立法會
Legislative Council

LC Paper No. CB(2)1314/15-16(02)

Ref : CB2/PS/2/12

Panel on Health Services

Subcommittee on Health Protection Scheme

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 19 April 2016

Voluntary Health Insurance Scheme

Purpose

This paper summarizes the views and concerns of the members of the Panel on Health Services ("the Panel") and its Subcommittee on Health Protection Scheme ("the Subcommittee") on the Voluntary Health Insurance Scheme ("VHIS") (formerly known as Health Protection Scheme ("HPS"))[1], including those on the way forward for VHIS in paragraphs 51 to 54.

Background

2. Further to the public consultation in 2005 on the future service delivery model of the healthcare system[2], 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". Based on the outcome of the first stage consultation which revealed strong resistance to any supplementary healthcare financing options of a mandatory nature, the Government proceeded to develop possible policy options along the principle of voluntary participation.

---

[1] As HPS is intended as a supplementary financing arrangement, the Administration renames the scheme as Voluntary Health Insurance Scheme in the consultation document published on 15 December 2014 to better reflect its objectives and nature.

[2] 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.

3. On 6 October 2010, the Government published the Healthcare Reform Second Stage Public Consultation Document entitled "My Health My Choice" ("the Second Stage Public Consultation") in which a voluntary and government-regulated private health insurance ("PHI") scheme, 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 proposed HPS products involved a range of requirements on operational rules, benefit structure and other consumer protection measures.

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 for the provision of an alternative to those who are willing and may afford to pay for private healthcare services. To take forward HPS, a Working Group and a Consultative Group on HPS were set up under HMDAC to make recommendations on matters concerning the implementation of HPS. To provide professional and technical support to the Working Group and the Consultative Group, the Administration commissioned a Consultant to study and advise on key issues relating to HPS, inter alia, the formulation of a viable and sustainable product design for HPS and areas where public funding could be considered to ensure the viability and sustainability of HPS.

5. On 15 December 2014, the Government published the Consultation Document on Voluntary Health Insurance Scheme ("the 2014 Consultation Document"). The consultation exercise lasted for four months until 16 April 2015.

Deliberations of the Subcommittee and the Panel

6. The Subcommittee has held a number of meetings to study issues relating to HPS since December 2012 and has also received views from deputations on the proposed VHIS. The Panel held a special meeting to discuss, among others, the 2014 Consultation Document on 13 January 2015. The deliberations and concerns of members are summarized in the following paragraphs.

<u>Policy objectives of VHIS</u>

7. Some members, including Mr Vincent FANG, Mr CHAN Kin-por, Mr YIU Si-wing and Mr POON Siu-ping, expressed support for the concept and policy objectives of VHIS to enhance the accessibility, quality and transparency

of individual indemnity[3] hospital insurance products and foster consumer confidence in using private healthcare services, so as to adjust the balance of the public-private healthcare sectors and enhance the long-term sustainability of the overall healthcare system. Some other members, including Mr Albert HO, Mr Albert CHAN, Dr KWOK Ka-ki and Dr Fernando CHEUNG, had reservation about the introduction of VHIS. They considered that the effort of the Government should be focus on improving the public healthcare system. Any shortcomings of the existing private health insurance market could be addressed through enhanced regulatory control without VHIS.

8. The Administration stressed that under the dual-track healthcare system, the Government would continue to strengthen its commitment to the public healthcare system (including the public health infrastructure) which was the safety net for the whole population. It was, however, necessary to identify measures to adjust the public-private balance. By providing a value-for-money choice to those who could afford and were willing to pay for private healthcare services with personalized choices and better amenities (i.e. mainly the middle class) through VHIS, resources could be released in the public sector to enhance service quality and shorten the waiting time.

The Minimum Requirements approach

9. There was a concern that the latest proposal of requiring all individual indemnity hospital insurance products to meet or exceed a proposed set of 12 Minimum Requirements[4] upon the implementation of VHIS would interfere with the free market, limit the diversity of PHI in the market and limit consumer choice over products that did not meet the Minimum Requirements. In addition, the proposal would lead to an increase in average annual standard premium due to enhanced benefits. There was a suggestion that the Administration should allow co-existence of a regulated market segment under the aegis of VHIS and an unregulated market segment where products were not bound by Minimum Requirements, so that consumers could choose among different grades of products with diverse benefit limits and correspondingly different premium levels to suit their needs and affordability.

---

[3] According to the Administration, an indemnity insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss.

