當局就衞生事務委員會醫療保障計劃小組委員會
二零一三年六月四日會議跟進事項所作的回應

(a)項—

請提供醫療保障計劃工作小組及／或醫療保障計劃諮詢小組有關受醫療保障計劃(醫保計劃)規管的私人醫療保險保單設計的工作文件。

當局的回應

當局已委聘顧問就醫保計劃進行研究(顧問)。**附錄**載有顧問就受醫保計劃規管的私人醫療保險保單的設計準備的資料，以供參考(只有英文版)。醫療保障計劃工作小組及諮詢小組已在會議上考慮和討論這些資料。

(b)項－

請概述私營醫療服務提供者就特定治療或手術提供的套餐式收費包含哪些項目，並列舉套餐範例，說明一些普通手術(例如涉及住院或非住院手術的胃鏡檢查、闌尾切除手術等)的現有套餐式收費所涵蓋的項目。

當局的回應

2. 套餐式收費的主要目的，是提高醫療收費的透明度和確定性，讓病人可事先估算須繳交的費用。為此，海外的醫療服務提供者提供的套餐式收費，通常會涵蓋某項治療或手術所需的一切服務。舉例來說，一般住院手術套餐涵蓋普通病房收費、醫生診金、化驗費用、手術室租金和外科手術費。然而，一般套餐通常不提供較高級別病房的住宿或住院期間的非必要醫療設施。至於非住院手術，一般套餐會涵蓋診金、外科手術費和設施收費。

3. 訂定套餐式收費的主要技術困難是疾病的複雜性。即使同一類疾病，其複雜程度也會有所不同，其中有些情況更是難以預見的。因此，海外醫療服務提供者或會容許套餐式收費因應疾病的複雜程度而變動，或在特殊情況下豁免使用套餐式收費。

4.　為了令收費更加透明和明確，顧問提出「服務預算同意書」及「免繳付套餐／定額套餐」這兩項與海外慣常做法一致的建議安排。顧問的建議與本港市場現行的一些做法有所不同。現時一些私家醫院提供的套餐只涵蓋指定的服務，例如住院三天、一項化驗及其他指定服務。假如病人最終留院四天，便須繳付額外的一天病房費用。這項安排與顧問建議的「免繳付套餐／定額套餐」安排不盡相同。在「免繳付套餐／定額套餐」安排下，除非疾病的複雜程度並不在原來套餐所涵蓋的範圍內，否則病人無須繳付額外費用。

(c)項－

當局已採取或正考慮採取什麼措施(包括根據《競爭條例》(第 619 章)採取的規管措施)，以確保私家醫院服務存在良性競爭，從而保障病人權益。

當局的回應

5.　醫保計劃的其中一個目的，是提高消費者支付的私營醫療服務費用的透明度和確定性。在顧問建議的「服務預算同意書」安排下，病人在接受治療前，會通過書面報價方式，得知私營醫療服務的預算費用，以及任何須自付的款項。此外，我們鼓勵私營醫療服務提供者為常見的手術或治療提供套餐式收費。新的私家醫院每年最少須以 30%住院病床日數，提供套餐式收費服務。這些安排可增加收費透明度，方便消費者比較不同醫療服務提供者的收費，從而鼓勵市場良性競爭。

6.　當局正同時檢討私營醫療機構的規管情況。檢討的其中一個主要目的，是提升私營醫療服務收費的透明度，以保障病人權益。當局會參考海外經驗，研究可行的措施，例如套餐式收費、報價制度、建立通用平台以公布私家醫院實際收費統計數字等。當局會就這些檢討的建議諮詢公眾，然後進行所需的立法程序。

7.　立法會於二零一二年六月制定的《競爭條例》，旨在禁止和阻遏各行各業的「業務實體」採用欺壓手法或作出其他反競爭行為，以至具有妨礙、限制或扭曲在香港的競爭的目的或效果。「業務實體」指任何從事經濟活動的實體(不論其法定地位或獲取資金的方式)，包括從事經濟活動的自然人。大部分私家醫院都符合「業務實體」的定義，故此須受該條例規管。具體來說，該條例禁止任何業務

實體組織作出具有妨礙、限制或扭曲在香港的競爭的目的或效果的協議、經協調做法及決定。《競爭條例》也禁止具有相當程度的市場權勢的業務實體濫用該權勢，藉以從事具有妨礙、限制或扭曲在香港的競爭的目的或效果的行為。

8. 《競爭條例》全面實施後，競爭事務委員會可以主動、因應接獲的投訴或按政府或法庭轉介的個案，調查涉嫌反競爭的行為，並採取執法行動。

(d)項－

醫保標準計劃所訂明的最低要求之一，是「終身可獲的保障總額不設上限」和「受保人須支付的墊底費及自費分擔款額設有每年上限」。請說明提出這些建議的理據。

當局的回應

9. 「終身可獲的保障總額上限」和「墊底費及自費分擔款額」屬於承保機構與受保人之間的費用分擔安排。這些安排旨在遏制道德風險，以及更有效地控制醫療成本。不過，在設計費用分擔安排時，我們必須詳細考慮是否會損害消費者的權益，尤其是低收入人士分擔費用的能力，以免減低他們尋求所需治療的意欲。

