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

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Contents

Abbreviations

A&E	Accident & Emergency
APRA	Australian Prudential Regulation Authority
BNM	Bank Negara Malaysia
CHA	Canada Health Act 1984
CIRC	China Insurance Regulatory Commission
CPF	Central Provident Fund
C&SD	Census and Statistics Department
FCA	Financial Conduct Authority
FDRC	Financial Dispute Resolution Centre
FDRS	Financial Dispute Resolution Scheme
FHB	Food and Health Bureau
FIDReC	Financial Industry Disputes Resolution Centre
FOS	Financial Ombudsman Service
FSPO	Financial Services and Pensions Ombudsman
HIA	Health Insurance Authority
HITF	Health Insurance Task Force
HKCIB	Hong Kong Confederation of Insurance Brokers
HKFI	Hong Kong Federation of Insurers
HKPHA	Hong Kong Private Hospitals Association
HSE	Health Service Executive
IA	Insurance Authority
IARB	Insurance Agents Registration Board
ICA	Insurance Contracts Act 1984
ICB	Insurance Complaints Bureau
ICCB	Insurance Claims Complaints Bureau
ICOBS	Insurance Conduct of Business Sourcebook
IHIP	Indemnity Hospital Insurance Plan
IPs	Integrated Shield Plans
LCR	Lifetime Community Rating
LHC	Lifetime Health Cover

LIA	Life Insurance Association
Mainland	Mainland China
MAS	Monetary Authority of Singapore
NHS	National Health Service
OFS	Ombudsman for Financial Services
PHI	Private Health Insurance
PHIA	Private Health Insurance Act 2007
PHIO	Private Health Insurance Ombudsman
PHIS	Private Health Information Statement
PIBA	Professional Insurance Brokers Association
PRA	Prudential Regulatory Authority
R&C	Reasonable and Customary
SIS	Standard Information Statement
SROs	Self-regulatory Organisations
The 2012 Act	The Consumer Insurance (Disclosure and Representations) Act 2012
THSR	Thematic Household Survey Report
UK	United Kingdom
VHIS	Voluntary Health Insurance Scheme

Acknowledgement

The Consumer Council thanks the following organisations for their support and participation in the Study.

Elder Academy, City University of Hong Kong

Elder Academy, Hong Kong Shue Yan University

Elder Academy, Lingnan University Hong Kong

Elder Academy, The Education University of Hong Kong

Elder Academy, The Open University of Hong Kong

Institute of Active Ageing, The Hong Kong Polytechnic University

Network of Ageing Well for All, CUHK Jockey Club Institute of Ageing

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.

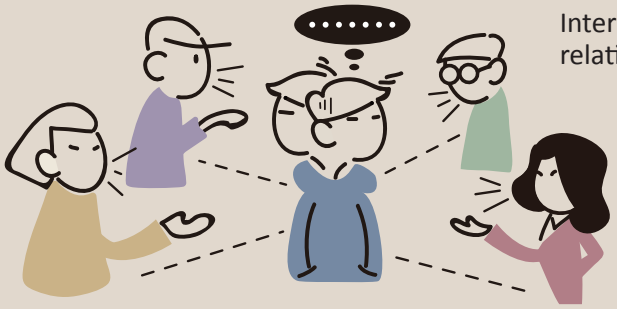
During the purchasing stage, elderly consumers had difficulties in applying for PHI as currently the maximum entry age limit for common PHI is set at between 64 to 70 years of age. Questions contained in the application forms were too general and not specific enough, causing confusion to the consumers 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

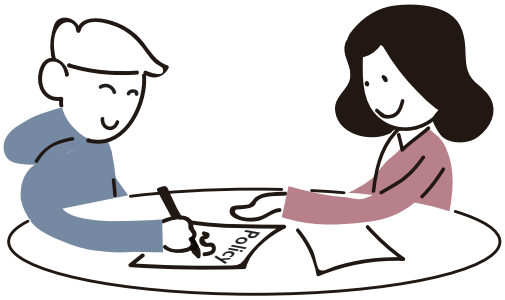
Want to have a peace of mind & continuous protection

Trade Practice of Insurance Companies/ Policy Terms and Conditions

Contract samples not easily accessible

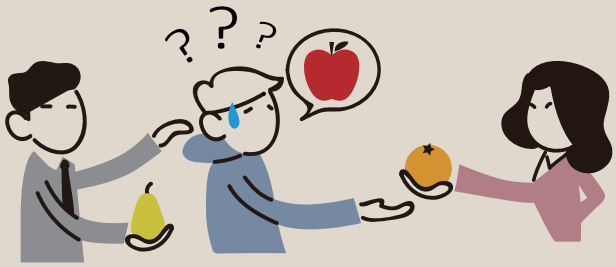
Behind the attractive sales wording, there are many terms and limitations which may be easily overlooked by consumers

Purchasing



Post-purchase

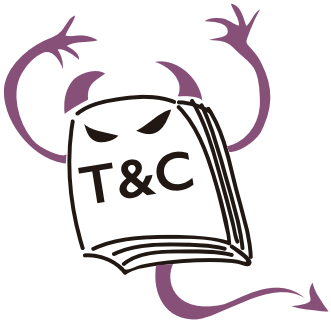
Rely on memory when making health declarations



- 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)



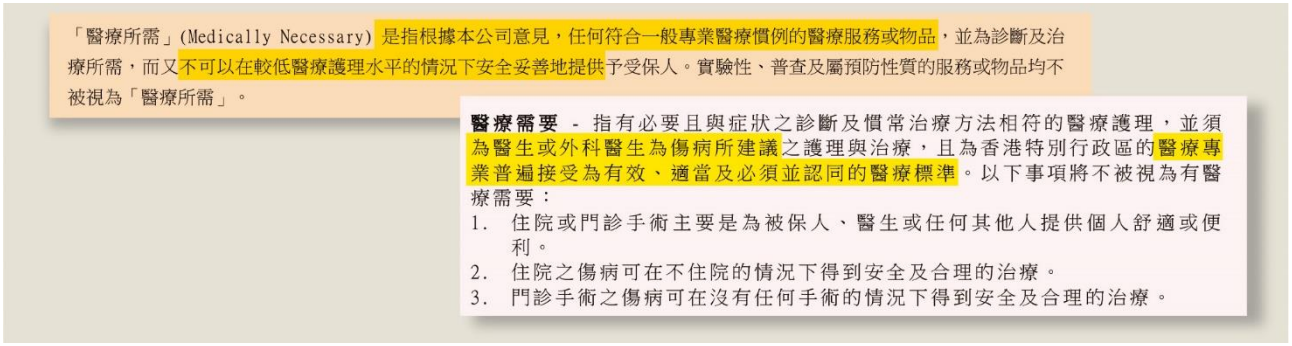
Problems encountered

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

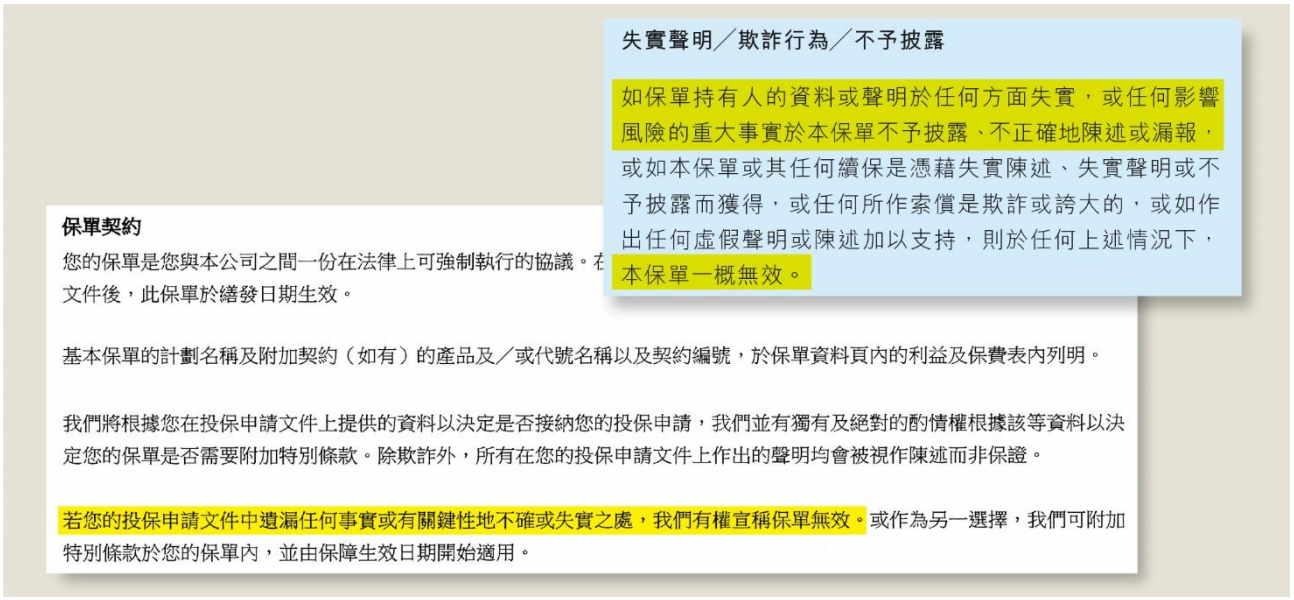
T & C are wordy, complicated and not clearly explained by intermediaries

以下列舉一些例子，簡述從法律研究中找出的一些有關保單條款及細則的問題：

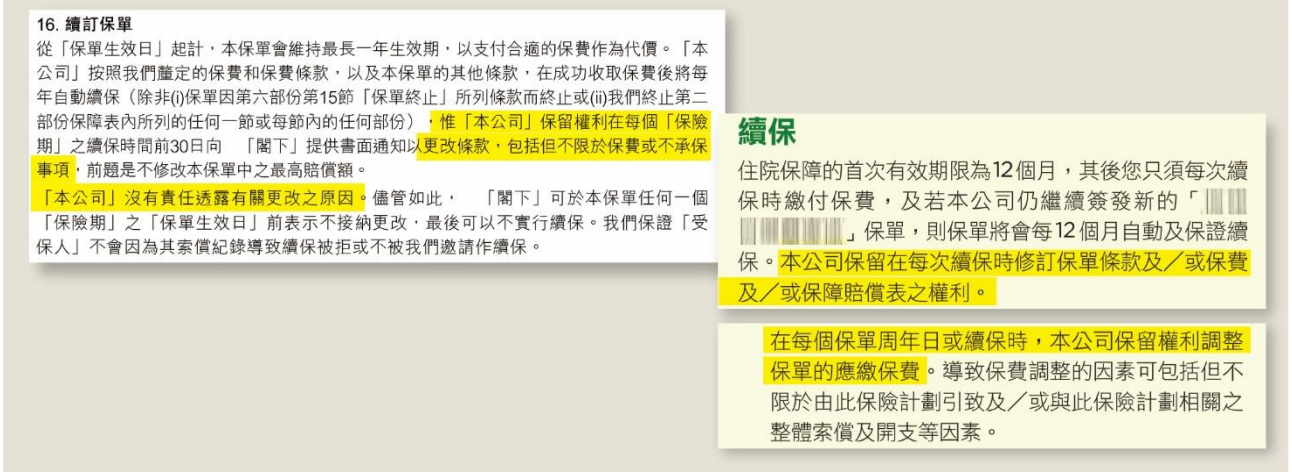
- 不同醫保計劃及保險公司之保單的重要條款各有不同定義，例如「醫療所需」：



- 若保單持有人因多種情況下而沒有披露已發生的事件，保險公司會以「沒有披露事實」條款排除其賠付責任。



- 保險公司有權就保單合約進行修改。



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

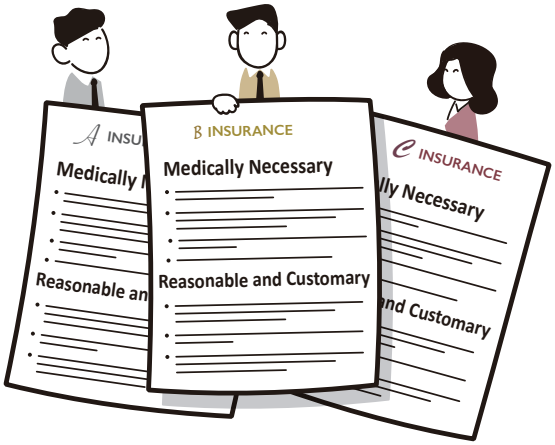
The 14 recommendations as set out above is the result of a rigorous study in understanding the key concerns of consumers, the current offerings in the market, the regulatory practices from selected jurisdictions and the opinions of stakeholders on the viability and practicality of the recommendations.

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.

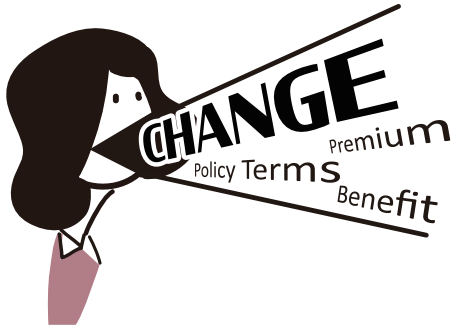
The Council will continue to undertake its role as a conciliator in disputes and a watchdog of the industry; it will also inform and educate the public on aspects of the industry through its various publicity initiatives. The Council will also stay in close dialogue with stakeholders to encourage them 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

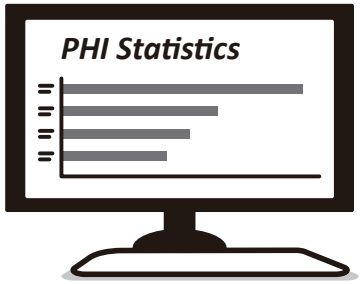
7. Improve transparency of sources of reference for "Reasonable and Customary" charges

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

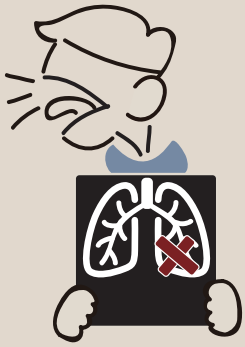


6. Provide market and complaint statistics of PHI policies

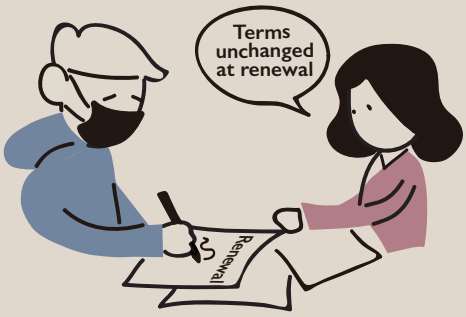
10. Strengthen consumer education

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

摘要

迅速增長的個人醫療保險市場

香港擁有雙軌並行的醫療系統，公私營醫療界別互相配合。於 2016 年，私營機構佔門診服務的 68%；而公立醫院佔住院病人出院總數的 82%。

2016 年，香港超過三分之一的本地人口即 240 萬人以上[3]擁有個人醫療保險（個人醫保），保費收入總額高達 103 億港元。面對香港人口急劇老化，以及隨著社會變得富裕而對更佳的醫療服務有需求，個人醫保的需求必然繼續上升。

隨著醫療保險越趨普及，於 2016/17 財政年度，個人購買的醫療保險佔總體醫療衞生開支（包括公營及私營醫療服務）9%，相比 1989/90 財政年度僅為 1%。

2018 年，香港有 79 間從事「一般保險業務」的保險公司提供醫療保險。雖然有眾多保險公司參與個人醫保市場並提供多種產品選擇，但這並未能推動保險公司為個人醫療保險提供一個可持續的長期保障。

儘管市場迅速發展，一項研究報告顯示於 2016 年，在僅受個人醫保保障的住院病人當中，約有 43%仍於公營醫院接受治療。[4] 這情況的出現原因包括：容易令人混淆的保單條款及細則、對醫療費用或療程是否符合索償資格缺乏肯定性、擔心索償影響將來的保費水平，以及保障範圍不足等因素，均影響消費者對購買和仗賴個人醫保對自身醫療保障的信心。

消費者對個人醫保缺乏信心，加上影響個人醫保市場發展的多種複雜因素，例如醫療服務費用、保險公司所提供的資訊透明度，以及消費者對可索償的範圍與實際賠償有所出入的理解不足，不但損害個別消費者的利益，還侷限了個人醫保對整體醫療融資的潛在作用，同時亦妨礙了推動私營醫療市場的發展以滿足日益增長的醫療服務需求。

消費者的期望

消費者往往帶著期望購買個人醫保，例如期望個人醫保可以應付他們可能需要的醫療服務開支，以及可持續受到保障。然而，由於個人醫保屬長期性的產品，其問題往往只有在消費者啟動索償程序時及當索償失敗或只獲部分賠償才會出現，對消費者在財務上所帶來的壓力，遠較其他一般的服務市場嚴重。消費者購買個人

[3] 政府統計處。（2017）主題性住戶統計調查第 63 號報告書。

[4] 立法會秘書處資料研究組。（2018）香港的個人醫療保險。

醫保時，往往無法知悉有關產品的保障範圍是否覆蓋他們全部所需的醫療程序或判別相關療程是否屬醫療所需，亦無法理解重新核保的實質意義，對考慮轉用其他保險公司的消費者構成障礙。另外，保險公司的保險中介人及客戶服務人員的質素及專業水平，對提供清晰、準確及個人化的資訊及服務，以致消費者能就購買的個人醫保有清楚的理解和期望，發揮重要作用。

此外，消費者一般期望個人醫保產品應可提供長期保障。然而消費者委員會（消委會）的投訴個案顯示，消費者對個人醫保所提供的保障缺乏確定性，以及對持續獲得保障的期望未能實現，例如出乎意料的保費增幅、被施加不保事項、對保單條款及細則缺乏理解及溝通等某些情況下，均導致希望從購買個人醫保以享安枕無憂的消費者產生不滿及憂慮。

消費者的不滿或爭議通常源於期望與現實的落差。前者是消費者在簽訂個人醫保合約時按被告知及提供的資訊去理解保單的保障範圍和他們對個人醫保所提供的保障的期望；後者是個人醫保實際所提供的保障。舉例而言，「保證續保」表面上看來為消費者提供無條件續保的承諾；但實際上，保險公司保留修改保單的保費、保障範圍、條款及細則的權利，這些都會影響個人醫保的可延續性。

個人醫保對消費者的價值

為瞭解這種期望與現實之間的明顯差距，消委會就香港的個人醫保市場進行深入研究（研究），當中包括評估消費者對個人醫保的滿意程度、他們對保險產品的保障範圍的理解及認識、找出限制消費者投保以及保險公司向保單持有人支付賠償責任的潛在不公平條款及程序。

消委會自 2016 年至 2018 年，透過不同的量化及非量化研究方法，進行了一系列的深入研究，包括：

- 透過電話訪問，向 1,000 名 18 歲或以上的人士進行消費者意見調查；於街頭訪問 205 名於過去 30 個月內曾就個人醫保提出索償的消費者；與 20 名 18 歲至 54 歲曾經索償人士及 8 名 55 歲至 74 歲的年長消費者進行深入訪問，他們均在接觸或使用個人醫保上遇到問題。
- 分析消委會於 2015 年至 2018 年收到的 299 宗與個人醫保有關的消費者投訴；
- 搜集香港 14 間提供個人醫保的主要保險公司合共 18 份個人醫保計劃的保單合約樣本，進行檢視和法律研究（參考澳洲、加拿大、新加坡及英國的經驗）；及
- 研究 6 個選定司法管轄區，包括澳洲、愛爾蘭、中國大陸、馬來西亞，新加坡及英國就個人醫保採取的規管策略。

