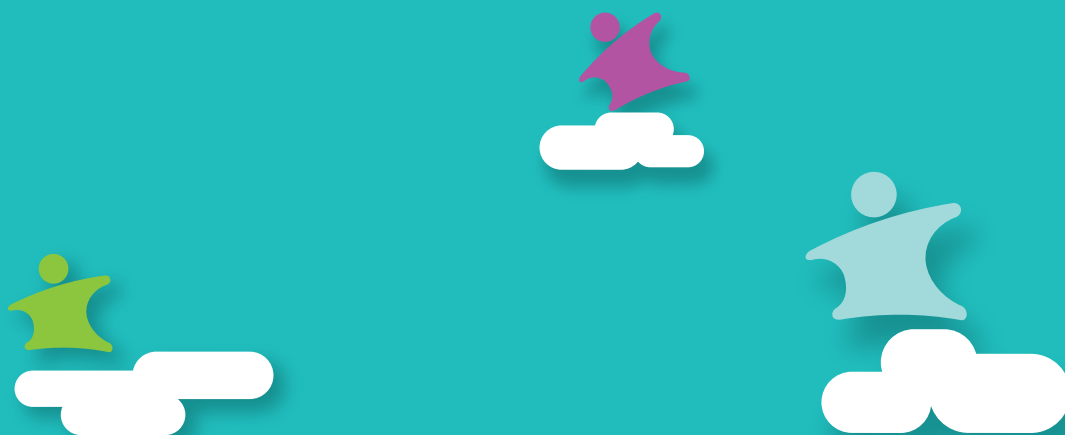




Consultation Document

VOLUNTARY

HEALTH INSURANCE SCHEME



Food and Health Bureau
Hong Kong Special Administrative Region Government

Consultation Document on Voluntary Health Insurance Scheme

Food and Health Bureau
Hong Kong Special Administrative Region Government
December 2014

ABBREVIATIONS

ADR	Alternative Dispute Resolution
C&SD	Census and Statistics Department
CDRM	Claims Dispute Resolution Mechanism
CT	Computed Tomography
CUHK	The Chinese University of Hong Kong
DH	Department of Health
DRG	Diagnosis-related Groups
FDRC	Financial Dispute Resolution Centre
FHB	Food and Health Bureau
HA	Hospital Authority
HKU	The University of Hong Kong
HMDAC	Health and Medical Development Advisory Committee
HPPA	Hospital Purchaser Provider Arrangement
HPS	Health Protection Scheme
HRP	High Risk Pool
ICCB	Insurance Claims Complaints Bureau
ICO	Insurance Companies Ordinance
IIA	Independent Insurance Authority
MPPA	Medical Purchaser Provider Arrangement
MRI	Magnetic Resonance Imaging
OCI	Office of the Commissioner of Insurance
PCIP	Pre-existing Conditions Insurance Plan
PET	Positron Emission Tomography
PHF	Private Healthcare Facility
PHI	Private Health Insurance
SFH	Secretary for Food and Health
THS	Thematic Household Survey
VHIS	Voluntary Health Insurance Scheme

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MESSAGE FROM DR KO WING-MAN, BBS, JP, SECRETARY FOR FOOD AND HEALTH

Dear Citizens,

For years, we have prided ourselves over Hong Kong's efficient healthcare system – our heavily government subsidised public healthcare system is equitable, affordable and accessible to all; for those who choose to use private services, our private healthcare sector complements the public system by providing personalised choices and amenities that better suit their specific requirements. The Government will continue to uphold the dual-track healthcare system and strengthen its commitment to the sustainable development of public system as the safety net for all.



On the other hand, the rapidly ageing population and escalating medical costs pose serious challenges to the sustainability of our healthcare system. In particular, the pressure on the public healthcare system, currently the predominant provider of secondary and tertiary services, will continue to increase. Ensuring the sustainable and balanced development of the dual-track system requires a delicate balancing act – clearer positioning of the respective roles of the public and private sectors, enhancing public-private collaboration, and facilitating interflow of medical information and patients between the two sectors.

The Voluntary Health Insurance Scheme (VHIS, formerly the Health Protection Scheme) is part of our effort in recalibrating the public-private balance among other important policy initiatives that we are taking forward, such as developing electronic health record sharing, promoting public-private partnership, and ensuring supply of public and private healthcare manpower, services and facilities. The VHIS proposes to require all individual indemnity hospital insurance in the market to comply with a set of minimum standards, which are designed to address the shortcomings of the existing market as revealed in previous rounds of public consultation on healthcare reform in 2008 and 2010. By improving the accessibility, quality and transparency of hospital insurance, consumers will have more confidence in making use of private healthcare services with a choice of doctor and in a more convenient setting. Users of public healthcare services can also benefit. As more people are willing to make use of private healthcare services through the VHIS, resources can be released in the public sector to enhance service quality and reduce waiting time. In this way, the VHIS will help promote synergy between the public and private sectors and more efficient use of public and private healthcare resources.

The VHIS is not intended as a total solution to the problems of our healthcare system, but it is an important tool for building a more integrated and balanced healthcare system for the benefit of all in the community. I look forward to receiving your views on the proposals we put forth for implementing the VHIS.

Finally, I would like to express my sincere gratitude to, among others, members of the Working Group and Consultative Group on Health Protection Scheme, and the Subcommittee on Health Protection Scheme of the Legislative Council Panel on Health Services. Their valuable suggestions and advice have been pivotal in the formulation of the proposals for the VHIS.



Dr KO Wing-man
Secretary for Food and Health
December 2014

EXECUTIVE SUMMARY

HEALTHCARE REFORM (CHAPTER 1)

1. Hong Kong has a dual-track healthcare system by which the public and private healthcare sectors complement each other. The public sector is the predominant provider of secondary and tertiary healthcare services. Around 88% of in-patient services (in terms of number of bed days) are provided by public hospitals. Public hospitals provide about 27 400 hospital beds, accounting for about 88% of total hospital beds. The private sector complements the public healthcare system by offering choice to those who can afford and are willing to pay for healthcare services with personalised choices and better amenities.

2. The dual-track healthcare system has served us well over the years and it is the Government's policy to maintain and strengthen the dual-track healthcare system. Nevertheless, as with other advanced economies, Hong Kong is facing the challenges of an ageing population, rising public expectation of healthcare services and increasing medical costs. Confronted by these challenges, the Government has substantially increased investment in public healthcare system over the years, including increasing recurrent expenditure on medical and health services in the past seven years from \$32 billion in 2007-08 by over 60% to \$52 billion in 2014-15 (public health expenditure now accounts for about 17% of total recurrent expenditure of the Government) and embarking on a major public hospitals redevelopment and expansion programme, including the construction of the Tin Shui Wai Hospital and the Hong Kong Children's Hospital, expansion of United Christian Hospital, redevelopment of Kwong Wah Hospital and Queen Mary Hospital, etc.

3. Notwithstanding the Government's commitment to public healthcare, it is necessary to identify suitable measures to improve the quality of our healthcare services and to readjust the public-private balance, so as to maintain the long-term sustainability of our healthcare system. Multiple rounds of public consultation on healthcare reform had been conducted since the 1990s to identify ways to reform the healthcare system through recalibrating the balance of the public-private healthcare sectors. Various proposals were put forth, including capping Government subsidy or increasing user fees of public healthcare services, social health insurance, medical savings account, etc. While the public was generally supportive of the need for reform, opinions on different reform options varied and no general consensus was reached.

4. During 2008 to 2010, the Government launched two stages of public consultation on healthcare reform to look for ways to improve the quality of our healthcare services, and to enhance the long-term sustainability of our healthcare system. The First Stage Public

Consultation “Your Health, Your Life” in 2008 consulted the public, among other service reform proposals, six supplementary financing options, including increasing user fees for public healthcare services, social health insurance, mandatory medical savings accounts, voluntary private health insurance (PHI), mandatory PHI, and personal healthcare reserve (mandatory savings cum insurance). As the public expressed reservations about mandatory financing options, the Government put forth the Health Protection Scheme (HPS) proposal, a voluntary, government-regulated PHI scheme, in the Second Stage Public Consultation “My Health, My Choice” in 2010.

5. The objective of the HPS is to provide an alternative to those who are able and willing to use private healthcare services through enhancing the quality of health insurance in the market. In doing so, the HPS could facilitate a greater use of private healthcare services as an alternative to public services, thereby better enabling the public sector to focus on providing services in its target areas. A number of key features designed to enhance the accessibility, quality and transparency of health insurance were proposed for HPS products, including guaranteed renewal for life; covering pre-existing conditions subject to a waiting period; accepting high-risk groups through a high risk pool; and standardisation of policy terms and conditions, etc.

6. To take forward the HPS, a Working Group and a Consultative Group on the HPS were set up under the Health and Medical Development Advisory Committee to make recommendations on matters concerning the implementation of the HPS. With reference to the deliberation by the Working Group and the Consultant’s recommendations, we hereby put forth the detailed proposals for implementing the HPS for public consultation.

7. The HPS is not intended as a total solution to the challenges faced by our healthcare system, but a supplementary financing arrangement complementing public healthcare, and one of the control knobs in redressing the public-private balance. To better reflect its objectives and nature, we propose to rename the scheme to “Voluntary Health Insurance Scheme” (VHIS).

MINIMUM REQUIREMENTS (CHAPTER 2)

Regulation of Individual Hospital Insurance

8. The proposed VHIS intends to **regulate individual indemnity¹ hospital insurance**, meaning a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (Cap. 41)(**ICO)(Class 2)** which provides for benefits in the nature of **indemnity** against risk of loss to the insured attributable to **sickness or infirmity**

¹ An “indemnity” insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss.

that **requires hospitalisation**² (**Hospital Insurance**) and the policyholder/person insured is an **individual**. An individual Hospital Insurance policy may be issued to an individual as a standalone Class 2 policy or as an additional cover combined with, hence, forming part of a contract of long-term business (e.g. a medical insurance rider attached to and forming part of a life insurance policy).

9. **In selling and/or effecting individual Hospital Insurance, an insurer must comply with the Minimum Requirements** prescribed by the Government. An individual Hospital Insurance that meets all (but not exceeding) the Minimum Requirements is considered a **Standard Plan**, which insurers selling individual Hospital Insurance must offer as one of the available options to consumers, regardless of whether they also offer individual Hospital Insurance products with enhanced benefits (please refer to paragraphs 20 to 22). **Upon the implementation of the VHIS, insurers will not be allowed to offer individual Hospital Insurance that do not comply with the Minimum Requirements.**

Standard Plan

10. The 12 Minimum Requirements proposed for Standard Plan aim to improve accessibility and continuity of individual Hospital Insurance, enhance the quality, and promote transparency and certainty of insurance protection. They are summarised below –

- (a) guaranteed renewal without re-underwriting;
- (b) no “lifetime benefit limit”;
- (c) coverage of pre-existing conditions subject to a standard waiting period;
- (d) guaranteed acceptance with premium loading capped at 200% of standard premium for –
 - (i) all ages within the first year of implementation of the VHIS; and
 - (ii) those aged 40 or below starting from the second year of implementation of the VHIS;
- (e) portable insurance policy with no re-underwriting when changing insurer, provided that no claims were made in a certain period of time (say, three years) immediately before transfer of policy;

2 For the purpose of the VHIS, hospitalisation here refers to a setting where the patient may not be discharged on the same calendar day of admission; and the expected total duration of the procedure, recovery, treatment and care requiring continuous confinement within the facility may exceed 12 hours.

- (f) benefit coverage must include medical conditions requiring hospital admissions and/or prescribed ambulatory procedures³ ;
- (g) benefit coverage must include prescribed advanced diagnostic imaging tests, subject to a fixed 30% co-insurance to combat moral hazard; and non-surgical cancer treatments up to a prescribed limit;
- (h) benefit limits must meet prescribed levels;
- (i) no cost-sharing (deductible or co-insurance) by policyholders except the fixed 30% co-insurance for prescribed advanced diagnostic imaging tests; and annual cap of \$30,000 on cost-sharing by policyholders (excluding excess amount payable by policyholders if actual expenses exceed benefit limits);
- (j) budget certainty for policyholders through –
 - (i) Informed Financial Consent: a policyholder should be informed of estimated charges and estimated claims amount through written quotation before treatment;
 - (ii) No-gap/known-gap arrangement for at least one procedure/test: a policyholder can enjoy “no-gap” (no out-of-pocket payment is required) or “known-gap” (a pre-determined amount of out-of-pocket payment) if the procedure concerned, the institution (e.g. hospital) and doctor selected by the policyholder are on the lists agreed among his/her insurer and healthcare providers;
- (k) standardised policy terms and conditions; and
- (l) transparent information on age-banded premiums through easily accessible platform (e.g. websites of insurers and the VHIS regulatory agency to be established).

11. The Minimum Requirements proposal was formulated having regard to public concerns over the existing Hospital Insurance market as revealed by the previous public consultations, such as decline of cover; exclusion of pre-existing conditions; no guaranteed renewal of policies; lack of budget certainty; or dispute over insurance claims due to lack of standardised policy terms and conditions. These shortcomings have often discouraged the insured from making use of private healthcare services through their insurance cover,

3 The ambulatory procedures to be covered under Standard Plan will be determined and prescribed by the regulatory agency (please see paragraph 36) to be established to monitor the implementation and operation of the VHIS, subject to the advice of an advisory committee constituted mainly of major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.)

leading them to fall back to the public system. By improving the quality and certainty of Hospital Insurance protection through the Minimum Requirements, and by fostering consumer confidence in using private healthcare services, Hospital Insurance would be able to play a greater role in financing the growing health expenditure. According to the findings of the Public Opinion Survey on Supplementary Healthcare Financing conducted alongside the Second Stage Public Consultation, about 90% of the respondents supported strengthening regulation of health insurance in order to provide better protection to the consumers.

12. The Minimum Requirements proposal is in line with international experience. In overseas jurisdictions where PHI plays a significant role in the healthcare system, such as Australia, Ireland, the Netherlands, Switzerland and the United States, the governments have prescribed by law basic requirements for PHI to safeguard consumer interest. These basic requirements are broadly similar to the proposed Minimum Requirements, including guaranteed renewal, guaranteed acceptance, coverage of pre-existing conditions, minimum benefit coverage and benefit limits, standardised policy terms and conditions, etc.

13. From the perspectives of health policy and consumer protection, we consider it desirable that individual Hospital Insurance sold in the name of “hospital”/“health”/“medical” insurance should provide at least the benefits offered by a Standard Plan, such that consumers who purchase such products will not be misled into thinking that those non-compliant products fulfill the Minimum Requirements of the VHIS. We propose that, upon the implementation of the VHIS, only those health insurance products complying with the Minimum Requirements may be sold in the name of “hospital”/“health”/“medical” insurance, or such other name which denotes or connotes that such product is an individual Hospital Insurance.

14. The Minimum Requirements of the VHIS would only be confined to individual Hospital Insurance. The VHIS does not intend to cover –

- (a) any fixed pecuniary benefits (e.g. hospital cash, critical illness cover)⁴ which may be added to an individual Hospital Insurance policy; and
- (b) a group policy, i.e. a policy being held by an employer for the benefit of its employees⁵.

4 Typically, a critical illness cover provides a lump-sum cash payment if the insured is diagnosed with a disease as designated in the insurance policy whereas a hospital cash cover provides a fixed cash benefit paid for each day of hospitalisation due to a sickness or accident. In both examples, since the payment is one of fixed pecuniary benefits, the cover itself will not be regulated under the VHIS. It will also not be regulated for reason that the cover is attached to an individual Hospital Insurance Policy.

5 For the avoidance of doubt, the VHIS does not intend to cover insurance policies purchased by employers for foreign domestic helpers where indemnity hospital insurance is featured incidentally as a small, non-core component and is not intended to cover the full cost of private healthcare services of the person insured. Insurance policies purchased by employers for foreign domestic helpers will not be subject to the arrangements proposed for group policies described in paragraphs 16 and 17.

Arrangements for Group Hospital Insurance

15. Ideally, it is desirable for group Hospital Insurance to comply with the Minimum Requirements for better consumer protection. Nevertheless, given that the group market is inherently different from the individual market in the sense that the cost of purchasing the group policies is borne by employers, rather than employees who are the direct beneficiaries; and the fact that some of the products in the market are of limited protection due to budget constraint of some employers, we propose not to require group Hospital Insurance to comply with the Minimum Requirements.

16. To better protect employees' interests, we propose to adopt the following arrangements for group Hospital Insurance –

- (a) **Conversion Option:** We propose to require insurers to offer as an option to employers an elective component – the Conversion Option – in the group Hospital Insurance products. If the employer decides to purchase the group policy together with the Conversion Option, an employee covered by such group policy can exercise the Conversion Option upon leaving employment so that he/she can switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that he/she has been employed for a full year immediately before transferring to the individual Standard Plan; and
- (b) **Voluntary Supplement(s):** We propose that insurers may offer, on a group policy basis, Voluntary Supplement(s) to individual members covered by a group Hospital Insurance policy who wish to procure at their own costs additional protection on top of their group policy. The group policy, enhanced by the Voluntary Supplement, should provide insurance protection at a level comparable to the protection of an individual Standard Plan.

17. Since group Hospital Insurance would not be regulated by the Minimum Requirements, and some of which may provide benefits lesser than that of an individual Standard Plan, we propose that, for any group Hospital Insurance products to be sold in the name of "hospital"/"health"/"medical" insurance, it must be specified in the product name that such products are group products (e.g. "group hospital insurance", "group health insurance" or "group medical insurance").

PRODUCT DESIGN (CHAPTER 3)

Standard Plan

18. Below is an illustrative outline of how the benefit schedule of Standard Plan will be structured.

Illustrative Outline of Benefit Schedule of Standard Plan⁽¹⁾
(Indicative dollar figures for illustration only)

Category	
(A) Itemised benefit limits (for hospitalisation only)	
(1) Room and board (daily), maximum 180 days	\$ 650
(2) Attending physician's visit (daily), maximum 180 days	\$ 750
(3) Specialist's visit (per admission)	\$ 2,300
(4) Surgical limit (including surgeon, anaesthetist, operating theatre ⁽²⁾) (per surgery)	Maximum \$ 58,000 (varies by surgery type)
(5) Miscellaneous hospital expenses (per admission)	\$ 9,300
(B) Packaged benefit limits	
(1) Prescribed ambulatory procedures (per procedure), e.g. endoscopy, cataract extraction and intra-ocular lens implantation surgery	Lump-sum packaged benefit limit ⁽³⁾ (varies by procedure type)
(2) Prescribed advanced diagnostic imaging tests (per test), e.g. Magnetic Resonance Imaging (MRI) examination, Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan	Lump-sum packaged benefit limit ⁽³⁾ (varies by test type) subject to 30% co-insurance
(3) Non-surgical cancer treatments (per disability)	\$ 150,000

(C) "No-gap/known-gap" cover	
Applicable to the list specified by insurer on: (1) procedures/tests; (2) hospitals or clinics; (3) doctors	Out-of-pocket payment varies by procedure/ test type ⁽⁴⁾ ; no out-of-pocket payment for "no-gap" cover
(D) Annual benefit limit	\$ 400,000
(E) Lifetime benefit limit	Nil
(F) Deductible	Nil
(G) Co-insurance (other than 30% for prescribed advanced diagnostic imaging tests)	Nil

Notes:

- (1) The illustrative outline is intended to demonstrate the structure of the benefit schedule of Standard Plan under the Minimum Requirements.
- (2) The respective sub-benefit limits for surgeon, anaesthetist and operating theatre fees would be determined in consultation with relevant stakeholders.
- (3) Packaged benefit limit includes doctor's fee and other expenses. The respective sub-benefit limits for doctor's fee and other expenses would be subject to consultation with relevant stakeholders. The sub-benefit limits would only be applicable if the billed amount exceeds the packaged benefit limit, so as to safeguard proper apportionment among the charging parties.
- (4) Amount paid by insurer includes doctor's fee and other expenses. The respective amounts of doctor's fee and other expenses would be subject to consultation with relevant stakeholders.

19. Standard Plan offers enhanced benefits compared to existing individual Hospital Insurance products which likewise target at general ward level services. For instance, for non-surgical cancer treatments (e.g. chemotherapy, radiotherapy) and advanced diagnostic imaging tests (e.g. MRI examination, CT scan, PET scan), a lot of existing products do not provide coverage for these treatments and tests as a separate benefit item. These treatments and tests are usually only claimable under the benefit item of "miscellaneous hospital expenses", which under normal circumstances would not be sufficient for covering the cost of these treatments and tests. Under Standard Plan, rather than being covered under "miscellaneous hospital expenses" as in existing individual Hospital Insurance products, these treatments and tests will be covered under separate benefit items, subject to respective benefit limits that would provide sufficient coverage for policyholders for using these services. Taking into account these enhanced benefits, the average annual standard premium of Standard Plan is estimated by the Consultant to be around **\$3,600**⁶ (in 2012 constant prices), about 9% higher than the average premium of existing individual Hospital Insurance products (ward level) in the market (i.e. about \$3,300 in 2012 constant prices). The above notwithstanding, enhanced transparency and product comparability under the VHIS is expected to result in a reduction of the expense loading (i.e. the amount of insurer expenses, including commissions and broker fees, profit margins, expenses and other overhead expenses, as a percentage

⁶ The figure lies between the estimated standard premiums of Standard Plan for the age groups from 40 to 49.

of the amount of premium). The average expense loading of the individual health insurance market (36% in 2013⁷) and the whole health insurance market (29% in 2013) in Hong Kong were the highest among jurisdictions studied by the Consultant. The average expense loading of the whole health insurance market was 13% in Australia (2012), 13% in Ireland (2012), 7% in the Netherlands (2012) and 9% in Switzerland (2012). Under the VHIS, standardisation, quality assurance and better flow of market information will facilitate easy comparison by consumers, foster market competition, and hence lead to a more moderate expense loading. A modest improvement in the expense loading to a level more in line with international experience can partly offset the estimated increase in premium of Standard Plan in comparison with existing products in the market, which lack the enhanced features and benefits proposed under the Minimum Requirements.

Flexi Plans and Top-up Plans

20. Insurers are not restricted to offer Standard Plan only but may provide enhanced benefits in the form of a Flexi Plan or a Top-up Plan to suit the specific needs of consumers.

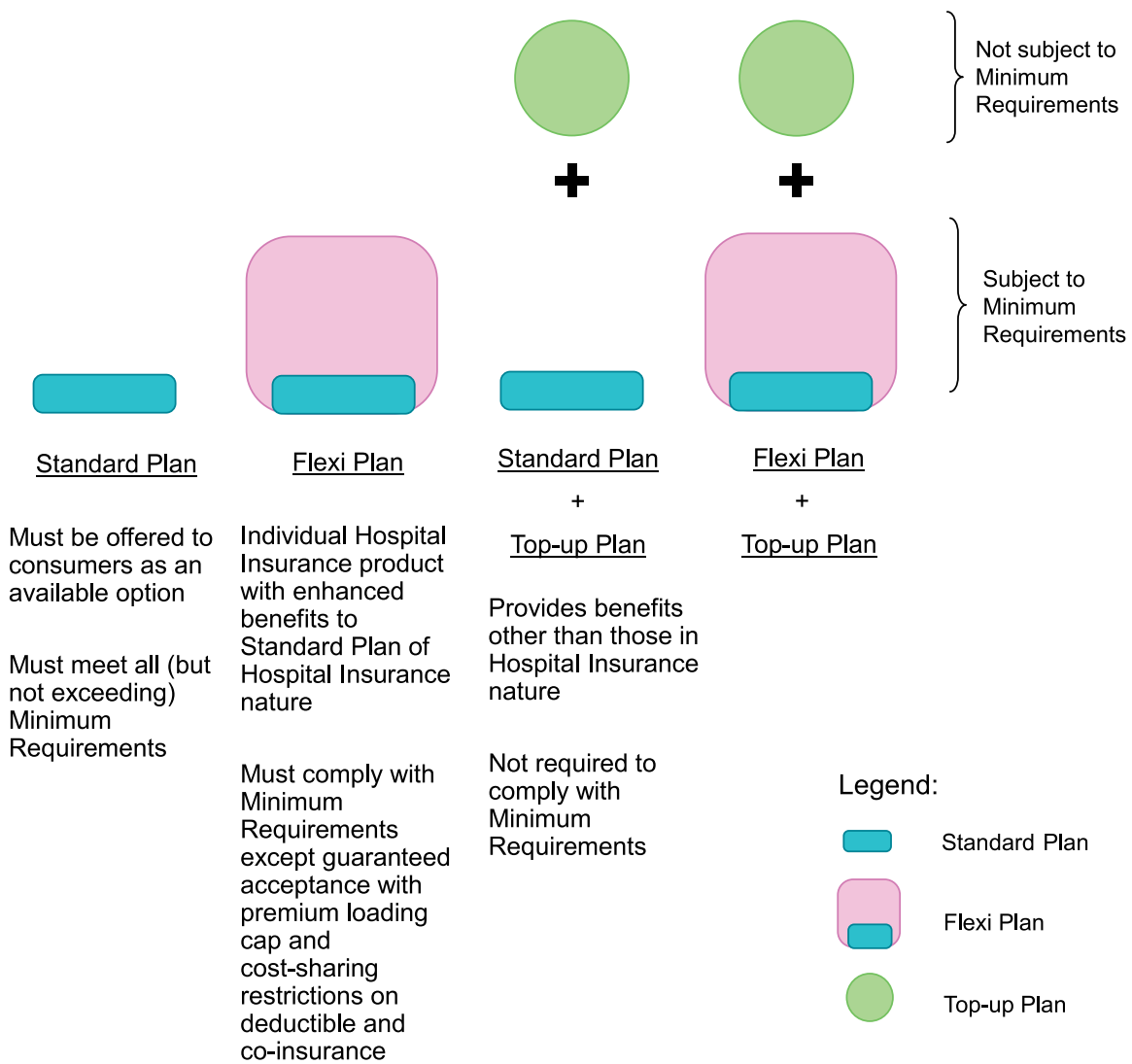
21. A Flexi Plan refers to a Hospital Insurance plan with enhancement to any or all of the benefits of a Standard Plan (e.g. higher room and board benefit limits than those required for a Standard Plan) of Hospital Insurance nature. With a view to allowing more flexibility in promoting product innovation and competition, the enhanced benefits in a Flexi Plan will not be subject to the requirements of –

- (a) guaranteed acceptance with premium loading cap; and
- (b) the cost-sharing restriction (no deductible or co-insurance) of Standard Plan, except that the amount of the deductible or co-insurance would be subject to the same annual cap of \$30,000 proposed for Standard Plan.

22. A Top-up Plan refers to one providing benefits other than those in the nature of a Hospital Insurance and may be attached to, hence forming part of, a Standard Plan or a Flexi Plan. Since a Top-up Plan, whether as a rider or as a standalone plan, is not a Hospital Insurance, it will not be subject to the Minimum Requirements.

7 Source: Office of the Commissioner of Insurance. The corresponding figure for the group health insurance market was 19% in 2013.

Possible Product Structuring of Standard Plan, Flexi Plan and Top-up Plan



PUBLIC FUNDING (CHAPTER 4)

High Risk Pool (HRP)

23. During the Second Stage Public Consultation, one of the major misgivings expressed by the community is that high-risk individuals (their applications are either rejected by insurers, or accepted with additional clauses imposed in their policies excluding their pre-existing conditions, or charged a premium loading at a rate deemed appropriate by insurers) have significant difficulties in purchasing Hospital Insurance. To meet the community's aspirations to enable high-risk individuals to purchase Hospital Insurance, we propose to require under the Minimum Requirements that insurers must provide to consumers a Standard Plan with guaranteed acceptance with a premium loading cap of 200%, and coverage of pre-existing conditions. Nevertheless, if insurers are mandated to accept such individuals and the loading is capped without proper mitigating measures, they may not be able to collect adequate

premium income to offset the claims payout.

24. To ensure that high-risk individuals can also buy Hospital Insurance, the Consultant recommends that a HRP be established. The HRP will be open to all in the first year upon the implementation of the VHIS and limited to those aged 40 or below thereafter. We propose that the HRP should be established by legislation with the following framework –

- (a) the HRP will be a legal entity, which can enter into contracts, sue and be sued; it will be funded by premium income and Government funding;
- (b) it accepts only Standard Plan high-risk policies⁸ transferred by an insurer; despite such transfer, the policy remains as a contract between the policyholder and the insurer who underwrites and issues the policy;
- (c) the insurer will administer the policy and receive an administration fee payable by the HRP;
- (d) in the course of administration, the insurer shall separate a portfolio for the high-risk policies from other policies with a view to ensuring that underwriting of risks of non-high-risk individuals will not be adversely affected;
- (e) all premiums payable and claims and liabilities under the policy will be accrued to the HRP;
- (f) the HRP may contract out its day-to-day operation to a claims specialist;
- (g) the policyholder shall pay the premium with a premium loading at 200% of the standard premium prescribed by the insurer;
- (h) the HRP will be monitored by the regulatory agency provided in paragraph 36; and
- (i) the insurer is expected to transfer a high-risk policy underwritten by it to the HRP upon the policy inception. The HRP will not subsequently accept any high-risk policy not so transferred and the insurer cannot later on request the HRP to accept any high-risk policy for reason of increasing health risk of the insured or otherwise. If it chooses not to transfer it to the HRP at the policy inception, while it may receive the premium payable (subject to the cap), it will have to bear the claims and liabilities of the policy until the expiry or termination without the benefit of the HRP.

8 A high-risk policy refers to one of which an insurer will charge a premium loading at or more than 200% of its standard premium.

25. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the VHIS's goal to improve access to Hospital Insurance. We consider it reasonable and justifiable for the Government to use public funds to support the HRP. Without the HRP, many high-risk individuals would likely fall back on the public system, which is heavily subsidised by the Government. Enabling some of the high-risk individuals to obtain Hospital Insurance coverage through the HRP not just offers them the choice to use private healthcare services, but also enables the public healthcare system to better focus its resources on serving its target areas.

26. It is estimated that the total cost to Government for funding the operation of the HRP for a 25-year period (2016 to 2040) would be about \$4.3 billion (in 2012 constant prices). We will review and consider in due course the funding arrangements for the HRP beyond 2040 having regard to operational experience.

Tax Deduction for Hospital Insurance

27. Tax incentives for health insurance plans meeting Government-sanctioned requirements are commonly observed around the world. Tax deduction has the merits of being simple and easy to understand, and its continuous nature would incentivise policyholders to stay insured over a long period of time. Compared with other forms of financial incentives, such as direct premium subsidy or discount, tax deduction is less susceptible to abuse and is administratively less costly.

28. We propose introducing tax deduction for premiums paid for all individual Hospital Insurance policies that meet or exceed the Minimum Requirements (Standard Plan and Flexi Plan policies; the portion of premiums paid for Top-up Plan will not be eligible for tax deduction as Top-up Plans are not compliant products); and Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies. A person (i.e. taxpayer) may claim tax deduction on his/her own policy and/or his/her dependants⁹ policies; the proposed tax deduction will be provided on a per person insured basis and the claims for tax deductions for dependants' policies should be capped at, say, no more than three dependants per taxpayer.

29. For pure illustration purposes, by capping the annual ceiling of claimable premiums at \$3,600 (i.e. the average standard premium of Standard Plan in 2012 and in 2012 constant prices) per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone is estimated to be \$256 million (in 2012 constant prices) in year 2016¹⁰, and the average tax benefit per eligible taxpayer would be about \$450.

⁹ The definition of dependants should be aligned with that of the existing tax code for claiming tax allowance, i.e. spouse, child, dependent parent, dependent grandparent, dependent brother or sister, etc.

¹⁰ Assuming that both the VHIS and tax deduction would be implemented in 2016.

MIGRATION ARRANGEMENTS (CHAPTER 5)

30. To facilitate policyholders of existing individual Hospital Insurance policies to migrate to compliant policies under the VHIS, we propose that, where the expiry of the existing individual Hospital Insurance policies falls within the first year of implementation of the VHIS, insurers are required to, upon such expiry, offer an option to policyholders concerned to migrate to an individual Hospital Insurance policy that meets or exceeds the Minimum Requirements.

31. During the one-year window period, policyholders can enjoy a “streamlined migration” arrangement. They would not be re-underwritten for benefit coverage and benefit limits in existing policies. For case-based exclusions in existing policies, policyholders could choose to retain the existing exclusions when migrating to the new policy, and only upgrade the benefit coverage and benefit limits in keeping with the Minimum Requirements. Alternatively, policyholders may choose to remove the existing case-based exclusions, subject to the possibility of being re-underwritten and charged a premium loading. They may need to serve the standard waiting period for the pre-existing conditions newly covered under the new policy.

32. When migrating to compliant policies, some policyholders may need to increase the benefit coverage (e.g. non-surgical cancer treatment) or benefit limits (e.g. surgical limits) of their existing policies in order to meet the Minimum Requirements. Since these new benefits or higher benefit limits have not been underwritten under the existing policy, policyholders may be re-underwritten if considered necessary by the insurer concerned, but the re-underwriting should be restricted to the new benefits and higher limits only. Policyholders may need to serve the standard waiting period for pre-existing conditions related to these new benefits or higher benefit limits.

33. Migrant plans – with or without exclusions – will be eligible for tax deduction since they are deemed compliant with the Minimum Requirements.

34. After the migration window period, policyholders who wish to migrate to compliant policies would be treated as new customers and may be subject to full underwriting if deemed necessary by the insurer concerned.

35. For policyholders who do not wish to migrate but to renew their policies, whether within or after the said one-year period, on the same old terms or any other terms which fall short of the Minimum Requirements, such policies will be grandfathered, i.e. exempted from the Minimum Requirements as long as the insurers concerned continue to administer such policies. Grandfathered policies will not be entitled to tax deduction as they are not deemed compliant with the Minimum Requirements.

INSTITUTIONAL FRAMEWORK (CHAPTER 6)

Regulatory Agency for VHIS

36. We propose to set up a regulatory agency under Food and Health Bureau (FHB) to supervise the implementation and operation of the VHIS, which would be primarily the regulation of VHIS products. The functions of the regulatory agency will include promulgating, reviewing and enforcing the Minimum Requirements, filing compliant products, monitoring the operation of the HRP, handling complaints from consumers, and investigation of cases of non-compliance with the Minimum Requirements. In carrying out these functions, the regulatory agency will be vested with the necessary regulatory and disciplinary powers on insurers. The regulatory agency would also facilitate market development by building up infrastructure to support the implementation of the VHIS, including developing information systems for product filing, data collection and publishing data from insurers and private healthcare service providers, and promoting consumer education on the VHIS, etc. An advisory committee comprising major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.) would be established to provide professional advice concerning matters of the VHIS. To ensure proper exercise of power by the regulatory agency, we propose that a review committee, whose operation would be independent from the regulatory agency, should be appointed to review decisions made by the agency in respect of its regulatory functions, such as filing of compliant products and investigation of non-compliant cases.

37. We would liaise closely with relevant existing regulatory bodies on matters related to their respective responsibilities to ensure compatibility with the existing and future legislative regime for regulation of the insurance industry and effective coordination of duties and avoid duplication of roles and responsibilities, e.g. matters concerning prudential and conduct regulation of insurers, regulation of insurance intermediaries, quality of healthcare services, regulation of healthcare professionals, etc.

Claims Dispute Resolution Mechanism

38. We propose to establish a Claims Dispute Resolution Mechanism (CDRM) to provide a credible and independent channel alternative to litigation for resolving claims disputes under the VHIS. Currently, there are several avenues in Hong Kong for handling disputes related to health insurance claims, including the Insurance Claims Complaints Bureau (ICCB), a self-regulatory body funded by the insurance industry; and the Financial Dispute Resolution Centre (FDRC) that handles claims disputes involving a financial institution authorised by the Hong Kong Monetary Authority or licensed by/registered with the Securities and Futures Commission.

39. We propose that the CDRM should cover all financial disputes related to claims arising from individual VHIS policies. This is because individual consumers are in general less financially capable in resorting to legal proceedings to settle claims disputes. The CDRM could take the form of mediation and/or arbitration, which are the two most widely used means of alternative dispute resolution. We will discuss with the insurance industry, the ICCB and FDRC on the operation details of the CDRM as well as the latter's interface with existing mechanisms for handling claims disputes related to health insurance.

SUPPORTING INFRASTRUCTURE (CHAPTER 7)

40. The successful implementation of the VHIS hinges on having in place the necessary supporting infrastructure, including an adequate supply of healthcare manpower and sufficient healthcare capacity to provide quality private healthcare services. In this connection, we have been taking forward the following measures in conjunction with formulating proposals for the VHIS –

- (a) **review healthcare manpower planning:** we have established a steering committee to conduct a strategic review on healthcare manpower planning and professional development. The strategic review is now progressing in full swing. The recommendations will shed light on ways to ensure an adequate supply of healthcare professionals for meeting future healthcare needs. In the interim, for the triennial cycle starting from the 2012/13 academic year, the Government has substantially increased the number of first-year first-degree places in medicine by 100 (i.e. from 320 to 420 per year), nursing by 40 (i.e. from 590 to 630 per year), and allied health professionals by 146 (i.e. from 231 to 377 per year);
- (b) **enhance private healthcare capacity:** we estimate that the known expansion or redevelopment projects of existing private hospitals would provide around an additional 900 hospital beds, and the new private hospital development at Wong Chuk Hang would provide 500 beds by 2017. We are also considering various proposals from different organisations to develop new or expand existing private hospitals, including a proposal by the Chinese University of Hong Kong to develop a new teaching hospital at its campus. In order to facilitate the development of private hospitals for meeting community needs, we will consider granting loans to organisations that have difficulties in obtaining adequate capital funding in financing the development costs of non-profit-making private hospitals; and
- (c) **review the regulation of private healthcare facilities:** a steering committee was established in October 2012 to review the regulation of private healthcare facilities with a view to enhancing the safety, quality and transparency of private healthcare services, including strengthening regulatory control over the corporate and clinical

governance, price transparency and management of complaints and sentinel events of private hospitals, as well as putting ambulatory centres providing high-risk procedures and clinics under the management of incorporated body under regulatory control. In particular, on enhancing price transparency, we will encourage private hospitals to provide greater budget certainty to consumers through disclosure of price information, Informed Financial Consent, disclosure of historical statistics and introduction of packaged charges for common operations/procedures. These measures will enhance consumer confidence in using private healthcare services, thereby contributing to achieving the VHIS's policy objective. Based on the recommendations of the steering committee, the Government is consulting the public on revamping the regulatory regime for private healthcare facilities in conjunction with the VHIS public consultation.

IMPLICATIONS FOR HONG KONG'S HEALTHCARE SYSTEM (CHAPTER 8)

41. The VHIS aims to facilitate choice of private healthcare services by providing better insurance protection to those who are willing and able to afford private healthcare services. By making Hospital Insurance a more attractive option to the public, the VHIS could facilitate more people to make use of private healthcare services, thereby better enabling the public sector to focus on serving its target areas and enhancing its services.

42. Considering the voluntary nature of the VHIS and the fact that it is intended as a supplementary financing arrangement, the projected impact of the VHIS must be seen in context and considered in conjunction with the concurrent influence of other long-term factors, including the increase in demand for both public and private healthcare services amidst an ageing population.

43. In terms of projected¹¹ uptake of individual Hospital Insurance, the implementation of the VHIS is expected to bring about a considerably higher uptake rate as compared with the baseline scenario (without the VHIS). The uptake rate is projected to be 29% (versus 26%¹² in the baseline scenario, meaning about 223 000 more in terms of membership) of the total population in 2016. As more people purchase and make use of Hospital Insurance as a result of the VHIS, it is expected that there would be a growth in utilisation of private healthcare services compared with the baseline scenario. In terms of number of procedures (vast majority are advanced diagnostic imaging tests, endoscopies and non-surgical cancer treatments), it is projected that in 2016, an additional 231 000 procedures would be performed in the private sector as compared with the baseline scenario. A major factor underlying the

11 The projections consider a 25-year horizon from 2016 to 2040, assuming that the VHIS commences in 2016.

12 Under the baseline scenario, individual Hospital Insurance is not required to comply with the Minimum Requirements, and some of the products may not necessarily provide adequate protection to policyholders.

growth of activities in the private sector would be nominal substitution of activities from the public sector, i.e. activities that would otherwise be sought to be performed in the public sector under the baseline scenario. Among the additional 231 000 procedures, the number of procedures nominally substituted from the public sector would be around 120 000.

44. The substitution of activities from the public sector is nominal in the sense that it would unlikely be translated into any direct reduction in activities, bed days or health expenditure in the public sector because of the continued rise in demand for public healthcare services due to an ageing population. Nevertheless, patients in the public sector would be able to benefit through reduction of waiting time and optimisation of resource allocation for improving the quality of public healthcare services.

45. As one of the turning knobs in adjusting the balance of the public and private healthcare sectors, the growth in utilisation of private healthcare services and the nominal substitution of activities from the public sector under the VHIS are expected to lead to a notable adjustment of the public-private healthcare balance in the long-term. By better enabling the private sector to take on more patients with the means and inclination to seek care from outside the public sector, the VHIS will recalibrate the public-private balance to a healthier and more sustainable level. In terms of in-patient (overnight and day cases) discharge, the public to private ratio in 2040 is projected to change from a baseline of 86:14 to 81:19 under the VHIS. There would be significant expansion of private sector share by 36%, while the public sector share would be reduced by 6%. In terms of health expenditure, the Consultant projects that the cumulative amount of nominally substituted public health expenditure arising from nominal substitution of activities from the public sector would be approximately \$70 billion (in 2012 constant prices) over the 25-year projection horizon (2016 to 2040). This would be considerably higher than the \$4.3 billion required for supporting the HRP and the estimated \$6.4 billion (\$256 million x 25 years, assuming a \$3,600 annual ceiling on claimable premiums) of tax revenue forgone under the tax deduction proposal over the same projection horizon.

WAY FORWARD (CHAPTER 9)

46. We need your support and constructive views to the proposals for implementing the VHIS. In particular, we welcome your views on the following issues –

- (a) Do you support introducing a regulatory regime for individual Hospital Insurance so that such products must comply with the Minimum Requirements prescribed by the Government?
- (b) Do you have any particular views on the 12 Minimum Requirements proposed for improving the accessibility, continuity, quality and transparency of individual Hospital Insurance?
- (c) In order to encourage employers to maintain Hospital Insurance cover for their employees, we propose that group Hospital Insurance should not be subject to the Minimum Requirements. Do you agree with this proposal?
- (d) In order to enhance protection for employees, we propose the arrangements of Conversion Option and Voluntary Supplement(s) for group Hospital Insurance. Do you agree with the proposed arrangements?
- (e) Do you support setting up a HRP with Government financial support, which is the key enabler of guaranteed acceptance with premium loading cap?
- (f) Do you support providing tax deduction for premiums paid for individual Hospital Insurance policies owned by taxpayers covering themselves and/or their dependants that comply with the Minimum Requirements (i.e. policies of Standard Plan and Flexi Plans); and premiums paid for Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies?
- (g) Do you support the arrangements proposed for policyholders of existing individual Hospital Insurance policies who, upon expiry of the existing policies, wish to migrate to VHIS policies (i.e. policies that comply with the Minimum Requirements); and the grandfathering arrangements proposed for existing policies that do not comply with the Minimum Requirements?
- (h) Do you support establishing a regulatory agency under the FHB to supervise the implementation and operation of the VHIS; and a CDRM for resolving claims disputes under the VHIS?

47. We will consolidate and analyse the views received from this public consultation exercise. With community support for the proposals in this Consultation Document, we plan to proceed to implement the VHIS through enacting a new legislation. We expect that the bill and subsidiary legislation required for the VHIS would be introduced in 2015/16.

48. Please send us your views on this Consultation Document on or before 16 March 2015 through the contact below. Please indicate if you do not want your views to be published or if you wish to remain anonymous when your views are published. Unless otherwise specified, all responses will be treated as public information and may be publicised in the future.

Address: Healthcare Planning and Development Office,
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2 Tim Mei Avenue, Tamar, Hong Kong

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Website: www.vhis.gov.hk

CHAPTER 1 BACKGROUND

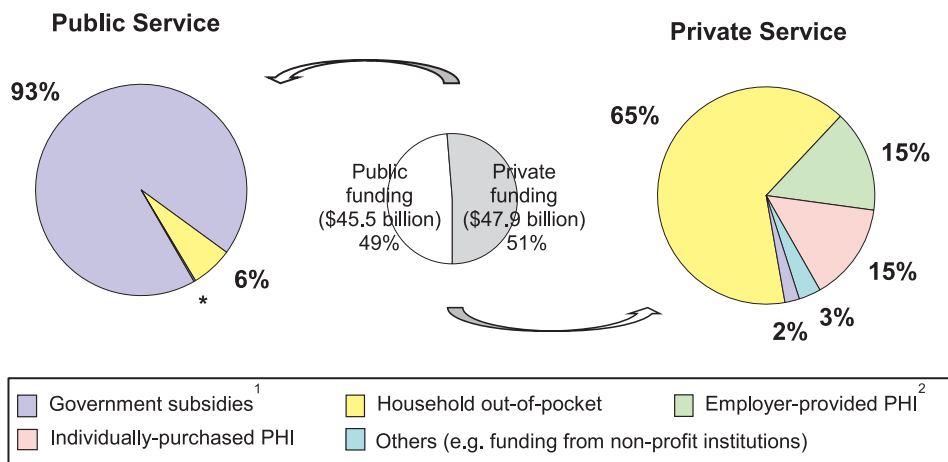
HONG KONG'S DUAL-TRACK HEALTHCARE SYSTEM

1.1. Hong Kong has a dual-track healthcare system by which the public and private healthcare sectors complement each other. The public sector is the predominant provider of secondary and tertiary healthcare services. Around 88% of in-patient services (in terms of number of bed days) are provided by public hospitals. Public hospitals provide about 27 400 hospital beds, accounting for about 88% of total hospital beds. Apart from hospital services, the public sector also provides medical treatment and rehabilitation services to patients through specialist clinics and outreaching services. The public healthcare system provides the Hong Kong population with equitable access to healthcare service at highly subsidised rates (at a flat rate of \$100 per day of hospitalisation in most circumstances). As the safety net for all, the public sector focuses its services on four target areas: (a) acute and emergency care; (b) lower-income and under-privileged groups; (c) illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and (d) training of healthcare professionals.

1.2. The private sector complements the public healthcare system by offering choice to those who can afford and are willing to pay for healthcare services with personalised choices and better amenities. It provides a variety of choices of healthcare services, including primary care (about 70% of out-patient services in terms of attendance) as well as specialist and hospital care. There are 11 private hospitals in the private sector providing about 3 900 beds in total.

1.3. In terms of financing source, according to Hong Kong's Domestic Health Accounts 2010/11, total healthcare services were funded roughly equally by public and private sources at \$45.5 billion and \$47.9 billion respectively. Private healthcare services were mainly financed by household out-of-pocket expenditure (65%) and insurance pay-out (30%, including individually-purchased private health insurance (PHI) and employer-provided PHI) (Figure 1.1). Public healthcare services were almost fully financed by public funding from Government budget – 93% of the cost was financed by Government funding.

Figure 1.1 Expenditure on Public and Private Healthcare Services by Financing Source in 2010/11



Notes: * Smaller than 0.5%.

1 Include expenditure on civil servant and Hospital Authority staff medical benefits.

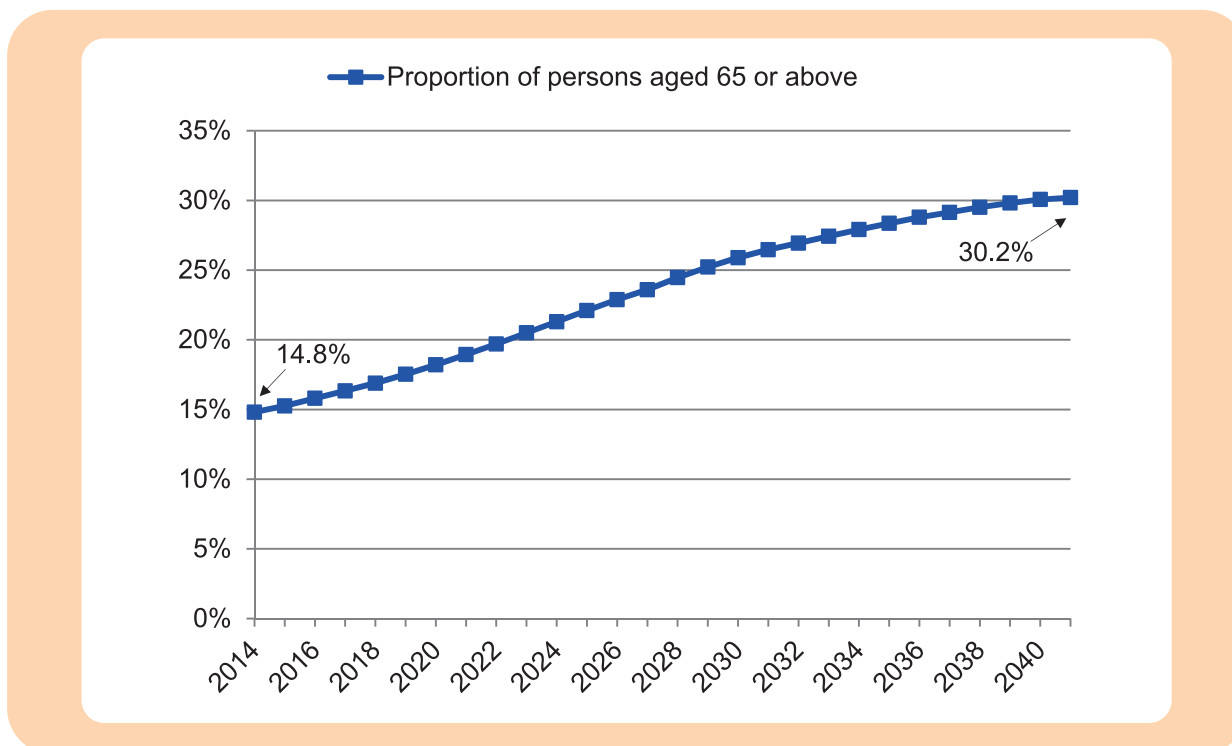
2 Includes medical benefits not in the form of medical insurance provided by private companies/organisations, and excludes expenditure on civil servant and Hospital Authority staff medical benefits.

