



中華人民共和國香港特別行政區政府總部食物及衛生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

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28 April 2015

Ms Maisie LAM
Clerk to Subcommittee on Health Protection Scheme
Legislative Council Secretariat
Legislative Council Complex
1, Legislative Council Road
Central

Dear Ms LAM,

**Panel on Health Services
Subcommittee on Health Protection Scheme**

Follow-up to the meeting on 11 March 2015

I refer to your letter of 10 April 2015. The requested supplementary information is provided at **Annex**.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Sheung-yuen LEE'.

(Sheung-yuen LEE)

for Secretary for Food and Health

Encl.

**Supplementary information requested by the meeting of
Subcommittee on Health Protection Scheme
of the Panel on Health Services on 11 March 2015**

Item (a) -

In respect of the proposed Minimum Requirement of “coverage of pre-existing conditions”, provide, on the basis of population profile and empirical data from the insurance industry, an actuarial analysis on the estimated increase in premium in comparison with existing products in the market for those policyholders with pre-existing conditions, with a breakdown by different types of pre-existing condition (e.g. diabetes mellitus and hypertension) and health risk profile;

Administration’s response

In providing coverage of pre-existing conditions for policyholders, insurers have to take into account extra claims costs arising and hence the increase in premium revenue required to compensate for the extra claims costs. In estimating the impact of coverage of pre-existing conditions on the average standard premium of the Standard Plan, the Consultant to Health Protection Scheme (HPS) (renamed to Voluntary Health Insurance Scheme (VHIS))(the Consultant) assumes that this factor would have premium impact in respect of enrollment of migrants who have pre-existing conditions excluded in their existing insurance policies. Under the proposed migration arrangement, the migrants may opt to either keep or remove such case-based exclusions, but re-underwriting by insurers may be required under the latter scenario. To the extent that some migrants opt to keep the case-based exclusions and some insurers impose premium loading on those migrants who opt to remove the case-based exclusions, no impact on the standard premium would be generated. Yet for prudence sake, the Consultant assumes in the actuarial calculation that all migrants with case-based exclusions opt to remove the exclusions, and that all insurers concerned opt to waive re-underwriting and instead raise the standard premium to cover the extra claims costs upon removal of the exclusions. In other words, the extra claims costs would be shared by all insured persons (including those without case-based exclusions) through increase in standard premium. In this connection, the Consultant assumes that the overall claims amount would increase on average by about 5%, leading to a broadly similar magnitude of increase in

standard premium.

2. In providing coverage of pre-existing conditions for new policyholders, the Consultant anticipates that, instead of raising the standard premiums for all policyholders as in the case set out in the preceding paragraph, insurance companies would more likely charge a premium loading on top of standard premium for policyholders with pre-existing conditions.

3. However, since pre-existing conditions are quite commonly excluded from coverage in the local market at present, there is a lack of data and information that could enable the Consultant to estimate a set of premium loading rates by health conditions that the insurers would adopt under the VHIS in the future. The actuarial analysis related to the coverage of pre-existing conditions, including the financial position of the High Risk Pool (HRP), could thus draw reference only from the local and overseas data regarding claim incidents and morbidity risk profile. Due to technical constraint, it is difficult to estimate an average or a range of premium loading rates by health conditions under the VHIS. The exact set of applicable premium loading rates can vary considerably across insurance companies due to difference in business strategy and claims experience, as well as inherent complexity of risk factors involved that can be highly individualized.

4. First, a large number of health conditions pertaining to different body parts and body systems would have impacts on the applicable premium loading rate, and such impacts would also vary by the degree of complexity for each condition. It is because even for the same condition, there could be a variety of complexities that entail different level of health risks and hence the expected claims costs. By varying the premium loading rate in accordance with the risk level of individual insured persons pertains to risk-based pricing method, insurers would be able to maintain a viable operation while attracting customers with diverse health status.

5. Secondly, even if a pre-existing condition and its complexity are held constant, the health risks and claims costs involved can differ considerably from one person to another, depending on a host of personal risk factors such as the co-existence of other inter-related health conditions, age and gender, family history, etc. In other words, even for the same condition of the same complexity, the degree of health risks and hence the expected amount of claims costs can vary considerably across different insured persons.

