

**Response to the Food and Health Bureau of  
Government of the Hong Kong Special Administrative Region**

**Voluntary Health Insurance Scheme Consultation**

The Actuarial Society of Hong Kong

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## 1 Executive Summary

The Actuarial Society of Hong Kong (ASHK) appreciates the opportunity to comment on the Voluntary Health Insurance Scheme (VHIS) Consultation Paper dated December 2014 issued by the Food and Health Bureau. VHIS will cause major change to the health insurance environment upon its implementation. This brief Response Paper contains our preliminary comments on actuarially related issues or aspects of the VHIS proposal as the basis for further discussion.

The proposed VHIS will significantly affect how individuals purchase private health insurance and use healthcare services, how insurers assume and manage morbidity-related insurance risks, how private healthcare providers market and charge for their services, and how the Government finance health expenditures. The current proposal with further structural modifications to ensure the sustainability of VHIS will offer long-term insurance protection in alignment with VHIS' objective. Throughout this Response Paper, we focus primarily on actuarially sound pricing and reserving practices during the transition to new health insurance market rules under VHIS. Based on our overall assessment, we have identified multiple areas that require clarification or modifications, including the following four key proposed enhancements:

- *Clearly defined acceptance criteria and risk management framework for the High Risk Pool*

We recommend that the acceptance criteria should be specified in consistent and factual terms to identify conditions within the High Risk Pool, instead of the proposed +200% loading limit alone, while the risk management framework of the High Risk Pool is further developed. The clearly defined acceptance criteria ensure proper alignment between insurers and the High Risk Pool and facilitate advance planning for appropriate healthcare provider contracting arrangement and care management programs to control medical costs within the High Risk Pool.

- *Transitional risk-sharing support between the Government, insurers, and the insureds for covering pre-existing conditions during the initial years of VHIS implementation*

We recognize that changing health insurance market rules can lead to significant adverse selection. Because insurers overall lack credible experience to support actuarially sound pricing or reserving basis for conditions below the premium loading cap, additional transitional risk-sharing support during the initial years of VHIS implementation is necessary to mitigate the risk of unexpected adverse experience that would otherwise threaten the sustainability of VHIS.

- *Group conversion option with further risk mitigation rules and feasible pre-funding mechanism*

The group conversion option in its current form presents significant anti-selection risk and undermines the VHIS framework by allowing individuals to obtain VHIS coverage without necessary premium loadings. We recommend measures to mitigate the anti-selection risk and a pre-funding mechanism to ensure long-term reserve adequacy.

- *Simplified portability provision with premium loading in lieu of the three-year clean “look back” period to support feasibility of the portability feature in an actuarially sound manner*

We recommend a simplified provision to make the portability feature feasible while avoiding adverse impacts on the solvency of multiple insurers.

The above four highlighted enhancements, together with other recommended changes to the VHIS proposal, are assessed in this Response Paper in detail in terms of likely impact on the sustainability of VHIS and estimated implementation difficulty. There are also other factors elaborated in our responses as well as those beyond the scope of this Response Paper which require due attention because collectively they can have significant impacts on the feasibility and sustainability of VHIS.

We will be happy to work with the Food and Health Bureau and other government bodies by providing appropriate actuarial input to support relevant actuarial best practices and make VHIS feasible and sustainable.

## **2 Introduction**

### **2.1 Background**

The Actuarial Society of Hong Kong (ASHK) appreciates the opportunity to comment on the Voluntary Health Insurance Scheme (VHIS) Consultation Paper dated December 2014 issued by the Food and Health Bureau. The ASHK is a professional membership organization for actuaries in the industries of insurance, consultancy, finance, educational institutions and government. The ASHK has been a full member of the International Actuarial Association since 1999. The ASHK is governed by an elected Council with a President, an Immediate Past President, a Vice President and ten Council Members. Currently the ASHK has over 900 members.

Among the objectives of the ASHK are the following:

- To discuss and comment on the actuarial aspects of public, social and economic and financial questions which from time to time may be the subject of public interest;
- To consider the actuarial aspects of legislation existing and proposed and to take such action as is considered desirable.

Actuaries play an important role in the proposed VHIS due to their in-depth understanding of the market and other relevant regulations. The ASHK in particular helps develop standards of practice to which all insurance company actuaries are held accountable. The involvement of the ASHK facilitates a well-regulated environment by prescribing generally accepted actuarial principles and practices which emerge from the adaptation of actuarial concepts and risk management techniques.

### **2.2 Role of the Actuary in Healthcare**

Actuaries fulfill many roles in a broad range of environments, including insurance companies, health organizations, risk management, government, regulatory regimes, educational and research institutes, and in other fields. Actuaries, through systematic and disciplined training and professional practice, develop a detailed understanding of economic, financial, demographic and insurance risks and expertise in:

- Developing and using statistical and financial models to inform financial decisions;
- Pricing, establishing the amount of liabilities, and setting capital requirements for uncertain future events.