[4] The proposed Minimum Requirements included: (a) guaranteed renewal; (b) no "lifetime benefit limit"; (c) coverage of pre-existing conditions; (d) guaranteed acceptance with premium loading cap; (e) portable insurance policy; (f) coverage of hospitalization and prescribed ambulatory procedures; (g) coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments; (h) minimum benefit limits; (i) cost-sharing restrictions; (j) budgetary certainty; (k) standardized policy terms and conditions; and (l) premium transparency.

10. The Administration advised that according to the 2011 Thematic Household Survey ("THS"), among those who were covered by PHI, about 54% of their local hospital admissions still pertained to the public sector. One possible reason was that patients might feel uncertain about the out-of-pocket payment when the insurance protection was insufficient to cover all expenses, or were concerned over the possibility of an increase in premium or even termination of policy after claims. The Minimum Requirements were designed to 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 policy. The Minimum Requirements proposal was also in line with international experience. In the Administration's view, a two-market situation would be untenable as adverse selection would undermine the sustainability of VHIS: insurers could cherry pick customers from the healthy population by offering relatively lower premium for the unregulated products, leaving VHIS a choice mainly for the unhealthy population.

11. There were views that the above findings revealed by the 2011 THS could not serve as inferences of shortcomings of existing PHI products and hence a justification for the introduction of Minimum Requirements, as the relevant percentages were referring to the number of admissions, instead of the number of respondents. There might be cases that the respondents concerned used both public and private hospital services. Some insured who had already exhausted the benefit limits of their insurance might also resort to the public healthcare sector for follow-up treatment.

Product design requirements for the Standard Plan[5]

Coverage of pre-existing conditions

12. On the proposal that insurers had to cover pre-existing conditions subject to a standard waiting period and partial reimbursement arrangement (viz. no coverage in the first year and a respective coverage of 25%, 50% and 100% in the second year, the third year, and fourth year onwards), some members cast doubt about the Consultant's estimations that the price impact of coverage of pre-existing conditions on the premiums to be paid by insured persons with standard-risk under VHIS[6] would be 5%, whereas that on the average claims cost

---

[5] An individual indemnity hospital insurance product that met all (but not exceeding) the 12 Minimum Requirements was considered a Standard Plan.

[6] Taking into account all the enhanced features and benefits proposed under the Minimum Requirements, the average annual standard premium of Standard Plan was estimated by the Consultant to be around $3,600 (in 2012 constant prices).

of members of the high risk pool ("HRP")[7] would be six times (or 600%) than that of an average standard-risk policyholder. The Administration explained that the former referred to the price impact arising from the enrollment of those migrants with pre-existing conditions excluded in their existing insurance policies who opted to remove these case-based exclusions and the required increase in overall standard premium if all such migrants went for this option and the insurers chose to finance the extra claims cost through standard premium increase. It was estimated that the overall claims amount would increase on average by about 5%, leading to a broadly similar magnitude of increase in standard premium. The cost impact of covering pre-existing conditions on members of HRP referred to that arose from enrollment of high-risk people who would be transferred to HRP, a separate risk pool from the generic one of which the standard premium was estimated. Such impact would have no bearing on the standard premium and was not accounted for as part of the calculation.

13. Question was raised about how common was the market practice that policyholders who were of higher-risk would be charged "normal" premium yet with reduced coverage due to exclusion of pre-existing medical conditions, or premium loadings over and above the "normal" premium due to their existing medical conditions. The Administration advised that a survey conducted by the Consultant on the market practices of insurance companies in Hong Kong (which was estimated to be constituting a market share of about 70%) from the latter part of 2012 to the early part of 2013 revealed that amongst the insurance companies responded to the survey, the proportion of health insurance policies in force as at end-2011 with specific pre-existing health condition(s) stated for exclusion from policy coverage mostly ranged from 7% to 15%. The proportion of health insurance policies in force with premium loading applied ranged from 5% to 8%. In other words, the majority of these health insurance policies were only charged "normal" premium.

14. Mr CHAN Kin-por expressed the view that the insurance sector remained unconvinced of the Consultant's estimation that the price impact to be brought about by the requirement of covering pre-existing conditions on the premiums to be paid by insured persons with standard-risk would only be 5%. Noting the anticipation of the Consultant that under VHIS, insurance companies would more likely charge a premium loading on top of standard premium for new policyholders with pre-existing conditions, members sought information about the estimated premium loading rates corresponding to different types of pre-

---

[7] An HRP, which was the key enabler of guaranteed acceptance with premium loading cap, was proposed to be set up to accept policies of Standard Plan of which the premium loading was assessed to be 200% or more of the standard premium offered by the insurer. Under the proposal, the claims cost arising from the acceptance of high-risk subscribers would be met by their own premiums and Government funding for HRP.

existing health conditions to be applied by the insurers. The Administration advised that due to the lack of data and information in the existing local market, it was difficult to estimate with acceptable degree of precision an average or a range of premium loading rates by health conditions under VHIS. The exact set of applicable premium loading rates could vary considerably across insurance companies due to difference in business strategy and claims experience of insurers, as well as inherent complexity of risk factors involved that could be highly individualized.