消費者的脆弱點及不滿

研究顯示有若干因素能影響個人醫保的可及性，延續性及其保障的確定性。而消費者在購買個人醫保的不同階段中遭遇的問題不盡相同。儘管在購買時，消費者的滿意度頗高，但在購買後的滿意度卻相對地下降。

在選購階段，個人醫保的合約樣本並非能輕易取得，由於消費者無法得知保單條款及細則的詳細內容以深入瞭解何種產品符合他們所需，削弱了他們比較不同產品的機會和作出最佳選擇的能力。根據消委會的消費者意見調查，當消費者搜尋個人醫保時，大多數受訪者從他們的朋友或親戚轉介的保險中介人獲得訊息（61%），或會與他們的朋友或親戚商討他們的保單（59%）。相比之下，較少受訪者會貨比三家，只有大約三分之一的受訪者從不同的保險公司獲得報價（38%），或從互聯網上搜尋資訊（32%）。除此之外，研究亦發現不同公司的保單，甚至相同公司的不同醫保計劃，保單條款定義及細則各有不同，消費者若想進行比較，會深感困難及不便。因此，消費者選擇個人醫保產品時，保險中介人及個人的人脈網絡在提供資訊及建議方面起關鍵作用。

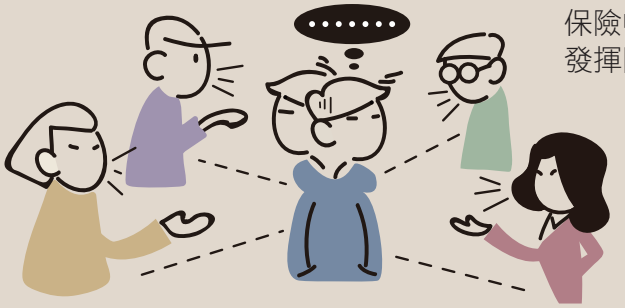
在購買個人醫保時，由於現時一般的投保年齡上限為 64 至 70 歲，年長消費者會難以成功投保。在投保申請表上的問題亦因可能過分籠統及有欠具體，令消費者對需要披露的病歷之詳細程度感到無所適從。有些情況，保單持有人因沒有披露重要事實會不幸引起索償爭議。另外，研究亦發現保險中介人沒有充分及清楚地向消費者講解條款及細則的重點，例如保險公司保留單方面更改條款及保費的權利，及一些條款的實質意義，例如「醫療所需」、「合理及慣常」收費及「投保前已有病症」等。

購買個人醫保後，消費者主要的憂慮是保單是否可以延續及是否可成功索償。在一些個案中，尤其是年長消費者，保單持有人在續保時面對出乎意料的保費增幅，而導致保費增加的條件和原因亦未能令消費者明白。亦有一些個案，在成功索償後，保單持有人可能被重新核保，並被施加不保事項。這些做法均會大大影響保單的延續性。另一方面，法律研究揭示保險公司會有不同手法限制其理賠責任，比如於保單合約中使用不同的條款（例如整份合約條款、重複保險條款、單方面修改合約條款、投保前已有病症條款、醫療所需條款、合理及慣常條款）以回避其理賠責任，特別是審批索償程序令消費者對所提供的保障感到失望。研究亦指出，由於保單條款往往使用複雜的語言，一些條款亦未有清楚或詳細的定義，因而留有空間給保險公司作出詮釋，這些均令消費者難以捉摸和充分理解保單條款的實質意義。

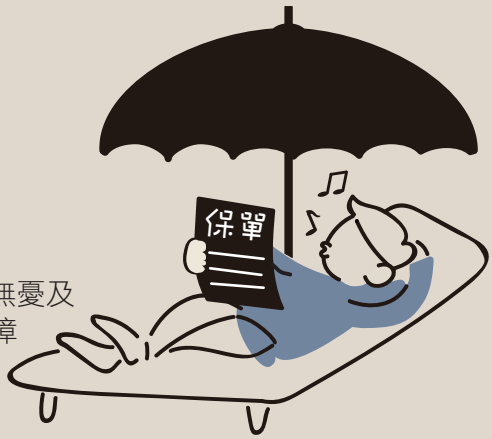
消費者行為及在不同階段消費者購買個人醫保遇到的問題

購買前

消費者行為



保險中介人、親戚朋友的建議
發揮關鍵作用



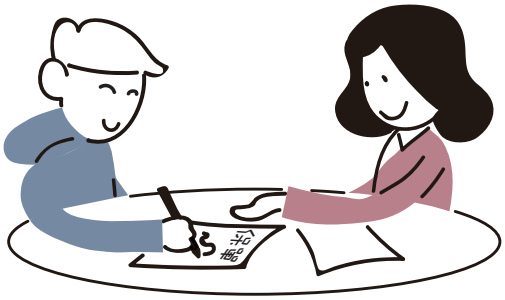
希望可安枕無憂及
獲得持續保障

保險公司的營商手法 / 保單的條款及細則

無法輕易取得合約樣本

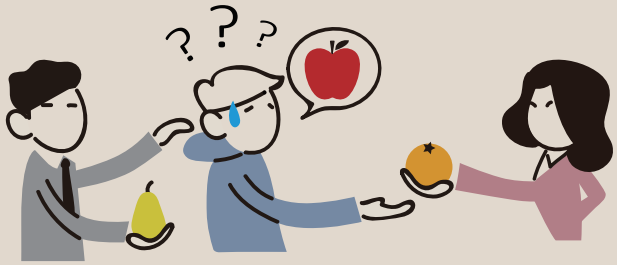
吸引的推銷字眼背後，
有很多消費者容易
忽略的條款及細則

購買時



購買後

依靠記憶作
健康申報



- 甚少作出投訴
- 因保險中介人提供不準確資料而引起爭議；期望與實際保障和賠償金額存有落差

過分依賴保險中介人提供的資訊

投保時遇上困難(例如：一般投保年齡上限為64至70歲；部分人或因病歷被施加附加保費/不保事項)

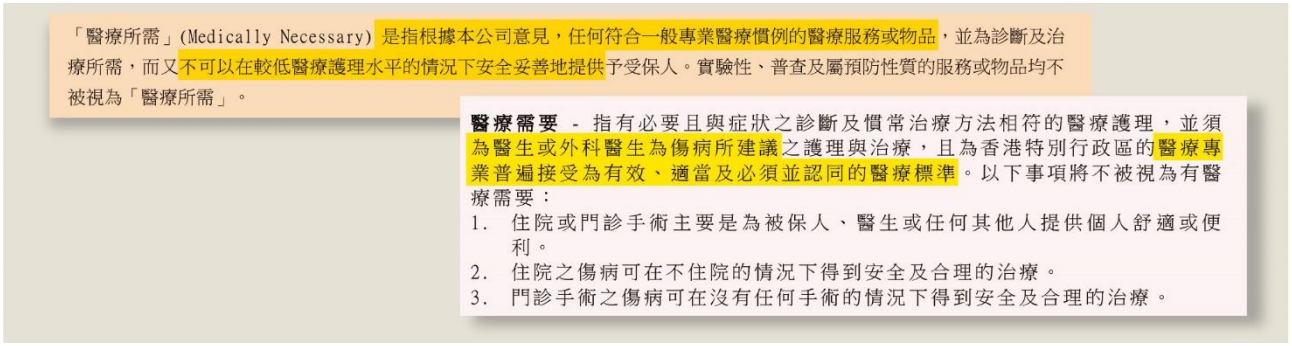
遇到的問題

- 超乎預期的保費增幅
- 單方面更改條款
- 利用條款及細則限制賠償責任

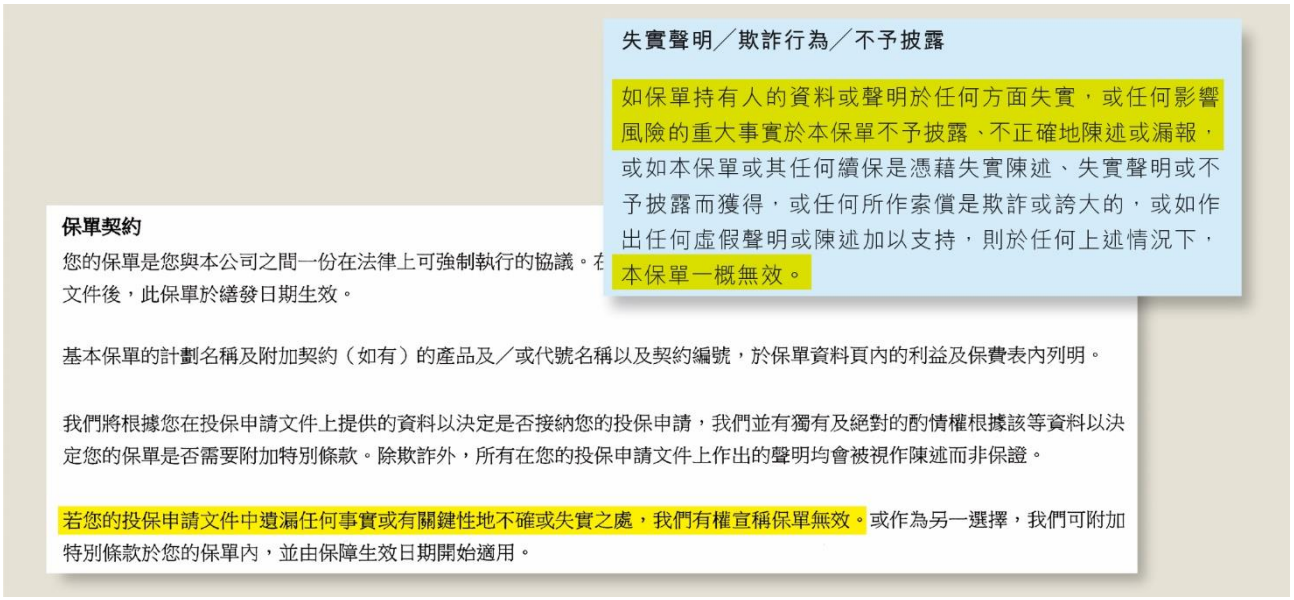
條款及細則複雜冗長、保險中介人亦未有清楚解釋

以下列舉一些例子，簡述從法律研究中找出的一些有關保單條款及細則的問題：

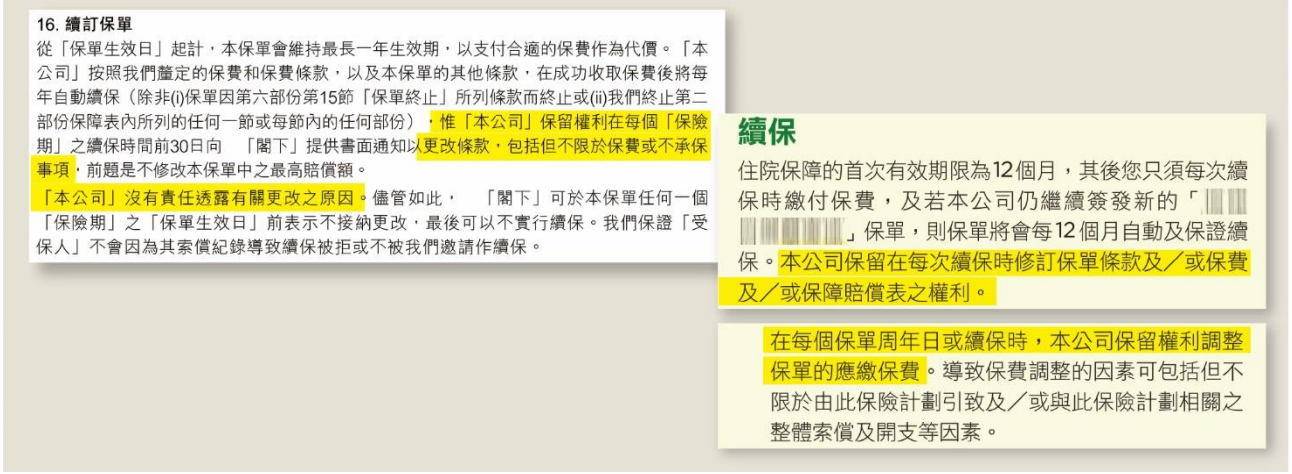
- 不同醫保計劃及保險公司之保單的重要條款各有不同定義，例如「醫療所需」：



- 若保單持有人因多種情況下而沒有披露已發生的事件，保險公司會以「沒有披露事實」條款排除其賠付責任。



- 保險公司有權就保單合約進行修改。



其他司法管轄區的經驗

消委會就 6 個選定司法管轄區進行深入研究，以期借鑒適合香港的個人醫保規管策略。人口老齡化是一個全球性問題，這些司法管轄區在提高個人醫保的可及性，透明度和質素方面作出了重大努力，以促進和善用個人醫保以加強其在醫療融資中的作用。其採取的規管模式對香港個人醫保市場的規管甚具參考意義，儘管這些司法管轄區有不同的市場情況，研究顯示，為加強消費者保障及有效推動市場持續健康發展，各地區均採取了以下一種或以上的措施：

- 審批保險條款和保費率（中國大陸）；
- 確保保障範圍的確定性及個人醫保產品的質素，例如統一保障的水平及療程的定義（澳洲）；
- 促進可及性，可負擔性和延續性，例如承保投保前已存在病症，保證承保、續保及轉換承保機構（澳洲）；限制保險公司調整含有保證續約條款的產品（中國大陸）；容許消費者轉用可負擔的產品（新加坡，適用於綜合健保計劃）；
- 加強披露，提升透明度及增加選擇，例如要求保險公司提供劃一的資訊清單以提供產品摘要（澳洲）及規定需披露的資訊項目（中國大陸、新加坡）。部分地區提供資訊平台協助消費者比較不同產品（澳洲、愛爾蘭），亦有地區立法訂明消費者向保險公司披露資訊及作出聲明的責任（英國）。另外，在法律研究部分亦引述了加拿大法院的註釋，表示保險公司應至誠履行其責任；
- 所有地區均設有法定強制性（中國大陸（適用於長期健康保險）、馬來西亞、新加坡、英國）或按照行業一貫慣常做法（澳洲、愛爾蘭）所推行的冷靜期；及
- 一些新措施，包括就住院醫保分門別類、引入醫療程序分類、為因保險公司終止產品而提供轉換選項（澳洲）、設立預先批核的機制及推出可供選擇的醫療服務提供者名單（新加坡的綜合健保計劃）。

自願醫保計劃

為提高住院保險產品的保障水平，和長遠平衡公營和私營醫療服務讓香港醫療系統得以可持續發展，政府已於 2019 年 4 月推出自願醫保計劃（自願醫保）。自願醫保是一個消費者和保險公司自願參與的計劃，其認可產品是受政府監管的個人償款住院保險產品，並要符合各種最低要求。自願醫保將產品設計劃一，在增強消費者保障之餘，能有助促進市場吸納。

自願醫保為個人償款住院保險產品提供更佳的可及性、延續性、質素、確定性和透明度。例如延長投保年齡上限至 80 歲；不論於保單生效後的健康狀況有任何變化能保證續保至 100 歲；在特定的等候期及賠償安排下，保障範圍擴展至包括投保時未知的已有疾病；保單持有人可要求保險公司提供可賠償金額估算；標準化的條款及細則；以及保費透明度。

消委會建議

總括而言，本報告中揭露的問題可分為兩大重點：(一) 消費者對其購買的個人醫保所提供的保障的期望與他們實際可享有的保障存在的落差 — 縮窄兩者的差距有助消費者作出更明智的知情選擇；及 (二) 個人醫保缺乏可延續性 — 為個人醫保產品保障引入可延續性及確定性，將可推廣私營醫療服務的使用並同時有助平衡社會對公私營醫療服務的需求。

從一方面來說，消費者需要明白個人醫保的價值及其限制；而另一方面，個人醫保行業亦務必要以公平為原則提供個人醫保產品，同時要讓消費者清楚瞭解其產品的局限。消委會期望各持份者能積極採取措施以回應本報告所揭示的問題，令個人醫保市場可以持續發展。自願醫保是政府為提高個人醫保市場的可及性和透明度而邁出的重要一步，然而，市場還有很大的改進空間，為香港消費者營造一個可持續和良好的個人醫保市場。消委會提出以下建議，供監管機構及個人醫保行業參考：

縮窄消費者對個人醫保保障的期望與他們實際可享有的保障存在的落差

統一重要合約條款的定義

個人醫保保單中的條款及定義不盡相同，不單止在不同的保險公司之間發生，同一公司的不同保單亦有同樣情況。此等差異為消費者在購買個人醫保，比較不同的保單時帶來困難和混亂。

建議 (一)：消委會建議監管機構應考慮為重要的合約條款訂立標準定義，並強制要求所有個人醫保產品跟隨。自願醫保計劃的認可產品保單範本可作為參考。

改善投保申請表的設計使問題具體化

「沒有披露事實」是其中一個常被保險公司引用以拒絕索償申請的條款。現時披露責任盡在於消費者，而作出披露時有部分消費者被申請表上有關健康問題的字眼困惑，例如保險公司要求投保人需要提供哪種或哪段期間內發生的病症。

英國的經驗或可作為參考以回應這問題。英國採取的原則是，透過具體問題在接受投保申請時從消費者收集所有相關資料以進行核保，屬保險公司的責任。在此原則下，保險公司不能以「沒有披露事實」為由拒絕索賠，除非保單持有人草率或故意撒謊或歪曲他/她的情況而沒有披露事實。

建議（二）：消委會建議監管機構訂立合適的指引，訂明保險公司的投保申請表的問題必須充分具體及明確。另外，消委會認為有關需披露資料的期限必須於申請表中明列，亦應以 7 年為上限。

於公開平台上提供保單合約樣本

由於銷售文件（例如宣傳單張或小冊子）的空間有限，可能無法包含所有資訊，但從消費者權益保障而言，消費者如在作出購買決定前，有機會從合約樣本深入瞭解當中的細節，如條款及細則、不保事項、保障表等，有利他們作出更佳購買決定。現時只有少數保險公司會上載保單的合約樣本到其公司網頁，消費者無法輕易獲取。

建議（三）：為促進資訊透明度，消委會建議保險公司應透過可輕易又方便接觸到的渠道提供保單合約樣本，例如除了透過熱線查詢，亦應上載於公司網頁供消費者閱覽。

提升與更改保單合約內容、保障及保費相關條款的透明度

保險公司通常保留在續保時增加保費的權利，而常見的加保費原因包括「提供更佳的保障」及「醫療通脹」。另一方面，「保證終身續保」是大部分個人醫保產品常用的賣點，不過，保證續保與保險公司保留單方面修改合約的權利，兩者實存矛盾之處。若消費者被這些銷售字眼吸引，而忽略了保單條款實際上容許保險公司單方面修改合約條款、保障項目及保費等而身陷不利位置，容易造成期望落差。

建議（四）：消委會建議在同一個人醫保產品中，相同年齡/背景的受保人的保費資料應清楚列明，和不時向保單持有人提供更新資料。保險公司亦應向消費者提供醫療通脹的相關數據，作為調整保費的客觀理據。此外，其他導致保費增加的觸發條件應在保單合約中列明。若保險公司保留單方面修改合約條款及進行重新核保的權利，他們應將相關的條文並列於所有「保證續保」的句語及清楚向潛在保單持有人解釋。