Health actuarial practice has been a growing and dynamic part of the profession. Healthcare involves people, scarce resources, and uncertainty. It is an important and continually evolving area for actuaries globally, with new actuarial tools and skills to support emerging healthcare financing and delivery models.

Actuaries can play a significant role in developing and managing VHIS by covering a wide spectrum of functions such as:

- Product development, pricing, product marketing, product management, premium adjustments, and experience studies;
- Development of reserve requirements and capital requirements;
- Modeling, profit testing, reserve calculation, solvency calculations, financial forecasts and controls for long-term guarantee provisions;

- Analysis of healthcare utilization, benchmarking, and cost trend forecasts;
- Underwriting, health risk status analysis, risk adjustment, and predictive modeling;
- Estimation of savings, utilization rate changes, and return on investment of wellness and disease management programs;
- Healthcare provider contracting management including provider reimbursement analysis, provider profiling, payment methods, and financial incentives;
- Risk management including reinsurance, stop-loss insurance and high-risk pool analysis;
- Providing advice to regulators and legislators.

### **2.3 Role of the ASHK**

The ASHK strives to promote actuarial best practice in Hong Kong through development of best practice guidelines:

- ASHK By-Law 1: Due process for the development of professional standards and guidance notes;
- ASHK By-Law 2: Continuing professional development;
- Guidance on professional conduct;
- Professional Standard 1 in relation to the statutory duties of an actuary in life insurance companies;
- Professional Standard 2 in relation to actuarial reports for the Occupational Retirement Scheme;
- AGN 3 Additional guidance for appointed actuaries;
- AGN 4 Outstanding claims in general insurance;
- AGN 5 Principles of life insurance policy illustrations;
- AGN 6 Continuing professional development;
- AGN 7 Dynamic solvency testing;
- AGN 8 Determination of liabilities for investment guarantees.

As will be discussed in detail in section 3, the proposed VHIS requires significant actuarial support to ensure its sustainability, such as:

- The Guaranteed Renewal provision confers long-term business characteristics on VHIS policies, which in our professional opinion should follow long-term reserving principles and involve appointed actuaries to sign off premium rates and reserve provisions;
- Since insurers overall lack the claim experience of pre-existing conditions, actuaries will have to derive actuarially sound premium rates from emerging experience;
- The sustainability of the High Risk Pool relies on defined risk acceptance criteria, care management programs, demographic and financial projections;

- The Portability and Conversion Option provisions create additional reserve requirements for higher expected future claim obligations;
- Supervision of VHIS implementation requires continuous analysis of medical claims data and healthcare provider cost data to assess cost, utilization, and the effectiveness of package pricing arrangement;
- Product design of VHIS plans requires actuarial review to ensure risk controls and affordability;
- Migration of existing policies to the Standard Plan requires actuarially sound, equitable, and expedient methods.

In conclusion, changing health insurance market rules can lead to market disruption and adverse selection. The sustainability of VHIS depends on the right balance between attractive product features and risk management. Actuaries with their professional training in evaluating the current financial implications of future contingent events, help measure, manage, and mitigate risks. The ASHK as the local professional organization for actuaries will be happy to develop appropriate guidance notes to support actuarial best practice in this area.

#### **2.4 Analytical Approach**

Our review and recommendations follow the following four principles:

- **Actuarial soundness** of pricing and reserving bases in anticipation of anti-selection and potential behavioral changes as a result of VHIS implementation;
- **Sustainability** of the healthcare financing system to ensure consumers' confidence in VHIS plans and solvency of the insurance industry;
- **Equity** among insurers, current and prospective insured populations;
- **Feasibility** so that proposed requirements can be translated into practical operational and administrative initiatives for implementation.

#### **2.5 Limitations**

- We are not in a position to assess the demographic and financial projections in the Consultation Paper.
- This Response Paper focuses primarily on actuarial issues and recommended changes which, in our opinion, have significant impacts on the feasibility and sustainability of VHIS and constitute necessary conditions for the proposed healthcare reform. We recognize that there are various important success factors, such as healthcare policy or public finance considerations, which are outside the scope of this Response Paper at this particular stage but nonetheless require due attention.
- We have considered relevant actuarial principles, local market development, and international experiences in varying contexts, but have not relied on any database in formulating our responses.

## **2.6 *Organization of Our Responses***

In section 3 we offer responses to each of the questions in the Consultation Paper and recommendations on relevant matters. To help readers better comprehend the connection and dependency between different aspects of the VHIS proposal and our thoughts, we cross-reference relevant sections of our responses. Throughout this Response Paper, the term “section” refers to other parts of the document, not those of the Consultation Paper.



