SINGAPORE ACTUARIAL SOCIETY

PORTABILITY OF INTEGRATED SHIELD PLANS

A Discussion Paper

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Executive Summary

There have been increasing calls from the public for more freedom to switch Integrated Shield Plan and associated riders. Advocates posit that existing rules are unfair to policyholders who deserve flexibility to seek better coverage or lower prices for themselves. This paper highlights that portability rules that require a risk pool to accept a policyholder that may be expected to claim more from the pool than what is implied in the premium rate, could increase premium rates for incumbents of the risk pool. Fairness of such premium increase from the perspective of the incumbents – over 80% of them being the "silent majority" who have not made a claim in the past year – should be adequately considered.

This paper does not advocate for a specific set of portability rules. Instead, the paper presented several perspectives of what is deemed fair along the continuum of possible beliefs amongst the insured public who wanted more flexibility – as well as potential unintended consequences that may result if the impact of changes are not properly understood.

- At one end of the continuum, one may believe that the existing rules are largely fair when it comes to how risks are shared between policyholders of different risk profiles. Free switching of Integrated Shield Plans not involving an upgrade between insurers can be tested. As Integrated Shield Plans are largely similar in features between providers, allowing free switch may reduce the prevailing price differentiation between insurers. Current rules continue to apply for switching of riders.

- At the other end of the continuum, one may believe that access to health insurance, without restraint on coverage, is a basic right of the population, regardless of health condition. One may therefore accept a much higher premium increase to ensure that nobody is permanently denied insurance coverage. For any condition, a time-bound exclusion may be imposed at entry into the IP ecosystem or at the time of any switching of plans. Also, incentives may be required to ensure subsidies remain for healthy lives within the higher premium environment. This more communal philosophy is akin to that seen in Australia.

This Singapore Actuarial Society Health Committee believes that, through dialogue involving public from diverse backgrounds, Singapore can build consensus in the community about what kind of portability rules best fit the Singapore context.

The work is the product of research commissioned by the SAS. SAS' Health Committee hopes that this paper will help promote discourse in Singapore about portability rules for Integrated Shield Plans so as to build consensus in the community on what kind of portability rules best fit the Singapore context. Words "Portability" and "switch" are used interchangeably in the paper.

Fairness is in the eyes of the beholder. This message came through quite strongly in our research about health insurance portability[1] rules around the world. Portability rules in different countries reflects the consensus of how people in each country sees the role of health insurance and also their wider social contract. Such consensus can range from a highly communal one, as seen in how Australia implements health insurance pricing and portability, to one that places more emphasis on individual responsibilities. The debate about fairness of claims-based pricing of riders to Integrated Shield Plans ("IP") in Singapore can be seen as part of such consensus-building process. Policyholders' choice between different riders can sometimes be seen as their expression of which fairness regime they subscribe to.

It should be noted that such consensus is not static. It can evolve over time due to changing societal attitudes and/or the vision of the political leadership. As the Singapore Actuarial Society ("SAS") is an apolitical organization, it would refrain from making recommendation based on a single view of fairness. This note therefore sets out how IP portability rules may look like under three different perspectives of fairness. The SAS Health Committee ("SAS HC") hopes that this would facilitate discourse in Singapore about portability rules for IP so as to build consensus in the community on what kind of portability rules best fit the Singapore context accommodating different views of fairness. After all, there is inherent trade-off between freedom and fairness[2].

Before discussing different perspectives of fairness, the SAS HC would like to

(i) reiterate the basic principles of risk pooling in insurance; and
(ii) highlight several ways that support efficient portability implementation regardless of perspective chosen.

Risk Pooling In IP Plans

There are currently seven IP insurers in Singapore, each offering multiple plans with different targeted level of coverage. One may consider insureds in each plan belonging to a different risk pool. Premium rates in each risk pool generally reflect the average cost of providing insurance service to the pool. It covers cost of claims, and associated administrative and distribution expenses. Premiums are higher when insureds in the pool are riskier; or when the plan covers a wider scope of healthcare service and/or reimburses a larger portion of the bill. Premiums can also be higher when an insurer provides higher-touch servicing, operates less efficiently, or incurs higher marketing cost and commission.