以書面及淺白用語提供解釋

有些投訴人及接受深入訪問的受訪者指出，他們的保險中介人就其申請個人醫保或索償被拒時只提供口頭解釋，這做法令消費者更感困惑。

建議（五）：消委會建議，應強制保險公司以書面及淺白用語向消費者/保單持有人提供有關個人醫保申請及索償決定的解釋。

披露個人醫保的市場及與投訴相關的數據

現時，與個人醫保或醫療保險相關的投訴數字，已公布的資料分散零碎，甚或很難取得，消費者難以比較不同監管機構或投訴渠道的數據。

建議（六）：為提高公眾及社會對個人醫保相關的事宜及發展的瞭解及監察，消委會建議監管機構及各投訴途徑應定時發布與個人醫保相關的投訴數字及市場數據（例如整體保費收入、個人醫保產品的數目、保單數目等）。

加強「合理及慣常」收費的參考資料來源的透明度

「合理及慣常」收費屬保險公司常用於限制其賠償責任（例如只作部分賠償）的條款。適當應用此條款有助控制醫療通脹、賠償額及保費的上升幅度。然而，由於不同個人醫保產品的保單合約中，有關「合理及慣常」收費條文的內容及當中列出用以釐訂該金額的參考因素各有不同，而保險公司往往只在已作出賠償決定後才知會保單持有人屬「合理及慣常」收費的金額，這令保單持有人無法在索償前確定賠償的多寡。

建議（七）：消委會建議保險公司用以釐訂合理及慣常收費的因素應清楚於保單合約上列明；同時，若保險公司引用此條款作出部分賠償的決定時，應向保單持有人解釋，用以釐訂相關金額的實際因素及統計數據。此外，由香港政府於憲報刊載的「私家症收費標準」應納入為其中一個參考指標。

為非緊急醫療服務提供預先批核服務

推行預先批核程序有助進一步提高保障範圍及保障金額上限的確定性。此種做法可讓保單持有人就療程費用是否屬保單保障範圍之內及早有所理解和索償會否能成功或被拒增加確定性，有助消除不必要的擔憂。即使預先批核的賠償額與合理及慣常收費未必最終相等，前者無疑能為保單持有人消除一定程度的不確定性。現時，自願醫保規定提供認可產品的保險公司，須在保單持有人要求下提供可賠償金額估算。

建議（八）：消委會認為監管機構應鼓勵保險公司就可選或非緊急的療程提供預先批核服務，以及就該服務的回覆時間訂立服務承諾。

加強保險中介人的培訓及改善行政程序

在部分投訴個案中，投訴人指責涉事的保險中介人/客戶服務員提供了「具誤導性」或「不準確」的資料，以致他們對療程是否符合索償資格及索償金額產生錯誤期望，或導致他們未能披露重要資訊。亦有一些投訴與保險公司未能提供滿意的服務有關，例如在保單終止後仍繼續收取保費、在未有明確同意下自動續保及未能及時提供醫療卡等。

建議（九）：現時行業已有守則建議保險公司須向保險代理提供足夠培訓。消委會認為監管機構應要求保險公司加強該等培訓措施，務求保險從業員與消費者/保單持有人對保單的認知和理解一致及加強他們之間的溝通，以期減少爭議。消委會亦建議為保險中介人及/或前線員工提供持續及與個別產品的特色相關之培訓。至於保險公司的服務質素，消委會建議他們應訂立並公布其服務承諾，以供顧客參考及評核。

加強消費者教育

研究發現由於個人醫保產品本質複雜，消費者普遍對其整體運作及對購買個人醫保相關的概念缺乏足夠認識。重要合約條款的實質意義及對他們的影響，是消費者教育的首要重點。

建議（十）：消委會建議消費者教育應涵蓋保險的概念；重要合約條款的實質意義，例如與保險公司保留單方面更改合約條款的權利、醫療所需、投保前已有病症、沒有披露事實、重複保險有關的條款；消費者在簽署保單合約前應獲取及理解的資訊；以及消費者尋求資訊、解釋及遇到問題時可申訴的權利。

提升個人醫保的延續性

調高投保年齡上限

現時，接近退休年齡或已經退休的消費者在購買個人醫保時可能會遇上困難。根據本研究收集的保單樣本，不同產品的投保年齡上限由 59 歲到沒有上限不等，而大部分的產品則以 64 歲到 70 歲為上限。

建議（十一）：為增加年長消費者購買個人醫保的機會，消委會建議保險公司上調個人醫保的投保年齡上限。這有助促使有能力負擔的長者使用私營醫療服務，亦可舒緩已超負荷的公營醫療系統的壓力。

為非主要保障項目的升級提供退出選擇

超乎消費者意料的保費增幅是常見的爭端。保險公司就增加保費所提供的普遍理據，是由他們單方面提出的升級保障，目的是為受保人「提供更佳保障」。然而，有些保障屬保單持有人並不需要的非主要保障項目（例如家居照顧服務、幼兒照顧、寵物照顧等），但保險公司並沒有為他們提供不接受這些額外保障的選項。這種做法會對長者而言甚為棘手，因為出乎預期的保費加幅會打亂他們的退休計劃，更甚者在負擔不起的情況下，不情願地放棄續保，即使步入了人生中最需要醫療保障的階段。

建議（十二）：基於公平原則及維持個人醫保的延續性，消委會建議保險公司在續保時應提供維持現狀的選項，讓產品對保單持有人而言合乎預算，尤其是在增加屬非主要的保障項目時，可讓保單持有人有退出選擇。

為投保前未知的已有病症提供保障

在大部分的個人醫保產品中，「投保前已有病症」屬其中一種不保事項。消委會認為，（一）若消費者在投保前已知悉有關自身的醫療情況，消費者便應在投保時，向保險公司披露有關情況以作核保；及（二）保險公司有責任透過具體問題向消費者收集足夠資料以作核保。另一個減低因沒有披露「投保前已有病症」而引起爭議的可行辦法，是在投保前進行「預先評估」（例如身體檢查）。至於有關屬未知悉的醫療情況，消委會認為按照公平原則，保險公司理應將該等情況納入保障範圍。

建議（十三）：消委會建議保險公司應承保投保前未知的已有病症。他們可就此設立等候期，例如參考自願醫保計劃的 3 年等候期。假若保險公司將投保前未知的已存在病症訂為不保事項，他們便須向潛在的保單持有人清楚解釋相關條款。

不作重新核保 ／ 提高重新核保政策和條件的透明度

從投訴個案及深入訪問中發現，保單持有人在提出索償申請及收到賠償後，有可能被保險公司進行重新核保，增加他們的附加保費或於保單合約中新增不保事項。這些手法某程度上與保單列出的可續保的概念相違背。換句話說，對保單持有人而言，重新核保可能在某個階段出現，導致保費變得不能負擔或保障範圍變得不適用，他們實際上可能無法享有保險公司所承諾的「保證」「終身續保」。

建議（十四）：消委會認為基於公平原則，比較理想的情況是保險公司實施一次性核保來取代現時每年核保的做法，讓個人醫保能提供真正的長期保障，例如應避免或盡量減少在保單生效後進行重新核保，為社會提供更安穩的醫療保險市場。然而，消委會瞭解個別保險公司（或個別產品）的重新核保政策可能取決於多種因素，例如定價策略或風險池管理。若保險公司認為進行重新核保屬不可避免，消委會認為與該安排的有關資訊，包括：重新核保的可能性、引致保險公司重新核保的各種誘因、以及在重新核保時考慮的因素等，應於保單合約中清楚列明及於潛在保單持有人簽訂保單合約前清楚說明。

未來路向

上述 14 項建議是經過嚴謹研究的成果；研究涵蓋到消費者主要關注的問題、市場當前提供的產品、其他選定地方的監管措施以及各持份者對建議的可行性和實用性的意見。

根據研究結果，消委會認為各持份者需要攜手合作，循序漸進地就個人醫保市場實施清晰的規管指引，以改善提供個人醫保的保險公司的營商手法，以及提升消費者教育和加強相關保障措施。消委會相信，在各持份者的共同努力下，將為促進消費者保障和個人醫保行業的可持續發展締造一個公平的市場。

就此，消費者亦扮演著重要的角色。他們應加強對個人醫保產品的認知，瞭解切合他們需要的保障範疇及個人醫保產品，並在就保障範圍和條款及細則的意義有疑問時，要求保險公司作出說明。消委會一直鼓勵消費者作出負責任及經深思熟慮的購買決定。

消委會會繼續擔當爭議調解及市場監察的角色，並透過各種公共渠道向公眾傳遞有關個人醫保市場的資訊和提供消費者教育。消委會亦會與各持份者保持密切對話，鼓勵他們積極考慮研究所揭示的問題，並提出和實施適合本地市場的措施。消委會認為要促進消費者對個人醫保的信心和支持，優質的個人醫保產品和就醫療需要提供合理的經濟保障是不可或缺。個人醫保行業要得以持續發展，亦應以消費者的利益為依歸。長遠而言，希望透過增加消費者的信心和市場推出更具透明度和優質的產品，可以推動更多人使用私營醫療服務，並減輕已超負荷的公營醫療系統的壓力，最終目標是為香港能享受平衡、可負擔、透明度高和優質的醫療服務。

有效調整消費者期望與實際保障的建議

1. 統一重要合約條款的定義

2. 改善投保申請表的設計使問題具體化

4. 提升與更改保單合約內容、保障及保費相關條款的透明度

5. 以書面及淺白用語提供解釋

7. 加強「合理及慣常」收費的參考資料來源的透明度

8. 為非緊急醫療服務提供預先批核服務

9. 加強保險中介人的培訓及改善行政程序

3. 於公開平台上提供保單合約樣本

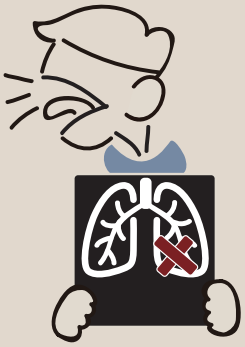
6. 披露個人醫保的市場及與投訴相關的數據

10. 加強消費者教育

提升個人醫保的延續性的建議

11. 調高投保年齡上限

12. 為非主要保障的升級提供退出選擇



13. 為投保前未知的已有病症提供保障

14. 不作重新核保／提高重新核保政策和條件的透明度

1 Introduction

According to the 2016 Government statistics, close to 34% of the local population had purchased private health insurance (PHI). However, a research report also showed that a significant portion of the insured individuals still chose public healthcare over private healthcare due to a wide range of shortcomings in PHI such as disputes over insurance claims, exclusion of pre-existing conditions and a potential increase in premium upon renewal, etc. Complaints statistics recorded by the Insurance Complaints Bureau (ICB) and the Consumer Council (the Council), and findings from the Government's healthcare paper further supported this fact.

Given that PHI is a long-term product by nature, the Council took the initiative to investigate the problems associated with PHI and has made recommendations for appropriate measures be taken to enhance consumer safeguards.

This Study aimed to:

- Assess the level of PHI consumer satisfaction, consumer understanding and certainty of protection coverage in their health insurance plans;
- Understand if consumers encountered any difficulties when engaging with PHI;
- Identify possibly unfair conditions and procedures which could limit consumer's access to PHI and the insurance companies' payout obligations to policyholders;
- Review overseas regulatory frameworks to shed light on possible area(s) of improvement; and
- Make recommendations that may enhance consumer protection in PHI.

The Study took a mixed-method approach comprising of consumer survey, claimant survey, in-depth interviews, complaint analysis, market and legal review of policy terms and conditions, as well as desk research on relevant regulations and approaches in selected jurisdictions.

This Chapter highlights the growing penetration of PHI in Hong Kong, which provides consumers with important protection against unexpected and unforeseen substantial medical bills arising from chronic illness or severe injuries. However, due to the long-term nature of the product, problems with PHI tend to result in higher detriment to the consumer compared to other consumer services. In PHI, consumers are often in no position to judge if treatments they undergo are medically necessary, whether their PHI plan at the time of purchase covers medical procedures they need, or if re-underwriting issues may bar some consumers from shifting to other insurance companies. This Chapter outlines the perceived shortcomings of PHI, along with an introduction to the objectives of the Study and the methodology applied.

1.1 Background

Given the ageing population with growing medical needs in Hong Kong, PHI plays a vital role in financing healthcare expenditure. According to the Thematic Household Survey Report No. 63 (THSR-63) conducted by the Census and Statistics Department (C&SD) of Hong Kong Government,[5] Hong Kong recorded a 78% increase in the number of people covered by medical insurance purchased by individuals in 10 years, surging from 1.35 million people in 2006[6] to 2.4 million people in 2016, representing 34% of the local population being covered by PHI.[7]

According to the latest statistics[8] from the Hong Kong Federation of Insurers (HKFI), in this growing market, the gross earned premium of the reimbursement type of PHI has increased by 56% from HK$6.6 billion in 2012 to HK$10.3 billion in 2016. In 2016, the total claims incurred stood at HK$6.58 billion.

In 2016, approximately 57% of inpatients covered only by individually-based health insurance policies were treated in private hospitals, almost ten times the corresponding figure of 6% for those uninsured persons. That said, 43% of these insured persons were still treated in Hospital Authority hospitals.[9]

Statistics from the ICB revealed that the top three reasons for complaints regarding individual-based hospitalisation/medical insurance policies are related to the application of policy terms (e.g. medically necessary, hospital confinement), non-disclosure (e.g. material fact, reasonableness to expect an applicant to disclose the fact), and excluded items (e.g. pre-existing conditions, congenital condition) in the contracts between consumers and insurance companies. The complaints received by the Council, as shown in Chapter 4, also reflected similar problems. Other consumer grievances included frustration from premium increase, the uncertainty of reimbursement claim and application refusal.

Consumers found health insurance plans confusing and misleading in their complexity, as shown from the Council's in-depth interviews. As revealed by the legal study in Chapter 5, insurance documents were lengthy, with difficult or unclear wording, terminology and exclusions/inclusions of specific treatments for medical conditions.

For example, a complaint made to the Council addressed a clause for coronary artery disease where non-surgical techniques such as balloon angioplasty or laser angioplasty were excluded from protection coverage. Other cases related to the definitions of some key policy terms, such as "medically necessary" and "reasonable and customary". These terms varied greatly not just from company to company, but from plan to plan in the same insurance company. Overall, each insurance company usually made its own decision on the interpretation of these terms.

In another complaint to the Council, the insurance company declared that hospital in-patient physiotherapy was not medically necessary for the insured and refused to settle the claim for the cost of hospital confinement, despite the complainant's attending doctor

[5] Census and Statistics Department. (2017) Thematic Household Survey Report No. 63.

[6] Census and Statistics Department. (2007) Thematic Household Survey Report No. 30.

[7] This included persons entitled to medical insurance purchased by individuals, irrespective of whether the persons have medical benefits provided by employers/companies concurrently.

[8] Hong Kong Federation of Insurers. Medical Insurance Association Annual Business Statistics.

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

declaring his recommendation of hospital confinement. Furthermore, there were cases where consumers were uncertain of the information to be declared in the health declaration form at the time of purchase. This confusion led to the insurance companies involved applying the "non-disclosure" clause to decline claim applications.

Despite the substantial growth of the PHI market over the last decade, the significant lack of confidence in health insurance limits the leveraging potential of PHI to finance the healthcare system in Hong Kong. Similar to the nature of complaints from the ICB and the Council, the Government's previous healthcare reform consultations also pointed out that the perceived shortcomings of PHI included the following:[10]

- Dispute over insurance claims;
- Exclusion of pre-existing conditions;
- Inadequate benefit coverage;
- Lack of portability and continuity of policies;
- No guaranteed renewal of policies;
- No assurance on future premium;
- Uncertainty over eligibility of medical claims for reimbursement and ratio of reimbursement; and
- Implications of medical claims on policy premium upon renewal.

The Council considers it essential to identify solutions to address these concerns to enable the sustainable development of the healthcare system in Hong Kong.

1.2 Objectives of the Study

Given the growing penetration rate of PHI products and their shortcomings in protecting consumers against major medical expenses, the Council conducted an in-depth study into the PHI market.

The objectives of the Study are to:

- Assess the level of consumer satisfaction on PHI, their understanding and certainty of protection coverage in the health insurance plans;
- Understand if consumers encountered any difficulties when engaging with PHI;
- Identify possibly unfair conditions and procedures which may limit consumer's access to PHI and the insurance companies' payout obligations to policyholders;
- Review overseas regulatory frameworks to shed light on possible areas for improvement; and
- Recommend measures, from selling to servicing, to enhance consumer protection in PHI.

[10] Food and Health Bureau. (2010) My Health My Choice, Healthcare Reform Second Stage Consultation Document; Food and Health Bureau. (2014) Consultation Document on Voluntary Health Insurance Scheme.

The scope of the Study is confined to individually-purchased PHI covering hospitalisation and medical services, which should indemnify the insured persons against incurred medical expenditures applicable to hospitals or medical services.

The term "health insurance" is used interchangeably with "medical insurance" in the Report to broadly mean an insurance that compensates the insured persons for expenses or losses incurred for medical reasons.

1.3 Study Methodology

In order to achieve the above objectives, the Study took a mixed-method approach. This comprised of:

(1) Quantitative surveys to gauge consumer perception and experience of PHI;

(2) Qualitative interviews to explore claimants' and elderly consumers' experience and opinion in detail; and

(3) Desk research to explore the nature of PHI complaints, problematic policy terms and conditions from the legal perspective, and regulations and approaches adopted by selected jurisdictions in safeguarding consumer interests.

The sum of the percentages for survey questions in the consumer research as presented in the Report may not equal to 100 due to rounding.

Consumer Research

The Council commissioned a research agency to conduct consumer research regarding PHI in Hong Kong to better understand consumer attitudes, behaviours, expectations and experiences towards PHI. This research served to identify critical areas of concern and help provide guidance on the direction of future policies to enhance consumer protection.

To achieve the above, both quantitative (telephone survey and on-street survey) and qualitative (in-depth interviews) approaches were adopted in three different stages, each with specific areas of focus.

Stage 1: Telephone Survey (Establishment Survey)

The objective of the establishment survey was to discover the penetration of PHI and demographics of health insurance buyers as well as the drivers leading to their purchase, selection criteria, buying process and policy details.

The survey was conducted from 16 – 31 May and 22 June – 18 July 2016. Target respondents were Cantonese-speaking Hong Kong residents aged 18 or above. Households were sampled by random digit dialling. Demographic quota based on age and gender was set and the data collected was weighted with reference to the Demographic Statistics Section from the C&SD as of February 2016, so as to ensure the representativeness of the survey. A total of 1,000 respondents were surveyed.

Stage 2: On-street Survey (Claimant Survey)

The second stage of the survey – the claimant survey – was designed to discover consumer satisfaction level and consumer experience of medical claims.

The quantitative survey was carried out from 3 – 10 and 13 – 18 January 2017. Interviews were conducted face-to-face through street intercept recruitment. Target respondents were Cantonese-speaking Hong Kong residents aged 18 or above, owners of PHI at the time of interview (excluded those who only had medical insurance provided by employers), and claimants of medical claims within the past 30 months.

Target respondents were randomly approached in 14 locations across Hong Kong Island, Kowloon and New Territories. Quotas were set for age and gender based on the profile of the respondents who had indicated in the establishment survey that they had made a claim to their insurance company within the 30 months prior to the interview. A total of 205 respondents were successfully interviewed.

Stage 3: In-depth Interviews

After the completion of the quantitative telephone and on-street surveys, qualitative interviews with individual consumers were conducted. These interviews delved into the details of the consumers' experience of PHI, particularly of rejected medical claims if applicable. A total of 28 individual consumers were interviewed.

20 interviewees (see Table 1 (i) for profile) who had experienced rejected claim applications (fully or partially rejected) by insurance companies in the last 30 – 60 months were recruited via the research agency for individual phone interviews during the period of 21 March – 19 May 2017. The interviewees' ages ranged between 18 to 54 at the time of the research.

