VOLUNTARY HEALTH INSURANCE SCHEME

Consultation Report

Food and Health Bureau
Hong Kong Special Administrative Region Government

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MESSAGE FROM DR KO WING-MAN, BBS, JP, SECRETARY FOR FOOD AND HEALTH

Dear Citizens,

The publication of this report marks the conclusion of the public consultation exercise of the Voluntary Health Insurance Scheme (VHIS).

The VHIS is part and parcel of our efforts in strengthening the healthcare system and recalibrating the balance of the public and private healthcare sectors. To support the long-term development of the healthcare system, it is essential to build upon the existing strengths and characteristics of the dual-track healthcare system of Hong Kong. Under the VHIS, the enhanced accessibility, quality and transparency of hospital insurance would facilitate and encourage more people to make use of private healthcare services. This, in turn, will allow the public healthcare sector to focus on servicing its target areas.

I am encouraged that the community has rendered strong support for the concept and policy objectives of the VHIS. Among the 600 written submissions received and views expressed on various occasions during the consultation period, a majority considered the VHIS a positive step forward for enhancing the sustainability of the healthcare system, along with other initiatives that we are undertaking, such as promoting public-private partnerships, enhancing primary care, strengthening the regulation of private healthcare facilities and managing the supply of public and private healthcare manpower.

We have also received many insightful views and valuable suggestions on the specific proposals of the VHIS, which are summarised in this consultation report. In refining the detailed proposals of the VHIS and formulating relevant operational and technical details, we would give due regard to these suggestions and will continue to engage relevant stakeholders, with a view to working out a sensible and practical proposal that aligns with the objectives of the VHIS and meets the needs of the community.

Finally, I would like to thank you all for sharing your views by taking part in the public consultation. Your contributions have formed a solid basis for us to take forward and implement the VHIS for the betterment of all.

Dr Ko Wing-man
Secretary for Food and Health
January 2017

EXECUTIVE SUMMARY

THE PUBLIC CONSULTATION (CHAPTER 1)

1. The public consultation on Voluntary Health Insurance Scheme (VHIS) was conducted between 15 December 2014 and 16 April 2015. We consulted the public on our proposal to introduce a regulatory regime for individual indemnity hospital insurance (Hospital Insurance)[1] so that such products must comply with relevant Minimum Requirements prescribed by the Government. The Minimum Requirements serve to improve the accessibility, continuity, quality and transparency of individual Hospital Insurance.

2. During the consultation period, we launched a publicity campaign through various channels, including Announcements in the Public Interest, distribution of posters, leaflets, brochures, consultation documents, souvenirs, animation videos, advertisement, a dedicated website and Facebook page. A telephone survey was commissioned from January to May 2015 to facilitate collation and assessment of views on the VHIS. We also attended 73 briefing sessions to present the proposed VHIS and listen to the views expressed by the community, including Legislative Council and District Council meetings, community forums and briefings and seminars organised by different parties and organisations. We received a total of 600 written submissions, comprising 478 from individuals and 122 from organisations.

PUBLIC VIEWS ON PROPOSED REGULATION OF INDIVIDUAL HOSPITAL INSURANCE AND MINIMUM REQUIREMENTS (CHAPTER 2)

Policy Objectives of the VHIS and Strengthening Regulation of Individual Hospital Insurance

3. There was broad support for the concept and policy objectives of the VHIS in general. Many considered it a positive step towards redressing the balance of the public-private healthcare sectors and enhancing the long-term sustainability of the healthcare system as a whole. Many respondents supported the VHIS in providing an alternative to public healthcare for those who were willing and able to use private healthcare services, and pointed out that this would help alleviate the pressure on the public healthcare system. There was also a general consensus on introducing a regulatory regime for individual Hospital Insurance. Many concurred that strengthened regulation and the proposed Minimum Requirements approach would enhance the accessibility, quality and transparency of individual Hospital Insurance.

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1. For the purpose of this report, the expression "Hospital Insurance" refers to the insurance business falling under Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (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 hospitalisation. A Hospital Insurance policy held by an individual policyholder, not being an employer insuring for the benefit of his/her employees, will be referred to as an "individual Hospital Insurance policy". The expression "individual Hospital Insurance" will be construed accordingly.

4. At the same time, some respondents held the view that the VHIS might not be attractive enough to the elderly or the young and healthy, and expressed doubt on the effectiveness of the VHIS in achieving its objectives. Some submissions, including those from the insurance industry, considered it necessary to allow more flexibility in implementing the Minimum Requirements, such as modifying some of the Minimum Requirements; and allowing more flexibility for the market in designing products catering for the needs of different consumers. Some respondents considered that consumer choice should be valued, and that existing insurance plans should not be barred from the market.

5. Some submissions pointed out that other policy measures must be implemented in parallel with the VHIS for building an integrated and holistic healthcare system, such as public-private partnerships, promotion of preventive care, greater emphasis on primary care and more transparency in private hospital charges. A number of submissions held the view that, instead of implementing and spending public money on the VHIS, the Government should focus on enhancing public healthcare services.

Minimum Requirements

6. There was strong support for those Minimum Requirements, including guaranteed renewal, no "lifetime benefit limit", coverage of hospitalisation and prescribed ambulatory procedures, coverage of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments, budget certainty, adoption of standardised policy terms and conditions, and premium transparency. Regarding guaranteed acceptance with premium loading cap, some respondents questioned the concept and financial sustainability of the proposed High Risk Pool (HRP), whilst proponents of this Minimum Requirement considered that it was essential for high risk individuals who often encounter difficulties in obtaining Hospital Insurance under existing market practice.

7. Notwithstanding majority support for the Minimum Requirements of minimum benefit limits and cost-sharing restrictions, some submissions suggested allowing more flexibility in order to suit different consumer needs and to encourage market innovation, such as providing plans with lower benefit limits for consumers who are already covered by an existing individual or group policy; or relaxing the restrictions on cost-sharing by policyholders in exchange for a lower premium.

8. There were divergent views on the coverage of pre-existing conditions and portable insurance policy. While some respondents considered the requirement of coverage of pre-existing conditions important in benefiting those individuals with adverse health conditions, others expressed concern on whether coverage of pre-existing conditions would result in much higher claims payout and drastic increase in premiums, and whether the higher premiums would discourage the young and healthy people from

taking out insurance intended to be regulated under the VHIS, hence, lowering their desire to use private healthcare services. Some suggested allowing case-based exclusions so that consumers with higher health risks might choose to take out a policy with a lower premium. As regards the requirement of portable insurance policy, some submissions agreed with the principle of portability, pointing out that portability would facilitate consumer choice and drive market competition. Other respondents, however, were concerned whether portability without re-underwriting would pose financial risk to the insurer accepting the policy so transferred.

Arrangements for Group Hospital Insurance

9. A majority of submissions supported the proposed exemption of group Hospital Insurance from the Minimum Requirements, so as to encourage employers to maintain group cover for their employees. Nevertheless, a minority of respondents considered that having "one standard" for all Hospital Insurance products more ideal and less confusing to consumers, and suggested that group Hospital Insurance should be subject to VHIS regulation in the long-run.

10. There was broad support for the proposed Conversion Option and Voluntary Supplement(s). Most submissions agreed that the two arrangements could enhance protection for employees. Some respondents suggested that measures should be put in place to mitigate possible anti-selection risk brought about by the Conversion Option; others suggested that the Voluntary Supplement(s) should be individual-based rather than group-based to allow an employee to maintain the cover if he/she changed employment.

PUBLIC VIEWS ON PROPOSED USE OF PUBLIC FUNDING (CHAPTER 3)

HRP

11. There were divergent views over the proposed establishment of the HRP. On one hand, many supported the policy objective of establishing the HRP. They agreed that the HRP was essential for implementing the requirement of guaranteed acceptance with premium loading cap. Some respondents suggested setting a higher entry age limit (originally proposed at 40), and extending the one-year window period to allow more time for people to consider taking out insurance which was compliant with the VHIS.

12. On the other hand, a number of submissions expressed grave concern on the long-term sustainability of the HRP. They remarked that the HRP would be a drain on public finance, and questioned whether

the amount of public funding reserved for maintaining the operation of the HRP was sufficient. Other respondents considered that public funding should be spent on enhancing public healthcare instead of subsidising those who could afford to purchase private Hospital Insurance.

Tax Concession

13. There was overwhelming support for the proposal of providing tax concession for VHIS-compliant policies. Many submissions considered that the tax concession should be enhanced to attract young and healthy people to take out insurance under the VHIS, such as setting a higher annual ceiling on claimable premiums; or to relax the cap on the number of dependants' policies. Some submissions considered that the Government should ensure that public funds would be well spent.

PUBLIC VIEWS ON PROPOSED MIGRATION ARRANGEMENTS (CHAPTER 4)

Migration Window Period

14. Many supported the proposal of requiring insurers to offer a migration option to policyholders of existing individual Hospital Insurance policies within the migration window period. They considered that the proposed one-year window period should be extended, so as to allow more time for policyholders to better understand the VHIS and to consider migrating to compliant policies.

Grandfathering Arrangements

15. There was broad support for the proposed grandfathering of existing individual Hospital Insurance policies in the case where existing policyholders did not wish to migrate to VHIS compliant policies. Nevertheless, the insurance industry expressed doubts on the sustainability of the grandfathered portfolio in the longer term, and stressed their view that the industry should have the flexibility to design different products to be sold alongside VHIS products.

PUBLIC VIEWS ON PROPOSED INSTITUTIONAL FRAMEWORK (CHAPTER 5)

Regulatory Agency

16. Many views supported the proposed establishment of a regulatory agency. They considered Government regulation important for monitoring the VHIS and the operation of the HRP, and that a well-designed regulatory system could enhance consumer confidence and encourage the public to participate in the VHIS. On the other hand, some submissions considered a separate regulator not

necessary, and that the proposed functions of the regulatory agency should be taken up by existing regulatory bodies to avoid duplication of duties.

Claims Dispute Resolution Mechanism (CDRM)

17. Many submissions considered that a credible and impartial CDRM would help resolve and minimise claims disputes. Some submissions noted that the existing Insurance Claims Complaints Bureau (ICCB), a self-regulatory body sponsored by the insurance industry that handles complaints about insurance claims, was equipped with the necessary expertise and had accumulated rich experience in handling health insurance claims disputes. Instead of setting up a new CDRM, these submissions considered that the ICCB should continue with its role in handling insurance claims disputes.

PUBLIC VIEWS ON SUPPORTING INFRASTRUCTURE (CHAPTER 6)

Supply of Healthcare Manpower and Capacity of Private Healthcare Sector

18. Most of the submissions attached great significance to the need for an adequate supply of healthcare manpower and sufficient capacity of the private healthcare sector. Many respondents questioned whether the additional demand arising from the VHIS would draw more healthcare personnel to the private market, leading to "brain-drain" from the public sector. Many respondents considered an adequate supply of private healthcare facilities crucial to absorbing the additional demand brought about by the VHIS and keeping the fees and charges of private healthcare services under better check.

Price Transparency of Private Healthcare Services

19. Many submissions concurred that price transparency of private healthcare services would play an essential role in protecting consumers and keeping medical costs under check. This would, in turn, help keep premium levels under better control and ensure the long-term sustainability of the VHIS.

Premium Levels

20. Some submissions expressed concern on whether increased utilisation under the VHIS would result in a drastic increase in the premium levels. Some respondents held the view that the premiums might be unaffordable to some members of the community, especially the elderly, low-income groups or chronic disease patients. Others expressed concern over the relatively high expense loading of the Hong Kong individual health insurance market as compared with overseas markets. Some suggested that, in addition to the proposed transparency measures, the Government should consider measures that would help monitor premium levels.

CONCLUSION AND WAY FORWARD (CHAPTER 7)

21. With general support from the community, we will proceed to take forward the VHIS. We propose to refine some specific proposals taking into account the views received from the public and relevant stakeholders. To strike a balance between consumer protection and consumer choice, we agree that there should be room for product design and innovation. Insurers should have reasonable flexibility of offering products that do not fully meet the requirements under VHIS, alongside VHIS-compliant products provided that consumers are well informed with ample avenues for access to VHIS-compliant products.

22. As regards the HRP, it is necessary for the introduction of the two Minimum Requirements of "guaranteed acceptance" and "portable insurance policy". Given the public's diverse views on the proposed establishment of the HRP, we consider that a more prudent approach is to separate the consideration of them from the other proposed Minimum Requirements which have received broad support in the public consultation exercise. In order not to delay the implementation of the VHIS, we propose to adopt a phased approach by launching a VHIS with ten Minimum Requirements and re-examine the HRP proposal, related Minimum Requirements and the need of legislation, at a later stage, taking into account, among others, the experience of actual implementation of the VHIS.

23. We also propose to make some refinements to the originally proposed Minimum Requirements. These include permitting case-based exclusions of pre-existing conditions, subject to the standardisation of wordings of the exclusion clauses to be drawn up in consultation with stakeholders and availability of an option to choose premium loading for covering pre-existing conditions in the case of Standard Plan; relaxing the cost-sharing restrictions; making the migration arrangement more flexible; and providing more flexibility in the design of Flexi Plan.

24. In the Consultation Document, we proposed that insurers might offer, on a group basis, Voluntary Supplement(s) to individual employees who wish to procure additional protection on top of their group cover. During the consultation period, we received views that people already with group coverage might prefer to purchase an individual-based plan with benefit limits lower than that of a Standard Plan instead of group-based Voluntary Supplement(s). In this regard, the refined proposal that allows insurers to offer various forms of hospital insurance products alongside VHIS-compliant products can address their concern and provide the choices needed. Under the refined proposal, insurers will also be encouraged to offer Conversion Option to facilitate people with group coverage to purchase an individual-based plan.

25. With regard to dispute resolution, we have further examined the necessity and desirability of setting up a separate CDRM to settle claims disputes related to VHIS policies, since a number of submissions pointed

out that there already exist a wealth of resources and expertise in handling claims disputes, most notably the ICCB. As revealed by the statistics of the ICCB, the vast majority of current disputes of health insurance claims concern the application of policy terms, exclusion items and non-disclosure. We consider that the standardisation of wordings of the exclusion clauses as well as policy terms and conditions, combined with the improvements in transparency and budget certainty under the VHIS through Informed Financial Consent, should help reduce and resolve most of these claims disputes. Taking into account the above, we propose that the ICCB should continue to handle claims disputes arising from individual health insurance policies, including VHIS policies.

26. Regarding the tax concession, only VHIS-compliant products would be eligible. We will further examine the relevant arrangements and details, including the annual ceiling on claimable premiums and the cap on the number of dependants' policies. As regards other types of financial incentives such as direct premium subsidy, we are of the view that any proposal must be carefully examined having regard to various considerations such as the amount of public funding required, cost-effectiveness in encouraging take up of VHIS policies, administration cost, possibility of abuse, etc., so as to ensure the prudent, reasonable and cost-effective use of public money.

27. To implement the VHIS, the Food and Health Bureau (FHB) will issue a set of VHIS practice guidelines encompassing the Minimum Requirements and the ancillary proposals, as refined. The Independent Insurance Authority (IIA) will, in parallel, be invited to issue a Guidance Note under the Insurance Companies Ordinance (Cap. 41) on the principle of fair treatment of clients and other relevant considerations to provide guidance on various aspects of conducting Hospital Insurance business under which insurers would be recommended to comply with the VHIS practice guidelines. In certain extreme cases, the FHB may refer such cases to the IIA for consideration if the action would amount to a "misconduct" in the Insurance Companies Ordinance. If the IIA considers that the failure amounts to misconduct, it can consider taking appropriate disciplinary actions for the misconduct, including the order of a pecuniary penalty, reprimand, or even revocation or suspension of the authorisation of the insurer. We will set up a VHIS office under FHB to certify VHIS-compliant products and engage key stakeholders in taking forward the VHIS.