Movements of insureds between risk pools can affect existing equilibrium in each pool. Before discussing the merits of different portability design, it is important to first understand the dynamics involved in a market with multiple risk pools.

Consider two insurers – Insurer A and Insurer B - offering plans with exactly the same coverage, same level of service with the same level of efficiency. The only difference is that Insurer A aims to keep its premium rate low by imposing stricter underwriting criteria such that only the very healthy can enrol into the plan. Insurer B is less strict and allows those with minor health issues to enrol with no additional exclusions. To achieve the same profitability as Insurer A, Insurer B charges a higher premium rate.

[1] The word "portability" has been used to mean different things in various discussion about health insurance in Singapore. The "portability" concept has been used to encourage employers to pay for employees' individual IP premiums because employees can bring the coverage with them even when employees subsequently change jobs. The concept is also used to label tax incentive schemes to employers when they help fund continuity of coverage for their employees, including the purchase of group health insurance with predefined design. For the purpose of this note, "portability" refers to the ability to switch from one insurer to another for one's IP and riders. There have been calls from the public for more freedom to switch IP and riders. Refer to recent question raised in parliament. (https://www.moh.gov.sg/news-highlights/details/feasibility-of-making-integrated-shield-plan-insurance-fully-portable)

[2] Friedman. 1977. "Free versus fair". Newsweek, page 70. (https://miltonfriedman.hoover.org/internal/media/dispatcher/214184/full)

For an insured currently with Insurer B, but has good health and is eligible to enrol with Insurer A, the rational choice is to make the switch. As more of such insureds switch from Insurer B to Insurer A, the average health of those that remain with Insurer B will get worse. This forces Insurer B to increase its premium rate, prompting even more healthy insureds eligible for Insurer A's plan to switch. Insureds that remain with Insurer B may feel this trend as unfair to them.

Assume further that a new law is introduced prohibiting insurers from rejecting switch-in requests from insureds currently enrolled into plans with similar coverage issue by another insurer. Insureds with Insurer B, regardless of health status, will most likely switch to Insurer A to see a better price. This worsens the average health in Insurer A's risk pool, triggering an increase in rate. To the incumbent insureds of Insurer A, this new law may seem unfair.

There are other examples where similar premium rates dynamics can arise. While individual underwriting conducted at the time of entry into a risk pool helps insurers align the average health of new insureds to that assumed in their pricing, insurers have less control over any subsequent deterioration in health of members in the pool. Without new members entering the pool, there is a tendency for the average health of a risk pool to trend towards the average seen in the general population. As a result, even if Insurer A – an established player in the IP market – and Insurer B – a new entrant – are equally strict in underwriting new members, Insurer A is likely to experience higher average claims cost from members who have been underwritten some time ago. This phenomenon allows Insurer B to offer more competitive premium rates due to lower claims cost[3] on the overall portfolio. If insureds with Insurer A is allowed unrestricted portability, switches from Insurer A to Insurer B seeking lower premium will cause the average health of risk pool of Insurer B to deteriorate. Insurer B will have to increase premium rate to avoid making a loss. This process will continue until an equilibrium is reach between the two risk pools.

Another example that is very relevant to today's IP market is where Insurer A's plan, say, offers higher limits for cancer treatment than Insurer B, all else being equal. If insureds with Insurer B currently claiming for cancer treatment are allowed to switch freely into Insurer A's plan, migration of cancer patients from Insurer B to Insurer A may force insurer A to raise rates or reduce cancer coverage.

It is worth highlighting that typically less than 20% of insureds in an IP risk pool makes a claim in any single year. Non-claimants who dutifully fulfil their premium obligations form the majority of the risk pool. Insureds generally have no visibility to the risk profile and consumption pattern of fellow insureds in the same risk pool. Insureds who went through the process of claiming from their IP plans might be in a better position to understand the benefits of the plan compared to insureds who are not claiming. This information asymmetry signals the need for greater emphasis on the welfare of non-claimants when assessing the fairness of any portability design.

[3] Setting aside the effects of economies of scale on unit operating cost for the time being.

