LC Paper No. CB(2)855/13-14(01)

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Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

Our Ref.： *FHB/H/1/5/4/2 Pt. 11*
Your Ref.： *CB2/PS/2/12*

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13 February 2014

Ms Maisie LAM
Chief Council Secretary
Legislative Council Secretariat
Legislative Council Complex
1, Legislative Council Road
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Dear Ms LAM,

Panel on Health Services
Subcommittee on Health Protection Scheme

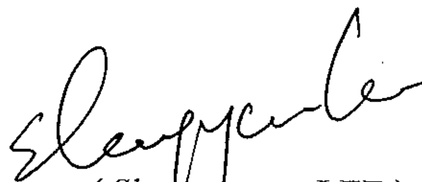
Meeting on 9 December 2013

I refer to your letter of 17 December 2013. The requested supplementary information is provided at **Annex A**.

As Members are aware, the detailed proposals for the Health Protection Scheme (HPS) are drawn up in close consultation with the stakeholders concerned, including, among others, the insurance sector, healthcare services providers, representatives of consumer groups and the civic society; and having regard to the findings and recommendations of the consultancy study commissioned by the Food and Health Bureau. We have given due regard to a host of factors and sought to strike a right balance between the interests and concerns of different stakeholders when formulating the package of proposals for the HPS. Our main consideration in devising the HPS remains consumer protection and

through promoting clarity, simplicity and certainty in policy terms and conditions, so as to encourage more individuals who are willing and able to afford it to take out private indemnity hospital insurance plans. For reference by the Subcommittee, the key aspects of the HPS which we are currently in discussion with the insurance sector are set out at **Annex B**.

Yours sincerely,



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

Encl.

Annex A

Supplementary Information Requested by the Meeting of Subcommittee on Health Protection Scheme of the Panel on Health Services on 9 December 2013

Item (a) -

The justifications for proposing, as part of the minimum requirements prescribed by the HPS Standard Plan, a fixed 30% co-insurance for the prescribed advanced diagnostic imaging tests, and the overseas experience in this regard.

Administration's response

2. Advanced diagnostic imaging tests such as Magnetic Resonance Imaging (MRI) examinations and Computed Tomography (CT) scans are basic diagnostic tools in modern day medical diagnosis and treatment. We are of the view that, to ensure consumers have basic protection and value-for-money indemnity hospital insurance plans, these two types of diagnostic procedures should be covered under the Minimum Requirements of the HPS. However, international experiences reveal that advanced diagnostic imaging tests such as MRI examinations and CT scans are prone to abuse induced by moral hazard, and thus require concerted efforts to bring utilization under proper control. A recent report by Organisation for Economic Co-operation and Development (OECD)[1] identifies this risk in relation to the rapid increase in utilization of advanced diagnostic imaging tests within OECD countries in recent years. For example, the number of MRI examinations per 1 000 population in 11 selected OECD countries[2] surged by 45% from 2007 to 2011. The report also observes that some OECD countries are now striving to promote a more rational use of such diagnostic technologies from the point of view of medical necessity.

3. As a measure to tackle moral hazard, the use of co-payment is commonly used abroad to promote judicious use of diagnostic test imaging services, though it is difficult to gauge a common level of co-payment as another OECD report[3] points out. For example, in

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[1] OECD, "Health at a Glance 2013" (http://www.oecd.org/health/health-systems/health-at-a-glance.htm).

[2] Including the United States, the United Kingdom, Canada, Australia, France, Spain, Iceland, Luxembourg, Belgium, Hungary and Czech Republic. The percentage change is calculated with reference to the corresponding figures published in the 2009 issue of the report.

[3] OECD, "Private Health Insurance in OECD Countries" (2004) (http://www.oecd.org/health/privatehealthinsuranceinoecdcountries-theoecdhealthproject.htm).