### 3 Responses to VHIS Consultation Paper

#### 3.1 Question 1 Product Regulation

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

Changing health insurance market rules can lead to significant adverse selection. Guaranteed acceptance provisions give individuals the abilities to delay purchasing insurance until they have need for healthcare services, since VHIS policies are purchased on a voluntary basis. Likewise, allowing individuals upon retirement or change of employment to convert from group insurance to the Standard Plan at standard premium rates without underwriting offers incentives to avoid individual purchase of the Standard Plan. The possibilities of such adverse selection may result in younger and healthier individuals opting out of VHIS coverage, leaving a higher risk insured population and higher premiums on average that threaten the sustainability of VHIS, though the limited one-year open enrolment period of the High Risk Pool for individuals above age 40 may alleviate the adverse selection risk to some extent.

Risk controls with further recommended changes within the VHIS framework will help minimize adverse impacts on current and prospective insured populations. As will be addressed in more detail in other sections of this Response Paper, there are areas where the proposed measures need review and modification through the implementation phase to make VHIS feasible and sustainable. Implementation of these recommended changes will help strengthen the viability and long-term sustainability of the proposed VHIS and regulatory regime.

Table 1 summarizes 10 key issues that require clarification.

**Table 1: Summary of areas for clarifications**

#	Clarification	Relevant Minimum Requirement
1	Definition of “Guaranteed Renewal”	Guaranteed renewal
2	Geographic coverage	Coverage of hospitalization & ambulatory procedures
3	Coverage of new or infrequent procedures	
4	Definition of “Hospital”	
5	Definition of “general ward level”	
6	Benefit coverage for accommodation above general ward level	Coverage of hospitalization & ambulatory procedures and Cost-sharing restrictions
7	Coverage of new advanced imaging tests	Advanced imaging & non-surgical cancer treatment
8	Coverage of cancer drug formulary	
9	Determination of minimum benefit limits	Minimum benefit limits
10	Premium tables by age or by age and gender	Premium transparency

Table 2 summarizes 16 recommended modifications or further initiatives, of which 10 are considered as having the most significant impacts on the sustainability of VHIS. We further estimate their respective implementation challenge by high, moderate, and low categories.

**Table 2: Summary of areas for further actions and recommended changes (tabulated in the order of decreasing priority or likely impacts on the VHIS framework)**

#	Recommendation	Minimum Requirements	Group Insurance	High Risk Pool	Migration & Grandfathering	Impact on VHIS *	Complexity **
1	Define acceptance criteria and risk management framework for the High Risk Pool	X		X		H	H
2	Provide insurers with transitional support for covering pre-existing conditions below the loading cap	X				H	H
3	Ensure adequate supply of private healthcare providers	X				H	H
4	Revise Conversion Option with further risk mitigation rules and feasible pre-funding mechanism	X	X			H	H
5	Revise the Portability feature with premium loading in lieu of clean “look back” period requirement	X	X			H	M
6	Follow consistent long-term reserving principles and solvency provision	X				H	L
7	Regulate private healthcare provider charging practices	X				H	H
8	Collect healthcare provider cost data for continuous supervision of VHIS implementation	X		X		H	M
9	Standardize medical claims data for industry-wide analysis	X		X		H	M
10	Revise migration methods for existing policies				X	H	M
11	Revise cost-sharing restrictions	X				M	L
12	Include adequate risk controls in the Standard Plan and subject the plan design to actuarial review	X				M	L
13	Define the qualification criteria for Flexi Plans	X				M	L
14	Define the criteria of Voluntary Supplement plans for tax incentives		X			M	L
15	Use average market premium rates for calculating High Risk Pool premium rates	X		X		M	L
16	Revise the maximum premium loading definition to avoid loopholes	X				M	L
						<b>H</b>	10
						<b>M</b>	6
						<b>L</b>	-
						<b>Total</b>	<b>16</b>
							5
							4
							7
							<b>16</b>

Note:

\* Items representing significant impacts on the sustainability of VHIS: H (high) and M (moderate).

\*\* Estimated implementation challenge: H (high), M (moderate), and L (low).

Ultimately, the feasibility of the proposed Minimum Requirements depends on a sustainable overall VHIS framework that helps shift healthcare delivery from public hospitals to the private sector. The Government should ensure both the quality and cost effectiveness of healthcare delivery, and remain open to ongoing adjustment of the VHIS framework given the threat of price competition from offshore products which are not subject to the VHIS requirements.

### **3.2 Question 2 Minimum Requirements**

*Do you have any particular views on the 12 Minimum Requirements proposed for improving the accessibility, continuity, quality and transparency of individual Hospital Insurance?*

#### **3.2.1 Guaranteed Renewal**

- (a) The definition of Guaranteed Renewal should include the following four attributes:
- i. The insured has the right to renew the policy by paying the applicable premium in a timely manner, without being subject to re-underwriting or re-serving the standard waiting period;
  - ii. The insurer has the right to change premium rates, provided that the rates will change only for the entire portfolio, without consideration of any particular individual's experience or health status, subject to any premium loadings that may be applicable on an individual basis at policy inception;
  - iii. The insurer has the right to change benefits and policy provisions provided that such changes apply to the entire portfolio;
  - iv. The Guaranteed Renewal provision does not affect the insurer's right to terminate the policy due to nonpayment of premium, fraud, misrepresentation or nondisclosure of material facts.
- (b) One critical issue concerns if the Guaranteed Renewal provision is contingent upon the insurer's decision to offer a particular VHIS product, i.e., if the insurer is able to unilaterally terminate a portfolio instead of having to continue renewing all existing VHIS policies until complete run-off. The following comparison demonstrates that the insurer's right to portfolio withdrawal has significant impacts on reserving and solvency requirements.

