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Panel on Health Services

Meeting on 9 July 2021

Updated background brief on Voluntary Health Insurance Scheme

Purpose

This paper provides updated background information and summarizes the major views and concerns expressed by members of the Panel on Health Services ("the Panel") on the Voluntary Health Insurance Scheme ("VHIS").

Background

2. The Government conducted two stages of public consultation exercise on healthcare reform in 2008[1] and 2010[2] respectively to look for ways to maintain the long-term sustainability of the healthcare system. While the consultation exercise revealed strong public resistance to any supplementary healthcare financing options of a mandatory nature, the public expressed support for the introduction of a voluntary and government-regulated private health insurance scheme to enhance transparency, competition and efficiency of private health insurance for the provision of an alternative to those who are willing and may afford to pay for private healthcare services.

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[1] In March 2008, the Government put forth a package of healthcare service reforms and six possible supplementary healthcare financing options in the First Stage Healthcare Reform Consultation Document entitled "Your Health Your Life". The six options for addressing the long-term sustainability of healthcare financing were (a) social health insurance (i.e. mandatory contribution by the workforce); (b) out-of-pocket payments (i.e. increase user fees for public healthcare services); (c) medical savings accounts (i.e. mandatory savings for future use); (d) voluntary private health insurance; (e) mandatory private health insurance; and (f) personal healthcare reserve (i.e. mandatory savings and insurance).

[2] In October 2010, the Government published the Healthcare Reform Second Stage Public Consultation Document entitled "My Health My Choice" in which a voluntary and government-regulated private health insurance scheme was proposed for public consultation.

3. Subsequently, the Government conducted another four-month public consultation exercise in December 2014 to gauge public views on the Consultation Document on Voluntary Health Insurance Scheme which put forth the detailed proposals for implementing VHIS to enhance the accessibility to and quality of hospital insurance [3] and in turn help addressing the imbalance of the public-private healthcare sectors and enhancing the long-term sustainability of the healthcare system as a whole. It was proposed that all individual indemnity hospital insurance products would be required to meet or exceed a proposed set of 12 Minimum Requirements[4] upon the implementation of VHIS.

4. The Administration released the Consultation Report on VHIS in January 2017. According to the Administration, there is broad support for the concept and policy objectives of the proposed VHIS. While there is support for most of the Minimum Requirements, there are divergent views on those relating to guaranteed acceptance with premium loading cap which have to be underpinned by a High Risk Pool ("HRP"), coverage of pre-existing conditions and portable insurance policy. Taking into account the aims of VHIS, its extensive impact on the insurance sector and the views collected during the public consultation exercise, the Administration decided to first implement a VHIS with 10 Minimum Requirements, [5] with refinements to some of these Minimum Requirements and related proposals, through a non-legislative framework in collaboration with the Insurance Authority.

5. On 1 April 2019, VHIS was fully implemented. Under VHIS, all Certified Plans offered by VHIS providers[6] must meet or exceed the minimum product standard of the scheme and be officially certified by the Food and Health Bureau ("FHB"). There are two types of Certified Plans, namely

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[3] "Hospital insurance" refers to the insurance business falling under Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (renamed as Insurance Ordinance with effect from 26 June 2017) (Cap. 41) which provides for benefits in the nature of indemnity against risk of loss to the insured attributable to sickness or infirmity that requires hospitalization.

[4] The proposed 12 Minimum Requirements include (a) guaranteed renewal without re-underwriting; (b) no "lifetime benefit limit"; (c) coverage of pre-existing conditions; (d) guaranteed acceptance with premium loading cap; (e) portable insurance policy with no re-underwriting when changing insurers; (f) coverage of hospitalization and prescribed ambulatory procedures; (g) coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments; (h) minimum benefit limits; (i) no cost-sharing by policyholders; (j) budgetary certainty; (k) standardized policy terms and conditions; and (l) transparent information on age-banded premiums.

[5] The remaining two Minimum Requirements which were not included in the first phase of implementation are (a) guaranteed acceptance with premium loading cap; and (b) portable insurance policy with no re-underwriting when changing insurers.

[6] All insurance companies must be successfully registered with the Food and Health Bureau as VHIS providers and obtain a registration number before they can offer Certified Plans in the market.

Standard Plan and Flexi Plan. Standard Plan is fixed in product design and adheres to the minimum complying requirements of VHIS. Flexi Plans is more flexible in product design with enhanced protection for the insured provided generally all protection under a Standard Plan is preserved.

6. Salient features of Certified Plans include –

(a) guaranteed renewal up to the age of 100 regardless of change in the health condition of the insured persons;
(b) no limit on "lifetime benefit";
(c) cooling-off period of 21 days;
(d) coverage extended to cover unknown pre-existing conditions, day case surgical procedures (including endoscopy), congenital treatment, etc; and
(e) transparency on the premiums.

