Administration's Response to Follow-up to the Meeting of Subcommittee on Health Protection Scheme of the Panel on Health Services on 4 June 2013

Item (a) -

The relevant working papers of the Working Group on Health Protection Scheme and/or the Consultative Group on Health Protection Scheme on matters concerning the design of private health insurance policies regulated under the Health Protection Scheme ("HPS").

Administration's response

The information considered and discussed in the meetings of Working Group and Consultative Group on Health Protection Scheme concerning the design of private health insurance policies regulated under the HPS, as prepared by the Consultant appointed to conduct the consultancy study on HPS (the Consultant), is at **Appendix** for reference (only English version is available).

Item (b) –

An outline of what constituted packaged charging offered by private healthcare providers for specific treatments or procedures, including illustrative packages to demonstrate items that would be covered by the existing packages for some common procedures (such as gastroscopy related to hospital admission or ambulatory procedure, appendicectomy, etc.)

Administration's response

2. A key objective of packaged pricing is to provide budget upfront certainty to patients by making healthcare charges more transparent and predictable. To this end, it is common for healthcare providers abroad to offer packaged prices that cover all the necessary services specific to a particular treatment or procedure. For example, for a hospital admission, a typical package covers general ward charges, doctors' consultation fees, laboratory charges, operation theatre rents and surgeon fees. Nonetheless, a typical package usually does not provide for accommodation above ward levels or not medically-necessary amenities during hospital stay. For

ambulatory procedures, a typical package covers consultation fees, surgical fees and facility charges.

3. A major technical challenge for formulating packaged pricing is the complexity of diseases. There could be varying degrees of complexity even under the same category of disease, some of which may not be anticipated in advance. In this connection, overseas experience shows that healthcare providers may allow the packaged charges to vary by degree of complexity, or exempt the applicability of packaged charges under exceptional circumstances.

4. The current proposal by the Consultant to enhance upfront payment transparency and certainty, namely the "informed financial consent" and "no-gap/known-gap" arrangement, is consistent with common overseas practice. The proposal differs from some existing market practice in Hong Kong whereby the packages offered by a private hospital only cover a defined set of services, e.g. three-day hospital stay, one laboratory test and other prescribed services. If, for example, the patient ends up staying four days in the hospital, an additional day of room charge is required. Such arrangement differs from the Consultant's proposed "no-gap/known-gap" arrangement under which the additional cost would not be borne by the patient, unless the degree of complexity is not covered by the original package.

Item (c) –

Information on measures in place or under consideration of the Administration to ensure healthy competition in private hospital services, including regulatory measures under the Competition Ordinance (Cap.619), in order to safeguard patient interest.

Administration's response

5. One of the objectives of the HPS is to enhance transparency and certainty of payment for private healthcare services by consumers. Under the "informed financial consent" arrangement proposed by the Consultant, the patient would be informed in the form of a written quotation the estimated charges for the private healthcare services and any out-of-pocket payment before he/she receives treatment. In addition, private healthcare providers are encouraged to provide packaged charges for common procedures or treatments. New private hospital developments are required to offer at least 30% of in-patient bed days each year for packaged

priced services. These arrangements would enhance payment transparency by facilitating the consumer to compare prices between different healthcare service providers, thus encouraging healthy competition in the market.

6. The Administration is in parallel conducting a review on the regulation of private healthcare facilities. A key objective of the review is to enhance transparency of private healthcare service charges in order to safeguard patient interest. The Administration will look into feasible measures such as packaged pricing, quotation system, common platform for disclosing historical statistics of private hospitals' charges etc., by making reference to overseas experience. The Administration will consult the public on the recommendations of the review and proceed with the necessary legislative procedure.

7. As regards the Competition Ordinance ("the Ordinance") enacted by the Legislative Council in June 2012, it aims to prohibit and deter undertakings in all sectors from adopting abusive or other anti-competitive conduct which has the object or effect of preventing, restricting and distorting competition in Hong Kong. An "undertaking" is defined as any entity, regardless of its legal status or the way in which it is financed, engaged in economic activity and includes a natural person engaged in economic activity. Most private hospitals fall within the definition of "undertakings" and would therefore be subject to the regulation of the Ordinance. Specifically, the Ordinance prohibits agreements, concerted practices as well as decisions of an association of undertakings that have the object or effect to prevent, restrict or distort competition in Hong Kong. The Ordinance also prohibits an undertaking with a substantial degree of market power to abuse that power by engaging in conduct that has as its object or effect the prevention, restriction or distortion of competition in Hong Kong.

8. When the Ordinance comes into full operation, the Competition Commission could conduct investigation into cases of alleged anti-competitive behaviour and take enforcement action of its own volition, or upon receipt of a complaint or a referral of case from the Government or the courts.

Item (d) –

The rationale for proposing, as part of the minimum requirements prescribed by the HPS Standard Plan, "no lifetime limits" and "annual cap on deductible and co-payment paid by insured person".

