CHAPTER 2  MINIMUM REQUIREMENTS
STRENGTHENING REGULATION OF HEALTH INSURANCE

Health Insurance Market in Hong Kong

2.1. The health insurance market is lightly regulated in Hong Kong, subject only to prudential regulation under the Insurance Companies Ordinance (ICO) (Cap. 41). There is no statutory product requirement for health insurance, and insurers are free to create, design and sell health insurance products as they deem fit from the business perspective. There is a large variety of health-related insurance products in the market, which are sold through various distribution channels, including sales by insurance agents or brokers. Health insurance products could be offered in the form of individual policies or group policies that are mostly purchased by employers for their employees as staff benefits.

2.2. Generally speaking, the major types of insurance products that are health-related and currently on offer in Hong Kong could be categorised as follows –

(a) “indemnity hospital insurance”, which reimburses the policyholders for expenses incurred as a result of treatment of illness in hospital, such as elective surgeries or more complex treatments requiring hospitalisation. The indemnity is commonly based on a pre-set benefit schedule with itemised benefit limits by spending type such as room and board, doctor consultation and surgical fee;

(b) “indemnity out-patient insurance”, of which the benefit is typically payable per consultation, such as consultation in clinic for treatment of relative minor sickness (e.g. influenza). Insurers usually limit the number of consultations claimable per year;

(c) “hospital cash insurance”, which offers a fixed amount of benefits in cash per day to a policyholder during the period of hospitalisation. The benefit amount is not tied to the level of spending on hospital care, and is usually inadequate for meeting the expenses of private hospital care. Such products could serve as a form of income protection to policyholders; and

(d) “critical illness insurance”, which offers a substantial lump-sum cash payment upon confirmation of a critical illness on a pre-defined list (e.g. cancer, heart attack, kidney failure, etc.), without requiring the policyholder to undertake treatment.

1 An “indemnity” insurance generally refers to an insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual loss.
Minimum Requirements for Individual Hospital Insurance

2.3. We propose to regulate under the Voluntary Health Insurance Scheme (VHIS) the first type of products mentioned above sold to individuals, namely individual indemnity hospital insurance. More specifically, individual indemnity hospital insurance refers to a contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the ICO (Cap 41) (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 (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).

2.4. We propose that, in selling and/or effecting individual Hospital Insurance, an insurer must comply with the Minimum Requirements prescribed by the Government, as described in detail in this Chapter and Chapter 3. 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.

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

1. any fixed pecuniary benefits (e.g. hospital cash, critical illness cover) which may be added to an individual Hospital Insurance policy. This is because the pay-out of insurance benefit of such policies is not tied to the level of spending on hospital care, and therefore does not necessarily pertain to health protection of the policyholder or contribute to achieving the objective of the VHIS, namely providing a choice to those who are able and willing to use private healthcare services; and

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2 For the purpose of the VHIS, hospitalisation here 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.

3 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 hospitalisation 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.
2.6. For the avoidance of doubt, we propose that an out-patient only policy will not be regulated by the Minimum Requirements. As discussed in Chapter 1, the objective of the Health Protection Scheme (HPS) proposed in the Second Stage Public Consultation on Healthcare Reform (Second Stage Consultation) was to provide more choices with better protection to those who were able and willing to use health insurance for private healthcare services, particularly the more routine procedures performed under an in-patient setting in the public sector. In doing so, the public sector could better focus on serving its target areas. In view of the aim and focus of the VHIS, we propose that out-patient only policies will not be subject to the Minimum Requirements. However, the role of primary care in the healthcare system should not be overlooked and has important contribution in the process. We will discuss this perspective in Chapter 3.

2.7. 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.

**Views from the Insurance Industry**

2.8. We have consulted, among other stakeholders, representatives of the insurance industry, including members of the Working Group and Consultative Group on Health Protection Scheme and the Hong Kong Federation of Insurers on the proposed Minimum Requirements. While there was general consensus amongst stakeholders for introducing Minimum Requirements for VHIS products, there were divergent views on whether the Minimum Requirements should apply to all individual Hospital Insurance products. One of the major concerns of the insurance industry was that the introduction of Minimum Requirements for all individual Hospital Insurance products might stifle product innovation and

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4 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 2.60 to 2.64 below.
reduce consumer choice over products that did not meet the Minimum Requirements. It was proposed that insurers should be allowed to, alongside compliant products, sell products that do not comply with the Minimum Requirements.

