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

Funding For Health Protection Scheme

PURPOSE

This paper briefs Members on the Administration's considerations on providing public funding support for the implementation of the Health Protection Scheme (HPS).

BACKGROUND

2. To facilitate the Working Group and Consultative Group on HPS to formulate detailed recommendations on the HPS, the Administration has commissioned PricewaterhouseCoopers Advisory Services Limited (the Consultant) to provide technical and professional advice on key issues relating to the implementation of the HPS, including areas where public funding could be considered to ensure the viability and sustainability of the HPS. Taking into account comments from Members and other stakeholders, the Consultant will refine its recommendations in a full report to be tendered later this year. We will develop detailed funding proposal, if necessary and justified, for supporting the implementation of the HPS having regard to the Consultant's recommendation and other relevant considerations.

3. In the 2008-09 Budget Speech, the Financial Secretary agreed to set aside $50 billion from the fiscal reserves to assist the implementation of healthcare reform. We will ensure proper and judicious use of the funding such that it contributes to the aim of healthcare reform and helps enhance the long-term sustainability of our healthcare system amid an aging population and the challenges posed by rising public expectation and advancement in medical technologies. We will consider making use part of the $50 billion fiscal reserve to provide essential and well-justified support to facilitate the implementation of the HPS in consultation with stakeholders concerned.

UTILISATION OF PUBLIC FUNDING TO SUPPORT THE HEALTH PROTECTION SCHEME

Considerations

4. In considering the use of public funding to support the HPS, we would have regard to all relevant considerations including, but not limited to, the following –

(a) the use of public funding should contribute to the achievement of the objectives of the HPS, namely providing value-for-money services to those who are willing and can afford to use private healthcare services, such as improving access to health insurance coverage;

(b) the use of public funding should be conducive to the sustainability of the HPS in the long-run, including encouraging participation in the HPS;

(c) the use of public funding should contribute to enhancing the protection of consumers' rights, such as enhancing payment transparency and certainty; and

(d) any provision of public subsidy or financial incentives should be considered on the basis of prudent and sustainable use of public funding, bearing in mind any possible pitfalls or adverse effects that may arise. For instance, the provision of public subsidies might aggravate moral hazards in using private health insurance and private healthcare services and distort the market mechanism, hence contributing to medical inflation and increased insurance costs. Considerations should also be given to ensure that the public funding would benefit the insured and the community at large.

Possible Areas Where Public Funding Might be Considered

5. Taking into account the preliminary findings of the Consultant, we have initially identified a number of areas where public funding might be considered necessary to support the implementation of the HPS.

(A) Accept high-risk individuals

6. In the Second Stage Public Consultation on Healthcare Reform, one of the main misgivings expressed by the community is that high-risk individuals have major difficulties and are often unable to buy private health insurance even if they are willing to do so. Currently, individuals with pre-existing medical conditions or those with higher health risks are often unable to obtain proper health insurance coverage since their applications for health insurance coverage are usually rejected by insurers. Even if their applications for health insurance coverage are accepted, additional exclusion clauses would be incorporated into their insurance plans so that the claims arising from their pre-existing medical conditions, either directly or indirectly, would be excluded from coverage. Such exclusion clauses are often the source of disputes as there are no standardised wordings or uniform interpretation of these clauses across the industry.

7. To deal with this particular issue and to enable those with pre-existing medical conditions to have access to private health insurance if they wish to do so, under the HPS we propose to require insurers offering indemnity hospital insurance plans to accept all individuals applying for health insurance coverage and forbids insurers from incorporating exclusion clauses based on pre-existing medical conditions. Insurers are allowed to charge a premium with additional loading commensurate with the extra risks that they have taken on by providing health insurance coverage to high-risk individuals. In order to ensure premium affordability for high-risk individuals, we have further proposed to cap the premium loading at 200% of the standard premium. We recognise that while this requirement will enable those with pre-existing medical conditions and who are rejected by insurance companies to be able to access private health insurance coverage with more affordable premium, there will be circumstances under which insurers would not be able to collect adequate premium to cover the risks that they have taken on. Without proper mitigation measures, insurers may have to increase premium for all subscribers, which may discourage other people (especially those healthier individuals) from taking out private health insurance and will go against the objective of the HPS to encourage and facilitate more people to take out private health insurance.