Implementing Portability Rules Efficiently

The SAS HC would like to highlight several ways that would smoothen the implementation of new portability rules regardless of perspective chosen:

- **Central claims history and exclusions[4] database.** Portability rules may require access to policyholders' claims history and previous underwriting decisions by another IP insurer. To minimize the cost of providing this access, past claims history[5] and exclusions added during underwriting currently applicable should be centralised in a national database for IP insurers to draw upon. Policyholders may retain control of their claims history and current exclusion list in the same way citizens control their personal data via SingPass. SGFinDex[6] , which allows the population to share their financial holdings with banks and insurers, operates on the same consent-based principles. When policyholders apply for IP or riders, they would also authorise the insurer to access their claims records and current exclusions on the national database.This reduces form filling by policyholders and/or doctors about policyholders' claims history. Insurers that a policyholder does not apply to do not get access to such past claims history and current exclusions. Given the diversity in IT systems used by IP insurers, and how insurers have stored underwriting and claims data, building such central database will require significant investment in manpower and financial resources. Associated costs will likely be passed onto policyholders through premium adjustments.

- **Standardisation of exclusion definition.** Currently, different insurers have different ways of articulating their exclusions. It would improve interoperability within the IP ecosystem (i.e. both IP and riders) if these exclusions are articulated in a standardised manner. Such standardisation may also improve efficiency in IP claims processing, quality of financial consultation pre-admission, and ease of populating the aforementioned central database. There will be some costs involved in modifying existing IT systems to adapt to the standardised definition.

- **Control on distributors' incentives.** Typically, distributors' incentives (including commission, production bonus and other soft-dollar incentives such as overseas trips) for IP and riders are higher in the first policy year or first few policy years, and lower in later years. One may consider the higher incentives in early years as distributors' value add to policyholders when distributors help policyholders secure a financial safety net. The lower incentives in later years can be seen as a retainer fee for distributors to stand ready to support policyholders in coverage review and any claims-filing administration. High incentives in early policy years require closer scrutiny when it comes to plan switching. For a switch not involving an upgrade, incremental value add to a policyholder will be far less than the incremental value add from putting a safety net in place for those who did not have it. It may be justified to ban insurers from paying first year incentives for switch not involving upgrades. This is to avoid burdening the system with excessive distribution cost from churning, and the associated administrative cost involved in handling switches. For plan upgrade, there may also be controls on first year incentives calibrated to how much the upgrade benefit policyholders. MAS has built up knowledge of scrutinising distributor incentives such as production bonus and soft-dollar pay outs when it implemented controls on insurers' expense charging to the participating business. That knowledge would be useful in designing incentives controls related to portability.

[4] For the purpose of this note, discussions about exclusions applied as a result of underwriting are generally applicable to premium loadings imposed on IP and riders.
[5] Coverage of claims history aggregation should ideally be based on institution, instead of whether the claim is made on IP policies. In another words, for the same hospital that is contributing to the claims history database, the hospital would contribute history not only for claims that are reimbursed by IP, but also claims reimbursed by non-IP personal health insurance plans and group insurance plans. The practical challenge of this is acknowledged as healthcare institutions may not have full line of sight to how patients intend to make claims.
[6] https://www.singpass.gov.sg/main/sgfindex/

We can now move on to the different perspective of fairness, and how portability rules may be designed under each perspective. For completeness, we acknowledge that some in the society may view that existing rules where those who switch IP and riders are subject to the same underwriting rules as new policyholders as fair, and therefore no new portability rules should be created based on that perspective.

"Perspective 1": Communal Approach
Offers maximum risk pooling effects, no permanent exclusions, and limited scope to add new ones.

This perspective involves an overhaul of how IP and riders operate in Singapore. It sees access to health insurance, without restraint on conditions covered, as basic rights of the population. No one knows what accident, illness or disease may befall us in future. Therefore, as a society, this perspective expects everyone to contribute to the risk pool and share the cost of healthcare through health insurance, including those who are currently in pink of health and are actively keeping themselves healthy. This perspective also believes that it is unfair to permanently deny someone insurance coverage for specific conditions, especially when there is evidence that one has recovered from a condition or has brought the condition under control.