Guaranteed acceptance with premium loading cap

15. Members expressed concern that insurers offering Standard Plan would only be required to guarantee acceptance with premium loading capped at 200% of standard premium of all ages within the first year of implementation of VHIS; and those aged 40 or below starting from the second year of implementation of VHIS. Noting that the total cost to the Government for funding the operation of HRP over the period of 2016 to 2040 would only be increased from $4.3 billion[8] (if the age limit was set at the proposed level of 40) to $5.3 billion (if the age limit was raised to the age of 50) or $6.4 billion (if the age limit was raised to the age of 55), they considered that the entry age limit of guaranteed acceptance should be set at an older age, say, 50 or 55, to enable more time for older age people to consider to subscribe to the Standard Plan or at times when they had greater affordability to do so. They surmised that the proposed guaranteed acceptance age limit of 40 was meant to limit the size of HRP membership and the public funding support required to ensure the sustainability of HRP.

16. The Administration advised that the proposed guaranteed acceptance age limit of 40 was aimed to encourage people to enroll VHIS when they were young and healthy. A lower age limit for guaranteed acceptance with premium loading cap would lead to a lower membership of HRP over the projection horizon, as well as early participation of healthy people which was conducive to the risk pooling function of PHI. Without such a limit, there would be incentive for more people to join VHIS until an older age when their health condition already deteriorated. The Administration, however, kept an open mind on the setting of the age limit subject to the outcome of the public consultation.

17. There was a suggestion that insurers should be allowed to offer individual indemnity hospital insurance policies with exclusion of specific pre-existing

---

[8] According to the Administration, the total cost to operate HRP for a period of 25 years would be $17.8 billion, of which $15.8 billion was the claims cost and the remaining $2 billion was the administration cost. Under the assumption that the estimated total premiums collected under HRP would be $13.5 billion, the required Government funding to finance HRP over the period was estimated to be $4.3 billion.

conditions to provide accessible and affordable PHI coverage to those high-risk individuals aged above 40 who chose to subscribe health insurance after the first year of launch of VHIS. At the meeting of the Panel on 13 January 2015, the Administration undertook to give consideration to the suggestion.

18. Dr KWOK Ka-ki suggested that, to enable more insured persons with premium loading to be eligible for entry into HRP, the premium loading cap should be lowered from the proposed level of 200% to, say, 50% of the standard premium. The Administration advised that it would consider whether or not the premium loading cap should be lowered having considered the views received during the public consultation exercise and the financial implications. It should be noted that the steeper the reduction in premium loading cap, the more the membership of HRP would increase. This would lead to a rise in the operation cost for HRP arising from the claims cost of the new HRP members as well as the increase in administrative work to handle a larger number of HRP members, and hence, an increase in the amount of public funding required for financing HRR[9].

Coverage of hospitalization and prescribed ambulatory procedures

19. Question was raised about the Consultant's estimation that covering endoscopy/colonoscopy through packaged pricing in ambulatory settings would decrease the average standard premium of the Standard Plan by approximately 12%. The Administration advised that the Consultant had adopted the individual PHI market's average expense loading ratio in 2011 (i.e. 43%, and hence a claim ratio of 57%) in the calculation. It was estimated that the claims cost per insured person[10] at all ages for coverage of endoscopy/colonoscopy would be about $560 for the Standard Plan, which was lower than that of $790 for comparable individual indemnity hospital insurance product in the market. This was mainly due to a higher use of more cost-effective[11] ambulatory procedures with packaged pricing to substitute for unnecessary hospital admissions[12]. Such cost

---

[9] Based on the actuarial model of the Consultant for estimating the financial position of HRP, a ballpark assessment conducted by the Administration for the scenario of lowing the premium loading cap from 200% to 100% would lead to an increase in the total amount of public funding required for HRP (from 2016 to 2040) from $4.3 billion to $24.6 billion.

[10] According to the Administration, claims cost per insured person was a function of claims frequency, average billed size and claims-to-bill ratio.

[11] According to the estimate of the Consultant, in 2010, the average cost of the procedure "colonoscopy with removal of tumor, polyp or lesion" performed under an ambulatory setting was around $8,600. The average cost was around $19,100 for those who stayed overnight in a hospital (general ward level).