CHAPTER 1
THE PUBLIC CONSULTATION

1.1. The public consultation on Voluntary Health Insurance Scheme (VHIS) (previously named Health Protection Scheme) was conducted between 15 December 2014 and 16 April 2015 (the consultation period was extended from 16 March 2015 to 16 April 2015 to allow more time for the public to express their views). We consulted the public our proposal to introduce a regulatory regime for individual indemnity hospital insurance (Hospital Insurance)[2] so that such products must comply with relevant Minimum Requirements prescribed by the Government. The Minimum Requirements serve to improve the accessibility, continuity, quality and transparency of individual Hospital Insurance.

1.2. During the consultation period, we publicised the Consultation Document and the VHIS through a publicity campaign. We engaged different organisations and various stakeholders in the community through various briefings and public forums to explain to them the proposed VHIS and to listen to their views. Submissions from the public and stakeholders were received in written and electronic form during the consultation period.

1.3. We would like to take this opportunity to thank members of the community, Legislative Council Members and various stakeholders for their active participation and constructive opinions provided during the consultation period. Their views and suggestions have helped us better understand public expectations on the VHIS and are pivotal to refining our proposals.

1.4. The section below summarises activities that took place in connection with the consultation.

GENERAL PUBLICITY

1.5. A publicity campaign was launched since the commencement of the public consultation. We aired three Announcements in the Public Interest on television and radio, and posted 3 000 posters at District Offices, public libraries, public hospitals and clinics, government offices, etc. A total of 64 000 copies of leaflet, 10 000 copies of brochure and 25 000 copies of the Consultation Document were printed for distribution to the public. We also produced a total of 32 000

2. For the purpose of this report, the expression "Hospital Insurance" refers to the insurance business falling under Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Companies Ordinance (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 hospitalisation. A Hospital Insurance policy held by an individual policyholder, not being an employer insuring for the benefit of his/her employees, will be referred to as an "individual Hospital Insurance policy". The expression "individual Hospital Insurance" will be construed accordingly.

token souvenirs to draw public attention to the public consultation. In addition, we launched a dedicated website and Facebook page for the VHIS. 17 animation videos were produced to explain to the public key issues concerning the proposals. Advertisement was also placed in public transport, outdoor televisions and e-platforms to further raise public awareness on the public consultation.

LEGISLATIVE COUNCIL

1.6. We attended the meeting of the Panel on Health Services of the Legislative Council on 15 December 2014 and its special meeting on 13 January 2015 to brief Members on the Consultation Document. We also listened to the views of a total of 25 deputations at the meeting of the Subcommittee on Health Protection Scheme of the Panel on Health Services on 6 February 2015. Please see **Appendix A** for links to the notes of the meetings.

DISTRICT COUNCILS

1.7. We briefed the Chairmen and Vice-chairmen of the 18 District Councils (DCs) on the proposed VHIS on 18 December 2014. We also attended meetings of all 18 DCs (or their relevant subcommittees as advised by the respective DCs) to listen to Members' views on the proposals. Please see **Appendix B** for links to the notes of the relevant DC or subcommittee meetings.

BRIEFINGS/SEMINARS/FORUMS IN THE COMMUNITY

1.8. We attended during the consultation period 73 briefing sessions, including the aforementioned Legislative Council and District Council (or the relevant subcommittee) meetings, community forums organised by FHB as well as briefings and seminars organised by various political parties, professional bodies, labour unions, chambers of commerce, trade associations, social welfare organisations, district organisations and community groups. These occasions provided the opportunity for the Government to present the proposed VHIS and to listen to the views expressed and exchanged by various interested parties and members of the public. Please see **Appendix C** for the list of the briefing sessions, forums and seminars held.

WRITTEN SUBMISSIONS AND OPINIONS EXPRESSED

1.9. The Government received a total of 600 submissions on VHIS from individuals and organisations by hand, email, post, facsimile and online feedback form, etc. These included 478 submissions from individuals and 122 submissions from organisations. Please see **Appendix D** for the list of all written submissions received (except where the sender requested to remain anonymous). Copies of the submissions are available on the VHIS website (http://www.vhis.gov.hk), except where the sender requested not to make public the submission. We have also monitored commentaries and opinions expressed through other channels, including the media (both electronic and printed) and online forums. We have taken all these into account when analysing the public responses.

TELEPHONE SURVEY

1.10. To facilitate collation and assessment of views on the proposals and issues related to the VHIS, we commissioned a household survey by telephone interview from January to May 2015. The summary of the results of the survey is at **Appendix E**. The detailed report is available on the VHIS website (http://www.vhis.gov.hk). Meanwhile, we have also received and taken note of a number of questionnaire surveys conducted by third-parties, and made reference to these surveys when analysing public responses to the VHIS.

1.11. The ensuing chapters set out our analysis of the public views reflected in the consultation exercise and the recommended way forward.

CHAPTER 2
PUBLIC VIEWS ON PROPOSED REGULATION OF INDIVIDUAL HOSPITAL INSURANCE AND MINIMUM REQUIREMENTS

WHAT WE CONSULTED THE PUBLIC ON

2.1. In the VHIS Consultation Document, we proposed the VHIS as a supplementary financing arrangement and one of the turning knobs for redressing the balance of the public-private healthcare sectors. By encouraging those who are willing and able to make use of private healthcare services, the VHIS aims to provide an alternative to public healthcare and to alleviate the pressure on the public healthcare system.

2.2. In the Consultation Document, we proposed to implement the VHIS through introducing a regulatory regime for individual Hospital Insurance. We proposed that, in selling and/or effecting individual Hospital Insurance, an insurer must comply with the Minimum Requirements prescribed by the Government. Products that did not comply with the Minimum Requirements could no longer be offered to new customers upon the implementation of the VHIS. Details of the Minimum Requirements proposed are set out in Chapters 2 and 3 of the Consultation Document.

2.3. In Chapter 2 of the Consultation Document, we proposed to exempt group Hospital Insurance from the Minimum Requirements in order to encourage employers to maintain Hospital Insurance cover for their employees. We also proposed introducing a Conversion Option and Voluntary Supplement(s) for group Hospital Insurance in order to enhance protection for individual employees.

HOW THE PUBLIC RESPONDED

Policy Objectives of the VHIS and Strengthening Regulation of Individual Hospital Insurance

2.4. There was broad support for the concept and policy objectives of the VHIS in general. Many considered it a positive step towards redressing the balance of the public-private healthcare sectors and enhancing the long-term sustainability of the healthcare system as a whole. Many respondents supported the VHIS in providing an alternative to public healthcare for those who were willing and able to use private healthcare services, and pointed out that this would help alleviate the pressure on the public healthcare system. This is echoed by the results of the telephone survey. A majority of respondents (68.1%) strongly agreed or agreed with the policy objectives of the VHIS, with a small minority (8.2%) strongly disagreeing or disagreeing with the proposal.

2.5. Many also concurred that strengthened regulation on individual Hospital Insurance and the proposed Minimum Requirements approach would enhance the accessibility, quality

and transparency of individual Hospital Insurance. They also pointed out that the Minimum Requirements would enhance consumer protection and foster consumer confidence in using private healthcare services. The telephone survey results revealed that the majority of respondents (71.5%) strongly agreed or agreed with the proposal of strengthening regulation of individual Hospital Insurance through the Minimum Requirements approach, with a small minority (7.5%) strongly disagreeing or disagreeing.

2.6. While agreeing with the policy direction of the VHIS, a small but not insignificant proportion of views cast doubt on the effectiveness of the VHIS in achieving its stated objectives, especially in relieving the pressure on the public system. Some opined that the elderly, who are the major users of public healthcare services, would unlikely be able to afford the relatively high premium and would continue to rely on the public system. Some held the view that the VHIS might not be attractive enough to the young and healthy, and expressed concern over the long-term sustainability of the scheme if only those in an older age would join the VHIS. A few submissions considered that the VHIS, being a voluntary scheme, would not be as effective as a mandatory scheme in achieving its policy objectives. Some submissions suggested the Government to step up promotion of the VHIS, so as to help the public better understand the key features of the scheme and encourage them to join the VHIS.

2.7. Some respondents, while supporting the strengthening of regulation of individual Hospital Insurance, pointed out that support from the insurance industry was crucial to ensuring the feasibility, effectiveness and sustainability of the VHIS. They suggested that the Government should closely engage the insurance industry (including insurers and insurance intermediaries) in both the implementation and promotion of the VHIS. A significant number of submissions emphasised that the success of the VHIS hinged on having in place sufficient infrastructure to support the implementation of the scheme, especially an adequate supply of healthcare manpower and sufficient capacity of private healthcare services (please refer to Chapter 6 for detailed comments).

2.8. Some submissions agreed that the VHIS, which is designed to focus on hospital care, was only one of the turning knobs for reforming the healthcare system. They pointed out that other policy measures must be implemented in parallel for building an integrated and holistic healthcare system. The suggested policy measures include public-private partnerships to help shorten the queue for public healthcare services, promotion of preventive care to reduce the need for healthcare services, greater emphasis on primary care to reduce the necessity for the more expensive hospitalisation services, and more transparency in private hospital charges. Some submissions considered that primary care should be covered under the VHIS or play a greater role in the

scheme, as primary care could provide integrated and continued care to policyholders. In tandem with taking forward the VHIS and other policy measures, most submissions emphasised that the Government must continue to strengthen its commitment to the public healthcare system as the safety net for all, including those who had purchased individual Hospital Insurance under the VHIS.

2.9 Notwithstanding the majority support for the VHIS, a minority of submissions took a different view. Instead of implementing the VHIS, they considered that the Government should focus on enhancing the public healthcare services, such as shortening the queues and further improving the quality of service. They held the view that public funding should not be spent on promoting the development of the private health insurance market, or subsidising those who were financially capable of purchasing private health insurance or utilising private healthcare services. Some of the respondents expressed concern over the relatively high level of expense loading (i.e. the proportion of insurer expenses, including commissions, broker fees, profit margins and other overhead expenses, against the amount of premium) of the Hong Kong private health insurance market, as well as possible escalation of fees and charges in the private healthcare sector induced by the VHIS. They were concerned that the VHIS would increase moral hazard, and that the increased demand would aggravate medical inflation and significant increase in premium levels (please refer to Chapter 6 for detailed comments).

2.10. Some submissions, including those from the insurance industry, expressed reservations over the proposal of introducing the Minimum Requirements for all individual Hospital Insurance products. They considered that insurers should be allowed to sell products that might not be compliant with all the Minimum Requirements. They opined that some of the Minimum Requirements, although designed for consumer protection, might lead to increase in premium levels, and hence would not be attractive to those who preferred non-compliant products in exchange for a lower premium. They considered it necessary to allow more flexibility in implementing the Minimum Requirements, such as modifying some of the Minimum Requirements; and allowing more flexibility for the market to design products catering for the needs of different consumers, such as high-end products or products designed for consumers already covered by existing group or individual policies. Some respondents considered that consumer choice was of paramount importance, and that existing insurance plans should not be totally barred from the market.

Minimum Requirements

2.11. In the Consultation Document, we proposed that insurers selling individual Hospital Insurance products must offer a Standard Plan as one of the options to consumers. The Standard Plan

must comply with all the Minimum Requirements prescribed by the Government. The ensuing paragraphs summarise public views on the Minimum Requirements proposed.

A. Improving Accessibility to and Continuity of Insurance

(1) Guaranteed Renewal; and

(2) No "Lifetime Benefit Limit"

2.12. There was overwhelming support for both the proposals of guaranteed renewal for life without re-underwriting and no "lifetime benefit limit". Most submissions considered guaranteed renewal a core requirement of the VHIS. Some pointed out that there was a need to maintain a healthy risk pool by encouraging new subscribers to join the VHIS, otherwise the guaranteed renewal requirement might result in higher premium levels in the long-term and affect the sustainability of the scheme. Most submissions also supported the proposal of introducing a no "lifetime benefit limit" clause as part of the Minimum Requirements. Some respondents suggested that this requirement could be waived for high-end plans that offer rich benefits.

2.13. The telephone survey showed that a clear majority of respondents (73.4%) strongly agreed or agreed with the proposals of guaranteed renewal without re-underwriting and no "lifetime benefit limit". A small minority (6.6%) strongly disagreed or disagreed with the two proposals.

(3) Coverage of Pre-existing Conditions

2.14. There were divergent views on the proposal of requiring insurers to cover all pre-existing conditions subject to a three-year standard waiting period (during which no/partial reimbursement will be provided to the policyholder). Some respondents considered this requirement important in benefiting those individuals with adverse health conditions and allowing them an alternative in using private healthcare services in treating illnesses arising from pre-existing conditions. They opined that they were willing to pay a higher premium in exchange for coverage of pre-existing conditions. The telephone survey results revealed that a clear majority (78.5%) of respondents strongly agreed or agreed with the proposal of coverage of pre-existing conditions subject to a waiting period. A small percentage (6.1%) strongly disagreed or disagreed with the proposal.

2.15. A number of respondents remarked that the three-year waiting period was too long, and suggested to shorten the waiting period to two years or one year. Some respondents asked for

further clarification on the definition of "pre-existing conditions", and considered that there should not be any blanket exclusion of illnesses such as mental disorders, diabetes-related illnesses or congenital diseases.

2.16. On the other hand, some respondents, including those from the insurance industry, expressed concern on whether coverage of pre-existing conditions would result in much higher claims payout and drastic increase in premiums. They were concerned whether the higher premiums would discourage the young and healthy people from taking out insurance intended to be regulated under the VHIS, hence, lowering their desire to use private healthcare services. Some submissions pointed out that insurers in Hong Kong might not have sufficient underwriting experience on coverage of pre-existing conditions. They considered it difficult for insurers to properly price risks associated with pre-existing conditions, especially smaller insurance companies that might not possess a large enough risk pool for absorbing the additional risks, or sufficient resources for developing expertise in providing coverage of pre-existing conditions. Some submissions suggested allowing case-based exclusions so that consumers with higher health risks might choose to take out a policy with a lower premium. There was a view that some form of standardised exclusion clauses would give consumers greater clarity and enable them to make an informed choice on whether to accept case-based exclusions in their policies.

(4) Guaranteed Acceptance with Premium Loading Cap

2.17. In the Consultation Document, we proposed requiring insurers to provide guaranteed acceptance with a premium loading cap of 200% when offering Standard Plan. It was proposed that such arrangement would be open to all ages within the first year of implementation of the VHIS, and to those aged 40 or below starting from the second year.

2.18. Some respondents questioned the concept and financial sustainability of the proposed High Risk Pool, whilst proponents of this Minimum Requirement suggested extending the "open to all" window period from one year to at least two years, so as to allow more time for the public, especially those over 40, to understand the scheme and to consider whether to take out VHIS products. As regards the proposed age limit of 40, some respondents agreed with the need for an age limit so as to encourage more people to join the VHIS while they were relatively young and healthy. A few submissions suggested lowering the age limit from 40 to, say, 35 or 30. On the other hand, some respondents considered it more equitable to lift the age limit from 40 to, say, 45 or 50, so that more people in the community could benefit from guaranteed acceptance. A few submissions went further and suggested removing the proposed age limit altogether.

