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Panel on Health Services

Subcommittee on Health Protection Scheme

Background brief prepared by the Legislative Council Secretariat for the meeting on 9 December 2013

Proposed design of private health insurance policies regulated under the Health Protection Scheme

Purpose

This paper summarizes the concerns of the members of the Subcommittee on Health Protection Scheme ("the Subcommittee") on the preliminary design for private health insurance ("PHI") policies regulated under the Health Protection Scheme ("HPS").

Background

2. Further to the public consultation on the future service delivery model of the healthcare system[1], the Government initiated a two-stage public consultation to take forward the reform. On 13 March 2008, it put forth a package of healthcare service reforms and six possible supplementary healthcare financing options in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life". The consultation came to an end in June 2008. Based on the outcome of the first stage consultation which revealed strong resistance to any supplementary healthcare financing options of a mandatory

[1] The Health and Medical Development Advisory Committee ("HMDAC") released a Discussion Paper entitled "Building a Health Tomorrow" on 19 July 2005 proposing the future service delivery model of the healthcare system.

nature, the Government proceeded to develop possible policy options along the principle of voluntary participation.

3. On 6 October 2010, the Government published the Healthcare Reform Second Stage Public Consultation Document entitled "My Health My Choice" in which a voluntary and government-regulated HPS was proposed for public consultation. It was proposed that insurers would be required to offer standardized indemnity insurance plans that would enable the insured to access general ward class of private healthcare services when needed. Key features of the HPS plans involved a range of requirements on operational rules (including guaranteed acceptance, guaranteed renewal, premium loading capped at 200% of standard premium through a high-risk pool ("HRP") mechanism, barrier-free portability), benefit structure (including minimum benefit coverage of inpatient and ambulatory care, minimum benefit limits, coverage of pre-existing medical conditions subject to waiting period) and other consumer protection measures (including standardized policy terms and conditions, more transparency and benchmarking on premium, a claims arbitration mechanism). On top of the HPS Standard Plan, insurers would be free to offer top-up benefits and add-on components that cater for different consumer needs.

4. According to the Healthcare Reform Second Stage Public Consultation Report released on 11 July 2011, members of the public have expressed support for the introduction of HPS to enhance transparency, competition and efficiency of PHI and private healthcare sectors for the provision of value-for-money services to consumers, as well as an alternative to those who are willing and may afford to pay for private healthcare services. A three-pronged action plan is adopted by the Administration to take forward HPS, which includes, among others, setting up a Working Group and a Consultative Group on HPS under HMDAC to make recommendations on matters concerning the implementation of HPS. To facilitate the work of the Working Group and the Consultative Group, the Administration commissioned a consultancy study by PricewaterhouseCoopers Advisory Services Limited ("the Consultant") to provide professional and technical advice on key issues relating to HPS, including the formulation of a viable and sustainable product design for HPS.

Deliberations of the Subcommittee

5. The Subcommittee held two meetings in 2013 to discuss the preliminary product design for HPS proposed by the Consultant. The deliberations and concerns of members are summarized below.

The minimum requirements approach

6. Some members considered that the latest proposal of requiring all hospital indemnity insurance products to be offered after the launch of HPS to meet or exceed a proposed set of minimum requirements would interfere with the free market, and limit the diversity of PHI in the market and consumers' choices. These members considered that the Administration should allow co-existence of a regulated market segment under the aegis of HPS and an unregulated market segment where product offering was not bound by minimum requirements on product design.

7. The Administration advised that while around 2.79 million people (i.e. about 40% of the population) were currently covered by PHI, over one third of hospital admissions by these people still pertained to the public sector due to the various shortcomings of the current PHI market. A notable reason was the uncertainty over out-of-pocket payment when the insurance protection was insufficient to cover all the private hospital expenses. The minimum requirements approach would provide simplicity, clarity and certainty to consumers and help those who did not possess insurance professional knowledge to understand easily and clearly the minimum protection they would receive when taking out a hospital indemnity insurance product. In the Administration's view, a two-market situation would be untenable as adverse selection would undermine the sustainability of HPS: insurers could cherry pick customers from the healthy population by offering relatively lower premium for the unregulated products and reject them after they started making a claim or their health began to deteriorate, leaving HPS a choice mainly for the unhealthy population.

Impact of the minimum requirements approach on existing PHI subscribers

8. Members noted that of the 2.79 million persons covered by PHI, about 1.25 million persons were covered by individually-purchased PHI only, about 0.96 million persons by employer-provided PHI only, and about 0.59 million persons by both. Concern was raised over the impact to be brought about by the introduction of the minimum requirements on these existing PHI subscribers, in particular those at the lower end of the range of premium. Pointing out that

most of the existing employer-provided hospital indemnity insurance policies were of limited protection in terms of benefit coverage and limits, members called on the Administration to carefully assess, whether and to what extent, the introduction of the minimum requirements would discourage employers from providing group indemnity hospital insurance for their employees.

9. The Administration advised that for HPS Standard Plan for individual policies, it was estimated that the average premium per insured member would be around $3,600 for hospital indemnity policies. The introduction of the minimum requirements on all hospital indemnity products was estimated to translate into an increase of about 10% in premium as compared to existing ward level hospital indemnity products. The increase could be partly offset if tax incentives were to be introduced under HPS. As regards the group-based hospital insurance policies not meeting the minimum requirements of the HPS Standard Plan, an option under consideration was to encourage insurers to offer top-up options with additional benefits to enable employees covered by these plans to purchase at their own cost insurance protection at a level tantamount to that of the Standard Plan if they so wish.