Switzerland where private health insurance enrollment is mandatory, insured patients are required to bear a co-insurance of 10% subject to an annual limit when making claim for healthcare services that include diagnostic imaging tests. In Australia, Medicare (the social health insurance scheme) adopts packaged benefit limits for diagnostic imaging tests, and the insured patients often have to pay out-of-pocket the costs of diagnostic imaging service above the packaged benefit limits, sometimes up to 50% of the costs. Co-insurance apart, some countries like the Netherlands adopt a more interventionist approach with the government directly controlling the supply of diagnostic imaging test devices in order to limit utilization growth. Another approach is seen in Ireland where Vhi, the largest and government-owned health insurer, publishes a list of clinical indicators for providing cover for MRI examinations. The intention is to promote a more rational utilisation of MRI examinations with a view to reducing the occurrence of unnecessary ones from the point of view of medical necessity.

4. After reviewing local and overseas market experiences, our Consultant considers the co-insurance approach the most suitable for avoiding abuse of advanced diagnostic imaging tests services covered under the Health Protection Scheme (HPS). This would be conducive to managing the risk of utilization growth arising from moral hazard, which would in turn help keep premium levels in better check in the longer-term. On the other hand, it is important that the co-insurance level be set at a reasonable level so that the insured persons would not be deterred from seeking necessary advanced diagnostic imaging services. The co-insurance ratio would also have a bearing on the premium of the HPS Standard Plan – a higher co-insurance ratio would likely result in a lower premium, and vice versa. After taking into account the above factors and based on actuarial analysis, the Consultant recommends introducing a fixed 30% co-insurance (subject to an annual ceiling) for claims on advanced diagnostic imaging tests under the HPS Standard Plan. Noting the Consultant's finding that the average out-of-pocket payment by policyholders of existing individual-based indemnity hospital insurance products (ward level) is about one-third of the total costs, we consider the 30% co-insurance ratio proposed by the Consultant a reasonable proposal that balances between the need to combat moral hazard, premium affordability of the Standard Plan as well as affordability of policyholders.

Item (b) -

Explanations on the discrepancy between the figures provided by the Hong Kong Federation of Insurers ("HKFI") and the Administration on

the proportion of persons covered by private health insurance ("PHI") who chose to use private healthcare services. HKFI stated in its press release dated 6 December 2013 that "about 90% of reimbursed claim cases took place in private hospitals or private day care centres", whereas the Administration advised at the meeting that only about 50% of persons covered by PHI chose to use private healthcare services.

Administration's response

5. According to the Thematic Household Survey (THS) conducted by the Census and Statistics Department in 2011, among those who are covered by private health insurance, about 54% and 46% of their local hospital admissions pertained to the public sector and private sector respectively. This means that for people who have bought private health insurance policies and who have recently been admitted to hospital for treatment, for every 100 admissions, 54 pertained to public hospitals and 46 pertained to private hospitals. For those who were treated at public hospitals, they may not have made any claim or use of their insurance policies. This set of figures, however, may not be directly comparable with the figure of "about 90%" cited in the press release issued by Hong Kong Federation of Insurers (HKFI) on 6 December 2013, which refers to "reimbursed claim cases took place in private hospitals or private day care centres". The HKFI figure refers to the ratio of those who have actually made use of their private health insurance and made claim of their policies. What it means is that for every 100 people who have made claims of their private health insurance policies, about 90 people had used private hospital or private day care centre services.

Item (c) -

The detailed actuarial models, methodology used and the calculations for the estimated average premium per insured member under the HPS Standard Plan, which according to the Administration, was estimated to be around $3,600.

Administration's response

6. The average standard premium (i.e. premium for insured persons with standard-risk) per insured person under the HPS Standard Plan is estimated to be $3,600 in 2012 constant dollar by the Consultant, around 9% higher (subject to a potential range of variation between -8% and +45%) than the average premium of existing individual-based indemnity hospital insurance policies (ward level) in the market. The premium

estimation was derived through a sophisticated actuarial pricing model developed by the Consultant[4]. At the risk of over generalization, the following is a high-level summary of the actuarial pricing model for general illustration only.