7. To provide an incentive for the public to purchase Certified Plans under VHIS, premiums paid by a person for himself/herself and their dependants will be allowed for tax deduction under the Inland Revenue Ordinance (Cap.112). The deduction ceiling is $8,000 per insured person per year. There is no cap on the number of dependants that are eligible for tax deduction.

8. As of 31 May 2021, 78 Certified Plans had been certified by FHB and were available in the market, offering 296 products for consumers' choice.

9. According to the estimation by an independent consultant before the launch of VHIS, about 1 million people would purchase Certified Plans in the first two years of the implementation of VHIS. As at 31 March 2021, the number of policies under Certified Plans reached 791 000. Among these policies, 97% purchased Flexi Plans. The others purchased Standard Plans. 53% of the insured are aged below 40 and 34% are aged below 30. According to the statistics for 2020, 94% of the applications for policy coverage were accepted.

Major views and concerns of members

10. At the Panel meeting held on 19 March 2018, members were briefed on the implementation of VHIS and consulted on the legislative proposal for introducing tax deduction for taxpayers who purchase Certified Plans under VHIS. The Panel also discussed the Consultation Report on VHIS and the way forward for the implementation of VHIS at its meeting on 16 January 2017. The major views and concerns expressed by members are summarized in the following paragraphs.

Re-examination of the High Risk Pool proposal

11. Some members were of the view that VHIS without the Minimum Requirement in relation to guaranteed acceptance with premium loading cap which had to be underpinned by HRP and portable insurance policy would leave high-risk individuals such as elders and chronic disease patients, who accounted for the largest proportion of patients of public hospital services, unable to benefit from VHIS. Nonetheless, some other members had strong reservation on the proposal which required injection of public money. Members enquired about the timetable for the Administration to complete the re-examination of the HRP proposal.

12. The Administration advised that the 2014 public consultation exercise on VHIS revealed that there were divergent views over the proposed establishment of HRP. Apart from the concern of the insurance industry on the HRP proposal which was mainly on the financial sustainability of HRP, some members of the public had concerns on spending public money on high-risk individuals who could afford private hospital insurance and how far the HRP proposal would affect the uptake of private hospital insurance. Hence, a phased approach was adopted by launching VHIS first and re-examining the HRP proposal at a later stage, taking into account, among others, the experience of actual implementation of VHIS. It stressed that VHIS was not intended as a total solution to all the challenges brought about by a rapidly ageing population and the associated increasing prevalence of chronic diseases to the healthcare system. The Administration was determined to step up its efforts to promote primary healthcare with a view to, among others, enhancing the public's ability in self-management of health and thereby reducing the demand for hospitalization.

Features of VHIS

Incentives for younger age groups

13. Some members considered that the current benefit schedule of Standard Plan which did not cover specialist outpatient services could not benefit people who were young and relatively healthy as people aged 25 to 45 accounted for the smallest proportion of admissions to public hospitals. Other members also asked how the young and healthy people would be incentivized to take out insurance under VHIS.

14. The Administration advised that the Minimum Requirement of guaranteed renewal of policies without re-underwriting could provide life-long insurance cover to the insured. At a young age, they were more likely to be healthy and

thus might be able to lock in an underwriting class with a lower premium. They could then maintain in that underwriting class without re-underwriting even when they developed health conditions at a later stage. The Administration would step up the promotion of VHIS to encourage more people to take up VHIS policies when they were young and healthy so as to enjoy guaranteed renewal until 100 years old.

Regulation on premium levels and private healthcare service charges

15. Under VHIS, there was no regulation on the premium levels and the level of expense loading of VHIS providers. Some members were concerned policyholders who took up VHIS policies at their younger age might, for various reasons, become unable to afford the premium at an older age after staying insured under VHIS for years. They called for the Administration to subsidize half of the premiums paid by those who subscribed VHIS between the ages of 25 to 45.

16. Some other members remarked that about 80% of the premiums for hospital indemnity insurance policies were used to cover fees and charges by private hospitals and doctors. Any regulation on the premium levels should only be imposed if the fees and charges of private hospitals and doctors would be regulated. They suggested that the Administration should introduce diagnosis-related groups packaged pricing to contain healthcare expenses for certain treatment or procedures so as to facilitate the VHIS providers to set a lump-sum benefit level for these treatment and procedures.

