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Legislative Council

LC Paper No. CB(2)100/14-15
(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 seventh meeting
held on Monday, 9 December 2013, at 2:30 pm
in Conference Room 3 of the Legislative Council Complex

Members present	:	Dr Hon LEUNG Ka-lau (Chairman) Hon Albert HO Chun-yan Hon Vincent FANG Kang, SBS, JP Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Hon Charles Peter MOK Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki
Members absent	:	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN Hon Mrs Regina IP LAU Suk-yee, GBS, JP Hon CHAN Han-pan
Public Officers attending	:	Mr Richard YUEN Ming-fai, JP Permanent Secretary for Food and Health (Health) Food and Health Bureau Mr Chris SUN Yuk-han, JP Head, Healthcare Planning and Development Office Food and Health Bureau
Clerk in attendance	:	Ms Maisie LAM Chief Council Secretary (2) 5

Staff in attendance	:	Ms Mina CHAN Senior Council Secretary (2) 5 Ms Michelle LEE Legislative Assistant (2) 5

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I. Refined proposal on the design of private health insurance policies regulated under the Health Protection Scheme
[LC Paper Nos. CB(2)412/13-14(01) and (02)]

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

2. At the invitation of the Chairman, the Administration briefed members on the latest proposal for the design of private health insurance policies regulated under the Health Protection Scheme ("HPS"), details of which were set out in the Administration's paper (LC Paper No. CB(2)412/13-14(01)).

3. Members noted that the Hong Kong Federation of Insurers ("HKFI") had separately written to the Administration on its views on some of the proposed features of HPS and the Administration would provide a written reply to HKFI. To facilitate members' consideration of the viability of the proposed product design for HPS, the Subcommittee requested the Administration to provide the following information in writing -

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(a) justifications for proposing, as part of the minimum requirements prescribed by the HPS Standard Plan, a fixed 30% co-insurance for the prescribed advanced diagnostic imaging tests, and the overseas experience in this regard;

(b) explanations on the discrepancy between the figures provided by HKFI and the Administration on the proportion of persons covered by private health insurance ("PHI") who chose to use private healthcare services. HKFI stated in its media release dated 6 December 2013 that "about 90% of reimbursed claim cases took place in private hospitals or private day care centres", whereas the Administration advised at the meeting that only about 50% of persons covered by PHI chose to use private healthcare services;

(c) the detailed actuarial models, methodology used and the calculations for the estimated average premium per insured member under the HPS Standard Plan, which according to the Administration, was estimated to be around $3,600; and

(d) example(s) (with illustrative figures) to demonstrate the calculations

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of the standard premium for an individual classified under HPS's standard risk group and the premium for a high-risk individual whose premium loading was assessed to be 200% or more of standard premium and would be transferred to the proposed High Risk Pool ("HRP"). For the latter, the illustration should cover the scenario of the premium loading being capped at 200% of standard premium and the Government providing financial support to HRP.

II. Public funding support for the implementation of the Health Protection Scheme

[LC Paper Nos. CB(2)412/13-14(03) and (04)]

4. At the invitation of the Chairman, the Administration briefed members on its considerations in providing public funding support for the implementation of HPS, details of which were set out in the Administration's paper (LC Paper No. CB(2)412/13-14(03)).

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5. The Subcommittee requested the Administration to provide after the meeting the estimated financial support required for operating HRP; and explanations (in financial terms) on how the provision of public funds to support HRP to enable those high-risk individuals who were willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage could benefit the general public as a whole.

III. Any other business

Invitation of public views

6. Members noted that PricewaterhouseCoopers Advisory Services Limited, which was commissioned by the Administration to provide professional and technical advice on key issues relating to HPS, was in the process of finalizing the detailed proposals for HPS. It would submit the consultancy report to the Working Group on Health Protection Scheme by the end of 2013 or early 2014. Taking into account the Working Group's recommendations, the plan of the Administration was to consult the public on the detailed proposals for implementing HPS within the first half of 2014, probably in March or April 2014.

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7. Having regard to the Administration's intended timeframe for its work, members agreed that the Subcommittee should invite views from the relevant stakeholders on the consultancy report in mid-February 2014. The Administration was requested to provide the consultancy report to the

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Subcommittee when available.

