

## **LEGISLATIVE COUNCIL BRIEF**

### **Voluntary Health Insurance Scheme**

#### **INTRODUCTION**

At the meeting of the Executive Council on 2 December 2014, the Council ADVISED and the Chief Executive ORDERED that a public consultation on implementing the Voluntary Health Insurance Scheme (VHIS) should be launched on 15 December 2014 for three months by putting forward the proposals in the form of a consultation document (draft executive summary at **Annex A**).

#### **JUSTIFICATIONS**

##### **Two Stages of Public Consultation on Healthcare Reform**

2. Confronted by the challenges brought about by the ageing population and increasing healthcare needs, the Government conducted two stages of public consultation on healthcare reform in 2008 and 2010 to look for ways to maintain the long-term sustainability of our healthcare system. The First Stage Public Consultation consulted the public, amongst other service reform proposals, six possible supplementary financing options<sup>1</sup>. As the public expressed reservations about mandatory options as solutions to address the long-term sustainability of healthcare financing, we formulated the HPS, a voluntary, government-regulated private health insurance scheme, for consultation during the Second Stage Public Consultation. The Health Protection Scheme (HPS) is intended as a supplementary financing arrangement that complements the public healthcare system. It 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<sup>2</sup>. By enhancing accessibility to and quality of health insurance products, the HPS aims to strengthen consumer confidence in using private healthcare services, thereby alleviating the long-term financing

---

<sup>1</sup> The six supplementary financing options included 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).

<sup>2</sup> The other turning knobs include public-private partnerships (“PPPs”), the electronic health record sharing, development of public and private healthcare facilities, etc.

pressure on the public healthcare system. We have set up a Working Group and a Consultative Group on HPS under the Health and Medical Development Advisory Committee to formulate detailed proposals for implementing the HPS. A Consultant was also appointed to provide professional and technical support<sup>3</sup>. As the HPS is intended as a supplementary financing arrangement, we propose to rename the scheme as VHIS to better reflect its objectives and nature. While taking forward the VHIS, the Government will continue with 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<sup>4</sup>.

### **Proposals for Implementing the VHIS**

3. Based on the deliberations of the Working Group and the recommendations by the Consultant, we put forth the following proposals for implementing the VHIS as described in ensuing paragraphs.

#### ***All Individual Hospital Insurance Products Must Comply with Minimum Requirements***

4. We propose that, upon the implementation of the VHIS, insurers in selling and/or effecting individual indemnity hospital insurance will be required to comply with the Minimum Requirements prescribed by the Government<sup>5</sup>. Individual indemnity hospital insurance means a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (Cap.41)(“ICO”)(“**Class 2**”) which provides for benefits in the nature of **indemnity** against risk of loss to the insured attributable to **sickness or infirmity that requires hospitalisation**<sup>6</sup> (“**Hospital Insurance**”) and the policyholder/person insured is an **individual**. An individual Hospital Insurance policy may be issued to an individual as a standalone Class 2 policy or as an additional cover combined with, hence, forming part of a contract of

---

<sup>3</sup> PricewaterhouseCoopers Advisory Services Limited was commissioned.

<sup>4</sup> The annual Government recurrent expenditure on medical and health services has reached \$52 billion in 2014-15, 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 under construction and planning through substantial investment from the Government, including the construction of the Tin Shui Wai Hospital and the Hong Kong Children’s Hospital, expansion of United Christian Hospital, redevelopment of Kwong Wah Hospital and Queen Mary Hospital, etc.

<sup>5</sup> For the avoidance of doubt, the VHIS does not intend to cover any fixed pecuniary benefits (e.g. hospital cash, critical illness cover) which may be added to an individual Hospital Insurance policy. Typically, a critical illness cover provides a lump sum cash payment if the insured is diagnosed with a disease as designated in the insurance policy whereas a hospital cash cover provides a fixed cash benefit paid for each day of hospitalization due to a sickness or accident. In both examples, since the payment is one of fixed pecuniary benefits, the cover itself will not be regulated under the VHIS. It will also not be regulated for reason that the cover is attached to an individual Hospital Insurance Policy.

<sup>6</sup> For the purpose of the VHIS, hospitalisation refers to a setting where a patient may not be discharged on the same calendar day of admission; and the expected total duration of the procedure, recovery, treatment and care requiring continuous confinement within the facility may exceed 12 hours.

long-term business (e.g. a medical insurance rider attached to and forming part of a life insurance policy). Upon the implementation of the VHIS, insurers will not be allowed to offer individual Hospital Insurance products that do not comply with the Minimum Requirements. Insurers selling individual Hospital Insurance must offer a “**Standard Plan**” (i.e. one which meets all (but not exceeding) the Minimum Requirements) to consumers as an available option, regardless of whether they also offer individual Hospital Insurance products with enhanced benefits (please see paragraph 5). The 12 Minimum Requirements proposed for Standard Plan aim to improve accessibility and continuity of individual Hospital Insurance, enhance the quality and promote transparency and certainty of insurance protection. They are summarised below (a more detailed description is at **Annex B**) –

- (a) guaranteed renewal with no re-underwriting;
- (b) no “lifetime benefit limit”;
- (c) coverage of pre-existing conditions subject to standard waiting period;
- (d) guaranteed acceptance with premium loading capped at 200% of standard premium for –
  - (i) all ages within the first year of implementation of the VHIS; and
  - (ii) those aged 40 or below starting from the second year of implementation of the VHIS;
- (e) portable insurance policy with no re-underwriting when changing insurer, provided that no claims were made in a certain period of time (say, three years) immediately before transfer of policy;
- (f) benefit coverage must include medical conditions requiring hospital admissions and/or prescribed ambulatory procedures<sup>7</sup>;
- (g) benefit coverage must include prescribed advanced diagnostic imaging tests, subject to a fixed 30% co-insurance to combat moral hazard; and non-surgical cancer treatments up to a prescribed limit;

---

<sup>7</sup> The ambulatory procedures to be covered under Standard Plan will be determined and prescribed by the regulatory agency (please see paragraph 14) to be established to monitor the implementation and operation of the VHIS, subject to the advice of an advisory committee constituted mainly of major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.).

- (h) benefit limits must meet prescribed levels;
- (i) no cost-sharing (deductible or co-insurance) by policyholder except the fixed 30% co-insurance for prescribed advanced diagnostic imaging tests; and annual cap of \$30,000 on cost-sharing by policyholder (excluding excess amount payable by policyholder if actual expenses exceed benefit limits);
- (j) budget certainty for policyholder through –
  - (i) Informed Financial Consent: a policyholder should be informed of estimated charges and estimated claims amount through written quotation before treatment;
  - (ii) No-gap/known-gap arrangement for at least one procedure/test: a 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 institution (e.g. hospital) and doctor selected by the policyholder are on the lists agreed among his/her insurer and healthcare providers;
- (k) standardised policy terms and conditions; and
- (l) transparent information on age-banded premiums through easily accessible platform (e.g. websites of insurers and the VHIS regulatory agency to be established).

5. The Minimum Requirements proposal was formulated having regard to public concerns over the existing Hospital Insurance market as revealed by the previous public consultations, such as decline of cover; exclusion of pre-existing conditions; no guaranteed renewal of policies; lack of budget certainty; or dispute over insurance claims due to lack of standardisation of policy terms and conditions. These shortcomings have often discouraged the insured from making use of private healthcare services through their insurance cover, leading them to fall back to the public system<sup>8</sup>. By improving the quality and certainty of Hospital Insurance protection through the Minimum Requirements, and by fostering consumer confidence in using private healthcare services, Hospital Insurance would be able to play a greater role in financing the growing health expenditure. International experience also reveals that it is

---

<sup>8</sup> According to the Thematic Household Survey conducted by Census and Statistics Department in 2011, amongst those who are covered by private health insurance, about 54% of their local hospital admissions pertained to the public sector.

common for overseas governments to impose requirements similar to the Minimum Requirements on private health insurance (please refer to **Annex C**), such as in Australia, Ireland, the Netherlands, Switzerland and the United States. Insurers are not restricted to offer Standard Plan only but may provide enhanced benefits in the form of a Flexi Plan or a Top-up Plan. In brief, for the purpose of the VHIS –

- (a) a Flexi Plan refers to a Hospital Insurance plan with enhancement to any or all of the benefits of a Standard Plan (e.g. higher room and board limits than those required for a Standard Plan) of Hospital Insurance nature; with a view to allowing more flexibility in promoting product innovation and competition, the enhanced benefits in a Flexi Plan will not be subject to the requirements of –
  - (i) guaranteed acceptance with premium loading cap; and
  - (ii) the cost-sharing restriction (no deductible or co-insurance) of Standard Plan, except that the amount of the deductible or co-insurance would be subject to the same annual cap of \$30,000 proposed for Standard Plan; and
- (b) a Top-up Plan refers to one providing for benefits other than those in the nature of a Hospital Insurance and may be attached to, hence forming part of, a Standard Plan or a Flexi Plan. Since a Top-up Plan, whether as a rider or as a standalone plan, is not a Hospital Insurance, it will not be subject to the Minimum Requirements.

6. From the perspectives of health policy and consumer protection, we consider it desirable that individual Hospital Insurance sold in the name of “hospital”/“health”/“medical” insurance should provide at least the benefits offered by a Standard Plan, such that consumers who purchase such products will not be misled into thinking that these products fulfill the Minimum Requirements of the VHIS. We propose that, upon the implementation of the VHIS, only those health insurance products complying with the Minimum Requirements may be sold in the name of “hospital”/“health”/“medical” insurance, or such other name that denotes or connotes that such product is an individual Hospital Insurance<sup>9</sup>.

---

<sup>9</sup> For group Hospital Insurance, since they would not be regulated by the Minimum Requirements (please see paragraph 9), and some of which may provide benefits lesser than that of an individual Standard Plan, we propose that, for any group Hospital Insurance products to be sold in the name of “hospital”/“health”/“medical” insurance, it must be specified in the product name that such products are group products (e.g. “group hospital insurance”, “group health insurance” or “group medical insurance”).

7. Standard Plan offers enhanced benefits compared to existing individual Hospital Insurance products which likewise target at general ward level services<sup>10</sup>. Taking into account these enhanced benefits, the average annual standard premium of Standard Plan is estimated by the Consultant to be around **\$3,600**<sup>11</sup> (in 2012 constant prices), about 9% higher than the average premium of existing individual Hospital Insurance products (ward level) in the market (i.e. about \$3,300 in 2012 constant prices). The above notwithstanding, enhanced transparency and product comparability under the VHIS is expected to result in a reduction of the expense loading (i.e. the amount of insurer expenses, including commissions and broker fees, profit margins, expenses and other overhead expenses, as a percentage of the amount of premium)<sup>12</sup>. Under the VHIS, the standardisation of design of Standard Plan and better flow of market information will facilitate easy comparison by consumers, foster market competition, and hence lead to a more moderate expense loading. A modest improvement in the expense loading to a level more in line with international experience can partly offset the estimated increase in premium of Standard Plan in comparison with existing products in the market, which lack the enhanced features and benefits proposed under the Minimum Requirements. The proposed requirements for enhancing premium and budget certainty are designed to enhance consumer choice, foster market competition, and help premium levels in check. The coverage of prescribed ambulatory procedures would also facilitate more cost-effective delivery of healthcare by reducing unnecessary hospitalisation. In the long run, the expected improvements in market efficiency is expected to lead to a less marked increase in average premium of individual Hospital Insurance<sup>13</sup> compared with the baseline scenario (without the VHIS).

---

<sup>10</sup> For instance, for non-surgical cancer treatments (e.g. chemotherapy, radiotherapy) and advanced diagnostic imaging tests (e.g. Magnetic Resonance Imaging (“MRI”) examination, Computed Tomography (“CT”) scan, Positron Emission Tomography (“PET”) scan), a lot of existing products do not provide coverage for these treatments and tests as a separate benefit item. These treatments and tests are usually only claimable under the benefit item of “miscellaneous hospital expenses”, which under normal circumstances would not be sufficient for covering the cost of these treatments and tests. Under Standard Plan, rather than being covered under “miscellaneous hospital expenses” as in existing individual Hospital Insurance products, these treatments and tests will be covered under separate benefit items, subject to respective benefit limits that would provide sufficient coverage for policyholders for using these services.

<sup>11</sup> The figure lies between the estimated standard premiums of Standard Plan for the age groups from 40 to 49.

<sup>12</sup> According to statistics from the Office of the Commissioner of Insurance, the average expense loading of the individual health insurance market (36% in 2013, the corresponding figure for the group health insurance market was 19% in 2013) and the whole health insurance market (29% in 2013) in Hong Kong were the highest among jurisdictions studied by the Consultant. The average expense loading of the whole health insurance market was 13% in Australia (2012), 13% in Ireland (2012), 7% in the Netherlands (2012) and 9% in Switzerland (2012).

<sup>13</sup> In 2040, the average premium of individual Hospital Insurance is projected to be 6% below that of the baseline scenario.

### ***Migration Arrangements for Existing Individual Hospital Insurance Policies***

8. Where the expiry of the existing individual Hospital Insurance policies fall within one year of implementation of the VHIS, we propose to require insurers to, upon such expiry, offer an option to policyholders concerned to migrate to a policy that complies with the Minimum Requirements without re-underwriting for existing benefit coverage and benefit limits. Any relevant policyholders who migrate their policies only after the said one-year period may be subject to re-underwriting if deemed necessary by the insurer concerned. If the policyholders choose not to migrate but to renew their policies, whether within or after the said one-year period, on the same old terms or any other terms which fall short of the Minimum Requirements, such policies will be exempted from the Minimum Requirements under a grandfathering arrangement as long as the insurers concerned continue to administer such policies. Further details of the migration arrangements are provided in paragraphs 30 to 35 of Annex A. Nevertheless, in order to encourage early migration to policies complying with the Minimum Requirements, grandfathered policies will not be entitled to any financial incentives, including tax deduction provided by the Government (please refer to paragraphs 12 to 13 below).