[12] It was assumed that the percentage of endoscopy/colonoscopy performed under an inpatient setting would decrease from the current 70% to 15% under VHIS.

savings was expected to outweigh the cost increases due to a higher claims frequency (i.e. an estimated 35% increase) as greater demand would be generated by coverage of ambulatory procedures under VHIS, and the cost increases due to a higher claims-to-bill ratio (i.e. from the current 89% to 100% as it was assumed that the full cost of ambulatory procedures would be covered under VHIS).

20. There was a view that the Administration should use up-to-date claim ratio, which stood at 69% in 2013 according to the Hong Kong Federation of Insurers ("HKFI") statistics (and hence an expense loading ratio of 31%) for the whole PHI market, for calculating the relevant price impact.

Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments

21. Question was raised as to the reason why the Administration would consider that advanced diagnostic imaging tests would be more easily subject to mis-use or abuse and, hence, should be subject to a fixed 30% co-insurance arrangement. The Administration advised that in the course of discussing with the insurance and healthcare sectors on the requirement, there were concerns that covering advanced diagnostic imaging tests under VHIS might lead to moral hazard and a rapid increase in utilization of these tests. The imposition of a fixed 30% co-insurance for claims on these tests 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. Noting the Consultant's finding that the average out-of-pocket payment by policyholders of existing individual indemnity hospital insurance products (ward level) was about one-third of the total costs, the Administration considered the 30% co-insurance ratio (subject to an annual ceiling) proposed by the Consultant reasonable, as it balanced between the need to combat moral hazard and premium affordability of the Standard Plan.

22. There was a view that the proposal would be a step backward in consumer protection, as advanced imaging tests for surgical purpose were covered under some existing individual indemnity hospital insurance policies in the market and were likely to be fully claimable under the benefit item of miscellaneous hospital expenses. It was suggested that the co-insurance arrangement should only be imposed on those tests conducted for diagnostic purpose. The Administration advised that the existing arrangements would entail unnecessary hospitalization and the reimbursement might not be sufficient for covering the full cost of these tests.

Budget certainty

23. In the Second Stage Public Consultation, it was proposed that HPS plans should offer coverage for common procedures using diagnosis-related groups[13] ("DRG")-based packaged pricing. On the Administration's latest stance that it would take a relatively longer time for Hong Kong to develop an operable system of DRG suitable for local use in the private sector that a "no-gap/known-gap" arrangement and an "informed financial consent" would instead be introduced under VHIS to promote budget certainty, some members expressed concern that there would be a lack of mechanism to govern the healthcare costs. Concern was also raised as to whether private healthcare providers would be interested in contracting with the insurers and providing the estimated service charges required to map out the lists of "no-gap" or "known-gap" procedures to be covered in the insurance policies regulated under VHIS, given the present overwhelming demand for private hospital services.

24. The Administration explained 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 "no-gap/known-gap" and "informed financial consent" arrangements. The Administration advised that the major technical challenges for formulating packaged pricing was the complexity of diseases and the fact that a 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.

25. Some members expressed concern 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. In addition, the Steering Committee on Review of the Regulation of Private Healthcare Facilities had conducted a root-and-branch review of the regulatory regime for private healthcare facilities, which included, among others, private hospitals, with a view to strengthening the regulatory standards to meet the public aspiration and better safeguard public health. The Administration had put forth various measures to enhance price transparency of private healthcare

---

[13] Diagnosis-related groups was a sophisticated coding system for classifying medical conditions requiring treatments or procedures by diagnosis and complexity.

facilities in the Consultation Document on Regulation of Private Healthcare Facilities[14] for public consultation.

Impact of VHIS on existing PHI subscribers

Average annual standard premium of Standard Plan

26. The Consultant's estimation was that the average annual standard premium of the Standard Plan would be around $3,600 in 2012 constant prices (viz. 9% or $300 higher as compared to the average premium of existing individual indemnity hospital insurance products (ward level) of $3,300 in 2012), subject to a potential range of variation between -8% and +45%. Mr CHAN Kin-por remarked that as the actual premiums offered by different insurers would vary by factors such as pricing strategy and risk profile of individual insurers, it would be difficult for the insurance industry to come up with their figures concerning the average annual standard premium of Standard Plan. Members were concerned that those existing PHI subscribers who were at the lower end of the range of premium and/or in the older age group might be priced out as they would be unable to afford a 30% to 40% higher premium under the Standard Plan. According to the insurance sector, the annual premium of about 50% of the existing individually-purchased PHI policies was below $3,000.