Table 1: Profile of interviewees for in-depth interviews

Age / Gender	Female	Male	Total
(i) Recruited via research agency			
Aged 18 – 24	0	1	1
Aged 25 – 34	8	6	14
Aged 35 – 44	4	0	4
Aged 45 – 54	1	0	1
Sub-total	13	7	20
(ii) Recruited from elderly academies/universities and patient groups			
Aged 55 – 64	0	3	3
Aged 65 – 74	2	3	5
Sub-total	2	6	8
Total	**15**	**13**	**28**

Given the ageing population with growing medical needs in Hong Kong, health insurance plays a vital role in financing healthcare expenditure, especially among elderly consumers (persons aged 55 and over). In 2016, 31% of the whole Hong Kong population within the age group of 55 to 64 were covered by PHI. The proportion dropped sharply as age increased. Only 10% of the whole Hong Kong population within the age group 65 or above were covered by PHI. This is far less than the average level of 34% of the Hong Kong population covered by PHI.[11]

[11] Census and Statistics Department. (2017) Thematic Household Survey Report No. 63.

Apart from identifying possible underlying causes of low participation rate, the in-depth interviews conducted with elders also aimed to understand the problems they encountered before or when they engaged with PHI. Using these findings, the Council could then recommend proper measures to enhance the protection of vulnerable consumers.

Elders from seven elderly academies/universities in Hong Kong[12] and some patient groups were invited to participate in a screening survey in the fourth quarter of 2017 regarding their experiences of purchasing PHI and making claims. Elders who were shortlisted for in-depth interviews met three criteria: (i) had encountered problems/difficulties[13] purchasing or engaging with PHI; (ii) had expressed dissatisfaction with PHI; and (iii) were above a certain age. Council Staff interviewed a total of eight elders in the period of 30 January – 8 March 2018 (see Table 1 (ii) for profile).

Complaint Analysis

The Council regularly receives complaint cases lodged by consumers. For this Study, the Council analysed complaint cases received between January 2015 to December 2018, to identify common grievances or disputes related to PHI. A total of 299 complaint cases in the Council's database were reviewed. The policy type, subject and nature of complaints as well as policy terms and conditions involved in the complaints were identified. Through this analysis, the Council can better understand the nature and possible causes of PHI disputes, shedding light on the direction of recommendations to enhance consumer protection.

Legal Analysis

The Council commissioned a legal consultancy team to carry out legal research from May to August 2018. The team researched the terms and conditions of PHI policies to deliver a legal opinion identifying highly disputed and problematic areas in PHI that were detrimental to consumers. They also advised on possible directions to enhance consumer protection and empower consumers in their understanding of PHI rights and choices in Hong Kong.

The legal research reviewed 18 PHI plans from 14 insurance companies in the Hong Kong market, collected from March 2017 to April 2018. The selected insurance companies were major market players in the health insurance industry,[14] representing more than 87% of the total gross premium of Accident and Health (Direct Business) sector in 2017.[15] To reflect the policy features available for the majority of the public, the 18 PHI policies selected were sample policies of common hospitalisation insurance plans offering general ward as one of the benefit levels. The sample policy contracts and sales materials were downloaded from

[12] These included the elder academies of CityU, EdUHK, HKSYU, LingnanU and OUHK, Institute of Active Ageing of PolyU and Network of Ageing Well for All of CUHK.

[13] Experienced one or more of the following scenarios related to PHI: (a) policy application at older age was refused by an insurance company/had explored some PHI plans at older age but did not purchase any at all eventually; (b) once owned a policy but already lapsed at older age; (c) encountered difficulties during policy renewal, such as significant premium increment at older age, benefit enhancements without opt-out option or being imposed excluded items.

[14] References were taken from the following 3 sources: (i) top 10 insurance companies carried out a business of medical insurance by gross premium based on Annual General Business Statistics (2016) (Direct Business, Accident & Health) and Quarterly Release of Provisional Statistics for General Business (January to December 2017) (Direct Medical Business) published by the Insurance Authority; (ii) insurance companies which offered PHI products for sales through top 5 local banks based on total asset of 2017; and (iii) 5 most popular insurance companies based on the Council's consumer research. Insurance companies overlapped in these sources so the total number of selected insurance companies for the Study was less than 20.

[15] Insurance Authority. Annual General Business Statistics 2017. Data of one of the 14 insurance companies was not available on this list as it was grouped under the Long Term Insurance Business sector, thus it was not included in the calculation of the share of total gross premium.

the insurance companies' websites (or banks' websites for cases where the bank acted as an agent of the insurance company) or obtained through insurance agents by field workers recruited by the Council.

The legal research also referenced the latest judicial interpretations, literature in insurance law and regulatory regimes from Hong Kong and other Common Law jurisdictions, including Australia, Canada, Singapore and the United Kingdom.

Benchmarking with Regulation and Experience in Selected Jurisdictions

To benchmark Hong Kong's regulatory framework and explore good practices from the health insurance industry in other jurisdictions, the Council conducted desk research on the regulatory framework, consumer protection and dispute resolution mechanism of PHI in jurisdictions comparable to Hong Kong situation.

The Council reviewed six countries, namely, Australia, Ireland, the Mainland China, Malaysia, Singapore, and the United Kingdom. These countries were selected based on three considerations: (i) reference from Government's previous healthcare reform consultations; (ii) countries reviewed in the legal analysis; and (iii) neighbouring Asian countries. The Council also scrutinised other jurisdictions including Canada, Netherlands, Switzerland, Taiwan and the United States in its preliminary research, but found the different roles of PHI in these countries of less relevant value to the Study.[16]

1.4 Structure of the Report

The remainder of this Report is structured as follows:

- Chapter 2 presents an overview of the PHI market in Hong Kong;
- Chapter 3 explores consumer experience and satisfaction of PHI, from pre-purchase, purchasing and post-purchase stages as observed through the establishment and claimant surveys;
- Chapter 4 identifies consumer vulnerability, PHI disputes and claimant dissatisfaction through the analysis of complaint cases and in-depth consumer interviews;
- Chapter 5 discusses how well-informed consumers are, and whether the terms and conditions of PHI policies are fair and understandable to consumers from the legal perspective;
- Chapter 6 describes regulatory frameworks and good practices adopted by selected jurisdictions;
- Chapter 7 illustrates how the Government's Voluntary Health Insurance Scheme will be able to address some of the problems identified in the Study; and
- Chapter 8 provides the conclusion and recommendations to potentially enhance consumer protection, empower consumers and promote the healthy development of Hong Kong's PHI industry.

[16] For instance, in Canada, the Canada Health Act (CHA) is a federal legislation for publicly funded healthcare insurance unrelated to PHI. The Insurance Companies Act is the primary legislation governing all federally incorporated or registered insurance companies in Canada, which do not contain any specific provisions related to consumer protection in relation to PHI that may be of referential value to the Study.

2 The Medical Insurance Market in Hong Kong

Hong Kong runs a dual-track healthcare system where the private healthcare sector provides 68% of out-patient care services and the public healthcare sector serves 82% of in-patient hospital services.

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". The gross earned premium of the reimbursement type of PHI has increased by 56% in 4 years, reaching HK$10.3 billion in 2016.

Out-of-pocket payment accounted for 56.3% of private healthcare services paid for by individuals and households in 2016/17. Employer-based payment accounted for 15.5% and individually purchased medical insurance accounted for 14.1%.

Although competition in the PHI market fosters a fairer market, it does not motivate insurance companies to offer medical insurance policy for a continuous protection, which the Council sees a crucial element for protecting consumers' interest.

Hong Kong people can enjoy healthcare services either through public or private healthcare; while some people choose to opt for both. In Hong Kong, the Government provides healthcare services at low cost to eligible persons. Eligible persons mean (i) holders of the Hong Kong Identity Card; (ii) children who are Hong Kong residents and under 11 years of age; or (iii) other persons approved by the Chief Executive of the Hospital Authority or by the Director of Health (in the case of the Department of Health). Public medical care is administered jointly by the Hong Kong Department of Health and the Hospital Authority.

If one opts for private healthcare services, a PHI purchase is one of the options made to cover the high expense incurred. There are a variety of choices in the market, and this Chapter describes the general features of Hong Kong's PHI market.

2.1 Healthcare Market

Hong Kong's Dual-track Healthcare System

Hong Kong runs a dual-track healthcare system where the public and private healthcare sectors complement each other. The private sector provides the primary medical services (out-patient healthcare services) in Hong Kong, which accounted for 68% of out-patient care in 2016 (Table 2). The public sector is the primary provider of secondary (specialist) and tertiary (in-patient) healthcare services. Public hospitals made up 82% of the total number of in-patient discharges in the same year (Table 2).[17] The private sector complements the public healthcare system by offering care to those who can afford and are willing to pay for healthcare services with personalised choices and better amenities.

Table 2: Provision of local healthcare services by sector, 2016

	Private	Public
In-patient[18]	18%	82%
Out-patient[19]	68%	32%

Private Hospitals

To cope with rising healthcare demand, a new private hospital opened in 2017 and another one is currently in development; by 2020, the total number of private hospitals will reach 13.[20] The number of hospital beds provided by private hospitals has increased from 3,438 in 2007 to 4,644 in 2017, an overall increase of 35.1% within the last ten years. In comparison, the number of hospital beds in public hospitals has only increased by 2% over the same period, from 27,784 in 2007 to 28,329 in 2017.

Moreover, the occupancy rate of private hospital beds remained around 65% from 2006 – 2015, with a slight drop of 4% from 66% in 2006 to 62% in 2015.[21] Such occupancy rate may imply that there is flexibility to re-distribute some of the public sector medical services to the private sector.

[17] Department of Health. Health Facts of Hong Kong 2018 Edition. As of end 2017, there are 42 public hospitals and institutions in the public sector, comprising 28,329 beds; and there are 12 private hospitals, comprising 4,644 beds.

[18] Census and Statistics Department. Annual Digest of Statistics (2017 Edition). Excluding nursing homes and hospitals in correctional institutions.

[19] Census and Statistics Department. (2017) Thematic Household Survey Report No. 63.

[20] These included the Gleneagles Hong Kong Hospital which opened in 2017 (500 beds) and the Chinese University of Hong Kong Medical Centre to be completed by 2020 Q2.

[21] Research Office, Legislative Council Secretariat. (2012) Development of private hospitals in Hong Kong; Department of Health. Replies to written questions raised by Finance Committee Members in examining the Estimates of Expenditure 2015-16 and 2017-18.

Pilot Programme for Enhancing Price Transparency for Private Hospitals

With a view to better regulating private healthcare services, the Government launched a public consultation in December 2014 on a proposal to revamp the existing regulatory regime for private healthcare facilities. Given that increasing price transparency was one of the key elements in the proposed regulatory regime, the Government and the Hong Kong Private Hospitals Association (HKPHA) rolled out a joint pilot programme for enhancing private hospital's price transparency in October 2016. All the private hospitals in Hong Kong voluntarily participated in the pilot programme, which included the following three measures:

- Hospitals and doctors are encouraged to provide budget estimates for patients receiving non-emergency operations/procedures at the hospitals in order to give patients a better idea of the overall costs involved;[22]
- Private hospitals will publicise fee schedules of major chargeable items on their respective websites; and
- Private hospitals will publicise historical billing statistics for public reference on their respective websites.[23]

An electronic platform has been set up for all participating private hospitals to release their historical billing statistics to facilitate public comparison.[24]

Healthcare Financing Source in Hong Kong

In Hong Kong, the turnover of the public and private sectors healthcare services are roughly equal, estimated at HK$74.6 billion (49.8%) and HK$75.2 billion (50.2%) respectively in 2016/17.[25] Private healthcare services are mainly financed by household out-of-pocket expenditure (56.3%) and insurance payouts (29.6%), including individually-purchased (14.1%) and employer-provided (15.5%) medical insurance. Public healthcare services are financed by public funding from the Government budget (around 94.3% in 2016/17).[26]

[22] The Department of Health has recommended a list of 30 common and non-emergency operations/procedures (such as thyroidectomy, colonoscopy, LASIK, knee arthroscopy) for which budget estimates can be provided to patients for their next of kin before hospital admission.

[23] It refers to the historical bill sizes of the 30 recommended common operations/procedures.

[24] See https://www.orphf.gov.hk/Public/Enquiry/Main.aspx.

[25] This includes dental care, medical goods and others(including ancillary services and administration).

[26] Food and Health Bureau. Estimate of Health Expenditure, 1989/90 – 2016/17.

2.2 Health Insurance Market

As of May 2018, there were 79 authorised insurance companies of the "General Business" class (55 local companies, 24 overseas companies) supplying the medical insurance services in Hong Kong.[27] There is no official published figure regarding the specific number of insurance companies providing individual based medical insurance in the market. Industry statistics show that the gross earned premium of the reimbursement type of PHI has increased by 56% in 4 years, from HK$6.6 billion in 2012 to HK$10.3 billion in 2016.[28]

According to industry classification, PHI products are broadly divided into four types: (a) hospital insurance reimbursing hospitalisation cost, indemnifying the insured persons against actual medical expenditure incurred; (b) out-patient insurance reimbursing treatment cost of doctor consultation at clinics;[29] (c) hospital cash insurance offering income protection to policyholders, usually in the form of a fixed amount of benefits per day during the period of hospitalisation, which may not be related to in-patient cost; and (d) critical illness insurance offering a lump-sum payment to policyholders upon confirmation of critical illness found on a pre-defined list, which may be unrelated to treatment cost.[30]

Overview of PHI Industry

According to the THSR-63, approximately 3.26 million people were entitled to medical benefits provided by employers/companies[31] or covered by medical insurance[32] purchased by individuals or had both kinds of medical insurance protection, representing 46.7% of the Hong Kong resident population at the time of enumeration.

Of this total, approximately 2.4 million people (34.4% of the population) were covered by medical insurance purchased by individuals. Amongst them, 1.27 million people (52.8%) only had medical insurance purchased by individual, and roughly 1.13 million people (47.2%) had medical benefits provided by employer concurrently. On the other hand, 16.7% or 1.17 million of the population were entitled to medical benefits provided from their employers or companies only (including medical benefits provided by Civil Service/Hospital Authority only) (Figure 1).

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[27] Refers to the number of insurance companies supplying insurance business which refers to Class 2 (sickness) of Part 3 Classes of General Business of the First Schedule of the Insurance Ordinance (Cap. 41). Insurance Authority. Number of Authorized Insurers by Class of Insurance Business as at 28 May 2018.

[28] Hong Kong Federation of Insurers. *Medical Insurance Association Annual Business Statistics*.

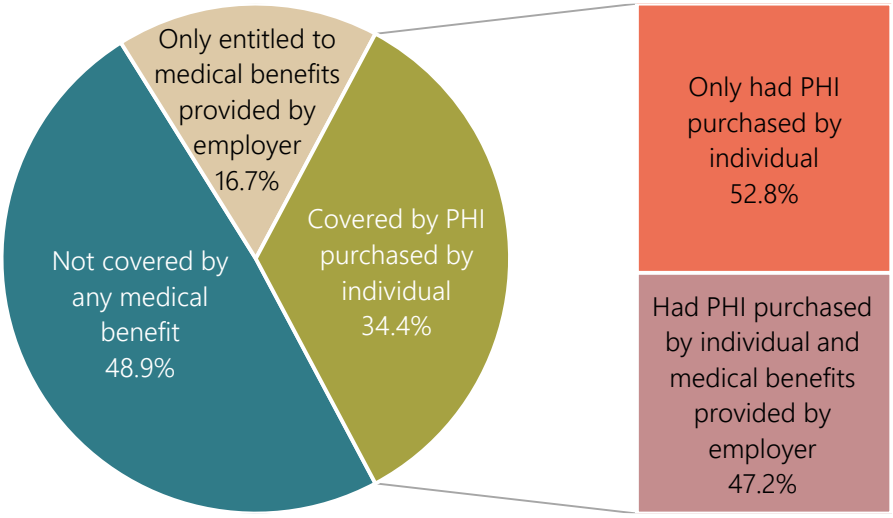
[29] This is different from the out-patient surgery benefits in some hospital insurance products, which reimburse the expenditure incurred by treatments carried out in the out-patient setting of a hospital or a clinic.

[30] Food and Health Bureau. (2010) My Health My Choice, Healthcare Reform Second Stage Consultation Document.

[31] This excludes medical benefit provided by Civil Service/Hospital Authority only (4.4%).

[32] In THSR-63, "Medical insurance" refers to any package of medical insurance policies purchased by individuals covering any combinations of medical benefits (such as consultation with practitioner of Western medicine, hospitalisation, dental consultation, consultation with practitioner of Chinese medicine including practitioners of Chinese medicine (general practice)/bone-setters/ acupuncturists, medical check-up, maternity, etc.) for general health care or a specific disease, including medical insurance rider packaged in combination with other types of insurance (such as life and accident insurance). It should be noted that the "medical insurance" which THSR-63 refers to is different from the scope of "PHI" applied in this Study, which is confined to individually-purchased PHI covering hospitalisation and medical services (see Chapter 1).

Figure 1: The coverage of medical benefit and PHI in 2016

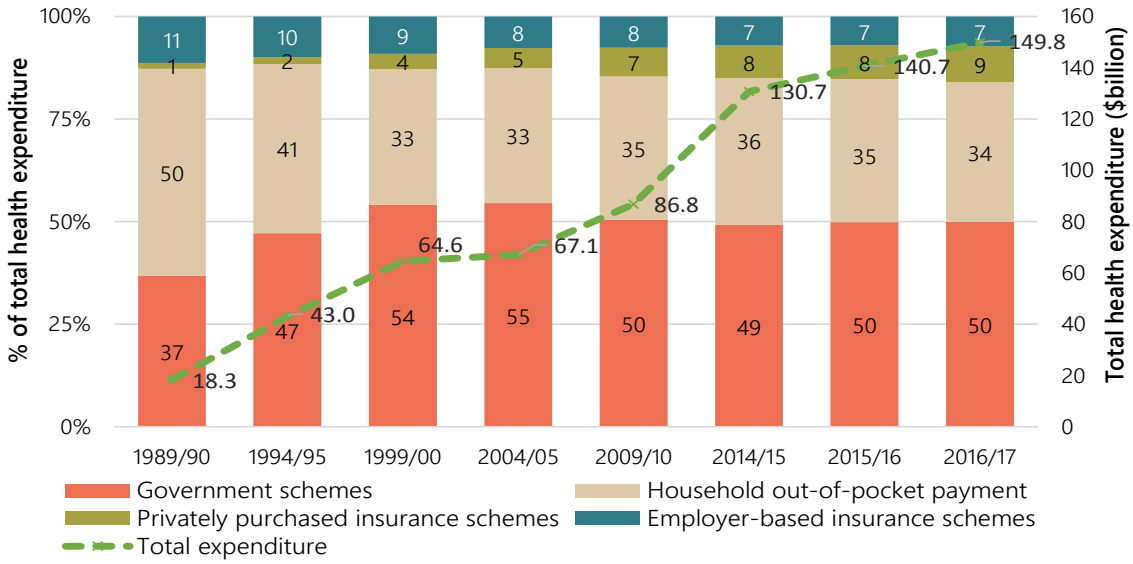


(Source of information: THSR-63)

Role of PHI in Healthcare

Currently, medical insurance does not play a significant role in financing healthcare in Hong Kong, despite the wider population coverage. The combination of individually-purchased and employer-provided medical insurance only adds up to 16% of overall health expenditure in 2016/17 (Figure 2).[33]

Figure 2: Total health expenditure of Hong Kong by financing sources 1989 - 2016



Remark: Total health expenditure includes both public and private healthcare services. The figures for employer-based 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 benefits categorised into government funding.