2.19. The telephone survey results reflected that a majority of respondents supported the proposal of guaranteed acceptance with premium loading cap. 79.0% of respondents strongly agreed or agreed that insurers must guarantee acceptance of all in the first year of implementation of the VHIS; whereas 8.5% strongly disagreed or disagreed with the proposal. 75.1% strongly agreed or agreed that insurers must provide guaranteed acceptance to those of age 40 or below starting from the second year of implementation of the VHIS; whereas 11.5% strongly disagreed or disagreed with the proposal. 76.8% strongly agreed or agreed that insurers could not charge individuals with high health risk a premium loading above the cap prescribed by the VHIS; whereas 8.5% strongly disagreed or disagreed with the proposal.

(5) Portable Insurance Policy

2.20. There were divergent views on the portability proposal in the Consultation Document, i.e. policyholders of VHIS products 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.

2.21. On one hand, some submissions agreed that portability would facilitate consumer mobility and drive market competition. A number of submissions, while supporting the principle of portability, considered the three-year no-claims period too long, and suggested shortening the said period to two years or one year. A few respondents cautioned that any transfer of personal data across insurers should be limited to the extent as necessary for the purpose of the transfer, and that all reasonably practicable steps must be taken to ensure that personal data were protected against unauthorised or accidental access or use.

2.22. Similar to the above views, the findings of the telephone survey reflected that a majority (79.4%) of respondents strongly agreed or agreed with the portability proposal, with a small percentage (7.1%) strongly disagreeing or disagreeing with it.

2.23. On the other hand, other respondents, including those from the insurance industry, were concerned about the financial risk brought about by the portability requirement. They were concerned that the "new" insurer (who is required to accept the transfer of policy without re-underwriting) might be required to bear risks that might not be fully reflected in the premium or underwriting class determined by the "original" insurer. For instance, the policyholder's health conditions might have deteriorated over the years and that the higher health risks might not be fully reflected if the "new" insurer was not allowed to re-underwrite the policy. Some respondents

pointed out that if an insurer was required to acquire policies of inferior health risks without adequate premium compensation, the overall health conditions of the insurer's risk pool would deteriorate and might not be sustainable in the long-run. Some respondents opined that appropriate and fair portability rules should be formulated so as to balance between consumer choice and commercial viability. For instance, the portability arrangements could be refined (such as allowing insurers to charge a transfer fee for each transfer case, or allowing re-underwriting in case of major deviation between the risk assessments by the "original" and "new" insurers) in order to minimise the financial risk of the "new" insurer.

B. Enhancing Quality of Insurance Protection

(6) Coverage of Hospitalisation and Prescribed Ambulatory Procedures; and

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

2.24. Most submissions supported both proposals, namely that the benefit coverage must include treatment of medical conditions requiring hospitalisation and a list of prescribed ambulatory procedures; as well as prescribed advanced diagnostic imaging tests and non-surgical cancer treatments. In particular, the public welcomed the proposal of requiring insurers to provide coverage of ambulatory procedures, so as to reduce the need for hospitalisation and to encourage more cost-effective delivery of healthcare. As for the proposal of providing coverage of a list of prescribed advanced diagnostic imaging tests and non-surgical cancer treatments, most submissions supported this as part of the Minimum Requirements. A few submissions commented on the details of the proposal, including suggesting a lower co-insurance ratio for advanced diagnostic imaging tests; a lower benefit limit or, in other submissions, a higher benefit limit for non-surgical cancer treatments.

2.25. The telephone survey results indicated that a vast majority (87.1%) of respondents strongly agreed or agreed with the proposals of providing coverage of prescribed ambulatory procedures, advanced diagnostic imaging tests and non-surgical cancer treatments. Only a very small percentage (2.9%) strongly disagreed or disagreed with the proposals.

2.26. Some submissions commented on the benefit coverage of VHIS plans. Notwithstanding that the primary focus of the VHIS was on hospital care, some respondents considered that the benefit coverage should be extended to include treatments or items such as out-patient services (general

and specialist out-patient services), Chinese medicine services, dental services, rehabilitation services, post-surgery drugs or drugs for chronic diseases.

(8) Minimum Benefit Limits

2.27. A majority of public views agreed with the proposal of setting minimum benefit limits for VHIS products. A significant number of submissions considered the illustrative benefit limits proposed for Standard Plan insufficient for covering the fees and charges of private healthcare services. Some submissions opined that it might be difficult to determine the level of benefits unless the transparency of fees and charges of private healthcare services was enhanced. Some agreed that a mechanism should be set up to regularly review and adjust the benefit schedule to cater for medical inflation and other market developments. A few respondents pointed out that standardised and quality claims data should be collected for regular review of the benefit schedule.

2.28. The telephone survey results echoed the positive attitude of the public on the proposal. A vast majority (84.6%) of respondents strongly agreed or agreed with the proposal of setting a minimum level for benefit items, whereas a very small percentage (3.8%) strongly disagreed or disagreed with the proposal.

2.29. On the other hand, some submissions, including those from the insurance industry, considered that flexibility should be allowed to suit different consumer needs. For instance, some consumers who were already covered by an existing individual or group policy might prefer to purchase a plan with lower benefit limits as a supplementary plan. Some submissions also considered that plans with lower benefit limits would be more affordable for consumers with a limited budget.

(9) Cost-sharing Restrictions

2.30. There were not many submissions commenting on the proposed cost-sharing arrangements. In the Consultation Document, we proposed that no cost-sharing (deductible or co-insurance) should be included in Standard Plan, except the fixed 30% co-insurance proposed for prescribed advanced diagnostic imaging tests. We also proposed an annual cap of $30,000 for any cost-sharing to be borne by a policyholder. Some submissions supported the principle of no cost-sharing in protecting consumers, whereas others considered that the restrictions should be relaxed to allow for more market flexibility and innovation. Some respondents considered deductibles and co-insurance important tools for controlling moral hazard and preventing abuse, especially in the

case of high-end plans. They also opined that deductibles or co-insurance would have the effect of making premiums more affordable.

C. Promoting Transparency and Certainty

(10) Budget Certainty

2.31. Most submissions agreed with the policy objective of providing budget certainty to consumers through the proposed No-gap/known-gap (i.e. no out-of-pocket/pre-determined out-of-pocket payment by policyholders selecting a specified hospital/clinic and doctor for a specified procedure) arrangement, and the proposed Informed Financial Consent (i.e. estimated insurance reimbursement and estimated amount of out-of-pocket payment upon or before hospital admission). The telephone survey revealed that a vast majority (84.4%) of respondents strongly agreed or agreed with the proposals, with only a very small percentage (4.2%) strongly disagreeing or disagreeing.

2.32. Notwithstanding the above, some submissions considered it difficult for insurers, especially those of a smaller size, to negotiate with private healthcare service providers in providing the No-gap/known-gap arrangement, unless there was an increased supply of private healthcare service providers (e.g. hospitals) in the market. A few respondents suggested that it should be mandatory for private hospitals to provide packaged pricing for common treatments or procedures, so as to facilitate the provision of No-gap/known-gap arrangements by insurers. There was also concern on whether the No-gap/known-gap arrangement would restrict policyholders in their choice of doctors or drugs. Some considered diagnosis-related groups (DRG)-based packaged pricing or greater standardisation of coding and charging crucial to containing healthcare expenses and medical inflation.

2.33. Some submissions opined that, in providing Informed Financial Consent, estimates on hospital charges and doctor fees should be separately provided. They also cautioned that any estimated fees or charges provided in the Informed Financial Consent should be for reference only and might be subject to change.

(11) Standardised Policy Terms and Conditions

2.34. There was strong support for the proposal of requiring insurers to adopt standardised policy terms and conditions, in order to enable consumers to better understand the policy terms upfront and

to minimise disputes. The telephone survey revealed that a vast majority (80.5%) of respondents strongly agreed or agreed with the proposal, with only a very small percentage (4.2%) strongly disagreeing or disagreeing.

(12) Premium Transparency

2.35. In the Consultation Document, we proposed that the premium schedules set by insurers must be age-banded and must be published for consumers' reference, and that insurers should make known the reasons for assessing any premium loading to the consumer. We also proposed that an easily accessible platform should be established with information on VHIS products offered by different insurers, so as to facilitate consumers in comparing the products and drive market competition.

2.36. Most submissions supported the principle of enhancing premium transparency to safeguard consumer interest. Most respondents agreed that premium transparency was essential to offering meaningful choice to consumers and crucial to the success of the VHIS. Some respondents commented that insurers should disclose to the policyholder the criteria and justifications when applying premium loading.

2.37. The telephone survey also revealed an overwhelming support from respondents on premium transparency. 91.9% of respondents strongly agreed or agreed with the proposal that insurers must make publicly available premium schedules and information on VHIS products. Only 2.0% of respondents strongly disagreed or disagreed with the proposal.

2.38. In connection with the comments on premium transparency, many respondents were concerned about the premium levels after the implementation of the VHIS. Their comments are set out in detail in Chapter 6.

Arrangements for Group Hospital Insurance

2.39. In the Consultation Document, we proposed to exempt group Hospital Insurance from the Minimum Requirements in order to encourage employers to purchase or maintain group cover for their employees. To enhance protection for individual employees, we proposed that insurers must offer a Conversion Option as part of the group Hospital Insurance products offered to employers. The Conversion Option, if purchased, would allow an employee to transfer to an individual Standard Plan at the same underwriting class as the group in which he/she participated without re-underwriting upon retirement or leaving employment, provided that the

employee had been employed for a full year immediately before the transfer. We also proposed that insurers might continue to offer Voluntary Supplement(s) to individual employees who wish to procure additional protection on top of their group cover.

2.40. A majority of submissions supported the proposed exemption of group Hospital Insurance from the Minimum Requirements, so as to encourage employers to maintain group cover for their employees. Some opined that the benefit level of the individual Standard Plan would serve as a benchmark and would have the effect of encouraging employers to provide better benefits to their employees. Some suggested a more stringent definition of "group Hospital Insurance" to prevent individuals from forming informal "groups" or "associations" for the purpose of getting around VHIS regulations.

2.41. On the other hand, a minority of respondents disagreed with the proposed exemption of group Hospital Insurance, or suggested that group Hospital Insurance should be subject to VHIS regulation in the long-run. They considered that having "one standard" for all Hospital Insurance products more ideal and less confusing to consumers. Moreover, since the working population was, in general, healthy and productive individuals, enrolling them under the VHIS would benefit the overall risk pool.

2.42. There was broad support for the proposed Conversion Option and Voluntary Supplement(s). Most submissions agreed that the two arrangements could enhance protection for employees. The telephone survey revealed that a clear majority of respondents (81.9%) strongly agreed or agreed with the Conversion Option proposal, with a very small minority (4.1%) strongly disagreeing or disagreeing.

2.43. While agreeing with the policy objective of the Conversion Option, some submissions raised the concern that this arrangement might pose anti-selection risk to insurers because employees with a higher health risk would be more likely to exercise the Conversion Option. As a result, the cost of the Conversion Option might be high so that the premiums of group Hospital Insurance might need to be increased. Some respondents suggested that measures should be put in place to mitigate the anti-selection risk.

2.44. There were not many comments on the details of the proposed Voluntary Supplement(s). A few respondents pointed to possible operational difficulties in implementing the arrangement. For instance, it might be difficult for an employee to maintain the Voluntary Supplement if he/she changed employment, because the new employer might offer a different group cover or no group cover at all. They suggested that the Voluntary Supplement(s) should be individual-based rather than group-based as proposed in the Consultation Document.

CHAPTER 3
PUBLIC VIEWS ON PROPOSED USE OF PUBLIC FUNDING

WHAT WE CONSULTED THE PUBLIC ON

3.1. In Chapter 4 of the VHIS Consultation Document, we proposed to set up a High Risk Pool (HRP) with Government financial support. The HRP, a key enabler of the Minimum Requirement of guaranteed acceptance with premium loading cap and could potentially facilitate portability, will allow high-risk individuals to have access to individual Hospital Insurance. We proposed that the HRP would be open to all in the first year upon the implementation of the VHIS, and would be open to those of age 40 or below starting from the second year onwards. The amount of public funding required for the operation of the HRP for a 25-year period (2016 to 2040) was estimated to be about $4.3 billion (in 2012 constant prices).

3.2. To encourage people to take out VHIS products, we proposed to introduce tax concession for premiums paid for all individual Hospital Insurance policies that met or exceeded the Minimum Requirements, and Voluntary Supplements purchased by individual on top of their group Hospital Insurance policies. A taxpayer might claim tax concession on his/her own policy and/or his/her dependants' policies (subject to a cap at, say, no more than three dependants per taxpayer). For illustrative purpose, by capping the annual ceiling of claimable premiums at $3,600 (i.e. the average standard premium of Standard Plan in 2012 constant prices) per person insured, the average tax benefit per eligible taxpayer would be about $450.

HOW THE PUBLIC RESPONDED

HRP

3.3. There were divergent views from the public over the proposed establishment of the HRP. On one hand, many supported the policy objective of establishing the HRP. They agreed that the HRP was essential for implementing the requirement of guaranteed acceptance with premium loading cap, especially for high-risk individuals who often encounter difficulties in obtaining Hospital Insurance under existing market practice. Without the HRP, many high-risk individuals would either be rejected insurance coverage or charged a very high premium loading. Some respondents pointed out that by enabling high-risk individuals to use private healthcare services, the VHIS could contribute to relieve the pressure on the public healthcare system.

3.4. The telephone survey showed that many respondents (63.3%) strongly agreed or agreed with the proposal of providing public funding to enable high-risk individuals in purchasing private Hospital Insurance at a premium capped at three times standard premium. A minority (10.2%) strongly disagreed or disagreed with the proposal.

3.5. Notwithstanding their support for the establishment of the HRP, some respondents commented on the proposed entry age limit of 40 as well as the length of the proposed one-year window period during which the HRP would be open to all. Some respondents suggested setting a higher entry age limit, and extending the one-year window period to allow more time for people to consider taking out insurance which was compliant with the VHIS. On the other hand, some respondents agreed with the proposed one-year period, and suggested a lower age limit in order to encourage people to take out insurance early. There was also a suggestion of devising a mechanism to allow high-risk policyholders to be relieved from the HRP if they made no claims after certain years.

3.6. On the other hand, a number of submissions expressed grave concern on the long-term sustainability of the HRP. They remarked that the HRP would be a drain on public finance, and questioned whether the amount of public funding reserved for maintaining the operation of the HRP was sufficient. They further queried the financial arrangements of the HRP after the 25-year projection period, and considered that the Government should make a long-term commitment to maintaining the financial viability of the HRP. Some suggested that proper risk management measures should be put in place to mitigate the financial risk borne by the HRP, including implementing disease management programmes. A number of respondents considered that there should be objective and clearly defined guidelines or criteria on the acceptance of high-risk policies into the HRP. For example, a few respondents raised the concern on whether the elderly or disabled persons would be indiscriminately treated as high-risk individuals and have their policies transferred to the HRP. There was also concern on how claims disputes arising from high-risk policies would be handled.

3.7. A number of submissions disagreed with the proposed establishment of the HRP. They considered that public funding should be spent on enhancing public healthcare instead of subsidising those who could afford to purchase private Hospital Insurance. Some opined that since the public healthcare system was already acting as the safety net for all Hong Kong people, including high-risk individuals, it was not necessary for the Government to set up the HRP to enable high-risk individuals to purchase private Hospital Insurance. Some respondents considered that the provision of public funding for the HRP might give the impression that insurers, rather than policyholders, were the beneficiaries of the HRP proposal. A few submissions considered the illustrative administration cost of the HRP (12.5% of total claims costs as provided in the Consultation Document) too high.