Date of next meeting and items for discussion

8. Members noted the Administration's proposals to discuss the "Detailed proposal on the setting up of a dedicated regulatory agency for HPS" and "Proposed design of the claims dispute resolution mechanism for HPS" at the next meeting of the Subcommittee. The Chairman said that the Clerk would follow up with the Administration on the arrangements and members would be informed of the details in due course.

(*Post-meeting note*: With the concurrence of the Chairman, the eighth meeting of the Subcommittee has subsequently been scheduled for 18 February 2014 at 2:30 pm to discuss the Administration's response to issues raised at the seventh meeting of the Subcommittee and the above two subjects.)

9. There being no other business, the meeting ended at 4:25 pm.

Council Business Division 2
Legislative Council Secretariat
17 October 2014

Annex

Proceedings of the seventh meeting of the Subcommittee on Health Protection Scheme on Monday, 9 December 2013, at 2:30 pm in Conference Room 3 of the Legislative Council Complex

Time marker	Speaker	Subject	Action Required
Agenda item I:		*Refined proposal on the design of private health insurance policies regulated under the Health Protection Scheme*	
000334 - 000432	Chairman	Opening remarks	
000433 - 000830	Chairman Admin	Briefing by the Administration on the refined proposal for the design of private health insurance policies regulated under the Health Protection Scheme ("HPS"). [LC Paper No. CB(2)412/13-14(01)]	
000831 - 001118	Chairman Mr CHAN Kin-por Mr Vincent FANG	Arrangement for members' speaking time	
001119 - 001642	Chairman Dr KWOK Ka-ki Admin	Dr KWOK Ka-ki's enquiry about whether there were any findings to support the Administration's view that advanced diagnostic imaging tests, such as Magnetic Resonance Imaging examinations and Computed Tomography scans, were more easily subject to mis-use or abuse as compared to other healthcare services and hence, should be subject to cost-sharing arrangements under HPS; and the estimated premium of a high-risk individual who was in the older age group, say, 50 years old, and whose policy would be transferred to the High-Risk Pool ("HRP") under HPS. The Administration's advice that - (a) most private health insurance ("PHI") products in the market currently did not cover advanced diagnostic imaging tests. In the course of discussing with the insurance and healthcare sectors on the Minimum Requirements of HPS, there were concerns that covering these tests under HPS might lead to moral hazard and a rapid increase in utilization of the tests; (b) subject to the outcome of the public consultation, a fixed 30% co-insurance (subject to an annual ceiling on co-payment by the insured person) for claims on these tests under the HPS Standard Plan would be imposed to promote a rational utilization of prescribed advanced diagnostic imaging tests and reduce the occurrence of unnecessary ones from the point of view of medical necessity. The Administration would be willing to provide in writing the detailed justifications for the proposal and the overseas experience in this regard; and (c) according to the preliminary estimation of the Consultant, the standard premium of an HPS Standard	**Admin**

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		Plan for an individual aged 50 was around $5,000 a year. Those insured persons assessed by the insurers to have sub-standard risk might be charged a premium loading up to a maximum of 200% of standard premium, i.e. a premium of around $15,000 a year if that individual was at the age of 50. Under the HRP mechanism, an insurer could transfer to HRP a policy which was assessed to equal or exceed 200% of the standard premium it charged. The above is applicable to applicants of all ages within the first year of implementation of HPS, and to those of age 40 or below starting from the second year onwards. Dr KWOK Ka-ki's view that the HPS Standard Plan would be unaffordable to many high-risk individuals in the older age groups if the annual premium of which would be as high as about $15,000 for those aged 50.	
001643 - 003000	Chairman Mr CHAN Kin-por Admin	Mr CHAN Kin-por's recap of the major views of the Hong Kong Federation of Insurers ("HKFI") on HPS as set out in its letter dated 4 December 2013 to the Administration and its media release of 6 December 2013 entitled "The Effectiveness of the Proposed Health Protection Scheme is Highly Doubtful"; and his views that the latest proposal on the design of PHI policies regulated under HPS went against the original objectives of HPS for the following reasons - (a) at present, a main proportion of the premium paid for PHI policies was used to cover the charges of private healthcare providers. Given that the Administration would not pursue the development of a standardized system of packaged charging for common procedures according to diagnosis-related groups ("DRG") in the short-term, there would be a lack of mechanism to govern the healthcare costs and price transparency of private healthcare services. He therefore could not see any rooms for insurers to lower the premium under HPS in the future; (b) the Consultant estimated that the standard premium per insured person under the HPS Standard Plan would be around 9% higher than the average premium of exiting individual-based ward-level indemnity hospital insurance products in the market. The insurance sector however estimated that, for existing policyholders whose individual-based indemnity hospital insurance was priced at the lower end of the range of premium, they had to pay 30% to 40% more in order to migrate to the HPS Standard Plan. Hence, the Minimum Requirements approach not only interfered with the free market, but also deprived consumers of their rights to choose PHI products which provided less coverage but were of a relatively lower premium; and (c) without the provision of financial incentives in the form of premium discount for new joiners and	

