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LOCAL MARKET SITUATION AND OVERSEAS EXPERIENCE OF PRIVATE HEALTH INSURANCE AND ANALYSES OF STAKEHOLDERS' VIEWS

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CHAPTER 1

REVIEW OF HONG KONG PRIVATE HEALTH INSURANCE MARKET

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SECTION 1.1: INTRODUCTION

Scope of Work

The Food and Health Bureau ("FHB") has commissioned a series of studies to devise a proposal for a feasible incentivised voluntary Health Protection Scheme ("HPS", "the Scheme"), guided by the policy direction in the Chief Executive's Policy Address 2009-10 to propose a supplementary health care financing option based on voluntary participation with insurance and savings components for the second stage public consultation on health care reform. Milliman Limited ("Milliman") has been appointed by FHB to carry out a background research study about private health insurance ("PHI"), entitled "Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views".

As part of this study Milliman is to conduct a review of the current markets of health care and private health insurance ("PHI") services in Hong Kong based on the readily available sources of information, statistics and data, focusing on:

- the degree of competition,
- measures to deal with information asymmetry, moral hazard and adverse selection,
- PHI product offering and participation by both individuals and employers, and
- funding of health care services by PHI in the market,

The express purpose is to provide a frame of reference for designing the Scheme features.

Caveats and Limitations

This report is not meant to be a comprehensive report on the Hong Kong PHI market. Instead, it is a summary of findings from a study limited to readily available market information.

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In order to understand and rely upon Milliman's work, this report must be read in its entirety. Milliman recommends all recipients be aided by their own actuary or other qualified professional when reviewing the Milliman work product.

We have relied on data from various sources. We have not audited this information and in many cases are not able to verify this information against an independent source. In particular, we have relied on the following information:

- Excerpts from the 2005 and 2008 Thematic Household Survey conducted by the Census and Statistics Department
- Provisional statistics from the Hong Kong Federation of Insurers ("HKFI")
- Provisional statistics from the Office of the Commissioner of Insurance ("OCI")
- Excerpts from the Hong Kong's Domestic Health Accounts from FHB
- Milliman experience

SECTION 1.2: OVERVIEW OF PHI INDUSTRY

Overview of PHI Industry

Market Size

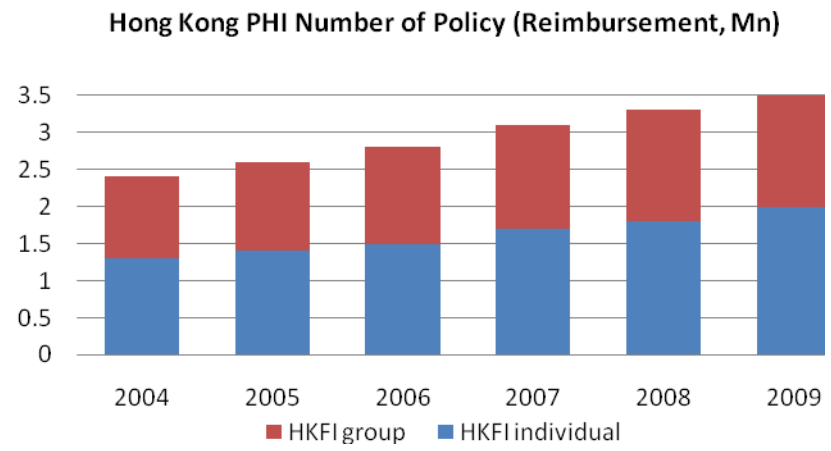
Based on Thematic Household Survey conducted by the Government in February-May 2008 ("THS 2008"), the size of PHI insured population in 2008 was around 2.4 million lives, i.e., 34% of the Hong Kong resident population. Of this total, about 1.1 million were covered by individually purchased PHI only, about 0.9 million by employer-provided PHI only, and about 0.5 million by both[1]. The above figures exclude 0.34 million persons (including employees and dependents) who received civil servants and Hospital Authority ("HA") staff medical benefits only.

Based on the statistics provided by HKFI, there were around 3.5 million insurance memberships in force in 2009, comprising 2.0 million individual insurance memberships and 1.5 million group insurance memberships. Compared with the THS statistics on population coverage of PHI, the total number of PHI policies provided by HKFI was somewhat larger because some people have both individual and group covers, with the latter counting coverage of the dependents of employees separately in some instances.

Both the HKFI and THS statistics are intended to reflect the ownership of PHI products of which eligible claims are tied to occurrence of treatment corresponding to the coverage of diagnoses and medical procedures. HKFI statistics cover products that reimburse the policyholder based on the actual medical expenses incurred. THS statistics cover not only these reimbursement PHI products but also PHI products that pay fixed benefits in the event of treatment, such as the so-called Hospital Cash Plans (described further in Section 1.3). The insurance products that offer compensation upon confirmation of covered diagnoses without the requirement for the insured to undergo treatment, such as Catastrophic Cash Products, are not covered by both HKFI and THS statistics.

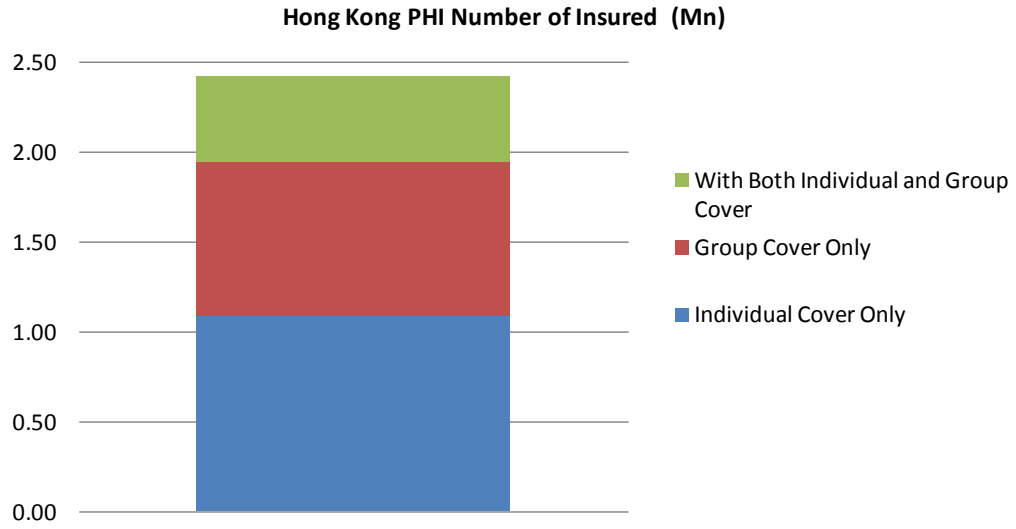
[1] Due to data constraints, the figure of 0.9 million here also covers employer-provided medical benefits not in the form of PHI provided by employers other than the Government and Hospital Authority, but no significant impact to the broad picture of population coverage of PHI is envisaged. Also, the sub-total figures do not add up to the total figure of 2.4 million exactly due to rounding.

Exhibit 1.2.1 PHI Number of Policies (Reimbursement Plans)



Source: Hong Kong Federation of Insurers (HKFI)

Exhibit 1.2.2 PHI Number of Insured (Reimbursement Plans)



Source: Thematic Household Survey 2008 (THS 2008)

The penetration rate of PHI in Hong Kong at some 34% of population is not particularly low. For example, in Australia, where penetration rates are around 45%, the government achieved this by providing premium rebates of 30% or more, imposing tax penalties on those who do not purchase PHI, and imposing additional premiums on those who purchase PHI after the age of 30. Similar to Australia, PHI in Hong Kong exists because:

- There are long queues at the public hospitals where highly subsidised services rationed and triaged, while private services are readily accessible for those who can afford private care.

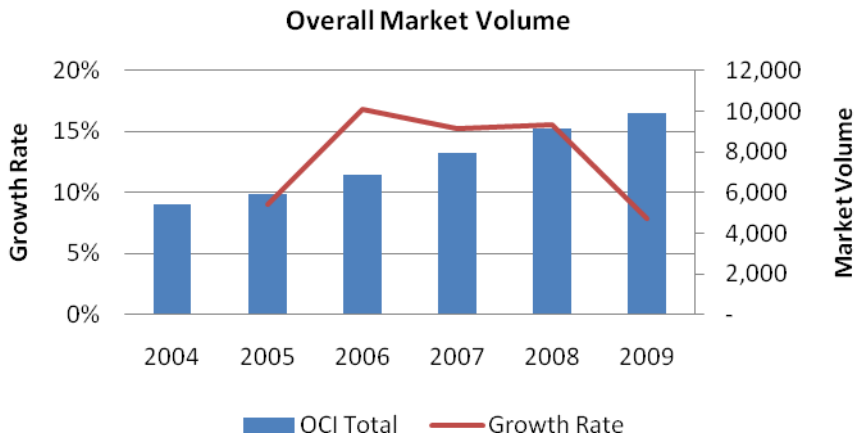
- There is no choice of doctor at public hospitals, while patients can directly access specialists in the private market.

- Some prefer the better amenities and services of the private hospitals over the often crowded general wards of public hospitals

- Services of private hospitals are expensive; much more so than highly-subsidised services at public hospitals. PHI gives access to a broader segment of the population who would otherwise not be able to afford private hospital care, by spreading the high cost of a hospital admission amongst both the healthy and unhealthy PHI policyholders.

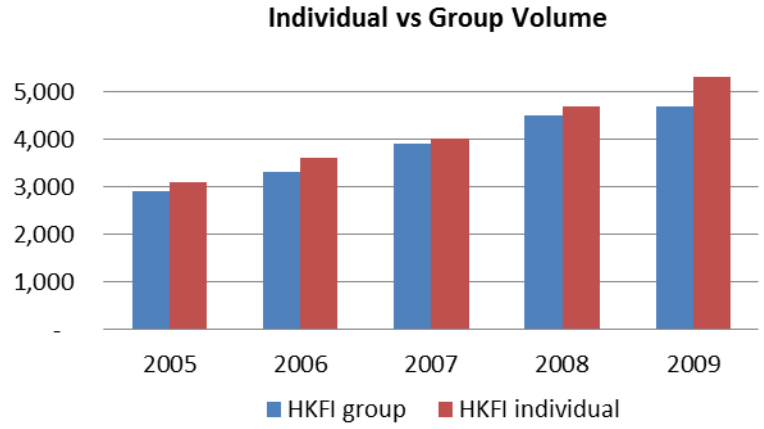
Market Growth

Exhibit 1.2.3 Historical Premium and Growth of Overall Market (HK$ million)



Source: Office of the Commissioner of Insurance (OCI)

Exhibit 1.2.4 Historical Premium of Individual and Group Business (HK$ Million)



Source: HKFI

Exhibit 1.2.5 Historical Growth of Individual and Group Business, in Terms of Premium Volume

	2005	2006	2007	2008	2009
HKFI Group Growth	16%	14%	18%	15%	4%
HKFI Individual Growth	11%	16%	11%	18%	13%

Source: HKFI

The number of individual PHI lives grew significantly in the recent years due to a confluence of factors:

- With the improving economy from 2003-2008, some segments of the population were more able and willing to pay for private health care and for PHI.

- The outbreak of SARS in 2003 heightened the awareness of the population for health care protection. With the HA hospitals seen as giving priority to infectious disease control (e.g. for SARS prevention) over treatment, some observers feel this has shifted patient preferences towards private hospitals and resulted in more people seeking PHI cover to access private hospitals.

- The reported medical incidents in public hospitals have encouraged more people to seek private health care as an alternative, and many private hospitals have developed specific niche services to attract patients.

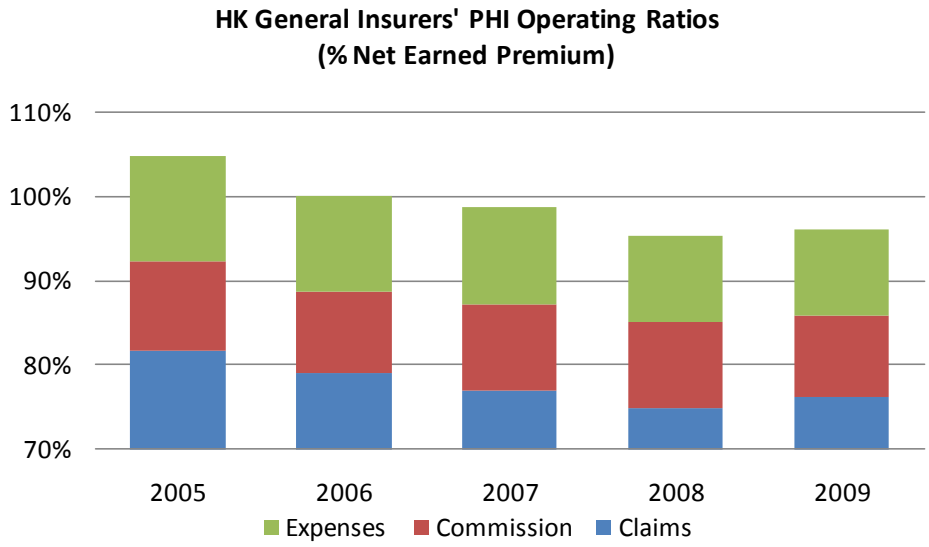
The growth of group insurance has been relatively modest. Around 38% of the working population is estimated to have some form of medical benefits or employer-sponsored PHI.

Competition and Profitability of the PHI market

Virtually all life insurance companies and most general insurance companies sell some forms of PHI. We estimate over 80% of PHI premiums are written by ten insurance groups/corporations. The competition among insurers in the PHI market is intense, especially for the group PHI. General insurance companies have been increasingly aggressive in the recent past and are growing quickly because PHI is one of the few portfolios that offer growth opportunities. Other traditional general business lines, such as Fire, Motor and Employees' Compensation, are relatively stagnant. Although the profit margin of PHI is not as high as life insurance products, life insurance companies are keen to sell PHI to customers with a view of cross-selling other more profitable products, adding value to their services, and enhancing their relationships with their customers.

Based on the 2009 provisional statistics from Office of the Commissioner of Insurance (OCI), the reported net operating profit margin (after commission and other insurance costs) of medical products written by the general insurers in the market was around 4% (as % of net turnover) before allowance of the relevant investment income (please refer to Exhibit 1.2.6 below).

Exhibit 1.2.6 General insurers' PHI operating ratios (% net earned premiums)



Note: Exhibit 1.2.6 is based on medical plan premiums underwritten by general insurers in Hong Kong.
Source: OCI

Group

Group PHI mainly refers to employer-sponsored PHI in Hong Kong. It is mostly distributed through brokers (in particular the large employers' groups), but agents and direct sales forces (i.e. employees of insurers) are also involved. This has always been a very competitive sector and the underwriting profit margins are generally extremely narrow or sometimes non-existent. This is partially because the medical claim experience of groups are relatively predictable and employers or their brokers have a good sense of what future costs will be, allowing them to negotiate lower premiums. Generally, the larger the insured group, the narrower the profit margin. In some cases, large groups are able to ascertain their claims experience more accurately and such groups may choose to self-insure and use the insurers for administrative purposes only.

In cases where the claims experience is less predictable, which is generally true for smaller groups, the insurers charge higher premiums with better margins. The smaller group size also means that employers have less bargaining power with the insurers.

Medical insurance plans provided by employers normally include both outpatient and inpatient covers. Often, the outpatient premium will make up around 60% to 70% of the total insurance PHI premium. Over the past few years, employers have been generally

reluctant to increase their level of medical benefits due to the uncertain economic outlook. This has led to relatively stagnant benefit limits of some group policies, which have effectively reduced the coverage for accessing private hospitals and increased the likelihood that patients will fall back on the HA.

Individual

The profitability of individual PHI products is not reported separately in any publicly available documents. From our working experience in Hong Kong, reimbursement products (see description of reimbursement products in Section 1.3) were generally profitable to insurers (after commission and other insurance costs) in the past. However, in the last five years the claims costs have increased rapidly which has led to losses for many insurers. According to anecdotal experience of insurers, this is driven by unnecessary admissions for investigations such as endoscopies, gastroscopies, etc. Insurers have been increasing premium rates significantly over the last two to three years to restore profitability. We expect the profitability of reimbursement products to return in the long run.

Traditionally, individual PHI products are mainly distributed by the agents. However, distribution of insurance products through banks has been growing steadily, and this is also true for PHI.

SECTION 1.3: OVERVIEW OF PHI PRODUCTS – INDIVIDUAL MARKET

Overview of Products

In this section, we review the types of individual PHI products sold in the market, namely:

- Reimbursement products
- Supplementary major medical products
- Hospital cash products
- Long-term products
- Catastrophic cash products
- High-end products
- Outpatient products

Reimbursement Product

Reimbursement is the most common type of PHI product in the market for risk pooling and indemnifying the insured against the financial risk of medical expenditure. Insurers sell reimbursement products either as standalone coverage or as a rider to life insurance policies. These products are very similar in terms of design across the market. Exhibit 1.3.1 illustrates a typical product design. Deductibles and coinsurance are not commonly included in these products.

Exhibit 1.3.1 Illustrative Individual Reimbursement Product

	Ward ($)	Semi-Private ($)	Private ($)
Hospital Confinement Benefit			
Daily Room and Board (per day)	700	1,400	2,800
	up to 90 days	up to 90 days	up to 90 days
Doctor's Visit	700	1,400	2,800
	up to 90 days	up to 90 days	up to 90 days
Intensive Care	3,000	5,000	8,000
	up to 90 days	up to 90 days	up to 90 days
Specialist's Fees	2,500	5,000	10,000
Miscellaneous Hospital Expenses	10,000	20,000	30,000
Surgical Benefit			
Surgical Expenses	40,000	60,000	80,000
Anaesthetist's Fees	14,000	21,000	28,000
Operating Theatre Fees	14,000	21,000	28,000
Other Benefit			
Emergency Outpatient (Accident)	Covered		
Worldwide Assistance	4,000	6,000	10,000
Premium			
25 Years Old	**1,700**	**3,000**	**5,900**
35 Years Old	**2,300**	**4,200**	**8,100**
45[2] Years Old	**2,300**	**4,200**	**8,100**

[2] Premiums of older ages are higher and vary from company to company.

Notable Exceptions

1. Most companies offer three levels of benefits that resemble the Ward, Semi-Private room, and Private room plans illustrated above. However, a few companies offer an additional "Sub-ward" level, which has relatively low benefit limits (daily room and board limit of around $350) and premiums (of around $1,200 for a male age 30-35). Because of the low limits, we suspect these policyholders will likely use HA hospitals.

2. For surgical benefits, many companies apply a surgical schedule that sets out the benefit limits, varying with the complexity of the surgery, usually classified as minor, intermediate, major and complex operations.

3. No Claim Discount ("NCD") is now increasingly becoming popular. When we surveyed 12 leading insurers in 2003, only one out of the 12 products surveyed offered an NCD. In contrast, seven out of ten leading companies offer this discount now. The NCD ranges from 5% to 15% that can be earned for 3 years of no-claim history.

"Bells and Whistles"

Apart from the core benefits illustrated in Exhibit 1.3.1, different insurers offer a variety of other benefits, sometimes referred to as "bells and whistles" to make the product more attractive to customers. These include:

1. Accidental death benefits, ranging from $5,000 to $58,000.

2. Hospital cash benefits for admissions to HA hospitals, ranging from $380 to $2,000 per day.

3. Medical negligence benefits, where $50,000 to $60,000 is paid if the negligence results in the insured's death. Some insurers offer a lower benefit for a non-lethal negligence.

4. Accompanying bed benefits of $200 to $760 per day, where some insurers require the insured to be either a minor or senior.

5. Chemotherapy, radiotherapy and kidney dialysis, with benefits of $100,000 to $400,000 per annum.

6. Pre- and/or post-hospitalisation consultations, with benefits ranging from $1,000 to $14,000.

Supplementary Major Medical

Supplementary Major Medical ("SMM") polices are sold as riders to reimbursement products. SMM covers the expenses that exceed reimbursement products' benefit limits. In effect, it increases the benefit limits of the basic policy. Approximately, between 30% and 50% of the basic reimbursement policies have an SMM policy, with the level depending on how reimbursement benefits are defined for such policies.

Exhibit 1.3.2 illustrates a typical SMM product.

Exhibit 1.3.2 Illustrative SMM Product

	Ward($)	Semi-Private($)	Private($)
Per Disability Limit	100,000	200,000	300,000
Daily Room & Board (per day)	700	1,400	3,000
	Starting from the 91st day	Starting from the 91st day	Starting from the 91st day
Daily Doctor's Visits	700	1,400	3,000
	Starting from the 91st day	Starting from the 91st day	Starting from the 91st day
Intensive Care	3,000	5,000	8,000
	Starting from the 91st day	Starting from the 91st day	Starting from the 91st day
Co-Insurance	20%	20%	20%
Premium			
25 Years Old	**700**	**1,000**	**1,600**
35 Years Old	**700**	**1,100**	**1,700**
45[3] Years Old	**800**	**1,200**	**1,900**

Many insurance companies impose a minimum length of hospitalisation before SMM coverage becomes effective (e.g., around 91 to 150 inpatient days, with ICU cover generally starting earlier.), while a couple of SMM products include a dollar deductible up to $8,000. The co-insurance percentage is commonly set at 20%. A few companies specify a higher co-insurance percentage for treatment received outside of Hong Kong.

[3] Premiums of older ages are higher and vary from company to company.

Hospital Cash Products

Hospital cash cover is often sold as a rider to life insurance policies. In some cases it is also sold as a standalone product as a form of income protection. The table below illustrates a plain vanilla hospital cash product. Payment of cash is conditional only upon admission to hospital irrespective of treatment and actual medical charges incurred.

Exhibit 1.3.3 A Typical Hospital Cash Product

	Ward($)	Semi-Private($)	Private($)
Daily Benefit	500	1,000	2,000
Annual Premium			
25 Years Old	**500**	**1,000**	**2,000**
35 Years Old	**600**	**1,100**	**2,300**
45[4] Years Old	**700**	**1,700**	**3,000**

Insurers also enhance the product by adding other benefits to their hospital cash products, such as:

1. Additional cash benefits if surgery is involved, where the amount of the cash payment may vary with the complexity of the procedure.

2. Double benefit for accidents occurred on public transportation.

3. Compassionate death benefit.

4. Worldwide emergency assistance

Some of the life insurers also issue a multi-year policy (e.g., five or ten-year policies) that returns the premiums paid at the end of the policy period if the policyholder has not made any claims.

[4] Premiums of older ages are higher and vary from company to company.

Long-term Products: Accelerated Life-Health / "Savings Account" Products

These policies are essentially life insurance policies that offer a death benefit and a maturity benefit. In addition, they also cover medical benefits per a schedule of benefits; usually the benefits are similar to reimbursement products, but sometimes take the form of hospital cash plans. The medical benefit payments are deducted from the death/maturity benefit and the policy expires when the death/maturity benefit is depleted.

These products are sometimes referred to as "savings account" medical products, because it draws down on "account balance", which is in fact the sum insured. In effect, the medical payments are an acceleration of the benefits that the insurer would have paid on death of the policyholder or maturity of the policy. The PHI benefits add limited risk to the insurer. There is effectively limited risk-pooling or indemnity offered by these products as all payouts are drawn from the insured's account. They should not be confused with true Medical Savings Account products, which are not available in Hong Kong.

These products typically provide cover until age 100 or for life. The risk associated with lifetime cover in this format is limited, since the medical benefits paid are an acceleration of the death benefit.

The premiums charged are usually level premiums. Like traditional life insurance policies, the premiums are higher for those who purchase insurance at an older age, but thereafter the premiums remain same throughout the term of the policy. Premiums and benefit limits may be adjusted during the term of policy to keep up with medical inflation.

Catastrophic Cash Products

This category of products, also being referred as critical illness products, provides coverage against a set of predetermined catastrophic medical conditions.

The majority of the catastrophic cash products in the market are sold as riders to an existing life policy, as an accelerated life-health product. When the insured is diagnosed with predefined disease or disability, irrespective of whether the insured is going to receive treatment, a lump sum of the life policy's death benefit is paid out in advance. A maturity benefit is provided if there are no claims during the policy period. Since the critical illness incidence rate is generally low, most policyholders ultimately receive the maturity benefit, and therefore effectively, these products resemble savings-type insurance products and are often not considered as traditional PHI products.

There are also pure protection critical illness products but these are not very popular in Hong Kong.

High-end Products

These products are targeted at expatriates and high net worth individuals. High-end products typically cover a wide scope of services, including dental and outpatient cover, and have very few benefit limits. Typical benefits include:

1. Hospitalisation benefit

   This type of plan commonly reimburses the insured's hospitalisation cost incurred anywhere in the world with very high benefit limits, for example:

   - Room and board: as charged,
   - Miscellaneous hospital charges: as charged
   - Surgeon's fee: as charged
   - Anaesthetist's fee: as charged
   - Companion bed: as charged

2. Physician's visits, specialist's fee, pathologist's fee and radiologist's fee

3. Private care and physiotherapy services

4. Mental or nervous disorders

5. Maternity benefit

Outpatient Insurance

Very few companies offer this policy, because some insurers see it as "dollar-swapping" where the effect of risk-pooling is limited. Also, outpatient visits are often discretionary and therefore prone to abuse. Some companies offer outpatient insurance only as a rider to inpatient insurance.

The following table illustrates the benefit schedule of such a product.

Exhibit 1.3.4 A Typical Outpatient Product as a Basic Policy

Benefit	Bronze	Silver	Gold
General Practitioner Consultation in Doctor's Office including medication for 3 days			
Co-pay per visit ($)	30	30	30
No. of visits per year	Unlimited	Unlimited	Unlimited
Specialist Consultation including Medication for 3 days (Subject to Referral)			
Co-pay per visit ($)	80	80	80
No. of visits per year	5 visits	12 visits	Unlimited
Chinese Medicine Practitioner Consultation (General Practice Only) including 2 packs of medication			
Co-pay per visit ($)	N/A	30	30
No. of visits per year	N/A	5 visits	10 visits
Diagnostic X-ray and Laboratory Test			
Co-pay per visit	N/A	20%	0%
Annual limit ($)	N/A	2000	5000
Physiotherapist Treatment (Subject to Referral)			
Co-pay per visit ($)	N/A	N/A	60
No. of visits per year	N/A	N/A	10 visits
Clinical Procedures			
Co-pay per visit	20%	20%	20%
Annual limit ($)	4000	4000	4000
Preventive Check-up	N/A	Once per year	Once per year

Note: All treatments and consultations must be undertaken by the network doctors or appointed centres.

In addition, outpatient insurance also tends to have stricter conditions including but not limited to:

1. Only available as an option for those who purchase more expensive inpatient cover

2. Restricted health care provider network

3. Co-pays / cost-sharing arrangement to deter moral hazard

Recent Developments and Product Trends

- Guaranteed Renewal

  Up until the last few years, only one or two insurers in the market explicitly guaranteed renewal of the policy. Of late, about half of the top ten players in the market offer products that have guarantee renewal. However, none of these companies guarantee premium rates on renewals.

- Increasing Maximum Insured Age

  In the past, coverage would cease at around age 70 or 75. The current generation of products extend their coverage to 100 years old, and two companies out of the ten major insurers we surveyed cover the insured for the entire life.

- Increasing Maximum Age at Entry

  Most companies do not issue (as opposed to renew) policies to applicants older than 65 years old. In the past, this has been as low as 60. There are now a few companies with maximum issue ages 70 or 75 and at least one insurer does not have an upper limit on the entry age.

- Higher Benefit Limits

  The benefit limits have been increasing over the last five years. Some companies have increased these limits quite aggressively, mostly likely in an effort to capture market share in the higher income segments.

SECTION 1.4: OVERVIEW OF PHI PRODUCTS – GROUP MARKET

Benefit Coverage

The benefit designs for employers are typically tailor-made to meet the specific needs of the employer. The medical insurance plans provided by employers normally include both outpatient and inpatient covers, with the former sometimes including preventive care and vaccination. Because of higher rate of incidence, the total cost of providing outpatient benefits is higher than that of providing inpatient benefits. Quite a number of large employers interviewed indicated that the cost for providing outpatient benefits and inpatient benefits stand at a ratio of about 6:4 or 7:3.

Most of the employers consider medical benefits as fringe benefits to staff and tend to provide only the minimum benefit coverage to control the staff cost. However, some employers offer more generous medical benefits to compete for quality staff and to adopt common remuneration practice within the same industry.

Large employers and multinational companies generally purchase more generous insurance protection that covers both inpatient and outpatient care. Some employers only offer the more expensive semi-private plan to senior management. A small portion of them with a limited budget may not include outpatient cover and offer plans with relatively restrictive benefit limits and relatively high cost sharing for inpatient cover.

Typically, an employer offers better medical benefits to more senior employees. For example, in Exhibit 1.4.1, the ward-level plan may be offered to junior rank and file staff, the semi-private plan to middle management, and private plans to senior management. For management staff, the employer may also cover the employee's spouse and children.

Most insurers only offer a standard package to small employers since it is not cost-effective to tailor make a package for a smaller group. Some small employers with limited budgets purchase low-benefit-limit medical insurance plans, which are generally inadequate to even cover medical costs for ward-class accommodation in private hospitals. The employees in such plans usually end up going to HA hospitals. We refer to these as "Sub-ward" coverage and list an example in Exhibit 1.4.1.

Exhibit 1.4.1: Typical Group Medical Insurance Benefit Coverage

Basic Coverage (note 1)	Sub-ward	Ward	Semi-Private	Private
Room & Board (note 2)	350	500	800	1,600
Miscellaneous Hospital Expenses	5,000	6,000	12,000	20,000
Physician's Services (note 2)	350	500	800	1,600
Surgeon's Fee	20,000	30,000	48,000	96,000
Anaesthetist's Fee	6,000	9,000	14,400	28,800
Operation Theatre Fee	6,000	9,000	14,400	28,800
Hospital Cash	N/A	250	400	800
Emergency Assistance	N/A		Unlimited	
Compassionate Benefit	N/A		1,000	

Notes:

1. Limit per disability unless otherwise specified.
2. Limit per day, maximum 45 days per disability

Recent Trends

- Some employers have seen outpatient medical costs increasing, driving by increasing utilisation, particularly since the SARS episode in 2003.

- Some employers expressed concerns on the increasing cost of providing inpatient medical benefits that arise from higher fees charged by private hospitals and doctors. Some considered it was the result of the limited capacity at private hospitals and opaque charging practices of private hospitals and doctors.

- The financial crisis has led to employers putting more price pressure on insurers. From our conversations with insurers and brokers, PHI premiums for coverage have generally not been reduced but also not increased to match the rising medical fees either.

- The PHI benefits offered by employers have been relatively stable over years. However, the insurers have been enhancing the product features in other ways to attract consumers:

- Some plans are extending the insurance coverage to the individuals who retire from work.

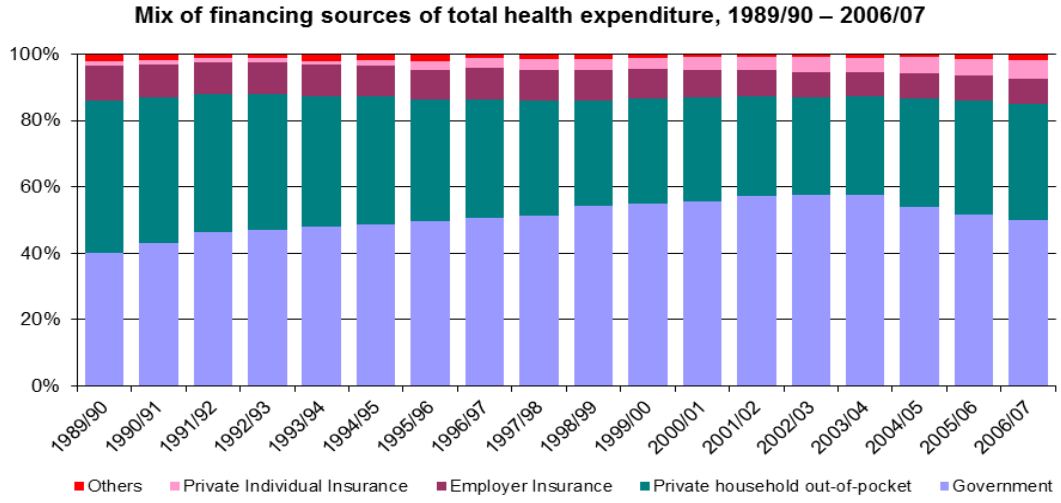
- More and more insurers are providing direct settlement to the private providers (i.e., no out-of-pocket cash payment from the employee is required).

SECTION 1.5: STATE OF THE MARKET

Role of PHI in Health Care Financing

PHI plays a relatively small role in the overall financing of health care in Hong Kong despite the apparently broader population coverage. While the population coverage of PHI has been on the rise and exceeded one-third in recent years, the combined contribution of individually purchased PHI and employer-provided medical benefits (encompassing mostly employer-provided PHI) to the total health expenditure in Hong Kong hovers narrowly at around 12-13% from 1989/90 to 2006/07 (see Exhibit 1..5.1). Yet this should be considered in conjunction with the crowding out effect of rapid increase in the pubic health expenditure, averaging at 9.7% per annum from 1989/90 to 2006/07. Against this backdrop, the share of PHI in healthcare financing still held firm and edged up from 11.9% in 1989/90 to 13.0% in 2006/07. In terms of the health expenditure it financed, the PHI market grew at an average annual rate of 8.8% over the period, comprising increase of 17.7% in the individual segment and 6.0% in the group segment. The share financed by individually purchased PHI thus surged from 1.3% to 5.6% over the period, for reasons discussed in Section 1.2.