Tax Concession

3.8. There was overwhelming support for the proposal of providing tax concession for VHIS-compliant policies. Most of the submissions agreed that tax concession could encourage people to take out VHIS plans and utilise private healthcare services. The telephone survey showed that a clear majority of respondents (74.3%) strongly agreed or agreed with the proposed tax concession to encourage purchasing of Hospital Insurance. A minority (9.2%) strongly disagreed or disagreed with the proposal.

3.9. Notwithstanding the broad support for tax concession, many submissions considered that the tax incentive should be enhanced to attract young and healthy people to take out insurance under the VHIS. They considered the illustrative annual ceiling on claimable premiums too low ($3,600 per person insured) and of limited attraction to taxpayers. Many suggested setting a higher annual ceiling on claimable premiums, the suggested level ranging from $12,000 to $30,000 per person insured. Some respondents suggested that different ceilings could be set for different age groups. For instance, a higher ceiling could be set for young people to attract them to join the VHIS early.

3.10. Most submissions welcomed the proposal that a taxpayer might claim tax concession on his/her dependants' policies. Some commented that the cap on the number of dependants' policies should be relaxed or lifted. They opined that if more people were covered by Hospital Insurance and made use of private healthcare services, the pressure on the public healthcare system would be relieved.

3.11. A number of submissions considered that other financial incentives should be provided to complement tax concession, so that non-taxpayers (such as those young people who do not need to pay tax) could also benefit from the incentives. The major types of financial incentives suggested include a one-off "early-bird" premium rebate to those migrating to the VHIS, a first-year premium discount, no-claims bonus, premium subsidy for those in the old age, or premium rebate for long-term subscription to the VHIS. On the other hand, some submissions considered that the Government should ensure that public funds would be well spent.

CHAPTER 4
PUBLIC VIEWS ON PROPOSED MIGRATION ARRANGEMENTS

WHAT WE CONSULTED THE PUBLIC ON

4.1. In Chapter 5 of the VHIS Consultation Document, we proposed to require insurers to, within a one-year "migration window period", offer an option to policyholders of existing individual Hospital Insurance policies to migrate to VHIS-compliant policies. Within the migration window period, policyholders would enjoy streamlined migration arrangements. For policyholders who did not wish to migrate to VHIS-compliant policies, their existing policies would be grandfathered and exempted from the Minimum Requirements.

HOW THE PUBLIC RESPONDED

Migration Window Period

4.2. Many supported the proposal of requiring insurers to offer a migration option to policyholders of existing individual Hospital Insurance policies within the migration window period. They considered that the proposed one-year window period should be extended, so as to allow more time for policyholders to better understand the VHIS and to consider migrating to compliant policies.

4.3. There were not too many comments on the details of the proposed migration arrangements during the window period. Some were of the view that the migration arrangements should be simple and attractive to consumers. They considered that consumers should be properly informed before deciding whether to migrate to compliant policies. There should also be a robust mechanism to monitor the migration process to ensure fairness to consumers, such as the re-underwriting of new benefits and benefit limits, or any premium increase after the migration process.

4.4. The insurance industry emphasised the need for itself to be prepared for the migration arrangements, and that these arrangements should not place too much administrative burden or cost on the industry.

Grandfathering Arrangements

4.5. There was broad support for the proposed grandfathering of existing individual Hospital Insurance policies in the cases where existing policyholders did not wish to migrate to VHIS compliant policies.

4.6. The insurance industry expressed concerns over the grandfathering of existing individual Hospital Insurance policies. They expressed doubts on the sustainability of the grandfathered portfolio in the longer term, and raised the possibility that insurers might need to raise premiums of grandfathered policies if they could no longer sell products that were non-compliant with the VHIS. The industry reiterated their view that the industry should have the flexibility to design different products to be sold alongside VHIS products, so as to maintain the sustainability of the existing portfolio of products that might not be compliant with the VHIS.

CHAPTER 5
PUBLIC VIEWS ON PROPOSED INSTITUTIONAL FRAMEWORK

WHAT WE CONSULTED THE PUBLIC ON

5.1. In Chapter 6 of the VHIS Consultation Document, we proposed to set up a regulatory agency under the FHB to oversee the implementation and operation of the VHIS, including the regulation of VHIS products and the operation of the proposed HRP. We also proposed to establish an independent Claims Dispute Resolution Mechanism (CDRM) for resolving claims disputes arising from individual VHIS policies.

HOW THE PUBLIC RESPONDED

Regulatory Agency

5.2. Many views obtained during the consultation supported the proposed establishment of a regulatory agency. They considered Government regulation important for implementing the VHIS and operating the HRP. They also opined that a well-designed regulatory system could enhance consumer confidence and encourage the public to participate in the VHIS.

5.3. Many respondents pointed to the need for engaging stakeholders from different sectors (including, among others, insurers, healthcare service providers, consumer and patient group representatives) in the work of the regulatory agency. They considered that a balanced representation of different stakeholders in the proposed Advisory Committee crucial to the impartiality and credibility of the regulatory agency. A few submissions supported the proposed Review Committee to ensure fairness and transparency of the work of the regulatory agency. Some respondents stressed that the regulatory agency, in collecting and/or publishing data from insurers and consumers, must handle sensitive information with care and in strict accordance with privacy protocols.

5.4. The telephone survey showed that the vast majority of respondents (85.9%) strongly agreed or agreed with the establishment of the regulatory agency, so as to oversee the implementation of the VHIS and to ensure that individual Hospital Insurance products comply with the Minimum Requirements. Only a small minority (3.7%) strongly disagreed or disagreed with the proposal.

5.5. While supporting in principle the establishment of the regulatory agency, some submissions pointed out the necessity of clearly delineating the roles and responsibilities of the regulatory agency, so as to ensure effective communication and avoid duplication of duties with existing authorities or regulatory bodies, such as the Office of the Commissioner of Insurance (OCI) or the Independent

Insurance Authority (IIA) to be established, the Hong Kong Federation of Insurers (HKFI), Insurance Agents Registration Board, Hong Kong Confederation of Insurance Brokers, Professional Insurance Brokers Association, etc. A significant number of submissions expressed concern over the size and administration cost of the regulatory agency. They were of the view that the regulatory agency should be of suitable size and that the administration cost should be minimised in order to make best use of public resources.

5.6. Some submissions, including those from the insurance industry, took a different view and disagreed with setting up a separate regulator for the VHIS. They considered that the proposed functions of the regulatory agency should be taken up by existing regulatory bodies to avoid duplication of duties. More specifically, they suggested that the functions of the regulatory agency could be passed on to the OCI or the IIA to be established, which is or will be responsible for prudential and conduct regulation of insurers and regulation of insurance intermediaries. Separately, some submissions expressed the view that the administration cost of the regulatory agency should not be borne by insurers.

CDRM

5.7. The availability of an equitable and well-functioning CDRM was considered important in most submissions. They considered that a credible and impartial CDRM would help resolve and minimise claims disputes, particularly as insured persons are usually relatively less equipped or have less resource in pursuing settlement of claims dispute cases. Some suggested involving different stakeholders (such as patient group representatives) in the CDRM in order to safeguard the credibility of the mechanism and to enhance consumer confidence.

5.8. At the same time, a number of submissions pointed out that claims dispute resolution would require specialised skills and expertise, such as professional knowledge in insurance, medical and legal issues. More specifically, some submissions noted that the existing Insurance Claims Complaints Bureau (ICCB), a self-regulatory body sponsored by the insurance industry that handles complaints about insurance claims, was equipped with the necessary expertise and had accumulated rich experience in handling health insurance claims disputes. Instead of setting up a new CDRM, these submissions considered that the ICCB should continue with its role in handling insurance claims disputes given that it had been functioning effectively over the years. A few respondents suggested that, apart from the ICCB, it was also worth exploring whether the existing Financial Dispute Resolution

Centre (FDRC) had capacity in taking over the CDRM's function. Some considered that a single channel for handling claims disputes would be the most efficient and could minimise confusion to consumers.

5.9. There were not many comments on the mode of operation of the CDRM. A few respondents suggested that the CDRM should be operated by the Government or independent professionals, or that an independent board should be established to review "appeal cases" filed by insured persons in case of claims rejection by insurers. It was also suggested that the procedures for handling claims disputes should be transparent to complainants. Some views considered arbitration or mediation cost-effective measures for resolving claims disputes, whereas others held the view that adjudication was more effective than arbitration or mediation as most claims disputes were related to contractual terms of complex insurance policies.

CHAPTER 6
PUBLIC VIEWS ON SUPPORTING INFRASTRUCTURE

6.1. The success of the VHIS hinges on having in place the necessary supporting infrastructure, including an adequate supply of healthcare manpower and sufficient healthcare capacity. In Chapter 7 of the VHIS Consultation Document, we outlined the policy measures that the FHB has been taking forward in conjunction with the VHIS. These include reviewing healthcare manpower planning and professional development, enhancing private healthcare service capacity, and reviewing the regulation of private healthcare facilities. In particular, under the proposed revamped regulatory regime for private healthcare facilities, price transparency of private healthcare services would be enhanced through measures such as disclosure of price information, uniform arrangement for providing estimates of fees and charges, introduction of Recognised Service Packages for common procedures, and disclosure of historical statistics.

SUPPLY OF HEALTHCARE MANPOWER AND CAPACITY OF PRIVATE HEALTHCARE SECTOR

6.2. Most of the submissions received during the consultation period attached great significance to the need for an adequate supply of healthcare manpower and sufficient capacity of the private healthcare sector. Many respondents questioned whether the additional demand arising from the VHIS would draw more healthcare personnel to the private market, leading to "brain-drain" from the public sector. They were concerned whether this would further strain the public healthcare system and affect the quality of public healthcare services. Some respondents considered that there should be regular monitoring and planning of healthcare manpower supply. They also suggested various ways of increasing the supply of healthcare personnel, such as extending the retirement age of doctors in public hospitals or recruiting qualified doctors from overseas by way of limited registration.

6.3. Regarding the capacity of the private healthcare sector, many respondents opined that a substantial expansion of private healthcare facilities was necessary for absorbing the additional demand brought about by the VHIS, given the limited capacity of the existing private hospitals. They considered an adequate supply of private healthcare facilities crucial to keeping the fees and charges of private healthcare services under better check.

PRICE TRANSPARENCY OF PRIVATE HEALTHCARE SERVICES

6.4. Many submissions concurred that price transparency of private healthcare services would play an essential role in protecting consumers and keeping medical costs under check. Some respondents opined that comprehensive and complete pricing information should be provided to patients in advance, so that patients could be better informed before making decisions on meeting their healthcare needs. Furthermore, some respondents pointed out that price transparency would contribute significantly to the control of medical costs. This would, in turn, help keep premium levels under better check and ensure the long-term sustainability of the VHIS. Some respondents opined that some form of standardisation of coding of fees and charges, such as DRG, would be important in controlling medical inflation in the long-run.

PREMIUM LEVELS

6.5. In connection with the comments on the increased utilisation and medical costs, some submissions commented on the premium levels after the implementation of the VHIS. They expressed concern on whether the VHIS would cause moral hazard and abuse of private healthcare services, and whether the increased utilisation under the VHIS would result in medical inflation and a drastic increase in the premium levels. Some respondents considered the illustrative premiums of Standard Plan provided in the Consultation Document relatively high. They held the view that the premiums might be unaffordable to some members of the community, especially the elderly, low-income groups or chronic disease patients. They also raised concern on whether the proposed premium loading cap of 200% was affordable to the public. Some respondents noted that the estimated premium figures provided in the Consultation Document were in 2012 constant prices and sought more updated estimations, taking into account any medical inflation and market changes in recent years.

6.6. Some submissions expressed concern over the relatively high expense loading (36% in 2013 as provided in the Consultation Document) of the Hong Kong individual health insurance market as compared with overseas markets. They considered that, in addition to the transparency measures proposed in the

Consultation Document, the Government should consider measures that would help monitor premium levels, such as mandating insurers to disclose expense loading ratios, schedule of policy commissions or broker fees. Some went further and suggested the Government to put in place some form of mechanism to regulate premium increase.

CHAPTER 7
CONCLUSION AND WAY FORWARD

CONCLUSIONS FROM THE PUBLIC CONSULTATION

7.1. Having studied and analysed the views received during the public consultation, the major outcomes of the consultation are summarised below –

(a) there was broad support for the proposed VHIS as a supplementary financing arrangement to complement public healthcare and to enhance the sustainability of our healthcare system as a whole. Many submissions stressed the need for the Government to continue its commitment to public healthcare and to take forward other measures for developing a holistic and integrated healthcare system, such as primary care and public-private partnerships;

(b) there was a general consensus for strengthening the regulation of individual Hospital Insurance through the proposed Minimum Requirements, so as to enhance the accessibility, quality and transparency of individual Hospital Insurance products. The public and stakeholders provided valuable comments on the details of the proposed Minimum Requirements, which we have taken into account when refining the proposals (please refer to paragraphs 7.3 to 7.17 below);

(c) there were divergent views over the proposed establishment of the HRP to enable implementing the guaranteed acceptance with premium loading cap requirement. While many supported the policy objective of establishing the HRP, a number of submissions expressed grave concern over its long-term sustainability and considered that public funding should be spent on enhancing public healthcare instead;

(d) there was overwhelming support for the proposed tax concession. Many views suggested enhancing the attractiveness of the tax concession or providing other kinds of incentives to encourage early subscription to the VHIS;

(e) many views supported the establishment of a dedicated office to oversee and regularly review the implementation and operation of the VHIS. They considered it necessary to put in place platforms to engage stakeholders in the course of developing operational and technical details for the VHIS; and

(f) most respondents agreed that the success of the VHIS depended much on strengthening the supporting infrastructure, including healthcare manpower supply, private healthcare capacity, as well as measures to enhance price transparency of private healthcare services.

WAY FORWARD FOR THE VHIS

7.2. With general support from the community, we will proceed to take forward the VHIS. We propose to refine some specific proposals taking into account the views received from the public and relevant stakeholders.

REFINEMENTS TO THE PROPOSALS

(a) Design of VHIS products

7.3. We received many comments emphasising the need for flexibility in designing VHIS products, so as to promote innovation and healthy market competition. Under the refined VHIS, there will be two types of compliant individual Hospital Insurance products, namely the Standard Plan and the Flexi Plan. The Standard Plan is intended to be fixed in product design that provides a basic level of protection (e.g. benefit limits for room and board at ward class) and just meets all the Minimum Requirements. Anchored to the Standard Plan, the Flexi Plan has modular product design, encompassing basic coverage tantamount to Standard Plan plus add-on hospital insurance coverage of which product template is not fixed. Flexi Plan provides enhanced benefits in terms of more relaxed limits of indemnity (e.g. higher room and board benefit limits) and/or wider benefit coverage which is primarily in the nature of Hospital Insurance with less restriction for the part of enhanced protection. The definitions of these VHIS-compliant products are set out at **Appendix F**.