2.9. After careful deliberation, we consider the Minimum Requirements a balanced proposal that could enhance consumer protection without compromising consumer choice. Our considerations are set out in detail in the following section.

Why Minimum Requirements for all Individual Hospital Insurance?

2.10. The Minimum Requirements are proposed based on the following considerations –

(A) To Address Public Concern Over the Existing Health Insurance Market

2.11. As revealed in previous public consultations, there was general consensus among the community on strengthening regulation over the existing Hospital Insurance market and addressing existing shortcomings in market practices, 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. According to the findings of the Public Opinion Survey on Supplementary Healthcare Financing conducted alongside the Second Stage Consultation, about 90% of the respondents supported strengthening regulation of health insurance in order to provide better protection to consumers. By requiring all individual Hospital Insurance products to comply with the Minimum Requirements, public concerns over the existing Hospital Insurance market can be addressed, and consumer confidence in purchasing Hospital Insurance and using private healthcare services can be enhanced. This would be conducive to the development of the health insurance and private healthcare service sectors.

2.12. The Minimum Requirements are designed to provide simplicity, clarity and certainty to consumers and help consumers who do not possess professional insurance knowledge to understand easily and clearly the protection they can receive when taking out a Hospital Insurance policy. On top of the Minimum Requirements, insurers would be free to innovate and offer tailor-made products to suit specific consumer needs (please refer to Chapter 3 for more details).

2.13. The Minimum Requirements proposal is in line with international experience. In jurisdictions where private health insurance (PHI) plays a significant role in the healthcare system, including Australia, Ireland, the Netherlands, Switzerland and the United States, the governments have prescribed by law basic requirements for PHI in order to safeguard consumer interest. These basic requirements are broadly similar to the proposed Minimum Requirements, including guaranteed acceptance, coverage of pre-existing conditions,
guaranteed renewal, minimum benefit coverage and benefit levels, standardised policy terms and conditions, etc. The table at Appendix D summarises the regulatory requirements for PHI in the abovementioned five jurisdictions.

(B) **Enhancing the Financing Role of PHI**

2.14. As mentioned in paragraph 1.14 of Chapter 1, among those covered by PHI, about 54% of their local hospital admissions pertained to the public sector; and one possible reason is that patients may feel uncertain about their insurance protection in terms of whether the admission is claimable or by how much the insurance benefits can cover the expenses, etc. By improving the quality and certainty of insurance protection through the Minimum Requirements, PHI can play a bigger role in financing the growing health expenditure.

(C) **Sustainability of Compliant Products**

2.15. The introduction of Minimum Requirements for all individual Hospital Insurance products would be crucial to the sustainability of compliant products, because it would 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 products are not bound by Minimum Requirements (non-compliant products). The Minimum Requirements are designed for meeting the community’s aspirations and the long-term sustainable development of our healthcare system. Achieving these goals would have cost implications. Under a “two-market” situation where regulated and unregulated market segments co-exist, the healthier population may be induced to purchase non-compliant products with relatively low premiums, leaving the compliant products a choice mainly for the unhealthy population. As explained in paragraphs below, under such situation, the interest of buyers of both non-compliant and compliant products will be impaired, and the sustainability of the VHIS will be threatened.