10. 有見及此，顧問建議禁止醫保標準計劃及靈活計劃就「終身可獲的保障總額」設有上限，但准許就「每年可獲的保障總額」設有上限。這意味着受保人即使在某合約年度內已用盡該年的最高賠償額，在接着的合約年度仍能重新獲得保險賠償。如果准許就「終身可獲的保障總額」設有上限，當受保人的累積索償額達到終身保障總額上限時，便不能再享有保險保障，終身續保也會變得毫無意義。

11. 顧問亦建議就墊底費及自費分擔款額設定每年上限，以保障消費者。這裏所指的墊底費及自費分擔款額都屬前付性質。如受保人的實際開支超出其保單的保障限額，則受保人須繳付的款額並不受有關上限所限制。

(e)項－

請提供精算模式計算的保費範例(扣除保險公司收取的行政費)，說明如何根據投保人不同的健康風險而調整醫保標準計劃的保費，例如年齡、健康狀況、投保前已有病症等風險因素。

當局的回應

12. 顧問以精算模式計算保費，其中一個主要步驟，是按年齡組別、性別和風險組別(包括標準風險組別和較高風險組別)估算預計的醫療索償成本。這個步驟相當複雜，因為按年齡組別、性別和風險組別計算的預計醫療索償成本，會因應預期發病率和嚴重程度而有所不同。一般而言，較年長組別人士的醫保標準計劃保費，會比較年青組別人士的保費為高（嬰兒和幼童除外）。就性別而言，較年長組別男士的保費一般較同齡的女士為高，因為前者使用較多醫療服務。

13. 就風險組別而言，受保人經核保後，會由承保機構按照其健康狀況、投保前已有病症及其他相關風險因素，歸類為標準風險組別或較高風險組別。由於醫保計劃擬按年齡分級訂立保費架構，受保人經核保後如被歸類為標準風險組別，承保機構便會按適用於其年齡組別及性別的標準保費率收取保費。

14. 至於經核保後被納入較高風險組別的受保人，承保機構或會收取附加保費(標準保費的若干百分比)，以彌補預計較高的醫療索償成本。附加保費的上限為 200%，而附加保費評定為 200%或以上的個案，可從承保機構轉移至高風險池。承保機構在扣除由醫保計劃監管機構訂定的公認處理費後，便會將收取的保費轉移至高風險池。承保機構會繼續負責該等保單的行政管理，但這些保單的保費收入（扣除支出）、索償須付的款項以及利潤虧損，均歸入高風險池而非該承保機構。

15. 有意見認為，承保機構可能會標高附加保費率，以便把較高風險的投保人轉往高風險池，因而影響高風險池在財政上的可持續性。顧問認為這種現象不大可能出現。這是因為只要承保機構可按其承擔的額外風險收取相應的附加保費，他們仍應期望能保留該等投保人在他們的保險組合內，以賺取承保利潤。在這情況下，承保機構按照其承擔的風險釐定合適的附加保費率，而非標高附加保費率以便將保單轉移至高風險池，才是符合他們利益的做法。此外，所有承保機

構均須向消費者提供醫保標準計劃作為其中一項選擇。在價格競爭下，承保機構標高附加保費並無好處，因為消費者可比較不同承保機構提供的醫保標準計劃保費。

(f)項－

請評估為所有償款住院保險產品訂定最低要求，對現有償款住院保險計劃投保人或投保團體所帶來的影響，包括按計劃種類和保費水平分項列出現有保單持有人的數目。

當局的回應

16. 根據政府統計處於二零一一年十月至二零一二年一月進行的主題性住戶統計調查結果，近年來擁有私人醫療保障的人數逐漸上升，由二零零五年的 223 萬人上升至二零一一年的 279 萬人(約香港人口的四成)。在這個總數中，約 125 萬人只擁有由個人名義購買的私人醫療保險保障，約 95 萬人只擁有由僱主提供的團體醫療保險保障，約 59 萬人同時擁有這兩種保障。

17. 顧問正根據醫保計劃的初步設計進行消費者意見調查，測試市場對醫保計劃的反應，包括消費者是否願意投購醫保計劃，或從現有保單轉投醫保計劃。調查結果將有助顧問制定產品的最後設計，以及評估最低要求模式對現時醫療保險市場的影響，包括估計會轉投醫保計劃或繼續投購現有保險計劃的保單持有人的數目。

食物及衞生局
二零一三年六月

附 錄
(只有英文版)

www.pwchk.com

Consultancy Study for the Health Protection Scheme

Relevant Working Papers Discussed by the Working Group and Consultative Group on Matters Concerning the Design of Private Health Insurance Policies Regulated under Health Protection Scheme

pwc

1. International Experience - Implications for HPS
(presented to the Working Group on Health Protection Scheme (WG)/Consultative Group on Health Protection Scheme (CG) on 30.1.2013/7.2.2013)

2. Initial HPS Product Design
(presented to the WG/CG on 30.1.2013/7.2.2013)

3. Pricing the proposed HPS Standard Product
(presented to the WG/CG on 13.3.2013/21.3.2013 and 29.5.2013/6.6.2013)

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Approach

International literature research and consultations were conducted for:

1. **Australia**
2. **Ireland**
3. **the Netherlands**
4. **Switzerland**
5. **US: focus is on current health reforms**

Approach

Lessons for helping to achieve the objectives of HPS?