### ***Arrangements for Group Hospital Insurance***

9. Ideally, it is desirable for group Hospital Insurance policies (i.e. policies being held by an employer for the benefit of its employees) to comply with the Minimum Requirements for better consumer protection. Nevertheless, given that the group market is inherently different from the individual market in the sense that the cost of purchasing the group policies is borne by employers, rather than the employees who are the direct beneficiaries; and the fact that some of the products in the market are of limited protection due to budget constraint of some employers, we propose not to require group Hospital Insurance to comply with the Minimum Requirements<sup>14</sup>. To better protect employee's interests, we propose to adopt the following arrangements for group Hospital Insurance –

- (a) ***Conversion Option***: we propose to require insurers to offer as an option to employers an elective component – the Conversion Option – in the group Hospital Insurance products. If the employer decides to purchase the group policy together with the Conversion Option, an employee covered by such group policy can exercise the Conversion

---

<sup>14</sup> For the avoidance of doubt, the VHIS does not intend to cover insurance policies purchased by employers for foreign domestic helpers where indemnity hospital insurance is featured incidentally as a small, non-core component and is not intended to cover the full cost of private healthcare services of the person insured. Insurance policies purchased by employers for foreign domestic helpers will not be subject to the arrangements proposed for group policies described in this paragraph.

Option upon leaving employment so that he/she can switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that he/she has been employed for a full year immediately before transferring to the individual Standard Plan; and

- (b) ***Voluntary Supplement(s)***: we propose that insurers may offer, on a group policy basis, Voluntary Supplement(s) to individual members covered by a group Hospital Insurance policy who wish to procure at their own costs additional protection on top of their group policy. The group policy, enhanced by the Voluntary Supplement, should provide insurance protection at a level comparable to the protection of an individual Standard Plan.

### ***High Risk Pool to Enable High-risk Individuals to Obtain Hospital Insurance***

10. During the Second Stage Public Consultation, one of the major misgivings expressed by the community is that high-risk individuals have significant difficulties in purchasing Hospital Insurance. To meet the community's aspirations to enable high-risk individuals to purchase Hospital Insurance, we propose to require under the Minimum Requirements that insurers must provide to consumers a Standard Plan with guaranteed acceptance with a premium loading cap of 200%, and coverage of pre-existing conditions. Nevertheless, if insurers are mandated to accept such individuals and the loading is capped without proper mitigating measures, they may not be able to collect adequate premium income to offset the claims payout. To ensure that high-risk individuals can also buy Hospital Insurance, the Consultant recommends that a High Risk Pool ("HRP") be established. The HRP will be open to all in the first year upon the implementation of the VHIS and limited to those aged 40 or below thereafter. We propose that the HRP should be established by legislation with the following framework –

- (a) the HRP will be a legal entity, which can enter into contracts, sue and be sued; it will be funded by premium income and Government funding;
- (b) it accepts only Standard Plan high-risk policies<sup>15</sup> transferred by an insurer; despite such transfer, the policy remains as a contract between the policyholder and the insurer who underwrites and issues the policy;
- (c) the insurer will administer the policy and receive an administration fee payable by the HRP;

---

<sup>15</sup> A high-risk policy refers to one of which an insurer will charge a premium loading at or more than 200% of its standard premium.



- (d) in the course of administration, the insurer shall separate a portfolio for the high-risk policies from other policies with a view to ensuring that underwriting of risks of non-high-risk individuals will not be adversely affected;
- (e) all premiums payable and claims and liabilities under the policy will be accrued to the HRP;
- (f) the HRP may contract out its day-to-day operation to a claims specialist;
- (g) the policyholder shall pay the premium with a premium loading at 200% of the standard premium prescribed by the insurer;
- (h) the HRP will be monitored by the regulatory agency provided in paragraph 14; and
- (i) the insurer is expected to transfer a high-risk policy underwritten by it to the HRP upon the policy inception. The HRP will not subsequently accept any high-risk policy not so transferred and the insurer cannot later on request the HRP to accept any high-risk policy for reason of increasing health risk of the insured or otherwise. If it chooses not to transfer it to the HRP at the policy inception, while it may receive the premium payable (subject to the cap), it will have to bear the claims and liabilities of the policy until the expiry or termination without the benefit of the HRP.

11. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the VHIS's goal to improve access to Hospital Insurance. We consider it reasonable and justifiable for the Government to use public funds to support the HRP. Without the HRP, many high-risk individuals would likely fall back on the public system, which is heavily subsidised by the Government. Enabling some of the high-risk individuals to obtain Hospital Insurance coverage through the HRP not just offers them the choice to use private healthcare services, but also enables the public healthcare system to better focus its resources on serving its target areas. **Annex D** is an illustrative example on how the provision of public funding support to the HRP can benefit the healthcare system as a whole. It is estimated that the total cost to Government for funding the operation of the HRP for a 25-year period (2016 to 2040) would be about \$4.3 billion (in 2012 constant prices) (please refer to **Annex E** for

details). The major reason for limiting the projection horizon (25-year) to 2040 is that the population projection results from Census and Statistics Department are available up to 2041 only. We will review and consider in due course the funding arrangements for the HRP beyond 2040 having regard to operational experience.

### ***Tax Deduction for Hospital Insurance***

12. Tax incentives for health insurance plans meeting Government-sanctioned requirements are commonly observed around the world. Our Consultant recommends tax incentive under the VHIS as this is more sustainable and administratively cost-effective than direct premium subsidy. Apart from its positive effect on insurance take-up rate, tax incentive is a long-sought-after recognition by the tax-paying middle class who have subscribed to health insurance plans to cover their healthcare needs in the private sector and free up resources in the public healthcare sector – which is funded by the taxes they contribute – for the benefit of the community at large. Given the large variety of health insurance products in the market, we need to prevent abuse and ensure that only genuine Hospital Insurance that offer reasonable protection to consumers and help contribute to rebalancing the public and private healthcare sectors can benefit from the tax incentive. Having regard to the above, we propose to introduce tax deduction after the implementation of the VHIS, so that only individual Hospital Insurance policies that comply with the Minimum Requirements are eligible for tax deduction. We propose introducing tax deduction for premiums paid for individual Hospital Insurance policies that meet or exceed the Minimum Requirements<sup>16</sup>, and Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies. A person (i.e. taxpayer) may claim tax deduction on his/her own policy and/or his/her dependants’<sup>17</sup> policies; the proposed tax deduction will be provided on a per person insured basis and the claims for tax deductions for dependants’ policies should be capped at, say, no more than three dependants per taxpayer.

---

<sup>16</sup> For avoidance of doubt, we propose that the tax deduction should not apply to premiums paid for the following types of policy –

- (a) a Hospital Insurance policy that does not meet the Minimum Requirements, including a grandfathered policy. The purpose is to encourage early migration of grandfathered policies to those that comply with the Minimum Requirements; or
- (b) a non-Hospital Insurance policy, such as an out-patient only policy, hospital cash policy or critical illness policy. This is because the purchase of such policies would not necessarily contribute to achieving the objective of the VHIS. For out-patient services, the majority of demand is currently being met by the private sector; and the purchase of out-patient only policies may not necessarily contribute much to relieving the pressure on the public system. For hospital cash or critical illness policies, the pay-out of insurance benefit for these policies is not tied to the level of spending on hospital care, and therefore do not necessarily pertain to health protection of the policyholder.

<sup>17</sup> The definition of dependants should be aligned with that of the existing tax code for claiming tax allowance, i.e. spouse, child, dependent parent, dependent grandparent, dependent brother or sister, etc.

13. For pure illustration purposes, by capping the annual ceiling of claimable premiums at \$3,600 (i.e. the average standard premium of Standard Plan in 2012 and in 2012 constant prices) per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone is estimated to be \$256 million (in 2012 constant prices) in year 2016<sup>18</sup>, and the average tax benefit per eligible taxpayer would be about \$450.

### ***Regulatory Agency for VHIS***

14. We propose to set up a regulatory agency under Food and Health Bureau (“FHB”) to supervise the implementation and operation of the VHIS, which would be primarily the regulation of VHIS products. The functions of the regulatory agency will include promulgating, reviewing and enforcing the Minimum Requirements, filing compliant products, monitoring the operation of the HRP, handling complaints from consumers, and investigation of cases of non-compliance with the Minimum Requirements. In carrying out these functions, the regulatory agency will be vested with the necessary regulatory and disciplinary powers on insurers. The regulatory agency would also facilitate market infrastructure development to support the implementation of the scheme, including developing information systems for product filing, data collection and publishing data from insurers and private healthcare service providers, and promoting consumer education on the VHIS, etc. To ensure proper exercise of power of the regulatory agency, we propose that a review committee, whose operation would be independent from the regulatory agency, should be appointed to review decisions made by the agency in respect of its regulatory functions, such as filing of compliant products and investigation of non-compliant cases. We would liaise closely with existing regulatory bodies on matters related to their respective responsibilities to ensure compatibility with the existing and future legislative regime for regulation of the insurance industry and effective coordination of duties<sup>19</sup>.

---

<sup>18</sup> Assuming that both the VHIS and tax deduction would be implemented in 2016.

<sup>19</sup> We would liaise closely with relevant regulatory bodies to ensure effective coordination of duties and avoid duplication of roles and responsibilities, including –

- (a) prudential regulation of insurers, which will continue to rest with the Office of the Commissioner of Insurance/Independent Insurance Authority (“IIA”) to be established;
- (b) regulation of insurance intermediaries, which will continue to rest with the existing self-regulatory organisations (Insurance Agents Registration Board, Hong Kong Confederation of Insurance Brokers and Professional Insurance Brokers Association), or, after its establishment, the IIA; and
- (c) quality of healthcare services and regulation of healthcare professionals, which will continue to rest with the Department of Health and relevant statutory boards, councils and professional bodies.

We would reflect the above intent in the legislative proposal for the VHIS and further discuss with relevant regulatory bodies to explore possible means of coordination.

15. We propose to establish a Claims Dispute Resolution Mechanism (“CDRM”) to provide a credible and independent channel alternative to litigation for resolving claims disputes under the VHIS. The CDRM should cover all financial disputes related to claims arising from individual VHIS policies. The CDRM could take the form of mediation and/or arbitration, which are the two most widely used means of alternative dispute resolution. We will discuss with the insurance industry and other stakeholders on the operation details of the CDRM as well as the latter’s interface with existing mechanisms for handling claims disputes related to health insurance (Insurance Claims Complaints Bureau and Financial Dispute Resolution Centre).

### **Supporting Infrastructure**

16. The successful implementation of the VHIS hinges on having in place the necessary supporting infrastructure, including an adequate supply of healthcare manpower and sufficient healthcare capacity to provide quality private healthcare services. In this connection, we have been taking forward the following measures in conjunction with formulating proposals for the VHIS –

- (a) ***review healthcare manpower planning:*** we have established a steering committee to conduct a strategic review on healthcare manpower planning and professional development. The review is now progressing in full swing. The recommendations will shed light on ways to ensure an adequate supply of healthcare professionals for meeting future healthcare needs. In the interim, for the triennial cycle starting from the 2012/13 academic year, the Government has substantially increased the number of first-year first-degree places in medicine by 100 (i.e. from 320 to 420 per year), nursing by 40 (i.e. from 590 to 630 per year), and allied health professionals by 146 (i.e. from 231 to 377 per year);
- (b) ***enhance private healthcare capacity:*** we estimate that the known expansion or redevelopment projects of existing private hospitals would provide around an additional 900 hospital beds, and the new private hospital development at Wong Chuk Hang would provide 500 beds by 2017. We are also considering various proposals from different organisations to develop new private hospitals, including a proposal by the Chinese University of Hong Kong to develop a new teaching hospital at its campus.

Private hospital development is a very long term investment involving a huge capital outlay upfront, given the cost of medical equipment and

the hospital building. To facilitate the development of private hospitals, we will consider granting loans to organisations in obtaining the necessary capital funding in financing the development of new non-profit-making private hospitals. The Government will impose suitable requirements on the hospital development to help achieve its policy objectives, such as ensuring that the service coverage of these new hospitals would complement that of public hospitals and meet community needs and that services in packaged charge would be offered in support of the VHIS. We expect that, with the additional facilitation measure and upon completion of the new hospital(s) and redevelopment of existing hospitals, the overall capacity of the healthcare system in Hong Kong will be increased, enabling the public to have more choices of affordable and quality private hospital services; and

- (c) *review the regulation of private healthcare facilities:* a steering committee was established in October 2012 to review the regulation of private healthcare facilities with a view to enhancing the safety, quality and transparency of private healthcare services, including strengthening regulatory control over the corporate and clinical governance, price transparency and management of complaints and sentinel events of private hospitals, as well as putting ambulatory centres providing high-risk procedures and clinics under the management of incorporated body under regulatory control. In particular, on enhancing price transparency, we will encourage private hospitals to provide greater budget certainty to consumers through disclosure of price information, Informed Financial Consent, disclosure of historical statistics and introduction of packaged charges for common operations/procedures. These measures will enhance consumer confidence in using private healthcare services and contribute to achieving the VHIS's policy objectives. Based on the recommendations and findings of the steering committee, the Government is launching a public consultation exercise on revamping the regulatory regime for private healthcare facilities in conjunction with the VHIS public consultation.

### **Benefits of VHIS to the Healthcare System**

17. Considering the voluntary nature of the VHIS and the fact that it is intended as a supplementary financing arrangement, the projected impact of the VHIS must be seen in context and considered in conjunction with the concurrent influence of other long-term factors, including the increase in demand for both public and private healthcare services amidst an ageing population. **Annex F**

provides a detailed assessment of the projected impact of the VHIS<sup>20</sup>. In gist, in terms of projected uptake of individual Hospital Insurance, the implementation of the VHIS is expected to bring about a considerably higher uptake rate as compared with the baseline scenario (without the VHIS). The uptake rate is projected to be 29% (versus 26%<sup>21</sup> in the baseline scenario, meaning about 223 000 more in terms of membership) of the total population in 2016. In terms of number of procedures (vast majority are advanced diagnostic imaging tests, endoscopies or non-surgical cancer treatments), it is projected that in 2016, an additional 231 000 procedures would be performed in the private sector as compared with the baseline scenario. A major factor underlying the growth of activities in the private sector would be nominal substitution of activities from the public sector, i.e. activities that would otherwise be sought to be performed in the public sector under the baseline scenario. Among the additional 231 000 procedures, the number of procedures nominally substituted from the public sector would be around 120 000. The substitution of activities from the public sector is nominal in the sense that it would unlikely be translated into any direct reduction in activities, bed days or health expenditure of the public sector because of the continued rise in demand for public healthcare services due to an ageing population. Nevertheless, if we could encourage and facilitate more people to make use of private healthcare services through the VHIS, patients in the public sector would be able to benefit from reduction of waiting time and improved quality of public healthcare services. As one of the turning knobs in adjusting the balance of the public and private healthcare sectors, the growth in utilisation of private healthcare services and the nominal substitution of activities from the public sector under the VHIS are expected to lead to a notable adjustment of the public-private healthcare balance in the long-term. In terms of in-patient (overnight and day cases) discharge, the public to private ratio in 2040 is projected to change from a baseline of 86:14 to 81:19 under the VHIS. There would be significant expansion of private sector share by 36%, while the public sector share would be reduced by 6%. In terms of health expenditure, the Consultant projects that the cumulative amount of nominally substituted public health expenditure arising from nominal substitution of activities from the public sector would be approximately \$70 billion (in 2012 constant prices) over the 25-year projection horizon (2016 to 2040). This would be considerably higher than the \$4.3 billion required for supporting the HRP and the estimated \$6.4 billion (\$256 million x 25 years) of tax revenue forgone over the same projection horizon.

