds do not voluntarily inform their members, for example, that they have terminated the contracts of various hospitals, thereby reducing access options for members using no-gap insurance products. These products depend upon funds negotiating hospital and doctor contracts.

In essence, it is up to each fund to decide what is a "***broadly comparable benefit***". It is quite possible that each fund makes inconsistent findings. The continuing level of disputation, indicated at one level by the number of complaints taken to PHIO, is confirmation that this remains a sticking point.

The solutions to this issue are twofold:

- a return to the spirit of the legislation, so that funds are not able to use immaterial differences in products to claim lack of comparability and thus impose waiting periods;
- the Minister's delegate (DHA or PHIAC) to determine the broad categories for each product (and therefore to resolve any uncertainties were it to appear that a product might fit more than one category) and
- For this information to be accessible through the on-line sharing of information (as per 7.2 above).

A potentially gaining fund would then be in a position to provide reliable on-the-spot advice to any potentially transferring member as to which products will be comparable and which would involve a new waiting period.

Ideally, the categories determined by the Minister's delegate should be kept as broad as possible. The following list of categories is indicative (the complexity of health insurance products may require some expansion of the list):

- All flagship or top level (full cover) products;
- All no-gap products;
- All front-end deductible products with, perhaps, subcategories taking account of any material differences between the level of the front-end deduction in various products; and
- All exclusionary products with, perhaps, subcategories taking account of any material differences in the types of services excluded by various products.

7.4 REVIEW OF WAITING PERIODS

The problems with portability raise questions about the waiting period regimes. The rationale for the imposition of waiting periods is to counter "hit and run" raids by members who join, on an itinerant basis, to snare benefits. A common example is taking out membership before the birth of a child and cancelling membership after the relevant benefits have been enjoyed.

In other insurance markets (automotive, home and house contents, general), different strategies are used to counter "hit and run". Importantly, insurance companies can risk rate persons with a bad claims history. In Australia's regulated private health insurance regime, funds cannot risk rate members.

Reduced to its essentials, the waiting period is a new member surcharge which increases the cost of, and therefore reduces the likelihood of, "hit and run" activity.

A second, and perhaps more important, defence against hit and run is the pre-existing ailment rules.

An underlying theme of this paper is that benefit limitation periods imposed on transferring members run counter to the spirit of the legislation which was promulgated on the basis of the right to choose. The introduction of benefit limitation periods in these circumstances does raise some questions as to whether waiting periods themselves remain appropriate, especially having regard to other policies which have been introduced subsequently (such as Lifetime Health Cover). The questions are, not, however, limited to issues of portability. Therefore, a comprehensive re-examination of the rationale for waiting periods is outside the scope of this report.

8. REFERENCES

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APPENDIX A: CURRENT LEGISLATION

NATIONAL HEALTH ACT 1953
EXTRACT FROM SCHEDULE 1: PORTABILITY PROVISIONS

(l) Subject to the condition set out in paragraph (bb), the organization will not provide for a waiting period for contributors for benefits who have transferred to the health benefits fund conducted by the organization from:

(i) another health benefits fund conducted, before 1 July 1995, by the organization; or

(iii) the health benefits fund conducted by another organization whose registration under Part VI has been cancelled or is under consideration by the Minister with a view to cancellation;

and those contributors shall:

(iv) only be affected by any waiting periods that applied to them for the purposes of the fund from which they transferred; and

(v) have the same entitlements to benefits that they would have had if they had been members of the fund to which they transferred for the period for which they were members of the fund from which they transferred, being benefits of a kind available to members of the fund to which they transferred.