27. The Administration explained that since some premium impacts might vary considerably depending on market reaction, the estimated figure of $3,600 was subject to a range of variation from -8% to +45%. Among the 12 proposed Minimum Requirements, the Consultant considered that the coverage of pre-existing conditions, coverage of hospitalization and ambulatory procedures, coverage of advance diagnostic imaging tests and non-surgical cancer treatments, and minimum benefit limits would carry significant and quantifiable impacts on the standard premium of the Standard Plan, while the impacts of the remaining requirements were considered non-quantifiable and/or insignificant[15]. A key driver for the variation was how well VHIS was able to contain moral hazards on the use of advanced diagnostic imaging tests. In the scenario with a premium variation of +45%, it was assumed that per-person usage of these tests would be on the high side, as in the United States, which illustrated a scenario with

---

[14] The Government has published the Consultation Document on Regulation of Private Healthcare Facilities on 15 December 2014, in which price transparency is put forward as one of the proposed regulatory aspects, for a three-month public consultation.

[15] In particular, the Consultant considered that guaranteed acceptance with premium loading cap would not carry significant impact on the standard premium as the price impact primarily translated into premium loading. As regards guaranteed renewal, the Consultant considered it acceptable not to include this requirement in the scope of quantification since the price impact would occur only gradually and incrementally in the long term and offset through improved market dynamics.

ineffective control over abuse in usage. The Administration further advised that the increase in the estimated average annual standard premium under VHIS could be partly offset if tax incentives were to be introduced.

28. Some members expressed concern that the Minimum Requirements could not help containing medical inflation arising from, among others, advances in medical technology and medications. They considered that the proposed regulatory measure to enhance price transparency of private hospitals could not contain increase in hospital charges. With higher medical cost as a result, the reimbursement levels would get less unless there was corresponding upward adjustment in the level of premium.

29. The Administration advised that while there was no official medical inflation index available in Hong Kong, the Consultant assumed that the excess medical inflation (i.e. the excess of medical inflation over general inflation) would be lower during the projection horizon of 2016 to 2040 with the implementation of VHIS. This was due to greater budget and cost certainty for consumers and insurers through the "no-gap/known-gap" and "informed financial consent" arrangements on the one hand, and on the other hand more efficient use of private healthcare resources through facilitating delivery of healthcare in ambulatory setting. The Consultant had adopted the working assumptions that the excess medical inflation per annum was 3.6% under the baseline scenario (i.e. without VHIS), and ranged from 2.1% to 4.1% under the forecast scenario (i.e. with VHIS) for projecting the long-term impact of VHIS.

30. Some members, including Mr CHAN Kin-por, cast doubt about the accuracy of the estimated premium growth rate of individual indemnity hospital insurance products (ward level) under the VHIS regime from 2016 to 2040. According to the Consultant, the projected premium growth rate concerned was 3.5% per annum (in excess of the general inflation rate). The Administration advised that according to the Census and Statistics Department, the general inflation rate had hovered at around 2% to 4% in recent years. The latest estimate by HKFI in September 2015 was that the growth rate of average premium of health insurance had been around 5% per annum in recent years. Against the above backdrop, the Administration considered that the estimation of the Consultant was broadly consistent with the current market situation.

31. Mr CHAN Kin-por held the view that the average annual standard premium would not be affordable to many members of the public. Assuming that the premium would grow at a rate of 6% per annum, the average standard premium for those aged 45 to 49, who would most likely purchase health insurance, would be around $6,356 (or as high as about $9,216 as Consultant's estimation was subject to a potential range of variation between -8% and +45%) if VHIS was to be implemented in 2017. The average annual standard premium for people aged 15 to 19 would be in the range of $2,000 to $2,900.

32. Concern was also raised about the high expense loading (i.e. the amount of insurer expenses as a percentage of the amount of premium) of individual health insurance market, which stood at 36% in 2013 and was the highest among the jurisdictions studied by the Consultant[16]. The Administration advised that it was expected that under VHIS, standardization, quality assurance and better flow of market information would facilitate easy comparison by consumers, foster market competition, and hence lead to a more moderate expense loading. Mr CHAN Kin-por remarked that according to the statistics of HKFI, the up-to-date ratio of expense loading was 31% for individual health insurance market, and around 25% if group indemnity hospital insurance polices were included.

Premium of high-risk individuals

33. 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.

34. 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 VHIS 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 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 Standard Plan.

35. Members sought clarification 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

---

[16] The corresponding figure for the group health insurance market in Hong Kong was 19% in 2013. According to the Consultant, the average expense loading of the whole health insurance market was 13% in Australia (2012), 13% in Ireland (2012), 7% in the Netherlands (2012) and 9% in Switzerland (2012).

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.

Migration arrangements

36. There was a view that the window period for policyholders of existing individual hospital insurance policies to migrate to compliant policies under VHIS, which was proposed to be one year, should be longer; and both compliant and non-compliant products should be made available for prospective customers to choose during the migration window period. The Administration took note of the suggestions.