Under this perspective, all permanent policy-specific exclusions are disallowed for IP and riders, for both new IP and riders issued and for plan switches. All exclusions imposed must have a waiting period attached; and such waiting period would be standard across all insurers. The waiting period may be condition-specific and is consistent with the duration of heightened risk the condition posed to the risk pool, but capped at a duration beyond which any heightened cost should be shared by all members in the risk pool. This controls the anti-selective behaviour where one only seeks insurance coverage or a plan upgrade when one expects higher pay outs from insurance. Generally, there should not be exclusions imposed on claims directly arising from acute conditions. Past permanent exclusions will be automatically converted by law into time-bounded ones instead of being grandfathered so as to avoid fragmentation of risk pools.

An insured is considered to have "served out" his/her waiting period for exclusions on a specific condition when he/she is continuously insured in the IP ecosystem for that specific period of time. The receiving insurer will not be allowed to impose exclusions on the same condition, or to extend the waiting period at the time of switch.

If an insurer accepts an application to switch into a higher plan, exclusions may be added for the additional benefits based on claims history. This is to prevent a policyholder whose treatment is currently funded by a plan with lower limits from upgrading the plan for immediate higher pay outs. All new exclusions must also have waiting period attached.

For an insurer receiving a policyholder switching in, if the insurer practices claims-based pricing, insurer is expected to apply the claims history of the incoming policyholder to calculate premium as if the policyholder has been continuously insured with the receiving insurer. In another words, all discounts and loadings under the claims-based pricing rule applied to an existing policyholder with the same claims history will be applied to the incoming policyholder[7].

This fundamental change in what is deemed fair sharing of risks in the IP ecosystem will see many claims that are not payable due to existing permanent exclusions becoming payable. Policyholders who had exclusions in the IPs and require lengthy and expensive treatments for the conditions previously excluded will see a greater share of their costs borne by other members in the risk pool. This would happen even without any policyholder switching plans. Insurance pay outs, and therefore premiums, are expected to increase sharply. Several additional regulatory measures are needed to support transition to the new regime:

[7] This treatment also applies to "Perspective 2" and, where relevant, "Perspective 3".

- To buffer the sticker shock, a time-limited and means-tested premium support from Government should be provided to policyholders.

- Healthier and younger individuals may decide to drop their IP coverage due to premium hike. These individuals are necessary to keep the risk pool sustainable and avoid a "death spiral" of premium hikes. A financial incentive like tax deduction or premium loading for late joiners such as in the Australian context may be applied to those without IP to drive IP take up rate. The level of penalty should be calibrated to closely match the financial impact on remaining members in the IP risk pool, whilst making suitable concessions to those unable to afford the high premium increases.

- Establish a "High Risk Pool" – a claims equalization mechanism where large claims from high risk individuals are aggregated in a central pool administered by the Government as the independent party, and re-spread the claims proportionally across all IP insurers. This reduces the stigma of accepting high risk individuals into the risk pool, giving such individuals access to better coverage. It also reduces the need for IP insurers to spend large acquisition cost to draw in young and healthy individuals to balance their risk pools and fund the cost of high risk claimants. Such risk equalisation mechanism is seen in the Australian system. Some niche riders offered by a minority of IP insurers may be excluded from such High Risk Pool.

To those who wish to switch plans, the revised approach in applying exclusion reduces the underwriting friction associated with switching.

Younger and healthier individuals, especially those who do not believe in such strong mutualisation of healthcare cost, will feel most aggrieved by the premium increase. Lower income households may also find themselves priced out of the IP market.

For IP insurers, the number of policyholders in their risk pool and rider take up rate will be determined by the price-elasticity of their respective clientele. It is difficult to determine the net impact on revenue at this stage. The effects of the High Risk Pool will bring insurers' claims experience of plans covered by the Pool closer to each other, thereby reducing variations in pricing. This encourages insurers to compete on service quality and innovate on service delivery. Product innovation and price competition are still viable for coverages not within the scope of the High Risk Pool.

"Perspective 2": Grandfathering Approach
Offers medium risk pooling, phase out permanent exclusions, and some scope to add new ones.

This perspective shares that view in "Perspective 1" that permanently denying someone coverage for specific conditions is unfair. However, this perspective also acknowledges that a material proportion of members in existing risk pools may be comfortable with existing IP rules in Singapore that has greater emphasis on individual responsibilities.

Under this "Perspective 2", for new business all exclusions imposed must have a waiting period attached which is also called a moratorium underwriting.

