For information on
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Legislative Council Panel on Health Services
Subcommittee on Health Protection Scheme

Institutional Framework for the Governance and Operation of the Health Protection Scheme

PURPOSE

This paper briefs Members on the preliminary proposal for the institutional framework for the governance and operation of the Health Protection Scheme (HPS), including the supervisory structure and the claims dispute resolution mechanism. In devising the proposal, reference has been made to the preliminary findings of the consultancy study conducted by PricewaterhouseCoopers Advisory Services Limited (the Consultant). The proposal will be further refined later this year, taking into account comments by Members and other stakeholders.

SUPERVISORY STRUCTURE

2. In the Second Stage Public Consultation on Healthcare Reform, it was proposed that a governing framework be put in place for implementing the HPS. The governing framework was proposed to comprise three separate but inter-related components, namely, (a) prudential regulation of insurers[1], (b) quality assurance on healthcare services, and (c) scheme supervision.

3. As mentioned in the consultation document, the existing regulatory regimes have already been managing issues related to the first two components. The role of prudential regulation of insurers is being taken up by the Office of the Commissioner of Insurance (OCI). When the HPS is in place, the OCI or the future Independent Insurance Authority (IIA) proposed to be established in place of OCI, should continue to serve this function. As regards quality assurance of

[1] The purpose of prudential regulation is to supervise, inter alia, the financial soundness of insurers participating in the HPS and to ensure the financial capability of insurers to discharge obligations to the insured.

healthcare services, it is proposed that the existing regulatory institutions of private healthcare facilities and healthcare professionals, namely the Department of Health (DH) and the relevant statutory boards, councils and professional bodies, should continue with their work under their respective responsibilities.

4. As regards scheme supervision, it essentially pertains to establishing a sound institutional framework for governance and operation of the HPS. It is proposed that a new dedicated agency (the HPS agency) should be set up to perform related functions such as to supervise the implementation and operation of the HPS and administer consumer protection measures specific to the HPS including the claims dispute resolution mechanism.

Objective, Functions and Powers of the HPS Agency

5. The Consultant preliminarily proposes to set up a dedicated agency for HPS to ensure that the operation of the HPS can achieve the desired policy objectives, including providing value-for-money private health insurance products to those who are willing and may afford to use private health services, enhancing consumer protection for the insured, and promoting market transparency and competition, etc. The proposal is consistent with the common practice in countries such as Australia, Ireland, the Netherlands, Switzerland and the United States, where private health insurance is an important health policy tool in healthcare financing (a summary of the regulatory framework for private health insurance of the five countries is at **Annex A**). In each of these countries, there is a specialist health insurance regulator which enforces the statutory requirements for private health insurance products.

6. The Consultant also recommends that the HPS agency should perform a host of functions that are regulatory or facilitating in nature. In the regulatory aspect, the HPS agency would need to ensure that indemnity hospital insurance plans being offered in the market will comply with the minimum requirements prescribed by the HPS Standard Plan. The regulatory functions of the HPS agency should include at least the following –

(a) promulgate, review and enforce rules and regulations concerning the minimum requirements prescribed by the HPS Standard Plan (e.g. guaranteed acceptance and renewal, coverage of pre-existing conditions, portability, minimum benefit coverage and limits, standardization of policy terms and conditions, etc.);

(b) register HPS Standard Plans, Flexi Plans and Top-up Plans;

(c) manage and operate the High-risk Pool;

(d) ensure the transparency of plans under the HPS (e.g. setting up a website to facilitate easy comparison of plans offered by different insurers);

(e) handle complaints by consumers, including investigation of cases of non-compliance with the minimum requirements, and referral of cases to the relevant regulatory bodies or the claims dispute resolution mechanism; and

(f) administer financial incentives or subsidies provided by the Government.