7. The modelling work starts with estimating the base standard premium of existing individual-based ward-level indemnity hospital insurance products in the local market in 2012. This step involves professional analysis of the existing market data in Hong Kong, including health insurance premium data, healthcare cost data, and claims data held by the HKFI. The Consultant then identifies the key aspects of product design difference between the HPS Standard Plan and existing individual-based ward-level indemnity hospital insurance products that carry significant upward or downward premium impact. Pertinent examples include coverage of pre-existing conditions subject to waiting period; coverage of chemotherapy and radiotherapy; coverage of advanced diagnostic imaging tests subject to 30% co-insurance; coverage of endoscopy (e.g. oesophago-gastro-duodenoscopy, colonoscopy) on the basis that the service would be provided in ambulatory setting with packaged pricing; and determination of benefit limits of the HPS Standard Plan at a level slightly lower than the market average to facilitate migration of existing policies and encourage product innovation.

8. To estimate the premium impacts of the above key aspects, the Consultant assesses the respective claim costs and claim frequency for each aspect with reference to HKFI claims data and overseas claims data where appropriate, such as those from the OECD, the United States and Australia. The resulted premium impacts are then applied to the base standard premium in order to derive the average standard premium per insured person under the HPS Standard Plan.

9. The key driver for estimated premium variation is how well the HPS is able to contain moral hazards on the use of advanced diagnostic imaging tests. It is for this reason that a 30% co-insurance is proposed for the use of such services under the HPS to keep the cost under check.

[4] Due to the sophistication of the model, the Consultant cautions that it is important to read the consultancy report in its entirety. It is desirable to have the assistance of professional actuaries to avoid incomplete or misleading interpretations. The consultancy report will be released in conjunction with the public consultation exercise on the HPS to be launched in the first half of 2014.

Item (d) -

Example(s) (with illustrative figures) to demonstrate the calculations of the standard premium for an individual classified under HPS's standard risk group and the premium for a high-risk individual whose premium loading was assessed to be 200% or more of standard premium and would be transferred to the proposed High Risk Pool ("HRP"). For the latter, the illustration should cover the scenario of the premium loading being capped at 200% of standard premium and the Government providing financial support to HRP.

Administration's response

10. Under the HPS, insurers are required to provide to consumers as an available option a Standard Plan that meets all the Minimum Requirements prescribed by the Government, including guaranteed acceptance with a 200% premium loading cap. If the premium loading of a Standard Plan policy of an individual is assessed to equal or exceed 200% of standard premium charged by the insurer, the insurer may decide, upon the inception of the policy, to transfer the policy to a High Risk Pool (HRP). The HRP would be financed by the premiums collected from members of the HRP and Government funding under necessary circumstances.

11. A hypothetical example is provided below to illustrate the amount of premiums to be paid by insured persons with standard-risk and high-risk respectively under the HPS. For illustrative purpose, it is assumed that the following standard premium schedule is used by an insurer for its HPS Standard Plan.

Illustrative Example: Standard Premium of HPS Standard Plan

Age	**Male ($)**	**Female ($)**
…..	…..	…..
30	2,000	2,200
31	2,100	2,300
32	2,300	2,400
33	2,400	2,600
…..	…..	…..

Note: Under the HPS, insurers would set their own premium schedule for HPS plans. The figures in the table are for illustrative purpose only.

12. Under the example, a 30-year-old male who is assessed to be of standard-risk by this insurer would pay an annual premium of $2,000 for purchasing a HPS Standard Plan. A 32-year-old female, whose health condition is assessed by the insurer to be below average and premium loading to be 250% of standard premium, should pay an annual premium of $8,400 ($2,400 x 3.5). However, as premium loading is capped at 200% of standard premium under the HPS, only $7,200 ($2,400 x 3) would be payable by the 32-year-old female for purchasing the HPS Standard Plan, and her policy would be transferred to the HRP. As the premium collected is less than the premium assessed by the insurer to be adequate for covering her risk, it is possible that the premium collected would not be sufficient for covering her claims cost. In such case, Government funding may be required to cover shortfall if the aggregate premium collected to the HRP is less than the total actual claim amounts on the HRP.

