消費者委員會
CONSUMER COUNCIL

Creating Sustainable Value for Private Health Insurance Market in Hong Kong

為香港個人醫療保險市場締造可持續的價值

Creating Sustainable Value for Private Health Insurance Market in Hong Kong

Executive Summary

EXECUTIVE SUMMARY

The Growing PHI Market

Hong Kong runs a dual-track system where the public and private healthcare sectors complement each other. In 2016, the private sector accounted for 68% of out-patient care; where the public hospitals made up 82% of the total number of in-patient discharges.

More than 2.4 million people[1] in Hong Kong, or over one third of the local population had private health insurance (PHI), representing a gross earned premium of HK$10.3 billion in 2016. Faced with Hong Kong's rapidly ageing population, and a call for better healthcare services as the market turns affluent, demand for PHI will indeed continue to rise.

With increasing popularity, the individually purchased medical insurance attributed to 9% of the total health expenditure (includes both public and private healthcare services) in 2016/17, as compared with 1% in 1989/90.

In 2018, the medical insurance market was served by 79 authorised insurance companies under the class of "General Business". Although there are many players giving a variety of choice in the PHI market, it does not motivate insurance companies to offer medical insurance policy for a continuous protection.

Despite such a growth, according to a research report, some 43% of inpatients covered by PHI only were still treated in public hospitals in 2016.[2] A combination of confusing medical insurance terms and conditions, uncertainty over medical cost or eligibility of medical claims, worry about implications of medical claims on policy premium and inadequate benefit coverage has deterred the market confidence in relying on PHI for healthcare protection.

The lack of confidence in PHI by consumers coupled with the complex factors affecting the development of the PHI market such as cost of healthcare service, transparency of information from insurance companies, consumer understanding on the outcome falls short of the coverage, would not only be detrimental to individual consumer interest, but would also limit the potential of leveraging PHI to finance the healthcare system in Hong Kong, as well as limiting the potential of the private sectors to meet the rising demand in healthcare services.

Consumers Expectation

Very often, consumers take out PHI cover with an expectation that they can protect themselves against financial burdens associated with medical treatments or procedures they feel they may need. There is also expectation of continued PHI coverage. However, due to the long-term nature of the product, problems with PHI tend to emerge only when the consumers activate the claim procedures and if the claim fails or only partially met, it could result in higher detriment to consumers in managing their own finance as compared to other regular consumer services. In PHI, consumers are often in no position to tell at the

[1] Census and Statistics Department. (2017) *Thematic Household Survey Reports No. 63.*

[2] Research Office, Legislative Council Secretariat. (2018) *Health insurance for individuals in Hong Kong.*

time of purchase whether their PHI plan covers all the medical procedures they might need, or to judge if treatments they need to undergo are medically necessary, or to comprehend the significant meaning of re-underwriting which may bar some consumers from shifting to other insurance companies. The quality and professionalism of insurance intermediaries and customer service staff of the insurance companies in providing clear, accurate and personalised information and services therefore play an important part in formulating consumer understanding and expectation of the PHI offered.

Moreover, general expectation amongst consumers regarding continuity of their PHI plans has also been observed. Complaint statistics from the Consumer Council (the Council) indicate that the lack of certainty on protection and the expectation that there would be continuity of the PHI they had bought turning out not to be the case in some situations (e.g. due to unexpected increase in premium, imposition of excluded items, poor understanding or communications of policy terms and conditions) caused discontent and rising concern to consumers who are seeking peace of mind in the purchase of PHI.

Consumer grievances and disputes arose when there was a gap between consumer understanding of what was being told or offered when entering into a PHI policy contract and his/her expectation on PHI protection; and the actual protection provided by the PHI he/she purchased. For instance, "guaranteed renewal" sounds like a renewal promise without any condition to the consumers. In reality, the insurance company reserves the right to adjust the premiums, benefits, terms and conditions of the policy contract which could affect the continuity of PHI coverage.

Value of PHI to Consumers

In order to understand this apparent disconnect between expectation and reality, the Council conducted an in-depth study into the PHI market in Hong Kong (the Study) by assessing the level of consumer satisfaction on PHI, their understanding and certainty of protection coverage in the PHI plans, and identifying possibly unfair conditions and procedures which may limit consumer's access and coverage to PHI and the insurance companies' payout obligations to policyholders.

The Council undertook a series of intensive research from 2016 to 2018 utilising a range of qualitative and quantitative methods:

- Consumer research through telephone survey of 1,000 respondents aged 18 or above; on-street survey of 205 respondents who had filed PHI claims within the past 30 months; in-depth interviews with 20 claimants aged between 18 to 54 and 8 elderly consumers aged between 55 to 74, all of them having encountered problems when engaging with PHI;
- Analysis of 299 complaint cases related to PHI received by the Council from 2015 to 2018;
- Collection of 18 local PHI sample policy contracts from 14 key insurance companies providing PHI products in Hong Kong for review and legal research (with reference to the experience in Australia, Canada, Singapore and the United Kingdom (UK)); and
- Desktop research into the regulatory approaches that are being taken in six selected jurisdictions i.e. Australia, Ireland, the Mainland China (Mainland), Malaysia, Singapore and the UK.