Exhibit 1.5.1 Total health expenditure of Hong Kong by financing sources (1989/90 -2006/07)



Source: Hong Kong's Domestic Health Accounts: 1989/90 –2006/07, Food and Health Bureau

Note: the figures for employer insurance include all medical benefits provided by employers in the form of medical insurance or other means, but exclude the Civil Servant and Hospital Authority staff medical benefits which are categorised into government funding.

However, the importance of PHI varies with the type of health care expenditure. Exhibit 1.5.2 illustrates that while the majority of public health care and private outpatient expenses were from government subsidies and out-of-pocket expenses respectively, about half of the private inpatient expenses were financed by PHI.

Exhibit 1.5.2 Total health expenditure of Hong Kong in 2006/07 analysed by financing source and function (HK$ million)

	Government Subsidies	Household Out-of-pocket	Employer-provided PHI	Individually purchased PHI	Others (note 8)	Total
Public inpatient (note 1)	20,343	856 (note4)	-	-	36	21,235
Public specialist outpatient	7,217	864 (note4)	-	-	*	8,081
Public primary care/ general outpatient	4,445	321 (note4)	-	-	21	4,787
Private inpatient (note 1)	760 (note3)	2,805 (note 5)	2,240	1,302	7	7,113
Private primary care/ outpatient (note 2)	2	11,431	2,341	920	5	14,697
Dental care	483	1,932	76	57	9	2,555
Medical goods outside patient care settings	261	8,065	-	-	113	8,439
Others (including ancillary medical services, investment and administration)	3,906	179	916 (note 6)	1,935 (note 7)	1,204	8,140
Total	**37,417**	**26,451**	**5,573**	**4,213**	**1,394**	**75,048**

Source: Hong Kong's Domestic Health Accounts: 1989/90 –2006/07, Food and Health Bureau

Notes:

* Less than 0.5

1. Include inpatient curative care, inpatient rehabilitative care, inpatient and institutional long-term care, and day patient hospital services.
2. Private outpatient included both specialist and general outpatient.
3. Subsidised inpatient and institutional long-term care.
4. Include employer-provided and individually purchased PHI insurance for which there are no separate statistics.
5. Include $282 million that was spent on inpatient and institutional long-term care.
6. Include expenditures on ancillary services to healthcare (such as laboratory services and diagnostic imaging services) as well as the administration and operation of employer-provided PHI.
7. Include expenditures on ancillary services to healthcare (such as laboratory services and diagnostic imaging services) as well as the administration and operation of individually purchased PHI.
8. Include non-profit institutions serving households, corporations and non-patient care related revenue.

Looking at the increasing number of individuals purchasing private health insurance from 2005 – 2008 (Exhibit 1.5.3), we expect the share of health care expenditure financed by PHI, in particular individually purchased PHI, would have continued to grow in the more recent years.

Exhibit 1.5.3 Statistics on population coverage of individually-purchased medical insurance / employer-provided medical benefits in 2005 and 2008

Coverage of medical insurance	2005		2008	
	No. of persons	%	No. of persons	%
Private individual insurance only	853,000	13%	1,088,300	16%
Employer insurance (note 1) only	881,600	13%	856,300	13%
Both Private individual insurance & Employer insurance (note 1) concurrently	493,900	7%	477,600	7%
Civil servant and HA staff medical benefit only	332,700	5%	337,700	5%
No coverage	4,088,200	61%	3,893,700	59%
Total (note 2)	**6,649,400**	**100%**	**6,653,600**	**100%**

Source: Thematic Household Survey conducted during Nov 2005 to March 2006 and February to May 2008

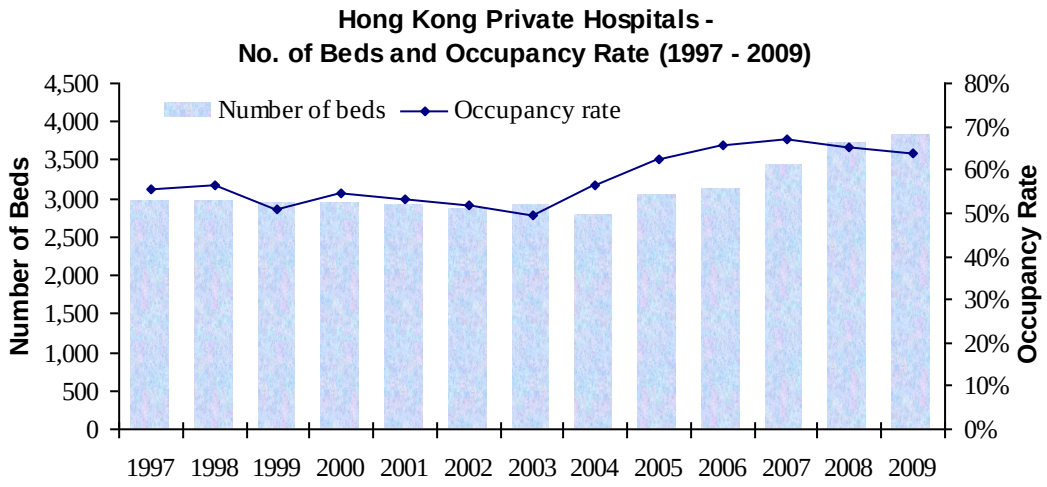
Notes:

1. Refers to medical benefit provided by employers other than the Government or Hospital Authority. Persons with employer medical benefit not in the form of medical insurance were also included.
2. Refers to land-based non-institutional population excluding foreign domestic helpers

PHI in Hong Kong is most commonly used as a financing mechanism for private hospital services. To some extent, its growth over the last five years reflects the growing demand for private hospital services. In 2006/07, about a quarter of expenditure on inpatient care was incurred in the private sector, which reflects the role of private hospitals in Hong Kong, relative to HA hospitals that provide around 80% of beds and 90% of bed-days in Hong Kong. About 50% of the expenditure on private inpatient care was financed by PHI, considerably larger than the corresponding proportion of 22% for private primary/outpatient care.

Private Hospital Market

Exhibit 1.5.4 Hong Kong Private Hospitals – number of beds and occupancy rate (1997 – 2009)



Source: Department of Health

The number of private hospitals in Hong Kong have been stable at around 12 to 13 in the last decade (one new hospital was established in 2008), but the number of hospital beds provided by these hospitals have been increased by around one-third over the last five years to cope with the increasing demand for private hospital beds, as discussed in Section 1.2.

Part of the demand increase has come from maternity patients from Mainland China, while the remainder of the demand increase is mostly from local Hong Kong patients. We believe the increase in local demand is due to the strong economic growth from 2003 to 2008 and also partly from supply-induced demand, as public doctors moved into the private sector. As a result, hospital admissions have grown by around two-thirds over the last five years, i.e., around double the growth of the number of beds over the same period. This is not fully reflected in the occupancy rates in Exhibit 1.5.4 because occupancy is measured at midnight; while the bed is empty at midnight, the bed may have been occupied by two to three patients during the day. Some doctors believe around 30% of admissions at private hospitals are day admissions for investigative procedures such as endoscopies and gastroscopies.

It is interesting to note that Exhibit 1.5.4 probably reflects the true demand for hospital beds for overnight stays, in an environment where there are frequent complaints of a shortage of private hospitals beds from patients, doctors and insurers.

Existing PHI Challenges to Insurers

- Anti-selection and non-disclosure during underwriting

  Insurance companies exclude pre-existing medical conditions to avoid the situation where people only buy PHI when they need care ("anti-selection"). Without this, there would be no motivation for healthy individuals to purchase PHI and there would be no risk pooling amongst the healthy and those who become unhealthy prospectively.

  Insurance companies use proposal forms and medical questionnaires to detect if applicants have pre-existing medical conditions, which are not covered by insurance. PHI industry practitioners tell us that over the past five years or so, there have been more suspected cases of non-disclosure of pre-existing conditions at the point of application. When claims occur, it can be difficult to prove that the condition was pre-existing.

  Anecdotally, some of these claims can occur quite soon after the policy is purchased, and PHI practitioners suspect there has been an increasing incidence of collusion between claimants and insurance agents (and possibly doctors) to mask pre-existing conditions. Some skeptics believe that a portion of the growth in PHI in the last five years also came from the unhealthy gaining access to PHI.

- Moral hazard and unnecessary admissions due to investigations

  Currently, hospitalisation PHI plans do not cover investigations or health checks that are not medically necessary. However, some policyholders and private health care providers have seemingly worked out ways to be admitted into the hospitals for these health checks and claim the relevant expenses for reimbursement from the insurers. This has led to increasing claims and premium rates across all PHI policyholders.

Health insurers have dedicated claims staff that review itemised hospital bills to check for unusually high charges and items and services that may not be medically necessary. Insurers may have staff with medical backgrounds and may seek opinions from an independent doctor on issues of medical necessity.

Even if it is found that a procedure is not medically necessary, it is difficult for the insurer to challenge the medical judgement of the attending doctor, in which case either the insurance company pays for the service in question, or rejects that portion of the claim, in which case the policyholder has to pay for it. Most insurance companies, sometimes under pressure from insurance agents, choose to avoid upsetting the insurance agent and/or customer (who may also be a life insurance policyholder) and instead cover the costs through general premium rate increases in the future

Meanwhile, there are also cases where investigations or even treatment procedures (even if medically necessary) that can be appropriately performed in an outpatient clinic setting are conducted on an inpatient basis in order to qualify for insurance coverage. Some insurers recognise that these procedures would cost less if performed on an outpatient basis and have started to extend coverage to include medically necessary investigations and procedures performed in outpatient settings.

- Limited private providers and limited application of clinical guidelines and audits

There is a shortage of private hospital beds and facilities (notwithstanding the empty midnight bed phenomenon in the prior section though), and limited supply of specialists, doctors and skilled nurses. As a result of this, despite financing some 50% of patients at private hospitals, insurers do not appear to have made much headway in terms of negotiating better terms of business with private hospitals (e.g., fee schedules, discounts on fees, curbing unnecessary admissions, etc.).

In addition, private hospitals have limited application of clinical guidelines and audits of actual practice against these guidelines. Many private specialists practising as solo practitioners are also highly autonomous in their professional judgement and clinical decisions with little or no oversight from private hospitals where they bring in patients as visiting doctors. In most cases, the private hospitals provide nursing support and medical facilities, often with limited control over the clinical process.

The more recent trend of private hospitals hiring their own resident doctors and taking in patients through them suggests that private hospitals are taking greater charge of clinical services. However, the apparent shortage of private hospital beds and high demand for private medical care, coupled with the relatively limited number of specialist doctors who have no problem in getting patients paid either in cash or through PHI, have not made it attractive to apply any clinical guidelines and in turn cost control on private medical care.

- Non-transparent and rising medical fees

  Insurance companies control their risks and liabilities through benefit schedules and benefit limits. The benefit schedule is itemised in line with the usual charging practice of private hospitals and doctors, but is kept simple to minimise administration costs of claims processing and facilitate understanding of the policyholder. For various reasons mentioned in previous sections, the number of claims and the average billed amounts have been increasing substantially.

  Meanwhile, insurance companies find that increasingly private hospitals and doctors try to "maximise" claims and "minimise" their patients' out-of-pocket payments by juggling the items on the medical bills to fit the PHI benefit schedule structure and limits. There is also anecdotal experience that doctors and hospitals charge differently for insured patients according to their benefit coverage.

  In the absence of transparency requirements upfront for medical fees charged and negotiating power viz. private providers, insurance companies often resort to raising premium rates, thereby transferring the rising costs to the insured. In the short run, this has helped the insurers to balance their books and maintain a profit margin. In the long run, however, this is expected to have a negative impact on the attractiveness of PHI to the young and healthy, and the willingness of the healthy to stay insured, when the insurance premium continues to rise while public health care continues to charge very low fees.

- PHI's attractiveness dimmed by public services

  The continued improvement of public hospital services over the past two decades under HA has rendered private services and in turn PHI less attractive in relative

terms. This is further exasperated by the heavy subsidisation for public hospital services, including public fees which have remained extremely low while private medical fees continue to rise. Only the lengthening queues in public hospitals in recent years for both specialist services and non-urgent surgeries, and the heightened awareness of the need for healthcare protection especially after SARS, have revived people's interests in private services and PHI.

Existing PHI Challenges to Customers

- Uncertainty of coverage and charges

  While insurance companies try to curb anti-selection and moral hazards through exclusions and other underwriting rules, not all policyholders understand the scope of coverage and that pre-existing conditions are not covered. In some cases, there may have been misrepresentation or lack of awareness, which manifests itself only at the point of claim. That has resulted in some disputes over health insurance coverage and claims.

  The benefit limits seen in PHI plans are generally set to cover, on average, around 80% of the hospital bill, leaving, on average, around 20% of the hospital bill paid by the policyholder. However, this is an average and in practice, with the current itemised charging structure, policyholders are often not able to predict in advance the proportion paid out-of-pocket, and typically the proportion paid by the policyholder is lower for small bill sizes and higher for higher bill sizes. This creates significant uncertainties for the policyholder for the more complex and expensive admissions. Faced with this uncertainty, some patients choose to fall back on HA services.

- Disputes over policy terms and conditions and their application

  Different insurance companies may have different interpretation of similar policy terms and conditions, sometimes even for those commonly used. That has resulted in disputes over interpretation of various policy terms including exclusions. In particular, the fineprint in policies are generally written in technical legal language making it difficult for customers to comprehend fully the terms and conditions at the point of sale and argue their case if their claims are rejected. Some insurance

companies have been trying to improve the situation by including an explanation of key terms and conditions in plain language and providing better training to agents. However, these practices are not uniform across the industry.

On the other hand, insurance companies are also quick to point out that there are suspected abuse cases where customers make doubtful claims and yet companies are reluctant to act and instead are inclined to settle by paying fully or partially to avoid potential bad publicity and customer relations. The lack of an effective arbitration mechanism to adjudicate genuine dispute cases and monitor moral hazards has resulted in increasing PHI costs.

- Non-transparent medical fees and lack of quality assurance

Patients seek private medical services and subscribe to PHI cover for the wider range of choices offered and the shorter waiting times compared to public medical services. In many respects, patients may be less capable of negotiating fees with private doctors than insurers. Further, those with PHI may have less incentive to do so under the possibly false sense of security that their PHI would be able to provide full or substantial cover of the charges. Meanwhile, the heavy demand for private hospitals and doctors mean there is little competition in medical services and their fees. Patients in general also lack information on the range of applicable charges in general in the private sector.

Meanwhile, apart from professional regulation of doctors by the Medical Council and limited licensing regulation of private hospitals by the Department of Health, there is very little quality assurance for customers on the services rendered by private hospitals and doctors. This is true for both on the quality of services rendered and whether the level of charging is commensurate. Patients in general are often in no position to judge if hospitals and doctors are providing unnecessary services or charging them excessively.

- Non-portability of PHI

  Most current PHI policies are not portable between jobs, after retirement, or between insurers. While some insurers have started to offer plans with limited portability to attract retiring customers, the lack of portability in general means policyholders face uncertainty of the continuity of coverage when switching jobs or switching insurers.

Existing PHI Challenges to Private Hospitals and Doctors

- Inadequate coverage

  Private providers point to PHI coverage being inadequate, leading to out-of-pocket costs for patients. In response, some private providers have indicated that they will in some cases re-categorise their charges (and not necessarily inflated charges) to fit the benefit structure and benefit limits of the PHI policy in question in order to minimise the out-of-pocket costs to the patient.

- Coverage of outpatient procedures

  As mentioned earlier, PHI policies have traditionally only covered procedures performed on an inpatient basis. However, many procedures that would previously have been performed on an inpatient basis, due to technological advances, can now be performed in an outpatient setting at greater convenience to the patient and at a lower cost. Although an increasing number of PHI plans now recognise this and cover procedures performed in an outpatient setting, many PHI plans still do not.

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CHAPTER 2

REVIEW OF LITERATURES ON THE THEORETICAL FRAMEWORK ON ANALYZING THE ROLE OF PRIVATE HEALTH INSURANCE IN A HEALTHCARE SYSTEM

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SECTION 2.1: INTRODUCTION

Scope of Work

The Food and Health Bureau ("FHB") has commissioned a series of studies to devise a proposal for a feasible incentivised voluntary Health Protection Scheme ("HPS", "the Scheme"), guided by the policy direction in the Chief Executive's Policy Address 2009-10 to propose a supplementary health care financing option based on voluntary participation with insurance and savings components for the second stage public consultation on health care reform. Milliman Limited ("Milliman") has been appointed by FHB to carry out a background research study about private health insurance ("PHI"), entitled "Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views".

As part of this study Milliman has been asked to conduct a review of literatures that focuses on broadly analysing the theoretical framework of the role of PHI in a healthcare system, the pros and cons of promoting its function in the system, and the policy and regulatory challenges involved in this policy direction

Approach

We conducted a literatures search of the major health care journals, research papers, and publications by organisations such as Organisation for Economic Cooperation and Development (OECD), World Bank, and the World Health Organisation (WHO).

A complete list of the articles and publications reviewed are listed in Appendix 1A.

We have in some cases supplemented the information from the literatures search with our firsthand experience in some of the economies mentioned in this report.

Caveats and Limitations

This report is not a distillation of experiences around the world, culminating in a definitive view of the pros and cons of PHI and its role in government policy. Instead it is a presentation of the more important issues that economies have grappled with when looking at the role of PHI from a policy perspective, as documented in published literatures. We may have come to different conclusions if we had studied these issues in some of these economies firsthand.

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SECTION 2.2: SUMMARY

In a duplicative public-private system, PHI offers a choice of using private healthcare services, but may increase total healthcare expenditure if there are inadequate policy or market measures to address the various downside risks, in particular those related to moral hazards.

PHI enhances choice of healthcare to patients and improves healthcare system responsiveness to their needs, but on the basis of people's ability and willingness to pay PHI premium and co-pay expenses on healthcare not fully covered by PHI according to the insurance contract. In a voluntary system without government subsidies, consumers are expected to bear the appropriate price for the desired PHI services, as with any other services in a free market.

If public money is involved, government intervention is often called upon to address equity concern out of unequal access to PHI protection by:

- Narrowing price differentials between public and private, possibly via targeted subsidies of premiums or cost of healthcare services, particularly for the lower income groups and the chronically ill.

- Restricting the role of PHI and the scope for insurers to select only the healthy risks. This may involve imposing restrictions on the types of premium rate structures and the degree of underwriting/exclusions that can be used by insurers in the market, while preserving the principles of risk pooling to ensure the financial viability of the insurance pool. However, if such restrictions are not applied uniformly across all PHI products in the same place, two market segments i.e. regulated market and open market would be created. The resultant arbitrage would lead to over-concentration of unhealthy risks in the regulated market segment and healthy risks in the open market segment, thereby leading the former segment to be unsustainable.

In a voluntary PHI system there is inequality for consumers in accessing PHI because those who are able to pay have better access to care and in lightly regulated environments, high-risk individuals often have difficulty in obtaining insurance at an affordable price or may even be declined coverage as insurers combat anti-selection. To

some extent, there is an inherent conflict between equity perspective and commercial viability consideration.

In a mandatory PHI system where all people with higher or lower health risks have to take out PHI cover by legislation, the problem of anti-selection in theory can be avoided but in reality, it may remain to the extent that insurers charge higher premium for high-risk individuals as a subtle means to refuse their enrolments. This explains why in mandatory systems, premium control through community rating of premium is witnessed to avoid risk selection by insurers.

Equity apart, there is efficiency perspective to view the impact of a more active role of PHI on the healthcare system. Many of the arguments involve moral hazard stemming from injudicious and even abusive behaviours of the insured persons and healthcare providers in respect of disease prevention, choice of healthcare and cost of treatment. Without appropriate control, the problem of moral hazard can be serious in either voluntary or mandatory PHI systems. Because its prevalence is positively related to the richness of insurance benefits, moral hazard can be more problematic in a mandatory system which requires richer benefits for all qualified PHI products.

By and large, there is limited evidence to date that without an effective policy framework to address the downside risks particularly those related to moral hazard, PHI can improve efficiency of the health care system, reduce overall healthcare cost pressure, and relieve the crowdedness of the public healthcare sector. However, in literatures, there is no comprehensive documentation of an established theoretical framework for designing the policy measures that can be generally applicable. This is notwithstanding availability of examples of some PHI systems outperforming others and specific design features that work better than others. To sum up, policy directions along the following lines may help mitigate the downside risks:

- To overcome moral hazard from consumers (when there is asymmetry of knowledge between insurer and insured), the introduction of cost sharing mechanisms such as deductibles, copays and coinsurance.

- To overcome moral hazard from providers:

    - Alternative reimbursement mechanisms other than fee-for-service, such as DRG payments.

- Transparency of medical practices, and benchmarking of medical practices amongst providers and against evidence-based best practice medical protocols.

- Information to help consumers make informed decision when selecting insurers and providers.

- To avoid private insurers from dumping patient load back to the public healthcare system, inclusion of design features that discourage or restrict those with PHI from utilising the public system, or creation of a means for the public system to at least recover its cost of providing services delivered to patients with PHI.

- To ensure sufficient competition amongst insurers:

  - Removing barriers to mobility of policyholders between insurers such that benefits are portable. This will require addressing issues where a policyholder's health or other risk status has changed materially over time.

  - Making it convenient for the population to compare the types of PHI plans available. To this end, some standardisation of key terms and conditions and making available better quality information at the point of sale will reduce misunderstandings and facilitate informed choice at the outset. But overdoing standardisation is not wise at this may preclude innovation.

- PHI is potentially useful as a medium for implementing health policy across population segments that generally do not utilise public providers as well as acting as a bridge between public and private providers. This includes policies relating to the use of family doctors, preventive care, and disease management.

SECTION 2.3: THE ROLE OF PRIVATE HEALTH INSURANCE AROUND THE WORLD

PHI is used at different levels, and for different reasons, in various economies. In some economies it is the primary source of health coverage for at least part of the population; in others it supplements the public system either by offering a private alternative or filling up gaps in the public health programs.

In several economies, public healthcare programs cover only certain sections of the populations - for instance those individuals falling below a certain age or income level. PHI is source of primary coverage for such population groups without access to public healthcare cover.

- For example, in the USA, where public coverage through Medicare and Medicaid is restricted to the elderly, disabled and certain low-income populations, around 70% of the population relies on PHI as their primary source of cover if and when they purchase coverage.

- The situation is slightly different in Germany, where there is universal social insurance, but individuals above an income threshold are given the option to opt out of social health insurance and purchase PHI.

PHI can supplement the publicly funded health care system (including subsidised public healthcare delivery system and publicly funded health insurance system) in a variety of ways.

- In many economies like Hong Kong, Australia, and the United Kingdom, where privately funded providers operate in parallel to the public delivery system, PHI duplicates existing public universal coverage, offering a choice of private services. In some of these economies, the private health delivery system includes the private wings of public hospitals. The charges or user fees for these private wings are far higher than those for the public wings, which are typically heavily subsidised but with long waiting times for elective procedures.

- PHI also supplements in healthcare financing by covering the co-pays required by public system, such as the social health insurance namely Medicare in Australia.

- PHI may further supplement public systems by financing goods and services that are excluded from public coverage. In Netherlands, for example, 90% of the population supplements basic mandatory health coverage with a voluntary PHI policy mainly for this purpose. In the United States, individuals eligible for Medicare, a social health insurance program, can buy separate policies to cover not only co-payments, but also other service gaps in the public program.

PHI contributed around 19% of the total health expenditure of US$4.7 trillion in the world in 2006, according to World Health Organisation.

Population coverage of voluntary PHI varies considerably across different places. According to OECD, in France and the United States, over half of the population had voluntary PHI cover in 2006 and 2007 respectively. In Germany and Denmark, less than 20% of the population had cover in 2007. In Norway and Hungary, less than 1% of the population had cover in 2007.

In the Hong Kong context, PHI mostly finances a duplicative private healthcare system, providing the population with a choice of private care. In the public sector, most services are heavily subsidised with low user fees. Although there are some Self Financed Items (expensive prostheses and drugs that are paid out-of-pocket), they constitute a small part of the overall expenditure at public facilities. Assuming this will continue to be the case, expansion of PHI coverage in Hong Kong is effectively an expansion of the duplicative role, by:

- Extending the choice of private care to a broader population
- Enhancing the experience of the consumers opting for PHI and private care

The remainder of this report examines how PHI may be used as a policy tool in a context that is relevant to the potential voluntary Scheme in Hong Kong, and the pros and cons of PHI as a policy tool.

SECTION 2.4: PRIVATE HEALTH INSURANCE AS A POLICY TOOL

Around the world, PHI has been used as a policy tool to try to achieve a variety of objectives, as outlined in this section of the report.

Improve Access to Care

In duplicative public-private systems such as in Hong Kong, Australia, and the United Kingdom, queues at public hospitals are typically very long. PHI provides the choice or option of using private sector services where queues are significantly shorter, albeit at a higher premium. Uncertainty over the length of waiting times, lacks of choice of doctor, and desire for higher level of amenities are among the main reasons for people buying PHI in these economies.

Without PHI, only the more affluent people would have access to private care of medical significance/complication. With PHI, there is pre-payment of services (i.e. the insurance premium) and risk pooling between the sick and the healthy, so the relatively high cost of accessing the private healthcare system is spread across the insured population.

However, in a voluntary PHI system there is inequality in the access to PHI:

- Those who are able to pay the insurance premium have better access to care although some would argue this is inevitable in a voluntary system.

- In lightly regulated environments, high-risk individuals often have difficulty in obtaining insurance at an affordable price or may even be declined coverage.

In a mandatory PHI system, accessibility of high-risk individuals to insurance protection is improved but insurers can still use subtle means to select risks by charging prohibitive premium for the customers they do not favor. It is for this reason that guaranteed acceptance (open enrolment) often comes with premium control (community-rated premium) in mandatory systems. Besides, if the benefit requirement for mandatory PHI is not sufficiently regulated, anti-selection remains to the extent that the healthy lives tend to purchase low-premium-low-protection PHI products to fulfill mandatory requirement

while the unhealthy lives look for high-premium-low-protection PHI products. As anti-selection by consumers continues, risk selection (or so-called "cream skimming") by insurers remains, by such ways, as passive marketing efforts for high-risk individuals to minimise acceptance of their enrolment.

Relieve Pressure on Public Hospitals

With better access to care at private hospitals, it can be argued that PHI reduces the strain on public hospitals, or at least reduces the waiting times at public hospitals if the throughput remains unchanged. However, there is as yet no concrete evidence of this in the literatures reviewed. For example, in Australia, the government introduced explicit policies to encourage the purchase of PHI. As a result, the proportion of the population purchasing PHI increased from around 30% at the start of 1999 to 43% in June 2000. Several academics have studied the effects of this on waiting times at public hospitals, but the conclusions are mixed. It may be reasonable to assume that, as PHI finances an increasing share of hospital procedures, the shift of demand between the public and the private sector will be higher for procedures for which long waits exist in the public system compared to other types of surgery. In overall terms, the impact on waiting time in the public sector may be negative if the greater demand for private healthcare stemming from PHI intensifies resource competition and leads to a shift in healthcare manpower and other resources from public to private, thereby reducing the capacity in the public sector.

In duplicative systems, for example, the private sector usually pays doctors and medical staff much more than the public sector does. In such an environment, there is also a concern that expansion of the PHI market and the private hospital system, will lead to a flow of physicians from the public to private sector, particularly for the more experienced physicians, thus compromising the quantity and quality of services in the public sector.

Some commentators view this as a necessary evil, and believe PHI is actually a useful tool for retaining experienced doctors in the economy. Without the private sector, doctors would be faced with the choice of working in the public sector in the economy, or working in better paying private sectors overseas.

Policy intervention in allowing access of public hospitals by both public and private patients can encourage the involvement of public hospitals in the private sector. This

could be done by differential remuneration to public hospitals for public and private patients. This approach may also provide a mechanism to improve revenue collection by public hospitals if they draw on this source of private financing.

Provide More Choice and Better Responsiveness to the Consumer

The availability of PHI in itself provides the consumers with an additional option for financing out-of-pocket healthcare costs.

Private insurers and private hospitals are usually more flexible to respond to demands by consumers than the public sector. There are also many more insurers to choose from, each offering different products to suit different needs. Consumers also have a choice of different private hospitals and different private doctors.

The private insurers respond to the market by finding appropriate gaps and developing innovative tailor-made health insurance products. For example, in the United Kingdom, where the public system has long waiting times, some insurers have developed cost-effective products to cover only a few elective procedures in the private system. The pressure to innovate is generally driven by competition.

Private insurers tend to be quicker to respond to decisions on whether to cover new technologies in treatment. However, the implications on quality and costs are not clear since their impact on health outcomes take time to emerge.

In an environment where there is an abundance of insurance products and choice to consumers:

- Insurance companies tend to segment the population, and in lightly regulated environments, they tend to try to select the healthier risks, making it challenging for less healthy individuals to obtain coverage. In government-sponsored PHI programs, regulations are usually introduced to restrict the ability of PHI plans to select risks by specifying the rating structure that must be followed by all plans and limiting the extent of underwriting allowed.

- At the same time, in such an environment, insurers are prone to anti-selection, especially in relation to voluntary and supplementary PHI. This occurs because

without appropriate underwriting controls, the unhealthy have more incentive to purchase PHI than the healthy; a behaviour commonly referred to as "anti-selection." Without appropriate underwriting controls, this may result in a disproportionate number of unhealthy lives in the risk pool, thus reducing the ability to spread these costs across the healthy population. In the long run, an insurance pool that is subject to anti-selection is not financially sustainable.

- A large number of PHI products in the market can also lead to confusion for the policyholders. Different products often use different terms and conditions that are not always well explained at the point of sale. This results in misunderstandings about the exact terms of the contract and conflicts at the time of making claims. To overcome this, some economies adopt standardised key terms and conditions and require insurance companies to follow specified sales protocols. The downside of over-standardisation is that it can prevent product innovation that could improve efficiencies of the system.

Improve the Efficiency of the Healthcare System

With choice and "money following the patient", insurers and private providers are expected to compete for patronage of the policyholder.

At a micro-level:

- There can be competition amongst providers, usually with regards to the less complicated procedures and services; some would describe these as "commodity-type" services. This can lead to specialization of care, e.g. small hospitals focusing on specific procedures, development of expertise, real efficiency gains, and cost reductions.

- There may be efficiency gains in terms of shorter lengths of stay in hospitals, particularly in systems where providers are not compensated for excessive lengths of stay.

- It is generally more difficult to create true competition in health delivery sector for non-commodity-type services, particularly if there is a limited supply of providers with the necessary expertise.

Whether there are efficiency gains in the overall treatment of patients across the entire episode of care with PHI is likewise difficult to assess due to inherent issues found in PHI systems.

- Private systems are typically fragmented and can suffer from duplication of services compared to a public provider system partially due to lack of ineffective information sharing system across private doctors and partly due to excessive order of medical treatments caused by supply side moral hazard.

- Efficiencies in this area depend on the degree of fragmentation of the private healthcare system, and the ability of the insurer to coordinate care and help the patient navigate the healthcare system. We shall discuss this further when discussing quality of care under PHI.

In general a PHI system is prone to moral hazard (but so are public systems if they allow elements of choice and/or mandated rich coverage):

- Patients with adequate insurance have a tendency to over-utilise resources, for example agreeing to tests or scans that do not offer significant value. This is so-called the demand-side moral hazard. This can be overcome partially by introducing cost sharing requirements such as deductibles, copays and coinsurance.

- Providers with no incentive to contain costs tend to over-prescribe. Typically, this occurs when the provider is paid a fee for each service provided, and gets paid more when more services are provided. This is so-called the supply-side moral hazard. Public and private insurers have tried to overcome this by introducing different payment mechanisms other than fee-for-service. A relatively common approach used is Diagnoses Related Groups ("DRG") payments, where the hospital is paid a flat fee for each admission, with the fee varying by the type of diagnosis. Another approach is capitation, where the risk is partially passed on to the provider. In addition, public and private insurers have tried to get providers to agree to evidence-based, best practice clinical protocols.

We note that efficiency has a direct impact on quality and costs, which we shall discuss further below. We also note that a gain in the efficiency of the delivery of care is not necessarily at the expense of quality of care. For example, there is a movement towards

using medical protocols or clinical pathways to reduce the variation in care between providers for the same diagnoses. In addition to reducing variation in care, it also reduces the volume of excessive medical services delivered.

Improve Quality of Care

Compared to a tax-funded public health care delivery systems, PHI separates the roles of financing and delivering care. This separation of roles, in theory, allows the financier to more objectively make demands on the quality of services satisfied by the deliverer of care. Some would even view the insurer not as the ultimate financier (the buck stops with the policyholder), but as the coordinator of care and an aggregator to bulk purchase services and negotiate prices with providers.

Healthcare systems are a balance of cost, coverage and access to quality care. Any separation of roles between financing and delivery is good if it results in improvement in one area without harming a different area to an equal or greater degree. Yet this type of result has been observed frequently in systems where lower costs or utilisation or better care in one area mean higher costs or utilisation or less care in another. The focus should be on the aggregate result of all components combined when evaluating a system, and not just one or a few aspects.