Item (e) -

Explanations (in financial terms) on how the provision of public funds to support HRP to enable those high-risk individuals who were willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage could benefit the general public as a whole.

Administration's response

13. The HPS is meant to be a supplementary financing arrangement that complements the public healthcare system. Its objective is to provide an alternative to those who are able and willing to use private healthcare services through enhancing the quality of private health insurance products in the market. When more people make use of private healthcare services, the pressure on the public system would be alleviated and the public sector can better focus on serving its target areas.

14. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the HPS's goal to improve access to private health insurance. We consider it reasonable and justified for the Government to use public funds to support the HRP. It would be equitable to provide public funding support to enable those high-risk individuals who are willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage. Without

the HRP, most of these high-risk individuals would likely fall back on the public system, which is heavily subsidised by the Government. An example on the procedure of tonsillectomy is provided below for better illustration.

15. According to publicly available information provided by a private hospital in Hong Kong, the average cost of conducting tonsillectomy is about $34,000, and the average length of hospital stay is about three days. For the sake of illustration, it is assumed that the cost and average length of hospital stay of conducting tonsillectomy in a public hospital is the same as that in the private hospital.

16. At present, public hospitals are heavily subsidised by the Government and a patient only needs to pay $100 per day for receiving public hospital service. As such, if the patient chooses to undergo the tonsillectomy procedure in a public hospital, the amount subsidised by the Government would be $33,700 ($34,000 - $100 x 3).

17. On the other hand, if the patient has purchased HPS Standard Plan through the HRP, and chooses to undergo the tonsillectomy procedure in a private hospital, he would be able to pay his own healthcare cost with the support of his private health insurance. In exchange, he could have his operation conducted in a private hospital setting and a choice of doctor. Assuming that the patient would need to pay about one-third of the total costs[5] for receiving private healthcare services, if he chooses to undergo the tonsillectomy procedure in a private hospital, he would need to pay $11,300 ($34,000/3) out-of-pocket. The remaining amount would be payable by the HRP, i.e. $22,700 ($34,000 - $11,300). Taking into account the fact that the HRP would be partly financed by the premium collected from the patient (three times standard premium of the corresponding age-band), the amount of Government subsidy provided to the patient in this case, even taking into account the operation costs of HRP, would be significantly less (a portion of $22,700) compared with the case where he chooses to undergo the procedure in a public hospital ($33,700).

[5] According to the findings of the Consultant, the average out-of-pocket payment by policyholders for existing individual-based indemnity hospital insurance products (ward level) is about one-third of the total costs. For illustration purpose, it is assumed in this example that the level of out-of-pocket payment by HRP members would be one-third of the total cost. It should however be noted that the actual average level of out-of-pocket payment by HRP members may be different from that of non-HRP members, depending on factors such as the healthcare service utilization pattern of HRP members.

18. Given the strong demand for public healthcare services, the HPS is not expected to bring about direct reduction in activities or savings in the public sector because of the continued rise in demand for public healthcare services due to an ageing population. However, if we could encourage and facilitate more people to make use of private healthcare services through the HPS, it will help relieve the capacity congestion in the public hospitals and users of public healthcare services can benefit from shorter waiting time, enhanced accessibility and improved quality of public healthcare services.

Items (f) and (g) -

The estimated financial support required for operating HRP.

The final proposal for HPS to be submitted by PricewaterhouseCoopers Advisory Services Limited, the Consultant commissioned by the Administration to provide professional and technical advice on key issues relating to HPS, to the Working Group on HPS by the end of 2013 or early 2014.

Administration's response

19. We are formulating recommendations for the implementation of the HPS with reference to the Consultant's advice, overseas experience and local circumstances. Thorough discussions have already been made on the details of the HPS by the Working Group and Consultative Group on the HPS under the Health and Medical Development Advisory Committee. The Consultant will also provide in its report recommendations on various matters concerning the implementation of the HPS, such as the introduction of Minimum Requirements for all individual-based indemnity hospital insurance products in order to enhance consumer protection; key components of the HPS Standard Plan; supervisory and institutional frameworks; possible options of providing public funding to support the implementation of the HPS, including details on the operation and financial support required for the HRP. The consultancy report will be released in conjunction with the public consultation exercise to be launched in the first half of 2014.