---

<sup>20</sup> The projections consider a 25-year horizon from 2016 to 2040, assuming that the VHIS commences in 2016.

<sup>21</sup> Under the baseline scenario, individual Hospital Insurance is not required to comply with the Minimum Requirements, and some of the products may not necessarily provide adequate protection to policyholders.

18. Subject to community support for the above proposals, we plan to implement the VHIS through enacting a new legislation. We expect that the bill and subsidiary legislation required for the VHIS would be introduced in 2015/16. The implementation of VHIS would be subject to the deliberation and passage of the bill and relevant subsidiary legislation at the Legislative Council.

## **OTHER OPTIONS**

19. We have considered whether it is desirable or feasible to introduce the VHIS as a separate product to be sold alongside other individual Hospital Insurance products not complying with the Minimum Requirements. According to the advice of the Consultant, it will not be practicable to allow co-existence of a regulated market segment where products are bound by Minimum Requirements (compliant products), and an unregulated market segment where product offering is not bound by Minimum Requirements (non-compliant products). It is because the Minimum Requirements are designed for meeting the community's aspirations, and achieving these goals would have cost implications. Under a "two-market" situation where regulated and unregulated market segments co-exist, insurers can target the healthy population by offering relatively lower premium for the unregulated products, leaving the compliant products a choice mainly for the unhealthy population. Given the peculiar feature of Hospital Insurance products, uninformed consumers might be induced to take out a "cheaper" policy that does not meet the Minimum Requirements (such as no guaranteed renewal). After a few years, when the consumer gets older with onset of disease and starts making claims, his policy renewal could be rejected by his insurer. With a claim record and deteriorated health conditions, it would be difficult for him to find a new insurer who will be willing to insure him. Even if he could, the premium is likely to be much higher than the same age group due to premium loading. Such consumer behaviour would also mean that the regulated segment have to manage a pool of policyholders of higher health risks than an average consumer, leading to a higher premium than that of unregulated products with similar coverage. The higher premium would drive price-sensitive and healthy consumers away from the regulated segment, resulting in a deterioration of the pool of compliant products in terms of health risks of policyholders. Such vicious cycle would lead to an ever increasing premium of compliant products and dwindling pool of policyholders with higher and higher health risks. Eventually, the premium would become unaffordable and the regulated segment would no longer be sustainable<sup>22</sup>.

---

<sup>22</sup> Singapore's experience in MediShield illustrates why a "two-market" situation (co-existence of a regulated market segment and an unregulated segment for health insurance) is not practicable. Operated by the

## **IMPLICATIONS OF THE PROPOSALS**

20. The proposals are in conformity with the Basic Law, including the provisions concerning human rights. There are no environmental or productivity implications arising from taking forward the proposals. The proposals have financial, civil service, economic, sustainability and family implications as set out in **Annex G**.

## **PUBLIC CONSULTATION**

21. We are launching a three-month public consultation on the implementation proposals for the VHIS on 15 December 2014. We will conduct open consultation forums for the public in general, and arrange targeted consultation sessions with specific groups of relevant sectors, professions and stakeholders. We will also launch platforms for e-engagement during the consultation period. Polling will be conducted to gauge public views on key issues concerning the VHIS.

## **PUBLICITY**

22. We will brief the Legislative Council Panel on Health Services on 15 December 2014. We will organise a press conference and issue a press release to launch the consultation. More detailed briefings for editors and commentators will be arranged. Announcement in the Public Interest on TV and radio will be issued on the consultation. A government spokesman will be available to answer enquiries. All relevant consultation materials and study reports will be made available online on a dedicated website.

---

Central Provident Fund, MediShield is a voluntary, low-cost basic medical insurance scheme introduced in 1990. The aim is to help subscribers to meet large hospital bills that the Medisave (a national medical savings scheme which helps individuals put aside part of their income to meet their future personal or immediate family's hospitalisation, day surgery and certain out-patient expenses) balance is insufficient to cover. As insurers were allowed to concurrently offer similar health insurance products, private insurers found it more profitable to pick and choose healthier and younger customers, leaving the unhealthy and old customers to MediShield (which provides guaranteed acceptance of subscription). This cherry picking behaviour drove up the MediShield premium and rendered it eventually unsustainable. As a result, the Singapore government introduced the MediShield reform package in 2005, including a measure to prohibit insurers from offering products that are of same or lesser coverage than that of MediShield, although insurers could provide enhancement plans on top of what MediShield already provided.



## **ENQUIRY**

23. Enquiries on this brief may be directed to Mr Sheung-yuen LEE, Deputy Head, Healthcare Planning and Development Office, Food and Health Bureau, at 3509 8929.

**Food and Health Bureau  
15 December 2014**

## **Draft Executive Summary of Consultation Document on Voluntary Health Insurance Scheme**

### **Healthcare Reform (Chapter 1)**

Hong Kong has a dual-track healthcare system by which the public and private healthcare sectors complement each other. The public sector is the predominant provider of secondary and tertiary healthcare services. Around 88% of in-patient services (in terms of number of bed days) are provided by public hospitals. Public hospitals provide about 27 400 hospital beds, accounting for about 88% of total hospital beds. The private sector complements the public healthcare system by offering choice to those who can afford and are willing to pay for healthcare services with personalised choices and better amenities.

2. The dual-track healthcare system has served us well over the years and it is the Government's policy to maintain and strengthen the dual-track healthcare system. Nevertheless, as with other advanced economies, Hong Kong is facing the challenges of an ageing population, rising public expectation of healthcare services and increasing medical costs. Confronted by these challenges, the Government has substantially increased investment in public healthcare system over the years, including increasing recurrent expenditure on medical and health services in the past seven years from \$32 billion in 2007-08 by over 60% to \$52 billion in 2014-15 (public health expenditure now accounts for about 17% of total recurrent expenditure of the Government) and embarking on a major public hospitals redevelopment and expansion programmes, including the construction of the Tin Shui Wai Hospital and the Hong Kong Children's Hospital, expansion of United Christian Hospital, redevelopment of Kwong Wah Hospital and Queen Mary Hospital, etc.

3. Notwithstanding the Government's commitment to public healthcare, it is necessary to identify suitable measures to improve the quality of our healthcare services and to readjust the public-private balance, so as to maintain the long-term sustainability of our healthcare system. Multiple rounds of public consultation on healthcare reform had been conducted since the 1990s to identify ways to reform the healthcare system through recalibrating the balance of the public-private healthcare sectors. Various proposals were put forth, including capping Government subsidy or increasing user fees of public healthcare services, social health insurance, medical savings account, etc.

While the public was generally supportive of the need for reform, opinions on different reform options varied and no general consensus was reached.

4. During 2008 to 2010, the Government launched two stages of public consultation on healthcare reform to look for ways to improve the quality of our healthcare services, and to enhance the long-term sustainability of our healthcare system. The First Stage Public Consultation “Your Health, Your Life” in 2008 consulted the public, among other service reform proposals, six supplementary financing options, including increasing user fees for public healthcare services, social health insurance, mandatory medical savings accounts, voluntary private health insurance (PHI), mandatory PHI, and personal healthcare reserve (mandatory savings cum insurance). As the public expressed reservations about mandatory financing options, the Government put forth the Health Protection Scheme (HPS) proposal, a voluntary, government-regulated PHI scheme, in the Second Stage Public Consultation “My Health, My Choice” in 2010.

5. The objective of the HPS is to provide an alternative to those who are able and willing to use private healthcare services through enhancing the quality of health insurance 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. A number of key features designed to enhance the accessibility, quality and transparency of health insurance were proposed for HPS products, including guaranteed renewal for life; covering pre-existing conditions subject to a waiting period; accepting high-risk groups through a high risk pool; and standardisation of policy terms and conditions, etc.

6. To take forward the HPS, a Working Group and a Consultative Group on the HPS were set up under the Health and Medical Development Advisory Committee to make recommendations on matters concerning the implementation of the HPS. With reference to the deliberation by the Working Group and the Consultant’s recommendations, we hereby put forth the detailed proposals for implementing the HPS for public consultation.

7. The HPS is not intended as a total solution to the challenges faced by our healthcare system, but a supplementary financing arrangement complementing public healthcare, and one of the control knobs in redressing the

public-private balance. To better reflect its objectives and nature, we propose to rename the scheme to “Voluntary Health Insurance Scheme” (VHIS).

## **Minimum Requirements (Chapter 2)**

### *Regulation of Individual Hospital Insurance*

8. The proposed VHIS intends to **regulate individual indemnity<sup>1</sup> hospital insurance**, meaning a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (Cap. 41)(ICO)(**Class 2**) which provides for benefits in the nature of **indemnity** against risk of loss to the insured attributable to **sickness or infirmity** that **requires hospitalisation<sup>2</sup> (Hospital Insurance)** and the policyholder/person insured is an **individual**. An individual Hospital Insurance policy may be issued to an individual as a standalone Class 2 policy or as an additional cover combined with, hence, forming part of a contract of long-term business (e.g. a medical insurance rider attached to and forming part of a life insurance policy).

9. **In selling and/or effecting individual Hospital Insurance, an insurer must comply with the Minimum Requirements** prescribed by the Government. An individual Hospital Insurance that meets all (but not exceeding) the Minimum Requirements is considered a **Standard Plan**, which insurers selling individual Hospital Insurance must offer as one of the available options to consumers, regardless of whether they also offer individual Hospital Insurance products with enhanced benefits (please refer to paragraphs 20 to 22). **Upon the implementation of the VHIS, insurers will not be allowed to offer individual Hospital Insurance that do not comply with the Minimum Requirements.**

### *Standard Plan*

10. The 12 Minimum Requirements proposed for Standard Plan aim to improve accessibility and continuity of individual Hospital Insurance, enhance the quality, and promote transparency and certainty of insurance protection. They are summarised below –

---

<sup>1</sup> An “indemnity” insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss.

<sup>2</sup> For the purpose of the VHIS, hospitalisation here refers to a setting where the patient may not be discharged on the same calendar day of admission; and the expected total duration of the procedure, recovery, treatment and care requiring continuous confinement within the facility may exceed 12 hours.

- (a) guaranteed renewal without re-underwriting;
- (b) no “lifetime benefit limit”;
- (c) coverage of pre-existing conditions subject to a standard waiting period;
- (d) guaranteed acceptance with premium loading capped at 200% of standard premium for –
  - (i) all ages within the first year of implementation of the VHIS; and
  - (ii) those aged 40 or below starting from the second year of implementation of the VHIS;
- (e) portable insurance policy with no re-underwriting when changing insurer, provided that no claims were made in a certain period of time (say, three years) immediately before transfer of policy;
- (f) benefit coverage must include medical conditions requiring hospital admissions and/or prescribed ambulatory procedures<sup>3</sup>;
- (g) benefit coverage must include prescribed advanced diagnostic imaging tests, subject to a fixed 30% co-insurance to combat moral hazard; and non-surgical cancer treatments up to a prescribed limit;
- (h) benefit limits must meet prescribed levels;
- (i) no cost-sharing (deductible or co-insurance) by policyholders except the fixed 30% co-insurance for prescribed advanced diagnostic imaging tests; and annual cap of \$30,000 on cost-sharing by policyholders (excluding excess amount payable by policyholders if actual expenses exceed benefit limits);

---

<sup>3</sup> The ambulatory procedures to be covered under Standard Plan will be determined and prescribed by the regulatory agency (please see paragraph 36) to be established to monitor the implementation and operation of the VHIS, subject to the advice of an advisory committee constituted mainly of major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.).

- (j) budget certainty for policyholders through –
  - (i) Informed Financial Consent: a policyholder should be informed of estimated charges and estimated claims amount through written quotation before treatment;
  - (ii) No-gap/known-gap arrangement for at least one procedure/test: a 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 institution (e.g. hospital) and doctor selected by the policyholder are on the lists agreed among his/her insurer and healthcare providers;
- (k) standardised policy terms and conditions; and
- (l) transparent information on age-banded premiums through easily accessible platform (e.g. websites of insurers and the VHIS regulatory agency to be established).

11. The Minimum Requirements proposal was formulated having regard to public concerns over the existing Hospital Insurance market as revealed by the previous public consultations, such as decline of cover; exclusion of pre-existing conditions; no guaranteed renewal of policies; lack of budget certainty; or dispute over insurance claims due to lack of standardised policy terms and conditions. These shortcomings have often discouraged the insured from making use of private healthcare services through their insurance cover, leading them to fall back to the public system. By improving the quality and certainty of Hospital Insurance protection through the Minimum Requirements, and by fostering consumer confidence in using private healthcare services, Hospital Insurance would be able to play a greater role in financing the growing health expenditure. According to the findings of the Public Opinion Survey on Supplementary Healthcare Financing conducted alongside the Second Stage Public Consultation, about 90% of the respondents supported strengthening regulation of health insurance in order to provide better protection to the consumers.

12. The Minimum Requirements proposal is in line with international experience. In overseas jurisdictions where PHI plays a significant role in the healthcare system, such as Australia, Ireland, the Netherlands, Switzerland and the United States, the governments have prescribed by law basic requirements for PHI to safeguard consumer interest. These basic requirements are broadly similar to the proposed Minimum Requirements, including guaranteed renewal, guaranteed acceptance, coverage of pre-existing conditions, minimum benefit coverage and benefit limits, standardised policy terms and conditions, etc.

