A Review of the Proposed Regulated Voluntary Health Insurance Scheme for Hong Kong

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Abstract

This article reviews the government proposed Health Protection Scheme (HSP) — a voluntary regulated private health insurance scheme — in terms of its ability to significantly mitigate the health care financing problem associated with the aging population in Hong Kong. It examines the attractiveness of the Scheme in terms of its ability to (1) attract employers currently providing varying types of health insurance plans to their employees to migrate their plans to HSP; and (2) attract individuals and families, especially elderly persons, to subscribe to and remain in the Scheme. The analyses show that it is not likely that the Scheme is able to attract enough individual or group subscribers so as to divert demand from the public sector to the private sector in a significant manner. The article proposes the setting up of a government health care fund for public hospitals as a more effective way in dealing with the health care financing problem as result of population aging.

Introduction

While many countries in the Far East implemented substantive reforms in their health care financing systems in 1980's and 1990's, Hong Kong did not. Singapore, for example, introduced medical savings account and major illness insurance in the eighties (Lim 2004); South Korea and Taiwan both established national health insurance systems in the eighties and nineties respectively (Kwon 2008, Lu & Chiang 2011). These reforms aim to provide universal access to health care services and at the same time move the system away from being too reliant on general taxation to finance health care.

In Hong Kong, the bulk of specialist and inpatient care is financed and delivered through the public sector. The Hospital Authority, a statutory autonomous public corporate body, owns and manages over 40 public health care institutions, providing over 90 percent of all hospital beds in Hong Kong. Institutions under the Hospital Authority provide a comprehensive range of services at a heavily subsidized rate. The Hospital Authority receives over 90 percent of its income from the government's general revenue. All Hong Kong

residents are eligible to receive care from public hospitals and clinics at a heavily subsidized rate. Patients in public hospitals pay a fixed per diem fee of HK$100, which covers less than 4 percent of the actual average cost of a patient day in an acute public hospital. The per diem fee is all-inclusive with the exception of a short list of the "Privately Purchased Medical Items (PPMI)" which the patients have to pay the full cost separately (Yuen & Gould 2006).

Private hospital services are financed privately in the form of direct payment or through private health insurance. Currently, private hospitals deliver less than 10% of total inpatient care, despite the fact that close to 2.4 million persons (34% of the population) have private health insurance either through employment or purchased individually (Food & Health Bureau 2010, p.72). As with most private insurance plans, premium is "experience rated" - increases with age and with claim history. The elderly and persons with pre-existing and chronic conditions are either excluded or subjected to prohibitively higher premium. Employers often spend more for outpatient benefits than hospitalization benefits (Gainmiles 2011, p. 110-111) Many plans purchased by individuals are indemnity plans, providing a mere few hundred dollars a day in the event of hospitalization. In short, the majority of these private health insurance plans do not provide adequate hospitalization protection, resulting in the situation whereby the majority of persons with private health insurance end up in public hospitals to receive care in the advent of major illnesses. The situation is clearly not satisfactory.

Many, including the Hong Kong Special Administrative Region (SAR) Government, fear that the current financing pattern will not be sustainable in the long run in view of medical inflation and the aging population (Food & Health Bureau 2008).

The Health Protection Scheme

After a series of consultation activities, the Hong Kong SAR Government proposes the implementation of a government-regulated voluntary private health insurance scheme the Health Protection Scheme (HSP) as the way forward. The key features of the Scheme are described below (Food & Health Bureau 2011).

Nature and Governance: Participation in the Scheme will be voluntary for both insurance providers and subscribers. Private insurance companies enrolled in the Scheme will be subjected to a set of regulations including requirements such as no refusal and lifetime coverage for subscribers, and guidelines on premium, benefits, transparencies, providers quality requirements, and arbitration procedures. The Scheme will be supervised by the Commissioner of

Insurance, and eventually governed by a statutory body. The Department of Health will be responsible for accrediting participating hospitals. Payment to providers will be based on case-mix or fixed fee schedule. While individuals and employers will not be required to join, government subsidies will be provided to young persons and to high risk individuals as incentives. Government intends to use the HK$50 billion earlier earmarked for health financing reform to set up the infrastructure and to provide subsidies.

Benefits: The Scheme covers expenses incurred in hospitals (general ward class) and some day procedures. There will be deductibles and co-payments — the first $10K incurred will have to borne by the patient; thereafter, the patient will have to pay 20% co-payment for the next $10K and 10% for the rest. General outpatient services, prevention and early detection services will not be covered.