Source: Hong Kong's Domestic Health Accounts 2010/11

NEED FOR HEALTHCARE REFORM

1.4. The dual-track healthcare system has served us well over the years and it is the Government's policy to maintain and strengthen the dual-track healthcare system. Nevertheless, as with other advanced economies, Hong Kong is facing a number of major challenges to our healthcare system. First, longevity brings with it the challenges of an ageing population and a rising demand for healthcare services. According to the statistics compiled by the Census and Statistics Department (C&SD), the proportion of elders in our population is about one in seven in 2014. This figure will become about one in three by 2041 (**Figure 1.2**). In particular, in about two to three decades' time, we will witness the emergence of middle class elderly who will be more affluent, better educated and have higher expectation of healthcare services. Second, lifestyle-related diseases are now more common as our society has become more affluent. Third, advances in medical technology, while lengthening lifespan and improving our quality of life, contribute to the escalating medical costs that we have witnessed in recent decades.

Figure 1.2 Ageing Population



Source: Mid-year population estimates for 2014 and projected mid-year population for 2015-2041, C&SD

1.5. Confronted by these challenges, the Government has substantially increased its investment in public healthcare over the years. The annual Government recurrent expenditure on medical and health services has reached \$52 billion for 2014-15, accounting for 17% of total recurrent expenditure of the Government. In terms of public health infrastructure, the construction of Tin Shui Wai Hospital and Hong Kong Children's Hospital has commenced. The preparatory work for the expansion of United Christian Hospital and the redevelopment of Kwong Wah Hospital and Queen Mary Hospital have also started. The Government also plans to seek the Legislative Council's funding approval for the redevelopment of Kwai Chung Hospital and the expansion of Hong Kong Red Cross Blood Transfusion Service Headquarters. The Government would spend about \$55 billion on these projects as part of an ongoing effort to improve public healthcare facilities and provide about 1 400 additional hospital beds. Besides, the Government is conducting strategic studies on the construction of an acute general hospital in the Kai Tak Development Area. In the longer term, the Hospital Authority (HA) will start planning for the redevelopment of Queen Elizabeth Hospital and phase two redevelopment project of Prince of Wales Hospital to address the community's long-term demand for healthcare services.

1.6. In addition, the Legislative Council Finance Committee approved in December 2013 a one-off grant of \$13 billion for the HA to implement minor improvement and planned maintenance works programmes for the next ten years. This covers the renovation of over 500 wards in 34 hospitals; provision of around 800 additional beds in 11 hospitals; expansion of operating theatres, accident and emergency departments, and general out-patient clinics;

and setting up additional endoscopy centres and ambulatory facilities, etc. We treasure public healthcare as the cornerstone of our healthcare system and safety net for all Hong Kong people. We will continue to strengthen our commitment to the public healthcare system.

1.7. Notwithstanding the Government's commitment to public healthcare, it is necessary to identify suitable measures to improve the quality of our healthcare services and to readjust the public-private balance, so as to enhance the long-term sustainability of our healthcare system.

1.8. Multiple rounds of public consultation on healthcare reform had been conducted since the 1990s to identify ways to reform the healthcare system through recalibrating the balance of the public-private healthcare sectors, including "Towards Better Health" (1993), "Improving Hong Kong's Healthcare System: Why and For Whom" (1999) and "Lifelong Investment in Health" (2000). Various proposals were put forth, including capping Government subsidy or increasing user fees of public healthcare services, social health insurance, medical savings account, promoting integrated healthcare and collaboration between the public and private sectors and between primary, secondary and tertiary care, etc. While the public was generally supportive of the need for reform, opinions on different reform options varied and no general consensus was reached.

1.9. In 2005, the Health and Medical Development Advisory Committee (HMDAC) issued a discussion paper "Building a Healthy Tomorrow", making a number of recommendations covering various aspects of the healthcare system, including primary medical care, hospital services, tertiary and specialised services, elderly, long-term and rehabilitation care services, integration between the public and private sectors, and infrastructural support. Based on the recommendations by the HMDAC, the Government published the Consultation Document "Your Health, Your Life" in March 2008 to initiate a two-stage public consultation on healthcare reform, with a view to engaging the community and stakeholders and building consensus to improve the sustainability of our healthcare system.

HMDAC

Chaired by the Secretary for Food and Health and comprising mainly non-official members, the HMDAC was tasked to assist the Government in identifying solutions to challenges faced by our healthcare system, including an ageing population and escalating healthcare costs due partly to technology advancement. Its terms of reference included reviewing and developing service models for healthcare in both the public and private sectors; and proposing long-term healthcare financing options.

FIRST STAGE PUBLIC CONSULTATION ON HEALTHCARE REFORM (FIRST STAGE CONSULTATION)

1.10. During the First Stage Consultation, the Government consulted the public on healthcare service reforms proposals, including enhancing primary care, promoting public-private partnership, developing electronic health record sharing, and strengthening public healthcare safety net. At the same time, the Government also proposed to reform the current healthcare financing arrangements to complement healthcare service reforms. Six supplementary healthcare financing options were put forth, including –

- (a) social health insurance (mandatory contribution by the workforce);
- (b) out-of-pocket payments (increase user fees for public healthcare services);
- (c) medical savings accounts (mandatory savings for future use);
- (d) voluntary PHI;
- (e) mandatory PHI; and
- (f) personal healthcare reserve (mandatory savings and insurance).

1.11. The consultation came to an end in June 2008. There was broad consensus in the community to take forward service reforms, although divergent views were expressed on the supplementary financing options. In general, the public expressed reservations about mandatory financing options as solutions to address the long-term sustainability of healthcare financing. Relatively more people expressed a preference for voluntary PHI as a supplementary means of financing healthcare, which would offer them a choice for personalised healthcare services. The tax-funded public healthcare system should continue to offer essential healthcare as a safety net for the whole population.

1.12. At the same time, many respondents pointed out various shortcomings they perceived of health insurance currently offered in the market, such as exclusion of pre-existing conditions, no guarantee on renewal of policies, inadequate benefits coverage, disputes over insurance claims, etc. On private healthcare services, some recognised that there were significant uncertainties and financial risks for using them due to inadequate price transparency and predictability, rendering many who could have afforded private healthcare services to resort to the public healthcare system.

HONG KONG'S HEALTH INSURANCE MARKET

1.13. Based on the consultation outcome, we proceeded to develop possible policy options along the principle of voluntary participation. In developing a voluntary supplementary financing option, we came to realise that health insurance has the potential to play a more active role in financing health expenditure. According to Hong Kong's Domestic Health Accounts 2010/11, PHI accounted for 14.6% of total health expenditure. Compared to other financing sources such as out-of-pocket household expenditure, health insurance is a relatively stable financing source as it is less affected by economic cycles. Health insurance has been undergoing major growth as a financing source, especially individually-purchased PHI, the contribution of which to total health expenditure rose markedly by an average of 17% per annum from 1989/90 to 2010/11 (**Table 1.1**). Statistics from the 2011 Thematic Household Survey (THS) conducted by the C&SD shows that around 2.79 million people were covered by PHI. Among them, about 2.00 million (about 30% of Hong Kong's population) were covered by indemnity hospital insurance, including 1.30 million with individually-purchased policies only, 0.47 million with employer-provided medical benefits only, and 0.23 million with both individually-purchased policies and employer-provided medical benefits.

Table 1.1 Total Health Expenditure by Financing Source, 1989/90 – 2010/11 (\$ million)

	1989/90	1999/00	2008/09	2009/10	2010/11	Average Annual Change 1989/90 to 2010/11
Government	7,749	35,997	41,257	43,868	45,491	+8.8%
PHI	2,315	8,108	11,847	12,636	13,627	+8.8%
(a) Individually-purchased PHI	263	2,374	5,417	6,041	6,682	+16.7%
(b) Employer-provided PHI	2,051	5,734	6,430	6,595	6,945	+6.0%
Out-of-pocket	9,212	21,358	29,032	30,264	32,685	+6.2%
Others	370	597	1,557	1,301	1,631	+7.3%
Total	19,645	66,060	83,693	88,069	93,433	+7.7%

Source: Hong Kong's Domestic Health Accounts 1989/90 – 2010/11

1.14. According to the 2011 THS, among those who were covered by PHI, about 54% of their local hospital admissions pertained to the public sector. There can be a number of reasons for this phenomenon. Apart from emergency cases and cases requiring inter-disciplinary care, which are usually treated at public hospitals, patients may hesitate to choose private hospitals for receiving treatment due to uncertainty about the adequacy of their insurance protection for covering private hospital charges, and hence whether and by how much out-of-pocket expenses are required to fill the shortfall. Another deterring factor is the uncertainty over whether the hospitalisation expenses are claimable due to difficulties encountered by some policyholders¹ in comprehending the insurance policy terms and conditions, which may vary considerably from one insurer to another and from one product to another. Some policyholders may also be worried about the possibility of being re-underwritten by insurers upon policy renewal (which might lead to significant increase in the premium required to maintain cover) after making claims.

1.15. The above demonstrates that, with enhanced quality and certainty of insurance protection, consumers would have greater confidence in using health insurance and private healthcare services. As a result, health insurance can play a more significant role in supplementing the financing of Hong Kong's health expenditure and supporting the dual-track healthcare system.

SECOND STAGE PUBLIC CONSULTATION ON HEALTHCARE REFORM: HEALTH PROTECTION SCHEME (SECOND STAGE CONSULTATION)

1.16. Against this backdrop, we put forth the Health Protection Scheme (HPS) in the Second Stage Consultation "My Health, My Choice" conducted from October 2010 to January 2011. The HPS is a voluntary, government-regulated PHI scheme meant to complement the public healthcare system. Its objective is to provide an alternative to those who are able and willing to use private healthcare services by enhancing the quality of health insurance in the market. In doing so, the HPS could facilitate a greater use of private healthcare services as an alternative to public services, thereby better enabling the public sector to focus on providing services in its target areas, and indirectly relieving the pressure on the public healthcare system.

1.17. The HPS is not designed as a total solution to the challenges faced by our healthcare system, but one of the turning knobs for adjusting the balance of the public-private healthcare sectors, together with other turning knobs such as public-private partnership, the electronic health record platform, and development of public and private healthcare facilities. By providing a choice to those who are willing and able to afford private healthcare services

¹ In this Consultation Document, policyholder(s) generally includes all person(s) insured under the same policy.

through insurance, resources in the private sector can be better utilised to meet community needs, particularly the more routine procedures that can be readily performed in the private sector.

1.18. Under the HPS, insurers would offer health insurance products providing the policyholders with benefit coverage and reimbursement levels that would enable them to access general ward class of private healthcare services. A number of key features designed to enhance the accessibility, quality and transparency of health insurance were proposed for HPS products, including the following –

- (a) no turn-away of subscribers and guaranteed renewal for life;
- (b) publish age-banded premiums subject to adjustment guidelines;
- (c) cover pre-existing medical conditions subject to a standard waiting period and time-limited reimbursement limits;
- (d) cap premium plus high-risk loading at 3x published premium;
- (e) make higher risk groups insurable with High-Risk Pool reinsurance;
- (f) offer no-claim discount up to 30% of published premiums;
- (g) insurance plans portable between insurers and on leaving employment;
- (h) transparent insurance costs including claims and expenses;
- (i) standardised health insurance policy terms and definitions; and
- (j) Government regulated health insurance claims arbitration mechanism.

1.19. The Second Stage Consultation revealed broad-based community support for the Government's healthcare reform direction: a strengthened public healthcare sector as the core, complemented by a competitive and vibrant private healthcare sector. Many considered the HPS a positive step forward to enhancing the long-term sustainability of our healthcare system, and supported the introduction of the HPS to provide value-for-money choices to the community.

TAKING FORWARD THE HPS

Working Group and Consultative Group

1.20. Based on the outcomes of the Second Stage Consultation, we set up a Working Group and a Consultative Group on Health Protection Scheme under the HMDAC in January 2012 to formulate detailed proposals for the HPS. The Working Group was tasked to tender recommendations on matters concerning the implementation of the HPS, including supervisory and institutional frameworks, measures aiming to enhance the viability and mitigate potential risks of the HPS, key components of Standard Plan under the HPS, rules and mechanism in support of the operation of the HPS, as well as options of financial incentives or public subsidy to support the implementation of the HPS. The Working Group was supported by the Consultative Group, which collected views and suggestions from the wider community and passed them to the Working Group for reference and consideration. Members of the Working Group and Consultative Group came from a wide range of backgrounds, including the healthcare and medical sector, the insurance sector, employers, the civil society and the academic sector. The membership and terms of reference of the Working Group and Consultative Group are at **Appendix A**.

Consultancy Study

1.21. To provide professional and technical support to the Working Group and Consultative Group, we commissioned a Consultant² to conduct a study on the HPS, including performing a comprehensive review, survey and analysis of the current market situation of health insurance in Hong Kong; proposing a feasible, sound and detailed design for implementing the HPS; and carrying out projections on the short to long-term implications of the HPS on the healthcare system.

1.22. In conducting the study, the Consultant collected or made use of data in both the healthcare service and health insurance sectors, including data of the C&SD, Department of Health, HA, Office of the Commissioner of Insurance, the Hong Kong Federation of Insurers, individual insurers and private healthcare service providers. Apart from studying the local markets, the Consultant also made reference to overseas experience, including conducting in-depth study on five overseas jurisdictions with a significant PHI market, namely Australia, Ireland, the Netherlands, Switzerland and the United States.

1.23. To better gauge consumer response to the HPS, the Consultant conducted a household survey in private housing estates from all districts in Hong Kong with a view to understanding consumer preference towards health insurance products. The survey result shows that more than half of the respondents considered a number of HPS features

² PricewaterhouseCoopers Advisory Services Limited.

attractive, such as guaranteed renewal for life; coverage of advanced diagnostic imaging tests, ambulatory procedures, chemotherapy and radiotherapy; and government regulation of product design. Around 70% of respondents (with or without indemnity hospital insurance coverage) indicated that they were willing to consider purchasing or migrating from their existing plans to the illustrative HPS Standard Plan. A summary report of the consumer survey is at **Appendix B** for reference.

The consumer survey was conducted via face-to-face household interviews from May to August 2013. The survey was targeted at middle-income individuals who were considered more likely to subscribe to HPS products. The key objective was to test their willingness-to-pay and preference towards the key features of the HPS Standard Plan. A total of 1 109 households and 1 936 individual respondents were successfully interviewed.

1.24. The Consultant presented its findings, analyses and recommendations at various meetings of the Working Group and Consultative Group for members' discussion and deliberation. An executive summary of the consultancy report is at **Appendix C** for reference.

Subcommittee on Health Protection Scheme of Legislative Council Panel on Health Services

1.25. To study the various issues relating to the HPS, members of the Legislative Council Panel on Health Services appointed the Subcommittee on Health Protection Scheme under the Panel in August 2011. Among other issues, the Subcommittee deliberated in detail on the following areas –

- (a) manpower planning and supply for the sustainable development of the healthcare system;
- (b) healthcare services development;
- (c) supervisory framework for health insurance and healthcare service markets;
- (d) design and operation of the HPS;
- (e) role of health insurance in financing healthcare services; and
- (f) utilisation of Government subsidy.

1.26. The Subcommittee held a total of six meetings during the fourth legislative term (2008-2012). It rendered valuable comments and detailed recommendations to the Administration on the above issues in its report³ issued on 4 July 2012. In the current legislative term (2012-2016), the Subcommittee has continued to follow up on various issues relating to the HPS in close liaison with the Administration. We have duly considered and incorporated their views in our proposals as appropriate.

LATEST PROPOSAL: VOLUNTARY HEALTH INSURANCE SCHEME

1.27. Based on the deliberations of the Working Group and recommendations by the Consultant, and taking into account views from relevant stakeholders, we have worked out the latest proposals for the HPS as elaborated in the following Chapters.

1.28. After taking into account the objectives of the HPS and the experience of the local market and overseas jurisdictions, our latest proposal is to regulate all individual indemnity hospital insurance in the local market. In selling and/or effecting individual indemnity hospital insurance, insurers must comply with the Minimum Requirements prescribed by the Government. Our considerations for proposing the Minimum Requirements, as well as details of the Minimum Requirements, are set out in Chapters 2 and 3.

1.29. As the HPS is intended as a supplementary financing arrangement, we propose to rename the scheme to “Voluntary Health Insurance Scheme” (VHIS) to better reflect its objectives and nature.

VOTE OF THANKS

1.30. We would like to take the opportunity to express our gratitude to all members of the community for their suggestions and support during the formulation of detailed proposals for the HPS/VHIS. We have received valuable comments and suggestions from relevant stakeholders and the community at large, including the Working Group and Consultative Group on Health Protection Scheme, the Subcommittee on Health Protection Scheme of the Legislative Council Panel on Health Services, Legislative Council members, Consumer Council and consumer representatives, representatives of the insurance industry (including the Hong Kong Federation of Insurers, agents and brokers associations), representatives of healthcare service providers (including the Hong Kong Academy of Medicine, Hong Kong Medical Association, Medical Council of Hong Kong, HA, Hong Kong Private Hospitals Association, Hong Kong Doctors Union, pharmacy associations), academics, trade, commerce and industrial organisations, patient groups, social welfare organisations, etc. Their contribution and advice, which we have duly considered and incorporated into our recommendations as appropriate, have been invaluable for us in formulating the HPS/VHIS proposals as well as taking forward this public consultation exercise.

³ Available online at http://www.legco.gov.hk/yr11-12/english/panels/hs/hs_hps/reports/hs_hpsc2-2527-e.pdf.

CHAPTER 2 MINIMUM REQUIREMENTS

STRENGTHENING REGULATION OF HEALTH INSURANCE

Health Insurance Market in Hong Kong

2.1. The health insurance market is lightly regulated in Hong Kong, subject only to prudential regulation under the Insurance Companies Ordinance (ICO)(Cap. 41). There is no statutory product requirement for health insurance, and insurers are free to create, design and sell health insurance products as they deem fit from the business perspective. There is a large variety of health-related insurance products in the market, which are sold through various distribution channels, including sales by insurance agents or brokers. Health insurance products could be offered in the form of individual policies or group policies that are mostly purchased by employers for their employees as staff benefits.

2.2. Generally speaking, the major types of insurance products that are health-related and currently on offer in Hong Kong could be categorised as follows –

- (a) **“indemnity¹ hospital insurance”**, which reimburses the policyholders for expenses incurred as a result of treatment of illness in hospital, such as elective surgeries or more complex treatments requiring hospitalisation. The indemnity is commonly based on a pre-set benefit schedule with itemised benefit limits by spending type such as room and board, doctor consultation and surgical fee;
- (b) **“indemnity out-patient insurance”**, of which the benefit is typically payable per consultation, such as consultation in clinic for treatment of relative minor sickness (e.g. influenza). Insurers usually limit the number of consultations claimable per year;
- (c) **“hospital cash insurance”**, which offers a fixed amount of benefits in cash per day to a policyholder during the period of hospitalisation. The benefit amount is not tied to the level of spending on hospital care, and is usually inadequate for meeting the expenses of private hospital care. Such products could serve as a form of income protection to policyholders; and
- (d) **“critical illness insurance”**, which offers a substantial lump-sum cash payment upon confirmation of a critical illness on a pre-defined list (e.g. cancer, heart attack, kidney failure, etc.), without requiring the policyholder to undertake treatment.

¹ An “indemnity” insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss.

Minimum Requirements for Individual Hospital Insurance

2.3. We propose to **regulate** under the Voluntary Health Insurance Scheme (VHIS) the first type of products mentioned above sold to individuals, namely **individual indemnity hospital insurance**. More specifically, individual indemnity hospital insurance refers to a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the **ICO** (Cap 41) (**Class 2**) which provides for benefits in the nature of **indemnity** against risk of loss to the insured attributable to **sickness or infirmity** that **requires hospitalisation**² (**Hospital Insurance**) and the policyholder/person insured is an **individual**. An individual Hospital Insurance policy may be issued to an individual as a standalone Class 2 policy or as an additional cover combined with, hence, forming part of a contract of long-term business (e.g. a medical insurance rider attached to and forming part of a life insurance policy).

2.4. We propose that, **in selling and/or effecting individual Hospital Insurance, an insurer must comply with the Minimum Requirements** prescribed by the Government, as described in detail in this Chapter and Chapter 3. Upon the implementation of the VHIS, **insurers will not be allowed to offer individual Hospital Insurance products that do not comply with the Minimum Requirements.**

2.5. The Minimum Requirements of the VHIS would only be confined to individual Hospital Insurance. The VHIS does not intend to cover –

- (a) any fixed pecuniary benefits (e.g. hospital cash, critical illness cover)³ which may be added to an individual Hospital Insurance policy. This is because the pay-out of insurance benefit of such policies is not tied to the level of spending on hospital care, and therefore does not necessarily pertain to health protection of the policyholder or contribute to achieving the objective of the VHIS, namely providing a choice to those who are able and willing to use private healthcare services; and

2 For the purpose of the VHIS, hospitalisation here refers to a setting where a patient may not be discharged on the same calendar day of admission; and the expected total duration of the procedure, recovery, treatment and care requiring continuous confinement within the facility may exceed 12 hours.

3 Typically, a critical illness cover provides a lump-sum cash payment if the insured is diagnosed with a disease as designated in the insurance policy whereas a hospital cash cover provides a fixed cash benefit paid for each day of hospitalisation due to a sickness or accident. In both examples, since the payment is one of fixed pecuniary benefits, the cover itself will not be regulated under the VHIS. It will also not be regulated for reason that the cover is attached to an individual Hospital Insurance Policy.

- (b) a group policy, i.e. a policy being held by an employer for the benefit of its employees. Please refer to paragraphs 2.57 to 2.64 below for details of the proposed arrangements for group Hospital Insurance⁴.

2.6. For the avoidance of doubt, we propose that an out-patient only policy will not be regulated by the Minimum Requirements. As discussed in Chapter 1, the objective of the Health Protection Scheme (HPS) proposed in the Second Stage Public Consultation on Healthcare Reform (Second Stage Consultation) was to provide more choices with better protection to those who were able and willing to use health insurance for private healthcare services, particularly the more routine procedures performed under an in-patient setting in the public sector. In doing so, the public sector could better focus on serving its target areas. In view of the aim and focus of the VHIS, we propose that out-patient only policies will not be subject to the Minimum Requirements. However, the role of primary care in the healthcare system should not be overlooked and has important contribution in the process. We will discuss this perspective in Chapter 3.

2.7. From the perspectives of health policy and consumer protection, we consider it desirable that individual Hospital Insurance sold in the name of “hospital”/“health”/“medical” insurance should provide at least the benefits offered by a Standard Plan, such that consumers who purchase such products will not be misled into thinking that those non-compliant products fulfill the Minimum Requirements of the VHIS. We propose that, upon the implementation of the VHIS, only those health insurance products complying with the Minimum Requirements may be sold in the name of “hospital”/“health”/“medical” insurance, or such other name which denotes or connotes that such product is an individual Hospital Insurance.

Views from the Insurance Industry

2.8. We have consulted, among other stakeholders, representatives of the insurance industry, including members of the Working Group and Consultative Group on Health Protection Scheme and the Hong Kong Federation of Insurers on the proposed Minimum Requirements. While there was general consensus amongst stakeholders for introducing Minimum Requirements for VHIS products, there were divergent views on whether the Minimum Requirements should apply to all individual Hospital Insurance products. One of the major concerns of the insurance industry was that the introduction of Minimum Requirements for all individual Hospital Insurance products might stifle product innovation and

4 For the avoidance of doubt, the VHIS does not intend to cover insurance policies purchased by employers for foreign domestic helpers where indemnity hospital insurance is featured incidentally as a small, non-core component and is not intended to cover the full cost of private healthcare services of the person insured. Insurance policies purchased by employers for foreign domestic helpers will not be subject to the arrangements proposed for group policies described in paragraphs 2.60 to 2.64 below.

reduce consumer choice over products that did not meet the Minimum Requirements. It was proposed that insurers should be allowed to, alongside compliant products, sell products that do not comply with the Minimum Requirements.

2.9. After careful deliberation, we consider the Minimum Requirements a balanced proposal that could enhance consumer protection without compromising consumer choice. Our considerations are set out in detail in the following section.

Why Minimum Requirements for all Individual Hospital Insurance?

2.10. The Minimum Requirements are proposed based on the following considerations –

(A) To Address Public Concern Over the Existing Health Insurance Market

2.11. As revealed in previous public consultations, there was general consensus among the community on strengthening regulation over the existing Hospital Insurance market and addressing existing shortcomings in market practices, such as decline of cover; exclusion of pre-existing conditions; no guaranteed renewal of policies; lack of budget certainty; or dispute over insurance claims due to lack of standardised policy terms and conditions. According to the findings of the Public Opinion Survey on Supplementary Healthcare Financing conducted alongside the Second Stage Consultation, about 90% of the respondents supported strengthening regulation of health insurance in order to provide better protection to consumers. By requiring all individual Hospital Insurance products to comply with the Minimum Requirements, public concerns over the existing Hospital Insurance market can be addressed, and consumer confidence in purchasing Hospital Insurance and using private healthcare services can be enhanced. This would be conducive to the development of the health insurance and private healthcare service sectors.

2.12. The Minimum Requirements are designed to provide simplicity, clarity and certainty to consumers and help consumers who do not possess professional insurance knowledge to understand easily and clearly the protection they can receive when taking out a Hospital Insurance policy. On top of the Minimum Requirements, insurers would be free to innovate and offer tailor-made products to suit specific consumer needs (please refer to Chapter 3 for more details).

2.13. The Minimum Requirements proposal is in line with international experience. In jurisdictions where private health insurance (PHI) plays a significant role in the healthcare system, including Australia, Ireland, the Netherlands, Switzerland and the United States, the governments have prescribed by law basic requirements for PHI in order to safeguard consumer interest. These basic requirements are broadly similar to the proposed Minimum Requirements, including guaranteed acceptance, coverage of pre-existing conditions,

guaranteed renewal, minimum benefit coverage and benefit levels, standardised policy terms and conditions, etc. The table at **Appendix D** summarises the regulatory requirements for PHI in the abovementioned five jurisdictions.

(B) Enhancing the Financing Role of PHI

2.14. As mentioned in paragraph 1.14 of Chapter 1, among those covered by PHI, about 54% of their local hospital admissions pertained to the public sector; and one possible reason is that patients may feel uncertain about their insurance protection in terms of whether the admission is claimable or by how much the insurance benefits can cover the expenses, etc. By improving the quality and certainty of insurance protection through the Minimum Requirements, PHI can play a bigger role in financing the growing health expenditure.

(C) Sustainability of Compliant Products

2.15. The introduction of Minimum Requirements for all individual Hospital Insurance products would be crucial to the sustainability of compliant products, because it would not be practicable to allow co-existence of a regulated market segment where products are bound by Minimum Requirements (compliant products), and an unregulated market segment where products are not bound by Minimum Requirements (non-compliant products). The Minimum Requirements are designed for meeting the community's aspirations and the long-term sustainable development of our healthcare system. Achieving these goals would have cost implications. Under a "two-market" situation where regulated and unregulated market segments co-exist, the healthier population may be induced to purchase non-compliant products with relatively low premiums, leaving the compliant products a choice mainly for the unhealthy population. As explained in paragraphs below, under such situation, the interest of buyers of both non-compliant and compliant products will be impaired, and the sustainability of the VHIS will be threatened.

2.16. Under a "two-market" situation, some consumers may be induced to take out a non-compliant policy at a relatively low premium that does not provide adequate protection. For instance, without guaranteed renewal, a policyholder may be denied renewal of policies, or being charged new premium loadings upon policy renewal after making claims. With a claims record and deteriorated health conditions, it would be difficult for the policyholder to find a new insurer who will be willing to insure him/her. Even if he/she could, the premium is likely to be much higher than that of the same age group due to premium loading. A policyholder may only come to realise these shortcomings when making claims, which may occur years after purchasing the policy. He/she may not be well-aware of the relevant risks at the time of purchase, particularly if the policy terms and conditions are not easy to comprehend. Although the policyholder may still switch to compliant products, he/she will have to be re-underwritten and might be charged a premium loading.

2.17. For buyers of compliant products, they will also be affected by the “two-market” situation. The regulated segment would have to manage a pool of policyholders of higher health risks than an average consumer. The premiums will be driven up in consequence, making compliant products less affordable and more likely to be acceptable only to those who foresee they would make claims. Moreover, the market segmentation will generate a vicious cycle. The higher premiums would drive healthy and price-sensitive consumers away from the regulated segment, resulting in a further deterioration of the pool of compliant products in terms of health risks of policyholders. As a result, an even higher premium would have to be charged on policyholders of compliant products, which would further drive away the relatively healthy consumers from the regulated segment. Such vicious cycle would lead to an ever increasing premium and dwindling pool of policyholders of compliant products with higher and higher health risks. Eventually, the premium would become unaffordable and the regulated segment would no longer be sustainable.

The MediShield experience in Singapore

Operated by the Central Provident Fund, MediShield is a voluntary, low-cost basic medical insurance scheme introduced in 1990. The aim is to help subscribers to meet large hospital bills that the Medisave (a national medical savings scheme which helps individuals put aside part of their income to meet their future personal or immediate family's hospitalisation, day surgery and certain out-patient expenses) balance is insufficient to cover. As insurers were allowed to concurrently offer similar health insurance products, private insurers found it more profitable to pick and choose healthier and younger customers, leaving the unhealthy and old customers to MediShield (which provides guaranteed acceptance of subscription). This cherry picking behaviour drove up the MediShield premium and rendered it eventually unsustainable. As a result, the Singapore government introduced the MediShield reform package in 2005, including a measure to prohibit insurers from offering products that are of same or lesser coverage than that of MediShield, although insurers could provide enhancement plans on top of what MediShield already provided. Singapore's experience helps illustrate why a “two-market” situation (co-existence of a regulated market segment and an unregulated segment for health insurance) is not practicable.

What are the Minimum Requirements?

2.18. The proposed Minimum Requirements encompass key features proposed for the HPS in the Second Stage Consultation. Taking into account the views received during the Second Stage Consultation, as well as the need to balance between consumer protection and viability

and sustainability of the VHIS under the Minimum Requirements approach, we have proposed some refinements to the implementation details of certain key features.

2.19. We propose that **insurers** selling individual Hospital Insurance products **must offer a Standard Plan as one of the options to consumers**, regardless of whether they also offer individual Hospital Insurance products with enhanced benefits. **An individual Hospital Insurance that meets all (but not exceeding) the Minimum Requirements proposed below is considered a Standard Plan.** These Minimum Requirements for Standard Plan can be grouped under three categories, namely (a) improving accessibility to and continuity of insurance, (b) enhancing quality of insurance protection, and (c) promoting transparency and certainty. They are summarised in **Table 2.1** below.

Table 2.1 12 Minimum Requirements for Standard Plan

(A) Accessibility to and continuity of insurance	
(1) Guaranteed renewal	<ul style="list-style-type: none"> • Guaranteed renewal for life • No re-underwriting is allowed for policy renewal
(2) No "lifetime benefit limit"	<ul style="list-style-type: none"> • No "lifetime benefit limit" can be imposed on the policy
(3) Coverage of pre-existing conditions	<ul style="list-style-type: none"> • Insurers are required to cover pre-existing conditions, subject to a standard waiting period and reimbursement arrangement during the waiting period as follows – <ul style="list-style-type: none"> • first year – no coverage • second year – 25% reimbursement • third year – 50% reimbursement • fourth year onwards – full coverage
(4) Guaranteed acceptance with premium loading cap	<ul style="list-style-type: none"> • Guaranteed acceptance for – <ul style="list-style-type: none"> • all ages within the first year of implementation of the VHIS; and • those aged 40 or below starting from the second year of implementation of the VHIS • Premium loading capped at 200% of standard premium
(5) Portable insurance policy	<ul style="list-style-type: none"> • Re-underwriting would be waived when changing insurer if no claims made in a certain period of time (say, three years) immediately before transfer of policy

(B) Quality of insurance protection	
(6) Coverage of hospitalisation and prescribed ambulatory procedures	<ul style="list-style-type: none"> • Benefit coverage must include medical conditions requiring hospitalisation and/or prescribed ambulatory procedures
(7) Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments	<ul style="list-style-type: none"> • Benefit coverage must include prescribed advanced diagnostic imaging tests subject to a fixed 30% co-insurance; and non-surgical cancer treatments up to a prescribed limit
(8) Minimum benefit limits	<ul style="list-style-type: none"> • Benefit limits must meet the prescribed levels
(9) Cost-sharing restrictions	<ul style="list-style-type: none"> • No deductible and co-insurance, except the 30% co-insurance fixed for prescribed advanced diagnostic imaging tests • Annual cap of \$30,000 on cost-sharing by policyholders (however, if the actual expenses exceed benefit limits, the excess amount is still payable by the policyholder)
(C) Transparency and certainty	
(10) Budget certainty	<ul style="list-style-type: none"> • No-gap/known-gap arrangement • Informed Financial Consent
(11) Standardised policy terms and conditions	<ul style="list-style-type: none"> • Minimise claims disputes arising from different interpretations of terms and conditions
(12) Premium transparency	<ul style="list-style-type: none"> • Transparent age-banded premium structure • Transparent information on premiums through easily accessible platform for consumers' reference

2.20. The ensuing paragraphs describe in detail the Minimum Requirements for Standard Plan. The Minimum Requirements, such as benefit coverage and benefit limits, would be subject to regular review and update by the regulatory agency (please refer to Chapter 6) to be set up to monitor the implementation and operation of the VHIS as necessary and appropriate, taking into account market developments such as price level of private healthcare services, advancement in medical technology, etc.

(A) Improving Accessibility to and Continuity of Insurance

(1) Guaranteed Renewal

2.21. We propose to require insurers to provide guaranteed renewal without re-underwriting as part of the Minimum Requirements in order to provide life-long insurance cover to consumers. To protect consumers from sharp premium hike due to illness, insurers would not be allowed to re-underwrite individual policyholders during policy renewal.

2.22. The renewal of VHIS policies should not be conditional upon the continuation of other insurance policies. For example, if a VHIS policy is a rider to a life insurance policy, then the renewal of the VHIS policy should not be conditional upon the renewal of the latter. Or, say, in the case of a family policy which covers more than one persons insured, and that the policyholder passes away, then the other persons insured should be allowed to continue their insurance cover without being subject to re-underwriting or re-serving the standard waiting period.

(2) No “Lifetime Benefit Limit”

2.23. We note that currently some insurers have imposed “lifetime benefit limit” on some Hospital Insurance policies. Under a “lifetime benefit limit”, the insurance cover terminates when the cumulative claims amount of a policyholder reaches the lifetime limit. This could render the requirement of guaranteed renewal ineffective because the continuation of insurance cover would be conditional upon previous claims, rather than payment of premium on the part of the policyholder. Moreover, “lifetime benefit limit” might have the unwanted effect of deterring a policyholder from seeking necessary medical care earlier in his/her life for fear of using up his/her lifetime benefit limit too soon. This could be detrimental to the health of the policyholder, and even aggravate his/her medical costs because of delay in treatment. We thus propose to impose an explicit no “lifetime benefit limit” clause as part of the Minimum Requirements.

(3) Coverage of Pre-existing Conditions

2.24. We propose to require insurers to cover pre-existing conditions subject to a standard waiting period. Full coverage for pre-existing conditions would be provided after the three-year waiting period, and no/partial coverage would be provided during the waiting period according to the reimbursement arrangement below –

- (a) first year – no coverage
- (b) second year – 25% reimbursement

- (c) third year – 50% reimbursement
- (d) fourth year onwards – full coverage

(4) Guaranteed Acceptance with Premium Loading Cap

(i) *Guaranteed Acceptance*

2.25. We propose to require insurers offering Standard Plan to guarantee acceptance of –

- (a) all ages within the first year of implementation of the VHIS; and
- (b) those aged 40 or below starting from the second year of the implementation of the VHIS,

regardless of the health status of prospective customers.

2.26. The first proposal above aims to provide accessible and affordable Hospital Insurance cover to older age people who did not have a chance to do so when they were young. The second proposal aims to encourage more people to enroll in Hospital Insurance when they are young and healthy. Without an entry age limit, there would be incentive for individuals to defer taking out Hospital Insurance until an older age when their health condition deteriorates. At a young age, a consumer is, upon taking out Hospital Insurance, more likely to be healthy and thus may be able to lock in an underwriting class that attracts a lower premium. He/she can then maintain that underwriting class without re-underwriting even when he/she develops health conditions at a later age. In comparison, if a consumer subscribes to Hospital Insurance at an older age, he/she may already have developed pre-existing conditions. The consumer would then need to pay a higher premium than he/she would otherwise have to pay if he/she took out Hospital Insurance earlier.

2.27. We consider the proposed age limit of 40 appropriate as those who would like to subscribe to Hospital Insurance should have ample opportunities to do so before reaching the age of 40. In Australia, for example, consumers are encouraged to purchase PHI before age 30. A consumer who takes out PHI after the age of 30 is charged a loading on the insurance premium⁵.

2.28. For those who choose to subscribe to Hospital Insurance after the age of 40, they would still be able to enjoy the benefits of all other Minimum Requirements proposed for Standard Plan except for guaranteed acceptance (i.e. their applications for Hospital Insurance might be rejected by insurers) and the premium loading cap proposed for Standard Plan.

⁵ Those who purchase PHI after 30 years of age are charged 2% of the base premium for each year over age 30, subject to a maximum of 70% of the base premium.

(ii) *Premium Loading Cap*

2.29. We propose to cap the premium loading at 200% of standard premium in order to ensure premium affordability for high-risk individuals for policies taken out under the guaranteed acceptance requirement proposed in paragraph 2.25. A High Risk Pool (HRP)⁶ is proposed to be set up to accept policies of Standard Plan of which the premium loading is assessed to be 200% or more of the standard premium offered by the insurer. Please refer to Chapter 4 for details on the latest proposal concerning the HRP.

(5) **Portable insurance policy**

2.30. In principle, we consider that policyholders should enjoy free portability (i.e. without re-underwriting) as far as possible in order to enhance consumer choice and promote healthy competition among insurers. This notwithstanding, we have to be aware of the technical challenges for insurers in managing financial risk and administrative cost. For example, the incidents of claims would become more difficult to predict, and additional administration cost would be incurred due to checking of claims records between insurers. If these challenges cannot be properly tackled, some insurers may have to raise premiums to compensate for the uncertainty and cost. To address this problem, we propose that policyholders of products complying with the Minimum Requirements may enroll in a Standard Plan of other insurers without being re-underwritten and required to re-serve the standard waiting period as long as they did not make any claims in a certain period of time (say, three years) immediately before the transfer of policy to another insurer. Given the technicality of the subject, we will review whether the proposed arrangement should be refined taking into account the actual implementation of the VHIS and in consultation with the industry.

6 HRP is an industry reinsurance mechanism proposed in the Second Stage Consultation for insurers participating in the HPS to share out the high risks insured by their HPS Plans. All high-risk policies, defined as those policies with risk premium assessed to be equal or above the cap for premium loading (i.e. three times the standard premium of Standard Plan) will be put into the HRP. Please refer to Chapter 4 for details of the current proposal for the HRP.

(B) Enhancing Quality of Insurance Protection

(6) Coverage of Hospitalisation and Prescribed Ambulatory Procedures

2.31. We propose to cover under the Minimum Requirements –

- (a) hospitalisation necessitated by diagnosed medical conditions; and
- (b) a list of prescribed ambulatory procedures necessitated by diagnosed medical conditions, including endoscopies (e.g. oesophago-gastro-duodenoscopy, colonoscopy, etc.) and certain relatively simple surgeries such as cataract extraction and intra-ocular lens implantation surgery. The ambulatory procedures to be covered under Standard Plan will be determined and prescribed by the VHIS regulatory agency in consultation with major stakeholders (e.g. members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.)

2.32. Currently, some of the Hospital Insurance products in the market only provide reimbursement for procedures performed under an in-patient setting and requiring overnight hospital stay. Hence, even if a procedure could be performed under an ambulatory setting, the patient would be obliged to stay overnight at the hospital for the expenses to be claimable. This not only causes inconvenience to the patient, but also leads to a waste of healthcare resources. According to the Consultant's estimate, around half of the endoscopies received by persons insured in private hospitals occurred as overnight stays. In comparison, in Australia, less than 10% of endoscopies involve in-patient overnight stays. Coverage of prescribed ambulatory procedures would help avoid unnecessary overnight hospital stay, deliver healthcare in a more cost-effective way, and better utilise private sector capacity in providing in-patient care for genuine cases.

According to the estimate of the Consultant, in 2010, the average cost of the procedure "colonoscopy with removal of tumor, polyp or lesion" performed under an ambulatory setting was around \$8,600. The average cost was around \$19,100 for those who stayed overnight in a hospital (general ward level).

(7) Coverage of Prescribed Advanced Diagnostic Imaging Tests and Non-surgical Cancer Treatments

2.33. Advanced diagnostic imaging tests are basic diagnostic tools in modern day medical diagnosis and treatment. We are of the view that, to ensure consumers have basic and value-for-money protection, these tests should be covered under the Minimum Requirements. However, international experiences such as in Organisation for Economic Co-operation and

Development countries reveal that advanced diagnostic imaging tests are prone to abuse induced by moral hazard, and thus require concerted efforts, including the adoption of co-payment arrangement, to bring utilisation under proper control. We therefore propose to cover under the Minimum Requirements a list of prescribed advanced diagnostic imaging tests necessitated by assessed medical conditions, including Magnetic Resonance Imaging (MRI) examination, Computed Tomography (CT) and Positron Emission Tomography (PET) scans, subject to a prescribed rate of 30% of co-insurance (please refer to paragraphs 2.39 to 2.40) to combat moral hazard.

2.34. We also propose to cover under the Minimum Requirements non-surgical cancer treatments up to a prescribed limit (\$150,000 per disability per year as currently proposed), including chemotherapy, radiotherapy, targeted therapy and hormonal therapy. These treatments, which are potentially expensive items, are of increasing importance as an integral part of cancer treatment. We consider it appropriate and desirable to cover these treatments under the Minimum Requirements.

2.35. The benefit coverage of Standard Plan would be reviewed and updated by the VHIS regulatory agency at regular intervals. The benefit coverage of existing policies of Standard Plan would be updated upon policy renewal in accordance with the prevailing benefit coverage as published by the regulatory agency.

(8) Minimum Benefit Limits

2.36. We propose that the benefit limits of Standard Plan should be at the prescribed levels with the aim of providing reasonable coverage for general ward in average-priced private hospitals. The benefit limits of Standard Plan would be reviewed and updated at regular intervals by the VHIS regulatory agency.

2.37. For hospital treatments, we propose that the benefit limits should be itemised in a way that is broadly consistent with the existing fee structure of private hospitals. This would be in line with the current insurance market practice and claims settlement process. Examples of benefit items include room and board, attending physician's visit, surgeon and anaesthetist fees, operating theatre fees, and miscellaneous expenses.

2.38. With regard to the prescribed advanced diagnostic imaging tests, prescribed ambulatory procedures and non-surgical cancer treatments, we propose setting out the benefit limits in packaged form, i.e. a lump-sum benefit limit per episode of care/disability. We consider it appropriate to adopt packaged benefit limits for these procedures and tests since they are relatively simple without significant cost variation. Adopting packaged benefit limits can encourage private healthcare providers to offer similarly structured pricing packages for these procedures and tests, hence bringing about budget certainty to the policyholders.

We also propose to set the benefit limits of these procedures and tests with reference to the price levels in ambulatory setting. This is because these procedures and tests can usually be conducted under an ambulatory setting in a more cost-effective way, and setting their benefit limits with reference to the price levels in ambulatory setting can promote better utilisation of ambulatory services and help reduce unnecessary hospital admissions.

(9) Cost-sharing Restrictions

2.39. While cost-sharing arrangements by policyholders, such as co-insurance and deductible, could encourage judicious use of healthcare services, we note that such arrangements might reduce the attractiveness of VHIS plans and affect the desire of policyholders to seek necessary treatments.

2.40. In view of the above, we propose that, in principle, no cost-sharing arrangements (deductible or co-insurance) should be included in Standard Plan. On the other hand, we recognise that there is a need to combat moral hazard in cases where healthcare services are most prone to mis-use or abuse. We therefore propose to introduce a fixed 30% co-insurance for the prescribed advanced diagnostic imaging tests, which are more easily subject to mis-use or abuse as compared to other healthcare services such as surgical operations or application of medication (e.g. chemotherapy). Other than the said 30% co-insurance, no cost-sharing arrangements (deductible or co-insurance) should be included in Standard Plan. We also propose an annual cap of \$30,000 for any cost-sharing to be paid by a policyholder (excluding any amount that the policyholder has to pay if the actual expenses exceed the benefit limits in his/her insurance policy).

(C) Promoting Transparency and Certainty

(10) Budget Certainty

2.41. In the Second Stage Consultation, it was proposed that HPS plans should offer coverage for common procedures using diagnosis-related groups (DRG)-based packaged pricing. DRG is a sophisticated coding system for classifying medical conditions requiring treatments or procedures by diagnosis and complexity. Insurers would set a lump-sum benefit level for the treatment/procedure with DRG-based packaged pricing. Packaged charging would provide cost transparency and certainty for consumers, and would help promote healthy competition in the private healthcare services market.

2.42. We note that DRG-based packaged pricing may not be feasible for all hospital admissions or ambulatory procedures, and would be more easily implementable where a certain treatment or procedure is performed at a sufficiently high frequency, allowing any variation in costs to be averaged out among different cases; or where a certain treatment or

procedure is relatively routine or standardised with low variation in actual utilisation or costs involved. In cases where packaged pricing is not considered feasible due to complexity of the treatments or procedures, HPS plans would still need to offer itemised benefit schedules for these treatments or procedures.

2.43. After taking into account the views received during the Second Stage Consultation and the advice of the Consultant, we consider that it would take a relatively longer time for Hong Kong to develop an operable system of DRG suitable for local use in the private sector. The exercise would require comprehensive and regular collection, compilation and analysis of healthcare, claims and pricing data from the health insurance industry and healthcare service providers. Regular and structural review is also required to keep the DRG system up-to-date. As Hong Kong currently does not possess such sophisticated mechanism for conducting the above work, there will be significant challenges in implementing a DRG system in the short-term.

International experience reveals that DRG is a popular payment method to reimburse healthcare providers for the services they provide to patients, and its application is observed in both public and private sectors. A major advantage of this payment method is to encourage healthcare providers to control cost and avoid unnecessary services for profit sake, while a key challenge involved is to balance cost of care with quality of care (e.g. to avoid inadequate provision of healthcare service as reimbursement by DRG is fixed per diagnosis). DRG is generally not pursued for centralised price-setting or price-fixing. It is through mutual agreement that healthcare providers and healthcare payers determine whether to adopt DRG-based payment method, its structure and level of payment. In the United States, for instance, Medicare (social health insurance for the elderly and disabled people) has adopted DRG as the payment method for hospital charges since 1983. Hospitals opting to participate in Medicare (and hence can accept Medicare patients) have to agree to receive reimbursement from Medicare according to the DRG-based payment schedule the latter sets. Yet for doctor charges, Medicare does not adopt DRG and instead uses a fee schedule by procedure and service which is subject to review and recommendation from the American Medical Association. In the private sector of the United States, healthcare providers and health insurers have full liberty regarding whether to follow Medicare practice. Besides DRG, there are other payment methods such as capitation payment, contracted fee-for-service payment, and per-diem payment that are agreed between healthcare providers and health insurers.

International experience also reveals that implementing DRG would require considerable efforts, such as substantial investment in information technology systems, comprehensive data collection on costs and benchmarks, or even introduction of specific legislation to require services to be purchased using DRG. In Switzerland, for example, the enabling legislation (amendment of the Federal Health Insurance Act) was passed in 2007, but it was not until 2012 that the system could be implemented in full due to lack of data and inconsistencies in the way diagnoses and treatments were recorded for DRG purposes. In the Netherlands, it took several years to gradually expand the range of procedures subject to DRG packaged pricing, from 10% of the total hospital budget in 2005 to 33% in 2009 and 75% in 2012.