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		premium rebate for long stay as originally proposed by the Administration in the Healthcare Reform Second Stage Public Consultation ("the Second Stage Public Consultation"), the proposal of providing tax deduction for premiums paid for individual-based indemnity hospital insurance policies that complied with the Minimum Requirements could not incentivize the purchase of HPS Standard Plans and encourage the insured to stay on. The Administration's response that it would separately provide a reply letter to HKFI to address its concerns over some of the features of HPS; and its explanation that - (a) with the rapid growth of the PHI market in recent years, it was considered necessary to address the existing shortcomings in market practices for consumer protection by strengthening regulation over PHI. According to the Thematic Household Survey conducted by the Census and Statistics Department in 2011, among those who were covered by PHI, about 54% of their local hospital admissions pertained to the public sector. One of the possible reasons is the lack of confidence in making use of health insurance coverage due to inadequate benefits, or concerns over the possibility of an increase in premium or even termination of policy after claims; (b) past statistics showed that the claims ratio (i.e. amount of claims to amount of premium) for individual PHI plans was about 57% on average. About 43% of the amount of premium was for other expenses such as administrative fee; and (c) by introducing a set of Minimum Requirements for all individual-based indemnity hospital insurance products, including guaranteed acceptance, guaranteed renewal, coverage of hospitalization and ambulatory procedures, coverage of advanced diagnostic imaging tests and cancer treatments, minimum benefit coverage and benefit limits, etc., the quality and certainty of insurance protection would be enhanced. This would provide simplicity, clarity and certainty to consumers and help those consumers who did not possess insurance professional knowledge to understand easily and clearly the minimum protection they could receive when taking out a hospital indemnity insurance plan.	
003001 - 003737	Chairman Miss Alice MAK Admin	Miss Alice MAK's concern about the arrangements for group-based indemnity hospital insurance products after the launch of HPS, in particular whether employees could enjoy continuity of health insurance after retirement. The Administration's advice that it proposed to require insurers to offer employers a conversion option in the group-based indemnity hospital insurance products so that	

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		employees covered by the group plan could, upon leaving their employment, choose to switch to an individual Standard Plan at standard premium without re-underwriting when they left their employment, provided that the employee had been employed for a full year before transferring to the individual Standard Plan. It was also proposed that insurers might offer, on a group policy basis, voluntary supplementary plan(s) to individual members covered by a group-based indemnity hospital insurance plan who wished to procure at their own costs additional protection on top of their group plan. In response to Miss Alice MAK's enquiry about how the Administration could encourage a greater use of private healthcare services by the existing PHI policyholders and those who had yet taken out PHI in order to alleviate the burden on the public healthcare system, the Administration's reiteration of the existing shortcomings in market practices of PHI and how the Minimum Requirements proposed for individual-based indemnity hospital insurance products could provide a value-for-money choice to those who were willing and able to afford private healthcare services through making use of their PHI cover.	
003738 - 005004	Chairman Mr Albert HO Admin	Mr Albert HO's concern about the appropriateness of using public money to enable high-risk individuals to have access to health insurance through Government injection to HRP; and the Administration's explanation that - (a) the Second Stage Public Consultation revealed that it was not uncommon for insurers to decline health insurance applications by individuals with pre-existing conditions or those with higher health risks. Guaranteed acceptance with premium loading cap of 200% of standard premium was an essential component of the Minimum Requirements in support of HPS's goal to improve access to PHI. HRP was the key enabler of these features of HPS, or else insurers might have to assimilate the excessive risks among their policyholders by charging higher premium across the board, which would have the effect of discouraging healthier individuals from taking out PHI; (b) under the HRP mechanism, if, at the opinion of the insurer providing Standard Plan coverage, the premium loading of the policy was assessed to equal or exceed 200% of standard premium charged by the insurer, the insurer might decide, upon the inception of the policy, to transfer the policy to HRP, which was a separate pool from the "normal" pools consisting of other non-high risk policyholders. The premium income (net of administrative fee), claims/liabilities and profit/loss of the policy would be accrued to HRP. The Government would consider injecting funding, which was estimated to be in the region of several billion dollars, to HRP directly to ensure its sustainability; and	