(la) For the purposes of the conditions set out in paragraphs (ld) and (le), a person (the ***relevant person***) is a transferred contributor in relation to a benefit (the ***relevant benefit***) included in an applicable benefits arrangement or a table of the organization if the following conditions are satisfied:

(i) the relevant person is, in relation to the organization, a contributor for benefits in accordance with the arrangement or table;

(ii) at the time of becoming such a contributor, or within 7 days or such longer period as the rules of the organization allow before that time, the relevant person was, in relation to another health benefits organization, a contributor for benefits in accordance with a comparable benefits arrangement (see paragraph (laa));

(iii) the comparable benefits arrangement included a benefit (the ***broadly comparable benefit***) that was broadly comparable to the relevant benefit;

(iv) at the time of becoming a contributor for benefits in accordance with the applicable benefits arrangement or table, the person had paid all contributions due to the other organization.

(laa) The reference in subparagraph (la)(ii) to a comparable benefits arrangement is a reference to:

(i) if the relevant benefit is included in an applicable benefits arrangement, whether or not modified by an election of the kind referred to in the condition set out in paragraph (ba)—an applicable benefits arrangement, whether or not modified by such an election, of the other health benefits organization; or

(iv) if the relevant benefit is included in a table— a table of the other health benefits organization.

(lab) In working out whether a benefit (the ***original benefit***) is broadly comparable to the relevant benefit for the purposes of subparagraph (la)(iii), disregard whether the following facts apply:

(i) the relevant benefit is included in an applicable benefits arrangement under which the organization has, or had, a hospital purchaser/provider agreement with a particular hospital or day hospital facility;

(ii) the original benefit is included in an applicable benefits arrangement under which the other organization does not have a hospital purchaser/provider agreement with that hospital or day hospital facility.

(lb) For the purposes of paragraphs (ld) and (le), the relevant part of the relevant benefit is:

(i) if the relevant benefit is less than or equal to the broadly comparable benefit—the whole of the relevant benefit;

(ii) if the relevant benefit or the broadly comparable benefit consists of the provision of services or treatment which provision is, because of a direction under subsection 75(1), treated as the payment of a benefit in respect of the services or treatment—the whole of the relevant benefit; or

(iii) if the relevant benefit is greater than the broadly comparable benefit and subparagraph (ii) does not apply—so much of the relevant benefit as does not exceed the broadly comparable benefit.

(lba) In working out whether a relevant benefit is greater than a broadly comparable benefit for the purposes of subparagraph (lb)(iii), and the extent to which the relevant benefit does not exceed the broadly comparable benefit, disregard whether the following facts apply:

(i) the relevant benefit is included in an applicable benefits arrangement under which the organization has, or had, a hospital purchaser/provider agreement with a particular hospital or day hospital facility;

(ii) the broadly comparable benefit is included in an applicable benefits arrangement under which the other organization does not have a hospital purchaser/provider agreement with that hospital or day hospital facility.

(lc) For the purposes of paragraph (lb), if the broadly comparable benefit could consist of either:

(i) the actual payment of a benefit; or

(ii) the provision of services or treatment;

it shall be assumed that the benefit could consist only of the payment of the benefit.

(ld) If the relevant person is a transferred contributor in relation to the relevant benefit and became such a contributor on or after the commencement of this paragraph, the rules of the organisation shall not be such that there is a waiting period applicable to the entitlement of the relevant person, or of any dependant of the relevant person, to receive the relevant part of the relevant benefit except as follows:

(i) a waiting period may be imposed in respect of the relevant part of the relevant benefit if:

(A) had the relevant person become a contributor for benefits in accordance with the applicable benefits arrangement or table in circumstances that did not

make the person a transferred contributor in relation to the relevant benefit, a waiting period would have applied in relation to the relevant person's entitlement to receive the relevant benefit;

(B) the relevant person, before becoming a transferred contributor in relation to the relevant benefit, was subject to a waiting period in respect of the broadly comparable benefit, whether or not that waiting period had expired at the time the relevant person became such a contributor; and

(C) the relevant person, before becoming such a contributor, was notified in writing, by the organisation, that a waiting period would be imposed in respect of the relevant benefit;

(ii) a waiting period imposed in accordance with subparagraph (i) shall not exceed a period equal to the number of days in the waiting period referred to in sub-subparagraph (i)(A) reduced by:

(A) if the whole of the waiting period referred to in sub-subparagraph (i)(B) had expired at the time the relevant person became a transferred contributor in relation to the relevant benefit—the number of days in that waiting period; or

(B) in any other case—the number of days in so much of the waiting period referred to in sub-subparagraph (i)(B) as had expired at the time the relevant person became a transferred contributor in relation to the relevant benefit.