*i. Scenario One: portfolio withdrawal is permitted*

Since the insurer retains the right to unilaterally terminate the entire portfolio of a particular VHIS product, it is appropriate that VHIS policies are classified as Class 2 (Sickness) of general insurance business and that the insurer does not have to hold long-term reserves in respect of health insurance business.

*ii. Scenario Two: portfolio withdrawal is not permitted*

The Guaranteed Renewal provision in this scenario increases the reserve requirement so that insurers can meet their future obligations in a run-off scenario. In particular, the risk of premium rate spiral (i.e., accelerating premium rate increases due to cumulative anti-selective lapses) in a closed block necessitates additional reserve. It is necessary for VHIS to follow the reserving principles for long-term business, and to involve appointed actuaries to provide recommendations on reserve adequacy and solvency provision. At present, only

insurers writing long-term business are required to have their reserve provisions signed off by appointed actuaries.

Under such circumstances, the Guaranteed Renewal provision confers long-term business characteristics on VHIS and such guaranteed renewable individual policies should be classified as either Class D (Permanent Health) of long-term business under CAP 41 Insurance Companies Ordinance or a new class of long-term business specific to VHIS, instead of Class 2 (Sickness) of general insurance business. Nevertheless, VHIS policies containing only indemnity benefits should not be subject to unrelated long-term business regulation.

To ensure the sustainability of VHIS, we recommend that VHIS should not permit portfolio withdrawal, so that insurers are not allowed to unilaterally terminate a portfolio except for bankruptcy, liquidation, or total exit from health business due to extreme financial distress.

At present, hospital indemnity insurance policies are sold either as standalone policies or as riders attached to long-term policies. As a result, hospital indemnity insurance policies are classified as either Class 2 (Sickness) of general insurance business or various classes of long-term business and are therefore subject to different statutory requirements. We recommend that all VHIS plans including both standalone and rider policies should be subject to the same classification and statutory requirements.

In conclusion, we recommend that all VHIS policies should consistently follow long-term reserving principles and that appointed actuaries are required to provide recommendations on reserve adequacy and solvency provision.

- (c) It is reasonable that the renewal of VHIS policies should not be conditional on the continuation of other insurance policies. This requirement is consistent with our assessment that the Guarantee Renewal provision represents longer durational risk guarantee nature and hence the reserves for VHIS policies should be strengthened accordingly.

### 3.2.2 *No “Lifetime Benefit Limit”*

We support this requirement in principle, provided that the VHIS product design allows adequate risk controls such as appropriate benefit sub-limits and annual overall benefit limit.

### 3.2.3 *Coverage of Pre-existing Conditions*

- (a) This requirement presents significant risks due to the following three reasons:
  - i. Insurers overall do not have claim experience of pre-existing conditions and therefore cannot properly price or reserve for such contingencies;
  - ii. While the group insurance market to some extent covers pre-existing conditions, such experience is inappropriate reference for VHIS products due to significant demographic differences between group and individual markets;
  - iii. The High-Risk Pool and the three-year phase-in waiting period do not mitigate the risks faced by insurers because, in the absence of actuarially sound practice,

competition may lead to under-estimating the cost of covering individuals whose loadings fall below the +200% limit.

In conclusion, this requirement may result in financial distress of insurers that have mispriced the VHIS products and the subsequent need for significant premium increases that affect the entire portfolio.

- (b) To address the risks, we recommend the following three measures:
- i. The Government can offer transitional support for covering pre-existing conditions during the initial years of VHIS implementation (e.g., first three years), in the form of phase-in benefit risk-sharing between insurers, individuals with pre-existing conditions, and the Government. This arrangement allows insurers to offer affordable coverage (at less than +200% loading) to individuals with pre-existing conditions, thus supporting the growth of the VHIS market. In addition, insurers will be able to derive risk-adequate premium rates after credible experience has become available.
  - ii. The Government can assist in quality and timely medical claims data collection both from the High Risk Pool and from the individuals with pre-existing conditions among insurers, by promoting or enforcing standardized medical coding schemes among private healthcare providers and insurers.
  - iii. Each insurer is required to have an appointed actuary to approve VHIS rates so that the risk of financial distress arising from mispricing can be alleviated.