[33] Food and Health Bureau. Estimate of Health Expenditure, 1989/90 – 2016/17. Here, the overall health expenditure which medical insurance contributes to refer to expenditure for both public and private healthcare services, which is different from the percentage of contribution to private healthcare services as mentioned in Section 2.1 "Healthcare Financing Source in Hong Kong".

2.3 Economics of Medical Insurance

Many argue that medical insurance itself is a moral hazard. Moral hazard means a situation exists where one party has an incentive to use more resources than otherwise would have been used because another party bears the costs. The aggregate effect of moral hazard in any market will restrict supply, raise prices, and encourage overconsumption. Applied to medical insurance, anyone who has purchased medical insurance may have more incentive to use and claim medical services than one who has not, resulting in higher medical expenses. This will increase the total demand and expense of medical services in the economy.

However, this is only true if the costs to the customer, such as insurance premiums and deductibles, are the same for everyone. In a competitive insurance market, insurance companies charge higher rates to riskier customers. The concern over moral hazard is mostly removed when prices can reflect real information. For instance, premiums for cigarettes smokers can be higher than those who are not.

Insurance underwriting is crucial for this very reason. To offset moral hazard, insurance companies raise premium rates and offer short-term medical insurance policies instead of long-term ones. Short-term policies allow insurance companies to re-evaluate or re-classify a customer's medical risk into different underwriting categories on an annual basis (or within a fixed period) and do not specify a constant cost-share. Instead, insurance companies specify the consumer cost-sharing as a function of the cumulative amount (over the covered year) of healthcare spending. Under this short-term contract, the meaning of the contract terms and conditions can vary over time; consumers may wrongly assume the interpretation of contract terms and conditions by the insurance companies, as what the consumers understood at the time of purchase will prevail in the future. Different underwriting approaches adopted by insurance companies at pre- and/or post-claim stages also end up clouding consumers understanding.

Under the existing private medical insurance market, there is no motivation for insurance companies to offer a long-term medical insurance policy. Unless regulations designed to promote fairness are in place to require all insurance companies offer long-term medical insurance (with no re-classification or re-underwriting allowed), there will always be gaps between insurance companies and consumers regarding the interpretation and understanding on the terms or conditions. This is particularly true for insurance companies as they have their own modelling on the terms and conditions of the complex medical insurance contract. Without a clear rule to limit the wide scope and variety of ways to interpret the terms and conditions of a medical insurance contract, consumers will always be in a disadvantaged situation if they do not have knowledge of insurance and medical services. In later Chapters, Hong Kong consumers are observed to be facing this market problem. The Council seeks to redress the unfair terms and conditions of the medical insurance contract.

3 Consumer Research on PHI

The findings from consumer research suggest that while consumers are generally satisfied with the PHI market, there are factors which may affect the continuity of insurance protection.

The following patterns of consumer behaviour such as how they choose and purchase PHI, how they seek advice on medical treatments, how they make claim and seek redress regarding PHI are observed:

- Penetration of PHI – 38% of persons aged 18 or above in Hong Kong currently own PHI (individually purchased and/or top-up insurance in addition to employer-provided medical insurance); PHI ownership rate is the highest in the age group 45 – 54 (54%);
- Friends and relatives are major information sources – Over half of the respondents indicated friends and relatives as the informational sources when they looked for PHI while fewer respondents shopped around (about one-third);
- High reliance on agents – The majority of consumers seek advice from their agents throughout the different stages of purchasing;
- Inadequate attention when giving medical history – Consumers may not pay attention to detail when declaring their health conditions, 51% used their own understanding and knowledge to fill in health declaration forms and 7% did not check any medical records at all; non-disclosure clauses may result in claim rejection by insurance companies;
- Medical practitioners were sought for advice on necessity of treatments – 93% of claimants approached medical practitioners to discern whether hospitalisation is justified; and
- High trust placed in insurance companies and few complaints – 99% of claimants who did not receive full reimbursement did not make a complaint; four-fifths of them were satisfied with the explanation given by insurance companies while others were discouraged by the expected difficulty of the complaint procedure.

Survey results also suggest elderly consumers aged 55 and up struggle with differing problems from other age groups. Elderly consumers who have not purchased or have discontinued PHI were largely dissuaded by unaffordable premiums, unacceptable increase in premiums or unsuitable benefit coverage.

This Chapter presents the findings of the establishment and claimant surveys which looked into (1) penetration of PHI in Hong Kong and profile of the insured persons; (2) consumer behaviour and selection criteria in relation to PHI; and (3) consumer satisfaction levels towards their PHI and their experience of making a claim.

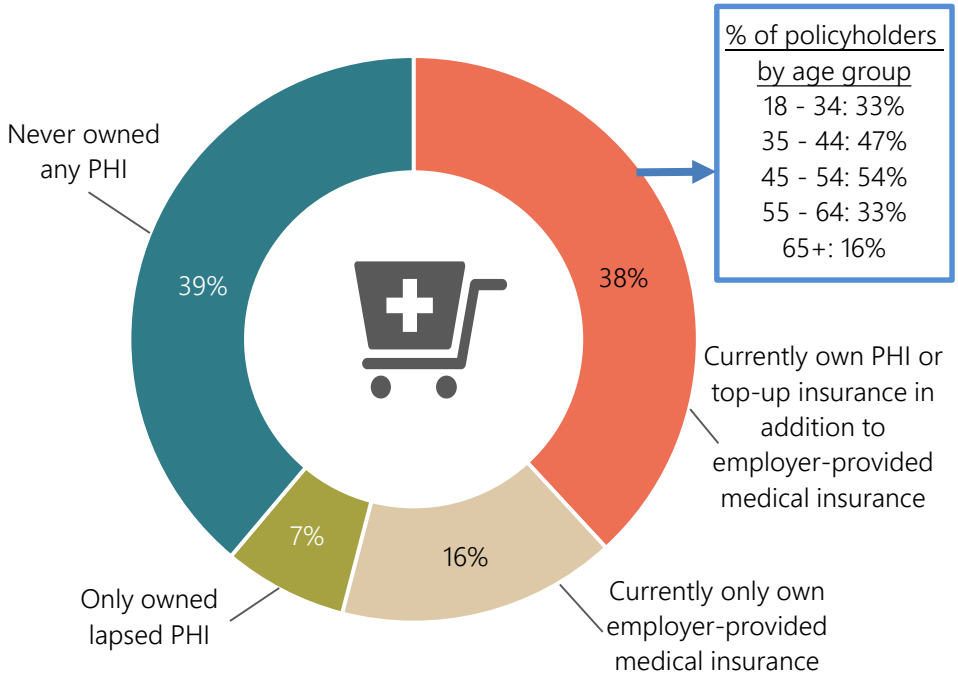
To understand the factors affecting consumer decision-making in the PHI market, findings are set out in three parts to mimic the PHI consumer purchasing journey: the pre-purchase, purchasing and post-purchase stages.

3.1 Ownership

PHI Penetration

The establishment survey reveals that at the time of the interview, 38% of the respondents owned PHI (individually purchased and/or top-up policy in addition to employer-provided medical insurance). A similar proportion of 39% of respondents had never owned any PHI (Figure 3). All other respondents only had either lapsed PHI (7%) or employer-provided medical insurance (16%). Almost all of the respondents (94%) indicated that the PHI they owned covered hospitalisation benefits.

Figure 3: Coverage of PHI



(Establishment survey, n= 1,000.)

The results largely align with the THSR-63 findings published at the end of 2016; 34% of the Hong Kong population was covered by individually purchased medical insurance, and 17% only had medical insurance provided by their employers.

Profile of PHI owners

In terms of age, the proportion of respondents who had PHI was the highest in the age group 45 – 54 (54%) followed by the age group 35 – 44 (47%). It is worth noting only 16% of the elderly respondents aged 65 or above were covered by PHI, which suggests either lack of awareness or possible existence of barriers for elderly to purchase or renew their PHI.

Income was another notable factor highly related to the ownership of PHI. 15% of respondents with a monthly household income less than HK$10,000 subscribed to PHI and the proportion gradually increased to 55% for those with a monthly household income of HK$40,000 or above (Table 3).

Table 3: Relationship between household income and ownership of PHI

Monthly household income	Ownership of PHI
HK$40,000 or above	55%
HK$30,000 – 39,999	48%
HK$20,000 – 29,999	32%
HK$10,000 – 19,999	24%
Less than HK$10,000	15%

(Establishment survey, n= 1,000.)

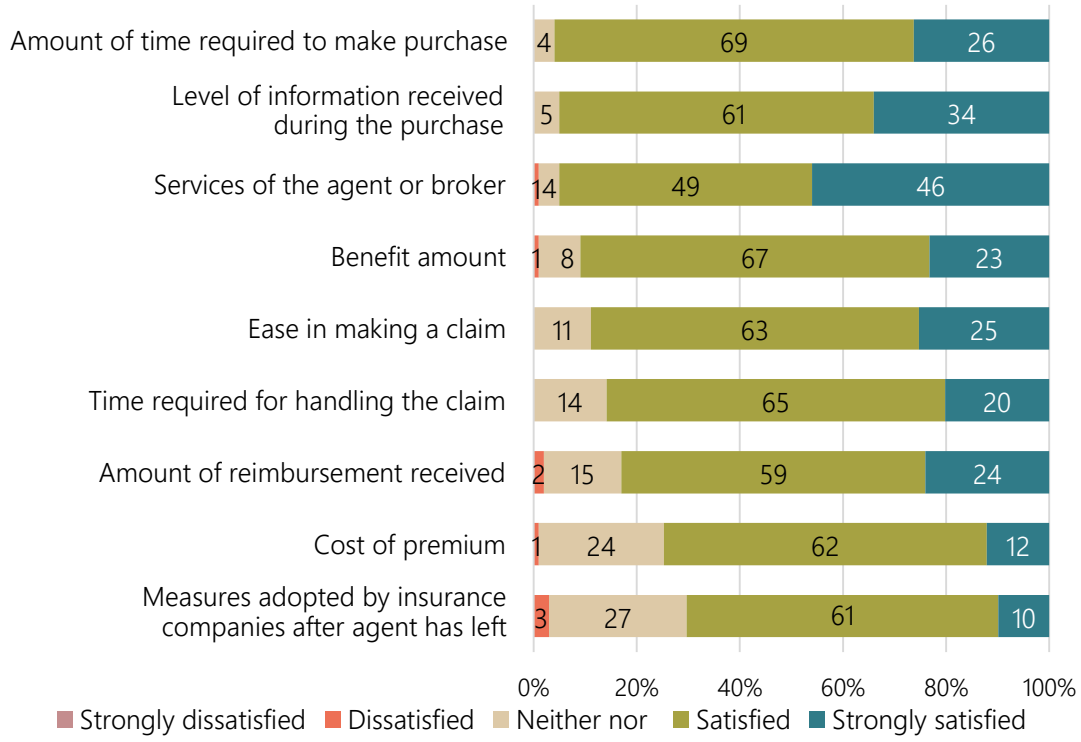
3.2 Consumer Perception

Satisfaction towards PHI

In general, the respondents were more satisfied with the services of their insurance companies at the purchasing stage than the post-purchasing stage. For example, over 90% of the respondents were satisfied or strongly satisfied with "amount of time required to make a purchase" (95%) and "level of information received during the purchase" (95%) as shown in Figure 4.

On the flip side, when it came to filing a claim after purchasing PHI, a lesser proportion of the respondents (claimants) were satisfied or strongly satisfied with "ease in making a claim" (88%) and "time required for handling the claim" (85%). The satisfaction level was even lower when there was a change in the insurance agent. Only 71% of the respondents were satisfied or strongly satisfied with the measures adopted by the insurance company after the insurance agent responsible for their policies had left, implying the high reliance of the policyholders on insurance agents as the conduit of communication with the insurance companies.

Figure 4: Satisfaction level towards the various aspects of the services provided

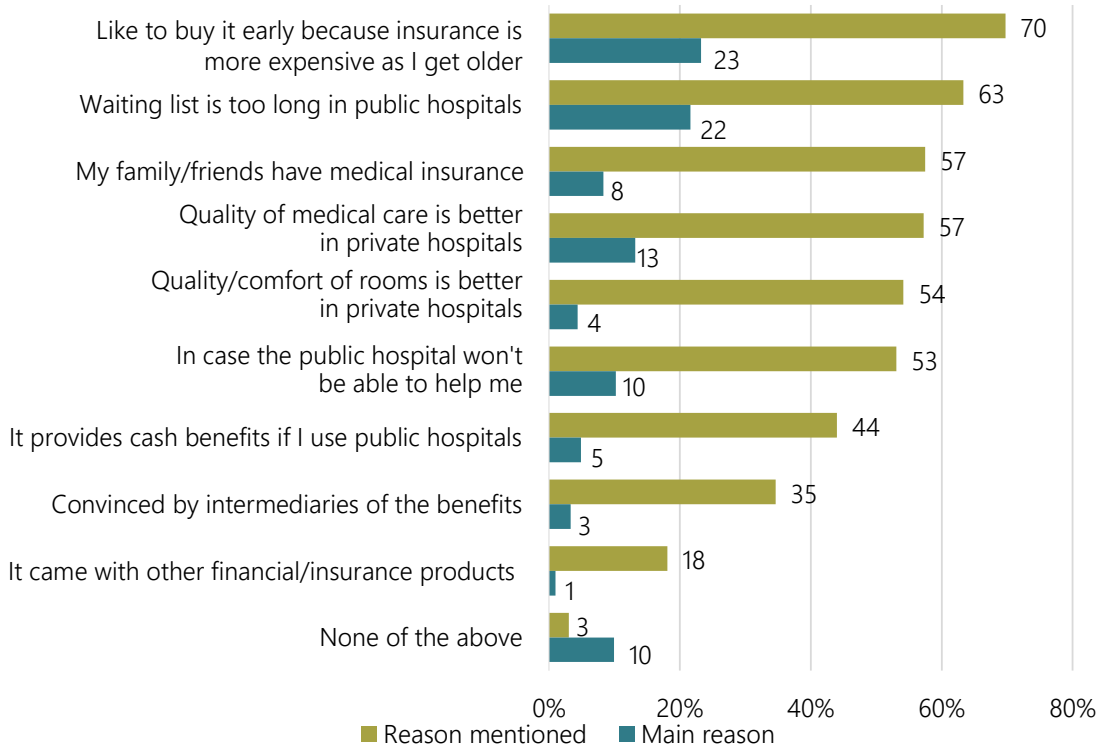


(Claimant survey, n= 205.)

Reasons for Purchasing PHI

When asked for the reasons they purchased PHI, a majority of the respondents indicated that "I would like to buy it early because insurance is more expensive as I get older" (70%) as one of the reasons, followed by "waiting list is too long in public hospitals" (63%), "my family/friends have medical insurance" (57%) and "quality of medical care is better in private hospitals" (57%) (Figure 5).

Figure 5: Reasons for buying PHI



(Establishment survey, n= 473. For reason mentioned, multiple answers were allowed.)

While all age groups shared higher premiums at older age as their top concern, it is noted that respondents aged 55 – 64 expressed the greatest concern about this issue (78%) compared to other age groups (Figure 6). For older respondents aged 65 or above, they were as concerned about higher premiums as they were worried about long waiting lists of public healthcare services and believed there was better quality of healthcare services in private hospitals (all 69%).

Figure 6: Reasons for buying PHI – by age group

Age group	Like to buy it early because insurance is more expensive as I get older	Waiting list is too long in public hospitals	My family/friends have medical insurance
18-34	69%	58%	61%
35-44	71%	61%	59%
45-54	64%	68%	51%
55-64	78%	64%	60%
65 or above	69%	69%	59%
Age group	**Quality of medical care is better in private hospitals**	**Quality/comfort of rooms is better in private hospitals**	**In case the public hospital won't be able to help me**
18-34	56%	50%	51%
35-44	53%	53%	56%
45-54	58%	51%	55%
55-64	59%	63%	46%
65 or above	69%	69%	59%

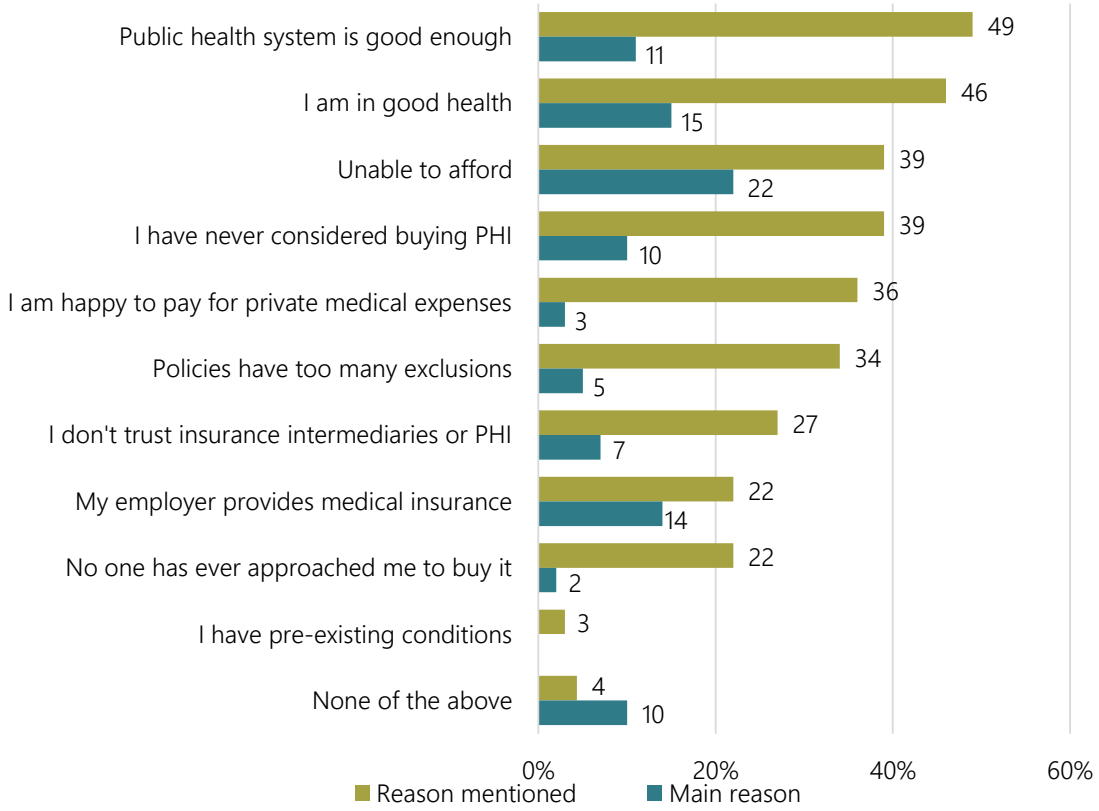
(Establishment survey, n= 473. Multiple answers were allowed.)

Reasons for NOT Purchasing PHI

In contrast, 49% of the respondents who did not purchase any PHI claimed it was because they were satisfied with the public healthcare system (Figure 7). This implies the respondents who had bought PHI and those who had not, view the quality and services of public and private healthcare systems differently. Other common reasons for not purchasing PHI were "I am in good health" (46%), "unable to afford" (39%) and "I have never considered buying PHI" (39%). "Policies have too many exclusions" accounted for 34% of the reasons hindering consumers from purchasing PHI.

It is worth noting that affordability was the most important reason for not purchasing PHI amongst all the respondents (22%) (Figure 7). Of all the respondents, the older respondents expressed greater concern over affordability of PHI (Figure 8).

Figure 7: Reasons for not buying PHI



(Establishment survey, n= 527. For reason mentioned, multiple answers were allowed.)