(i) No-gap/known-gap Arrangement

2.44. After taking into account the local situation and surveying international experience, we propose adopting the No-gap/known-gap arrangement, which is more readily implementable in the short-term and has been widely adopted in Australia. “Gap” refers to the out-of-pocket expenses a patient pays for hospital and doctor’s fees (except pre-set deductible and co-insurance). A policyholder can enjoy “no-gap” (no out-of-pocket payment is required) or “known-gap” (a pre-determined amount of out-of-pocket payment) if the procedure concerned, the hospital and doctor selected by the policyholder are on the lists specified by the insurer concerned.

2.45. To facilitate market adaptation, we propose to require that at least one procedure/test covered under Standard Plan should comply with the No-gap/known-gap arrangement. Insurers may limit the No-gap/known-gap arrangement to a particular list of procedures, institutions (e.g. hospitals) and doctors. A policyholder pays “no-gap” or “known-gap” if –

- (a) the procedure concerned is on the specified list;
- (b) the institution is from the specified list; and
- (c) the doctor is from the specified list.

2.46. As the market gradually adjusts, we expect that the No-gap/known-gap arrangement would become more popular over time as revealed by the experience in Australia. The No-gap/known-gap arrangement would be akin to packaged pricing in the sense that it provides budget certainty and convenience to a policyholder, who can ascertain the amount of out-of-pocket payment, if any, before receiving the treatment.

Since June 2000, all insurers in Australia are required by law to offer “no-gap/known-gap” policies for hospital cover. A policyholder with this type of insurance policy enjoys “no-gap” or “known-gap” when choosing a hospital with which his/her insurer has a “Hospital Purchaser Provider Arrangement” (HPPA, under which the insurer pays a contracted hospital fee), and a doctor who agrees to use his/her insurer’s fee schedule through “Medical Purchaser Provider Arrangement” (MPPA, under which a doctor can opt to use the insurer’s fee schedule). The policyholder may still opt for other hospitals and doctors, but this would normally result in larger out-of-pocket payments, since under such cases insurers generally provide relatively modest reimbursements to encourage policyholders to choose healthcare service providers under the HPPA and MPPA. The “no-gap/known-gap” policies have proliferated remarkably in Australia over the past decade or so. Before the “no-gap/known-gap” requirements were introduced in 2000, only about 50% of in-patient medical services were provided with no-gap payable by patients. In 2012, about 90% of in-patient medical services were paid on a no-gap basis, and insurers in Australia now compete for customers on the basis of how successful their “no-gap/known-gap” arrangements are.

2.47. The policyholder would still be free to choose services provided by hospitals or doctors not on the No-gap/known-gap list. The insurance benefit will be calculated based on the actual fees and charges against the benefit limits in accordance with the insurance policy, and out-of-pocket expenses may be necessary. In such case, the policyholder would still be able to benefit from the budget certainty provided by the Informed Financial Consent arrangement described below.

(ii) Informed Financial Consent

2.48. In Singapore, private hospitals are required to provide estimated total charges (known as “financial counselling”) to patients before treatment and inform patients of any changes in a timely manner. Patients are informed, in the form of a uniform written quotation, of the estimated charges of the healthcare services (including doctor’s fee and hospital fees) before receiving treatment. Under such arrangement, patients would have greater certainty in estimating the amount of out-of-pocket expenses before receiving treatment.

2.49. We propose to adopt the approach of Singapore in enhancing budget certainty of VHIS policyholders. As a general rule, private healthcare service providers should inform patients of the estimated total charges for investigative procedures or elective, non-emergency therapeutic operations/procedures for known diseases on or before admission to private hospitals. Patients should be provided with a written quotation in a standardised form, i.e. Informed Financial Consent, of the estimated total charges, including separate items

for estimated doctor's fee and estimated hospital charges⁷. Insurers would also be required to indicate in the same form the reimbursement amount for the operations/procedures concerned, as well as estimated out-of-pocket expenses to be paid by the patients given their existing insurance cover. A sample of the Informed Financial Consent is attached at **Appendix E** for reference.

2.50. We are aware that there might be circumstances where the Informed Financial Consent requirement should be exempted. For example, if, at a doctor's clinical judgment, further treatment is required for a patient undergoing an operation/procedure, emergency or life threatening situations, price quotation for items beyond those that the patient had consented to would be exempted. There may also be medical conditions for which it is not clinically possible to identify a definite diagnosis for the disease, e.g. abdominal pain, and therefore the doctor would be unable to provide an estimate of the charges of the operations/procedures. In such cases, we propose that the doctor should be required to indicate and justify why this is the case on the price quotation form. Wherever possible, the doctor/hospital should endeavour to provide an estimated charge for items that are relatively certain or foreseeable, e.g. charge for attending physician's visit. When a definite diagnosis is subsequently received and elective therapeutic operations/procedures are required, the patient should be given an estimate of the total charges, the reimbursement amount and estimated out-of-pocket payment as soon as practicable.

2.51. Noting that there could be varying degrees of complexity or unforeseen circumstances arising from treatments or procedures, we propose that private healthcare service providers should inform patients of the range of potential variation of the estimates in the Informed Financial Consent. In case there are any material changes in estimates (e.g. surgical fee, medication fee, specialist visit fee, etc.), patients should be informed of the reasons for change of the estimated charges, as well as the latest estimated charges as soon as practicable. For example, the actual charges for a surgical procedure might vary significantly from the original estimates if there are complications during the operation. In such cases, patients should be informed of the reasons for change in estimates, as well as the latest estimated charges. When applicable, insurers should also inform patients of the revised reimbursement amount and out-of-pocket payment if providers have provided a revised estimate of charges due to substantial variation from the original estimates. For example, a patient suffering from complications during an operation may be required to stay in the hospital for a longer period of time than originally estimated. In such cases, the patient should be informed of the revised reimbursement amount and estimated out-of-pocket payment as far as practicable.

⁷ While hospital charges can be quoted by hospital administration separately from doctor's fee, for the sake of expediency, doctors may use their best endeavours (such as making reference to the hospital website) in providing price quotes for individual items of hospital charges based on the fee schedule of private hospitals.

(11) Standardised Policy Terms and Conditions

2.52. We propose to require insurers to adopt a standardised set of policy terms and conditions as well as associated definitions. This means that Standard Plans offered by different insurers must adopt the same set of policy terms and conditions, so as to enable consumers to better comprehend the terms upfront and minimise disputes over interpretations afterwards.

2.53. The standardised policy terms and conditions will cover, among others, definitions, interpretation and wordings; policy provisions in regard to guaranteed renewal, coverage of pre-existing conditions, standard waiting period, etc.

(12) Premium Transparency

2.54. During the Second Stage Consultation, there was considerable interest in how to keep the future premiums under better check. While we acknowledge the public's concern over possible premium increase over the long-term, we are aware that insurance premium is influenced by a host of factors, including medical costs, claims experience, administration cost, risk assessment, etc. Moreover, the interplay of these factors may differ from one insurer to another, and may change alongside dynamic market situation over time. All these mean that direct interference with premium setting is undesirable. It would be difficult to ensure that the premium setting mechanism is fair and reasonable to both consumers and insurers, and direct regulation of premium setting may result in excessive interference to the detriment of market development as well as consumer interest.

2.55. To balance between consumer protection and avoidance of over-interference in market operation, we consider that consumer interest can best be safeguarded through transparency measures that foster market competition. By creating a level-playing field for all insurers and minimising information asymmetry between consumers and insurers, these transparency measures can enhance consumer choice, foster market competition and help keep premium levels in check. Moreover, given that Standard Plans by different insurers would be essentially identical, consumers can easily compare different offers by insurers. Against this backdrop, we propose that –

- (a) insurers may apply premium loading to individual policies in accordance with their own underwriting practice and risk-taking preference, but the premium loading is subject to a cap of 200% of standard premium. Insurers would have incentive to compete and offer the best price as consumers can shop around for value-for-money products offered by different insurers;
- (b) insurers should make known the reasons for assessing any premium loading to the

consumer, who should be allowed to provide supporting evidence to request loading reduction; and

- (c) insurers may set and adjust its premium schedules for compliant products, but the premium schedules must be age-banded and must be published for consumers' reference.

2.56. We also propose that an easily accessible platform (e.g. websites of insurers and the VHIS regulatory agency) should be established with information on VHIS products offered by different insurers in the market, including the premium schedules. This will allow consumers to easily compare VHIS products and drive the market to provide value-for-money products and services to consumers. We consider competition and transparency the most effective and sustainable measures to safeguard consumer interest. That said, we do not rule out the possibility that the regulatory agency might have to take stronger action if the market behaviour falls short of reasonable expectations. If necessary, the regulatory agency will review whether further measures such as premium adjustment guidelines are necessary and appropriate for protecting consumer interest, based on the experience and market development after the implementation of the VHIS.

Arrangements for Group Hospital Insurance

2.57. Among the about 2.0 million persons covered by indemnity hospital insurance, about 0.7 million are covered by employer-provided medical benefits in the form of group Hospital Insurance⁸. Ideally, it is desirable for group Hospital Insurance to comply with the Minimum Requirements for better consumer protection. A prudent and more practical approach, however, is called for in the light of the unique characteristics of group Hospital Insurance.

2.58. The group market is inherently different from the individual market since the cost of purchasing the group policies is borne by employers, rather than employees who are the direct beneficiaries of the insurance cover. Given that purchase of Hospital Insurance is voluntary under the VHIS, it would be important to encourage employers to maintain or take up group Hospital Insurance – even if it falls short of the Minimum Requirements – for their employees. Some of the products in the market are of limited protection in terms of benefit coverage and limits due to budget constraint of the employers, especially the small and medium enterprises. If all group Hospital Insurance is required to comply with the Minimum Requirements, some of the employers might drop the cover altogether because they may not be able to afford to pay for the more comprehensive coverage of compliant products. Besides, since the cost of the group cover is borne by employers, who do not benefit directly from the insurance cover, there might be a risk that some of the employers currently offering above-par group coverage might reduce the protection level to that of the perceived “standard level” of the Minimum Requirements.

⁸ Includes medical benefits not in the form of medical insurance provided by private companies/organisations, and excludes civil servant and Hospital Authority staff medical benefits.

2.59. Taking into account the characteristics of the group market as well as employers' affordability, we propose not to require group Hospital Insurance to comply with the Minimum Requirements. Nevertheless, to better protect employees' interests, we propose to adopt the following arrangements for group Hospital Insurance.

(1) Conversion Option

2.60. We propose to require insurers to offer as an option to employers an elective component – the Conversion Option – in the group Hospital Insurance products offered to employers. Employers would be allowed to decide whether to purchase the group policy with the Conversion Option component. If the employer decides to purchase the group policy together with the Conversion Option, an employee covered by such group policy can exercise the Conversion Option upon retirement or leaving employment so that he/she can switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that the employee has been employed for a full year immediately before transfer to individual Standard Plan. If the insurer concerned does not practise individual underwriting for group policies, which is quite common in the local market, the employee only needs to pay for standard premium for individual Standard Plan irrespective of his/her health conditions. The premium of the Conversion Option would be determined by the insurer, depending on the profile and characteristics of the group (e.g. the age profile of the employees).

2.61. The Conversion Option would help ensure continuity of Hospital Insurance cover of an employee into old age. Compared with purchasing a separate individual Standard Plan, the benefits of the Conversion Option are that an employee will not need to undergo re-underwriting when switching to an individual Standard Plan, and does not need to take on an individual policy beforehand in order to secure a sustained and affordable insurance protection upon retirement or leaving employment.

(2) Voluntary Supplement(s)

2.62. At present, some insurers offer Voluntary Supplement(s) to individual members covered by a group policy. We consider this arrangement consistent with our policy objective and worthwhile to promote. We propose that insurers may, on a group policy basis, continue to offer Voluntary Supplement(s)⁹ to individual members covered by a group Hospital Insurance policy who wish to procure at their own costs additional protection on top of their group policy. The Voluntary Supplement(s) would be provided on a group policy basis, i.e. the supplement(s) will not be individual policies. The intention is that the group policy, enhanced by the Voluntary Supplement, should provide insurance protection at a level comparable to the protection of an individual Standard Plan. Individual policy members will have the choice of whether to purchase the Voluntary Supplement(s) or not.

⁹ As a rider to the group policy or an integrated component of the group policy.

(3) Disclosure of Information

2.63. In order to facilitate better understanding of the level of protection received by employees from their group policy, we propose to require insurers to keep a prescribed checklist of whether the group Hospital Insurance products they offer to each individual employer meet the Minimum Requirements. The insurer would be obliged to divulge such information to employees upon enquiry.

(4) Naming of Group Hospital Insurance Products

2.64. In the individual market, after the implementation of the VHIS, only those Hospital Insurance products complying with the Minimum Requirements may be sold in the name of "hospital"/"health"/"medical" insurance, or such other name which denotes or connotes that such product is an individual Hospital Insurance. Since group Hospital Insurance would not be regulated by the Minimum Requirements, and some of which may provide benefits lesser than that of an individual Standard Plan, we propose that, for any group Hospital Insurance products to be sold in the name of "hospital"/"health"/"medical" insurance, it must be specified in the product name that such products are group products (e.g. "group hospital insurance", "group health insurance" or "group medical insurance"). In addition, to protect employer's interests, we propose that insurers should state clearly in the product information provided to employers whether such products are compliant with the Minimum Requirements.

CHAPTER 3 PRODUCT DESIGN

3.1. Upon the implementation of the Voluntary Health Insurance Scheme (VHIS), all individual Hospital Insurance to be offered by insurers must meet the Minimum Requirements as described in Chapter 2. These Minimum Requirements are recapped below –

- (1) Guaranteed renewal
- (2) No “lifetime benefit limit”
- (3) Coverage of pre-existing conditions
- (4) Guaranteed acceptance with premium loading cap
- (5) Portable insurance policy
- (6) Coverage of hospitalisation and prescribed ambulatory procedures
- (7) Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments
- (8) Minimum benefit limits
- (9) Cost-sharing restrictions
- (10) Budget certainty
- (11) Standardised policy terms and conditions
- (12) Premium transparency

3.2. This Chapter illustrates how the Minimum Requirements would be manifested in the form of three product types, namely Standard Plan, Flexi Plan and Top-up Plan.

STANDARD PLAN

3.3. Under the VHIS, insurers participating in individual Hospital Insurance business must offer as one of the options to consumers a Standard Plan that meets all (but not exceeding) the Minimum Requirements. A major aspect of the Minimum Requirements is minimum benefit limits, which will correspond to the benefit schedule of Standard Plan. Below is an illustrative outline of how the benefit schedule of Standard Plan will be structured. All dollar figures in the benefit schedule and in all examples in this Chapter are indicative and are for illustration purposes only.

Table 3.1 Illustrative Outline of Benefit Schedule of Standard Plan⁽¹⁾
(Indicative dollar figures for illustration only)

Category	
(A) Itemised benefit limits (for hospitalisation only)	
(1) Room and board (daily), maximum 180 days	\$ 650
(2) Attending physician's visit (daily), maximum 180 days	\$ 750
(3) Specialist's visit (per admission)	\$ 2,300
(4) Surgical limit (including surgeon, anaesthetist, operating theatre ⁽²⁾) (per surgery)	Maximum \$ 58,000 (varies by surgery type)
(5) Miscellaneous hospital expenses (per admission)	\$ 9,300
(B) Packaged benefit limits	
(1) Prescribed ambulatory procedures (per procedure), e.g. endoscopy, cataract extraction and intra-ocular lens implantation surgery	Lump-sum packaged benefit limit ⁽³⁾ (varies by procedure type)
(2) Prescribed advanced diagnostic imaging tests (per test), e.g. Magnetic Resonance Imaging (MRI) examination, Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan	Lump-sum packaged benefit limit ⁽³⁾ (varies by test type) subject to 30% co-insurance
(3) Non-surgical cancer treatments (per disability)	\$ 150,000

(C) "No-gap/known-gap" cover	
Applicable to the list specified by insurer on: (1) procedures/tests; (2) hospitals or clinics; (3) doctors	Out-of-pocket payment varies by procedure/test type ⁽⁴⁾ ; no out-of-pocket payment for "no-gap" cover
(D) Annual benefit limit	\$ 400,000
(E) Lifetime benefit limit	Nil
(F) Deductible	Nil
(G) Co-insurance (other than 30% for prescribed advanced diagnostic imaging tests)	Nil

Notes:

- (1) The illustrative outline is intended to demonstrate the structure of the benefit schedule of Standard Plan under the Minimum Requirements.
- (2) The respective sub-benefit limits for surgeon, anaesthetist and operating theatre fees would be determined in consultation with relevant stakeholders.
- (3) Packaged benefit limit includes doctor's fee and other expenses. The respective sub-benefit limits for doctor's fee and other expenses would be subject to consultation with relevant stakeholders. The sub-benefit limits would only be applicable if the billed amount exceeds the packaged benefit limit, so as to safeguard proper apportionment among the charging parties.
- (4) Amount paid by insurer includes doctor's fee and other expenses. The respective amounts of doctor's fee and other expenses would be subject to consultation with relevant stakeholders.

Category A – Itemised Benefits for Hospitalisation

3.4. Category A of the benefit schedule follows the currently common approach in providing hospitalisation benefits in the Hospital Insurance market. It indemnifies in-patient expenses incurred by policyholders, irrespective of the choice of hospitals and doctors. In calculating the amount claimable, the actual expenses are categorised into corresponding service items. For expenses claimed for an item not exceeding the corresponding benefit limit, no out-of-pocket payment would be required from the policyholder. However, if the expenses claimed for an item exceeds the corresponding benefit limit, the policyholder will have to pay for the excess (**Example 3.1**).

Example 3.1 Itemised Hospital Charges for Thyroidectomy Procedure

(Length of stay: 4 days)

	Billed amount	Benefit limit	Claimable amount	Excess over benefit limit
Room and board	\$ 2,800 (\$700/day)	\$ 2,600 (\$650/day)	\$ 2,600	\$ 200
Attending physician's visit fee	\$ 3,200 (\$800/day)	\$ 3,000 (\$750/day)	\$ 3,000	\$ 200
Surgeon's fee	\$ 26,000	\$ 17,400	\$ 17,400	\$ 8,600
Anaesthetist's fee	\$ 8,000	\$ 5,800	\$ 5,800	\$ 2,200
Operating theatre fee	\$ 11,000	\$ 5,800	\$ 5,800	\$ 5,200
Miscellaneous hospital expenses	\$ 5,000	\$ 9,300	\$ 5,000	\$ 0
Total amount	\$ 56,000	-	\$39,600 Paid by insurer	\$16,400 Paid by policyholder

Category B – Packaged Benefits

3.5. Category B of the benefit schedule provides benefits for prescribed procedures or tests (prescribed ambulatory procedures, prescribed advanced diagnostic imaging tests, and non-surgical cancer treatments) in the form of lump-sum packaged benefit limits per procedure or test. The procedures or tests prescribed in Category B can normally be performed in ambulatory setting for which packaged pricing is more likely to be offered by private healthcare providers. The expenses are claimable irrespective of whether the procedure or test is performed in hospital or ambulatory setting (such as clinics or hospital day centres).

3.6. Where the policyholder chooses a healthcare provider that offers packaged pricing, the policyholder will not have to pay for any excess if the packaged price is within the packaged benefit limit (**Example 3.2(a)**).

Example 3.2(a) Packaged Price for Colonoscopy Procedure in Ambulatory Setting
(Length of stay: 0 day)

Total billed amount*	\$ 7,800
<i>Packaged benefit limit</i>	\$ 8,000
Amount paid by insurer	\$ 7,800
Amount paid by policyholder	\$ 0

Note* The respective amount of doctor's fee should be made known to the policyholder as far as practicable if the bill is packaged.

3.7. Where the policyholder chooses a healthcare provider that charges on an itemised basis, there will be no excess payment by the policyholder if the sum of itemised charges is within the packaged benefit limit (**Example 3.2(b)**).

Example 3.2(b) Itemised Charges for Colonoscopy Procedure in Ambulatory Setting
(Length of stay: 0 day)

Surgeon's fee	\$ 7,000
Operating theatre fee	\$ 1,000
Total billed amount	\$ 8,000
<i>Packaged benefit limit</i>	\$ 8,000
Amount paid by insurer	\$ 8,000
Amount paid by policyholder	\$ 0

3.8. In both cases below, the policyholder will need to pay for the excess as the packaged benefit limit is exceeded (**Example 3.2(c)** and **Example 3.2(d)**).

Example 3.2(c) Packaged Price for Colonoscopy Procedure in In-patient Setting
(Length of stay: 1 day)

Total billed amount*	\$ 20,000
<i>Packaged benefit limit</i> [#]	\$ 8,000
Amount paid by insurer	\$ 8,000
Amount paid by policyholder	\$ 12,000

Note* Please see Note* under Example 3.2(a).

Note[#] Please see Note (3) under Table 3.1.

Example 3.2(d) Itemised Charges for Colonoscopy Procedure in In-patient Setting
(Length of stay: 1 day)

Room and board (\$500/day)	\$ 500
Attending physician's visit fee (\$700/day)	\$ 700
Surgeon's fee	\$ 10,000
Anaesthetist's fee	\$ 3,500
Operating theatre fee	\$ 3,500
Miscellaneous hospital expenses	\$ 3,000
Total billed amount	\$ 21,200
<i>Packaged benefit limit</i> [#]	\$ 8,000
Amount paid by insurer	\$ 8,000
Amount paid by policyholder	\$ 13,200

Note[#] Please see Note (3) under Table 3.1.

3.9. Prescribed advanced diagnostic imaging tests under Category B require 30% co-insurance by the policyholder. The claimable expenses will be net of co-insurance and subject to the packaged benefit limits. This applies to tests conducted in both ambulatory and in-patient settings (**Example 3.3(a)** and **Example 3.3(b)** respectively). In other words, the amount paid by the policyholder includes (a) the 30% co-insurance, and (b) any amount in excess of the packaged benefit limit. The amount paid by the insurer equals 70% of the total billed amount, up to the packaged benefit limit.

**Example 3.3(a) Packaged Benefit Limit with Co-insurance in Ambulatory Setting
MRI of Brain (Plain and Contrast)**

Total billed amount	\$ 3,800
Billed amount net of 30% co-insurance	\$ 2,660
<i>Packaged benefit limit</i>	\$ 4,000
Amount paid by insurer	\$ 2,660
Amount paid by policyholder	\$ 1,140

**Example 3.3(b) Packaged Benefit Limit with Co-insurance in In-patient Setting
MRI of Brain (Plain and Contrast)**

Total billed amount	\$ 6,000
Billed amount net of 30% co-insurance	\$ 4,200
<i>Packaged benefit limit[#]</i>	\$ 4,000
Amount paid by insurer	\$ 4,000
Amount paid by policyholder	\$ 2,000

Note[#] Please see Note (3) under Table 3.1.

Category C – “No-gap/Known-gap” Cover

3.10. Category C of the benefit schedule pertains to “no-gap/known-gap” cover, which provides greater budget certainty to the policyholders. Category C can possibly apply to all prescribed procedures and tests so long as the procedure/test concerned, the institution (e.g. hospital) and doctor selected by the policyholder are on the lists specified by the insurer. An illustrative example is shown in **Example 3.4(a)** below.

Example 3.4(a) Illustrative “No-gap/Known-gap” Cover

Procedure/Test	Specified Institution (e.g. Hospital/Clinic) List(s)	Specified Doctor List(s)	Gap Amount
Appendectomy	Hospital list I	Doctor list I	\$ 0 [“no-gap”]
Appendectomy	Hospital list II	Doctor list II	\$ 1,000 [“known-gap”]
Colonoscopy	Hospital list I and Clinic list I	Doctor lists I and II	\$ 0 [“no-gap”]
MRI of Brain (Plain and Contrast)	Clinic list II	Doctor list I	\$ 1,500 [“known-gap”]

Note: The examples in this table are for illustration purposes only. The gap amount in each case would depend on the procedure/test that the policyholder undergoes, the institution and the doctor selected by the policyholder.

3.11. Depending on the specification by the insurer, the policyholder will enjoy either “no-gap”, i.e. full cover of expenses without out-of-pocket payment (**Example 3.4(b)** and **Example 3.4(c)**); or “known-gap”, i.e. partial cover of expenses with pre-determined amount of out-of-pocket payment (**Example 3.4(d)** and **Example 3.4(e)**). The “no-gap/known-gap” arrangement would apply in the same way regardless of whether the bill is itemised or packaged.

Example 3.4(b) “No-gap” Cover for Packaged Price for Tonsillectomy Procedure
(Length of stay: 3 days)

Total billed amount (including hospital and doctor charges)	\$ 30,000
Amount paid by insurer^{&}	\$30,000
Amount paid by policyholder	\$ 0

Note[&] Amount paid by insurer includes doctor’s fee and other expenses. The respective amount of doctor’s fee should be made known to the policyholder as far as practicable if the bill is packaged.

Example 3.4(c) “No-gap” Cover for Itemised Charges for Tonsillectomy Procedure
(Length of stay: 3 days)

Room and board (\$500/day)	\$ 1,500
Attending physician's visit fee (\$700/day)	\$ 2,100
Surgeon's fee	\$ 18,000
Anaesthetist's fee	\$ 6,000
Operating theatre fee	\$ 5,000
Miscellaneous hospital expenses	\$ 2,000
Total billed amount (including hospital and doctor charges)	\$ 34,600
Amount paid by insurer	\$34,600
Amount paid by policyholder	\$ 0

Example 3.4(d) “Known-gap” Cover for Packaged Price for Haemorrhoidectomy Procedure
(Length of stay: 3 days)

Total billed amount (including hospital and doctor charges)	\$ 30,000
Gap amount (pre-determined and known in advance)	\$ 5,000
Amount paid by insurer^{&}	\$25,000
Amount paid by policyholder	\$ 5,000

Note[&] Please see Note[&] under Example 3.4(b).

Example 3.4(e) “Known-gap” Cover for Itemised Charges for Haemorrhoidectomy Procedure
(Length of stay: 3 days)

Room and board (\$500/day)	\$ 1,500
Attending physician's visit fee (\$700/day)	\$ 2,100
Surgeon's fee	\$ 18,000
Anaesthetist's fee	\$ 6,000
Operating theatre fee	\$ 5,000
Miscellaneous hospital expenses	\$ 1,000
Total billed amount (including hospital and doctor charges)	\$ 33,600
Gap amount (pre-determined and known in advance)	\$ 5,000
Amount paid by insurer	\$28,600
Amount paid by policyholder	\$ 5,000

3.12. Compared to Category A (itemised benefits for hospitalisation) and Category B (packaged benefits), Category C (“no-gap/known-gap” cover) offers the best budget certainty to policyholders as they can know clearly in advance of treatment whether they would need to pay out-of-pocket and the amount of out-of-pocket payable. As for Category B, it offers better budget certainty to policyholders when compared to the traditional itemised benefit structure of Category A, as policyholders can have upfront certainty about the total reimbursement amount payable by the insurer in advance of treatment, even though the actual charges by

providers are not specified in the insurance policies. In the cases where “no-gap/known-gap” cover is not available (i.e. where Categories A and B apply), the policyholders can still have greater certainty about the amount to be charged by providers through the Informed Financial Consent described in paragraphs 2.48 to 2.51 in Chapter 2. **Table 3.2** illustrates the differences between Categories A, B and C.

Table 3.2 Comparison Between Categories A, B and C

	Category A (Itemised Benefits for Hospitalisation)	Category B (Packaged Benefits)	Category C ("No-gap/ known-gap" Cover)
Upfront certainty of total reimbursement amount payable by insurer	Little certainty	Yes	Yes
Upfront certainty of total out-of-pocket amount payable by policyholder	Little certainty (budget certainty can be enhanced through Informed Financial Consent)	Greater certainty especially if provider also offers packaged pricing for procedure/test concerned	Best certainty
Applicable to all procedures/ tests and/or all providers	Yes	Procedures/tests specified by insurer only	Procedures/tests and providers specified by insurer only

Indicative Annual Standard Premiums for Standard Plan

3.13. Under the VHIS, insurers would each set their own age-banded premium schedules for Standard Plan, which would be published in the public domain for consumer's information. Insurers are allowed to charge a premium loading over standard premium rates for policyholders who are assessed to have higher health risks based on individual insurers' own underwriting guidelines. The premium loading will be subject to a cap of 200% of standard premium, making the total premium no more than three times the standard premium of the corresponding age band.

3.14. Standard Plan offers enhanced benefits compared to existing individual Hospital Insurance products which likewise target at general ward level services. For instance, for non-surgical cancer treatments (e.g. chemotherapy, radiotherapy) and advanced diagnostic imaging tests (e.g. MRI examination, CT scan, PET scan), a lot of existing products do not provide coverage for these treatments and tests as a separate benefit item. These treatments and tests are usually only claimable under the benefit item of "miscellaneous hospital expenses", which under normal circumstances would not be sufficient for covering the cost of these treatments and tests. Under Standard Plan, rather than being covered under "miscellaneous hospital expenses" as in existing individual Hospital Insurance products, these treatments and tests will be covered under separate benefit items, subject to respective benefit limits that would provide sufficient coverage for policyholders for using these services. Taking into account these enhanced benefits, the average annual standard premium of Standard Plan is estimated by the Consultant to be around \$3,600 (in 2012 constant prices), about 9%¹ higher than the average premium of existing individual Hospital Insurance products (ward level) in the market (i.e. around \$3,300 in 2012 constant prices).

3.15. For illustration purposes, an indicative schedule of annual standard premiums for Standard Plan estimated by the Consultant is shown at **Table 3.3**.

¹ Subject to a potential range of variation between -8% and +45%. The key driver for estimated premium variation is how well the VHIS is able to contain moral hazard on the use of advanced diagnostic imaging tests. It is for this reason that a 30% co-insurance is proposed for the use of such services to keep the cost under check.

Table 3.3 Indicative Annual Standard Premiums of Standard Plan*
(Year 2012², in 2012 constant prices)

Age Group	Illustrative Annual Standard Premium
Under 15	\$ 1,250
15 to 19	\$ 1,500
20 to 24	\$ 1,450
25 to 29	\$ 2,200
30 to 34	\$ 2,200
35 to 39	\$ 3,200
40 to 44	\$ 3,300
45 to 49	\$ 4,750
50 to 54	\$ 5,300
55 to 59	\$ 6,250
60 to 64	\$ 6,900
65 to 69	\$ 8,600
70 and above	\$ 9,950
Average	\$ 3,600

Note* The premium schedule presented here is for illustration purposes only. Insurers may structure the age bandings flexibly, for instance by having more age bandings for people aged under 15, or 70 and above. Premium differentiation by gender may also be allowed.

3.16. As explained further in paragraph 3.29 below, the VHIS would bring about enhanced transparency and product comparability, which in turn is expected to lead to a reduction of expense loading (i.e. the amount of insurer expenses, including commissions and broker fees, profit margins and other overhead expenses, as a percentage of the amount of premium). The average expense loading of the individual health insurance market (36% in 2013³) and the whole health insurance market (29% in 2013) in Hong Kong were the highest among jurisdictions studied by the Consultant. The average expense loading of the whole health insurance market was 13% in Australia (2012), 13% in Ireland (2012), 7% in the Netherlands (2012) and 9% in Switzerland (2012). Under the VHIS, standardisation, quality assurance and better flow of market information will facilitate easy comparison by consumers, drive market competition, and hence leading to a more moderate expense loading. A modest improvement in the expense loading to a level more in line with international experience will partly offset the estimated increase in premium of Standard Plan in comparison with existing products in the market, which lack the enhanced features and benefits proposed under the Minimum Requirements.

2 Assuming the VHIS would be fully implemented in 2012.

3 Source: Office of the Commissioner of Insurance. The corresponding figure for the group health insurance market was 19% in 2013.

Expense loadings in the United States

In the United States, the legislation under the Patient Protection and Affordable Care Act sets a ceiling on expense loading at 20% for individual and small group health insurance policies (consisting of up to 99 employees), and 15% for large group health insurance policies (consisting of 100 employees or more).

FLEXI PLANS AND TOP-UP PLANS

3.17. The Minimum Requirements are designed to provide a basic level of Hospital Insurance protection to individual consumers with simplicity, clarity and certainty. However, it is not our intention to prescribe a uniform “product template” for all individual Hospital Insurance products. We consider it important to provide flexibility for the market to offer products with enhanced benefits, so as to encourage product innovation and competition, and facilitate the healthy development of the market. Insurers are not restricted to offer Standard Plans only but may provide enhanced benefits in the form of a Flexi Plan or a Top-up Plan to suit the specific needs of consumers.

Flexi Plans

3.18. A Flexi Plan refers to a Hospital Insurance plan with enhancement to any or all of the benefits of a Standard Plan (e.g. higher room and board benefit limits than those required for a Standard Plan) of Hospital Insurance nature. Since Flexi Plan is a Hospital Insurance product, it should comply with the Minimum Requirements. Nevertheless, in order to allow more flexibility in promoting product innovation and competition, a Flexi Plan would not be subject to the following two Minimum Requirements.

Guaranteed Acceptance with Premium Loading Cap

3.19. We propose that Flexi Plans would not be subject to the requirement of guaranteed acceptance with premium loading cap (paragraphs 2.25 to 2.29 in Chapter 2), which is mandatory for Standard Plan. Although this requirement is conducive to consumer interest, it does not come at no cost. The cost of providing Standard Plan coverage to high-risk individuals at relatively affordable premiums would be borne by the High Risk Pool (HRP), which would be financially supported by the premiums collected and public funding. If the requirement of guaranteed acceptance with premium loading cap is extended to Flexi Plans, which offer richer benefits than Standard Plan, the financial support required from the Government would be much more substantial. For the sake of optimal use of public money, we consider it appropriate for the HRP to accept policies of Standard Plan only.

3.20. We have considered whether it is appropriate to require Flexi Plans to provide guaranteed acceptance without premium loading cap, or premium loading cap without guaranteed acceptance. In the first case, if insurers are required to provide guaranteed acceptance but without any cap on premium loading, then the premium after loading could become unaffordable to higher-risk individuals. This would discourage them from enrollment and render guaranteed acceptance meaningless. In the second case, it is not in the consumer's interest to keep the premium loading cap requirement without guaranteed acceptance. If insurers are not allowed to charge a premium loading above the cap to commensurate with the risks that they have taken on, they would likely reject applications from higher-risk individuals in order to avoid taking on excessive risks.

3.21. Taking into account the above, and given that consumers would be able to benefit from guaranteed acceptance with premium loading cap under Standard Plan, we consider it justifiable to relax this requirement for Flexi Plans.

Cost-sharing Restrictions

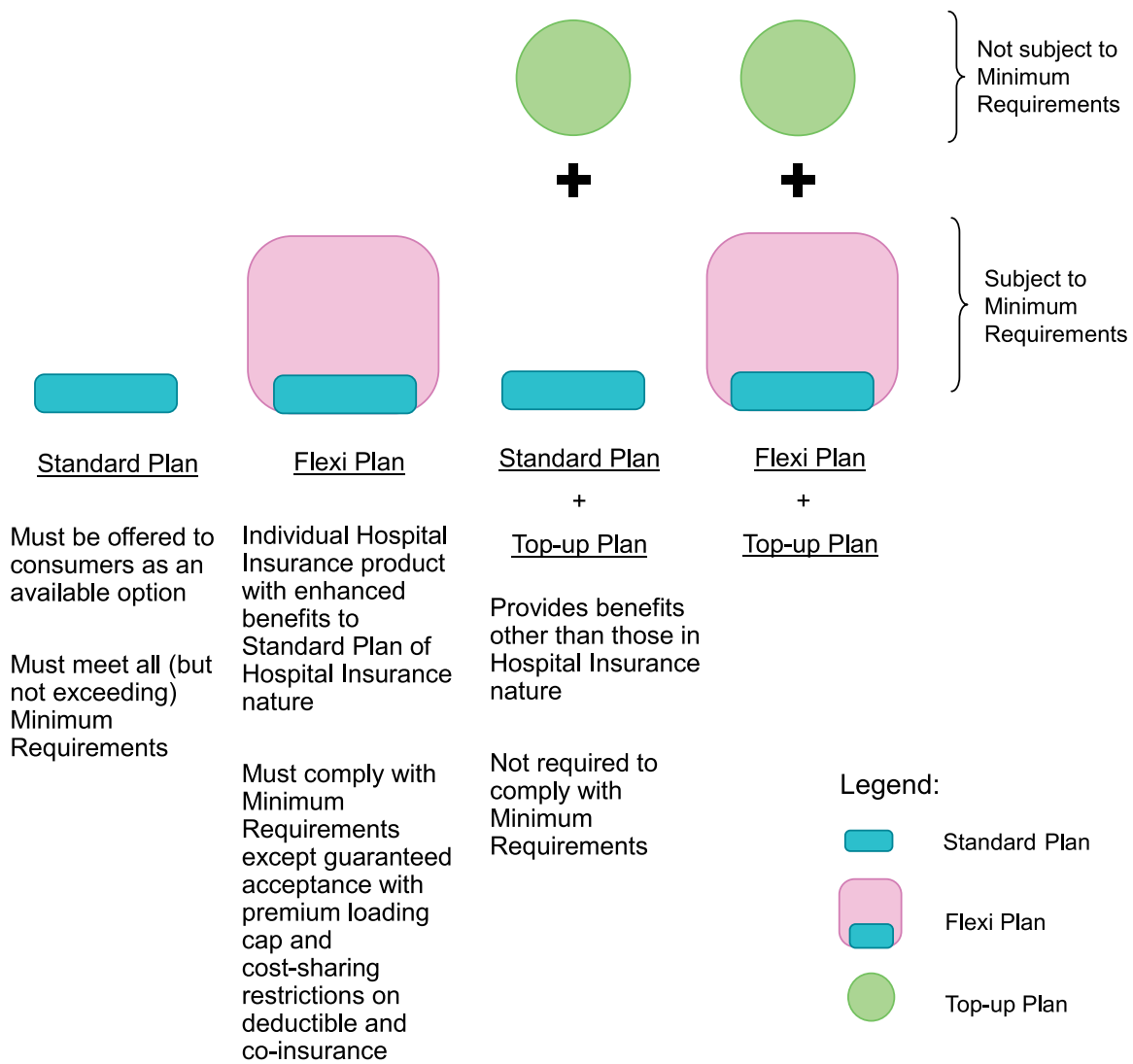
3.22. Cost-sharing arrangement is another area that we consider appropriate to allow for some flexibility in order to provide more product choices to consumers. We propose to allow insurers to introduce deductible and co-insurance for Flexi Plans, but the amount of deductible or co-insurance that a policyholder bears would still be subject to the annual cap of \$30,000 (excluding any amount that the policyholder has to pay if the actual expenses exceed the benefit limits in his/her policy) proposed for Standard Plan (paragraph 2.40 in Chapter 2).

Top-up Plans

3.23. A Top-up Plan refers to one providing benefits other than those in the nature of a Hospital Insurance (e.g. hospital cash) and may be attached to, hence forming part of, a Standard Plan or a Flexi Plan. Since a Top-up Plan, whether as a rider or as a standalone plan, is not a Hospital Insurance, it will not be subject to the Minimum Requirements.

3.24. **Figure 3.1** illustrates the possible product structuring options of Standard Plan, Flexi Plan and Top-up Plan.

Figure 3.1 Possible Product Structuring of Standard Plan, Flexi Plan and Top-up Plan



3.25. **Table 3.4** summarises the product design requirements for Standard Plan, Flexi Plan and Top-up Plan as described in Chapter 2 and this Chapter.

Table 3.4 Product Design Requirements for Standard Plan, Flexi Plan and Top-up Plan

Product Design Requirements	Standard Plan	Flexi Plan	Top-up Plan
(A) Accessibility to and continuity of insurance			
(1) Guaranteed renewal	Yes	Yes	Not regulated
(2) "Lifetime benefit limit"	Not allowed	Not allowed	Not regulated
(3) Coverage of pre-existing conditions	Yes, after a standard waiting period	Yes, after a standard waiting period	Not regulated
(4) Guaranteed acceptance with premium loading cap	Yes	Not regulated	Not regulated
(5) Portable insurance policy	Yes, re-underwriting should be waived if no claims made in a certain period of time (say, three years) immediately before policy transfer	Yes ⁴ , re-underwriting should be waived if no claims made in a certain period of time (say, three years) immediately before policy transfer	Not regulated
(B) Quality of insurance protection			
(6) Coverage of hospitalisation and prescribed ambulatory procedures	Yes	Yes, may offer benefits above prescribed benefit coverage	Not applicable

4 The new insurer (i.e. the insurer to whom the policyholder is transferring his/her policy to) must at least offer a Standard Plan as one of the options for the policyholder. The new insurer may offer Flexi Plans to the policyholder in addition to the Standard Plan.

Product Design Requirements	Standard Plan	Flexi Plan	Top-up Plan
(B) Quality of insurance protection			
(7) Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments	Yes	Yes, may offer benefits above prescribed benefit coverage	Not applicable
(8) Minimum benefit limits	Yes	Yes, may offer benefits above prescribed benefit limits	Not applicable
(9) Cost-sharing restrictions	30% co-insurance fixed for prescribed advanced diagnostic imaging tests No deductible and other co-insurance allowed Annual cap of \$30,000 on expenses by policyholder on co-insurance	Deductible and co-insurance allowed and not regulated Annual cap of \$30,000 on expenses by policyholder on deductible and co-insurance	Not regulated
(C) Transparency and certainty			
(10) Budget certainty	Yes	Yes	Not regulated
(11) Standardised policy terms and conditions	Yes	Yes	Not regulated
(12) Premium transparency	Yes	Yes	Not regulated

OTHER PRODUCT DESIGN ISSUES

Savings

3.26. In order to encourage policyholders to stay insured continuously and to enhance premium affordability at older age, the Second Stage Public Consultation on Healthcare Reform (Second Stage Consultation) proposed the option of building in a savings component in Health Protection Scheme (HPS) plans where the savings would be used for paying future premiums. Nevertheless, the outcomes of the Second Stage Consultation revealed that there was considerable reservation within the community against inclusion of compulsory savings component as an essential part of the HPS. In particular, the public raised concern over the inflexible use of savings only for paying future premium. Some considered that a mandatory savings component would make HPS plans less attractive and discourage people from enrolling. Others raised questions on the administration costs of the savings account, and whether the savings accrued could generate sufficient return over time to finance the future premiums.

3.27. Apart from public views on this issue, it is worth noting that the circumstances in Hong Kong and overseas countries are different. Generally speaking, medical savings accounts are more relevant in countries with high taxes on investment earnings and interests from savings, such as the United States, where people are more willing to accept the restrictions on the use of funds in the medical savings accounts in return for tax incentives provided by the Government. Given there is no tax payable on investment and interest income of individuals in Hong Kong, and that Hong Kong people are culturally more accustomed towards personal savings, we consider it more appropriate for the savings component to be an optional product feature offered through Top-up Plans, rather than a mandatory feature of compliant products under the Minimum Requirements.

No-claim Discount

3.28. The Second Stage Consultation proposed that insurers would be required to offer no-claim discount for HPS plans to policyholders who have not made claims over a period of time. However, there were divergent views in the community regarding the proposal. Although some agreed that no-claim discount might attract more lower-risk individuals and young people to join the HPS, others pointed out that no-claim discount might have the unintended effect of discouraging policyholders from seeking necessary treatments. Taking into account the above, we propose not to include no-claim discount as a Minimum Requirement. Yet to allow for market flexibility, insurers may provide no-claim discounts to policyholders as an optional feature under Flexi Plans.

Utilisation and Cost Control

3.29. Control of utilisation and medical cost would be a key factor in ensuring the long-term viability and sustainability of the VHIS. We have proposed under the Minimum Requirements a number of measures aiming to bring utilisation and medical costs under better control, which in turn would help keep premium levels under better check. They are recapped below –

- (a) the setting of packaged benefit limits for prescribed ambulatory procedures, prescribed advanced diagnostic imaging tests, and non-surgical cancer treatments according to price levels in ambulatory setting. This would discourage unnecessary overnight hospital stay and help control medical costs;
- (b) a fixed 30% co-insurance rate for prescribed advanced diagnostic imaging tests to combat moral hazard and control utilisation growth due to abuse;
- (c) the “no-gap/known-gap” arrangement, packaged benefit structure and Informed Financial Consent would enhance price transparency and budget certainty for consumers and insurers; and
- (d) enhanced transparency of premiums and comparability of VHIS compliant products would foster market competition and help keep premium levels under better check.

3.30. Although the VHIS is designed to focus primarily on hospital services, primary care would have an important role in ensuring that healthcare resources are judiciously used for those genuinely in need. Appropriate involvement of primary care providers could be an effective check against utilisation of private healthcare services induced by moral hazard under the VHIS. Effective primary care can often improve the health of individuals in the community; reduce their need for more expensive medical services, especially specialist and hospital services; and help ensure continuity and coordination of care. With more effective healthcare utilisation, the claims cost of health insurance could be better controlled, which would help keep the premium levels under better check and help contain medical costs.

3.31. In this connection, the Food and Health Bureau has been taking forward a number of policy initiatives to strengthen primary care, promote prevention and early identification of disease, including starting a pilot programme to subsidise colorectal cancer screening for higher-risk groups; enhancing and turning the Elderly Health Care Voucher Pilot Scheme and Outreach Primary Dental Care Services for the Elderly in Residential Care Homes and Day Care Centres into recurrent support programmes; and exploring the feasibility of setting up an Integrated Elderly Centre on a pilot basis to provide one-stop, multi-disciplinary healthcare and social services for the elderly at the community level.

CHAPTER 4 PUBLIC FUNDING

PRINCIPLES FOR USE OF PUBLIC FUNDING

4.1. When considering whether public funding is called for and weighing options available for supporting the implementation of the Voluntary Health Insurance Scheme (VHIS), we deliberate and reach our recommendations having regard to the following principles –

- (a) the use of public funding should directly contribute to the achievement of the objectives of the VHIS, namely providing value-for-money services to those who are willing and can afford to use private healthcare services;
- (b) the use of public funding should contribute to the implementation of Minimum Requirements, including those that are socially desirable yet have cost implications, such as guaranteed acceptance with premium loading cap;
- (c) the use of public funding should encourage behavioural changes that would enhance the sustainability of the VHIS, such as encouraging individuals to take out health insurance when young and healthy; and
- (d) the use of public funding should be considered on the basis of prudent and reasonable use of public money. Any provision of public subsidy or financial incentives should be weighed against administration cost and non-financial alternatives, such as regulatory means.

4.2. With the above principles in mind, we have examined the provision of public funding in the following areas for supporting the implementation of the VHIS.

FUNDING SUPPORT FOR THE HIGH RISK POOL (HRP)

4.3. During the Second Stage Public Consultation on Healthcare Reform (Second Stage Consultation), one of the major misgivings expressed by the community is that high-risk individuals have significant difficulties in purchasing Hospital Insurance even if they are willing to do so. Currently, it is not uncommon for insurers to decline Hospital Insurance applications by individuals with pre-existing conditions or those with higher health risks (e.g. those with diabetes or suffering from stroke or heart attack, etc.). Where their applications are accepted, case-based exclusion clauses would be imposed so that claims arising from pre-existing conditions, directly or indirectly, would be excluded from coverage. Exclusion clauses are often the source of disputes. There are no standardised wordings with consensual meaning for these clauses across the industry. Nor is there uniform interpretation over such clauses, which are often expressed in highly technical and legal terminologies. Insurers can also charge, as they deem appropriate, premium loading at a rate commensurate with the risk being taken on.

Premium loading, if set at a prohibitive level, would have the effect of deterring high-risk individuals from seeking Hospital Insurance cover.

4.4. To meet the community's aspirations to enable high-risk individuals to purchase Hospital Insurance, we propose to require under the Minimum Requirements that insurers must provide to consumers a Standard Plan with guaranteed acceptance with premium loading cap of 200% of standard premium for –

- (a) all ages within the first year of implementation of the VHIS; and
- (b) those aged 40 or below starting from the second year of implementation of the VHIS.

In addition, insurers are also required to provide coverage for pre-existing conditions subject to a standard waiting period (please refer to paragraph 2.24 in Chapter 2).

4.5. Given the above requirements, we recognise that insurers might not be able to collect adequate premiums commensurate with the risks taken on for cases which the insurers have to charge a premium loading more than 200% of standard premium. Without proper mitigating measures, insurers may have to assimilate the excessive risks among their policyholders by charging higher standard premiums across the board. Since the VHIS is a voluntary system, the higher standard premiums would have the effect of discouraging potential customers from taking out Hospital Insurance, especially those healthier individuals. This will go against the objective of the VHIS to encourage and facilitate take out of Hospital Insurance.

HRP

4.6. To ensure that high-risk individuals can also buy Hospital Insurance, we proposed in the Second Stage Consultation to set up an industry-operated HRP to accept policies of the Health Protection Scheme (HPS) Standard Plan of high-risk individuals which insurers would have to charge a premium loading at or more than 200% of standard premium. Under this approach, policies of Standard Plan of these high-risk individuals would be transferred to the HRP, which is a separate pool from the “normal” pools consisting of other non-high-risk policyholders. All premiums payable, claims and liabilities of the policies of the high-risk individuals would be accrued to the HRP, and any shortfall would be met by Government funding. In this way, the premiums for non-high-risk policyholders in the “normal” pools would not be affected by the excess risks being taken on to provide Hospital Insurance coverage to high-risk individuals.