10. There was a call for the Administration to address the insurance industry's questions concerning whether and to what extent re-underwriting was allowed on change of insurers under HPS, as well as how to maintain the sustainability of the risk pools of those health insurance plans which did not migrate to HPS plans. On the suggestion that consideration should be given to enabling employees covered by employer-provided group plans to switch their plans to individual plans under HPS without undergoing re-underwriting when they went into retirement, the Administration advised that it was discussing with the insurance industry and employers' associations on the migration arrangements and the proposed conversion option.

Risk-profile management

11. Members noted that a HRP would be put in place to balance between requiring insurers to accept all prospective subscribers to the HPS Standard Plan, and introducing excessive risks into the insurance pool which would result in escalating premium and discouraging people from taking out HPS plans, especially the young and healthy. While it was proposed that only those applicants whose premium loading was assessed to equal or exceed 200% of standard premium would be admissible to HRP, there was a concern that insurers might mark up the premium loading rate in order to pass on all higher-risk subscribers to HRP.

12. The Administration advised that by transferring the policies of those applicants whose premium loading was assessed to equal or exceed 200% of standard premium to HRP, the insurer would surrender the premium collected for these policies after deducting a nominal handling fee to be prescribed by the HPS agency. While the insurer would continue to be responsible for the administration of the policies, the premium income (net of expense), claim liabilities and profit/loss of these policies would be accrued to HRP instead of the insurer concerned. Hence, as long as the insurers could charge a premium loading on higher-risk applicants commensurate with the extra risks that they took on, they could still expect to have an underwriting profit by keeping the higher-risk subscribers under their own portfolio. In addition, given that all insurers would 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 could compare offers from other insurers for coverage of the HPS Standard Plan.

13. Question was raised as to whether insurers could introduce premium loading at next policy renewal, so as to pass on unfavourable risks to HRP, in case the low-risk policyholders had made a claim. The Administration advised that insurers would only be allowed to underwrite a prospective insured person, taking into account the latter's health status, pre-existing medical conditions and other relevant risk factors, before effecting a health insurance policy. No re-underwriting would be allowed for policy renewal. It would be made a legal requirement that the premium structure of HPS had to be age-banded.

Measures to enhance upfront payment transparency and certainty

14. Members had expressed grave concern about the measures to be put in place under HPS to promote transparency and certainty of upfront payment by consumers. They were concerned that while it was proposed in the Healthcare Reform Second Stage Public Consultation Document that the benefit limits of the health insurance plans to be offered under HPS should be based on packaged charging for common procedures according to diagnosis-related groups ("DRG"), the advice of the Consultant was that Hong Kong currently did not possess the required mechanism for putting in place a standardized system of DRG in the short-term. The proposal of the Consultant was to introduce an "informed financial consent" and a "no-gap/known-gap" arrangement, which were considered to be more readily implementable in the short-term. Some members cautioned that there would be a lack of mechanism to govern the healthcare costs if DRG-based packaged charging was not to be implemented.

15. There was another concern that given the present overwhelming demand for private hospital services, private healthcare providers would not be interested in contracting with the insurers to map out the lists of "no-gap" or "known-gap" procedures to be covered in the insurance policies regulated under HPS. For services provided by non-contracted hospitals, insurers would not be able to work out the estimated out-of-pocket expenses to be paid given the existing insurance coverage acquired by the patients unless the hospital concerned provided the estimated service charges in the first place.

16. The Administration advised that the proposal to develop DRG-based charging system was only a means to meeting the end of enhancing payment certainty. Patients would enjoy greater payment transparency and certainty under the "informed financial consent" and "no-gap/known-gap" arrangements. The Administration further explained that a major technical challenge for formulating packaged pricing was the complexity of diseases. There could be varying degrees of complexity even under the same category of disease, some of which might not be anticipated in advance. Another challenge was that the majority of private hospitals' admissions were handled by visiting doctors. Nevertheless, the Administration would continue to discuss with the existing private hospitals the introduction of packaged charging for common treatments or procedures. In addition, new private hospital developments were required to offer at least 30% of in-patient bed days each year for packaged priced services. In parallel, the Steering Committee on Review of the Regulation of Private Healthcare Facilities would explore, among others, measures to enhance price transparency of private healthcare service charges in order to safeguard patient interest.

17. Some members pointed out that private hospitals might form a price cartel to maintain the packaged charges for common procedures at a high level. They asked the Administration whether private hospital services would be subject to the regulatory regime of the Competition Ordinance (Cap. 619). The Administration advised that most private hospitals fell within the definition of "undertakings" and would therefore be subject to the regulation of the Ordinance. When the Ordinance came into full operation, the Competition Commission would 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.

Subscription

18. Since HPS was a voluntary scheme, members were concerned about how the current proposal could appeal to healthy individuals to purchase the HPS plans at younger age in order to make HPS financially viable.

19. The Administration advised that under HPS, the young and healthy would have greater incentive to join the scheme early given that the premium would be age-banded and that the amount of premium loading would be calculated on the basis of the health conditions of the insured at the time he/she joined the health insurance. The requirement of guaranteed renewal for life would also enable the early entrants to enjoy lifelong protection without having to undergo re-underwriting even if they suffered from catastrophic illnesses after purchasing their HPS plans.

Relevant papers

20. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

Council Business Division 2
Legislative Council Secretariat
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Appendix

Relevant papers on the proposed design of private health insurance policies regulated under the Health Protection Scheme

Committee	Date of meeting	Paper
Subcommittee on Health Protection Scheme	4.6.2013 (Item II)	Agenda Minutes CB(2)1507/12-13(01)
	8.7.2013 (Item I)	Agenda Minutes CB(2)151/13-14(01)

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