Due regard will be given to local circumstances

How do these countries use regulation to support and manage PHI?

The proposal for HPS will be developed in consultation with all stakeholders

Implications for HPS - Summary

1. **HPS goals are consistent with PHI goals in the countries we studied**
2. **Most features of the HPS (as in the 2nd Stage Consultation Document) are consistent with the countries we studied.**
3. **Common overseas practice to require all PHI products to comply with regulatory requirements**
4. **Statutory minimum requirements are broad**
5. **Cost sharing (out-of-pocket costs) is often regulated in order to protect members.**
6. **Medical inflation and demand pressures are real risks which must be managed and monitored.**

Implications for HPS - Summary

7. **Financial Incentives / Disincentives are widely offered, but must be well designed to be effective.**
8. **Some features of HPS not supported by evidence: no claims discount, savings accounts.**
9. **PHI reform requires a clear vision of public and private sector roles in health care delivery.**
10. **Market Transparency is critical for competition, consumer protection and optimal regulation.**
11. **PHI reform is an incremental process requiring long-term commitment and ongoing oversight.**
12. **A government-led claims dispute resolution system is desirable**

Role of PHI and Key Features

	Australia	Ireland	Netherlands	Switzerland	US	Hong Kong
Role of PHI	Voluntary supplementary	Voluntary supplementary	Mandatory & Voluntary supplementary	Mandatory & Voluntary supplementary	Mandatory	Voluntary supplementary
Coverage as % of population	47% (for hospital treatment)	47%	~100%	~100%	65% (prior to PPACA)	41%
PHI Expenditure as % of healthcare financing	11%	9%	45%	50%	34%	14%
Product Regulation by Law	✓	✓	✓	✓	✓	×
Premium Regulation by Law	✓	✓	✓	✓	✓	×
All PHI Products subject to same regulatory standards?	✓	✓	✓	✓	Minor differences for large group plans	n/a
Financial Incentives	✓ (means tested)	✓	✓ (means tested)	✓ (means tested)	✓ (means tested)	×
Government led alternative dispute resolution mechanism	✓	✓	✓	✓	✓	Industry-run

Product Regulation

	Australia	Ireland	Netherlands	Switzerland	US	HK HPS (as in 2nd Stage Consultation Document)
Guaranteed issuance	✓	✓	✓	✓	✓	✓ Up to 65
Guaranteed renewal	✓	✓	✓	✓	✓	✓
Must cover pre-existing conditions?	✓ Except during waiting periods	✓ Except during waiting periods	✓	✓	✓	✓ Except during waiting periods
Minimum benefit coverage	✓	✓	✓	✓	✓ (except for Group & some grandfathered plans)	✓
Restrictions on cost-sharing	✓	✗	✓	✓	✓	✗
Standardised terms	✓	✗	✓	not required as mandatory plans are identical	✓	✓

Premium Regulation

	Australia	Ireland	Netherlands	Switzerland	US	HK HPS (as in 2nd Stage Consultation Document)
Premium Structure	Community Rating	Community Rating	Community Rating	Community Rating	Age banded	Age-banded
Premium loadings	Late entry loading (Up to 70% - rare)	×	×	×	Tobacco use. (up to 50%) Non-participation in group wellness program. (Up to 50%)	Full flexibility on loading factors (Up to 200%).
Required to submit new products for approval	✓	✓	✓	Not required as products are standardized	✓	×
Can regulator reject premium increases?	✓	✓	×	✓	✓	×
Can regulator set premiums?	×	×	×	✓	×	×

Implications for HPS

1. **HPS goals are consistent with PHI goals in the countries we studied:**
   - Greater consumer choice and protection
   - Increased market transparency
   - Relief to public healthcare system
   - Sustained PHI protection into older ages.
2. **Most features of the HPS (as in the 2nd Stage Consultation Document) are consistent with the countries we studied.**
   - Guaranteed acceptance & renewal
   - Coverage of pre-existing conditions and maximum waiting periods
   - Standardised benefit coverage.

Comparison with HPS

Most features of the HPS (as in the 2nd Stage Consultation Document) are consistent with the countries we studied, *except for*:

- In all five countries, legislation requires **all PHI policies** to comply with the **minimum requirements**.
- **Health status** can be used as a rating variable. This is not allowed in any of the five countries studied (with the exception of smoker status in the US).
- No caps/restrictions on **cost sharing / out-of pocket payments**.
- No claim discount is not commonly used in the five countries
- Medical Savings element is uncommon in the five countries

3. Common overseas practice to require all PHI products to comply with regulatory requirements.

- Limited examples where 'less regulated' products are sold alongside 'more regulated' products.
  - Evidence from US suggests this situation is unsustainable
  - Limited examples from Europe (eg: France) of dominant not-for-profit mutuals sustainably offering more-regulated products. **BUT** …
    - Differences relate to underwriting only. Other minimum product requirements remain.
    - Very different cultural and historical context.