Employees covered by existing group hospital insurance policies

37. Pointing out that most of the existing employer-provided indemnity hospital insurance policies were of limited protection in terms of benefit coverage and limits, Dr LEUNG Ka-lau requested the Administration to estimate the impact on premiums if employer-provided group indemnity hospital insurance policies would be subject to Minimum Requirements. Concern was also raised that existing group indemnity hospital insurance in the market was not limited to policies held by employers for the benefit of employees. Mr CHAN Kin-por, however, held another view. He considered that the introduction of the Minimum Requirements would discourage employers, in particular the small to medium sized enterprises, from providing group indemnity hospital insurance for their employees. Concern was raised as to whether employees could enjoy continuity of health insurance after retirement and whether those covered by group indemnity hospital insurance products taken up by their employers would be given the choice to take up products with lower premium but fewer benefits, such as those with case-based exclusions of pre-existing conditions.

38. The Administration advised that insurers would be required to offer employers a Conversion Option in the group indemnity hospital insurance products so that employees covered by the group policy could, upon leaving their employment, chose to switch to an individual Standard Plan at standard premium without re-underwriting, provided that the employees concerned had been employed for a full year before transferring to the individual Standard Plan. It was also proposed that insurers might, on a group policy basis, offer Voluntary Supplement to individual members covered by a group policy who wished to procure at their own costs additional protection on top of their group policy at a level tantamount to that of the Standard Plan. Subject to the outcome of the consultation, the Administration would consider changing the proposed Voluntary Supplement into a mandatory nature (in parallel with the required provision of Conversion Option).

Public funding for VHIS

Financing of HRP

39. Some members expressed strong reservations about the use of public funds to subsidize the uptake of PHI. Some members considered it not cost effective to use public funds to subsidize the middle-income group for taking out VHIS plans as the insured might continue to utilize the public system, in particular for the more expensive healthcare services. Hence, whether VHIS could achieve, among others, its objective of relieving pressure on the public healthcare system and hence, benefiting the lower-income group was in doubt. There was also a view that given the high administrative fees charged by the private insurers, any such subsidies might benefit the insurers more than the insured themselves. Some members considered that it would be more cost effective to use the $50 billion fiscal reserve earmarked to support healthcare reform to improve public healthcare services, particularly in promoting primary care and prevention and early identification of disease in order to reduce the need of the population for the more expensive hospital services. Another suggestion was that in face of an ageing population, the $50 billion fiscal reserve should be used to provide direct subsidy to elderly persons aged 65 or above in using private healthcare services, as they might not be able to afford continuous health insurance protection after retirement when they needed it most.

40. According to the Administration, Hong Kong was unique in that both the public and private hospital systems were well developed to provide a comprehensive range of quality services. However, there was a significant public-private imbalance that the highly subsidized public system provided around 88% of inpatient services (in terms of number of bed days), resulting in longer waiting lists and waiting time for services. To provide better choice of individualized healthcare for the public under the dual-track healthcare system, an objective of VHIS was to enable more middle-income persons who could afford and were willing to purchase PHI to use the readily available private services on a sustained basis. In so doing, the public system could focus on serving its target areas and population groups, including, among others, illnesses that entailed high cost and advanced technology, and the low-income and under-privileged population groups. The Administration explained that VHIS was not intended to be a total solution to the challenges faced by the healthcare system, but a supplementary financing arrangement complementing public healthcare, and one of the control knobs in reducing the long waiting time for public healthcare services (in particular that for the elective surgeries which had reached a bottleneck).

41. The Administration stressed the need to use public funds to support HRP, which was the key enabler of guaranteed acceptance with premium loading cap and without which insurers might have to assimilate the excessive risks among their policyholders by charging higher premium across the board causing those high-risk individuals who could not afford to pay the premium to fall back on the public system. Given that only about $4.3 billion from the $50 billion fiscal reserve earmarked to support healthcare reform would be required to support HRP for a period of 25 years (i.e. 2016 to 2040), part of the remaining sum of the $50 billion would be used for setting up an endowment fund for the Hospital Authority to make use of the investment returns for public-private partnership initiatives. Any remaining sum of the $50 billion would be reserved for general use, including provision of support for public hospital projects.

