

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.

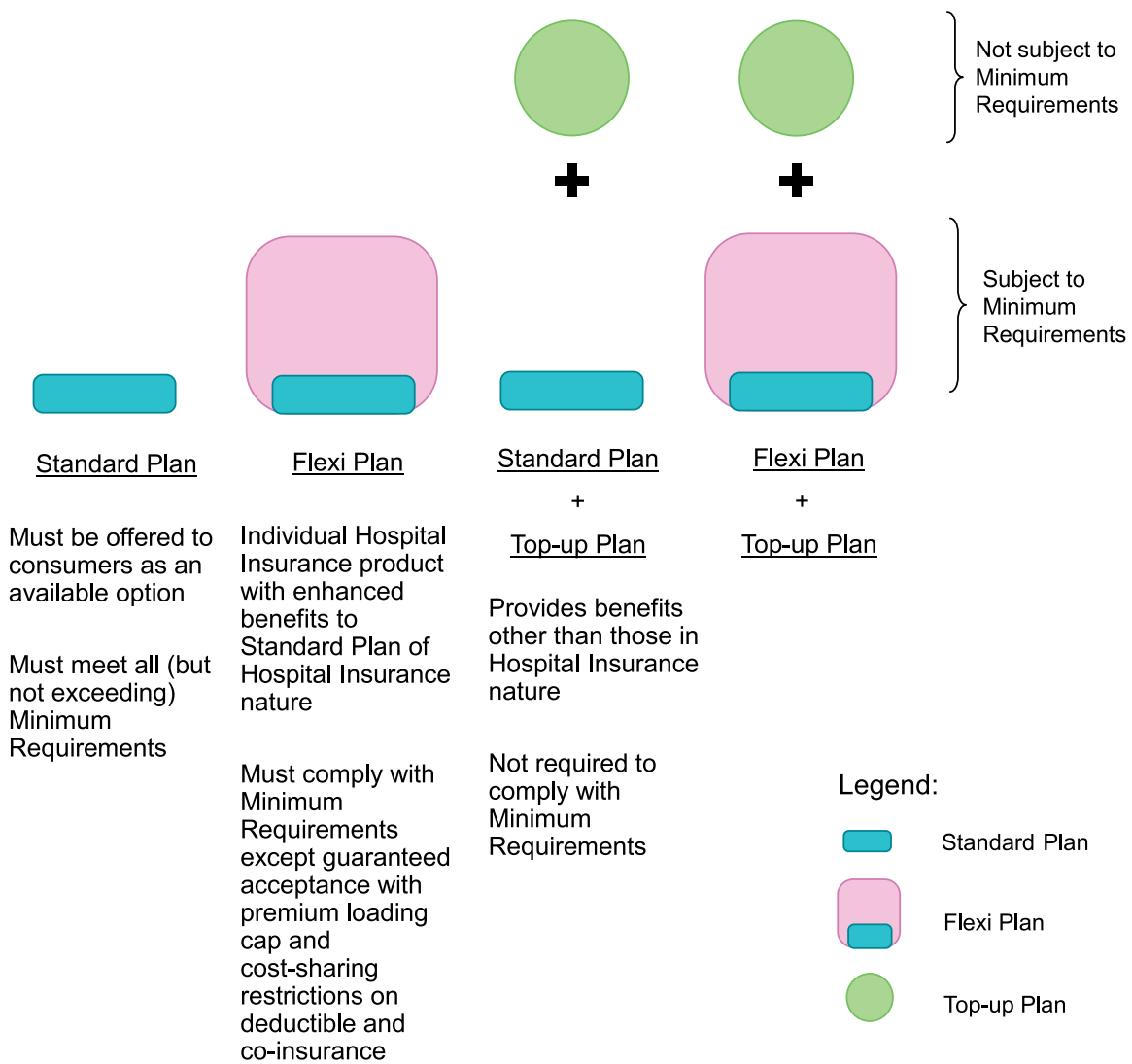
21. A Flexi Plan refers to a Hospital Insurance plan with enhancement to any or all of the benefits of a Standard Plan (e.g. higher room and board benefit limits than those required for a Standard Plan) of Hospital Insurance nature. With a view to allowing more flexibility in promoting product innovation 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,
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

Website: www.vhis.gov.hk