2.16. Under a “two-market” situation, some consumers may be induced to take out a non-compliant policy at a relatively low premium that does not provide adequate protection. For instance, without guaranteed renewal, a policyholder may be denied renewal of policies, or being charged new premium loadings upon policy renewal after making claims. With a claims record and deteriorated health conditions, it would be difficult for the policyholder to find a new insurer who will be willing to insure him/her. Even if he/she could, the premium is likely to be much higher than that of the same age group due to premium loading. A policyholder may only come to realise these shortcomings when making claims, which may occur years after purchasing the policy. He/she may not be well-aware of the relevant risks at the time of purchase, particularly if the policy terms and conditions are not easy to comprehend. Although the policyholder may still switch to compliant products, he/she will have to be re-underwritten and might be charged a premium loading.
2.17. For buyers of compliant products, they will also be affected by the “two-market” situation. The regulated segment would have to manage a pool of policyholders of higher health risks than an average consumer. The premiums will be driven up in consequence, making compliant products less affordable and more likely to be acceptable only to those who foresee they would make claims. Moreover, the market segmentation will generate a vicious cycle. The higher premiums would drive healthy and price-sensitive consumers away from the regulated segment, resulting in a further deterioration of the pool of compliant products in terms of health risks of policyholders. As a result, an even higher premium would have to be charged on policyholders of compliant products, which would further drive away the relatively healthy consumers from the regulated segment. Such vicious cycle would lead to an ever increasing premium and dwindling pool of policyholders of compliant products with higher and higher health risks. Eventually, the premium would become unaffordable and the regulated segment would no longer be sustainable.

The MediShield experience in Singapore

Operated by the 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. Singapore’s experience helps illustrate why a “two-market” situation (co-existence of a regulated market segment and an unregulated segment for health insurance) is not practicable.

What are the Minimum Requirements?

2.18. The proposed Minimum Requirements encompass key features proposed for the HPS in the Second Stage Consultation. Taking into account the views received during the Second Stage Consultation, as well as the need to balance between consumer protection and viability
and sustainability of the VHIS under the Minimum Requirements approach, we have proposed some refinements to the implementation details of certain key features.

2.19. We propose that insurers selling individual Hospital Insurance products must offer a Standard Plan as one of the options to consumers, regardless of whether they also offer individual Hospital Insurance products with enhanced benefits. An individual Hospital Insurance that meets all (but not exceeding) the Minimum Requirements proposed below is considered a Standard Plan. These Minimum Requirements for Standard Plan 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. They are summarised in Table 2.1 below.

Table 2.1 12 Minimum Requirements for Standard Plan

<table>
<thead>
<tr>
<th>(A) Accessibility to and continuity of insurance</th>
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<tr>
<td>(1) Guaranteed renewal</td>
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<td>• No re-underwriting is allowed for policy renewal</td>
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<td>(2) No “lifetime benefit limit”</td>
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<tr>
<td>(3) Coverage of pre-existing conditions</td>
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<tr>
<td>• first year – no coverage</td>
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<td>• second year – 25% reimbursement</td>
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<td>• third year – 50% reimbursement</td>
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<td>• fourth year onwards – full coverage</td>
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<tr>
<td>(4) Guaranteed acceptance with premium loading cap</td>
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<td>• all ages within the first year of implementation of the VHIS; and</td>
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<tr>
<td>• those aged 40 or below starting from the second year of implementation of the VHIS</td>
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<tr>
<td>• Premium loading capped at 200% of standard premium</td>
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<td>(5) Portable insurance policy</td>
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### (B) Quality of insurance protection

<table>
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<th>Coverage</th>
<th>Requirement</th>
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<tr>
<td>6</td>
<td>Coverage of hospitalisation and prescribed ambulatory procedures</td>
<td>Benefit coverage must include medical conditions requiring hospitalisation and/or prescribed ambulatory procedures</td>
</tr>
<tr>
<td>7</td>
<td>Coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments</td>
<td>Benefit coverage must include prescribed advanced diagnostic imaging tests subject to a fixed 30% co-insurance; and non-surgical cancer treatments up to a prescribed limit</td>
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<tr>
<td>8</td>
<td>Minimum benefit limits</td>
<td>Benefit limits must meet the prescribed levels</td>
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<tr>
<td>9</td>
<td>Cost-sharing restrictions</td>
<td>No deductible and co-insurance, except the 30% co-insurance fixed for prescribed advanced diagnostic imaging tests; Annual cap of $30,000 on cost-sharing by policyholders (however, if the actual expenses exceed benefit limits, the excess amount is still payable by the policyholder)</td>
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### (C) Transparency and certainty