A switch not involving an upgrade will not be re-underwritten and there will be a review of existing exclusions to either remove the exclusion or convert it to time-based exclusion. As a result, for conditions not seen in claims history of sufficient duration, exclusions on them will be unlocked and removed at the time of switch. Over time, permanent exclusions will be phased out in the IP ecosystem. Where a policyholder currently is, or has recently been, undergoing treatment for a chronic condition seeks a plan upgrade, receiving insurer may also impose time-bounded exclusions on that condition.

For plan upgrades, underwriting will be allowed, and addition of new time-bounded exclusions permitted to be consistent with treatment of new policy issuance. Past permanent exclusions are similarly converted into time-bounded ones. An insurer receiving an application for an upgrade retains the right to reject the application.

Similar to "Perspective 1", "Perspective 2" also offers a relatively high degree of freedom to switch plans for those who wishes to do so. Policyholders who had exclusions in the IPs and require lengthy and expensive treatments for the conditions previously excluded will see a greater share of their costs borne by other members in the risk pool.

Rules described above will likely lead to a wave of requests to switch, in order to unlock past permanent exclusions. To protect existing policyholders who are not switching from the increase in claims cost, and therefore in premium rate, arising from the unlock, some IP insurers may choose to close existing IP and riders to new business, and launch a new product series where the effects of the new exclusion rules are properly priced in. To existing policyholders of IP and riders, they are given the freedom to express how they believe health insurance should function. More specifically, they may choose to pay higher premium for a friendlier exclusion regime, or pay a lower premium to be in a risk pool with members who accepts the status quo. Some policyholders would value this freedom. It should be noted that having multiple similar products co-existing will fragment the risk pools in the ecosystem, making each pool's claims experience more volatile.

"Perspective 2"'s impact on existing competitive dynamics between insurers will be relatively muted compared to "Perspective 1". Insurers retain reasonable room to innovate, compete on prices and on service quality.

If, in contrast, no IP insurer create new product series to house policyholders accepted under the new exclusion rules, the ecosystem will trend towards the situation described under "Perspective 1" with large increase in premium rates for all policyholders.

If one were worried about the size of premium impact under "Perspective 2", a slight variation of perspective 2 with tighter underwriting rules for cases not related to upgrade at the time of switching as follows can be considered:

- Instead of fully banning re-underwriting, re-underwriting would be allowed for cases underwritten more than 5 years ago, and new time-bound exclusions may be added, if the last underwriting for the previous plan(s) happened more than, say, 5 years ago.
- Do not automatically convert past permanent exclusions into time-bound ones.
- Allow insurers receiving an application for such switch to retain the right to reject the switch.

Fewer insureds will be incentivised to, and be able to, switch under these tighter rules; and may not trigger insurers to launch a new product series. Cost from the relaxation of exclusion rules will be absorbed by existing risk pools.

"Perspective 3": Portability on IPs only
Offers largely status quo. Some relaxation in switching rules.

Unlike "Perspective 1" and "Perspective 2", "Perspective 3" believes that Singapore's existing IP and rider rules have been accepted by the population as largely fair when it comes to how risks are shared between policyholders of different risk profiles. Systemic issue of premium increase causes widespread unhappiness rather than the one about fairness between different policyholder groups.

The SAS HC noted that a significant proportion of insureds, if polled, would prefer the ability to switch if there are no new exclusions and if premium increase is modest. However, a commitment for no new exclusions, regardless of upgrade or downgrade, will lead insureds to upgrade only when they need to consume care. Price increase from such anti-selective behaviour will not be modest. This is similar to running a poll on public's attitude towards the "as charged" feature before it was introduced close to two decades ago. "Buffet syndrome" ensued as predicted, triggering strong healthcare cost inflation. Subsequent dialling back of "as charged" feature led to unhappiness in some policyholders. Adequate safeguards should be put in place in advance before a popular feature is introduced.

Under this perspective, there will be no re-underwriting and no new exclusions imposed. Existing exclusions and/or loadings will remain. Insurer receiving such applications to switch are not allowed to reject it.

Plan upgrades and purchase of riders will continue to be subjected to re-underwriting. As IP and riders are often designed such that any switch must happen at the same time, an insurer will first inform a policyholder applying for a rider switch of the underwriting decision on the rider application, and let the policyholder decide if he/she still wants to proceed with a switch of both IP and rider.