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		(c) it would be equitable to provide public funding to enable those high-risk individuals who were willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage. Without HRP, most of these high-risk individuals would likely fall back on the public system, which was heavily subsidized by the Government. The Chairman's elaboration, using the procedure of colorectal cancer as an example, of the operation of HRP and why the Government would need to provide subsidy to high-risk individuals under the HRP mechanism. At the request of the Chairman and Mr Albert HO, the Administration agreed to provide in writing further information on - (a) examples (with illustrative figures) to demonstrate the calculations of the standard premium for an individual classified under HPS's standard risk group and the premium for a high-risk individual whose premium loading was assessed to be 200% or more of standard premium and would be transferred to HRP. For the latter, the illustration should cover the scenario where the premium loading was capped at 200% of standard premium and the Government provided financial support for HRP; and (b) the estimated financial support required for operating HRP; as well as explanations (in financial terms) on how the provision of public funds to support HRP to enable those high-risk individuals who were willing to contribute to their own healthcare costs through paying premium to obtain health insurance coverage could benefit the general public as a whole.	**Admin**
005005 - 005550	Chairman Admin Mr CHAN Kin-por	The Chairman's remarks that the fact that people who had bought PHI policies would, for various reasons, use both public and private hospital services might explain why there was a discrepancy between the figure cited in the media release issued by HKFI on 6 December 2013 and the set of figures provided by the Administration at the meeting concerning the proportion of persons covered by PHI who chose to be treated at private hospitals; and Mr CHAN Kin-por's affirmation that the reimbursed claim cases referred by HKFI included cases making claim of the $100 expense per day for receiving public hospital services. The Administration's clarification that its set of figures, which referred to the choice of hospital admission among people who had bought PHI policies and who had recently been admitted to hospital for treatment, might not be directly comparable with the figure cited in the media release issued by HKFI on 6 December 2013, which referred to "reimbursed claim cases took place in private hospitals or private day care centres". The Administration undertook to provide after the meeting a detailed explanation in writing.	**Admin**

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005551 - 010430	Chairman Mr CHAN Kin-por Admin	Mr CHAN Kin-por's view that around 100 000 to 200 000 existing PHI subscribers at the lower end of the range of premium might be priced out and had to resort to the public healthcare system as they were unable to afford a 30% to 40% higher premium arising from the broader benefit coverage under the HPS Standard Plan; and his enquiry as to whether the Administration would consider subsidizing these policyholders to migrate to the HPS Standard Plan if the difference between the standard premium under the HPS Standard Plan and the premium of their existing individual-based indemnity hospital insurance policies turned out to be higher than the average figure of around 9% as estimated by the Consultant. The Administration's emphasis that it had all along been working closely with the insurance sector in working out the estimated average standard premium per insured person under the HPS Standard Plan. The premium of those PHI policies in the market with features similar to the Minimum Requirements was close to the estimation of the Consultant. Mr CHAN Kin-por's grave concern that the estimation of the Consultant has not been verified by the insurance sector; and the Administration's undertaking to provide in writing the detailed actuarial models, methodology used and the calculations for the estimated average premium per insured member under the HPS Standard Plan.	**Admin**
010431 - 011631	Chairman Admin	Referring to the proposed requirement that insurers offering a Standard Plan were required to guaranteed acceptance of all ages within the first year of launch of HPS with a premium loading cap of 200% of standard premium, and those aged 40 or below starting from the second year of launch of HPS with a premium loading cap of 200% of standard premium, the Chairman's views that - (a) for people aged above 40, the time for consideration to purchase or migrate to an HPS Standard Plan with guaranteed acceptance and a premium loading cap was too short. If those aged above 40 who were assessed by the insurers to have sub-standard risk did not subscribe in the first year of the launch of HPS, they might become unable to obtain health insurance coverage in the future. This would induce more disputes from consumers, especially those in the older age groups, on what constitute a high underwriting risk; and (b) the proposed feature of HPS to cover pre-existing medical conditions subject to a waiting period and partial reimbursement arrangement until the fourth year of subscription would already encourage early subscription of the healthier individuals. The fact that the number of persons covered by individually-purchased indemnity PHI had grown steadily in recent years to about two million persons also showed that many people would not wait until their health	