An insurer should ideally focus on both financing and the opportunity to help patients navigate through their coverage system. This may include coordinating care, acting as an agent to promote the use of evidence-based medical protocols, enforcing the family doctor concept, and implementing disease management programs and preventive care policies as appropriate. In most parts of the world, this has not happened in voluntary PHI programs. Insurers by and large do not influence how care is delivered because:

- They choose not to, to avoid limiting choice of care to their customers
- They have limited ability to change how providers practice medicine due to provider resistance within the health care system; most of interaction between insurers and providers is around price negotiations
- The cost of intervention outweighs the benefits of the intervention.

One exception is the United States where private health insurers have developed managed care or "HMO" (“Health Maintenance Organisation) benefit plans that attempt to improve the quality of care delivered to their policyholders while keeping expenditure low, by providing a broader scope of services such as quality management oversight of providers, evidence-based clinical protocols, wellness programs, disease management, utilisation management, quality-driven provider reimbursement methods, etc. Some initiatives appear to have worked better than others and there are commendable aspects to some of these programs. Some of these HMO plans, particularly those that operate hospitals with salaried doctors, have fundamentally changed treatment processes and helped reduce cost trends in their programs to some degree. But these programs have not been able to moderate cost trends or control medical inflation sufficiently.

In particular, HMOs, which make up only a small percentage of total PHI, face the pressures which have limited their ability to balance costs, coverage and access to quality care:

- During good economic times, employers (who purchase the majority of PHI) prefer not to purchase HMO plans and restrict the choice of provider to employees. HMOs were more prevalent in previous bad economic times.

- State government regulations that restrict cost sharing and mandate broad scopes of minimum coverage frustrate the operating principles of HMOs. Some commentators believe such regulations are often implemented on behalf of special interest groups, such as hospitals and physicians

Incentives to providers need to strike a balance between delivery and financing efficiencies, and must be combined with appropriate levels of quality measurement and necessary reporting systems. The inability to achieve this can result in a high cost environment and still small and nonsystematic impact of private health insurance on overall quality improvements.

Relieve Cost Pressures

It is debatable whether PHI systems help to relieve overall health care cost pressures.

- As mentioned when discussing efficiency, there may be specific examples where there have been efficiency gains and cost savings. However, the bigger picture would appear to indicate the opposite if the practical constraints cannot be resolved such as those discussed in the earlier paragraphs on efficiency.

- Governments and single payer systems have more bargaining power in negotiating prices and quantum of care with the providers, as compared to private insurance companies. Therefore, costs in such a system can be contained more easily. However, price controls by governments have generally over time compromised the ability of an economy to retain and/or attract doctors and nurses.

The inherent nature of the PHI business and markets also tend to increase overall healthcare costs if there are inadequate measures, policy measures or market practices, to:

- Combat moral hazard; as mentioned earlier, PHI is prone to significant moral hazard on both demand side and supply side unless incentives are properly aligned. For example, on the supply side if providers are to be incentivised to contain costs, it should be done in a manner where quality of care is not compromised. On the demand side, adequate level of cost sharing may help reducing unnecessary utilisation thereby containing costs.

- Keep insurance markets truly competitive. Non-competitive markets can occur when:

    - The insurance market is mature (i.e. limited new policyholders) and the mobility of existing policyholders is low (i.e. when policyholders tend not to switch from one insurer to another) or with barriers and risk equalisation mechanism does not exist in the market. In these circumstances, there is a risk of insurers not truly competing. Since there is a low probability of losing customers, insurers may choose to pass on increases in medical costs directly to policyholders rather than find ways to contain them.

On the other hand, there are examples of insurers being over-competitive, especially when a new government insurance program is introduced and insurers fight for market share, leading to worries about the financial strength of some insurers and their ability to fulfill their commitments to pay claims. Adequate prudential supervision over financial health of insurers is therefore important.

- Insurers have the means to improve loss ratio by selecting healthier risks and by pushing high cost patients to the public sector.

- Avoid excessive regulations that interfere with innovation and developing market efficiencies. Markets by necessity require adhering to fundamental economic and actuarial principles; otherwise results will generally prove unsatisfactory.

- Allow flexibility for insurers to negotiate contractual relationships with providers, constantly increase their client base, offer a variety of plans to existing policyholders and keep pace with developments in the industry.

Transfer Costs from Public to Private Sector

Another reason why governments have introduced PHI systems is to contain the rise in public expenditure on health and avoid over-reliance of healthcare financing on the public sector. However, there is little evidence so far suggesting that the introduction of PHI programs has significantly reduced the financial burden of the public health care systems mainly for the following reasons:

- Prevalence of risk selection by insurers so that the high-risk individuals remain embarred from PHI protection and stay in the public sector for healthcare. As healthcare for these people involves higher cost on average, the impact on public healthcare cost becomes insignificant.

- Prevalence of moral hazard heightens the cost of insurance and hence PHI premium so that some people still refrain from taking out PHI and hence going private when sick.

- Private hospitals and PHI often provide a limited range of services, typically those with lower average costs, leaving the burden of more expensive services with the public sector.

- After the public patient load is reduced, the healthcare authorities tend not to cut back the resources proportionately and rather divert the resources to other areas for service enhancement.

- After the waiting time for public healthcare is reduced as more patients are diverted by PHI to go private, the shorter queue especially in the case of elective and non-urgent care would attract some of those patients who used to ignore their healthcare need due to reluctance to wait.

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APPENDIX 2B: GLOSSARY

Anti-selection / Adverse selection	Anti-selection or adverse selection refers to the consumer behavior in the situation whereby individuals with worse-than-average health status are more likely to take out health insurance than those with better health status.
Asymmetry of knowledge	Asymmetry of knowledge refers to the situation when the insured knows more true information about his/her expected loss than the insurer knows.
Capitation	Capitation relates to the practice of charging for cover by forecasting the likely claims on an individual basis and charging this, adjusted for expenses and profit, as the premium. In effect, the insurance company "carves out" a set of medical benefits (such as dental claims or mental health claims) and passes this risk onto the provider, by giving a proportion of the insurance premium for each person managed to the provider up-front over a period of time rather than an amount per claim.
Community Rating	Community rating most often refers to the practice of charging all policyholders or a significant subset of the persons insured the same premium rate irrespective of rating factors such as age, sex and medical history. Community rating sometimes refers to the process of applying tabular rates to applicants irrespective of claims history.
Risk Selection	Risk selection refers to the insurer behavior of selecting the healthy individuals in a population and deterring the unhealthy ones. It is common for insurers to try to select healthy risks through marketing or plan designs. For example, a plan that offers excellent obstetric care but poor oncology care will probably attract a healthier population than one that offers the opposite.

Disease Management	Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasises prevention of exacerbations and complications utilising evidence-based practice guidelines and patient empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.
DRG Payment System	The Diagnosis Related Groups (DRG) were developed as a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. While all patients are unique, groups of patients have common demographic, diagnostic and therapeutic attributes that determine their resource needs. The DRGs form a manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital.
Health Maintenance Organisation (HMO)	A form of health organisation akin to insurance which combines a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a monthly subscription. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary doctor within the HMO handles referrals. They are more common in the US.
Loss ratio	Loss ratio is the ratio of total losses paid out in claims divided by the total earned premiums. For example, if an insurance company pays out $60 in claims for every $100 in collected premiums, then its loss ratio is 60%.

Managed Care	Managed care is the term given to a process whereby an insurer intervenes in the provision of medical care with the dual objective of optimising the quality of treatment for the policyholder and controlling the cost (by such means as preferred provider utilisation and claims pre-authorisation).
Medical inflation	This term generally refers to the annual increase in the average cost of medical treatment.
Consumer Moral hazard (Demand-side)	Consumer moral hazard occurs when insured individuals use insurance cover for personal financial gain by claiming for reimbursement for unnecessary or overly expensive services. Moral hazard from consumers can be seen on two aspects. One is that due to having insurance an individual may not take necessary preventive steps to avoid getting sick. Another is that in the event of sickness, the individual may demand more services and more expensive services due to lower out of pocket payments.
Provider Moral Hazard (Supply-side)	Provider moral hazard happens when a provider tends to prescribe excessive treatments for an insured patient in absence of proper monitoring by insurer.
Open Enrollment	Open enrolment refers to the process in some markets whereby an insurer is obliged under the law to accept all enrollees for insurance.
Risk equalisation	Risk equalisation applies in some markets where the profits or losses on specified policies or risks are pooled and reapportioned among participating insurers so that each insurers shares the average market experience.
Utilisation management	Utilisation management is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. Typically it includes new activities or decisions based upon the analysis of a case.

Risk Pool	A large number of people grouped together in order to spread the risks/costs of insurance. Risk pools may be specific to a defined set of services.
Underwriting	Underwriting is a function performed by insurer in order to determine the risks associated with a specific group or individual to determine whether or not to offer coverage and to establish a premium rate to charge the group or individual.

APPENDIX 2C: KEY FINDINGS OF THE OECD STUDY ON PRIVATE HEALTH INSURANCE

The analysis in this chapter has made reference to the findings of a study on PHI by the Organisation for Economic Cooperation and Development (OECD) in 2001-2004[1]. The study is one component of a larger OECD Health Project that has investigated several areas of health system's performance.

The OECD study revealed that PHI if positioned as a health policy tool could present both opportunities and challenges. While PHI can help governments attain health system performance goals, it can also put them at risk. The effect depends, in part, on the role of PHI, in terms of market size and function with respect to public systems. In economies where PHI plays a prominent role, it can be credited with injecting resources into health systems and helping to make them more responsive. However, it has also given rise to considerable equity and cost control challenges in most of those same economies.

The OECD study did not come up with any hard-and-fast rule or one-size-fit-all solution in making use of PHI to achieve health system goals. Rather, it assesses the strengths and weaknesses of PHI in contributing to health system performance in several perspectives, including access to health coverage and health care, choice and responsiveness, quality of care, and health expenditure. It also sets out useful practices for policy makers to help to direct PHI markets to good performance. The assessment and recommendation on useful practices are summarised below.

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Contribution of PHI to Health System Performance

(a) access to health coverage and health care	• Contribution of PHI to access to health coverage has varied depending on how large a PHI market has developed, how broad the pool of risks is for which it provides financial protection and the scope of regulations of coverage and delivery system. Despite large gaps in population or services covered by public systems, PHI markets have failed to develop enough to provide significant financial protection in countries such as Korea, Mexico, Greece or Turkey. • Even where they have developed, access to coverage remains one main challenge facing private health insurance markets. Under light or little regulation, risk selection by insurers is a typical of PHI markets so that higher-risk individuals face access difficulties. • When public cover is not comprehensive or universal, access to PHI has enhanced access to care. However, there is no clear evidence that waiting times are reduced in the public sector. • Access is often not equitable across income-groups, largely because PHI is typically purchased by high-income groups. Where the private sector offers higher remuneration levels to providers than public systems do, this can lead to resources being diverted from the public system, which can reduce access to care for those who cannot afford PHI.
(b) choice and responsiveness	• PHI has enhanced choice and responsiveness of health systems in many OECD countries. In most countries with duplicate PHI markets, PHI has often improved individuals' choice over health providers and timing of care. The scope of this added choice depends, however, on the regulation of health care delivery system, freedom of choice already existing within public systems, and insurers' contractual terms with providers.

	• Most PHI markets offer a wide array of products to consumers, allowing them to tailor their risk and product preferences, although the precise nature of the choices depends upon insurers' strategies and product regulation. For consumers to exercise meaningful choice, insurers' marketing and product informational materials need to be transparent and enable comparisons across the market. • There are trade-offs between system responsiveness and access concerns. To avoid vulnerable groups from being priced out of PHI markets, policy makers have sometimes limited the scope for insurers' flexibility and innovation in product design. Standardisation of benefit packages is a way to promote consumers' ability to make informed choices as well as to reduce certain risk selection activities of insurers. However, insurance product innovation in response to market changes might be inhibited.
(c) quality of care	• There is only weak evidence that PHI has promoted the delivery of high-quality care in the OECD area, mainly due to lack of regulatory and financial incentives for insurers, resistance by consumers to restraints on individual choice, and providers' resistance to the introduction of new source of influence on decisions over appropriateness of care. • The United States has been the only OECD country where private insurers have been substantially involved in directing and overseeing certain aspects of care delivery. Pressure from employers and purchasers for cost-effective care supported the development and spread of managed care techniques to improve health care quality in the PHI industry, including selective networks of approved providers, pre-approval of certain services, and the promotion of preventive care. Yet the overall evidence of the impact of managed care on quality of care is mixed. • PHI may actually not be the best lever to improve health care quality, particularly where its role in a health system is small.

	• If insurers are to play a role, they need adequate incentives, regulatory or financial, to invest in quality-improvement initiatives and foster value-based competition.
(d) health expenditure	• PHI has not significantly assumed financing burdens from the public sector. Cost shifting from publicly to privately financed providers in systems with duplicate PHI has remained small. Privately insured have often continued to rely upon publicly financed hospital services as privately financed hospitals have often focused on a limited range of elective services, leaving the responsibility for more expensive services or populations to public programmes. Delisting of services from public coverage, another strategy to shift cost onto the private sector, has generally remained confined to less expensive services, such as dental care and optical services. • PHI has also added to public health spending in some cases, partly due to significant public subsidies to PHI take-out. Besides, where PHI covers cost-sharing on public coverage systems, as in France, PHI-induced utilisation increases raises the cost of publicly financed health system. There is also evidence of PHI-induced utilisation increases in the public sector of systems where PHI plays a duplicate or supplementary role. Some of the PHI-induced utilisation derives from individuals that would, in the absence of PHI, self-finance private care, thereby not using the public system altogether. In Ireland and Australia, public funding as a share of total health spending has increased between 1990 and 2000, while the proportional contribution of PHI to total health spending has conversely diminished, despite increases in the privately covered population in both countries. • PHI has also often added to total health expenditure. Most OECD countries apply less tight governmental control over private sector activities and prices, compared to public programmes and providers. Private insurers tend to have less bargaining power over the price and quantity of care as compared with public systems, particularly single-payer ones. Cost control is more problematic to achieve in multiple payer systems because payers (insurers) have less bargaining powers over providers on the

	price and quantity of care. In several OECD countries, insurers have faced few incentives to manage care cost-effectively, due to a combination of desire not to restrict individual choice, providers' resistance, and the cost of implementing such action. • Administrative cost is another reason why PHI may add to total health expenditure. Insurers need to sustain high administrative costs in order to attract and retain insurees, provide them with a diversity of insurance plans, and negotiate multiple contractual relationship with providers. • In most countries where PHI has a prominent role, PHI has resulted in higher public and total health cost as a result of higher health prices, increased utilisation, or both. • Overall, the desirability or acceptability of cost increases depends on what benefits result from higher healthcare expenditure.

Useful Practices to Help to Direct PHI Markets to Good Performance

- Access related PHI challenges can be overcome by setting up a combination of insurance and rating rules. These may help promoting insurance coverage for high-risk individuals and may be particularly useful in primary PHI markets.

- Fiscal incentives and subsidies can boost the purchase of PHI. However, compared with other types of policy interventions, fiscal incentives and individuals may not be the most cost-effective way to increase take-up of insurance among certain populations. In addition, especially if large incentives are needed to spur purchase of PHI, the cost of such incentives need to be weighed against the savings in public health spending with increased PHI enrollment.

- Policymakers can intervene in case PHI creates access disparities between those with and those without PHI cover. These interventions could relate to regulating price differentials between publicly and privately financed medical practice, specifying providers' obligation to public patients and monitoring compliance with those obligations.

- When cost sharing in public systems is high, PHI enhances access to care. However, if PHI offers full coverage of high cost-sharing levels on public programmes (i.e. user fees), it may reduce cost awareness of the insurees and lead to moral hazard induced utilisation, creating trade-off with cost-containment goals.

- Effective choice within PHI system can be maximised if policymakers foster disclosure of product benefits such that it can be easily understood by consumers. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage. Some standardisation of products sold to vulnerable population groups, such as the elderly and chronically ill, may be appropriate. However, standardisation may limit introduction of innovative insurance products in the PHI market.

- Policymakers can maximise cost shifting between the public and private sector control by encouraging private insurees not to rely on public systems for PHI-covered services. Applying cost control measures within the overall health system, including the private sector, improves the ability to control cost within the PHI markets.

- Policymakers can provide incentives or impose regulatory requirements that enable cost effective care, such as by providing incentives for insurers to be involved in care management or preventive care. Improved consumer information could facilitate effective competition among insurers. Systems to compensate insurers with a worse risk structure (e.g. risk equalisation) can help reduce insurers' incentives to engage in risk selection, thus promoting equitable risk pooling, although they can also remove or reduce incentives for insurers' efficiency.

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CHAPTER 3

REVIEW OF PRIVATE HEALTH INSURANCE IN SELECTED OVERSEAS COUNTRIES

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SECTION 3.1: INTRODUCTION

Scope of Work

The Food and Health Bureau ("FHB") has commissioned a series of studies to devise a proposal for a feasible incentivised voluntary Health Protection Scheme ("HPS", "the Scheme"), guided by the policy direction in the Chief Executive's Policy Address 2009-10 to propose a supplementary health care financing option based on voluntary participation with insurance and savings components for the second stage public consultation on health care reform. Milliman Limited ("Milliman") has been appointed by FHB to carry out a background research study about private health insurance ("PHI"), entitled "Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views".

As part of this study Milliman has been asked to review the experiences of overseas countries in their approach towards using private health insurance ("PHI") as a policy tool.

In particular, Milliman has been asked to review overseas experiences in policies concerning PHI and their relation to the healthcare systems, including promoting PHI as a healthcare financing source, regulating PHI products for consumer protection, and incentivising PHI take-out and desired features, including the accompanying regulatory and administrative measures. We are also asked to analyse the relevant background, evolution, common approach and recent trend, for the purpose of identifying relevant issues in designing the Scheme features.

Approach and Organisation of this Report

We have focused on four countries, namely Netherlands, Switzerland, Australia, and the United States. We have indentified experts in each of these countries to provide insight into the PHI systems of these countries. Sections 3.3 through 3.6 of this report provide a comprehensive overview of the different aspects of the health care of these countries.

In Section 3.2, we highlight the key features from each of these countries that may be useful to the design of the Scheme. We also include several additional comments based on our experience from other countries around the world.

Caveats and Limitations

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Where this report is distributed, it should be distributed in its entirety.

SECTION 3.2: SUMMARY OF LESSONS FROM OVERSEAS

Background

The health care systems that we observe today in different countries and the roles of PHI therein are the result of decades of evolution. They reflect the history of the country, its socio-political values, its culture, and its financial resources, amongst other factors.

Certainly, there are no perfect health care systems and even if there were, the differences in environments or "ecosystems" would make it impossible to transplant a health care system that works in one country to another country and expect it towork just as effectively.

However, we believe there are particular elements of health care systems and the PHI markets in other countries that may be useful references for design of the Scheme, both in terms of features that may be adapted / incorporated and things that may be avoided.

Scope of Cover

- Inpatient and outpatient coverage

  The scope of PHI cover in either a mandatory or voluntary setting is much related to its role in health care financing. In the Netherlands and Switzerland where mandatory PHI programs are the main source of health care financing, PHI covers both inpatient and outpatient services. In particular, Netherlands places very strong emphasis on primary and preventive care, to the extent that insurers are even not allowed to impose copays. In USA, PHI products offered in the market cover both inpatient and outpatient services as PHI covers a large proportion of population and is the primary source of health care financing.

  In countries like Australia and Singapore, the financing role of PHI is supplementary. PHI mainly covers inpatient care, because outpatient care is covered by a separate scheme (in Australia and subsidised public clinics in Singapore) or is already mainly financed out-of-pocket (in Singapore). In

short, there are no immediate and significant financing concerns with outpatient care in these countries.

Hong Kong is in a similar position to Singapore. However, in the longer term, there are potential benefits to putting both inpatient and outpatient care under "one roof" so that insurance product designs and health care provider reimbursement systems can be better aligned with societal objectives on primary and preventive care, relative to secondary and tertiary care. This thinking is based on the assumption that the insurer or "care coordinator" is able to add value in terms of coordinating care between inpatient and outpatient care and between public and private providers while controlling any unnecessary utilisation.

- Coverage of treatment overseas
  The Dutch Mandatory Health Insurance system allows treatments to be performed overseas with the approval of the insurer, because of the shortage of providers and waiting lists. For Hong Kong, the Scheme could provide the option of having procedures performed overseas if it is cost-effective, with the approval of the insurer. This would, in a small way, work towards addressing concerns about the tight supply of private hospitals and doctors in Hong Kong.

Cost Sharing

Cost sharing arrangements for PHI can take the form of deductible and coinsurance. These are included in PHI product design to:

- Keep the policyholder financially engaged in the cost of medical treatment and thus address potential moral hazard or over-utilisation. Both coinsurance and deductibles are used for this purpose in Singapore and USA.

- Reduce the premium rate. Usually, deductibles are used to achieve this objective, as in the case in Switzerland, Australian, Singapore, and the USA.

It should be noted that, in terms of containing moral hazard, coinsurance and deductibles have limited impact for genuine inpatient admissions. However, they are useful if there are unnecessary admissions or if care is being provided in an inpatient setting when it should be provided in an outpatient setting or in a step-up /down facility.

Inappropriate admissions tend to occur when inpatient care is insured, while outpatient care and step-down care are not.

Benefit Limits and Out-of-Pocket ("OOP") Costs

In the Netherlands, Switzerland and USA, private insurers pay providers according to negotiated fee schedules, and so there are, in principle, noOOP costs for policyholders, except for any cost sharing built into the design of the product. Providers are not allowed to charge the patient over and above the negotiated fees for services covered under the scope of the PHI coverage with a few exceptions in the United States, i.e. "balance billing" is not generally allowed. This is the ideal in terms of reducing uncertainty of charges to patients, but this is unlikely to be feasible in Hong Kong given the tight supply of private hospitals and specialists.

In Australia, "balance billing" is allowed, but health plans have adequate leverage to negotiate fee schedules with hospitals so there is generally no OOP cost to the patient, other than for chosen deductibles and co-payments. However, insurers mostly do not have negotiated fees with doctors, so the insured is exposed to potential excessive charging by the doctor. To address this, insurers introduced a Gap Cover Scheme, where insurers indicate a payment schedule, and the doctor retains the discretion whether to charge in excess of the schedule. If the fee charged by the doctor is higher than the reimbursement by the insurer, the patient must be informed about the extent of the gap, and the doctor is obliged to obtain the patient's "informed financial consent" before delivering the treatment. Insurers are allowed to advise patients on which doctors have charges with no or known gaps. Since its introduction in 2000, this system has helped to reduce the number of admissions with gaps from around 50% to 20%, out of which roughly half have known gaps (i.e. roughly 10% of all admissions have unknown gaps). This improvement is also due to the efforts put into publicity and education of the patient around the Gap Cover Scheme, including questions the patient should ask hospitals and doctors to identify known gaps between expected charges and insured benefits.

In Singapore, as in Hong Kong, insurers do not necessarily have fee agreements with providers. In these cases, insurers use benefit limits built into the product design to limit the insurer's exposure to potential excessive charging. In Singapore, benefit limits for surgeries are based on the complexity of the surgery, which may be categorised into seven tiers. In the UK, some insurers use up to 25 or so tiers.

Provider Reimbursement

In Switzerland, some health plans negotiate capitation rates with primary care providers, while in the USA, some integrated provider groups supplying a comprehensive range of services accept global capitation rates, i.e. a per capita fee in return for meeting the medical needs of the member for one year.

However, in most developed markets, insurers negotiate fee schedules with providers. Within the same market, a variety of fee schedules may be used. For example, in Australia, some admissions are paid by diagnosis-related groups (DRG), while others are based on per diems that are differentiated by type of service and level of complexity.

There are some lessons to be learned from overseas markets when implementing a new provider reimbursement system:

- DRG or episodic-type payment systems, which are used in countries such as USA, Australia, and the Netherlands. This form of "packaged pricing" facilities market transparency and benchmarking of performance and charges between hospitals.

- Provider payment mechanisms that rely on coding are open to abuse; some providers have been known to "upcode" the actual service provided to receive a higher payment. This has been observed in many countries including the USA and Netherlands. While a coding-driven payment system facilitates monitoring, it does not entirely eliminate abuse.

- Provider charges almost always go up when there is a change in payment mechanisms. Sometimes the increase in provider charges is to "take advantage" of change and lack of continuity and direct comparability of how charges have changed, and other times it is driven by uncertainty, such as was the case when DRGs were introduced in the Netherlands.

- Price fixing and price controls in the health care market always results in distortions in ways that are sometimes unpredictable, ranging from cost-shifting to uninsured patients or other insurance programs, providing more services to make up for lower income per service, and doctors leaving the country to work in better-paying markets. This has been seen in various forms in South Africa and the USA.

- Updating rules consistent with changes in environment is critical. Systems can become outdated quickly with changes in care patterns, new types of services, etc.

Premium Rating, Underwriting, and Anti-selection

In the Netherlands and Switzerland, PHI is mandatory and so the government can dictate the premium rate structure (in these cases, community rating) and insurers cannot do any medical underwriting. There is virtually 100% compliance in these countries, so anti-selection is not an issue. It is interesting to note that in these countries, the sense of solidarity is strong. For example, in the Netherlands, employers effectively pay 7.05% of employees' income towards mandatory PHI. The contribution rate is a flat percentage of income despite the fact that some employers, for example those employing younger high salaried staff, are very likely paying much more in premiums than the actual costs incurred by their employees.

Community rating is also used in Australia, despite it being a voluntary PHI system. This was possible in the first place because the PHI market is closely regulated and all PHI products in the country must be community-rated and insurers are not allowed to medically underwrite. However, insurers are allowed to impose a one-year waiting period to counter potential anti-selection by those people with pre-existing medical conditions. Despite this, there is still some occurrence of anti-selection amongst the elderly who purchase PHI to get hip replacement surgery done at private hospitals, while the queue at the public hospitals exceeds one year. Also, the industry was concerned with the lack of young lives purchasing PHI and the government introduced Lifetime Health Cover, where those joining the scheme after age 30 had to pay an additional 2% of the community rate for each year after the age of 30.

In the USA, the system is fragmented and individuals can purchase insurance from different states or even relocate to a different state to seek more affordable PHI. The USA mostly operates under free-market principles today. However, for political reasons, some states imposed restrictive rate classifications without a strong mandate and without limiting choice of PHI product. This resulted in anti-selection and severe aggregate financial outcomes for those schemes. In the recent reform proposals by Obama administration, people with pre-existing conditions would no longer be denied insurance as from 2014. There could be a serious risk of aggravating anti-selection in the country if no balancing measures such as waiting period are to be introduced concurrently.

The situation in Hong Kong should be similar to the USA, where the Scheme would not be the sole PHI market, but would be competing against existing PHI products, and even products sold in neighbouring countries. Unless similar restrictions are placed on the existing PHI market and overseas products, the premium rating and approach to risk classification between Scheme and the existing market would need to be consistent to avoid significant anti-selection and price arbitrage.

It is interesting to note that Singapore has adopted a different approach to medical underwriting. The government-driven Medishield scheme excludes pre-existing conditions for administrative reasons. Medishield product is a high-deductible, low premium product. Covering pre-existing conditions would require full medical underwriting upfront and incur relatively high administrative expenses.

Risk Selection, Risk Equalisation and High Risk Pools

In community-rated plans, some form of risk-adjustment or risk equalisation occurs in the background to discourage insurance companies from only enrolling the relatively young and healthy. This involves redistributing premiums so that insurers with relatively unhealthy portfolios receive more premiums and vice versa. However, risk adjustment is an imperfect science and insurance companies still try to select risk through marketing and using different product designs for different target markets, sometimes with undesirable consequences for the customer.

In systems where there is freedom to classify risks, such as the USA, high risk pools have been used to facilitate access to PHI for the unhealthy. High-risk individuals are eligible to join the pool with premiums subsidised by the pool. The pool in turn is typically funded by a levy (percentage of premium) placed on PHI policies.In addition, there may be funding from bed-taxes (levies on hospital beds) and government funds to facilitate the arrangement.

It is interesting to note that, due to the imperfections of risk-adjustment mechanisms, high-risk pools or reinsurance pools are also used in the Netherlands, Switzerland, and Australia, to further equalise the risks between insurance companies.

Cost Containment

Cost containment measures appear to be limited in the countries that we have reviewed, other than the USA. There are some elements of "managed care" in Switzerland, but this appears to be limited to selected capitation of primary care physicians.

In the USA, a myriad of managed care initiatives have been attempted by government agencies as well as private health insurers. Not all initiatives have been effective. Some, like prior authorisation (the permission of the insurer has to be sought before admission) initially had a material impact, but later generated more costs than savings when admission practice patterns changed; when the number of unnecessary admissions later declined in response to the prior authorisation program, the cost of running the program no longer justified the diminished potential savings from avoiding any further unnecessary admissions. Some initiatives were seen to be interfering with the clinical decision-making of the doctor and ultimately resulted in political backlash. There are probably two keys lessons to be learnt from the USA in this respect:

1. Focus on cost containment initiatives where there are real savings or benefits relative to costs.

2. Be cognisant of "bigger picture" approaches to managing costs where the impact can be significant, rather than trying to micro-managing costs where the impact may only be marginal.

The bigger picture and less antagonistic approaches being used now include creating more individual responsibility for health care costs ("consumer-driven health care") and great transparency and dissemination of information so that the consumer can make informed choices. Both of these elements have been part of the strategic thinking of Singapore for many years.

Transparency, Benchmarking, and Competition

Amongst Health Care Providers

Transparency and benchmarking of private providers is something that is being pursued in several countries to facilitate comparisons across providers to help patients select their providers and allow providers to compare their performance against their peers with the aim of spurring efforts to improve quality and outcomes.

The USA probably has the largest repository of medical encounter data in the world, enabling it to derive just about any benchmark it requires. In the past few years, these benchmarks have only been used by insurance companies to compare and contrast different providers. These benchmarks are now being integrated into "consumer-driven health plan" designs, where the individual takes more financial responsibility for his or her health care costs, but at the same time is provided with more information on the range of hospitals and doctors available. However, these initiatives are carried out by multiple parties across different parts of the country and the information is fragmented.

The Dutch government is pushing hard for transparency and benchmarking. To support health organisations in achieving the goal of making care transparent and developing a set of publicly available information on quality of care, the government has set up the program called "ZichtbareZorg" (Transparent Healthcare). This program supports the different sectors in health care and connects developments from one sector to another. Also, the program is intended to guarantee that the published information is valid, reliable, and truly comparable. This program has done extensive research on the development and the administration of quality indicators in nine different countries.

Zichtbare Zorg aims to develop quality indicators for the whole health care market, from GP-care to care for the disabled to hospital care and pharmaceutical care. This broad approach is seldom seen in other countries, where the control for development and maintenance of quality indicators is often fragmented or divided across different organisations.

Amongst Private Health Insurers

Several countries, such as Australia and the Netherlands have created information platforms, where potential customers can readily compare PHI products offered by the insurers in the market. Having all the information available in one place helps the consumer make a more informed decision and also works towards creating greater competitive pressure amongst insurers.

Appeals Mechanisms

There are specialised appeals mechanisms in each of the countries we studied. These are independent organisations charged with dealing with complaints and conflicts between insurers, providers, and policyholders. In some cases, their roles extend to determining whether a procedure, medicine, or treatment should be covered by the PHI scheme.

Regulation

The fundamental areas of regulation are mostly similar across the different countries we reviewed. These include areas such as product regulation to ensure the products sold meet with the objectives of the government, prudential regulation of the insurers to ensure they have sufficient funds to meet their obligations to policyholders, customer protection, and in some cases premium rate regulation. However, how the responsibilities are spread between different regulatory bodies and the extent of the regulations varies. The regulatory structure in the Netherlands and Switzerland can be complicated, with multiple bodies involved in different aspects of regulation. The Netherlands in particular has streamlined the number of regulatory bodies involved in recent years. However, there continue to be complaints of excessive bureaucracy and excessive workload on insurance companies simply to comply with regulations.

In Australia, most of the PHI regulatory burden falls under one body, i.e. the Private Health Insurance Administration Council. Even then, efforts have been made to streamline the regulatory framework and adopt an "outcome-based" regulatory approach since 2003. The principle here is not to over-regulate and create unnecessary paper work, but instead to focus on key performance indicators, such as premium rate inflation and management expense efficiency, and require additional reporting if an insurer's performance falls below the requisite standard.

Encouraging PHI Ownership

Singapore encourages the ownership of PHI without the use of government subsidies while Australia continues to subsidise 30% or more of PHI premiums each year.

Singapore has used what could perhaps be described as a step-wise approach. The government Medishield PHI scheme, a high-deductible, low premium insurance package had premium rates of just SGD12 a year in the early 1990s and now still costs only SGD33 a year for individuals aged 30 and under. Central Provident Fund (CPF) members were automatically enrolled unless they opted out of the scheme; a very small proportion of members opted out. After that, top-up covers were introduced on an opt-in basis, and eventually insurance companies were invited to sell integrated Medishield and top-up Medishield products (called Integrated Shield), with most of the Medishield claims administration handled by the insurance companies.For the first time in the Singapore PHI market, the Integrated Shield products provided guaranteed renewable coverage up until age 100 or for life. In recent years, while continuously propagating the need for individual responsibility for health care costs, the government has not only been expanding the benefit coverage, but also the scope of population covered to include newborns, dependents and self-employed individuals. Currently, Medishield covers over 80% of Singaporean citizens and permanent residents.