4. Statutory minimum requirements are broad:

- Benefit design (eg: type of care, benefit limits, waiting period)
- Out-of-pocket payments (eg: no gap plans in Australia)
- Operational Rules (eg: guaranteed acceptance)
- Premium adjustment (ranges from premium filing to US minimum loss ratio approach).

Implications for HPS

5. Cost sharing (out-of-pocket costs) is often regulated in order to protect members.

- Cost-sharing is significantly restricted in Australia, Netherlands, Switzerland and the US, such that **insurers cannot cap their risk**. eg: lifetime limits and annual limits for essential health services will no longer be allowed in US.
- Patient co-payments help manage demand, but they can lead to poor health outcomes
  (eg: 10% increased risk of death in US study).
- **'No gap' and 'Known Gap'** policies in Australia provided a clear impetus for insurers and health providers to negotiate to manage costs.

Implications for HPS

6. Medical inflation and demand pressures are real risks which must be managed and monitored.

- Moral hazard for consumers to over-order and providers to over-prescribe.
- Some issues are health system issues rather than health insurance issues . (eg: to minimise provider's 'conflict of interest', few countries allow doctors to profit from ordering drugs or diagnostic tests).
- Contracting between insurers and hospitals / doctors now standard practice
  - Increasingly sophisticated contracts adopted overseas to control price **and volume**

Implications for HPS
- Managing costs (cont.)

- Product Design to encourage efficient practice.

  - Australia, Ireland, the Netherlands and Switzerland all define a very **detailed list of procedures** and fees which are included in the minimum benefits package. Same fee applies regardless of location/setting (promotes day procedures & out-of-hospital care).

  - All five countries allow certain day procedures as well as '**step-down**', **hospital-in-the-home** or **convalescent care** to reduce the length of stay in hospital.

  - Targeted measures for country-specific issues, e.g.

  - List of clinical indications for MRI and provider volume limits in Ireland.
  - Endoscopy and colonoscopy funded only as a day procedure in Australia.
  - Higher cost sharing for problem areas.

Implications for HPS
- Managing costs (cont.)

- Substantial savings are possible through **prevention and good management of chronic conditions**.
  - ➢ eg: Kaiser Canada's over 65's have bed days which are 70% lower than England NHS, 60% lower than US Medicare and 40% lower than Canada Medicare.
  - ➢ **OECD experts believe this is the single most important influence which private health insurance can bring**.
  - ➢ High Risk Pool - opportunity to develop this expertise in HK.
  - ➢ Important for all insurers, not just for the High Risk Pool.
  - ➢ Flexibility in product design to provide appropriate primary care, co-ordinated care, wellness programs.

Implications for HPS - Managing costs (cont.)

- Claims management to encourage efficient practice.
  - Premium savings of 20% in the US for GP gatekeepers
  - Premium discounts of 20% for **restricted choice of doctor** in Switzerland and Netherlands.
  - **Informed financial consent** (similar to pre-admission quotation) to incentivise provider choice

	Australia	Ireland	Netherlands	Switzerland	US (PPACA)
Can insurers require GP Gate-keeping?	✓	✓	✓	✓	✓
Can insurers restrict choice of doctors?	Incentives	✓	✓	✓	✓

Implications for HPS - Managing costs (cont.)

- DRGs require a long lead time and considerable investment.
  - ➢ Standardised data collection critical, but need not be DRGs.
  - ➢ Contracting between insurers and providers is critical, but can take different forms. Support to drive contracting may be required.

	Australia	Ireland	Netherlands	Switzerland	US (PPACA)
Is DRG purchasing required?	✗	✗	✓	✓	✗

7. Financial Incentives / Disincentives are widely offered, but must be well designed to be effective.

- No one-size-fit-all design. Essential to consider with due regard to local situation.
- Tax based incentives are common in OECD.
- Direct premium subsidies are common in mandatory system & system with community rating. Increasingly targeted to improve affordability for poor/elderly in recent years
- Growing consensus that financial incentives can be more effective when combined with :
  - Disincentives eg:
    Lifetime Health Cover Loading in Australia to encourage early entry
    Tax penalties for employers in US and high earners in Australia
  - Regulatory measures (proper product regulation)

8. Some features of HPS not supported by evidence.

- **No claims discounts** are uncommon and not considered efficient or effective.
  - ➢ People may defer required treatment, or fall back on public health system.
  - ➢ Positive incentives (eg: Wellness Programs) send a better message.
- **Savings accounts** not common.

