For information on
4 June 2013

Legislative Council Panel on Health Services
Subcommittee on Health Protection Scheme

Design of Private Health Insurance Policies Regulated Under the Health Protection Scheme

PURPOSE

This paper briefs Members on the preliminary design proposed for private health insurance policies regulated under the Health Protection Scheme (HPS).

BACKGROUND

2. As reported to the Subcommittee on Health Protection Scheme in previous meetings, a Working Group and Consultative Group on the HPS have been set up under the Health and Medical Development Advisory Committee to make recommendations on matters concerning the implementation of the HPS. To facilitate the work of the Working Group and Consultative Group, we have commissioned a consultancy study by PricewaterhouseCoopers Advisory Services Limited (the Consultant) to provide professional and technical advice on key issues relating to the HPS, including the formulation of a viable and sustainable product design for the HPS.

3. This paper sets out the preliminary product design for the HPS as proposed by the Consultant. Taking into account comments by Members and other stakeholders, the Consultant will tender later this year a full report containing details for implementing the HPS. The report will be published for public information as part and parcel of the work of the Working Group and Consultative Group on the HPS.

MINIMUM REQUIREMENTS OF HEALTH PROTECTION SCHEME

Second Stage Public Consultation on Healthcare Reform

4. As proposed in the Second Stage Public Consultation on Healthcare Reform, under the HPS, insurers will be required to offer standardised

indemnity[1] insurance plan for hospital admissions and ambulatory procedures, namely the HPS Standard Plan, which incorporates a number of key features designed to offer value-for-money services to those who are willing and may afford to pay for private healthcare services. The key features for the HPS Standard Plan involve a range of requirements on operational rules (including guaranteed acceptance, guaranteed renewal, premium loading cap at 200% of standard premium through a high-risk pool mechanism, barrier-free portability), benefit structure (including minimum benefit coverage of inpatient and ambulatory care, minimum benefit limits, coverage of pre-existing medical conditions subject to waiting period) and other consumer protection measures (including standardised policy terms and conditions, more transparency and benchmarking on premium, a claims arbitration/dispute resolution mechanism). On top of the HPS Standard Plan, insurers are free to offer top-up benefits and add-on components that cater for different consumer needs.

5. After taking into account the objectives of the HPS, the experience of both the local market and overseas jurisdictions, sustainability and viability of the HPS, as well as discussions with various stakeholders, the Consultant has recommended a minimum requirements approach to implement the HPS.

Minimum Requirements Approach

6. In the consultation document of the Second Stage Public Consultation on Healthcare Reform, it was proposed that the key features and requirements stated in paragraph 4 should apply to indemnity hospital insurance products under the aegis of HPS. For reasons elaborated below, the Consultant has recommended that a set of minimum requirements encompassing the key features and requirements prescribed by the HPS should be applied to all indemnity hospital insurance products in the market –

(a) *To address public concern over the existing health insurance market*: as revealed in the outcomes of the Second Stage Public Consultation on Healthcare Reform, there was general consensus among the community for strengthening regulation over private health insurance (PHI) and to address the existing shortcomings in market practices, such as insufficient price transparency, no certainty of payment upfront, restrictive insurance policy terms, limited access to health insurance by high-risk individuals, etc. The community also

[1] Indemnity products indemnify the insured persons against actual medical expenditure incurred, so that the amount claimable should not exceed the expenditure.

considered the proposed features and requirements for HPS an appropriate means to enhance consumer protection as well as market transparency, competition and efficiency. The application of such features and requirements to all indemnity hospital insurance products can address public concerns more fully and enhance consumers' confidence in using their insurance coverage and private healthcare services.

(b) *To fulfill the objectives of the HPS*: as a means to complement the public healthcare system, the aim of the HPS is to provide value-for-money services to those who are able and willing to use private healthcare services. By introducing a set of minimum requirements for all indemnity hospital insurance products, including guaranteed acceptance and guaranteed renewal, minimum coverage and benefit levels, standardised policy terms and conditions, portability, more upfront payment certainty, etc., the quality and certainty of insurance protection would be enhanced. More consumers, including but not limited to those who are currently declined from coverage for one reason or another, would be encouraged to purchase and make fuller use of PHI products, thus indirectly providing relief to the public healthcare system;

(c) *International experience*: the recommendation to introduce a set of minimum requirements for all indemnity hospital insurance products is in line with the findings of the Consultant on overseas experience. Their study reveals that a set of basic requirements for PHI products have been prescribed by the Government in countries with a significant PHI market, including Australia, Ireland, the Netherlands, Switzerland and the United States (please refer to **Annex** for details) for the purpose of consumer protection; and

(d) *Sustainability of the HPS*: according to the Consultant's advice, 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 is not bound by minimum requirements on product design. It is because the minimum requirements are designed for meeting the community's aspirations and the long-term sustainable development of our healthcare system and would have cost implications. The co-existence of a regulated and an unregulated market segments would lead to adverse selection.