Under the above rules, for policyholders that do not intend to own riders, a possible response is to switch to a plan in the same tier with the cheapest premium, assuming service quality is similar. Motivation for such switch is the highest for those that are less well-off, are currently consuming care and/or have developed new medical conditions since they were last underwritten. Eventually, IP will become even more standardised both in feature and in price, encouraging insurers to compete based on service delivery and quality. More product standardisation will also make it easier for the public to compare and choose IP.

Assuming no material difference in coverage provided for IP plans among insurers, the system-level aggregate claims cost is expected to remain largely unchanged in the process; only how that is shared by different insurers change. No significant system-wide premium increase attributable to claims cost is expected from such portability rules[8]. Premiums may increase for insurers who are offering competitive premiums at this stage[9]. Having said that, system-wide premium increase may arise from higher administrative expense and distributor incentives if churning is poorly controlled.

Actual policyholders' behaviour may differ from that described above. Anecdotal evidence based on IP market share shows that lowest price does not always lead to higher market share. Distributors too plays an important role in IP sales. It would be helpful to engage distributors to understand how policyholders may perceive changes to portability rules, and to ensure that distributors have an

[8] The assumption of no significant system-wide premium increase depends heavily on a tight definition of what constitutes a plan upgrade. Put differently, if there is material difference in, say, coverage limits for cancer drugs between IP plans deemed to be in the same tier, relaxation of portability rules will drive individuals with higher cancer risk/ currently being treated for cancer towards the insurer that provides higher cancer drugs limit or cancer drug services. This will lead to a system-wide increase in claims payment, which in turn drives up premium. Before roll out of "Perspective 3", IP insurers should be given adequate lead time (circa 12 months) to review and adjust their IP product features and limits to achieve their desired positioning vis-à-vis other IP insurers to avoid large swings in profile of risks in their risk pool. Avoiding such large swings also helps to mute the impact of any unforeseen behavioural change on the part of insureds and healthcare providers to a level that can be absorbed by existing pricing.

[9] While this may seem unfair for existing insureds of such risk pool to experience such premium increase, it is a by-product of acceding to requests of freedom to switch insurer without being re-underwritten.

accurate understanding of the effects of any rule change. Such engagement will ultimately help policyholders make the appropriate choice.

Research should be conducted on each IP insurer's profitability, pricing strategy and capability to take risk so as to ensure that the change will not trigger solvency issues that may negatively impact policyholders.

Riders will continue to be the platform where innovation happens as insurers retain the ability to control how they take on risks. Imposing changes to portability rules described above on riders will drive a standardisation in rider offerings, killing product innovation. If both IP and riders become highly standardised, it begs the question of the need for private insurers' involvement in the first place. In addition, existing heterogeneity in the rider space means that it would be quite easy for any insured to find another rider that is an upgrade (i.e. offer higher pay out) based on one's medical condition at the relevant times. It is much harder to define what constitutes an "upgrade" for riders due to the interaction between diverse benefit designs and insureds' medical conditions. Anti-selective switching will make the rider risk pools unsustainable.

This paper sets out a number of scenarios under which portability of health insurance plans can be considered in Singapore's context, and discusses possible implications, benefits and risks under each strategy. This analysis is not meant to be exhaustive and there may be additional implications to consider and quantify. SAS does not currently possess the data necessary to estimate the impact on claims, and in turn, premium rates involved in implementing the above changes. Nonetheless, SAS believes that such analysis to be necessary before rolling out any change.

To conclude, a major change in IP and rider portability rules would be successful only if it is backed from strong consensus in the public about how health insurance should work - and thorough analysis on the intended and possible unintended impact on all stakeholders. There will be trade-off between freedom and fairness. We hope that this note will help Singapore in choosing portability rules that best fit the Singapore consensus.

Appendix: Portability Framework in Other Countries

Australia

The health insurance landscape is rather different in Australia. It focuses on accessibility, affordability and non-discrimination against individuals based on age, gender, pre-existing health conditions, or other individual risk factors.