Consumer Vulnerabilities and Grievances

The Study identified certain factors affecting the accessibility, continuity and certainty of the coverage provided by PHI and found that consumers encountered different problems when engaging in different stages of purchase. Despite the satisfaction rate was high at the time of purchase, it was declining at the post-purchasing stage.

At the pre-purchase stage, it was found that samples of policy contracts were not easily accessible, and this limited consumer choice, at the same time impeded consumers' ability to shop around as they could not look into the details of the terms and conditions for better understanding of the products to enable them to find one which best suited their needs. According to the Council's consumer survey, when people looked for PHI, most of the respondents obtained information from insurance intermediaries referred by their friends or relatives (61%), or spoke to their friends or relatives about their policies (59%). Comparatively, lesser people shopped around; approximately one-third of the respondents obtained quotes from different insurance companies (38%) or searched for information from the internet (32%). Also, it was discovered that policy terms and conditions varied among policies, both within the same and across different insurance companies, causing extreme difficulties and inconvenience to consumers if they wished to make comparison. As a result, insurance intermediaries and personal network tended to play a significant role in the provision of information or advice to the consumers on their choice of PHI.

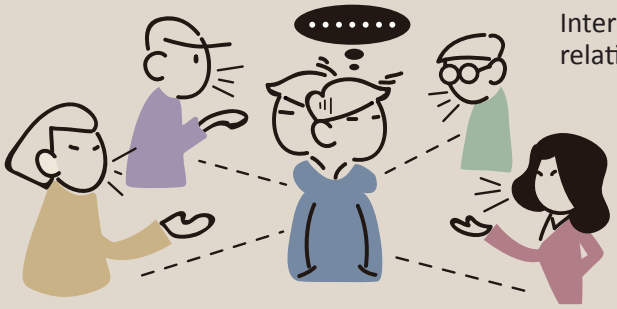
During the purchasing stage, elderly consumers had difficulties in applying for PHI as currently the maximum entry age limit for common PHI is set at between 64 to 70 years of age. Questions contained in the application forms were too general and not specific enough, causing confusion to the consumers as to how much detail they should disclose from their medical history. On occasions, non-disclosure of material facts became the subject of claim disputes. It also emerged that key policy terms and conditions were not explained fully or clearly by the insurance intermediaries, such as the insurance company's right of unilateral revisions of terms and premiums; and the significance of some terms which could affect claim results, for example "medically necessary", "reasonable and customary" and "pre-existing conditions", etc.

At the post-purchase stage, major concerns were about continuity and whether claims could be reimbursed. The Study found cases where the level of premium increased at renewals was unexpected to the policyholders, especially for elderly consumers; and the trigger conditions or justifications for increase of premiums were not made understandable to the policyholders. In some other cases, re-underwriting was also applied to policyholders after claims were made and settled, leading to the imposition of excluded items. Such practices largely affected the continuity of PHI. In addition, legal research revealed that insurance companies used different methods to limit their liabilities, for instance, using different terms (e.g. entire agreement clause, double insurance clause, unilateral variation clause, pre-existing conditions clause, medically necessary clause, reasonable and customary clause) in the policy contracts to protect their payout obligation, especially in granting approval in claims to limit payout amounts, causing disappointment to consumers on the aspect of insurance coverage. The Study also highlighted that there was a lack of understanding by consumers in relation to the significance of policy wordings, which tended to use complex language, not clearly or extensively defined, and this meant that they could be open for interpretation by the insurance companies.

Consumer Behaviour and Problems Encountered by Consumers at Different Stages of Purchasing Private Health Insurance (PHI)

Pre-purchase

Consumer Behaviour



Intermediaries, friends & relatives play a key role

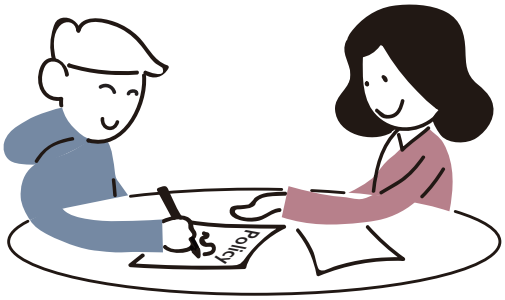
Want to have a peace of mind & continuous protection

Trade Practice of Insurance Companies/ Policy Terms and Conditions

Contract samples not easily accessible

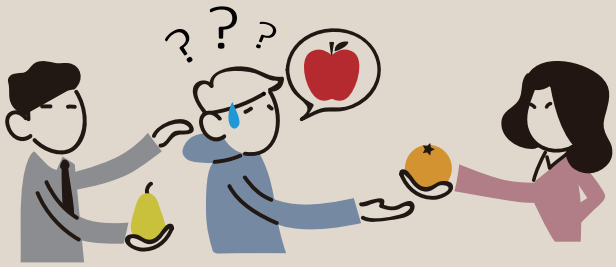
Behind the attractive sales wording, there are many terms and limitations which may be easily overlooked by consumers