Insurers can target the healthy population by offering relatively lower premium for the unregulated products, leaving the HPS a choice mainly for the unhealthy population. Many would take advantage of the "two-market" situation for individual benefits at the expense of the interest of the community. Some of the healthy insured, for example, may opt for the unregulated segment and switch to the HPS segment only when their health condition deteriorates, taking advantage of the guaranteed acceptance feature of HPS plans. The HPS would then have to manage a pool of subscribers who bear disproportionately higher health risks than an average consumer, driving up the premium and eventually becoming unaffordable in the long-run. It would also be unfair to those who have joined the HPS when they are young and healthy and have stayed loyal to the scheme, since they would have to pay a higher average premium vis-à-vis other pools comprising subscribers being relatively healthier on average.

HPS Standard Plan

7. To ensure that consumers would be guaranteed of minimum health insurance coverage, the Consultant has proposed that insurers offering indemnity hospital insurance products must make HPS Standard Plan available as one of the options to consumers. Compared to existing PHI products generally offered in the market, the HPS Standard Plan prescribes a set of minimum requirements that would provide enhanced quality and certainty of insurance protection to consumers –

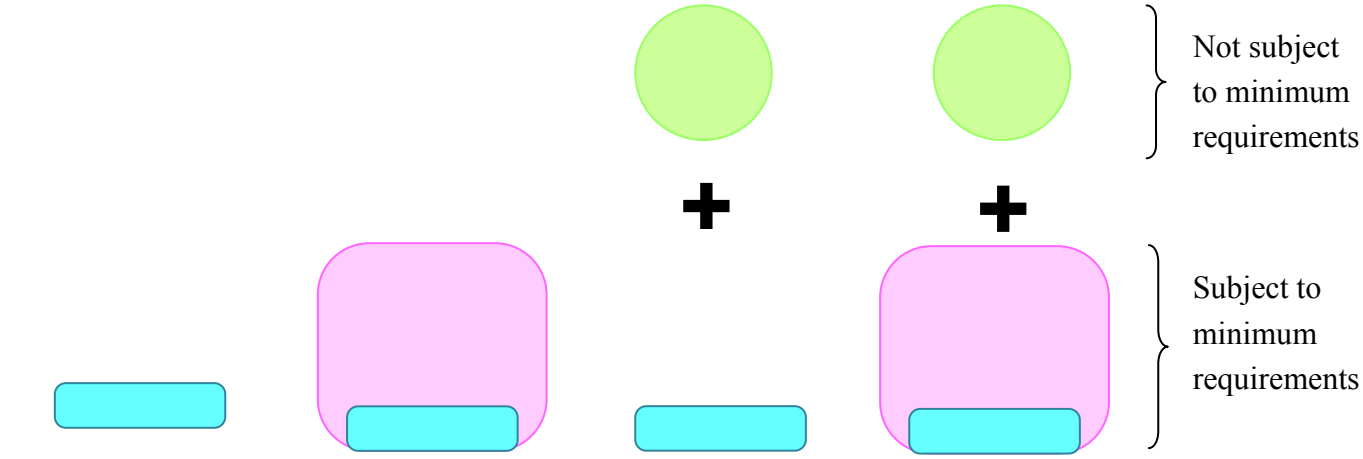
Current PHI products generally offered in the market	**Products meeting minimum requirements prescribed by HPS Standard Plan**
Access and continuity of insurance coverage	
◆ No guaranteed acceptance	◆ Guaranteed acceptance
◆ Exclusion of pre-existing conditions	◆ Coverage of pre-existing conditions subject to waiting period, and premium loading capped at 200%
◆ May not offer guaranteed renewal ◆ Absence of guaranteed renewal	◆ Guaranteed renewal for life ◆ No re-underwriting is allowed for contract renewal