13. From the perspectives of health policy and consumer protection, we consider it desirable that individual Hospital Insurance sold in the name of “hospital”/“health”/“medical” insurance should provide at least the benefits offered by a Standard Plan, such that consumers who purchase such products will not be misled into thinking that those non-compliant products fulfill the Minimum Requirements of the VHIS. We propose that, upon the implementation of the VHIS, only those health insurance products complying with the Minimum Requirements may be sold in the name of “hospital”/“health”/“medical” insurance, or such other name which denotes or connotes that such product is an individual Hospital Insurance.

14. The Minimum Requirements of the VHIS would only be confined to individual Hospital Insurance. The VHIS does not intend to cover –

- (a) any fixed pecuniary benefits (e.g. hospital cash, critical illness cover)<sup>4</sup> which may be added to an individual Hospital Insurance policy; and
- (b) a group policy, i.e. a policy being held by an employer for the benefit of its employees<sup>5</sup>.

---

<sup>4</sup> Typically, a critical illness cover provides a lump sum cash payment if the insured is diagnosed with a disease as designated in the insurance policy whereas a hospital cash cover provides a fixed cash benefit paid for each day of hospitalization due to a sickness or accident. In both examples, since the payment is one of fixed pecuniary benefits, the cover itself will not be regulated under the VHIS. It will also not be regulated for reason that the cover is attached to an individual Hospital Insurance Policy.

<sup>5</sup> For the avoidance of doubt, the VHIS does not intend to cover insurance policies purchased by employers for foreign domestic helpers where indemnity hospital insurance is featured incidentally as a small, non-core component and is not intended to cover the full cost of private healthcare services of the person insured. Insurance policies purchased by employers for foreign domestic helpers will not be subject to the arrangements proposed for group policies described in paragraphs 16 and 17.

### *Arrangements for Group Hospital Insurance*

15. Ideally, it is desirable for group Hospital Insurance to comply with the Minimum Requirements for better consumer protection. Nevertheless, given that the group market is inherently different from the individual market in the sense that the cost of purchasing the group policies is borne by employers, rather than employees who are the direct beneficiaries; and the fact that some of the products in the market are of limited protection due to budget constraint of some employers, we propose not to require group Hospital Insurance to comply with the Minimum Requirements.

16. To better protect employees' interests, we propose to adopt the following arrangements for group Hospital Insurance –

- (a) ***Conversion Option***: We propose to require insurers to offer as an option to employers an elective component – the Conversion Option – in the group Hospital Insurance products. If the employer decides to purchase the group policy together with the Conversion Option, an employee covered by such group policy can exercise the Conversion Option upon leaving employment so that he/she can switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that he/she has been employed for a full year immediately before transferring to the individual Standard Plan; and
- (b) ***Voluntary Supplement(s)***: We propose that insurers may offer, on a group policy basis, Voluntary Supplement(s) to individual members covered by a group Hospital Insurance policy who wish to procure at their own costs additional protection on top of their group policy. The group policy, enhanced by the Voluntary Supplement, should provide insurance protection at a level comparable to the protection of an individual Standard Plan.

17. Since group Hospital Insurance would not be regulated by the Minimum Requirements, and some of which may provide benefits lesser than that of an individual Standard Plan, we propose that, for any group Hospital Insurance products to be sold in the name of “hospital”/“health”/“medical” insurance, it must be specified in the product name that such products are group



products (e.g. “group hospital insurance”, “group health insurance” or “group medical insurance”).

### Product Design (Chapter 3)

#### Standard Plan

18. Below is an illustrative outline of how the benefit schedule of Standard Plan will be structured.

#### Illustrative Outline of Benefit Schedule of Standard Plan<sup>(1)</sup> (Indicative dollar figures for illustration only)

<i>Category</i>	
<b>(A) Itemised benefit limits (for hospitalisation only)</b>	
(1) Room and board (daily), maximum 180 days	\$ 650
(2) Attending physician’s visit (daily), maximum 180 days	\$ 750
(3) Specialist’s visit (per admission)	\$ 2,300
(4) Surgical limit (including surgeon, anaesthetist, operating theatre <sup>(2)</sup> ) (per surgery)	Maximum \$ 58,000; (varies by surgery type)
(5) Miscellaneous hospital expenses (per admission)	\$ 9,300
<b>(B) Packaged benefit limits</b>	
(1) Prescribed ambulatory procedures (per procedure), e.g. endoscopies, cataract extraction and intra-ocular lens implantation surgery	Lump-sum packaged benefit limit <sup>(3)</sup> (varies by procedure type)
(2) Prescribed advanced diagnostic imaging tests (per test), e.g. Magnetic Resonance Imaging (MRI) examination, Computed Tomography (CT) scan, Positron Emission Tomography (PET) scan	Lump-sum packaged benefit limit <sup>(3)</sup> (varies by test type) subject to 30% co-insurance
(3) Non-surgical cancer treatments (per disability)	\$150,000

<b>(C) “No-gap/known-gap” cover</b>	
Applicable to the list specified by insurer on: (1) procedures/tests; (2) hospitals or clinics; (3) doctors.	Out-of-pocket payment varies by procedure/test type <sup>(4)</sup> ; no out-of-pocket payment for “no-gap” cover
<b>(D) Annual benefit limit</b>	\$400,000
<b>(E) Lifetime benefit limit</b>	Nil
<b>(F) Deductible</b>	Nil
<b>(G) Co-insurance (other than 30% for prescribed advanced diagnostic imaging tests)</b>	Nil

Notes:

- (1) The illustrative outline is intended to demonstrate the structure of the benefit schedule of Standard Plan under the Minimum Requirements.
- (2) The respective sub-benefit limits for surgeon, anaesthetist and operating theatre fees would be determined in consultation with relevant stakeholders.
- (3) Packaged benefit limit includes doctor’s fee and other expenses. The respective sub-benefit limits for doctor’s fee and other expenses would be subject to consultation with relevant stakeholders. The sub-benefit limits would only be applicable if the billed amount exceeds the packaged benefit limit, so as to safeguard proper apportionment among the charging parties.
- (4) Amount paid by insurer includes doctor’s fee and other expenses. The respective amount of doctor’s fee and other expenses would be subject to consultation with relevant stakeholders.

19. Standard Plan offers enhanced benefits compared to existing individual Hospital Insurance products which likewise target at general ward level services. For instance, for non-surgical cancer treatments (e.g. chemotherapy, radiotherapy) and advanced diagnostic imaging tests (e.g. MRI examination, CT scan, PET scan), a lot of existing products do not provide coverage for these treatments and tests as a separate benefit item. These treatments and tests are usually only claimable under the benefit item of “miscellaneous hospital expenses”, which under normal circumstances would not be sufficient for covering the cost of these treatments and tests. Under Standard Plan, rather than being covered under “miscellaneous hospital expenses” as in existing individual Hospital Insurance products, these treatments and tests will be covered under separate benefit items, subject to respective benefit limits that would provide sufficient coverage for policyholders for using these services. Taking into account these enhanced benefits, the average annual standard

premium of Standard Plan is estimated by the Consultant to be around **\$3,600**<sup>6</sup> (in 2012 constant prices), about 9% higher than the average premium of existing individual Hospital Insurance products (ward level) in the market (i.e. about \$3,300 in 2012 constant prices). The above notwithstanding, enhanced transparency and product comparability under the VHIS is expected to result in a reduction of the expense loading (i.e. the amount of insurer expenses, including commissions and broker fees, profit margins, expenses and other overhead expenses, as a percentage of the amount of premium). The average expense loading of the individual health insurance market (36% in 2013<sup>7</sup>) and the whole health insurance market (29% in 2013) in Hong Kong were the highest among jurisdictions studied by the Consultant. The average expense loading of the whole health insurance market was 13% in Australia (2012), 13% in Ireland (2012), 7% in the Netherlands (2012) and 9% in Switzerland (2012). Under the VHIS, the standardisation, quality assurance and better flow of market information will facilitate easy comparison by consumers, foster market competition, and hence lead to a more moderate expense loading. A modest improvement in the expense loading to a level more in line with international experience can partly offset the estimated increase in premium of Standard Plan in comparison with existing products in the market, which lack the enhanced features and benefits proposed under the Minimum Requirements.

### *Flexi Plans and Top-up Plans*

20. Insurers are not restricted to offer Standard Plan only but may provide enhanced benefits in the form of a Flexi Plan or a Top-up Plan to suit the specific needs of consumers.

21. A Flexi Plan refers to a Hospital Insurance plan with enhancement to any or all of the benefits of a Standard Plan (e.g. higher room and board benefit limits than those required for a Standard Plan) of Hospital Insurance nature. With a view to allowing more flexibility in promoting product innovation and competition, the enhanced benefits in a Flexi Plan will not be subject to the requirements of –

- (a) guaranteed acceptance with premium loading cap; and

---

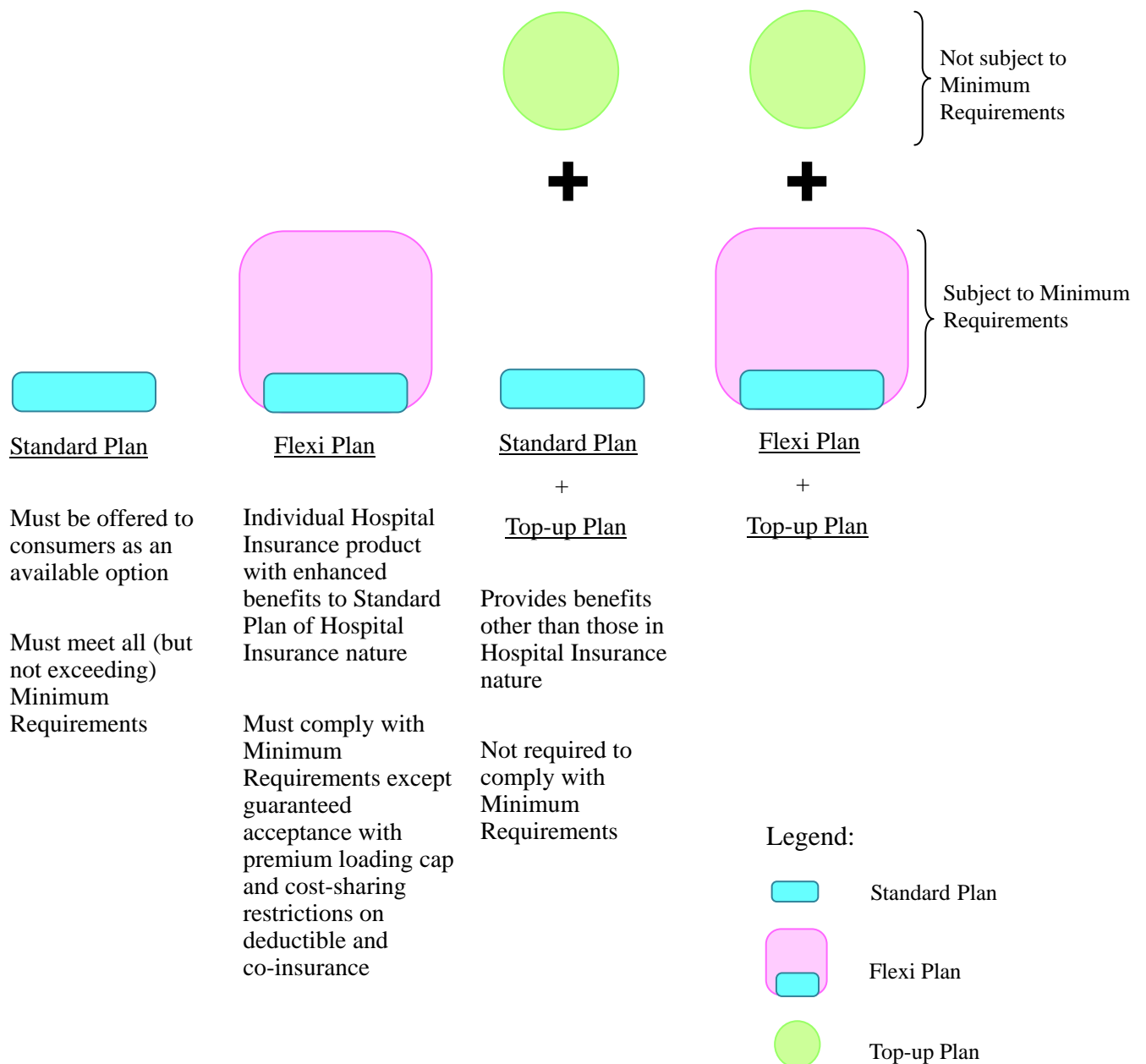
<sup>6</sup> The figure lies between the estimated standard premiums of Standard Plan for the age groups from 40 to 49.

<sup>7</sup> Source: Office of the Commissioner of Insurance. The corresponding figure for the group health insurance market was 19% in 2013.

- (b) the cost-sharing restriction (no deductible or co-insurance) of Standard Plan, except that the amount of the deductible or co-insurance would be subject to the same annual cap of \$30,000 proposed for Standard Plan.

22. A Top-up Plan refers to one providing benefits other than those in the nature of a Hospital Insurance and may be attached to, hence forming part of, a Standard Plan or a Flexi Plan. Since a Top-up Plan, whether as a rider or as a standalone plan, is not a Hospital Insurance, it will not be subject to the Minimum Requirements.

### Possible Product Structuring of Standard Plan, Flexi Plan and Top-up Plan



## **Public Funding (Chapter 4)**

### *High Risk Pool (HRP)*

23. During the Second Stage Public Consultation, one of the major misgivings expressed by the community is that high-risk individuals (their applications are either rejected by insurers, or accepted with additional clauses imposed in their policies excluding their pre-existing conditions, or charged a premium loading at a rate deemed appropriate by insurers) have significant difficulties in purchasing Hospital Insurance. To meet the community's aspirations to enable high-risk individuals to purchase Hospital Insurance, we propose to require under the Minimum Requirements that insurers must provide to consumers a Standard Plan with guaranteed acceptance with a premium loading cap of 200%, and coverage of pre-existing conditions. Nevertheless, if insurers are mandated to accept such individuals and the loading is capped without proper mitigating measures, they may not be able to collect adequate premium income to offset the claims payout.