(le) If:

(i) the relevant person is a transferred contributor in relation to the relevant benefit and became such a contributor before the commencement of this paragraph;

(ii) at the time of that commencement, the relevant person was subject to a waiting period in respect of the relevant benefit; and

(iii) before becoming a transferred contributor in relation to the relevant benefit the relevant person was subject to a waiting period in respect of the broadly comparable benefit, whether or not that waiting period had expired at the time the relevant person became such a contributor;

the rules of the organisation shall be modified so that the waiting period to which the entitlement of the relevant person, or of any dependant of the relevant person, to receive the relevant part of the relevant benefit is subject expires:

(iv) if, had the waiting period referred to in subparagraph (ii) been shorter by a number of days equal to:

(A) if the whole of the waiting period referred to in subparagraph (iii) had expired at the time the relevant person became a transferred contributor in relation to the relevant benefit—the number of days in that waiting period; or

(B) in any other case—the number of days in so much of the waiting period referred to in subparagraph (iii) as had expired at the time the relevant person became a transferred contributor in relation to the relevant benefit;

the waiting period referred to in subparagraph (ii) would have expired on a day (in this subparagraph called the ***notional expiration day***) after the commencement of this paragraph—on the notional expiration day; or

(v) in any other case—on the commencement of this paragraph.

(lf) The rules of the organisation will not include any provision limiting a person's entitlement to benefits in a way that has substantially the same effect as the imposition of a waiting period except where the imposition of such a waiting period would be in accordance with these conditions.

APPENDIX B: PHIO PAMPHLET

THE RIGHT TO CHANGE
PORTABILITY IN HEALTH INSURANCE

A consumer guide to transferring from one health insurance product to another, either within your existing health fund, or to another health fund.

THE RIGHT TO CHANGE - Portability in Health Insurance

From time to time, health fund members may wish to vary their cover to take account of their changing needs. For this reason, registered health insurance funds are required by law to offer the facility for members to transfer from one hospital product to another. Some health funds may also offer this same 'portability' for their ancillary (extras) cover but are not required to do so.

There are many health fund products available in the market place, designed to meet the varied needs of consumers. The purpose of this document is to outline what the National Health Act provides should a member wish to transfer to a different level of cover within their existing health fund or transfer to another registered health fund.

Members of any health fund hospital product are entitled to transfer between all hospital products offered by any registered health fund of which they are eligible to be members. To gain the protection of portability, members should ensure that they are paid up to date before transferring.

When do the new benefits apply following a change of cover?

The overriding principle which underpins the portability provisions or 'right to change' is that any member transferring from one product to another, either within a fund or between funds, will never be placed in a more adverse position than a new member entering that product for the first time.

In some circumstances, it would be unfair to the wider membership if a transferred member could immediately access the higher benefits of a new product. Federal legislation therefore allows health funds to apply waiting periods in a range of circumstances.

The 'Legislated Waiting Periods' provide for a 12 month wait for pre-existing ailments and obstetric conditions and a two month waiting period for all other conditions for new members and those upgrading their hospital cover.

It is the effect of these waiting periods that we address in this brochure.

Products where there are exclusions

Some members may choose products that exclude certain procedures, to reduce the costs of premiums or for lifestyle reasons.

Where the previous fund product has an exclusion attached, and the member is seeking to transfer to a product without an exclusion, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund product.

The examples below show the effect of a transfer away from a product with exclusions (Mr Blue) and a transfer into a product with exclusions (Mrs Green).