means possibility of re-underwriting at the discretion of insurers, which could lead to refusal to renew or acceptance of renewal with extra exclusion and premium loading	
◆ Require re-underwriting for an applicant who is currently with another insurer	◆ Re-underwriting may be relaxed for portability subject to claims history
◆ May not offer guaranteed insurance coverage on retirement or termination of employment	◆ Portability from group plan to individual plan on retirement and leaving employment
Quality of insurance protection	
◆ No minimum standards on benefit coverage and limits ◆ Lifetime benefit limits imposed by some insurers	◆ Minimum benefit coverage and limits ◆ No lifetime benefit limits
◆ May not cover ambulatory procedures, leading to unnecessary overnight hospital stay	◆ Cover prescribed ambulatory procedures
◆ No restrictions on co-payment	◆ Annual cap on deductible and co-payment paid by insured person
Transparency and certainty	
◆ Uncertainty on payment and charges	◆ Informed financial consent ◆ No-gap/known gap payment (Please refer to section on "Upfront Payment Transparency and Certainty" below)
◆ Uncertainty on policy terms and conditions	◆ Standardised policy terms and conditions
◆ Lack of transparency on insurance premium adjustment	◆ Transparency on premium ◆ Easy comparison between Standard Plans offered by different insurers

Flexi and Top-up Plans

8. On top of the minimum requirements of the Standard Plan, insurers may offer Flexi or Top-up Plans to provide consumers with choices of additional benefits, such as higher benefit limits, higher ward class, coverage of overseas emergency, coverage of drugs, out-patient services, etc. Insurers could structure the minimum and additional benefits flexibly. They could combine the minimum and additional benefits into a single product in the form of a Flexi Plan. Flexi Plans must meet all minimum requirements of the HPS Standard Plan (except guaranteed acceptance because only Standard Plans are accepted to the High-risk Pool as explained in the section below). Alternatively, insurers could put the additional benefits under a separate top-up plan. Top-up Plans would not be subject to the regulation of the minimum requirements. The **Diagram** below illustrates the application of the minimum requirements approach and possible structuring options for HPS Standard Plan, Flexi Plan and Top-up Plan.

Diagram Minimum Requirements Approach



Standard Plan (must be offered)
- Minimum requirements

Flexi Plan
- Minimum requirements
- Additional benefits (e.g. higher benefit limits, higher ward class, coverage of overseas emergency)

Standard Plan + Top-up Plan
Additional benefits (e.g. coverage of drugs, out-patient services)

Flexi Plan + Top-up Plan

Legend:
Standard Plan
Flexi Plan
Top-up Plan

Consumer Choice and Product Innovation

9. We have consulted, among other stakeholders, the Hong Kong Federation of Insurers (HKFI) on the proposed minimum requirements approach. While HKFI agrees about the need to improve existing market practice in several areas (including standardising policy terms; fewer exclusions; including in-patient, day-case and ambulatory care under policy scope; and developing diagnosis-related groups or packaged pricing to enhance transparency and predictability of medical costs), one of their major concerns is that the introduction of minimum requirements for all indemnity hospital insurance products might reduce choice for consumers and stifle product innovation by insurers.

10. We believe that it is essential to protect consumer's right to choose among different health insurance products, and consider that the minimum requirements approach could ensure consumer's choice without compromising essential consumer protection. Under the minimum requirements approach, we do not intend to prescribe a uniform "plan" as such but will only set out the minimum protection which any hospital indemnity insurance plans must offer to consumers. This will provide simplicity, clarity and certainty to consumers and help consumers who do not possess insurance professional knowledge to understand easily and clearly the minimum protection they can receive when taking out a hospital indemnity insurance plan. This, in turn, would minimise the chance of claims disputes and enhance consumer protection and confidence. The minimum requirements will be set in consultation with 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. After meeting these minimum requirements, insurers would be able to innovate and offer tailor-made Flexi or Top-up Plans to suit specific consumers' needs. The minimum requirements would only be confined to indemnity hospital insurance products, which are designed to cover the actual hospital charges and related medical expenses incurred by a patient. Non-indemnity health insurance products (such as hospital cash [2] and catastrophic cash plans[3]) or outpatient health insurance products would not be subject to the minimum requirements.

---

[2] Hospital cash plans offer a fixed amount of benefits per day to an insured person during the period of hospitalisation. The product usually serves as a form of income protection and the benefit amount is not tied to the level of spending on hospital care.