Australia has had a long history of PHI. The proportion of the population with PHI ("penetration rate) had been steadily declining since peaking at 67.9% in 1982 until the Howard administration introduced several programs that ultimately increased the penetration rate from around 30% at the end of 1998 to 45% in mid-2001.

Exhibit 3.2.1: History of PHI penetration rates in Australia

Date	Event	Penetration Rate
Jun 1982	The highest proportion of the Australian population with PHI over the past 20 years	67.9%
Dec 1983	Two months before the introduction of Medicare, the government social health insurance program primarily used to finance private primary care and public inpatient care, with partial financing of private inpatient care.	61.5%
Mac 1984	One month after the introduction of Medicare.	54.3%
Jun 1997	Introduction of Private Health Insurance Incentives Scheme in July 1997, among other things, introducing tax penalty to high-income earners that do not take out PHI.	31.9%
Dec 1998	The lowest proportion of the Australian population with private health insurance over the past 20 years – one month before the introduction of the 30% rebate for PHI private health insurance	30.1%
Sep 1999	Lifetime Health Cover (LHC) announced on 29 September 1999, whereby those aged over 30 taking out PHI for the first time, pay an additional 2% premium for each year above age 30. This was introduced to encourage the young to purchase PHI.	31.0%
Jun 2000	15 days before the cut-off date for LHC	43.0%
Jun 2001	The first year of LHC	44.9%

Source: Private Health Insurance Administration Council and "The 30% Rebate for Private Health Insurance: A Critical Review", Greg Ford, Health Issues 2002, Number 70, pp.10-13.

From Exhibit 3.2.1, it would appear that the tax penalty (June 1997) and the 30% rebate (December 1998) had little impact on PHI penetration rates, while the LHC had an immediate and significant impact. In March 2000, 26.9% of people aged 30-34 had PHI. In September 2000, three months after the introduction of LHC, this percentage had grown to 45.9%. However, the cause-effect relationship is not so clear because, from a financial perspective, the 30% rebate would have been more valuable than the "2% per year over age 30" penalty to this age group. Instead, the combination of incentives and penalties probably played a part and the final push came from a massive joint marketing campaign by the government and the insurance industry with the theme "Run for Cover." To some observers, the campaign discredited the public health care system by highlighting its weaknesses, and it emphasised a "limited window of opportunity" for applicants to purchase PHI without incurring the LHC penalty.

Certainly, the marketing and positioning of the respective PHI schemes have been important to the success of Singapore and Australia as far as improving penetration rates are concerned.

One lesson of what not to do can be seen in South Africa. In a populist bid to make PHI more accessible, the South African government in the late 1990s mandated that insurers could not refuse an insurance applicant and that premiums be community rated, in a system where PHI membership is voluntary. This resulted in anti-selection leading to distortions in the types of products insurers offered and large financials losses for many health plans. Furthermore, to keep medical costs down, the government instituted price controls on providers, resulting in a large outflow of doctors out of South Africa. Certainly, a scheme that violates economic and actuarial principals will not be financially sustainable.

SECTION 3.3: NETHERLANDS

Overview of Health Care System

Prior to 2006, Netherlands operated a social health insurance ("SHI") program for the relatively low income (covering around 63 % of the population), while the remainder of the population, who could afford it, purchased voluntary private health insurance ("PHI"). The system was reformed because:

- Medical costs were rising from 8.2% of GNP in 1999 to 9.7% of GNP in 2004 and the dichotomous model was seen as not being an effective platform for managing medical costs. Due to this fragmented character of the health system the Dutch government was forced to impose health suppliers with strict rules in order to control costs. This in turn lead to suffocating innovation and took away incentives to serve patients efficiently (for example, leading to long waiting lists).

- Although SHI organisations were supposed to compete there was little incentive to do so because mobility of the insured's was very low.

- Some people did not have access to care, such as i) people who marginally did not qualify for SHI cover, but at the same time found voluntary PHI unaffordable, and ii) high-risk individuals who do not qualify for SHI had problems getting PHI coverage.

The government was of the opinion that a system where patients (by having a free choice of insurer), health insurers and health suppliers all are directly responsible for the consequences of their choices is the best possible solution to increase efficiency and affordability in health care.

The healthcare financing system was reformed in 2006, and is now financed by three programs:

- Mandatory Private Health Insurance ("MPHI"), which is the foundation of the Dutch healthcare financing system. It covers basic short-term health services delivered by general practitioners ("GP"), specialists and hospitals.

- Exceptional Medical Care Social Health Insurance, which is intended to provide the insured with chronic and continuous care that involves considerable financial consequences, such as care for disabled people with congenital physical or mental disorders. It covers selected preventive care, high-risk prenatal services, and long-term health care, such as personal care, nursing care, and stays in medical facilities exceeding 365 days

- Supplementary Voluntary PHI ("VPHI") that covers less essential health services, such as alternative care, speech therapy, additional postnatal care, additional glasses/contact lenses, additional dental care, physiotherapy for the first nine days (which is not by MPHI), diabetes care, additional care abroad, acne care for younger people, and dental prosthesis or hearing aids for the elderly. Overall, the benefits and premiums are marginal compared to mandatory PHI despite there being very minimal regulation of the product design; this speaks to the comprehensiveness of the MPHI coverage. Over 90% of the population purchases this cover.

The remainder of this section focuses on the MPHI program.

Eligibility, Enrolment, and Mobility

The population is obliged by law to purchase PHI from one of the approved insurance companies. Those that do not purchase PHI within four months of arriving in the Netherlands are fined 130 % of the premium payable.

The population has free choice of insurer and insurers must accept any resident in their coverage area (although most insurers operate nationally). The population purchases insurance directly from insurers. Intermediaries such as brokers and agents are not used.

The consumer can get extensive information on insurers and the types of health plans from the government website and several private independent websites which compare the various Health Insurance Plans. When the new health insurance system was introduced there was a lot of public awareness campaigns in the mass media, and there continues to be a lot of coverage in the mass media to sustain the awareness of the scheme, including ranking of hospitals, for example.

The insureds are allowed to switch insurer once a year. However, mobility is low and turnover has been hovering around 4%-5%. Most members do not seem to bother to spend the time to shop around. This could be because the basic cover (which is comprehensive) is standardised and the differences in supplemental cover between insurers are not significant. In most part, the premium rates also do not vary significantly by insurer. It is mostly the young who may go on the internet and look for the cheapest premium rate.

We note that all plans are essentially individual plans, although collectively purchased plans (i.e. employer group contracts, which make up around 60% of all members) do receive a premium discount. As such, the basic cover is completely portable from one insurer to another.

Scope of Cover

As mentioned earlier, MPHI is the foundation of the Dutch healthcare financing system and covers comprehensive range of basic inpatient and outpatient health services. It follows a standard benefit design, which cannot be varied by private insurers. The scope of services covered includes:

- Medical Care, including care by general practitioners and specialists
- Dental, (up to the age of 22 ; coverage from age 22 is confined to specialist dental care and dentures)
- Paramedical Care, limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice
- Maternity care
- Pharmaceutical care
- Medical devices
- Accommodation
- Transport of patients

There are some exclusions to cover, such as:

- Experimental procedures and drugs
- Influenza vaccines
- Certain plastic surgical treatments (like the treatment of upper eye lid that are weak or paralysed, but not due to a congenital defect)

Insurers may offer one or both types of health insurance coverage: "in-kind" and "reimbursement model". Under the "in-kind" model, the insurer provides insured with care through its own care providers or through care providers with which it has contracted while if the model of care is the "reimbursement model", the insured may receive care from a provider with whom the insurer has no contractual relationship. An insured person pays for the provided care first and then receives reimbursement of the cost from the insurer.

Benefit Limits and Cost Sharing

There are no monetary benefit limits, such as per admission or annual limits in monetary terms.

Benefit limits take the form of restrictions on scope of cover. For example:

- Physiotherapy is only covered if it is chronic. The first nine visits are not covered under mandatory PHI, but can be covered if we purchase voluntary supplemental products.

- Hospital stays exceeding 365 days are covered under SHI, rather than MPHI.

In terms of cost sharing every insured person aged 18 and over must now pay the first €155 of any health care costs in a given year. Children are exempt from the deductible. Also, this annual deductible does not apply to some services, such as GP costs. The Netherlands has a very strong culture of primary and preventive care, and any cost sharing or out-of-pocket costs on GP visits is not allowed.

Health insurance companies sometimes refund the deductible if insured goes to particular provider, i.e. a financial incentive to steer the insured towards particular providers. This can also happen if patients use preferred pharmaceuticals or medical aids, or follow preventive programmes (since 2009).

The general view is that the deductible has no noticeable impact on the utilisation of inpatient services. Before the introduction of the deductible, the MPHI scheme operated a no claims discount on the flat-rated premium. However, the general consensus was this also did not have much impact on utilisation, while adding to the administrative burden.

Other than the deductible, there are no other forms of cost sharing.

Funding

The MPHI system is financed by three types of premium:

- Income-linked premium, contributing about 50% of total premiums
- Flat-rated premium, contributing about 45% of total premiums
- Premium for the population aged under 18, contributing about 5% of total premiums. The government pays this premium and negotiates with the insurers on the appropriate premium level.

As a safety net, low-income populations receive a monthly allowance to help meet the cost of the flat-rated premium. The monthly allowance is calculated as a percentage of the difference between a standard premium (an average premium that insureds have to pay) and a normpremium (usually 5% of taxable income). Eligibility for the allowance is based on income-level. An estimated 40 percent of households qualify for such assistance.

Income-linked premium

The contribution rates are set by the government and summarised below (rates as per 1 January 2010).

- For employees, this is 7.05% of income and paid as a salary by the employers. (employees pay tax on this).
- For retirees, the contribution 7.05% is generally paid by pension scheme administrators and deducted from the individual's pension. Some pension administrators may not deduct the full amount, in which case the balance needs to be paid out of pocket by individual.
- For the self-employed, i.e. those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.95%.

- The government pays the premiums for social security recipients and adults without income as well as for children below the age of 18.

The income-linked premium is paid to the government-run Health Insurance Fund, and then distributed to the insurers via the Risk Equalisation Mechanism ("REM", described further below). The objective is to allocate the premiums so that insurers with higher risk populations receive a higher share of the income-linked premiums. In this way, insurers are encouraged to improve their profit margins by reducing administrative costs and managing the health and medical costs of its members more effectively, rather than by risk selection, i.e. targeting healthier population segments while avoiding the less healthy segments. We discuss this further later in this section of the report.

Flat-rated premium

This is collected directly by the insurance companies.

Each insurer sets its own premium rate, which does not vary by enrolee, health status, or other risk characteristics.

The insurance market has been extremely competitive. For individual contracts, premiums fall within +/- 8% of the median, with most plans following within +/- 2%.

Insurers can offer a discount of up to 10 percent for collective contracts, e.g. when employers organise a group contract that entitles employees to discounts on the flat premiums paid by employees. Around 60% of the population is covered under collective contracts.

Risk Equalisation Mechanism and High Cost Balancing

Risk Equalisation Mechanism

The government Health Insurance Fund distributes the income-linked premium amongst health insurers on the basis of the risk profile of the insurers' enrolees. There are two parts to this allocation: ex-ante and ex-post.

- The ex ante risk adjustment factors are calculated prior to the calendar year it concerns. The risk factors are used to approximate the expected cost of care corresponding to different health profiles of the insured persons. The risk factors used are (a) age and gender, (b) sources of income, (c) region of residence, (d) pharmacy cost groups, and (e) diagnostic cost groups. An adjustment is made to the payment amount to reflect the actual number of insured persons and their characteristics during the year.

It is worth noting that when they were implemented, the ex-ante risk adjustment factors were based on data available at that time, which reflected a different environment. Differences in the risk profiles of different population segments were not fully appreciated and it is argued by health insurers that some of the risk adjustment factors were miss-calibrated. This resulted in a few notices of objections by health insurance companies and might result in lawsuits by insurers against the government.

- At year-end, there is another process, called ex-post risk equalisation, which compensates for the shortcomings in the ex-ante equalisation contribution. The ex-post corrections are based on the actual population and realised medical expenses during the year. These ex-post corrections (balancing of medical costs between insurance companies) are set by the government. This adjustment is officially finalised two years after the end of book year, when all claims are expected to have been fully settled. In practice the ex-post corrections for the year 2006 are still not finalised. Therefore it is hard to determine the actual result for a health insurer. The ex-post adjustment is necessary as the ex-ante risk adjustment factors are not able to predict the expected costs to within the desired level accuracy. However, the quantum of ex-post adjustment is expected to reduce over time as improvements are made to the ex-ante algorithm.

Also, the larger insurers have requested for lower ex-post adjustments. The Dutch system relies on insurers to drive improvements in the efficiency of health care delivery system. However, if the ex-post adjustments are too high, then there is little incentive for the insurers to drive improvements in efficiency since the financial benefits will be mostly shared with other insurers through the ex-post adjustment. If an insurer does a good job in reducing hospital costs part of it will be taken by the ex-post risk equalisation. With high ex-post adjustment, there is also a risk of rewarding insurers that experience high costs because they are administratively inefficient or because they do a poor job of controlling utilisation and prices

At the same time, a lower ex-post adjustment without improvements to the ex-ante risk adjustment factors results in more room for risk-selection.

High Cost Balancing

This is a reinsurance pool to protect any one insurer against extremely high cost individuals who may destabilise the risk-pooling mechanism within that insurance company (e.g., if insurer is located in an area where there are a lot of HIV cases). If an individual is deemed to be high cost, then that individual is placed in a pool, with costs shared amongst all insurance companies. In 2010, the high cost threshold was Euro 22,500 per claimant per year. 90% of costs above this level are pooled.

Every insurer brings 90% of its claims burden over the threshold on an individual level into the pool (virtually, there is no real transaction of the money). This claims burden is then all added together and related to the total claims burden of all insurers together. When an insurer has a relatively low claims burden, it has to pay to the pool to compensate the insurers that have a relatively high claims burden of high cost individuals.

Risk Selection

Because of deficiencies in the Risk Equalisation Mechanism, insurers do try to select risks that are more likely to be profitable.

Although this is not allowed through differentiation in premium rates of benefits by risk profile of the enrolee, an insurance group typically owns several health insurance companies or "labels", with each label focused on a different customer segment. Through the different labels, the insurance group will use advertising, different distribution channels, product designs and premium rates to attract different market segments.

For example, an insurance group may have one label that focuses on the younger and healthier population, with a basic plan that is sold over the internet, has a very narrow network of providers, a deductible, and a relatively low premium. It would also market supplementary cover that is attractive to that population segment.

Some have tried to attract the chronically ill, such as chronic diabetics. The business plan was to create superior profit margins by organising care more efficiently. However, this did not work out, essentially because the Risk Equalisation Mechanism did not differentiate sufficiently between diabetics of different severity levels and co-morbidities.

Provider Reimbursement

The Netherlands has a history of provider fees negotiated between the government and providers.

GP tariffs are negotiated with government at national level. There is a fixed fee per patient on their practice list, and then additional fee per consult. Certain procedures can be negotiated between GP and insurer (e.g. certain scans, or certain procedures carried out by GPs instead of specialist).

Most specialists are hospital based. Roughly two-thirds of hospital-based specialists are self-employed, organised in partnerships and paid on a capped fee for service basis. The remainder are salaried. The hourly rate of medical specialists is based on a standard practice income and based on 1555 billable hours per year. It is based on the cost components income, individual costs and practice related costs (like secretarial support, liability insurance etc). Besides the hourly rate there are standard times for the activities of a medical specialist within each DTC per relevant specialism. There is a bandwidth around the hourly rate leaving room for negotiations between hospital boards and medical specialists

Payments are related to activity through the Dutch version of DRGs known as Diagnosis Treatment Combinations (DTC). In the DTCs, average medical specialists' hours are set and the hourly tariff is negotiated between medical specialists and the government, so DTCs include the remuneration of medical specialists.

Most hospitals are quasi-public, non-profit organisations. Hospitals are financed through the billing of DTCs to health insurance companies or patients. The tariff for a DTC is set by the Netherlands Care Authority (approximately 66% of all DTCs in 2009, which we refer to as "A-DTC") or is negotiated between the health insurance company and the hospital (approximately 34% of DTCs in 2009, which we refer to as "B-DTC"). For the part that is financed through A-DTCs, hospital budgets are developed using a formula that pays a fixed amount per bed, patient volume and

number of licensed specialists, in addition to other factors. A hospital has to stay within this budget. If there is a difference between the budget and the production through A-DTCs, the tariff of the A-DTCs will be adjusted (and thus can differ per hospital). Additional funds are provided for capital investment, although hospitals are increasingly encouraged to obtain capital via the private market. From 2000, for several years payments to hospitals were rated according to performance on a number of accessibility indicators.

The insurer-negotiated B-DTCs are usually the more basic, routine-type procedures. There is still considerable debate about the desired speed of further liberalisation of the hospital market.

There have also been experiments with pay-for-performance reimbursement mechanisms, where agreed key performance indicators and quality measures are explicitly reflected in the final reimbursement amounts. Some examples on P4P projects are on COPD, physiotherapy and diabetes. The focus is very much on integrated care and measuring health outcomes from different perspectives- health provider, patient (quality of life, but also patient experience as to the process of health care provided), and innovative technology.

Claims Control Mechanisms

Various cost containment measures have been implemented, such as:

- Gate keeping
    - By law, a referral by the general practitioner is required for access to specialist care.

- Pre-authorisation
    - There are a number of services and supplies that require prior approval of the insurer before they can be provided.
    - This includes treatments abroad and for some medicines and medical supplies because certain pre-conditions have to be met by law.
    - Some health insurers do require pre-authorisation for some other treatments but insurers have cut down pre-authorisations over the last few years.

- Provider contracting
    - By-and-large, this mostly revolves around fee negotiations, although there are significant efforts being made into measuring and comparing medical outcomes and quality of care.
    - Although most insurers contract with all providers, some products targeted at the younger population do have networks with restricted numbers of providers.
    - Some insurers encourage use of specific providers by reimbursing deductible if the insured go to those providers.
    - It is interesting to note that the networks include providers outside of the Netherlands.

- Disease management programs
    - The government has been pushing insurers to develop disease management programs. The major conditions covered are diabetes, COPD, asthma, heart failure, and depression. It appears that most of the progress has been made with diabetes, with some provider groups agreeing to capitation payments.
    - These programs aim to bridge the gap between hospital and community care, although there is conflicting evidence about their effectiveness.

- Pharmacy benefit management
    - Insurance companies have contracts with the providers, whereby the providers agree to substitute branded drugs with generic drugs, where suitable.

Case management is not really done, which is understandable, given services are funded by DRG. Case management in the Netherlands is mostly focused around long term care for example care for dementia patients, which is financed by the social health insurance

Quality Assurance and Benchmarking

Initiatives in these areas are being driven by the government and the insurance companies.

The government website provides information on health care providers (including indicators of quality) and health insurers, with the aim of allowing the consumer to make informed decisions when selecting health care and insurance providers.

To support health organisations in achieving the goal of making care transparent and developing a set of publicly available information on quality of care, the government has set up the program "Zichtbare Zorg" (Transparent Healthcare) in 2007. This program supports the different sectors in health care and connects developments from one sector to another. Also the program is to guarantee that the published information is valid, reliable, and truly comparable. This program has done extensive research on the development and the administration of quality indicators in nine different countries.

'Zichtbare Zorg' aims to develop quality indicators for the whole health care market, from GP-care to care for the disabled to hospital care and pharmaceutical care. This broad approach is seldom seen in other countries, where the control for development and maintenance of quality indicators is often fragmented or divided across different organisations.

Transparency of quality of care is high on the priority list of health insurance companies as they see increased transparency (by gathering comparable information, and sharing and discussing this information with health care providers) as a strong incentive for quality improvement.

Quality information is gathered by insurers on the basis of diagnoses (e.g. CVA, different forms of cancer, heart failure, hip or knee replacements, cataract etc). The information can usually be split into three groups: medical (for example the number of readmissions, wound infections, severe pain etc), processes (for example door-to-needle time with a CVA) and structure (for example presence of a registration system for complications, having standard multidisciplinary meetings before a surgery etc).

Currently, health insurers are reluctant to actually use quality information for health purchasing strategies, because they feel that quality improvement can only be established through partnership with health care providers. When a benchmark on quality of hospital care is more developed and more accepted by the health care providers, the information can be used for health purchasing strategies.

Some commentators see increased transparency of quality of care as being essential for the success of the system. If there is no transparency, then contracting with providers does not matter. Some are optimistic that this can ultimately be achieved.

Others are worried that the low mobility from one insurer to another may be indicative that mobility will also be low between providers, which would mean that quality measures may make little difference to the flow of members and patients. Distance and waiting lists, i.e. convenience may be more important than quality of care, particularly if the perceived quality of care is not materially different between hospitals.

Appeals Mechanism

If there are differences of opinion as to what is covered under the insurance, the insured has the right to address the issue to an independent organisation Health Insurance Complaints and Disputes Foundation (SKGZ) to judge whether the procedure / medicine / treatment should be covered. The SKGZ can ask the Health Care Insurance Board (CvZ) for opinions on cases where medical expertise is required, but it does not have to abide by their recommendations.

The criteria applied in the decision-making include:

- Is the specific request for coverage described in the Health Insurance Act?
- Does the insured meet the requirements for the specific procedure?
- Is there a reasonable need for this type of treatment?

Regulations

Regulation by the government is constituted by the Health Insurance Act (ZVW) and the Health Market Regulation Act (WMG). The latter has replaced the Healthcare Tariffs Act with the objective of stimulating competition in the health care market.

The ZVW describes the duties and capacities of the Healthcare Insurance Board (CVZ). The CVZ is a consultant as well as an implementation organisation for the ZVW and the Exceptional Medical Care Act (AWBZ). The CVZ has an important role in keeping up the level of quality, accessibility and affordability of Dutch health care. This role is carried out by performing three nuclear tasks:

1. Advise on the health insurance scope of coverage
2. Distributing risk equalisation amounts to health insurance companies

3. Executing special regulations for certain groups (for example for retirees abroad).

The Netherlands Care Authority (NZA) handles the majority of the day-to-day supervision of the lawful execution of the ZVW. Its powers are derived from the WMG, which contains regulations that promote efficient health care system and cost control and consumer protection. The WMG also describes how tariffs are established.

The NZA supervises both healthcare providers and insurers, covering all three insurance programs, i.e. MPHI, VPHI, and Extended Medical Care Social Health Insurance. Its objective is to ensure consumers receive value for money by promoting efficiency, choice, quality and accessibility of health care and health insurance, and ensures there is sufficient disclosure of information on the service / product at the point of care / sale. In its role as "caretaker" of the health care market, the NZA monitors the performance and market conduct of the different health insurance companies and intervenes, when necessary.

Besides a supervisory role, the NZA has also a regulatory role. It negotiates the tariffs and budgets for nearly all health care providers in the Dutch health care market. Applications for new health insurance licenses go through the NZA. Insurers have to get their "model agreements" approved by the NZA before selling health insurance products in the market.

The division of roles between politics and the NZA is clearly defined in the WMG. The government determines the outlines of health care policy and the NZA supervises the application of the WMG. For example, the government decides which segments of the health care market can be more or less deregulated, and the NZA decides on the precise design of the regulation.

There are areas of potential conflict between politics and the NZA. The NZA is allowed to (independently) set tariffs, but on the other hand, the government is responsible for the national health expenditure. There is an agreement that the NZA informs the government if it thinks a particular change in tariff will have a substantial impact on the national budget.

Other government agencies that are involved in the regulation of insurers and health care providers include:

- The Netherlands Bank (DNB) licenses insurance companies, including health insurance companies, and supervises the prudential / solvency aspects of health insurance companies.

- The Netherlands Authority for the Financial Markets (AFM) has been responsible for supervising the operation of the financial markets since 1 March 2002. This means that AFM supervises the conduct of the entire financial market sector: savings, investment, insurance and loans. By supervising the conduct of the financial markets, AFM aims to make a contribution to the efficient operation of these markets.

- The Health Care Inspectorate (IGZ) promotes public health through effective enforcement of the quality of health services, prevention measures and medical products.

- The Netherlands Competition Authority (NMa) is the competition regulator of Netherlands. They supervise health Insurance companies on the basis of the Law of Competition

Observations

The new Health Insurance Act aims to increase competition between private health insurers and providers to control costs and increase quality.

- Private health insurers are currently very competitive; margins range from –3% to +3% of premiums. And insurers appear to be relatively efficient in that medical costs making up 80%-90% of premiums. In fact, when mandatory PHI was first introduced, the regulators were worried about capitalisation of insurance companies because insurers were competing for market share via low premium rates.

  However, although there are around 30 health insurance companies in the Netherlands, these belong to 12 health insurance groups, with the four largest health insurance groups making up 80% of the market. In 2006, the first year of implementing the new system, some 18% of the insured population changed their insurers. Since then, the mobility of members in the last few years has been low, around 4%-5%. There is a fear that eventually insurers may settle into their respective niches and there could be less competition in the future.

- There is also increased competition amongst the hospitals.

  Hospitals used to get a budget from government every year. Now the fees for 34% of the services are negotiated with health insurance companies. Insurance companies looking at quality of care, transparency to compare hospitals, and identify preferred providers for different specialties/conditions. This is quite new to the hospital market in the Netherlands and is driving hospitals to be more competitive. The traditional Dutch hospital model is that of large multi-specialty hospitals. However, some hospitals are now specialising in certain procedures to improve their expertise, seek large volume of patients, and be more efficient. This is creating a market for new types of providers.

On the balance, the current report card appears to be quite good. By and large, the various stakeholders and observers appear to hold the Dutch healthcare system in high regard, with only minor complaints from the various healthcare system stakeholders and a few areas for improvement.

- Insurers complain about the bureaucracy and costs of regulatory compliance.

- Some healthcare providers remain cautious and express concern that greater bargaining power of insurers may undermine professional accountability by pushing the healthcare sector to prioritise cost control ahead of care quality.

- The Risk Equalisation Mechanism needs to be improved. It is relatively expensive to administer and the predictive power of the ex-ante risk adjustment system is still low. There are plans to improve this further.

The conceptual building blocks appear to be fundamentally sound. There is an emphasis on primary care, a push for chronic disease management and integrated care, transparency, and promotion of competition. The overall health care system does certainly appear to be more dynamic since the reform of 2006.

However, it is still too early to conclude whether all this activity and competition will be able to contain costs in the long run. Also, does competition impact quality, and what are the consequences if the socially minded culture of Dutch healthcare providers is replaced by a more entrepreneurial one? And finally, the financing system still operates on a pay-as-you-go basis, with large cross-subsidies between the relatively young and the old; the problem of financing healthcare for the aged remains.

SECTION 3.4: SWITZERLAND

Overview of Health Care System

Switzerland has an insurance-based health system that focuses on individuals and is governed by cantons similar to the decentralised political system. Mainly, the 26 cantons are responsible for the provision of healthcare. The national government's role is limited by the constitution to one largely of public health and regulation. Medical services are mainly paid for through an insurance system that covers all residents in the country. Insurance coverage is an individual choice. Therefore, every individual, including children, can choose a plan for himself or herself which is being offered by the competing insurers in their canton.

A new Federal Health Insurance Law (LAMal) was passed in 1994, which introduced full coverage in basic health insurance through insurer competition. The LAMal increased the scope of services offered under statutory health insurance and made the basic package richer in benefits. LAMal also made the basic package mandatory as defined by the Swiss federal government and regulated by the Federal Office of Health.

Individuals can purchase supplementary insurance to fund any additional health care.

The providers in Switzerland can be either public or private. Almost 80% hospital beds are in public hospitals. Public hospitals get guaranteed deficit coverage and/or subsidies from public funds and private hospitals do not. The insurers are responsible for only 50% of the operating costs to be paid to the providers, the remaining 50% are funded through government subsidies for public hospitals whereas supplementary insurance or out of pocket payment fill that gap for private hospitals. Depending on the canton public providers can get subsidies that may amount up to 50% of their income. This is a big disadvantage for private providers. It is to be noted though that some private hospitals that have significant basic package insurance clientele can also get some subsidy depending on the canton.

The other 50% of public hospital costs – and the costs of private hospitals ineligible for government subsidy – are funded through competitive means. This is either through payment from insurance companies as part of an individual's insurance policy; or fixed co-payments, supplementary insurance and/or out-of-pocket payments.

Eligibility, Enrolment, and Mobility

It is mandatory for every individual to enrol for the basic package. Individuals who do not purchase the mandatory basic package get automatically registered by their canton. However, they are liable to pay a penalty.

There is an open enrolment policy to ensure that insurers accept all applications and each insurer also offers same price for same product to all the individuals in a given canton. Insurers cannot refuse individuals deemed at risk of incurring high medical costs. The open enrolment policy also ensures that vulnerable groups have good access to healthcare and that health care is universal.

Individuals can change their insurers two times in a year if they are not satisfied with the insurer they are enrolled with.

The supplementary insurance is voluntary. Supplementary policies may be offered by any insurer. For supplementary insurance there is no open enrolment and insurers are free to charge higher premiums to those individuals they deem to be of higher health risk. It is however illegal for insurers to sell a joint basic and supplementary policy and insurers have a responsibility to inform patients which treatments are and are not covered by their basic package.

Scope of Cover and Benefit Limits of the Basic Package

The "basic package" is mandatory and is categorised under two headings:

- Sickness Insurance
- Maternity Insurance

In combination, they cover the following scope of services:

- Hospital stay in any general ward of the canton of residency;
- Semi-inpatient treatment, e.g. eye or psychiatric clinic;
- Outpatient care;
- Nursing care, of up to 60 hours per week at home or in a nursing home;
- Examination, treatment and nursing in a patient's home by a physician or chiropractor;

- Rehabilitation ordered by a physician, including health resorts (of up to CH 10 per day);
- Physiotherapy and ergo therapy (maximum 9 sessions)*;
- Nutritionist consultation (maximum 6 sessions)*;
- Diabetic consultation (maximum 6 sessions)*;
- Psychiatric consultation*;
- Emergency treatment abroad;
- Transportation and rescue costs (50% of emergency transport costs up to CHF 5,000 per year and 50% of non-life threatening transport up to CHF 500 per year);
- Legal abortion;
- Maternity costs, including 7 routine examinations, post-natal examination, childbirth and 3 breast-feeding consultations;
- Dental treatment is not generally covered unless it is accident or sickness related;
- Contribution to spectacles and contact lenses of CHF180 per year for children and CHF 180 over 5 years for adults;
- Pharmaceutical benefits.

* After physician referral

The cost sharing in the basic package includes a deductible and coinsurance.

- The minimum deductible is CHF 300 and maximum is CHF 2,500 per annum depending on the product chosen. Though the scope of cover remains same, premiums vary depending on the deductible chosen

- There is a 10% coinsurance after meeting the deductible with a maximum limit of CHF 700 (CHF 350 for children) to safeguard individuals from high out of pocket payments

- Individuals without children under age 18 must also pay a small "hotel charge" of CHF10 per day for inpatient care.

Variety of products

Insurance companies can compete on the levels of premiums and deductibles required of the insured as the package of services covered is defined in law and is uniform.

In addition, insurers can offer health plans that employ managed care organisation (MCO) initiatives to control medical costs; typically by reducing the patient's choice of health care provider. The MCO premium is generally less than that for a health plan with no restrictions on choice of provider. The other benefit features and cost sharing remain the same. Approximately 8%-9% of people enrol into MCOs. In terms of how intensely MCOs try to manage medical costs, this can range from tightly managed (like Health Maintenance Organisations in the USA) to loosely managed plans.

The basic package itself is very comprehensive; hence supplementary insurance is strictly speaking not necessary. Approximately 30% of the population purchases supplementary insurance mainly for the choice of a superior hospital room because the basic package only covers treatment in a general ward.

Examples of supplementary insurance packages include:

- Ensuring increased comfort and privacy during treatment; such as "private", a one-bedroom room;
- Extending coverage to treatments not included in the basic package e.g. more comprehensive dental care;
- The freedom to choose any hospital for "basic" treatment;
- Guarantees of receiving treatment from the most senior physicians.

Exclusions

Services not covered include routine dental care, complementary medicine, pharmaceuticals not listed in the approved lists, and non-essential interventions.

Transportation and emergency rescue services, spectacles and medical aids are partially covered.

Premium Pricing

Switzerland has community rating, whereby adults pay the same premium within a given health insurance plan by the same insurer and within a given premium region. Insurers can have up to three premium regions within a canton to accommodate the disparities between urban, semi-urban and rural communities. However, insurers are allowed to compete on price, subject to oversight from the Federal Office of Health.

Insurers give premium discounts for children that are insured along with their parents, with the discounts given often increasing with the number of children.

There are approximately 87 insurers in Switzerland who offer the basic package with deductibles ranging from CHF 300 – CHF2,500 and with different premium rates.

Insurers in Switzerland cannot write group contracts after the advent of new insurance law in 1994. The new law explicitly makes it illegal to write any group contracts.

Funding of Premiums and Subsidies

Every individual is required to pay for his/her insurance.

There are subsidies for the poor and needy. The subsidy is directly paid to the individual and not routed through the employer or insurer, which is different from many other social health insurance systems.

The subsidy is based on income tax filings. If the premium is deemed excessive relative to income by the canton, then the individual receives a personal subsidy to pay the premium upon furnishing the required documentary proof. Some cantons are more generous and provide subsidies if the premium reaches 5% of the annual income for a family, whereas other cantons are more strict, allowing the subsidy to kick in only if the premium reaches 10% of the annual income.

