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Panel on Health Services

Subcommittee on Health Protection Scheme

Minutes of the fourth meeting
held on Monday, 30 April 2012, at 8:30 am
in Conference Room 2B of the Legislative Council Complex

Members present	:	Dr Hon LEUNG Ka-lau (Chairman) Hon CHEUNG Man-kwong Hon Audrey EU Yuet-mee, SC, JP Dr Hon Joseph LEE Kok-long, SBS, JP Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Dr Hon PAN Pey-chyou Hon Alan LEONG Kah-kit, SC
Member absent	:	Hon LI Fung-ying, SBS, JP
Public Officers attending	:	Mr Richard YUEN Ming-fai, JP Permanent Secretary for Food and Health (Health) Food and Health Bureau Mr Chris SUN Yuk-han Head, Healthcare Planning and Development Office Food and Health Bureau Dr CHEUNG Wai-lun Director (Cluster Services) Hospital Authority

Clerk in attendance	:	Ms Elyssa WONG Chief Council Secretary (2) 5
Staff in attendance	:	Ms Priscilla LAU Council Secretary (2) 5
		Miss Liza LAM Clerical Assistant (2) 5

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I. Meeting with the Administration

[LC Paper Nos. CB(2)1839/11-12(01) and (02)]

The Subcommittee deliberated (index of proceedings attached at **Annex**).

Follow-up to issues raised by members at the meeting on 16 April 2012

2. The Chairman expressed his dissatisfaction with the Administration's written response to issues raised by members at the meeting on 16 April 2012 (LC Paper No. CB(2)1839/11-12(01). He considered the Administration's response too short to provide sufficient information to address members' concerns. Pointing out that the number of patient days had decreased by 14% from 1998-1999 to 2010-2011 as shown in the annual reports of the Hospital Authority ("HA"), the Chairman was sceptical of whether there was an increase in the demand for public healthcare services, thereby causing a shortage in doctor manpower.

3. The Administration explained that the ageing population, the development of more advanced medical technologies and the introduction of new services were factors leading to a surge in demand for doctor manpower. For instance, the impact on hospital services of the ageing population was reflected by a higher number of admissions of elderly patients and their longer stay in hospital, which implied more intensive use of HA services as elderly patients normally had more complex healthcare needs. While recognizing that the ageing population would have an impact on the public healthcare services, the Chairman stressed the need to have a detailed analysis on the manpower requirement arising from the ageing population and advancement in medical technologies.

4. Ms Audrey EU sought information on whether there was an association between treatment for diseases and medical manpower requirement. The Administration advised that the level of care required for

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patients was increasing in complexity as patients often suffered from multiple diseases and conditions. Hence, the medical manpower resources required for treating a particular disease could not be simply translated into a projection for medical manpower requirement for meeting the overall healthcare needs of Hong Kong.

5. The Chairman enquired whether the manpower projection could be made based on the diagnosis-related groups ("DRG") system as it could be used as a basis for costing and charging for medical services. The Administration responded that DRG could only apply to about 30% of hospital admissions or ambulatory procedures and might not be feasible for all hospital admissions or ambulatory procedures. For instance, DRG was not available for psychiatric care. Therefore it might not be a suitable tool for projecting the overall medical manpower requirement.

6. Dr PAN Pey-chyou considered that geriatric medicine had been developed to meet the challenges brought about by the ageing population and had been proven to address the healthcare needs of elderly patients in a cost-effective manner. The ageing population might not bring about a substantial increase in the healthcare costs. In his view, HA had not utilized its resources efficiently and effectively. He pointed out that the existing resource allocation mechanism of HA, which was generally based on the service volume of the hospital clusters, might only encourage hospital clusters to introduce new services without catering for the needs of the local residents. He called on HA to improve its existing resource allocation mechanism so that resources would be targeted to prioritized areas and population groups.

7. To better measure the increases in service throughputs arising from the ageing population, development of advanced medical technologies and provision of new services, the Chairman requested HA to adopt an objective and quantitative method to assess the impact of these factors on the service demand for public healthcare services.

Regulation of private health insurance

8. Mr CHEUNG Man-kwong considered that a cap on the administration costs, commission and profits should be imposed on the insurance companies participating in the Health Protection Scheme ("HPS") so as to ensure that a reasonable amount of premium revenue would be spent on medical care. Ms Cyd HO concurred with Mr CHEUNG's view and added that premium rebate and other incentives that aimed to encourage the take-up of private health insurance ("PHI") should also be regulated in order to avoid premium escalation.