6. Thirdly, apart from the health status of an insured person, the premium loading rate also would depend on the business strategy of an insurer in respect of pricing, competition, risk appetite and financial management. This means that even for the same insured person, the applicable premium loading rate can differ from one insurer to another. Moreover, insurers may adjust the business strategy having regard to changes in market conditions, which could lead to different premium loading rate assessments over time.

7. Given the complexity pertaining to the above three factors, it is difficult to estimate with acceptable degree of precision the average premium loading rates to be applied corresponding to different types of pre-existing health conditions and health risk profiles. It is not our policy intention to regulate the underwriting and risk assessment practices of insurers regarding VHIS products, in view of the flexibility needed by insurers to manage their financial risks and satisfy the prudential requirements.

Items (b) and (c) -

Provide, on the basis of historical data of annual medical inflation rate, the estimated average annual premium of Standard Plan for the 25-year period from 2016 to 2040 having taken into account the influencing factor of medical inflation;

Provide a forecast of the average annual premium of individual indemnity hospital insurance products for the 25-year period from 2016 to 2040 under the respective scenarios of with and without the implementation of Voluntary Health Insurance Scheme (“VHIS”) having taken into account the general influencing factors and the additional influencing factors that VHIS entailed; and

Administration’s response

8. Although there is no official medical inflation index available in Hong Kong, for the purpose of projecting the impact of the VHIS, the Consultant assumes that the excess medical inflation, i.e. the excess of medical inflation over general inflation, would be lower during the projection horizon with the implementation of the VHIS (VHIS scenario) as compared with the baseline scenario without the VHIS (baseline

scenario). This is due to the following measures to be introduced under the VHIS –

- (a) greater budget and cost certainty for consumers and insurers through the “no-gap/known-gap” and Informed Financial Consent arrangements, which would increase price transparency and foster market competition in the private healthcare sector; and
- (b) more efficient use of private healthcare resources through facilitating delivery of healthcare in ambulatory setting, which would increase cost efficiency in the private healthcare sector.

9. Apart from easing the long-term excess medical inflation, which directly affects the health insurance claim costs, the implementation of the VHIS can also keep long-term insurance premium level under better check by fostering competition in the health insurance market. Certain features of the VHIS designed to enhance market transparency, including premium transparency and product comparability offered by different insurers, would better enable and encourage consumers to conduct price search and product comparison.

10. Under the combined influence of the above two factors, the Consultant projects that the VHIS would help ease the long-term upward pressure on premiums of the individual indemnity hospital insurance products. The projection is focused on the premiums of ward-level VHIS products which should constitute the major market share, including the Standard Plan and ward-level Flexi Plans. In the Consultant’s actuarial model, further breakdown of the projection results by the Standard Plan and ward-level Flexi Plans is not available. As shown in the Consultation Document on the VHIS¹, during the projection horizon (from 2016 to 2040), the projected premium growth rate of individual indemnity hospital insurance products (ward level) averages at 3.5% per annum under the VHIS scenario, vis-a-vis the corresponding figure of 4.3% per annum under the baseline scenario.

¹ Figure 8.4 in Chapter 8 “Implications for Hong Kong’s Healthcare System”.

Item (d) -

Provide, in the form of a table (similar to Table 3 in the Annex to LC Paper No. CB(2)2260/13-14(01)), the respective expected total cost for the operation of the High Risk Pool (“HRP”) and the corresponding estimated cost to be borne by the Government for financing HRP, for the 25-year period from 2016 to 2040 if the premium loading cap was lowered from the proposed level of 200% to 150%, 100% and 50% of standard premium.

Administration’s response

11. The Consultant’s actuarial model for estimating the financial position of the HRP involves a set of complicated assumptions, including the demographic profile of potential HRP members, their relativity in respect of morbidity risks, and the price elasticity of their demand for individual indemnity hospital insurance products. Due to technical constraints associated with such complexities, it is difficult to estimate the precise impact on the funding requirement for the HRP if the premium loading cap is lowered from the proposed level of 200% to 150%, 100% and 50% of standard premium of the Standard Plan. Yet the actuarial model of the Consultant provided a conceptual framework for a ballpark assessment of such impact, which is summarized in the ensuing paragraphs.