Purchasing



Post-purchase

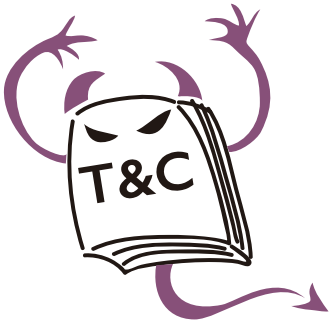
Rely on memory when making health declarations



- Seldom complain
- Grievance arises when inaccurate information given by intermediaries; expectation gap on coverage and claimable amount

Over-reliance on intermediaries to provide information

Accessibility problems (e.g. entry age limit commonly up to 64 to 70; some people may be imposed of premium loading / exclusions due to his / her medical history)



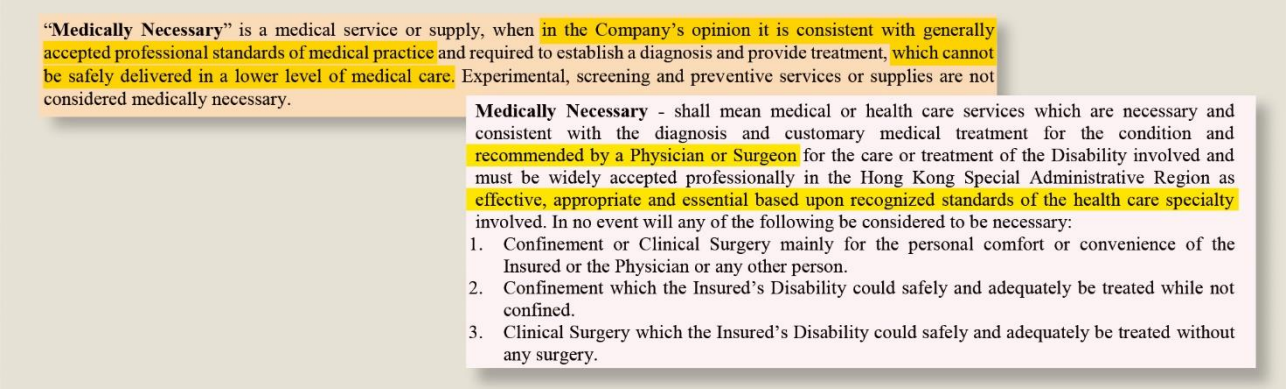
Problems encountered

- Unexpected premium increase
- Unilateral revisions on terms
- Use of T & C to limit liability

T & C are wordy, complicated and not clearly explained by intermediaries

The followings are examples illustrating the problems of policy terms and conditions identified in the legal research:

- Definitions of key policy terms vary among different plans and insurance companies, for example "Medically Necessary":

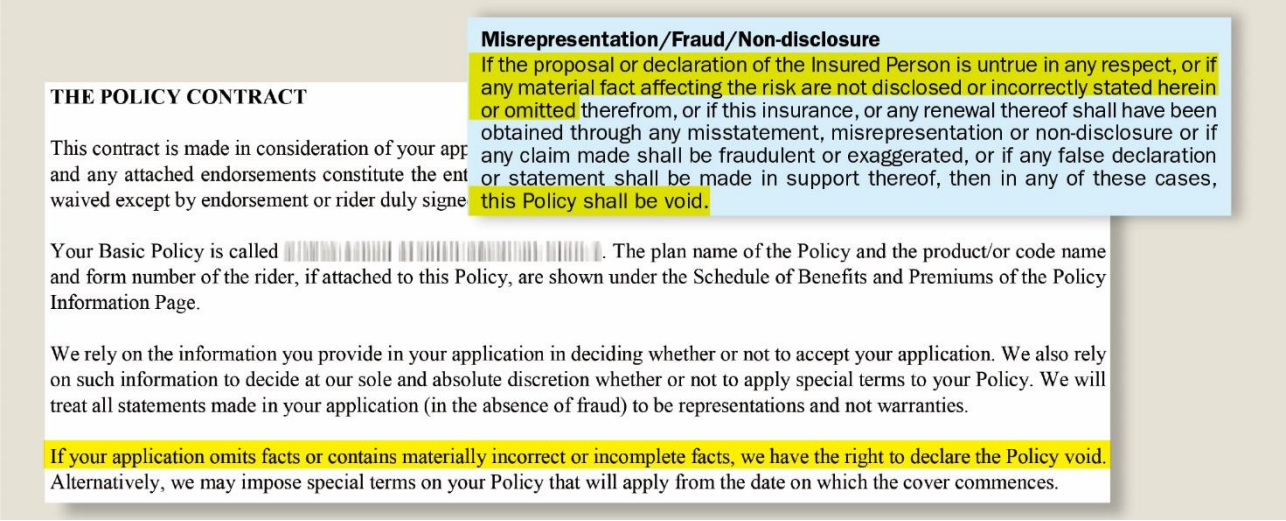


"**Medically Necessary**" is a medical service or supply, when in the Company's opinion it is consistent with generally accepted professional standards of medical practice and required to establish a diagnosis and provide treatment, which cannot be safely delivered in a lower level of medical care. Experimental, screening and preventive services or supplies are not considered medically necessary.