7.4. As a related issue, there were suggestions that insurers should be allowed to sell products that might not be compliant with all the Minimum Requirements. Some considered that consumer choice was of paramount importance, and that existing insurance plans should not be totally barred from the market. To strike a balance between consumer protection and consumer choice, we propose to allow insurers to issue and sell non-compliant individual Hospital Insurance products in the market to satisfy the needs of some consumers. We further propose that insurers that offer non-VHIS-compliant products should be encouraged to (a) concurrently make available the Standard Plan to consumers; and (b) provide all policyholders of non-VHIS-compliant products an option to convert to a VHIS-compliant product with or without payment of an additional premium. For the avoidance of doubt, non-VHIS-compliant products would not be eligible for tax concession.

7.5. In the Consultation Document, we proposed that insurers might offer, on a group basis, Voluntary Supplement(s) to individual employees who wish to procure additional protection on

top of their group cover. During the consultation period, we received views that people already with group coverage might prefer to purchase an individual-based plan with benefit limits lower than that of a Standard Plan instead of group-based Voluntary Supplement(s) (please refer to paragraphs 2.10 and 2.29 in Chapter 2). In this regard, the refined proposal that allows insurers to offer various forms of hospital insurance products alongside VHIS-compliant products can address their concern and provide the choices needed. Under the refined proposal, insurers will also be encouraged to offer Conversion Option to facilitate people with group coverage to purchase an individual-based plan.

(b) HRP

7.6. Given the public's diverse views on the proposed establishment of the HRP and the refinements to the Minimum Requirements (please see paragraphs 7.7 to 7.10 below), we consider that a more prudent approach is to further examine and re-assess the implications and financial model of the HRP. In order not to delay the implementation of the VHIS, we propose that the HRP and the need of legislation be separately considered in a phased manner.

(c) Minimum Requirements

7.7. We propose to make some refinements to the originally proposed Minimum Requirements. More specifically, since "guaranteed acceptance with premium loading cap" and "portable insurance policy" would hinge on the introduction of the HRP, we propose that these two Minimum Requirements should be dealt with at a later stage together with the HRP.

7.8. There were diverse views on the proposal of requiring insurers to provide coverage of pre-existing conditions (please refer to paragraphs 2.14 to 2.16 in Chapter 2). Whilst some submissions considered this a key feature of the VHIS, there were also some respondents who commented against requiring coverage of pre-existing conditions in all VHIS products. They considered it important to provide a choice to consumers on whether to accept case-based exclusions in their policies, noting that a policy with case-based exclusions would likely be relatively more affordable to the policyholder. After carefully considering the different views received and the balance between consumer protection, product choice and premium burden, we propose that insurers, when offering acceptance to subscribers for Standard Plan, may provide an extra option to subscribers with case-based exclusions in exchange of a lower premium (i.e. avoidance of premium loading that insurers may charge if pre-existing conditions are covered). This relaxation is necessary to facilitate policyholders with health conditions to obtain insurance coverage in the absence of guaranteed acceptance under the original

proposal with HRP. To allow greater market flexibility, insurers are not required to be bound by this arrangement when offering acceptance to subscribers for Flexi Plan. This means that the offer may encompass premium loading and/or case-based exclusions according to prevailing market condition. Yet in order to safeguard consumer interest, the applicability and prescription of case-based exclusions will be subject to a set of guiding principles and interpretations as far as practicable.

7.9. As regards the proposal on cost-sharing restrictions (please refer to paragraphs 2.30 in Chapter 2), many respondents suggested that some form of cost-sharing (e.g. deductible or co-insurance) would help control moral hazard and make premiums more affordable. To strike a balance between consumer protection on one hand and premium affordability on the other hand, we propose to refine the cost-sharing arrangements for Standard Plan and Flexi Plan. Specifically, for Standard Plan, fixed cost-sharing arrangement will continue to apply while its application may extend to cover insurance coverage prone to abuse, including prescribed ambulatory procedures and advanced diagnostic imaging tests. As regards Flexi Plan, the cost-sharing arrangement would be set in such a way as to allow more flexibility for insurers to offer choices of higher cost-sharing in exchange for lower premium, or vice-versa.

7.10. For the No-gap/known-gap requirement, some insurers have indicated that they might have difficulties in introducing No-gap/known-gap procedures at the beginning (please refer to paragraphs 2.31 to 2.32 in Chapter 2). We would further discuss with insurers on how best they can do to provide No-gap/known-gap procedures for the benefits of policyholders. The Government will also encourage private hospitals to provide packaged pricing for common procedures, so as to facilitate the implementation of No-gap/known-gap arrangements by insurers.

(d) Dispute resolution

7.11. Given that many submissions pointed out that there already exist a wealth of resources and expertise in handling claims disputes (please refer to paragraphs 5.7 to 5.9 in Chapter 5), most notably the ICCB that currently handles complaints about insurance claims arising from nearly all types of individual insurance policies taken out in Hong Kong, we have further examined the necessity and desirability of setting up a separate CDRM to settle claims disputes related to VHIS policies. According to statistics of the ICCB, amongst the 167 cases closed in 2015 related to hospitalisation/medical, the vast majority concerned the application of policy terms (55), exclusion items (43) and non-disclosure (40). Regarding the first type of disputes, the proposed standardisation of policy terms and conditions under the VHIS would help minimise disputes

over different interpretations. Regarding the latter two types of disputes, the arrangement we propose in paragraph 7.8 above should also help reduce and resolve most, if not all, of the claims disputes related to case-based exclusion of pre-existing conditions and non-disclosure. Besides, market transparency is also important for avoidance of disputes. The VHIS would provide a platform for standardisation of practice, where feasible, in product marketing, policy administration and claims settlement, etc. This would assist consumers to make informed decision with due regard to their rights and obligations, and avoid unnecessary disputes with the insurers.

7.12. Taking into account the above as well as the improvements on budget certainty under the VHIS, we consider that it may not be cost-effective to set up a separate CDRM to handle claims disputes related to VHIS policies. We propose that the ICCB should continue to handle claims disputes arising from individual health insurance policies, including VHIS policies. We will liaise with the ICCB to ensure that there are suitable interface arrangements and that guidelines are issued as and when necessary for enhancing consumer's experience on settling claims disputes.

(e) Migration Window Period

7.13. In the VHIS Consultation Document, we proposed that within one-year of the implementation of the VHIS, insurers would be required to provide an option to policyholders to migrate to a VHIS-compliant plan. Given that most submissions suggested a longer migration window period (please refer to paragraph 4.2 in Chapter 4), we propose to extend the one-year window period to two years (if necessary to three years) and to require insurers to offer at least one opportunity for policyholders of existing Hospital Insurance products to migrate to a VHIS-compliant product (i.e. either Standard Plan or Flexi Plan) during the window period.

(f) Tax Concession

7.14. Many submissions welcomed the tax concession proposal and suggested the Government to consider enhancing the tax incentive, such as setting a higher ceiling on claimable premiums, and giving maximum flexibility for the inclusion of policies (please refer to paragraphs 3.9 to 3.10 in Chapter 3). We will examine the relevant arrangements and details with a view to introducing tax concession as soon as possible.

7.15. Apart from the proposed tax concession, some submissions suggested the Government to consider providing other forms of financial incentives to attract more people to join the VHIS

(please refer to paragraph 3.11 in Chapter 3). As explained in the Consultation Document, the decision to use public money to encourage take up of VHIS presents both opportunities and risks that warrant prudent consideration, such as whether the financial incentives would be susceptible to abuse, or whether the administration cost for giving out premium subsidy would be too high.

7.16. Considering that about half (51%) of the population insured with individual Hospital Insurance is under age 40[3], it seems that financial incentive is not the only workable measure to encourage young and healthy people to join the VHIS. The experience of Australia also reveals that premium rebate for encouraging take out of private health insurance may impose significant fiscal pressure on the Government, which had to resort to means testing in recent years in order to better control its premium rebate budget. We consider that any form of financial incentive proposed must be carefully examined so as to ensure the prudent, reasonable and cost-effective use of public money.

7.17. In addition to tax or other forms of financial incentives, it is worth considering spending public money on building the supporting infrastructure for the VHIS, such as promoting the VHIS, developing information system for data collection and publishing, exploring cost-saving measures to contain medical inflation, etc.

IMPLEMENTATION

7.18. We are mindful of the need to strike a careful balance having regard to the aims of the VHIS and its extensive impact on the insurance industry. We note that implementing the VHIS via a non-legislative means has the merits of reducing the unintended impact of a brand new regulatory regime on the industry, whilst benefiting the public with enhanced protection as soon as possible. Having considered the major objective of the VHIS, which is to enhance the accessibility, quality and transparency of individual Hospital Insurance products, we consider that this objective is in line with the principal function of the future Independent Insurance Authority (IIA) on the protection of existing and potential policyholders. Against this backdrop, VHIS will be implemented via a non-legislative regulatory framework in collaboration with the IIA. As the policy bureau in healthcare, FHB will be responsible for issuing and updating a set of VHIS practice guidelines in consultation with relevant stakeholders based on the refined

3. Source: 2014 Thematic Household Survey, Census and Statistics Department.

Minimum Requirements. FHB will also handle public enquiries on and monitor compliance of the practice guidelines. On the other hand, IIA as the regulator of the insurance industry, will be invited to issue a Guidance Note based on the principle of fair treatment of clients and other relevant considerations to provide guidance on various aspects of underwriting individual Hospital Insurance business, under which insurers would be recommended to comply with the VHIS practice guidelines issued by FHB [4]. In certain extreme cases, such as where an insurer markets a non-VHIS-compliant product as VHIS compliant and misleads consumers in purchasing it, the FHB may refer such cases to the IIA for consideration if the action would amount to a "misconduct" in the Insurance Companies Ordinance. If the IIA considers that the failure amounts to misconduct, it can consider taking appropriate disciplinary actions for the misconduct, including the order of a pecuniary penalty, reprimand, or even revocation or suspension of the authorisation of the insurer.

7.19. We will set up a VHIS office under FHB to certify VHIS-compliant products and engage key stakeholders (such as members from the insurance industry, the healthcare service sector, relevant regulatory/self-regulatory bodies, representatives of consumer and patient groups, etc.) in taking forward the VHIS.

7.20. The VHIS office will work out the operational and technical details for implementing the VHIS, including but not limited to the following items –

(a) design of VHIS plans, including, among others, standardised policy terms and conditions, the benefit coverage and benefit limits for Standard Plan;

(b) technical details for implementing the Minimum Requirements;

(c) mechanism for reviewing and updating the Minimum Requirements;

(d) mechanism for promulgating, reviewing the definitions, wordings and guidelines on case-based exclusions of pre-existing conditions, and for making clarifications in relevant claims disputes;

4. Under the Insurance Companies Ordinance (Cap. 41), the IIA may publish codes or guidelines that it considers appropriate for giving guidance in relation to a matter relating to a function of the IIA under Cap. 41 or in relation to the operation of a provision of Cap. 41. Over the years, the Commissioner of Insurance, being the Insurance Authority, has issued 17 Guidance Notes to insurers on various matters. Authorised insurers have been amenable in complying with the requirements of Guidance Notes.

(e) technical details for implementing the migration arrangements; and

(f) guidelines and codes of practice on the requirements of the VHIS.

VOTE OF THANKS

7.21. We would like to take this opportunity to express our sincere thanks to all members of the community for their support and contribution to the public consultation exercise. Their invaluable comments and suggestions put to us during the consultation have helped us better understand public expectations and provided us a foundation of taking forward the scheme with refinements and enhancements.

APPENDIX A - MEETINGS OF PANEL ON HEALTH SERVICES OF LEGISLATIVE COUNCIL RELATED TO THE VOLUNTARY HEALTH INSURANCE SCHEME PUBLIC CONSULTATION

Date	Meeting
15 December 2014	Regular Meeting, Panel on Health Services Link to notes of meeting available online at - http://www.legco.gov.hk/yr14-15/english/panels/hs/minutes/hs20141215.pdf
13 January 2015	Special Meeting, Panel on Health Services Link to notes of meeting available online at - http://www.legco.gov.hk/yr14-15/english/panels/hs/minutes/hs20150113.pdf
6 February 2015	Meeting of the Subcommittee on Health Protection Scheme of Panel on Health Services (meeting with deputations) Link to notes of meeting available online at – http://www.legco.gov.hk/yr14-15/english/panels/hs/hs_hps/minutes/hps20150206.pdf

APPENDIX B - MEETINGS OF DISTRICT COUNCILS RELATED TO THE VOLUNTARY HEALTH INSURANCE SCHEME PUBLIC CONSULTATION

District	Meeting	Date	Link to meeting notes
Kwai Tsing	District Council	8 January 2015	http://www.districtcouncils.gov.hk/kwt/doc/2012_2015/en/dc_meetings_minutes/dc93_en.pdf
Sham Shui Po (Chinese version only)	District Council	13 January 2015	http://www.districtcouncils.gov.hk/ssp/doc/2012_2015/tc/dc_meetings_minutes/MIN%2019(13-01-2015)Endorsed.pdf
Wong Tai Sin (Chinese version only)	Community Building and Social Services Committee	13 January 2015	http://www.districtcouncils.gov.hk/wts/doc/2012_2015/en/committee_meetings_minutes/CBC/CBC_M20_M.pdf
Tai Po	Social Services Committee	14 January 2015	http://www.districtcouncils.gov.hk/tp/doc/2012_2015/en/committee_meetings_minutes/SSC/SS_M1_20150114_ENG.pdf
Southern	District Council	15 January 2015	http://www.districtcouncils.gov.hk/south/doc/2012_2015/en/dc_meetings_minutes/DC_Mins_20_EN.pdf
Sai Kung	Social Services & Healthy and Safe City Committee	20 January 2015	http://www.districtcouncils.gov.hk/sk/doc/2012_2015/en/committee_meetings_minutes/sshscc/SSHSCC_15_1_me.pdf
Tsuen Wan	District Council	27 January 2015	http://www.districtcouncils.gov.hk/tw/doc/2012_2015/en/dc_meetings_minutes/TWDC_Summary%20Tran_20th%20meeting_27012015e.pdf
Central and Western	Culture, Leisure and Social Affairs Committee	5 February 2015	http://www.districtcouncils.gov.hk/central/doc/2012_2015/en/committee_meetings_minutes/clsac/2015_6.docx
Kowloon City (Chinese version only)	Food and Environmental Hygiene Committee	5 February 2015	http://www.districtcouncils.gov.hk/kc/doc/2012_2015/en/committee_meetings_minutes/4FEHC/4FEHC_19cmin.pdf
North	District Council	12 February 2015	http://www.districtcouncils.gov.hk/north/doc/2012_2015/en/dc_meetings_minutes/ndc_2012-2015_minutes_20_en.pdf
Islands	District Council	16 February 2015	http://www.districtcouncils.gov.hk/island/doc/2012_2015/en/dc_meetings_minutes/DCmin0215-EN.pdf
Yuen Long	District Council	17 February 2015	http://www.districtcouncils.gov.hk/yl/doc/2012_2015/en/dc_meetings_minutes/1st_DC_Meeting_17.2.2015_eng.pdf
Yau Tsim Mong	District Council	26 February 2015	http://www.districtcouncils.gov.hk/ytm/doc/2012_2015/en/dc_meetings_minutes/Synopsis_of_the_Meeting_of_21st(2012-2015)dc.pdf

