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Legislative Council Panel on Health Services
Subcommittee on Health Protection Scheme

Refined Proposal on the Design of Private Health Insurance Policies Regulated Under the Health Protection Scheme

PURPOSE

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

BACKGROUND TO HEALTH PROTECTION SCHEME

2. Over the past decades, Hong Kong has developed a healthcare system with high efficiency and good quality providing accessible and affordable healthcare to the population. However, as in the case of many advanced economies, our healthcare system faces a number of major challenges, including increasing healthcare needs due to a rapidly ageing population and increasing occurrence of lifestyle-related diseases; rising medical costs due to advances in medical technology and public expectation for healthcare to keep up with such advances; health expenditure growing at a rate faster than that of the economy; and as a result increasing burden on our future generations. Confronted by these challenges, we have to look for ways to maintain the long-term sustainability as well as improve the service and quality of our healthcare system.

3. In July 2005, the Health and Medical Development Advisory Committee issued a discussion paper entitled "Building a Healthy Tomorrow". Among other things, the paper examined our healthcare system and identified the following structural weaknesses: insufficient emphasis on holistic primary care; over-reliance on the public hospital system; significant imbalance between public and private healthcare services; and limited continuity and integration of healthcare at different levels. The paper made a number of recommendations on the future service delivery models, which received broad support from the community and stakeholders and formed the basis for subsequent healthcare reform.

First Stage Public Consultation – "Your Health, Your Life"

4. Building on the discussion paper in 2005, the Government published the consultation document "Your Health Your Life" in March 2008 to initiate a two-stage public consultation on healthcare reform. The First Stage Public Consultation in 2008 consulted the public on service reform proposals, including enhancing primary care, promoting public-private partnership in healthcare, developing electronic health record sharing, and strengthening public healthcare safety net. Six possible supplementary financing options were also put forth for public discussion, including increasing user fees for public healthcare services, social health insurance, mandatory medical savings accounts, voluntary private health insurance, mandatory private health insurance, and personal healthcare reserve (mandatory savings cum insurance).

5. The consultation came to an end in June 2008. There was broad consensus in the community to take forward service reforms, although divergent views were expressed on the supplementary financing options. In general, the public expressed reservations about mandatory financing options as solutions to address the long-term sustainability of healthcare financing. Relatively more people expressed a preference for voluntary private health insurance as a supplementary means of financing for healthcare, which they considered should offer them voluntary choice for personalised healthcare services. The tax-funded public healthcare system should continue to offer essential healthcare as a safety net for the whole population.

6. At the same time, many respondents pointed out various shortcomings they perceived of voluntary private health insurance currently offered in the market, such as the exclusion of pre-existing conditions, no guarantee on renewal of policies, inadequate benefits coverage, disputes over insurance claims, etc. On private healthcare services, some recognized that there were significant uncertainties and financial risks for using them due to inadequate charging transparency and predictability, rendering many who could have afforded private healthcare services to resort to the public healthcare system.

Second Stage Public Consultation – "My Health, My Choice"

7. Against this backdrop, we put forth the HPS proposal, a voluntary, government-regulated private health insurance, in the Second Stage Public Consultation "My Health, My Choice" conducted from October 2010 to January 2011. The HPS is meant to be a supplementary financing arrangement that

complements the public healthcare system. Its objective is to provide an alternative to those who are able and willing to use private healthcare services through enhancing the quality of private health insurance products in the market. In doing so, the HPS could facilitate a greater use of private healthcare services as an alternative to public services, thereby better enabling the public sector to focus on providing services in its target areas. Under the HPS, insurers would offer health insurance products providing the policyholders with benefit coverage and reimbursement levels that would enable them to access general ward class of private healthcare services when needed. A number of key features designed to enhance the access, quality and transparency of private health insurance were proposed for HPS products, including no turn-away of subscribers and guaranteed renewal for life; covering pre-existing medical conditions subject to waiting period; accepting high-risk groups through a high-risk pool; and transparent insurance costs including claims and expenses, etc.

8. The Second Stage Public Consultation on Healthcare Reform revealed broad-based community support for the Government's healthcare reform direction: a strengthened public healthcare system as the core, complemented by a competitive and vibrant private healthcare sector. Many considered the HPS a positive step forward to enhance the long-term sustainability of our healthcare system. They supported the introduction of HPS to provide value-for-money choices to the community, indirectly providing relief to the public healthcare system by better enabling it to focus on serving its target areas.