Approximately 35%-40% of households get some form of subsidy. The maximum premium subsidy offered is typically the average premium in a given canton.

Risk Equalisation

Risk equalisation is handled by "Foundation 18", a body established by registered insurers and run by the government. This system redistributes funds from those health plans with lower health risks to those with higher health risks.

Risk equalisation is based on the age and sex of enrolees. This risk equalisation is retrospective, with the adjustment being made after a lag of about a year.

Physicians by law are supposed to transmit diagnostic information to the insurers. However, they have resisted so far, in order to avoid too much control by the insurers, citing concerns over patient privacy.

Without diagnostic information, the factors that can be taken into account in the risk equalisation process are rather limited. A new formula for risk equalisation is expected to be implemented by 2012 with a new variable of "hospitalisation of more than three days during the previous year" subject to parliamentary approval.

Risk Selection

With open enrolment to guarantee universal coverage, insurers are technically not allowed to "risk-select"', that is to avoid insuring those with higher health risks in favour of the young and healthy. In a competitive market, the incentive for insurers to select favourable risks will only be removed if risk equalisation is perfect; i.e. when insurers receive adequate compensation for having the old and sick on their books. Moreover, being largely retrospective, risk equalisation undermines insurers' incentives for cost control. In fact, cost overruns in under-performing funds are partly passed on to other insurers.

In Switzerland, risk equalisation is based only on sex and age. There is plentiful evidence to suggest that insurers have continued to select favourable risks. For example, insurers seeking to attract good risks by proposing additional options such as

high no-claims bonuses and targeted marketing. No claims bonuses are regulated by law and cannot exceed 45% of baseline premium.

Another way of risk selection is to come out with different types of supplementary insurance policies that could be purchased along with the basic package from the same insurer. Through selecting risks for supplementary cover, some risk selection happens for the basic package automatically.

A recent approach to risk selection is the establishment of financial conglomerates where the riskier individuals are shifted to an insurer of the same conglomerate who charges a high (but still uniform) premium. In this way, it becomes possible, to a degree, to differentiate premiums for different risk groups within the conglomerate, while complying with the letter of the law.

Provider Reimbursement

Primary care providers are funded purely through reimbursement from insurers. Doctors are paid by insurers on a fee-for-service basis for services encompassed by the basic package. As a result, cantons have limited influence over the organisation of its provision – the vast majority of primary care providers are independent practices of GPs and specialists.

The fees for ambulatory care are based on a points schedule, TarMed, negotiated by the medical association and the health insurers' association at the federal level. The schedule indicates the relative price, which is based on "points" calculated for specific services on account of the time spent on each patient, the competence of the doctor and the type of treatment provided. The price in terms of money is then negotiated between associations of insurers and doctors at the cantonal level. Not surprisingly, this process has been criticised by many, including the OECD, for being over-bureaucratic, although it is somewhat a function of cantonal independence.

Unlike primary care, cantons have extensive authority over the hospital sector. Cantons are responsible for planning the provision of services according to local needs, negotiating uniform prices for medical treatment (payable by insurers to providers) and compiling a list of hospitals eligible for reimbursement of the services covered by the basic package that is delivered in public wards. This decentralised authority means that patient experience at hospitals varies to some extent across Switzerland because

cantonal objectives differ in terms of the relative focus on delivering high quality services, ensuring cost-efficiency and curbing excess capacity. However, the disparity in terms of outcomes is not very high because the treating physician can recommend a particular individual living in a rural area to be treated in a more sophisticated hospital in an urban area that may be outside the canton.

Insurers fund hospitals on a per diem basis, with flat, all-inclusive daily fees for a delivered for basic package in a public ward. The fee does not vary by type of diagnosis or differ if a surgery is involved. This creates an incentive to extend the length of stay of a patient in order to earn more revenue. This could be the reason why the average length of stay is high in Switzerland when compared to international average

All the cantons are supposed to move to the DRG payment system by 2012. Two small cantons have already adopted this system. Some hospitals are not very confident about this because their accounting systems currently do not allow them to identify its profit margins for different DRGs. They have resisted the change so far under the pretext that it requires too much regulation.

Claims Control Mechanisms

Individuals are free to go straight to a specialist for treatment without a GP referral, unless the individual is a member of an MCO plan. MCOs require a referral from a GP to see a specialist, which generally helps them achieve up to 30% savings in cost.

MCOs generally take the following initiatives to control costs:

- Form physician networks
- Transfer some risk from insurers to physicians via capitation payments
- Formulate second opinion programs within the physician network
- Physician gate keeping, designed especially to avoid costly hospitalisation

There are no disease management programs in Switzerland and wellness programs are generally added as a feature in supplementary insurance.

Quality Assurance and Benchmarking

As in most countries, health care is characterised by an asymmetry of information to the detriment of consumers. Health insurers have done little to improve the situation; for example, they do not have lists of recommended providers except in MCOs. There are no guides that rate hospitals on any quality parameters.

There are some independent industry publications that provide information on customer satisfaction, quality systems, financial reports and the level of required reserves for different insurers to facilitate individuals in choosing their insurers. However such publications are not very sophisticated.

There are some private independent intermediaries(sort of agents and brokers) who can help individuals choose a right plan for them and suggest good quality insurers based on available parameters. They charge a fee from the individual for this service.

There is a National Association for Promotion of Quality in Health Care that largely caters to the information exchange amongst the providers so that they can benchmark themselves.

Appeals Mechanism

Dissatisfied consumers can send a complaint to the insurer, who is required by law to send a written response to the complaint. For addressing any disputes that are not resolved directly by the insurer, consumers can either appeal through an independent ombudsman or through a specialised court that deals with issues of insurance.

The ombudsman is generally not very powerful and only has a reputational impact, being a senior person of the industry. An appeal to the insurance court would require representation by a lawyer.

In the case of hospitals, physicians, and ambulatory care centres, an appeal could be made to the medical association of the given canton.

Regulations

The Federal Office of Health is responsible for the day-to-day regulation of the health insurance industry, including solvency, for the basic package. Insurers must register with the Federal Office of Health to be able to sell the basic health insurance package. The premiums are subject to annual auditing before their introduction, and the Office can force insurers to reduce them if they are deemed to be too high.

For supplementary insurance, the regulatory authority is vested with the Federal Office of Private Insurance. Insurers who are offering both the basic package and supplementary insurance have to meet the requirements of both regulatory bodies.

There is a Federal Commission that decides about admission of new procedures and pharmaceuticals in the basic benefit package.

The decentralised financial mechanisms of the Swiss health care system are mirrored in the organisation of provision. There is some federal authority, for example the National Association for Promotion of Quality in Health Care, which is charged with managing and monitoring provision. Moreover, physicians can enrol both in the medical association of their canton and the federal association. However, the provision of primary care is largely independent and it is local cantons that have substantial authority over the provision of hospital service.

Observations

The basic insurance package covers the entire population. The basic package is quite comprehensive, and supplementary insurance is largely viewed as a means for getting treatment in a superior room rather than the general ward.

Waiting times for treatment are short or non-existent and the uptake of new technology and drugs is high. The quality of care is generally good, with patients generally satisfied with the care they receive.

There are limit variations in the basic insurance package and within these packages, insurers are competitive on the only parameter on which they can compete, which is premium rate.

However:

- The Swiss health care system is expensive with costs increasing every year and not much cost control mechanisms in place for the basic package. Switzerland spent 10.8% of its Gross Domestic Product (GDP) on health in 2007. The cost has been increasing steadily in Switzerland, rising by 2.4% points of GDP between 1990 and 2004, above the OECD average increase of 1.5%. Due to the increase in medical costs, premiums have been generally increasing every year.

- Providers do not generally compete on price. As to ambulatory care, fees are regulated by TarMed. As for public hospitals, they form cantonal associations which negotiate uniform per diems with cantonal health insurance associations. In addition, the canton will bail them out if there is any deficit. As to private hospitals, they cater to patients with complementary health insurance coverage who therefore are not much concerned about price either. However, providers compete on quality to attract individuals and earn per diems.

- There is not much transparency in the information provided to consumers about the quality parameters or rankings of insurers as well as providers.

- The risk equalisation system is weak because providers will not provide the necessary diagnostic information to develop a more sophisticate and robust system.

Overall, the Swiss system delivers unimpeded high quality care to its citizens, despite what appears to be relatively loose controls. Some countries may not be able to afford to maintain such a system.

SECTION 3.5: AUSTRALIA

Overview of Health Care System

Health care in Australia is provided by both public health care providers and private health care providers. Most of the following comments focus on primary care and inpatient care.

Public Health Care System

Public health care providers deliver a negligible proportion of primary care services. The government's role in the delivery of primary care is mainly restricted to public infant health services, antennal clinics, immunisation clinics, community health centres, hospital outpatient departments and accident and emergency units – all mostly provided from within public hospital campuses.

Around two thirds of inpatient hospital beds are financed by state governments but many are actually owned by religious and charitable groups. There are significant waiting times for elective surgery in the public sector but comparatively little waiting times for elective surgery in the private sector. The waiting times in the public sector are mainly caused by restrictions on the funding provided by State Governments. These restrictions are known in Australia as funding "caps". Often procedures in public hospitals can be suddenly cancelled on the "doorstep" of the operating theatre because the theatre is suddenly needed for a higher priority patient.

Nearly all medical practitioners practice in the private sector but many specialists also work part time in public hospitals and receive a modified fee for their services in that sector from State governments. The modified fee for service is generally derived from the Commonwealth Medical Benefits Schedule (i.e. 100% of the MBS is often used). The fees are determined from negotiations between area health services (or State Governments) and the Salaried Medical Officers' Association or their equivalents. Some hospital specialists are paid salaries and some are paid sessional fees instead of fee for service or even low sessional fees plus fee for service. The fee for service amounts may be different for different specialists and may vary according to whether the specialist is on call or not and in accordance with his or her other rights and conditions. The remuneration structures and conditions are confidential between each specialist and the Area Health Service.

Private Health Care System

Private General Practitioners deliver the majority of primary medical care. There is a financial incentive to obtain referral from a GP before consulting with a specialist as the specialist consultation services are reimbursed by Medicare at a higher rate when there is a valid referral. In some general practices a nurse practitioner may work under the supervision of the GP and there is a move by government to extend the role of nurse practitioners working in GP practices.

There is no requirement for referral from GPs to physiotherapists, chiropractors, dentists, etc and private health insurers are specifically debarred from such requirement to obtain benefit entitlement. PBS Pharmaceuticals may only be purchased on prescription from a medical practitioner or dentist. So a pharmacist's role in delivering primary care is more restricted than in some countries.

Most ancillary private service providers are required to be registered with state registration boards and insurers restrict benefits to registered providers. Some provider groups are not registered and insurers then use membership or proof of capability of membership with specified professional bodies as the main requirement to be recognised for benefit purposes.

Private hospitals provide around one third of inpatient beds. However, they do provide the majority of procedural operative services[1]. While public hospitals operate private beds, private hospital charges are significantly higher than public hospital charges to private patients. There are two reasons for this. Firstly, public hospitals get separate grants for capital expenditure from state governments whereas private hospitals have to fund capital costs out of their operational income. Secondly, Medicare is supposed to provide free, at point of service, public hospital care to all Australian residents, therefore the charges raised by public hospitals to privately insured patients theoretically are for the additional costs of being a private patient (as distinct from being a public patient). In practice there is a political process which sets the minimum benefits to be paid by private health insurers for private patients in public hospitals. Currently these benefits are indexed annually by the change in the consumer price index. State Governments set the public hospital charges to be raised to non-

[1]Private hospitals do all of the procedures provided in the public sector with the exception of a small number of highly complicated procedures such as heart/lung and liver transplants. Even then these procedures are done in one hospital that has a co-located private hospital by specialists who operate in both sectors. So it is not correct to say the private sector does less complicated procedures

Australian residents and for services covered by Workers' Compensation laws and the like. These charges tend to be higher than those by private hospitals.
The Productivity Commission has recently released a report into the relative efficiency of public and private hospitals. The supplementary report, which was based on three years data (not one as was the main report) suggested, in relation to efficiency, that:

- Australian acute hospitals were estimated to have scope to improve their efficiency by about 10 per cent under the existing policy environment.
    - For-profit and 'public contract' hospitals were estimated to be more efficient than public hospitals on average, in terms of their potential to increase output for a given set of inputs.
    - However, for-profit, not-for-profit and public hospitals were found to be similarly efficient with respect to their potential to economiseon input use for a given level of output.

- Smaller public hospitals, many of which are located in more remote communities, were found to be less efficient than similar-sized private hospitals, possibly due to lower occupancy rates.

- The Commission also sought to measure the determinants of hospitals costs, but the available financial data such as capital and medical costs was inadequate.

- There are various other shortcomings in data quality and availability. These would need to be overcome if policy analysts and other researchers are to produce improved estimates of efficient costs of providing hospital care.

Overview of Health Care Financing System

The main sources of financing are:

- Public tax funded Commonwealth programs, i.e. Medicare medical benefits, the Pharmaceutical Benefits Scheme ("PBS"), residential aged care and contributions to States public hospital funding through the Commonwealth/State health care agreements.

- A tax funded Commonwealth program of hospital services for veterans, war widows and their eligible dependants under legislation administered by the Department of Veterans' Affairs. Also there is a similar program for defence personnel but it costs comparatively very little.

- State government funding of public health (mainly hospital) facilities. The Commonwealth also provides funding directly to the States through a Health Care Agreement between the Commonwealth and each State Government although these moneys are further subsumed into a Council of Australian Government's agreement which is signed by the Australian Prime Minister and every Premier of every State and Territory.

- Voluntary private health insurance

- Private charges, i.e. amounts paid directly by the patient

- Others sources, which are mainly workers' compensation insurance and other third party insurance sources.

Appendix 3A illustrates the financing of each component of health care provided in Australia in 2007/8.

The following are further highlights on some of the major insurance programs.

Medicare

Medicare covers outpatient and inpatient care in both the public and private sector.

Medicare benefits are based on the Medicare Benefits Schedule ("MBS") set by the government. On non-hospital charges, Medicare usually pays 100% of the fees charged by general practitioners and 85% of the MBS fees for other non-hospital services listed on the MBS, with a safety net on out-of-pocket expenses exceeding an annual threshold.

Under Medicare, treatment is provided for free in a public hospital but there is no choice of doctor. People can choose doctors in public hospitals only when they opt to be treated as private patients, but this incurs two co-payment burdens for the individuals. Firstly the public hospital raises a relatively low per diem charge and secondly the hospitals do not pay doctors for treating private patients so the doctors charge their patients. Medicare only reimburses private patients in public or private

hospitals 75% of MBS fees but medical charges can exceed 250% of the MBS fees. In private hospitals patients have to bear all of the hospital costs such as accommodation, operating theatre fees, prostheses charges, etc. Most private hospital patients are therefore covered by private health or other third party insurance.

Pharmaceutical Benefits Scheme (under Medicare)

Medicare also provides pharmaceutical benefits under the PBS, which subsidises an agreed list of over 2,600 prescription medicines. Except for some very high-cost medicines, which are dispensed only through hospital pharmacies, the vast majority of subsidised medicines can be dispensed through private community-based pharmacies.

Patients are required to make co-payment towards the cost of medicine under PBS. The general co-payment in 2010 is up to AUD33.30 per prescription, while concession cardholders can enjoy a more favourable charge at AUD5.40. The amount of co-payment is adjusted each year in line with the consumer price inflation[2]. The co-pays are subject to an annual limit, after which a safety net kicks in.

Medicare and PBS are financed out of consolidated taxation revenue. There is also an explicit payroll tax of 1.5% of incomes above a low threshold administered by the Commonwealth government, known as the Medicare Levy but this levy only meets a fraction[3] of the costs of Medicare. For individual taxpayers in 2010/11, the income threshold is AUD18,488 with the full rate cutting in at AUD21,750. Families have a threshold of AUD31,196 plus AUD2,865 for each child. Seniors (over pension age) and other pensioners (under pension age) get higher thresholds than individuals. This levy is paid to consolidated revenue and not separately reported. It is understood to raise only around 15% of the total cost of Medicare (including state hospital costs).

Veterans

The Commonwealth Department of Veterans Affairs provides direct funding to War Veterans and their spouses of hospital treatment through a program that is equivalent to top-end PHI cover. It costs around AUD3.0 Billion per annum and is decreasing slowly. The main claimants are 2nd world war veterans, few of whom are younger than

[2]Why not medical inflation instead of CPI? If Medical inflation was used it would set a precedent for a number of Commonwealth benefits including some income benefits to be indexed by medical inflation. For example the MBS, prescribed public hospital benefits and disability income benefits.

[3]Believed to be about 15% but the amount raised by the levy is not reported

85 and so this part of the veteran population is declining rapidly. Also veterans from Korea and Vietnam are starting to claim significant amounts but they were far fewer in number than those who served in the 2nd World War.

Service Personnel

The Commonwealth also provides equivalent to PHI cover for defence personnel (but not their families). The cost of insuring service personnel is relatively insignificant.

Commonwealth Medical Benefits Schedule

The Commonwealth Medical Benefits Schedule lists rebates payable to patients for private medical services provided on a fee-for-service basis. It is a cornerstone of the Australian health care system, which facilitates patient access to general practice, specialist medical services, and allied health. In theory the benefits for each item contained in the schedule is assessed against contemporary evidence of safety, effectiveness and cost-effectiveness. In practice only about three per cent of all MBS items have been formally assessed, though a process has commenced to increase that percentage.

Around 20 years ago a resource based relative value study into the MBS was undertaken by the Commonwealth Government with participation by the Australian Medical Association. When it became clear that the study would show that the MBS fees were much lower than they should be across all practice areas the study was abandoned by the Commonwealth Government.

The Australian Medical Association maintains its own suggested fee schedule. This schedule has consistently higher suggested fees than the MBS with some items being a multiple of the corresponding MBS fees. This schedule doesn't have any overarching political bias but the various professionals that create this schedule would have their own biases in respect of their own specialties. The AMA suggested fee schedule is not a public document, its item numbers are different from those in the MBS and some do not have an equivalent MBS item number[4]. Some doctors use the AMA item numbering on their accounts to patients, which can cause interpretation problems for the Medicare benefit assessment.

[4]Both the AMA and the Doctor's Health Fund had been clients of consultant so he had access to AMA Schedule.

MBS items numbers are being added continually and there is a process whereby new experimental items can be listed for a limited period before review to determine permanency.

MBS item numbers tend to follow the structure of version ten of the International Classification of Diseases.

Voluntary Private Health Insurance ("PHI")

Australia has a history of PHI that extends back into the nineteenth century, which has laid the foundation for the scheme today.

Today, PHI essentially supplements Medicare for inpatient care, thereby reducing the out-of-pocket costs to patients choosing to seek care as a private patient at public or private hospitals. Medicare coverage of primary services is relatively comprehensive.

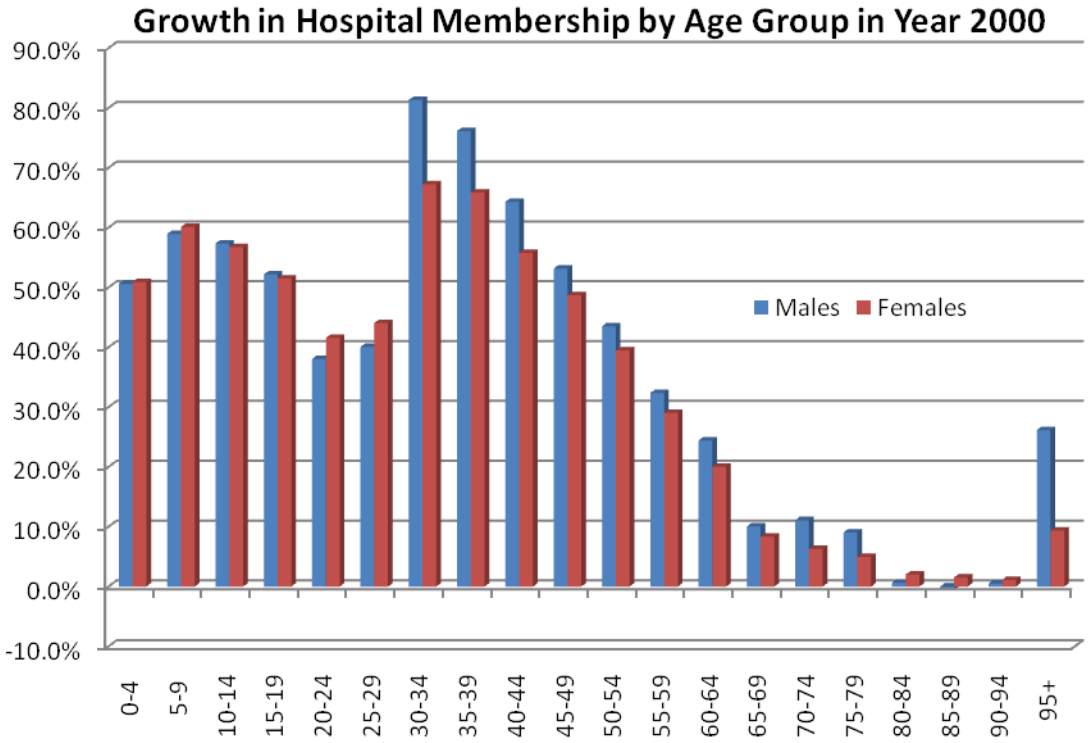
The Commonwealth Government uses a "stick and carrot" approach to encourage more people to purchase PHI.

- In 1997, the government introduced levy of 1% of income on high-income earners without PHI cover ("stick").

- In 1999, the government introduced a 30% PHI premium rebate ("carrot"), regardless of income.

A surcharge system, known as Lifetime Health Cover ("LHC"), was introduced in July 2000, following suggestions by actuaries concerned at the propensity of younger population to not be covered for PHI until they perceived that they had reasonably urgent need of it. The LHC imposes a premium surcharge of 2% on new entrants to PHI for each year older than age 30 at commencement, up to a maximum of 70% (at age 65).

A combined government and private health insurance industry publicity campaign in the first six months of the year 2000 increased the proportion of the population covered by PHI from 32% to 44% (See graph below for increases by age group in hospital insurance from December 1999 to December 2000). As the LHC program was introduced a year or two after the Medicare Levy surcharge and the 30% PHI rebate, the increase in PHI coverage will have been caused by the combined effect of all three measures and the joint marketing of the Commonwealth and private health insurers.



The remainder of this document focuses on PHI.

Eligibility, Enrolment, and Mobility

To ensure that applicants with higher health risks can gain access to PHI protection, health insurers are prohibited from selecting customers. There is no right of refusal on the part of insurers in handling fresh enrolment and renewal of contracts.

There is no maximum entry age but the LHC loadings are added onto hospital insurance to new entrants over age 30.
Cover is guaranteed for life. That is the insurer cannot cancel the contract and guarantees to renew it – upon the payment of the required premium.

The insurance is individual-based, and insured members are free to move from one insurer to another without penalty. There is specific "portability" legislation to enable transfers from one insurer to another or one product to another without serving waiting periods for existing coverage.

Small discounts are allowed for group contracts. The maximum discount permitted is 12% but this has to be theoretically justified by a reduction in management expense changes.

Some insurers also provide discounts of around 2% to 4% for premiums paid half yearly or yearly in advance. Others provide a small discount for premiums paid automatically through a bank account[5].

Scope of Cover

Cover is broadly divided into:

- Hospital/Medical cover
- Ancillary cover

Hospital/Medical cover

Health insurers are not permitted to cover ambulatory medical services.
PHI essentially supplements Medicare and covers the policyholder for the additional costs of being a private patient in either a public or private hospital. It also allows the policyholder to choose his/her own doctor or specialist, and the timing for any treatments required.

Policyholders can choose comprehensive cover with higher premiums, or pay lower premiums for reduced cover. Reduced cover may mean certain procedures (e.g. hip replacements, corneal transplants, coronary artery bypass operations, etc) are excluded or can only be sought as a private patient in a shared room at public hospitals without incurred co-pays. Policyholders can also reduce their premiums by opting to pay some of the costs through an excess or co-payment. Currently nearly 80% of all PHI policyholders reduce their premiums by electing to have excesses or co-pays or take cover with some exclusions (and perhaps excesses and co-pays).

[5]In NSW and ACT the state governments have ambulance schemes which all members of PHI hospital cover are automatically enrolled. Because full government pensioners are entitled to free ambulance cover in these states some insurers reduce the hospital cover premiums by the amount of the levy otherwise payable to the state government. Many insurers have stopped this practice on the grounds that hospital cover costs more for these pensioners so they should not be given the discount just because the insurer did not have to pay the levy.

Health plans must cover 25% of the MBS fee schedule for doctors' fees, taking the combined Medicare and PHI benefit to 100% of the MBS fee. However, nearly all hospital insurance includes a "Gap Cover" program[6] that often extends the cover up to the level of the actual fee, which can exceed 250% of the MBS fee[7]. If a patient's doctor chooses to participate in the Gap Cover program, this results in no or limited known out-of-pocket costs to the patient. Doctors who choose to participate in such programs are required where possible to make known their fees to the patient before the treatment or procedure. As a result 80% of all medical services covered by PHI have no additional patient copayment. For another 9% the patient has a known gap. This leaves 11% of medical services with an unknown gap. However, the average amount of OOP for the 11% of services not included in gap cover programs average around 70% of MBS fees.

There are some mandatory items in hospital/medical cover.

- Private insurers must cover the 25% doctor's fees co-payment required for private patients in public or private hospitals. They may set up approved gap-cover schemes beyond this and nearly all do.

- Each insurer must have policies that cover psychiatric, rehabilitation and palliative care at the minimum (public hospital) level.

- They must cover charges raised by public hospitals, but can exclude some services. For example an exclusionary policy might not cover obstetrics, hip replacements and treatment of glaucoma so as to make it particularly attractive to young singles and couples and relatively unattractive to couples planning a family, families and older singles and couples.

Ancillary cover

Policyholders can also choose to purchase ancillary cover, which may include a combination of the following:

[6]The major insurers would be heavily criticized by the Government and the media if they did not have significant gap cover schemes. The reason for these schemes is simple. The MBS fees are far too low to be realistic and the Government generally only increased MBS fees for specialists by increases in CPI rather than AWE or medical inflation.

[7]PHIAC provides statistics on this. For example in the December quarter 2009 1% of the no gap services and 3% of the known gap services had gap benefits of more than 200% of the MBS fee. An example is the MBS fees for obstetrics are only about one third to one quarter of the average charge by obstetricians.

- Dental treatment
- Chiropractic and acupuncture treatment
- Home nursing
- Podiatry
- Physiotherapy, occupational, speech and eye therapy
- Glasses and contact lenses
- Artificial aids and appliances: hearing aids, crutches, wheelchairs, nebulisers, c-pap machines, artificial limbs, etc.

Insurers are allowed to sell comprehensive packages[8], bundling inpatient cover with ancillary cover.

Broader Health Cover

Since 2007 insurers can also provide cover for chronic disease management programs but this is a very minor component of private health insurance so far. Most of the smaller insurers do not provide this cover.

The intention of broader health cover was to encourage insurers to provided chronic disease management and early discharge programs. In the December 2009 quarter total benefits for chronic disease management programs were 0.183% of all benefits paid (AUD5.4 million in $2.954 Billion). Early discharge programs are not specifically identified in statistics but insurers had been developing these programs for many years before the legislation for broader health cover was implemented.

Benefit Rules

There is a complex set of rules that govern the extent of benefits that may be provided by registered private health insurers. The details of each product being offered must be provided to the Health Insurance Ombudsman in a specific format for inclusion on the government website (www.privatehealth.gov.au). For information regarding the

[8]Insurers are not permitted to cover ambulatory medical services – except for some medical services included in a chronic disease management program. So, full medical/hospital comprehensive packages cannot be provided to Australian residents. However, some insurers do offer this cover to overseas residents temporarily living in Australia, such as overseas students etc.

legislated product compliance and obligations refer chapters 3 and 4 of the Private Health Insurance Act 2007 (updated to April 2010). The specifications of the Standard Information Statements are detailed in the Private Health Insurance (Complying Product) Rules, also a legislated instrument.

It should be noted that these rules exist in an environment where most benefits are defined in the contractual arrangements with providers. There are strong penalties for breach of the Private Health Insurance Act. These penalties may include action by the Commonwealth against the directors, closing the insurer, fines, imprisonment and commencing proceedings under Corporations Act and criminal laws. Generally the various penalties are shown in Chapter 5 of the Private Health Insurance Act.

100% Rule

Benefits cannot be more than 100% of costs.

Exclusions for pre-existing conditions, waiting periods and loyalty benefits

Insurers are entitled to impose a waiting period of up to twelve months on hospital/medical benefits for any medical condition the signs and symptoms of which existed during the six months ending on the day the person first took out insurance. They are also entitled to impose a twelve-month waiting period for benefits for treatment relating to an obstetric condition, and a two-month waiting period for all other benefits when a person first takes out private insurance.

They are permitted to have longer waiting periods (say two or three years for expensive selective items covered by the ancillary cover). Longer waiting periods are often included for such things as blood glucose monitors, hearing aids and full upper and lower orthodontic banding. They also are permitted to have loyalty bonuses for ancillary items – for example full orthodontic benefit entitlement may take 8 or 10 years continuous membership.

Insurers have the discretion to reduce or remove such waiting periods in individual cases. They are also free not to impose them to begin with, but this would place such a fund at risk of "anti-selection", attracting a disproportionate number of members with

pre-existing conditions from other insurers with lower benefits or tighter benefit conditions. Insurers usually waive the two-month waiting period but seldom, if ever, waive pre-existing or other waiting periods.

Benefit Limits

The limits on benefits paid are defined either by fee schedules with providers or policy rules in contracts with policyholders.

- MBS Fee Schedule
  - Firstly, after the Medicare benefit of 75% of MBS fee is paid the insurer must pay the balance of the charge up to a maximum of 25% of the MBS fee.
  - Secondly, subject to the gap cover arrangements implemented by the insurer a second benefit can be paid which meets the balance of the charge above the CMBS fee but this is limited to the maximum benefit limitation in the insurer's policy rules or contract with the doctors. It is not permissible to have overall annual or episodic limits on medical benefits payable.

- Pharmaceutical items
  - Ambulatory PBS items cannot be insured. Drugs issued to a patient in a private hospital can be covered under a private hospital contract This is irrespective of whether they are covered by the PBS system or not. If the drug is covered by the PBS system then only the patient co-pay is covered.

  - Some very expensive often new or experimental drugs that are not covered by the PBS system may be only partially covered by the insurer.
  - Overall limits on benefits for drugs provided in private hospitals are not permissible.
  - Public hospitals do not charge patients for drugs.

- Inpatient hospital treatment
  - No overall limits are permissible. People are covered for 365 days of acute hospital treatment a year. However, contracts with private

hospitals may specify maximum amounts payable for an item (could be defined by ICD10, DRG or MBS fees).

- There are government regulations about the maximum acute level benefits that are payable to people with chronic disabilities or degenerative illnesses. These patients may be defined as "nursing-home-type patients and are limited to 35 days acute level cover after which per diem benefits are severely restricted and patient co-pays are required. About 4% of public hospital days paid and 0.2% of private hospital days paid relate to nursing-home-type patients.
- Limits are permitted for ancillary covers. A typical annual limit for physiotherapy benefits might be AUD600 per person and AUD1200 per couple, family, etc. Some insurers define benefit limits in terms of calendar years or financial years but others use membership year (years based on anniversary of joining date).
- Most insurers also put a lifetime limit on certain elective benefits, such as orthodontic benefits.

Cost Sharing

Cost sharing mostly takes the form of the level of excess or co-payment selected by the policyholder and any shortfalls in the benefit limits vs. actual charges.

Generally hospital contracts are for the full amount of insurance cover except for chosen deductibles or co-payments. The table below provides industry statistics at March 31, 2010 on the percentages of hospital covers with deductibles and copayments and with or without exclusions.

Type of Insurance	**Policies**	**Persons Covered**
Exclusionary policies		
Excess & co-payments	11.7%	9.6%
No excess & no co-payments	4.5%	2.7%
Total exclusionary policies	16.2%	12.3%
Non-exclusionary policies		
Excess & co-payments	62.7%	66.7%
No excess & no co-payments	21.1%	21.0%
Total non-exclusionary policies	83.8%	87.7%
All Hospital Policies	100.0%	100.0%

As there is generally no direct contract between the insurer and a doctor, the insured is exposed to excessive charging but the doctor is strongly encouraged to give informed financial consent because of the increased benefits this brings patients. (This is because gap cover schemes require, where possible, for informed financial consent to have been provided by the doctor). Charges are unregulated for ancillary service providers so the patient has to meet the difference between the benefit and the provider's fee although some insurers are contracting with some preferred providers.

Currently, there is no specific regulation concerning limitation of cost sharing on private health insurance, although some insurance policies set maximum amount of co-payments that a policyholder can pay in a given year.

Legislation on maximum OOP costs is not considered to be necessary because OOP costs for hospital/medical treatment are generally known in advance and policyholders always have the safety net of the public health system. For example, elderly members on fixed incomes often use the public hospital sector for urgent and emergency treatment or regular treatment for chronic conditions and use their private health insurance cover for elective surgery where there is a significant waiting period at the public hospitals. This enables them to minimise medical OOP costs.

Premium Pricing

Premium rates are community-rated by law. All members regardless of age and health risk pay the same amount of premium for the same PHI product offered by the same insurer.