District	Meeting	Date	Link to meeting notes
Tuen Mun	District Council	3 March 2015	http://www.districtcouncils.gov.hk/tm/doc/2012_2015/en/dc_meetings_minutes/dc_21st_report_20150303.pdf
Wan Chai	District Council	3 March 2015	http://www.districtcouncils.gov.hk/wc/doc/2012_2015/en/dc_meetings_minutes/4th_term_wcdc_21_e.pdf
Kwun Tong	District Council	3 March 2015	http://www.districtcouncils.gov.hk/kt/doc/2012_2015/en/dc_meetings_minutes/DC_21E.pdf
Eastern (Chinese version only)	Community Building and Services Committee	5 March 2015	http://www.districtcouncils.gov.hk/east/doc/2012_2015/en/committee_meetings_minutes/cbsc/cbsc_7th_minutes_150305_tc.pdf
Sha Tin (Chinese version only)	Health and Environment Committee	12 March 2015	http://www.districtcouncils.gov.hk/st/doc/2012_2015/en/committee_meetings_minutes/hec/hec_minutes_15_03.pdf

APPENDIX C - BRIEFING SESSIONS, FORUMS AND SEMINARS RELATED TO THE VOLUNTARY HEALTH INSURANCE SCHEME PUBLIC CONSULTATION

Date	Name of Organisations / Bodies / Events
18 December 2014	District Council Chairmen and Vice-Chairmen
8 January 2015	Hong Kong Chinese People's Political Consultative Conference (Provincial) Members Association
9 January 2015	Community Forum organised by Food and Health Bureau (FHB) (Kowloon session)
13 January 2015	The Hong Kong Chi Tung Association Ltd
14 January 2015	Hong Kong Public Doctors' Association
15 January 2015	The Hong Kong Medical Association
16 January 2015	The Third Joint Conference organised by Union of Government Primary School Headmasters and Headmistresses and Association of Deputy Heads of Government Primary School
19 January 2015	Forum organised by FHB for the medical sector (private sector)
20 January 2015	The Hong Kong Federation of Insurers (HKFI)
	Consumer Council
22 January 2015	Community Forum organised by FHB (Hong Kong session)
23 January 2015	Forum organised by FHB for the medical sector (public sector)
26 January 2015	Community Forum organised by FHB (New Territories session)
27 January 2015	The Association of Hong Kong Professionals
	Hong Kong Alliance of Patients' Organizations Limited
28 January 2015	The Hong Kong Federation of Trade Unions (HKFTU)
29 January 2015	Chinese Medicine Practitioners Board of the Chinese Medicine Council of Hong Kong
	Economic Policy Committee of the Hong Kong General Chamber of Commerce
	Hong Kong Health Leaders Forum organised by KPMG
	Hong Kong Doctors Union
2 February 2015	The Hong Kong Association of the Pharmaceutical Industry
3 February 2015	The Lions Club Hong Kong East Limited
	Federation of Hong Kong Industries
	Insurance Industry Regulatory & Development Concern Group
5 February 2015	The Chinese General Chamber of Commerce
	Professional Forum on Child Health 2015 organised by Hong Kong Paediatric Foundation and Hong Kong Paediatric Society

Date	Name of Organisations / Bodies / Events
6 February 2015	Federation of Hong Kong Guangdong Community Organisations
7 February 2015	The Provisional Hong Kong Academy of Nursing
8 February 2015	Nursing Conference 2015 organised by College of Nursing, Hong Kong
9 February 2015	Industry Forum organised by the HKFI
12 February 2015	The Federation of Medical Societies of Hong Kong
13 February 2015	Actuarial Society of Hong Kong
27 February 2015	Hong Kong Chinese Civil Servants' Association
28 February 2015	Forum organised by Dashun Policy Research Centre
3 March 2015	Forum organised by the Hong Kong Council of Social Service
4 March 2015	District Forum organised by HKFTU (Tin Shui Wai)
6 March 2015	Technology Education Section, Curriculum Development Institute, Education Bureau
7 March 2015	The Hong Kong Medical Association
9 March 2015	Seminar organised by SME Global Alliance and Tuen Mun And Yuen Long Commerce and Industry Association
	Seminar organised by the Association of Hong Kong Accountants and Deloitte China
	The Federation of Hong Kong and Kowloon Labour Unions
10 March 2015	The American Chamber of Commerce in Hong Kong
	The Hong Kong Chi Tung Association Ltd
11 March 2015	HKFI
12 March 2015	District Forum organised by HKFTU (Kwai Chung)
16 March 2015	Liberal Studies Section, Curriculum Development Institute, Education Bureau
21 March 2015	2nd AGM cum Symposium 2015 of Hong Kong Association of Family Medicine and Primary Health Care Nurses Ltd
28 March 2015	Hong Kong Pharmacy Conference 2015 organised by the Pharmaceutical Society of Hong Kong, the Practising Pharmacists Association of Hong Kong, the Society of Hospital Pharmacists of Hong Kong, the Department of Pharmacology and Pharmacy of the University of Hong Kong, School of Pharmacy of the Chinese University of Hong Kong, Department of Health and Hospital Authority
10 April 2015	District Forum organised by HKFTU (Kwai Tsing)
15 April 2015	HKFTU, Hong Kong Insurance Practitioners General Union and Hong Kong Clerical and Professional Employees General Union
	Civic Party
	Professional Affairs Committee of Democratic Alliance for the Betterment and Progress of Hong Kong

APPENDIX D - LIST OF WRITTEN SUBMISSIONS RECEIVED IN THE VOLUNTARY HEALTH INSURANCE SCHEME PUBLIC CONSULTATION

Submissions from Organisations

Serial No.	Name
(O)001	愛護理服務集團
(O)002	Hong Kong Institute of Certified Public Accountants
(O)003	民建聯大埔支部
(O)004	Mazars Tax Services Limited
(O)005	民協九龍中支部
(O)006	公民黨
(O)007	民建聯九龍城支部
(O)008	香港醫院藥劑師學會
(O)009	Hong Kong Women Doctors Association
(O)010	CPA Australia
(O)011	The Chinese University of Hong Kong
(O)012	Equal Opportunities Commission
(O)013	亞洲持續發展中心
(O)014	Hong Kong Academy of Medicine
(O)015	香港工業總會
(O)016	City University of Hong Kong
(O)017	Hong Kong College of Dermatologists
(O)018	Hong Kong Retail Management Association
(O)019	家長組織座談會
(O)020	中小企國際聯盟、屯元區工商業聯合會、國際傑人會香港區總會及香港公民協會中小企業委員會
(O)021	Faculty of Health and Social Sciences, The Hong Kong Polytechnic University
(O)022	The Government Doctors' Association
(O)023	Hong Kong College of Physicians
(O)024	香港中醫藥管理委員會
(O)025	智經研究中心
(O)026	Hong Kong Doctors Union

Serial No.	Name
(O)027	KSY Speciality Limited
(O)028	Hongkong Civic Association
(O)029	The Actuarial Society of Hong Kong
(O)030	Employers' Federation of Hong Kong
(O)031	香港中華總商會
(O)032	Independent Financial Advisors Association
(O)033	香港視網膜病變協會
(O)034	香港會計師專業協會
(O)035	Hong Kong Dental Association
(O)036	The Hong Kong Federation of Insurers
(O)037	香港專業及資深行政人員協會
(O)038	Hong Kong College of Paediatricians
(O)039	北角區街坊福利事務促進會
(O)040	Hong Kong Women Professionals & Entrepreneurs Association
(O)041	Business and Professionals Federation of Hong Kong
(O)042	School of Nursing, The University of Hong Kong
(O)043	Hospital Authority
(O)044	香港專業人士協會
(O)045	The Hong Kong Paediatric Society and the Hong Kong Paediatric Foundation
(O)046	Association of Private Medical Specialists of Hong Kong
(O)047	Institute of Biomedical Science, Hong Kong Branch
(O)048	AIA International Limited
(O)049	香港中華廠商聯合會
(O)050	The Hong Kong Medical Association
(O)051	Dashun Policy Research Centre
(O)052	新民黨
(O)053	The Taxation Institute of Hong Kong
(O)054	(The sender requested anonymity) (來信人要求以不具名方式公開)
(O)055	風濕科團體
(O)056	The Office of the Privacy Commissioner for Personal Data, Hong Kong
(O)057	Hong Kong Private Hospitals Association

Serial No.	Name
(O)058	(The sender requested anonymity)(來信人要求以不具名方式公開)
(O)059	香港愛滋病基金會
(O)060	Hong Kong College of Community Medicine
(O)061	香港婦聯
(O)062	香港護士協會
(O)063	工聯會
(O)064	香港經濟民生聯盟
(O)065	香港聖公會麥理浩夫人中心
(O)066	(The sender requested anonymity)(來信人要求以不具名方式公開)
(O)067	香港基督教協進會社會公義與民生關注委員會
(O)068	東華三院
(O)069	香港專業保險經紀協會
(O)070	The Pharmaceutical Society of Hong Kong
(O)071	香港人壽保險經理協會
(O)072	港九勞工社團聯會
(O)073	107 動力
(O)074	The Provisional Hong Kong Academy of Nursing
(O)075	Hong Kong Society of Endocrinology, Metabolism and Reproduction
(O)076	The Insurance Claims Complaints Bureau
(O)077	爭取低收入家庭保障聯席
(O)078	The Hong Kong Retirement Schemes Association
(O)079	葵青區基層人士醫療關注組
(O)080	The Hong Kong College of Family Physicians
(O)081	香港保險業總工會
(O)082	The Hong Kong Association of the Pharmaceutical Industry
(O)083	工黨
(O)084	自由黨
(O)085	Insurance & Financial Practitioners Alliance
(O)086	Hong Kong General Chamber of Commerce
(O)087	香港保險中介人商會
(O)088	香港復康會

Serial No.	Name
(O)089	Institute of Financial Planners of Hong Kong
(O)090	香港衛生界專業團體聯席會議
(O)091	新論壇
(O)092	香港放射學技師會
(O)093	Asia Diabetes Foundation, Association of Hong Kong Diabetes Nurses, Hong Kong Specialist Medical Association, and Youth Diabetes Action
(O)094	Healthcare Policy Forum
(O)095	Manulife
(O)096	香港保險中介行業協會
(O)097	香港社會服務聯會
(O)098	香港一般保險代理協會
(O)099	The Institute for Health Policy & Systems Research
(O)100	Insurance Industry Regulatory & Development Concern Group
(O)101	香港病人組織聯盟
(O)102	Zurich Insurance Company Limited
(O)103	香港復康聯盟
(O)104	The Medical Centre for Cognition and Emotion (Hong Kong)
(O)105	民建聯
(O)106	香港復康聯會
(O)107	Swiss Re Hong Kong Health TaskForce
(O)108	The Federation of Medical Societies of Hong Kong
(O)109	The British Chamber of Commerce in Hong Kong
(O)110	Towers Watson Hong Kong Limited
(O)111	長期病患者關注醫療改革聯席
(O)112	香港社區組織協會
(O)113	Hong Kong Physiotherapists' Union
(O)114	Consumer Council
(O)115	路向四肢傷殘人士協會
(O)116	Diabetes Hongkong
(O)117	香港天主教正義和平委員會
(O)118	(The sender requested confidentiality) (來信人要求以保密方式處理)
(O)119	香港職工會聯盟

Serial No.	Name
(O)120	民主黨
(O)121	Hong Kong Physiotherapy Concern
(O)122	愛護家庭家長協會

Copies of the written submissions are available on the Voluntary Health Insurance Scheme's website (http://www.vhis.gov.hk).

Submissions from Individuals

Serial No.	Name
(I)001	(Name not provided) (沒有署名)
(I)002	謝國民
(I)003	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)004	Ng Yuk Kai
(I)005	(Name not provided) (沒有署名)
(I)006	(Name not provided) (沒有署名)
(I)007	KO WAI KIN
(I)008	LEUNG YUEN YING
(I)009	Flora Ip
(I)010	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)011	楊鳳美
(I)012	Y T LIU
(I)013	(Name not provided) (沒有署名)
(I)014	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)015	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)016	Manley Tai
(I)017	Debbie Wong
(I)018	Benjamin Lee
(I)019	梁先生
(I)020	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)021	Angela Man
(I)022	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)023	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)024	潘淑媚
(I)025	Peter Y.T. Kong
(I)026	Mr. LEUNG SIK HUNG Ms. CHIU SHUN KUEN
(I)027	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)028	黃淑英
(I)029	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)030	Betty Li
(I)031	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)032	Mr.C.Chui

Serial No.	Name
(I)033	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)034	龐瑞霞
(I)035	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)036	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)037	(Name not provided) (沒有署名)
(I)038	chan man cho
(I)039	nip yin
(I)040	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)041	蔡志傑
(I)042	梁穎恩
(I)043	何小姐
(I)044	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)045	陳志民
(I)046	Margaret
(I)047	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)048	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)049	Steven Tse
(I)050	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)051	FUNG Wai Man
(I)052	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)053	(Name not provided) (沒有署名)
(I)054	生於六十年代的人
(I)055	Jo PARK
(I)056	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)057	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)058	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)059	Cliff Lam
(I)060	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)061	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)062	Cindy
(I)063	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)064	Albert L
(I)065	Monica Yu
(I)066	Anny Ho
(I)067	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)068	(Name not provided) (沒有署名)
(I)069	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)070	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)071	(Name not provided) (沒有署名)
(I)072	小蜜蜂
(I)073	CNn01
(I)074	(Name not provided) (沒有署名)
(I)075	鮑德禮
(I)076	Kan Lee
(I)077	梁金塘
(I)078	公民力量西貢區區議員區能發、溫悅昌、譚領律、何觀順；社區發展主任陳健淩、張澤松

Serial No.	Name
(I)079	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)080	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)081	李志華
(I)082	Pun
(I)083	Lee Charn Wah William
(I)084	(Name not provided) (沒有署名)
(I)085	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)086	李健樂
(I)087	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)088	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)089	(Name not provided) (沒有署名)
(I)090	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)091	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)092	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)093	Joe Wong
(I)094	LEUNG KA YAN
(I)095	Dr Wong Sze Chai Peter
(I)096	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)097	我是中國人
(I)098	邱躍清
(I)099	James
(I)100	(Name not provided) (沒有署名)
(I)101	九龍城區議員梁美芬、劉偉榮、楊永杰、左滙雄、李蓮、張仁康、勞超傑、鄭利明、黃潤昌

Serial No.	Name
(I)102	Yu chun fai
(I)103	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)104	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)105	梁貴明 SIR
(I)106	Cheung Mun Biu
(I)107	ivan
(I)108	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)109	Y K LEE
(I)110	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)111	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)112	林小姐
(I)113	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)114	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)115	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)116	Jamila
(I)117	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)118	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)119	Tam yiu sing
(I)120	John
(I)121	Chiu
(I)122	PEKY
(I)123	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)124	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)125	K T Kwong

Serial No.	Name
(I)126	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)127	李世豪
(I)128	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)129	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)130	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)131	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)132	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)133	張振榮
(I)134	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)135	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)136	Leung irene
(I)137	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)138	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)139	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)140	Ian Charles
(I)141	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)142	(The sender requested confidentiality) (來信人要求以保密方式處理)
(I)143	Li Wai Hong
(I)144	金刀
(I)145	silvia
(I)146	Steve Lau
(I)147	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)148	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)149	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)150	市民 M
(I)151	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)152	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)153	一市民
(I)154	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)155	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)156	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)157	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)158	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)159	鄭先生
(I)160	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)161	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)162	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)163	Ms Betty Chan
(I)164	Wan chi wai
(I)165	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)166	黃
(I)167	C.F. Yam
(I)168	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)169	Kien Chan
(I)170	Becky Lau
(I)171	劉葆儀