[3] Catastrophic cash plans offer a large lump-sum payment upon confirmation of a catastrophic illness on a pre-defined list, without requiring the insured person to undertake treatment.

Acceptance of High-risk Groups

11. Another key concern of HKFI over the minimum requirements approach is the management of risks associated with guaranteed acceptance and coverage of pre-existing medical conditions. Under the minimum requirements approach, although insurers would be required to accept all prospective subscribers to the HPS Standard Plan and to cover their pre-existing medical conditions, such conditions would only be fully insured after the waiting period. Moreover, as proposed in the Second Stage Public Consultation on Healthcare Reform, insurers are permitted to charge premium loading on high-risk applicants, and transfer to the High Risk Pool (HRP) high-risk cases whose premium loading is assessed to equal or exceed 200% of standard premium. The Consultant considers that the HRP arrangement can balance consumer protection with commercial viability.

12. As regards the funding arrangement for HRP, where necessary and justifiable, the Government would consider providing financial support to the HRP so that the high-risk groups may have access to health insurance protection. Since the HRP is designed to manage the risks associated with the guaranteed acceptance feature which is applicable to HPS Standard Plan only, it is further recommended that only the HPS Standard Plan of policies of high-risk applicants would be admissible to the HRP.

13. The Consultant will provide an estimation of the financial support required for the HRP in the final report. The operation of the HRP and any use of public money will be closely monitored by the Government and the authority overseeing the implementation of the HPS. The Administration will seek approval from the Legislative Council for any allocation of financial resources to support the HRP.

Upfront Payment Transparency and Certainty

14. We proposed in the consultation document of the Second Stage Public Consultation on Healthcare Reform to enhance upfront payment certainty by developing packaged charging for common procedures according to diagnosis-related groups (DRG). According to the advice of the Consultant, the development of a standardised system of DRG suitable for local use would require comprehensive and regular collection, compilation and analysis of healthcare, claims and pricing data from the health insurance industry and

healthcare service providers. Regular and systemic review is also required to keep the DRG system up-to-date. As Hong Kong currently does not possess such sophisticated mechanism for conducting the above work, the Consultant considers that there will be significant challenges for Hong Kong to implement a DRG system in the short-term. After taking into account the local situation and surveying international experience, the Consultant proposes two arrangements for enhancing the transparency and certainty of upfront payment by consumers, namely "informed financial consent" and "no-gap/known-gap", which are more readily implementable in the short-term.

Informed financial consent

15. In Australia and Singapore, doctors and hospital must, except for emergency cases, obtain the patient's "informed financial consent" before providing treatments to the patient. Patients are informed, in the form of a written quotation, of the estimated charges of the healthcare services (including doctor's fees and hospital fees) before receiving treatment. The Consultant proposes that the "informed financial consent" arrangement could be applied in the local context. In addition to indicating the estimated charges of healthcare services, insurers would be required to indicate the estimated out-of-pocket expenses to be paid given the existing insurance coverage acquired by the patient. Under such arrangement, patients would have greater certainty in estimating the amount of out-of-pocket expenses before receiving treatment.

No-gap/known-gap arrangement

16. In Australia, insurers are required to offer at least one "no-gap" or "known-gap" policy. "Gap" refers to the out-of-pocket expenses (e.g. deductible, fees in excess of benefit limits) a patient pays for hospital or doctor's fees. The policyholder pays "no-gap" (no out-of-pocket payment is required) or "known-gap" (a pre-determined amount of out-of-pocket payment) if (i) they choose a hospital which their insurer has a contract with, and (ii) the doctor agrees to the insurer's fee schedule.

17. The Consultant has proposed that, as part of the minimum requirements prescribed by the HPS Standard Plan, the "no-gap/known-gap" arrangement could be applied to certain prescribed procedures covered in the insurance policy. Insurers may contract with doctors and hospitals (including clinics for ambulatory procedures) to determine the list of "no-gap" or "known-gap" procedures. The policyholder pays "no-gap" or "known-gap" if

(i) he/she chooses a hospital which his/her insurer has a contract with, (ii) the doctor agrees to the insurer's fee schedule and (iii) the procedure concerned is on the list agreed among the insurer, doctors and hospitals. The policyholder would still be able to benefit from the certainty provided by the "informed financial consent" arrangement in the case that he/she is willing to pay a higher out-of-pocket amount for services provided by non-contracted hospitals, or doctors who do not agree to the insurer's fee schedule, as he/she would still be provided with a written quotation indicating the estimated out-of-pocket expenses.