In terms of coverage, private health insurance policies are categorized into four tiers: Basic, Bronze, Silver, and Gold:

Tier	Descriptions
Basic	The most affordable tier, minimally must provide coverage for rehabilitation, psychiatric services and palliative care on a restricted basis. In other words, a member is typically only covered as a private patient in a public hospital.
Bronze	Typically less affordable than Basic but with greater coverage of hospital services. Eighteen prescribed clinical categories must be covered on an unrestricted basis.
Silver	Provides further coverage compared with Bronze. Twenty-six prescribed clinical categories must be covered on an unrestricted basis. Popular among those seeking more extensive coverage but not wanting particular clinical categories.
Gold	The highest level of coverage among the tiers. All thirty-five clinical categories must be covered on an unrestricted basis in addition to covering rehabilitation, psychiatric services and palliative care on an unrestricted basis.

Within these clinical categories, individual insurers have the flexibility to create their own products, resulting in variations in coverage, pricing and policy terms and conditions.

From an underwriting and pricing perspective, private healthcare in Australia operates under a community rating system in which insurers are required to offer the same premium for the same product type to all individuals residing in the same state regardless of their age, gender and other factors. There is no traditional medical underwriting but "Lifetime Health Cover (LHC) loading" acts as a financial incentive to encourage people to take out private health insurance early in their lives. Individuals who do not take out private hospital cover before the 1st of July following their 31st birthday, they incur a 2% loading on their premium for every year they delay signing up for health insurance. Such loading can accumulate up to a maximum of 70%. Insurers can also offer discounts up to 10% to people aged 18-29.

Portability between health insurance providers is an important aspect of the healthcare system. It allows policyholders to seek better deals, different coverage options, or superior customer service by transferring their policy from one insurer to another without losing any waiting periods or continuity of care. The Australian government has regulations in place to ensure that this transition is smooth for consumers. Some important points to take note:

The Australian government has regulations in place to ensure that this transition is smooth for consumers. Some important points to take note:

Metrics	Details
Guaranteed Acceptance	Private health insurers are not allowed to reject or refuse ported policies when individuals transfer their coverage from one insurer to another
Waiting Periods	When an individual transfers one's policy to a new insurer, the waiting periods already served for specific treatments and services must be recognized by the new insurer. Insurers are not allowed to require the individual to restart waiting periods for benefits one previously had.
Switching Policies	While insurers must accept ported policies, the specific policy options they offer may vary. An individual may choose a different policy from the new insurer if it better suits one's needs, but this may come with changes in coverage and cost and waiting periods will need to be served for benefits that are being newly covered.
Pre-Existing Conditions	Under the principles of community rating and lifetime health cover loading, insurers cannot discriminate against individuals with pre-existing conditions when accepting ported policies. Waiting periods for pre-existing conditions that have already been served are not required to be served again. This helps ensure that individuals can maintain their coverage without being penalized for their health status.

Such flexibility encourages competition among insurers and empowers consumers to make informed choices about their health coverage, ultimately benefiting the policyholders by promoting better options and improved services.

To support community rating as well as to mitigate the adverse selection problem, high-risk pools, also known as risk adjustment mechanisms, play a crucial role. It helps to balance the risk pool within the private health insurance system by redistributing funds from insurers with younger (i.e. healthier and lower-risk) policyholders to insurers with older (i.e. higher-risk) policyholders. It uses risk adjustment method that considers factors such as the policyholder age and hospital claim size to determine the amount of funds that should be redistributed among insurers. This redistribution helps ensure that the financial burden of covering high-risk individuals is more equitably shared among insurers. Besides, it reduces risk selection by insurers.

This model has been the main reference for the SAS HC's proposal under "Perspective 1". This approach takes longer time to implement, but it would eventually change the health insurance landscape to "minimum coverage for all" without sacrificing competitiveness among insurers in terms of service excellence.

Netherlands

In the Netherlands, portability (or consumer mobility) is central to the concept of competition in health insurance. Individuals can switch insurance providers without losing their coverage or having to worry about pre-existing conditions.

One of the key factors in achieving portability is the standardization of insurance policies. All insurance providers are required to offer a basic insurance package that covers a set of essential healthcare services. This ensures that individuals have access and can compare across the same level of coverage, regardless of which insurance provider they choose.