17. The Administration advised that efforts had been and would continuously be made to enhance the price transparency of private healthcare services to enable people to exercise informed choice. A case in point was the Pilot Programme for Enhancing Price Transparency for Private Hospitals jointly rolled out by the Administration and the Hong Kong Private Hospitals Association, which encouraged private hospitals to provide budget estimates on specified common and non-emergency treatments and procedures, and publicize on their websites the fee schedules of the major chargeable items and the historical bill sizes of specified common treatments and procedures.

Benefit limits on cancer treatments

18. Some members considered that the benefit limit of $80,000 per policy year under the benefit item of non-surgical cancer treatments of Standard Plan was far from adequate to cover the high medical costs on radiotherapy, chemotherapy and targeted therapy for treatment of cancer. Since an aim of VHIS was to enable the public healthcare sector to focus on serving its target areas and population groups by encouraging more people to use private

healthcare services, these members opined that the Administration should cover the medical expenses of the insured that exceeded the above benefit limits. The Administration explained that consumers who wished to have enhanced protection could choose to purchase Flexi Plan policies under VHIS, and that there was a need to strike a balance between higher benefit limits and an affordable premium.

Tax Deduction

19. Noting that the maximum deduction for qualifying premiums paid by the taxpayer for himself or herself and/or each of his or her dependants under VHIS policies for a year of assessment was $8,000, some members expressed concern on whether the amount of net saving in tax, which would be at a maximum of $1,360 per insured person at a marginal tax rate of 17%, could provide adequate incentive to encourage people to take up VHIS policies so as to alleviate the pressure on the public healthcare system. In addition, low-income earners who did not need to pay tax would not benefit from the tax deduction. Some other members suggested that the maximum deduction should be raised from $8,000 to $10,000 per insured person, and an option should be offered to those policy holders aged 45 or above for having the payment of the relevant premiums be covered by the accrued benefits held in their Mandatory Provident Fund account, so long as the accrued benefits so used did not exceed $5,000 per year.

20. The Administration advised that the tax deduction was an added incentive for the public to purchase VHIS-compliant plans. According to the independent consultant commissioned by the Administration, about 90% of the policy holders of Standard Plans could have their qualifying premiums fully deductible under the current proposal. It should also be noted that there was no cap on the number of dependants that were eligible for tax deduction.

21. Some members sought clarification as to whether tax deduction was allowed for premiums paid in respect of individual hospital indemnity insurance plans which met the minimum compliant product requirements of VHIS but with a savings component. The Administration advised that VHIS providers might opt to offer Flexi Plans with enhancement(s) of indemnity hospital insurance nature to any or all of the protections or terms that the Standard Plan provided and with certification to be in compliance with VHIS. Qualifying premiums paid in respect of a VHIS policy in so far as it related to the coverage of a Certified Plan, be it a Standard Plan or Flexi Plan, would be eligible for tax deduction.

<u>Governance of VHIS</u>

22. Some members were of the view that the Insurance Authority, instead of

the VHIS Office under FHB, should take up the function of monitoring VHIS in the long run to avoid duplication of duties. The Administration explained that the Insurance Authority would continue to serve as the regulator of the insurance industry, whereas the VHIS Office would be responsible for issuing the VHIS practice guidelines and handling public enquiries on and monitor compliance of these guidelines.

Use of the $50 billion earmarked for healthcare reform

23. Members noted that it was announced in the 2015-2016 Budget that out of the $50 billion earmarked in the 2008-2009 Budget to support healthcare reform, funds would be injected into HRP under VHIS. Given that the plan of the Administration was to re-examine the HRP proposal at a later stage, they sought information about the use of the $50 billion.

24. The Administration advised that $10 billion had been allocated to set up an endowment fund for Hospital Authority to pursue public-private partnership initiatives, and a loan of $4.033 billion had been offered to The Chinese University of Hong Kong for developing a non-profit-making private teaching hospital. Separately, a one-off provision of $200 billion had been earmarked for the implementation of the 10-year Hospital Development Plan.

Relevant papers

25. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

Council Business Division 4
Legislative Council Secretariat
6 July 2021

Appendix

List of relevant papers

Committee	Date of meeting	Paper
Panel on Health Services	16 January 2017 (Item III)	Agenda Minutes CB(2)1370/16-17
	19 March 2018 (Item III)	Agenda Minutes CB(2)2014/17-18
Bills Committee on Inland Revenue (Amendment) (No. 4) Bill 2018	15 June 2018	Agenda Minutes CB(2)198/18-19
	9 July 2018	Agenda Minutes CB(2)199/18-19
	19 July 2018	Agenda Minutes CB(2)223/18-19
Council Meeting	8 May 2019	LCQ4: Prices for private healthcare services
	15 July 2020	LCQ19: Encouraging wider use of private healthcare services

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