Administration's response

9. "Lifetime benefit limit" and "deductible and co-payment" are examples of cost-sharing arrangements between insurers and insured persons. They are designed to combat moral hazard and to bring healthcare costs under better control. Yet in designing cost-sharing arrangements, due regard should be given to possible adverse impact on consumer interests, particularly concerning the ability of lower-income persons in paying the shared cost, which might affect their desire to seek necessary treatments.

10. With the above in mind, the Consultant proposes to prohibit the adoption of "lifetime benefit limit" in HPS Standard and Flexi Plans, whilst allowing the adoption of "annual benefit limit". This means that an insured person may exhaust his/her annual maximum insurance benefit in a given contract year, but he/she can still enjoy the insurance benefit anew in the ensuing contract year. If a "lifetime benefit limit" is adopted, the insured person would not be able to enjoy insurance protection after his/her cumulative claim amount reaches the lifetime limit, thus rendering the feature of guaranteed renewal meaningless.

11. The Consultant also proposes to impose an annual cap on the amount of deductible and co-payment for the sake of consumer protection. The deductible and co-payment referred here are front-end in nature, meaning that the cap does not apply to the amount that an insured person needs to pay if his/her actual expenses exceed the benefit limits in his/her insurance policy.

Item (e) –

Illustrative actuarial premium calculation models (net of administrative fees charged by the insurers) to demonstrate how the premiums of the HPS Standard Plan would be adjusted according to different health risks of the subscribers based on risk factors such as age, health status, pre-existing medical conditions.

Administration's response

12. A key step in the actuarial premium calculation by the Consultant is to estimate the expected medical claim costs by age bands, gender, and risk groups (including standard risk groups and higher risk groups). This step involves considerable complexity as the differences in expected medical claim costs by age bands, gender and risk-groups hinge on the anticipated incidence rates and severity. Generally speaking, the premium levels of the HPS Standard Plans are higher for older age groups and lower for younger age groups (except for infancy and early childhood). In terms of gender, the premium levels for male of older age groups are generally higher than that of female due to higher healthcare utilisation by the former.

13. In terms of risk groups, an insured person would be classified as standard risk group or higher risk groups upon underwriting by the insurer concerned, taking into account his/her health status, pre-existing medical conditions and other relevant risk factors. As the HPS premium structure is proposed to be age-banded, an insured person who is classified under standard risk group would be charged the standard premium rate that applies to his/her age band and gender.

14. Regarding the insured persons classified under higher risk group after underwriting, insurers may charge premium loading (as percentage of standard premium rates) to compensate for the expected higher claim costs. The loading is capped at 200% and the cases with premium loading assessed to be 200% or more can be transferred from the insurer's portfolio to the High-risk Pool (HRP). The insurer will surrender the premium collected for these policies after deducting a nominal handling fee to be prescribed by the HPS agency. The insurer will continue to be responsible for the administration of the policies, but the premium income (net of expense), claim liabilities and profit/loss of these policies would be accrued to the HRP instead of the insurer concerned.

15. There has been a concern that insurers might mark up the premium loading rate in order to pass on higher-risk subscribers to the HRP, thus affecting the financial sustainability of the Pool. The Consultant considers it unlikely for such phenomenon to happen on any significant scale. This is because as long as insurers can charge a premium loading rate commensurate with the extra risks that they take on, they can still expect to have an underwriting profit by keeping the

higher-risk subscribers under their own portfolio. In such case, it is in the interests of insurers to charge an appropriate premium loading rate corresponding to the risks that they are taking on, rather than marking up the premium loading rate for the sake of transferring the policies to the HRP. In addition, as all insurers offering indemnity hospital insurance plans will be required to provide the HPS Standard Plan as an option to the consumer, it would not be in the interest of an insurer to mark up the premium loading rate due to price competition, given that the consumer can compare offers from other insurers for coverage of the HPS Standard Plan.

Item (f) –

An assessment of the impact to be brought about by the introduction of the minimum requirements for all indemnity hospital insurance products on existing individual and group subscribers of indemnity hospital insurance plans, including a breakdown of the number of existing policy holders by types of plans and premium levels.

Administration's response

16. According to the Thematic Household Survey (THS) conducted by the Census and Statistics Department (C&SD) during October 2011 to January 2012, the number of persons covered by private health insurance has grown steadily in recent years, from 2.23 million persons in 2005 to 2.79 million persons (about 40% of Hong Kong's population) in 2011. Of this total, about 1.25 million were covered by individually-purchased private health insurance only, about 0.96 million by employer-provided private health insurance only, and about 0.59 million by both.

17. The Consultant is conducting a consumer survey to test market response to the HPS based on the preliminary design for HPS plans, including the consumer's willingness to subscribe or migrate from existing policies to HPS plans. The survey results will facilitate the Consultant to, amongst others, finalise the product design and assess the impact of the minimum requirements approach on the existing health insurance market, including the estimated numbers of policyholders migrating to HPS plans or staying with their existing plans.

Food and Health Bureau
June 2013

Appendix

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)

1. International Experience - Implications for HPS
   (presented to the WG/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)

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.