Figure 8: Reasons for not buying PHI – by age group

Age group	Public health system is good enough	I am in good health	Unable to afford
18-34	49%	58%	31%
35-44	52%	38%	23%
45-54	53%	30%	39%
55-64	51%	50%	51%
65 or above	37%	39%	60%

Age group	Policies have too many exclusions	I don't trust insurance intermediaries or PHI	My employer provides medical insurance
18-34	35%	27%	26%
35-44	26%	16%	40%
45-54	28%	21%	29%
55-64	42%	43%	12%
65 or above	37%	26%	

(Establishment survey, n= 527. Multiple answers were allowed.)

46% of the respondents cited their current good health as a reason for not buying PHI (Figure 7). This percentage was much higher for the younger respondents; 58% of the respondents aged 18 – 34 (Figure 8) cited this reason. 37% of respondents aged 65 or above cited "policies have too many exclusions". The proportion of respondents aged 55 – 64 (43%) and 35 – 44 (40%), who cited "I don't trust insurance intermediaries or PHI" and "my employer provides medical insurance" respectively, were the highest amongst other age groups.

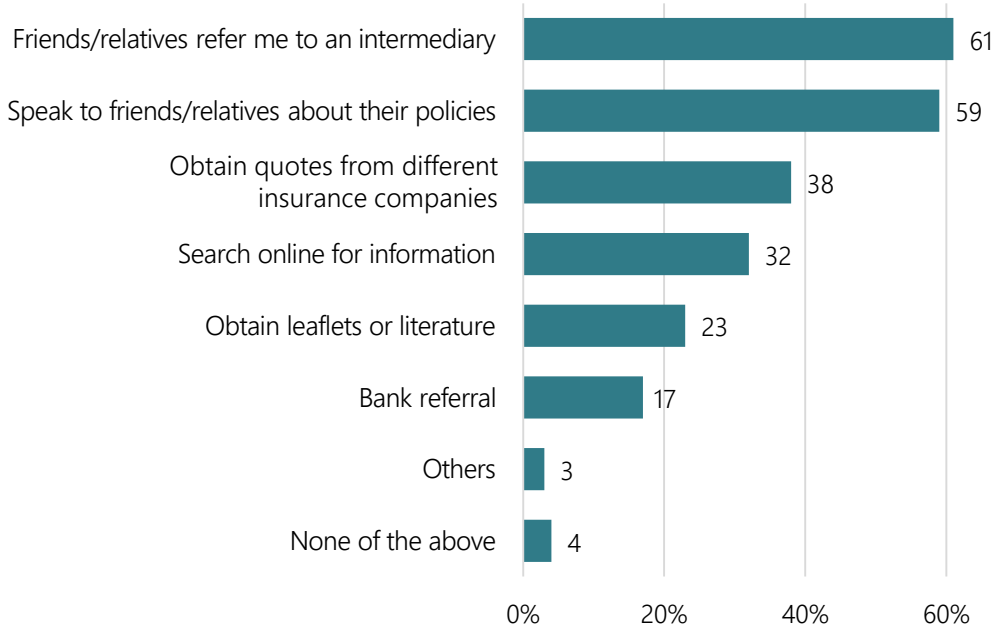
3.3 Consumer Purchasing Journey

At the Pre-purchase Stage

Information Sources

The respondents were asked what information sources they used when looking for PHI. It was found friends and relatives played a significant role in the search process; 61% of the respondents obtained information from insurance intermediaries referred by their friends or relatives, and 59% spoke to their friends or relatives about their policies (Figure 9). Comparatively, lesser people shopped around; approximately one-third of the respondents obtained quotes from different insurance companies (38%) and searched for information from the internet (32%).

Figure 9: Sources of information used before purchase



(Establishment survey, n= 473. Multiple answers were allowed.)

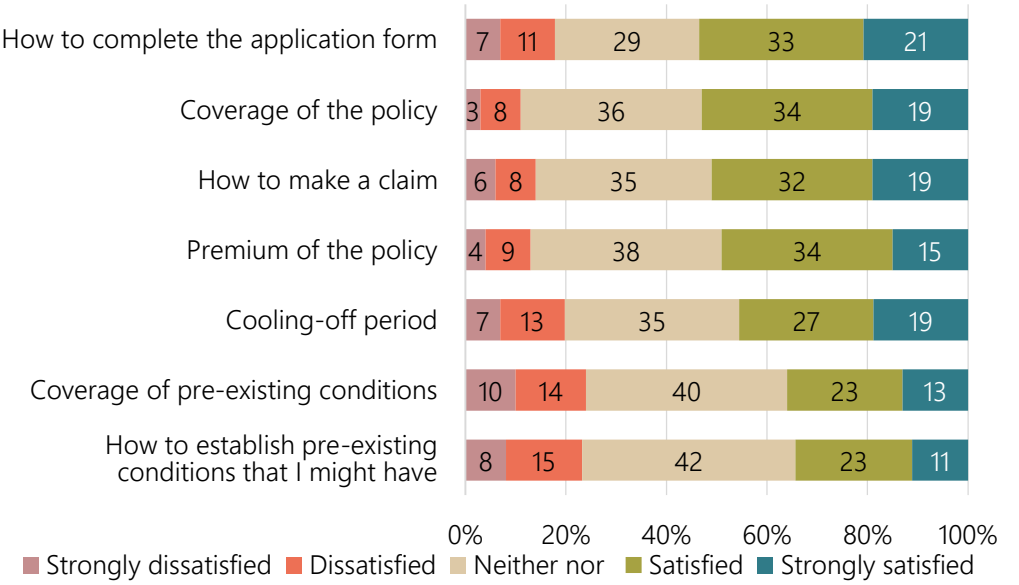
During the Purchasing Stage

Explanations of Policy Applications

When asked whether insurance intermediaries provided information at a satisfactory level during the purchasing process (based on their last purchase experience), slightly over half of the respondents claimed that they were satisfied or strongly satisfied on the aspects related to "how to complete the application form" (54%), "coverage of the policy" (53%) and "how to make a claim" (51%) (Figure 10).

Respondents expressed a lower satisfaction rate over information provided regarding policy limitations that could affect claim results, for instance, "coverage of pre-existing conditions" (36%) and "how to establish pre-existing conditions that I might have" (34%).

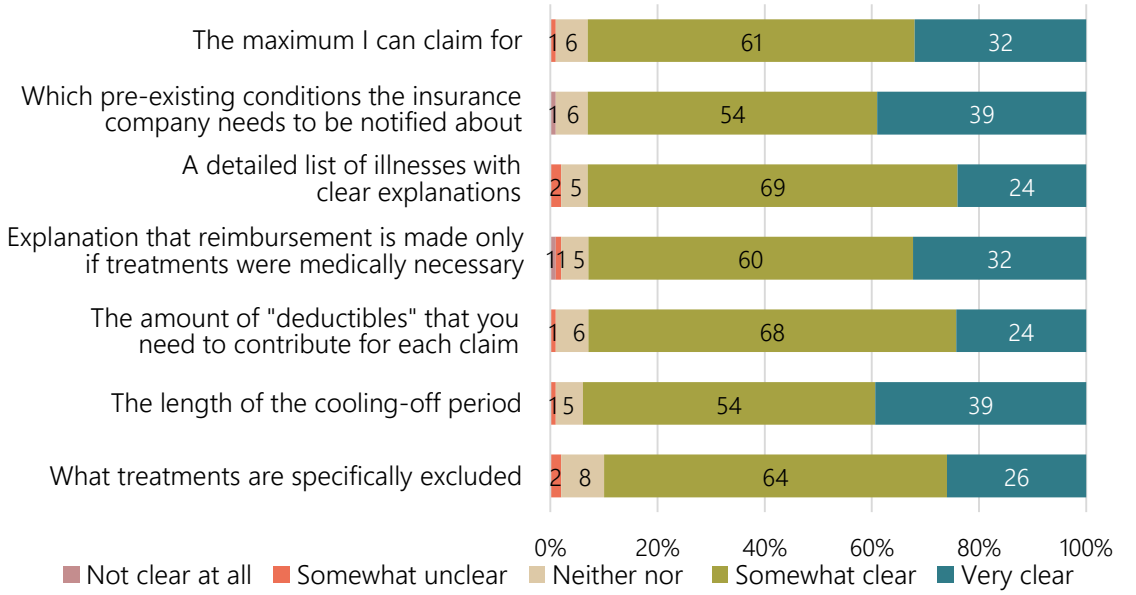
Figure 10: Satisfaction level towards information provided by insurance intermediaries



(Establishment survey, n= 401.)

A similar observation was found in the claimant survey, implying a lower understanding of limitations within policies. "What treatments are specifically excluded" was the item which had the least number of respondents claiming it was somewhat clearly or very clearly explained (90%) compared to the other survey question responses (92% – 93%) (Figure 11). Interesting enough, while "which pre-existing conditions the insurance company needs to be notified about" and "the length of the cooling-off period" both recorded a 39% "very clear" response from the respondents, these two options also recorded the lowest "somewhat clear" response (54%) from the respondents.

Figure 11: Clarity of information explained by insurance intermediaries

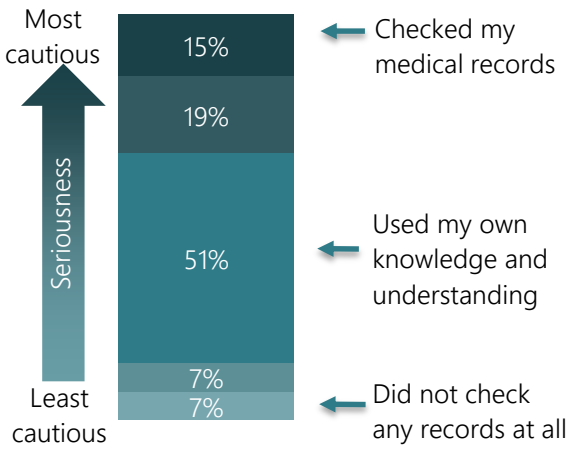


(Claimant survey, n= 205.)

Filling in of the Health Declaration Form

Respondents were asked how cautious they were when filling in PHI health declaration forms. 51% claimed that they only answered to the best of their knowledge and understanding of their own health condition (Figure 12). On the opposite end of the spectrum, only 15% of the respondents checked their medical records, and 7% did not check any records at all.

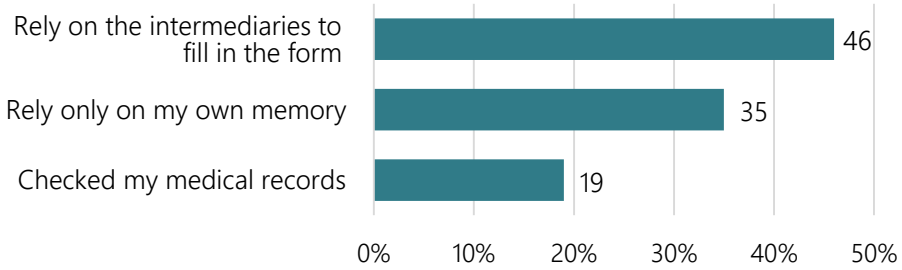
Figure 12: Level of care taken by respondents to fill in the health declaration form at time of purchase



(Establishment survey, n= 473.)

A similar finding was found in the claimant survey. When PHI holders were asked how they ensured their health declaration forms were accurately filled at time of purchase, most relied on the insurance intermediaries (46%) or their own memory (35%) to fill in the form (Figure 13). Less than one-fifth (19%) of the respondents checked their medical records, showing there is much room for consumer education improvement and communication from insurance intermediaries to strengthen more accurate disclosure in this area.

Figure 13: How to ensure health declaration form was accurately filled at time of purchase



(Claimant survey, n= 205.)

From a consumer protection perspective, it is highly undesirable for consumers to rely solely on their own memory or insurance intermediaries when making health declarations. Incomplete disclosure or misrepresentation of medical information may lead to declined claim applications or termination of insurance policies by the insurance company. Given these possible outcomes, information accuracy in health declarations form is of paramount importance.

At the Post-purchase Stage

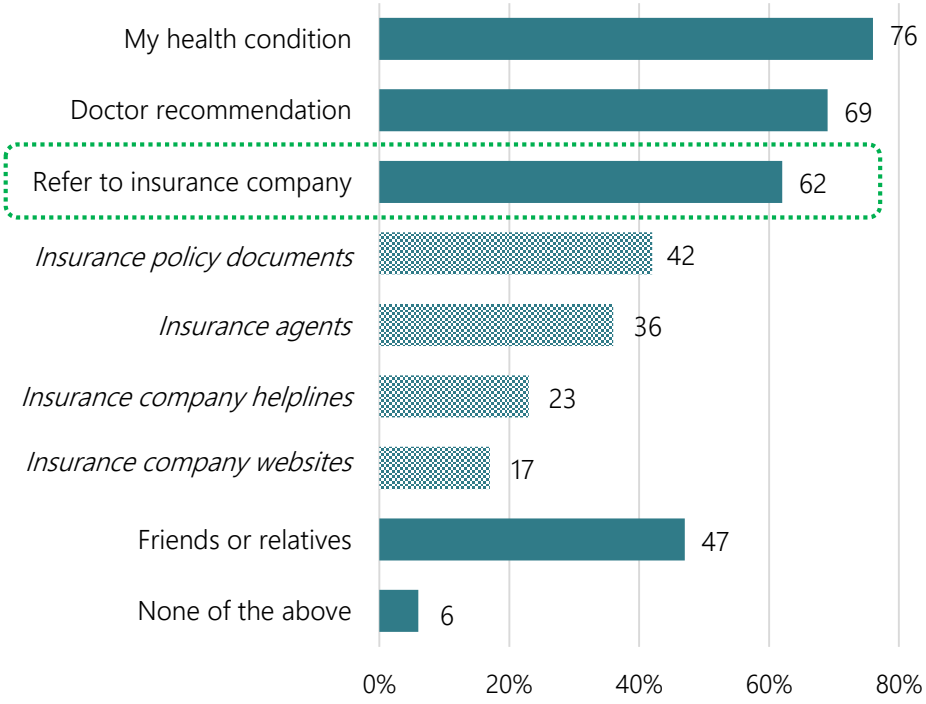
Channels for Establishing the Necessity of Medical Treatment

When asked how respondents decided the necessity of medical treatment for a condition, 76% of the respondents said they assessed the necessity by themselves based on their health condition (Figure 14). 69% of the respondents said they relied on doctor recommendations, 62% referred to insurance companies and 47% checked with friends or relatives.

Of those who consulted insurance companies, most referred to the insurance policy documents (42%), some consulted insurance agents (36%), insurance company helplines (23%) and websites (17%).

It is worth noting that 38% of the respondents did not consult the insurance companies beforehand, and 6% did not consult any channels at all to establish the necessity of medical treatment.

Figure 14: Channels used to check necessity of medical treatment



(Establishment survey, n= 401. Multiple answers were allowed.)

On the claimant survey, 94% of the respondents claimed they had consulted insurance intermediaries or companies to establish whether treatments were covered by their policies (Table 4). Almost equally, 93% of the respondents approached medical practitioners on whether hospitalisation was justified. It is worth noting that across all items, only a handful (1% – 7%) of respondents sought advice from both medical practitioners and insurance intermediaries/companies at the same time.

Table 4: Sources approached for information before receiving treatment

	Which doctor to use	Whether hospitalisation was justified	Soft quotation of likely cost	Whether the treatment was covered by policy	Cash limit / reimbursement limit
Insurance agent, broker or company	59%	8%	24%	94%	95%
- Insurance agent	55%	7%	18%	84%	84%
- Insurance broker	3%		3%	5%	5%
- Insurance company	4%		5%	7%	10%
Medical practitioner	36%	93%	82%	9%	3%
Bank Staff	2%			3%	3%
Not applicable	10%	2%			

(Claimant survey, n = 205. Multiple answers were allowed.)

Most PHI policies contain a "medically necessary" clause. This clause is one of the problems encountered by policyholders. It is common for insurance companies to determine whether the treatment is considered "medically necessary" under the definition set out in the policy instead of relying on an attending medical practitioner's recommendations. Policyholders, in most cases, would not know who determines "medically necessary".

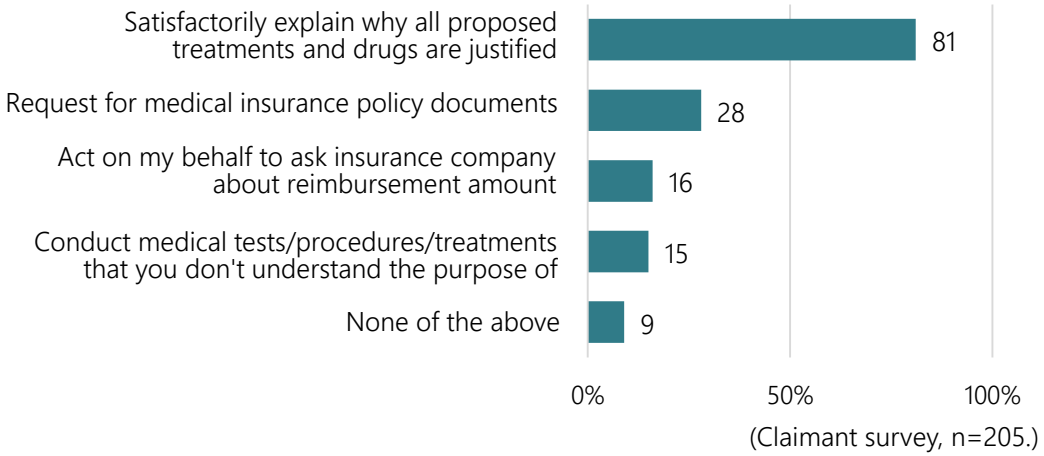
In other words, whether a treatment is deemed "medically necessary" by an insurance company is one of the most common factors influencing claim results. In some cases, there may be different views regarding the necessity of hospitalisation and a specific medical treatment between the medical practitioner, insurance company and policyholder. This discrepancy often leads to an unsuccessful claim and consumer dispute, as discussed in Chapter 4 regarding consumer complaints and vulnerability.

Role of the Medical Sector

In a survey question, the respondents were asked to revisit the actions taken by medical practitioners or staff, including medical doctors/specialists, nursing staff and administrative staff before they received treatment. 81% of the respondents said medical practitioners or staff had explained the necessity of the treatment/drugs in a satisfactory manner (Figure 15). This satisfaction is encouraging as it suggests most medical practitioners or staff were doing their job to explain the purpose and necessity of the treatment. In addition, this may also provide some hints to a possible source of consumer disputes, as what is considered "medically necessary" treatment usually rests on the discretion of the insurance companies.

28% of the respondents reported they were asked by medical practitioners to disclose their insurance policy documents and 16% had medical practitioners or staff acted on their behalf to enquire about treatment reimbursement amounts with the insurance company. There is doubt whether these practices benefit the insured; the medical practitioner may take the chance to offer medical treatment that may not be necessarily needed by the patient or charge a price higher than the usual rate, which is then eventually paid by the patient's PHI.