Tax deduction vs other forms of financial incentives

42. Some members, including Mr CHAN Kin-por, Miss Alice MAK and Mr POON Siu-pan, were concerned that the proposal of introducing tax reduction for premium paid for individual hospital insurance policies owned by taxpayers covering themselves and/or their dependants that complied with the Minimum Requirements in encouraging the taking out of hospital insurance might not provide a strong incentive for the young and healthy to take out VHIS, as the average tax benefit per eligible taxpayer was estimated to be only about $450[17]. This called into question the sustainability of VHIS as only individuals of higher risk would join. There was a view that an annual ceiling on claimable premiums, which was proposed to be $3,600 per person insured, should not be imposed. Mr CHAN Kin-por considered that the proposal would not be as attractive as the previously proposed options of premium discount and premium rebate for long stay under the savings options put forward in the Second Stage Public Consultation as an incentive for new joiners to the Standard Plan and the insured to stay on.

43. The Administration clarified that the exact amount eligible for tax deduction would be determined by the Government upon implementation of VHIS. However, it was likely that a cap would be imposed given that VHIS was aimed at enabling policyholders to access general ward class of private healthcare services. According to the Administration, the provision of direct premium subsidy or discount might provide an incentive for some insurers to

---

[17] Assuming that the annual level of claimable premiums was capped at $3,600 per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone was estimated to be $256 million (in 2012 constant prices) in 2016 (assuming that both VHIS and tax deduction would be implemented in 2016).

mark up the premiums of the VHIS plans, thus effectively pocketing a significant portion of the premium subsidy or discount. Some form of premium control would therefore be necessary. There were considerable reservations within the community over the inclusion of compulsory savings component as an essential part of VHIS, as it would result in a higher premium at the younger age and discourage people from enrolling in VHIS plans. It was considered more appropriate for the savings component to be an optional feature under VHIS.

44. The Administration advised that tax deduction was not the only measure that could promote the uptake of individual indemnity hospital insurance. Under VHIS, 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 life-long protection without having to undergo re-underwriting even if they suffered from catastrophic illnesses after purchasing their VHIS plans. According to the market survey conducted by the Consultant to gauge the willingness of middle-income individuals to purchase or migrate to the Standard Plan focusing on the main scenario of $3,600, about 70% of the respondents, with or without cover of indemnity hospital insurance, indicated that they were willing to consider to do so.

45. Some members expressed concern about the high annual premium level under VHIS of which subscribers might become unable to continue to afford when they aged or retired. Mr CHAN Kin-por estimated that the average annual premium for a high-risk individual in the age group of 60 to 64 could be in the range of $27,696 to $40,158 if VHIS was implemented in 2017. Taking into consideration that some policyholders might, for various reasons, become unable to afford the premium after continuing staying insured under VHIS for years, Prof Joseph LEE, Mr YIU Si-wing and Dr KWOK Ka-ki suggested that Government subsidy should be provided to enable the insured to enjoy an extended period of protection, say, three years for a thirty-year subscription, after expiry of the payment term. The Administration advised that the proposal was complex and might entail high administration cost, and warranted careful consideration. The market could, in any way, decide whether to provide an option for the insured to pay higher premium at a younger age to offset the premium at older age from the business perspective.

Institutional framework for the governance and operation of VHIS

46. There was a view that the proposed regulatory agency for VHIS should serve its function of ensuring a smooth implementation and operation of VHIS and not end up becoming a "white elephant". Given that the existing Insurance

Claims Complaints Bureau which provided adjudication services for free had all along been effective in dealing with claims disputes arising from individual insurance policies, the proposed claims dispute resolution mechanism for VHIS would be suitable for resolving disputes involving a larger amount of money.

47. According to the Administration, the setting up of the proposed regulatory agency was to ensure that individual indemnity hospital insurance plans being offered in the market would comply with the prescribed Minimum Requirements, and handle complaints about insurance claims arising from the VHIS plans. Claims disputes between insurers and healthcare service providers under direct billing arrangement would not be covered under the proposed claims dispute resolution mechanism during the initial phase of implementation of VHIS.

Supporting infrastructure

48. Some members held the view that the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development should take into account the potential decrease in demand for public healthcare services after the implementation of VHIS, the impact of enhanced inpatient beds in private hospitals, the distribution of medical manpower in public and private healthcare sectors and the imbalance of public-private healthcare services in formulating the recommendations on how to ensure an adequate supply of healthcare professionals for meeting the projected demand for healthcare services on a sustainable basis.

49. The Administration advised that at present, public and private healthcare sectors each accounted for about 50% of the medical manpower. While over 90% of the inpatient services (in terms of number of bed days) were provided by public hospitals (viz. a total of 25 000 beds), the majority of outpatient consultations were provided by medical practitioners practising in the private sector. It was expected that the introduction of VHIS, which aimed to provide a value-for-money alternative to those who were willing and could afford to use private healthcare services, could indirectly provide relief to the public healthcare system. It should also be noted that the number of private hospital beds would be increased from around 4 000 to more than 6 000 in the next five to six years upon completion of various hospital expansion and development projects.