24. To ensure that high-risk individuals can also buy Hospital Insurance, the Consultant recommends that a HRP be established. The HRP will be open to all in the first year upon the implementation of the VHIS and limited to those aged 40 or below thereafter. We propose that the HRP should be established by legislation with the following framework –

- (a) the HRP will be a legal entity, which can enter into contracts, sue and can be sued; it will be funded by premium income and Government funding;
- (b) it accepts only Standard Plan high-risk policies<sup>8</sup> transferred by an insurer; despite such transfer, the policy remains as a contract between the policyholder and the insurer who underwrites and issues the policy;
- (c) the insurer will administer the policy and receive an administration fee payable by the HRP;

---

<sup>8</sup> A high-risk policy refers to one of which an insurer will charge a premium loading at or more than 200% of its standard premium.

- (d) in the course of administration, the insurer shall separate a portfolio for the high-risk policies from other policies with a view to ensuring that underwriting of risks of non-high-risk individuals will not be adversely affected;
- (e) all premiums payable and claims and liabilities under the policy will be accrued to the HRP;
- (f) the HRP may contract out its day-to-day operation to a claims specialist;
- (g) the policyholder shall pay the premium with a premium loading at 200% of the standard premium prescribed by the insurer;
- (h) the HRP will be monitored by the regulatory agency provided in paragraph 36; and
- (i) the insurer is expected to transfer a high-risk policy underwritten by it to the HRP upon the policy inception. The HRP will not subsequently accept any high-risk policy not so transferred and the insurer cannot later on request the HRP to accept any high-risk policy for reason of increasing health risk of the insured or otherwise. If it chooses not to transfer it to the HRP at the policy inception, while it may receive the premium payable (subject to the cap), it will have to bear the claims and liabilities of the policy until the expiry or termination without the benefit of the HRP.

25. The HRP is the key enabler of guaranteed acceptance with premium loading cap, which is an essential component of the Minimum Requirements in support of the VHIS's goal to improve access to Hospital Insurance. We consider it reasonable and justifiable for the Government to use public funds to support the HRP. Without the HRP, many high-risk individuals would likely fall back on the public system, which is heavily subsidised by the Government. Enabling some of the high-risk individuals to obtain Hospital Insurance coverage through the HRP not just offers them the choice to use private healthcare services, but also enables the public healthcare system to better focus its resources on serving its target areas.

26. It is estimated that the total cost to Government for funding the operation of the HRP for a 25-year period (2016 to 2040) would be about \$4.3 billion (in 2012 constant prices). We will review and consider in due course the funding arrangements for the HRP beyond 2040 having regard to operational experience.

### *Tax Deduction for Hospital Insurance*

27. Tax incentives for health insurance plans meeting Government-sanctioned requirements are commonly observed around the world. Tax deduction has the merits of being simple and easy to understand, and its continuous nature would incentivise policyholders to stay insured over a long period of time. Compared with other forms of financial incentives, such as direct premium subsidy or discount, tax deduction is less susceptible to abuse and is administratively less costly.

28. We propose introducing tax deduction for premiums paid for all individual Hospital Insurance policies that meet or exceed the Minimum Requirements (Standard Plan and Flexi Plan policies; the portion of premiums paid for Top-up Plan will not be eligible for tax deduction as Top-up Plans are not compliant products); and Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies. A person (i.e. taxpayer) may claim tax deduction on his/her own policy and/or his/her dependants'<sup>9</sup> policies; the proposed tax deduction will be provided on a per person insured basis and the claims for tax deductions for dependants' policies should be capped at, say, no more than three dependants per taxpayer.

29. For pure illustration purposes, by capping the annual ceiling of claimable premiums at \$3,600 (i.e. the average standard premium of Standard Plan in 2012 and in 2012 constant prices) per person insured, and based on an estimate of about 570 000 taxpayers and 360 000 dependants eligible for tax deduction, the tax revenue forgone is estimated to be \$256 million (in 2012 constant prices) in year 2016<sup>10</sup>, and the average tax benefit per eligible taxpayer would be about \$450.

---

<sup>9</sup> The definition of dependants should be aligned with that of the existing tax code for claiming tax allowance, i.e. spouse, child, dependent parent, dependent grandparent, dependent brother or sister, etc.

<sup>10</sup> Assuming that both the VHIS and tax deduction would be implemented in 2016.

## **Migration Arrangements (Chapter 5)**

30. To facilitate policyholders of existing individual Hospital Insurance policies to migrate to compliant policies under the VHIS, we propose that, where the expiry of the existing individual Hospital Insurance policies falls within the first year of implementation of the VHIS, insurers are required to, upon such expiry, offer an option to policyholders concerned to migrate to an individual Hospital Insurance policy that meets or exceeds the Minimum Requirements.

31. During the one-year window period, policyholders can enjoy a “streamlined migration” arrangement. They would not be re-underwritten for benefit coverage and benefit limits in existing policies. For case-based exclusions in existing policies, policyholders could choose to retain the existing exclusions when migrating to the new policy, and only upgrade the benefit coverage and benefit limits in keeping with the Minimum Requirements. Alternatively, policyholders may choose to remove the existing case-based exclusions, subject to the possibility of being re-underwritten and charged a premium loading. They may need to serve the standard waiting period for the pre-existing conditions newly covered under the new policy.

32. When migrating to compliant policies, some policyholders may need to increase the benefit coverage (e.g. non-surgical cancer treatment) or benefit limits (e.g. surgical limits) of their existing policies in order to meet the Minimum Requirements. Since these new benefits or higher benefit limits have not been underwritten under the existing policy, policyholders may be re-underwritten if considered necessary by the insurer concerned, but the re-underwriting should be restricted to the new benefits and higher limits only. Policyholders may need to serve the standard waiting period for pre-existing conditions related to these new benefits or higher benefit limits.

33. Migrant plans – with or without exclusions – will be eligible for tax deduction since they are deemed compliant with the Minimum Requirements.

34. After the migration window period, policyholders who wish to migrate to compliant policies would be treated as new customers and may be subject to full underwriting if deemed necessary by the insurer concerned.



35. For policyholders who do not wish to migrate but to renew their policies, whether within or after the said one-year period, on the same old terms or any other terms which fall short of the Minimum Requirements, such policies will be grandfathered, i.e. exempted from the Minimum Requirements as long as the insurers concerned continue to administer such policies. Grandfathered policies will not be entitled to tax deduction as they are not deemed compliant with the Minimum Requirements.

## **Institutional Framework (Chapter 6)**

### *Regulatory Agency for VHIS*

36. We propose to set up a regulatory agency under Food and Health Bureau (FHB) to supervise the implementation and operation of the VHIS, which would be primarily the regulation of VHIS products. The functions of the regulatory agency will include promulgating, reviewing and enforcing the Minimum Requirements, filing compliant products, monitoring the operation of the HRP, handling complaints from consumers, and investigation of cases of non-compliance with the Minimum Requirements. In carrying out these functions, the regulatory agency will be vested with the necessary regulatory and disciplinary powers on insurers. The regulatory agency would also facilitate market development by building up infrastructure to support the implementation of the VHIS, including developing information systems for product filing, data collection and publishing data from insurers and private healthcare service providers, and promoting consumer education on the VHIS, etc. An advisory committee comprising major stakeholders (including members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.) would be established to provide professional advice concerning matters of the VHIS. To ensure proper exercise of power by the regulatory agency, we propose that a review committee, whose operation would be independent from the regulatory agency, should be appointed to review decisions made by the agency in respect of its regulatory functions, such as filing of compliant products and investigation of non-compliant cases.

37. We would liaise closely with relevant existing regulatory bodies on matters related to their respective responsibilities to ensure compatibility with the existing and future legislative regime for regulation of the insurance industry and effective coordination of duties and avoid duplication of roles and responsibilities, e.g. matters concerning prudential and conduct regulation of

insurers, regulation of insurance intermediaries, quality of healthcare services, regulation of healthcare professionals, etc.

### *Claims Dispute Resolution Mechanism*

38. We propose to establish a Claims Dispute Resolution Mechanism (CDRM) to provide a credible and independent channel alternative to litigation for resolving claims disputes under the VHIS. Currently, there are several avenues in Hong Kong for handling disputes related to health insurance claims, including the Insurance Claims Complaints Bureau (ICCB), a self-regulatory body funded by the insurance industry; and the Financial Dispute Resolution Centre (FDRC) that handles claims disputes involving a financial institution authorised by the Hong Kong Monetary Authority or licensed by/registered with the Securities and Futures Commission.

39. We propose that the CDRM should cover all financial disputes related to claims arising from individual VHIS policies. This is because individual consumers are in general less financially capable in resorting to legal proceedings to settle claims disputes. The CDRM could take the form of mediation and/or arbitration, which are the two most widely used means of alternative dispute resolution. We will discuss with the insurance industry, the ICCB and FDRC on the operation details of the CDRM as well as the latter's interface with existing mechanisms for handling claims disputes related to health insurance.

### **Supporting Infrastructure (Chapter 7)**

40. The successful implementation of the VHIS hinges on having in place the necessary supporting infrastructure, including an adequate supply of healthcare manpower and sufficient healthcare capacity to provide quality private healthcare services. In this connection, we have been taking forward the following measures in conjunction with formulating proposals for the VHIS –

- (a) **review healthcare manpower planning:** we have established a steering committee to conduct a strategic review on healthcare manpower planning and professional development. The strategic review is now progressing in full swing. The recommendations will shed light on ways to ensure an adequate supply of healthcare

professionals for meeting future healthcare needs. In the interim, for the triennial cycle starting from the 2012/13 academic year, the Government has substantially increased the number of first-year first-degree places in medicine by 100 (i.e. from 320 to 420 per year), nursing by 40 (i.e. from 590 to 630 per year), and allied health professionals by 146 (i.e. from 231 to 377 per year);

- (b) **enhance private healthcare capacity:** we estimate that the known expansion or redevelopment projects of existing private hospitals would provide around an additional 900 hospital beds, and the new private hospital development at Wong Chuk Hang would provide 500 beds by 2017. We are also considering various proposals from different organisations to develop new or expand existing private hospitals, including a proposal by the Chinese University of Hong Kong to develop a new teaching hospital at its campus. In order to facilitate the development of private hospitals for meeting community needs, we will consider granting loans to organisations that have difficulties in obtaining adequate capital funding in financing the development costs of non-profit-making private hospitals; and
- (c) **review the regulation of private healthcare facilities:** a steering committee was established in October 2012 to review the regulation of private healthcare facilities with a view to enhancing the safety, quality and transparency of private healthcare services, including strengthening regulatory control over the corporate and clinical governance, price transparency and management of complaints and sentinel events of private hospitals, as well as putting ambulatory centres providing high-risk procedures and clinics under the management of incorporated body under regulatory control. In particular, on enhancing price transparency, we will encourage private hospitals to provide greater budget certainty to consumers through disclosure of price information, Informed Financial Consent, disclosure of historical statistics and introduction of packaged charges for common operations/procedures. These measures will enhance consumer confidence in using private healthcare services, thereby contributing to achieving the VHIS's policy objective. Based on the recommendations of the steering committee, the Government is consulting the public on revamping the regulatory regime for private

healthcare facilities in conjunction with the VHIS public consultation.

### **Implications for Hong Kong's Healthcare System (Chapter 8)**

41. The VHIS aims to facilitate choice of private healthcare services by providing better insurance protection to those who are willing and able to afford private healthcare services. By making Hospital Insurance a more attractive option to the public, the VHIS could facilitate more people to make use of private healthcare services, thereby better enabling the public sector to focus on serving its target areas and enhancing its services.

42. Considering the voluntary nature of the VHIS and the fact that it is intended as a supplementary financing arrangement, the projected impact of the VHIS must be seen in context and considered in conjunction with the concurrent influence of other long-term factors, including the increase in demand for both public and private healthcare services amidst an ageing population.

43. In terms of projected<sup>11</sup> uptake of individual Hospital Insurance, the implementation of the VHIS is expected to bring about a considerably higher uptake rate as compared with the baseline scenario (without the VHIS). The uptake rate is projected to be 29% (versus 26%<sup>12</sup> in the baseline scenario, meaning about 223 000 more in terms of membership) of the total population in 2016. As more people purchase and make use of Hospital Insurance as a result of the VHIS, it is expected that there would be a growth in utilisation of private healthcare services compared with the baseline scenario. In terms of number of procedures (vast majority are advanced diagnostic imaging tests, endoscopies and non-surgical cancer treatments), it is projected that in 2016, an additional 231 000 procedures would be performed in the private sector as compared with the baseline scenario. A major factor underlying the growth of activities in the private sector would be nominal substitution of activities from the public sector, i.e. activities that would otherwise be sought to be performed in the public sector under the baseline scenario. Among the additional 231 000 procedures, the number of procedures nominally substituted from the public sector would be around 120 000.

---

<sup>11</sup> The projections consider a 25-year horizon from 2016-2040, assuming that the VHIS commences in 2016.

<sup>12</sup> Under the baseline scenario, individual Hospital Insurance is not required to comply with the Minimum Requirements, and some of the products may not necessarily provide adequate protection to policyholders.

44. The substitution of activities from the public sector is nominal in the sense that it would unlikely be translated into any direct reduction in activities, bed days or health expenditure in the public sector because of the continued rise in demand for public healthcare services due to an ageing population. Nevertheless, patients in the public sector would be able to benefit through reduction of waiting time and optimisation of resource allocation for improving the quality of public healthcare services.

45. As one of the turning knobs in adjusting the balance of the public and private healthcare sectors, the growth in utilisation of private healthcare services and the nominal substitution of activities from the public sector under the VHIS are expected to lead to a notable adjustment of the public-private healthcare balance in the long-term. By better enabling the private sector to take on more patients with the means and inclination to seek care from outside the public sector, the VHIS will recalibrate the public-private balance to a healthier and more sustainable level. In terms of in-patient (overnight and day cases) discharge, the public to private ratio in 2040 is projected to change from a baseline of 86:14 to 81:19 under the VHIS. There would be significant expansion of private sector share by 36%, while the public sector share would be reduced by 6%. In terms of health expenditure, the Consultant projects that the cumulative amount of nominally substituted public health expenditure arising from nominal substitution of activities from the public sector would be approximately \$70 billion (in 2012 constant prices) over the 25-year projection horizon (2016 to 2040). This would be considerably higher than the \$4.3 billion required for supporting the HRP and the estimated \$6.4 billion (\$256 million x 25 years, assuming a \$3,600 annual ceiling on claimable premiums) of tax revenue forgone under the tax deduction proposal over the same projection horizon.