- *Mr Blue had 12 months membership on a product that excluded benefits for cardiac conditions and transferred to a product without exclusions.*
- *Mr Blue suffered a heart attack three months after transferring to his non exclusionary product.*
- *If Mr Blue had previously had signs and symptoms which were later shown to be associated with his heart attack, it would be deemed pre-existing and he would not be entitled to any benefits for this problem for a further nine months.*
- *If in similar circumstances, Mr Blue suffered a heart attack where he had no previous signs or symptoms, and therefore the pre-existing ailment rule did not apply, he would be entitled to the benefits of his new cover, as he had already served the general two month waiting period for higher benefits.*

- *Mrs Green was 46 years of age and her family had all left home.*
- *She previously had a full cover hospital product without any exclusions but decided, for a lesser contribution rate, to transfer to a product which excluded obstetrics, hip replacement and heart surgery.*
- *Six weeks after taking out the cover, Mrs Green suffered a heart attack and was taken to the local private hospital for heart surgery.*
- *Even though Mrs Green had previously held full cover for heart surgery for several years, the effect of her new exclusion product came into force as soon as she transferred and she was not covered for the heart surgery and hospitalisation.*

Products where there are benefit limitations/restrictions

Some members may choose, for lifestyle reasons or to reduce the cost of premiums, a product where the benefits on some or all hospital procedures are limited to a level significantly below the hospital charge, or the cost of admission as a private patient in a public hospital.

Where the previous fund product has a benefit limitation, and the member is seeking to transfer to a product without a benefit limitation, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund product.

The examples below show the effect of a transfer away from a product with benefit limitations (Mr Blue)and a transfer into a product with benefit limitations (Mrs Green).

- *Mr Blue had 12 months membership on a product that had a benefit limitation for obstetrics, hip replacement and cardiac procedures and transferred to a product that had no limitations.*
- *Mr Blue suffered a heart attack three months after transferring from his benefit limited product.*
- *If Mr Blue had previously had signs and symptoms which were later shown to be associated with his heart attack, it would be deemed pre-existing and he would therefore be entitled to the restricted benefits under his previous cover for this problem for a further nine months.*
- *If in similar circumstances, Mr Blue suffered a heart attack where he had no previous signs or symptoms, and the pre-existing ailment rule did not apply, he would be entitled to the benefits of his new cover, as he had already served the two month general waiting period for higher benefits.*

- *Mrs Green was 46 years of age and her family had all left home.*
- *She previously had a full cover hospital product without any limitations but decided, for a lesser contribution rate, to transfer to a product which paid lower benefits for obstetrics, hip replacement and heart surgery.*
- *Six weeks after taking out the cover, Mrs Green suffered a heart attack and was taken to the local private hospital for heart surgery.*
- *Even though Mrs Green had previously held full cover for heart surgery for several years, the effect of her benefit limitation product came into force as soon as she transferred. The benefit she received was therefore less than half of the accommodation cost of her stay in hospital and no benefits for the extensive theatre costs.*

Products that have an excess

Some products are available where the member agrees to pay an excess up front when they go to hospital. The excess may be a fixed amount each time a member goes to hospital in a given period, or a set amount payable per year, or a combination of both.

Where the previous fund product has an excess attached, and the member is seeking to transfer to a product without an excess, the fund has the right to apply the

legislated waiting periods before the member is entitled to the higher benefits under the new fund product.

The examples below show the effect of a transfer away from a product with an excess (Mr Blue) and a transfer into a product with an excess (Mrs Green).