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9. Pointing out that there were over 130 insurance companies operating in Hong Kong and about 20 to 30 of them might be interested in offering health insurance, Mr CHAN Kin-por was of the view that the competition in the insurance market should be able to keep the prices in check. As public money would be used to incentivize enrolment in HPS, Mr CHAN concurred that consideration should be given to improving transparency on insurance costs such as claims, administration costs and commission. He however pointed out that the experience of the United States ("US") in controlling the costs and profits of insurance companies was not relevant to Hong Kong as the US insurance market had a much larger scale of operations than the local insurance market.

10. Ms Cyd HO was concerned about the number of health insurance companies which would participate in HPS. She expressed worry that in the absence of adequate market competition, the PHI market might be monopolized by a few large health insurance companies, leading to high administration costs and premium escalation. She sought information on measures to contain increases in medical charges and premium level.

11. According to the Administration, there was currently no regulation on the setting of premium level. The setting of premium level and its adjustments were left entirely to market forces. The Administration advised that coupled with an effective mechanism to ensure market competition, market forces would be the best tool to ensure that the premium level would remain competitive. HPS aimed to enhance price transparency and market competition in the PHI and private healthcare markets as well as enable subscribers to access affordable private healthcare services. A consultant would be appointed shortly to perform a comprehensive review and analysis of the current market situation of PHI as well as conduct research on PHI and private healthcare markets in overseas jurisdictions.

12. Pointing out that one of the objectives of HPS was to address the shortcomings of the PHI and private healthcare markets, the Chairman sought the Administration's view on the feasibility of using legislative means, without the support of the $50 billion fiscal reserve earmarked for supporting healthcare reform, to address the shortcomings of the markets, such as requiring participating insurance companies to provide health insurance plans with features like no turn-away of subscribers, guarantee renewal for life and covering pre-existing conditions.

13. The Administration advised that a health insurance scheme providing additional coverage and protection would incur a higher level of risk exposure to the insurers. Reflecting all such risk exposure would result in a

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higher premium that might discourage the young and healthy from joining, which would further reduce the risk pool and push up the premium level. The Administration further advised that HPS, coupled with the support of the $50 billion fiscal reserve earmarked for supporting healthcare reform, aimed to address the risk pool issue, maintain the premium at an affordable level and provide incentives for the young and healthy to join early so as to ensure the long-term sustainability of the scheme.

Private health insurance in Australia

14. Mr CHAN Kin-por noted from the Administration's paper that even though Australia was also having a voluntary health insurance scheme, a flat premium was offered to the insured regardless of health risk factors such as age and health history. He sought information on the sustainability of this voluntary scheme in Australia. Mr Alan LEONG also enquired if reference would be made to the Australian model when designing the features of HPS.

15. The Administration advised that the Australian government had adopted a "carrot-and-stick" approach to encourage enrolment of the young and healthy. To ensure a substantial number of subscribers with a balanced distribution of age and gender to share out the risks, the Australian government had offered a premium rebate of 30% to encourage purchase of PHI. On the other hand, a person who took out a PHI plan after age 30 would be charged an extra premium on top of the community-rated annual premium. The extra premium is calculated at 2% of annual premium per year of deferral since age 30 in taking out a PHI plan, subject to a ceiling of 70% of the annual premium. To maintain the financial viability of the voluntary scheme, a risk equalization system was put in place to transfer and share out costs across all insurers according to their risk pool size. The Administration explained that unlike the Australian model which was subject to relatively heavy regulation by the government, the proposed voluntary HPS would be relatively simple in its design with an "age-banded" premium structure.

Supervisory framework for HPS

16. Noting that a new dedicated HPS authority was proposed to be set up to supervise the implementation and operation of HPS, Mr Alan LEONG expressed concern about its role and relationship with the existing regulatory authorities of the insurance industry, private hospitals and healthcare professionals.

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17. According to the Administration, the supervisory framework for HPS was proposed to comprise three separate but inter-related components, namely, prudential regulation, quality assurance and scheme supervision. The first component of the HPS supervisory framework was proposed to rely on the existing regulatory regime, that is, the Office of the Commissioner of Insurance ("OCI") to supervise the financial soundness of insurers participating in HPS and to oversee complaint handling mechanisms applicable to insurance in general. As for quality assurance, the Department of Health ("DH") was proposed to assume the role through the regulation of private hospitals. As for the third component of the supervisory framework, a new dedicated HPS authority and an independent dispute resolution/arbitration/mediation mechanism for HPS were proposed to be established to supervise the implementation and operation of HPS and handle disputes over health insurance claims under HPS respectively. The Administration advised that although the three components were inter-related, the HPS authority, OCI and DH performed different functions and had their own respective roles under the regulatory framework.