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>10</td>
<td>Budget certainty</td>
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<tr>
<td>11</td>
<td>Standardised policy terms and conditions</td>
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<tr>
<td>12</td>
<td>Premium transparency</td>
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2.20. The ensuing paragraphs describe in detail the Minimum Requirements for Standard Plan. The Minimum Requirements, such as benefit coverage and benefit limits, would be subject to regular review and update by the regulatory agency (please refer to Chapter 6) to be set up to monitor the implementation and operation of the VHIS as necessary and appropriate, taking into account market developments such as price level of private healthcare services, advancement in medical technology, etc.
(A) Improving Accessibility to and Continuity of Insurance

(1) Guaranteed Renewal

2.21. We propose to require insurers to provide guaranteed renewal without re-underwriting as part of the Minimum Requirements in order to provide life-long insurance cover to consumers. To protect consumers from sharp premium hike due to illness, insurers would not be allowed to re-underwrite individual policyholders during policy renewal.

2.22. The renewal of VHIS policies should not be conditional upon the continuation of other insurance policies. For example, if a VHIS policy is a rider to a life insurance policy, then the renewal of the VHIS policy should not be conditional upon the renewal of the latter. Or, say, in the case of a family policy which covers more than one persons insured, and that the policyholder passes away, then the other persons insured should be allowed to continue their insurance cover without being subject to re-underwriting or re-serving the standard waiting period.

(2) No “Lifetime Benefit Limit”

2.23. 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

2.24. 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 below –

| (a) first year – no coverage |
| (b) second year – 25% reimbursement |
(c) third year – 50% reimbursement

(d) fourth year onwards – full coverage

(4) Guaranteed Acceptance with Premium Loading Cap

(ii) Guaranteed Acceptance

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

(a) all ages within the first year of implementation of the VHIS; and

(b) those aged 40 or below starting from the second year of the implementation of the VHIS,

regardless of the health status of prospective customers.

2.26. 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 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 that 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.

2.27. 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 PHI before age 30. A consumer who takes out PHI after the age of 30 is charged a loading on the insurance premium⁵.

2.28. 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.

⁵ Those who purchase PHI 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.
(ii) **Premium Loading Cap**

2.29. 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 2.25. A High Risk Pool (HRP)\(^6\) 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. Please refer to Chapter 4 for details on the latest proposal concerning the HRP.

(5) **Portable insurance policy**

2.30. 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 among insurers. This notwithstanding, we have to be aware of the technical challenges for insurers in managing financial risk and administrative cost. 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 products complying with the Minimum Requirements may enroll in a Standard Plan of other insurers without being re-underwritten and required to re-serve the standard waiting period as long as they did not make any claims in a certain period of time (say, three years) immediately before the transfer of policy to another insurer. Given 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.

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\(^6\) HRP is an industry reinsurance mechanism proposed in the Second Stage Consultation for insurers participating in the HPS to share out the high risks insured by their HPS Plans. All high-risk policies, defined as those policies with risk premium assessed to be equal or above the cap for premium loading (i.e. three times the standard premium of Standard Plan) will be put into the HRP. Please refer to Chapter 4 for details of the current proposal for the HRP.
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(B) Enhancing Quality of Insurance Protection

(6) Coverage of Hospitalisation and Prescribed Ambulatory Procedures

2.31. We propose to cover under the Minimum Requirements –

(a) hospitalisation necessitated by diagnosed medical conditions; and

(b) a list of prescribed ambulatory procedures necessitated by diagnosed medical conditions, including endoscopies (e.g. oesophago-gastro-duodenoscopy, colonoscopy, etc.) and certain relatively simple surgeries such as cataract extraction and intra-ocular lens implantation surgery. The ambulatory procedures to be covered under Standard Plan will be determined and prescribed by the VHIS regulatory agency in consultation with major stakeholders (e.g. members from the insurance industry, private healthcare service providers, relevant regulatory authorities, etc.)

2.32. 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.

According to the estimate of the Consultant, in 2010, the average cost of the procedure “colonoscopy with removal of tumor, polyp or lesion” performed under an ambulatory setting was around $8,600. The average cost was around $19,100 for those who stayed overnight in a hospital (general ward level).