#### 3.2.4 *Guaranteed Acceptance with Premium Loading Cap*

- (a) We support the Guaranteed Acceptance requirement in principle, subject to the following four controls of anti-selection risk:
- i. The three-year phase-in waiting period for pre-existing conditions and, in relation to section 3.2.3 (b) (i), additional support from the Government in the form of a transitional risk-sharing program;
  - ii. Premium loadings up to +200% for individuals in sub-standard health conditions;
  - iii. In relation to section 3.5, premium loading of +200% and transfer to the High Risk Pool for individuals with pre-defined, more severe conditions (all ages in year 1, and age 40 or below from year 2 onwards);
  - iv. In relation to section 3.5, the Government's financial support for the High Risk Pool.
- (b) We support the premium loading limit though, in relation to section 3.5 (c), the proposed +200% level should be further discussed. Furthermore, in relation to sections 3.2.8 and 3.2.9, we recognize that VHIS features also affect cost and utilization and hence the claim costs and premium rates for both insurers and the High Risk Pool.
- (c) In relation to section 3.2.12 (b), we recommend that the +200% premium loading limit should be specified as a 300% maximum difference between the highest and lowest rates that could be charged by respective insurers under the VHIS rating system, to prevent insurers from circumventing this requirement by offering discounts on standard premium rates. In relation to section 3.5 (d), we suggest to use the average

of the highest and lowest rates of all Standard Plan policies charged by the industry, instead of the standard premium charged by any particular insurer, as the basis of premium rates calculation for individuals in the High Risk Pool.

### 3.2.5 *Portable Insurance Policy*

- (a) The rules for individual portability and group-to-individual Conversion Option should be aligned to ensure consistency and sustainability of the VHIS framework. Please refer to section 3.4 (c) for detailed discussion about the relationship between these two features. We conclude that under certain Conversion Option arrangement it is difficult for these two features to co-exist.
- (b) The proposed portability arrangement will not be feasible unless the following three concerns can be addressed:
  - i. The three-year claim-free “look back” period does not offer sufficient risk mitigation for the severe conditions it intends to address (e.g., chronic diseases), since the Standard Plan may not cover outpatient treatment or hospitalization in public hospitals;
  - ii. The nature of claims is not clearly defined because some Standard Plans and Flexi Plans will likely include pre-admission and post-hospitalization outpatient follow-up treatment and there may be considerable differences between different policies due to insurer-specific definition of treatment episodes under the package pricing arrangement;
  - iii. If portability is intended to ensure uninterrupted insurance coverage, the “look back” period is inconsistent with this objective because individuals who have health conditions cannot change insurers if the current insurer is faced with extreme financial distress.
- (c) In addition, we recognize that the portability feature will affect the solvency of multiple insurers:
  - i. If the current insurer is faced with cumulative anti-selection, the portability feature may increase anti-selective lapsation (i.e., the tendency for healthier individuals to lapse results in unhealthy individuals constituting a bigger portion of the portfolio), thus exacerbating the premium rate spiral. Such a phenomenon may be more profound among insurers with smaller, less stable portfolios.
  - ii. The insurer that accepts a transfer policy has to ensure additional reserve due to the impacts of potential anti-selection, accelerated underwriting wear-off, and potential risk under-estimation at original policy inception. Individual-based reserve transfer or information-sharing between insurers is practically infeasible.
- (d) In conclusion, we recommend that the portability arrangement should be simplified to become operationally feasible by removing the “look back” period restriction, provided that the individual who transfers a policy, upon each transfer, will be equitably charged an extra X% of premium onwards. Such extra charges are collected by the current insurer to reserve for its overall expected increase in claim experience due to the portability feature without reserve transfer from other insurers.

The above arrangement is consistent with comparable international practice so that the individual has to pay a price for this feature, in the form of either fees or re-serving the

standard waiting period. Please note that this portability arrangement under VHIS will not affect the standard three-year pre-existing condition phase-in waiting period since original policy inception. In addition, individuals will only be allowed to transfer from Standard Plan or Flexi Plan to Standard Plan.

### 3.2.6 *Coverage of Hospitalization and Prescribed Ambulatory Procedures*

We support this requirement in principle, subject to the following five modifications or clarifications:

- (a) The geographic scope is confined to the Hong Kong Special Administrative Region;
- (b) Coverage of new or infrequent procedures not on the prescribed procedures list should be clarified;
- (c) The terms “hospital” and “hospitalization” should be clearly defined to exclude rehabilitation and other non-acute health care;
- (d) The term “general ward level” should be clearly defined to prevent private hospitals from introducing multiple accommodation levels into this category;
- (e) In relation to section 3.2.9, we request clarification of VHIS benefit coverage and cost-sharing arrangement if the insured is accommodated higher than the general ward level.

### 3.2.7 *Coverage of Prescribed Advanced Diagnostic Imaging Tests and Non-surgical Cancer Treatments*

We support this requirement in principle, subject to the following two clarifications:

- (a) Coverage of new or infrequent advanced diagnostic imaging tests;
- (b) Coverage of the cancer drug formulary, i.e., if the formulary follows that used by the Hospital Authority.