However, the obligation within Health Insurance Act[10] does not extend to additional insurance (i.e. supplementary coverage). This means insurers can set premiums, decide on cover provided, or reject applications for additional insurance.

- If an individual changes basic plan, the new insurer must accept for basic coverage but is not required to offer supplementary coverage.
- Instead, the individual's previous insurer is required to continue to provide supplementary coverage at the same rate that would apply if the individual had continued basic coverage.

Another important factor is the use of risk equalization. This is a system where insurance providers are compensated for taking on high-risk individuals, such as those with pre-existing conditions. This encourages insurance providers to compete based on quality of service rather than cherry-picking healthy individuals. This is a common feature among countries with community-rated premiums (i.e. no premium differentiation by gender, age, etc).

[10] https://www.government.nl/topics/health-insurance/standard-health-insurance/changing-your-health-insurance

India

The health insurance landscape in India is a mix of public schemes and private plans. The government supports the poor and vulnerable by running various government-subsidized insurance schemes with the support of private insurers. The majority of the white collar working population is covered under employer-employee group insurance schemes. The rest of the population either buys private insurance or pays out of pocket for medical expenses.

Private individual medical insurance: The usual coverage provided is inpatient care (including day care, pre and post hospitalization care, etc.). Different insurers have different underwriting practices, where underwriting can vary by combination of product type, sales channel, age band or sum insured. Waiting period for pre-existing conditions varies by product construct, and can be from 2 to 4 years.

The IRDAI (Insurance Regulatory and Development Authority of India) established rules for **portability** (when an insured person wishes to terminate a plan with one insurer to buy one with another insurer) and **migration** (when an insured person wishes to change from one plan to another plan offered by the same insurer).

Portability (Switching of Plans from One Insurer to Another)

Portability rules for private individual health insurance plans were introduced by the IRDAI in the 2016 Health Regulations. Key features of these Regulations are:

1. IRDAI mandates allowance of portability for all individual health insurance plans in India from one insurer to other. An insured person has a right to apply to switch from a plan with one insurer to a plan with another insurer subject to rules.

2. The standard rules set by the IRDAI are that:

   a) A switch is allowed only at the time of renewal of the existing plan and that all the persons insured under that plan must be transferred to the new plan simultaneously.

   b) The application shall be submitted within 60 but no less than 45 days before the renewal date of the existing plan.

   c) If an insured person is presently covered and has been continuously covered without any lapses under the existing plan and all other preceding insurance plans, the insured person will accrue continuity benefits in the application of waiting periods. The time from the date the person was first insured will be considered towards the waiting period applied for any medical conditions during previous underwritings.

   d) Insurers must apply a standard application process and use a standard form across the industry.

IRDAI has made no recommendation on the re-underwriting or pricing of plans for switching purposes. Different insurers adopt different approaches towards underwriting. Most of the insurers re-underwrite the insured persons upon the receipt of an application to switch to one of its plans.

3. Given the time-based exclusions of pre-existing conditions, portability plays an important role by allowing the time from the start of the insurance of an insured person to be counted towards the exclusion waiting period.

Migration (from One Plan to Another with the Same Insurer)

Along with the portability rules, the IRDAI established rules for the migration of insured persons from one plan to another with the same insurer.

The IRDAI allows migration of an insured person from one plan, whether an individual or a group plan, to another individual or group plan with the same insurer.

Every insured person (including members under a family floater policy) covered under an indemnity-based individual health insurance policy shall be provided an option of migration at the explicit option exercised by the policyholder:

a) To an individual health insurance policy or a family floater policy, or;

b) To a group health insurance policy, if the member complies with the norms relating to the health insurance coverage under the concerned group insurance policy.

A family floater policy offers to provide health insurance to the entire family unit in a single policy with shared benefits across the covered members.

Only the unexpired/residual waiting period not exceeding the applicable waiting period of the previous policy with respect to pre-existing diseases and time bound exclusions shall be made applicable on migration to the new policy.

Migration may be subject to underwriting. However, for individual policies, if the policyholder has been continuously covered under the previous policy without any break for a period of four years or more, migration shall be allowed without subjecting any insured person to any underwriting to the extent of the sum insured and the benefits available in the previous policy.

Individual members, including the family members covered under an indemnity-based group health insurance policy shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy.