# *立法會*
# *Legislative Council*

LC Paper No. CB(2)1657/12-13
(These minutes have been seen by the Administration)

Ref : CB2/PS/2/12

**Panel on Health Services**

**Subcommittee on Health Protection Scheme**

**Minutes of the fourth meeting**
**held on Tuesday, 4 June 2013, at 2:30 pm**
**in Conference Room 2A of the Legislative Council Complex**

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| **Members present** | : | Dr Hon LEUNG Ka-lau (Chairman)<br>Dr Hon Joseph LEE Kok-long, SBS, JP<br>Hon CHAN Kin-por, BBS, JP<br>Hon CHEUNG Kwok-che<br>Hon Mrs Regina IP LAU Suk-yee, GBS, JP<br>Hon CHAN Han-pan<br>Hon Alice MAK Mei-kuen, JP |
| **Member attending** | : | Dr Hon Priscilla LEUNG Mei-fun, JP |
| **Member absent** | : | Dr Hon KWOK Ka-ki |
| **Public Officers attending** | : | Mr Richard YUEN Ming-fai, JP<br>Permanent Secretary for Food and Health (Health)<br>Food and Health Bureau<br><br>Mr Chris SUN Yuk-han, JP<br>Head, Healthcare Planning and Development Office<br>Food and Health Bureau |

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| **Clerk in attendance** | : | Ms Elyssa WONG<br>Chief Council Secretary (2)5 |
| **Staff in attendance** | : | Ms Maisie LAM<br>Senior Council Secretary (2)5<br><br>Ms Michelle LEE<br>Legislative Assistant (2)5 |

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**I. Confirmation of minutes**
(LC Paper No. CB(2)1272/12-13)

The minutes of the meeting held on 4 March 2013 were confirmed.

**II. Design of private health insurance policies regulated under the Health Protection Scheme**
(LC Paper Nos. CB(2)1237/12-13(01) and CB(2)1267/12-13(01))

2. The Subcommittee deliberated (index of proceedings attached at **Annex**).

Minimum requirements approach

3. Dr Joseph LEE cautioned that the proposal of imposing a set of minimum requirements on hospital indemnity products sold in Hong Kong would interfere with the free market, and limit the diversity of private health insurance ("PHI") in the market and consumers' choices. Mr CHAN Kin-por relayed views of the Hong Kong Federation of Insurers ("HKFI") that the minimum requirements approach would reduce choices for consumers. The steady double-digit annual growth rate in PHI premium in recent years had demonstrated public confidence in the market. While the Administration could request all insurers offering indemnity hospital insurance products to make HPS Standard Plan available as one of the options to consumers, it should not standardize the basic terms and coverage of all hospital indemnity products in the market. Mr CHAN Han-pan was concerned about how this proposal could help achieve the objective of the Health Protection Scheme ("HPS") to provide relief to the public healthcare system. Miss Alice MAK remarked that while the proposal would strengthen the regulation over PHI, she could not see how it could encourage the uninsured to purchase PHI and use private healthcare services on a sustained basis, thereby enhancing the healthcare financing role of PHI.

4. The Administration advised that at present, there were around 2.79 million people covered by PHI. However, over one third of hospital admissions by

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people with PHI coverage 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. It was also worthy to note that among the 278 cases closed by the Insurance Claims Complaints Bureau in 2012, hospitalization or medical insurance policies constituted the largest category of claim disputes (i.e. 132 cases). The outcomes of the Second Stage Public Consultation on Healthcare Reform ("the Second Stage Consultation") also revealed a general consensus that it was necessary to strengthen regulation over PHI and address the existing shortcomings in market practices. In the light of the above, the minimum requirements approach would provide simplicity, clarity and certainty to consumers and help consumers 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. With the enhancement of the quality and certainty of insurance protection to consumers, more of the working population, about four million, who were able and willing to pay for private services would be encouraged to purchase and make fuller use of PHI products. It was expected that some healthcare needs for common diseases (such as surgeries for treating gallstones and cataract) that were currently met by the public healthcare system could be diverted to the private sector, thus providing relief to the public system in the long run. Mr CHEUNG Kwok-che and Dr Priscilla LEUNG urged the Administration to step up consumer education on the benefit coverage of PHI.

5. As regards the suggestion to 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, the Administration explained that 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. The Administration assured members that the minimum requirements would be set in consultation with the members of the public as well as the insurance industry, and with reference to the level of protection and common features of products now generally available in the market so as to avoid creating excessive risk on the insurers.

Prescribed minimum requirements

6. Dr Priscilla LEUNG asked whether consideration could be given to covering Chinese medicine under HPS. The Administration advised that HPS would cover inpatient services and ambulatory procedures only. Since a more

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extensive basic benefit coverage would lead to a higher premium, services that were largely elective or relatively affordable, such as Chinese medicine outpatient services, were not proposed to be included under HPS.

7. The Chairman was of the view that a reasonable lifetime limit should be imposed on HPS Standard Plan in order to encourage judicious use of healthcare services and to contain moral hazards. In addition, there should be no restrictions on the amount of co-payment paid by the insured. The Administration advised that while insurers were allowed to impose annual benefit limits on health insurance policies under HPS, they would not be allowed to impose a lifetime benefit limit because this would render the feature of guaranteed renewal meaningless. The proposal to place an annual cap on co-payment was designed to limit the shared costs paid by consumers per year and was conducive to consumer protection. The Chairman requested the Administration to provide supplementary written information on the rationale for proposing, as part of the minimum requirements prescribed by the HPS Standard Plan, "no lifetime limits" and "annual cap on deductible and co-payment paid by insured persons".

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Migration to HPS plans

8. Dr Priscilla LEUNG urged the Administration to put in place measures to facilitate seamless migration of existing health insurance policies to HPS plans. Consideration should also 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 for individual employees to convert to individual HPS plans upon retirement.

9. The Chairman was concerned about the impact to be brought about by the introduction of the minimum requirements for all indemnity hospital insurance products on existing subscribers of group health insurance policies. The Administration advised that it was in the process of engaging the insurance industry and employers' associations to discuss the proposed arrangements for group health insurance policies under HPS. As regards the HPS Standard Plan for individual policies, statistics of HKFI revealed that the average premium per insured member was about $2,900 for indemnity (hospital and non-hospital) and hospital cash policies in 2011. According to the preliminary calculations by the Consultant, the average premium per insured member would be around $3,600 for hospital indemnity policies, based on the assumption that the base average premium per insured member was about $3,300 for hospital indemnity policies. The introduction of the minimum requirements on all hospital indemnity

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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. The Chairman considered it necessary to assess the impact of the minimum requirements approach on those existing subscribers at the lower end of the range of premium. Mr CHAN Kin-por opined that instead of working out the expected HPS premium on the basis of the Consultant's views alone, the Administration should look into the feasibility in greater detail in consultation with the insurance industry. The Administration affirmed that it would do so, adding that the membership of the Working Group on Health Protection Scheme comprised representatives from the insurance industry.

Admin

10. The Administration was requested to provide in writing a detailed assessment of the impact to be brought about by the introduction of the minimum requirements for all indemnity hospital insurance products on existing individual and group subscribers of PHI plans, including a breakdown of the number of existing policy holders by types of plans and premium levels.

Acceptance of high-risk groups

11. Some members including Dr Joseph LEE and Mr CHAN Han-pan were concerned about the classification of high-risk groups. They were concerned that the insurers might transfer more than appropriate number of policies to the high-risk pool ("HRP"). The Administration explained that as long as the insurers were permitted to charge premium loading on higher-risk applicants commensurate with the associated risks that they took on, they would still expect to make underwriting profits by keeping the high-risk subscribers under their own portfolio. The HRP arrangement was to address the existing market practice of limited access to health insurance by high-risk individuals on the one hand, and maintain the commercial viability of HPS plans on the other hand. Only those applicants whose premium loading was assessed to equal or exceed 200% of standard premium would be admissible to HRP. By transferring the policies of these applicants to HRP, the premium income, claims liabilities and profit or loss of these policies would be accrued to HRP instead of the insurance company concerned. The proposed HRP would be financed by the premium income of these policies and operated by the Government. Subject to the findings from the Consultant, using part of the $50 billion fiscal reserve earmarked to support healthcare reform to support HRP would be considered as necessary. A preliminary estimation was that the amount of injection should not exceed $10 billion. Mr CHAN Kin-por was concerned about whether transferral of the policy of the insured into HRP would be strictly confined to the time a person first started to subscribe to health insurance plans under HPS. He urged the Administration to discuss with the insurance industry whether insurers could

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transfer the policies of those subscribers originally classified under the standard risk group to HRP on contract renewal.