### 3.2.8 *Minimum Benefit Limits*

- (a) It remains unclear how to determine the minimum benefit limits to “provide reasonable coverage for general ward in average-priced private hospitals,” particularly given physician charges constitute a significant portion of medical expenses amid limited supply of private hospital wards and experienced specialists. Furthermore, if charges vary across private healthcare providers, low benefit limits will not offer adequate protection but high benefit limits will result in relentless upward pressure of provider charges while there is nothing to prevent a private healthcare provider whose fees are below the limits from adjusting upward.

In conclusion, we recommend that the Government should ensure adequate supply of private healthcare providers and address current charging practices such as unbundling of fees or arbitrary add-on fees through proper regulation to avoid increasing medical cost inflation.

- (b) In addition, we recommend that the Government should help standardize medical claims data and ensure quality and timely medical claims data collection that forms the basis for determining appropriate minimum benefit limits.

### 3.2.9 *Cost-sharing Restrictions*

- (a) We support this requirement in principle, subject to further discussion about deductible, co-insurance features, and the annual cost-sharing cap.
- (b) As mentioned in section 3.2.8 (b), we recommend that the Government should standardize medical claims data and ensure quality and timely data collection that forms the basis for determining appropriate annual cost-sharing limit.

### 3.2.10 *Budget Certainty*

- (a) We recommend that the role of private healthcare providers should be clarified in alignment with the requirements of insurers; otherwise the expected benefits of this requirement will be largely eliminated. Current provider charging practices such as unbundling, arbitrary add-on fees, excessive lab tests, and falsification of medical records to justify insurance payment should be addressed by proper regulation to ensure feasibility of the package pricing arrangement.
- (b) This requirement presents the most product development and operational challenges among all twelve Minimum Requirements, due to the following three reasons:
  - i. The impact of price transparency (i.e., information about the cost or price of healthcare services available to consumers) depends on the supply and demand of private healthcare providers. It will be difficult to achieve VHIS' objective if package pricing results in a wide price range or packages covering infrequent treatment, or if hospitals and physicians maintain their current charging practices. Overall, the limited supply of private hospital beds and experienced specialists will remain a major bottleneck.
  - ii. The fact that insurers have to individually negotiate with private healthcare providers will likely result in considerable variations in covered procedures, definition of service package, and package price. Such variations will affect VHIS premium rates, utilization of the portability feature and, in relation to section 3.2.11, the extent to which policy terms and conditions can be standardized.
  - iii. The Informed Financial Consent arrangement is operationally infeasible in the absence of readily accessible and up-to-date healthcare provider cost data. In addition, the illustrative outline of the Standard Plan contains benefits on a "per admission" or "per procedure" basis that may increase utilization through more hospital admissions or treatment episodes.
- (c) To address the above implementation challenges, we recommend the following three additional measures:
  - i. The Government should ensure adequate supply of private healthcare providers;
  - ii. The Government should collect healthcare provider cost data to help insurers design economical and medically appropriate treatment episodes and fulfill the Informed Financial Consent requirement;
  - iii. The design of the Standard Plan should be subject to actuarial review to ensure adequate risk controls.



- (d) In conclusion, we recommend that the feasibility and supervision of VHIS implementation should be further discussed to include continuous assessment about the degree to which package pricing arrangement helps manage cost and utilization. The Government will improve the affordability and sustainability of VHIS by collecting quality, timely, and standardized healthcare provider cost data and medical claims data for appropriate analysis of package pricing arrangement.

#### *3.2.11 Standardized Policy Terms and Conditions*

- (a) We support in principle standardization of policy terms and conditions such as benefit schedule, policy provision, definitions, exclusions, and limitations. Flexi Plans may contain additional provisions and divergent benefit schedules, though such differences from the Standard Plan should be clearly marked.
- (b) We recommend that plans should include meaningful additional benefits than the Standard Plan to be considered Flexi Plans.

#### *3.2.12 Premium Transparency*

We support this requirement in principle, with the following four comments:

- (a) Because VHIS offers whole-of-life guaranteed renewal, as a Minimum Requirement we suggest that the published premium rates will cover up to age 99 on an Age Last Birthday basis either by age only or by age and gender.
- (b) In relation to 3.2.4 (c), the standard premium should be defined as the lowest rate that could be charged by respective insurers under the VHIS rating system.
- (c) We recommend that insurers should disclose the reasons for assessing any premium loadings to the customer, who will be allowed to provide supporting evidence to request appropriate adjustment. This practice may lead to convergence of underwriting standards among insurers and help maintain premiums at reasonable levels.
- (d) As mentioned in section 3.2.10 (b) (ii), if package pricing results in significant variations among Standard Plans and Flexi Plans, premium transparency will not ease product comparison for prospective customers.

### **3.3 Question 3 Group Insurance**

*In order to encourage employers to maintain Hospital Insurance cover for their employees, we propose that group Hospital Insurance should not be subject to the Minimum Requirements. Do you agree with this proposal?*

Yes, we agree in principle.