(7) Coverage of Prescribed Advanced Diagnostic Imaging Tests and Non-surgical Cancer Treatments

2.33. 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 such as in Organisation for Economic Co-operation and
Development 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 paragraphs 2.39 to 2.40) to combat moral hazard.

2.34. 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.

2.35. The benefit coverage of Standard Plan would be reviewed and updated by the VHIS regulatory agency at regular intervals. The benefit coverage of existing policies of Standard Plan would be updated upon policy renewal in accordance with the prevailing benefit coverage as published by the regulatory agency.

(8) Minimum Benefit Limits

2.36. 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. The benefit limits of Standard Plan would be reviewed and updated at regular intervals by the VHIS regulatory agency.

2.37. For hospital treatments, we propose that the benefit limits should be itemised in a way that is broadly consistent with the existing fee structure of private hospitals. This would be in line with the current insurance market practice and claims settlement process. Examples of benefit items include room and board, attending physician’s visit, surgeon and anaesthetist fees, operating theatre fees, and miscellaneous expenses.

2.38. With regard to the prescribed advanced diagnostic imaging tests, prescribed ambulatory procedures and non-surgical cancer treatments, we propose setting out the benefit limits in packaged form, i.e. a lump-sum benefit limit per episode of care/disability. We consider it appropriate to adopt packaged benefit limits for these procedures and tests since they are relatively simple without significant cost variation. Adopting packaged benefit limits can encourage private healthcare providers to offer similarly structured pricing packages for these procedures and tests, hence bringing about budget certainty to the policyholders.
We also propose to set the benefit limits of these procedures and tests with reference to the price levels in ambulatory setting. This is because these procedures and tests can usually be conducted under an ambulatory setting in a more cost-effective way, and setting their benefit limits with reference to the price levels in ambulatory setting can promote better utilisation of ambulatory services and help reduce unnecessary hospital admissions.

(9) Cost-sharing Restrictions

2.39. 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 affect the desire of policyholders to seek necessary treatments.

2.40. In view of the above, we propose that, in principle, no cost-sharing arrangements (deductible or co-insurance) should be included in Standard Plan. On the other hand, we recognise that there is a need to combat moral hazard in cases where healthcare services are most prone to mis-use or abuse. We therefore propose to introduce 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 medication (e.g. chemotherapy). Other than the said 30% co-insurance, no cost-sharing arrangements (deductible or co-insurance) should be included in Standard Plan. 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

2.41. In the Second Stage Consultation, it was proposed that HPS plans should offer coverage for common procedures using diagnosis-related groups (DRG)-based packaged pricing. DRG is a sophisticated coding system for classifying medical conditions requiring treatments or procedures by diagnosis and complexity. Insurers would set a lump-sum benefit level for the treatment/procedure with DRG-based packaged pricing. Packaged charging would provide cost transparency and certainty for consumers, and would help promote healthy competition in the private healthcare services market.

2.42. We note that DRG-based packaged pricing may not be feasible for all hospital admissions or ambulatory procedures, and would be more easily implementable where a certain treatment or procedure is performed at a sufficiently high frequency, allowing any variation in costs to be averaged out among different cases; or where a certain treatment or
procedure is relatively routine or standardised with low variation in actual utilisation or costs involved. In cases where packaged pricing is not considered feasible due to complexity of the treatments or procedures, HPS plans would still need to offer itemised benefit schedules for these treatments or procedures.

2.43. After taking into account the views received during the Second Stage Consultation and the advice of the Consultant, we consider that it would take a relatively longer time for Hong Kong to develop an operable system of DRG suitable for local use in the private sector. The exercise would require comprehensive and regular collection, compilation and analysis of healthcare, claims and pricing data from the health insurance industry and healthcare service providers. Regular and structural review is also required to keep the DRG system up-to-date. As Hong Kong currently does not possess such sophisticated mechanism for conducting the above work, there will be significant challenges in implementing a DRG system in the short-term.

