中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

Our Ref. : *L/M to FHB/H/1/5/4/2 Pt.2*
Your Ref. : *CB2/PS/5/10*

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31 May 2012

Ms Elyssa WONG
Clerk to Subcommittee
Subcommittee on Health Protection Scheme
Panel on Health Services
Legislative Council Complex
1, Legislative Council Road
Central

Dear Ms WONG,

Panel on Health Services
Subcommittee on Health Protection Scheme

Follow-up to the meeting on 30 April 2012

I refer to your letter of 8 May 2012. The supplementary information on item (b) is provided at **Annex**. Together with our interim reply of 17 May 2012, all issues raised should have been addressed.

Yours sincerely,

(Sheung-yuen LEE)
for Secretary for Food and Health

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Annex

Administration's Response to
Follow-up to the meeting of Subcommittee on Health Protection Scheme of the Panel on Health Services on 30 April 2012

Item (b)(i) -

Detailed information to explain the determination of the level of premium for individuals belonging to different risk levels in respect of the features of the Health Protection Scheme ("HPS").

Administration's response

In the existing health insurance market, insurers are free to set and adjust premiums for their private health insurance products. Generally speaking, the premium of private health insurance would vary in correspondence with the risk level of the subscriber concerned, taking into account risk factors such as age, health status, lifestyle, pre-existing medical conditions, claim history, etc. Individuals who are considered high-risk by insurers will be charged premium loadings over and above the "normal" premium level, or will be charged the "normal" premium yet with reduced coverage due to exclusion of pre-existing medical conditions and other illnesses to which a subscriber is relatively vulnerable, or a combination of the two. In some cases, insurers may even refuse to accept higher-risk individuals and underwrite their risks.

2. In the Second Stage Public Consultation on Healthcare Reform, we proposed to require insurers participating in the Health Protection Scheme (HPS) to set and publish transparent premium schedules for HPS plans, which should be age-banded subject to adjustment guidelines. This means that the levels of "normal" premium for different age groups will be assessed separately to fairly reflect the risk factors pertaining to different age groups. The premium level is normally higher for older groups and lower for younger groups (except for infancy and early childhood). Premium loading could be imposed on subscribers with higher risks, but the rate was proposed to be limited to a maximum of 200% of the published premium for the HPS standard plan.

3. As regards the "normal" premium level of the illustrative HPS standard plan set out in Appendix A to the Consultation Document, the consultant commissioned by the Food and Health Bureau estimated that the

net annual premium (net of commission and acquisition costs) would be lowest at $790 for age 10-14, rising to $1,570 for age 20-24, $2,930 for age 40-44, $5,570 for age 60-64 and $15,000 for age 85 and above. The premium estimation has taken into account the additional coverage and protection that the HPS requires participating insurers to offer for the standard plan, including key features such as no turn-away of subscribers and guaranteed renewal for life; covering pre-existing medical conditions subject to waiting period; and accepting high-risk groups through a high-risk pool mechanism, etc.

4. A health insurance scheme which provides the above additional coverage and protection will incur a higher level of risk in aggregate. If all the risks are fully reflected in the "normal" premium levels of HPS standard plans, the higher premium will discourage people from joining the scheme when they are young and healthy, thereby undermining the risk-pooling function of the scheme and pushing up the premium level. In order to achieve the policy objectives of the HPS and to implement the key features of the HPS, in formulating the detailed proposals for the HPS, we will consider the option of utilising the $50 billion fiscal reserve earmarked to support healthcare reform to, among other things, address the risk pool issue, maintain the premium at an affordable level, and provide incentives for the young and healthy and all potential participants to join early so as to ensure the long-term sustainability of the scheme.

5. The consultant to be appointed by the Food and Health Bureau for carrying out a study on the HPS will formulate a proposed premium schedule for the HPS standard plan with reference to the proposed coverage and benefit limits of the HPS standard plan, existing market data and experience, policy objectives of the HPS and other relevant considerations.

Item (b)(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 in respect of the features of the HPS.

Administration's response

6. One of the key objectives of the HPS is to better protect the high-risk groups by enabling them to gain access to health insurance coverage. Currently, it is difficult for individuals with pre-existing medical conditions or those with higher health risks to subscribe to health insurance plans. Most

existing health insurance products for individuals in general do not cover pre-existing medical conditions in order to reduce insurers' risk exposure and manage the risk profile of their risk pool. On the other hand, previous public consultations indicated that members of the public were concerned about the exclusion of pre-existing conditions because it would severely restrict the access of higher-risk groups to health insurance protection. A balance would need to be struck between maintaining the financial viability of health insurance plans on the one hand, and requiring insurers to cover pre-existing conditions on the other hand.

7. To enable the higher-risk groups to have access to health insurance while ensuring the financial viability of the HPS plans, we have proposed in the Second Stage Public Consultation on Healthcare Reform to set up a high-risk pool mechanism to enable participating insurers to accept the enrollment of high-risk individuals.