Implications for HPS

9. PHI reform requires a clear vision of public and private sector roles in health care delivery.

- PHI and minimum benefits should cover services which private sector is best placed to provide, or where capacity expansion is most desirable/manageable.
- Internationally, it is common for private providers to have a strong role in **elective inpatient care and same-day procedures** while the public sector retains dominant role in emergency cases and more complex acute cases.

Implications for HPS

10. Market Transparency is critical for competition, consumer protection and optimal regulation.

- **Standardised policy terms** and conditions facilitate greater comparability
- Many countries have **easy-to-access platforms** to allow consumers to compare prices, products, services
- Market data is required to facilitate policy formulation, regulatory oversight.
- Market participants will benefit from enhanced market data:
  - ➢ supports insurer / provider negotiations
  - ➢ Helps identify best practice in healthcare delivery.

11. PHI reform is an incremental process requiring long-term commitment and ongoing oversight.

- A sustained process where policymakers, healthcare providers, insurers and consumers intricately balance and realign competing goals and expectations.
- Monitoring outcomes and responding to experience is essential for long-term success.

Implications for HPS

12. A government-led claims dispute resolution system is desirable

- Government participation is conducive to consumer confidence and credibility
- The system can provide the Government with timely information to identify areas for improvement and monitor PHI market performance

1. International Experience - Implications for HPS
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Initial HPS Product Design

Major Refinements

2nd Stage consultation document	Current Proposal
All **HPS** products meet required minimum	All **PHI** products meet required minimum
Coverage defined by a **product template**	Coverage defined by **minimum benefits**, hence some features become optional, e.g. No Claim Discount, Deductible, and Savings Account.
Upfront certainty through DRGs	Develop long-term plans for DRG implementation **No gap / known gap** products Support for contracting '**Informed Financial Consent**'

Minimum Requirement Approach

Key min. requirements

Benefit Limits

•Minimum benefit limits

•No lifetime limit

•No-gap / known-gap

•Annual cap on deductible and coinsurance paid by insured member

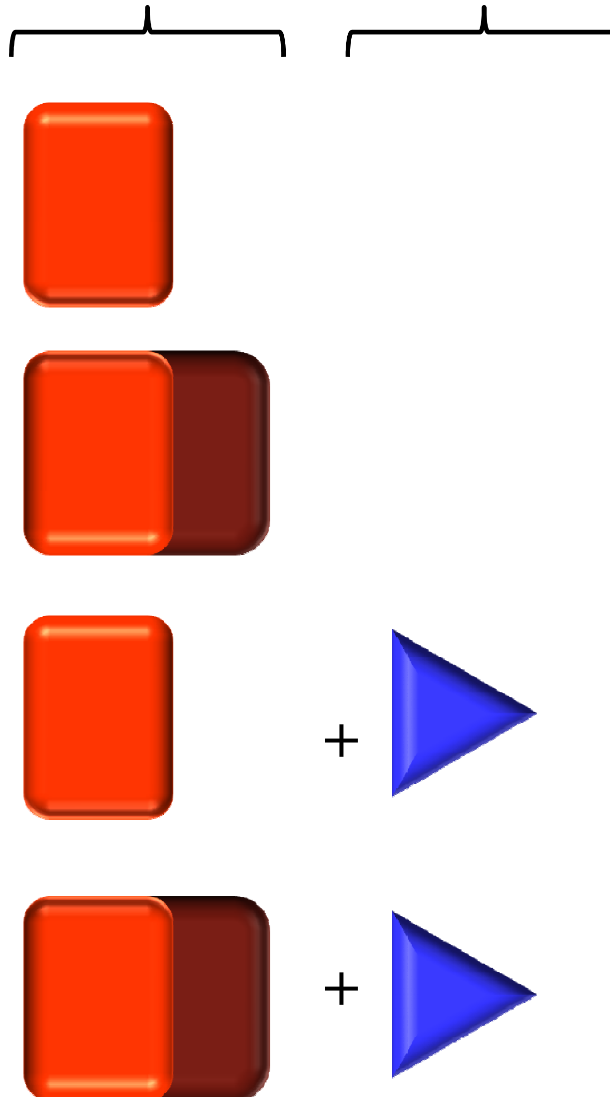
Operation Rules

•Commitment on turn-around time on estimation of claims

•Portability (to Standard Plan)

•(Standard Plan) Guaranteed acceptance with cap on loading %

•Guaranteed renewal



Standard Plan (**Must be offered)**
- ***Min. requirements***
- Guaranteed acceptance
- No NCD

Flexi Plan
- ***Min. requirements*** plus richer/additional benefits (e.g. emergency overseas)
- Optional NCD, deductible and savings account

Standard Plan +
Top-up of additional benefits (e.g. drugs, OP)

Flexi Plan +
Top-up of additional benefits (e.g. drugs, OP)