- *Mr Blue had 12 months membership on a product that had an excess of $200 for each hospital admission and decided that he should transfer to a product without an excess.*
- *Mr Blue suffered a heart attack three months after transferring from his old excess product.*
- *If Mr Blue had previously had signs and symptoms which were later shown to be associated with his current heart disease, the heart attack would be deemed pre- existing and he would therefore be required to pay the excess for this hospitalisation.*
- *If in similar circumstances, Mr Blue suffered a heart attack where he had no previous signs or symptoms, and therefore the pre-existing ailment rule did not apply, he would be entitled to the benefits of his new cover and would not have to pay his excess, as he had already served the two month general waiting period for higher benefits.*

- *Mrs Green was 46 years of age and her family had all left home.*
- *She previously had a full cover hospital product without any excess but decided, for a lesser contribution rate, to transfer to a product which had a $200 excess for each hospital admission.*
- *Six weeks after taking out the cover, Mrs Green found she had bladder cancer and required chemotherapy once each month.*
- *Even though Mrs Green had previously held full cover without an excess for several years, the effect of her excess product came into force as soon as she transferred and she was required to pay the excess of $200 for each treatment in the private hospital.*
- *To reverse her position back to where she was previously (ie: to return to a product without an excess) may require Mrs Green to wait for a full 12 months before the treatments would not attract the $200 excess.*

The distinction between hospital and ancillary (extras) products

There is no requirement for a health fund to offer the benefits of portability to their ancillary cover, although some funds may. If a fund does offer portability to its ancillary cover, they undertake to advise new members of any significant lessening of benefits they may incur. The underlying principle would then apply, that any transferring member will not be placed in a more adverse position than a new member to that product.

The application of loyalty bonuses on transfer

Loyalty bonuses have been a component of ancillary tables for many years. Recent legislation has enabled funds to provide for loyalty bonuses within hospital arrangements. These bonuses can take many forms, from additional benefits for items after a set period of years through to the ability to roll over benefits not used in particular years. These bonuses can be quite significant, particularly in high cost ancillary areas such as orthodontic or major dental costs. They are common throughout most funds in some form and are given as a reward to longer term members of the particular fund.

Some members have a view that their membership of private health insurance is continuous even though they may have held their cover with different funds over the period. This is generally not the case with loyalty bonuses.

Members need to be aware that loyalty bonuses are exclusively applied to membership of a particular fund, and sometimes within specific products of a fund; they are not usually transferable to other funds or products.

- *Mrs Aqua had been with her health fund for some 5 years.*
- *Her orthodontic limit was $500 but this increased by $100 after each full calendar year's membership up to a maximum of $800. Mrs Aqua had reached the $800 maximum.*
- *She then transferred to a health fund which likewise has a benefit for orthodontics of $500 rising annually by $100 to $800.*
- *Unless specifically advised otherwise, Mrs Aqua should assume that her benefit will drop to $500 initially and she will need to re qualify by waiting three calendar years for the full $800 benefit. Her years with the previous fund do not increase her benefit with the new fund.*

Members who transfer to another fund to provide better hospital cover will usually find that if they also transfer their ancillary cover, they may lose the loyalty bonus years built up with their old fund and need to recommence their years of membership from zero for the new fund. Members should check this aspect carefully prior to changing cover.

Lifetime Health Cover and Portability

The Lifetime Health Cover provisions and any aged based penalties only apply to your hospital cover. Therefore if you have a product which includes ancillary cover, or a separate ancillary product and you choose at any time to discontinue the ancillary component of that policy, you will not be penalised with respect to your Lifetime Health Cover contribution age category.

You are able to transfer between hospital products without affecting your lifetime health cover age category, provided your contributions are up to date when you transfer.

In the event that you elect to temporarily discontinue your hospital cover and sometime later, transfer to another fund or product, you should ask your fund about what effect this may have on your Lifetime Health Cover age category.

Best practice within the private health insurance industry is for your health fund to provide you with specific written details of the changes you arrange and their effect on your membership.

In a document such as this it is impossible to detail every scenario which you may face if you transfer within or between funds.

If after reading this guide you are still uncertain of your rights you should ask your fund to provide you with written answers to your specific enquiries.

This document has been produced by the Private Health Insurance Ombudsman in consultation with the private health insurance industry. The Ombudsman can be contacted by telephoning our Freecall number, 1800 640695.

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