### **Way Forward (Chapter 9)**

46. We need your support and constructive views to the proposals for implementing the VHIS. In particular, we welcome your views on the following issues –

- (a) Do you support introducing a regulatory regime for individual Hospital Insurance so that such products must comply with the Minimum Requirements prescribed by the Government?

- (b) Do you have any particular views on the 12 Minimum Requirements proposed for improving the accessibility, continuity, quality and transparency of individual Hospital Insurance?
- (c) In order to encourage employers to maintain Hospital Insurance cover for their employees, we propose that group Hospital Insurance should not be subject to the Minimum Requirements. Do you agree with this proposal?
- (d) In order to enhance protection for employees, we propose the arrangements of Conversion Option and Voluntary Supplement(s) for group Hospital Insurance. Do you agree with the proposed arrangements?
- (e) Do you support setting up a HRP with Government financial support, which is the key enabler of guaranteed acceptance with premium loading cap?
- (f) Do you support providing tax deduction for premiums paid for individual Hospital Insurance policies owned by taxpayers covering themselves and/or their dependants that comply with the Minimum Requirements (i.e. policies of Standard Plan and Flexi Plans); and premiums paid for Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies?
- (g) Do you support the arrangements proposed for policyholders of existing individual Hospital Insurance policies who, upon expiry of the existing policies, wish to migrate to VHIS policies (i.e. policies that comply with the Minimum Requirements); and the grandfathering arrangements proposed for existing policies that do not comply with the Minimum Requirements?
- (h) Do you support establishing a regulatory agency under the FHB to supervise the implementation and operation of the VHIS; and a CDRM for resolving claims disputes under the VHIS?

47. We will consolidate and analyse the views received from this public consultation exercise. With community support for the proposals in this Consultation Document, we plan to proceed to implement the VHIS through enacting a new legislation. We expect that the bill and subsidiary legislation required for the VHIS would be introduced in 2015/16.

48. Please send us your views on this Consultation Document on or before 16 March 2015 through the contact below. Please indicate if you do not want your views to be published or if you wish to remain anonymous when your views are published. Unless otherwise specified, all responses will be treated as public information and may be publicised in the future.

Address:  
Healthcare Planning and Development Office,  
Food and Health Bureau,  
19/F, East Wing,  
Central Government Offices,  
2 Tim Mei Avenue, Tamar,  
Hong Kong.  
Fax: 2102 2525  
E-mail: [vhis@fhd.gov.hk](mailto:vhis@fhd.gov.hk)  
Website: [www.vhis.gov.hk](http://www.vhis.gov.hk)

**Minimum Requirements for Standard Plan under  
Voluntary Health Insurance Scheme**

The ensuing paragraphs set out the proposed Minimum Requirements for Standard Plan under the Voluntary Health Insurance Scheme (VHIS), which can be grouped under three categories, namely (a) improving accessibility to and continuity of insurance, (b) enhancing quality of insurance protection, and (c) promoting transparency and certainty.

(a) Improving Accessibility to and Continuity of Hospital Insurance

*(1) Guaranteed renewal*

2. We propose to require insurers to provide guaranteed renewal with no re-underwriting as part of the Minimum Requirements in order to provide life-long insurance cover to consumers.

*(2) No “lifetime benefit limit”*

3. We note that currently some insurers have imposed “lifetime benefit limit” on some Hospital Insurance policies. Under a “lifetime benefit limit”, the insurance cover terminates when the cumulative claims 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*

4. We propose to require insurers to cover pre-existing conditions subject to a standard waiting period. Full coverage for pre-existing conditions would be provided after the three-year waiting period, and no/partial coverage would be provided during the waiting period according to the 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

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

- all ages within the first year of implementation of the VHIS; and
- those aged 40 or below starting from the second year of implementation of the VHIS,

regardless of the health status of prospective customers.

6. The first proposal above aims to provide accessible and affordable Hospital 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 Hospital Insurance when they are young and healthy. Without an entry age limit, there would be incentive for individuals to defer taking out Hospital Insurance until at an older age when their health condition deteriorates. At a young age, a consumer is, upon taking out Hospital Insurance, more likely to be healthy and thus may be able to lock in an underwriting class which attracts a lower premium. He/she can then maintain that underwriting class without re-underwriting even when he/she develops health conditions at a later age. In comparison, if a consumer subscribes to Hospital Insurance at an older age, he/she may already have developed pre-existing conditions. The consumer would then need to pay a higher premium than he/she would otherwise have to pay if he/she took out Hospital Insurance earlier.

7. We consider the proposed age limit of 40 appropriate as those who would like to subscribe to Hospital Insurance should have ample opportunities to do so before reaching the age of 40. In Australia, for example, consumers are encouraged to purchase private health insurance by age 30. A consumer who takes out a private health insurance plan after the age of 30 is charged a loading on the insurance premium<sup>1</sup>.

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

(ii) Premium loading cap

9. We propose to cap the premium loading at 200% of standard premium in order to ensure premium affordability for high-risk individuals for policies taken out under the guaranteed acceptance requirement proposed in paragraph 5. 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.

*(5) Portable insurance policy*

10. 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. This notwithstanding, we have to be aware of the technical challenges for insurers in financial risk and administrative cost management. For example, the incidents of claims would become more difficult to predict, and additional administration cost would be incurred due to checking of claims records between insurers. If these challenges cannot be properly tackled, some insurers may have to raise premiums to compensate for the uncertainty and cost. To address this problem, we propose that policyholders of VHIS plans may enroll in Standard Plans of other insurers without being re-underwritten and required to re-serve standard waiting period as long as they did not make any claims in a certain period of time (say, three years) immediately before changing to another insurer. Given

---

<sup>1</sup> 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.

the technicality of the subject, we will review whether the proposed arrangement should be refined taking into account the actual implementation of the VHIS and in consultation with the industry.

## (b) Enhancing Quality of Insurance Protection

### *(6) Coverage of hospitalisation and prescribed ambulatory procedures*

11. We propose to cover under the Minimum Requirements –
  - (i) hospital admissions necessitated by diagnosed medical conditions; and
  - (ii) a list of prescribed ambulatory procedures necessitated by diagnosed medical conditions, including endoscopy (e.g. oesophago-gastro-duodenoscopy and colonoscopy) and certain relatively simple surgeries like cataract extraction and intra-ocular lens implantation surgery.

12. Currently, some of the 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's estimate, around half of the endoscopies received by persons insured in private hospitals occurred as overnight stays. In comparison, in Australia, less than 10% of endoscopies 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 prescribed advanced diagnostic imaging tests and non-surgical cancer treatments*

13. Advanced diagnostic imaging tests are basic diagnostic tools in modern day medical diagnosis and treatment. We are of the view that, to ensure consumers have basic and value-for-money protection, these tests should be covered under the Minimum Requirements. However, international experiences of Organisation for Economic Co-operation and Development

(OECD) countries reveal that advanced diagnostic imaging tests are prone to abuse induced by moral hazard, and thus require concerted efforts, including the adoption of co-payment arrangement, to bring utilisation under proper control. We therefore propose to cover under the Minimum Requirements a list of prescribed advanced diagnostic imaging tests necessitated by assessed medical conditions, including Magnetic Resonance Imaging (MRI) examination, Computed Tomography (CT) and Positron Emission Tomography (PET) scans, subject to a prescribed rate of 30% of co-insurance (please refer to paragraph 17) to combat moral hazard.

14. We also propose to cover under the Minimum Requirements non-surgical cancer treatments up to a prescribed limit (\$150,000 per disability per year as currently proposed), including chemotherapy, radiotherapy, targeted therapy and hormonal therapy. These treatments, which are potentially expensive items, are of increasing importance as an integral part of cancer treatment. We consider it appropriate and desirable to cover these treatments under the Minimum Requirements.

#### *(8) Minimum benefit limits*

15. 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 in average-priced private hospitals.

16. The benefit coverage and benefit limits of 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 VHIS.

#### *(9) Cost-sharing restrictions*

17. While cost-sharing arrangements by policyholders, such as co-insurance and deductible, could encourage judicious use of healthcare services, we note that such arrangements might reduce the attractiveness of VHIS plans, and might affect the desire of policyholders to seek necessary treatments. We therefore propose that in principle, no cost-sharing arrangements (deductible or co-insurance) should be included in 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 a 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) Budget certainty*

(i) No-gap/known-gap arrangement

18. 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 and doctor’s fees. A 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 lists specified by the insurer concerned.

19. We propose to require that at least one procedure/test covered under Standard Plan should comply with the No-gap/known-gap arrangement. Insurers may limit the No-gap/known-gap arrangement to a particular list of procedures, institution (e.g. hospitals) 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 customers on the basis of how successful their “no-gap/known-gap” arrangements are.

20. 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

21. To enhance budget certainty by consumers, we propose that private healthcare service providers should inform patients 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 fee 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.

22. 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 for which it is not clinically possible to identify a definite diagnosis for the disease, e.g. abdominal pain, and therefore the doctor would be 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 on the price quotation form. Wherever possible, the doctor/hospital should endeavour to provide an estimated charge for items that are relatively certain/foreseeable, e.g. charge for attending physician's visit. 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*

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

*(12) Premium transparency*

24. 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 Standard Plans offered by different insurers in the market, including the premium schedules. This will allow consumers to easily compare Standard Plans offered by different insurers and drive the market to provide value-for-money products and services to consumers.

## Regulatory Requirements for Private Health Insurance Products in Five Overseas Jurisdictions

	Australia	Ireland	Netherlands	Switzerland	United States
<b>Role of Private Health Insurance (PHI)</b>	Supplementary (voluntary PHI)	Supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI) and supplementary (voluntary PHI)	Primary (mandatory PHI <sup>1</sup> )
<b>Share of PHI in healthcare financing<sup>2</sup></b>					
PHI	12%	13%	44%	49%	33%
Government	65%	67%	43%	25%	48%
Out-of-pocket	18%	17%	9%	25%	12%
Others	6%	2%	3%	1%	7%
	(Figures as at 2012/13)	(Figures as at 2012)	(Figures as at 2012)	(Figures as at 2012)	(Figures as at 2012)
<b>Product regulation by law</b>	✓	✓	✓	✓	✓

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

<sup>2</sup> Figures may not add up due to rounding.



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

	<b>Australia</b>	<b>Ireland</b>	<b>Netherlands</b>	<b>Switzerland</b>	<b>United States</b>
<b>Minimum benefit coverage</b>	✓	✓	✓	✓	✓ (except for large group and grandfathered plans)
<b>Fixed benefits package</b>	✗	✗	✗	✓	✗
<b>Restrictions on cost-sharing</b>	✓	✗	✓	✓	✓
<b>Portability</b>	✓	✓	✓ (may change insurer during designated time of year)	✓ (may change insurer during designated time of year)	✓
<b>Standardised policy terms and conditions</b>	✓	✗	✓	✓	✓
<b>Premium structure</b>	Community rating <sup>3</sup>	Community rating <sup>3</sup>	Community rating <sup>3</sup>	Modified community rating (allows variation by selected age groups and locations)	Modified community rating (allows variation by age, location, tobacco use and family status)

<sup>3</sup> Community rating of premium means that insurers are not allowed to set premium according to age and health condition of individual persons insured, and is usually supported by risk equalisation mechanism which redistributes premium across insurers according to risk exposure.

	<b>Australia</b>	<b>Ireland</b>	<b>Netherlands</b>	<b>Switzerland</b>	<b>United States</b>
<b>Premium loading</b>	Late entry loading to those who delay take-up of PHI until over 30 years of age: 2% of the base premium for each year over age 30 at the time of joining, subject to a maximum of 70%	✘	✘	✘	Rating rules to limit premium variation based on age and tobacco use to 3:1 and 1.5:1 respectively

**Illustrative Example on  
How the Provision of Public Funding Support to  
High Risk Pool can Benefit the Healthcare System as a Whole**

An example of tonsillectomy procedure is provided below to illustrate how the provision of public funding support to the High Risk Pool (HRP) can benefit the healthcare system as a whole.

2. According to publicly available information provided by a private hospital in Hong Kong, the average cost of conducting tonsillectomy is about \$34,000, and the average length of hospital stay is about three days. For the sake of illustration, it is assumed that the cost and average length of hospital stay of conducting tonsillectomy in a public hospital is the same as that in the private hospital.

3. At present, public hospitals are heavily subsidised by the Government and a patient only needs to pay \$100 per day for receiving public hospital service. As such, if the patient chooses to undergo the tonsillectomy procedure in a public hospital, the amount subsidised by the Government would be \$33,700 ( $\$34,000 - \$100 \times 3$ ).

4. On the other hand, if the patient has purchased Voluntary Health Insurance Scheme (VHIS) Standard Plan through the HRP, and chooses to undergo the tonsillectomy procedure in a private hospital, he/she would be able to pay his/her own healthcare cost with the support of his/her health insurance. In exchange, he/she could have his/her operation conducted in a private hospital setting and a choice of doctor. Assuming that the patient would need to pay about one-third of the total costs<sup>1</sup> for receiving private healthcare services, if he/she chooses to undergo the tonsillectomy procedure in a private hospital, he/she would need to pay \$11,300 ( $\$34,000/3$ ) out-of-pocket. The remaining amount would be payable by the HRP, i.e. \$22,700 ( $\$34,000 - \$11,300$ ). This payable amount will first be met by aggregate premiums collected from HRP

---

<sup>1</sup> According to the findings of the Consultant, the average out-of-pocket payment by policyholders for existing individual Hospital Insurance products (ward level) is about one-third of the total costs. For illustration purpose, it is assumed in this example that the level of out-of-pocket payment by HRP members would be one-third of the total cost. It should however be noted that the actual average level of out-of-pocket payment by HRP members may be different from that of non-HRP members, depending on factors such as the healthcare service utilisation pattern of HRP members.

members, including premiums collected from the patient himself (three times standard premium of the corresponding age-band). In the case where the aggregate premiums collected from HRP members are not sufficient for covering the payable amount, the shortfall will be met by the Government funding injected into the HRP.