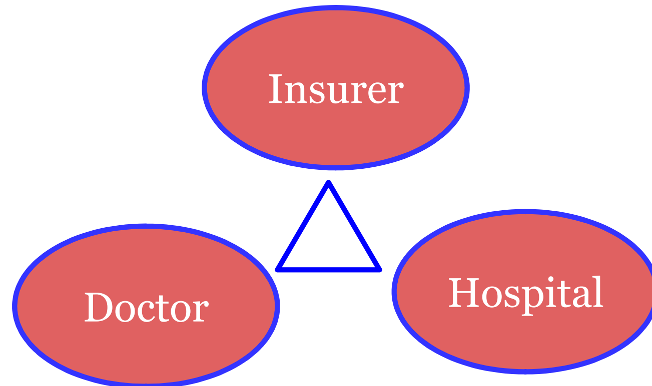
Illustrative Example of Standard Plan and Flexi Plan*

Benefit limit where lump sum package limit is not available: **Hospitalization benefit**	**2nd Stage Consultation Standard Plan**	**Flexi Plan**
Room & board (per day, max. 180 days per disability)	$550	$650 / 185 days
Attending Physician's visit (per day, max. 180 days per disability)	$650	$650 / 185 days
Specialist's visit (per disability)	$2,000	$2,500
Intensive care unit (per day)	$2,000	$2,000
Miscellaneous hospital expenses (per disability)	$8,000	$8,000
Surgeon's fees	See surgical schedule	See surgical schedule
Anesthetist's fees	Up to 30% of surgeon's fees	Up to 30% of surgeon's fees
Operating theatre fees	Up to 30% of surgeon's fees	Up to 30% of surgeon's fees
Ambulatory procedures		
Procedure (per procedure)	$5,000	$5,000
Specialist's consultation (per consultation, max. 3 per procedure)	$600	$680
Advanced diagnostic imaging tests (per disability)	$5,000	$10,000
Chemotherapy or radiotherapy (per disability)	$200,000	$200,000
No claim discount	None	**5%/10%/15% if no claim in past 1/2/3 yrs**

* Figures for the Standard Plan are taken from the HPS Illustrative Plan as in the 2nd stage Consultation Document. All figures in the table are for illustrative purpose only.

No-gap / known-gap

Contracting between parties



To agree on:

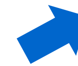
- List of no gap / known gap procedures (e.g. appendectomy, hernia)
- Schedule of doctor's fees and hospital fees

Claims (require prior consultation with the insurers for quotation)

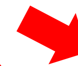
- ✓ Panel doctor
- ✓ Hospital on the list
- ✓ Procedure on the list

\+

Doctor's fees within agreement?

Yes 

No or known gap
No or known out-of-pocket payment, based on policy terms

No 

Higher 'gap'
Patient pays higher out-of-pocket payment; some certainty provided by quotation system (i.e. informed financial consent).

Key Features and Refinements

Features	Concept	Practical implementation
Guaranteed acceptance	No turn away of subscribers <65 (and 65+ in the first year of introduction but no cap on loading).	✓ Test viability and consider lower entry age limit to encourage early joiners.
Coverage of pre-existing conditions	Cover pre-existing conditions subject to 3-yr waiting period : Year 1 – no coverage Year 2 – 25% coverage Year 3 – 50% coverage Year 4 onward – 100%	✓(fully implementable) Test viability and impact on current membership
Portability	Members can switch insurers w/o re-underwriting, re-serving waiting period; Medical benefits portable on retirement or leaving employment	✓ (if no claim in past 3 years) ✓(if continuously employed for 1 yr) Switch to Individual HPS Standard Plan w/o premium loading irrespective of health status

Key Features and Refinements

Features	Concept	Practical implementation
No claim discount	Reward members who do not make claims	✓ Optional feature (Not a desirable way to encourage healthy lifestyle as overseas experience reveals)
Seamless migration	Individual members can opt to migrate to HPS w/o re-underwriting	For individual policyholders: Test viability and impact on current membership. Transition period and flexibility may be required if HPS benefits are considerably different from current contracts.
	Employers can opt to migrate to HPS by meeting the minimum requirements	Transition for employers: 5-yr transition period; new plans (voluntary) must meet min. requirements afterwards

Key Features and Refinements

Features	Concept	Practical implementation
Cost Sharing	Coinsurance percentage: 20% for the first $10,000 10% for the next $90,000 0% for subsequent amount	✓✗ Optional Annual cap on deductible and coinsurance paid by insured member
High Risk Pool	Industry-run high risk pool supported by government and reinsurance levy	✓ Government support for high risk pool
Savings	Government incentives to encourage savings by individuals for paying future premium at older age	✓✗ Optional / rest with individual initiatives hence no direct government incentives. Other measures to contain long term rise in medical cost (e.g. manpower supply, increased market transparency, promotion of no gap/known gap plans)

Value-added for consumers

Current market	HPS
Uncertainty of coverage and policy terms	✓ Minimum requirement and standardized terms and conditions
Uncertainty of claims outcome	✓ Quotation / No Gap / Known Gap
Exclusion of pre-existing conditions	✓ Guaranteed acceptance, optional / time-limited exclusion, premium loading capped at 200%
No guarantee on policy renewal	✓ Guaranteed renewal for life
Lack of transparency on insurance premium adjustment	✓ Transparency on premium; easy comparison between Standard Plans
Unnecessary overnight hospital stay	✓ Cover ambulatory procedures
Re-underwriting if changing insurer	✓ Individual to individual portability
No guarantee after retirement	✓ Group to individual portability