7. The Consultant also recommends that the HPS agency should perform at least the following facilitating functions –

(a) build up market infrastructure to facilitate the implementation of the HPS, e.g. developing information systems for product registration, data collection and publishing of data from various sources (e.g. insurers and private healthcare service providers), etc.;

(b) liaise with relevant supervisory and regulatory agencies (e.g. Food and Health Bureau (FHB), DH, Hospital Authority (HA), OCI, other professional bodies, etc.);

(c) set up a platform for health insurers and private healthcare service providers to discuss HPS-related matters; and

(d) consumer education on the HPS.

Legal Form and Organization Structure of the HPS Agency

8. The Consultant considers it more desirable for the HPS agency to be set up in the form of a Government-led body because a Government-led agency has the advantages of being directly accountable to the public and possessing the necessary authority in carrying out its functions effectively. Indeed, in all of the five overseas jurisdictions under study, the health insurance regulator is a Government-led body. While being Government-led, we consider that in the long run the HPS agency should function as a statutory authority independent from the Government. Being a statutory body would give the HPS agency greater clarity of purpose and the necessary authority in carrying out its functions. As an organisation independent from the Government, the HPS agency would have more flexibility in operation and staff recruitment. It can also better respond to local and overseas market changes and developments in international regulatory requirements, thereby facilitating a stable development of the insurance industry and providing better protection to the public. In the interim, we consider that the HPS agency could be set up as an administrative unit under FHB. Apart from the comparatively shorter establishment time, an administrative unit under FHB would also ensure direct Government accountability in the implementation of the HPS in the initial phase.

9. We propose that an advisory committee could be formed for major stakeholders (members from the insurance industry, private healthcare service providers, relevant regulatory authorities and other stakeholders) to build up consensus and draw up the operational details for implementing the HPS. A number of supporting committees could be established as necessary to oversee and advise the agency on specific areas of work (e.g. regulatory, enforcement, market infrastructure, etc.).

10. When establishing the future independent statutory authority to be established, we consider that due regard should be given to the followings –

(a) the governing board/committee should comprise representatives of relevant fields to ensure its independence and impartiality, such as official members from the Government, relevant regulatory authorities, members with knowledge in the insurance industry and healthcare services, and representatives of other stakeholders;

(b) the staff establishment of the authority should be contained to avoid unnecessary duplications with existing regulatory/supervisory bodies; and

(c) adequate check and balance measures should be put into place to ensure the proper exercise of power by the authority, such as setting up an independent and impartial appeals tribunal, and requiring the authority to submit the annual budget and/or corporate plan to the Government and the Legislative Council.

CLAIMS DISPUTE RESOLUTION MECHANISM

11. As indicated in paragraph 6(f) above, the Second Stage Public Consultation on Healthcare Reform proposed to establish a claims dispute resolution mechanism (CDRM) for the HPS to better protect consumer interests. The CDRM should aim to provide an independent, impartial, easily accessible, expeditious and affordable channel to resolve financial disputes involved in claims settlement of HPS products as an alternative to litigation, which is in general a much more costly and lengthy process.

Existing Claims Dispute Resolution Mechanism for Private Health Insurance in Hong Kong

12. Currently, there are several avenues for resolving disputes related to health insurance claims apart from legal proceedings. A major channel is the Insurance Claims Complaints Bureau (ICCB) that handles complaints about insurance claims arising from all types of individual insurance policies taken out in Hong Kong. It is a self-regulatory mechanism operated by the insurance industry as a company limited by guarantee. The adjudication decision of the ICCB is binding on the insurer but not the consumer, who can resort to legal redress if he/she is

not satisfied with the outcome.

13. If an insurance claims dispute involves a financial institution which is one authorised by the Hong Kong Monetary Authority or licensed by/registered with the Securities and Futures Commission, consumers may also resort to the Financial Dispute Resolution Centre (FDRC) for dispute resolution through mediation[2] or, failing which, arbitration[3].

14. Meanwhile, the Office of the Commissioner of Insurance (OCI) maintains a monitoring role to ensure that complaints are properly handled. The Consumer Council also helps consumers follow up complaints with the relevant institutions or entities for appropriate action.

