Chapter 13 SUPPLEMENTARY FINANCING OPTION (6) - PERSONAL HEALTHCARE RESERVE

Personal Healthcare Reserve as Supplementary Financing

13.1 With a view to inducing changes in the healthcare system that would enhance its long-term sustainability, and having regard to the experience of overseas economies over different financing options, we have also explored the option of a Personal Healthcare Reserve (PHR) Scheme as an additional financing option in the context of Hong Kong's healthcare system. PHR seeks to combine the desirable features of medical savings accounts and regulated private health insurance, while allowing room for a certain level of subsidization by the Government.

13.2 The basic concept of a PHR is to require those above a certain income level in the working population to deposit a fixed percentage of their income to their own PHR account for the purpose of financing their own healthcare, with the following features –

(a) **Health protection scheme**: the PHR will serve as a healthcare protection scheme for its participants both during their working life and after their retirement[13], by affording them the following two layers of protection –

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[13] For instance, if a PHR scheme is applied to those in the working population aged 18-64 with income above a certain specified level, it is envisaged that an individual will save and use the deposit under the PHR scheme as follows –

(1) <u>During age 18-64</u> –
   a. the individual will save a fixed percentage of his/her income to his/her PHR account for as long as he/she is employed with income above the specified level;
   b. the individual will stop saving to his/her PHR account when he/she ceases employment (e.g. change jobs or stop working), or when his/her income is below the specified level;
   c. the individual will be required to subscribe to a regulated medical insurance scheme and the premium will be deducted from the deposit in his/her PHR account, for as long as there is still deposit, even while he/she may be out of employment temporarily;
   d. the individual will no longer be required to subscribe to the regulated medical insurance scheme after he/she has exhausted the deposit in his/her PHR account, say when he/she has ceased employment for a long period, though he may continue to subscribe the insurance on a voluntary basis using his own funds; or
   e. the remaining deposit will be accrued in the individual's PHR account through investment for meeting his/her future healthcare needs, and the deposit could not be used before 65 for purposes other than paying for the regulated medical insurance premium.

(2) <u>Age 65 and after</u> –
   a. the individual will no longer be required to save his/her income to his/her PHR account even if he may still remain in employment with income above the specified level;

(i) to use part of the PHR deposit to subscribe to a compulsory regulated medical insurance scheme (see sub-paragraph (c) below) to provide basic and continuous healthcare protection at all ages, both **before and after retirement**[13]; and

(ii) to accrue the remaining deposit in the PHR account through investment, to meet one's own future healthcare needs and pay for healthcare expenses **after retirement**[13] (including insurance premium, insurance co-payment and other out-of-pocket healthcare expenses).

(b) **Scope of application**: the PHR scheme is intended to apply to those whose income is above a certain level. The Scheme will allow these participants the option to extend voluntarily the protection offered by the Scheme to their family members.

(c) **Regulated medical insurance**: all PHR holders with deposit in their PHR account (including those who are no longer required to save, such as those after their retirement) will be required to subscribe to a regulated medical insurance scheme. This scheme addresses a substantial number of shortcomings of voluntary private health insurance in the following ways –

(i) **Flat rate premium for all ages**: the basic insurance will be regulated to charge community-rated premium for all participants irrespective of age, gender and health conditions. The flat premium rate for the basic insurance would mean that the insured who suffered from illnesses would not have their insurance premium drastically increased after major claims. This would enable the high-risk population (e.g. patients with chronic illnesses or elderly patients) to get and stay insured. The cost for the basic insurance may also be subject to regulation for it to operate solely on a cost-recovery basis. This together with the large insurance pool would ensure a premium that is lower in general than that of voluntary medical insurance of similar

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b. the individual will be required to subscribe to a regulated medical insurance scheme and the premium will be deducted from the deposit in his/her PHR account, for as long as there is still deposit;
c. the individual will also be able to use the deposit in his/her PHR account to pay for other day-to-day medical expenses, and any remaining deposit will continue to be accrued in his/her PHR account with investment; and
d. the individual will no longer be required to subscribe to the regulated medical insurance scheme after he/she has exhausted the deposit in his/her PHR account, but depending on the design of the scheme he/she may be allowed to continue to subscribe to the insurance voluntarily using his/her own funds.

coverage currently available in the market.