International experience reveals that DRG is a popular payment method to reimburse healthcare providers for the services they provide to patients, and its application is observed in both public and private sectors. A major advantage of this payment method is to encourage healthcare providers to control cost and avoid unnecessary services for profit sake, while a key challenge involved is to balance cost of care with quality of care (e.g. to avoid inadequate provision of healthcare service as reimbursement by DRG is fixed per diagnosis). DRG is generally not pursued for centralised price-setting or price-fixing. It is through mutual agreement that healthcare providers and healthcare payers determine whether to adopt DRG-based payment method, its structure and level of payment. In the United States, for instance, Medicare (social health insurance for the elderly and disabled people) has adopted DRG as the payment method for hospital charges since 1983. Hospitals opting to participate in Medicare (and hence can accept Medicare patients) have to agree to receive reimbursement from Medicare according to the DRG-based payment schedule the latter sets. Yet for doctor charges, Medicare does not adopt DRG and instead uses a fee schedule by procedure and service which is subject to review and recommendation from the American Medical Association. In the private sector of the United States, healthcare providers and health insurers have full liberty regarding whether to follow Medicare practice. Besides DRG, there are other payment methods such as capitation payment, contracted fee-for-service payment, and per-diem payment that are agreed between healthcare providers and health insurers.
Chapter 2  Minimum Requirements

(ii) No-gap/known-gap Arrangement

2.44. After taking into account the local situation and surveying international experience, we propose adopting the No-gap/known-gap arrangement, which is more readily implementable in the short-term and has been widely adopted in Australia. “Gap” refers to the out-of-pocket expenses a patient pays for hospital and doctor’s fees (except pre-set deductible and co-insurance). 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 are on the lists specified by the insurer concerned.

2.45. To facilitate market adaptation, 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, institutions (e.g. hospitals) and doctors. A policyholder pays “no-gap” or “known-gap” if –

(a) the procedure concerned is on the specified list;

(b) the institution is from the specified list; and

(c) the doctor is from the specified list.

2.46. 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. The No-gap/known-gap arrangement would be akin to packaged pricing in the sense that it provides budget certainty and convenience to a policyholder, who can ascertain the amount of out-of-pocket payment, if any, before receiving the treatment.

International experience also reveals that implementing DRG would require considerable efforts, such as substantial investment in information technology systems, comprehensive data collection on costs and benchmarks, or even introduction of specific legislation to require services to be purchased using DRG. In Switzerland, for example, the enabling legislation (amendment of the Federal Health Insurance Act) was passed in 2007, but it was not until 2012 that the system could be implemented in full due to lack of data and inconsistencies in the way diagnoses and treatments were recorded for DRG purposes. In the Netherlands, it took several years to gradually expand the range of procedures subject to DRG packaged pricing, from 10% of the total hospital budget in 2005 to 33% in 2009 and 75% in 2012.
Since June 2000, all insurers in Australia are required by law to offer “no-gap/known-gap” policies for hospital cover. A policyholder with this type of insurance policy enjoys “no-gap” or “known-gap” when choosing a hospital with which his/her insurer has a “Hospital Purchaser Provider Arrangement” (HPPA, under which the insurer pays a contracted hospital fee), and a doctor who agrees to use his/her insurer’s fee schedule through “Medical Purchaser Provider Arrangement” (MPPA, under which a doctor can opt to use the insurer’s fee schedule). The policyholder may still opt for other hospitals and doctors, but this would normally result in larger out-of-pocket payments, since under such cases insurers generally provide relatively modest reimbursements to encourage policyholders to choose healthcare service providers under the HPPA and MPPA. The “no-gap/known-gap” policies have proliferated remarkably in Australia over the past decade or so. 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.

2.47. 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

2.48. In Singapore, private hospitals are required to provide estimated total charges (known as “financial counselling”) to patients before treatment and inform patients of any changes in a timely manner. Patients are informed, in the form of a uniform written quotation, of the estimated charges of the healthcare services (including doctor’s fee and hospital fees) before receiving treatment. Under such arrangement, patients would have greater certainty in estimating the amount of out-of-pocket expenses before receiving treatment.

2.49. We propose to adopt the approach of Singapore in enhancing budget certainty of VHIS policyholders. As a general rule, 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. A sample of the Informed Financial Consent is attached at Appendix E for reference.