Overseas Experiences

15. In developing the proposed design for the CDRM, the Consultant has made reference to overseas claims dispute handling mechanisms. A summary of the claims dispute resolution mechanisms in five selected countries is given at **Annex B**.

16. Generally speaking, the Consultant finds the proposed concept of the CDRM in the second-stage public consultation on healthcare reform consistent with the international trend of progressively accepting and expanding the function of independent alternative dispute resolution (ADR) mechanisms to settle insurance disputes, with a view to enhancing consumer protection and choice in addition to costly and protracted litigation. Although the design of ADR mechanisms differs place by place, the Consultant observed that their independence and credibility are

[2] Mediation is a voluntary, non-binding and private dispute resolution process. An independent and neutral mediator helps the parties communicate in a rational way. The aim of mediation is to reach a solution that both parties can agree. The agreement is private and confidential. Source: Financial Services and the Treasury Bureau (2010), "Proposed Establishment of an Independent Insurance Authority" Consultation Paper.

[3] Arbitration is a form of legal process where the disputes are not heard by a court but by a private individual or a panel of several private individuals known as arbitrators. An arbitrator is usually appointed by agreement of the two disputing parties to facilitate the fair and speedy resolution of disputes; to act fairly and impartially between parties; and to give the parties a reasonable opportunity to present their cases. Arbitration, unlike court proceedings, is conducted in private and generally less formal settings. Arbitration awards are final and binding on the parties. Source: Financial Services and the Treasury Bureau (2010), "Proposed Establishment of an Independent Insurance Authority" Consultation Paper.

essential for fostering confidence for all parties concerned. Most governments either manage the mechanism direct or have legal requirements related to the mechanism. Besides, the ADR mechanisms should offer quick resolution with minimal formality in order to lessen the administrative caseload and settle the dispute expeditiously. It is a common requirement in jurisdictions studied that the complainant should first attempt to settle the dispute with the financial institution before reverting to the ADR mechanisms. The dispute resolution mechanism usually encompasses mediation, while there is no consensual approach regarding whether arbitration should also be instituted in the mechanism after mediation fails to settle a dispute.

Coverage and Eligibility for the Proposed CDRM

17. The Consultant recommends that the proposed CDRM should primarily cover all disputes related to the claims arising from the HPS Standard Plan and that part of the HPS Flexi Plan and Top-up Plan concerning reimbursement of inpatient and ambulatory care expenses according to the indemnity principle.

18. The Consultant advised that both retail customers and business customers (mainly employers buying group plans) can seek assistance from the CDRM. This arrangement can fill the gap in employee protection as manifested by exclusion of group health insurance plans and business customers in the ICCB and FDRC mechanisms at present. In the case where an employee is dissatisfied with the claims outcome, he/she can only rely on the employer to represent his/her interests to negotiate with the insurer. There is a lack of external mechanisms in settling the dispute if the employer cannot reach an agreement with the insurer. It is proposed that individuals covered by group plans under the HPS, with consent from their employers, be included as eligible claimants under the CDRM.

Legal Form and Interface With Existing Dispute Resolution Mechanisms

19. Given that the CDRM would share some similarities with the existing the ICCB in terms of functionality, the Consultant proposes three

options for setting up the CDRM –

(a) to establish a single statutory claims dispute resolution channel taking over the functions of the ICCB, which would be credible, administratively efficient and help avoid consumer confusion;

(b) the CDRM to act as an appeal channel for consumers if they are dissatisfied with decisions of the ICCB (but not insurers because ICCB's decision is binding on them). Under this option, the CDRM would only handle cases that are already adjudicated by the ICCB (i.e. complaints by retail consumers) or group policies which do not fall under the terms of reference of the ICCB to avoid duplication of efforts in handling the complaints. Under this proposal, the ICCB would serve as a gatekeeper for the CDRM; or

(c) to expand the functions of the ICCB to handle claims complaints arising from group policies, with more representation from the Government and other stakeholders[4].