5. Therefore, even taking into account the operation costs of HRP, the amount of Government subsidy provided to the patient would be considerably less (a portion of \$22,700) than the case where he chooses to undergo the procedure in a public hospital (\$33,700).

## Estimated Fiscal Implications of High Risk Pool to Government

Taking into account overseas and local market experience, the Consultant appointed to study the Voluntary Health Insurance Scheme (VHIS) estimates that the total cost to be borne by the Government for financing the High Risk Pool (HRP) would be about \$4.3 billion (in 2012 constant prices) for a period of 25 years (2016 to 2040). The average annual cost to Government per member of the HRP would be about \$7,200 (in 2012 constant prices). The following table sets out the estimated fiscal implications of the HRP to the Government as provided by the Consultant.

### Estimated Fiscal Implications of HRP to Government for a 25-year Period (2016 to 2040) (in 2012 constant prices)

(a) Claims cost (cost factor=6x)		\$15.8 bn
(b) Administration cost (12.5% of claims cost)	+	\$ 2.0 bn
<b>Total cost for HRP's operation [(a)+(b)]</b>	<b>=</b>	<b>\$17.8 bn</b>
(c) Premiums collected (3x standard premium)	-	\$13.5 bn
<b>Required funding [(a)+(b)-(c)]</b>	<b>=</b>	<b>\$ 4.3 bn</b>
<b>Average number of HRP members per annum</b>		<b>23 980</b>
<b>Total cost for HRP's operation per HRP member per annum<sup>1</sup></b>		<b>\$29,700</b>
<b>Required funding per HRP member per annum<sup>2</sup></b>		<b>\$ 7,200</b>

2. The estimations are worked out based on the following key assumptions –

- (a) guaranteed acceptance is applied to all ages within the first year of launch of the VHIS (assuming 2016 for planning purpose), and those

<sup>1</sup> This figure is obtained by dividing the average annual cost for the HRP's operation from 2016 to 2040 (\$17.8 billion/25 years = \$712 million) by average number of HRP members per annum during this period (i.e. 23 980).

<sup>2</sup> This figure is obtained by dividing the average annual funding requirement for HRP from 2016 to 2040 (\$4.3 billion/25 years = \$172 million) by average number of HRP members per annum during this period (i.e. 23 980)

- aged 40 or below starting from the second year;
- (b) coverage of pre-existing conditions subject to waiting period and partial reimbursement arrangement in the initial years as below –
    - (i) first year – no coverage
    - (ii) second year – 25% reimbursement
    - (iii) third year – 50% reimbursement
    - (iv) fourth year onwards – full coverage;
  - (c) premium loading is capped at 200% of standard premium;
  - (d) claims cost of a policyholder in the HRP is six times (i.e. cost factor) that of an average-standard-risk policyholder<sup>3</sup>; and
  - (e) administration cost for operating the HRP (including management costs, claims management, compliance and nominal administration fee for insurers) is 12.5% of total claims cost<sup>4</sup>.

---

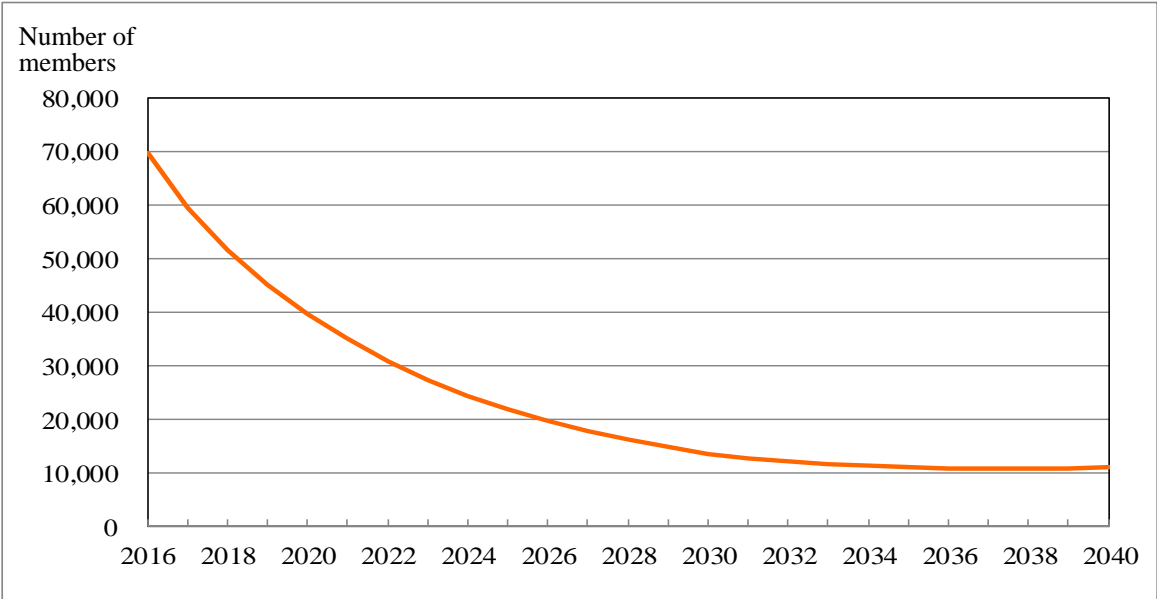
<sup>3</sup> The estimation of claims cost of an average-standard-risk policyholder begins with estimating the base claims cost of existing individual ward-level Hospital Insurance products in the local market. This step involves professional analysis of the existing market data in Hong Kong, including health insurance premium data, healthcare cost data, and claims data held by the Hong Kong Federation of Insurers (HKFI). The Consultant then identifies the key aspects of product design difference between the Standard Plan and existing individual ward-level Hospital Insurance products that carry significant upward or downward claims cost impact, including coverage of pre-existing conditions subject to waiting period; coverage of chemotherapy and radiotherapy; coverage of advanced diagnostic imaging tests subject to 30% co-insurance; coverage of endoscopy on the basis that the service would be provided in ambulatory setting with packaged pricing; and determination of benefit limits of the Standard Plan. The Consultant assesses the respective claims costs and claim frequency for each of the above aspect with reference to HKFI claims data and overseas claims data where appropriate, such as those from the Organisation for Economic Cooperation and Development, the United States and Australia. The resulted claims cost impacts are then applied to the base claims cost in order to derive the claims cost of an average-standard-risk policyholder under the Standard Plan for all years within the projection period.

<sup>4</sup> In deciding on the assumption of administration cost for operating the HRP, the Consultant draws reference from a number of insurance schemes or market segments that bear a certain degree of similarity with the proposed HRP. An example is the Pre-existing Condition Insurance Plan of the United States, which likewise only accepted high-risk lives. It was non-profit making in nature and incurred an administration cost at about 9% of total claims cost. Given that the proposed HRP would count on specialised managers to manage claims, the cost profiles of local and overseas healthcare network provider markets also provide useful references. For instance, the Consultant estimates that the administration cost roughly equals 8-10% of total claims cost in the network provider market of Hong Kong, and 8-12% in the market for health maintenance organisations in the United States. Since the proposed HRP would be akin to a group insurance scheme, the Consultant also considered the experience of the group health insurance market in Hong Kong, where

**Further Details on Assumptions**

3. In essence, the funding requirement for the HRP is equivalent to the excess of operating costs (claims cost and administration cost) over the premiums. Accounting for almost 90% of operating costs, the claims cost is the major cost factor which hinges on the size of HRP membership and the claims cost per head. Based on the assumption that guaranteed acceptance is only applied to those aged 40 or below starting from the second year of implementation of the VHIS, and having regard to the health profile of those with Hospital Insurance cover, the Consultant estimates that the membership of the HRP would be around 69 800 in 2016 (3.6% of total population<sup>5</sup> covered by individual Hospital Insurance), dropping gradually over time to about 10 900 in 2040 (0.5% of total population covered by individual Hospital Insurance)(please see **Chart 1**).

**Chart 1 Projected Membership of High Risk Pool (2016 to 2040)**



Note : The average number of HRP members per annum from 2016 to 2040 is 23 980.

---

according to the Consultant the administration cost roughly about 20% of total claims cost.

<sup>5</sup> Based on the results of the Thematic Household Survey conducted by the Census and Statistics Department, the Consultant projects the population coverage from 2016 to 2040 under the baseline scenario (i.e. without the VHIS) by taking into account regular influencing factors such as population ageing and medical inflation. The Consultant then further projects the population coverage from 2016 to 2040 under the forecast scenario (i.e. with the VHIS) by considering additional influencing factors that the VHIS entails, including guaranteed acceptance, benefit coverage, premium change, tax incentives, etc.



4. As regards the claims cost per head, HRP members will very likely entail higher claims cost than standard-risk policyholders paying standard premiums. Based on local and overseas experiences, the Consultant considers it reasonable to assume that the average claims cost of an HRP member is six times<sup>6</sup> that of a standard-risk policyholder. Although the average annual claims cost of HRP members is expected to trend upward alongside medical inflation, which is assumed to be 3.1 percentage points over annual general inflation rate as measured by Gross Domestic Product (GDP) deflator under the forecast scenario<sup>7</sup>, due to the predominant impact of declining membership of the HRP, the total claims cost for HRP is expected to trend downward in the long term, with the total cost (including claims cost and administration cost) settling at around \$310 million per annum by 2040 (**Chart 2**). The spurt in claims cost during the first few years of VHIS implementation is due to a large inflow of new joiners in the first year of implementation of the VHIS, though the effect will be partly offset by the standard three-year waiting period for pre-existing conditions. The restraining impact of waiting period on claims cost is poised to subside as these new joiners will have served the waiting period fully after the first three years and treatment costs relating to their pre-existing conditions will become fully claimable.

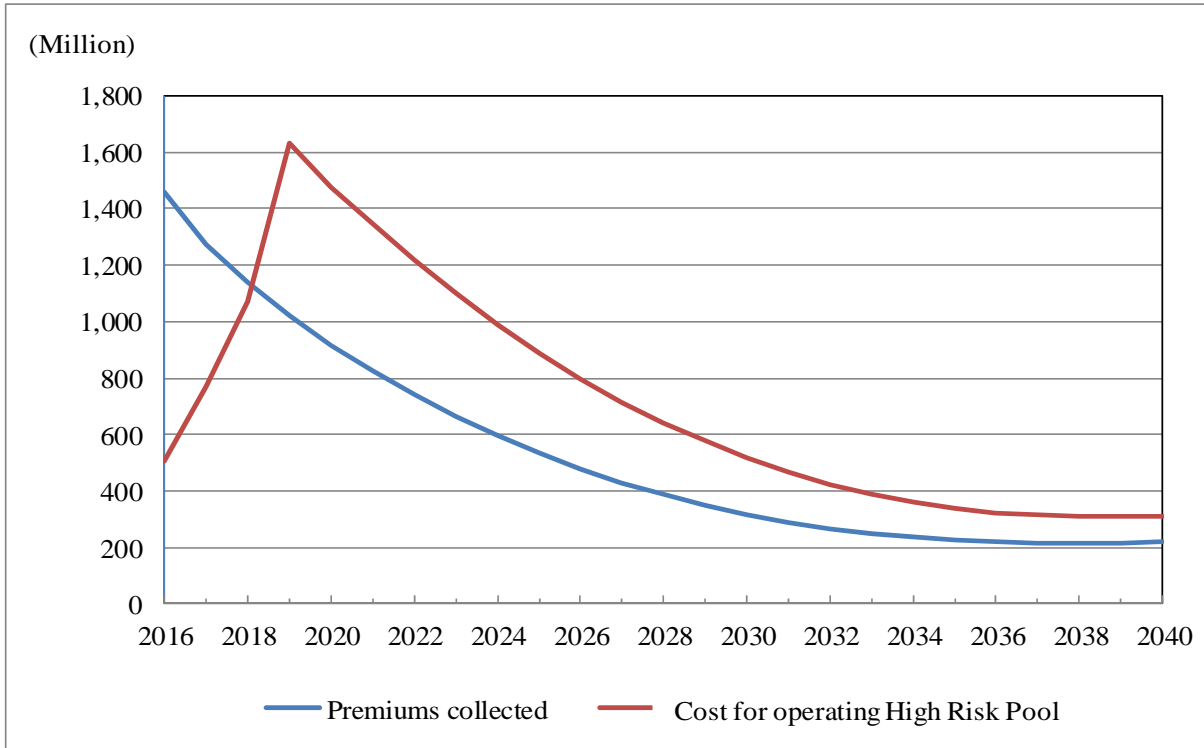
---

<sup>6</sup> The six times cost factor is assumed on the basis of claims data from the Hong Kong Federation of Insurers and the United States' experience in the Pre-existing Conditions Insurance Plan, which was broadly similar to the proposed HRP in terms of operation mode –

- in terms of local claims experience, the Consultant assumed the top 2% of policyholders are of high-risk, 18% are of non-standard risk and 80% are of standard risk. High-risk policyholders had a claims cost of about six times that of the standard risk policyholders;
- experience in the United States revealed that high-risk claimants could have claims costs of up to ten times that of non-high risk claimants. It should however be noted that the claims cost is likely to be much higher in the United States than in Hong Kong due to substantial differences between the two healthcare systems. In particular, the absence of a robust public healthcare system in the United States, and the greater readiness of their private hospitals to handle complex cases mean that the claims cost in the United States would likely be much higher than that of the proposed HRP. Moreover, in the case of the United States, there is no waiting period for people with pre-existing conditions, which would also mean that the claims cost in the United States is likely to be higher than that of the proposed HRP; and
- based on the local and market experiences, the Consultant considers it important to introduce care management programmes for HRP members in order to control cost. The six times cost factor is based on the assumption that effective care management programmes for HRP members are in place. If such programmes do not exist, the Consultant considers that the cost factor would increase to seven times.

<sup>7</sup> The forecast scenario presented here refers to the one with medium impact within the range of scenarios projected by the Consultant.