The insurers are allowed to charge different premiums across different plans and geographical area (state and/or territory but not geographic regions within a state).
Premiums also vary by six classes of membership; singles, couples, families, single parent families, no parent families and families with three or more adults. However, insurers do not have to quote premiums rates for each class for every type of plan. The premiums for non-singles are standard multiples of the single rate.

Applications for premium rate increases have to be filed with the Commonwealth Department of Health and to the regulator. These must be filed almost six months prior to the premium rate increase date (usually April 1 of each year for all plans). Premium rating tends to be a political exercise where the Commonwealth Minister for Health

can make the final decision. The regulator will provide input to the Commonwealth Department of Health (the Minister) and if the rate increases are considered to be excessive the insurer will be told to resubmit or face having the increases disallowed. When the Commonwealth Department of Health has decided that all applications are acceptable a composite overall average rate increase is worked out for each insurer and for the industry as a whole and announced usually around six to eight weeks prior to the increase becoming effective. The Minister will announce what the average increase is for the industry and the average increases for each insurer are published by The Private Health Insurance Administration Council (PHIAC).

Because the premium is community-rated, to encourage the young to purchase PHI cover, a loading of 2% for every year above the entry age of 30 is applied, subject to a cap of 70%. However, even with this loading, the premiums for a late entrant are still lower than the expected costs, resulting in a cross-subsidy between young entrants and older entrants. The loading is removed after 10 years of coverage[9].

Process of Premium Approval

Section 66-10(1) of the Private Health Insurance Act requires insurers to apply to the Minister using the approved form. By convention insurers change their premiums once a year on a common date. This reduces the political risk for both the insurers and the Government as all the bad news is concentrated at one time. The common date is currently April 1. This date was chosen as it is the least likely quarter beginning day which is likely to clash with a Federal election campaign and quarter beginning days are the most appropriate dates for statistical collections and risk equalisation arrangements.

Section 66-10(3) states that "the Minister must, by written instrument, approve the proposed changed amount or amounts, unless the Minister is satisfied that a change that would increase the amount or amounts would be contrary to the public interest." "The public Interest" in relation to a premium increase is the – minimum necessary to ensure insurer solvency, support benefits outlays, and meet prudential standards concerning capital adequacy, while also ensuring the affordability and value of private health insurance as a product.

[9]The coverage may not be continuous if, for example, the policyholder was overseas for some period and had suspended his membership for that period.

According to the Department of Health and Ageing the purpose of the approval process is to:

- Ensure an attractive private health insurance product for consumers
- Keep downward pressure on premiums
- Protect the Government's interest in private health insurance
- Maintain transparency in the approval of premiums
- Be timely in the approval of premiums
- Be consistent in the approval of premiums

The approval process involves the Minister who is the decision maker, The Commonwealth Department of Health and Ageing is the coordinator and advisor to the Minister, PHIAC who is the advisor to the Department and the Commonwealth Government Actuary who advises PHIAC.

The Commonwealth Government Actuary examines the applications of the major insurers and any smaller insurers referred to him by PHIAC. In this regard it is important to note that the appointed actuary of each insurer is not required to certify the proposed premium rates but is required to certify that the assumptions underpinning the projections accompanying the applications are reasonable. This ensures that the process doesn't become bogged down in professional actuarial matters. (If the actuary had certified the premium rates but they were unacceptable to the Minister then the actuary would have a professional problem with certifying a lower set of premium rates).

The approval process is as follows:

- The approved form (required letters, workbook, certifications etc) is designed by the Department of Health (with support from PHIAC) and the timelines for the process are decided and communicated to insurers.
- Application submissions are forwarded to the Department on or before the required date
- Initial advice to the Minister and to insurers whose premium rate increases are too high

- Resubmissions are invited and received by the required resubmission date
- Approval of application (or resubmission) is obtained from Minister

- Any refusal of application (or resubmission) is notified to insurer in writing and the reasons for refusal tabled in Parliament

- Announcement of the increases by Minister (Department on his behalf) together with the date of effect.

From 2010 the average increases for each insurer is also published.

In practice there has been only one refusal of one insurer under the Private Health Insurance Act. The refusal appeared to be for political reasons and would have been appealed probably successfully in Federal Court however the matter was settled in a separate deal between the Government and the insurer.

There was a case in 1977 where a premium approval was disallowed for political reasons. The decision was overturned in the Administrative Appeals Tribunal and the insurer subsequently sued the Government. In the ensuing legal process the insurer was given access to cabinet documents – something which had never been permitted in any previous legal action against Government. In the end the action was settled after the insurer's management was replaced by persons more amenable to the government of the day. However the precedents established by that legal action has put considerable restraint on any Minister considering abusing his powers for political reason.

Incentives and Disincentives

The Medicare Levy Surcharge aims to encourage high-income earners to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system.People whose taxable income is greater than a specified amount (In 2010/11 AUD77,000 for singles and AUD153,000 for couples,increasing by $1,500 for each additional child after the first) and who do not have an adequate level of private hospital cover must pay a 1% surcharge on top of the standard 1.5% Medicare Levy. Private hospital cover is not considered adequate if it includes an annual deductible or excess of more than $500 single or $1000 family. The taxable income thresholds are indexed each financial year and include fringe benefits and concessional superannuation contributions.

To encourage the young to purchase PHI, a loading of 2% for every year above the entry age of 30 is applied, subject to a maximum loading of 70% (at age 65 and over). The loading is removed after 10 years of membership.

In addition, the government subsidises PHI premiums, including ancillary covers. Currently, it subsidises:

- 30% of premiums for those aged 64 or under, and higher at older ages.
- 35 % of premiums for those aged 65-69
- 40% of premiums for those aged 70 or over

Risk Equalisation and Reinsurance

The Private Health Insurance Administration Council (PHIAC) is responsible for administering the risk equalisation system which transfers and shares costs across all insurers so that insurers with an older and less healthy customer profile are less disadvantaged.

There are two components to this system.

- The first is the pooling of claims costs within states as follows. A portion of hospital benefits paid for each claimant over age 55 is claimed on the risk equalisation arrangements. The portions are 15% for persons aged 55-59, 42.5% for persons aged 60-64, 60% for persons aged 65-69, 70% for persons aged 70-74, 76% for persons aged 75-79, 78% for persons aged 80-84 and 82% for persons aged over 85.
- The second is a high cost claims pool where claims over AUD50,000 for one year for a person not pooled by the first arrangement can be also claimed on the risk equalisation arrangements.

The total of the claims on the risk equalisation arrangements for all persons covered of all insurers within a state is divided by what is known as single equivalent units of membership for all insurers in the state. The resultant amount is then distributed notionally between the insurers, based on their equivalent single units of membership.

The difference between the notionally distributed amount and the actual amount claimed by each insurer is the settlement amount. These amounts can be either an amount to be received or an amount to be paid by the insurer. The amounts to be paid are paid to PHIAC and the amounts to be received by the insurers are paid by PHIAC. The calculations are performed for the persons residing in each state separately and settlements are made to the insurers.

To enable these calculations PHIAC obtains from each insurer an enormous amount of summarised data in the form of a specially formatted workbook. This workbook known as the PHIAC 1 return (it is also printed and signed by the public officer) is forwarded to PHIAC within 4 weeks of the end of each calendar quarter. The risk equalisation calculations are performed by PHIAC within the next two weeks (to allow for obvious errors to be picked up by PHIAC, notified to the insurer and corrected) and then the results are notified to each insurer. To enable appropriate provisions to be made one insurer provides an unofficial pre-determination during the first four weeks after the end of the quarter using abbreviated data sent to it by each insurer and disseminates the results of this to all participants. Usually all industry insurers participate in this so insurers are able to fairly &accurately provide estimates of payments or distributions from the risk equalisation arrangements in their quarterly accounts which also have to be provided to PHIAC on a PHIAC 2 return.

About 10 years ago the health insurance industry did consider moving from what were known as reinsurance arrangements to a more comprehensive form of risk equalisation arrangement based on something similar but expressed in terms of annual risk costs (ex-ante) rather than claims costs (ex-post). The exercise was divisive as the insurers that clearly would have lost out from the change campaigned strongly against it and the winners obviously campaigned for it. In the end, true risk equalisation was abandoned in 2006. However the high cost claims arrangement, which is needed in a risk equalisation ex-ante environment, was implemented. The compromised changes commenced in April 2007. So the ex-ante component of risk equalisation, which is necessary to provide a strong incentive to manage health and claims costs, is missing in the Australian arrangements. The high cost claims pool which reduces the high skewness and leptokurtic nature of the hospital claims cost distribution is in place for when Australia eventually adopts an ex-ante structure of risk equalisation.

Community Rating

The concept of community rating has applied to voluntary private health insurance ever since friendly societies commenced offering health insurance cover in the mid to late nineteenth century. It was later endorsed by both major political parties when the National Health Act 1953 was legislated and has been sacrosanct ever since. Voluntary community rating could not remain if either of 3 important components were eliminated. These components are: strong incentives to insure when relatively young, premium subsidies so that health insurance is a reasonable proposition for the young and healthy and an equalisation system. If there are not incentives to insure when relatively young then the cost of cover escalates too rapidly causing a "death spiral" where healthy policyholders lapse due to affordability issues causing higher average claim rates. If premium rates are not subsidised so that product offerings are seen to be reasonable value then young people will not join voluntarily. (Then there have to be other compelling reasons for voluntarily insuring). The equalisation system is to ensure new insurer entrants don't "cherry pick" new memberships. Of course community rating will always work in a compulsory private health insurance environment but if there is to be a competitive environment then risk equalisation between insurers is also required.

If community rating were to start to break down substantially then there would be an immediate impact on private hospitals and specialist doctors. The consequent reduction in the market value of private hospitals would signal to specialists that their talents might be more profitably employed elsewhere (probably other countries). In the meantime the public hospitals would be even less able to cope than currently as even with additional government monies to open wards and operating theatres there would not be the specialists to be able to man them. This is because a high proportion of many specialists' incomes arise from the private sector.

Risk Selection

As Insurers are unable to selectively lower their premiums to appeal to lower risk persons, they select risks indirectly by:

- Advertising to attract the young and healthy

- Benefit design

    - Certain "entry level" products exclude services that may not be useful to the young, to reduce premiums for these new entrants.
    - For chronic illnesses, Insurers compete to give the lowest benefits. Given the full portability between health insurers, insurers do not want to be known as providing the most generous benefits for the chronically ill. There is some regulation on minimum benefits, i.e. the benefits cannot be lower than payments to public hospital, which are very low.

- Wellness programs / member activities

    - Most insurers provide some benefits for wellness and health management programs. So comprehensive cover might include benefits for attending smoking cessation courses or weight reduction classes.

Claims Controls Mechanisms

In most part, control of claim costs takes the form of fee negotiations. The considerable power of insurers in negotiating contract arrangements[10] with private hospitals led to significant consolidation of providers into some fairly large hospital groups.

Prior authorisation is not usually practiced. However, prior to elective surgery patients are requested to contact the hospital to get financial consent. The financial arrangements between their insurer and the hospital will then be disclosed if this hasn't already been disclosed by the insurer. If the hospital is on contract then this usually means the hospital will normally tell the patient that they will be fully covered for everything provided by the hospital, except for any co-payment or excess built into the patient's policy.

Concurrent case management is not a usual practice. It may occur with some long stay patients but this is rare. Private hospitals usually bill weekly so long stay patients can be identified. Public hospitals don't usually bill weekly. PHI benefits paid for public hospitalisation is about 10% of total hospital benefits paid.

[10] See section on hospital contracts

Utilisation review is done extensively, covering things such as lengths of stay and readmission rates by type of admission. Most of the major insurers (or contracting agencies for smaller insurers) employ highly regarded medical practitioners to assist in their development of utilisation protocols and act as the conduit between the insurer and provider and sometimes the patient.

Retrospective claims adjudication does occur. Insurers contact providers if the services provided appear to be irregular, taking into consideration the patients' claims histories. Occasionally legal action or even criminal action ensues if retrospective claims profiling shows this is necessary.

Wellness programs are used more as a measure to attract younger members, and perhaps also encourage healthy lifestyles amongst members.

Disease management programs are being used by insurers. But the difficulty in providing these programs is that providers will recommend that patients move to the insurer(s) that provide the best programs and so this makes these insurers a target for the chronically ill.

Some insurers own optical clinics and dental clinics as a means of managing the costs of these ancillary benefits. Apparently some insurers make good money from these initiatives.

Evolution of Hospital Benefits to Current Contractual Arrangements

Hospital benefits in Australia have evolved through three evolutionary stages.

The first stage was simple per diem benefits. Insurers had three levels of per diem benefit. These were payable from three separate tables: for standard (nightingale) wards, for intermediate wards and for private (single occupant) rooms. Benefits were limited to a number of days. Because these limits discriminated against long stay patients with chronic conditions, the Commonwealth Government took over the funding after benefits ceased through what was known as "special account". Special account became the reinsurance arrangements in the Medibank Mark 2 changes from October 1976.

The second stage started with health insurers moving towards cost centre funding of private hospitals. So benefits were created for theatre usage, labour wards or birthing

units, intensive care and coronary care as well as per diem benefits for accommodation, hospitality and general nursing and administrative services. Benefits evolved in this stage to 12 or more theatre fee benefits based on time used in theatre and then to categorisation based on MBS item numbers. Intensive care and coronary care benefits were also differentiated into time (hours) in this care and the type of unit and care provided. (There are different levels of care in ICU and CCU). Benefits were introduced for prostheses and pharmaceuticals. Hospitals became categorised (Category A had intensive care units regularly used, category B was the suburban surgical, Category C was predominantly medical and Category D was mainly psychiatric and/or rehabilitation). Different levels of accommodation categories had different levels of per diem benefits. Hospitals accredited with the Australian Council of Health Care Standards received higher per diem benefits than non-accredited hospitals. Finally per diem benefits were themselves redesigned so that higher benefits were payable in the first few days of more intensive treatment, phasing down in one or two steps to lower benefits as patients moved from the acute phase of treatment to non-acute and then the rehabilitative phase.

This stage of hospital benefit evolution occurred over about 20 -25 years from around 1975 but these changes occurred only for private hospitals. Public hospitals continued with per diem funding although a couple of states adopted the per diem step down funding arrangements. This stage in the hospital benefit development also enabled the evolution of private hospitals from a mainly cottage industry into sophisticated hospital service providers equivalent in many respects to public hospitals.

By the early 1990's the benefit prescriptions for private hospitals had become voluminous and beyond the comprehension of policy holders (and most of the administrative staff of the insurers and hospitals). Services provided to many private hospital patients were charged at more than their insurers provided in benefits leaving increasingly large OOPs. This led to lots of complaints to the Commonwealth Minister's office about the gaps in hospital coverage. These complaints also led to the creation of the Commonwealth Private Health Insurance Ombudsman.

The third stage of hospital funding commenced when some insurers started contracting directly with a few private hospitals in the early 1990's. The Commonwealth Government realised that if they forced the whole industry to contract with hospitals they would reduce or even eliminate complaints about hospital OOPs. Although hospital contracts were initially designed within the framework of hospital cost centre benefits because the contracts would not be seen by policy holders they were able to move to higher levels of sophistication by referring directly to MBS item numbers or ANDRG or even ICD10 numbers. Then it became possible to merge several of the cost

centre benefits into a single benefit referencing that particular itemisation. Insurers' computer programs developed in this period to handle electronic claims based on very much larger itemisation references and at the hospitals for generating these electronic claims and giving informed financial consent to prospective patients. In this way the patient recording data at the hospitals became directly useful in producing the electronic claim to the insurer. So there were integration benefits for the hospitals in moving to these arrangements.

Contracts are still evolving in this third evolutionary stage and currently it would seem unlikely that contracts will move to solely paying one ANDRG, MBS or ICD10 related benefit for many hospital episodes of service particularly where there is a considerable range in the treatment options, lengths of stay and patient morbidities. Where ANDRG based benefits are specified most contracts provide for a single lump sum benefit plus per diem benefits using step downs as developed in stage two of the evolution. Each of the major 5 insurers have their own contracting arrangements and these have been developed on different bases. In addition most of the smaller insurers (but including NIB) contract through the Alliance. Most of the regional insurers use the Regional Health Group as their contracting agency and the rest of the regional insurers use the Alliance.

Complaints are minimised because hospitals provide informed financial consent to incoming patients as part of their contractual arrangement with the insurer.

Quality Assurance and Benchmarking

Transparency is a big issue in Australian health insurance because much is hidden in contracts between the insurer and provider and health insurance policies can be several hundred pages long. So the Private Health Insurance Ombudsman ("PHIO") publishes on the government website (www.privatehealth.gov.au) the key features of every product offered by insurers in a standard format.

The PHIO also publishes an annual report on the state of the industry, including the number and types of complaints received and relative ranking (i.e. complaints per unit of policyholders).

Insurers do their own quality assurance of hospital providers and do not contract with providers who are not up to the mark. There is generally a quality culture among hospital providers because for many years insurers provided higher benefits to hospital

providers who were accredited with the Australian Council of Healthcare Standards (ACHS). As the contracting environment developed these additional benefits became incorporated in the benefits specified in the contract. Generally, insurers do not renew contracts with hospitals that do not retain accreditation with ACHS.

Insurers also use extensive utilisation review procedures to examine lengths of stay and readmission rates by procedure and may refuse to renew contracts with providers that do not measure up to established norms even though the provider has ACHS accreditation. Patients of hospitals not contracted with their insurer are still entitled to benefits but these are usually significantly below what would have been provided if the hospital was contracted with that insurer.

Appeals Mechanism

The Private Health Insurance Ombudsman (PHIO) is responsible for resolving complaints related to PHI and acts as an umpire in dispute resolution but the Ombudsman does not have direct coercive powers. However his annual report could lead to the naming and shaming of recalcitrant insurers in the press. PHIO reports directly to the Minister and could theoretically alert the Minister of an insurer that is causing industry disrepute. This might lead the Minister into having a much closer look at that insurer's subsequent proposed premium increases or directing PHIAC to further examine that insurer's risk management and/or operational management structures in relation to certain criteria.

- PHIO is involved in disputes on medical necessity and other disputes between hospitals and insurers where the policyholder is caught in the middle.

- Large insurers employ one or more than one medical referee to help adjudicate on difficult claims. However insurers cannot disallow a claim solely on the grounds of medical necessity. Smaller insurers usually use a medical referee employed by their contracting agency (the Alliance or the Regional Health Group)

Regulations

The Private Health Insurance Administration Council (PHIAC) is the financial regulator and regulates the licensing of insurers and their solvency, capital adequacy and risk management systems. PHIAC also administers the Risk Equalisation Trust Fund.

The other financial regulator in Australia is Australian Prudential Regulatory Authority (APRA). APRA regulates life and general insurance as well as banks, building societies, credit unions and the like. PHIAC and APRA have close contacts with each other. The issue of a merger between PHIAC and APRA has been raised but dismissed as PHIAC reports to the Minister of Health and APRA to the Treasurer. PHIAC does obtain informal advice from APRA on solvency and capital adequacy issues.

The policy regulation regarding what can be included in health insurance policies is done by the Commonwealth Department of Health and Ageing.

The Private Health Insurance (Complying Product) Rules is a legislative document which defines the standard information statements which are detailed on www.privatehealth.gov.au, a website maintained by the Private Health Insurance Ombudsman.

Insurers also have to be aware of the general requirements of the Australian Competition and Consumer Commission.

Appointed Actuary

Every insurer is required to have an appointed actuary. The appointed actuary must be consulted when an insurer is introducing a new product or significantly changing an existing one. Also the actuary has to approve the investment strategy and be involved in the development of strategic and business plans.

A financial condition report has to be produced on the insurer as on June 30 each year and the insurer has to forward it on to PHIAC by September 30. The appointed actuary does not have to certify premiums (because of the political elements in this process) but does have to certify the financial projections that are required with the premium application.

Observations

PHI has a long history in Australia, extending over a century. Reflecting the belief that a well-functioning health care system should be based on a mixed system of insurance and provision, Australia's policy makers have encouraged the development of private financing and delivery arrangements operating in parallel to the public system. Using the "carrot and stick" approach, the penetration rate increased from 32% to 44% in the year 2000 and has remained around that level until now. The overall proportion of the population that is insured with a private health insurer (including those insured only for ancillary benefits) is a little over 50% of the total population.

PHI is seen as a vehicle for enhancing individuals' choice of provider and care options, and for reducing cost and demand pressures on public hospitals.

Currently, private hospitals provide roughly 70% of the total number of elective surgeries in Australia, while supplying around one third of the beds. 40 years ago the private hospital industry would have provided an insignificant percentage of procedures in Australia because then it was mainly a "cottage" industry and 20 years ago it was providing roughly 50% of the total number of elective procedures. PHI has certainly moved people out of the public hospital queues into private hospitals. However, at the same time as the private hospital sector was growing the public hospital sector was being starved of funds and was closing wards. Thus queues to get into public hospitals have actually grown.

Very few private hospitals have emergency departments that accept acute patients direct from ambulances. This is because it is not usually possible to know if a comatose patient or one in a highly shocked state is insured and hence can afford private hospital fees. This has led to public hospitals mainly catering to accidents and emergencies and patients with chronic illnesses and private hospitals catering for non-acute elective procedures. Private hospitals that do have accident and emergency admission department usually have a very high front end charge (AUD300+) and this doesn't get reimbursed by private health insurance. There is no front end charge at an accident/emergency department of a public hospital, however unless your condition is immediately life-threatening there may be a wait of several hours before treatment is provided and many more hours, even days, before bed in a ward is made available.

Some observers question if the money directed at PHI premium subsidies would have been better spent on enhancing the public health system. Some question if the money was not spent on subsidies, whether it would even have been spent on health care.

With the explicit premium subsidies, the government is now committed to budgeting for this element of health care costs.

There is an on-going debate in Australia as to whether the premium subsidies would be better employed if spent directly on public healthcare. In the very short term the abolition of premium subsidies and the redirection of this money into public healthcare would alleviate some of the immediate pressure on the public health system. But the subsequent premium rate increase of probably more than 55% (43% - 45% because of the removal of the subsidy 6% for health inflation and at least 5% for initial selective withdrawals) would reduce health insurance memberships by around 50%. Ongoing annual increases would likely to be 15% or more mainly due to anti-selection. Therefore, within months private hospitals would be struggling, specialists working in both systems would be emigrating, prices on all private health care equities would have plummeted and as a result capacities in both public and private systems would have reduced. Also many private health insurers would not survive such a change and this would further destabilise health care systems generally and almost certainly result in the end of the community rating principle. As a result the Government that did this would lose the following election and several subsequent elections. Many Australian state and federal elections have been won or lost on health issues.

The only way the consequences of premium subsidy removal could be averted is through either:

1) Significantly increasing the incentives to insure – like increasing the Medicare Levy surcharge to 5% and halving its income threshold, or

2) Making private health insurance compulsory for a large segment of the population.

Version 1) was tried in Australia in 1976 but the Government initially rejected advice relating to the framing of the levy in such a way as to remove its effect from the consumer price index. It was able to explain away the initial CPI effect of introducing the levy. Two years later when the levy had to be increased due to significant and unpredicted cost shift from the public to the private sector the government couldn't increase the levy without suffering the political consequences of the consequent change in the rate of increase in the CPI. The government therefore scrapped that particular scheme.

Some observers say the main importance of PHI in Australia is that it has enabled a viable private hospital sector, which yields several benefits:

- It provides an option for patients that are dissatisfied with public hospital services, which reduces the pressure on politicians for any service delivery shortcomings of the public sector. PHI is therefore a political safety net. At the same time, public sector acts as a safety net for patients who are dissatisfied with the services provided by private hospitals. The two have a symbiotic relationship, with PHI as the financing vehicle.

- A thriving private market is seen as necessary as it allows the Commonwealth Government to pay lower medical benefits than it would otherwise have to in the public sector, while using the private market to keep medical skills in Australia that would have otherwise migrated to more remunerative environments.

- In addition, because of the way PHI hospital benefits were structured for the private sector the private hospitals thrived and became as good as the public sector in many areas of medical care, and according to the Productivity Commission, more efficient at doing this.

Overall, it is not clear if PHI will help to contain health costs. Below are a number of concerns about the structural inefficiencies of the Australian PHI system. Also included are prescriptions to reduce these inefficiencies.

- The health insurance industry is competitive but it is oligopolistic. When looked at State by State the top three insurers have 70% or more of the PHI membership in each state. In each state 70% of insurers have less than 10% of the membership in total. This inefficiency would be eliminated if the government were to actively limit their risk of market failure. The Global Financial Crisis exposed the difficulties governments have when institutions are "too big to fail". If something is too big to fail then it is too big to exist. This maxim should apply to any industry operating in an oligopolistic market but this requires governments to enact very strong anti-trust laws that are very unpopular with large employers and institutions.

- Most of the cost containment initiatives on behalf of health insurers have been in the form of fee negotiations, which has contributed to pressure on hospitals to merge and form large hospital groups. The level of competition between hospitals is therefore questionable. These mergers may not have occurred to the same extent if the PHI market was not oligopolistic. Now the private hospital

market has also become oligopolistic and some participants should be recognised as being too big to exist. However it would be unreasonable to tackle this oligopoly in isolation to the PHI oligopoly.

- The public and private hospital sectors should compete on price as well as on quality. Australia's two sectors do not compete on price and thus system efficiencies are not as good as they could be. This is a consequence of making PHI a supplement to the public system instead of regarding it as a complimentary component of the overall health system. In Australia public hospitals should be allowed to fully cost recover their private patients as they do their foreign patients and those that are covered by other third party arrangements. If this was done then the inefficiencies in public hospitals would be exposed and consequently they would have incentive to deal with them.

- There is political pressure for insurers not to increase rates too quickly, despite rising medical costs. This has led to insurers not increasing ancillary benefits, or even reducing these benefits. Also insurers have changed many full cover hospital products to excess or co-payment products or migrated policyholders to these products. Consequently in the last five years the proportion of full cover policies has fallen from just on 40% of all hospital/medical policies to half that percentage. This issue results from the political process involved in the approval of premium increases. The Minister wants to look as though he/she is in control but transparency would be forgone if each of the roughly 10,000 products' premium changes were announced (each product of each insurer has separate premium rates in each state). Therefore the average for each insurer and for the industry is announced. Because the decisions are based on averages the components with the least benefit cost pressures get little or no increases in order to reduce the average. The antidote is to adopt a model that doesn't rely on government subsidies and so doesn't need political involvement. Community rating can still be used in an unsubsidised model provided the penalties for not insuring are substantial enough. This can work in Australia but the problem for Hong Kong is how would you develop a tax penalty when the majority of residents don't pay income tax?

Other criticisms of PHI are:

- PHI is still exposed to open-ended funding risks of an aging population. The LHC loadings were designed to encourage the public to purchase PHI while young, and so LHC appears to have had a significant psychological effect on the insured. It was also decided that if the public were going to understand

what LHC loading were then they had to be structured in a very simplistic manner. So it was not designed to reflect the actuarial costs of providing PHI cover to different age groups. As such, PHI operates with very significant cross subsidisation across ages (as well as health statuses and membership classes).

- Many of the chronically ill and elderly do not join or retain membership because they are not working or are retired, have low incomes and therefore cannot afford the premiums. The burden of this segment is still on the public sector and will conceivably always be while the public sector provides a "free" service.

- Some people consider the "carrot" unfair to the poorer because the premium rebate is not means-tested[11] and cannot benefit those who cannot afford PHI anyway. Meanwhile, the high-income earners are discontented with the "stick", which led to the move by the government to relax the income threshold for Medicare Levy Surcharge as from mid-2008. However the Government subsequently tightened up the definition of income to include fringe benefits and concessional superannuation contributions thus reducing the transparency of the test. There was little effect on memberships caused by the combination of these changes.

- PHI is prone to anti-selection. As the waiting period in public hospitals can be very long, some elderly join the private health insurance just for specific surgeries. An example would be hip replacement surgery, where the 12 month waiting period for PHI cover is shorter than the public hospital queue. This encourages many elderly members to misuse PHI.

- Consequently, some detractors see PHI as a mechanism for jumping the queue at public hospitals - at least for those who can afford it.

[11] A bill to means test the premium rebate has been twice rejected by the Senate. There is a premium rebate because otherwise the people who are covered by PHI are paying twice for their hospital insurance. Once for the national scheme through their taxes and a second time through their PHI.

SECTION 3.6: USA

Overview of Health Care System

The U.S. health care system today has roughly 50% of costs covered by private payers (insurers, employers and consumers) and 50% of costs paid by government. Private coverage in the system consists of private health insurance covering individuals, small groups and large groups of working aged people plus supplemental coverage where government is the primary insurer. The consumer costs in the private healthcare market reflect out-of-pocket costs of for the insured and uninsured populations. The private market includes many types of coverage including comprehensive medical, major medical, and supplemental medical (intended to supplement other medical coverage but it can also be used as a stand-alone product).

Government coverage is composed of Medicare (a program targeting those over age 65 or with a Medicare-qualified disability), Medicaid (a program targeting the poor – currently limited to those at or below the Federal Poverty Level), and various other programs or agencies. Due to the numerous public health programs offered by the government, populations can belong to multiple categories. Distinctions between these populations and programs are addressed below.

Markets in the U.S. Health Care System

The primary markets that produced about $2.4 trillion of health care expenditure in 2008 relative to an economy of about 14 trillion dollars (in terms of GDP) are:

- Large Group:

  This is a private market with more than 130 million people covered and total costs of more than $550 billion. All employer premiums / costs in the U.S. are tax deductible and do not count as taxable income to employees. All costs are paid by employers or individuals with the vast majority of costs paid by employers, although employee contributions and cost sharing have increased significantly in recent years. Large groups generally refer to an employer with more than 50 eligible employees, although a few states have a different

definition (i.e., 100+ employees). Note that Federal and / or state laws typically differ between large groups that are self-insured versus those that are partially or fully insured, as well as for "large" groups of 50 eligibles or less. Thus, groups can fall under different regulations depending on size and how they are funded as well as their state of domicile. In addition to the large group employees who receive coverage through the private market, federal and state governmental employees generally receive coverage through the large group market as members of the Federal Employees Health Benefits Program (FEHBP). The FEHBP is designed as a "managed competition" system wherein insurance companies can provide healthcare coverage to civilian government employees and retirees.

- Small Group:

  This is a private market with about 30 million members with costs in excess of $150 billion. It includes employers of typically 2-50 eligible employees (variations in some states allow groups of 1 and others go up to 100 employees). This market is more expensive than large group primarily due to eligibility and rating rules. Under federal law, all groups must be guaranteed issue with some pre-existing condition exclusions allowed but states vary widely in terms of how plans are allowed to rate their members (some states even require community rating). Tax rules are the same as for large group. Local government employees are covered in this market.

- Individual:

  This is a private market with about 15 million members covered and over $65 billion of cost. It has limited tax breaks compared to the group markets with premiums fully paid by individuals and therefore is only used by people without employer coverage. Coverage periods are shorter in this market than group markets due to the unequal tax treatment with group markets. The majority of states currently allow full underwriting and risk rating in this market (although some states require community rating).

- Medicaid:

  This program covers the population that is considered low income (less than or equal to 100% of the Federal Poverty Limit). It is divided into needy families in the under age 65 market needing medical care, a program for disabled, those

over age 65 or with an approved disability that are eligible for both Medicare and Medicaid, and a long term care program, each with its own set of rules. The benefits and provisions also differ to some degree across each state but due to the low income status of the members, Medicaid services are offered with no member cost-sharing. Over 50 million recipients receive coverage in a year, but a significant percentage of the population is covered for less than one year. Costs are financed by both federal and state governments, with the Federal share varying by state and program but typically averaging a little under 60%. Total cost for this program is in excess of $325 billion.

- Uninsured:

  The Uninsured population is effectively private pay as they have no form of coverage. Out of the roughly 47 million uninsured, less than half of these are uninsured for the full year. Most have relatively short periods of no coverage and move between Medicaid, uninsured and / or the private markets. Total cost for this group, after reductions for uncompensated care, is in excess of $70 billion.

- Medicare:

  This program (catering to those over age 65 or with a Medicare-approved disability) has four parts: Part A (primarily for hospitalisation), Part B (primarily for physician services), Part C (a combination of Part A and B coverage called Medicare Advantage which is offered by private companies who receive payments by the government to cover portions of the Medicare-eligible population), and Part D (prescription drug coverage). Funding for each part is different and may be comprised of payroll taxes, premiums from individuals, or general government revenue. The largest part of this program relates to the coverage of the elderly (those aged 65 and over). A smaller part of the program covers disabled under age 65 and some members may be eligible for both Medicaid and Medicare but the definition of disability within each program differs materially. The program currently has roughly 44 million people with total costs for both the government and private costs of over $600 billion. The federal portion of these costs now poses a serious drain to the Federal budget.

These groups represent over 75% of total costs in the healthcare system. Remaining costs are divided into many buckets with most of the costs being attributable to the government. Examples of additional government costs include those for the military (active and retired), worker's compensation, hospital construction costs, and research costs. Remaining private costs generally include items not covered by typical major medical policies such as dental, long term care and vision.

Exhibit 3.6.1 summarises the estimated costs and population by market, split between private and government.

Exhibit 3.6.1: Size of insured and uninsured market segments in 2008

Market	Enrolment (millions)	Total Healthcare Cost (USD billions)
Commercial – Large Group	132.3	555
Commercial – Small Group	29.5	154
Commercial – Individual	14.5	66
Medicaid	50.9	325
Uninsured	46.5	73
Medicare	44.0	624

A further summary of key features of the Medicare program is provided in Appendix 3B.