8. Overseas experience reveals a similar dilemma in ensuring both accessibility and affordability of health insurance protection for high-risk

individuals. There are two common approaches in tackling this dilemma. The first is through community rating of premiums and risk equalization as in the Netherlands, Switzerland, the United States and Australia. Insurers there are required to accept all applicants at community-rated premiums, meaning that each insurer is required to charge all customers at a flat premium for the same product regardless of age and health risks[1]. Community rating of premiums is supported by a risk equalization mechanism to share costs across all insurers according to their risk profiles. In a nutshell, a risk equalization mechanism transfers payment from those with lower-than-average risk exposure to those with higher-than-average risk exposure. The disadvantage of this approach is that the community-rated premiums would be relatively high for the younger age groups, who generally carry lower-than-average risks. This would discourage the healthier population, especially those who are young and healthy, to purchase private health insurance. In addition, the risk equalization mechanism are usually complex in design and expensive to operate, and very heavy involvement of a third party who will act as the impartial arbitrator (usually the regulator) would be necessary. Furthermore, the operation of the risk equalization mechanism also involves the collection of a wide range of data and calculation of various risk factors, such as age, gender, health status, region, or socio-economic status.

9. It would require significant investment and considerable time to set up a fair and viable risk equalization system in Hong Kong. The substantial increase in premiums for the young and healthy would also drive many away from health insurance under Hong Kong's voluntary market. An alternative and a relatively simple approach is to set up a high-risk pool.

10. Under the high-risk pool approach, higher-risk subscribers are carved out into a separate pool with premium loading capped at a prescribed maximum and injection of other financial sources to meet the excess, uncovered risks. The premiums for lower-risk subscribers would not be affected (unless a levy is charged to fund the high-risk pool). In the United States, more than 30 states have experience in running high-risk pools created by state legislatures to offer health insurance

[1] Under the Patient Protection and Affordable Care Act (PPACA) of 2010, individuals are required to obtain private health insurance coverage starting from 2014. A modified community-rating system will be adopted, which allows variation by age, location, tobacco use and family status only.

coverage for individuals with higher health risks[2]. The high-risk pools are funded by premiums collected, levy on health insurers or state government subsidy. The modus operandi is broadly similar to the arrangements of the High-risk Pool (HRP) being proposed for the HPS.

11. To balance between consumer protection and commercial viability of the HPS, we have proposed to set up a HRP to accept policies of the HPS Standard Plans of high-risk individuals. Where the premium loading of such policies, at the opinion of the insurer providing coverage, is assessed to equal or exceed 200% of standard premium charged by the insurer for providing HPS Standard Plan coverage, the insurer may transfer these policies to the HRP by surrendering the premium collected for these policies after deducting a nominal handling fee to be prescribed by the HPS agency. The insurer will continue to be responsible for the administration of the policies, but the premium income (net of expense), claim liabilities and profit/loss of these policies would be accrued to the HRP instead of the insurer concerned. Where necessary, the Government would consider injecting funding to the HRP directly to ensure the Pool's sustainability.

12. The Consultant is working on an estimation of the financial support required for the HRP based on a variety of factors, including the estimated number of eligible cases for the HRP and the morbidity rate of high-risk cases, etc. The Consultant will provide the estimated figures in its final report.

(B) Encourage take-up of HPS plans

13. For the HPS to be rolled out successfully, it is important to start off the scheme with a substantial number of subscribers to generate material impact and motivate market development, such as promotion of packaged charging and price transparency. The Consultant is examining the feasibility and desirability of a number of financial incentives to encourage take-out of HPS plans. One of the possible options is to introduce tax incentive for subscribers of HPS plans in the form of deduction to the taxable income, which is a common and relatively simple form of incentivzing purchase of private health insurance in overseas countries. Since the working population, especially those with

[2] The high-risk pools would be phased out with the introduction of a mandatory private health insurance system and modified community-rating under the PPACA. A risk equalization system will be adopted although the exact criteria and methods have yet to be established.

a relatively high disposable income, is the most likely ones to be able and willing to use private healthcare services, the availability of tax incentive would encourage them to take out HPS plans and stay with the plans over time.

(C) Promote care management

14. To promote better awareness of healthy lifestyle and encourage active care management, the Consultant is considering the possibility of introducing care management programmes for HPS subscribers in the HRP. For example, a wellness programme could be designed for high-risk subscribers in the HRP to induce behavioural changes and to promote greater health consciousness. Wellness programmes are a set of activities designed to proactively assist its members in making voluntary behaviour changes that improve their health and wellbeing. A wellness programme usually comprises of gathering health information from members, developing education and intervention programmes to address identified risk factors, and possibly providing incentives to reward good performance. Overseas experience suggests that such types of care management programmes could drive better chronic disease management and thus achieving more efficiency and better health outcomes.

ADVICE SOUGHT

15. Members are invited to note the content of the paper.

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