The United States’ experience in operating high risk pools

Under the healthcare reform in the United States (Patient Protection and Affordable Care Act), individuals are required to obtain private health insurance (PHI) coverage starting from 2014. Insurers are required to accept all enrollees, and are prohibited from varying premium by enrollee due to difference in health conditions. Before the healthcare reform, people who were denied access to PHI could only get insured through high risk pools, if available in the states they reside. More than 30 states had experience in running high risk pools, which were special programmes set up by states (e.g. California, Illinois and Texas) to accept enrollment of high-risk people, mainly those with pre-existing conditions. The funding arrangement and operation vary by state. Generally, members of the high risk pools were charged a premium higher than the standard premium for similar plans in the commercial market. The premiums collected, together with state government subsidy or levy on insurers, fund the high risk pools. In the lead-up to 2014, the federal government introduced a short-term programme in 2010, namely the Pre-existing Conditions Insurance Plan (PCIP). The PCIP functioned as a temporary federal high risk pool to accept enrollment of high-risk individuals who were denied access to PHI. With the implementation of the Patient Protection and Affordable Care Act, the state-run high risk pools and PCIP are gradually phased out as the policy goal to provide high-risk people with affordable health insurance cover is now met by cross-subsidy from the healthy to unhealthy insured people through mandatory enrollment, guaranteed acceptance and restriction on premium variation by health condition under the healthcare reform.

4.7. After careful consideration and with the Consultant's advice, we propose to set up a HRP with Government funding so that high-risk individuals can also have access to Hospital Insurance. The HRP will be open to all in the first year upon the implementation of the VHIS and limited to those aged 40 or below thereafter. We propose that the HRP should be established by legislation with the following framework –

- (a) the HRP will be a legal entity, which can enter into contracts, sue and be sued; it will be funded by premium income and Government funding;
- (b) it accepts only Standard Plan high-risk policies¹ transferred by an insurer; despite such transfer, the policy remains as a contract between the policyholder and the insurer who underwrites and issues the policy;
- (c) the insurer will administer the policy and receive an administration fee payable by the HRP;
- (d) in the course of administration, the insurer shall separate a portfolio for the high-risk policies from other policies with a view to ensuring that underwriting of risks of non-high-risk individuals will not be adversely affected;
- (e) all premiums payable and claims and liabilities under the policy will be accrued to the HRP;
- (f) the HRP may contract out its day-to-day operation to a claims specialist;
- (g) the policyholder shall pay the premium with a premium loading at 200% of the standard premium prescribed by the insurer;
- (h) the HRP will be monitored by the regulatory agency provided in Chapter 6; and
- (i) the insurer is expected to transfer a high-risk policy underwritten by it to the HRP upon the policy inception. The HRP will not subsequently accept any high-risk policy not so transferred and the insurer cannot later on request the HRP to accept any high-risk policy for reason of increasing health risk of the insured or otherwise. If it chooses not to transfer it to the HRP at the policy inception, while it may receive the premium payable (subject to the cap), it will have to bear the claims and liabilities of the policy until the expiry or termination without the benefit of the HRP.

¹ A high-risk policy refers to one of which an insurer will charge a premium loading at or more than 200% of its standard premium.

There has been a concern that insurers might mark up the premium loading rate in order to pass on the policies of higher-risk individuals to the HRP, thus affecting the financial sustainability of the Pool. We consider this scenario unlikely. This is because as long as insurers can charge a premium loading rate commensurate with the extra risks that they take on, they can still expect to have an underwriting profit by keeping the policies of higher-risk individuals under their own portfolio. In such case, it is in the interest of insurers to charge an appropriate premium loading rate corresponding to the risks that they are taking on, rather than marking up the premium loading rate for the sake of transferring the policies to the HRP. In addition, as all insurers offering individual Hospital Insurance will be required to provide Standard Plan as an option to the consumer, it would not be in the interest of an insurer to mark up the premium loading rate due to price competition, given that the consumer can compare offers from other insurers of Standard Plan.

In the unlikely event that an insurer marks up the premium loading rate of a policy of a higher-risk individual, it would not be detrimental to the financial condition of the HRP because the premium collected should be more than sufficient for covering the expected claims pay-out.

Financing of HRP

4.8. In the Second Stage Consultation, it was proposed that the HRP would be financed by premium income of the policies transferred to the Pool, and a reinsurance levy to be paid by insurers. Government funding would be considered if the HRP cannot be self-sustaining. After careful consideration of the views received in the Second Stage Consultation, we propose not to impose the reinsurance levy because the cost of such levy would likely be passed onto the policyholders through increasing the premiums for all policyholders. This is not in keeping with the objective of the VHIS to encourage and facilitate take out of Hospital Insurance. It might also cause existing policyholders to drop their Hospital Insurance cover.

4.9. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the VHIS's goal to improve access to Hospital Insurance. We consider it reasonable and justifiable for the Government to use public funds to support the HRP in lieu of the reinsurance levy. Without the HRP, many high-risk individuals would likely fall back on public healthcare services, which are highly subsidised by the Government². As such, it would be equitable to provide public funding support to enable these high-risk individuals to purchase Hospital Insurance, given

² The Hospital Authority's services are highly subsidised by the Government. For example, patients are only charged \$100 per day for in-patient (general acute beds) service, the subsidy rate of which is about 98%.

that they are willing to contribute to their own healthcare costs through insurance premium, and out-of-pocket expenses for using private healthcare services. Enabling some of the high-risk individuals to obtain Hospital Insurance coverage through the HRP not just offers them a choice to use private healthcare services, but also enables the public healthcare system to better focus its resources on serving its target areas.

Fiscal Implications for the Government

4.10. Taking into account both international and local market experiences, the Consultant estimates that³ the total cost to be borne by the Government for financing the HRP would be about \$4.3 billion (in 2012 constant prices) for a period of 25 years (2016 to 2040). **Table 4.1** sets out the estimated fiscal implications of the HRP to the Government for a period of 25 years (2016 to 2040) as provided by the Consultant.

Table 4.1 Estimated Fiscal Implications of the HRP for the Government (Cumulative Figures for 25-Year Period (2016 to 2040)(in 2012 Constant Prices))

(a) Claims cost (cost factor=6x)		\$ 15.8 billion
(b) Administration cost (12.5% of claims cost)	+	\$ 2.0 billion
Total cost for HRP's operation [(a)+(b)]	=	\$ 17.8 billion
(c) Premiums collected (3x standard premium)	-	\$ 13.5 billion
Required funding [(a)+(b)-(c)]	=	\$ 4.3 billion
Average number of HRP members per annum		23 980
Total cost for HRP's operation per HRP member per annum⁴	\$	29,700
Required funding per HRP member per annum⁵	\$	7,200

3 The scenario presented here refers to the one with medium impact within the range of scenarios projected by the Consultant.

4 This figure is obtained by dividing the average annual cost for the HRP's operation from 2016 to 2040 (\$17.8 billion/25 years = \$712 million) by average number of HRP members per annum during this period (i.e. 23 980).

5 This figure is obtained by dividing the average annual funding requirement for HRP from 2016 to 2040 (\$4.3 billion/25 years = \$172 million) by average number of HRP members per annum during this period (i.e. 23 980).

- 4.11. The estimations are worked out based on the following key assumptions –
- (a) guaranteed acceptance is applied to all ages within the first year of implementation of the VHIS (assuming 2016 for planning purpose), and those aged 40 or below starting from the second year onwards;
 - (b) coverage of pre-existing conditions subject to a standard waiting period and partial reimbursement arrangement in the initial years as below –
 - (i) first year – no coverage
 - (ii) second year – 25% reimbursement
 - (iii) third year – 50% reimbursement
 - (iv) fourth year onwards – full coverage
 - (c) premium loading is capped at 200% of standard premium;
 - (d) claims cost of a policyholder in the HRP is six times⁶ (i.e. cost factor) that of an average standard-risk policyholder; and
 - (e) administration cost for operating the HRP (including management costs, claims management and nominal administration fee for insurers) is 12.5% of total claims cost⁷.

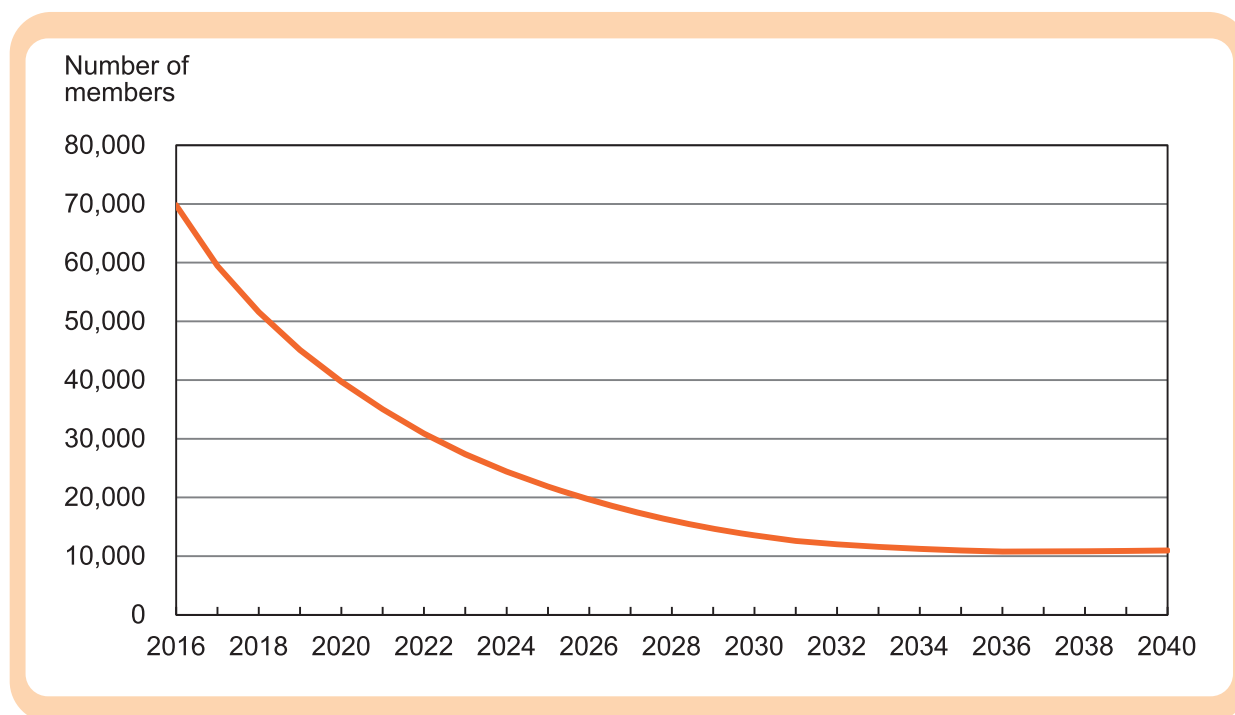
6 The six times cost factor is assumed on the basis of claims data from the Hong Kong Federation of Insurers and the United States' experience in the Pre-existing Conditions Insurance Plan, which was broadly similar to the proposed HRP in terms of operation mode –

- in terms of local claims experience, the Consultant assumed the top 2% of policyholders to be of high-risk, 18% of policyholders of non-standard risk and 80% of policyholders of standard-risk. The high-risk policyholders had a claims cost of about six times that of the standard-risk policyholders; and
- experience in the United States revealed that high-risk claimants could have claims costs of up to ten times that of non-high-risk claimants. It should however be noted that the claims cost is likely to be much higher in the United States than in Hong Kong due to substantial differences between the two healthcare systems. In particular, the absence of a robust public healthcare system in the United States, and the greater readiness of their private hospitals to handle complex cases mean that the claims cost in the United States would likely be higher than that of the proposed HRP. Moreover, in the case of the United States, there is no waiting period for people with pre-existing conditions, which would also mean that the claims cost in the United States would likely be higher than that of the proposed HRP.

7 In deciding on the assumption of administration cost for operating the HRP, the Consultant drew reference from a number of insurance schemes or market segments that bear a certain degree of similarity with the proposed HRP. An example is the Pre-existing Condition Insurance Plan of the United States, which likewise only accepted high-risk lives. It was non-profit-making in nature and incurred an administration cost at about 9% of total claims cost. Given that the proposed HRP would count on specialised managers to manage claims, the cost profiles of local and overseas healthcare network provider markets also provide useful references. For instance, the Consultant estimated that the administration cost roughly equals to 8-10% of total claims cost in the network provider market of Hong Kong, and 8-12% in the market for health maintenance organisations in the United States. Since the proposed HRP would be akin to a group insurance scheme, the Consultant also considered the experience of the group health insurance market in Hong Kong, where according to the Consultant the administration cost was roughly about 20% of total claims cost.

4.12. In essence, the funding requirement for the HRP is equivalent to the excess of operating costs (claims cost and administration cost) over the premiums. Accounting for almost 90% of operating costs, the claims cost is the major cost factor which hinges on the size of HRP membership and the claims cost per head. Based on the assumption that guaranteed acceptance is only applied to those aged 40 or below starting from the second year of implementation of the VHIS, and having regard to the health profile of those with Hospital Insurance cover, the Consultant estimates that the membership of the HRP would be around 69 800 in 2016 (about 3.6% of total population⁸ covered by individual Hospital Insurance). In the long-term, the membership of the HRP is expected to decline because only those aged 40 or below would be accepted to the HRP starting from the second year of implementation of the VHIS. The membership of the HRP is estimated to drop over time to about 10 900 in 2040 (about 0.5% of total population covered by individual Hospital Insurance). **Figure 4.1** shows the projected membership of the HRP from 2016 to 2040.

Figure 4.1 Projected Membership of the HRP (2016 to 2040)

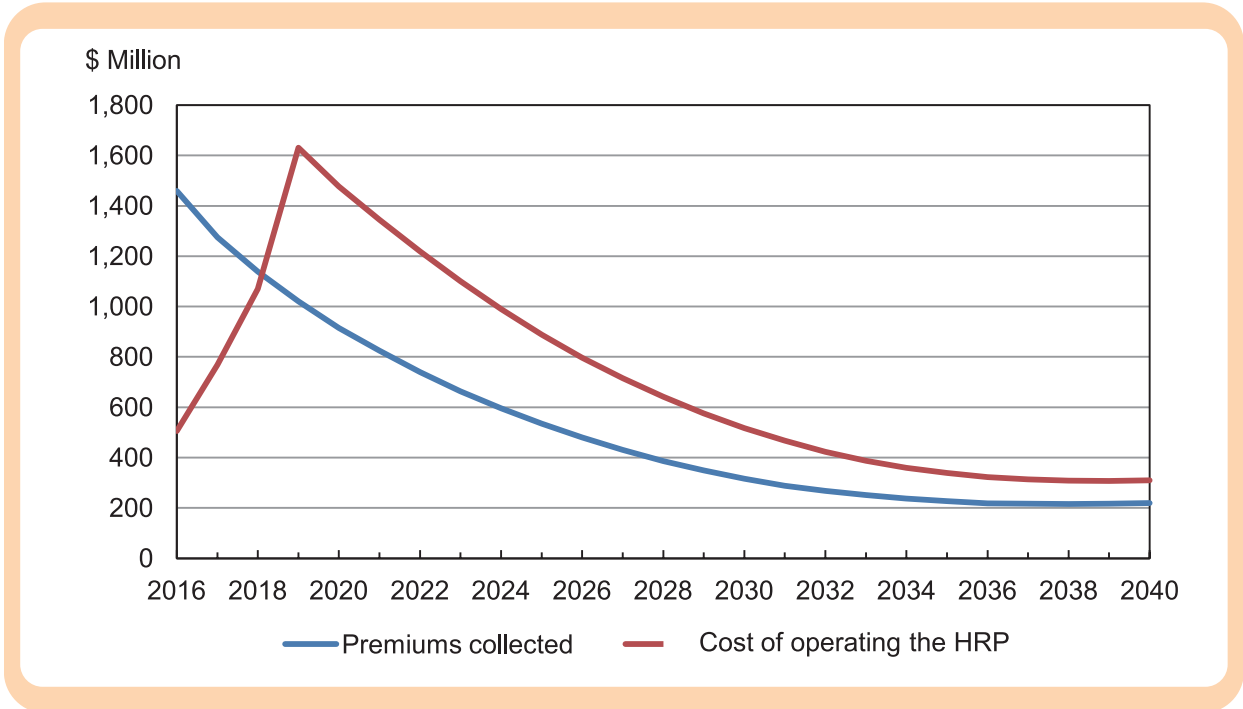


Note : The average number of HRP members per annum from 2016 to 2040 is 23 980.

8 Based on the results of the Thematic Household Survey conducted by the Census and Statistics Department, the Consultant projected the population coverage from 2016 to 2040 under the baseline scenario (i.e. without the VHIS) by taking into account influencing factors such as population ageing and medical inflation. The Consultant then further projected the population coverage from 2016 to 2040 under the forecast scenario (i.e. with the VHIS) by considering additional influencing factors that the VHIS entails, including guaranteed acceptance, benefit coverage, premium change, tax incentive, etc.

4.13. As regards the claims cost per head, HRP members will very likely entail higher claims cost than standard-risk policyholders paying standard premiums. Based on local and overseas experiences, the Consultant considers it reasonable to assume that the average claims cost of an HRP member is six times that of a standard-risk policyholder. Although the average annual claims cost of HRP members is expected to trend upward alongside medical inflation (assumed to be 3.1 percentage points over annual general inflation rate), the total claims cost for the HRP is expected to trend downward in the long term due to the predominant impact of a declining membership of the HRP, with the total cost settling at around \$310 million per annum by 2040 (Figure 4.2).

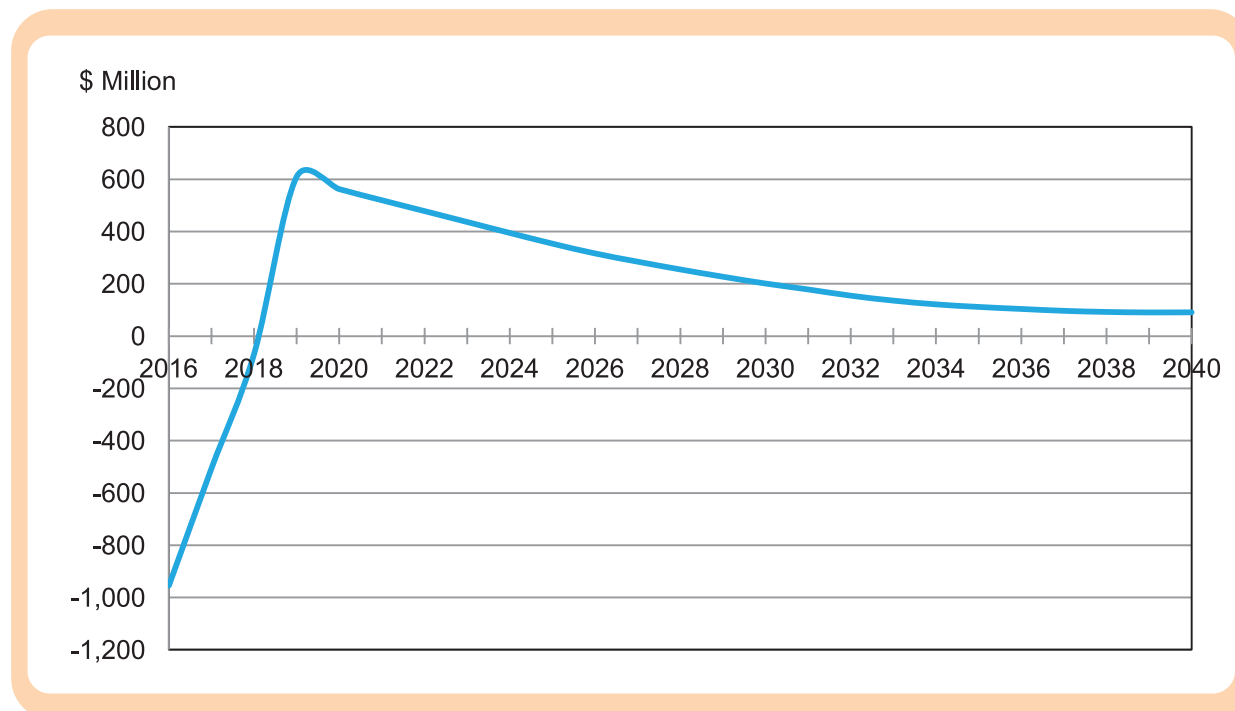
Figure 4.2 Annual Total Premiums Collected and Annual Total Cost of Operating the HRP (in 2012 Constant Prices)



4.14. There would be a spurt in claims cost during the first few years of VHIS implementation due to a large inflow of new joiners in the first year of implementation of the VHIS, although the effect will be partly offset by the three-year standard waiting period for pre-existing conditions. The restraining impact of waiting period on claims cost is poised to subside as these new joiners will have served the waiting period fully after the first three years and treatment costs relating to their pre-existing conditions will become fully claimable. On the premium side, by virtue of the premium loading cap, the premium income for the HRP will be equivalent to three times standard premiums of Standard Plan paid by HRP members. Although the average premium of VHIS is projected to trend upward due to medical inflation, the total premium income for HRP would trend downward due to the predominating impact of a declining HRP membership. The total premium income would settle at around \$219 million per annum by 2040.

4.15. Due to the restraining impact of waiting period on claims cost in the first few years of VHIS implementation, the HRP is expected to have a surplus position till 2018, and the cumulative surplus would defer the requirement of Government funding until 2021 onwards. As the total costs and premiums are expected to likewise stabilise in the long-term, the funding requirement is projected to settle at around \$91 million per annum by 2040 (**Figure 4.3**). The Food and Health Bureau will review and consider in due course the funding arrangements for the HRP beyond 2040 having regard to the operational experience.

Figure 4.3 Estimated Annual Cost of the HRP to Government (in 2012 Constant Prices)



An alternative scenario is that only those with very serious health conditions would join the HRP as in the case of the United States. Under this scenario, the number of HRP members is crudely assumed to be one-fifth of the HRP members in the forecast scenario, i.e. only 0.7% (instead of 3.6% assumed in the forecast scenario) of total population covered by individual Hospital Insurance in 2016. The cost factor of HRP members increases to ten times (instead of six times under the forecast scenario). Under this scenario, the total cumulative cost to Government over 25 years (2016 to 2040) would be \$3.0 billion (in 2012 constant prices).

A higher age limit for guaranteed acceptance with premium loading cap would also have a bearing on the amount of public funding required for supporting the HRP. It would increase the number of people entering the HRP in older ages, who would likely have health conditions and have a higher claims cost. An indicative estimate of the impact of the age limit is shown at **Table 4.2**.

Table 4.2 Estimated Cost to Government for Operating the HRP (Cumulative Figures for 25-Year Period (2016 to 2040)(in 2012 Constant Prices)) under Different Age Limit Scenarios

Age limit for guaranteed acceptance with premium loading cap starting from the second year of VHIS implementation	45	50	55	60	65
Estimated cost to Government	\$4.6 billion	\$5.3 billion	\$6.4 billion	\$8.0 billion	\$11.9 billion

A lower guaranteed acceptance age limit has the advantage of encouraging more people to enroll in the VHIS when they are young and healthy. At a young age, a person is more likely to be healthy and thus may be able to lock in an underwriting class which attracts a lower premium. The person can maintain the same underwriting class without re-underwriting even when he/she develops health conditions at a later age. In comparison, with a higher guaranteed acceptance age limit, a person would likely enroll in the VHIS at an older age when he/she may have already developed health conditions. The person would then need to pay a higher premium than otherwise if he/she enrolls in the VHIS earlier.

For those who choose to enroll in the VHIS after the guaranteed acceptance age limit of 40 is introduced from the second year of implementation, they can still enjoy all the benefits of Standard Plan except for guaranteed acceptance and premium loading cap, such as guaranteed renewal, coverage of pre-existing conditions and standardised policy terms and conditions.

4.16. Given that public funding would be required for supporting the HRP, we propose that only Standard Plan policies would be accepted to the HRP. Furthermore, we propose to follow the eligibility criteria adopted by the Hospital Authority and Department of Health for charging for public healthcare services at subsidised rate, i.e. only Standard Plan policies of the following types of persons (Eligible Persons) would be eligible for admission to the HRP, namely –

- (a) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Cap. 177); and
- (b) children who are Hong Kong residents and under 11 years of age.

Care Management

4.17. According to the Consultant, the cost of operating the HRP will be under better control if there are effective measures to promote better awareness of healthy lifestyle and encourage active care management. In this connection, we propose introducing care management programmes for HRP members, such as wellness programmes to induce behavioural changes and to promote greater health consciousness. Wellness programmes are a set of activities designed to proactively assist its members in making voluntary behavioural changes that improve their health and well-being. A wellness programme usually comprises gathering health information from members, developing education and intervention programmes to address identified risk factors, and possibly providing incentives to reward good performance. Overseas experience suggests that such types of care management programmes could drive better chronic disease management, thus achieving greater efficiency and better health outcomes.

According to the study by the Consultant, the experience of Organisation for Economic Co-operation and Development indicates that driving better chronic disease management is an important way in achieving more efficient and better health outcomes. Investments in early interventions and better chronic disease management can reduce avoidable hospitalisations and minimise the need for long in-patient stays. According to World Health Organisation (2011), a large percentage of chronic diseases are preventable through the reduction of major behavioural risk factors, including tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet. Wellness programmes, together with integrated care, can help prevent and encourage self-management of chronic diseases. A typical programme employs a multidisciplinary care team, including doctors, nurses, dieticians, etc. to educate and help individuals manage their chronic conditions. In the United States, for instance, disease management programmes such as home visits, counselling, medication compliance, etc., had resulted in significant reduction in hospitalisation and healthcare service use by patients with chronic diseases like diabetes, asthma or congestive heart failure.

4.18. The cost of implementing care management programmes will form part of the cost of running the HRP and is subsumed in the calculation of the fiscal estimations for the HRP. The Consultant estimated that, in the absence of effective care management, the cost factor of HRP members would be seven times, instead of the currently assumed six times that of an average standard-risk policyholder (i.e. an extra claims cost of about \$100 million per annum on average in 2012 constant prices).

FINANCIAL INCENTIVES

4.19. In order to achieve the objectives of the VHIS, it is necessary to start off and maintain a scale of subscription in order to operate the VHIS efficiently and generate material impact on the healthcare system. During the Second Stage Consultation, we have examined the pros and cons of various financial incentives to promote early take out of Hospital Insurance and encourage savings by policyholders. The options included offering tax incentive or premium discount for new joiners through a no-claim discount; and government incentives to encourage savings by policyholders. There were divergent views over these options, including whether it is appropriate to offer financial incentives to encourage purchase of Health Protection Scheme (HPS) plans or savings plans, as well as the feasibility and desirability of various financial incentive options.

4.20. After further consideration, we have come to the view that there is no perfect form of financial incentive to encourage take out of Hospital Insurance as different options have their own pros and cons, and that the decision to use public money to encourage consumer behaviors presents both opportunities and risks that warrant prudent consideration in deciding the mode and scale of the financial incentives to be offered.

Tax Deduction to Encourage Take Out of Hospital Insurance

4.21. Taking into account the views and suggestions received during and subsequent to the Second Stage Consultation, we have further considered the option of providing financial incentives for the VHIS in the form of tax deduction for the following reasons.

4.22. First, from the perspective of the consumer, tax deduction is simple and easy to understand. Continuous in nature, tax deduction has the merit of attracting people to stay insured over a long period of time. We also note that there have been considerable discussions in the community proposing tax deduction to encourage take out of Hospital Insurance.

4.23. Second, compared with other forms of financial incentives, such as direct premium subsidy or discount, tax deduction is less susceptible to abuse. Direct premium subsidy or discount would provide an incentive for some insurers to mark up the premiums of VHIS plans, thus effectively pocketing a significant portion of the premium subsidy or discount. In comparison, tax deduction would be less easily subject to abuse because the exact amount of tax deduction claimable by individual taxpayers would depend on their net chargeable income, which insurers would have insufficient knowledge or control over.

4.24. Third, tax deduction is relatively simple and easy to implement as there is already an established mechanism to do so. In fact, tax deduction is a common form of encouraging purchase of PHI in overseas countries.

Tax incentive for purchasing PHI and penalties for not taking up PHI exist in many overseas countries. For instance, in Germany and Ireland, premiums are eligible for tax deduction or tax subsidy. In Australia, people with high incomes pay a tax penalty if they do not have PHI coverage.

4.25. In comparison, the option of providing direct premium discount or subsidy to encourage purchase of VHIS plans would be more difficult to implement in practice. Considerable debate in the community would be needed to determine the eligibility for and rate of the premium discount or subsidy, such as whether the discount or rebate rate should be means-tested, or determined by entry age or length of subscription; whether breaks in-between subscriptions are allowed, etc. Moreover, unlike tax deduction where there is already an established mechanism, direct premium discount or subsidy requires a new administration system to deal with reporting, verification, release of subsidy, monitoring and investigation against fraudulence, etc., and hence resulting in a higher administration cost that will undermine the cost-effectiveness of the incentive measure.

4.26. With the above considerations, we propose to **introduce tax deduction for premiums paid for –**

- (a) individual Hospital Insurance policies that meet or exceed the Minimum Requirements, including policies of Standard Plan and Flexi Plans. Since Top-up Plans are not compliant products, the portion of premiums paid for the Top-up Plans would not be eligible for tax deduction. Nevertheless, consumers who purchase a Standard Plan or Flexi Plan with a Top-up Plan may claim tax deduction for the portion of premiums paid for the Standard Plan or Flexi Plan; and/or
- (b) premiums paid for Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies.

4.27. To broaden the scope of beneficiary to tax deduction, we propose that a person (i.e. taxpayer) may claim tax deduction on his/her own policy and his/her dependants⁹ policies; the tax deduction will be provided on a per person insured basis and the claims for tax deductions for dependants' policies should be capped at, say, no more than three dependants per taxpayer. The following examples demonstrate, for pure illustration purposes, how taxpayers can benefit from the proposed tax deduction.

9 The definition of dependants should be aligned with that of the existing tax code for claiming tax allowance, i.e. spouse, child, dependent parent, dependent grandparent, dependent brother or sister, etc.

Assumptions:

- The illustrative premiums paid shown in the examples below refer to the standard premiums of Standard Plan for the respective age-band, as estimated by the Consultant, in year 2012 and in 2012 constant prices.
- The annual ceiling on claimable premiums is \$3,600¹⁰ per person insured.
- The amount claimed falls within the highest tax band with a tax rate of 17%.

Example 4.1 A Taxpayer of Standard Risk Covered by a Standard Plan Policy

	Premium Paid	Premium Claimable for Tax Deduction
Taxpayer (aged 30)	\$ 2,200	\$ 2,200
Maximum annual savings on tax		\$ 374 (\$2,200 x 17%)

Example 4.2 A Taxpayer with One Dependent Spouse and One Dependent Parent, Each of Standard Risk Covered by a Standard Plan Policy

	Premium Paid	Premium Claimable for Tax Deduction
Taxpayer (aged 45)	\$ 4,750	\$ 3,600
Dependent spouse (aged 40)	\$ 3,300	\$ 3,300
Dependent parent (aged 68)	\$ 8,600	\$ 3,600
Total	\$ 16,650	\$ 10,500
Maximum annual savings on tax		\$ 1,785 (\$10,500 x 17%)

¹⁰ This illustrative figure refers to the average standard premium of Standard Plan as estimated by the Consultant, which is \$3,600 in year 2012 and in 2012 constant prices.

Example 4.3 A Taxpayer of Standard Risk Covered by a Flexi Plan Policy and a Top-up Plan Policy

	Premium Paid	Premium Claimable for Tax Deduction
Taxpayer (aged 30)		
- Flexi Plan	\$ 3,400	\$ 3,400
- Top-up Plan	\$ 1,000	\$ 0
Total	\$ 4,400	\$ 3,400
Maximum annual savings on tax		\$ 578 (\$3,400 x 17%)

4.28. For avoidance of doubt, we propose that the tax deduction should not apply to premiums paid for the following types of policy –

- (a) a Hospital Insurance policy that does not meet the Minimum Requirements, including a grandfathered policy (please refer to Chapter 5 for the proposed grandfathering arrangements). The purpose is to encourage early migration of grandfathered policies to those that comply with the Minimum Requirements; or
- (b) a non-Hospital Insurance policy, such as an out-patient only policy, hospital cash policy or critical illness policy. This is because the purchase of such policies does not necessarily contribute to achieving the objective of the VHIS. For out-patient services, the majority of demand is currently being met by the private sector; and the purchase of out-patient only policies may not necessarily contribute much to relieving the pressure on the public system. For hospital cash or critical illness policies, the pay-out of insurance benefit for these policies is not tied to spending on hospital care, and therefore does not necessarily pertain to health protection of the policyholder.

4.29. To demonstrate for pure illustration purposes how the tax revenue and taxpayers would be affected by the proposal, by capping the annual level of claimable premiums at \$3,600 (i.e. the average standard premium of Standard Plan in 2012 and in 2012 constant prices) per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone is estimated to be \$256 million (in 2012 constant prices) in year 2016¹¹, and the average tax benefit per eligible taxpayer would be about \$450.

¹¹ Assuming that both the VHIS and tax deduction would be implemented in 2016.

Incentives for Savings

4.30. Compared with tax deduction, the option of encouraging savings by policyholders has the advantages of encouraging long-term subscription after retirement and relieving the premium burden at older age. Nevertheless, as explained in paragraphs 3.26 to 3.27 in Chapter 3, the Second Stage Consultation revealed considerable reservations within the community against inclusion of compulsory savings component under the HPS, and we consider it more appropriate for the savings component to be an optional feature rather than a mandatory requirement. As the savings component is voluntary, the provision of incentives for savings may end up benefiting only a limited group of policyholders who are willing to incorporate a savings component in their VHIS plans, including those who are already saving or already prepared to save. This may not be an effective use of public money and hence not recommended for adoption.

NON-FINANCIAL INCENTIVES

4.31. The provision of financial incentives is not the only measure that can promote Hospital Insurance uptake or encourage long-term subscription. In fact, regulatory means can achieve the same objective by increasing consumer confidence. A combination of regulatory incentives and financial incentives can generate a more desirable effect than relying on financial incentives alone.

4.32. The Minimum Requirements currently proposed are a kind of regulatory incentive that can boost consumer confidence in taking out Hospital Insurance, as they would enhance the accessibility, continuity, quality and transparency of insurance protection for consumers. The proposed requirement of guaranteed acceptance with premium loading cap, and coverage of pre-existing conditions would enable and encourage more people to take out Hospital Insurance. The requirement of guaranteed renewal would better enable policyholders to stay insured continuously into old age; and the prohibition of re-underwriting during policy renewal would ensure that a policyholder who develops health conditions after joining the VHIS can enjoy a more affordable premium in his/her old age.

4.33. When implementing the VHIS, we will also organise educational and promotional activities to enhance public understanding of the VHIS and to encourage early subscription to VHIS products.

CHAPTER 5 MIGRATION ARRANGEMENTS

5.1. Upon the implementation of the Voluntary Health Insurance Scheme (VHIS), an insurer must comply with the Minimum Requirements in selling and/or effecting individual Hospital Insurance, and they will not be allowed to offer to consumers individual Hospital Insurance products that do not comply with the Minimum Requirements.

5.2. To facilitate the migration of existing individual Hospital Insurance policies to policies that comply with the Minimum Requirements, we propose to put in place the migration arrangements as explained in ensuing paragraphs.

MIGRATION OF EXISTING INDIVIDUAL HOSPITAL INSURANCE POLICIES

Principles

5.3. In formulating the migration arrangements for existing individual Hospital Insurance policies, we have given due regard to the following considerations. The migration arrangements should –

- (a) have the effect of encouraging policyholders to migrate their existing policies to a compliant policy;
- (b) be clear and simple in order to minimise administrative work and to facilitate smooth migration by policyholders to compliant policies; and
- (c) be fair to both policyholders and insurers, so as to balance between consumer choice and protection on one hand, and commercial viability of compliant products on the other hand.

Migration Window Period

5.4. We propose that, where the expiry of the existing individual Hospital Insurance policies falls within the first year of implementation of the VHIS, insurers are required to, upon such expiry, offer an option to policyholders concerned to migrate to an individual Hospital Insurance policy that meets or exceeds the Minimum Requirements. This one-year period is called “migration window period”. Policyholders will have the option of migrating to compliant policies or renewing their existing policies (please refer to paragraphs 5.10 to 5.11 below for arrangements for policyholders who choose to renew their existing policies).

5.5. Since individual Hospital Insurance policies are renewed annually, we consider a migration window period of one year appropriate and convenient to both policyholders and insurers. Moreover, we are of the view that the window period should not be too long in order to encourage early migration to compliant policies. If the migration window period is too long, some policyholders may defer decision to seek better protection from compliant policies only when their health condition deteriorates.

Under the current market practice, health insurance policies are yearly-contracts and are subject to renewal every year. Under the proposed one-year migration window arrangement, existing policyholders would be able to migrate to compliant policies when they renew their policies.

Migration during Window Period

Streamlined Migration for Existing Benefit Coverage and Benefit Limits

5.6. For policyholders choosing to migrate to compliant policies during the migration window period, they should enjoy a “streamlined migration” for the benefit coverage and benefit limits covered under existing policies (existing benefit coverage and benefit limits) –

- (a) insurers are not allowed to re-underwrite policyholders concerned with regard to the existing benefit coverage and benefit limits, irrespective of the claims history of the policyholders. This means that an insurer cannot apply any case-based exclusions that do not exist in the existing policy to the new policy, and the insurer cannot charge a premium loading over and above that (if any) in the existing policy. Only case-based exclusions and the premium loading already in the existing policy are allowed to be carried over to the new policy. If a policyholder wants to remove the case-based exclusions in the existing policy when migrating to the new policy, he/she may choose to do so, subject to the possibility of being re-underwritten and charged a premium loading. If, after re-underwriting, the policyholder decides to keep the case-based exclusions rather than paying the premium loading, he/she may do so; and
- (b) for policyholders choosing to remove case-based exclusions in their existing policies, they may be required to serve the standard waiting period for pre-existing conditions (please refer to paragraph 2.24 in Chapter 2 for details on the proposed standard waiting period for VHIS plans). We propose that the standard waiting period will be counted from the date when the existing policy first started to be in force, i.e. the period that the existing policy has been in force would be counted towards the calculation of the standard waiting period. For example, if the existing policy has

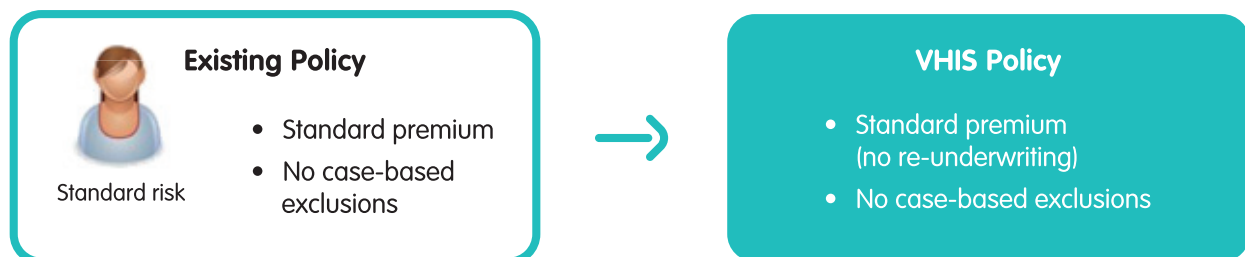
been in force for two years before the migration, the policyholder only needs to serve one year of standard waiting period before the pre-existing conditions excluded in the existing policy is fully covered under the new policy. Health conditions developed after the commencement date of the existing policy should not be treated as pre-existing conditions for the new policy and should be fully covered by the new policy immediately.

Figure 5.1 Streamlined Migration For Existing Benefit Coverage and Benefit Limits during Migration Period

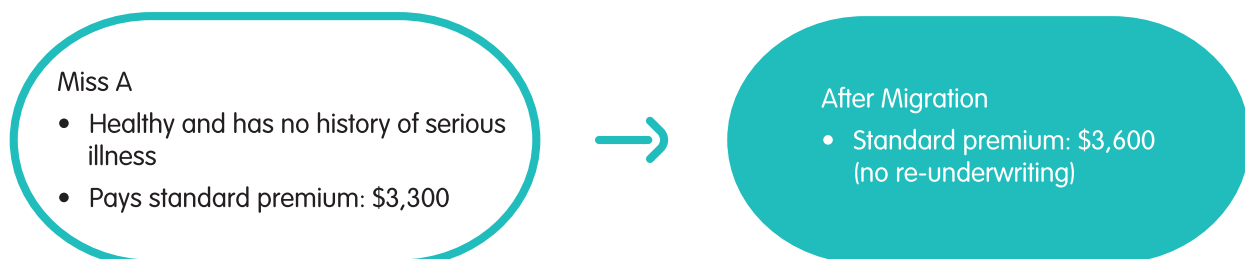
It is assumed in the following illustrative examples that -

- all persons are of the same age; and
- the annual standard premium of the existing policy is \$3,300, and the annual standard premium of VHIS policy is \$3,600 for both genders¹.

Case 1




Example 1



¹ The premium figures are assumptions for illustration purpose only. The standard premium rates which a policyholder pays for existing and VHIS policies would vary by his/her age and gender, and could differ from one insurer to another. For illustration purpose, the estimated annual standard premium of VHIS Standard Plan (\$3,600 as mentioned in paragraph 3.14 of Chapter 3) is adopted in the current examples. It should be noted that the aforementioned premium has incorporated the effects of new benefit coverage/higher benefit limits; whereas in the current examples, new benefit coverage/higher benefit limits are not involved.

Case 2

**Existing Policy**

- With premium loading
- No case-based exclusions

Non-standard risk



VHIS Policy

- Same premium loading (no re-underwriting)
- No case-based exclusions

Example 2

Mr B


- Pays premium with 25% loading for asthma: $\$3,300 \times (1+25\%) = \$4,125$
- No case-based exclusions



After Migration

- Pays premium with same loading (no re-underwriting): $\$3,600 \times (1+25\%) = \$4,500$
- No case-based exclusions

Case 3

**Existing Policy**

- Standard premium
- With case-based exclusions

Non-standard risk



VHIS Policy

- Standard premium (no re-underwriting)
- Same case-based exclusions

or



VHIS Policy

- Removes case-based exclusions
- Premium loading may be applied (re-underwriting may be required)

Example 3

Ms C

- Undertook heart surgery before purchasing existing policy
- All heart-related illnesses excluded
- Pays standard premium: \$3,300



After Migration

- Pays standard premium: \$3,600 (no re-underwriting)
- All heart-related illnesses excluded

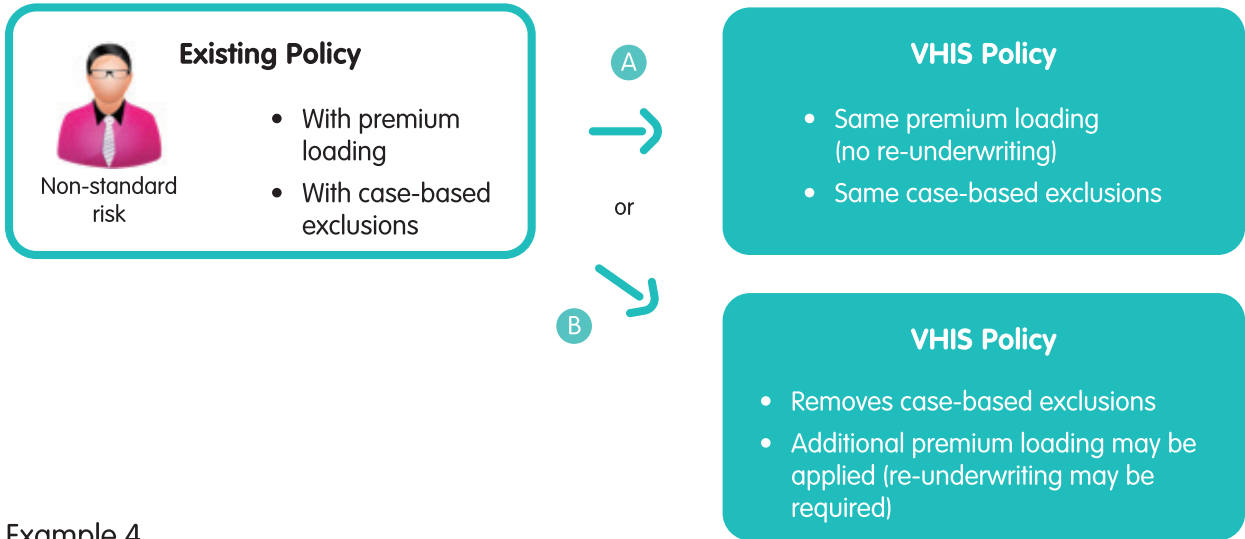
or



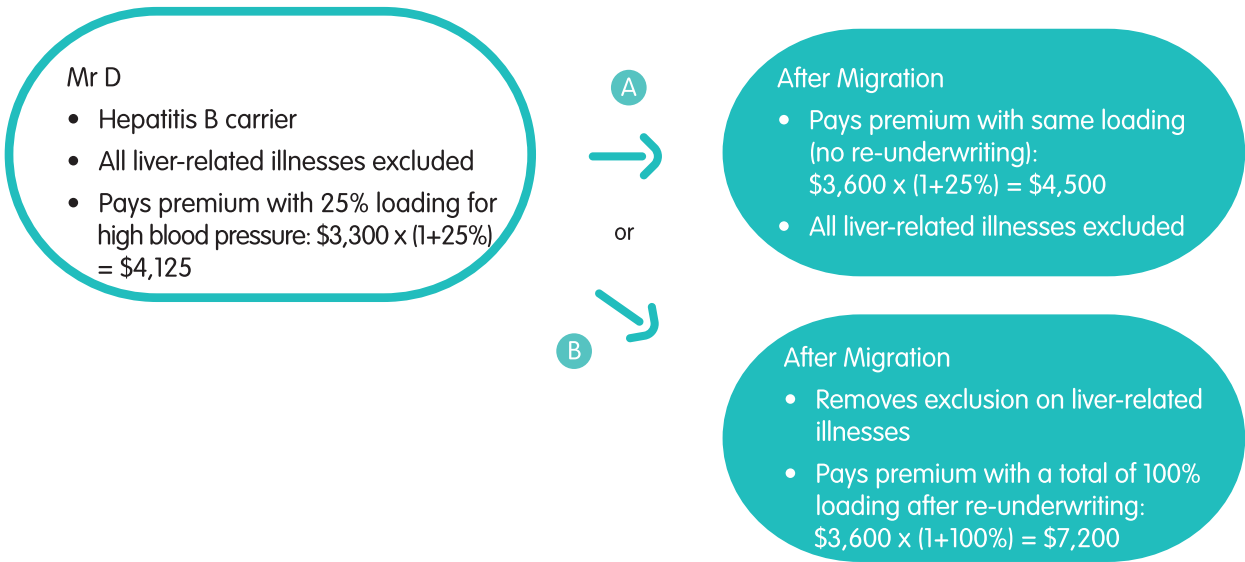
After Migration

- Removes exclusion on heart-related illnesses
- Pays premium with 50% loading after re-underwriting: $\$3,600 \times (1+50\%) = \$5,400$

Case 4



Example 4



New Benefit Coverage and Higher Benefit Limits

5.7. When migrating to compliant policies, some policyholders would need to increase the benefit coverage or benefit limits of their existing policies in order to meet the Minimum Requirements (coverage not included in the existing policy, e.g. non-surgical cancer treatments; or coverage included in the existing policy with benefit limits lower than that of the Minimum Requirements, e.g. surgical limits). Since these new benefit coverage and higher benefit limits are not covered and have not been underwritten under the existing policy, we consider it reasonable to allow re-underwriting of the policyholder if considered necessary by the insurer concerned, but the re-underwriting should be restricted to the new benefit coverage and higher benefit limits only, and the policyholder cannot be re-underwritten for the benefit coverage and benefit limits already covered in the existing policy. In this regard, it may be appropriate to develop a set of code of practice in consultation with relevant stakeholders, with the aim of avoiding disputes on matters such as the definition of “new benefit coverage” and “higher limits”, etc. Apart from re-underwriting, the new benefit coverage and higher benefit limits may also be subject to the standard waiting period for any pre-existing conditions.

5.8. To encourage policyholders to migrate to compliant policies, we propose that all migrated policies – with or without exclusions – should be entitled to tax deduction as proposed in Chapter 4. Migrated policies with assessed premium loading at 200% or above should also be entitled to admission to the High Risk Pool².

After Migration Window Period

5.9. After the migration window period, a policyholder who has not yet migrated and wishes to be covered by a compliant policy would need to procure a separate policy as a new customer, and may be subject to full underwriting if deemed necessary by the insurer concerned. Whether his/her existing non-compliant policy should be terminated, consolidated under the new policy, or renewed as a grandfathered policy would be decided by the policyholder himself/herself.

Grandfathering of Existing Individual Hospital Insurance Policies

5.10. From the health policy perspective, we consider that in the long-run all individual Hospital Insurance in the market should comply with the Minimum Requirements. Having said that, we recognise that some existing policyholders may wish to have a choice on whether or not to migrate to compliant policies.

² Including migrated policies with premium loading at 200% or more carried over from existing policies, and migrated policies with premium loading at 200% or more after re-underwriting during the migration process.