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12. The Chairman requested the Administration to provide after the meeting illustrative actuarial premium calculation models (net of administrative fees charged by the insurers) to demonstrate how the premiums of the HPS Standard Plan would be adjusted according to different health risks of the subscribers based on risk factors such as age, health status, and pre-existing medical conditions. The Administration agreed.

DRG-based packaged charging

13. Dr Joseph LEE noted with concern the Consultant's proposal to introduce the "informed financial consent" and "no-gap/known-gap" arrangements, instead of packaged charging for common procedures according to diagnosis-related groups ("DRG") as proposed in the Second Stage Consultation, on the grounds that there would be significant challenges for Hong Kong to implement a DRG system in the short term. Holding the view that there would be a lack of mechanism to govern the healthcare costs if DRG-based packaged charging was not to be implemented, Mr CHAN Han-pan expressed reservations on using the earmarked $50 billion fiscal reserve to subsidize the uptake of PHI and indirectly drive up the demand for private hospital services. Pointing out that about 80% of the premium paid for group PHI was used to cover the charges of the healthcare providers, Mr CHAN Kin-por considered that the government should play a role in requiring the private healthcare providers to enhance certainty and transparency of their service charges, say, through applying DRG to charges for most private hospital admissions or ambulatory procedures. Noting that there were at present excess demand for private hospital services, he was concerned about whether private healthcare providers would be interested in working with the insurers to enable the application of the "no-gap/known gap" arrangement to certain prescribed procedures covered in the insurance policies regulated under HPS. Pointing out the need to enhance price transparency of private hospitals, Mr CHEUNG Kwok-che queried whether the level of packaged charges would be set by the Administration.

14. The Administration advised that it was not appropriate for it to regulate the level of charges of private hospitals since Hong Kong was a free market. One of the technical difficulties in implementing DRG-based charging system in private hospitals was that the majority of their admissions were handled by visiting doctors. Nevertheless, the Administration would continue to discuss with the existing private hospitals on the introduction of packaged charging for common treatments or procedures. The Steering Committee on Review of the Regulation of Private Healthcare Facilities would also explore, among others,

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measures to enhance price transparency of private hospitals. It should also be noted that the tender exercise for the Wong Chuk Hang site reserved for private hospital development reflected the market's readiness in offering packaged charging, as the relevant proposal of the successful tenderer was that at least 51% (rather than at least 30% as specified in the tender requirements) of inpatient bed days each year would be used for provision of services at packaged charge through standard beds. The Administration stressed 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 two arrangements proposed by the Consultant as explained in paragraphs 15 to 17 in the Administration's paper.

15. The Chairman pointed out that existing private hospitals had offered certain services, such as gastroscopy, at packaged pricing. He drew members' attention that as affirmed by the Administration on previous occasions, DRG-based packaged charging was a claims reference rather than a price reference under the HPS proposal. Mr CHAN Kin-por was of the view that the DRG-based packaged charging should be a lump-sum packaged fee set for a certain medical condition requiring hospital admission or certain ambulatory procedure, providing for varying degree of complexity of the condition or procedure as well as complications arising from the procedure. It should serve as a price reference so that patients requiring specific treatments or procedures would know in advance the medical charges involved regardless of which doctor and private hospital they chose. At the request of the Chairman, the Administration undertook to provide in writing a list of service items commonly covered by packaged charging offered by private healthcare providers for specific treatments or procedures, as well as illustrative packages to demonstrate service items covered by the existing packages for some common procedures (such as gastroscopy related to hospital admission or ambulatory procedure and appendicectomy).

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16. Mr CHAN Han-pan remained concerned that not many existing private hospitals would introduce packaged charging. The Administration advised that the requirement for a new private hospital to offer at least 30% of inpatient bed days each year for services provided through standard beds at packaged charging would encourage more private hospitals to offer packaged charging for common procedures through market forces. It was also expected that private healthcare providers would have the incentive to offer packaged pricing for common procedures under the proposed "no-gap/known gap" arrangement.

17. Citing the retail prices of petroleum products as an example, Mr CHEUNG Kwok-che cautioned that private hospitals might form a price cartel to maintain the packaged charges for common procedures at a high level.

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The Chairman considered that the issue warranted attention, and private hospital services should be subject to the regulatory regime of the Competition Ordinance (Cap. 619). The Administration advised that the level of charges of private hospital services would be determined by interaction of market supply and demand. On the supply side, it was expected that more than 1 500 additional hospital beds would be available in the private healthcare sector in the coming years. By increasing supply in the market, inpatient service charges of private hospitals would come under greater competition pressure.