Food and Health Bureau
February 2014

Annex B

Latest Progress on the Health Protection Scheme

This note summarises the main issues which are currently under discussion between the Administration and the insurance sector on the Health Protection Scheme (HPS).

Proposed Minimum Requirements for Individual-based Indemnity Hospital Insurance Products

2. As reported in the Administration's papers (LC Paper No. CB(2)1237/12-13(01) and LC Paper No. CB(2)412/13-14(01)) for the Subcommittee on 4 June 2013 and 9 December 2013, we propose a Minimum Requirements approach under which all individual-based indemnity hospital insurance products to be offered after the implementation of the HPS must meet or exceed the Minimum Requirements. We also propose that insurers selling individual-based indemnity hospital insurance products must offer as one of the options to consumers a Standard Plan that meets all the Minimum Requirements, including guaranteed renewal, coverage of pre-existing conditions, guaranteed acceptance with premium loading cap, minimum benefit coverage and limits, budget certainty for consumers through "no-gap/known-gap" and "informed financial consent" arrangements, standardisation of policy terms and conditions, etc.

3. The Minimum Requirements would only be confined to individual-based indemnity hospital products. Group-based indemnity hospital products, individual-based non-indemnity insurance products (e.g. hospital cash products, catastrophic illness products) or out-patient only products would not be subject to the Minimum Requirements.

4. While the Hong Kong Federation of Insurers (HKFI) does not object to the proposal of introducing Minimum Requirements for HPS products, they hold the view that the introduction of Minimum Requirements for all individual-based indemnity hospital insurance products might reduce choice for consumers and stifle product innovation. It was proposed that insurers should be allowed to, alongside with compliant products, sell products that may not be compliant with the Minimum Requirements.

5. Another area of concern is price transparency of private healthcare services. It was proposed that private hospitals should adopt

packaged pricing for common procedures as well as greater standardisation of coding and charging such as a diagnosis-related groups (DRG).

6. We consider the Minimum Requirements a balanced proposal that could enhance consumer protection without compromising consumer choice. The Minimum Requirements are proposed to address public concern over the existing health insurance market. As revealed in previous public consultations, there was general consensus among the community on strengthening regulation over private health insurance and addressing the existing shortcomings in market practices, such as exclusion of pre-existing conditions; no guaranteed renewal of policies; or lack of budget certainty, etc. The 2011 Thematic Household Survey conducted by the Census and Statistics Department, among those with private health insurance, 54% of their local hospital admissions pertained to the public sector. One of the possible reasons is the lack of confidence in making use of health insurance coverage due to the above perceived/actual shortcomings of the private health insurance market. By requiring all individual-based indemnity hospital insurance products to comply with the Minimum Requirements, consumer confidence in purchasing and making use of health insurance coverage can be enhanced.

7. International experience reveals that it is common for overseas government to impose requirements similar to the Minimum Requirements as a means to regulate the health insurance market to enhance consumer protection. In countries where private health insurance plays a significant role in the healthcare system, including Australia, Ireland, the Netherlands, Switzerland and the United States, the governments have prescribed by law basic requirements broadly similar to the Minimum Requirements for all private health insurance products in order to safeguard consumer interests.

8. The introduction of Minimum Requirements for all individual-based indemnity hospital insurance products is also crucial to the sustainability of the HPS. According to the advice of the Consultant, it will not be practicable to allow co-existence of a regulated market segment where products are bound by Minimum Requirements (compliant products), and an unregulated market segment where product offering is not bound by Minimum Requirements (non-compliant products). It is because the Minimum Requirements are designed for meeting the community’s aspirations, and achieving these goals would have cost implications. Under a “two-market” situation, insurers can target the healthy population by offering relatively lower premium for the

unregulated products, leaving the compliant products a choice mainly for the unhealthy population. Given the peculiar feature of health insurance products, uninformed consumers might be induced to take out a "cheaper" policy that does not meet the Minimum Requirements (such as no guaranteed renewal). After a few years, when the consumer gets older with onset of disease and starts making claims, his policy renewal could be rejected by his insurer. With a claim record and deteriorated health conditions, it would be difficult for him to find a new insurer who will be willing to insure him. Even if he could, the premium is likely to be much higher than the same age group due to premium loading.