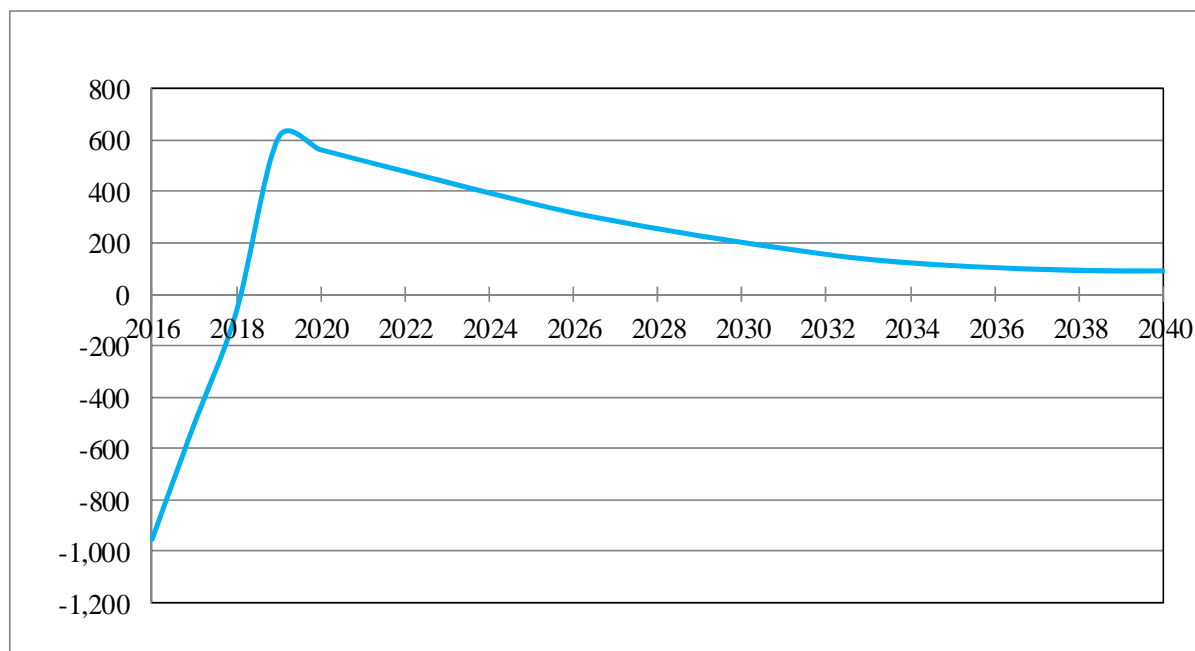
**Chart 2 Annual Total Premiums Collected from and Total Costs for Operating High Risk Pool (2016 to 2040) (in 2012 Constant Prices)**



5. On the premium side, by virtue of the premium loading cap, the premium income for HRP will be equivalent to three times standard premiums of Standard Plan paid by HRP members. Although the average premium of VHIS is projected to trend upward due to medical inflation, the total premium income for HRP would trend downward due to the predominating impact of a declining HRP membership. The total premium income would settle at around \$219 million per annum by 2040.

6. Due to the restraining impact of waiting period on claims cost in the first few years of VHIS implementation, the HRP is expected to have a surplus position till 2018, and the cumulative surplus would defer the requirement of Government funding from 2021 onwards. As the total cost and premium are expected to likewise stabilize in the long term, the funding requirement is projected to settle at around \$91 million per annum by 2040 (**Chart 3**).

**Chart 3 Estimated Cost of High Risk Pool to Government (2016 to 2040) (Annual Figures in 2012 Constant Prices)**



### Projection Model

7. All the financial projection results for the HRP are valued in 2012 constant prices, and the medical inflation assumption is in terms of excess over general inflation<sup>8</sup>. This approach is not uncommon in view of the uncertainty in forecasting long-term inflation, and is considered acceptable as general inflation will affect both the operating costs and premiums collected by the HRP. The major reason for limiting the projection horizon (25-year) to 2040 is that the population projection results from Census and Statistics Department are available up to 2041 only.

8. The HRP financial projection is subject to the following limitations –
- (a) uncertainty about the six times cost factor in respect of the average claims cost of an HRP member compared with a standard-risk policyholder. Nevertheless, based on overseas experience, the Consultant opines that if the actual cost factor of the HRP is higher than six times, it may also imply that only a small number of very high-risk policyholders would join the HRP. As such, there would be

<sup>8</sup> In the projection model, all financial projection results are valued in 2012 constant prices. This approach is adopted by the Consultant to reduce the complexity arising from explicit assumptions of general inflation and is considered by the Consultant sufficient for fulfilling the purpose of the study.

an offsetting effect that helps contain the additional funding requirement from Government;

- (b) effectiveness of care management programmes for the HRP, which is considered by the Consultant an important tool to help bring the claims cost of HRP members under better control. The Consultant estimates that effective implementation of these programmes can reduce the cost factor of an HRP member compared with a standard-risk policyholder from seven times to six times;
- (c) uncertainty about the long-term medical inflation. Despite consensual view that the medical inflation would likely outpace general inflation, the excess is difficult to predict as it depends on a host of factors such as technological advancement, utilization control, disease prevalence, disease prevention, etc.; and
- (d) effectiveness of cost-efficiency enhancement measures under the VHIS, such as co-insurance for claims arising from using advanced diagnostic imaging tests to combat abuse, promotion of delivery of healthcare services under ambulatory setting, and reduction of expense loading. The forecast scenario assumes that these measures have medium effect.

## **Projected Implications of the Voluntary Health Insurance Scheme on Healthcare System**

According to the projections by the Consultant appointed by Food and Health Bureau, the implementation of the Voluntary Health Insurance Scheme (VHIS) is expected to bring about a number of changes and benefits to the healthcare system –

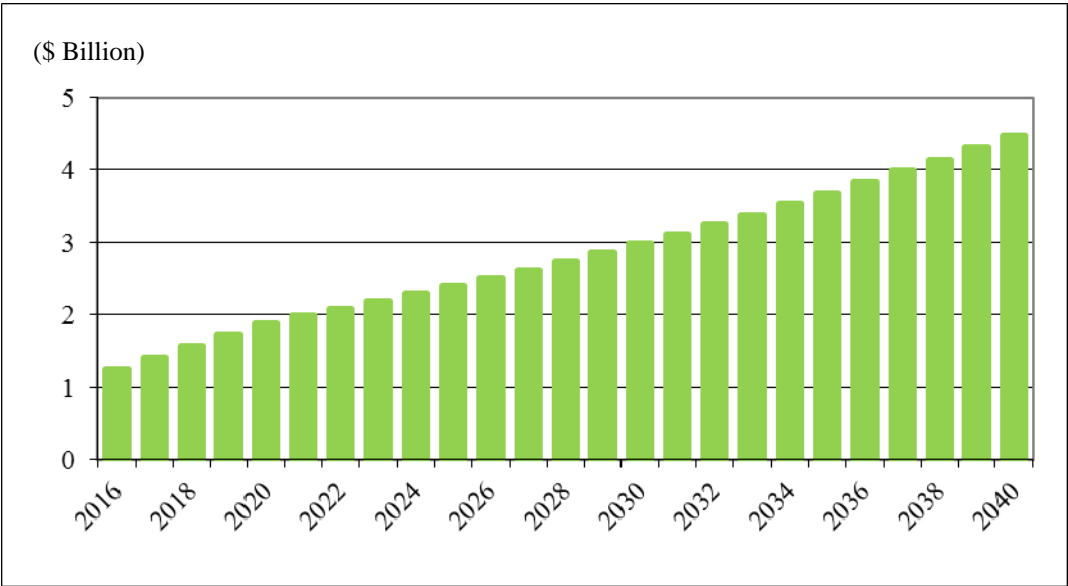
- (a) ***Increase in uptake rate of individual Hospital Insurance:*** Compared with the baseline scenario (without the VHIS), the implementation of the VHIS is expected to bring about a higher uptake rate in the individual market. Under the baseline scenario, the uptake rate is projected to be 26% of total population in 2016 and 21% in 2040. With the implementation of the VHIS, the uptake rate is projected to be 29% (223 000 more than baseline in terms of membership) in 2016 and 27% (443 000 more than baseline in terms of membership) in 2040. The reasons for the higher uptake rate include, amongst others, greater consumer confidence in Hospital Insurance, the guaranteed acceptance feature of the VHIS, and the provision of tax incentive.
- (b) ***Increase in activities in private sector:*** As more people take out and make use of Hospital Insurance as a result of the VHIS, it is expected that there would be a growth in utilisation of private healthcare services compared with the baseline scenario. In terms of procedures, it is projected that an additional 231 000 and 503 000 procedures<sup>1</sup> would be performed in the private sector in 2016 and 2040 respectively as a result of the VHIS. In terms of bed days, it is projected that the number of private overnight in-patient bed days would be 150 000 more than that under the baseline scenario in 2040, around 13% higher than baseline.
- (c) ***Nominal substitution of activities from the public sector:*** Amongst the increased activities in the private sector arising from the VHIS, a significant portion would be nominal substitution of activities from the public sector, i.e. activities that would otherwise be sought to be performed in the public sector under the baseline scenario. In terms

---

<sup>1</sup> Vast majority of these procedures are advanced diagnostic imaging tests, endoscopies, chemotherapy and radiotherapy.

of procedures, it is projected that around 120 000 and 267 000 procedures<sup>2</sup> would be nominally substituted from the public sector in 2016 and 2040 respectively. In terms of public overnight in-patient bed days, it is projected that the number of nominally substituted bed days arising from the nominally substituted activities would be around 53 000 in 2016 and 155 000 in 2040 respectively. Over the period from 2016 to 2040, the cumulative number of nominally substituted public overnight in-patient bed days is projected to be 2.8 million. In terms of expenditure, the nominal substitution of public health expenditure arising from the nominally substituted activities is projected to be around \$1.3 billion in 2016 and \$4.5 billion in 2040 (**Chart**). Over the period from 2016 to 2040, the cumulative amount of nominally substituted public health expenditure is projected to be approximately \$70 billion.

**Chart Nominal Substitution of Public Expenditure on Health due to VHIS**



The substitution of activities is nominal in the sense that it would unlikely be translated into any direct reduction in activities, bed days or public expenditure on health because of the continued rise in demand for public healthcare services due to an ageing population. Nevertheless, if we could encourage and facilitate more people to

<sup>2</sup> Vast majority of these procedures are advanced diagnostic imaging tests, endoscopies, chemotherapy and radiotherapy.

make use of private healthcare services through the VHIS, patients in the public sector would be able to benefit from enhance accessibility of public healthcare services through reduction of waiting time. Resources allocation could also be optimised for improving the quality of public healthcare services.

- (d) ***Balance of public and private healthcare sector:*** The growth in utilisation of private healthcare services and the nominal substitution of activities from the public sector are expected to lead to adjustment of the balance of public-private healthcare sectors in the long-term, including in-patient discharge and overnight in-patient bed days.

The significant increase in procedures, notably ambulatory ones performed on a same-day basis, would make greater use of the private sector as reflected in the projected number of in-patient (overnight and day cases) discharges. Under the baseline scenario, the ratio of public and private in-patient discharge is projected to be 86% and 14% in 2040. With the implementation of the VHIS, the ratio of public and private in-patient discharge is projected to be 81% and 19% in 2040. As the majority of the increase in private sector activities take the form of ambulatory procedures (which are more cost-effective and less costly to patients), the impact on overnight in-patient bed days are less prominent than in the case of total activities. In terms of overnight in-patient bed days, under the baseline scenario, the ratio of public and private overnight in-patient bed days is projected to be 87% and 13% in 2040. With the implementation of the VHIS, the ratio of public and private overnight in-patient bed days is projected to be 85% and 15% in 2040.

## **Financial, Civil Service, Economic, Sustainability and Family Implications**

### **Financial and Civil Service Implications**

The Voluntary Health Insurance Scheme (VHIS) is a voluntary supplementary financing arrangement to complement the public healthcare system. The VHIS is unlikely to be sufficient to contain or slow the growth of public health expenditure or resolve the long-term financing challenges to the Government. But it will help rationalise the use of healthcare resources in both sectors.

2. Apart from the funding required for supporting the High Risk Pool and the revenue forgone arising from the proposed tax incentive scheme as set out in paragraphs 11 and 13 of the paper respectively, Food and Health Bureau (FHB) will require additional manpower and financial resources for the preparatory work required for introducing relevant legislation into the Legislative Council, developing operational and technical details of the VHIS in consultation with stakeholders, and for the proposed establishment and operation of the VHIS regulatory agency under FHB, etc. We will work out the requirements in due course.

### **Economic Implications**

3. The VHIS should enhance the quality of Hospital Insurance products, strengthen consumer protection, and improve market transparency. As a supplementary financing arrangement, it is expected to help improve the overall uptake rates of Hospital Insurance and shift some demand for healthcare services from the public sector to the private sector, thereby contributing towards the long-term sustainability of the healthcare system as a whole.

4. Some compliance costs would be incurred by the insurance industry and additional cost by the Government to set up a regulatory agency to supervise the implementation and operation of the VHIS. Yet the Consultant expects that enhanced transparency and product comparability would lead to a reduction in the expense loading of the insurance companies.



5. However, from the perspective of economic efficiency, the proposal of removing from the market all Hospital Insurance products not meeting the Minimum Requirements would restrict competition and reduce the diversity of products in the Hospital Insurance market, which may not be in the best interest of consumers. Consumers who would otherwise take out an insurance plan with a lower coverage and lower level of benefits could now only take out the Standard Plan that offers more protection/benefit than what they perceive as adequate, and some may also choose not to take out any Hospital Insurance at all. Under the latter scenario of not taking out any Hospital Insurance, the consumer will probably go back to the public healthcare system when needed, and the VHIS's effect of shifting some demand for healthcare services from the public sector to the private sector may not be fully achieved.

### **Sustainability Implications**

6. Given the increasing health expenditure arising from demographic changes and rising medical costs, the sustainability of the healthcare system would likely remain an issue in the long-run. As a supplementary financing arrangement, the VHIS will contribute to the sustainable development of the dual-track healthcare system, including indirectly relieving the pressure on public healthcare by better enabling the public system to focus on its target groups, facilitating the development of private healthcare services, and improving the cost-efficiency of delivery of healthcare services. There may be divergent views on the Scheme and the different views should be handled with care.

### **Family Implications**

7. The granting of tax deduction for premiums paid for individual Hospital Insurance policies owned by taxpayers covering themselves and/or their dependants would encourage taxpayers to take out or maintain Hospital Insurance covers for their dependants, including children and elder family members. This would strengthen family functions in supporting one another and foster mutual care of family members.