18. Mr Alan LEONG was of the view that the supervisory, regulatory and administrative roles and relationship among different components in the regulatory framework should be clearly delineated. Ms Audrey EU considered that the new dedicated HPS authority should also deal with complaints in relation to any aspect of PHI, not just relating to HPS.

19. Dr PAN Pey-chyou expressed concern about how the proposed regulatory framework for HPS would ensure that the services provided by private hospitals and doctors would be guided by the patients' best interests and based on the clinical need for treatment. He considered an effective mechanism governing the conduct of doctors and handling disputes among doctors, patients and insurance companies crucial to the success of HPS. The Administration advised that an independent and credible dispute resolution/arbitration/mediation mechanism for HPS was proposed for such purposes. A consultant, to be appointed shortly, would draw up details for the proposed mechanism. Mr CHEUNG Man-kwong suggested that reference should be made to the supervisory framework for PHI in Switzerland when formulating a detailed proposal on HPS.

20. The Chairman urged the Administration to be mindful of the pitfalls of moral hazard and adverse selection. Mr CHAN Kin-por expressed a similar view. To avoid these problems, the Chairman suggested that consideration should be given to including features such as no claim discounts, deductibles and co-payments in HPS plans.

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Packaged charging based on DRG

21. The Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion.

22. Noting that HPS aimed to promote price transparency and reduce cost uncertainty, the Chairman sought information as to whether DRG-based packaged charging would be a reference for charging for private healthcare services or payment of claims.

23. The Administration advised that DRG-based packaged charging aimed to provide price transparency and certainty to users, whereby patients requiring specific treatment or procedures would know in advance the medical charges involved, and whether their insurance would be able to cover the charges in full or out-of-pocket payment would be required. The proposed DRG-based packaged charging under HPS would act as a claims reference for participating insurers and the insured for comparison of charges for the specific treatment or procedures, as well as provide benchmarking and monitoring of healthcare charges.

24. Mr CHAN Kin-por held the view that to safeguard consumers' interests and address the problem of cost uncertainty, DRG-based packaged charging should be adopted as a price reference rather than a claims reference. He also considered it important for private hospitals to provide packaged services to reduce cost uncertainty and increase price transparency. He urged the Administration to step up efforts to persuade private hospitals and healthcare providers to set their medical charges with reference to DRG-based packaged charging.

25. The Administration advised that DRG-based packaged charging could enhance transparency on medical charges and insurance claims. It could also help create and promote healthy competition in private healthcare services. As the concept of DRG-based packaged charging was still new to Hong Kong, it was hoped that with time, private hospitals and healthcare providers would be more willing to offer packaged charges by diagnosis.

26. Noting that the coverage of DRG-based packaged charging might only apply to about 30% of hospital admissions or ambulatory procedures, Mr CHAN Kin-por expressed grave concern about the arrangements for payment of claims under HPS for those treatment and procedures where no DRG-based packaged charging was available. In order to avoid confusion among the insured, participating insurers and private hospitals, Mr CHAN

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urged the Administration to set out clearly the reimbursement arrangements under HPS, irrespective of whether DRG-based packaged charging was available.

27. The Administration responded that HPS plans would set reimbursement levels for common treatment or procedures based on DRG so as to promote packaged charging for common procedures or treatment in the private healthcare sector. If the packaged price charged by a private healthcare provider was above the packaged benefit limit under a HPS plan, the insured would be required to pay the excess amount. Where the insured chose a private healthcare provider that charged on an itemized basis for a treatment/procedure covered by the packaged benefit limit under a HPS plan, the insurer might reimburse the insured up to the packaged benefit limit. HPS plans would still need to offer itemized benefit schedules to cater for medical conditions where no private healthcare provider offered packaged charging. In such cases, HPS plans would provide reimbursement in the same way as with existing health insurance products.

28. The Chairman proposed and members agreed to extend the meeting for another 15 minutes to allow more time for discussion.

29. In response to the Chairman's enquiry about the scope of services to be covered by packaged charging under HPS plans, the Administration advised that details of packaged charging would be determined after consultation with the private healthcare service providers and the insurers. The Chairman suggested that any service package should set out clearly items and services to be included and excluded based on a normal low-risk condition. Any extra services provided for those high-risk patients should be charged on a need basis to avoid driving up the premium.

