



中華人民共和國香港特別行政區政府總部食物及衛生局
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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29 June 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 4 June 2012

I refer to your letter of 12 June 2012 on the captioned. The requested supplementary information is provided at **Annex**.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Sheung-yuen LEE', written over the typed name.

(Sheung-yuen LEE)

for Secretary for Food and Health

**Administration's Response to
Follow-up to the meeting of Subcommittee on Health Protection Scheme of
the Panel on Health Services on 4 June 2012**

Item (a)(i) -

The detailed formula for calculating the net medical inflation, including the components making up the net medical inflation in the public and private healthcare sectors and their respective weights in the formula.

Item (a)(ii) -

Whether the net medical inflation rate of the private healthcare expenditure would always be higher than that of the public healthcare expenditure.

Administration's response

The Administration does not have any data or formula for calculating net medical inflation in Hong Kong. The concept of “net medical inflation” (i.e. medical inflation rate over and above per capita real Gross Domestic Product (GDP) growth) was adopted by the consultant, the School of Public Health of the University of Hong Kong, in projecting the future growth of health expenditure (up to the year 2033) in the First Stage Public Consultation on Healthcare Reform in 2008. When constructing the health expenditure projection model, the consultant assumed that the net medical inflation rates would be 0.8 percentage point and 1.6 percentage points over and above per capita GDP growth rate per year on average for public and private health expenditures respectively, having regard to international experience as well as local trend of health expenditure.

2. The consultant appointed by the Food and Health Bureau to conduct a study on the Health Protection Scheme (HPS) will, amongst others, carry out projections on the short to long-term implications of the HPS for Gross Domestic Product, consumption, inflation, income distribution and employment at macro level, and capacity, facility requirements, manpower need, and operating cost of the insurance and healthcare sectors, including medical inflation.

Item (a)(iii) -

Using examples to illustrate how the levels of premium for low-risk and high-risk individuals were determined, taking into account the morbidity rates for different age groups, the related medical costs, and key features of health insurance plans offered under the Health Protection Scheme ("HPS").

Administration's response

3. Actuarial calculation of private health insurance premium typically involves estimation of expected medical claim costs, commission expenses, administration and marketing expenses, reinsurance expenses, and targeted profit margin, etc. The difference in premiums charged on a low-risk individual versus a high-risk individual within same age group mainly hinges on the difference in expected medical claim costs and the difference in anticipated morbidity rates by disease type.

4. Since the HPS standard plan does not allow exclusion of pre-existing conditions in benefit coverage after the waiting period, the underwriting process will be premium-based rather than exclusion-based, meaning that the higher cost of insuring a high-risk individual will be offset by premium loading rather than reduced coverage. By the design of HPS, it is proposed that the premium loading rate would be capped at 200%. To assess whether premium loading should be applied and the rate of loading if applicable, insurance companies normally make reference to a subscriber's personal lifestyle (e.g. smoking habit), individual medical history and family medical history. Sometimes, medical examinations are required to make the assessment more rigorous.

Item (b)(i) -

The estimated number of people who would subscribe to HPS plans.

Administration's response

5. According to the consultant commissioned by Food and Health Bureau in 2010, the number of people who would subscribe to HPS plans would depend on a number of inter-related factors. These include, amongst others, whether the scheme design is attractive to the market; whether public subsidies or financial incentives provided by the Government, if any, could encourage enrolment; and the likelihood of enrollees staying on with the scheme in the long term. The complexity in estimation is compounded by the fact that

market response may differ by different market segments, including the uninsured versus the insured population, and the individual versus the group market.

6. When conducting the consultancy on the HPS, the consultant will carry out a projection on, amongst others, the short to long-term scheme take-up based on the proposed scheme design and taking into account the market situation.

Item (b)(ii) -

The average total premium paid into a Standard HPS plan to cover the whole life of an individual.

Administration's response

7. The average total premium paid by an individual into the HPS standard plan to cover his/her whole life would depend on various factors, such as the entry and exit age, applicability of premium loading for less healthy conditions, the long-term premium trend, etc. It is difficult to generalize an average total premium level that applies to all. Yet generally speaking, the earlier a person starts to be insured, the smaller the average annual premium amount to be paid for to cover his/her whole life. This is because the younger-aged normally tends to be healthier than the older-aged, and hence the premium level is normally lower for younger groups (except for infancy and early childhood) and higher for older groups.

**Food and Health Bureau
June 2012**