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		condition deteriorated to subscribe PHI. These policyholders would likely to migrate to HPS if they considered it attractive. Hence, there was no need to introduce an entry age limit in order to encourage the young and healthy population to subscribe HPS at an earlier time. The Administration's response that the proposed entry age limit was meant to encourage more people to enroll in health insurance when they were still young and healthy. Without such a limit, it was expected that more people would join HPS with their health condition already deteriorated after the first year. It should also be noted that as long as insurers could charge a premium loading rate commensurate with the extra risks that they took on, they could still expect to have an underwriting profit. In such case, it was in the interest of insurers to accept the higher-risk subscribers by charging an appropriate premium loading rate. The Chairman's expression of dissatisfaction with the Administration's response. In his view, the proposed entry age limit was meant to limit the membership of HRP and the public funding support required to ensure the sustainability of HRP. Whether this was the case should be clearly explained in the consultancy report which would be released in conjunction with the public consultation exercise on HPS.	
011632 - 012634	Chairman Dr KWOK Ka-ki Admin	Dr KWOK Ka-ki's reiteration of his concern about the rationale to impose a 30% co-insurance for the prescribed advanced diagnostic imaging tests to combat moral hazard; and his views that - (a) many high-risk individuals would not be able to afford HPS even if the premium loading was capped at 200% of standard premium. For those who could afford health insurance, he could not see the need to subsidize them to take out HPS; and (b) given the inadequate capacity of private hospitals and the lack of price transparency of and effective regulatory control over private hospitals, public money should be used to promote primary care, instead of encouraging a greater use of private hospital services. The Administration's response that - (a) the Steering Committee on Review of the Regulation of Private Healthcare Facilities was reviewing the regulatory regime for private healthcare facilities, which included, among others, private hospitals, with a view to strengthening the regulatory standards. Measures to enhance price transparency and upfront payment certainty would be covered in the review. This apart, it was expected that the increase of more than 1 000 private hospital beds in the coming few years would help lower the charges of private hospital services;	

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		(b) an objective of HPS was to provide a choice to those who were willing and able to afford private healthcare services through making use of their private health insurance cover by addressing the various shortcomings of PHI currently offered in the market. One of these main misgivings expressed by the community was that high-risk individuals had major difficulties and were often unable to purchase private health insurance even if they were willing to do so. The proposed features of guaranteed acceptance and premium loading cap, and the setting up of a separate HRP with injection from the Government to ensure the Pool's sustainability were therefore proposed with a view to enabling high-risk individuals to have access to health insurance; and (c) while taking forward HPS, the Government would continue to strengthen its commitment to the public healthcare system. This was evident from the increase in the annual Government recurrent expenditure on medical and health services in recent years and the public hospital redevelopment or expansion projects in the pipeline. Given that only several billion dollars from the $50 billion fiscal reserve earmarked to support healthcare reform would be required to support HRP for a 25-year period or so, the Administration was considering using part of the $50 billion to enhance public healthcare services.	
Agenda item II: Public funding support for the implementation of the Health Protection Scheme			
012635 - 013029	Chairman Mr CHAN Kin-por Admin	Briefing by the Administration on its considerations in providing public funding support for the implementation of HPS. [LC Paper No. CB(2)412/13-14(03)]	
013030 - 013422	Chairman Mr CHAN Kin-por Admin	Mr CHAN Kin-por's remarks that apart from managing the risk of utilization growth arising from moral hazard, the main reason for requiring a co-insurance for prescribed advanced diagnostic imaging tests under HPS was to lower the premium of the HPS Standard Plan. Mr CHAN Kin-por's views that it was estimated that under the tax deduction proposal for HPS, the amount of tax deduction claimable by individual policyholders would be in the range of several hundred dollars per year. When compared with the financial incentives in the form of premium discount for new joiners and premium rebate for long stay as originally proposed by the Administration in the Second Stage Public Consultation, the effectiveness of tax deduction in encouraging the take-out of health insurance and incentivizing the policyholders to stay insured over a long period of time was therefore limited. The Administration's advice that the Minimum Requirements approach would provide simplicity, clarity and certainty to consumers and hence, encourage the take-out of HPS plans. For the reasons set out in paragraphs 15 to 17 of its paper, the Administration considered that premium discount and	