Medically Necessary - shall mean medical or health care services which are necessary and consistent with the diagnosis and customary medical treatment for the condition and recommended by a Physician or Surgeon for the care or treatment of the Disability involved and must be widely accepted professionally in the Hong Kong Special Administrative Region as effective, appropriate and essential based upon recognized standards of the health care specialty involved. In no event will any of the following be considered to be necessary:

1. Confinement or Clinical Surgery mainly for the personal comfort or convenience of the Insured or the Physician or any other person.
2. Confinement which the Insured's Disability could safely and adequately be treated while not confined.
3. Clinical Surgery which the Insured's Disability could safely and adequately be treated without any surgery.

- Non-disclosure clause which excluded liability for non-disclosure of earlier events arising from a wide variety of circumstances.



Misrepresentation/Fraud/Non-disclosure

If the proposal or declaration of the Insured Person is untrue in any respect, or if any material fact affecting the risk are not disclosed or incorrectly stated herein or omitted therefrom, or if this insurance, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or non-disclosure or if any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this Policy shall be void.

THE POLICY CONTRACT

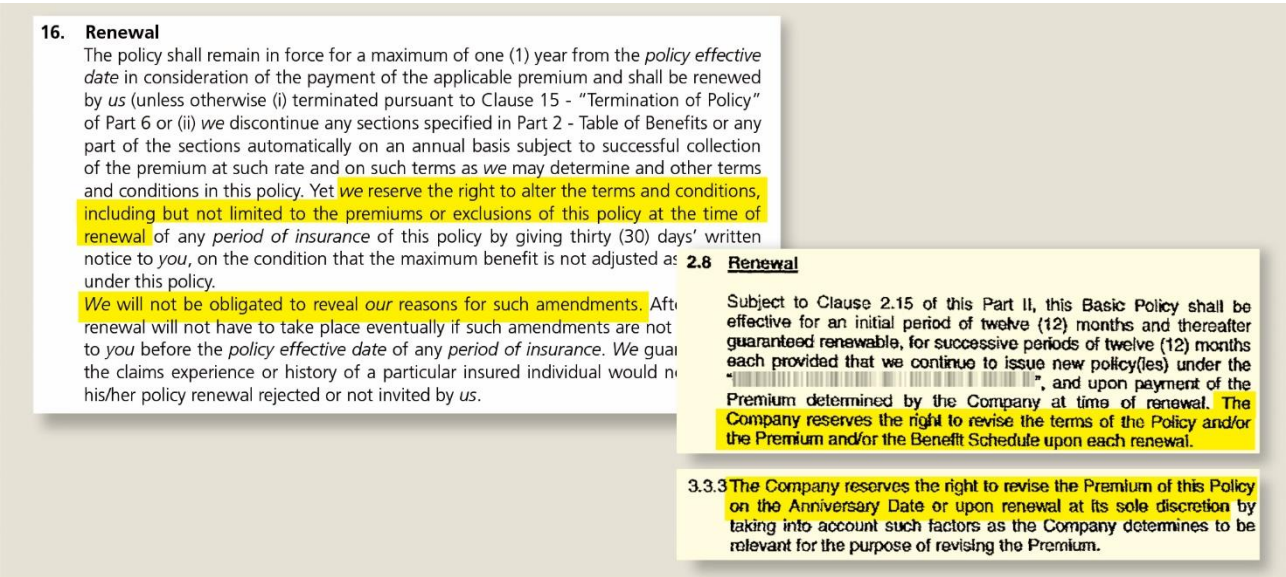
This contract is made in consideration of your app
and any attached endorsements constitute the ent
waived except by endorsement or rider duly signe

Your Basic Policy is called [redacted]. The plan name of the Policy and the product/or code name and form number of the rider, if attached to this Policy, are shown under the Schedule of Benefits and Premiums of the Policy Information Page.

We rely on the information you provide in your application in deciding whether or not to accept your application. We also rely on such information to decide at our sole and absolute discretion whether or not to apply special terms to your Policy. We will treat all statements made in your application (in the absence of fraud) to be representations and not warranties.

If your application omits facts or contains materially incorrect or incomplete facts, we have the right to declare the Policy void. Alternatively, we may impose special terms on your Policy that will apply from the date on which the cover commences.

- Right of insurance companies to make changes to policies.



16. Renewal

The policy shall remain in force for a maximum of one (1) year from the *policy effective date* in consideration of the payment of the applicable premium and shall be renewed by *us* (unless otherwise (i) terminated pursuant to Clause 15 - "Termination of Policy" of Part 6 or (ii) *we* discontinue any sections specified in Part 2 - Table of Benefits or any part of the sections automatically on an annual basis subject to successful collection of the premium at such rate and on such terms as *we* may determine and other terms and conditions in this policy. Yet *we* reserve the right to alter the terms and conditions, including but not limited to the premiums or exclusions of this policy at the time of renewal of any *period of insurance* of this policy by giving thirty (30) days' written notice to *you*, on the condition that the maximum benefit is not adjusted as
under this policy.
We will not be obligated to reveal *our* reasons for such amendments. Aft
renewal will not have to take place eventually if such amendments are not
to *you* before the *policy effective date* of any *period of insurance*. *We* gua
the claims experience or history of a particular insured individual would n
his/her policy renewal rejected or not invited by *us*.