Figure 15: Actions taken by medical practitioners or staff



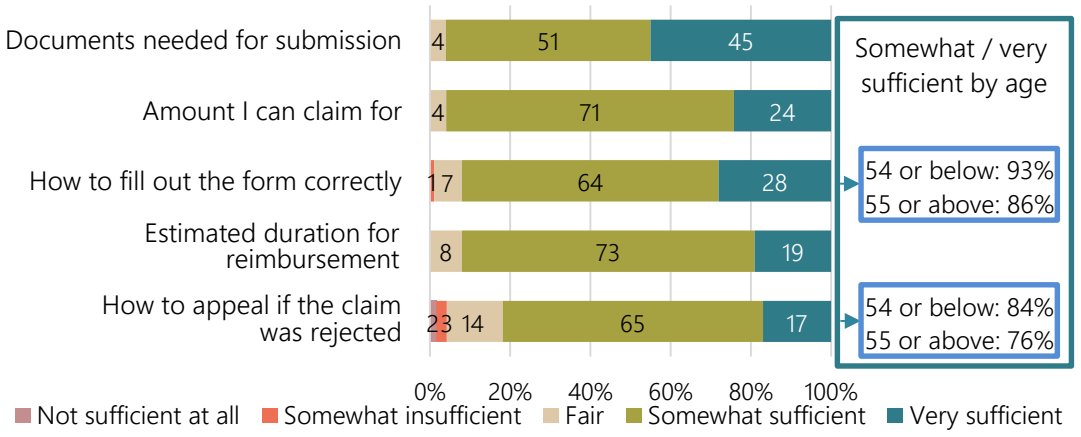
(Claimant survey, n=205.)

Making a Claim

In the claimant survey, the respondents were asked whether they had sufficient information needed to file a claim; over 80% of the respondents considered the provided information regarding claim procedure somewhat sufficient or very sufficient (Figure 16). The least sufficient information provided was "how to appeal if the claim was rejected"; 5% of the respondents felt the information was somewhat insufficient or not sufficient at all.

Regarding "how to appeal if the claim was rejected", fewer respondents aged 55 or above (76%) than respondents aged 54 or below (84%) responded that the information was somewhat sufficient/very sufficient. A similar observation was found on the item "how to fill out the form correctly".

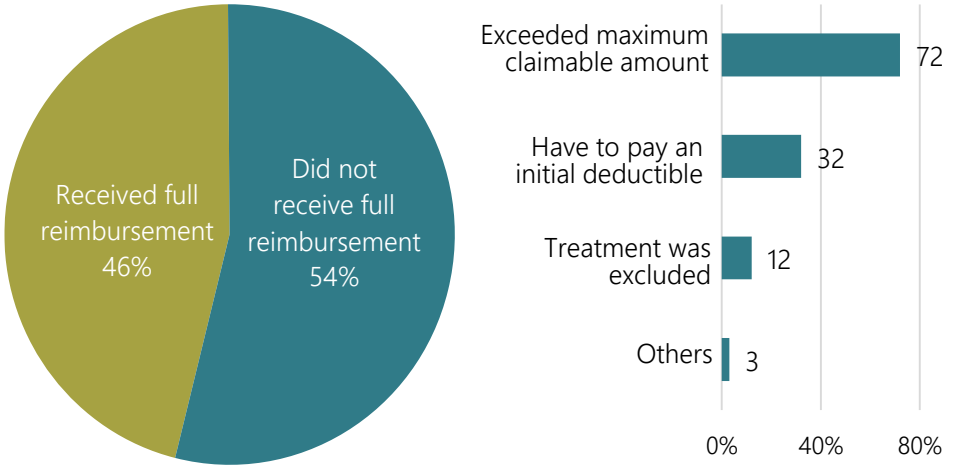
Figure 16: Whether sufficient information was available when making a claim



(Claimant survey, n=205.)

During their most recent claim, 54% of the respondents said they only received partial reimbursement or no reimbursement at all. The reasons for that were claim amounts exceeded maximum reimbursement limits (72%), claimants needed to pay an initial deductible (32%) and treatments were excluded under the policy (12%) (Figure 17).

Figure 17: Whether full reimbursement was received and reasons for not receiving full reimbursement

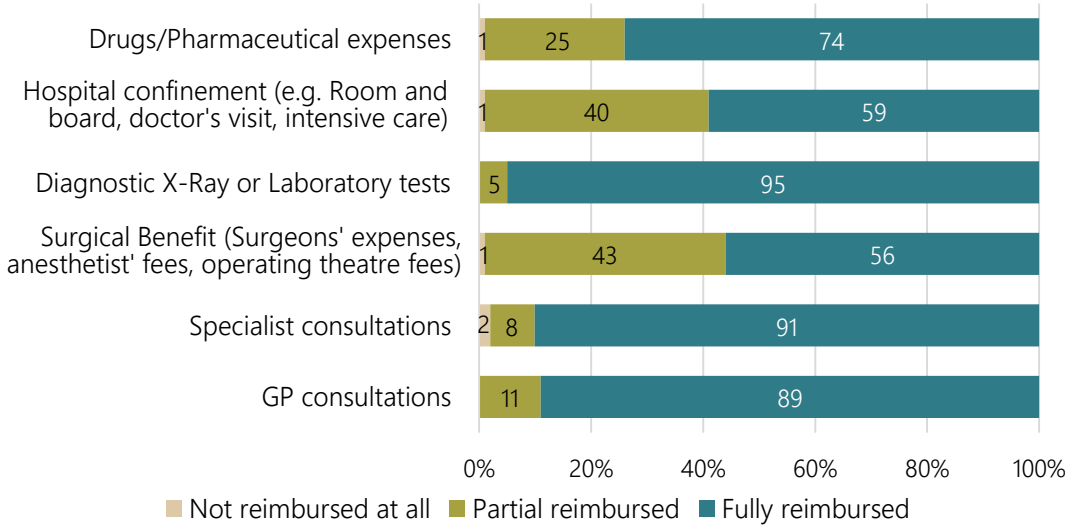


(Claimant survey, n=205. For reasons not receiving full reimbursement, multiple answers were allowed.)

Among the level of reimbursement given for treatment types, 44% and 41% of the respondents said their surgical benefit and hospital confinement respectively received partial or no reimbursement (Figure 18).

On the other hand, diagnostic X-Ray or laboratory tests, specialist consultations and GP consultations were the items that were more likely to receive full reimbursement.

Figure 18: Level of reimbursement – by treatment received

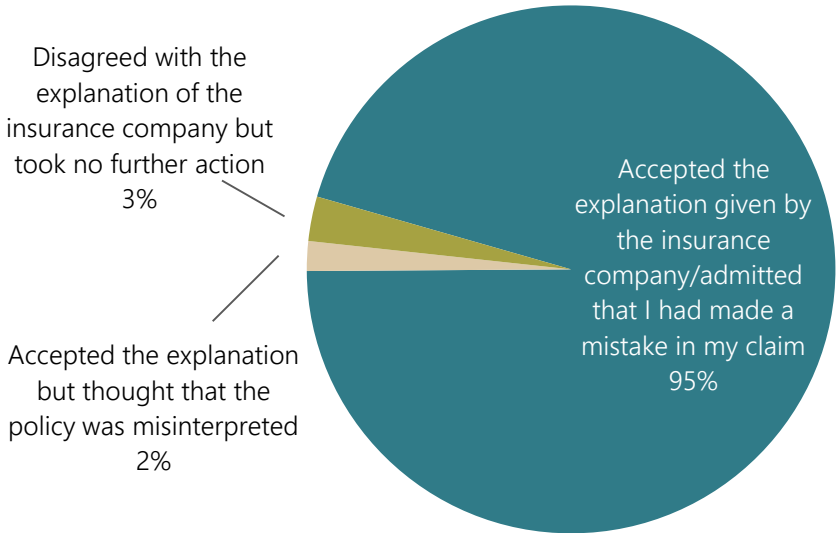


(Claimant survey, n = 205.)

Filing a Complaint

Among the respondents who did not receive full reimbursement, 95% accepted explanations given by the insurance companies or admitted they had made a mistake in their claim applications, 2% accepted explanations but felt the insurance company concerned had twisted the meaning of the terms and conditions of the policy (Figure 19). Those did not agree with the explanations were a minority 3% but did not take further action.

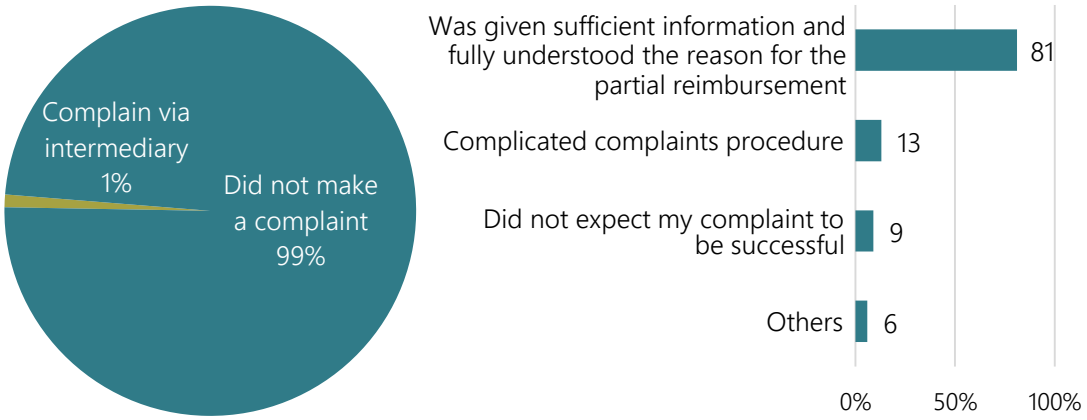
Figure 19: Reaction to the explanation given by the insurance company for not receiving full reimbursement



(Claimant survey, n=110.)

Respondents who did not receive full reimbursement were further asked if they lodged any complaints to existing channels in Hong Kong (Figure 20). 99% said they did not lodge any complaint. Within this group, 81% felt they were given sufficient information and fully understood the reasons for the partial reimbursement. However, it is also worth noting that 13% of the respondents within this group were deterred from filing a complaint due to complicated complaint procedures and 9% refrained because they did not expect the complaint to be successful.

Figure 20: Action taken – respondents who did not receive full reimbursement and reasons for not making a complaint

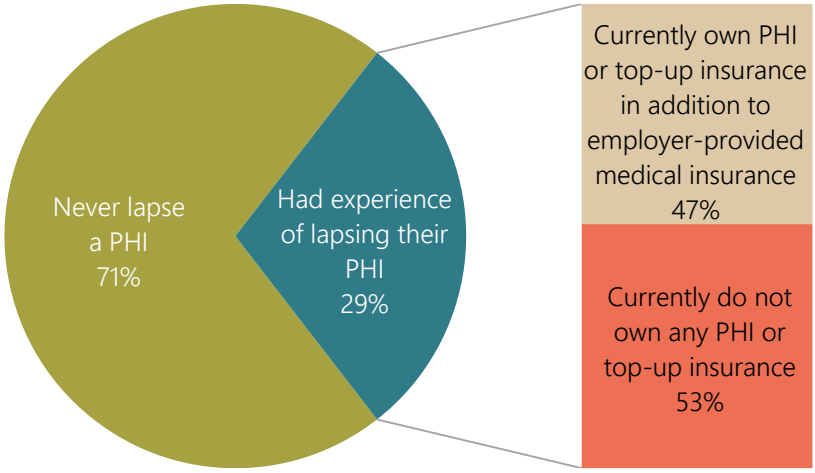


(Claimant survey, n=110. For reasons not making a complaint, multiple answers were allowed.)

Renewal of PHI

Amongst respondents who had purchased PHI, 71% of them did not have experience in letting their policies lapse, indicating the majority of PHI owners preferred to renew upon expiry (Figure 21). Of the 29% respondents who previously had lapsed PHI, 47% of them had another PHI and 53% of them had not taken out any PHI thereafter.

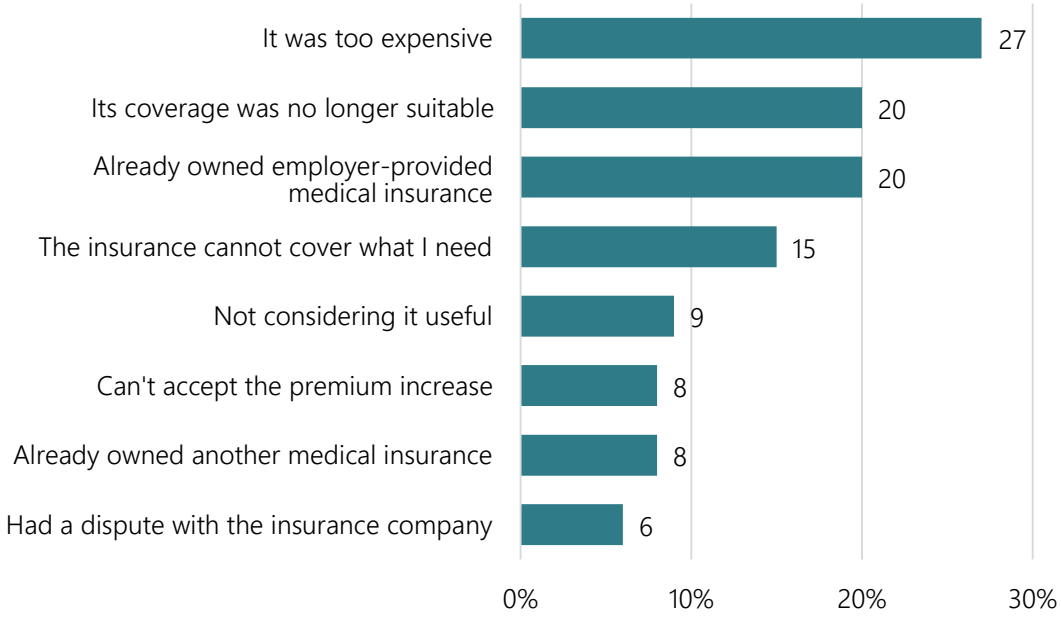
Figure 21: Experience on not renewing PHI – with breakdown on current ownership of PHI



(Establishment survey, n= 473.)

Top reasons given for not renewing PHI were "it was too expensive" (27%), "its coverage was no longer suitable" (20%) and "already owned employer-provided medical insurance" (20%) (Figure 22). This result echoes previous findings, where cost was the most important reason for not purchasing any PHI (Figure 7). (Major response when asked what was the main reason: unable to afford, 22%).

Figure 22: Reasons for not renewing PHI



(Establishment survey, n= 137. Multiple answers were allowed.)

When comparing respondents with lapsed PHI, discrepancies could be observed amongst different age groups. The proportion of older respondents with lapsed PHI due to expensive premiums were substantially higher than that of younger respondents; 76% for aged 65 or above and 41% for respondents aged 55 – 64 compared to not more than 21% for all age groups from 18 – 54 (Figure 23).

Compared to all other age groups, respondents aged 65 or above were notably more concerned about PHI premium surges (48%). A similar observation was found concerning policy coverage; compared to all other age groups, a markedly higher proportion of respondents aged 65 or above (48%) did not renew their PHI due to unsuitable coverage.

For respondents aged 65 or above, expensive premiums, unacceptable premium increases and unsuitable medical insurance coverage were the key reasons for their lapsed policies. This may indicate a barrier that hinders or limits their access to the PHI market.

As for the respondents aged 35 – 44, the top two reasons cited for not renewing PHI were "already owned employer-provided medical insurance" and "the insurance cannot cover what I need".

Figure 23: Reasons for not renewing PHI – by age group

Age group	It was too expensive	Its coverage was no longer suitable	Already owned employer-provided medical insurance
18-34	21%	28%	20%
35-44	16%	18%	36%
45-54	20%	14%	16%
55-64	41%	16%	16%
65 or above	76%	48%	

Age group	The insurance cannot cover what I need	Not considering it useful	Can't accept the premium increase
18-34	14%	3%	3%
35-44	35%	10%	13%
45-54	14%	10%	4%
55-64	4%	13%	4%
65 or above			48%

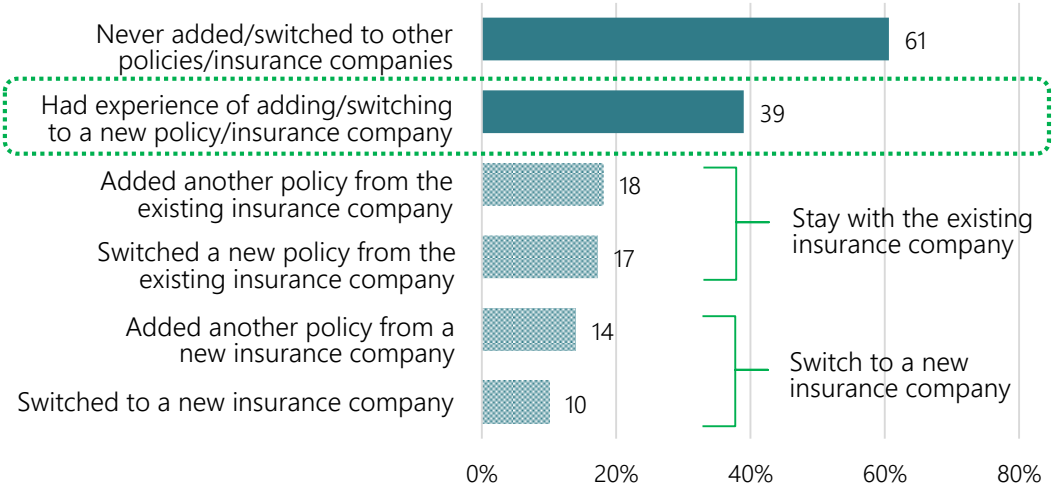
(Establishment survey, n= 137. Multiple answers were allowed.)

Many complaint cases received by the Council regarding PHI premium increase are related to elderly consumers aged 55 or above. This was explored further with in-depth interviews and discussed in Chapter 4.

Triggers for Switching to a New Policy/Purchasing an Extra Policy

When asked, 61% of the respondents had not switched from initial insurance companies or purchased other policies from new insurance companies (Figure 24). Amongst the remaining respondents, more of them had chosen to add another policy or switch to a new one from their existing PHI provider rather than switch to a new company, showing low consumer mobility in the PHI market. This may be due to the reason that their main contact is the intermediaries; thus the ability to compare policies by themselves is weak and thus less mobile.

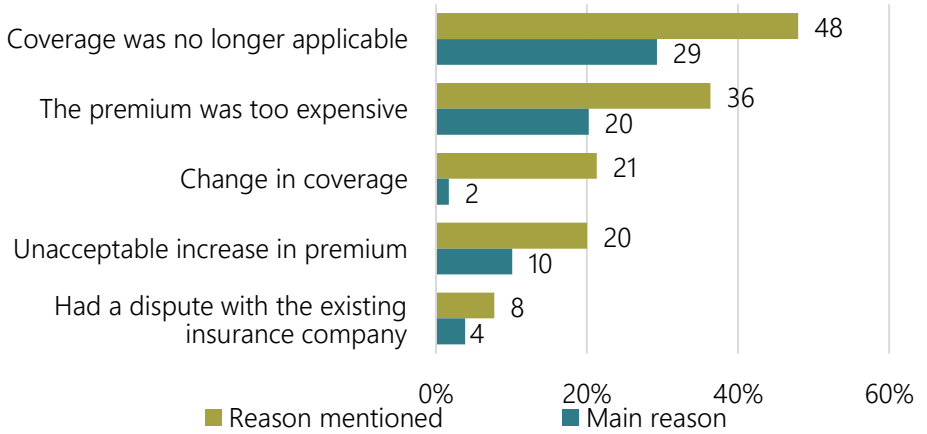
Figure 24: Experience of switching to new policies/insurance companies



(Establishment survey, n=473. Multiple answers were allowed.)

Only 10% had experience switching to a new insurance company. The reasons were "coverage was no longer applicable" (48%), "the premium was too expensive" (36%), "change in coverage" (21%) and "unacceptable increase in premium" (20%) (Figure 25). Out of this group, only 8% of the respondents cited past unpleasant experiences (e.g. dispute) with their insurance company as one of the reasons for switching companies.