CURRENT POSITION

9. The HPS is not designed as a total solution to the challenges of our healthcare system, but one of the turning knobs for adjusting the balance of the public-private healthcare sectors, together with other turning knobs such as public-private partnerships, the electronic health record sharing, and development of public and private healthcare facilities. By providing a choice to those who are willing and able to afford private healthcare services through making use of their private health insurance cover, resources in the private sector can be better utilized to meet community needs, particularly the more routine procedures that can be performed in the private sector.

10. While taking forward the HPS, the Government will continue to strengthen its commitment to the public healthcare system, which has been and will continue to be the cornerstone of our healthcare system and safety net for all

Hong Kong people. The Government has substantially increased its investment in public healthcare over the years. The annual Government recurrent expenditure on medical and health services reaches $49 billion in 2013-14, accounting for about 17% of total recurrent expenditure of the Government. In terms of public health infrastructure, a number of hospital redevelopment or expansion projects are now in the pipeline. The expansion of Tseung Kwan O Hospital and the phase two redevelopment of Caritas Medical Centre will be completed in 2013 and 2014 respectively. Construction of the Tin Shui Wai Hospital and the Centre of Excellence in Paediatrics have been commenced in 2013. The expansion of United Christian Hospital, redevelopment of Kwong Wah Hospital, Queen Mary Hospital and Kwai Chung Hospital are also underway through substantial public investment from the Government over a planning horizon that stretches into 2020 and beyond. In addition, the Government is also seeking the Legislative Council's funding approval for a one-off grant of $13 billion for Hospital Authority to implement the planned improvement works programmes over the coming decade or so.

11. 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.

MINIMUM REQUIREMENTS FOR INDIVIDUAL-BASED INDEMNITY HOSPITAL INSURANCE PRODUCTS

12. As reported in the Administration's paper (LC Paper No. CB(2)1237/12-13(01)) for the Subcommittee on Health Protection Scheme meeting held on 4 June 2013, the Consultant recommends introducing Minimum Requirements to all individual-based indemnity hospital insurance products in the market, having regard to the objectives of the HPS, the experience of the local market and overseas jurisdictions, sustainability and viability of the HPS, as well as discussions with various stakeholders. The Minimum Requirements comprise the consumer protection features and requirements proposed for the HPS in the Second Stage Public Consultation on Healthcare Reform as mentioned in paragraph 7. Under the Minimum Requirements approach, all

individual-based indemnity hospital insurance products to be offered after the launch of the HPS must meet or exceed the Minimum Requirements. To ensure that consumers would be guaranteed of minimum protection, we propose that insurers selling individual-based indemnity hospital insurance products must offer as one of the options to consumers a Standard Plan that meet all the Minimum Requirements. On top of the Minimum Requirements of the Standard Plan, insurers may offer Flexi or Top-up Plans with choices of additional benefits to suit the specific needs of consumers, such as higher benefit limits, higher ward class, coverage of overseas emergency, medication or drugs, out-patient services, etc.

13. To facilitate existing policyholders of individual-based indemnity hospital insurance to migrate to policies that comply with the Minimum Requirements, we propose to require insurers to, within a one-year window period after the launch of the HPS, offer an option to policyholders to convert their existing policies to one that meets or exceeds the Minimum Requirements. Clear and streamlined arrangements would be put in place to facilitate smooth migration by policyholders and minimize administrative work. For policyholders who do not wish to migrate to the HPS, they can keep their existing policies under a grandfathering arrangement as long as the insurers concerned continue to administer such policies under the applicable terms and conditions, although grandfathered policies will not be entitled to any financial incentive to be provided.

Minimum Requirements for Standard Plan

14. The ensuing paragraphs set out the proposed Minimum Requirements for the Standard Plan, which can be grouped under three categories, namely (A) improving access to and continuity of health insurance, (B) enhancing quality of insurance protection, and (C) promoting transparency and certainty. A table summarising the proposed Minimum Requirements is at **Annex** for reference.

(A) Improving access to and continuity of health insurance

(1) Guaranteed renewal

15. We propose to require insurers to provide guaranteed renewal without re-underwriting as part of the Minimum Requirements in order to provide life-long insurance cover to consumers.