Implications for HPS

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.

Implications for HPS

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.

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
   (presented to the WG/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)

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

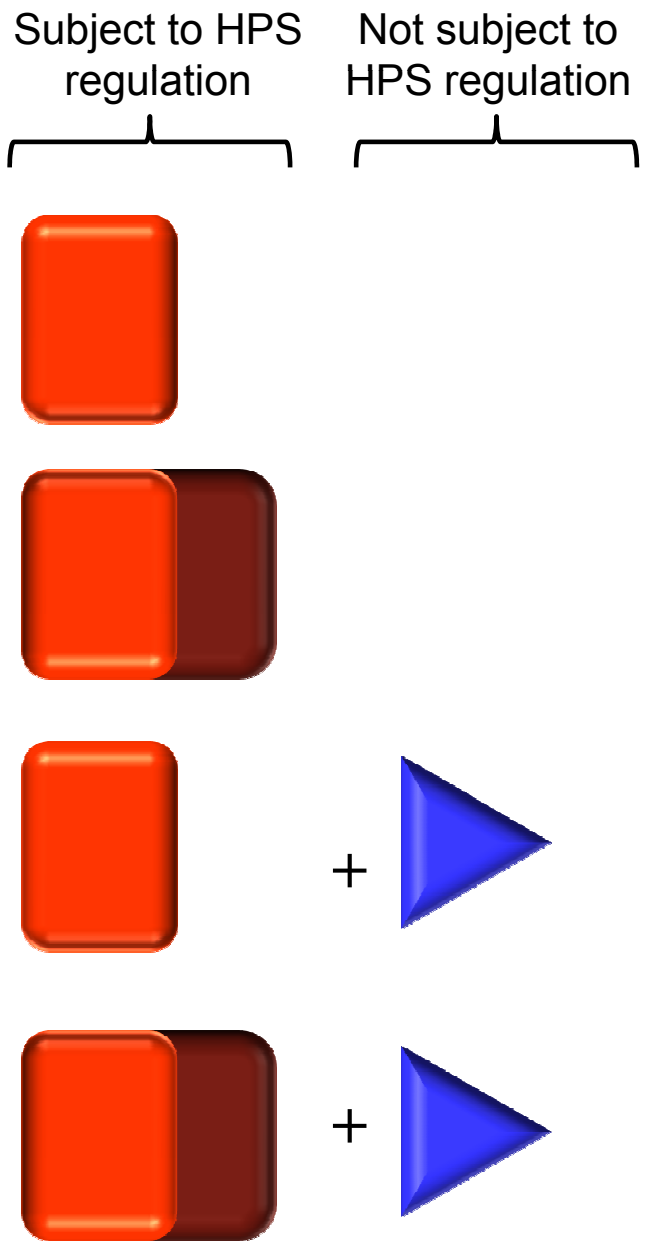
Key min. requirements

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)

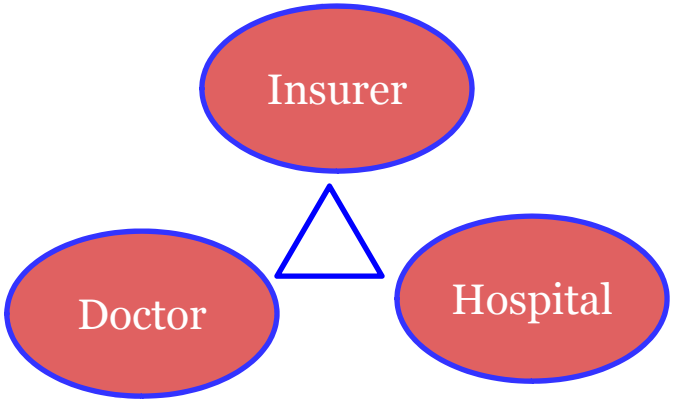
Illustrative Example of Standard Plan and Flexi Plan*

Benefit limit where lump sum package limit is not available:	**2nd Stage Consultation**	**Flexi Plan**
Hospitalization benefit	**Standard 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	<u>For individual policyholders</u>: 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	<u>Transition for employers:</u> 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

1. International Experience - Implications for HPS
   (presented to the WG/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)

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

Understand the current market	Build a model of the 2009 market	Project 2012 PHI market *before HPS*	Allow for HPS product design	Scenario testing and analysis
• Understand products currently on the market • Analyse claims experience and membership • Data reconciliation • Benchmark to International experiences • Consider healthcare providers capacity	• Set detailed assumptions on uptake, claim frequency, claim size and out of pocket proportions, which can be adjusted for HPS • Calibrate to multiple data sources	Project trends in: • Uptake • Claim frequency • Claim size (Future cost growth) • Out of pocket costs	• Estimate effect on all assumptions of HPS design, focusing on the major changes. • Cost effect of each key feature on HPS premium •Estimate HPS Standard premiums by age and gender	• Alternative scenarios if appropriate controls are not in place to manage HPS risks.

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)