5.11. We propose that policyholders who do not wish to migrate to compliant policies can choose to renew their existing policies, whether within or after the migration window period, on the same old terms or any other terms which fall short of the Minimum Requirements. Such policies will be grandfathered, i.e. exempted from the Minimum Requirements as long as the insurers concerned continue to administer such policies. Under this grandfathering arrangement, the following will apply –

- (a) grandfathered policies will not be entitled to the tax deduction as they are not deemed compliant with the Minimum Requirements; and
- (b) insurers are allowed to alter the terms and conditions (including benefit coverage and benefit limits) of grandfathered policies as agreed with the policyholders. If the terms and conditions of a grandfathered policy are altered to the extent that the policy meets the Minimum Requirements, the revised policy may be regarded as a policy of a compliant product, and would be entitled to the proposed tax deduction.

EXISTING GROUP HOSPITAL INSURANCE POLICIES

5.12. Since group Hospital Insurance is not subject to the Minimum Requirements, insurers may continue to offer existing group Hospital Insurance products to employers. Insurers would be free to offer group policies that comply with the Minimum Requirements proposed for individual Hospital Insurance. Employers who wish to purchase complying group policies may discuss with their insurers on voluntarily migrating their policies to those that comply with the Minimum Requirements.

5.13. As proposed in paragraphs 2.60 to 2.61 in Chapter 2, upon the implementation of the VHIS, insurers must provide the Conversion Option as an optional component in the group Hospital Insurance products that they offer to employers. The Conversion Option would allow an employee to transfer to an individual Standard Plan at the same underwriting class when leaving employment if he/she has been employed for a full year immediately before the transfer. Insurers may also provide Voluntary Supplement(s) (on a group policy basis) to employers so that employees who wish to procure at their own costs additional protection on top of their group plans can opt to do so. The intention is that the group plan, enhanced by the Voluntary Supplement, should provide protection at a level comparable to the protection of an individual Standard Plan.

CHAPTER 6 INSTITUTIONAL FRAMEWORK

SUPERVISORY STRUCTURE FOR THE VOLUNTARY HEALTH INSURANCE SCHEME

6.1. We propose to put in place a governing framework for overseeing the implementation of the Voluntary Health Insurance Scheme (VHIS). The governing framework would comprise three separate but inter-related components, namely –

- (a) prudential regulation of insurers, i.e. ensuring the financial capability of insurers to discharge obligations to the insured;
- (b) quality assurance of healthcare services, including quality, standard accreditation, collation of benchmarking information and statistics; and
- (c) scheme supervision of the VHIS, including administration of the VHIS, and measures to enhance price transparency.

6.2. Existing regulatory regimes have already been managing issues related to the first two components. The role of prudential regulation of insurers is being taken up by the Office of the Commissioner of Insurance (OCI). When the VHIS is in place, the OCI or the Independent Insurance Authority (IIA) proposed to be established in place of the OCI, should continue to serve this function. Regulation of insurance intermediaries should continue to rest with existing self-regulatory bodies, i.e. Insurance Agents Registration Board, Hong Kong Confederation of Insurance Brokers and Professional Insurance Brokers Association; or, the IIA after its establishment. As for quality assurance of healthcare services, it is proposed that the existing regulatory institutions of private healthcare facilities and healthcare professionals, namely the Department of Health (DH) and the relevant statutory boards, councils and professional bodies, should continue with their work under their respective responsibilities.

6.3. As regards scheme supervision, we propose that a new dedicated agency (the regulatory agency) should be set up to perform the functions essential for ensuring a smooth implementation and operation of the VHIS, and to ensure that the policy objectives of the VHIS are achieved. This is consistent with the common practice in overseas jurisdictions where private health insurance (PHI) is an important policy tool in healthcare financing, such as Australia, Ireland, the Netherlands, Switzerland and the United States (a summary of the regulatory framework for PHI in these five overseas jurisdictions is at **Appendix F**). In each of these jurisdictions, the enforcement of statutory requirements for PHI products rests with a dedicated health insurance regulator.

Guiding Principles for the Establishment of the Regulatory Agency

6.4. When setting out the powers, functions and organisation of the regulatory agency, we have given due regard to the following considerations -

- (a) the regulatory agency should contribute to and facilitate the implementation of the policy objectives of the VHIS, so as to provide value-for-money Hospital Insurance to those who are able and willing to use private healthcare services;
- (b) the regulatory agency should work closely with relevant regulatory bodies to ensure effective coordination of duties and avoid duplication of roles and responsibilities, e.g. matters concerning prudential and conduct regulation of insurers, regulation of insurance intermediaries, quality of healthcare services and healthcare professionals, etc.;
- (c) a balance should be struck between safeguarding public interests through regulation and the need to minimise adverse regulatory aspects such as excessive administration costs arising from compliance; and
- (d) due regard should be given to circumstances unique to the local markets of Hospital Insurance and healthcare services, while taking into account relevant experience of regulatory frameworks adopted in overseas jurisdictions for PHI.

Functions and Powers of the Regulatory Agency

6.5. We propose that the regulatory agency should perform a host of functions that are regulatory or facilitating in nature. In the regulatory aspect, the functions of the regulatory agency should include at least the following –

- (a) promulgate, review and enforce the rules and regulations concerning the Minimum Requirements prescribed for individual Hospital Insurance, and the Conversion Option proposed for group Hospital Insurance;
- (b) file compliant individual Hospital Insurance products;
- (c) maintain records of grandfathered individual Hospital Insurance policies;
- (d) monitor the operation of the High Risk Pool (HRP);
- (e) promulgate, review and enforce codes of practice or guidelines relating to the VHIS;
- (f) ensure the transparency of VHIS products in the market, including setting up a

website to facilitate easy comparison of VHIS products offered by different insurers;

- (g) handle non-claims related complaints by consumers, including investigation of cases of non-compliance of rules and regulations described in (a) and (e) above; and
- (h) refer cases to the appropriate regulatory bodies or professional self-regulatory bodies for investigation and handling as necessary and appropriate (please refer to paragraph 6.14 below).

6.6. We propose that the facilitating functions of the regulatory agency should include at least the following –

- (a) build up market infrastructure to facilitate the implementation of the VHIS, e.g. developing information systems for product filing, data collection and publishing of data from various sources (e.g. insurers and private healthcare service providers, etc.);
- (b) liaise with relevant regulatory or supervisory bodies on matters relating to the VHIS (e.g. Food and Health Bureau (FHB), DH, Hospital Authority, OCI/IIA, other professional self-regulatory bodies, etc.);
- (c) set up a platform for insurers and private healthcare service providers to discuss matters relating to the VHIS; and
- (d) consumer education on the VHIS.

Legal Form and Organisation Structure

Government-led

6.7. We consider it more desirable for the regulatory agency to be set up in the form of a Government-led body in order to ensure direct accountability to the public in the implementation of the VHIS. A Government agency would also possess the necessary administrative and operational experience in carrying out its functions effectively. As shown in Appendix F, in all of the five overseas jurisdictions under study, the health insurance regulator is a Government-led body.

6.8. We propose to set up the regulatory agency as an administrative unit under FHB, such that the former could respond quickly to policy directives from the Government. The objectives, power and responsibilities of the regulatory agency would be clearly defined in the form of legislation to provide the regulatory agency with sufficient authority in executing its functions.

6.9. In the long-run, depending on the implementation of the VHIS and under necessary circumstances, the regulatory agency could take the form of a statutory authority independent from the Government. As an independent organisation, the regulatory agency would have more flexibility in operation and staff recruitment. It can better respond to local and overseas market changes as well as developments in international regulatory requirements, thereby fostering a healthy development of the insurance industry and providing better protection to the public.

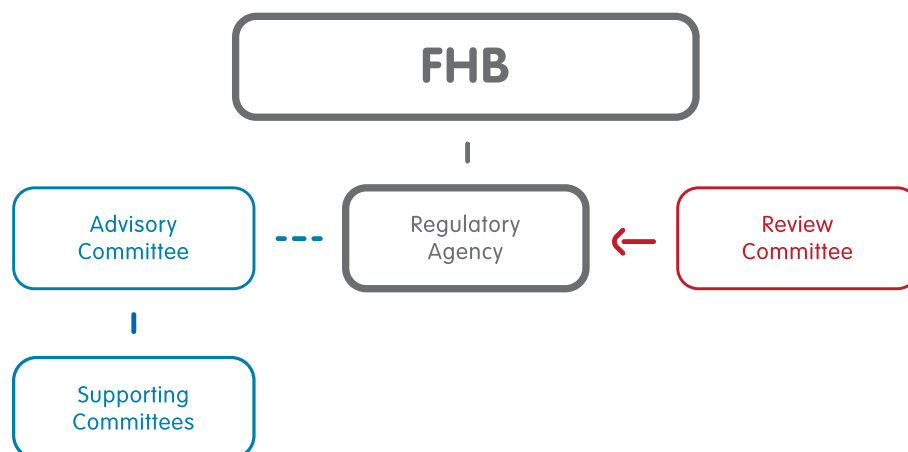
Organisation Structure

6.10. We propose to establish an advisory committee comprising major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory bodies and other stakeholders) to provide professional advice to the regulatory agency concerning the operational details for implementing the VHIS. The advisory committee can also act as a platform for stakeholders to exchange views on the VHIS. If necessary, supporting committees could be established to advise the regulatory agency on specific areas of work.

6.11. To ensure proper exercise of power by the regulatory agency, we propose that a review committee should be appointed to, upon appeal by an aggrieved party, review the decisions made by the regulatory agency in respect of its regulatory functions described in paragraph 6.5 (a), (b), (e) and (g). In cases where a party considers itself to be aggrieved by the decision of the regulatory agency in these areas, it may appeal to the review committee for reconsideration of the case. To ensure impartiality, the review committee should comprise mainly non-official members appointed by the Secretary for Food and Health, and the operation of the review committee should be independent from the regulatory agency.

6.12. **Figure 6.1** illustrates the proposed organisation structure for the regulatory agency.

Figure 6.1 Organisation Structure for Regulatory Agency



6.13. As regards staff establishment, we consider that the number of staff of the regulatory agency should be relatively modest as it is only responsible for regulating the product design of one line of insurance products. We consider that the regulatory agency should comprise a mix of officers from different specialties, including officers supporting the operation, policy and development of the VHIS; as well as professional officers with expert knowledge in health insurance and healthcare services in view of the technicality and complexity of the VHIS. For instance, the monitoring of the HRP would require highly specialised knowledge in respect of claims handling and care management. We will develop further assessments on the manpower and financial resources required for establishing the regulatory agency.

Interface with Other Regulatory Bodies

6.14. We would liaise closely with existing regulatory bodies on matters related to their respective responsibilities to ensure compatibility with existing and future legislative regime for regulation of the insurance industry and effective coordination of duties. For example, on issues concerning prudential regulation, the regulatory agency should work with the OCI or the proposed IIA. On cases regarding the professional conduct of insurance intermediaries, the regulatory agency should maintain close communication with the existing professional self-regulatory bodies, or the proposed IIA upon its establishment. On regulatory issues requiring joint investigation or cooperation between the regulatory agency and other regulatory bodies, we will explore possible means for enhancing collaboration among parties concerned, including the desirability and possibility of signing a memorandum of understanding to clarify the respective responsibilities and roles of each of these regulatory bodies.

CLAIMS DISPUTE RESOLUTION MECHANISM

6.15. As proposed in the Second Stage Public Consultation on Healthcare Reform, we propose to establish a Claims Dispute Resolution Mechanism (CDRM) for the VHIS to better protect consumer interests. The CDRM should aim to provide an independent, impartial, easily accessible, expeditious and affordable channel to resolve financial disputes concerning claims settlement of health insurance as an alternative to litigation, which is in general a much more costly and protracted process.

Existing Mechanisms for Handling Health Insurance Claims Disputes in Hong Kong

6.16. Apart from legal proceedings, there are currently several avenues in Hong Kong for handling disputes related to health insurance claims. A major channel is the Insurance Claims Complaints Bureau (ICCB), a self-regulatory body funded by the insurance industry

that handles complaints about insurance claims arising from nearly all types of individual insurance policies¹ taken out in Hong Kong. It has accumulated rich experience in handling claims disputes² arising from individual insurance policies, including health insurance policies. The decision of the ICCB is binding on the insurer but not the consumer, who can resort to legal redress if he/she is not satisfied with the outcome.

6.17. If an insurance claims dispute involves a financial institution which is one authorised by the Hong Kong Monetary Authority or licensed by/registered with the Securities and Futures Commission, an individual consumer may resort to the Financial Dispute Resolution Centre (FDRC) for dispute resolution through mediation or, failing which, arbitration.

6.18. Meanwhile, the OCI maintains a monitoring role to ensure that complaints are properly handled. The Consumer Council also helps consumers follow up complaints with the relevant institutions or entities for appropriate actions.

Overseas Experience

6.19. Generally speaking, the proposed concept of the CDRM is consistent with the international trend of progressively accepting and expanding the function of independent alternative dispute resolution (ADR) mechanisms to settle insurance disputes, with a view to enhancing consumer protection and choice apart from costly and protracted litigation. A summary of the mechanisms for handling claims disputes in overseas jurisdictions is at **Appendix G**.

6.20. Although the design of ADR mechanisms differs from place to place, their independence and credibility are essential for fostering confidence for all parties concerned. Most governments either manage the mechanism direct or have imposed proper governance on the mechanism. Besides, the ADR mechanisms should offer quick resolution with minimal formality in order to lessen the administrative caseload and settle the dispute expeditiously. It is a common requirement in the jurisdictions studied that the complainant should first attempt to settle the dispute with the financial institution concerned before resorting to the ADR mechanisms. The dispute resolution mechanism usually encompasses mediation, although there is no consensual approach regarding whether arbitration should also be instituted into the mechanism after mediation fails to settle a dispute.

1 ICCB does not deal with commercial, industrial and third-party insurance.

2 ICCB's Complaints Panel consists of members from other professional fields (legal, accounting and consumer representative). It adjudicates on claims complaints with reference to the advice of honorary secretaries, who are members of the insurance industry who voluntarily offer their service to the ICCB. All members of the ICCB's governing body (General Committee) are from the insurance industry.

Proposal for CDRM

6.21. We consider that the future CDRM should provide an independent and credible claims dispute resolution channel for policyholders of VHIS policies in order to meet public aspirations. The main features of the CDRM are described in the ensuing paragraphs.

Coverage

6.22. We propose that the CDRM should cover all financial disputes related to claims arising from individual VHIS policies. The proposal of covering claims disputes of individual policies is consistent with overseas practice, where individual consumers are eligible claimants under the ADR mechanisms because they are in general less financially capable in resorting to legal proceedings to settle claims disputes.

6.23. Apart from individual VHIS policies, we have considered whether it is necessary or desirable to expand the function of the CDRM to cover claims disputes arising from group health insurance policies, or claims disputes between insurers and healthcare service providers under direct billing arrangement. After careful consideration, we propose not to cover these types of claims disputes during the initial phase of implementation of the VHIS. Although there is currently no dedicated channel for settling these types of claims disputes, we recognise that business customers and healthcare service providers usually have larger bargaining power and greater financial resources in settling claims disputes with insurers. We propose that at the initial stage of the implementation of the VHIS, public resources should be focused on assisting retail customers. In the longer-term, depending on the experience and caseload of the CDRM, we may consider whether it is necessary and desirable to widen its scope.

Operation

6.24. From overseas experience, mediation and arbitration are the two most widely used forms of ADR means. Mediation is a voluntary, non-binding and private dispute resolution process, in which an independent and neutral mediator helps the parties resolve their disputes and reach a negotiated settlement. As a trained and impartial third person, the mediator acts as a catalyst to assist the disputing parties to communicate in a rational and problem solving way; to provide supportive and practical steps to facilitate discussions of the areas in dispute; to explore each party's needs and interests; and to assist the drawing up of a valid agreement setting out how the parties have agreed to solve the problem.

6.25. Arbitration is a form of legal process where the disputes are not heard by a court but by a private individual or a panel of several private individuals known as arbitrators. An arbitrator is usually appointed by agreement of the two disputing parties to facilitate the fair and speedy resolution of disputes; to act fairly and impartially between parties; and to give the

parties a reasonable opportunity to present their cases. Arbitration, unlike court proceedings, is conducted in private and generally less formal settings. Arbitration awards are final and binding on the parties. We will consider adopting mediation and/or arbitration under the CDRM with reference to local and overseas experience and in consultation with the industry. Subject to the caseload of the CDRM, we propose that secretariat support to the CDRM could be taken up by the VHIS regulatory agency.

Interface with Existing Mechanisms

6.26. Given that the CDRM would share some similarities with the existing FDRC, and to lesser extent the ICCB in terms of functionality, we will explore the room for building the CDRM on the foundation of the existing FDRC/ICCB. If it is necessary to set up a separate CDRM under the VHIS, we will endeavor to maximise synergy with the FDRC/ICCB and establish a communication mechanism to avoid causing confusion to consumers. We will further discuss the interface arrangements with the FDRC/ICCB.

6.27. In the long-run, it would be ideal to have a single claims dispute resolution channel to help avoid confusion and enhance administrative efficiency. In such case, we will discuss with relevant stakeholders on how the functions of the CDRM could be consolidated with existing mechanisms.

CHAPTER 7 SUPPORTING INFRASTRUCTURE

7.1. During the Second Stage Public Consultation on Healthcare Reform, many respondents pointed out that the success of the Health Protection Scheme (HPS) hinged on having in place the necessary supporting infrastructure, including an adequate supply of healthcare manpower, and sufficient healthcare capacity to provide quality private healthcare services. Some respondents were concerned that an increased demand arising from the implementation of the HPS would lead to “brain-drain” from the public sector, thus further straining the public healthcare system and affecting the level and quality of public healthcare services. Respondents also considered it necessary for the Government to facilitate supply of value-for-money private healthcare services to meet the increased demand after the implementation of the HPS.

7.2. As elaborated in Chapter 8, the implementation of the Voluntary Health Insurance Scheme (VHIS) is expected to lead to an increase in private sector activities. To ensure an adequate supply of healthcare manpower and private healthcare services, the Food and Health Bureau has been taking forward a number of policy measures in conjunction with developing detailed proposals for the VHIS. These measures include conducting a strategic review on healthcare manpower planning and professional development, facilitating private hospital development and reviewing the regulation of private healthcare facilities (PHFs).

HEALTHCARE MANPOWER PLANNING AND PROFESSIONAL DEVELOPMENT

7.3. We set up a high-level Steering Committee in January 2012 to take forward the strategic review on healthcare manpower planning and professional development (Healthcare Manpower Review Steering Committee). Chaired by the Secretary for Food and Health (SFH), the Healthcare Manpower Review Steering Committee is tasked to formulate recommendations on how to cope with anticipated demand for healthcare manpower, strengthen professional training and facilitate professional development having regard to the findings of the strategic review, with a view to ensuring the healthy and sustainable development of our healthcare system.

7.4. The strategic review covers primarily the 13 healthcare disciplines that are subject to statutory regulation, viz. medical practitioners, dentists, dental hygienists, nurses, midwives, Chinese medicine practitioners, pharmacists, chiropractors, medical laboratory technologists, occupational therapists, optometrists, radiographers and physiotherapists. For disciplines currently not subject to statutory regulation, the review also looks into issues relating to their future development, including whether or not they should be subject to regulatory control of some form.

7.5. To assist the Healthcare Manpower Review Steering Committee in making informed recommendations to the Government, we have commissioned the University of Hong Kong (HKU) and the Chinese University of Hong Kong (CUHK) to provide professional input and technical support to the review. HKU is tasked to conduct a comprehensive projection on the manpower demand for healthcare professionals from the designated disciplines based on objective data collated from a wide range of sources within the community to be analysed and aggregated through statistical methods and scenario modelling, taking into account all known and potential factors and considerations. CUHK is tasked to conduct a comparative review of the regulatory frameworks in local and overseas contexts governing registration, licensing, qualifications and professional conduct of the healthcare professions concerned, as well as mechanisms for setting and upholding professional standards and maintaining continuing competence.

7.6. The strategic review is now progressing in full swing. The recommendations, which will be published together with the findings from the two commissioned studies for public information upon completion of the review, will shed light on ways to ensure an adequate supply of healthcare professionals for meeting the healthcare needs of our community. To increase the supply of healthcare professionals in the interim, for the triennial cycle starting from the 2012/13 academic year, the Government has increased the number of first-year first-degree places in medicine by 100 (i.e. from 320 to 420 per year), nursing by 40 (i.e. from 590 to 630 per year) and allied health professionals by 146 (i.e. from 231 to 377 per year).

ENHANCE PRIVATE HEALTHCARE CAPACITY

7.7. It is the Government's policy to facilitate private hospital development with a view to increasing the overall capacity of the healthcare system in Hong Kong to cope with the increasing service demand and addressing the imbalance between the public and private sectors in hospital services. We also aim to provide more choices of healthcare services to the public through the continuing development of private hospitals.

Development of New Private Hospitals

7.8. In March 2013, the Government awarded a tender for development of a new private hospital of 500 beds at a site at Wong Chuk Hang. In order to ensure that the services of the new hospital are of good quality, will cater for the needs of the general public and help enhance the standard of healthcare services, a set of special requirements were included in the tender document, covering aspects like land use, date of commencement of operation, bed capacity, service scope, packaged charge and price transparency, service target and service standard, etc. These special requirements would ensure that the new private hospital will accord service priority to local residents, adopt a transparent fee-charging system and provide various specialty services so as to address local healthcare demand.

7.9. The new private hospital to be developed at the Wong Chuk Hang site is expected to commence operation by 2017. It will have the following service features –

- (a) services in general medicine, general surgery, orthopaedics and traumatology, and gynaecology, and 11 other specialties¹ will be provided;
- (b) the number of obstetric beds will be capped at no more than 3.2% of the total number of beds in the hospital;
- (c) at least 70% of in-patient bed days taken up in a year will be used for provision of services to local residents;
- (d) at least 51% of in-patient bed days taken up in a year will be used for provision of services to local residents at packaged charge through standard beds;
- (e) comprehensive charging information of its services will be made available to the public; and
- (f) the hospital will endeavour to participate in hospital assessment and attain accreditation within 36 months from the commencement of operation of the hospital.

7.10. Apart from the new private hospital at Wong Chuk Hang, we are also considering various proposals from different organisations to develop new private hospitals, including a proposal by the CUHK to develop a new teaching hospital at its campus. In order to facilitate the development of private hospitals for meeting community needs, we will consider granting loans to organisations that have difficulties in obtaining adequate capital funding in financing the development costs of non-profit-making private hospitals. The Government will impose suitable requirements on the hospital development to help achieve its policy objectives, non-profit-making as ensuring that the service coverage of these new hospitals would complement that of public hospitals and meet community needs, and that services in packaged charge would be offered in support of the VHIS.

¹ These 11 specialties are neurosurgery, cardiothoracic surgery, cardiology, haematology, oncology, paediatrics, intensive care services (including cardiac care, paediatrics, neonatal intensive care services), accident and emergency services, ophthalmology, Chinese medicines, and mental health services.

Redevelopment or Expansion of Existing Private Hospitals

7.11. A number of existing private hospitals are undergoing or have plans to undergo redevelopment or expansion. These include Hong Kong Baptist Hospital, Tsuen Wan Adventist Hospital, St Paul's Hospital and Hong Kong Sanatorium & Hospital. It is expected that the redevelopment or expansion of these existing private hospitals will provide around an additional 900 hospital beds.

7.12. We expect that, upon completion of the new hospital(s) and redevelopment of existing hospitals, the overall capacity of the healthcare system in Hong Kong will be increased, enabling the public to have more choices of affordable and quality private hospital services.

REGULATION OF PHFs

7.13. In order to enhance the safety, quality and transparency of private healthcare services, we established the Steering Committee on Review of the Regulation of Private Healthcare Facilities (PHF Steering Committee) in October 2012 to conduct a review on the regulatory regime for PHF in Hong Kong. The review covers two ordinances, namely the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) and the Medical Clinics Ordinance (Cap. 343), in which private hospitals, nursing homes, maternity homes and non-profit-making clinics are covered.

7.14. The two ordinances have yet to undergo any substantive amendments since 1960s and have outlived their usefulness in regulating private healthcare services amid the changing landscape of the healthcare market. We intend to, by revamping the legislative vehicle, expand the scope of regulatory standards to cover the essential facets of private hospital governance, such as corporate and clinical governance, price transparency and complaint management and also empower the regulatory authority to tighten the regulatory control. This is to answer the calls for enhanced regulation from the public over quality assurance of private healthcare services and the need for greater transparency in fees and charges. Furthermore, we would review and make recommendations on the appropriate regulatory control over ambulatory medical centres where ambulatory surgeries or high-risk medical services are performed, which have gained prevalence in healthcare markets worldwide with the advancement of medical technology and greater access to endoscopic screening. The proposed new regime would also regulate clinics under the management of incorporated body. The regulatory scheme would be complementary to the VHIS's efforts in facilitating the delivery of healthcare services in ambulatory setting.

7.15. Chaired by the SFH, the PHF Steering Committee was tasked to put forward recommendations on the regulatory approach and scheme for PHFs, taking into account views from various sectors of society. In conducting the review, reference was made to regulatory frameworks in overseas jurisdictions and the international trend for safeguarding patient interests, while taking into account the local circumstances of private healthcare services and the demands and expectations of the public at large. The PHF Steering Committee reviewed the scope of regulation of PHFs, such as whether to put under regulatory control facilities where high-risk medical procedures are conducted, and also tighten up the regulatory standards of private hospitals in order to safeguard the public's health.

7.16. The PHF Steering Committee was underpinned by four working groups to conduct in-depth research and work out options of way forward on certain priority areas. Specifically, the four working groups were tasked to tender recommendations on, respectively, -

- (a) differentiation between high-risk medical procedures and beauty services;
- (b) definition of high-risk medical procedures/practices performed in ambulatory setting;
- (c) regulation of premises processing health products for advanced therapy; and
- (d) regulation of private hospitals.

7.17. The reviews of the four working groups were completed and their recommendations were endorsed by the Steering Committee. In view of these findings and recommendations, we propose to introduce a revamped regulatory regime for PHFs. The revamped regime will include a list of regulatory requirements for enhancing corporate governance, clinical governance, standard of facilities and price transparency of private healthcare services. More specifically, with regard to price transparency, we propose to introduce the following requirements –

- (a) disclosure of price information: private hospitals should prepare a fee schedule setting out charges (e.g. wards, investigative and treatment procedures, medical supplies, medicines, medical reports, photocopy of medical records, etc.). The full fee schedule should be readily available at hospitals and easily accessible by the public;
- (b) uniform quotation system/Informed Financial Consent (please also refer to paragraphs 2.48 to 2.51 in Chapter 2): patients having investigative procedures or elective, non-emergency therapeutic operations/procedures for known diseases should be informed of the estimated total charges given individual patient's unique circumstances on or before admission to private hospitals;

- c) introduction of Recognised Service Packages for common operations/procedures: private hospitals are encouraged to offer Recognised Service Packages, which are identically and clearly defined standard services provided at packaged charge through standard beds for common operations/procedures on known diagnosis, e.g. cataract extraction surgery, appendectomy; and
- (d) disclosure of historical statistics: private hospitals should make available to the public key historical statistics as prescribed by the regulatory authority, such as actual bill sizes for common treatments/procedures, annual number of discharges, average length of stay, etc.

7.18. The Government is consulting the public on the detailed proposals for revamping the regulatory regime for PHFs from 15 December 2014 to 16 March 2015. Please refer to the Consultation Document "Regulation of PHFs" for further details.

CHAPTER 8 IMPLICATIONS FOR HONG KONG'S HEALTHCARE SYSTEM

8.1. The Voluntary Health Insurance Scheme (VHIS) aims to facilitate choice of private healthcare services by providing better insurance protection to those who are willing and can afford private healthcare services. By making Hospital Insurance a more attractive option to the public, the VHIS could encourage and facilitate greater use of private healthcare services, thereby better enabling the public sector to focus on serving its target areas and enhancing its services. Furthermore, with the inclusion of prescribed ambulatory procedures in its benefit coverage, the VHIS also contributes to more efficient use of resources within the private sector. Cases that have hitherto occupied private beds for claims reason could be released for more gainful purpose for the benefit of those who are genuinely in need of hospitalisation. The VHIS product design that facilitates use of ambulatory procedures would also help enhance access to more cost-effective private healthcare services. In such ways, the resources of the public and private healthcare sectors could be more efficiently allocated and utilised, and the long-term sustainability of our dual-track healthcare system could be enhanced.

8.2. The VHIS is only one of the turning knobs that would contribute to the performance and sustainability of our healthcare system. Considering the voluntary nature of the VHIS and the fact it is intended as a supplementary financing arrangement, the Consultant's projection of the implications of the VHIS on the healthcare system and healthcare financing must be seen in context and considered in conjunction with the concurrent influence of other long-term factors, including the increase in demand for both public and private healthcare services amidst an ageing population. The purpose of the projection exercise is to better inform healthcare planning and seeks to visualise in a macro way how changes to Hospital Insurance could help induce positive and sustainable improvements to the whole healthcare system.

8.3. This Chapter illustrates the implications of the VHIS on the healthcare system and healthcare financing as projected by the Consultant, including the uptake rate and premiums of Hospital Insurance, as well as long-term impacts on the public and private healthcare sectors. The implications of the VHIS, as elaborated in the ensuing paragraphs, are illustrated by comparing the baseline scenario (i.e. the scenario without the implementation of the VHIS) and the forecast scenario¹ (i.e. the scenario with the implementation of the VHIS in accordance with the proposals described in previous Chapters). The two scenarios are worked out on the basis of a number of inter-related factors and assumptions, including long-term medical inflation, expense loadings in the insurance sector, service utilisation in the healthcare sector,

¹ The forecast scenario presented here refers to the one with medium impact within the range of scenarios projected by the Consultant.

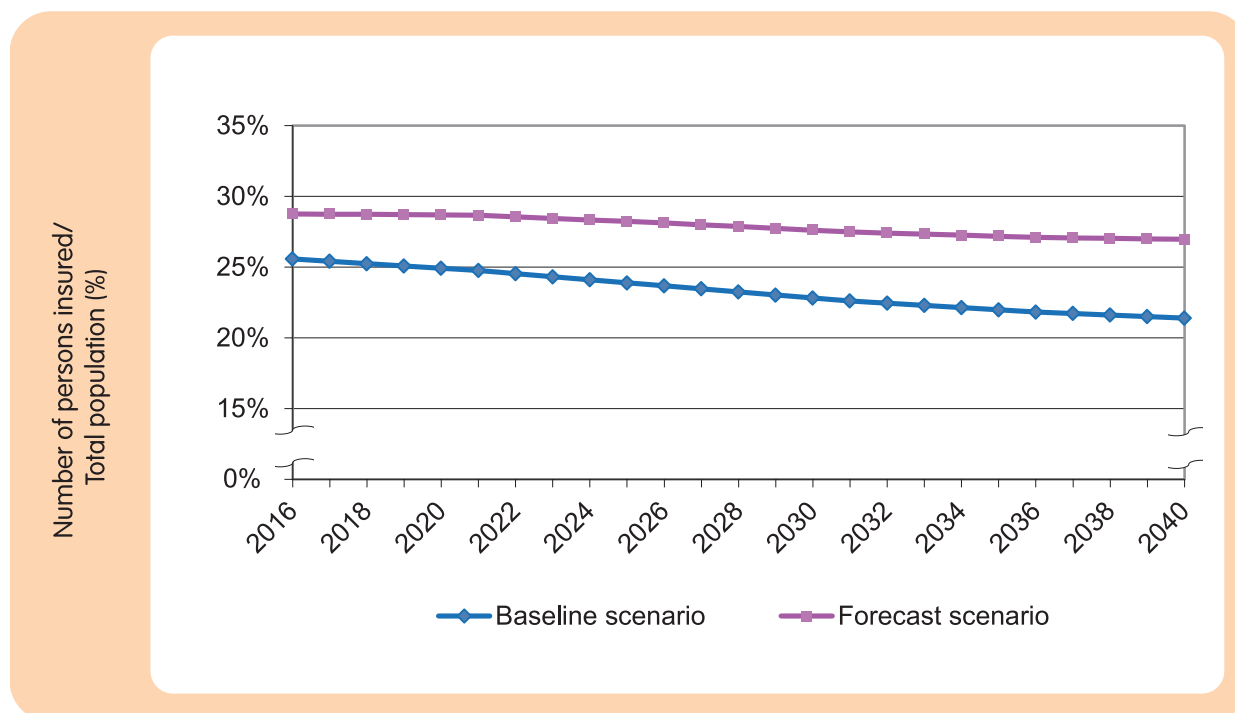
price sensitivity of consumers, impact of the VHIS on uptake of Hospital Insurance, migration to the VHIS during the window period, etc. The projections consider a 25-year horizon from 2016 to 2040, assuming that the VHIS commences in 2016. All dollar figures are in 2012 constant prices.

PROJECTED UPTAKE OF HOSPITAL INSURANCE

Individual Market

8.4. In terms of proportion to the total population, the uptake rate of Hospital Insurance in the individual market is projected to follow a declining trend over the projection horizon under both the baseline and forecast scenarios (**Figure 8.1**). Amidst population ageing, the elderly share in the total population is poised to increase over the years, irrespective of whether the VHIS is implemented. Since in general the elderly have no or low working income while the insurance premiums for them are relatively high due to greater likelihood of making claims, these people are financially less capable of purchasing or continuing their Hospital Insurance cover at old age. As a result, an ageing population would likely lead to a declining trend in overall Hospital Insurance uptake. Yet due to the positive impacts of the VHIS (as explained in paragraph 8.11 below), it is expected that the downtrend would be eased, albeit not reversed, under the forecast scenario.

Figure 8.1 Projected Uptake Rate of Individual Hospital Insurance



Note: Grandfathered policies and High Risk Pool (HRP) policies are included under the forecast scenario.

8.5. Under the baseline scenario, the uptake rate of Hospital Insurance in the individual market is projected to be 26%² in 2016. The uptake rate is expected to follow a long-term declining trend, dropping to 21% in 2040.

8.6. Under the forecast scenario, the uptake rate of Hospital Insurance in the individual market would be considerably higher at 29% in 2016 (or 223 000³ more than the baseline scenario in terms of persons insured). In the initial years, despite the possible increase in the premiums of individual Hospital Insurance, which might limit the uptake of Hospital Insurance, a number of offsetting factors are expected to contribute to the higher uptake rate as compared to the baseline scenario. These include greater consumer confidence in Hospital Insurance due to Government regulation, the guaranteed acceptance feature which allows high-risk individuals to enroll in the VHIS, the entry age limit for guaranteed acceptance which encourages early subscription, and the tax incentive offered by the Government, etc.

8.7. Towards the end of the projection period, the projected uptake rate under the forecast scenario is higher than that of the baseline scenario by a more visible margin. In 2040, the uptake rate is projected to be 27% (versus 21% under the baseline scenario), or 443 000 more than the baseline scenario in terms of persons insured. In addition to the positive factors mentioned in the preceding paragraph, the long-term uptake of Hospital Insurance is underpinned by a more moderate premium growth as a result of greater market efficiency brought by the VHIS, such as increased use of ambulatory procedures and improved market competition and transparency (see paragraph 8.11 below). Other contributory factors include the Conversion Option for group Hospital Insurance that would increase uptake at older ages, as well as the guaranteed renewal feature of VHIS plans that would allow more persons insured to maintain their Hospital Insurance cover at older ages.

Group Market

8.8. Similar to that in the individual market, the uptake rate of Hospital Insurance in the group market is expected to exhibit a long-term declining trend under both the baseline and forecast scenarios. Ageing population is likewise a predominant influencing factor, which implies that there would be fewer people who are economically active and covered by group Hospital Insurance towards the end of the projection period.

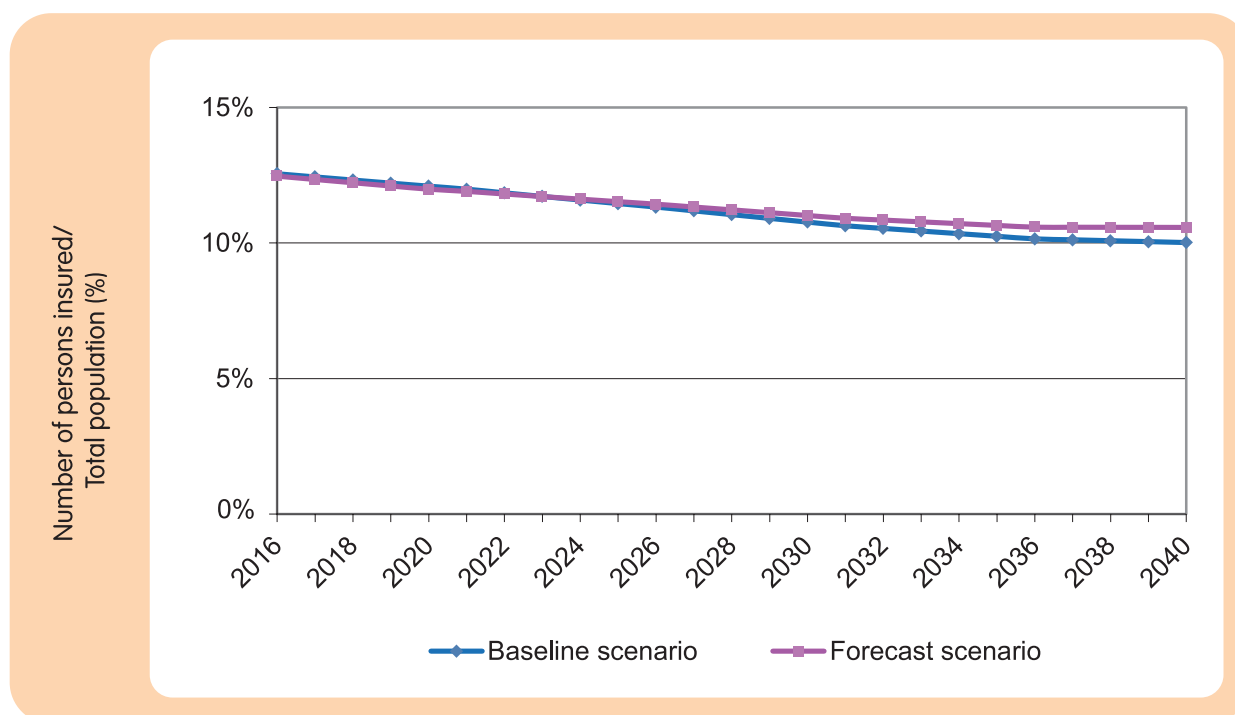
8.9. Under the baseline scenario, the uptake rate of group Hospital Insurance is projected to be 13% in 2016, which gradually declines to 10% in 2040 (**Figure 8.2**). Under the

2 Under the baseline scenario, individual Hospital Insurance is not required to comply with the Minimum Requirements, and some of the products may not necessarily provide adequate protection to policyholders.

3 Numbers (except dollar figures) in this Chapter are rounded to the nearest thousand and may not add up to the total.

forecast scenario, the uptake rate in 2016 would be similar to that of the baseline scenario. Nevertheless, in the long-term, the uptake rate would show a smaller decline as compared to the baseline scenario. Since the efficiency gains under the VHIS are expected to help ease the medical inflationary pressure, the premium growth of group Hospital Insurance is expected to be slower under the forecast scenario as compared to the baseline scenario. This would in turn result in more affordable premiums and a more sustained uptake rate. As a result, the uptake rate of group Hospital Insurance under the forecast scenario is projected to decline more modestly to 11% in 2040 (versus 10% under the baseline scenario), or 44 000 more than the baseline scenario in terms of persons insured.

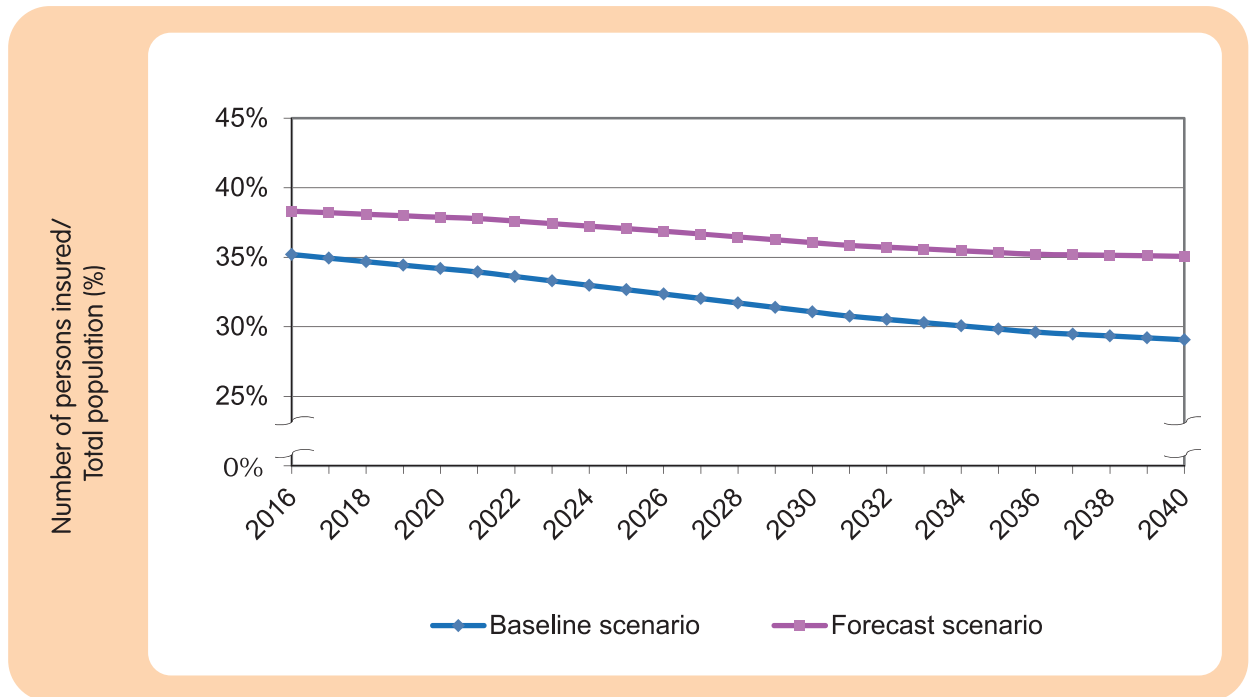
Figure 8.2 Projected Uptake Rate of Group Hospital Insurance



Aggregate Market

8.10. For the aggregate market (the individual and group markets taken together), the projected uptake rate trends downward during the projection period under both the baseline and forecast scenarios. Nevertheless, the downtrend under the forecast scenario is less distinct than that of the baseline scenario. Under the baseline scenario, the uptake rate of Hospital Insurance in the aggregate market is projected to be 35% in 2016 and 29% in 2040 (**Figure 8.3**). Under the forecast scenario, the corresponding figure is projected to be 38% in 2016 (or 219 000 more than the baseline scenario in terms of persons insured) and 35% (or 477 000 more than the baseline scenario in terms of persons insured) in 2040.

Figure 8.3 Projected Uptake Rate of Hospital Insurance in Aggregate Market



Note: Grandfathered policies and HRP policies are included under the forecast scenario.

PROJECTED GROWTH RATES OF PREMIUMS AND TOTAL PREMIUMS OF HOSPITAL INSURANCE

Individual Market

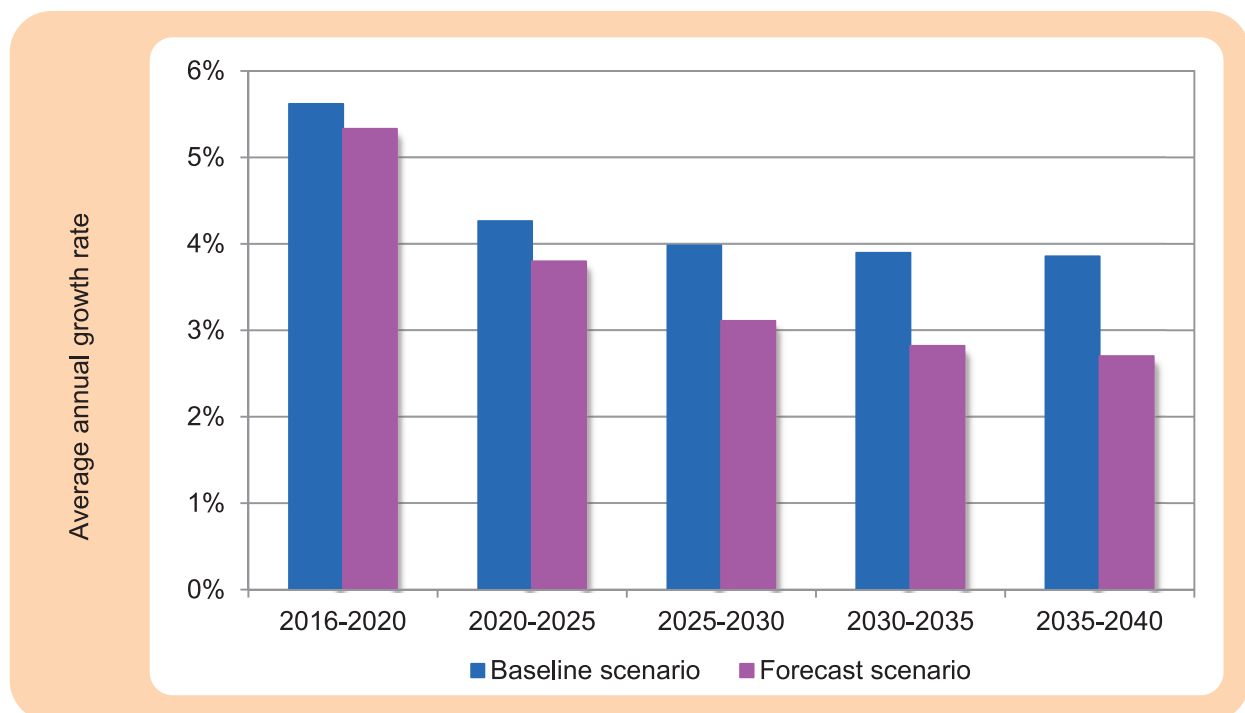
8.11. Although the enhanced benefits of the VHIS would likely lead to an increase in the premiums of Hospital Insurance in the initial period of its implementation, the price impact would be gradually offset and eventually outweighed by improved market efficiency that it brings about, including –

- (a) greater budget and cost certainty for consumers and insurers through the “no-gap/known-gap” and Informed Financial Consent arrangements;
- (b) more efficient use of private healthcare resources through facilitating delivery of healthcare in ambulatory setting;
- (c) enhanced premium transparency and comparability of VHIS products offered by different insurers, which would foster market competition;
- (d) more effective cost-control through co-insurance for prescribed advanced diagnostic imaging tests; and

- (e) a larger insurance market which provides economies of scale and improves cost-efficiency.

8.12. These efficiency gains would help contain medical inflation and expense loadings in the Hospital Insurance market. As a result, the long-term upward pressure for premiums of Hospital Insurance would be eased. Compared with the baseline scenario, the increase in the average premium of individual Hospital Insurance (ward level, excluding grandfathered policies and policies in the High Risk Pool (HRP)) is projected to be relatively moderate under the forecast scenario, and the accumulated effect is expected to be more obvious towards the end of the projection period. For instance, the average annual growth rate of average premium under the forecast scenario is projected to be lower than that of the baseline scenario by 0.3 percentage point from 2016 to 2020 (**Figure 8.4**). The corresponding difference in growth rates enlarges to 1.2 percentage point from 2035 to 2040. For the 25-year-period from 2016 to 2040, the projected premium growth rate averages at 3.5% per annum under the forecast scenario, vis-a-vis the corresponding figure of 4.3% per annum under the baseline scenario.

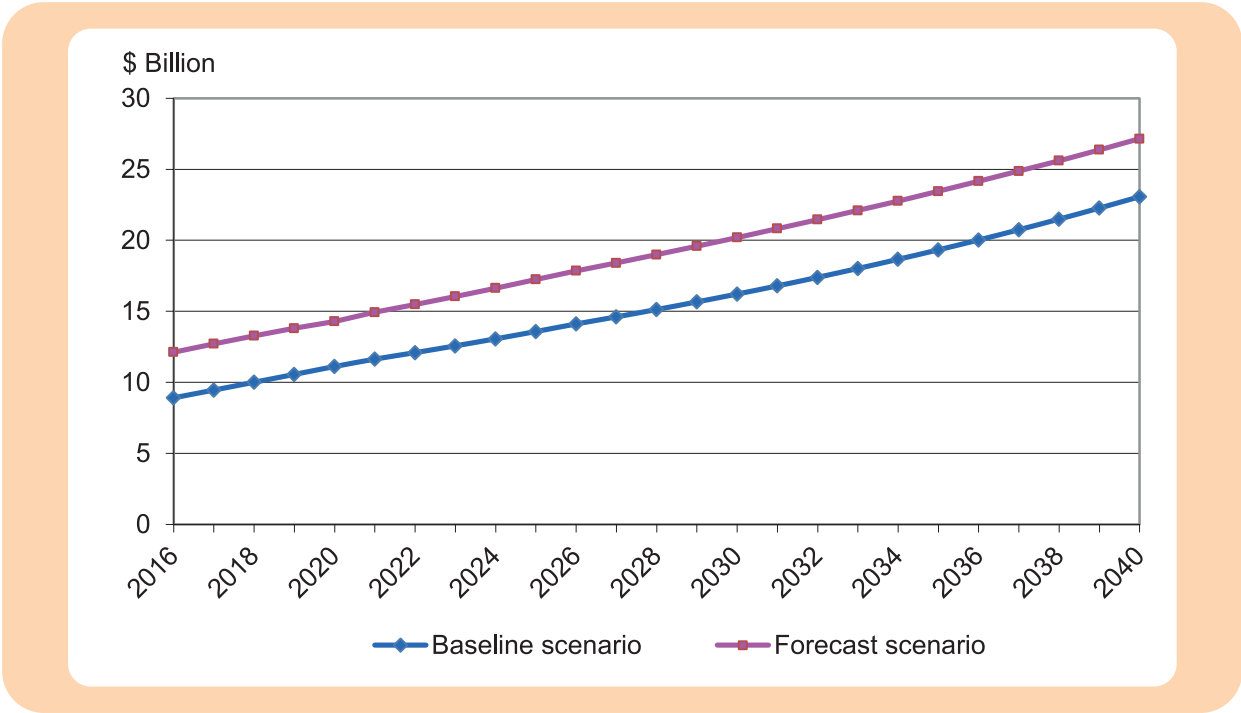
Figure 8.4 Long-term Trend of Average Premium of Individual Hospital Insurance (Ward Level)



Note: Grandfathered policies and HRP policies are excluded under the forecast scenario.