20. Regarding the eligible cases that fall under both the purviews of the FDRC and the CDRM (i.e. claims disputes involving HPS plans sold by FDRC scheme members), we could consider establishing a communication mechanism between the FDRC and CDRM so as to advise consumers on which service they should turn to.

Operation Mode

21. The Consultant advises that the mode of operation of the CDRM hinges on its interface with the ICCB. If it is a separate mechanism that handles claims disputes on its own, it could operate both mediation and arbitration services. If the CDRM serves instead as an appeal channel, it may be appropriate to offer arbitration service only as mediation service is already available at the stage of resolution by the

[4] All members of the ICCB's governing body (General Committee) are from the insurance industry. Its Complaints Panel adjudicates on claims complaints with reference to the advice of honorary secretaries, who voluntarily offer their service as members of the insurance industry. Although the Complaints Panel consists of members from other professional fields (legal, accounting and consumer representative), there may be a need to enhance the representativeness of the ICCB to meet public aspirations on the proposed CDRM.

ICCB. Under this second option, if the ICCB does not extend its function to cover group plans, both mediation and arbitration services could be provided by the CDRM to handle disputes related to group plans. The decision awarded through arbitration should be final and binding on both parties.

22. The three options of the CDRM are being considered and deliberated by the Working Group on the HPS together with the institutional setup for the regulation and supervision of the HPS.

ADVICE SOUGHT

23. Members are invited to note the preliminary proposed designs on the supervisory structure and the CDRM for the HPS.

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Annex A

Summary of Regulatory Framework 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])
Key legislation on health insurance	Private Health Insurance Act	Health Insurance Acts	The Health Insurance Act	The Federal Law on Health Insurance	Patient Protection and Affordable Care Act
Main health insurance regulator	The Private Health Insurance Administration Council (PHIAC) reporting to the Department of Health and Aging	The Health Insurance Authority (HIA) reporting to the Minister for Health and Children	The Dutch Healthcare Authority (NZa) and the Health Insurance Board (CVZ)	Mandatory PHI: the Federal Office of Public Health (FOPH) reporting to the Federal Department of Home Affairs Supplementary PHI: the Financial Market Supervisory Authority (FINMA)	State regulatory authorities in conjunction with the federal Centre for Consumer Information and Insurance Oversight (CCIIO)
Is the specialist health insurance regulator Government-led?	Yes	Yes	Yes	Yes	Yes

[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
Is the specialist health insurance regulator also responsible for prudential regulation?	Yes	No	No	Yes (for mandatory PHI)	Varies by States
Key functions of the specialist health insurance regulator	• Registration of private health insurers • Prudential regulation of private health insurers • Administer the Risk Equalization Trust Fund	• Enforce compliance with product regulation • Administer premium levies and subsidies	NZa: • Registration of health insurers and their products • Monitor performance and market conduct of health insurers • Supervise healthcare providers CVZ: • Advise on the mandatory benefit package • Administer risk equalization mechanism	FOPH: • Enforce compliance with product regulation on mandatory PHI • Prudential regulation of health insurers FINMA: • Enforce compliance of supplementary insurances • Review and approve private insurance operations	State regulator: • Registration of health insurers • Product and market conduct regulation • Prudential regulation of health insurers CCIIO: • Provides national oversight on compliance with federal insurance market rules

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Annex B

Mechanism for Handling Private Health Insurance Claim Disputes in Overseas Jurisdictions