9. On the other hand, there is a moral hazard that savvy customers would take advantage of the "two-market" situation for individual benefits, such as switching to the compliant products only when their health condition deteriorates, taking advantage of the guaranteed acceptance feature of compliant products. The regulated segment would then have to manage a pool of policyholders of higher health risks than an average consumer, leading to a higher premium than that of unregulated products with similar coverage. The higher premium would drive price-sensitive and healthy customers away from the regulated segment, resulting in an even higher premium for the regulated segment. Eventually, the premium would become unaffordable and the regulated segment would no longer be sustainable.

10. Singapore's experience in MediShield helps illustrate why a "two-market" situation is not practicable. Operated by the Central Provident Fund, MediShield is a voluntary low cost basic medical insurance scheme introduced in 1990. As insurers were allowed to concurrently offer similar health insurance products, private insurers found it more profitable to pick and choose healthier and younger customers, leaving the unhealthy and old customers to MediShield, which provides guaranteed acceptance of subscription. This cherry picking behavior had driven up the MediShield premium and made the latter eventually unsustainable. As a result, the Singapore government introduced the MediShield reform package in 2005, including a measure to prohibit insurers from offering products that are of same or lesser coverage than that of MediShield, although insurers could provide enhancement plans on top of what MediShield already provided.

11. As regards price transparency of private healthcare services, we agree that greater standardization of coding and enhanced market transparency would be important for promoting healthy competition and improving market efficiency. It is against this backdrop that we propose

the "no-gap/known-gap" and "informed financial consent" arrangements. The former is akin to packaged pricing in the sense that it provides budget certainty to consumers. The patient either pays a pre-determined out-of-pocket amount ("known-gap"), or does not need to pay at all ("no-gap") if the procedure concerned and the providers selected are on the list agreed with the insurer concerned. Under the "informed financial consent", patients would have greater budget certainty as they would be informed in advance of the estimated service charges and estimated reimbursement amount, and could therefore have a realistic estimation of any out-of-pocket expenses that they need to pay.

Illustrative Average Standard Premium of HPS Standard Plan

12. Under the HPS, insurers would each set their own age-banded premium schedules for the Standard Plan, which would be published in the public domain for consumer's information. For illustrative purpose, the Consultant estimated the average standard premium of the HPS Standard Plan is around $3,600 in 2012 constant dollar, around 9% higher (subject to a potential range of variation between -8% and +45%) than the average premium of existing individual-based indemnity hospital insurance policies (ward level) in the market. The estimated increase in average premium is attributable to the enhanced benefits of the Standard Plan (e.g. coverage of non-surgical cancer treatments, prescribed advanced diagnostic imaging tests, etc.) and coverage of more people with health conditions under the HPS. On the other hand, the estimated premium increase would be offset by savings from providing coverage for ambulatory procedures. The key driver for estimated premium variation is how well the HPS is able to contain moral hazards on the use of advanced diagnostic imaging tests. It is for this reason that a 30% co-insurance is proposed for the use of such services under the HPS to keep the cost under check.

13. We noted that it would be difficult for the industry to come up with their figures concerning the average standard premium of the HPS Standard Plan, as the actual premiums offered by different insurers would vary by factors such as pricing strategy and risk profile of individual insurers.