(2) No "lifetime benefit limit"

16. We note that currently some insurers have imposed "lifetime benefit limit" on some health insurance policies. Under a "lifetime benefit limit", the insurance cover terminates when the cumulative claim amount of a policyholder reaches the lifetime limit. This could render the requirement of guaranteed renewal ineffective because the continuation of insurance cover would be conditional upon previous claims, rather than payment of premium on the part of the policyholder. Moreover, "lifetime benefit limit" might have the unwanted effect of deterring a policyholder from seeking necessary medical care earlier in his/her life for fear of using up his/her lifetime benefit limit too soon. This could be detrimental to the health of the policyholder, and even aggravate his/her medical costs because of delay in treatment. We thus propose to impose an explicit no "lifetime benefit limit" clause as part of the Minimum Requirements.

(3) Coverage of pre-existing conditions

17. We propose to enable all individuals to have excess to health insurance by requiring insurers to cover pre-existing medical conditions subject to a waiting period and partial reimbursement arrangement as follows –

(i) First year –no coverage
(ii) Second year – 25% reimbursement
(iii) Third year – 50% reimbursement
(iv) Fourth year onwards – full coverage

(4) Guaranteed acceptance and premium loading cap

(i) Guaranteed acceptance

18. We propose to require insurers offering a Standard Plan to guarantee acceptance of –

(i) all ages within the first year of launch of the HPS with a premium loading cap of 200% of standard premium; and

(ii) those aged 40 or below starting from the second year of the launch of the HPS with a premium loading cap of 200% of standard premium.

19. The first proposal above aims to provide accessible and affordable health insurance cover to older age people who did not have a chance to do so when they were young. The second proposal aims to encourage more people to enroll in health insurance when they are young and healthy. Without an entry age limit, there would be incentive for individuals to defer taking out of health insurance until at an older age when their health condition deteriorates. At a young age, a policyholder is more likely to be healthy and thus may be able to lock in a standard underwriting risk class upon taking out health insurance. He/she can then maintain the underwriting risk class without re-underwriting even when he/she develops health conditions at a later age. In comparison, if a policyholder subscribes to health insurance at an older age, he/she may already have developed pre-existing conditions. The policyholder would then need to pay a higher premium than that for a standard underwriting risk class, which he/she would otherwise have locked in if they took out health insurance earlier.

20. We consider the proposed age limit of 40 appropriate as those who would like to subscribe to health insurance should have ample opportunities to do so before reaching the age of 40. In Australia, for example, policyholders are encouraged to purchase private health insurance by age 30. A person who starts to take out a private health insurance plan after the age of 30 is charged a loading on the insurance premium[1].

21. For those who choose to subscribe to health insurance after the age of 40, they would still be able to enjoy the benefits of all other Minimum Requirements proposed for the Standard Plan except for guaranteed acceptance (i.e. their applications for health insurance might be rejected by insurers) and the premium loading cap proposed for the Standard Plan.

(ii) Premium loading cap

22. We propose to cap the premium loading at 200% of standard premium in order to ensure premium affordability for high-risk individuals. A High Risk Pool is proposed to be set up to accept policies of Standard Plan of which the premium loading is assessed to be 200% or more of the standard premium offered by the insurer. Details of the proposed High Risk Pool are elaborated in the Administration's other paper "Public Funding Support for the Implementation of the Health Protection Scheme".

[1] In Australia, those who take-up private health insurance after 30 years of age are charged 2% of the base premium for each year over age 30, subject to a maximum of 70% of the base premium.

(5) Portable insurance policy

23. In principle, we consider that policyholders should enjoy free portability (i.e. without re-underwriting) as far as possible in order to enhance consumer choice and promote healthy competition amongst insurers. On the other hand, we have to guard against the risk that insurers might make use of free portability to build up or maintain a lower-risk profile at the expense of the policyholders. For example, a policyholder who has developed health conditions over the years may be induced to transfer his/her policy to another insurer because the original insurer does not offer satisfactory service to him/her. Free portability could potentially result in higher overall costs for the community because insurers would have to make a buffer by charging higher premium for unexpected risks arising from some of the portable cases. To address this problem, we propose that policyholders of products complying with the Minimum Requirements may switch to Standard Plans of other insurers without re-underwriting and re-serving waiting period as long as he/she did not make any claims in the past three years immediately before the transfer of policy to another insurer.