Serial No.	Name
(I)172	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)173	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)174	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)175	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)176	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)177	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)178	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)179	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)180	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)181	容仲華
(I)182	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)183	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)184	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)185	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)186	(Name not provided) (沒有署名)
(I)187	葉先生
(I)188	Levin Lee
(I)189	fung wing yan
(I)190	lee mei yan
(I)191	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)192	China
(I)193	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)194	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)195	Li HY
(I)196	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)197	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)198	趙少麗
(I)199	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)200	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)201	H. F LAU
(I)202	梁憲孫
(I)203	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)204	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)205	(The sender requested confidentiality) (來信人要求以保密方式處理)
(I)206	Y K Chan
(I)207	郭女士
(I)208	李建華
(I)209	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)210	Vishal Khurana
(I)211	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)212	Cheng
(I)213	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)214	Polly
(I)215	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)216	yeung karmen

Serial No.	Name
(I)217	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)218	Miss Chan Yuk Sim
(I)219	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)220	Conrad Sun
(I)221	Dr Wong Sze Chai Peter
(I)222	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)223	吳國鏘
(I)224	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)225	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)226	林小姐
(I)227	Kwan Ka Wai Carrie
(I)228	鄭德志
(I)229	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)230	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)231	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)232	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)233	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)234	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)235	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)236	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)237	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)238	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)239	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)240	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)241	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)242	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)243	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)244	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)245	李慧明
(I)246	(The sender's name cannot be ascertained) (未能確定來信人署名)
(I)247	虞錦輝 Tommy
(I)248	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)249	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)250	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)251	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)252	黃皓
(I)253	Tay Her Lim
(I)254	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)255	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)256	Ms Wong
(I)257	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)258	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)259	James Tong
(I)260	Ho Tak On

Serial No.	Name
(I)261	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)262	Yam Siu yee
(I)263	Dickson MAK
(I)264	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)265	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)266	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)267	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)268	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)269	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)270	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)271	(The sender requested confidentiality) (來信人要求以保密方式處理)
(I)272	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)273	謝礦華
(I)274	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)275	余亚斌
(I)276	Awan, Irfan Ali
(I)277	Lui Mong Yu
(I)278	Ruth Pine
(I)279	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)280	wendy
(I)281	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)282	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)283	Richard Chin-Shan Wu
(I)284	王紫燕
(I)285	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)286	Chris LAM
(I)287	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)288	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)289	林小姐
(I)290	Joe LEE
(I)291	林小姐
(I)292	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)293	(Name not provided) (沒有署名)
(I)294	何小姐
(I)295	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)296	Rainbow Poon
(I)297	Matthew Wong
(I)298	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)299	Rudolf Frei
(I)300	(Name not provided) (沒有署名)
(I)301	QYKL
(I)302	Joyce Chiang
(I)303	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)304	趙沛恒 CHIU PUI HANG
(I)305	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)306	Godfrey

Serial No.	Name
(I)307	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)308	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)309	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)310	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)311	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)312	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)313	陳海鳳
(I)314	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)315	Paul Jackson
(I)316	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)317	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)318	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)319	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)320	Louisa Tsang
(I)321	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)322	(Name not provided) (沒有署名)
(I)323	(Name not provided) (沒有署名)
(I)324	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)325	Kit Ling
(I)326	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)327	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)328	(Name not provided) (沒有署名)
(I)329	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)330	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)331	陳先生
(I)332	張小姐
(I)333	陳小姐
(I)334	鄭小姐
(I)335	羅先生
(I)336	Ken Wong
(I)337	Felix Wong
(I)338	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)339	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)340	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)341	Chan Ka Keung
(I)342	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)343	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)344	Joanna Lung
(I)345	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)346	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)347	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)348	Felix Wong
(I)349	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)350	cheung ka man
(I)351	李詠淇

Serial No.	Name
(I)352	Frankie Tang
(I)353	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)354	doris lee
(I)355	cheung fat wah
(I)356	Lilian Chou
(I)357	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)358	楊仲榮
(I)359	一名精神康復者
(I)360	Yeung Ka Yan Karry
(I)361	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)362	LAI KA YU
(I)363	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)364	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)365	Connie Tang
(I)366	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)367	黃小姐
(I)368	Estahaus
(I)369	kenny Chan
(I)370	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)371	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)372	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)373	Lau Tin Sing, Keith
(I)374	(Name not provided) (沒有署名)
(I)375	陳俊

Serial No.	Name
(I)376	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)377	Raymond FUNG
(I)378	林生
(I)379	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)380	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)381	志剛
(I)382	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)383	lee
(I)384	(Name not provided) (沒有署名)
(I)385	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)386	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)387	(Name not provided) (沒有署名)
(I)388	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)389	王紹爾 BBS, JP
(I)390	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)391	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)392	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)393	何先生
(I)394	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)395	(The sender requested anonymity) (來信人要求以不具名方式公開)
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(I)397	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)398	(Name not provided) (沒有署名)
(I)399	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)400	Tung Tsit Shan
(I)401	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)402	LI NGA CHI SAM
(I)403	立法會陳健波議員
(I)404	Chan Min Kwok
(I)405	Rovina Woo
(I)406	Marsha Lok
(I)407	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)408	李慧敏
(I)409	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)410	Lo chiu ming
(I)411	陳小姐
(I)412	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)413	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)414	(The sender requested anonymity) (來信人要求以不具名方式公開)
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(I)417	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)418	Victoria Lau
(I)419	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)420	WONG PANG TAT
(I)421	WONG PANG TAT

Serial No.	Name
(I)422	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)423	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)424	Joy Al-Sofi
(I)425	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)426	一香港市民
(I)427	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)428	(Name not provided) (沒有署名)
(I)429	鄧兆宗
(I)430	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)431	Miranda Lam
(I)432	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)433	Rong Huang
(I)434	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)435	譚以和
(I)436	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)437	(Name not provided) (沒有署名)
(I)438	(The sender requested anonymity) (來信人要求以不具名方式公開)
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(I)442	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)443	Wong Wai keung

Serial No.	Name
(I)444	李志豪
(I)445	FGG
(I)446	Connie Chan
(I)447	葉翠屏
(I)448	XIE Xing, CHEN Yue, WANG Chong
(I)449	Fu, Ching Wah
(I)450	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)451	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)452	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)453	(Name not provided) (沒有署名)
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(I)455	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)456	黃碧珍
(I)457	(Name not provided) (沒有署名)
(I)458	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)459	(Name not provided) (沒有署名)
(I)460	(The sender requested anonymity) (來信人要求以不具名方式公開)

Serial No.	Name
(I)461	石美君
(I)462	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)463	Mary Lee
(I)464	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)465	Chris
(I)466	Johnson Chong
(I)467	HUI Ching Yi
(I)468	(The sender requested anonymity) (來信人要求以不具名方式公開)
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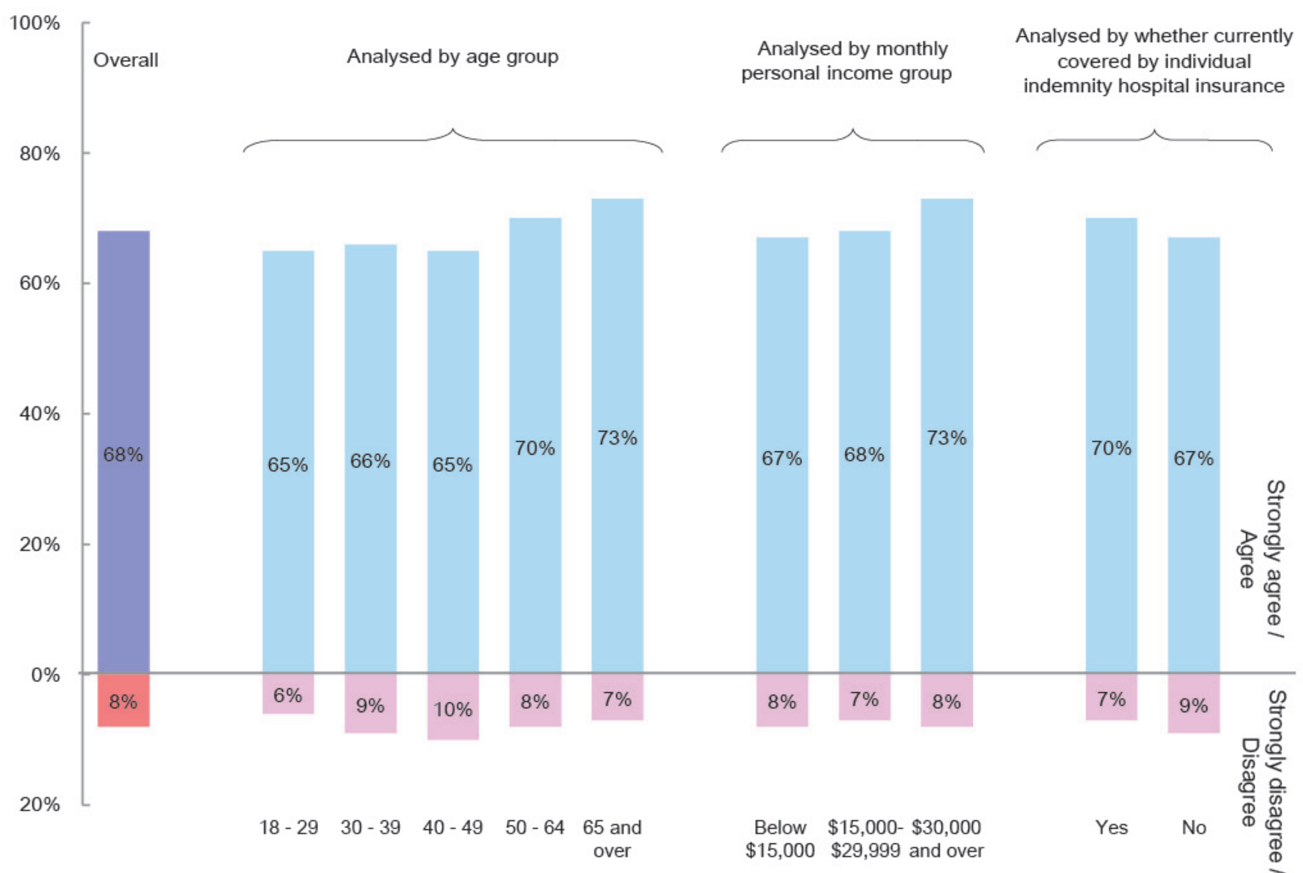
(I)470	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)471	(The sender requested anonymity) (來信人要求以不具名方式公開)
(I)472	Samuel Li
(I)473	徐秀英
(I)474	關小姐
(I)475	(Name not provided) (沒有署名)
(I)476	Dr David Fang
(I)477	東區區議員陳啟遠、梁兆新；公民黨執委梁穎敏
(I)478	Catherine Ching-yi Fung

Copies of the written submissions are available on the Voluntary Health Insurance Scheme's website (http://www.vhis.gov.hk).

APPENDIX E - SUMMARY OF KEY FINDINGS OF PUBLIC OPINION SURVEY ON THE VOLUNTARY HEALTH INSURANCE SCHEME

The Food and Health Bureau commissioned Consumer Search Group to conduct a Public Opinion Survey on the Voluntary Health Insurance Scheme (VHIS) to collect the public's views on the proposal for implementing a government-regulated, market-operated VHIS, which was put forward in the public consultation on VHIS launched from 15 December 2014 to 16 April 2015. The survey was conducted via telephone interviews during 19 January to 3 May 2015, and a random sample of 5 016 persons aged 18 or above were successfully interviewed. Key findings of the survey are summarised below. Please refer to the VHIS website (www.vhis.gov.hk) for the full report on this opinion survey.

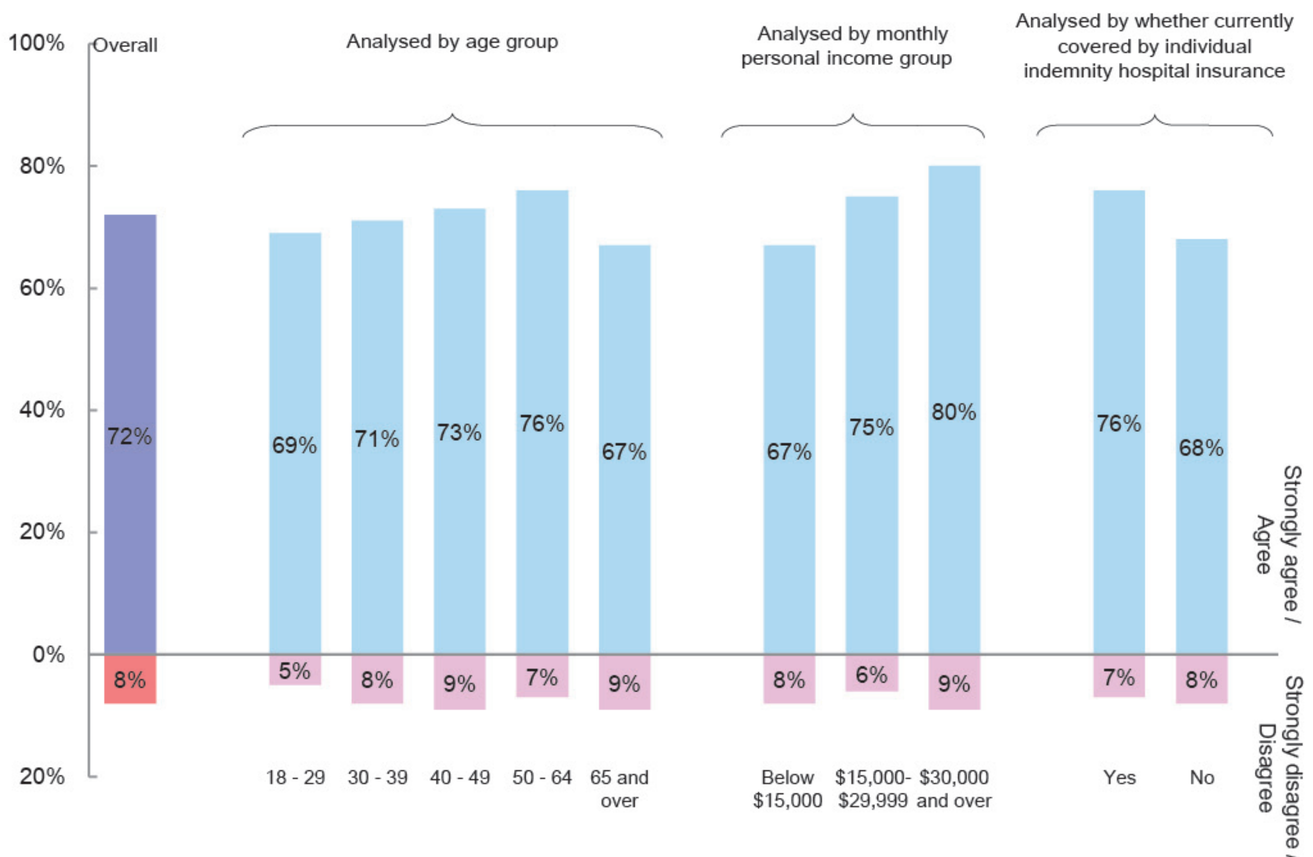
Figure 1 Views on the Policy Direction underlying the Voluntary Health Insurance Scheme



[Q1] (Introduction : Recently, the Government has proposed a Voluntary Health Insurance Scheme to encourage greater use of private healthcare services for those who could afford it through taking out individual indemnity hospital insurance. This would help relieve the pressure on the public sector and shorten the waiting time for public services. People concerned will still enjoy the right