Admin The Chairman requested the Administration to provide after the meeting information on measures in place or under consideration of the Administration to ensure healthy competition in private hospital services, and clarify whether private hospitals would also be subject to the regulation of the Competition Ordinance.

Subscription

18. Some members including Dr Joseph LEE, Dr Priscilla LEUNG and Miss Alice MAK were concerned about how the proposal could appeal to healthy individuals to purchase PHI at younger age in order to make HPS financially viable. 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.

19. Miss Alice MAK was of the view that the Administration should offer incentives to attract more of those who could afford to take out health insurance and accordingly make use of private healthcare services as an alternative to public services. Mr CHAN Kin-por considered that the current HPS proposal, which would not make use of the $50 billion earmarked fiscal reserve to provide financial incentives in the form of premium discount for new joiners and premium rebate after age 65 as proposed in the Second Stage Consultation, was unattractive to the young and healthy population. Dr Joseph LEE asked whether tax concession would be offered to HPS subscribers. The Administration explained that some form of premium control would be necessary if public money was used to provide premium discount for HPS plans. On the issue of offering tax concession to HPS subscribers, the Administration advised that tax incentive was one of the possible options under consideration to encourage take-out of HPS plans. In determining whether this option should be taken forward, due regard would be given to, among others, whether the PHI market could be

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effectively regulated to safeguard the interests of the insured in using health insurance products.

Government's commitment to public healthcare

20. On Dr Priscilla LEUNG's concern about whether the taking forward of HPS would diminish the Government's commitment to public healthcare, the Administration advised that apart from serving as the safety net for the low-income families and underprivileged groups, the public system would continue to be an alternative available to all, particularly for treatment of catastrophic and complex illnesses that required advanced technology and multi-disciplinary professional team work which might not be readily available or might entail very high cost in the private sector. Using part of the $50 billion fiscal reserve earmarked to support healthcare reform to improve the overall healthcare system would also be considered as necessary.

## III. Institutional framework for the governance and operation of the Health Protection Scheme

(LC Paper No. CB(2)1237/12-13(02))

21. Owing to the time constraint, the Chairman suggested and members agreed to defer the discussion of this item to the next meeting.

## IV. Dates of future meetings and items for discussion

22. The Chairman suggested and members agreed to hold further discussion with the Administration on the "Design of PHI policies regulated under HPS", and to discuss the "Institutional framework for the governance and operation of HPS" and "Funding for HPS" at the next meeting. Subject to the progress of discussion, the Subcommittee would consider whether to invite public views on the above subjects at the next meeting. Noting that the Administration needed more time to prepare for the subject on "Funding for HPS", members agreed to re-schedule the next meeting from 24 June 2013 to 8 July 2013 at 2:30 pm.

(*Post-meeting note:* With the concurrence of the Chairman, the next meeting has been advanced to start at 2:00 pm to allow sufficient time for discussion.)

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23. To facilitate discussion on the design of PHI policies regulated under HPS at the next meeting, the Administration was requested to provide a response to the issues raised by members at the meeting, and the relevant working papers of

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the Working Group on Health Protection Scheme and/or the Consultative Group on Health Protection Scheme on matters concerning the design of private health insurance policies regulated under HPS.

24. There being no other business, the meeting ended at 4:30 pm.

Council Business Division 2
Legislative Council Secretariat
29 July 2013

**Annex**

# Proceedings of the fourth meeting of the Subcommittee on Health Protection Scheme on Tuesday, 4 June 2013, at 2:30 pm in Conference Room 2A of the Legislative Council Complex