Packaged Pricing

18. Apart from "informed financial consent" and "no-gap/known gap" arrangements, we would encourage private healthcare providers to offer packaged pricing for common procedures to enhance payment certainty and transparency. In fact, under the "no-gap/known gap" arrangement, private healthcare providers would have the incentive to offer packaged pricing for common procedures. Moreover, we have set out a requirement for new private hospital developments that at least 30% of in-patient bed days taken up in the hospital each year must be for services provided through standard beds at packaged charging. Through this new policy, we hope to encourage more private hospitals to offer packaged charging for common procedures through market forces.

RECENT DEVELOPMENTS

19. In conducting research on the local health insurance market, we note that some of the key features proposed for the HPS have become more common among health insurance products in recent years. For instance, some products now available in the markets have already incorporated the features of lifetime guaranteed renewal, coverage of ambulatory procedures, or portability from group to individual plan upon termination of employment. While the fine details of these key features vary among different products, such market development demonstrates the commercial viability as well as desirability of the key features proposed for the HPS. The prescription of minimum requirements for hospital indemnity products sold in Hong Kong would help standardise the terms and protection of such products, providing more transparency, certainty and better protection for consumers. In the private healthcare market, there is evidence that packaged charging and upfront fee quotations have become more common in order to provide more budget

certainty to consumers. Such market development dovetails with the Consultant's recommendations on enhancing upfront payment transparency and certainty.

20. In working out the details of the Consultant's recommendations described in this paper, such as the appropriate levels of minimum benefit coverage and limits, the operation mode and management of the HRP, the "informed financial consent" and "no-gap/known-gap" arrangements, we will continue to maintain a close dialogue with various stakeholders, including the insurance industry, private healthcare providers and consumer advocates.

ADVICE SOUGHT

21. Members are invited to note and comment on the contents of the paper.

Food and Health Bureau
May 2013

Annex

Summary of Mandatory Requirements For Private Health Insurance (PHI) in Selected Countries

	Australia	Ireland	Netherlands	Switzerland	United States
Role of PHI	Supplementary (voluntary PHI)	Supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI[1])
Share of PHI in healthcare financing					
PHI	11%	9%	45%	51%	33%
Government / social health insurance	66%	80%	42%	23%	48%
Out-of-pocket	18%	10%	10%	25%	12%
Others	5% (Figures as at 2011)	1% (Figures as at 2009)	3% (Figures as at 2010)	1% (Figures as at 2010)	7% (Figures as at 2009)
Product regulation by law	✓	✓	✓	✓	✓

[1] Under the Patient Protection and Affordable Care Act (PPACA) of 2010, individuals are required to obtain PHI coverage starting from 2014.

	Australia	Ireland	Netherlands	Switzerland	United States
All PHI products subject to same regulatory standards?	✓	✓	✓	✓	✓ (minor differences for group plans, e.g. more stringent requirement on maximum waiting period, penalty for large employers not offering adequate health insurance coverage for employees, etc.)
Guaranteed acceptance	✓	✓	✓	✓	✓
Guaranteed renewal	✓	✓	✓	✓	✓
Must cover pre-existing conditions	Except during waiting periods	Except during waiting periods	✓	✓	✓
Maximum waiting period	✓	✓	No waiting period	No waiting period	✓
Minimum benefit coverage	✓	✓	✓	✓	✓ (except for large group and grandfathered plans)
Fixed benefits package	×	×	×	✓	×

	Australia	Ireland	Netherlands	Switzerland	United States
Restrictions on cost-sharing	✓	×	✓	✓	✓
Portability	✓	✓	✓ (may change insurer during designated time of year)	✓ (may change insurer during designated time of year)	✓
Standardised policy terms and conditions	✓	×	✓	✓	✓
Premium structure	Community rating	Community rating	Community rating	Community rating	Modified community rating (allows variation by age, location, tobacco use and family status only)
Premium loading	Late entry loading to those who delay take-up of PHI until over 30 years of age: 2% of the base premium for each year over age 30 at the time of joining, subject to a maximum of 70%	None	None	None	Rating rules to limit premium variation based on age and tobacco use ratio to 3:1 and 1.5:1 respectively

Food and Health Bureau
May 2013