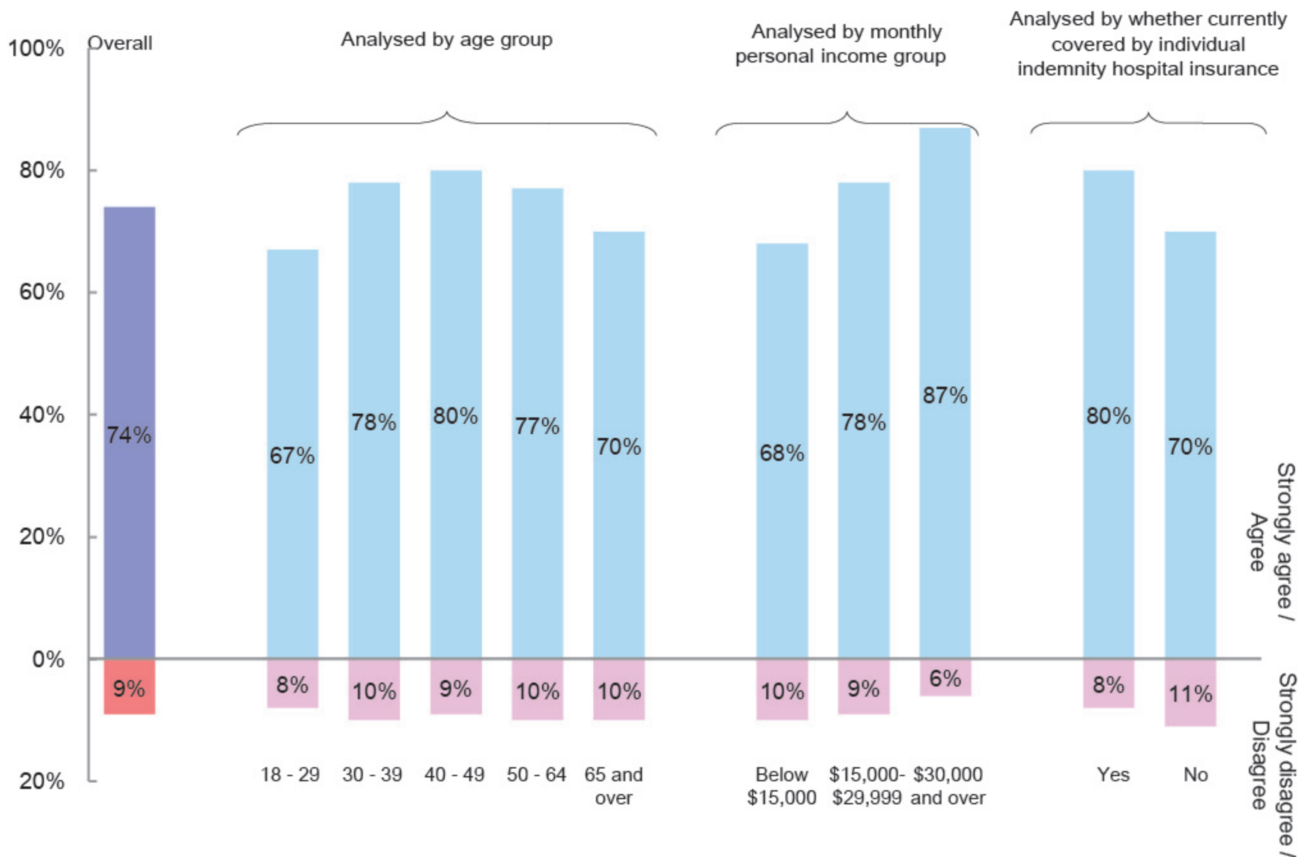
of using public healthcare services, and the Government spending on public healthcare will not be affected.) Do you agree with the policy direction that the Government should encourage using private healthcare services for those who could afford it, so as to relieve the pressure on the public sector and shorten the waiting time for public services?

Figure 2 Views on the Minimum Requirement Approach for Implementing the Voluntary Health Insurance Scheme



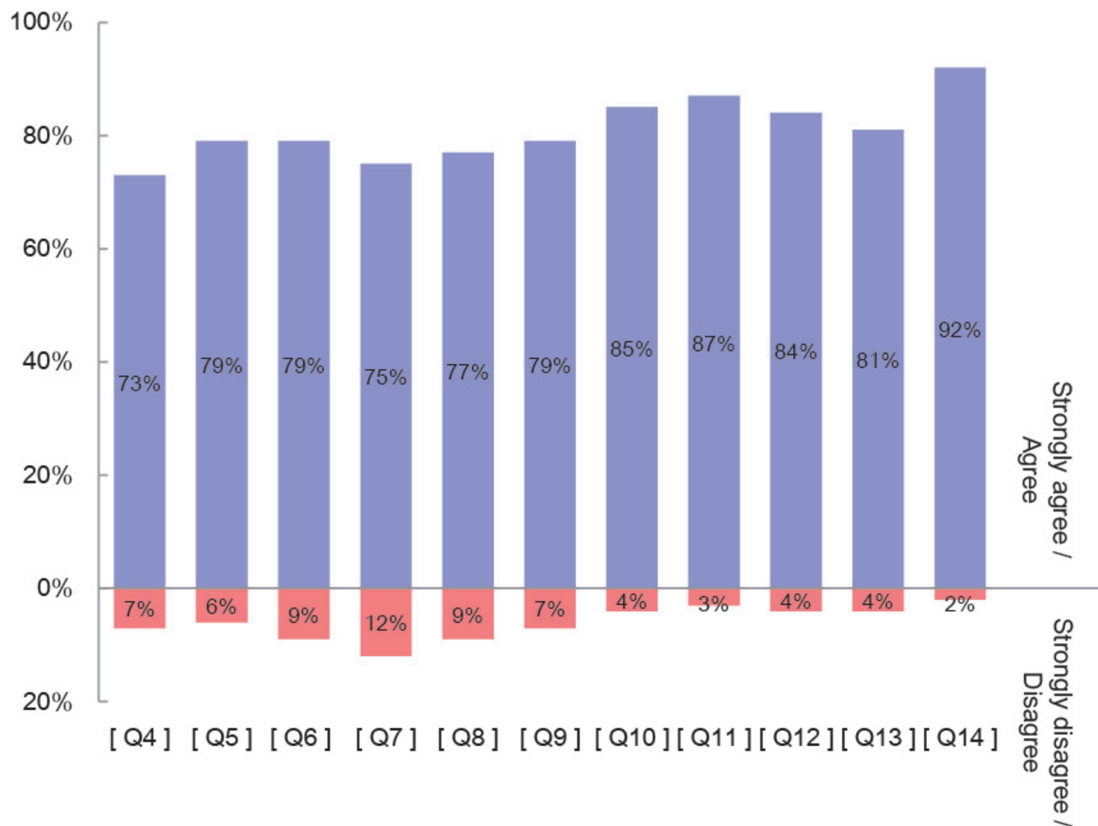
[Q2] (Introduction : The Government proposes to strengthen the regulation of insurers by requiring that all indemnity hospital insurance products they sell to individuals must comply with a set of Minimum Requirements prescribed by the Government. In other words, insurers would not be allowed to sell products with protection that does not meet the Minimum Requirements, even though the premiums of such products may hence be lower. This is intended to enhance consumer protection.) Do you agree with this regulatory requirement?

Figure 3 Views on the Use of Tax Deduction to Encourage Purchase of Insurance Products under the Voluntary Health Insurance Scheme



[Q3] (Introduction : The Government proposes tax deduction to encourage the purchase of individual indemnity hospital insurance. This will allow taxpayers who take out insurance policies compliant with the Voluntary Health Insurance Scheme to claim deduction on their salary or other income tax for insurance premiums they pay for themselves and their dependants.) Do you agree with this financial incentive?

Figure 4 Views on the Major Regulatory Requirements of the Voluntary Health Insurance Scheme



(Introduction : The Government proposes that insurers offering individual indemnity hospital insurance must make a product meeting all, but not exceeding the Minimum Requirements, namely the Standard Plan, available as an option for consumers.) Do you agree that this Standard Plan should meet the following Minimum Requirements?

[Q4] Guaranteed renewal for life, where insurers cannot re-underwrite at the time of policy renewal and cannot impose lifetime benefit limit.

[Q5] Coverage of pre-existing conditions, subject to a waiting period.

[Q6] In the first year of the Voluntary Health Insurance Scheme implementation, insurers are not allowed to decline any applications.

[Q7] From the second year onwards, insurers are not allowed to decline the applications made by people aged 40 or below.

[Q8] Insurers cannot charge a premium loading higher than the prescribed cap for persons of higher health risks.

[Q9] Flexibility for policyholders to change insurer such that the applications cannot be declined and the applicants cannot be re-underwritten for charging or increasing premium loading if the insured has no claim for a period of time, say 3 years, immediately before transfer of policies.

[Q10] Benefit limit of each itemised benefit must meet the level prescribed by the Government so that general private hospital treatment charges can be met as far as possible.

[Q11] Benefit coverage includes not only inpatient procedures, but also :

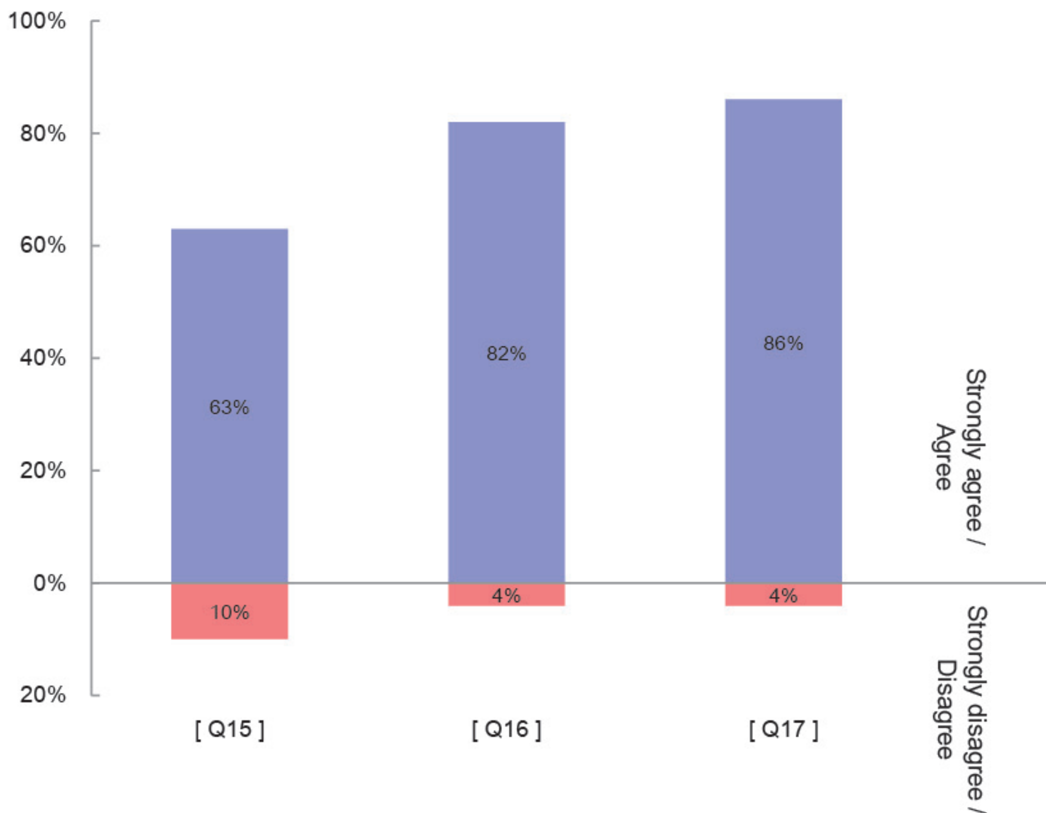
(1) prescribed ambulatory procedures, for example cataract surgery and colonoscopy;
(2) advanced diagnostic imaging tests, for example magnetic resonance imaging and computed tomography; and
(3) non-surgical cancer treatments, for example chemotherapy and radiotherapy.

[Q12] Private hospitals and doctors as well as insurers are required to provide upfront budget certainty to the insured before treatment; in addition, if the procedure received, and the hospital and doctor selected are on the lists specified by the insurer, then the insured does not need to pay out-of-pocket, or only needs to pay a pre-determined amount.

[Q13] Standardised policy terms and conditions for insurance policies that minimise disputes.

[Q14] Insurers are required to publish premium schedules and information on the relevant products for easy comparison by consumers.

Figure 5 Views on the Supporting and Enabling Measures for Implementing the Voluntary Health Insurance Scheme



Do you agree that the Government should implement the following supporting and enabling measures for implementing the Voluntary Health Insurance Scheme?

[Q15] Use public funding to support high-risk individuals to get insured so that the premiums they need to pay are capped by 3 times of "standard premium" while other insured persons will not be affected.

[Q16] Insurers are required to offer Conversion Option to employers who buy group indemnity hospital insurance; if the employers decide to take the offer, their employees can switch to a Standard Plan of individual indemnity hospital insurance without re-underwriting upon leaving employment or retirement.

[Q17] Set up a regulatory authority to monitor the implementation of the Voluntary Health Insurance Scheme and ensure individual indemnity hospital insurance products are compliant with the Minimum Requirements in order to achieve better consumer protection.

APPENDIX F - DEFINITIONS OF VOLUNTARY HEALTH INSURANCE SCHEME-COMPLIANT PRODUCTS

Under the refined Voluntary Health Insurance Scheme (VHIS), there will be two types of compliant individual Hospital Insurance products, namely the Standard Plan and the Flexi Plan. Their definitions are listed out as follows –

(i) Standard Plan

- Insurers must offer to all consumers as one of the available options.
- Standard Plan has fixed product template in terms of standard policy terms and conditions, benefit coverage, benefit limits and cost-sharing arrangement, etc.
- Standard Plan must meet but not exceed all Minimum Requirements.
- Insurers may accept or reject a subscription. For subscribers with pre-existing conditions, insurers may offer acceptance subject to exclusion clauses for these conditions (e.g. cataract) in the insurance policies, but should concurrently provide an option of covering pre-existing conditions with premium loading and waiting period. Moreover, the exclusion clauses for pre-existing conditions are subject to a set of guiding principles and interpretations to be developed by the Food and Health Bureau (FHB) as part of the practice guidelines for VHIS.
- Standard Plan is eligible for tax concession.

(ii) Flexi Plan

- Insurers may opt to offer Flexi Plan to consumers as available option or not.
- Flexi Plan has modular product design, encompassing basic coverage tantamount to Standard Plan plus add-on hospital insurance coverage of which product template is not fixed (e.g. higher benefit limits, broader hospital benefit coverage, etc.).
- Flexi Plan must meet or exceed all Minimum Requirements for the basic coverage tantamount to Standard Plan.

- Flexi Plan must meet some but not all of the Minimum Requirements for the add-on coverage (e.g. more relaxed cost-sharing arrangement to allow flexibility in product design), subject to further deliberation with stakeholders.

- Insurers may accept or reject a subscription. For subscribers with pre-existing conditions, insurers may offer acceptance subject to exclusion clauses for these conditions (e.g. cataract) in the insurance policies. The exclusion clauses are subject to a set of guiding principles and interpretations to be developed by FHB as part of the practice guidelines for VHIS. Unlike Standard Plan, insurers need not provide an option of coverage of pre-existing conditions.

- Flexi Plan is eligible for tax concession.

Published by the Food and Health Bureau
Printed by the Government Logistics Department
Hong Kong Special Administrative Region Government