Subscribers: Both groups and individuals can subscribe to plans under the Scheme. The Scheme will allow migration from existing plans. The maximum entry age is 65, and all subscribers will be guaranteed renewal for life. Persons with pre-existing conditions will also be allowed to join with delayed and reduced benefits for those pre-existing conditions (e.g. 25% after the 2nd year; 50% after 3rd year).

Premium: Premium will vary with age, and can be further adjusted at regular intervals as a result of medical inflation and utilization. There will be a maximum loading for high risk individuals — 3 times the normal premium for that age group. Government will provide subsidies to the high risk pool in the event the capped premium proves to be insufficient. Government intends to provide some subsidies to young subscribers as well as incentives for younger persons to join.

Evaluation

The following sections will assess the Scheme in terms of: (1) its ability to attract enough subscribers so as to ease the demand for public hospital services in a significant manner; (2) its ability to mitigate the health care financing problem in the next two decades caused by the aging population.

Group Subscribers: Whether the HSP can attract large numbers depend very much on whether employers will be willing to migrate their existing health insurance plans to HSP. This would very much depend on whether premium under the HSP is competitive as compared to their existing plans, and whether the benefits under the HSP are considered desirable from the point of views of the employees. The indicative benefits and premium of the HSP are compared with comparable median benefits and premium of existing plans provided by

employers for their general staff, based on a survey of 409 companies from 10 business sectors covering 35,678 employees conducted in 2011 (Gainmiles 2011). Table 1 summarizes the comparison.

Table 1: Benefits and Premium of Existing Plans vs HSP

	Existing Plans for General Staff[1] (Median)	**HSP**
Benefits		
General Outpatient	30 visits	None
Hospitalization		
Daily Room & Board	$525	$550
Daily Doctor's fee	$500	$650
Maximum days	60 per disability	180 total
Surgical limit	Surgeon's fee for complex procedures : $33,000 Anesthetist's fee : $9,983 Operating theatre : $9,900	$50,000
Premium (Annual)		
General Outpatient	$1,623	N.a.
Hospitalization	$912	Age 30-34: $1,290[2] 40-44: $2,000[2] 50-54: $2,710[2] 60-64: $4,070[2]

1. Returns from the Survey indicate that 67% were "general staff", 6% were "key executives", and the remaining 27% were "supervisory staff".

2. With $10K deductible

The Survey indicates that most employers with health insurance provide both outpatient and hospitalization benefits. HSP covers only hospitalization and some ambulatory procedures. **The comparison also shows that the** hospitalization benefits under HSP are comparable to the median figures of the existing plans for general staff in terms of daily room and board, daily doctor's fee, maximum hospital days and surgical limits. However, the premium of HSP is much higher than the median of existing plans for all of the age groups. Migration from existing plans to HSP would mean higher cost to the majority of employers. It is, therefore, likely that many employers will not choose to migrate.

Individual Subscribers: An important goal of the HSP is to attract older individuals to join and remain in the Scheme. Figures from Hong Kong show that a person aged 65 or above used on average six times more in-patient care in terms of public hospital bed-days than a person aged below 65. The number of elderly persons (aged 65 or above) will double from the present roughly one in eight to one in four by 2033 (Food & Health Bureau 2008, p.3). It is, therefore, of vital importance that HSP is able to include a significant number of elderly persons under its plans in order to alleviate pressures on public hospitals in a meaningful manner. Measures to attract and retain elderly subscribers include (1) guaranteeing policy renewal regardless of age, (2) capping premium for high-risk individuals at three times that of the premium for the normal age group, and (3) providing coverage (with delayed and reduced benefits) for pre-existing conditions.

The adequacy of these measures to draw and retain a significant number of elderly persons is highly questionable upon closer examination of other features of the HSP. As HSP practices 'experience-rating', premium will be largely determined by the age and health status of the subscriber. According to the "Indicative Premium Schedule" of the HSP, the premium for a relatively healthy person aged 65-69 for a standard plan with HK$10K deductible is HK$5,000, whereas the premium for a person aged 30-34 for the same plan is HK$1,290 (Food & Health Bureau 2010, p.70). In other words, the premium that a healthy elderly person has to pay is 3.8 times that of a young person. Moreover, many elderly persons will have conditions which will render them to be classified as high-risk individuals, who will be subjected to even higher premium. Many will also have pre-existing conditions, which will further increase their out-of-pocket payment in the event of hospitalization. While HSP caps the premium for high-risk individuals at three times that of the premium for the normal age group, a high-risk elderly person will still be paying more than 11 times the premium of a young person. Persons over the age of 65 are often retired individuals with no regular income. Many will find such premium level unaffordable. Furthermore, HSP requires deductible and co-payment for every hospitalization episode in amount of tens of thousands of dollars. Many retirees, especially high-risk individuals that require frequent hospitalization, are likely to find such out-of-pocket payment unaffordable or undesirable when public hospital services are still available at an all inclusive fee of HK$100 a day. Those elderly persons who find HSP premium and out-of pocket payments affordable are likely to be well-off, and have the means to purchase existing private health insurance products in the market or to pay the expenses out their own savings even without HSP.