8.13. Despite a slower growth in average premium under the forecast scenario, the total premiums of all individual Hospital Insurance would be larger than that of the baseline scenario due to the offsetting impact of increased uptake that the VHIS brings about. Under the forecast scenario, the total premiums of all individual Hospital Insurance (including grandfathered policies and policies in the HRP) are projected to be about \$12.1 billion in 2016 and about \$27.1 billion in 2040, larger than the corresponding figures of \$8.9 billion and \$23.1 billion under the baseline scenario (Figure 8.5).

Figure 8.5 Total Premiums of Individual Hospital Insurance



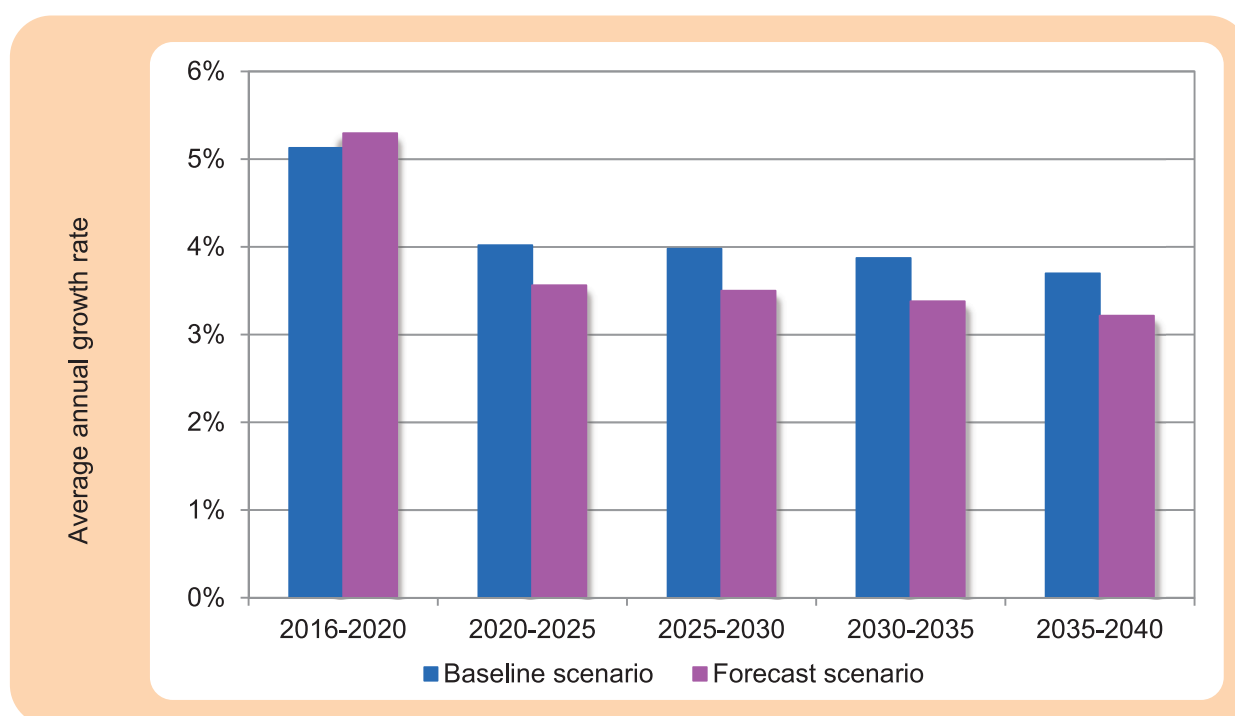
Note: Grandfathered policies and HRP policies are included under the forecast scenario.

Group Market

8.14. As in the case of the individual market, the average premium of Hospital Insurance (ward level) of the group market is expected to increase alongside medical inflation during the projection period under both the baseline and forecast scenarios. Yet the long-term premium growth is expected to be under better check under the forecast scenario as the efficiency improvements brought about by the VHIS, such as enhanced market transparency and more optimised use of ambulatory healthcare services, would have positive impacts on the group market as well.

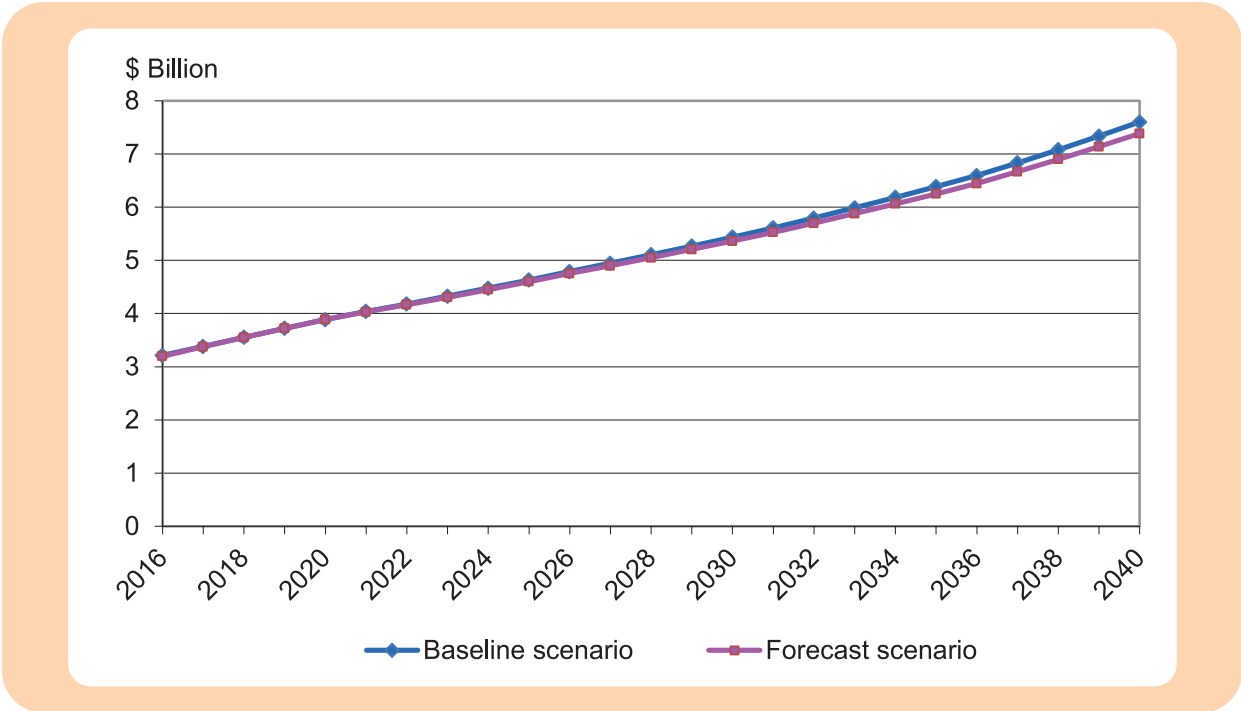
8.15. Under the forecast scenario, the average annual growth of the average premium of Hospital Insurance (ward level) of the group market is in general slower than that of the baseline scenario, despite an initial pick-up due to the effect of the Conversion Option. Under the forecast scenario, the average annual growth of average premium is projected to be slower than that of the baseline scenario by 0.5 percentage point from 2020 to 2025 (**Figure 8.6**). The slower growth in average premium is expected to continue throughout the remainder of the projection horizon by roughly the same magnitude.

Figure 8.6 Long-term Trend of Average Premium of Group Hospital Insurance (Ward Level)



8.16. In terms of the projected total premiums of the group Hospital Insurance market (premiums of all group Hospital Insurance), under the forecast scenario, the total premiums of the group market over the projection horizon would be broadly similar to those under the baseline scenario. This is because the effect of increase in uptake and the effect of a slower average premium growth under the forecast scenario would largely offset each other. Towards the end of the projection period, the total premiums of the group market under the forecast scenario would be marginally lower than that of the baseline scenario, as the effect of a slower premium growth slightly outweighs the effect of increase in uptake. Under the baseline scenario, the total premiums are projected to be about \$3.2 billion in 2016 and about \$7.6 billion in 2040 (**Figure 8.7**) Under the forecast scenario, the total premiums are projected to be similar to the baseline scenario in 2016 at about \$3.2 billion, and slightly lower than the baseline scenario in 2040 at about \$7.4 billion.

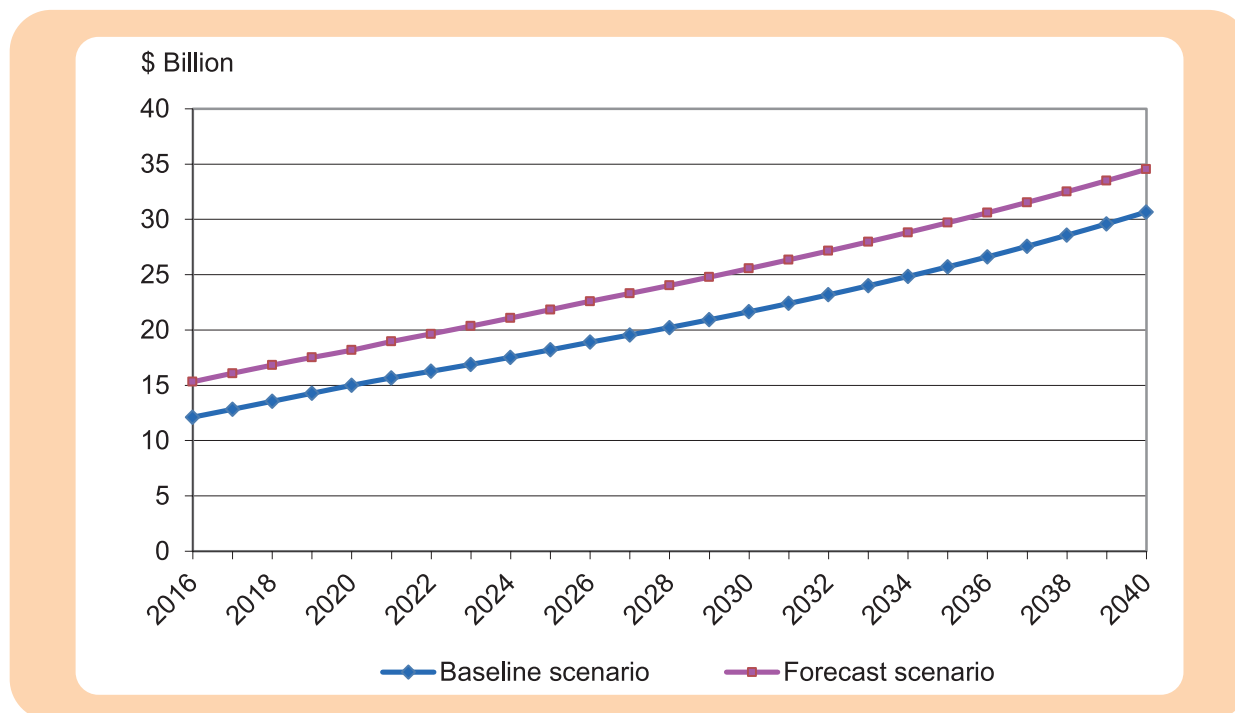
Figure 8.7 Total Premiums of Group Hospital Insurance



Aggregate Market

8.17. In terms of the projected total premiums of the aggregate market (aggregate premiums of all Hospital Insurance policies in the individual and group markets), the total premiums are projected to increase over the projection horizon under both the baseline and forecast scenarios. Under the baseline scenario, the total premiums are projected to be about \$12.1 billion in 2016 and about \$30.7 billion in 2040 (Figure 8.8). Under the forecast scenario, the total premiums are projected to be larger at about \$15.3 billion in 2016 and \$34.5 billion in 2040.

Figure 8.8 Total Premiums of Hospital Insurance in Aggregate Market



Note: Grandfathered policies and HRP policies are included under the forecast scenario.

IMPLICATIONS ON PUBLIC AND PRIVATE HEALTHCARE SECTORS

Increase in Private Healthcare Sector Activities

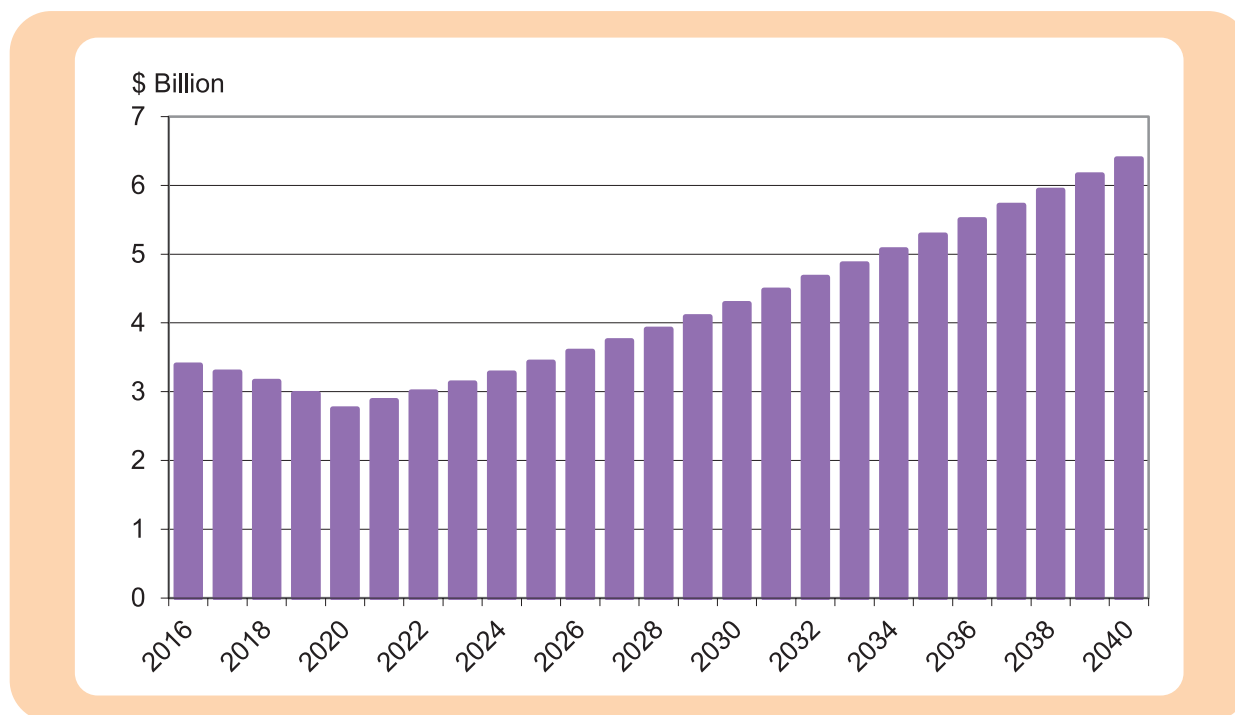
8.18. In comparison with the baseline scenario, it is expected that there would be a growth of activities in the private healthcare sector under the forecast scenario. In terms of number of procedures performed in the private sector, it is projected that there would be an increase of about 231 000 procedures in 2016 and about 503 000 in 2040 as compared with the baseline scenario (**Figure 8.9**). The vast majority of these procedures are advanced diagnostic imaging tests, endoscopies and non-surgical cancer treatments. Major growth impetus would come from increased uptake of Hospital Insurance; improved insurance protection under the VHIS, which would better enable policyholders to seek healthcare services in the private sector; as well as nominal substitution of activities from the public system by those who utilise private healthcare services through Hospital Insurance, instead of seeking to meet their medical needs in the public healthcare sector.

Figure 8.9 Additional Number of Procedures Performed in Private Healthcare Sector due to VHIS



8.19. Overall, the growth in private sector activities under the forecast scenario would result in higher private health expenditure as compared to the baseline scenario. The amount of additional private health expenditure is projected to be \$3.4 billion in 2016 and \$6.4 billion in 2040 (**Figure 8.10**). Cumulatively over the projection horizon, the total amount of additional private health expenditure is projected to be \$105 billion, representing an increase of approximately 3% as compared to the total private health expenditure under the baseline scenario.

Figure 8.10 Additional Private Health Expenditure due to VHIS



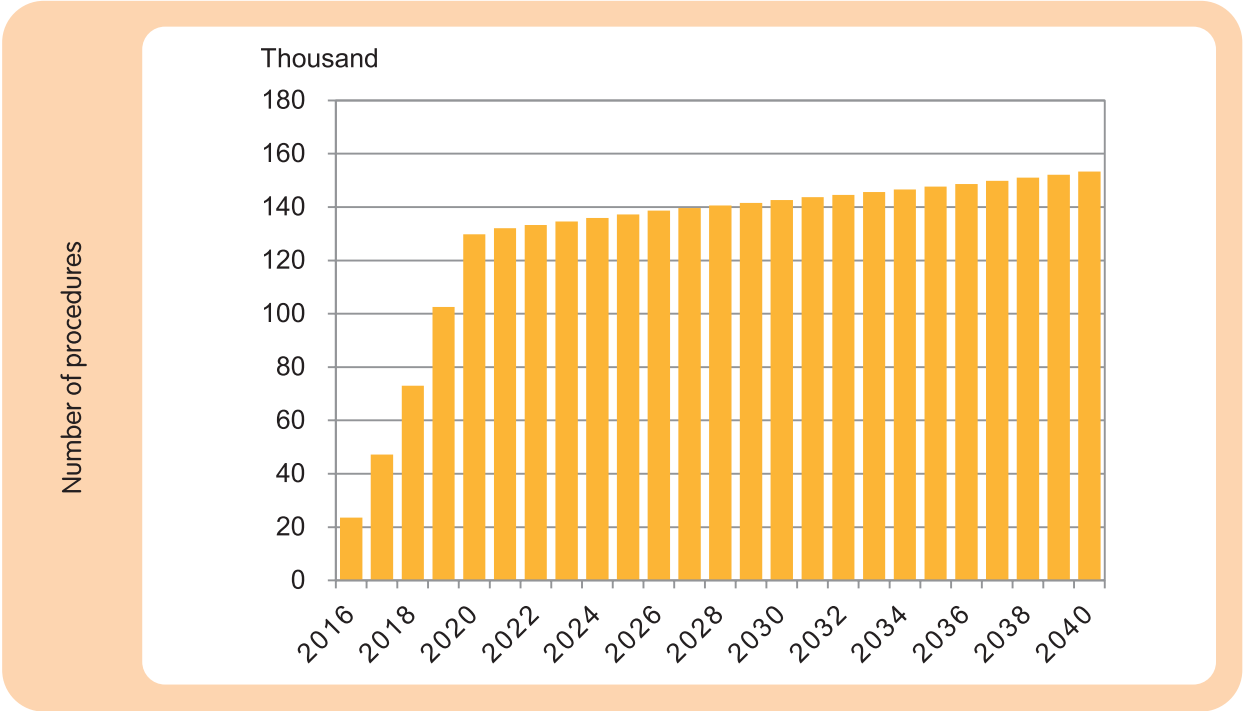
8.20. The projected additional private health expenditure under the forecast scenario has incorporated the effect of cost savings resulted from the shift of in-patient procedures to an ambulatory setting under the VHIS. For example, with the implementation of the VHIS, the majority of endoscopies are expected to be performed in ambulatory instead of in-patient setting, resulting in cost savings and a lower expenditure for these procedures. Since this offsetting effect is more notable in the early years of the implementation of the VHIS, the additional private health expenditure due to the VHIS is relatively less significant in these years.

Shift of Activities from In-patient to Ambulatory Setting

8.21. The effect of the VHIS on the healthcare system can also be manifested in terms of healthcare delivery mode. Currently, a significant proportion of clinical procedures such as endoscopies are performed in in-patient setting. According to the estimate by the Consultant, about 40%-65% of endoscopies are performed in an in-patient setting with overnight stay. This situation could be attributed to the fact that existing Hospital Insurance often requires proof of overnight stay in order to provide coverage for these procedures, even if the procedures concerned do not necessarily require hospitalisation. Under the VHIS, there would be opportunities for these procedures to be shifted from in-patient to ambulatory setting. This is because prescribed ambulatory procedures (such as endoscopies) would be covered under the Minimum Requirements, and the benefit levels would be set based on price levels in the ambulatory procedure market in order to encourage the shift of activities to ambulatory setting.

8.22. Under the forecast scenario, it is expected that a significant proportion of in-patient procedures would be conducted under ambulatory setting instead. This shift in activities, together with nominal substitution of public sector activities, could lead to an increase in the number of ambulatory procedures performed in the private sector. Take endoscopies as an example. Compared with the baseline scenario, it is projected that under the forecast scenario an additional 24 000 endoscopies would be performed in private ambulatory setting in 2016 (**Figure 8.11**). The corresponding figure in 2040 is projected to increase to 153 000.

Figure 8.11 Additional Number of Endoscopies Performed in Private Ambulatory Setting due to VHIS



8.23. As the shift of activities from in-patient setting to ambulatory setting would be concentrated in less complex activities with shorter hospital stays, private hospitals are expected to handle more complex procedures that generally require longer hospital stays. Compared with the baseline scenario, the average length of stay in private hospitals under the forecast scenario is projected to increase by 0.7 day in 2040. Meanwhile, the VHIS will bring about an increase in demand for private healthcare services that require hospitalisation, which would lead to an increase in the total number of private overnight in-patient bed days as compared with the baseline scenario. During the initial years, such increase would follow a narrowing trend as the activity shift toward ambulatory setting would be an offsetting factor. Yet the increase is expected to enlarge thereafter when the activity shift is largely realised in the medium term. In 2040, it is projected that the additional number of private overnight in-patient bed days under the forecast scenario would be around 150 000 or 13% more than that under the baseline scenario (**Figure 8.12**).

Figure 8.12 Additional Number of Overnight In-patient Bed Days in Private Healthcare Sector due to VHIS

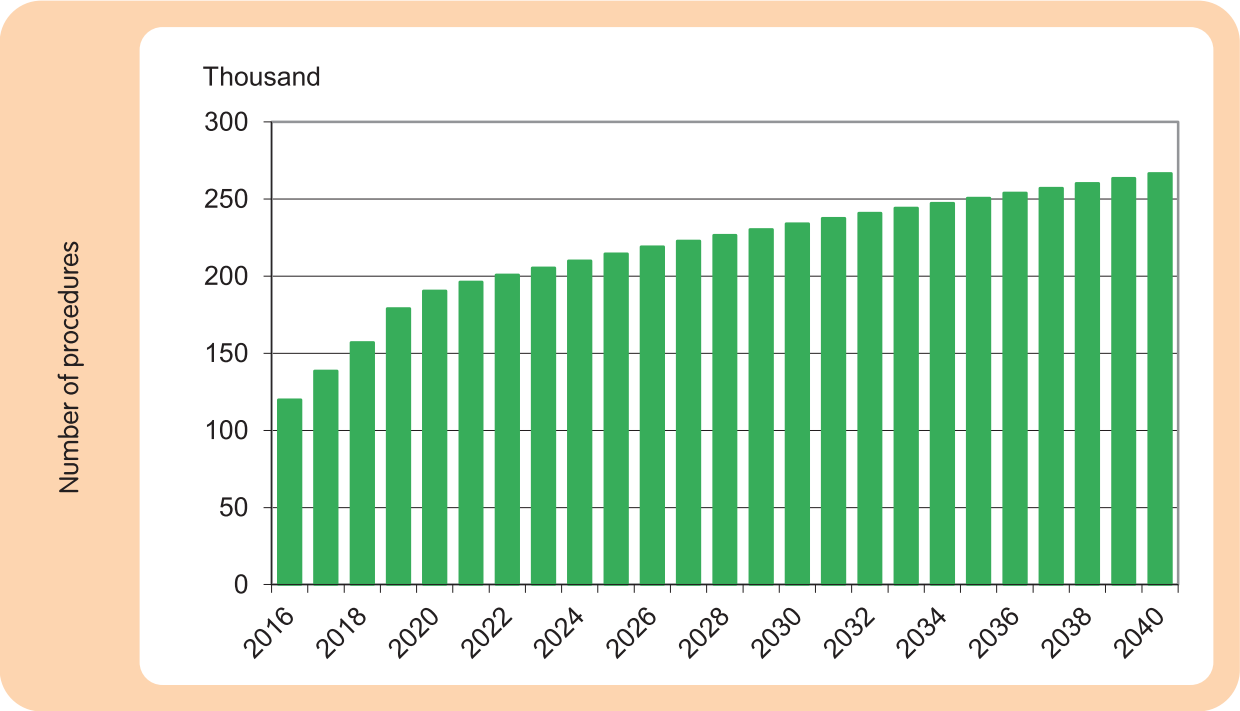


Nominal Substitution of Activities from Public Healthcare Sector

8.24. A major factor underlying the growth of activities in the private healthcare sector under the forecast scenario would be nominal substitution from the public sector, i.e. activities that would otherwise be sought to be performed in the public sector under the baseline scenario. It should be borne in mind that the substitution of these activities is nominal in the sense that it would unlikely be translated into any direct reduction in activities, bed days or expenditure of the public healthcare sector because of the continued rise in demand for public healthcare services due to an ageing population. Nevertheless, patients in the public healthcare sector would be able to benefit from enhanced accessibility of public healthcare services through reduction of waiting time. Resources allocation could also be optimised for improving the quality of public healthcare services.

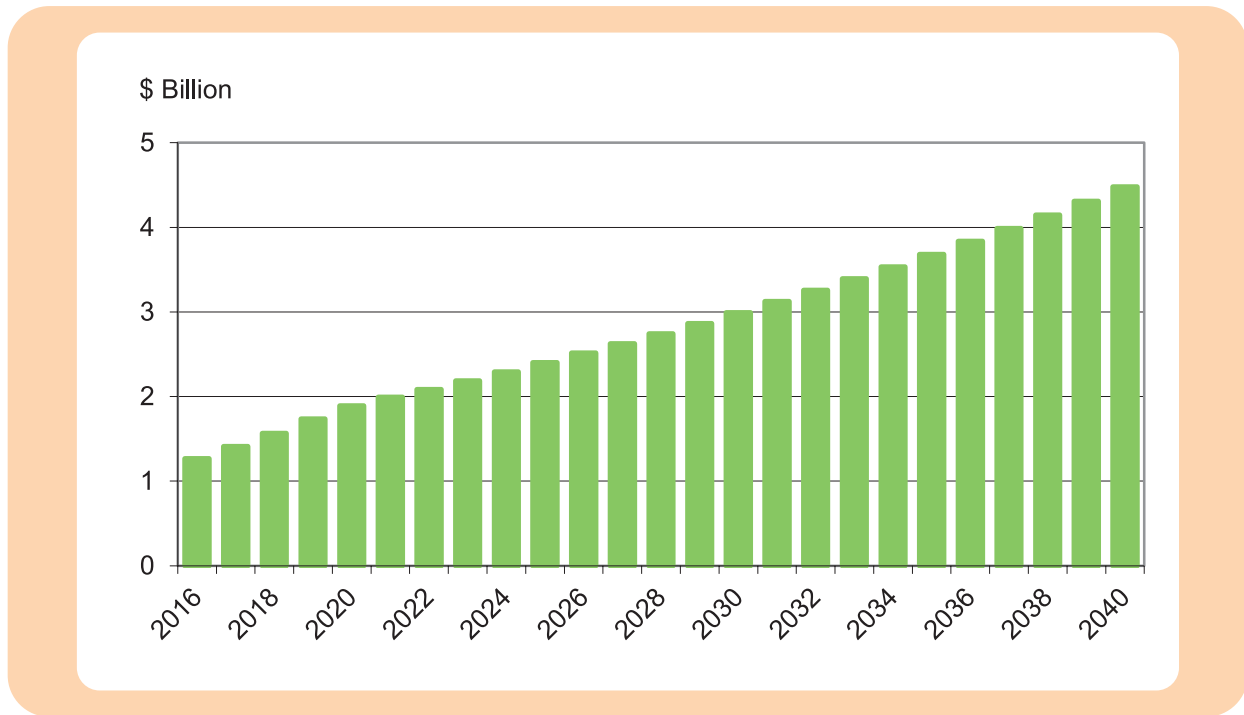
8.25. Under the forecast scenario, it is projected that in 2016, the number of procedures (the vast majority being advanced diagnostic imaging tests, endoscopies and non-surgical cancer treatments) nominally substituted from the public healthcare sector would be around 120 000 (**Figure 8.13**). In 2040, the corresponding figure is projected to increase to around 267 000.

Figure 8.13 Nominal Substitution of Procedures from Public Healthcare Sector under the VHIS



8.26. Compared with the baseline scenario, the nominal substitution of public health expenditure arising from the nominally substituted activities under the forecast scenario would be around \$1.3 billion in 2016 (**Figure 8.14**). The corresponding figure in 2040 is projected to be about \$4.5 billion. Over the projection horizon, the cumulative amount of nominally substituted public health expenditure would be approximately \$70 billion. This would be considerably larger than the \$4.3 billion required for supporting the HRP and the estimated \$6.4 billion (\$256 million x 25 years, assuming that the annual ceiling on claimable premiums is \$3,600 per person insured) of tax revenue forgone under the tax deduction proposal over the same projection horizon.

Figure 8.14 Nominal Substitution of Public Health Expenditure under the VHIS



8.27. In terms of public overnight in-patient bed days, under the forecast scenario, it is projected that the number of nominally substituted bed days arising from the nominally substituted activities would be around 53 000 in 2016 (**Figure 8.15**). The corresponding figure in 2040 is projected to be 155 000. Over the projection horizon, the cumulative number of nominally substituted public overnight in-patient bed days is projected to be 2.8 million.

Figure 8.15 Nominal Substitution of Overnight In-patient Bed Days From Public Healthcare Sector under the VHIS



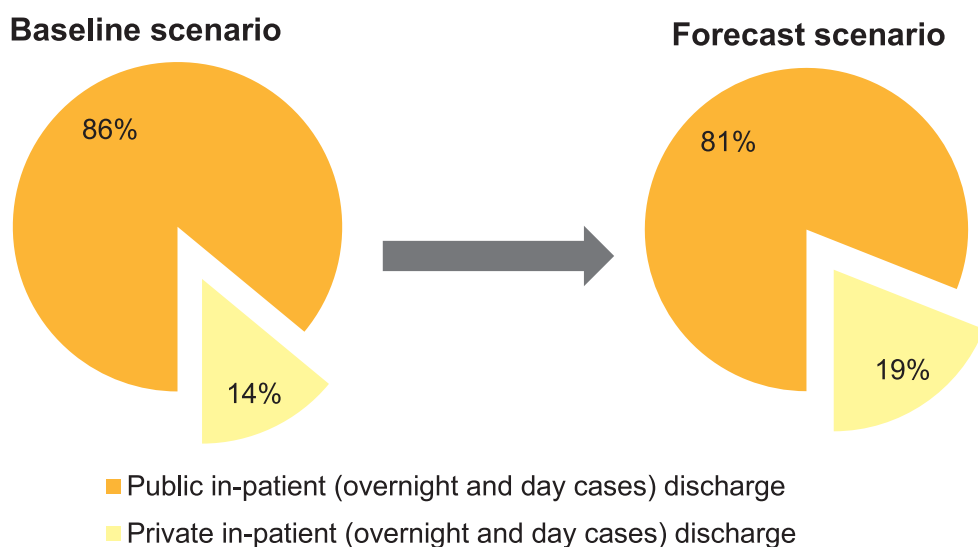
Balance of Public and Private Healthcare Sectors

8.28. The VHIS is not intended as a total solution to the challenges of our healthcare system, but one of the turning knobs in adjusting the balance of the public and private healthcare sectors to the benefit of long-term sustainability of our healthcare system. The ensuing paragraphs show how the VHIS is expected to affect the public-private balance in terms of in-patient (overnight and day cases) discharge, overnight in-patient bed days and health expenditure, thus leading to a notable adjustment in public-private balance in the long-term. By better enabling the private sector to take on more patients with the means and inclination to seek care from outside the public sector, the VHIS will recalibrate the public-private balance to a healthier and more sustainable level.

Analysis by In-patient (Overnight and Day Cases) Discharge

8.29. Under the forecast scenario, the growth of activities in the private sector and the nominal substitution of activities from the public sector are expected to help redress the public-private imbalance in respect of in-patient activities. In terms of in-patient (overnight and day cases) discharge, under the baseline scenario, the proportions of public and private in-patient (overnight and day cases) discharge are projected to be 86% and 14% respectively in 2040 (**Figure 8.16**). Under the forecast scenario, the private sector share is expected to expand significantly, and the proportions of public and private in-patient (overnight and day cases) discharge are projected to be 81% and 19% respectively.

Figure 8.16 Projected Proportions of Public and Private In-patient (Overnight and Day Cases) Discharge in 2040

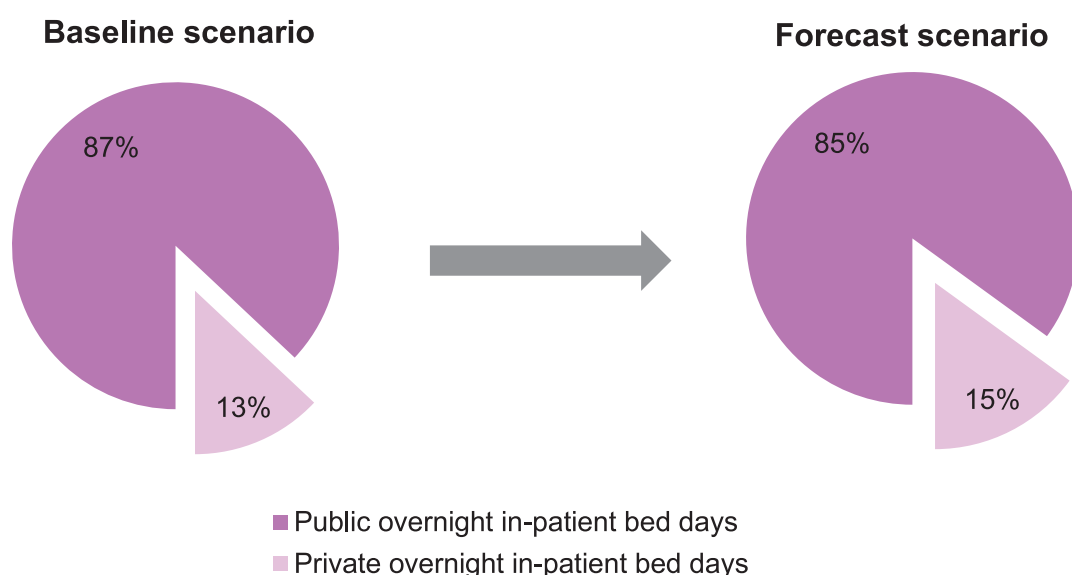


8.30. Although the projected adjustment is not phenomenal, it should be borne in mind that, due to predominance of the public sector in in-patient care, a small degree of nominal substitution of activities from the public healthcare sector already presents a remarkable increase in capacity demand for the private healthcare sector. It is important to ensure that the private healthcare market has the capacity to absorb the demand arising from nominal substitution of these activities.

Analysis by Overnight In-patient Bed Days

8.31. The adjustment in public-private balance in terms of overnight in-patient bed days is expected to be less prominent than in the case of in-patient (overnight and day cases) discharge. This is because the coverage of prescribed ambulatory procedures under the VHIS would help facilitate the delivery of healthcare services in ambulatory setting, thus resulting in a reduction of unnecessary overnight hospital stay in the private sector. In 2040, under the baseline scenario, the proportions of public and private overnight in-patient bed days are projected to be 87% and 13% respectively (**Figure 8.17**). Under the forecast scenario, the proportions of public and private overnight in-patient bed days are projected to be 85% and 15% respectively.

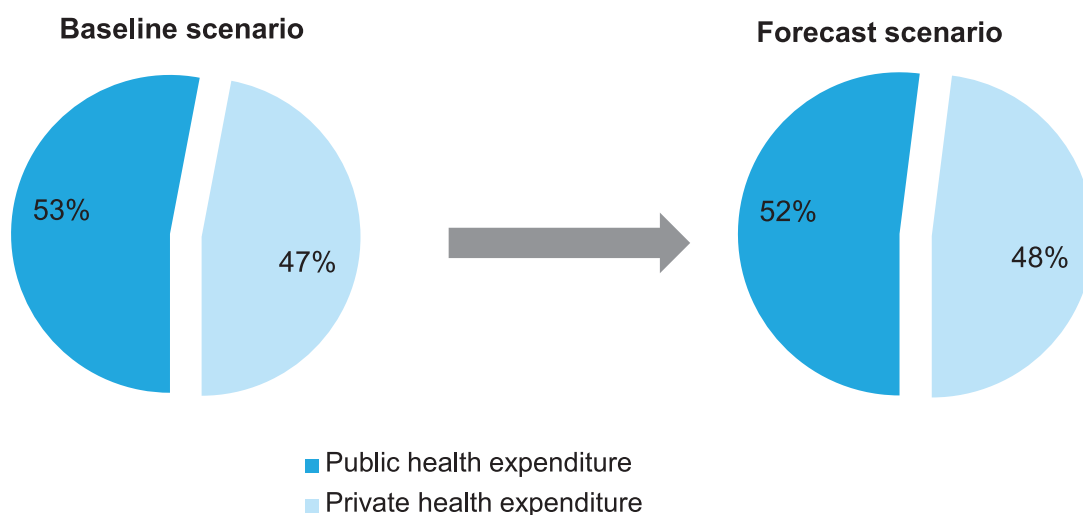
Figure 8.17 Projected Proportions of Public and Private Overnight In-patient Bed Days in 2040



Analysis by Health Expenditure

8.32. The adjustment in public-private balance in terms of health expenditure is also expected to be more moderate than in the case of in-patient (overnight and day cases) discharge. Despite the growth of private health expenditure and the nominal substitution of public health expenditure, the cost-efficiency measures to be introduced under the VHIS would help bring medical inflation in the private sector under better control, thereby helping contain the growth of private health expenditure. This would translate into a less significant change in public-private balance in terms of health expenditure compared to the change in balance of public-private in-patient (overnight and day cases) discharge. In 2040, under the baseline scenario, the proportions of public and private health expenditure are projected to be 53% and 47% respectively (**Figure 8.18**). Under the forecast scenario, the proportions of public and private health expenditure are projected to be 52% and 48% respectively.

Figure 8.18 Projected Proportions of Public and Private Health Expenditure in 2040



CHAPTER 9 WAY FORWARD

WE NEED YOUR VIEWS

9.1. We need your support and constructive views to the detailed proposals for implementing the Voluntary Health Insurance Scheme (VHIS). In particular, we welcome your views on the following issues –

- (a) Do you support introducing a regulatory regime for individual Hospital Insurance so that such products must comply with the Minimum Requirements prescribed by the Government?
- (b) Do you have any particular views on the 12 Minimum Requirements proposed for improving the accessibility, continuity, quality and transparency of individual Hospital Insurance?
- (c) In order to encourage employers to maintain Hospital Insurance cover for their employees, we propose that group Hospital Insurance should not be subject to the Minimum Requirements. Do you agree with this proposal?
- (d) In order to enhance protection for individual employees, we propose the arrangements of Conversion Option and Voluntary Supplement(s) for group Hospital Insurance. Do you agree with the proposed arrangements?
- (e) Do you support setting up a High Risk Pool with Government financial support, which is the key enabler of guaranteed acceptance with premium loading cap?
- (f) Do you support providing tax deduction for premiums paid for individual Hospital Insurance policies owned by taxpayers covering themselves and/or their dependants that comply with the Minimum Requirements (i.e. policies of Standard Plan and Flexi Plans); and premiums paid for Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies?
- (g) Do you support the arrangements proposed for policyholders of existing individual Hospital Insurance policies who, upon expiry of the existing policies, wish to migrate to VHIS policies (i.e. policies that comply with the Minimum Requirements); and the grandfathering arrangements proposed for existing policies that do not comply with the Minimum Requirements?

- (h) Do you support establishing a regulatory agency under the Food and Health Bureau to supervise the implementation and operation of the VHIS; and a claims dispute resolution mechanism for resolving claims disputes under the VHIS?

IMPLEMENTATION TIMETABLE

9.2. We will consolidate and analyse the views received from this public consultation exercise. With community support for the proposals in this Consultation Document, we will proceed to implement the VHIS through enacting a new legislation. We expect that the bill and subsidiary legislations required for the VHIS would be introduced in 2015/16.

INVITATION OF VIEWS

9.3. Please send us your views on this Consultation Document on or before 16 March 2015 through the contact below.

Address: Healthcare Planning and Development Office,
Food and Health Bureau, 19/F, East Wing,
Central Government Offices,
2 Tim Mei Avenue, Tamar, Hong Kong
Fax: 2102 2525
E-mail: vhis@fhb.gov.hk
Website: www.vhis.gov.hk

9.4. It is optional for you to supply your personal data in providing views on this Consultation Document. Any personal data provided with a submission may be transferred to the relevant Government bureaux and departments for purposes directly related to this consultation exercise. The Government bureaux and departments receiving the data are bound by such purposes in their subsequent use of such data.

9.5. The names and views of individuals and organisations which put forth submissions in response to this Consultation Document may be published for public viewing after conclusion of the public consultation exercise. This Bureau may, either in discussion with others (whether privately or publicly), or in any subsequent report, attribute comments submitted in response to this Consultation Document.

9.6. To safeguard your data privacy, we will remove your relevant data (if provided), such as residential/return address, e-mail address, identity card number, telephone number, facsimile number and signature, where provided, when publishing your views.

9.7. Please indicate if you do not want your views to be published or if you wish to remain anonymous when your views are published. Unless otherwise specified, all responses will be treated as public information and may be publicised in the future.

9.8. Any persons providing personal data to this Bureau in the submission will have rights of access and correction with respect to such personal data. Requests for data access and correction of personal data should be made in writing to:

Address: Senior Executive Officer (Healthcare Planning and Development Office)
Food and Health Bureau,
19/F, East Wing,
Central Government Offices,
2 Tim Mei Avenue, Tamar,
Hong Kong.

Fax: 2102 2525

E-mail: vhis@fhd.gov.hk

Appendix A Working Group and Consultative Group on Health Protection Scheme

Membership of Working Group on Health Protection Scheme of Health and Medical Development Advisory Committee

Chairman

Permanent Secretary for Food and Health (Health)

Non-official members

Mr David ALEXANDER

Mr Victor APPS

The Hon Bernard Charnwut CHAN, GBS, JP

Prof CHAN Wai-sum

Mr CHU Wing-yiu

Dr David FANG Jin-sheng, SBS, JP

Dr Anthony LEE Kai-yiu

Dr LEUNG Pak-yin, JP

Prof Raymond LIANG Hin-suen, JP

Ex-officio members

Director of Health

Head, Healthcare Planning and Development Office, Food and Health Bureau

Terms of Reference of Working Group on Health Protection Scheme of Health and Medical Development Advisory Committee

To draw up proposal and make recommendations, with regard to relevant consultancy studies and views from the Consultative Group on Health Protection Scheme, to the Health and Medical Development Advisory Committee on matters concerning implementation of the Health Protection Scheme (HPS), including, but not limited to, the following –

- (a) legislative and institutional proposals for the HPS, including powers, functions and composition of the statutory HPS authority; the key provisions governing the high-risk pool and dispute resolution/mediation mechanism; and the supervisory framework (e.g. scheme features and mandatory requirements) for insurance products and healthcare services offered under the aegis of the HPS;
- (b) measures aiming to enhance the viability and mitigate potential risks of the HPS, and matters requiring Government intervention justified on grounds of enhancing the long-term sustainability of our healthcare system and safeguarding legitimate public interest;
- (c) key components of standard plan(s) under HPS, including benefit coverage, benefit limits, premium schedule, co-payment requirement, and standardised terms and conditions;
- (d) rules and mechanisms in support of the operation of HPS, including those concerning acceptance, renewal, underwriting, portability, plan migration, premium adjustment, transparency requirements, high-risk pooling, dispute resolution/mediation, and provision of top-up/add-on products on top of standard plan(s) under the HPS; and
- (e) the manner and extent to which public subsidy, specifically the use of the \$50 billion fiscal reserve earmarked to support healthcare reform, should be provided in the form of financial incentives under HPS or for other purposes in connection with healthcare reform.

Membership of Consultative Group on Health Protection Scheme of Health and Medical Development Advisory Committee

Chairman

Head, Healthcare Planning and Development Office, Food and Health Bureau

Non-official members

Dr George CAUTHERLEY
Ms Audrey CHAN Miu-ling
Ms Elaine CHAN Sau-ho
Mr George CHEW (until 3 September 2012)
Mr CHEUNG Tak-hai (until 21 May 2012)
Ms Clara CHIN Sheung-chi (since 1 September 2013)
Ms Vivian CHOI Ling-chi
Mr Barry CHUNG Chor-chun
Ms Ann COUGHLAN (since 22 March 2013)
Mr Vincent FAN Chor-wah
Ms Agnes HO Kam-har (until 18 January 2013)
Ms Luzia Rosa HUNG (since 4 September 2012)
Mr Jimmy KWOK Chun-wah, BBS, MH, JP
Mr Ronald LAI Chi-shing
Dr David LAM Tzit-yuen
Mr Dominic LAM Wai-kuen, MH (until 6 March 2012)
Mr Andy LAU Kwok-fai (since 12 July 2012)
Mr Joseph LAU Man-wai, BBS, JP
Ms Connie LAU Yin-hing, JP (until 14 March 2014)
Dr LAW Chi-kwong, GBS, JP
Ms Angie LEUNG Shuk-lan (since 14 May 2013)
Dr Donald LI Kwok-tung, SBS, JP
Mr Michael SOMERVILLE
Mr Peter TAM Chung-ho
Ms Nancy TSE Sau-ling, JP (until 31 August 2013)
Mr Patrick WAN Chi-tak
Mr Jeff WONG Kwan-kit (since 7 March 2012)
Prof Ray YEP Kin-man
Dr Henry YEUNG Chiu-fat
Ms Shirley YUEN

Ex-officio member

Director of Health or representative

IN MEMORIAM

The Consultative Group is very saddened that one of its Members, Mr CHEUNG Tak-hai, passed away in May 2012. The Chairman and all Members of the Consultative Group would like to express their deepest condolences to Mr CHEUNG's family.

Terms of Reference of Consultative Group on Health Protection Scheme of Health and Medical Development Advisory Committee

To provide views and suggestions to the Working Group on Health Protection Scheme on matters concerning implementation of the Health Protection Scheme (HPS), including –

- (a) legislative and institutional proposals for the HPS;
- (b) measures aiming to enhance the viability and mitigate potential risks of the HPS;
- (c) key components of standard plan(s) under HPS;
- (d) rules and mechanisms in support of the operation of HPS; and
- (e) the manner and extent to which public subsidy should be provided.

Appendix B Key Findings of Consumer Survey for Health Protection Scheme (renamed as Voluntary Health Insurance Scheme)

Introduction

1. In order to test viability of the proposed product design under the Health Protection Scheme (HPS), a consumer survey through face-to-face household interviews was conducted by the Consultant during May to August 2013. The key objective was to test the respondents' preference and willingness-to-pay towards the HPS Standard Plan by showing them the key features of the Standard Plan and corresponding indicative premium by age. To ensure good quality of responses due to time constraint, the questionnaire focused on the key questions most relevant to the product design. Targeting middle-income individuals who are generally more likely to purchase private health insurance, the survey was responded by a sample of 1 109 households and 1 936 individuals aged 18-64 living in private housing estates¹. The response rate of the survey was about 55%².

Key Findings

2. Of the respondents not covered by individual or family indemnity hospital insurance products at the time of survey (uninsured respondents), 68% indicated that they were willing to consider purchasing the HPS Standard Plan at the indicative premium rates³. This figure includes 7 percentage points who indicated willingness to pay extra premium for higher benefit levels than those in the Standard Plan (e.g. semi-private ward accommodation), and hence could be considered as potential buyers of the Flexi Plans. The figure of 68% also includes 13 percentage points who were willing to purchase the Standard Plan if the premium could be reduced. These respondents could be considered as potential buyers of the Standard Plan with the availability of financial incentives. They could also be considered potential buyers of Flexi Plans which would be allowed to comprise deductibles in exchange of a lower premium.