2.8 Renewal

Subject to Clause 2.15 of this Part II, this Basic Policy shall be effective for an initial period of twelve (12) months and thereafter guaranteed renewable, for successive periods of twelve (12) months each provided that we continue to issue new policy(ies) under the "[redacted]", and upon payment of the Premium determined by the Company at time of renewal. The Company reserves the right to revise the terms of the Policy and/or the Premium and/or the Benefit Schedule upon each renewal.

3.3.3 The Company reserves the right to revise the Premium of this Policy on the Anniversary Date or upon renewal at its sole discretion by taking into account such factors as the Company determines to be relevant for the purpose of revising the Premium.

Learnings from Other Jurisdictions

Six jurisdictions were selected for in-depth research for the roles of PHI played when compared to Hong Kong. Population ageing is a global issue, these jurisdictions had make significant effort to improve accessibility, transparency and quality of PHI, with a view to promote the use of PHI and thus enhancing its role in healthcare financing. The Study reviewed and examined the regulatory approaches each jurisdiction adopted and learnings to the Hong Kong PHI market while recognised that these jurisdictions have different market situations. The review showed that efforts were made in these jurisdictions in order to enhance consumer protection and to promote a continued healthy development of the PHI industry, one or more of the following measures was present.

- Examination and approval on insurance clause and premium rate (the Mainland);
- Certainty of coverage and quality of PHI products, such as standardised level of benefits and definitions for treatments (Australia);
- Promotion of accessibility, affordability and continuity, such as coverage of pre-existing conditions, guaranteed access, renewal and portability (Australia); restriction on insurance companies' right to adjust liabilities for products containing a guaranteed renewable clause (the Mainland); options to switch to a more affordable plan (Singapore, for Integrated Shield Plans (IPs));
- Enhanced disclosure, transparency and choice, such as provision of a standardised information sheet of product summaries (Australia) as well as specified disclosure information (the Mainland, Singapore). Accessible platforms could help facilitate product comparison (Australia, Ireland) and legislation could help deal with a consumer's duty of disclosure and representation to an insurance company (the UK). While in the legal research, it is quoted that there is a duty of good faith on the insurance companies as set out by the court in Canada;
- Cooling-off period, this was either mandated (the Mainland (for long-term health insurance products), Malaysia, Singapore, the UK) or common practice (Australia, Ireland) in all the jurisdictions; and
- New initiatives such as the categorisation of hospital insurance products, the introduction of clinical categories, the provision of switching options to policyholders for terminating products (Australia), the introduction of pre-authorisation framework and a panel of preferred healthcare providers (Singapore for IPs).

Voluntary Health Insurance Scheme

To enhance the protection level of hospital insurance products and to achieve the long-term balance between the public and private healthcare services so as to maintain the sustainability of Hong Kong's healthcare system, the Government has launched the Voluntary Health Insurance Scheme (VHIS) in April 2019. The VHIS is a scheme for which participation of both consumers and insurance companies are voluntary. Certified Plans under the VHIS are government regulated indemnity hospital insurance plans (IHIP) complying with various minimum requirements so as to boost market adoption of PHI with enhanced features for consumer protection.

The VHIS offers IHIP with enhanced accessibility, continuity, quality, certainty and transparency. Such as extended entry limit to age 80; guaranteed renewal up to age 100 without re-underwriting due to changes in health conditions; coverage of unknown pre-existing conditions subject to waiting period and reimbursement arrangement; provision of claimable amount estimate on request by the policyholder; standardised policy terms and conditions; and premium transparency.

Council's Recommendations

In summary, the problems identified in the Study fall under two categories: (i) an apparent gap between consumer expectation and in reality what they could enjoy from the PHIs they purchased – narrowing it will empower consumers to make better informed choices; and (ii) a lack of continuity of PHI – bringing continuity and certainty to PHI coverage may help promote the usage of private healthcare services and help balance the private and public healthcare demand.

On one hand, consumers need to understand the value and limitation of PHI; on the other hand, the PHI industry needs to provide PHI of a fair value and clearly inform the limitations to consumers. For the sustainable development of the PHI market, the Council hopes that stakeholders will implement effective measures proactively to address the problems identified in the Study. The VHIS is an important step for the Government to step in to improve the accessibility and transparency of the PHI market, but there is still much room for the industry to improve to foster a sustainable and beneficial PHI market for the Hong Kong consumers. The Council puts forward the following recommendations for the consideration of the regulatory authority and the PHI industry:

Narrowing the Gap between Consumer Expectation and in Reality What They Could Enjoy

Standardise Definitions of Key Policy Terms

Variations of PHI terms and definitions in policies occur not just between different insurance companies, but even within the same insurance company. Consumers find it difficult and confusing to compare terms of different policies at the point of purchase due to this wide variation.

Recommendation (1): The Council recommends that the regulatory authority considers the possibility of setting out standard definitions for key policy terms and mandates this adoption in PHI policies. The VHIS Certified Plan Policy Template may possibly be used as a reference.