(B) Enhancing quality of insurance protection

(6) Coverage of hospitalisation and ambulatory procedures

24. We propose to cover under the Minimum Requirements –

(i) hospital admissions necessitated by diagnosed medical condition; and

(ii) a list of prescribed ambulatory procedures necessitated by diagnosed medical condition, including endoscopy and colonoscopy and certain relatively simple surgeries like cataract extraction and intra-ocular lens implantation surgery.

25. Currently, some of the indemnity hospital insurance products in the market only provide reimbursement for procedures performed under an in-patient setting and requiring overnight hospital stay. Hence, even if a procedure could be performed under an ambulatory setting, the patient would be obliged to stay overnight at the hospital for the expenses to be claimable. This not only causes inconvenience to the patient, but also leads to a waste of healthcare resources. According to the Consultant, around half of the endoscopies and colonoscopies received by the insured in private hospitals occurred as overnight stays. In

comparison, in Australia, less than 10% of endoscopies and colonoscopies involve in-patient overnight stays. Coverage of prescribed ambulatory procedures would help avoid unnecessary overnight hospital stay, deliver healthcare in a more cost-effective way, and better utilise private sector capacity in providing in-patient care for genuine cases.

(7) Coverage of advanced diagnostic imaging tests and cancer treatments

26. We propose to cover under the Minimum Requirements –

(i) a list of prescribed advanced diagnostic imaging tests necessitated by assessed medical condition, including Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) and Positron Emission Tomography (PET) scan subject to co-insurance at prescribed rate (30%)(please refer to paragraph 29) to combat moral hazard; and

(ii) cancer treatments up to a prescribed limit ($150,000 per disability per year as currently proposed), including chemotherapy, radiotherapy, targeted therapy and hormonal therapy.

(8) Minimum benefit limits

27. We propose that the benefit limits of Standard Plan should be at the prescribed levels with the aim of providing reasonable coverage for general ward at average-priced private hospitals.

28. The benefit coverage and benefit limits of the Standard Plan should be reviewed and updated at regular intervals by the regulatory agency to be set up to supervise the implementation and operation of the HPS.

(9) Cost-sharing restrictions

29. While cost-sharing arrangements by the policyholder, such as co-insurance and deductible, could encourage judicious use of healthcare services, we note that cost-sharing arrangements might reduce the attractiveness of health insurance plans, and might affect the desire of the policyholder to seek necessary treatments. We therefore propose that in principle, no cost-sharing arrangements (deductible or co-insurance) should be included in the Standard Plan, except a fixed 30% co-insurance for the prescribed advanced diagnostic imaging tests, which are more easily subject to mis-use or abuse as compared to

other healthcare services such as surgical operations or application of medications (e.g. chemotherapy). We also propose an annual cap of $30,000 for any cost-sharing to be paid by the policyholder (excluding any amount that the policyholder has to pay if the actual expenses exceed the benefit limits in his/her insurance policy).

(C) Promoting transparency and certainty

(10) Upfront payment certainty

(i) No-gap/known gap arrangement

30. To enhance transparency and certainty of upfront payment by consumers, we propose to introduce the "no-gap/known-gap" arrangement, which has been widely adopted in Australia. "Gap" refers to the out-of-pocket expenses a patient pays for hospital or doctor's fees. The policyholder can enjoy "no-gap" (no out-of-pocket payment is required) or "known-gap" (a pre-determined amount of out-of-pocket payment) if the procedure concerned, the hospital and doctor selected by the policyholder is on the agreed list negotiated between the insurers and healthcare providers.

31. We propose that the "no-gap/known-gap" arrangement must be offered under the Standard Plan. Insurers may limit the "no-gap/known-gap" arrangement to a particular list of procedures, hospitals/clinics and doctors. As the market gradually adjusts, we expect that the "no-gap/known-gap" arrangement would become more popular over time as revealed by the experience in Australia. Before the "no-gap/known-gap" requirements were introduced in 2000, only about 50% of in-patient medical services were provided with no-gap payable by patients. In 2012, about 90% of in-patient medical services were paid on a no-gap basis, and insurers in Australia now compete for policyholders on the basis of how successful their "no-gap/known-gap" arrangements are.