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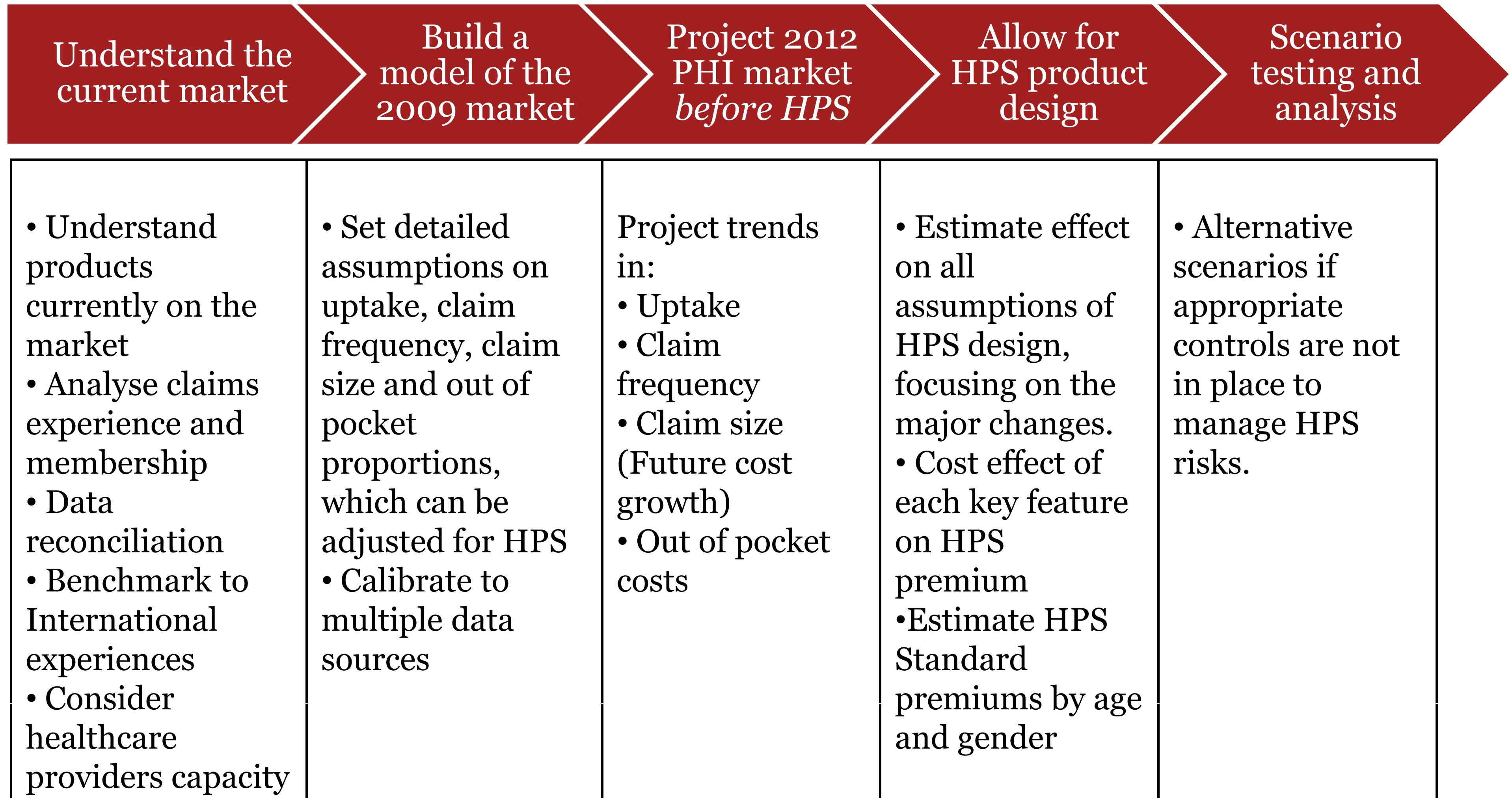
Introduction

- Results for Standard premiums for the **Individual HPS Standard** product
- Results are **preliminary** based on work done to date
- Topics to be considered in a future meeting:
  - Group HPS Standard product
  - Long-term projections on PHI market and health system
  - Policyholder migration
  - High risk pool

Approach



Allow for proposed HPS Product design parameters

HPS Product Key Feature	Impacts on granular assumptions
Minimum requirements regarding benefit structure	Scenario testing on the proportion of costs covered by insurance
Coverage of pre-existing conditions	Focus is on experience of **existing members** Will increase claim frequency of existing members with health conditions
Coverage of - **chemo & radiotherapy** - **MRI & CT scans**	Additional costs. Estimate - claim frequency - Cost per claim
Coverage of ambulatory procedures with packaged pricing (no-gap) for common ones	- Fund endoscopies / colonoscopies based on cost of clinical surgeries - Increase Claim frequency to reflect broader coverage of ambulatory services
Deductibles	Reduces claim size and frequency; increases out-of-pocket costs