2.50. We are aware that there might be circumstances where the Informed Financial Consent requirement should be exempted. For example, if, at a doctor’s clinical judgment, further treatment is required for a patient undergoing an operation/procedure, emergency or life threatening situations, price quotation for items beyond those that the patient had consented to would be exempted. 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. In such cases, we propose that the doctor 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 or foreseeable, e.g. charge for attending physician’s visit. When a definite diagnosis is subsequently received and elective therapeutic operations/procedures are required, the patient should be given an estimate of the total charges, the reimbursement amount and estimated out-of-pocket payment as soon as practicable.

2.51. Noting that there could be varying degrees of complexity or unforeseen circumstances arising from treatments or procedures, we propose that private healthcare service providers should inform patients of the range of potential variation of the estimates in the Informed Financial Consent. In case there are any material changes in estimates (e.g. surgical fee, medication fee, specialist visit fee, etc.), patients should be informed of the reasons for change of the estimated charges, as well as the latest estimated charges as soon as practicable. For example, the actual charges for a surgical procedure might vary significantly from the original estimates if there are complications during the operation. In such cases, patients should be informed of the reasons for change in estimates, as well as the latest estimated charges. When applicable, insurers should also inform patients of the revised reimbursement amount and out-of-pocket payment if providers have provided a revised estimate of charges due to substantial variation from the original estimates. For example, a patient suffering from complications during an operation may be required to stay in the hospital for a longer period of time than originally estimated. In such cases, the patient should be informed of the revised reimbursement amount and estimated out-of-pocket payment as far as practicable.

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7 While hospital charges can be quoted by hospital administration separately from doctor’s fee, for the sake of expediency, doctors may use their best endeavours (such as making reference to the hospital website) in providing price quotes for individual items of hospital charges based on the fee schedule of private hospitals.
(11) Standardised Policy Terms and Conditions

2.52. 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.

2.53. The standardised policy terms and conditions will cover, among others, definitions, interpretation and wordings; policy provisions in regard to guaranteed renewal, coverage of pre-existing conditions, standard waiting period, etc.

(12) Premium Transparency

2.54. During the Second Stage Consultation, there was considerable interest in how to keep the future premiums under better check. While we acknowledge the public’s concern over possible premium increase over the long-term, we are aware that insurance premium is influenced by a host of factors, including medical costs, claims experience, administration cost, risk assessment, etc. Moreover, the interplay of these factors may differ from one insurer to another, and may change alongside dynamic market situation over time. All these mean that direct interference with premium setting is undesirable. It would be difficult to ensure that the premium setting mechanism is fair and reasonable to both consumers and insurers, and direct regulation of premium setting may result in excessive interference to the detriment of market development as well as consumer interest.

2.55. To balance between consumer protection and avoidance of over-interference in market operation, we consider that consumer interest can best be safeguarded through transparency measures that foster market competition. By creating a level-playing field for all insurers and minimising information asymmetry between consumers and insurers, these transparency measures can enhance consumer choice, foster market competition and help keep premium levels in check. Moreover, given that Standard Plans by different insurers would be essentially identical, consumers can easily compare different offers by insurers. Against this backdrop, we propose that –

(a) insurers may apply premium loading to individual policies in accordance with their own underwriting practice and risk-taking preference, but the premium loading is subject to a cap of 200% of standard premium. Insurers would have incentive to compete and offer the best price as consumers can shop around for value-for-money products offered by different insurers;

(b) insurers should make known the reasons for assessing any premium loading to the
consumer, who should be allowed to provide supporting evidence to request loading reduction; and

(c) insurers may set and adjust its premium schedules for compliant products, but the premium schedules must be age-banded and must be published for consumers’ reference.

2.56. We also propose that an easily accessible platform (e.g. websites of insurers and the VHIS regulatory agency) should be established with information on VHIS products offered by different insurers in the market, including the premium schedules. This will allow consumers to easily compare VHIS products and drive the market to provide value-for-money products and services to consumers. We consider competition and transparency the most effective and sustainable measures to safeguard consumer interest. That said, we do not rule out the possibility that the regulatory agency might have to take stronger action if the market behaviour falls short of reasonable expectations. If necessary, the regulatory agency will review whether further measures such as premium adjustment guidelines are necessary and appropriate for protecting consumer interest, based on the experience and market development after the implementation of the VHIS.