| Time marker | Speaker | Subject | Action Required |
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| *Agenda item I: Confirmation of minutes* | | | |
| 000315 - 000343 | Chairman | Confirmation of minutes of the meeting held on 4 March 2013 | |
| *Agenda item II: Design of private health insurance policies regulated under the Health Protection Scheme* | | | |
| 000344 - 000530 | Chairman<br>Admin | Opening remarks | |
| 000531 - 001423 | Chairman<br>Admin | Briefing by the Administration on the preliminary design proposed for private health insurance policies regulated under the Health Protection Scheme ("HPS")<br>[LC Paper No. CB(2)1237/12-13(01)] | |
| 001424 - 001501 | Chairman | Arrangement for members' speaking time | |
| 001503 - 002742 | Chairman<br>Dr Joseph LEE<br>Admin | Dr Joseph LEE's concern about the impact on consumers' choices to be brought about by the proposed minimum requirements approach; future availability of packaged private healthcare services and charging based on diagnosis-related groups ("DRG"); admissibility to the high-risk pool ("HRP"); and measures to attract the young and healthy individuals to join HPS so as to make it sustainable, including whether consideration could be given to offering tax deduction for those who subscribed to health insurance plans under HPS.<br><br>The Administration's elaboration on how the proposed minimum requirements approach, as well as the "informed financial consent" and "no-gap/known-gap" arrangements, could enhance the quality and certainty of insurance protection to consumers; the operation of HRP; and reasons why the young and healthy population should subscribe to HPS early. | |
| 002743 - 004035 | Chairman<br>Mr CHAN Han-pan<br>Admin | In response to Mr CHAN Han-pan's enquiry about the arrangement under HPS if there were short-term breaks in subscription, the Administration's advice that while all indemnity hospital insurance plans regulated under HPS would offer guaranteed acceptance, the individuals concerned would have to go through a re-underwriting process. | |

| Time marker | Speaker | Subject | Action Required |
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| | | Mr CHAN Han-pan's concern about the availability of DRG-based service provision and charging among the existing private hospitals; the sustainability and viability of HPS if it could not attract a critical mass of young and healthy participants; and how the objective of providing relief to the public healthcare system could be met by the current HPS proposal.<br><br>The Administration's advice on the difficulty in implementing a DRG-based charging system; how the Administration's relevant policy on new private hospital developments could encourage the existing private hospitals to offer packaged charging; and its elaboration on the modus operandi of HRP, as well as how HPS could help the public healthcare system to better focus on its target service areas. | |
| 004036 - 004845 | Chairman<br>Dr Priscilla LEUNG<br>Admin | On Dr Priscilla LEUNG's concern on whether the Administration would reduce its commitment to public healthcare upon the implementation of HPS, the Administration's advice that the recurrent government expenditure on health had increased to around $49 billion in 2013-2014, and efforts had and would continuously be made to deploy resources for capital works projects on public hospitals. Using part of the $50 billion fiscal reserve earmarked to support healthcare reform to improve the overall healthcare system would also be considered necessary.<br><br>In response to Dr Priscilla LEUNG's enquiry about the arrangement to facilitate the migration of existing health insurance policies to HPS plans and whether HPS could also cover Chinese medicine services, the Administration's advice that it was working with the insurance industry and employers' associations on the arrangements and the minimum requirements would be set in consultation with members of the public as well as the industry. | |
| 004846 - 005648 | Chairman<br>Admin | The Chairman's concern about the impact to be brought about by the introduction of the minimum requirements for all indemnity hospital insurance products on existing subscribers of health insurance policies, in particular those at the lower end of the range of premium; and his clarification that DRG-based packaged charging was a claims reference under HPS.<br><br>The Administration's advice on its assessment of the expected average premium for HPS plans and the scope of the review being conducted by the Steering Committee on Review of the | |

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| | | Regulation of Private Healthcare Facilities, which would cover the price transparency of private hospitals; and its undertaking to provide the following information after the meeting -<br><br>(a) the relevant working papers of the Working Group on Health Protection Scheme and/or the Consultative Group on Health Protection Scheme on matters concerning the design of private health insurance ("PHI") policies regulated under HPS;<br><br>(b) a detailed assessment of the impact to be brought about by the introduction of the minimum requirements for all indemnity hospital insurance products on existing individual and group subscribers of PHI plans, including a breakdown of the number of existing policy holders by types of plans and premium levels; and<br><br>(c) a list of service items commonly covered by packaged charging offered by private healthcare providers for specific treatments or procedures, as well as illustrative packages to demonstrate items that would be covered by the existing packages for some common procedures (such as gastroscopy related to hospital admission or ambulatory procedure and appendicectomy). | **Admin** |
| 005649 - 010257 | Chairman<br>Mr CHAN Kin-por<br>Admin | Mr CHAN Kin-por's view that the design of DRG-based packaged charging should cater for different possibilities of complications for the same diagnosis and serve as a price reference under HPS, and the Administration should not introduce a set of minimum requirements for all hospital indemnity insurance products.<br><br>The Administration's explanation on the reasons why it would not be practicable to 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 the minimum requirements on product design. | |
| 010258 - 011400 | Chairman<br>Mr CHEUNG Kwok-che<br>Admin | Mr CHEUNG Kwok-che's call for enhancing the price transparency of private hospital services and stepping up public education on the benefit coverage of health insurance products; and his concern about the possibility that private hospitals might form a price cartel to maintain the packaged charges for common procedures at a high level.<br><br>The Chairman's concurrence of Mr CHEUNG Kwok-che's concern and his view that private | |