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		savings component should not be an essential part of HPS.	
013423 - 014050	Chairman Dr KWOK Ka-ki Admin	Dr KWOK Ka-ki's view that the Government should use the $50 billion to promote primary care to reduce avoidable hospital admissions and healthcare procedures. The Administration's further elaboration on how the setting up of an HRP, with Government injection to ensure its sustainability, could enable high-risk individuals to have access to health insurance; and its advice that using part of the $50 billion to promote primary care and improve public healthcare services under a twin-track system of public and private healthcare were options under consideration.	
014051 - 014617	Chairman Mr CHAN Kin-por Admin	Mr CHAN Kin-por's view that the reason why the Administration would use only around $4.3 billion (in the form of injection into HRP and with the introduction of an entry age limit for guaranteed acceptance and premium loading cap under HPS to contain the membership of HRP) out of the $50 billion to support the implementation of HPS was simply to mitigate political resistance; and his enquiry as to whether additional public funding would be provided to support the operation of HRP if the actual funding required far exceeded $4.3 billion. The Administration's response that the reason of providing an estimated total cost to the Government for funding the operation of HRP for a 25-year period was to enable members and the public to have a better understanding of the rough cost estimate of operating HRP. Additional public funding would be provided to ensure the sustainability of HRP as and when necessary. On Mr CHAN Kin-por's concern about whether HRP's indicative administrative cost (i.e. 12.5% of total claims cost on the part of the insurers) was sufficient for covering the fees for insurers, policy management and commission for intermediaries, the Administration's advice that it would further discuss with the insurance industry in determining an appropriate and reasonable level of administrative cost for operating HRP.	
014618 - 015234	Chairman Admin	On the Chairman's enquiry about whether there was any minimum benefit limits for the HPS Standard Plan, the Administration's reply in affirmative, adding that the details would be set out in the public consultation document. Pointing out that it was not uncommon that advanced imaging tests conducted during surgical operations were covered under the existing individual-based indemnity hospital insurance policies in the market, the Chairman's view that the proposal of introducing a 30% co-insurance ratio for the prescribed advanced diagnostic imaging tests under HPS was a step backward in consumer protection; and the Administration's response that subject to the outcome of public consultation, an alternative for consideration was to	

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		impose a co-insurance arrangement only on those advanced imaging tests conducted for diagnostic purpose. The Chairman's enquiry as to whether the latest proposal of using part of the $50 billion for healthcare purposes other than supporting the implementation of HPS represented a deviation from the scope of the original proposal (i.e. for taking forward the healthcare reform after the supplementary financing arrangements had been finalized for implementation); and the Administration's advice that the healthcare reform comprised both healthcare service reform, such as enhancing primary care and strengthening the public healthcare safety net, and healthcare financing reform.	
Agenda item III: Any other business			
015235 - 015518	Chairman Mr CHAN Kin-por Admin	In response to the Chairman's enquiry about the availability of the consultancy report and the timetable for the public consultation exercise on HPS, the Administration's advice that it was expected that the Consultant would submit the final report by the end of 2013 or early 2014. The plan of the Administration was to launch the public consultation within the first half of 2014, probably in March or April 2014. The Administration was requested to provide the consultancy report to the Subcommittee for consideration when available. Mr CHAN Kin-por's view that the Administration should seek the views of the insurance and medical sectors on the consultancy report prior to the launch of public consultation; and the Chairman's suggestion that the Subcommittee should invite views from the relevant stakeholders on the consultancy report in mid-February 2014.	**Admin**
015519 - 015640	Chairman Admin Mr CHAN Kin-por	Date of next meeting and items for discussion	

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17 October 2014