8. Without prejudice to the discussion and deliberation by the Working Group on Health Protection Scheme and the Health and Medical Development Advisory Committee (HMDAC) on the eventual *modus operandi* of the high-risk pool mechanism, we have set out some preliminary thoughts on how the mechanism might work in the Consultation Document for discussion. Under the proposed high-risk pool mechanism, the policies of high-risk individuals with premium assessed by an insurance company to exceed three times its published premium of the relevant age groups could be transferred to a high-risk pool. These high-risk individuals only have to pay three times the published premiums chargeable on them. The premium income collected together with the corresponding claim liabilities would be transferred to the high-risk pool. When necessary and under justified circumstances, the Government may consider injecting fund into the pool to maintain its financial sustainability.

9. Given that the proposed high-risk pool would be a mechanism new to the market, it would be difficult to project accurately the financial condition of the proposed high-risk pool because no existing market experience or data are available. In addition, the financial viability and sustainability of the high-risk pool would depend on a number of variables, such as the number of high-risk individuals joining the HPS, their health status and claims history, etc. For the purpose of providing a rough estimation, the consultant commissioned by the Food and Health Bureau in 2010 assumed that, under the baseline scenario, 10% of new subscribers would be high-risk individuals and their policies would be transferred to the high-risk pool in the first year of operation of the HPS. The percentage was assumed to fall to a stable level of 2% thereafter. The average medical costs incurred by high-risk individuals were assumed to be six times the corresponding figures for

normal-risk individuals. The higher risks would translate into a higher premium for these high-risk individuals. Under these assumptions, the financial condition of the high-risk pool would depend very much on the size of enrollment and claim outcomes of high-risk individuals.

10. It should be noted that the high-risk pool mechanism described above is only one of the many possibilities. Details of the proposed high-risk pool mechanism and operation will be worked out by the consultant to be appointed for carrying out a study on the HPS, and will be subject to discussion and deliberation by the Working Group on Health Protection Scheme and the HMDAC.

Item (b)(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 in respect of the features of the HPS.

Administration's response

11. The consultant commissioned by the Food and Health Bureau in 2010 estimated the indicative premiums of the HPS standard plan with regard to existing market experience as well as the proposed key features to be introduced into HPS plans. Estimation on healthcare utilisation and medical costs in relation to existing market experience is largely based on a proprietary database owned by the consultant consisting of around 700 000 private health insurance policyholders.

12. Regarding guaranteed acceptance with coverage of pre-existing conditions, the actuarial model of the consultant assumed that this scheme feature would lead to an average increase of about 5% in "normal" premium of the HPS standard plan in order to pay for the cost of covering the unknown pre-existing conditions of existing policyholders migrating to the scheme. However, the "normal" premium would not be affected by the cost of covering known pre-existing conditions of new subscribers, which would be compensated by premium loading instead.

13. As for the high-risk pool mechanism, it was assumed that this feature would not affect the "normal" premium of the HPS standard plan because the high-risk pool would be separate from the normal risk pool in operation.

The high-risk pool would only lead to an increase in the HPS standard plan premium if the normal risk pool shares out the cost of the high-risk pool. In its calculation, the consultant assumed, for the sake of actuarial modeling, the existence of such cost sharing between the high-risk pool and the normal risk pool, which was assumed to be 2% of the "normal" premium of the HPS standard plan.

14. It should be noted that the above assumptions were provided by the consultant for the purpose of calculating an illustrative premium schedule for the HPS standard plan. In carrying out the consultancy study on the HPS, the consultant to be appointed would work out the detailed design for, among other things, the rules and mechanisms for implementing the key features of the HPS such as guaranteed acceptance and renewal, portability, coverage of pre-existing medical conditions and access of high-risk groups. The consultant would also examine the implications of these key features to the premium level of the HPS standard plan, taking into account other related variables such as the number and proportion of migrants to the scheme with pre-existing conditions, the length of the waiting period for coverage of pre-existing conditions, and the administration cost to comply with the scheme rules.

Item (b)(iv) -

Detailed information on the arrangements for payment of claims under HPS with or without packaged charging based on diagnosis-related group ("DRG") in respect of the features of the HPS.

Administration's response

15. One of the features of the proposed HPS is to promote transparent medical fees in order to better protect consumer's rights. HPS plans would set reimbursement levels for common treatments or procedures based on diagnosis-related group (DRG), i.e. a lump-sum benefit limit for the treatment or procedure would be set for paying the medical fees, so as to promote packaged charging for common procedures or treatments in the private sector. If the packaged price offered by private healthcare providers is above the packaged benefit limit under the HPS plans, co-payment by the insured for the excess would be necessary. Where the insured chooses a provider that charges on an itemized basis for a treatment / procedure covered by packaged benefit limit under the HPS plans, the insurer would reimburse the insured up to the packaged benefit limit.

16. HPS plans would still need to offer itemized benefit schedules to cater for medical conditions where no private healthcare provider offers packaged pricing, e.g. where this is considered not feasible due to the complexity of the treatments or procedures involved. In such cases, the HPS plans will provide reimbursement in the same way as with existing health insurance products.

Food and Health Bureau
May 2012