(ii) **Essential and continuous coverage at all ages**: the insurance can be regulated to provide its participants with no exclusion of pre-existing medical conditions, guaranteed acceptance and renewal, portability between employment, and continuity beyond retirement age. Various coverage designs are possible, for instance:

- essential in-patient services only;
- essential in-patient services and long-term medications;
- essential hospital and specialist services as well as long-term medications, specialized drugs; or
- essential treatment for catastrophic illnesses.

The scope of services and level of benefits to be covered by the basic insurance will be subject to further design having regard to the views of the community on this supplementary financing option, as well as what essential services they would like to see protected by insurance. In this regard, it is not recommended to cover general out-patient services under the regulated medical insurance. This is because the risk of requiring such services is rather evenly spread among the vast majority of the population (i.e. most individuals would be using such services), and thus there is little risk-sharing effect in subscribing an insurance to cover such services. Such services are also relatively more affordable to the public, and for which voluntary top-up insurance can be purchased as necessary.

Claims payouts under the regulated medical insurance for healthcare services may be subject to co-payment or deductibles as appropriate to ensure judicious and responsible use of healthcare. Insurance companies may offer on profit-making basis different optional top-up insurance for participants to choose to suit their needs.

(d) **Government financial incentives**: as mentioned in paragraphs 6.16-6.17, the Government will examine, inter alia, how financial incentives can be provided for the participants of the PHR scheme, in return for their taking a greater share of responsibility for their own healthcare. The financial incentives may take different forms, for example, tax deduction for deposits made to PHR account (for oneself and for family members), or one-off government contribution to PHR account as start-up capital. The

form and amount of the financial incentives will be subject to further design.

(e) **Choice of healthcare services**: The PHR scheme will enable its participants to have a choice of various personalized healthcare services in the private sector, through the regulated medical insurance and any top-up insurance individuals may choose on their own. The participants may also choose healthcare services in the public sector, in which case the insurance will be charged the full cost for the public services used, subject to any applicable co-payments or deductibles, in the same way as the insurance would be charged for private sector services used by the insured. The participants may choose to use private services in public hospitals, or they may access general class public services, in the same manner as with other uninsured patients, through the same queuing and triage mechanisms. The former services are currently charged on a full-cost-recovery basis. If they choose the latter services, they will only need to pay out-of-pocket the standard fees of public hospital services. Since the participants have been insured up to a certain level that enables them to afford private sector service, in the case of choosing public sector service they may still prefer private services in public hospitals to general class services.

(f) **Public healthcare safety net**: if a participant in the PHR scheme uses public services and the cost exceeds the applicable benefit limits of the insurance, or if the participant has already exhausted the benefit limits of his/her insurance, the cost would continue to be borne by the public sector.

(g) **Second safety net**: consideration may also be given to introducing a second safety net for participants in the PHR scheme, by allowing an individual participant who has used healthcare services beyond his/her insurance benefit limit to access private services in the public sector at a lower rate, e.g. a rate set at a certain percentage of the cost or a rate capped at a certain percentage of the participant's household income. This second safety net provides those participants in the PHR scheme who have taken a greater share of responsibility for their own healthcare needs through supplementary financing, but who have unfortunately exhausted their insurance (e.g. due to catastrophic or complex illnesses requiring costly treatment) an extra option to access private services provided by the public sector with more choice and better amenities at lower fees than normally charged, apart from reverting to the basic safety net of general class public services.

13.3 The concept of a PHR comprising a combination of a savings component and an insurance component and involving a specified group of the population is a new concept. We propose this concept in the light of experience of savings schemes and insurance schemes in overseas economies, and having regard to our own circumstances, especially the need to reform our own healthcare system to address the public-private imbalance, the limited choice in healthcare for the community, and inadequate healthy competition in the healthcare market. We believe that the PHR concept is a worthwhile concept to explore to address the need for supplementary financing, as well as to drive the market structure reform to the healthcare system.