32. The "no-gap/known-gap" arrangement would be akin to packaged pricing in the sense that it provides budget certainty and convenience to the policyholder, who can ascertain the amount of out-of-pocket payment, if any, before receiving the treatment. The policyholder would still be free to choose services provided by hospitals or doctors not on the "no-gap/known-gap" list. The insurance benefit will be calculated based on the actual fees and charges against the benefit limits in accordance with the insurance policy, and out-of-pocket expenses may be necessary. In such case, the policyholder would

still be able to benefit from the budget certainty provided by the "informed financial consent" arrangement described below.

(ii) Informed financial consent

33. To enhance budget certainty by consumers, we propose that patients should be informed of the estimated total charges for investigative procedures or elective, non-emergency therapeutic operations/procedures for known diseases on or before admission to private hospitals. Patients should be provided with a written quotation in a standardised form, i.e. informed financial consent, of the estimated total charges, including separate items for estimated doctor's fees and estimated hospital charges. Insurers would also be required to indicate in the same form the reimbursement amount for the operations/procedures concerned, as well as estimated out-of-pocket expenses to be paid by the patients given their existing insurance cover.

34. We are aware that there might be circumstances where the informed financial consent requirement should be exempted, e.g. emergency or life threatening situations. There may also be medical conditions which the doctor considers it not clinically possible to identify a definite diagnosis for the disease, e.g. abdominal pain, and therefore unable to provide an estimate of the charges of the operations/procedures to be provided. In such cases, we propose that doctors should be required to indicate and justify why this is the case in the form showing the price quotation. In case there are any material changes in estimates (e.g. due to unforeseen complications), patients should be informed of the reasons for change of the estimated charges, as well as the latest estimated charges as soon as practicable.

(11) Standardised policy terms and conditions

35. We propose to require insurers to adopt a standardised set of policy terms and conditions as well as associated definitions. This means that the Standard Plans offered by different insurers must adopt the same set of policy terms and conditions, enabling consumers to better comprehend the terms upfront, and minimising disputes over interpretations afterwards.

(12) Premium transparency

36. To enhance market transparency and drive competition, we propose that the age-banded premium schedules must be published for consumers' reference.

We also propose to establish under the regulatory agency an easily accessible platform (e.g. website) with information on the Standard Plans offered by different insurers in the market, including the premium schedules. This will allow consumers to easily compare the Standard Plans offered by different insurers and drive the market to provide value-for-money products and services to consumers.

ARRANGEMENTS FOR GROUP-BASED INDEMNITY HOSPITAL INSURANCE PRODUCTS

37. In the long-run, it would be desirable for group-based indemnity hospital insurance products to comply with the Minimum Requirements for individual-based products for better consumer protection. Given that purchase of health insurance is voluntary under the HPS, we recognise that it would be important to encourage employers to maintain or take up group-based indemnity hospital insurance cover for their employees. The group market is inherently different from the individual market since the cost of the group health insurance cover is borne by the employer, rather than the employee, who is the direct beneficiary of the insurance cover. We also note that some of the plans in the market are of limited protection in terms of benefit coverage and limits due to budget constraint of some employers. If all group-based indemnity hospital insurance products are required to comply with the Minimum Requirements, some of the employers might drop the health insurance cover altogether because they may not be able to afford the more comprehensive coverage of compliant products.

38. Taking into account the above, we propose that group-based indemnity hospital insurance products should not be subject to the Minimum Requirements proposed for individual-based indemnity hospital insurance products. Nevertheless, to better protect the employee's interests, we propose to adopt the following arrangements for group-based indemnity hospital insurance products.

<u>Conversion option</u>

39. We propose to require insurers to offer as an option to employers an extra component – the "conversion option" – in the group-based indemnity hospital insurance products offered to employers. If the employer decides to purchase the group plan together with the "conversion option", an employee covered by such group plan can choose to exercise the "conversion option" upon

leaving their employment so that he/she can switch to an individual Standard Plan at standard premium without re-underwriting, provided that the employee has been employed for a full year immediately before transferring to the individual Standard Plan. The "conversion option" would help ensure continuity of health insurance cover of the employee into old age. Compared with purchasing a separate individual Standard Plan, the benefits of the "conversion option" are that the employee will not need to undergo re-underwriting when switching to an individual Standard Plan, and does not need to take on an individual plan beforehand in order to secure a sustained and affordable insurance protection upon retirement or leaving employment.