### **3.4 Question 4 Conversion & Voluntary Supplement**

*In order to enhance protection for individual employees, we propose the arrangements of Conversion Option and Voluntary Supplement(s) for group Hospital Insurance. Do you agree with the proposed arrangements?*

- (a) The Conversion Option feature in its current proposed form presents significant anti-selection risks particularly given that insurers are obligated to offer the Conversion Option to all group plans but employers are free to decide if they will purchase it. In addition, the conversions will have the portability right to change insurers under VHIS. This high level of uncertainty carries significant implications to the long-term reserve adequacy for the conversions with higher than average expected medical expenses and thus the long-term sustainability of VHIS. The significantly more preferential treatment of conversions (i.e., individuals who convert at standard rate after one-year employment without underwriting) relative to the acceptance criteria of the Standard Plan for individual applicants also creates substantial perverse incentives.
- (b) To properly manage the associated risks, we recommend the following three significant changes to the current proposal if Conversion Option is required to be offered by group health insurance:
- i. The Conversion Option is only allowed for employees (not dependents) either at the employer's documented retirement age or upon an employee's departure from the employer. Employees are subject to certain conditions such as actively-at-work during the waiting period before becoming eligible for the Conversion Option.
  - ii. The Conversion Option feature is only required for groups above a certain minimum size to ensure sufficient risk-pooling to balance the anti-selection risk and the conversions' higher than average expected medical expenses. To be eligible for the Conversion Option, the group plan should be a non-contributory compulsory plan (i.e., 100% employer contribution to the premium and full employee participation) of an authentic group (i.e., a group not formed for the purpose of obtaining insurance). Group plans that are not insurance based, including employer stop-loss insurance and administrative services only plans, are ineligible for the Conversion Option.
  - iii. The one-year waiting period for the Conversion Option should be changed to three years with the same employer, or be replaced with a three-year phase-in waiting period, to reduce anti-selection or the risk of abuse from false employer groups or false employees. The revised waiting period is consistent with the three-year phase-in waiting period for pre-existing conditions under the Standard Plan.
- (c) We recommend that the Conversion Option should be aligned with the Portability requirement under section 3.2.5, and the reserving framework should be handled in one of the following two arrangements:
- i. *Scenario One: insurers retain the right to price the Conversion Option and to determine the eligible groups*  
  
Under this scenario, insurers will set up their respective reserve funds and be held responsible for proper reserving for later conversion obligations. The conversions will be confined to the same insurer without individual portability so that other insurers are not exposed to potential reserve insufficiency arising from such higher-than-average-cost individuals. Allowing portability for converted individuals will necessitate all insurers to share their customer information for portability validation, thus presenting significant practical difficulties. We

conclude that Conversion Option and Portability are unlikely to co-exist under this separate reserving arrangement.

ii. *Scenario Two: insurers are not allowed to individually price the Conversion Option or to determine the eligible groups*

One feasible approach under this arrangement involves an industry-wide Conversion Risk Equalization Fund to ensure adequate reserve for the claim obligation arising from future conversions.

The reserve is equitably financed by an extra standard Y% of premium on all group members each year (to account for the overall higher cost payable by employers) plus an extra Z% of premium on each converted individual starting from conversion onwards (to account for the higher risk charges borne by the individual), whereas Y and Z will be determined in accordance with the eligibility criteria in section (b).

The Conversion Risk Equalization Fund should be managed by an independent administrator to adjust the appropriate risk charges and to ensure appropriate reserving for the pooled experience of all conversions. An eligible employee may exercise the Conversion Option to any insurer that offers the Standard Plan without incurring a Portability charge, and may subsequently switch insurers in accordance with the Portability provision in section 3.2.5.

The above proposal enables the co-existence of the Conversion Option and Portability features. In addition, an insurer writing group insurance business can satisfy the Conversion Option requirement without itself offering individual VHIS plans.

- (d) We support Voluntary Supplement in principle. Since the proposed Voluntary Supplement coverage is offered on a group basis, it will be an annually renewable policy without the Guaranteed Renewal provision. To encourage individuals to purchase adequate insurance coverage, we recommend that Voluntary Supplement plans should count toward creditable coverage for an employee's tax incentive if the total benefit level of group insurance and Voluntary Supplement meets or exceeds that of the Standard Plan.