1 The sample set comprised households living in major private housing estates with median household income falling in the range of 10th to 90th percentile of household income for private housing estates (according to the results of the 2011 Population Census conducted by Census and Statistics Department) across the territory of Hong Kong. For Wan Chai District where there was no major private housing estate, the survey covered large street block groups instead, according to the same sampling criteria.

2 Out of 2 023 households successfully approached for conducting the survey, 1 109 households were willing to participate, giving a response rate of 55% on household basis.

3 An indicative premium schedule by age and gender was shown to the respondents so as to inform each respondent of the indicative premium rate that applies to him/her specifically.

3. Of the respondents already covered by individual or family indemnity hospital insurance products at the time of survey (insured respondents), 73% indicated that they were willing to switch to the Standard Plan at the indicative premium rates. This figure includes 10 percentage points who were willing to pay extra premium for higher benefit levels than those in the HPS Standard Plan, and 9 percentage points who were willing to switch to the HPS Standard Plan if the premium could be reduced.

4. The response to the key features of the Standard Plan was generally positive and broadly similar between the insured and uninsured respondents. A number of features were considered attractive by a majority of the respondents, including guaranteed renewal for life, coverage of chemotherapy and radiotherapy, coverage of procedures conducted in hospital day centres or clinics, government regulation of product design, and coverage of advanced diagnostic imaging tests. Besides, other features such as coverage of pre-existing conditions, upfront certainty of payment and charges, enhanced portability, and standardised insurance policy terms and conditions appealed to around half of the respondents.

5. Guaranteed acceptance of enrollments up to age 64 was considered an attractive feature by about 40% of the respondents. While some of the relatively young and healthy respondents might not view this feature particularly relevant at the moment, the level of entry age limit was found to considerably affect the uptake of HPS plans at a younger age. Assuming that guaranteed acceptance was only offered to those subscribers of age 40 or below, the average age that the uninsured respondents indicate to enroll in HPS plans was 33, which was markedly lower than the average of 41 if the entry age limit was set at 64.

6. The premium loading cap was considered attractive by about a quarter of the respondents. Among insured respondents with pre-existing conditions excluded from their existing plans, and uninsured respondents who had previous illness, chronic disease or risk indicators, 29% indicated that they were not willing to pay any premium loading. These findings taken together reflect that the respondents were generally sensitive to premium loading.

7. The Conversion Option proposed for allowing an individual covered by a group-based indemnity hospital plan to switch to an individual Standard Plan without re-underwriting upon leaving employment received extensive support. 82% of the respondents covered by employer-provided indemnity hospital insurance⁴ considered this option important by giving a score of 7 or above on a scale of 10 in terms of importance, and the median score was 8.

4 Including cover obtained through employers of family members.

8. To test the viability of No-gap/known-gap arrangement, the respondents were asked how likely they would use a panel doctor (from a group of doctors specified by the insurer) for a routine procedure (e.g. endoscopy, cataract extraction surgery) if the out-of-pocket expenses for the whole procedure would be fixed or no out-of-pocket expenses would be required. On a scale of 10 in terms of likelihood, 58% of the respondents gave a score of 7 or above, and the median score was 7.

Consultancy Study for the Health Protection Scheme

PricewaterhouseCoopers
final report

Executive Summary

Consultancy Study for the
Health Protection Scheme



This report was prepared for the use and benefit of the Food and Health Bureau (FHB) of The Government of Hong Kong Special Administrative Region. PwC does not accept or assume any liability (including for negligence) or duty of care for any other purpose or to any other person to whom this work product is shown or into whose hands it may come save where expressly agreed in our agreement with the FHB for this Study, nor for any use of this report, without full understanding of the reliances and limitations noted in this report.

We have assumed that the information provided to us by the Government, external parties and through published sources to be accurate. However, using this information in our analysis does not indicate PwC's endorsement or assurance over the accuracy of the information, and the reliability of the method of preparation. Also, the actuarial analysis does not constitute opinion or any other form of assurance.

There is a limitation to the accuracy of the results contained in this report because of the inherent uncertainty of any estimation of forecasts. PwC recommends the recipient be aided by its own actuary or other qualified professionals when reviewing this work product.

This report must be read in its entirety. Individual sections of this report could be misleading if considered in isolation from each other.



12 December 2013

Mr Richard Yuen, J.P.
Permanent Secretary for Food and Health (Health)
Food and Health Bureau
Government of the Hong Kong Special Administrative Region

Dear Richard,

Consultancy Study for the Health Protection Scheme: Final Report

Enclosed is the final report by PricewaterhouseCoopers Advisory Services Limited (PwC) on the Consultancy Study for the Health Protection Scheme. This report presents recommendations for the Health Protection Scheme, supported by implementation details and a framework for regular industry data collection. The recommendations were developed drawing on research into the local market, relevant international experience and actuarial modelling to inform the HPS design.

This report represents the culmination of 16 months of data collection, research and analysis, over 40 workshops and consultations with industry stakeholders, two sector surveys and research into 5 comparator countries. The consultancy study was led and delivered by Kirsten Armstrong as the senior Actuary and team leader, working with a range of researchers and actuaries from PwC both in Hong Kong and globally.

A large number of individuals and organisations have contributed their time to this study. In particular we note the significant contribution of the Food and Health Bureau, the Hong Kong Federation of Insurers and members of the Consultative Group and the Working Group of the HPS Consultancy Study. We would like to thank them for participating in consultations, providing access to relevant data and their feedback and contribution throughout the project.

This work product has been prepared for, and only for, the Food and Health Bureau (FHB) of The Government of Hong Kong Special Administrative Region in accordance with the terms of the FHB contract of 28 May 2012, and for no other purpose. We do not accept or assume any liability (including for negligence) or duty of care for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

For and on behalf of PricewaterhouseCoopers Advisory Services Limited

Executive Summary

About the Project

Background and Scope

PricewaterhouseCoopers Advisory Services Limited (PwC) was contracted by the Food and Health Bureau (FHB) in May 2012 to undertake a consultancy study on the Health Protection Scheme (HPS), a voluntary government-regulated form of private health insurance (PHI). This project followed two previous Public Consultations on Healthcare Reform, which culminated in a high level proposal for the HPS.

This scope of this study required PwC to:

- Part I Review and analyse the current state of the PHI market in Hong Kong and PHI claims data held by insurers in Hong Kong; and recommend the framework for regular insurance market data collection and statistics compilation to support HPS implementation
- Part II Propose a technically feasible and actuarially sound design with full implementation details for the HPS and impact assessment.

Recommendations in relation to both Part I and Part II are set out in *Part A* of this report. The remainder of the report contains the supporting research and analysis for both Part I and Part II of the project, including additional research topics associated with scheme implementation.

Approach

Consistent with the Consultancy Brief which has guided this project, this report is supported by detailed actuarial modelling and extensive local and international market research using a wide range of methods. In line with the original proposal for HPS and the overarching goals of the PHI policy initiative, the focus of research has been **indemnity hospital insurance products** (IHIPs).

Actuarial modelling and analysis

An actuarial model of the market for IHIPs in Hong Kong was developed, in order to estimate the impact of HPS on premiums, and to project future uptake, policyholder profile, claims and premiums across the IHIP market, and to assess viability of financial incentives and dynamics of the high risk pool. The model also projects, at a high level, the impact of HPS on the public hospital sector and the private hospital and ambulatory sectors. Scenario testing of the viability of alternative options for HPS was undertaken. (See *Part B*)

Local Market Research

A range of research methods were used to understand and evaluate the current IHIP market, private hospital and ambulatory care markets, and consumer perspectives on IHIPs and the HPS. (See *Part C*)

- Data Collection** Data was collected from insurance companies, private hospitals and network panel providers. A wide range of existing data collections were collated, most notably the Thematic Household Survey, Census population estimates and projections, and data held by the Hong Kong Federation of Insurers (HKFI).
- Desktop Research** Desktop research was undertaken to develop a database of IHIPs currently on the market and to augment understanding of current market operation.
- Two market surveys** Two surveys were undertaken during this project. A survey of insurers was undertaken between October and November 2012, focusing on current practices in

underwriting and claims management. A survey of consumers was undertaken between May and August 2013 to test consumers' views on the HPS, the desirability of different product features and their interest in purchasing the product at different price levels.

Extensive Consultation More than 40 workshops and consultations have been conducted with industry participants throughout this project. This includes workshops with the Working Group, the Consultative Group and the Project Steering Group of the HPS, the HPS liaison group of the HKFI and the Academy of Medicine. Small group consultations and interviews were held with representatives of insurance companies, private hospitals, network panel providers, the Department of Health (DH), the Hospital Authority (HA) and the School of Public Health at the University of Hong Kong.

International Market Research

Considerable international literature was reviewed for this report, in order to inform recommendations for the design and implementation of the HPS and to benchmark and refine assumptions for the actuarial modelling. Eight thematic studies on topics relevant to HPS implementation were developed (See *Part D*).

This research was augmented with detailed case studies of five countries selected in consultation with the Food and Health Bureau: Australia, Ireland, the Netherlands, Switzerland and the US (See *Part E*). For each of these countries, desktop research was undertaken, data analysed and consultations held with in-country subject matter specialists to understand local practices, current debates and issues not addressed by the literature.

Background Research Findings

The research chapters in this report – Parts B to D – each highlight key findings of the research and implications for the HPS. In summary:

Many features of the HPS are supported by the evidence

This includes:

- The establishment of a specialist regulator to oversee the HPS (*Chapter 13*)
- Key benefits of the proposed HPS plan, such as guaranteed acceptance, guaranteed renewal, coverage of pre-existing conditions and maximum waiting periods (*Chapter 14*)
- Expansion of plan coverage to cover selected ambulatory procedures (*Chapters 14 and 17*)
- An enhanced claims dispute resolution organisation (*Chapter 16*)
- Packaged pricing as a strategy to manage costs and medical inflation (*Chapter 17*)
- Support for high cost claimants through a government subsidy for the High Risk Pool (*Chapter 18*)

Review of local market experience supports a need for the changes proposed through HPS, to address low coverage for people at older ages and people with health conditions, and the rapid drop-off in coverage as people transition into retirement.

Some features of the HPS are not supported by the evidence

No claims discounts (*Chapter 17*) for health insurance are not favoured internationally, as there is a strong risk that policyholders will fall back to the public health system, in order to preserve their no claims discount and policyholders may be discouraged from seeking appropriate treatment to improve their health.

Medical Savings Accounts (*Chapter 18*) are not widespread, but are most relevant in countries with high taxes on investment earnings and savings, such as the US, New Zealand and Hungary, where people are happy to accept the restrictions on use of funds associated with Medical Savings Accounts in return for tax incentives. Given the limited tax payable on interest and earnings, and the strong savings culture which exists in Hong Kong, further tax incentives for medical savings accounts are unlikely to boost overall savings and may simply result in a cost to government and increased product administration costs.

A dual market is not likely to be sustainable

The Second Stage Public Consultation on Healthcare Reform (hereinafter referred to as the ‘Second Stage Consultation’) proposed that the HPS could be a separate standalone product which is marketed alongside existing private health insurance products in the Hong Kong market. This would mean that HPS products are the only products on the market with guaranteed acceptance, guaranteed renewal, coverage of key health conditions and minimum benefits in general, while other products on the market would continue in their current form.

Dual markets, such as the one described above, where one set of products is heavily regulated and sold alongside less-regulated products, are rare in PHI, reflecting long-term sustainability issues. Many countries, including the five countries examined in detail for this project, require all indemnity hospital insurances to comply with the minimum benefit requirements. This is called a **single market**, where all products are subject to the same minimum standards.

The experience of the Blue Cross and Blue Shield plans in the US (see *Chapter 14*), provides a clear example of how dual markets can fail many consumers. More regulated products struggled to survive alongside less-

regulated fully-underwritten products with no guaranteed acceptance. The financial viability of community rating¹ in the not-for-profit Blue Cross and Blue Shield plans unravelled when for-profit insurers entered the market and expanded underwriting, “cherry picking” members with the lowest health risks, and leading to a gradual contraction in the availability and affordability of insurance for people with pre-existing conditions and growing levels of un-insurance for people with pre-existing conditions – ultimately the main driver of the 2010 US healthcare reforms. Policymakers first at State level and then at the Federal level had to intervene to ensure market sustainability.

While some countries in Europe have managed to maintain dual markets, there is an important distinction in comparison to the Hong Kong market. The Hong Kong market is dominated by fully-underwritten products without guaranteed acceptance, whereas most European markets were dominated by non-profit mutuals offering the more regulated community-rated, guaranteed acceptance products, before underwritten products were introduced by for-profit insurers. We are not aware of any examples where sustainable markets have developed in the reverse direction – that is, where more-regulated guaranteed-acceptance products have been able to grow sustainable market share, having been introduced alongside existing less-regulated products.

The dual market approach is unlikely to achieve the goals of the HPS. There is a clear risk that the US experience is replicated here, with healthy people opting for less regulated products, and HPS becoming only for those with poor health conditions. If that occurred, HPS would become prohibitively expensive, potentially unsustainable, and many of the objectives of HPS – such as enabling people to stay insured into older ages, better protection, enhanced consumer protection, relieving public queues – would unlikely be achieved.

There are clear opportunities to improve market efficiency and value-for-money for consumers

By way of example, insured private hospital activity is highly concentrated in a small number of procedures such as endoscopies and colonoscopies. About 40% of inpatient claims, in terms of both number and cost, in Hong Kong’s IHIP market are in respect of endoscopies and colonoscopies. A large proportion of this activity - between 40% and 65% - occur as overnight stays which has a higher cost than same day activity. Current PHI product design, which often requires proof of an overnight stay in order to cover a procedure, may well have contributed to this outcome. In contrast, less than 10% of colonoscopies and endoscopies involve inpatient stays in Australia. If the HPS design can encourage more of these procedures to be done as day procedures, there are clear cost and savings and efficiency gains to be achieved. Hospital resources and capacity could be released for the more complex procedures which might be required when access to PHI is strengthened for older people and those with health conditions – at present, private hospitals provide relatively few services to older people, compared to the public sector.

A second area to improve market efficiency relates to expense/profit loadings, particularly in the individual market. The individual PHI market offers lower value-for-money than the countries studied in detail for this report, with a benefit ratio (benefits as a percentage of premiums) of 57%. This is well below those of the countries we studied. The benefit ratio for Australian health insurers was 85% in 2010/11, in Ireland, the average benefit ratio (2010) for private insurers was 88% and in the US, legislation now sets a floor on the medical loss ratio (the percentage of premiums spent on healthcare services) of at least 80% for individual and small group plans and at least 85% for insurers selling to large groups (100 employees or more). These markets all make considerable use of online sales and telephone sales, have streamlined electronic claiming and payment processes, further simplified claims approval and payment processes for in-network health providers and legislated minimum benefits which reduce the need for advice before purchasing insurance. Many aspects of HPS allow Hong Kong’s insurance market to take advantage of these efficiencies.

A third area to improve market efficiency relates to the uncertainty in out-of-pocket costs and total billed amounts prior to treatment, creating uncertainty for members, insurers and providers. In the countries studied, consumers benefit from more upfront budget certainty when making claims, using features such as informed

¹ Community rating refers to premium structures which require health insurance providers to offer health insurance policies within a given territory at the same price to all persons without medical underwriting.

financial consent, packaged pricing, “known-gap arrangements” and packaged benefit limits. These arrangements have also increased upfront certainty for insurers and providers and have been a tool for long-term cost containment at system level, helping to bring medical inflation under better control and deterring unnecessary services. At present, these measures are not yet common in the Hong Kong market, particularly for the individual segment.

Portability between different insurers’ HPS products will present particular challenges

Probably the key difference between the proposed HPS design and the mandatory product features in other countries relates to the ability for insurers under HPS to apply premium loadings to policies, reflecting the policyholder’s health risks – none of the countries we reviewed allow premium loadings for health status. In Australia, Ireland, the Netherlands and Switzerland, community rating is in place, while in the US, only a limited number of ‘loading’ factors are allowed. This means that policyholders are not faced with unexpected premium changes when moving to a new insurer. Policies are highly portable and competition is enhanced by the ability for consumers to move easily between insurers.

In Hong Kong, there is no proposal for community rating and insurers will retain the ability to underwrite policyholders using whatever factors they consider appropriate, in order to manage adverse selection. This will lead to particular challenges for portability. If different insurers use different loading factors or underwriting variables, for example, then policyholders may face a real deterrent to shifting to a new insurer, if they are re-underwritten by that insurer. This in turn would be detrimental to competition.

Issues around portability will therefore need to be addressed for HPS to ensure policyholders can move between insurers, hence encouraging greater market competition. Prior to the 2010 US health insurance reforms, portability from group plans to individual plans at retirement was the key focus of portability provisions, and a similar focus is required for Hong Kong. FHB will need to monitor portability in the market to ensure that the provisions in place are adequate – the countries examined have generally needed to refine their portability provisions over time to protect consumer interests and stimulate competition.

Market transparency is critical for competition, consumer protection and optimal regulation

Real competition is stifled when consumers cannot make easy comparisons across products. Unfortunately, product comparison in Hong Kong is sometimes difficult as definitions and interpretation are not standardised across insurers and information is difficult to access and digest. Benefit levels for some components of care vary across insurers and patients would find it difficult to estimate out-of-pocket costs in many cases. Different insurers categorise different procedures as major, intermediate or minor, with different maximum benefit limits, and often this information may not be readily available in advance of policy purchase.

To be successful, the proposed HPS policy initiative needs to promote market competition and transparency, and support informed consumer choices. The proposal for standardised terms and conditions for HPS is an important step in this direction, but the countries in our international study have undertaken far more broad-ranging approaches to enhance transparency and comparability. All the countries examined have implemented a range of measures to enable effective comparison of products and premiums across the sector, in order to enhance consumer competition. These measures include standardised product levels and standardised wording and terms, standardised product information statements, and consumer-friendly web-based resources to enable consumers to compare PHI products and premiums.

Cost-sharing arrangements offer policyholders greater certainty in out-of-pocket costs

Cost sharing refers to the net out-of-pocket payments which policyholders make to health providers, after they have been reimbursed by health insurers. The PHI products currently available leave uncertainty for consumers in terms of out-of-pocket expenses. It is currently difficult for a consumer to understand the value of these benefit levels, the services covered and the out-of-pocket costs likely to be incurred. The actual costs for medical services also vary depending upon the hospital used and the ward setting.

Research revealed that the PHI offered in many other countries provides policyholders with considerably **more certainty** regarding their out-of-pocket costs than exists under typical insurance policies in Hong Kong. In both Australia and Ireland, for example, policyholders typically pay only the first \$x or €y of their claim (the ‘deductible’) with insurers paying the full cost of a claim above this level. ‘No gap / known gap’ arrangements in Australia have enabled this. In Switzerland and the Netherlands, the amount a policyholder pays in a year is heavily regulated, consistent with the mandatory nature of PHI and its role and as the primary funder of health in those countries. Lifetime limits and annual limits for essential health services are not allowed in any of the five countries.

Typical cost-sharing features include:

- Predictable out-of-pocket costs for essential services, like hospital costs, except where a patient chooses a non-network hospital.
- Some cost-sharing for health services more within the patient’s control, particularly primary care and out-patient services, and sometimes subject to an annual limit.
- Evidence-based limits on the number of advanced diagnostic procedures per annum, with the option for higher out-of-pocket costs to deter unnecessary advanced diagnostic procedures and reimbursement levels set to encourage patients to use day facilities.

One outcome of these arrangements is that insurers have been motivated to negotiate pricing arrangements and service level agreements with health providers – including packaged pricing – in order to manage their financial risks.

Packaged pricing requires regulatory support

Packaged pricing is an important goal of the planned HPS policy initiative, but will require regulatory support over a period of years. This is particularly important for Hong Kong because unlike Australia and Ireland, there is no dominant insurer which can use its market position to drive the introduction of packaged pricing and negotiate terms with health providers. Minimum requirements for the introduction of packaged pricing include:

- standardisation of the way in which hospitals and doctors record diagnoses and procedures, using ICD 10 or more recent codes, to support implementation of DRGs consistent with the public hospital service.
- Collection of data across the industry to support DRG-based analysis, and development of average or benchmark comparison prices using industry data. This data would include information on hospital costs, doctors’ fees, as well as length of stay.
- Benchmark cost data to inform insurers’ negotiations with health providers.

Other elements which have helped drive packaged pricing in the countries examined include the removal of annual and lifetime caps and limits, in order to motivate insurers to negotiate with hospitals and doctors on behalf of policyholders; and a ‘default’ benefit which could be referenced by insurers to support negotiations with health providers.

Government support through financial incentives is widely offered, but must be well-designed to be effective

Most countries have some form of financial incentive or disincentive arrangement for PHI. There is, however, no standard practice, and consistency with the overall tax system is key. There is some evidence that tax incentives and direct subsidies targeted at individuals have encouraged the uptake of PHI, and stronger evidence that tax incentives and direct subsidies targeted at employers can lead to more rapid growth in PHI coverage. Tax disincentives – penalties for not taking up PHI – have been more effective than financial incentives in encouraging uptake, but are inconsistent with the voluntary nature of the HPS.

Many countries have started with fairly broad incentives, and gradually narrowed them over time to limit the dollar cost of the incentive, better target them at those most responsive to the incentive, or those considered most in need - particularly low income or high risk groups. The US Pre-existing Condition Insurance Program (PCIP) and higher premium rebates for older people in Australia are two such examples.

Based on the available evidence, the HPS premium discount for new joiners proposed in the Second Stage Consultation is unlikely to be an adequate incentive (in isolation) to encourage a significant number of new people to take up PHI, although it will likely encourage some people to switch to HPS from a non-HPS policy. Further, there is a lack of convincing evidence to show that the proposed medical savings component would attract enrolment or boost overall savings. However, support from the Hong Kong Government to the High Risk Pool would be consistent with international trends to target incentives toward high risk groups.

Governments typically have a lead role in claims dispute resolution

The Second Stage Consultation proposal for a Government-regulated health insurance claims arbitration process to handle disputes over health insurance claims and arbitrate disagreements between patients, private health insurers and/or healthcare providers is consistent with international best practice. In the countries reviewed, the Government, working together with industry, typically manages the main dispute resolution scheme for health insurance, recognising the unique nature of health insurance in providing social protection, and consistent with government's more hands-on approach to regulation of health insurance, as compared to other forms of insurance. Where Government does not directly manage the dispute resolution scheme, it is actively involved in the governance of the system, and these organisations are jointly governed by consumers, industry and government - Switzerland and the Netherlands are two examples.

Data collections need to be enhanced

While the management of Kaiser Permanente, a leading health insurer in North America with considerable success in care co-ordination, attribute their success to a culture of measurement, many unsuccessful reforms can be attributed to a lack of measurement and good quality information for decision making. Insurers have insufficient information to properly price risks, health providers have inadequate information to understand what constitutes 'best practice' let alone convince their peers of the desirability of change, patients and insurers have inadequate information to assess health provider quality and so higher prices become a poor proxy, and governments have insufficient information to measure the effects of reforms, and so support for reforms wanes over time.

Interviews with private health insurers in Australia indicated that the relatively slow progress in uptake of Diagnosis Related Groups (DRGs) relative to the public sector was attributed to a wide range of factors, but high amongst them was limited data on DRG costs and prices for insurers and poor understanding of the cost structures of private hospitals.

Lack of data has been one driver behind poor implementation of some risk equalisation systems, which themselves mean insurers continue to focus on selecting better risks, and less so on improving health risks and managing health costs, because the financial advantages to insurers of risk-selection continue to outweigh potential gains from efficiency improvements.

Yet current data collections in Hong Kong are relatively limited. Private hospitals and private health insurers do not record patient procedures using standardised coding, so industry-wide data collections contain significant gaps. There are no timely data collections available on the profile of policyholders, or the cost of hospital services. Developing a clear data collection and reporting strategy will be an important component of a successful policy initiative.

Key risks will need to be managed when HPS is introduced

In several countries, PHI reforms have fuelled medical inflation and activity growth, because policyholders no longer fund private healthcare directly out-of-pocket and hence are less likely to question the need for services. Countries like the Netherlands have taken aggressive steps to limit health expenditure growth, by capping overall premium and health price increases in 2012, and all countries in our study have taken direct regulatory action to manage specific health inflation and demand increases in their PHI systems. *Chapter 17* discusses these risks and successful management strategies in detail.

Advanced diagnostic and imaging services have been growing strongly in Hong Kong and, with these services to be included in the HPS minimum benefits, careful management of coverage is essential, to ensure demand does not grow uncontrollably. The use of packaged pricing, amongst other measures, will help to manage the risks to insurers associated with this expanding coverage. Cost sharing for certain services may also be required.

Clearly-defined minimum benefits, rather than broad definitions about services provided in hospitals, are also a common feature to manage costs and promote care in the right setting. Australia, Ireland, the Netherlands and Switzerland all define a very detailed list of procedures which are included in the minimum benefits package and all four countries have also defined a minimum benefit to be paid in respect of those services. The US is in the process of defining a package of Essential Health Benefits to come into effect from 2014. Such an instrument does not yet exist in Hong Kong. In addition to defining what is covered at the outset, active management of the list is required, to respond to new technology and changing medical practices.

To harness the significant potential gains available to industry, consumers and society more broadly, and reflecting the findings of the research, the key recommendations for a technically feasible and actuarially sound design for HPS are set out overleaf, with full details contained in *Part A*.

Scheme Design: Minimum Requirements across all IHIPs

This report proposes that the HPS Standard Plan becomes a set of **minimum benefits which apply to all indemnity hospital insurance products (IHIPs)**. These minimum standards apply to all new products sold in the Individual market immediately upon implementation of HPS. For the Group market, voluntary supplementary plans and conversion option would be introduced in the short to medium term, with the long-term goal of full compliance with the minimum requirements (see *Arrangements for the Group Market* overleaf). All insurers participating in the IHIP market must offer at least one HPS Standard Plan which offers guaranteed acceptance. All new subscribers would be provided with information about the HPS Standard plan, as a minimum.

The minimum requirements for the HPS Standard plan are summarised below.

Table 1: Summary of HPS Minimum Requirements

Features	Concept
Guaranteed acceptance	No turn away of new or migrating subscribers to the HPS Standard Plan during migration window. After the migration window, guaranteed acceptance to the HPS Standard Plan will be capped at an agreed maximum age.
Guaranteed Renewability	Available for life
Coverage of pre-existing conditions	Cover pre-existing conditions subject to the following waiting period : Year 1 – no coverage Year 2 – 25% coverage Year 3 – 50% coverage Year 4 onward – 100%
Minimum Coverage and Benefits	A schedule of the minimum range of procedures to be covered by the HPS Standard plan, along with minimum benefits payable for those services. The range of procedures will include specified ambulatory procedures including diagnostic colonoscopy and endoscopy, certain advanced diagnostic procedures (MRI, CT, PET) and chemotherapy and radiotherapy and related cancer treatment services (subject to the scope as defined by the regulator). For certain advanced diagnostic tests and procedures, minimum benefits will be defined as a packaged benefit limit .
Policyholder out-of-pocket costs	Annual cap on deductible and the coinsurance paid by insured member Clarity of out-of-pocket charges in relation to no gap / known gap services, where member chooses a health provider within their insurer's gap arrangements. No cap on out-of-pocket charges for expenses in excess of benefit limits.
Premiums	Age-banded premiums, with insurers free to underwrite subject to a maximum loading in the HPS Standard Plan of 200%.
Portability	Members can switch insurers without re-serving waiting period. Members can switch insurers without re-underwriting if they have had no claims in the past 3 years. Switching from an insurer's group plan on retirement or leaving employment to that insurer's HPS Standard Plan at standard premium rates (zero loading) , if they have been continuously employed and covered by the Group plan for at least one year.
Streamlined migration	Individual members can opt to migrate to HPS Standard Plan without re-underwriting, for their existing coverages.
High Risk Pool	Only HPS Standard Plan applicants will be eligible for access to the High Risk Pool
Incentives	HPS Standard Plans and Flexi-Plans eligible for incentives, as well as voluntary supplementary plans held by members of Group plans.

These features expand and refine the high level design for HPS presented as part of the Second Stage Consultation, in order to ensure scheme viability and sustainability. Key features are explained further below.

Guaranteed Acceptance

This proposal sees guaranteed acceptance into the HPS Standard Plan available during the migration window for all new members and all members migrating from an existing IHIP, **regardless of age**. After the migration window, guaranteed acceptance would be available **only for new subscribers up to age 40, and for those eligible for portability** (see *Portability* overleaf). This is a departure from the Second Stage Consultation which proposed guaranteed acceptance up to age 65. Research indicates that a high guaranteed acceptance age may not be sustainable and may lead to significant government outlays through the High Risk Pool. It may send the wrong signal to consumers who may be encouraged to wait until they are older or have developed a health condition to take-up IHIP. A lower guaranteed acceptance age provides a clear signal to members to take-up IHIP at an earlier age, reduces uncertainty for insurers, and reduces the potential cost of the High Risk Pool.

Minimum Benefit Coverage

A detailed schedule identifying what procedures are to be covered in the minimum package, and what minimum amount will be paid in respect of those services will be established. This approach is quite different from current insurance products which are defined more in terms of the setting of care (ie: whether the care was provided in a hospital inpatient setting). Establishing a detailed schedule of procedures and treatments which are covered avoids the need to adopt general definitions of hospital services, according to minimum periods of stay in hospital, a feature of many Hong Kong IHIP contracts. These definitions have provided a perverse incentive to provide less efficient care – overnight stays, when a day procedure would be adequate; inpatient day surgery when outpatient treatment would be appropriate. As well as encouraging efficiency in service delivery, establishing a list of covered procedures establishes a clear boundary between primary care – which is not intended to be covered by the HPS - and the hospital-equivalent services, which are covered. Without a clear list of what is covered and what is not, there would be constant tension between what is covered and what is not, with health providers having strong incentives to find ways to fall within the HPS definition.

The procedures included in the schedule will include an agreed set of procedures and advanced diagnostic tests which are more typically provided in an ambulatory, rather than an inpatient setting, and the circumstances under which they are covered. Consultations and research for this project suggest this should include: Certain advanced diagnostic tests (MRI, CT and PET scans); diagnostic colonoscopies and endoscopies; and chemotherapy and radiotherapy and related treatment services.

The minimum benefits schedule will identify the minimum benefit limits to be paid in respect of those services, targeting Ward level care and an expected patient co-payment. Benefits can be set to give a clear signal to providers to provide care in an efficient way – setting the minimum benefit at a ‘day procedure’ rate rather than the cost of an overnight stay. For certain procedures, the benefit limits will be set in terms of a **packaged benefit limit** and not the more traditional ‘itemised’ benefit limits.

Policyholder out-of-pocket costs

To enhance certainty for policyholders, we propose four important changes. First, **insurers will offer ‘no gap / known gap’ arrangements for an agreed set of services**, which fix the out of pocket costs the policyholder will pay if they use health providers working within their insurers’ gap arrangements. Further information on ‘no gap / known gap’ follows later, and a complete discussion is included in the appendix to *Chapter 17*, including measures which Government and health providers will need to implement, to enable insurers to offer ‘no gap/ known gap’ reimbursement.

Second, except for emergency cases, providers will be required to obtain **informed financial consent** from the patients so that patients are aware of the costs and the out-of-pockets costs that they will pay **in advance** of

their treatment. This should be undertaken for all types of claims, not just those provided on a ‘no gap / known gap’ basis.

Third, there will be an annual cap on the deductible and coinsurance payable (up to the prescribed benefit limit) which insurers can include in a HPS Plan. A sensible annual cap on the deductible and co-insurance allowed in the plan will minimise the risk of policyholders falling back on the public hospital system, because of expensive out-of-pocket costs. This approach provides more protection and certainty for policyholders than the approach proposed in the Second Stage Consultation, which allowed insurers to set a deductible at any level.

Fourth, there will be **no lifetime benefit limits**. Lifetime benefit limits leave considerable uncertainty for policyholders who maintain their insurance over longer periods of time. Indeed, it can be particularly punitive for people who have held IHIP for some time, which is inconsistent with HPS goals to make coverage accessible into older ages.

Premium Structure

Under this proposal, insurers retain the ability to establish their own premium rates, subject to the prescribed premium structure for a HPS Standard plan. The Second Stage Consultation proposed that age-based premiums be charged, with insurers retaining the flexibility to underwrite new policyholders subject to a maximum loading of 200% of the standard premium for a person in that age band. To enhance consumer transparency, we propose that premiums are published on a standardised basis, using ‘age last birthday’ as the common standard. Rates may be separately identified for males and females. Insurers retain the right to use their own underwriting standards for HPS applicants. This includes determination of policyholders with a 200% or more loading and hence eligible for the High Risk Pool.

The No Claims Discount proposed in the Second Stage Consultation would be voluntary only. An alternative to the NCD being used in many countries is involvement in wellness programs and incentives or discounts for those who participate. Indeed, the US legislation will allow premium penalties for people who *don’t* participate in appropriate wellness programs. Research presented in *Chapter 17* highlights a number of ‘Best Buys’ and other strategies the World Health Organisation sees as effective in reducing the burden of chronic disease.

Portability

To enhance portability and so improve competition, specific provisions are proposed for policyholders transferring from one HPS-compliant product to another HPS Standard plan, and who have had no claims in the three preceding years. These people will be eligible for entry to the new Standard Plan using the same underwriting class as applied at their previous insurer, and will not be required to re-serve waiting periods. Detailed provisions and operational procedures for portability will need to be agreed with industry as HPS rolls out.

Without this provision, portability and hence both consumer protection and market competition would be seriously hampered. The approach we propose reflects a pragmatic balance between the need to provide barrier-free portability and the need to protect insurers from adverse selection. The operational success of these elements in enhancing portability must be monitored over time, and adapted where necessary to improve market competition.

Overall product viability

In order to test the viability of the proposed HPS Plan, a consumer survey targeted at middle-income individuals has been conducted through face-to-face household interviews. The main objective was to test respondents’ willingness-to-pay and preference towards a draft illustrative HPS Standard Plan. A strong majority of respondents (about 70%) indicated that they would be willing to purchase the proposed HPS Standard Plan. This result was consistent regardless of whether they are currently covered by individual or family indemnity hospital insurance. The respondents also responded strongly regarding the importance of

including Advanced Diagnostic Tests and Chemotherapy and Radiotherapy within the HPS benefit schedule. Full details of this survey are contained in *Chapter 11. Consumer Survey Results*.

Arrangements for the Group Market

The group market accounts for more than 40% of PHI membership, and ideally should enjoy all the elements of consumer protection which members in the Individual market can enjoy. Including group members in the minimum features of HPS will strengthen HPS as driver of market changes, such as ambulatory care, packaged pricing, tendency to use private services. Moreover, group insurance is far more cost effective than Individual insurance under current market dynamics, so efforts should be made to ensure Group coverage is maintained. However, international evidence indicates that employers are more sensitive to changes in the price of insurance than individuals, so phasing in of the requirements is required, to allow employers to gradually absorb the costs and minimise the risk of employers dropping Group insurance, to the detriment of employee interests. On balance, we consider it viable to set it as a long-term target to extend the minimum requirements to the group market, with a view to allowing time for employers to appreciate the enhanced protection and cost efficiency offered by the new system.

There should be a **transition period** in which employers and insurers can adjust their plans to meet the HPS minimum requirements. The length of the transition period depends on a number of factors including the implementation of the new system in the individual market and the risk of employers dropping coverage. During this transition period, arrangements are required to ensure Group members aged over 40 are appropriately protected with access to HPS, because they would not be eligible for guaranteed acceptance to the individual market after the first year. Any arrangements would need to be monitored over time to ensure they are effective and could include:

- Offering all Group members the option to take up additional protection at their own cost so that combined with their Group plans, total protection is at a level equivalent to the HPS Standard plan. Members would be incentivised in the same way as in the individual market.
- Offering a '**Conversion option**' to all group members. Members who have had continuous employment and coverage under their Group plan for at least one year would be eligible to take-up a HPS Standard plan with that insurer, at the same underwriting class, on retirement or ceasing employment.

Many of the features proposed for HPS bring Hong Kong's health insurance system into line with other countries, including the five countries studied in detail for this research. A summary of the key features of HPS is set out below, with comparisons to the five countries researched.

Table 2: Key Features of Private Health Insurance Products, HPS Standard plan and selected countries

	Australia	Ireland	Netherlands	Switzerland	US	HK HPS (proposed)
Guaranteed acceptance	✓	✓	✓	✓	✓	✓ Up to a maximum age
Guaranteed renewal	✓	✓	✓	✓	✓	✓
Must cover pre-existing conditions?	✓ Except during waiting periods	✓ Except during waiting periods	✓	✓	✓	✓ Except during waiting periods
Minimum benefit coverage	✓	✓	✓	✓	✓ (except for Group & some grandfathered plans)	✓ (except for Group & some grandfathered plans)
Restrictions on cost-sharing	✓	✗	✓	✓	✓	✓
Standardised terms	✓	✗	✓	not required as mandatory plans are identical	✓	✓
Premium Structure	Community Rating	Community Rating	Community Rating	Community Rating	Age-banded (with restriction)	Age-banded
Premium loadings	Late entry loading (Up to 70% - rare)	None	None	None	Tobacco use. (up to 50%) Non-participation in group wellness program. (Up to 50%)	Loading factors up to 200%
Specific Provisions to enhance Portability	✓	✓	✓	✓	✓	✓

Flexibility for market innovation

The recommendation for a ‘single market’ does not mean that all insurance plans related to health will be required to comply with every feature of the proposed HPS Standard Plan. Insurance plans which are not indemnity hospital plans – such as hospital cash plans, outpatient plans and lump sum critical illness plans, will not be subject to these requirements.

Insurers would also be able to offer IHIPs above the minimum prescribed by regulations. This could be done either as part of the insurer’s HPS Standard plan or as separate ‘**Flexi-plans**’ which meet all the minimum benefit requirements, but provide an additional range of benefits for consumer choice. Flexi-plan might offer cover for services not otherwise covered in the HPS Standard plan (for example, obstetrics) or may provide a higher level of cover for items included in the minimum benefits. Insurers could also offer **Top-up plans**, which offer ‘add-on’ benefits to those who already have a HPS Standard plan. Top-up plans would not need to meet the minimum benefit requirements on their own, but would need to be purchased in conjunction with a HPS Standard plan or Flexi-plan to ensure that the policyholder’s benefits meet the minimum benefit requirements.

Table 3 summarises the three different types of plans, along with the key features and minimum requirements with which each of the plans would need to comply.

Table 3: Features and requirements for Standard Plans, Flexi-plans and Top-Ups

Requirements	Standard Plan	Flexi-Plan	Top-up Plan
Product offering	Must be offered as basic product choice	Up to insurers to offer or not	Up to insurers to offer or not
Benefit limits	Equivalent to minimum benefit limits	Above minimum benefit limits	Not regulated
Guaranteed acceptance	Required , with coverage of pre-existing conditions after waiting period	Not required	Not required
Guaranteed renewal	Yes	Yes	Not regulated
Premium loadings	Premium loading capped at 200%	Not regulated	Not regulated
Lifetime limits	Not allowed	Not allowed	Not regulated
Annual limits	Allowed	Allowed	Not regulated
No-gap / known-gap procedures	Must offer on a defined coverage	Must offer on a defined coverage	Not regulated
Deductible and coinsurance rate	Annual cap on deductible and coinsurance. Prescribed coinsurance rate for certain advanced diagnostic procedures	Annual cap on deductible and coinsurance.	Not regulated
Free Portability	Yes; to Standard Plan	Yes; to Standard Plan	Not regulated
Access to High Risk Pool	Yes	No	No
Product Approval	Yes (File and use)	Yes (File and use)	No

Provisions to encourage uptake

Financial Incentives

To encourage uptake, a financial incentive available to all people with a HPS compliant product is proposed. **The incentive is available to all HPS policyholders, in order to encourage greater uptake of HPS products across a broad spectrum of the population.** Policyholders with HPS Standard plan, Flexi-plans, those in the High Risk Pool, as well as employees who take up voluntary supplementary plans, and their dependants, would be eligible. Fine details of implementation should reflect the intention to incentivize take-up of genuine IHIPS and avoid abuse. Three options are considered: A ‘capped’ tax deduction, a capped tax rebate and a direct premium subsidy for all policyholders. Tax deductions are less equitable than tax rebates or direct premium subsidies in the sense that they are worth more to people on higher tax rates. Direct premium subsidies, for the same effective cost to Government, incentivise more people to take-up HPS. However, administrative ease needs to be considered and tax deductions and rebates may be simpler to implement. They can also be available for some non-taxpayers, including retirees, if taxpayers can claim deductions or rebates on behalf of their dependants.

This broad incentive is different to the approach proposed in the Second Stage Consultation, which proposed a premium discount for new joiners under age 30 in the form of a No Claims Discount; and a government incentive to encourage savings by individuals to pay for future premiums. Review of international literature found little evidence to support the effectiveness of these incentives. No claims discounts may produce undesirable health outcomes by deterring policyholders from seeking appropriate health treatment. Medical Savings Accounts are not widespread, and savings incentives are unlikely to grow savings in countries like Hong Kong which already have a strong savings culture and enjoy low tax rates on investment returns.

Regulatory incentives

In deciding whether to take out insurance, consumers are concerned with not only affordability but also **adequacy** of protection. The minimum requirements for HPS product design would precisely address this concern and can be expected to boost consumer confidence. Results of the HPS consumer survey reveal that many consumers respond positively to the regulated features of HPS, such as guaranteed renewal and coverage of chemotherapy and radiotherapy.

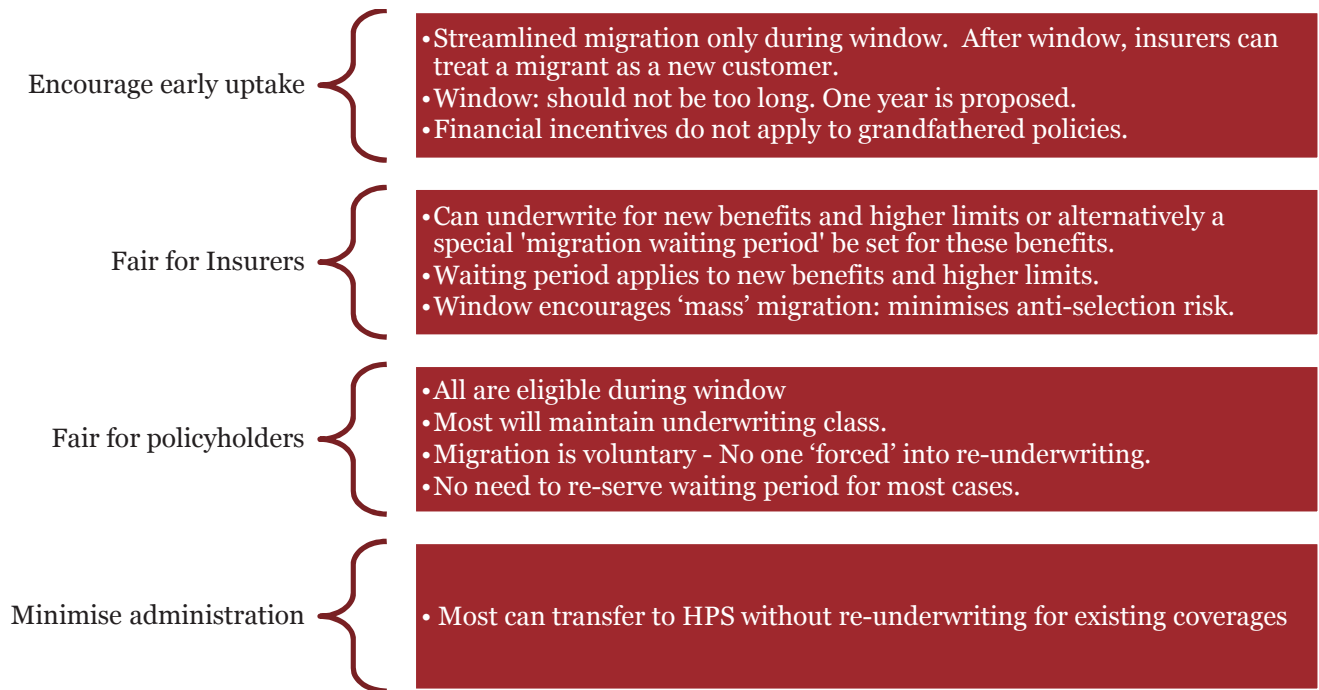
High-Risk Pool

The High-Risk Pool, which caps premiums at three times standard risk for their age group, provides high-risk lives with affordable access to HPS. For the market as a whole, the High-Risk Pool is an important enabler of guaranteed acceptance up to an entry age, which can encourage early uptake of HPS products.

Streamlined Migration

Migration concerns the first year of operation of the HPS, and the way in which people who currently hold health insurance are able to transfer into the new HPS system. Detailed provisions are set out in *Chapter 2*. They are designed to encourage early uptake of HPS, so that more people can enjoy the benefits and consumer protection offered by HPS, and insurers benefit from more predictable membership. Yet they recognise the risk of adverse selection for insurers, and the need to smooth any transition – particularly increased premiums – for existing policyholders.

Figure 1: Key arrangements for Streamlined Migration



A new regulator

The Second Stage Consultation proposed a new dedicated agency to supervise the HPS, including registering health insurance plans, administering the HPS core requirements and collecting data about HPS plans, their members and their experience, as well as private healthcare prices, costs and services.

This report supports the proposal for a new regulator to be established to provide scheme supervision of the IHIP market. Regulation of private health insurance enhances consumer protection, by addressing the information imbalance between consumers and insurance companies and helping consumers to make more informed and so more rational choices about the insurances they purchase.

Reflecting the role of IHIPs in funding the health system, the new regulator should be established under the Food and Health Bureau. As part of the Government's goals to enhance consumer protection, and the proposal to establish a single market for private health insurance, **the regulator should exercise its scheme supervision role across all indemnity hospital insurance products**, including HPS Standard Plans, Flexi-plans, Top-up plans, Group plans and any grandfathered indemnity hospital plans.

This approach will offer improved consumer protection for all policyholders with IHIPs, not just those holding a HPS Standard plan, and is consistent with a market whereby all policies are intended to meet the minimum requirements.

Functions of the new regulator

The new regulator's roles and functions need to be established consistent with the vision for the organisation and its functions relative to other departments and entities involved in regulating insurers and health providers. This will include specific **regulatory, facilitating** and **co-ordinating** functions including:

- Promulgate, review and enforce Minimum Requirements
- Co-ordinate with OCI to ensure that insurers offering IHIPs meet the requirements for market entry
- Product Registration
- A role in governance of the claims dispute resolution organisation
- Handle other non-claims related consumer complaints
- Manage and operate the High Risk Pool
- Administer non-tax financial incentives and subsidies
- Establish market infrastructure to facilitate HPS implementation
- Data Collection
- Reporting
- Support informed financial consent
- Consumer information and education
- Liaison with other regulators
- Liaison with industry

The regulator should be established with a **broad-ranging advisory function** to Government to ensure that the overall objectives underpinning HPS are achieved and consumer protection is enhanced.

As summarised in Table 4, the proposed regulatory framework aligns Hong Kong with the five countries studied in detail for this project. Further details on some key functions are set out below.

Table 4: Key regulatory issues, Hong Kong HPS and selected countries

	Australia	Ireland	Netherlands	Switzerland	US	HK HPS (proposed)
Role of PHI	Voluntary supplementary	Voluntary supplementary	Mandatory & Voluntary supplementary	Mandatory & Voluntary supplementary	Mandatory (PPACA*)	Voluntary supplementary
Coverage as % of population	47% (for hospital treatment)	47%	~100%	~100%	65% (prior to PPACA*)	~30% (for hospital treatment)
Product regulation by law	✓	✓	✓	✓	✓	✓
All PHI products subject to same regulatory standards?	✓	✓	✓	✓	Minor differences for large group plans	All IHIPs
Financial incentives	✓ (means tested)	✓	✓ (means tested)	✓ (means tested)	✓ (means tested)	✓
Government led alternative dispute resolution	✓	✓	Joint industry-consumer-government	Joint industry-consumer-government	✓	Government or jointly run.
New products submitted to regulator for approval	✓	✓	✓	Not required as products are standardized	✓	File and Use

* PPACA – Patient Protection and Affordable Care Act 2010

Product Approval

Product approval is being used increasingly by regulators to support consumer protection. **Insurers will be required to submit details of their new HPS Standard Plans or Flexi Plans**, including sample contracts and premium rates for standard risks, so that the regulator can register the product and ensure it complies with the minimum requirements. Significant changes to products would be notified to the regulator.

Premiums of all HPS Plans will be submitted to the regulator as part of this process, and on an ongoing basis when premiums are revised. This information will support the proposed consumer website, which includes a feature for consumers to compare HPS Plans and premiums across the market.

We propose that a ‘File and Use’ system be used and premium rates need not be approved by the regulator. ‘File and Use’ involves the insurer submitting details of premiums to the regulator and using them unless otherwise rejected by the regulator a later stage. The power to reject premiums would only be used rarely - for example, if the premiums were being artificially marked down, leading to ‘dumping’ in the High Risk Pool, or if premiums were being artificially inflated by insurers within bundled products to take advantage of financial incentives.