	Australia	Ireland	Netherlands	Switzerland	United States
Responsible Organisation	Private Health Insurance Ombudsman (PHIO)	Financial Services Ombudsman	Health Insurance Complaints & Disputes Foundation (SKGZ) (comprises Health Insurance Ombudsman and Health Insurance Disputes Committee)	Health Insurance Ombudsman	Varies by State. Some States adopt the Federal Department of Health & Human Services (DHHS) dispute resolution mechanism (managed by government but function outsourced to a private organisation). Other States allow insurers to choose an accredited Independent Review Organisations (IRO) which satisfy Federal standards for conducting external review
Sector coverage	Private health insurance	Financial services such as banks, insurance, investment companies etc.	Mandatory and supplementary private health insurance	Mandatory and supplementary private health insurance	Private health insurance[1]

[1] Under the Patient Protection and Affordable Care Act (PPACA) of 2010, consumers covered by individual or group health insurance plans (except grandfathered plans) have the right to appeal decisions, including claims denials, made by their health insurers.

	Australia	Ireland	Netherlands	Switzerland	United States
Types of disputes covered	Disputes about private health insurance, including claim and non-claim disputes	Claim disputes, mis-selling charges, maladministration of insurance companies, etc.	Disputes about private health insurance, including claim and non-claim disputes	Disputes about private health insurance, including claim and non-claim disputes	Disputes about private health insurance, including claim and non-claim disputes (including disputes involving claims denial due to medical opinions, e.g. insurer believes procedure was not medically necessary)
Legal form	Government agency	Statutory body	Private company	Private company	DHHS: government agency IROs: private company accredited by a nationally recognised accrediting organisation

	Australia	Ireland	Netherlands	Switzerland	United States
Governance	The Ombudsman is appointed by the Minister for Health and Ageing	Overseen by The Financial Services Ombudsman Council	The Board of Directors	The Board of Trustee	DHHS: Federal Government governs the process and appoints a private company to handle all cases. IROs: self-governing but must be accredited by a nationally recognised accrediting organization. In some states, IROs are also required to apply for certification issued by state governments.
Dispute resolution process	Mediation	Mediation (optional) and adjudication	Include two procedures: mediation by the Health Insurance Ombudsman and/or arbitration by the Health Insurance Disputes Committee	Mediation	DHHS: outcome based on examiner's review and decision IROs: outcome based on IRO's review and decision

	Australia	Ireland	Netherlands	Switzerland	United States
Who can complain?	The insured, insurers and providers. Mostly insured in reality. Complainants must demonstrate attempt to resolve disputes with the complainee first.	Individual consumers and small businesses. Complainants must demonstrate attempt to resolve disputes with the complainee first.	Individual consumers. Complainants must demonstrate attempt to resolve disputes with the complainee first.	Individual consumers. Complainants must demonstrate attempt to resolve disputes with the complainee first.	The insured, insurers and providers. Complainants must first go through the internal appeal process of insurance companies.
Claims limit	None	Euro 250,000	None	None	None
Final decision binding?	Not binding	Binding, subject to appeal to the High Court	Not binding (Health Insurance Ombudsman) Binding (Health Insurance Disputes Committee)	Not binding	Binding

	Australia	Ireland	Netherlands	Switzerland	United States
Funding	Government revenue	Levy from financial services providers	Levy from each insured person plus grant from the Minister of Health	Insurance companies	DHHS: Federal Government (no cost to insurers and policyholders). IRO: costs often borne by insurers. In some States, user fee may be paid by consumer (see row below)
User fee on complainant	None	None	None (Health Insurance Ombudsman) 37 euro (Health Insurance Disputes Committee) (refundable if decision is in favour of the consumer)	None	Maximum US$25 per review on consumer complainants, refundable if external review decision is in favour of the consumer

	Australia	Ireland	Netherlands	Switzerland	United States
Relationship with regulator	Required to submit an annual report to the Minister for Health and Ageing	The governing council is appointed by the Minister for Finance	There are regular meetings with the relevant regulatory bodies and SKGZ would report to regulators as necessary	Does not have a reporting relationship to the regulator	DHHS: DHHS is both regulator and administrator of the dispute resolution systems. IROs: IROs must be accredited by a nationally recognised accrediting organisation and potentially a state regulator also, but reporting requirements vary by State.

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