12. If the premium loading cap is reduced, the total membership of the HRP is poised to increase. The steeper the reduction in premium loading cap, the more the membership would increase. If the premium loading cap is reduced, more insured persons with premium loading would be eligible for entry into the HRP. These include insured persons with an assessed premium loading rate of less than 200% but higher than the new loading cap (e.g. 100%); and insured persons with an assessed premium loading rate at or above 200%, who are attracted by the lower premium loading cap to get insured. These two groups of new members, together with the original HRP members who are willing to pay the capped premium loading rate at 200%, would form the membership of the HRP after the reduction in premium loading cap.

13. The total cost of operation for the HRP would rise alongside the increase in membership. The increase would mainly come from the claims cost of the new HRP members, while the claims cost of the original HRP members would remain unchanged. There might also be cost pressure arising from administrative work to handle a larger number of

HRP members.

14. The amount of public funding required to finance the HRP operation would also increase. With the increase in membership, extra funding would be needed to subsidize the newly joining HRP members. Moreover, with the reduction in premium loading cap, extra funding would be needed to subsidize the original HRP members to a greater extent because the amount of premiums collected from these members would be reduced under a lower premium loading cap.

15. For illustrative purpose, under the scenario of lowering the premium loading cap from 200% to 100%, the total amount of public funding required for the HRP (from 2016 to 2040) would likely exceed \$20 billion under the following assumptions –

- (a) Under the original scenario (with 200% premium loading cap), the total amount of premium collected is \$13.5 billion (three times standard premium). With the premium loading cap lowered to 100%, the total premium paid by original HRP members would be \$9.0 billion (two times standard premium, i.e. \$13.5 billion x 2/3). The amount of extra public funding required to make up the shortfall would be \$4.5 billion (\$13.5 billion - \$9.0 billion);
- (b) The lower premium loading cap would attract more people with an assessed premium loading rate at or above 200% to join the HRP. Assuming the number of this new group of insured persons is same as that of the number of the original HRP members, the premium collected from this group of insured persons would be \$9.0 billion;
- (c) Under the original scenario, the total cost of operation of the HRP is \$17.8 billion (a total claims cost of \$15.8 billion plus an administration cost of \$2.0 billion). Assuming the same cost factor as that of an original HRP member (i.e. six times standard risk) is applied to the group of insured persons identified in (b) above, and that additional administration work would be absorbed within existing resources of the HRP, the additional cost of operation of the HRP arising from serving the group of insured persons identified in (b) above would be \$15.8 billion. The amount of extra public funding required for the HRP arising from the group of insured persons identified in (b) above would be \$6.8 billion (\$15.8 billion - \$9.0 billion); and

(d) There would be an additional group of insured persons joining the HRP. Their assessed premium loading rate is less than 200% but higher than the new loading cap of 100%. If the number of this group of insured persons is double that of the total number of insured persons with a premium loading rate at or above 200% (i.e. the number of original HRP members in (a) above plus the number of insured persons attracted by a lower premium loading rate under (b) above), the premium collected from this group of insured persons would be \$36.0 billion ($[\$9.0 \text{ billion} + \$9.0 \text{ billion}] \times 2$). Assuming the cost factor of this group of insured persons is on average 2.5 times standard risk (the mid-point between two and three times standard risk), then the claims cost would be 1.25 times ($2.5/2$) of the premium revenue (with 100% premium loading, the premium is two times standard premium). The total claims cost associated with this group of insured persons would be \$45.0 billion ($\$36.0 \text{ billion} \times 1.25$). Further assuming that additional administration work arising from serving this group of insured persons would be absorbed within existing resources of the HRP, the amount of extra public funding required for the HRP would be \$9.0 billion ($\$45.0 \text{ billion} - \36.0 billion).

16. Combining (a), (c) and (d) above, the total amount of extra public funding required for the HRP (from 2016 to 2040) would be \$20.3 billion ($\$4.5 \text{ billion} + \$6.8 \text{ billion} + \9.0 billion). The total amount of public funding required for the HRP with a 100% premium loading cap is thus \$24.6 billion ($\$20.3 \text{ billion} + \4.3 billion (the amount of public funding required under the original scenario)).

**Food and Health Bureau
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