30. The Chairman also suggested that consideration should be given to separating the fees charged by individual doctors and hospitals from the lump-sum charges to encourage more independent private doctors to participate in HPS.

31. To facilitate further discussion, the Administration was requested to provide the following information:-

(a) in respect of the Administration's response to issues raised at the meeting on 16 April 2012 (LC Paper No. CB(2)1839/11-12(01)):

(i) justifications for the Administration's position that the factors of (1) ageing population, (2) development of

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more advanced medical technologies and (3) introduction of new services would lead to a soaring demand in doctor manpower and hence a shortage of doctors; and

(ii) further information with examples illustrating the cost effectiveness of existing services of HA and the evaluation studies of selected pilot projects of HA;

(b) in respect of the features of HPS:

(i) detailed information to explain the determination of the level of premium for individuals belonging to different risk levels;

(ii) detailed information to explain the viability of operating a high risk pool to share out the high risks insured among insurers in the absence of government subsidy for the risk pool;

(iii) the corresponding increases in the premium level, having taken into account the morbidity rates of different diseases by age groups and their respective medical costs, if an insurance plan offered (1) guaranteed acceptance and renewal; (2) portability; (3) acceptance of pre-existing conditions; and (4) access for high-risk groups; and

(iv) detailed information on the arrangements for payment of claims under HPS with or without packaged charging based on DRG;

(c) a list of insurance companies in Hong Kong and their respective amounts of underwriting; and

(d) the formula for calculating medical inflation in the public and private sectors.

II. Date of next meeting

32. The Chairman informed members that the next meeting would be held on 21 May 2012. As agreed by members, the utilization of government subsidy would be discussed at the next meeting.

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33. There being no other business, the meeting ended at 11:07 am.

Council Business Division 2
Legislative Council Secretariat
19 September 2012

Annex

Proceedings of the fourth meeting of the Subcommittee on Health Protection Scheme on Monday, 30 April 2012, at 8:30 am in Conference Room 2B of the Legislative Council Complex

Time marker	Speaker	Subject	Action required
000000-000229	Chairman	Opening remark	
000230-000325	Chairman Admin	Briefing by the Administration on its response to issues raised by members at the meeting on 16 April 2012 (LC Paper No. CB(2)1839/11-12(01)).	
000326-001329	Chairman Admin	The Chairman's request for the justifications for the Administration's position that the factors of ageing population, development of more advanced medical technologies and introduction of new services would lead to a soaring demand in doctor manpower and hence a shortage of doctors.	**Admin** (paragraph 31 of the minutes)
001330-002507	Chairman Ms Audrey EU Admin	Ms Audrey EU's enquiries on the manpower projection based on the medical manpower resources required for treatment of diseases; and the mechanism to handle insurance complaints. The Administration's response that the medical manpower resources required for treating a particular disease could not be simply translated into a medical manpower projection for meeting the overall healthcare needs of Hong Kong. The Chairman's enquiries on the projection of manpower needs based on the diagnosis-related groups ("DRG") system. The Administration's response that DRG might not a suitable tool for such purpose as it could only apply to about 30% of hospital admissions or ambulatory procedures.	
002508-003208	Dr PAN Pey-chyou Admin	Dr PAN Pey-chyou's view that the Hospital Authority ("HA") should improve its existing resource allocation mechanism so that resources would be targeted to prioritized	

Time marker	Speaker	Subject	Action required
		areas and population groups. The Administration's response that HA had strengthened its services by introducing new services through pilot schemes.	
003209-003256	Chairman	The Chairman's request for further information with examples illustrating the cost effectiveness of existing services of HA and the evaluation studies of selected pilot projects of HA.	**Admin** (paragraph 31 of the minutes)
003257-004424	Mr CHEUNG Man-kwong Admin Chairman Ms Cyd HO	Mr CHEUNG Man-kwong's view that a cap on the administration costs, commission and profits should be imposed on the insurance companies participating in HPS. The Administration's response that market forces would be the best tool to ensure that the premium level would remain competitive. A consultant would be appointed shortly to perform a comprehensive review and analysis of the market situation of the private health insurance ("PHI") and private healthcare markets. Ms Cyd HO's concurrence with the view of Mr CHEUNG Man-kwong.	
004425-005621	Ms Cyd HO Admin Mr CHAN Kin-por Chairman Mr CHEUNG Man-kwong	Ms Cyd HO's concerns about the monopoly of the PHI market by a few large health insurance companies and increases in administration costs and premium. The Administration's response that HPS aimed to enhance price transparency and market competition in the private health insurance market. Mr CHAN Kin-por's information on the number of insurance companies in Hong Kong. The Administration was requested to provide a list of insurance companies in Hong Kong and their respective amounts of underwriting; and the formula for calculating medical inflation in the public and private sectors.	**Admin** (paragraph 31 of the minutes)
005622-010504	Dr PAN Pey-chyou Admin Mr CHEUNG Man-kwong	Dr PAN Pey-chyou's concern on an effective mechanism for governing the conduct of doctors and handling disputes among doctors, patients and insurance companies.	