Financing Implications

13.4 It is worth emphasizing again that the concept of a PHR scheme is explored as a **supplementary financing**, i.e. financing means for healthcare to supplement government funding which will continue to increase and will remain the primary funding source for healthcare. In particular, the public healthcare system will continue to be funded predominantly by government funding and will continue to provide a safety net (see Chapter 5) for the population, under the policy that no one should be denied adequate healthcare through lack of means.

13.5 The supplementary financing that could be made available through the PHR scheme, which in turn affects its viability, depend on the following design parameters of the Scheme –

(a) **Size of PHR population**: The greater the size of the population to which the PHR scheme is applied, the larger the reserve as potential financing for healthcare from the individual participants, and also the bigger the base for the regulated medical insurance which could ensure effective pooling of risks and lower insurance premium. The size of the PHR population is determined by the criteria defining mandatory participation in the PHR scheme.

For example, if the scheme were to apply to those in the present working population earning a monthly income at a certain level or above, the number of mandatory participants in the PHR scheme would be as follows –

Monthly income	Number of mandatory participants
$10,000 or above	1.70 million
$12,000 or above	1.39 million
$15,000 or above	1.07 million

(b) **Rate of deposit to PHR**: the higher the rate, the larger the reserve available to individual participants to finance their own healthcare, and also the greater the security of financing available to meet healthcare needs after retirement. On the other hand, to avoid the building up of excessive reserve, the deposit could be subject to a cap, i.e. a maximum income for deposit.

For example, for an individual who started contribution at the age of 25, the amount of deposit that would be accrued in his/her reserve by the age of 65 taking into account salary progression (based on the salary progression factor of a male worker at different age from 25 to 64) and assuming no withdrawal from reserve before 65 (in today's dollar terms, excluding inflation, at 3% real investment return, and monthly income for contribution capped at $30,000) is estimated as follows –

Starting monthly income	Accrued savings between age 25 to 65 at contribution rate		
	3%	4%	5%
$10,000	$525,000	$699,000	$874,000
$12,000	$624,000	$832,000	$1,040,000
$15,000	$747,000	$996,000	$1,245,000

(c) **Coverage of regulated insurance**: a major part of an individual's PHR deposit will be channelled into the healthcare system to fund his own healthcare through the mandatory regulated medical insurance. The design of the regulated medical insurance and in turn its premium will thus determine to a large extent the amount of supplementary financing that would be made available through the PHR scheme, and the amount of reserve left in the individuals' PHR account for future use.

We have conducted an actuarial study on the level of premium for a mandatory insurance scheme with the features in paragraph 13.2(c) above, covering in-patient services, specialist out-patient services, and long-term

western medications (e.g. those for chronic illnesses), and with benefit coverage pitched at 80th percentile of the current benefit levels of private medical insurance claims (i.e. 80% of claims for private in-patient services at the general ward level would be within the benefit limits of the insurance). Assuming that the PHR scheme is applied to those in the working population with income above a certain level, and all participants (including the working population below age 65 with income above a certain level, plus those retired persons who have joined the PHR scheme before age 65 and have positive savings in the PHR) subscribe to the regulated medical insurance, the estimated premium level and the resultant amount of accrued deposit in the PHR at age 65 of an individual who started contribution at age 25 (same assumptions as in (b) above) are as follows –

Starting monthly income (no. of scheme participants)	Initial monthly premium*	Accrued savings between age 25 to 65 at different contribution rate (after premium deduction)		
		3%	4%	5%
$10,000 (1.70 million)	$293	-$206,000	-$31,000	$144,000
$12,000 (1.39 million)	$296	-$114,000	$94,000	$302,000
$15,000 (1.07 million)	$300	-$1,000	$248,000	$496,000

*Note: premium level is affected by number of participants – in general a smaller number of participants will result in a higher premium level.

It should be noted that –

(i) If government subsidies are provided as financial incentives to participants in the PHR scheme (see paragraph 13.2(d) above), the amount of the accrued savings is expected to be higher.

(ii) The initial premium is expected to be higher if the scheme is applied to those with a higher income who constitute a smaller size of mandatory participants with different age profile.

(iii) The premium is expected to increase over the years due to the increasing age profile of the participants in the insurance and rising medical costs. The premium progression will also be affected by

changes in utilization.