| Time marker | Speaker | Subject | Action Required |
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| | | hospital services should be subject to the regulatory regime of the Competition Ordinance (Cap. 619).<br><br>The Administration's advice that by ensuring competition in the market, charges of private hospital services would remain competitive; and the Chairman's request that the Administration should provide after the meeting information on measures in place or under consideration of the Administration to ensure healthy competition in private hospital services, and clarify whether private hospitals would be subject to the regulation of the Competition Ordinance. | **Admin** |
| 011401 - 012216 | Chairman<br>Miss Alice MAK<br>Admin | Miss Alice MAK's view that incentives should be provided under HPS to attract more of those who could afford it to subscribe to health insurance protection early.<br><br>The Administration's advice that the increase in the certainty of insurance protection under HPS could strengthen public confidence in PHI products, and the offering of tax incentives to encourage the taking-out of health insurance cover would be considered as necessary. The Chairman's remark that the PHI market had expanded fast in the last two decades. | |
| 012217 - 012733 | Chairman<br>Mr CHAN Kin-por<br>Admin | Mr CHAN Kin-por's view that the current proposal had deviated from the original objective of HPS to encourage the offering of DRG-based services and charging for most medical conditions, and the absence of provision of financial incentives would make HPS unattractive to young people.<br><br>The Administration's advice that some form of premium control would be necessary if public money was used to provide premium discount for HPS plans. | |
| 012734 - 013459 | Chairman<br>Dr Priscilla LEUNG<br>Admin | Dr Priscilla LEUNG's view that efforts should be made to encourage the working population, in particular the young people, to subscribe to HPS in order to make it sustainable, and to ensure that the policy terms and conditions in PHI policies regulated under HPS would be in clear and simple terms and complaints lodged by consumers would be properly handled.<br><br>The Administration's elaboration on how the proposed minimum requirements approach would enable consumers to understand easily and clearly the minimum protection they could receive when taking out a hospital indemnity insurance product, the existing avenues for | |

| Time marker | Speaker | Subject | Action Required |
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| | | resolving disputes related to health insurance claims, and its proposal to set up a dedicated agency for HPS to, among others, handle complaints by consumers as set out in LC Paper No. CB(2)1237/12-13(02). | |
| 013500 - 014302 | Chairman<br>Mr CHAN Han-pan<br>Admin | Mr CHAN Han-pan's concern about the admissibility to HRP and the increased risk of the insurance pool of HPS in the face of an ageing population.<br><br>The Administration's advice that 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. | |
| 014303 - 014840 | Chairman<br>Admin | The Chairman's view that a reasonable lifetime limit should be imposed on HPS Standard Plan and there should be no restrictions on the amount of co-payment paid by the insured; and his request that the Administration should provide after the meeting supplementary information on the rationale for proposing, as part of the minimum requirements prescribed by the HPS Standard Plan, "no lifetime limits" and "annual cap on deductible and co-payment paid by insured person". | **Admin** |
| 014841 - 015230 | Chairman<br>Mr CHAN Kin-por<br>Admin | Mr CHAN Kin-por's remark on the need for the Administration to enhance regulation over private hospitals, and consult the insurance industry on the expected premium of HPS plans and whether insurers could transfer the policies of those subscribers originally classified under the standard risk group to HRP on contract renewal. | |
| 015231 - 015641 | Chairman<br>Admin | The Chairman's summing up of the follow-up actions required of the Administration; and the Administration's undertaking to provide in writing illustrative actuarial premium calculation models (net of administrative fees charged by the insurers) to demonstrate how the premiums of the HPS Standard Plan would be adjusted according to different health risks of the subscribers based on risk factors such as age, health status and pre-existing medical conditions. | **Admin** |
| *Agenda item III: Institutional framework for the governance and operation of the Health Protection Scheme* | | | |
| 015642 - 015710 | Chairman | Deferral of discussion on institutional framework for the governance and operation of HPS to the next meeting | |

| Time marker | Speaker | Subject | Action Required |
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| *Agenda item IV: Dates of future meetings and items for discussion* | | | |
| 015711 - 015823 | Chairman | Date of next meeting and items for discussion | |

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Legislative Council Secretariat
29 July 2013