Impact on HPS Average individual premium

Feature	Impact (Mid Scenario)	Potential Range($)	Potential Range(%)
2012 base (Before HPS)	**$3,300**		
New benefit structure (Product 2)	-$250 (-8%)	-$250	-8%
Coverage of pre existing conditions	+$150 (+5%)	+$150	+5%
Chemo & radiotherapy	+$250 (+8%)	+$150 to +$350	+5% to +11%
MRI, CT & PET diagnostic tests (30% co-pay)	+$550 (+17%)	+$150 to +$1,400	+5% to +42%
Coverage of endo colo in ambulatory setting with packaged pricing	-$400 (-12%)	-$450 to -$150	-14% to -5%
2012 HPS Premium	**$3,600** +$300 (+9%)	-$250 to +$1,500	-8% to +45%

MRI and CT costs

•Potentially a significant cost driver if not well controlled, through copayments and other measures to manage risk.

•'Mid' scenario assumes **30% co-payment** with some effectiveness of control measures in combating potential abuse.

Deductible

Approach	Impact on standard premiums
Uses 2010 HKFI claims data to test the relative impact of different deductible levels	A $2,000 deductible would reduce the standard premium by 9.7% and claim rates by 18%. Claim rates reduce because some claims will now fall below the deductible. Given the HPS intends to shift some ambulatory procedures towards clinical surgery settings, deductibles may further reduce claim numbers and the standard premium

Key Risks and Possible Controls

Feature	Risk	Typical Controls used internationally
MRI / CT	Both cost and usage could be higher than expected.	• Packaged pricing structure per scan • Work with hospitals / doctors to agree clear circumstances under which MRI / CT will be covered • Limited list of hospitals / providers who are allowed to offer 'insured' services. (Ireland) • Consider global contracting limits. (eg: Ireland) • Co-payments
Chemo / radio	Costs could be higher than predicted	• Packaged pricing structure. Cost of chemo drugs themselves may need to be separately identified / priced. • Clarify schedule of cancer drugs which will be covered.
Colonoscopy & Endoscopy	Controls required for both cost and usage	• Packaged pricing structure • Work with doctors to agree guidelines on colonoscopy (eg: regularity of screening) • Co-payments • Expand availability of benchmarking data at industry level (eg: length of stay; overnight/same day/CS mix)

Impact on HPS Average Group premium

Feature	Impact (Mid Scenario)	Potential Range($)	Potential Range(%)
2012 base (Before HPS)	**$2,050**		
New benefit structure (Product 2)	$0 (0%)	$0	0%
Coverage of pre existing conditions	+$0 (+0%)	+$0	+0%
Chemo & radiotherapy	+$150 (+7%)	+$100 to +$200	+5% to +10%
MRI, CT & PET diagnostic tests (30% co-pay)	+$250 (+12%)	+$50 to +$650	+2% to +32%
Coverage of endo colo in ambulatory setting with packaged pricing	-$200 (-10%)	-$200 to $0	-10% to 0%
Option to convert to individual policy at standard premium when leave employment/retire	+$50 (3%)	+$25 to $100	+1% to +5%
2012 HPS Premium	**$2,300** +$250 (+12%)	-$25 to +$950	-1% to +46%

Benefit schedules - 2012

Benefit (Maximum benefit amount)	HPS Product 1	HPS Product 2	HPS Product 3
Daily Room & Board	**$550** Max 180 days	**$650** Max 180 days	**$650** Max 180 days
Attending Physician's Visit	**$650** Max 180 days	**$750** Max 180 days	**$800** Max 180 days
Other Specialists' Visit	**$2,000**/Admission	**$2,300**/Admission	**$3,000**/Admission
Surgical Limit (Surgeon, Anaesthetist, OT)	**$50,000**/Procedure and 40% OOP for inpatient, 20% OOP for clinical surgery	**$58,000**/Procedure and 35% OOP for inpatient, 15% OOP for clinical surgery	**$58,000**/Procedure and 30% OOP for inpatient, 10% OOP for clinical surgery
Miscellaneous Hospital Expenses	**$8,000**/Admission	**$9,300**/Admission	**$11,500**/Admission
Radiotherapy & Chemotherapy	**$100,000**/Disability	**$150,000**/Disability	**$200,000**/Disability
MRI/CT/PET	Covered with packaged price and 30% out-of-pocket		
Colonoscopy / endoscopy	Covered with packaged price		

* Numbers shown are based on Mid scenario

Deductible

- A $2,000 deductible would reduce the premium by approximately 14% (~$300)
- A $5,000 deductible would reduce the premium by approximately 28% (~$650)
- A co-payment of 10% for first $100,000 of each eligible claim (0% thereafter), i.e. max co-pay of $10,000, would reduce the premium by approximately 9.5% (~$200)