Time marker	Speaker	Subject	Action required
		The Administration's response on the establishment of an independent and credible dispute resolution/ arbitration/ mediation mechanism for HPS. Mr CHEUNG Man-kwong's request for making reference to the supervisory framework for PHI in Switzerland when formulating a detailed proposal on HPS.	
010505-010834	Chairman Admin	The Chairman's view that no claim discounts, deductibles and co-payments were effective means to tackle the problems of moral hazard and adverse selection.	
010835-012021	Mr CHAN Kin-por Admin Chairman	Mr CHAN Kin-por's supplementary information on the number of insurance companies in Hong Kong. Mr CHAN Kin-por's view on the moral hazard problem and his request for consulting the insurance industry on the regulation of PHI. Mr CHAN Kin-por's enquiries on the financial viability and risk sharing of PHI in Australia. The Administration's elaboration on the operation of PHI in Australia. The Administration was requested to provide detailed information to explain the determination of the level of premium for individuals belonging to different risk levels.	**Admin** (paragraph 31 of the minutes)
012022-014129	Chairman Admin Mr CHAN Kin-por	The Chairman's view on the use of legislative means to address the shortcomings of the PHI and private healthcare markets. The Administration's response that HPS, to be supported by the $50 billion fiscal reserve earmarked for supporting healthcare reform, aimed to address the risk pool issue, maintain the premium at an affordable level and provide incentives for the young and healthy to join early so as to ensure the sustainability of HPS. Mr CHAN Kin-por's view that the Administration should ensure a balanced risk pool in the design of HPS.	

Time marker	Speaker	Subject	Action required
		The Administration was requested to provide detailed information - (a) to explain the viability of operating a high risk pool to share out the high risks insured among insurers in the absence of government subsidy for the risk pool; and (b) the corresponding increases in the premium level, having taken into account the morbidity rates of different diseases by age groups and their respective medical costs, if an insurance plan offered (1) guaranteed acceptance and renewal, (2) portability; (3) acceptance of pre-existing conditions; and (4) access for high-risk groups.	**Admin** (paragraph 31 of the minutes)
014130-015439	Chairman Mr Alan LEONG Admin	Mr Alan LEONG's enquiry on whether the Administration would make reference to the Australian model when designing the features of HPS; and the role and relationship of the new dedicated HPS authority with the existing regulatory authorities of the insurance industry, private hospitals and healthcare professionals. The Administration's view that the Australian model was more complicated and was subject to relatively heavy regulation by the Australian government; and the proposed HPS would be simpler in design with an "age-banded" premium structure.	
015440-020654	Chairman Mr CHAN Kin-por Admin	The Chairman's decision to extend the meeting for 15 minutes beyond its appointed time. The Administration's response to the Chairman's enquiry on DRG-based packaged charging that it would act as a claims reference for participating insurers and the insured. Mr CHAN Kin-por's view that DRG-based packaged charging should be adopted as a price reference rather than a claims reference; and his concern about the arrangements for payment of claims under HPS for those treatment and procedures where no DRG-based packaged charging was available.	

Time marker	Speaker	Subject	Action required
020655-022910	Chairman Admin Mr CHAN Kin-por	Members' agreement to further extend the meeting for 15 minutes to allow more time for discussion. The Administration's response to the Chairman's concern on the scope of services to be covered by packaged charging under HPS plans. Mr CHAN Kin-por's view that the provision of service packages by private hospitals was important. The Chairman's view that any service package should be based on a normal low-risk condition to avoid driving up the premium.	
022911-023733	Chairman Admin Mr CHAN Kin-por	The Chairman's view that consideration should be given to separating the fees charged by individual doctors and hospitals from the lump-sum charges to encourage more independent private doctors to participate in HPS. Mr CHAN Kin-por's request that the Administration should set out clearly the reimbursement arrangements under HPS, irrespective of whether DRG-based packaged charging was available.	**Admin** (paragraph 31 of the minutes)
023734-023911	Chairman	Date of next meeting	

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