Improve the Design of Application Forms to Ask Specific Questions

"Non-disclosure" was one of the policy terms commonly quoted by insurance companies the breach of which was a ground for claim rejection. In the current situation, all the responsibilities are put on the consumers, with some of them being confused by the wordings in the questions of application forms, e.g. the conditions and timeframe in which they are expected to disclose to the insurance companies.

To address this, reference may be made to the UK, which has adopted the principle that an insurance company has the responsibility to ask the consumer specific questions to obtain relevant information for underwriting. By doing so, the insurance company is not able to decline a claim on the grounds of non-disclosure unless the policyholder carelessly or deliberately lied or misrepresented his/her circumstances.

Recommendation (2): The Council recommends the regulatory authority to set appropriate guidelines requiring the insurance companies to ask specific questions in the application forms. For the timeframe of information disclosure, the Council suggests it should be clearly specified and should not exceed 7 years.

Provide Sample Policy Contracts on a Publicly Accessible Platform

Since information on sales materials (e.g. leaflets or brochures) may not be inclusive due to space limitations, it would be better for consumers to have examples of policies for better understanding of its content such as the terms and conditions, exclusions, benefit schedule etc., before making the purchase. Currently, policy contract samples are not easily accessible by consumers and only a few are available online.

Recommendation (3): The Council encourages informational transparency and accessibility, recommending insurance companies provide policy contract samples for public access in an easy and convenient way such as on company websites, apart from through the hotline request.

Enhance Transparency on Change of Policy Terms, Benefit and Premium

Premium increases are usually within the right of the insurance companies at renewal. Common reasons given are "offering of enhanced benefits" and "inflation of medical cost". It is also common for PHI policies to tout "Guaranteed lifetime renewal" as one of the selling point of its PHI plans. However, a guaranteed renewal and the right to unilaterally revise a policy are contradictory. Expectation gap could therefore occur if consumers are only attracted by these marketing words but overlook the significance of policy terms that insurance companies have the right to make unilateral changes on terms, benefits and premiums, leaving the consumers in a disadvantageous position.

Recommendation (4): The Council recommends clear indication of premium increases be given to each age group/profile of the same policy plan, and on an on-going basis. Data on medical inflation to justify the increase should also be provided to policyholders. Moreover, specific situations that trigger premium increases should be clearly stated in the policy contract. If insurance companies have the right to make unilateral revisions on policy terms and conditions and re-underwrite, it should be stated alongside "guaranteed renewal" statements at all occasions and clearly explained to prospective policyholders.

Provide Clear Explanations in Writing and in Plain Language

Some complainants and interviewees of the in-depth interviews pointed out that their insurance intermediaries only provided verbal explanations of the application and claim rejections, possibly adding to consumer confusion.

Recommendation (5): The Council recommends that insurance companies should be mandated to provide clear and easily understandable written explanations to consumers/policyholders regarding application and indemnity decisions.

Provide Market and Complaint Statistics of PHI Policies

Currently, published data on the breakdown of complaint statistics specifically for PHI or medical insurance are fragmented and are difficult to obtain and therefore consumers are not in a position to make any comparisons with statistics from regulatory or complaint channels.

Recommendation (6): To enhance public understanding and monitoring of PHI related issues and their development, the Council recommends relevant complaint statistics and market statistics (e.g. total premiums, quantity of available plans, quantity of policies sold) be published by regulator and complaint channels on a regular basis.

Improve Transparency of Sources of Reference for "Reasonable and Customary" Charges

"Reasonable and Customary" is one of the terms commonly used by insurance companies to limit their payout liability, for instance to make partial reimbursement. If such term is used in an appropriate way, it may help contain medical inflation, reimbursement and premium increases. However, wordings of the "Reasonable and Customary" term and list of factors which will determine it vary amongst different policy contracts, leaving uncertainty for the policyholders who are usually informed of the "Reasonable and Customary" charges determined by the insurance companies only after claim decisions have been made.

Recommendation (7): The Council suggests that factors which may be considered when determining the reasonable and customary charge be specified in the policy contracts; and in case such term is applied for partial reimbursement, the actual factor and statistics considered should be explained to the policyholders. In addition, the List of Private Charges as per the Gazette issued by the Hong Kong Government should be presented as one of the reference points.

Provide Pre-authorisation Services for Non-emergent Services

To further enhance the certainty of benefit limits and coverage, a pre-authorisation framework may be implemented. Such practice may help giving a policyholder's peace of mind, as it will provide affirmation as to whether the treatment charges are within the scope of insurance coverage and the policyholder will also be able to better manage his/her expectation if there is a possible denial of claim. Although pre-authorised reimbursement amount is not necessarily equal to reasonable and customary charges upon claim settlement, the former may somehow provide some certainty to the policyholders. Currently, the VHIS requires insurance companies offering Certified Plans to provide claimable amount estimate to policyholder when it is requested.

Recommendation (8): The Council is of the view that the regulatory authority may encourage the insurance companies to adopt pre-authorisation services to elective or non-emergent services and set up services pledge on response time.