Arrangements for Group Hospital Insurance

2.57. Among the about 2.0 million persons covered by indemnity hospital insurance, about 0.7 million are covered by employer-provided medical benefits in the form of group Hospital Insurance. Ideally, it is desirable for group Hospital Insurance to comply with the Minimum Requirements for better consumer protection. A prudent and more practical approach, however, is called for in the light of the unique characteristics of group Hospital Insurance.

2.58. The group market is inherently different from the individual market since the cost of purchasing the group policies is borne by employers, rather than employees who are the direct beneficiaries of the insurance cover. Given that purchase of Hospital Insurance is voluntary under the VHIS, it would be important to encourage employers to maintain or take up group Hospital Insurance – even if it falls short of the Minimum Requirements – for their employees. Some of the products in the market are of limited protection in terms of benefit coverage and limits due to budget constraint of the employers, especially the small and medium enterprises. If all group Hospital Insurance is required to comply with the Minimum Requirements, some of the employers might drop the cover altogether because they may not be able to afford to pay for the more comprehensive coverage of compliant products. Besides, since the cost of the group cover is borne by employers, who do not benefit directly from the insurance cover, there might be a risk that some of the employers currently offering above-par group coverage might reduce the protection level to that of the perceived “standard level” of the Minimum Requirements.

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8 Includes medical benefits not in the form of medical insurance provided by private companies/organisations, and excludes civil servant and Hospital Authority staff medical benefits.
2.59. Taking into account the characteristics of the group market as well as employers’ affordability, we propose not to require group Hospital Insurance to comply with the Minimum Requirements. Nevertheless, to better protect employees’ interests, we propose to adopt the following arrangements for group Hospital Insurance.

(1) Conversion Option

2.60. We propose to require insurers to offer as an option to employers an elective component – the Conversion Option – in the group Hospital Insurance products offered to employers. Employers would be allowed to decide whether to purchase the group policy with the Conversion Option component. 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 retirement or leaving employment so that he/she can switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that the employee has been employed for a full year immediately before transfer to individual Standard Plan. If the insurer concerned does not practise individual underwriting for group policies, which is quite common in the local market, the employee only needs to pay for standard premium for individual Standard Plan irrespective of his/her health conditions. The premium of the Conversion Option would be determined by the insurer, depending on the profile and characteristics of the group (e.g. the age profile of the employees).

2.61. The Conversion Option would help ensure continuity of Hospital Insurance cover of an employee into old age. Compared with purchasing a separate individual Standard Plan, the benefits of the Conversion Option are that an employee will not need to undergo re-underwriting when switching to an individual Standard Plan, and does not need to take on an individual policy beforehand in order to secure a sustained and affordable insurance protection upon retirement or leaving employment.

(2) Voluntary Supplement(s)

2.62. At present, some insurers offer Voluntary Supplement(s) to individual members covered by a group policy. We consider this arrangement consistent with our policy objective and worthwhile to promote. We propose that insurers may, on a group policy basis, continue to offer 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 Voluntary Supplement(s) would be provided on a group policy basis, i.e. the supplement(s) will not be individual policies. The intention is that the group policy, enhanced by the Voluntary Supplement, should provide insurance protection at a level comparable to the protection of an individual Standard Plan. Individual policy members will have the choice of whether to purchase the Voluntary Supplement(s) or not.

9 As a rider to the group policy or an integrated component of the group policy.
(3) Disclosure of Information

2.63. In order to facilitate better understanding of the level of protection received by employees from their group policy, we propose to require insurers to keep a prescribed checklist of whether the group Hospital Insurance products they offer to each individual employer meet the Minimum Requirements. The insurer would be obliged to divulge such information to employees upon enquiry.

(4) Naming of Group Hospital Insurance Products

2.64. In the individual market, after the implementation of the VHIS, only those Hospital 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. 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”). In addition, to protect employer’s interests, we propose that insurers should state clearly in the product information provided to employers whether such products are compliant with the Minimum Requirements.