(iv) It is expected that at a lower contribution rate, those with lower income may not be able to accrue sufficient deposit in their PHR accounts to continue to purchase the regulated medical insurance for a very long period due to increasing premium (shown as deficit above).

(v) If the regulated medical insurance is designed with less coverage and hence lower premium, the amount of accrued deposit in the PHR account will be larger, though at the same time the PHR scheme would provide less amount of supplementary financing for healthcare, and the benefits offered by the scheme to the insured would also be less.

13.6 We have estimated that, if the PHR scheme were to be implemented in 2011 and applied to the 1.70 million working population currently with monthly income at $10,000 or above, initially the scheme should be able to provide some $6.0 billion supplementary financing for healthcare, amounting to 10% of government budget on health. The amount and proportion of supplementary financing would gradually increase as the insured population becomes older and takes up a greater share of the healthcare needs of the population. It is expected that by 2033, PHR could provide supplementary financing representing an extra 22% on top of government budget on health. This has not discounted any financial incentives that may be provided by the Government to the participants.

13.7 For individual participants, the PHR scheme would enable them to have medical insurance protection and choice of services both before and after retirement. Since most individuals' salary should increase over their working life, it is expected that the amount of reserve of individual participants would enable them to enjoy the benefits of continued insurance coverage for a substantial period after retirement. For those whose salary stayed at the minimum level throughout their working life, they may have a smaller reserve that could not last for long. It remains possible that individual participants may not have sufficient reserve to last until their death. For these individuals, the insurance scheme could be designed to allow them to continue to purchase the insurance using their own resources, and the community-rated premium design of the insurance would make it affordable to them even at an advanced age. For those who do not want to continue to purchase the insurance or who do not have the means to do so, the public healthcare system will continue to serve as a safety net for them.

Overseas Experience

13.8 In Singapore where a medical savings account scheme (the Medisave) has been implemented, the government has introduced an insurance scheme for catastrophic illnesses (the Medishield) in order to enhance the risk-pooling effect of the arrangement. The Medishield premium is to be paid using savings in the medical savings accounts. Participation in Medishield is voluntary in principle, though in practice under an opt-out arrangement where participation is automatic unless the individual chooses to stay out of the scheme, very few people are not covered by the insurance. The high level of co-payment (at least 20%) in Singapore's public healthcare services also makes the catastrophic insurance more attractive. It should be noted that the premium of the Medishield scheme is not community-rated, but increases with age.

13.9 While mandatory health insurance is implemented on a population-wide basis in Switzerland and the Netherlands, the concept of a PHR, on the other hand, is to apply the scheme only to those who can better afford contributions. This is not dissimilar to the insurance scheme promoted in Australia. Although the insurance scheme in Australia is in principle a voluntary insurance scheme, various policy measures are put in place with a view to ensuring high penetration of the insurance scheme among those who can afford it.

Advantages as Supplementary Financing

13.10 We believe that the PHR scheme can bring benefits to everyone in the community in the following ways –

(a) **For those who have joined the PHR scheme**:

(i) **Continued protection:** the PHR scheme will provide individual participants with guaranteed insurance both before and beyond retirement, and at the same time a means for them to accrue savings through investments for their own healthcare needs after retirement.

(ii) **Better insurance and choice**: the regulated medical insurance provides community-rated premium with no exclusion of pre-existing medical conditions for everyone who joins through effective pooling of risks, and will enable participants to access a greater variety of more personalised choices for healthcare services in both private and public sectors apart from the government-funded safety net.

(iii) **Safety net**: the public healthcare safety net will remain available to the

participants in the PHR scheme at all times. Consideration could also be given to providing them with a second safety net through the public healthcare system so that they would have an extra option should they fall through their insurance for instance due to complex illnesses requiring costly treatment.

(b) **For those who have <u>not</u> joined the PHR scheme**:

(i) **Improved public services and safety net**: the PHR scheme will enable a substantial portion of the population to meet their healthcare needs through insurance-paid healthcare in the private sector (or private services offered by the public sector which will be charged at-cost), thereby relieving the pressure on the public healthcare system. This would help shorten the existing queues and waiting time in public hospitals, and make public healthcare services more accessible to those who have to rely on the public healthcare safety net. Reduced pressure on the public healthcare system would allow resources to be devoted to the priority areas of public healthcare services, including those for the low-income families and under-privileged groups. It would also allow room for improving standard public services and extending the safety net.