A report (Mercer 2011) models the health care costs of three Hong Kong families with and without HSP: Family-1, healthy family without the need for

any hospitalization; Family-2, relatively healthy family but with two elderly family members requiring two not serious hospital admissions; and Family-3, an unfortunate and sick family, with two elderly members with moderate chronic conditions, one elderly member with cancer, and two younger members hospitalized for not so serious conditions. The simulation shows that (a) Family-1 would be financially better off without HSP; (b) Family-2 would only be marginally better off financially with HSP, but would still incur more than HK$130,000 in HSP premiums and out-of-pocket costs per annum; and (c) Family-3 would clearly benefit from having HSP, but the family will still incur in excess of HK$337,000 a year in terms of premiums and out-of-pocket costs. Given the above, even for families which could benefit from taking up HSP, the associated costs would probably discourage many from subscribing.

In short, it is not likely that large numbers of working-age persons covered by employer sponsored plans will wish to migrate from their existing plans, which include outpatient services and cheaper hospitalization, to a more expensive hospitalization only HSP. It is also not likely that large numbers of individuals, especially elderly persons, will subscribe to HSP and will want to continue to subscribe using their own money after retirement, when premium is high and out-of-pocket payment for every hospitalization episode is also high. The impact of HSP to ease the pressure on public hospitals and to lighten the Government's health care burden is, therefore, not likely to be significant.

The Way Forward

Aging Population and Pay-as-you-go Systems: It is a known fact that insurance and taxation are pay-as-you-go systems, which are ineffective in tackling health financing problems arising from aging population. Main contributors to insurance and taxation are working-age individuals, whereas those who needed the services most are retirees. On the average, an elderly person consumes roughly six times the resources of a non-elderly person (Food & Health Bureau 2008, p.3), and most elderly persons do not contribute much in the form of income tax or insurance premium payment. Pay-as-you-go systems are effective health financing mechanisms if the population age structure remains more or less the same over time. However, for Hong Kong, where the percentage of elderly will double by 2033, even with the implementation of the HSP, taxes and HSP insurance premium will have to be increased very substantially in order to be viable.

Aging Population and Individual Savings Accounts: It is also a known fact that savings is the most desirable financing mechanism for an aging population. Mandatory medical savings accounts require young people with income and

little need for expensive health care services to put aside a percentage of their income every month and accumulate a significant sum of money to pay for their own health care expensive after retirement. Elderly persons with savings accounts will not be a burden to the younger generation, even if the percentage of elderly increases significantly. However, the political climate and constitutional arrangement in Hong Kong is such that it is almost impossible to implement mandatory medical savings schemes at this stage public consultations indicate that the public is not in favour of mandatory schemes (Food & Health Bureau 2010, p.7), and the Administration does not command enough votes in the legislature to push through unpopular programmes.

Aging Population and Public Savings: While it is not possible for Hong Kong to implement mandatory individual savings accounts, the same effect can be achieved through setting up of a public savings fund earmarked for health care purposes in the future. An earlier proposal (Bauhinia Research Centre 2007) recommended three percent of salary of wage-earners as contributions to the proposed individual mandatory savings account. Three percent of salary of all wages is roughly HK$11 billion in 2011. As pointed out above, Government has earlier earmarked HK$50 billion for health care financing reform, and the Secretary for Food and Health Bureau intends to use the sum to provide subsidies to HSP (Food & Health Bureau 2011, p.69). Instead of spending the money to subsidize private health insurance, the sum should be set aside as seed money for this public medical savings fund. HK$11billion should be injected to the fund every year. A larger injection should be made during the year when Government experiences large budget surplus. The Fund can be used to supplement income of public hospitals on the top of the regular recurrent subvention from Government to meet the additional requirements as a result of the aging population. This approach will not require individual contributions, and therefore will be politically much more feasible.

Conclusion

The above analysis shows that the government proposed HSP is not likely to be able to significantly mitigate the health care financing problem associated with the aging population in Hong Kong. The Scheme in is not likely to be able to attract sizeable number of elderly persons to subscribe to and remain in the Scheme. The Scheme is not likely to attract employers currently providing varying types of health insurance plans to their employees to migrate their plans to HSP. The Scheme will not be able to divert demand from the public sector to the private sector in a significant manner. A better and more feasible approach is for government to set up of a public health care savings fund for public hospitals to supplement regular subvention when population aging becomes more severe.

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