Voluntary supplementary plan(s)

40. We also propose that insurers may offer, on a group policy basis, voluntary supplementary plan(s) to individual members covered by a group-based indemnity hospital insurance plan who wish to procure at their own costs additional protection on top of their group plan. Combined with the group plan, the voluntary supplementary plan(s) should provide insurance protection at a level tantamount to the protection of an individual Standard Plan.

RISK OF MORAL HAZARD AND IMPORTANCE OF PRIMARY CARE INVOLVEMENT

41. The HPS is designed to focus primarily on hospital services as its objective is to provide a choice to those who are able and willing to use private health insurance for private healthcare services, particularly the more routine procedures performed under an in-patient setting in the public sector. Notwithstanding this, we recognise that primary care could have an important role to play to help ensure that healthcare resources are judiciously used for those genuinely in need. In addition to the cost-sharing arrangements proposed under the Minimum Requirements in paragraph 29, appropriate involvement of primary care providers could be an effective check against utiliazation of private healthcare services induced by moral hazard under the HPS. In fact, effective primary care can often improve the health of individuals in the community; reduce their need for more expensive medical services, especially specialist and hospital services; and help ensure continuity and coordination of care.

42. We will explore with primary care providers and other stakeholders the possibility of enhancing the involvement of primary care in the implementation

of the HPS. With more effective healthcare utilization, the claims cost of health insurance could be better controlled, which would help keep the premium levels in check and help contain medical costs.

WAY FORWARD

43. The Consultant is in the process of finalizaing the detailed proposals for the HPS, having regard to views and suggestions of various stakeholders. Taking into account the Consultant's recommendations, views from the Consultative Group on HPS and other stakeholders, the Working Group on HPS will tender its recommendation for the HPS by end of this year. The Administration will consult the public on the detailed proposals for implementing the HPS within the first half of 2014.

ADVICE SOUGHT

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

Food and Health Bureau
December 2013

Annex

Proposed Minimum Requirements for Standard Plan

(A)	Access to and continuity of insurance	
(1)	Guaranteed renewal	• Guaranteed renewal for life; no re-underwriting is allowed for policy renewal
(2)	No "lifetime benefit limit"	• No "lifetime benefit limit" can be imposed on policyholder
(3)	Coverage of pre-existing conditions	• Coverage of pre-existing medical conditions subject to waiting period – • First year –no coverage • Second year – 25% reimbursement • Third year – 50% reimbursement • Fourth year onwards – full coverage
(4)	Guaranteed acceptance and premium loading cap	• Guaranteed acceptance for - • all ages within the first year of launch of HPS • those aged 40 or below starting from the second year of launch of HPS • Premium loading capped at 200% of standard premium
(5)	Portable insurance policy	• Re-underwriting may be waived when changing insurer if no claims made in the past three years immediately before the transfer of policy
(B)	Quality of insurance protection	
(6)	Coverage of hospitalisation and ambulatory procedures	• Benefit coverage must include medical conditions requiring hospital admissions and prescribed ambulatory procedures
(7)	Coverage of advanced diagnostic imaging tests and cancer treatments	• Benefit coverage must include prescribed advanced diagnostic imaging tests subject to a fixed 30% co-insurance; and cancer treatments up to a prescribed limit (including chemotherapy, radiotherapy, targeted therapy and hormonal therapy)
(8)	Minimum benefit limits	• Benefit limits must meet the prescribed levels

(9) Cost-sharing restrictions	• No deductible and co-insurance, except the 30% co-insurance fixed for prescribed advanced diagnostic imaging tests • Annual cap of $30,000 on cost-sharing by policyholder (however, if the actual expenses exceed benefit limits, the excess amount is still payable by the policyholder)
(C) Transparency and certainty	
(10) Upfront payment certainty	• No-gap/known-gap arrangement • Informed financial consent
(11) Standardised policy terms and conditions	• Minimise claims disputes arising from different interpretations of terms and conditions
(12) Premium transparency	• Transparent age-banded premium structure • Transparent information on premiums through easily accessible platform (e.g. website) for consumers' reference