The health care system in the United States is very fragmented and known to be the most expensive in the world (around 17% of GDP), while delivering some of the best treatments available to people with serious illnesses. Virtually all of the population has access to treatment, including the uninsured (those without any private or government insurance), but access to quality and efficient treatments are quite different among various population segments. These issues are discussed further below.

The following sections of this report focus on some of the primary provisions / concepts underlying the U.S. health care system from both a financing and delivery perspective and lessons that might be learned from them in reforming Hong Kong's health care system. References to recent reforms just passed are included within bullets relating to the risk drivers of costs and inferences. The applicable reforms referenced are briefly summarised in Appendix 3C.

Risk Drivers of Cost and Inferences to the Entire System

The most serious cost drivers of health care in the United States include:

- Tax Policy that encourages over insurance and high utilisation:

  Coming out of World War II, the U.S. employed price and wage controls in an attempt to keep prices and wages from escalating under heavy demand for goods. As a means of increasing employee effective pay under such wage limits, the Federal government afforded employers a benefit of tax deductions for premiums paid on behalf of employees and dependents. This created an incentive for employees to seek the richest health care plans since someone else was paying for it. The reform provisions recently passed do not materially change this approach.

- Entitlement creation, expansion and mandates that encourage over insurance, utilisation and cost shifting:

  The tax policy that became effective after World War II created a sense that health care was not very expensive among consumers. However, for those without employer coverage, costs were seen as excessive by the early 1960s. Those who retired complained that insurance companies were gouging them when they retired for benefits that could possibly not be that expensive. Also, for those without employer coverage but limited means, they complained that they could not afford health care. Thus, in 1964 and 1965, Medicare (for those aged 65 and over) and Medicaid (for the poor) were created. These programs created benefits where someone else (the government) was paying for care. Over time, these programs expanded care, benefits, and eligibility so that more people fell under the Medicare and Medicaid umbrellas with little effective cost sharing and increasing mandates for ever-richer coverage. As the programs expanded, reimbursements to providers decreased relative to private markets as the government attempted to control costs. However, as reimbursement has decreased relative to private markets, utilisation relative to private markets has increased in general including increasing fraud. The results have been both funding problems (which threaten a heavy debt load in the future) and substantial cost shifting to private coverage and providers (which threatens future access to treatment). The latest reform efforts expand these programs and promise cost control (through fraud investigation and other

provisions) while creating more agencies and regulations (which seem destined to increase inefficiencies in the programs). We would expect results will be worse than anticipated for the reasons noted above.

- Limitations on Underwriting, Premiums, and Risk Classification:

  As costs have soared, policymakers have often sought to protect those in poor health or at older ages by limiting or precluding the use of risk characteristics in creating premiums or charges in voluntary markets. These changes have had serious negative consequences in the individual market where used, as they have increased premiums substantially across the market (since less premium differentiation is allowable). There have been at least seven states that have severely limited the use of underwriting and limited rating according to health status and/or age over time on all business. Two repealed those provisions in part or entirely due to serious increases in premiums and companies exiting the market due to severe losses. The other states have continued with such practices and generally have the highest or close to the highest premiums in the country.Impacts on the small group market have also been significant but much less so than the individual market. For larger groups, such rules are often not employed and where they are, the impacts are minor as long as the employer pays a large portion of the cost. The recent reform law attempts to implement such limitations while simultaneously mandating that everyone buy coverage to mitigate the adverse selection created by these underwriting and rating limitations. This method would succeed in limiting adverse selection but only if choices to individuals (consumers and providers) are severely limited and the government enforces sufficient penalties so that adequate participation is achieved. To this end, the current law allows substantial latitude in choices of benefits and has limited penalties on movements in and out of the system. As a result, we expect these types of reforms will exacerbate adverse selection and create significant upward pressure on costs in the United States in aggregate.

- Mandates of Benefits and Plans:

  Over the years, as health care costs have increased faster than wage growth, state governments have implemented numerous benefit and plan mandates on private insurance, particularly in the individual and small group markets. Today, slightly over 2,000 mandates exist across all 50 states and the District of Columbia. Although most of these mandates add less than 1% to premiums by themselves, the culmination of all mandates in a state often averages roughly

15% to 25%. The reform law only increases the requirements, further exacerbating the issue.

- Loss of Checks and Balances:

  Many items fall in this category including the following: Litigation awards that create excessive costs for errors, resulting in high costs for omission coverage and defensive medicine; lack of personal responsibility with too much focus on disease treatment and not enough on wellness; and insufficient monitoring of costs / experience. The reform law proposes many new agencies intended to increase regulation (with the aim of improved checks and balances) but this expansion without dramatic clarifications will likely create more ambiguity leading to fewer checks and balances.

  The aggregation of all these items (pre-reform) has resulted in a health care system that costs up to 50% [please quote source of this estimate] more than it probably should today. While this cost delivers access to quality treatment, there is no doubt that the system is priced beyond the means of many people trying to pay for coverage themselves. The new reforms will likely reduce the number of people that pay for their own care once fully effective but will create additional upward cost pressure and more issues related to receiving timely and quality treatment. If accurate, this reform will result in a serious need for further reform.

How Has the System Tried to Combat Risk Drivers of Cost?

- Making more people eligible for coverage with limited cost:

  Recent reforms have continued to focus on reducing cost to individuals with limited means, either through increased payments by the parties who provide coverage to those individuals or by government subsidies. While this can produce the intended result for such an individual, overall cost is increased as the individual has less cost sharing.

- Private initiatives:

    - Managed Care:

      Initially managed care (which first came on the scene in the 1970s) reduced costs through more efficient delivery of care. The programs were successful in spite of ignoring the possible personal responsibility financing implications. For example, savings achieved in one area were partially offset by increased utilisation in another (i.e., reduced hospitalisation days were offset by higher non-hospital utilisation). By the early 1990s, managed care was mainstream but annual cost increases on average were still higher than wage growth. This relationship of cost to wages created more pressure on managed care to do better. Hence, managed care added discounts to their focus and more aggressive approaches to savings while continuing to ignore personal responsibility/cost sharing or other user incentives to a substantial degree. This effort was met with public resistance in the form of a backlash against the managed care companies. Following that in the last 10 years, managed care has moved to add cost sharing, particularly co-pays, to a much greater degree. Today, well managed care can produce significant savings versus loosely managed care, and the link to financing is gradually becoming more prominent but still has a long way to go.

    - MSAs, HSAs with High Deductible Plans: MSAs and HSAs - linked with high deductible health plans (HDHP)

      This concept of Medical Savings Account(MSA) and Health Savings Account(HSA) became more prominent in the US with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MSA refers to a medical savings account program, generally associated with self-employed individuals, in which tax-deferred deposits can be made for medical expenses. Withdrawals from MSA go toward paying the deductible expenses in a given year. HSA is a tax-advantaged medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan (HDHP).

      Gradually, these plans have become more popular and are now found in over 20% or so of the private market population. Overall, the

results have been generally positive but once again cost increases have continued to exceed wage growth. These plans typically are used with the Preferred Provider Organisation (PPO) arrangements and make limited use of managed care delivery techniques. PPOs in general have less aggressive management of care than HMOs. For these plans, savings of prescription drug and physician costs are significant but hospital savings are very small. Overall, these concepts by themselves have not solved the upward cost pressure problem.

- Focusing on Care Management and / or Wellness:

  Studies performed to date have suggested savings (total cost reductions minus additional administrative costs) from this exercise can be produced only by targeting narrow populations that represent a profile where significant savings will be available. Targeting too broad a group has generally been found to create substantial aggregate screening costs, which can easily exceed savings produced from the at-risk population. For instance, for chronic disease, targeting populations for identification of a chronic disease without any predictor of it is more costly than the value that might be produced. However, if people with a high likelihood of chronic disease such as diabetes are targeted, cost savings can then be significant. Likewise, screening all women over age 18 for breast cancer produces minimal benefit for the cost but periodic screenings after some age or with a certain health status profile could be quite beneficial. In conclusion, care management can be a cost-effective way to achieve substantial savings but defining the appropriate target group can be a challenge.

- High Risk Pools:

  This type of mechanism separates out a group that is anticipated to produce higher costs due to their health status and is thus either uninsurable or insurable with a significant impairment load. High risk pools have been established in many states and some have performed well over the years, such as in the states of Wisconsin and Illinois. However, other state high risk pools have encountered more difficulty such as in Florida and Indiana. States that have maintained sustainable high risk pool principles (rates higher than other markets by a sufficient amount, partial subsidies to high risk pool costs from

sources outside the market remaining low, and targeting risk groups with similar characteristics), results have generally been good. Where states have violated such concepts, results have deteriorated.

For many states such as Wisconsin, funding is comprised of a few pieces

- Individuals pay a premium that is around 150% of the average in the private market. Illinois is a little lower than this and others are higher.

- Other companies in the market are assessed an amount on an annual basis to make up some of the difference between actual experience and the premium charged (the 150% rate). Some years ago, this amount made up the entire difference. This amount in Wisconsin when this was the entire additional amount generally added about 1% to premiums. In this instance, the companies must participate and the cost of the high risk pool beyond the charge to high risk participants (who must have failed to receive coverage from a few companies) is spread to those in the regular individual market. In other words, all those who buy individual insurance and are insurable make up the difference in cost of those n the high risk pool. Regulators understand this is part of the premium charge, so rate filings including such costs are recognised as a legitimate expense.

- Supplemental contributions by state governments or other parties such as providers. In recent years, the State of Wisconsin has contributed some money to cover part of ii, reducing assessments of the insurance industry. In some other states, assessments may be partially or totally covered by taxes on providers, such as bed taxes.

- Restricting Risk Classification:

Restricting risk classification to a substantial degree in the individual market without very strong mandates for coverage has produced disastrous results in multiple states (including Kentucky, New York, and Massachusetts). The only possible exceptions are if plan designs or provisions are allowed to reintroduce risk classification through policy design innovations or an adequate mix of healthy and unhealthy members are brought into the market (through the use of mandates) to offset the possible adverse selection that can result from limited risk classification. Use of a strong mandate requires sufficient penalties for

noncompliance, strong enforcement policing, and product offerings with minimal choice of benefits. Allowing substantial choice with substantial restrictions of risk classification is a formula for serious adverse selection. The same principle applies to group business and the larger the group the less the adverse selection, assuming the group makes decisions. For very small groups, results will approach individual results. To the contrary, consequences in the large group setting should be minimal absent any unusual risk bias.

- Limiting Awards under Litigation:

  As health care costs have escalated, problems such as fraud and other abuses of the system have escalated as have limits used by payers on access to benefits or treatment. All of these have resulted in increasing litigation over time. As this has occurred, the cost of coverage of errors and omissions (E&O) for providers has increased (much more for some types of services than others). Since this issue does not seem applicable to Hong Kong as the prevalence of litigation is much lower than in the US, we are not providing more detail on this issue here.

- Mandating Benefits:

  As time has progressed, the state and federal governments have required that certain services and / or coverage be provided in their respective markets. For individual and small group business, the 51 jurisdictions (states and District of Columbia) have over 2,000 mandated benefits (which in general have added between 10 - 30% to costs in most states). Federal programs (Medicare and Medicaid) have also added mandated benefits over the years, greatly increasing the cost of these programs. All such mandates are designed to ensure that people can receive benefits for treatment but this possible advantage should be considered in light of the cost involved. Benefit mandates require that a specific condition be covered either similar to other coverage or in at least a certain amount. If similar to other coverage, that means all deductibles, coinsurance and co-pays must apply to these services as to all other eligible services in the policy. Or the mandate may specify a minimum coverage for such a condition, which may be more or less extensive than other services typically covered by the policy. For instance, some mandates for preventative service mandates such as PAP smears for women or prostrate exams for men require no cost sharing. Other mandates may allow more cost sharing that for

other services or separate cost sharing, but limit what can be used. Still other mandates, such as mental parity mandates, require that mental and nervous conditions be treated the same as other covered illnesses with the same cost sharing.

- Coverage / Portability Provisions:

  Portability or maintaining coverage type provisions in insurance policies in the individual market have helped policyholders to renew their coverage for long periods of time if desired. However, there are distinct tax disadvantages in the individual market which limit the attractiveness of such policies and have generally resulted in short average policy durations. Group policies do not have any portability provisions except that employees who are dismissed can be eligible for extended coverage of up to 18 months after termination at a premium subsidised by the employer (called COBRA). The Medicaid program also has a short period of coverage after termination in many cases and loss of eligibility in some instances does not mean one will not have coverage options elsewhere. Finally, portability of coverage in the US has been hampered by the affordability problem (annual health cost increases regularly exceeding wage growth). Most individual policies are now guaranteed renewable until age 65, at which point they will become eligible for Medicare. Some policies have more limited portability, which will a company to non-renew in some limited circumstances. All of these provisions allow the company the right to change premiums, with or without state approval (varies by state) as long as the increase can be justified actuarially.

- Solvency and Other Regulation:

  Managing a successful healthcare system in a country means maintaining a delicate balance between too much regulation and too little. With too little regulation, companies may set reserves too low or employ rating practices that are risky or abusive. On the other hand, too much regulation can preclude pricing consistent with risk or actuarial principles; force individuals to buy coverage inconsistent with their needs; or abuse economic principles. In the US, regulation over time has increased and become excessive in many markets. For instance, mandated benefits have become substantial in the individual and small group markets of most states and have resulted in rates increasing significantly. Likewise, rating restrictions exist in most small group states and some individual states due to a combination of federal and state laws. When

such limitations are severe, they have generally driven up premiums substantially. Any reforms increasing cost relative to wage growth have created issues with premiums and coverage. Please see discussion on price controls below as an example of the impact on availability of providers and supplies.

- Limits on Prices:

  US has a combination of several single payer and free market systems with extremely complex integration. Roughly 50% of costs are covered by private entities (insurers, employers, consumers) and 50% by government (Medicare which is for aged and some disabled, Medicaid which is for poor including poor disabled, and a number of other programs such as for military and relatives, Indians, worker compensation, etc..) Reimbursement under government programs is generally prescribed via rule or formula with some modest exceptions, and such reimbursement is much lower on average than private markets after discounts. As with price controls in general, this creates some perverse incentives as to mix of services, availability of services, and the supply or providers in markets/programs.

  Government has used two types of limits on prices in the US. The most common has been setting of prices for health care services in Medicaid and Medicare. The second method is the implementation of limits on premium increases. In some states premiums cannot be changed without government approval, which in some cases is very difficult to achieve and may be political. In other states, premiums are filed and used as long as government does not object. The limits on prices of health care services have created provider shortages, particularly in Medicaid, to varying degrees by state and type of service; cost shifting to private marketsand inefficient delivery of some types of care. Reimbursements are higher in Medicare on average than Medicaid, so while similar problems have emerged in Medicare, they are much less than in the Medicaid market to date. However, problems are increasing as Medicare has grown. Both programs also have substantial problems with fraud. Such limits may produce lower short term costs for insureds but in the long run, they have done little (if anything) to change underlying costs and problems except to exacerbate them.

- Provider Laws or Large Coalitions to Produce Lower Discounts:

  In the early 1990s, the average discount in the private market on billed charges was just under 10%. Government discounts were greater than this but still very low by today's standards. Today the average discount for all private insurance coverage is estimated at about 45% and government coverage in the 60 to 70% range. These large discounts occurred in an attempt to rein in costs by the payers. But as these discounts ramped up, utilisation and gaming of the system ramped up so that cost trends continued to exceed wage growth. In summary, the inefficiencies of the system became much greater as the distortion of charges increased. In response to these pressures, the period from the early 1990s until now has seen providers consolidate into larger groups, whether coalitions or other relationships in an attempt to gain leverage over payers. Provider laws have been one response by policymakers to prevent or limit the ability of providers to do so or preclude certain actions by providers.

  Provider laws have attempted to prevent insurers from distinguishing between efficient and inefficient providers. Where this has been attempted, limited success has been found while a number of states have restricted these programs because of pressure from the excluded physicians and/or consumers. Coalitions have often focused on receiving greater discounts or other items but these attempts have had limited experience. These laws have resulted in shifting of services and more gaming of the system so that significant cost savings have not materialised. Since these laws often are targeted toward small cost drivers, any success is also limited.

- Limits on Expenses (Minimum Loss Ratios):

  These limits by themselves would reduce premiums if companies can survive the reduced retention. However, because profitable premiums must be so high due to underlying cost levels, companies have strained to find ways to create affordable premiums. As such, use of such limits can create a deterrent to companies entering the market (or those already present). In the current reform, loss ratios in the individual market are being set to a higher level than companies can normally tolerate. Some companies may try to satisfy this limit by selling all policies via the internet but this has typically met with limited success in past experience. Other options include subsidising losses in this market with other products in other markets (where the higher minimum loss

ratios are more tolerable) or finding ways to integrate policies outside the law with those subject to the law. Such efforts are likely to have small effects on results versus other efforts.

- Risk Equalisation:

  Risk classification as defined by actuarial principles is necessary to balance elements of choice in the system (whether they be choices in plan design, providers, payers, etc.). Some risk adjustment mechanisms have had success by reasonably reflecting differences in age, gender, income, benefits, health status, reimbursement, and provider availability. Examples of success would include high risk pools; individual market pricing reflecting such risk characteristics; and Medicare payment rate adjustment for age, risk scores, institutional status, and area. Failures would include Medicare failing to adjust the age of eligibility for increases in life expectancy; implementation of limits on costs due to health status without creating other means of cost control; and low physician reimbursement on Medicaid resulting in limited availability of primary care physicians and thus higher use of emergency rooms.

- Making Each Player (insurers, employers, providers, prescription drug companies) more responsible:

  As discussed above, the incentives of the system are not aligned in the appropriate manner to create a reasonable balance of cost, coverage, and access to quality treatment. Ever since World War II, the legislature has moved toward a system that makes each player in the system focus on what they could do within the laws rather than focus on delivering the best products and/or services at the lowest cost. Making players more responsible requires players to balance their interests between cost and quality of product or service. Failure to do so will make efforts to achieve the balance virtually unattainable, regardless of the expressed intent.

Conclusion

The system of checks and balances in the current U.S. Healthcare System has been distorted with increasing frequency over the years due to overregulation and the reaction by parties to the incentives or disincentives present therein. In general, what

has occurred is a focus on strategies that allow parties to survive and thrive under these laws rather than be driven to necessarily provide improving services at lower cost. Because someone else in the U.S. generally pays most of the cost, this has focused providers on delivering the best products to consumers (regardless of cost). This in turn has caused insurers to focus on provider discounts rather than cutting utilisation or changing the mix of services. Also, every limitation on coverage or service led to consumer complaints because demand was more important than cost. Furthermore, when consumers did not get the very best service for whatever reason, they demanded government pass laws to provide access, filed a lawsuit to obtain it, or found different providers who could deliver what they wanted. This created a self-fulfilling prophecy of high cost and comprehensive high quality services. With this have come increasing levels of fraud and administrative cost due to the imbalance of cost, coverage, and access to treatment.

Many lessons can be learned from failures in the US including the fact that a system should pay attention to the balance of the various parties; should not violate economic or actuarial principles; and should pay close attention to safety net principles and approaches.

APPENDIX 3A: TOTAL AUSTRALIAN HEALTH EXPENDITURE AND SOURCE OF FUNDS 2007–08 (AUD MILLION)

Area of expenditure	Government						Non-government				Total health expenditure
	Australian Government				State and local	Total	Health insurance funds	Individuals	Other[(d)]	Total	
	Department of Veteran Affairs (DVA)	Department of Health and Ageing (DoHA) and other[(b)]	Premium rebates[(c)]	Total							
Total hospitals	1,633	11,268	1,960	14,860	16,806	31,666	4,295	812	1,784	6,891	38,557
Public hospital services[(e)]	738	11,081	244	12,063	16,537	28,599	534	475	1,209	2,218	30,817
Private hospitals	895	186	1,716	2,798	269	3,067	3,762	337	575	4,673	7,740
Patient transport services	133	61	58	252	1,296	1,548	128	258	69	455	2,004
Medical services	871	13,093	371	14,335	—	14,335	813	2,170	1,021	4,003	18,338
Dental services	108	114	423	645	580	1,225	927	3,944	10	4,881	6,106
State/territory provider	. .	. .	. .	. .	580	580	. .	32	. .	32	612
Private provider	108	114	423	645	. .	645	927	3,912	10	4,849	5,493
Other health practitioners	172	666	203	1,041	—	1,041	446	1,574	312	2,332	3,373
Community health and other[(f)]	2	633	1	635	4,251	4,886	1	239	69	309	5,195
Public health	—	1,363	—	1,363	758	2,122	—	30	112	142	2,264
Medications	461	6,615	21	7,097	—	7,097	46	6,506	71	6,623	13,720
Benefit-paid pharmaceuticals	461	6,329	—	6,789	—	6,789	—	1,321	—	1,321	8,110
All other medications	—	287	21	308	—	308	46	5,185	71	5,303	5,611
Aids and appliances	2	331	148	480	—	480	325	2,264	45	2,634	3,114
Administration	56	984	402	1,442	292	1,733	881	—	—	881	2,614
Research	1	2,131	—	2,133	387	2,519	—	—	213	213	2,732
Total recurrent funding	**3,437**	**37,259**	**3,587**	**44,283**	**24,369**	**68,653**	**7,862**	**17,798**	**3,705**	**29,364**	**98,017**
Capital expenditure	—	108	. .	108	2,010	2,118	n.a.	n.a.	3,429	3,429	5,546
Total health funding[(g)]	**3,437**	**37,367**	**3,587**	**44,391**	**26,379**	**70,770**	**7,862**	**17,798**	**7,133**	**32,793**	**103,563**
Non-specific tax expenditure	. .	382	. .	382	. .	382	. .	–382	. .	–382	—
Total health funding	**3,437**	**37,749**	**3,587**	**44,773**	**26,379**	**71,152**	**7,862**	**17,416**	**7,133**	**32,411**	**103,563**

Source: Health Expenditure Bulletin 2007/8 - the Australian Institute of Health and Welfare

Notes to Appendix 3A tables

(a) Tables show funding provided by the Australian Government, state and territory governments and local government authorities and by the major non-government sources of funding for health care. They do not show total expenditure on health goods and services by the different service provider sectors.
(b) 'Other' comprises Australian Government expenditure on capital consumption and health research not funded by DoHA.
(c) Includes the 30–40% rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.
(d) Expenditure on health goods and services by workers compensation and compulsory third-party motor vehicle insurers, as well as other sources of income (for example, rent, interest earned) for service providers.
(e) Public hospital services exclude certain services undertaken in hospitals. Can include services provided off-site, such as hospital in the home, dialysis or other services.
(f) 'Other' denotes 'other recurrent health services n.e.c.'.
(g) Total health funding has not been adjusted to include non-specific tax expenditure as funding by the Australian Government.

APPENDIX 3B - SUMMARY OF UNITED STATES MEDICARE MARKET

Eligibility

Individuals over age 65 or those with a Medicare-approved disability are eligible for Medicare coverage. Open enrolment is offered to potential Medicare recipients between January 1 and March 31 for the majority of Medicare recipients but those who are turning 65 can enrol on the first day of the month they are to turn 65 and those who are dually eligible for Medicare and Medicaid coverage can enrol throughout the year.

Benefits

- Medicare Fee-for-Service (the portion of Medicare funded by the government) covers the following specified set of services with the described limitations:
    - Inpatient Hospitalisation – Subject to the Medicare Part A deductible and limited to 150 days
    - Skilled Nursing Facility – Subject to the Medicare Part A deductible and limited to 100 days per year
    - Outpatient Services – Medicare covers "medically necessary" outpatient services (such as emergency services, diagnostic radiology, and outpatient mental health services) subject to coinsurance of generally 20% (Outpatient Mental Health is subject to coinsurance of 45%)
    - Physician Services – Medicare covers most physician visits (exclusions include but are not limited to routine physical exams, routine chiropractic care, routine podiatry, routine vision exams and corresponding vision hardware, routinehearing exams and hearing aids) and are generally subject to a coinsurance of 20%

- Prescription Drugs – Some drugs are covered under Medicare Part B (those generally administered by a physician) and are subject to a coinsurance of 20%

- Medicare eligibles who do not want to face the above benefit limitations or be subject to the listed cost-sharing can instead purchase their coverage through Medicare Advantage plans, which are run by private insurance companies (who receive funding from the government), are often copay-driven (rather than deductibles and coinsurance), and often offer additional benefits in exchange for a member premium. Several examples of the additional benefits offered by Medicare Advantage plans are summarised below.

    - Inpatient Hospitalisation in excess of 150 days
    - Routine Physical Exams
    - Preventive Dental Coverage
    - Worldwide Emergency Coverage

- Overall, about 10 million of the 44 million people enrolled in Medicare belong to Medicare Advantage plans.

Funding

Primary Funding

The Medicare program is funded through payroll taxes, general revenue from the Federal Budget and benefit eligible premiums. The payroll taxes and premiums are intended to be set aside in Trust Funds for future use, but these monies have been mostly spent so the Trust Funds are grossly inadequate to pay benefits. General revenue use was supposed to be limited to 75% of Part B costs, but instead has generally exceeded this number. The average magnitude of Medicare payroll taxes is around $194 billion a year (as of 2008) and premiums add another $58 billion (as of 2008), but this pales in comparison to Medicare payments of around $454 billion (as of 2008). The Medicare Trustees prepare an annual report presenting the financial condition of Medicare and it is dire. In the 2007 report, they indicated unfunded liabilities in excess of $28.1 trillion (based on a 75 year reporting period), and that a

few trillion dollars of expense will be added each year. Despite these warnings, U.S. legislators have continued to expand the program in recent years adding such items as drug benefits. Issues that have created the massive shortfalls are numerous, including failure to adjust the age of eligibility as life expectancy has increased, trends well above wage growth due to heavy utilisation, adding benefits and populations over the year such as expanding eligibility to the disabled under the age of 65, and failure to manage the program despite constant warnings from the Trustees.

Supplementary Sources of Funding

- All Medicare eligibles receiving benefits must pay a Part B premium which currently is $96.40 a month. In addition individuals are responsible for the Medicare standard cost sharing described above (Part A deductible, Part B coinsurance).

- Medicare Advantage (MA) plans may have additional premiums that are due. These can range from $0 per member per month(PMPM) (for plans targeting a healthy population) to hundreds of dollars PMPM (for less healthy enrolees who are willing to sacrifice the cost of a monthly premium in exchange for low cost-sharing should they become ill) to even higher premiums (for plans that target certain disease-specific groups). These MA premiums are intended to cover the cost of benefits provided to the recipient.

- For the Medicare Advantage plans described above, there is generally an inverse relationship between the level of cost sharing and the level of monthly premium. As such, cost sharing as a percentage of costs can vary significantly by plan.

Allocation of Funds to Health Plans for MA

The government determines the cost of benefits provided to Medicare Fee-for-Service members in each county and allocates funds to Medicare Advantage plans based on the counties in which they operate and their projected enrolment in these counties. Fees are also adjusted based on age and institutional status. In addition, the payments the government provides to Medicare Advantage plans are adjusted for the risk scores of the members the plan attracts. We discuss risk score adjustment in section Risk Selection below.

Enrolment and Mobility

As mentioned above, people are eligible to enrol in Medicare on the first day of the month in which they turn 65. Disabled are eligible to enrol in Medicare on the first day of the 25th month after which they qualify for Social Security disability benefits. Once enrolled in Medicare, eligibles are able to move from plan to plan (or Medicare Fee-for-Service to Medicare Advantage) in the months of January-March of each year. In addition, dual eligible members (those eligible for both Medicare and Medicaid) are able to move from plan to plan throughout the year.

Risk Scores/Risk Adjustment

- Medicare diagnosis codes are tracked throughout the year and used by the Center of Medicare and Medicaid Services (CMS) to assign a risk score to the Medicare member each month. Payment rates on behalf of members are adjusted to reflect a risk score based on DRGs. Other potential risk measures reflecting lifestyle or medical conditions, except for those noted, are not used as yet. The starting point for a risk score is age/gender (plus an add-on for dual-eligibles) and then adjusted for diagnoses.

- Ultimately, the least healthy Medicare enrolees belong to the dual eligible and disabled segments of the population. Furthermore, those with the richest benefits are typically those who have employer retiree benefit coverage which is supplemented by a Medicare Prescription Drug Plan (PDP).

Risk Selection

Due to the payment rate adjustment effect, Medicare Advantage plans often work with providers to make certain that all appropriate diagnosis codes are reported to CMS in order to attain the highest possible payments for each member. As a result, CMS estimates that risk scores for Medicare Advantage members are over 3% higher than for Medicare FFS members. In spite of the ability to adjust payments for risk score, Medicare Advantage plans are still careful to avoid the least healthy populations since these populations cross over the threshold where cost increases cannot be offset by managing the risk scores.

Provider Reimbursement

Providers are reimbursed by Medicare according to a set fee schedule (a combination of per admit Inpatient rates based on DRGs, Outpatient rates grouped by Ambulatory Surgery Centres (ASCs), and physician fee schedules based on RBRVS (Resource Based Relative Value Scale) – the value of certain revenue codes relative to a defined base rate in a certain CMS-defined area) established by CMS each year. Both the Medicare Advantage and the Medicare FFS programs are subject to the fee schedules determined by CMS. Providers cannot be reimbursed for services provided to Medicare members at a rate greater than the Medicare (although in some circumstances, providers accept reimbursement at less than Medicare fee schedules.) Due to the restrictive nature of these fee schedules and the fact that the provider reimbursement is generally low (about 70% of reimbursement in the commercial market), providers tend to shift costs for the Medicare market to the commercial market in order to prevent losses.

Claims Control Mechanisms

- Both the Medicare Fee-for-Service and Medicare Advantage programs attempt to use cost sharing as a mechanism to control utilisation and prevent excessive claims. In addition, Medicare Fee-for-Service imposes benefit limits (such as 150 days on Inpatient Acute services) to further prevent excessive utilisation. However, MA plans tend to limit their cost sharing components in order to attract membership away from traditional Medicare FFS. Furthermore, in light of the passage of recent healthcare reform legislation, certain cost-control mechanisms (such as the coverage gap for prescription drug coverage) will be decreasing in future years. This change will result in a lack of cost sharing due to gap filling and requirements for MA and other plans authorised by the government that tend to limit cost sharing.

- The Medicare Fee-for-Service program does not have any claims control mechanisms in place at time of payment, although audits and review do occur later. However, many insurance companies who provide Medicare Advantage companies work with their provider networks to manage care. Several such programs are described below.

- Programs to limit coverage/reimbursement for hospital readmits within a certain period of time after discharge for the same condition

- Requirement of a certain length of Inpatient Hospital stay prior to admission to a Skilled Nursing Facility

- Emphasis on Preventive Care/Health & Wellness programs designed for the dual purposes of attracting a healthier population and detecting member health concerns at an early stage

- Case Management/Condition Counselling for subsets of a plan's membership with a common condition

Quality Assurance and Benchmarking

- CMS tracks the risk scores, enrolment, and costs of each covered county for both the Medicare Fee for Service and Medicare Advantage populations. The Medicare Fee for Service costs for each county are then used to determine the Medicare Benchmark Payment Rates by county (the amount CMS pays Medicare Advantage plans to offer coverage in that county).

- CMS has several programs to ensure they only pay for claims in compliance with Medicare's coverage, coding, payment, and billing policies. They have contractors to educate providers and detect and correct improper over- and underpayments including incorrect payment amounts, non-covered or medically unnecessary services or setting, incorrectly coded services, insufficient documentation and duplicate services. They also have contractors responsible for the detection, deterrence and prevention of fraud, waste and abuse. After many years of ineffective programs, CMS' recent efforts to reorganise and revitalised these programs has dramatically improved results, in particular, recouping overpayments.

- CMS also contracts with Quality Improvement Organisations (QIOs) whose current scope of work includes protecting beneficiary rights; patient safety, e.g., reducing rates of infections, and drug safety; prevention, e.g., improve immunisation rates and cancer screenings; and targeted projects such as diabetes self-management education efforts, seamless transitions across settings, and reducing unnecessary readmissions to hospitals. These initiatives

represent a recent and major shift in the QIO scope of work designed to make them more effective in improving health care quality.

- As a service to Medicare enrolees, CMS has designed their website in order to provide a resource to members for questions about their coverage, plans available in their county of residence, and the relative rating of these plans (CMS determines the rating on a 5 star scale of each plan based on 33 metrics in 5 categories). U.S. health care reform initiatives provide for bonus payments starting in 2012, including 'star' bonus payments that depend on quality measures of the Plan. The data transparency has had little impact on health plan quality to date. However, the prospect of performance based payment has caused health plans to pay attention to their quality scores.

- Medicare Advantage plans that offer coverage to Medicare eligibles are subject to some level of scrutiny by CMS on their processes each year. Each Medicare Advantage plan provides data to CMS to support payment, program integrity, program management, and quality improvement activities. In addition, CMS audits each Medicare Advantage contract roughly once every two years at which point the insurer is subject to more intensive scrutiny on the operational and financial aspects of their business (as it pertains to the Medicare Advantage segment), and the assumptions and adjustments underlying the bidding process. CMS also annually selects Medicare Advantage organisations for audits to confirm the presence of diagnoses used in to 'risk-adjust' the payment to the Medicare Advantage organisations. CMS audits have always been somewhat effective in keeping health plans compliant. However CMS' recent increase in oversight, shift to more expansive reporting and focused audits has raised the bar on health plan compliance.