50. Given the lead time required for completing the review on healthcare manpower planning and that medical manpower could not be trained and made available overnight, members were concerned about the short to medium-term measures to ensure an adequate supply of healthcare manpower to meet the service demand. The Administration advised that the number of first-year first-degree places in medicine had been increased by 100 to 420 for the triennial cycle starting from 2012-2013 to address the current shortfall of doctors. There

would also be an increase in the number of intake of university places for doctors starting from the 2016-2017 academic year. Apart from addition of new medical graduates to the total doctor pool, there would also be a constant inflow of qualified, overseas-trained doctors each year. To facilitate overseas-trained doctors to practise in Hong Kong, the Medical Council of Hong Kong had increased the number of the Licensing Examination to twice a year and introduced more flexibility into the internship arrangement.

The way forward for VHIS

51. Members noted that the Administration's original plan as set out in the 2014 Consultation Document was to introduce the bill and its subsidiary legislation required for VHIS into the Legislative Council in the 2015-2016 legislative session. Concern was raised about the Administration's latest timetable for taking forward the proposed VHIS.

52. At the meeting on 14 December 2015, the Administration advised that it was in discussion with the insurance sector through HKFI on refining the details of the VHIS proposals. Other than the two Minimum Requirements of guaranteed acceptance and portable insurance policy on which the insurance industry had grave concerns, it was expected that the Administration could reach consensus with the insurance industry on the other 10 Minimum Requirements in January or February 2016. In the meantime, the Administration was studying whether it was feasible to implement these 10 Minimum Requirements first in the form of industry agreement, particularly as to whether the arrangement would be in compliance with the Competition Ordinance which came into full effect on 14 December 2015. If it was found not feasible, another option was to proceed to implement VHIS through enacting a new new piece of legislation. Mr CHAN Kin-por held the view that implementing VHIS through industry agreement but not a regulatory regime could save time and immediately bring about enhanced quality and certainty of hospital insurance protection for the benefit of consumers, and could reduce the regulatory cost and the compliance burden on insurers.

53. Some members including Dr KWOK Ka-ki was of the view that the Administration should establish the proposed regulatory agency to monitor the implementation of the Minimum Requirements, irrespective of whether the Minimum Requirements concerned would be implemented through legislation or not. Mr CHAN Kin-por, however, held another view. He pointed out that the establishment of the independent Insurance Authority, a new insurance regulator independent of the Government, to exercise statutory regulation over the insurers and the insurance intermediaries would not only promote the stable development of the industry, but also provide better protection for existing and

potential policy holders. The insurance industry preferred to put the regulation over the Minimum Requirements under the purview of the independent Insurance Authority to obviate the need of subjecting the industry under two regulatory authorities.

54. The Administration advised that if the proposed Minimum Requirements were to be implemented first in the form of industry agreement, it would put in place a mechanism to closely monitor the compliance of the insurers with the requirements and handle the disputes that might arise. In the event that a separate regulatory agency was to be established for VHIS through legislation, it would be far less complicated than the original proposal if its functions did not cover the monitoring of the operation of a high risk pool.

Relevant papers

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

Council Business Division 2
Legislative Council Secretariat
15 April 2016

Appendix

Relevant papers on the Voluntary Health Insurance Scheme (formerly known as Health Protection Scheme)

Committee	Date of meeting	Paper
Subcommittee on Health Protection Scheme	14.1.2013	Agenda Minutes CB(2)698/12-13(01) CB(2)698/12-13(02)
	4.3.2013	Agenda Minutes CB(2)1634/12-13(01)
	4.6.2013	Agenda Minutes CB(2)1507/12-13(01)
	8.7.2013	Agenda Minutes CB(2)151/13-14(01)
	11.11.2013	Agenda Minutes
	9.12.2013	Agenda Minutes CB(2)855/13-14(01)
	18.2.2014	Agenda Minutes CB(2)1264/13-14(01)
	15.4.2014	Agenda Minutes CB(2)2260/13-14(01)
	12.9.2014	Agenda Minutes CB(2)388/14-15(01)

Committee	Date of meeting	Paper
	6.2.2015	Agenda Minutes CB(2)978/14-15(01)
	11.3.2015	Agenda Minutes CB(2)1357/14-15(01)
	4.5.2015	Agenda Minutes CB(2)36/15-16(01)
	14.12.2015	Agenda
Panel on Health Services	13.1.2015	Agenda Minutes CB(2)902/14-15(01)

Council Business Division 2
Legislative Council Secretariat
15 April 2016