Enhance Intermediary Training and Improve Administrative Process

In some of the complaint cases reviewed, complainants accused the insurance agents/customer service staff of providing "misleading" or "inaccurate" information, giving them a false expectation of claim eligibility and indemnity amount; or leading to their failure in disclosure of information. There were also complaints related to less than satisfactory services provided by the insurance companies, such as premiums continued to be charged after policy termination, auto-renewals without explicit consent and delays in delivering medical cards, etc.

Recommendation (9): Currently, there are industry codes which advise insurance companies to provide sufficient training to insurance agents. The Council is of the view that enhanced training should be required by the regulatory authority to align the knowledge and understanding of both industry employees and consumers/policyholders for better communication to reduce disputes in the long run. Continuous and product-specific training to insurance intermediaries and/or frontline staff to improve service quality is also recommended. As regards service quality of the insurance companies, the Council suggests that the insurance companies should implement and publish their service or performance pledge for general reference and to enable scrutiny by their customers.

Strengthen Consumer Education

The Study found that due to the complex nature of the products, there is a general lack of concept of how insurance works as a whole and consumers do not have the relevant knowledge of purchasing PHI products. Consumer education on the significance and implications of key policy terms and matters of high potential for dispute should be a priority.

Recommendation (10): The Council recommends that consumer education should cover the areas on insurance concept; significance of key policy terms such as clauses related to the right of insurance company to make unilateral changes, medically necessary, pre-existing conditions, non-disclosure, double insurance; information that should be obtained and understood before signing up for a policy; and consumer rights to seek information, explanations and redress when in doubt.

Enhancing Continuity of PHI

Extend Entry Age Limit

Currently, consumers who are approaching retirement or have already retired may find it difficult to take out a PHI. Within the policy samples collected for the Study, the maximum entry age limits varied among policies, ranging from between the age of 59 to no upper limit, with majority of them setting the age between 64 to 70.

Recommendation (11): In order to enhance elderly consumers' accessibility to PHI, the Council recommends the entry age limit be extended. This in turn may promote the use of private healthcare services by elders who can afford them and help release the pressure on overloaded public healthcare services.

Offer Opt-out Option for Enhancements of Non-core Benefits

Unexpected premium increase is a common consumer grievance. A common reason given by insurance companies to justify premium increase is the imposition of "enhanced benefits" decided by the insurance companies unilaterally. Some enhancements are sometimes for non-core benefits not needed by the policyholders (e.g. domestic home care service, child-care, pet care), but there is no option to opt-out of the enhancements. This is especially problematic for the elderly as the unexpected increase is disruptive to their retirement plan and some of them may have no choice but to reluctantly drop out from their policy even at the time when they need healthcare protection the most.

Recommendation (12): For fairness and continuity, the Council recommends insurance companies to offer policyholders the choice to retain a budgetary status quo which suits their needs, especially in cases of non-core related benefit enhancements.

Provide Coverage for Unknown Pre-existing Conditions

In most PHI policies, "pre-existing conditions" is one of the excluded items. The Council is of the view that in the case of known pre-existing conditions, (1) the consumer should disclose to the insurance company for underwriting during policy application; and (2) the responsibility of asking specific questions to collect sufficient information for underwriting purposes rests on the insurance company. Another way to reduce disputes based on "non-disclosure" of "pre-existing conditions" may be to introduce "pre-assessment" (e.g. body check) prior to policy inception. As for the case of unknown pre-existing conditions, the Council is of the view that they should be covered by insurance companies for the reason of fairness.

Recommendation (13): The Council recommends the insurance companies to provide coverage of unknown pre-existing conditions. A waiting period for unknown pre-existing conditions may be applied, such as 3 years as reference from the practice of VHIS. In case if unknown pre-existing conditions are excluded from coverage, such information should be clearly explained to prospective policyholders.

No Re-underwriting / Enhance Transparency on Re-underwriting Policy and Conditions

Complaint cases and in-depth interviews revealed that after the policyholders filed a claim and received reimbursement, re-underwriting resulting in the imposition of premium loading and/or excluded items might happen. Such practice is somehow in contrast with the stated "continuity" of insurance protection. In other words, policyholders may not be able to enjoy the pledged "lifetime renewal" "guaranteed" by insurance companies in real practice when the premium or coverage becomes unaffordable or unsuitable to them upon re-underwriting which may happen at a certain stage.

Recommendation (14): The Council is of the view that, for reason of fairness, a better practice for the insurance companies to follow is to adopt a one-off underwriting practice (instead of annual re-underwriting) with a view to make PHI a genuine continuous protection, for instance, re-underwriting after the inception of policy should be avoided or minimised in order to provide a more stable marketplace for the community as a whole. Having said that, the Council also acknowledges the re-underwriting policy of individual insurance companies (or individual PHI plans) may depend on many factors such as pricing

strategy or risk pool management. If insurance companies consider the avoidance of re-underwriting is not applicable, the Council is of the view that information of such arrangement, for instance, the possibility of re-underwriting, factors triggering the insurance companies to undergo re-underwriting and factors which will be considered for the re-underwriting should be clearly specified in the policy and should be made known to prospective policyholders before they enter into the policy contracts.