### **3.5 Question 5 High-Risk Pool**

*Do you support setting up a High Risk Pool with Government financial support, which is the key enabler of guaranteed acceptance with premium loading cap?*

- (a) We support the High Risk Pool in principle because it is otherwise difficult for the insurance industry to broaden the insured population as long as hospital indemnity insurance is purchased by individuals on a voluntary basis.
- (b) The acceptance criteria for the High Risk Pool should be clearly defined for the following two reasons:
- i. Avoiding substantial influx of substandard risks from insurers' setting low standard premium rates to attract healthy individuals, pricing any other undesirable individuals at +200% loadings, and transferring the latter to the High Risk Pool. Pre-defined acceptance criteria will ensure proper alignment between insurers and the High Risk Pool to optimize judicious use of funds for eligible

- individuals. To help insurers manage the remaining unexpected substandard conditions with loadings below the +200% limit, we recommend in section 3.2.3 (b) (i) transitional risk-sharing arrangement before the claim experience is fully developed under VHIS.
- ii. Early identification of conditions within the High Risk Pool to plan for effective cost containment through appropriate healthcare provider contracting arrangement and care management programs.
- (c) In conjunction with section (b) above, the Government should further adjust the target premium level, which is set at 300% of the average market rate of the Standard Plan, upon VHIS implementation, because of the following three additional considerations:
- i. If the target level is set too high, the High Risk Pool may fail to provide the necessary relief to insurers to effect desired changes under VHIS;
  - ii. If the target level is set too high, too few individuals within the High Risk Pool will not achieve the scale for necessary care management programs and will result in higher claim costs;
  - iii. If the target level is set too low, the Government will have to significantly increase financial support for the High Risk Pool.
- (d) The actual premium charged for individuals within the High Risk Pool should be based on the average market premium rates of all insurers instead of the standard rate of any particular insurer to ensure equity among these individuals. In other words, all else being equal, individuals within the High Risk Pool should be charged the same premium rates at +200% loading regardless of which insurer transferred them into the High Risk Pool.
- (e) Effective management of the High Risk Pool is critical to the sustainability of VHIS and should therefore be further discussed. First of all, standardized and timely patient encounter data with payment information are necessary for continuous assessment of health conditions, treatment, medical inflation, etc. Expert analysis of the data will help us understand utilization patterns, care management outcomes, and the projected long-term financial condition of the High Risk Pool. In addition, the emerging experience of the High Risk Pool is useful reference for insurers to price and manage their morbidity-related insurance risks. Actuaries are specially trained in such analyses and can play a positive role in managing the High Risk Pool. Last but not least, the administration and risk assessment of the High Risk Pool should be performed by a capable and independent third-party administrator.

### **3.6 Question 6 Tax Incentives**

*Do you support providing tax deduction for premiums paid for individual Hospital Insurance policies owned by taxpayers covering themselves and/or their dependents that comply with the Minimum Requirements (i.e., policies of Standard Plan and Flexi Plans); and premiums paid for Voluntary Supplements purchased by individuals on top of their group Hospital Insurance policies?*

We have no specific comments on this question at this stage.

### **3.7 Question 7 Migration & Grandfathering of Existing Policies**

*Do you support arrangements proposed for policyholders of existing individual Hospital Insurance policies who, upon expiry of the existing policies, wish to migrate to VHIS policies (i.e., policies that comply with the Minimum Requirements); and the grandfathering arrangements proposed for existing policies that do not comply with the Minimum Requirements?*

We support migration and grandfathering of existing policies in principle, subject to further review and modification:

- a) It is inappropriate to compare indemnity insurance plans without considering changes in the underlying risk nature (i.e., demographics and medical utilization behaviour) and claim cost distribution.
- b) The proposed migration methods will necessitate full underwriting of nearly every existing policy (i.e., underwriting for incremental benefits or for the removal of existing exclusions) within the one-year migration window. As a simplified alternative, we recommend that all insurers should offer a portfolio-level migration method by reflecting the risk profile and benefit coverage of the existing portfolio as well as the expected migration rate in developing the standard premium rate of respective Standard Plans. Insurers should be permitted to develop respective portfolio-level migration process, provided that the process allows each insured to decide whether to migrate, and that the method is equitable to all individuals in the portfolio. Such flexibility is critical given individual insurers are likely faced with multiple product-specific issues such as varying accumulated no-claim credits at an individual policy level.
- c) The provision to maintain exclusions within migrated Standard Plan policies is confusing. We recommend removal of this inconsistency among VHIS policies in relation to additional transitional risk-sharing arrangement for pre-existing conditions in section 3.2.3 (b) (i).

### **3.8 Question 8 Regulatory Framework**

*Do you support establishing a regulatory agency under the Food and Health Bureau to supervise the implementation and operation of the VHIS; and a claims dispute resolution mechanism for resolving claims disputes under the VHIS?*

We have no specific comments on this question at this stage.

\*\*\* End of The ASHK's Responses \*\*\*

***Appendix A ASHK Council Members***

- Queenie Hui (President)
- Billy Wong (Immediate Past President)
- Ka-Man Wong (Vice President)
- Tony Cheng
- Peter Duran
- Sai-Cheong Foong
- Nigel Ke
- Simon Lam
- Stuart Leckie
- Kevin Lee
- Dr. Louis Ng
- Jeremy Porter
- Simon Walpole

***Appendix B ASHK VHIS Taskforce Members***

- Jack Chan
- Fred Choi
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- Wing-Kin Lo
- Selina Ma
- Ben Ng
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- Lawrence Tsui
- Sam Yeung                   (Chair)
- Wynn timer Yeung