(c) **For the healthcare system as a whole**:

(i) **Sustainability**: the PHR scheme will secure a substantial pool of funding that can be tapped as supplementary financing source apart from government funding to finance future healthcare, thereby reducing the demand on future public expenditure and burden on future generations, and sustaining the continued development of the healthcare system, including continued investment in medical technology and training of healthcare manpower.

(ii) **Stability**: at times of economic downturn, the savings (for those after retirement) and the insurance (for all) can help sustain the participants with healthcare protection, without having to offload all the pressure for healthcare onto the public healthcare safety net.

(iii) **Address public-private imbalance**: by ensuring that a substantial portion of the population would have the means to access private healthcare services through effective risk-pooling, the scheme could help redress the current public-private imbalance and promote healthy

competition between the two sectors.

13.11 Introducing the PHR scheme would combine some of the advantages of mandatory health insurance and medical savings accounts as set out in paragraph 10.11 and paragraph 12.12 respectively. Moreover, the PHR scheme would also have the following additional advantages not available through either medical savings accounts or mandatory health insurance alone –

(a) **Complementary savings and insurance**: the regulated medical insurance could address the disadvantage of not having any risk-pooling under a pure savings scheme, and provides a way to making use of regular and predictable withdrawal of savings to provide healthcare protection before retirement without having to forego the benefits of accruing reserve in the PHR account through investments. At the same time, the reserve account could address the disadvantage of mandatory private health insurance that does not make provision for future healthcare needs, and would allow the insurance protection to continue even if the participant is temporarily out of employment.

(b) **Sustainable and stable financing**: with a guaranteed and predictable participation, and the feature of saving for future healthcare needs, the PHR deposits together with the regulated medical insurance would provide a stable and sustainable source of supplementary financing for healthcare.

Disadvantages as Supplementary Financing

13.12 The concept of a PHR scheme has its share of disadvantages, some of which are inherited from those of medical savings accounts and voluntary/mandatory private health insurance –

(a) **Incur administration costs and other costs for both insurance and savings**: the contribution to the PHR accounts, the regulated medical insurance, and disbursement of reserve from the PHR accounts to pay for healthcare expenses will all entail administration costs. The administration costs for the collection of deposit and administration of PHR accounts can however be minimized by making use of the established MPF framework, where there would be synergy and economy of scale, and measures are already being taken to reduce the administration costs of the MPF. The administration costs of the insurance can be reduced by regulating the insurance to control administration costs and to ensure that it operates on a

cost-recovery basis, provided there is a sufficiently large pool to achieve economy of scale in administration. The administration cost for disbursement of medical expenses is unavoidable, but there would be synergy if the disbursement is to be administered by the insurer alongside processing of insurance claims.

(b) **Regulatory costs**: the government will need to put in place stringent regulatory measures for both the PHR accounts operation and the regulated medical insurance. The regulatory costs for the PHR accounts operation could be minimized by making use of the established MPF framework, without having to set up an extra layer of regulatory framework. However, regulation of medical insurance will still require a separate regulatory framework, which also entails cost and intervention in the currently free market of voluntary private health insurance.

(c) **May encourage tendency to overuse healthcare**: like other financing options involving insurance or other third-party-pay, the PHR scheme may also have the effect of encouraging a tendency to overuse healthcare. As in the case of mandatory health insurance, however, the behaviour of the insured under a mandatory insurance scheme can be better controlled through design of the scheme in terms of coverage (e.g. to cover services less easily abused) and other rules for claims (e.g. by requiring higher co-payment or deductible for services that may be subject to abuse) to minimize the potential of abuse or overuse.

(d) **Increasing premium over time**: notwithstanding the putting in place of control measures including co-payment or deductible or other measures, the utilization and costs of healthcare services may still increase as a result of the introduction of the regulated medical insurance, partly because of the heightened expectations for healthcare under the insurance, and partly because of the incentives of the private sector to over-supply healthcare services. Even if the healthcare utilization and cost could be effectively controlled, the premium for the insurance would still escalate as the healthcare needs of the insured population increase, due to ageing population and medical inflation.