14. The estimated average standard premium of the HPS Standard Plan was derived by the Consultant through an actuarial pricing model, taking into account the premium impacts of the key aspects of product design for the HPS Standard Plan. The estimated figure is provided by the Consultant for illustrative purpose and the actual premiums of the HPS

Standard Plan would be set by individual insurers. The modelling work starts with estimating the base standard premium of existing individual-based ward-level indemnity hospital insurance products in the local market in 2012. This step involves professional analysis of the existing market data in Hong Kong, including health insurance premium data, healthcare cost data, and claims data held by the HKFI. To estimate the premium impacts of the key aspects of product design for the Standard Plan, the Consultant assesses the respective claim costs and claim frequency for each aspect with reference to HKFI claims data and overseas claims data where appropriate, such as those from the Organisation for Economic Co-operation and Development, the United States and Australia. The resulted premium impacts are then applied to the base standard premium in order to derive the average standard premium per insured person under the HPS Standard Plan.

High Risk Pool

15. The High Risk Pool (HRP) was proposed to be set up having regard to the community's aspiration to enable high-risk individuals to procure private health insurance. At present, high-risk individuals often have difficulties in obtaining health insurance. Their applications are either rejected by the insurer, or accepted with clauses excluding their pre-existing conditions or charged a premium loading at a rate deemed appropriate by insurers. Under the HPS, we propose to introduce the requirement of guaranteed acceptance with a 200% premium loading cap. Without a proper mitigation measure, insurers may have to assimilate the excessive risks among their policyholders by charging higher premiums across the board. Since the HPS is a voluntary system, the higher premiums would have the effect of discouraging potential customers, especially those healthier individuals, from taking out private health insurance. This will go against the objective of the HPS to encourage and facilitate more people to take out private health insurance.

16. To tackle the above dilemma, we propose to set up a separate HRP to accept policies of the Standard Plan of high-risk individuals. Under this approach, the Standard Plan policies of high-risk individuals would be transferred to a HRP, which is a separate pool from the "normal" pools consisting of other non-high risk policyholders. In this way, the premiums for non-high risk policyholders in the "normal" pools would not be affected by the excess risks being taken on for providing health insurance coverage to high-risk individuals.

17. Under the HRP mechanism, if, at the opinion of the insurer providing Standard Plan coverage, the premium loading of the policy is assessed to equal or exceed 200% of standard premium charged by the insurer, the insurer may decide, upon the inception of the policy, to transfer the policy to the HRP. The insurer will continue to be responsible for the administration of the policy and will receive a nominal administrative fee. The premium income (net of administrative fee), claims/liabilities and profit/loss of the policy will be accrued to the HRP under the full control of the regulatory agency to be set up to monitor the implementation of the HPS, instead of the insurer concerned. Where necessary, the Government would consider injecting funding to the HRP directly to ensure the Pool's sustainability.

18. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the HPS's goal to improve access to private health insurance. We consider it reasonable and justified for the Government to use public funds to support the HRP. It would be equitable to provide public funding support to enable those high-risk individuals who are willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage. Without the HRP, these high-risk individuals would likely fall back on the public system, which is heavily subsidised by the Government. Enabling some of the high-risk individuals to obtain health insurance coverage through HRP not just offer them the choice to use private healthcare services, but also enable the public healthcare system to better focus its resources on serving its target areas.

19. According to the estimation by the Consultation, the total cost to Government for funding the operation of the HRP for a 25-year period (2016-2040) would be about $4.3 billion (at 2012 constant dollar), assuming an administrative cost of 12.5% of total claims cost.

20. The industry considers it crucial for the Government to provide sustained financial support to the HRP to ensure its sustainability. Given the complexity of the HRP system, careful planning would be required to ensure a smooth operation and functioning of the HRP. The industry also has concern about the assumed administrative cost, which they consider might not be sufficient for covering the fees for insurers, policy management and commission for intermediaries.

21. The indicative administrative cost was provided by the Consultant with reference to comparable local and overseas experience

which bear a certain degree of similarity with the HRP, such as the Pre-existing Conditions Insurance Plan in the United States (about 9% of total claims cost), network healthcare services in Hong Kong (about 8-10% of total claims cost), healthcare maintenance organisations in the United States (about 8-12% of total claims cost) and the group health insurance market (about 23% of total claims cost) in Hong Kong.

22. We would further discuss with the industry in formulating the operational details for the HRP and in determining an appropriate and reasonable level of administrative cost for operating the HRP.

Food and Health Bureau
February 2014