Data Collection

Regulators, consumers and industry need appropriate data to monitor the implementation of the HPS, to enhance transparency for consumers and to provide the information which industry needs to successfully implement packaged pricing and manage medical inflation. The new regulator will have broad authority to collect the data required from industry participants, to prescribe the form that data takes and to enforce the provision of that data. An appropriate set of penalties will apply to industry participants who cannot provide data in the prescribed format and with sufficient quality.

The regulator need not collect, collate and analyse all data themselves, but may choose to outsource this function to other organisations. The regulator’s Data Collection Strategy would include:

Table 5: Overview of Data Collection Strategy

Data	Details
Information collected from Insurers	<ul style="list-style-type: none"> • Policy details • Premiums by age band for HPS Standard plans, and premium rate increases • Membership, policy types, benefit coverage, demographic characteristics of members • Premiums and loadings • Utilisation (claims) • Benefits paid and out-of-pocket costs • Use of packaged pricing and no/known gap arrangements • Information on applicants recommended for admission to the HRP. • Other financial statistics (eg: claims ratio) • Complaints resolved using internal dispute resolution procedures
Information collected from health providers	<p>Data collected from hospitals and facilities authorised to provide ambulatory services should expand significantly, consistent with the planned implementation of packaged pricing using DRGs. This data should include:</p> <ul style="list-style-type: none"> • Inpatient activity data, reported using a standardised terminology, and identifying overnight and same day procedures. • Outpatient activity • Demographic data on patients using the services • Data to support analysis for DRG pricing in the long run • Capacity – in addition to basic information such as beds and bed days, this would ideally include information type of beds, as well as workforce • Limited outcomes data (eg: infection rates, re-admissions)

Reporting to Consumers, Industry and Policymakers

The new regulator will set out a clear reporting plan, to deliver **relevant** and **timely** information to consumers, industry and policy makers. The planned reporting framework will include:

Table 6: Overview of Reporting Framework

Stakeholder	Details	Why?
Information for consumers	Information to enable consumers to easily compare products and their premiums, as well as information on the performance of insurers and health providers.	Enhanced transparency, consumer choice and market competition.
Information for industry	Summarised data on claims experience, claiming patterns, claims lodged and benefits. Summarised data on the claims experience and membership of the high risk pool. Summarised data on procedure expenditure, and other relevant indicators for health providers, subject to consensual definitions.	Enables insurers to understand their market role and performance, and better price existing and new risks. Enables insurers and health providers to conduct informed negotiations regarding packaged pricing.
Information for policymakers	Regular reporting on progress in meeting the objectives of HPS.	Enables policymakers to respond to issues in a timely manner.

Dispute Resolution

The Second Stage Consultation proposal for a Government-regulated health insurance claims arbitration process is consistent with international best practice. Three options are proposed in this report for a claims dispute resolution organisation. Government should consider the relative merits of the three options in order to choose the most suitable claims dispute resolution organisation to support the goals of the HPS.

- A. Establish a single statutory claims dispute resolution channel taking over the functions of the Insurance Claims Complaints Bureau (ICCB), which would be credible, administratively efficient and help avoid consumer confusion. Such a complaints organisation could also expand its remit to deal with non-claim complaints, including issues regarding informed financial consent.
- B. Establish a claims dispute resolution organisation which acts as an *appeal channel* for consumers if they are dissatisfied with decisions of the ICCB. The ICCB would continue in its current form and hence become a 'gatekeeper' for policyholders to access the government-led claims dispute resolution organisation. While this approach uses existing systems, there is some duplication of functions and potentially a lengthy process for retail customers.
- C. Enhance governance of the ICCB, to encompass both government and consumer representatives.

In line with good practice, consumers making a complaint to the Dispute Resolution organisation should not be required to pay a fee for services, participation would be voluntary for consumers, and decisions would be binding on insurers. Irrespective of which option is pursued, it is worth considering expanding the remit to cover group members (who are not currently covered by ICCB). Arguably, employers as policyholders have some responsibility to defend the interests of their employees in the event of claim disputes, however not all employers will be in a position to do so effectively.

Scope

Consistent with the proposal to create a 'single market' underpinned by common minimum standards for all IHIPs, all policyholders should be able to enjoy the consumer protection benefits offered by the claims dispute resolution mechanism. All IHIP policyholders and members, including those with HPS Standard products, Flexi-plans, Top-Up Plans, grandfathered plans, the High Risk Pool and members of Group plans, will be eligible to access the Claims Dispute Resolution mechanism. The scope of complaints which the Claims Dispute Resolution organisation can handle should be broad, without overlapping considerably with the role of other organisations involved in dispute resolution. However, **it should focus on disputes related to health insurance claims, and leave handling complaints regarding the quality of health services, to the Department of Health and the Medical Council**, as this is a specialist role.

Dispute minimisation

Minimising the likelihood of consumer disputes is a key aim of well-managed health insurance systems, and needs to be the first strategy for all industry participants. Ongoing monitoring of the volume and nature of disputes is good practice in scheme supervision, and will help to refine and improve the HPS over time to ensure that it continues to satisfy policyholder needs. The new regulator and claims dispute resolution organisation should have a monitoring and advisory role to advise Government on refinements to the HPS and the industry more generally to help address the issues raised by consumer disputes.

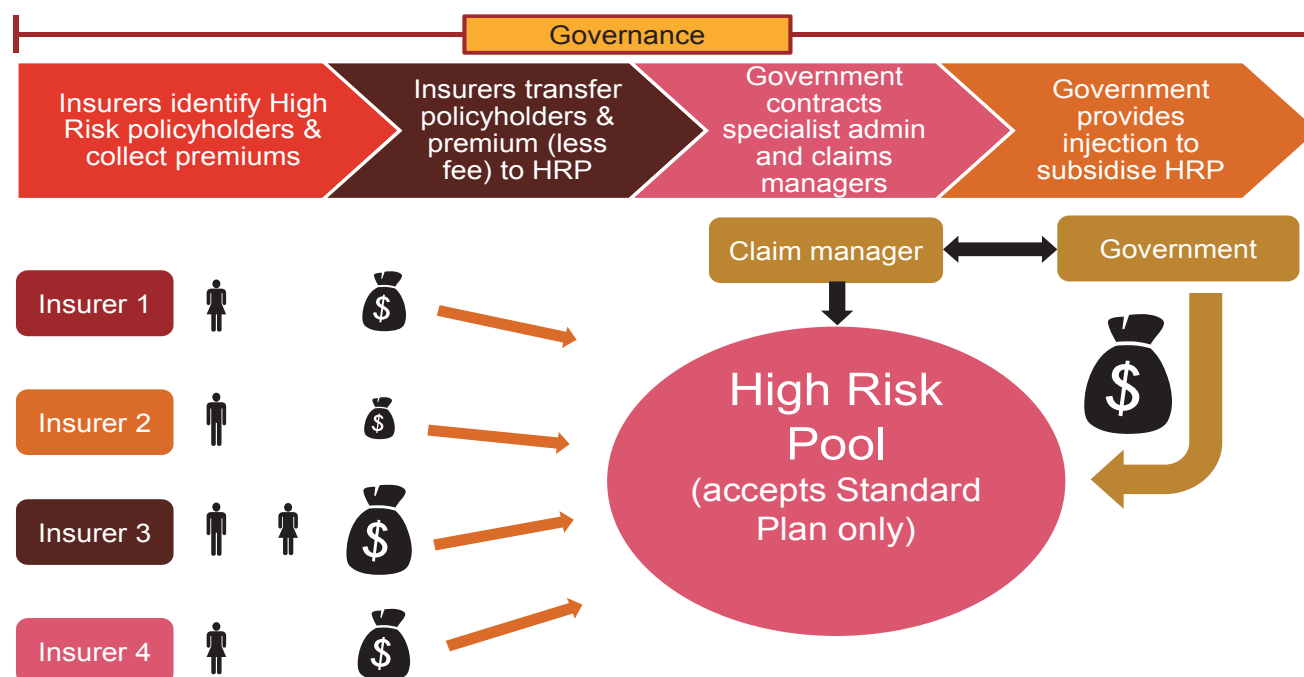
In the international models reviewed for this project, the insurance industry has been required by law to implement internal dispute resolution processes to help minimise the need for external intervention. The minimum requirements for an internal dispute resolution mechanism suitable for IHIPs should be agreed and promulgated across the industry, and become a minimum requirement for insurers to be authorised to offer HPS.

A Government-subsidised High Risk Pool

This proposal sees Government establish a stand-alone High Risk Pool to enable people with health conditions to access private health insurance and support ‘guaranteed acceptance’. Policies of high-risk individuals with premium assessed by an insurance company equal to or exceed three times published premiums of the relevant age groups are transferred into the HRP. After that, the premium income, claim liabilities and profit/loss of these policies accrues to the HRP.

This proposal sees the HRP governed by the new regulator with day-to-day management contracted out to a specialist claims manager who offers pro-active chronic disease management to improve health outcomes while also effectively managing claims costs. This is a far stronger initiative than the reinsurance mechanism proposed in the Second Stage Consultation. Concentrating high risk people into a single pool offers cost containment and a major opportunity for insurance market development. Creating a single pool enables the claims manager to develop skills and expertise in providing chronic disease management services and managing health care costs for this group. It also allows a database of experience of high cost claimants to be established, so that as implementation of the HPS continues, insurers can better price risks and potentially take on a greater share of policyholders with health conditions.

Figure 2: Governance and Operations of the High Risk Pool



The Pool is proposed to be funded by a combination of premiums paid by members of the Pool and a Government subsidy, estimated to be \$4.3 billion cumulatively between 2016 and 2040, measured in 2012 constant prices. **There is no industry levy to support the operations of the Pool.** We question the equity of an industry levy, because industry has no say in the management of the pool, and any costs would ultimately be transferred to other lower risk policyholders outside the HRP. To manage potential financial risk to Government, only applicants for HPS Standard plans are eligible for access to the High Risk Pool.

Insurers are free to use their own underwriting standards to identify applicants who meet the 200% loading requirement for entry to the Pool. Insurers’ own underwriting standards are the only realistic option for assessing high risks in the short term, though Government may wish to monitor uptake and entry to the HRP and, if necessary, define more consistent rules over time for entry to the HRP.

More Transparency and Certainty for Consumers

No gap / known gap

‘No gap / known gap’ arrangements are proposed here as a means to offer greater certainty in out-of-pocket costs for policyholders whilst encouraging more contracting between insurers and health providers, in order to encourage cost effective care. The proposal here draws on similar arrangements in Australia, though it is not necessary to follow every detail. In the next section we highlight the enablers, including packaged pricing, required to support gap arrangements.

The following table compares patient, insurer and provider funding arrangements when a ‘no gap’ arrangement is used, to when it is not.

Table 7: Funding Arrangements in Australia - No Gap versus Standard payments

No/Known Gap arrangement used	No/Known Gap arrangement NOT used.
<ul style="list-style-type: none"> Insurer pays direct to hospital and doctor. ‘Cash-less’ (or fixed excess i.e. gap) for member. Insurer pays contracted hospital fee to private hospital. Doctor opts to use insurer’s fee schedule and is paid direct by insurer. Member out-of-pocket costs are known in advance and often simply the fixed excess agreed in their policy. 	<ul style="list-style-type: none"> Member pays full cost and is reimbursed by insurer. Insurer reimburses only the prescribed benefit for hospital costs. Insurer reimburses doctor only in accordance with the prescribed benefit schedule. Member out-of-pocket costs can be high, as they pay hospital costs or doctor fees above the prescribed benefit schedule.

Informed Financial Consent

To enhance transparency, competition and consumer protection, **‘informed financial consent’ will become a requirement for health providers prior to treatment, except in emergency cases.** Informed financial consent means that patients are aware of the costs and the out-of-pocket costs they will pay in advance of their treatment. Health providers – both doctors and hospitals – must ensure that in the same way that they obtain *informed consent to treatment* from the patient before undergoing treatment, they must obtain *informed financial consent* from patients prior to treatment. Insurers must provide information in a timely manner to support health providers in obtaining informed financial consent.

Informed financial consent is a critical enabler of packaged pricing and assists in managing the potential for medical inflation as population coverage and benefit coverage expand under the HPS. Informed financial consent means that patients will be aware if their health provider is participating in their insurer’s ‘gap’ arrangements, and can opt to seek providers who are willing to participate in the gap arrangements.

It is critical that this process be made as simple as possible for health providers to achieve this informed financial consent. The new regulator should assist industry to develop the right infrastructure and guidelines to implement informed financial consent efficiently.

Market Transparency

Transparency is key to effective competition. All the countries examined for this project have implemented a range of measures to enable effective comparison of products and premiums across the sector, in order to enhance consumer competition, and HPS implementation could be greatly enhanced by:

- Standardised product levels and standardised wording and terms
- Standardised ways to inform policyholders of the benefits and exclusions offered by different insurance policies, such as a Standard Information Statement or Summary of Benefits and Coverage

- A consumer-friendly web-based resource to enable consumers to compare HPS products and premiums

Chapter 13 provides examples of and links to similar websites operated by the Australian and Irish regulators. Such a website might be expanded over time to report additional information which would allow policyholders to more easily compare value-for-money. For example:

- Insurer loss ratios
- Typical out-of-pocket costs (for example, as a percentage)
- Usage of gap arrangements.

Supporting Packaged Pricing

DRG-based package pricing was proposed as a key feature of the HPS in the Second Stage Consultation, yet throughout the consultation forums, it has been one of the least understood issues. Considerable challenges will need to be addressed if DRG-based packaged pricing is to be implemented. Health providers and insurers do not record the information required to develop DRGs, and considerable investment will be required to achieve this.

The appendix to *Chapter 17* contains a high level roadmap for the implementation of packaged pricing. Rather than mandating packaged pricing or fixing hospital fees, as some have interpreted packaged pricing to mean, the roadmap proposes using ‘gap’ arrangements and informed financial consent to drive contracting between insurers, hospitals and doctors. **This contracting would be in the form of packaged prices, and HPS minimum benefits for these procedures would be set as a packaged benefit limit.**

Figure 3: High level roadmap for packaged pricing implementation



The implementation of packaged pricing need not be delayed until hospital and insurer coding systems are standardised. The roadmap envisages an initial pilot during which easy-to-identify procedures are included in the packaged pricing arrangements. At a minimum, the procedures would include: colonoscopies and endoscopies, advanced diagnostic tests (MRI, CT, PET) and chemotherapy and radiotherapy.

The foundations for packaged pricing would be established over a one-year period before packaged pricing is piloted, including agreement to the preferred coding system which hospitals and insurers will use to record all hospital activity from Year 2 onwards. The list of procedures to be included in the ‘pilot’ of packaged pricing would be agreed, costs estimated and a minimum benefit for inclusion in the HPS would be set. Sample contract wording and operational requirements for the pilot would be developed.

No gap / known gap funding along with informed financial consent would be introduced as part of the pilot. Data collection and analysis to support later expansion of packaged pricing would continue in the ensuing three years, including the first collections of costing data across all private hospital activity.

We anticipate that ongoing Government support will be needed to ensure implementation of packaged pricing and establishment of the necessary infrastructure. A joint industry / Government / consumer working group with detailed knowledge of health purchasing will need to be established at the outset to ensure successful implementation.

Impact Assessment

If risks are well-managed, HPS can bring substantial, beneficial change to consumers, insurers and society more generally

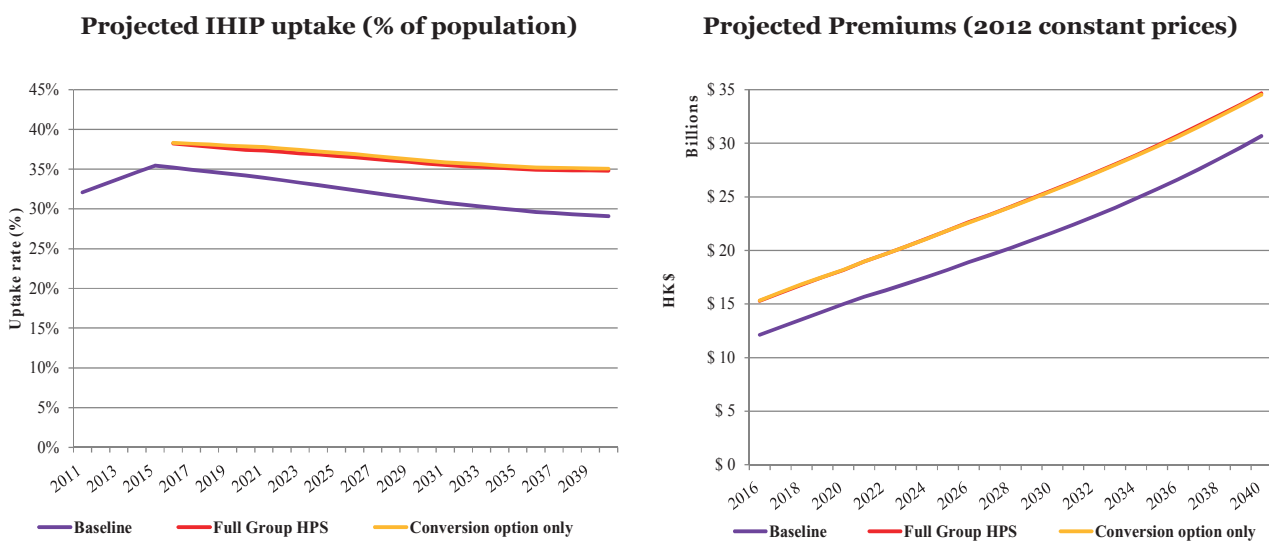
The actuarial analysis presented in *Part B* indicates that HPS could significantly grow the IHIP market, grow the private ambulatory sector, take pressure off the public sector, and lead to clear efficiencies in the private sector with better value-for-money for consumers.

Standard premiums (that is, premiums for people considered a ‘standard risk’ with no loading) would rise as a result of new benefits and expansion of coverage for pre-existing health conditions: estimates in *Chapter 5* suggest a 9% increase in standard premiums (being average across all age groups) for Ward level cover in the individual market, and a 12% increase in the average per-member premium for Ward level cover in the Group market, if minimum requirements are extended to the Group market, all else being equal.

However, this is only one part of the way the HPS policy initiative would affect premiums. As the projections in *Chapter 6* show, some of this increase is offset by a shift of high risk members to the High Risk Pool. Members could also choose a deductible within their HPS plan to reduce premium increases. In the long term, the cost of these new benefits is offset by **the improved efficiency and transparency which HPS brings** - packaged pricing, informed financial consent, easier product comparisons and premium transparency, which drive **lower medical inflation and reduced expense/profit loadings, and hence lower per-member premiums in the long term**, compared to the Baseline scenario without HPS.

The projection analysis considers a range of reasonable scenarios. The results below relate to a scenario where the policy initiative has a moderate impact. Figure 4 shows the results with HPS under two scenarios; the first with HPS fully implemented in the Group market (we have assumed a transition period of 5 years in these projections), and the second with the Group market offering a mandatory ‘Conversion option’ only. There is little difference in aggregate projection results for these two scenarios. Assuming that HPS is introduced in 2016, IHIP membership is projected to grow in the Moderate scenario by more than 200,000 people in that year, due to the effect of financial incentives and a rush to join before the maximum guaranteed acceptance age falls. In the long term improved market efficiencies mean that around 450,000 additional people will hold IHIPs under HPS than under a Baseline Scenario.

Figure 4: Projected IHIP uptake and total premiums, 2011-2040 – Total market



Note: Supplementary major medical is not included in projections of total market premiums. See Chapter 6 for full details and assumptions.

Baseline projections of uptake increase to 2015 in line with observed recent trends which likely reflect recent insurer and Government promotions around this insurance. In the longer term, population uptake rates will likely start to decline without intervention, due to population ageing. Uptake is generally lower in the older ages due to affordability constraints. HPS policy initiatives moderate this impact to some extent by improving consumer confidence and accessibility of insurance.

Total premiums under HPS are projected to be approximately HK\$3.2 billion (in \$2012 constant prices) or 25% higher than the Baseline projection in 2016. By 2040, the difference increases to approximately HK\$3.9 billion or 13% above Baseline.

The contribution of IHIPs to health costs also increases substantially under HPS. Under HPS, claims costs are around \$5.7 billion or 30% higher than Baseline in 2040. In the individual market, benefit ratios – benefits as a percentage of premiums – improve considerably, from 57% to 70% by 2040, while medical inflation is 0.5% per annum lower under HPS.

Impact on the healthcare system

The impact on the public healthcare system in Hong Kong will gradually build up and become notable in the long run, when compared to high-level projections of health expenditure and activity *before HPS*². In the Moderate scenario, the nominal substitution of overnight inpatient bed days increases from about 53,000 bed days in 2016 to 155,000 bed days in 2040, giving a cumulative total of over 2.8 million overnight inpatient bed days and representing around 2% of projected bed days between 2016 and 2040. This results in nominal substitution of public expenditure of around HK\$70 billion between 2016 and 2040. This would likely be much higher than estimates of government's financial injections to the High Risk Pool and forgone government revenue if a tax deduction on HPS premiums is granted.

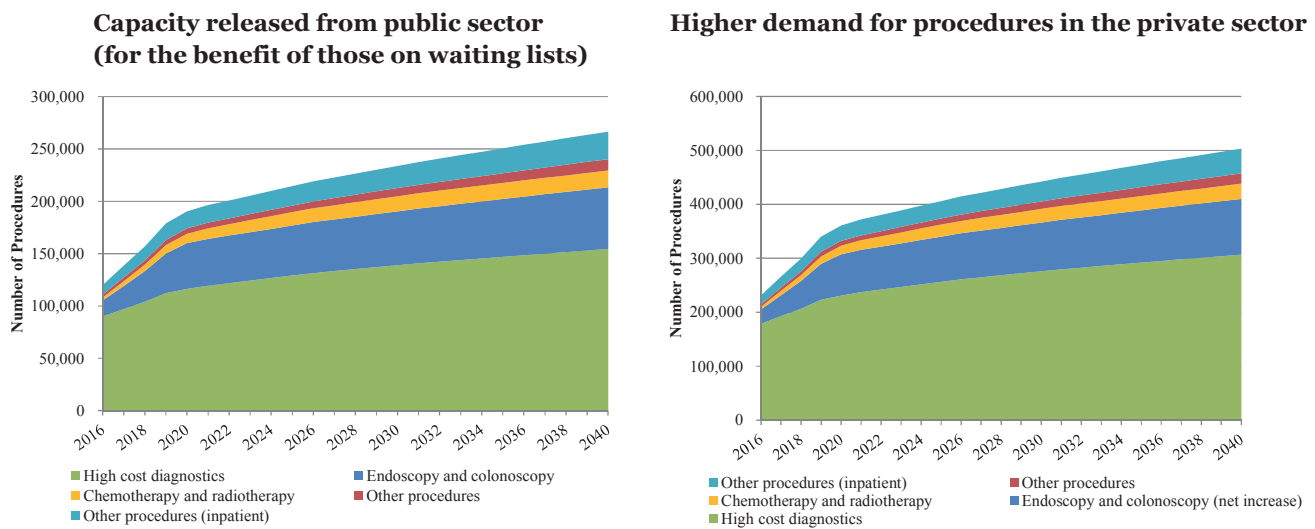
Given high demand for public healthcare, the impact of the HPS would translate into shorter waiting times rather than savings in budget and reduction in capacity. The estimated impact on expenditure and activity in the public sector is thus a “nominal substitution” in the sense that they represent resources and capacity that can be released to enhance public healthcare services and reduce waiting times. Yet due to the market dynamics involved, including the concurrent influence of other factors, it is difficult to single out and estimate with acceptable degree of precision the magnitude of reduction in waiting times.

In the projections, demand is diverted into the private sector, and so the results must be considered with regard to the capacity of the private market to absorb the diverted demand. Since the public sector is the major provider of inpatient care, a modest outflow of service demand relative to the public capacity could become a marked inflow of service demand relative to the private capacity. It is desirable to keep the diversion in a scale that the private sector can cater for.

In the projections, the role of the private sector in providing health services adapts to the new coverages. The volume of advanced diagnostics, chemotherapy, radiotherapy, colonoscopy and endoscopy services provided in private ambulatory and day procedure settings increases substantially throughout the projection and is over half a million services higher under HPS in 2040. A considerable number of the colonoscopy and endoscopy services shift out of inpatient settings and, as a result, the number of inpatient services are projected to be marginally lower. Despite this, private hospital bed days are actually higher. This is because private hospitals are doing more complex procedures – average length of stay in private hospitals is higher by about 0.7 days because of HPS. More, older people and more people with health conditions, receive treatment from the private sector.

² High-level projections of health expenditure before HPS were provided by FHB, as a broad-brush update of 2004-based long-term official health expenditure projection to serve as working inputs for this project. High-level projections of activity were provided by HKU School of Public Health, as part of the model results towards their long-term manpower projection.

Figure 5: Nominal substitution of procedures due to HPS, 2016-2040



Note: All are clinical surgeries unless otherwise noted. Assumes Group market is required to offer the Conversion Option only. See Chapter 7 for full details and assumptions.

The mix of acute care bed days in the public/private sectors is projected to change from 87/13 split in the Baseline 2040 to 85/15 with HPS. The mix of inpatient (overnight + day) activity changes more notably from 86/14 split in the Baseline 2040 to 81/19 with HPS. The mix of public and private expenditure changes marginally from 53/47 in Baseline 2040 to 52/48 with HPS. Despite the significant increase in activities in the private sector, the effect on private health expenditure is mitigated by the lower medical inflation and the efficiency gain from more ambulatory procedures and treatments.

These estimates should be viewed against the policy background that HPS is positioned as a supplementary policy instrument and meant to provide a partial rather than total solution to the long-term healthcare challenge in Hong Kong. It is inappropriate to expect that the HPS would bring a drastic change to the structure of the healthcare system. Nevertheless, the HPS would contribute towards sustainability of the dual-track healthcare system by which the public and private sectors develop concurrently. Attention should not be overwhelmingly focused on the HPS impact on the structure of healthcare system by public and private providers. From a wider perspective, the HPS is expected to bring about long-term benefits to the system as a whole, including opportunities to bring medical inflation under better control, enhance market efficiency, increase consumer choice and access to care, and achieve better health outcome for the population.

Monitoring to manage uncertainty

These projection results with HPS are shown as Scenario B in Figure 6 overleaf. Of course, there is considerable uncertainty in these results arising from management of the initiative and the subsequent market response. Chapter 7 shows a range of scenarios which might arise if the HPS policy initiative is not well managed or, alternatively, if it is better managed than the main forecast suggests.

For example, if new coverages under HPS lead to higher than anticipated demand for these services and higher costs per service (particularly for advanced diagnostics), if medical inflation is not well managed, and if efficiencies in the hospital and insurer sector do not transpire, then Scenario C indicates that uptake could in fact be lower than the Baseline, as people respond to higher premiums by dropping cover. Total premiums are higher in Scenario C, but this is largely because high medical inflation pushes premiums higher.

On the other hand, if the implementation of HPS is effectively monitored and adjusted to ensure that efficiencies can be harnessed, uptake could increase well beyond current levels, in line with Scenario A and high uptake levels could be maintained in the long term, despite population ageing.

Figure 6: Projected IHIP uptake and total premiums, Scenarios, 2016-2040 – Total market



Note: Assumes Group market is required to offer the Conversion Option only. Supplementary major medical is not included in projections of total market premiums. See Chapter 6 for full details and assumptions.

There will always be uncertainty in projecting the precise impact of a major policy initiative such as this. However this report documents the key requirements that need to be considered and addressed in order to make the HPS a feasible and sustainable success. The research and analysis conducted indicates that the HPS can build upon the strong growth of IHIPs in the Hong Kong market in recent years – improving customer protection and market transparency in the process.

Appendix D Regulatory Requirements for Private Health Insurance (PHI) Products in Five Overseas Jurisdictions

	Australia	Ireland	Netherlands	Switzerland	United States
Role of PHI	Supplementary (voluntary PHI)	Supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI ¹)
Share of PHI in healthcare financing²					
PHI	12%	13%	44%	49%	33%
Government	65%	67%	43%	25%	48%
Out-of-pocket	18%	17%	9%	25%	12%
Others	6% (Figures as at 2012/13)	2% (Figures as at 2012)	3% (Figures as at 2012)	1% (Figures as at 2012)	7% (Figures as at 2012)
Product regulation by law	✓	✓	✓	✓	✓
All PHI products subject to same regulatory standards	✓	✓	✓	✓	✓ (minor differences for group plans, e.g. more stringent requirement on maximum waiting period, penalty for large employers not offering adequate health insurance coverage for employees, etc.)
Guaranteed acceptance	✓	✓	✓	✓	✓
Guaranteed renewal	✓	✓	✓	✓	✓
Must cover pre-existing conditions	Except during waiting periods	Except during waiting periods	✓	✓	✓

1 Under the Patient Protection and Affordable Care Act of 2010, individuals are required to obtain PHI coverage starting from 2014.

2 Figures may not add up to total due to rounding.

	Australia	Ireland	Netherlands	Switzerland	United States
Maximum waiting periods	✓	✓	No waiting period	No waiting period	✓
Minimum benefit coverage	✓	✓	✓	✓	✓ (except for large group and grandfathered plans)
Fixed benefits package	✗	✗	✗	✓	✗
Restrictions on cost-sharing	✓	✗	✓	✓	✓
Portability	✓	✓	✓ (may change insurer during designated time of year)	✓ (may change insurer during designated time of year)	✓
Standardised policy terms and conditions	✓	✗	✓	✓	✓
Premium structure	Community rating ³	Community rating ³	Community rating ³	Modified community rating (allows variation by selected age groups and locations)	Modified community rating (allows variation by age, location, tobacco use and family status)
Premium loading	Late entry loading to those who delay take-up of PHI until over 30 years of age: 2% of the base premium for each year over age 30 at the time of joining, subject to a maximum of 70%	✗	✗	✗	Rating rules to limit premium variation based on age and tobacco use to 3:1 and 1.5:1 respectively

3 Community rating of premium means that insurers are not allowed to set premium according to age and health condition of individual person insured, and is usually supported by risk equalisation mechanism which redistributes premium across insurers according to risk exposure.

Appendix E Informed Financial Consent (For Illustration Only)

服務預算同意書 (只供參考) Informed Financial Consent to Services (For Illustration Only)

說明： 本頁由醫生及醫院填寫，並由病人、醫生及獲醫院授權人士簽名及蓋章作實。**預算費用只作參考**，最終收費視病人實際接受的治療、程序及服務而定。
Statement: This page is to be completed by doctor and hospital, and to be signed by patient, doctor and the authorised person of the hospital with hospital stamp. **The estimated charges are for reference only.** Final payments are subject to charges incurred from treatment, procedures and services performed.

病人姓名 (中文) (Chinese): _____ 身份證號碼 / 護照號碼*
Patient Name (英文) (English): _____ Hong Kong Identity Card/ Passport Number*: _____

初步診斷 Provisional Diagnosis: _____

入住的私家醫院 Private Hospital (to be) Admitted: _____

預計住院時間 Estimated Length of Stay: _____ 小時 Hour(s) / 日 Day(s)* 病房級別 Class of Ward: _____

治療 / 手術 Treatment / Surgical Operation: _____

轉介 / 主診醫生 Admitting / Attending Doctor: _____

是否能夠估算費用? 是 Yes (請填寫以下欄目。Please complete the following sections.)
Are estimated charges available? 否 No (請另頁提供理由。Please provide reasons on a separate sheet.)

預算醫院費用 Estimated Hospital Charges (由醫院填寫 To be completed by hospital)

醫院費用 Hospital Charges:	\$ _____ x _____ 日day(s)	\$ _____ ~ \$ _____
- 住宿及膳食 Room and Board:	\$ _____	\$ _____ ~ \$ _____
- 其他項目及收費 Other Items and Charges:	\$ _____	\$ _____ ~ \$ _____

(醫院須另頁補充醫院費用總額的明細供病人參考。)
(Hospital should provide a breakdown of total hospital charges on a separate sheet for patient's reference.)

預算醫生費用 Estimated Doctor's Fees (由醫院 / 醫生* 填寫 To be completed by hospital/doctor*)

每日醫生巡房費 Daily Doctor's Round Fee:	\$ _____ x _____ 日day(s)	\$ _____ ~ \$ _____
手術費 Surgical Fee:	\$ _____	\$ _____ ~ \$ _____
麻醉科醫生費 Anaesthetist Fee:	\$ _____	\$ _____ ~ \$ _____
住院時專科醫生診療費用 In-hospital Specialist's Fee:	\$ _____	\$ _____ ~ \$ _____
	\$ _____	\$ _____ ~ \$ _____
其他項目及收費 Other Items and Charges:	\$ _____	\$ _____ ~ \$ _____
	\$ _____	\$ _____ ~ \$ _____

(如不敷應用，請另頁補充。Please continue on a separate sheet if required.)

總計 Total \$

病人簽署 Patient's Signature

本人知悉上述預算費用及右列保險賠償額僅為參考，並不包括因併發症所產生的額外費用，並同意最終收費以醫院賬單所列為準。
I understand that the estimated charges above and the claimable amount from insurance on the right are for reference only. Additional charges incurred from complications are not covered. I agree that payment should be made in accordance with hospital invoice.

_____	_____	_____
病人 / 親屬 / 獲授權人士姓名* Name of Patient / Next-of-kin / Authorised Person*	病人 / 親屬 / 獲授權人士簽署* Signature of Patient / Next-of-kin / Authorised Person*	日期 Date

醫生及醫院聲明 Doctor's and Hospital's Declaration

本人已向病人解釋上述預算費用，並徵得其同意。
I have explained to the patient the details of the above estimated charges and have sought his / her agreement.

_____	_____	_____
醫生姓名 Name of Doctor	醫生簽署 Signature of Doctor	日期 Date

本院知悉上述預算費用。此表格正本會存放在本院的病人醫療記錄內，副本供病人和醫生參考。
This hospital has noted the above estimated charges. The original of this form will be filed as hospital's medical records, and copies will be given to patient and doctor for reference.

_____	_____	_____
獲醫院授權人士姓名 Name of Authorised Person of Hospital	獲醫院授權人士簽署及蓋章 Signature of Authorised Person of Hospital and Stamp	日期 Date

本欄只適用於受自願醫保計劃住院保險保障的人士 Only Applicable to Patients Covered by Hospital Insurance under Voluntary Health Insurance Scheme

說明： 本頁由承保機構填寫，並由獲承保機構授權人士簽名及蓋章作實。**預算賠償額及自付費用只作參考**，最終收費視病人實際接受的治療、程序及服務而定。
Statement: This form is to be completed by the insurer and signed, with stamp, by the authorised person of the insurer. **The estimated claimable amount and out-of-pocket payment are for reference only.** Final payments are subject to charges incurred from treatment, procedures and services performed.

承保機構名稱 (中文) (Chinese) _____

Name of Insurer: (英文) (English) _____

保單編號 Policy Number: _____

承保機構經辦人姓名
Name of Action Officer of Insurer: _____

承保機構經辦人聯絡電話
Telephone Number of Action Officer of Insurer: _____

保障限額 Benefit Limit

賠償額 Claimable Amount

\$ _____ / 日 day	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____

(承保機構須另頁補充賠償額的明細供病人參考。)
(Insurer should provide a breakdown of claimable amount on a separate sheet for patient's reference.)

保障限額 Benefit Limit

賠償額 Claimable Amount

\$ _____ / 日 day	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____
\$ _____	\$ _____ ~ \$ _____

總計 Total \$

\$ _____ ~ \$ _____

減 Less

因等候期 / 其他原因的調整 Adjustment due to Waiting Period/Other Reasons:	-\$ _____
分擔費用 Co-payment:	-\$ _____
淨賠償額 Net Claimable Amount:	\$ _____ ~ \$ _____
預計自付費用 Estimated Out-of-pocket payment:	\$ _____ ~ \$ _____

承保機構聲明 Insurer's Declaration

本公司已根據病人的保單估算預算賠償額及預計自付費用。資料僅供參考，最終賠償額及自付費用須按醫院賬單所列的最終收費及保單條款而定。
Our company has provided the estimated claimable amount and estimated out-of-pocket payment in accordance with the insurance policy of the patient. The estimated amounts are for reference only. The actual claimable amount and actual out-of-pocket payment will be subject to the final payment as stated in the hospital invoice and in accordance with the policy terms and conditions.

_____	_____	_____
承保機構獲授權人士名稱 Name of Authorised Person of Insurer	承保機構獲授權人士簽署及蓋章 Signature of Authorised Person of Insurer and Stamp	日期 Date

備註 Remarks:

1. 病人如因已知的疾病接受醫療檢查程序或選擇性的非緊急治療手術 / 程序，私家醫院應在他們入院時或之前，告知他們整個療程的預算費用總額。如因病情導致病人不能及早獲知預算，醫生須另紙說明詳細情況。
Patients having investigative procedures or elective, non-emergency therapeutic operations/ procedures for known diseases should be informed of the estimated total charges for the whole treatment course on or before admission to private hospitals. Doctors should provide details in separate sheets if patients' conditions do not allow them to be informed of the estimated total charges in advance.
2. 病人如在入院時或之前未獲提供預算住院費用的資料，他們入院後，在每次就確診病症接受選擇性的治療手術/程序時，醫院都應盡可能預先向他們提供預算費用的資料。
For patients who have not been given an estimation of their hospital bills on or before admission, whenever they receive a definite diagnosis where elective therapeutic operations/ procedures are required after admission, they should be given an estimate in advance as far as practicable.
3. 每間私家醫院都應公布一份「常見手術/程序清單」，向病人提供有關手術/程序的報價。該份清單應備存於入院登記處、繳費處、醫院網頁或適當地方，供市民參考。
Private hospitals should publish a "List of Common Operations/ Procedures" for which quotation will be provided for prospective patients. The List should be available at the admission office, cashier and hospital webpage and where appropriate for public's reference.
4. 如手術期間出現併發症，或須專科醫生會診，令預算費用有任何重大變動，超逾原來預算的幅度，而病人神智清醒和病情穩定，則醫院應告知病人最新的預算費用，並取得其同意，方可進行任何手術/程序。如病人神智不清和病情反覆，醫院則應告知其近親或獲授權人士。最新的預算費用應記入本費用預算表格內，並由醫生 / 醫院及病人 / 近親 / 獲授權人士妥為簽署。如有關醫生或醫院認為變動幅度太大，則可採用新的表格記錄。
In case of any material change in estimates beyond the range of the original estimates due to complications during operation or those from necessary specialist visits, patients who are conscious and stable (or their next-of-kin or authorised persons if otherwise) should be informed of and consent to the latest estimate before any further operation/ procedure is conducted. The latest estimate should be documented in this consent form and duly signed by doctors, authorised persons of hospitals and patients/ next-of-kin/ authorised persons of patients. A new form may be used if the changes are considered substantial by the doctor or hospital concerned.
5. 若病人在18歲以下、失去知覺或有認知障礙，其親屬或獲授權人士可代病人簽署文件。
In case the patient is under 18, unconscious or has cognitive impairments, the next-of-kin or authorised person should act on the patient's behalf.
6. 病人如選用認可服務套餐，醫院可獲豁免遵從報價規定。如醫生的臨床判斷認為，正接受手術/程序或病情緊急或危及性命的病人須進行其他緊急治療，則醫院可獲豁免就有關病人已同意的服務以外的收費項目提供報價。
Patients subscribing to Recognised Service Packages are exempt from quotation. In case at doctors' clinical judgment that patients undergoing operations/ procedures, emergency or life threatening situations require further urgent treatment, price quotation for items beyond those the patients concerned have consented to would be exempted.
7. 在自願醫保計劃下個人住院保險須就訂明的非住院程序、訂明的先進診斷成像檢測及非手術癌症治療訂定一筆過套餐式保障限額。這些保障限額因不同程序、檢測或治療而異。醫生及 / 或醫院須就這些項目另行報價。
Under the Voluntary Health Insurance Scheme, individual Hospital Insurance should provide coverage for prescribed ambulatory procedures, prescribed advanced diagnostic imaging tests and non-surgical cancer treatments in the form of packaged benefit limits. These benefit limits vary by procedure, test or treatment. Doctors and/or hospitals should provide separate quotation for these items.

Appendix F Regulatory Framework for Private Health Insurance (PHI) in Five Overseas Jurisdictions

	Australia	Ireland	Netherlands	Switzerland	United States
Role of PHI	Supplementary (voluntary PHI)	Supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI ¹)
Key legislation on health insurance	Private Health Insurance Act	Health Insurance Act	The Health Insurance Act	The Federal Law on Health Insurance	Patient Protection and Affordable Care Act
Main health insurance regulator	The Private Health Insurance Administration Council (PHIAC) reporting to the Department of Health	The Health Insurance Authority (HIA) reporting to the Minister for Health	The Dutch Healthcare Authority (NZa) and the Health Insurance Board (CVZ)	Mandatory PHI: the Federal Office of Public Health (FOPH) reporting to the Federal Department of Home Affairs Supplementary PHI: the Financial Market Supervisory Authority (FINMA)	State regulatory authorities in conjunction with the federal Center for Consumer Information and Insurance Oversight (CCIO)
Is the specialist health insurance regulator Government-led?	Yes	Yes	Yes	Yes	Yes
Is the specialist health insurance regulator also responsible for prudential regulation?	Yes	No	No	Yes (for mandatory PHI)	Varies by States

¹ Under the Patient Protection and Affordable Care Act (PPACA) of 2010, individuals are required to obtain PHI coverage starting from 2014.

	Australia	Ireland	Netherlands	Switzerland	United States
Key functions of the specialist health insurance regulator	<ul style="list-style-type: none"> • Registration of private health insurers • Prudential regulation of private health insurers • Administer the Risk Equalisation Trust Fund 	<ul style="list-style-type: none"> • Enforce compliance with product regulation • Administer premium levies and subsidies 	<p>NZa:</p> <ul style="list-style-type: none"> • Registration of health insurers and their products • Monitor performance and market conduct of health insurers • Supervise healthcare providers <p>CVZ:</p> <ul style="list-style-type: none"> • Advise on the mandatory benefit package • Administer risk equalisation mechanism 	<p>FOPH:</p> <ul style="list-style-type: none"> • Enforce compliance with product regulation on mandatory PHI • Prudential regulation of health insurers <p>FINMA:</p> <ul style="list-style-type: none"> • Enforce compliance of supplementary insurance • Review and approve private insurance operations 	<p>State regulators:</p> <ul style="list-style-type: none"> • Registration of health insurers • Product and market conduct regulation • Prudential regulation of health insurers <p>CCIO:</p> <ul style="list-style-type: none"> • Provides national oversight on compliance with federal insurance market rules

Appendix G Mechanism for Handling Private Health Insurance Claims Disputes in Five Overseas Jurisdictions

	Australia	Ireland	Netherlands	Switzerland	United States
Responsible organisation	Private Health Insurance Ombudsman (PHIO)	Financial Services Ombudsman's Bureau	Health Care Insurance Complaints and Disputes Foundation (SKGZ) (comprises Health Insurance Ombudsman and Health Insurance Disputes Committee)	Ombudsman of Health Insurance	Varies by State. Some States adopt the Federal Department of Health & Human Services (DHHS) dispute resolution mechanism (managed by government but function outsourced to a private organisation). Other States allow the use of accredited Independent Review Organizations (IROs) which satisfy Federal standards for conducting external review
Sector coverage	Private health insurance	Financial services such as banks, insurance, investment companies, etc.	Mandatory and supplementary private health insurance	Mandatory and supplementary private health insurance	Private health insurance ¹
Types of disputes covered	Disputes about private health insurance, including claims and non-claims disputes	Claims disputes, mis-selling charges, maladministration of insurance companies, etc.	Disputes about private health insurance, including claims and non-claims disputes	Disputes about private health insurance, including claims and non-claims disputes	Disputes about private health insurance, including claims and non-claims disputes (including disputes involving claims denial due to medical opinions, e.g. insurer believes procedure not medically necessary)

¹ Under the Patient Protection and Affordable Care Act of 2010, consumers covered by individual or group health insurance plans (except grandfathered plans) have the right to appeal decisions, including claims denials, made by their health insurers.

	Australia	Ireland	Netherlands	Switzerland	United States
Legal form	Government agency	Statutory body	Private company	Private company	DHHS: government agency IROs: private companies accredited by a nationally recognised accrediting organisation
Governance	The Ombudsman is appointed by the Minister for Health	Overseen by the Financial Services Ombudsman Council	The Board of Directors	The Board of Trustee	DHHS: Federal Government governs the process and appoints a private company to handle all cases IROs: self-governing but must be accredited by a nationally recognised accrediting organisation. In some States, IROs are also required to apply for certification issued by State governments
Dispute resolution process	Mediation	Mediation (optional) and adjudication	Include two procedures: mediation by the Health Insurance Ombudsman and/or arbitration by the Health Insurance Disputes Committee	Mediation	DHHS: outcome based on examiner's review and decision IROs: outcome based on IROs' review and decision

	Australia	Ireland	Netherlands	Switzerland	United States
Who can complain?	The insured, insurers and providers; mostly insured in reality Complainants must demonstrate attempt to resolve disputes with the complainee first	Individual consumers and small businesses Complainants must demonstrate attempt to resolve disputes with the complainee first	Individual consumers Complainants must demonstrate attempt to resolve disputes with the complainee first	Individual consumers Complainants must demonstrate attempt to resolve disputes with the complainee first	The insured, insurers and providers Complainants must first go through the internal appeal process of insurance companies
Claims limit	None	Euro 250,000	None	None	None
Final decision binding?	Not binding	Binding, subject to appeal to the High Court	Not binding (Health Insurance Ombudsman) Binding (Health Insurance Disputes Committee)	Not binding	Binding
Funding	Government revenue	Levy from financial services providers	Levy from each insured person plus grant from the Minister of Health, Welfare and Sport	Insurance companies	DHHS: Federal Government (no cost to insurers and policyholders) IROs: costs often borne by insurers. In some States, user fee may be paid by consumers (see row below)

	Australia	Ireland	Netherlands	Switzerland	United States
User fee on complainant	None	None	None (Health Insurance Ombudsman) Euro 37 (Health Insurance Disputes Committee) (refundable if decision is in favour of the consumer)	None	Maximum US\$25 per review on consumer complainants, refundable if external review decision is in favour of the consumer
Relationship with regulator	Required to submit an annual report to the Minister for Health	The governing council is appointed by the Minister for Finance	There are regular meetings with the relevant regulatory bodies and SKGZ would report to regulators as necessary	Does not have a reporting relationship to the regulator	DHHS: DHHS is both regulator and administrator of the dispute resolution systems. IROs: IROs must be accredited by a nationally recognised accrediting organisation and in some cases also a State regulator, but reporting requirements vary by States

GLOSSARY

- **“Annual / lifetime benefit limits”**

“Annual benefit limit” is the total cumulative amount claimable by a policyholder within a year under an insurance policy. “Lifetime benefit limit” is the total cumulative amount claimable by a policyholder under an insurance policy. “Lifetime benefit limit” has the effect of terminating the insurance cover when the cumulative claim amount of a policyholder reaches the limit.

- **Case-based exclusions**

Individually-specified clauses added to an insurance policy to exclude certain diagnoses or conditions from coverage of the insurance benefit for a person insured after the underwriting process. Such exclusions are applied on an individual basis, and may apply to one person but not another.

- **Co-insurance**

A percentage of the claimable healthcare expenses which a policyholder agrees to bear out-of-pocket according to the terms and conditions of an insurance policy.

- **Deductible**

Initial or upfront portion of claimable healthcare expenses that the policyholder agrees to bear out-of-pocket before the benefits apply in accordance with the terms and conditions of an insurance policy. Deductible is usually implemented in terms of a fixed amount.

- **Diagnosis-related groups**

A method of classifying medical conditions requiring hospital admissions or ambulatory procedures by diagnosis and complexity that can be used as a basis for costing or charging for medical services.

- **Expense loading**

Expense loading refers to the amount of insurer expenses as a percentage of the amount of total premium collected. Insurer expenses include commissions and broker fees, profit margins and other overhead expenses.

- **Pre-existing conditions**

Medical conditions existing before a policyholder purchases a health insurance product, including those that have been diagnosed or are being investigated or treated for.

- **Premium loading**

Additional premium assessed by the insurer to cover an individual with extra risks compared to an individual with standard risk for identical benefit coverage. The level of premium loading is correlated to the underwriting class determined through underwriting. One common form of premium loading is in multiples of standard premium.

- **Standard premiums**

Premiums determined by insurers to be charged on individuals with standard risk, i.e. without premium loading. Standard premiums of a health insurance product usually vary by age and gender. Standard premiums also vary from one product to another and from one insurer to another, depending on the cost factors and pricing strategy.

- **Underwriting class**

Grouping of insurance subscribers by risk classification through the underwriting process which facilitates pricing by insurers. For example, insurers would normally apply the same standard premiums (by age and gender) to all subscribers within the same standard risk underwriting class.

- **Underwriting / re-underwriting**

In the context of health insurance, underwriting refers to the process by which an insurer evaluates the risk of a prospective customer. The underwriting result helps the insurer decide whether to accept the subscription, and whether to introduce premium loading and/or case-based exclusions in the insurance policy to manage risk.

Re-underwriting refers to re-evaluation by an insurer of the risk of an individual after he/she is insured with a policy.

- **Waiting period**

A period after issuance of an insurance policy during which the policyholder is not eligible for, partially or fully, benefit coverage stated in the policy.