- CMS also provides web-based data that compares information on specific providers including hospitals, nursing homes, home health care, and dialysis facilities. The hospitals have a financial incentive to report the quality of their services. As a result of the reporting, some hospitals have instituted focused efforts to improve their scores. However, to date, when looking at results in aggregate, this type of reporting has not dramatically improved results.

- Physicians and other eligible professionals can participate in the Physician Quality Reporting Initiative (PQRI) by reporting quality measures information to CMS about specific services provided frequently to their Medicare patients with certain medical conditions. Providers submitting data qualify to earn a PQRI incentive payment. Although since the program started in 2006, the number of metrics has grown, as has the incentive payment, physicians cite

administrative challenges and CMS has published no reports on related quality improvements.

Regulations

- A massive array of rules and laws exist for each Part of Medicare relating to providers, insurers and consumers as applicable. CMS acts as the major regulating body for the Medicare program, subjecting insurers, consumers, and providers to intensive scrutiny. Furthermore, they regulate all steps of the process (from determining the FFS costs, risk scores, and payment rates in each county; normalising those values each year; setting provider reimbursement schedules; and reviewing the work of Medicare Advantage insurers).

- The program is suffering from substantial fraud and abuse by all accounts. For example, insurers work with providers to report all diagnosis codes to CMS in order to increase risk scores and thus payment rates. This subjects risk scores to inflation when some providers overstate the services they provide in order to gain more reimbursement. For instance, there have been reports of over reporting (excessive expenditures) the Durable Medical Equipment (e.g. wheelchairs) provided or codes for podiatry services provided on members who have had the foot in question amputated. Furthermore, services are subject to anti-selection by members who are able to research all plans offered in their county and select the plan with the lowest cost sharing for the services they intend to utilise in the coming year.

APPENDIX 3C - SUMMARY OF MAJOR PROVISIONS OF RECENTLY PASSED U.S. HEALTHCARE REFORMS

Tax Policy

The law does not change the taxability of insurance benefits to employers or individuals. However, an excise tax is implemented on insurance companies and is expected to increase premiums.

Entitlements

The law expands eligibility substantially for Medicaid; this is expected to increase enrolment here and increase government costs. The law also includes numerous provisions relating to Medicare which are expected to save substantial amounts of money in the federal budget by reducing funding to the Medicare program.

Limitations on Underwriting, Premiums and Risk Classification

Premium Rate Change

The regulations relating to the bill are in process of being drafted, and they may take as long as 12 to 18 months after passage (March 23, 2010) to complete. Current regulations on rate increase limitations may vary by state as described in the response to question #14. Types of rules that exist include:

- Limits on the amount by which premium increases may exceed trend. For instance, some states limit that to 15%.
- Maximum rate increases in a year or over a period of several years. Some states for instance have imposed limits of 10% at certain points in time.

- Some states have not allowed increases larger than 50%, requiring that any such increases be implemented over a period of several years.

Changes include no underwriting, no pre-existing condition recognition, and minimal recognition of risk characteristics in setting premiums. These are supplemented by a weak individual mandate to buy coverage and subsidies and penalties that vary by market and individual risk characteristics.

Non Compliance by Regulators

On occasion companies have been fined for non-compliance by regulators. But generally the laws do not state specific penalties for non-compliance with pre-existing condition limitations; however, a specified penalty may be helpful. Massachusetts has put in a penalty for not purchasing insurance from qualified insurers (an individual mandate). While the mandate has reduced the uninsured to a few per cent of the population, a number of people comply by purchasing coverage for a few months as needed and then lapsing. This practice has created high loss ratios for individual carriers.

Provision Relating to Employers

If the question refers to what risk characteristics can be supported by credible information in setting premiums, all of the risk factors shown in our Database plus many component parts of may be applicable depending on circumstances. These include these age, gender, dependency, income or assets, benefit levels including cost sharing, managed care, limits on or mandated benefits, service availability, provider availability, health status, reimbursements, subsidies and penalties, moral hazard or availability of insurance, etc.. If this question refers to what risk characteristics can be reflected in guarantee issue and community rating, the answer is:

- A person cannot be rejected coverage for any reason including health status, as long as if they are eligible for coverage according to any limits on purchase by age or income.

- In some situations, recognition of health status may be allowed by some states to a certain degree while other states do not allow such recognition.

- Some states allow recognition of variation by age such that premiums for the oldest individual are not more than 3 or 4 times the youngest rate. Many states afford a blend health status and aging requirements.

- Some states allow some pre-existing limitation with guarantee issue and community rating while others do not.

- Some states may allow variation due to certain health conditions, treating them as separate from health status. For instance, smoking discounts are allowed to vary to some degree in the reform bill in addition to the variation allowed in health status.

Provisions Relating to Employers

There is only an individual mandate in the bill, not an employer mandate. However, the employer can be responsible for the individual mandate penalty when terminating employer coverage for the individual. Given the cost increases under the bill, the possibility exists that some if not many employers could drop their coverage over time.

Benefit Mandates

The reform provisions include minimum benefit levels in aggregate, remove annual benefit limits and constrain other types of benefit limits. Some exceptions exist for plans in force.

Checks and Balances

The law includes the creation of many new agencies to control and implement the laws in addition to the many agencies already in place today as well as many other provisions above and beyond those already referenced. Overall, the law has many additional provisions and the references in this attachment are only intended to highlight significant risk drivers.

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CHAPTER 4

FINDINGS FROM HONG KONG SURVEYS AND INTERVIEWS

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SECTION 4.1: INTRODUCTION

Scope of Work

The Food and Health Bureau ("FHB") has commissioned a series of studies to devise a proposal for a feasible incentivised voluntary Health Protection Scheme ("HPS", "the Scheme"), guided by the policy direction in the Chief Executive's Policy Address 2009-10 to propose a supplementary health care financing option based on voluntary participation with insurance and savings components for the second stage public consultation on health care reform. Milliman Limited ("Milliman") has been appointed by FHB to carry out a background research study about private health insurance ("PHI"), entitled "Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views".

As part of this study Milliman has been asked to survey selected stakeholders regarding the desired objectives, attributes and features of an incentivised PHI package under the Scheme, analyze the common grounds and conflicts, assess their compatibility with the stated objectives of the Scheme, and prioritise the wish list of features for design of the Scheme features.

The key objectives of the Scheme are stated as:

- Encourage take-out of medical insurance and savings plans among the population and improve their sustained access to affordable, pre-paid private healthcare services, in order to provide choice to those who are able and willing to pay and induce their making greater use of private services as an alternative to public services; and

- Improve transparency about service standards and price levels in the private health insurance and healthcare markets, with a view to encouraging standardised product development and offering, promoting market transparency and competition, as well as enhancing consumer protection and confidence.

Approach

We have interviewed the key stakeholders in Hong Kong health care system, namely:

Health care and PHI consumers ("consumers")

1. Alliance for Patients' Mutual Help Organization
2. Consumer Council
3. Civil Service Bureau

Health care providers ("providers")

4. Hospital Authority ("HA")
5. Hong Kong Private Hospitals Association
6. Hong Kong Medical Association
7. Hong Kong Doctors Union

Health care financiers and insurers

8. Financial Services and Treasury Bureau
9. Medical Insurance Association and Healthcare Financing Reform Task Force under the Hong Kong Federation of Insurers
10. Hong Kong General Chamber of Commerce
11. Employers' Federation of Hong Kong

PHI intermediaries

12. Hong Kong Confederation of Insurance Brokers
13. Professional Insurance Brokers Association
14. The Life Underwriters Association of Hong Kong
15. General Agents and Managers Association of Hong Kong

Regulators

16. Office of the Commissioner of Insurance
17. Department of Health

Most interviews lasted between 90 minutes to two hours.

In addition, we have also sought informal input from various private hospitals, private health insurers, non-governmental organizations, and insurance agents and brokers, and have also incorporated feedback from the various stakeholders in their discussions with FHB.

Organization of this Report

Overall, we found that there are only a handful of important areas where there are divergences between the various stakeholders, in terms of what features they would like incorporated into the Scheme. These are discussed in Section 4.2.

The stakeholders generally agreed on the following key issues:

- The current health care financing system, where HA provides the majority of inpatient care at highly subsidised rates, is unsustainable in the long run with an aging population

- If the government is to launch the Scheme with a view to improving access of population to private health care, it will need to ensure that the PHI and private hospital markets are well regulated, with transparency and competition.

The remainder of the sections of this report look at the main concerns of the different groups of stakeholders, and their recommendations for the design of the Scheme, most of which do not result in any significant divergence. In particular, in Section 4.3, we prioritise the wish list of features that Consumers would like to see incorporated into the Scheme design.

Caveats and Limitations

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SECTION 4.2: MAIN AREAS OF DIVERGENCE

Overview

Overall, there appear to be a few areas of divergence between the various stakeholders in terms of the features they would like to see in the Scheme, and which may affect the achievement of the Scheme objectives.

The main areas of divergence, broadly in order of priority, are:

- Coverage of pre-existing medical conditions
- Uncertainty of medical provider charges, how much is covered by the insurer, and how much is to be paid out-of-pocket by the claimant
- Uncertainty of the medical necessity of services performed and consequently whether the service will be covered by the insurer
- Adequacy of PHI coverage for private health care services
- Transparency of commissions paid to insurance intermediaries

One other area of divergence is that consumers would like PHI premium rates to be guaranteed. Private insurance companies are unable from an actuarial perspective to provide long-term premium guarantees given the uncertainty of the cost of medical care, advances in medical technology, and changes in medical practices. Private insurers are accustomed to risk-poolingmedical insurance costs for a population over one year or even a few years. However, they are not able to forecast the necessary premium rates required to fund the pool over an extended period of time. The consumer associations we interviewed appear to understand this and we view this feature as a "nice to have" rather than a "must have." We therefore do not see this as a significant divergence. We believe the key issue is providing assurance to the public that insurers will not increase premium rates indiscriminately; putting in place Scheme guidelines on premium rate increases will hopefully provide sufficient reassurance. At the same time, provided there is sufficient competition amongst insurers, competitive pressures should help keep unreasonable premium rates increases in check. Ensuring adequate transparency in medical fees charged by healthcare providers and benchmarking changes in costs and technology should also help to keep a tab on premium increases.

Coverage of Pre-existing Medical Conditions

Currently, private insurers do not cover pre-existing medical conditions of individual policyholders for fear that this would lead to a disproportionate number of unhealthy individuals purchasing insurance and render the insurance plan not viable. Individuals with existing medical conditions, with full knowledge that they will financially benefit from making claims in excess of premiums paid, are more likely to purchase insurance ("anti-selection"). Without proper controls, this would lead to the collapse of the insurance portfolio.

In the case of group policies taken out by employers, insurers usually allow coverage of pre-existing medical conditions of employees, usually subject to a waiting period varying between six and twelve months and sometimes even waive the waiting period due to competitive pressures. This is possible with group insurance because the employee base represents relatively homogenous and healthy pool and there is much less risk of anti-selection as the policies are taken out by employers for their employees en bloc rather than the employees individually.

Both insurance companies and the Commissioner of Insurance are concerned about the risk of anti-selection which affects the financial viability of individual insurance plans and in turn the financial prudence of insurers.

To control the degree of anti-selection, the private insurers are willing to cover pre-existing conditions of individual policyholders after a suitable waiting period.

On the other hand, consumers would ideally like pre-existing medical conditions to be fully covered so that those in need of medical care have access to PHI..

The consumer associations interviewed understand the risk of anti-selection and the need for a waiting period. The outstanding question is what length of waiting period is acceptable to consumers, while at the same time is financially viable.

Uncertainty of Out-of-pocket Costs

Presently, when a policyholder is admitted to hospital, it is uncertain how much he or she must pay out-of-pocket because:

- Provider charges are uncertain for various reasons, including uncertainty on the actual volume and types of services to be provided, the exact length of stay in hospital, and the fee that the doctor will charge, which may vary considerably from one patient to another for the same procedure.

- Insurers apply different limits for different services and it can be difficult to figure out how much is actually covered

A logical approach to resolving this uncertainty is to encourage providers to offer more packaged prices, as opposed to itemised billing of each service or medical item. A common example of packaged pricing is the cataract surgery packages offered by private hospitals. At least one private hospital currently offers about 70 packages ranging from minor to major surgical procedures. This is also a practice commonly adopted in overseas economies where private health insurance is prevalent, for example in Australia, United States, and the Netherlands.

Correspondingly, insurers would indicate a benefit limit for each package, i.e. the budget it will provide the patient to purchase a particular package. This, together with the price of the package provided by the private hospital, would allow the patient to know exactly how much he or she will need to pay out-of-pocket.

Private hospitals are not willing to provide packaged pricing for the more complicated types of admissions (e.g. stroke and brain trauma admissions). They consider that insurers are in much better position to take on and share out such excessive risks with their much greater pool of policyholders, as opposed to the limited number of such complicated cases that each private hospital may handle.

For the less complicated admissions, where the private hospitals do offer a package, the package price cannot be inclusive of the fees of visiting doctors who usually retain the freedom to set their own fees to be charged for services rendered to the patients. The package can be inclusive of doctors' fees if the patient chooses a resident doctor, i.e. a doctor employed by the hospital. Some hospitals are also willing to include the fees of visiting doctors' with whom they are familiar, and would be comfortable taking the financial risk of actual costs exceeding the fixed price.

Doctors as solo practitioners offering services for a limited number of cases are less ready to take the financial risk and are not willing to offer a fixed price packages. Doctors also point to provisions in doctors' code of professional conduct governing financial arrangements for

healthcare services (Section D of Part II, Code of Professional Conduct for the Guidance of Registered Medical Practitioners (January 2009), Medical Council of Hong Kong).

Insurance companies consider providing benefit limits based on packages, where these are made available by private hospitals, would help enhance cost control and in turn enable premium adjustments to be more predictable. For admissions that are billed on an itemised basis, for instance for more complicated procedures, insurers would still require limits on different components of the bill for cost control and in turn to ensure actuarial viability and financial prudence. While insurers may be more able to absorb the incidence risks of such cases, not specifying benefit limits under the plan for such cases and in turn the amount of claims payout would be tantamount to issuing a "blank check" to policyholders and providers and make the insurance financially not viable.

At the end of the day, a proportion of admissions will have packaged prices available, leading to greater transparency and certainty of charges. The outstanding question is how extensive can the list of packages be and how providers could be encouraged to offer such packages.

Uncertainty of Medical Necessity of Services Performed

The other area of uncertainty is whether the insurance company will pay for a particular medical service provided. The differences in opinion between insurance companies and doctors seem to mostly revolve around the medical necessity of some procedures performed, for example, investigations such as endoscopies, colonoscopies, and gastroscopies. Insurers, hospitals, and doctors pointed to many cases of these investigations being done on an inpatient basis in order to get it covered by hospitalization insurance.

Doctors, like all professionals, want to retain their professional autonomy. Yet there may be different clinical judgments by different doctors on the medical necessity of a procedure or investigation, and it may not be easy for the insurers to verify medical necessity in the event of doubt. Rather than risking bad publicity, annoying the customer, and incurring the administrative costs in checking, some insurers tend to avoid the verification process unless there is a strong case for query. But they have been passing on the costs back to the policyholders by increasing premium rates in recent years when many insurers have only negative to narrowly positive underwriting margins. In other instances, some insurers will undertake verification of medical necessity and may choose to not pay the claim, leaving the claimant to pay for this out-of-pocket. In either case, the insurance policyholders end up bearing higher premiums or considerable uncertainty of out-of-pocket medical costs.

Ultimately, to reduce the uncertainty for the policyholder, the Scheme will need to consider the following options:

- Exclude such inpatient investigations altogether

- Cover them on an outpatient basis, only if they lead to a specific diagnosis, resulting in a hospital admission or equivalent outpatient treatment or procedure.

- Cover them on an outpatient basis with a significant policyholder cost sharing (e.g. 50% coinsurance), but waive this coinsurance if this leads to a medically necessary admission or equivalent outpatient treatment.

- Cover and pay for such investigations on an outpatient basis, but require doctors to have an agreed common standard for investigations done. Having a standard protocol for investigations and drawing a definitive line on medical necessity may be difficult to achieve for professional and political reasons. However, it is important that an attempt be made in the interest of the long-term sustainability of the Scheme, as there is no end to the amount of investigations that can be performed.

Adequacy of PHI Coverage

Feedback on the adequacy of PHI coverage for private healthcare services came mainly from providers:

- The private hospitals and doctors indicated that products under the Scheme need to provide adequate coverage, so as to reduce the out-of-pocket costs to patients.

- HA indicated that inadequate coverage would mean that the policyholders would still end up coming back to HA for the majority of services.

We did not get strong feedback on the adequacy of coverage from consumers or employers. Our sense is that they understand that they need to pay higher premiums for better cover, but may not be able or willing to do so given the availability of HA services as a fall-back option. However, the possibility of some consumers being unclear or very mindful about the adequacy of PHI coverage before actually utilizing the insurance protection cannot be excluded.

This raises various issues that need to be addressed when designing the Scheme benefits:

- What is the role of private hospitals vs. HA hospitals? For example, if the role of HA is to provide care requiring a team of doctors with interdisciplinary skills, then perhaps the basic Scheme PHI product needs not be generous enough to cover the more complicated admissions. Those that want to purchase the comprehensive range of care exclusively from private hospitals would need to purchase top-up cover.

- If the Scheme wants to expand access to the PHI and private health care market, we would need to understand the uninsured population's willingness to pay for insurance premiums and private health care. A large proportion of the uninsured population may decide to rely solely on HA services and would only be willing to pay very little (if anything at all) for PHI or private health care.

Transparency of Commissions

Brokers are independent intermediaries engaged by the buyer, rather than the insurance company, to find the buyer the best insurance policy by comparison shopping amongst insurance companies. Brokers in Hong Kong are typically hired by employers rather than by individuals. The broker organizations we spoke to are willing to disclose their commission rates to policyholders, but they opine that commission rate levels should be left to market forces.

On the other hand, the insurance agents, who represent insurance companies in selling insurance policies, are against disclosing their commission rates because:

- Potential customers may focus more on the commissions rather than the benefits of the products.

- The agent plays an important role in selling the product; disclosure of commission will make it more difficult for the agent to sell the product.

- The commission disclosure requirements may spill over into other insurance products.

- Eventually, the livelihood and role of the agent and sales volumes of insurance products could be jeopardised.

We think disclosure of commissions is certainly something that should be made transparent in the broker market, since the broker is being hired by the buyer for a fee, i.e. the commission. Hence, the fee charged, i.e. the commission, should be made known.

On the other hand, the insurance agent represents the insurance company and many non-insurance products are sold through agents and distributors without disclosure of commissions or sales incentives. This does not necessarily reduce the level of competition, because ultimately the sellers of products still need to compete on price, which includes the cost of distribution.

However, one of the fundamental objectives of the Scheme is to mitigate information asymmetry and promote transparency. At the very least, this means consumers have a right to know how much of premium dollar is spent on medical costs, versus administrative expenses, returns to shareholders (i.e. profit), and commissions. In other words, the disclosure could be retrospective through the accounting of the insurer, and not occur at the point of sale.

In addition, the Scheme could require that the insurance company offer a lower premium rate if the policyholder chooses to purchase the policy directly from the insurer, rather than through an intermediary. Again, this would be in support of the Scheme principles of transparency and consumer choice.

The remainder of the report summarises the main concerns of the various stakeholders and features that they would like to see incorporated into the Scheme.

SECTION 4.3: CONSUMERS

Consumers would like to see the following features incorporated into the Scheme design. The following is based on feedback from the Alliance for Patients' Mutual Help Organization, Consumer Council, and the Civil Service Bureau. We have broadly prioritised these features into those being essential, important, and desirable as a broad indication of the decreasing level of importance placed by the different organizations on the range of potential Scheme features explored. A feature is categorised as being "essential" when at least two out of the three organizations view the feature as being essential. A feature is categorised as being "important" when it is viewed by one of the organizations as being essential, but not by the other two. A feature is categorised as being "desirable" when the stakeholders do not see it as being essential, but it is still something they would like to see incorporated in the Scheme design.

- Essential to Scheme Design
    - Coverage of pre-existing conditions, as discussed in the previous section of this report.
    - Guaranteed renewal of the policy for the lifetime of the policyholder.
    - Accessible and affordable insurance coverage for elderly and chronic patients, possibly with government assistance.
    - Reduced uncertainty of medical charges and out-of-pocket costs, and product design where the benefit limits are easier to understand. In addition to our earlier discussion on this issue, consumers also raised the point that providers sometimes increased their charges after learning that the patient had PHI; those patients were taken aback by this behavior.
    - Reduced uncertainty of coverage and claims, in terms of whether a particular service or procedure is medically necessary and if the insurance company will pay for it.
    - Standardised terms and conditions to eliminate inconsistencies between insurance companies and reduce confusion to the consumer. In addition, the terms and conditions should be presented in a user-friendly format and language.

- Important features

    - Portability of the waiting period on pre-existing conditions when policyholders switch insurers

    - Guaranteed premium rates on renewal, otherwise guaranteed renewal on its own is meaningless. However, the consumers do understand that insurers cannot guarantee premium rates because they cannot predict future medical inflation and utilization trends.

    - A shorter and standardised list of exclusions to avoid arguments over individual claims, although the main concern is the exclusion of pre-existing conditions.

- Desirable features, although there was limited overlap between the different organizations in terms of the features that were seen as desirable.

    - Direct settlement between insurers and providers to reduce the cash payment required from the policyholder.

    - Coverage of primary and preventive care to improve the health condition of the policyholder.

    - Provide coverage for advanced medical technology that is not available in HA (e.g. the latest available medical equipment) to encourage policyholders to go to private hospitals rather than HA.

    - No claim discounts so that there is a sense of equity for those who do not claim.

    - Setting up a platform for comparing product features and prices for all Scheme products available in the market.

The above comments relate to the PHI protection component of the Scheme. The Scheme may also include a savings component. The organizations interviewed would like to see the following features incorporated into the savings component:

- Flexibility in how much individuals need to save
- Some form of incentive from the government to encourage individuals to save
- Administration fees would need to be reasonable; for example, the administration fees for the Mandatory Provident Fund are generally viewed as being excessive.

The above reflects the views of stakeholders from the consumer segment and may not fully represent the views of the whole spectrum of consumers. We understand that the Government will commission a separate consumer market research to gauge more in-depth the preferences of consumers, factoring in consideration of costs and benefits.

SECTION 4.4: HEALTH CARE PROVIDERS

Private Doctors

- Doctors must not take commercial risk, as would be the case with fixed packaged pricing. Doctors do not have enough volume for risk to be predictable and manageable.

- Doctors must have freedom to price services since their expenses (rent, equipment, etc.) are based on market prices. They already take on professional risk, which means clients will not use their services in the future if not satisfied with their performance or charges.

- Doctors must retain clinical autonomy. They have registration and disciplinary bodies to oversee professional standards.

- Doctors would like to see the government using subsidies in the Scheme as a tool to incentivise taking out of PHI for private services and regulate PHI products.

- They are fine with standardised fee schedules to be made transparent upfront, as long as the fee schedules are able to cater to the requirements of different areas of specialty.

- The application of medical protocols or clinical pathways is tricky because every patient is different. But a general move towards reducing variation of quality of care is a good thing.

- In principle, they are open to clinical audits, although this depends on the details of how the audit is done, such as who does the audit, the objective of the audit, the criteria applied, etc.

- They are willing to accept benchmarking of clinical practice for auditing purposes especially if public money will be involved. Again, this depends on the details of the benchmarking criteria to be used.

- They are not resistant to transparency of charges. In fact, their code of conduct requires doctors to disclose their charges to patients. But they will only reveal their charges to the government if the government is subsidizing the cost of services (directly or indirectly).

- Doctors would like the Scheme to cover preventive care (e.g. annual body checks) as they believe this would help to reduce the overall utilization of medical services since most health problems can be discovered in the early stages.

Private Hospitals

- The Scheme benefit design needs to:
    - Provide adequate coverage to reduce uncertainty of out-of-pocket costs for the patient.
    - Address unnecessary admissions for investigations such as gastroscopies, endoscopies, etc.
    - Reward policyholders for choosing the cheaper of two options. For example, laparoscopic surgery costs more than traditional surgery for hernias, even though the hospital stay is shorter. The insurer pays less for those who choose a normal procedure and so should the patient.
- Private hospitals are generally open to more packaged pricing, transparency of charges, benchmarking of clinical practices, and clinical audits, although some hospitals may be more willing to embrace this than others.
- Private hospitals would need time to develop the technical platform including IT systems such as electronic health record and billing system to implement the scheme.

HA

- It questions whether the private sector will have sufficient capacity to provide meaningful relief to HA. A 10% increase in private sector capacity will only reduce HA's hospital patient load by roughly 1%.
- The Scheme will need to cover pre-existing conditions, major surgeries, and catastrophic events in order to effectively redress the public-private imbalance in healthcare utilisation.
- It is willing to act as a clinical benchmark for the private sector.

SECTION 4.5: HEALTH CARE FINANCIERS, INSURERS, AND PHI INTERMEDIARIES

Financial Services and Treasury Bureau

- Its main concern is the impact on the overall funding of the healthcare system, including the administration costs of and any financial incentives to be provided under the Scheme. In particular, it is concerned about the long-term financial sustainability, which is why the government is looking at a voluntary PHI scheme in the first place; i.e. to supplement the current system, which is not financially sustainable in the long run. The Scheme will need to demonstrate value for money on any public monies spent, compared with the baseline of government-funded public health care.

- A secondary concern is how the Scheme will impact the public-private provider balance, which goes back to the question of long-term financial sustainability of the healthcare system as a whole. A shift of patients from public to private hospitals may be an indicator of a more sustainable system.

- In terms of potential government incentives, such as tax deductions, it would like to keep the tax code as simple as possible.

Employers

- For employers already providing PHI benefits, they would be more ready to embrace the Scheme if it enhances the benefits provided to employees at no additional cost to employers.

- Employers are concerned about where funding for PHI will come from if any subsidies initially provided by the government are subsequently removed.

- Employers are also wary that the Scheme may eventually be funded through higher taxes, which may compromise Hong Kong's global competitiveness.

- For smaller employers, the cost of providing PHI is more of an issue. PHI is considered a fringe benefit. It is not a core employee benefit and not necessarily an attraction to employees because of the very low-fee services provided by HA. Employers that currently do not purchase PHI for its employees will unlikely start providing medical benefits and participate in the Scheme unless there is social pressure to do so.

- Employers are generally concerned about increasing cost of private medical services and pressure for raising medical benefits. The Scheme will need to be able to manage medical costs, through standardization and enhancing transparency and competition.

- The supply of hospitals beds and doctors needs to be addressed. More new hospitals should be built. The Scheme should look at foreign doctors, including doctors with Hong Kong residency practicing overseas who may want to return to Hong Kong. However, the requirement to sit for local examinations is a stumbling block.

- PHI coverage for the elderly is currently lacking in the PHI market. But employers generally consider that they are not in a position to fund the post-retirement health care of employees.

- With regards to the savings component of the Scheme:

    - Individuals will have to see the value of saving for it to be accepted, including the attractiveness of any government incentives.

        - Vouchers used to offset the relatively high cost of PHI premiums at the older ages may be an attractive incentive to save.

        - Tax incentives may not be useful because a lot of the grass root population do not have to pay tax. This would only benefit the upper income segment of the population.

    - Any government subsidies with regards to savings should only be accessible to the account holder after a certain age.

It may be worthwhile to explore whether the medical savings scheme, if introduced, could follow a similar logic of Mandatory Provident Fund (MPF) and piggyback on the MPF infrastructure for ease of administration.

Insurers

- Private insurance companies are wary that the Scheme will impose terms and conditions that are not financially viable. They are concerned about the length of the waiting period for coverage of pre-existing medical conditions. If it is too short, the Scheme will be subject to anti-selection and will collapse.

- Insurers are also wary of irrational competition on standardised products. Some insurers may not have the necessary PHI expertise and may compete purely on price.

- Insurers consider that the PHI insured population should be expanded and should attract more young and healthy lives in order to ensure financial viability. They would like to see the government using financial incentives to do so.

- Some insurers are worried if the savings and protection pieces are completely integrated, then only life insurers will be able to participate in the Scheme. If the two components are separated, then the number of service providers for each component may be extended to banks, investment funds, and general insurers.

- Insurers want greater transparency and predictability of charging by private hospitals and doctors, as well as the medical necessity of procedures, so as to better control costs and assess financial liabilities under insurance plans.

- They are agreeable to using Diagnostic Related Groups or packaged prices used by hospitals as a basis for defining benefit limits. However, it will take them a number of years to put the necessary IT systems and manpower in place to handle this.

- They are generally amenable to policy intention on other product features, such as guaranteed policy renewal for life, portability of coverage, standardised terms and conditions, standardised coding of claims, etc.

- However, they are not able to guarantee future premium rates due to the uncertainty of future medical inflation, medical practices, and health care utilization patterns. They are willing to conform to pre-agreed guidelines on premium rate and benefit limit increases.

PHI Intermediaries

Brokers

- The brokers believe they have a role to play in the Scheme. In particular, brokers help employers structure their employee medical benefit programs and insurance benefits. They would also like to see if there is a role for them to play in the savings portion of the Scheme.

- The brokers are willing to disclose their commissions to policyholders. However, commission rate levels should be left to market forces.

- They are concerned whether the Scheme will disrupt the existing benefits being offered by employers to their employees.

- They also have suggestions for the Scheme design:

    - With existing PHI products, uncertainty of charges is not a major issue for minor operations. However, it is a significant issue for high cost events, such as cancer. The Scheme needs to make sure catastrophic events are adequately covered.

    - Guaranteed renewal in practice is not a significant issue. Insurers seldom terminate a policy at present. They normally refuse to renew a policy as an expedient means of dealing with suspected fraud or abuse.

    - The government needs to design benefits around the segments it is targeting. They do not expect the government to be targeting the poor.

    - Premium subsidies, if any, will have to be carefully designed in order to ensure the benefits go to the individuals insured instead of the employers.

Agents

- The agents strongly oppose disclosure of commissions for reasons mentioned earlier in Section 4.2.

- They had views and suggestions regarding the Scheme design:

- The majority of those currently without PHI are more likely people who trust the quality of HA services and/or are willing to accept longer waiting time, fewer amenities and lesser choice of drugs given much lower user fees. The uninsured are unlikely to join the Scheme unless there are fundamental changes that can narrow the disparity in the cost of accessing public versus private hospitals. This may involve setting up low-cost private hospitals and increasing the supply of private doctors. The Scheme will also have to address the practice of "over-charging" or moral hazard. In this regard, clinical audits and pre-hospitalization second opinions are possible means of avoiding unnecessary medical expenses.

- Some agents opine that possible scheme features like coverage of pre-existing conditions, barrier-free portability and life-time guaranteed renewal would be able to attract some new lives, though people thus attracted are more likely to be marginally less healthy. However, those people with serious pre-existing conditions and are currently receiving treatment from HA are unlikely to join the Scheme if they have to serve a three-year waiting period before such conditions are to be covered. Other agents are worried that coverage of pre-existing conditions will cause anti-selection and lead to higher premium rates that makes the insurance business unsustainable.

- Some agents consider deductible as a desirable feature as it may lower premium and make it affordable to more people. Other agents think that deductible is attractive only to the more affluent policyholders, e.g. professionals and expatriates, who are more ready to afford the deductible amount for each claim they make.

- Overall, some of the agents do not see the Scheme features proposed for discussion as being sufficiently attractive. The only real attraction to them would be the potential subsidy from the Government. However, if this is only a one-off or short-term incentive, it may not attract many new policyholders. They suggest providing ongoing tax deductions for insurance premiums.

SECTION 4.6: REGULATORS

Department of Health (DOH)

- Any supervisory role needs to be very clearly defined with the authority to take action where necessary. The source of authority can be contractual. If a hospital breaches the terms of the contract, then the contract can be cancelled.

- The current licensing regime for private hospitals would need to be revamped and updated. If there is any need for supervision of private hospitals under the Scheme to be linked to the licensing regime, legislation changes would be needed.

- The supervisor will need to have the necessary expertise and manpower, including for tasks such as clinical benchmarking and auditing, apart from licensing and monitoring.

- DOH supports the use of package pricing and cautions that development of DRG system will take time and it is important to properly communicate the concept to all relevant parties.

Office of the Commissioner of Insurance (OCI)

- OCI's key concern is that the Scheme is viable and sustainable and will not adversely impact the solvency and stability of insurers. Health insurance underwriting margins are rather thin, and the insolvency risk would be higher if the claim level is high, and the premium levels cannot be adjusted to reflect the risks/claim experience.

    - Appropriate checks and balances would need to be put in place to ensure the Scheme is financially viable.

    - Will Scheme attract sufficient membership to create a large enough risk pool thus rendering it financially viable? Will there be sufficient healthy lives in this pool to share out the risks of the unhealthy lives?

- Consumer protection / awareness will be important under the Scheme.

- The Scheme should encompass effective control measures because it involves public money. The government cannot allow public money to be abused. This is a voluntary scheme, so it is possible to consider supervision by way of agreement or contract. In other words, anyone (hospital or insurer) who wants to participate in the Scheme may be required to sign a contract with the Scheme, adhering to specified terms and conditions.

- Current prudential regulation regime for insurers should remain intact.

- In regard to the savings components, if the investment risk is to be borne by the policyholder, then market volatility could be a problem, and this could defeat the whole purpose of "saving up for future health care expenses."