The Way Forward

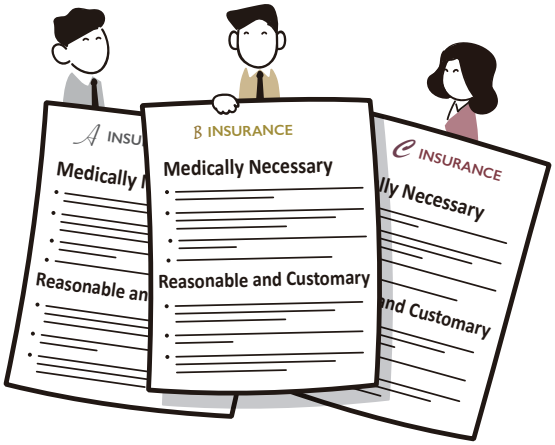
The 14 recommendations as set out above is the result of a rigorous study in understanding the key concerns of consumers, the current offerings in the market, the regulatory practices from selected jurisdictions and the opinions of stakeholders on the viability and practicality of the recommendations.

From the Study findings, the Council considers that it should be a priority of stakeholders to join hands and take a progressive approach by imposing clear regulatory guidance to the PHI industry to improve the trade practices of insurance companies offering PHI, and bringing in measures and initiatives to enhance consumer education. The Council believes that with joint efforts of all parties concerned, a fair marketplace will be fostered for better consumer protection and a sustainable growth of the PHI industry.

Consumers also play a very important part in this regard. They should enrich their knowledge on PHI, understand what protection they are looking for and which PHI products are suitable to their needs and must not hesitate to ask for clarification when there is doubt regarding benefits coverage and significance of key policy terms and conditions. Consumers are always encouraged to make a responsible and well-considered purchasing decision.

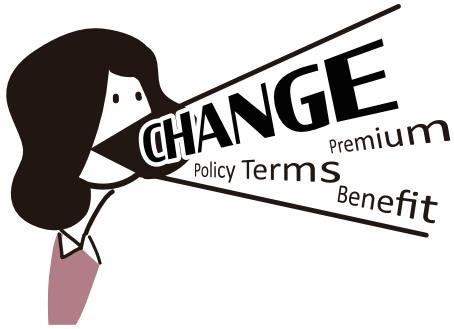
The Council will continue to undertake its role as a conciliator in disputes and a watchdog of the industry; it will also inform and educate the public on aspects of the industry through its various publicity initiatives. The Council will also stay in close dialogue with stakeholders to encourage them to take on board the issues identified in the Study positively and propose and implement initiatives and measures that are deemed suitable for the local market. A sustainable PHI industry that safeguards consumer interests and provides quality PHI products offering enriching financial protection against medical needs can positively promote the purchasing rate of PHI. In the long-run, it is the hope that with stronger consumer confidence and more transparency and quality offerings in the market, it can drive more usage of private healthcare services and relieve the pressure on the over-loaded public healthcare system, for the ultimate aim in achieving a balanced, affordable, transparent and quality healthcare services for Hong Kong.

Recommendations - Meeting Consumer Expectation and the Actual Protection



1. Standardise definitions of key policy terms

2. Improve the design of application forms to ask specific questions



4. Enhance transparency on change of policy terms, benefit and premium

5. Provide clear explanations in writing and in plain language

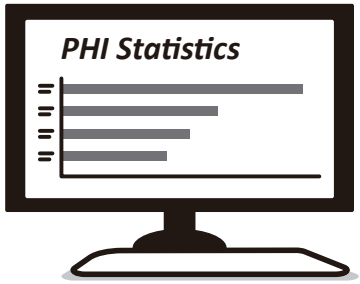
7. Improve transparency of sources of reference for "Reasonable and Customary" charges

8. Provide pre-authorisation services for non-emergent services

9. Enhance intermediary training and improve administrative process

Recommendations on Enhancing Continuity of PHI

3. Provide sample policy contracts on a publicly accessible platform

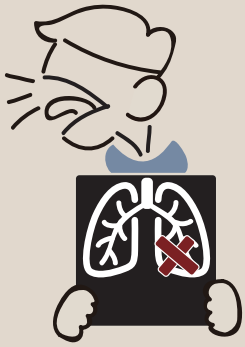


6. Provide market and complaint statistics of PHI policies

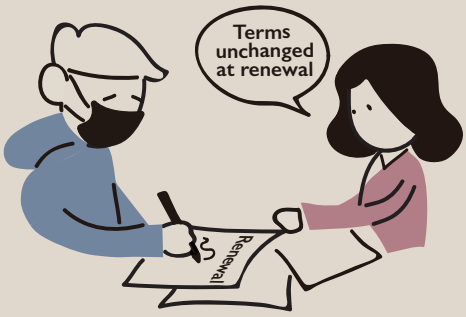
10. Strengthen consumer education

11. Extend entry age limit

12. Offer opt-out option for enhancements of non-core benefits



13. Provide coverage for unknown pre-existing conditions



14. No re-underwriting / enhance transparency on re-underwriting policy and conditions

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