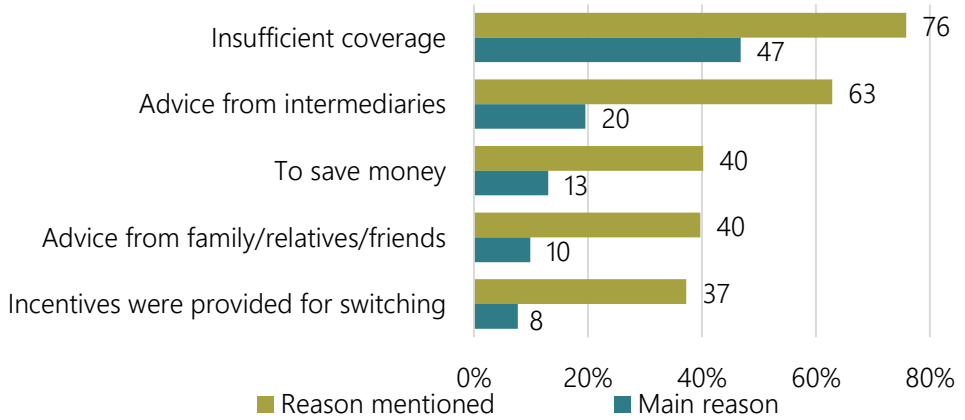
Figure 25: Reasons for switching to a new insurance company



(Establishment survey, n= 47. For reason mentioned, multiple answers were allowed.)

Expensive premiums and coverage were also among the top three triggers for respondents who had switched to a new policy within the same insurance company. Over three-fourths (76%) of respondents indicated insufficient coverage was one of the reasons for switching, followed by "advice from intermediaries" (63%), "to save money" (40%) and "advice from family/relatives/friends" (40%) (Figure 26).

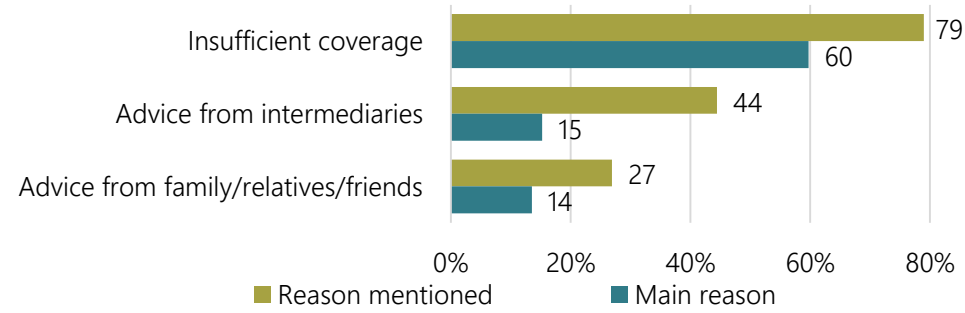
Figure 26: Reasons for switching to a new plan from the existing insurance company



(Establishment survey, n= 82. For reason mentioned, multiple answers were allowed.)

For respondents who bought an extra policy from their existing insurance company (18%) or a new insurance company (14%) (Figure 24), "insufficient coverage" was one of the triggers for the secondary purchase (79%). "Advice from intermediaries" (44%) and "advice from family/relatives/friends" (27%) were reasons also commonly given by the respondents (Figure 27).

Figure 27: Reasons for purchasing an extra policy from the existing insurance company or from a new insurance company



(Establishment survey, n= 118. For reason mentioned, multiple answers were allowed.)

Results show policy coverage, premium costs, and advice from intermediaries, relatives or friends were consistently ranked by the respondents as major reasons when they purchased an extra policy or switched policies or insurance companies.

3.4 Summary

Overall, research finds that consumers have a relatively high service and information provision satisfaction rate towards insurance companies and insurance intermediaries at the pre-purchase stage. Nevertheless, the Council receives PHI complaints from consumers from time to time. Chapter 4 looks into what may trigger consumer disputes at the post-purchase stage, as the consumer grievances relate to after-sales services and claim results.

This consumer research also highlights that premium increase and affordability of PHI can be a major concern as close to 30% of the respondents who did not renew policies suggested it was too expensive for them. This was also the main reason given by the older respondents who let their policies lapse.

"Non-disclosure" and "medically necessary", discussed in later chapters, are two of the most common subject of consumer disputes. Consumer research reveals many respondents may not have taken a sufficient level of conscientiousness when filling in health declaration forms for insurance companies; less than 20% of them had checked their medical records for accuracy at the time of purchase. Before treatment, most respondents relied on self-assessment and medical practitioner recommendations to decide whether a treatment is necessary for their health. However, insurance companies do not always rely on the attending doctor's recommendations when they determine what is "medically necessary", and therefore whether they will provide the indemnity. This is shown in upcoming case studies.

4 Consumer Vulnerability and Disputes over PHI

Study of medical insurance complaint cases and in-depth interviews revealed major areas of consumer grievances and disputes:

- Claim-related grievances: (1) poor understanding of policy terms and conditions (e.g. medically necessary, non-disclosure, pre-existing conditions, excluded items, etc.); (2) uncertainty of reasoning behind insurance companies' judgement of what constitutes a medical need; and (3) inaccurate information/verbal advice from insurance agents on eligibility of claims.
- Non-claim related grievances: (1) unexpected increase in premium/loading; (2) imposition of excluded items; (3) policy application refusal; (4) improper handling of policy termination; (5) auto-renewal/auto-transaction of premium; and (6) administrative delay and poor service quality.

Consumers have expectations of: (1) accessibility and continuity of the same medical insurance policy; and (2) transparent changes of premium/policy terms and conditions. These are critically important to elderly consumers due to their limited income and reliance on financial protection for medical expenses.

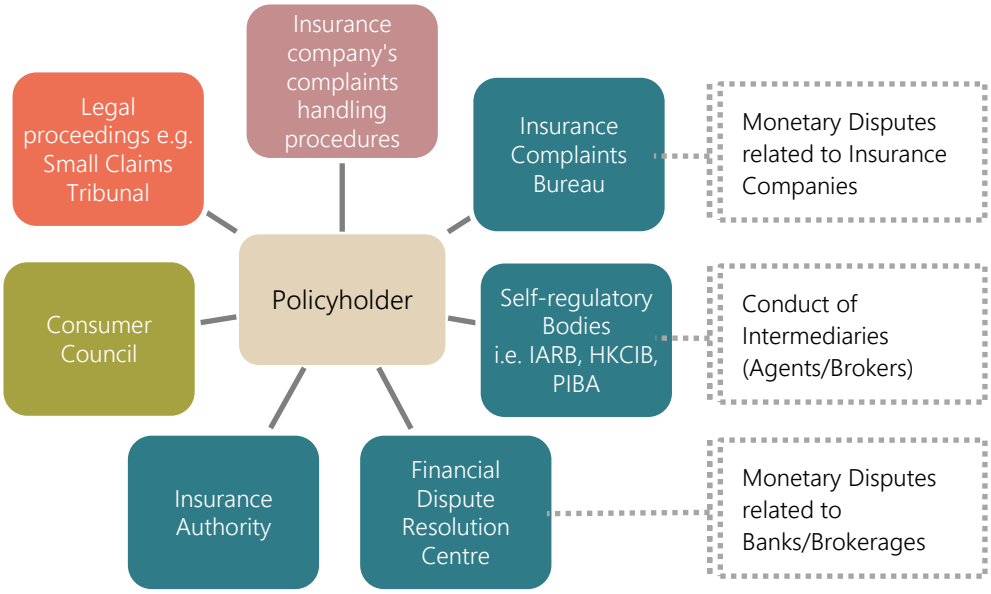
More work can be done by insurance companies to promote good practices in the industry, enhance consumer protection and empower consumers to improve their knowledge on PHI.

This Chapter delves into the types of consumer complaints that lead to disputes as well as common policy terms involved in complaints. Given Hong Kong's ageing population, the Chapter also looks into problems encountered by elderly consumers when they seek or engage in medical insurance for healthcare protection. Findings from the Council's in-depth interviews with claimants and elderly consumers and analysis of selected complaint cases available from the Council's database are discussed.

4.1 Existing Complaint Avenues

In Hong Kong, there are various channels for a dissatisfied insurance policyholder to make a complaint. Besides approaching the insurance company concerned[34] to lodge a complaint, a complainant may go to alternative dispute resolution mechanisms depending on the nature of the complaint and the type of financial institution and/or intermediary involved (Figure 28). From the complainant's perspective, it can be time consuming and inconvenient, if not confusing, to go through multiple steps to file a complaint if it involves both claim and conduct related disputes.

Figure 28: Existing channels for handling insurance complaints in Hong Kong



Below is a list of possible channels available to a complainant:

If the complaint is a monetary dispute:

- The complainant can lodge a complaint to the Insurance Complaints Bureau (ICB) if the insurance product is purchased from an insurance company which is a member of the ICB and the policy concerned is a personal insurance contract;
- The complainant can lodge a complaint to the Financial Dispute Resolution Centre (FDRC) if the insurance product is purchased from a bank/brokerage which acts in the capacity of insurance agent selling insurance products.

[34] Under the Code of Conduct for Insurers issued by the Hong Kong Federation of Insurers (HKFI), insurance companies are required to have effective procedures in place for the proper handling of insurance complaints. In general, if a policyholder has a question about the insurance policy or services provided, the respective insurance agent will help handling the enquiry on application/claim process, or claim results. If one is not satisfied with the agent's explanation, he/she may lodge complaint to the insurance company concerned. In case the insurance company has made its final decision on a complaint and that its reply or explanation given is still not satisfied by the policyholder, the policyholder may proceed to seek help from alternative dispute resolution mechanisms.

If the complaint is related to the conduct of insurance intermediaries:

- The complainant may, under the present arrangement,[35] lodge a complaint with the following self-regulatory organisations (SROs)[36] of which the intermediary concerned is a member and is subject to its regulation:
  - Insurance Agents Registration Board (IARB);
  - Hong Kong Confederation of Insurance Brokers (HKCIB);
  - Professional Insurance Brokers Association (PIBA).
- The complainant may also file the complaint to the below or take the matter to the arbitration or legal proceedings:
  - Insurance Authority (IA);[37]
  - Consumer Council.

4.2 Overview of the Complaint Statistics

The following provides the medical insurance complaint statistics from the ICB (the then Insurance Claims Complaints Bureau) and the Council. From 2015-2018, medical insurance complaints reported by the ICB and the Council were 748 and 426 respectively. Complaints data shows that most complaints were related to the application of policy terms, non-disclosure, excluded items, price dispute, and provision of inaccurate information.

Statistics published by other sources, such as the IARB, HKCIB, PIBA, FDRC and IA, cover insurance policy complaints of all types, and the breakdown for medical insurance complaints are not available in the public domain (Appendix 1 provides details of the respective complaint statistics on overall market).

It should also be noted that the statistics listed below represent only a part of consumer problems with medical insurance; some consumers may choose not to lodge complaints despite dissatisfaction with insurance products and/or services. As observed from the Council's claimant survey, only 1% of the respondents who were not satisfied with their claim results made a complaint. Having said that, there may be overlap in the complaint statistics as some complainants may have filed their cases to multiple complaint channels.

In the case studies illustrated below, the information presented represents the data that the Council received as far as from the complainants or interviewees.

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[35] At the time this Study Report was prepared, the conduct of insurance intermediaries were still under the regulation of the three SROs. Upon commencement of the new regulatory regime for insurance intermediaries under the Insurance Ordinance, the IA will take over the regulatory functions of the three SROs for insurance intermediaries and become the sole regulator to regulate all insurance intermediaries in Hong Kong. The new regulatory regime is set to commence in the second half of 2019, according to the IA.

[36] Under the self-regulatory regime for insurance intermediaries, insurance agents, their responsible officers and technical representatives need to be registered with and monitored by the IARB set up by HKFI in accordance with the Code of Practice for the Administration of Insurance Agents. As for insurance brokers, they need to be either authorised by the IA or become a member of one of the two approved broker bodies, namely HKCIB and PIBA. Their chief executives and technical representatives are also required to be registered with the IA or the relevant broker body.

[37] The IA is responsible for the regulation of the insurance industry - it maintains an overseer's role to ensure the complaints are properly handled by insurance companies and self-regulated organisations for insurance intermediaries concerned. As such, if a consumer is not satisfied with the way an insurance company or the IARB handles his/her complaint, he/she may lodge a complaint to the IA, which will then conduct the necessary reviews within the confines of the Insurance Ordinance.

The Insurance Complaints Bureau

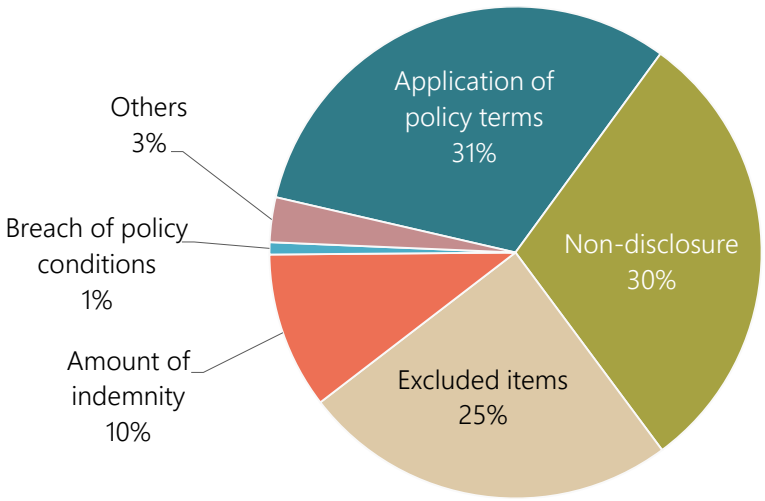
The ICB[38] is an independent organisation initiated by the insurance industry to handle all insurance-related disputes of a monetary nature within its jurisdiction. From 2015 – 2018, the ICB handled and closed 748 complaint cases related to hospitalisation/medical policies; this category comprises almost 50% of the total complaints handled and closed, making it the largest dispute group. Within hospitalisation/medical disputes, the top three categories of complaints were "application of policy terms", "non-disclosure" and "excluded items" (Table 5 and Figure 29).

Table 5: Complaints handled by the ICB – hospitalisation/medical insurance, 2015 – 2018

Nature of Complaints	2015	2016	2017	2018	Total
Application of policy terms	55	65	59	56	235
Non-disclosure	40	56	60	67	223
Excluded items	43	43	56	43	185
Amount of indemnity	24	17	19	17	77
Breach of policy conditions	1	1	4	0	6
Others	4	6	6	6	22
Total	**167**	**188**	**204**	**189**	**748**

Remark: In 2018, 49.7% (94 cases) of the total cases closed (189 cases) were unsubstantiated as considered by the Insurance Claims Complaint Panel. Published data by the ICB was updated to 2018 by the time this Study Report was edited.

Figure 29: Nature of complaints handled by the ICB – claims on hospitalisation/medical insurance, 2015 – 2018



[38] The ICB was inaugurated on 16 January 2018 to supersede The Insurance Claims Complaints Bureau (ICCB). It deals with all insurance-related disputes of a monetary nature (up to HK$1,000,000), from policyholders arising from personal insurance contracts, including claims decision of insurance companies, maladministration of insurance companies and incorrect policy information provided by insurance companies. Claim-related complaints are handled by way of adjudication under the Insurance Claims Complaints Panel while non-claim related complaints are handled by way of mediation provided by the ICB List of Mediators.

Consumer Council

One of the Council's statutory functions is to receive and examine complaints, and to give advice to consumers. The Council also receives complaints from policyholders and acts as a conciliator in an effort to settle the dispute between the consumer and insurance company. From 2015 and 2018, the Council received a total of 426 complaint cases concerning medical insurance. Among them, 299 cases were related to PHI (i.e. individually-purchased medical insurance covering hospitalisation and surgical benefits). The remaining 127 cases were related to other subjects or policy types such as group medical policy, critical illness or dental insurance, etc.

The majority of claim-related complaints involve the terms and conditions of insurance policy contracts. In 2018, these cases accounted for 74% (29 out of 39 cases) of overall claim-related complaints related to PHI. Within these 29 cases, the top 3 types of policy terms-related complaints are "application of policy terms" (41%), "non-disclosure" (28%) and "excluded items" (24%) (Table 6). Tellingly, these are also the main types of complaint cases handled by the ICB.

Since hospital insurance is the primary type of medical insurance complaints as observed by the Council, the rest of the Chapter discussion focuses on this area.

Table 6: Medical insurance complaints received by the Consumer Council, 2015 - 2018

Nature of Complaints	2015	2016	2017	2018	Total
Individually-purchased indemnity hospital insurance	**102**	**62**	**67**	**68**	**299**
Claim related					
Application of policy terms	4	8	11	12	35
Non-disclosure	8	1	8	8	25
Excluded items	5	6	6	7	24
Amount of indemnity	3	3	2	2	10
Delay in claim settlement	6	6	7	9	28
Others	4	1	1	1	7
Subtotal	30	25	35	39	129
Non-claim related					
Price dispute (e.g. premium increase, premium charged without consent)	23	20	12	10	65
Quality of services	29	11	12	10	62
Sales practices	8	3	4	3	18
Variation/Termination of contract	5	2	3	4	14
Late/Non-delivery/Loss	7	0	0	0	7
Others	0	1	1	2	4
Subtotal	72	37	32	29	170
Others [1]	43	34	28	22	127
Total	**145**	**96**	**95**	**90**	**426**

[1] This relates to group policies, accident insurance, critical illness insurance, dental benefits, hospital cash benefits, outpatient benefits and travel insurance.

4.3 Problems Encountered by Consumers

According to the complaints received and the in-depth interviews conducted with the claimants and the elderly, common grievances as observed by the Council stem from the following:

Claim related complaints	Non-claim related complaints
Gap in understanding ("medical necessary", "material non-disclosure")	Unexpected increase in premium/loading
Uncertainty as to judgment made on medical needs	Imposition of excluded items
Inaccurate information/verbal advice from insurance agents	Policy application refusal/termination
Pre-existing condition waiting period was not known by consumers	Auto-renewal/auto-transaction of premium
	Administrative delay/poor service quality

Unexpected Increase in Premium/Loading at Renewal

Further analysis of individual complaint cases shows that many cases involved the significant and unexpected increase in premiums (around 10%, based on the further analysis of cases related to PHI in 2017 and 2018). Looking at age, over 50% of these cases were related to elderly consumers aged 55 or above[39]. An unexpected increase in premium could be especially critical to the elders, as they generally do not have an income after retirement. There are also difficulties in switching to another insurance company's plans with similar coverage due to old age, deteriorating health condition and medical history. In some of these cases, the premium increased by 20% upon annual renewal. In an extreme case cited in an elderly's in-depth interview, the surge in premium was higher than 50% in a year (case study 1).

Reasons Given by the Insurance Companies

Based on information available to the Council, the insurance companies involved did not always provide clear explanations to the policyholders concerning the reason(s) for premium increases. In some cases, the insurance agents only verbally explained to the insured persons upon enquiry. Proactive and written forms of explanations were not given.

The most common reasons given by insurance companies were inflation of medical costs and the offering of enhanced benefits (see below quotes). The enhanced benefits usually included an expanded scope of coverage and increased maximum reimbursement limits not requested nor expected by the policyholders (case study 2). Some insurance companies also explained that it was due to the overall claim records of policyholders of the past year, even if the individual had not made a claim.

[39] With a view to identifying complaints lodged by ageing consumers, the Council has been requesting complainants to indicate the age range they belong to when filling out the complaint form since October 2015. It is worth noting that since the information of age range is provided by complainants on a voluntary basis, complainants could choose not to provide it when lodging complaints. According to the Council's statistics, only around half of the complainants provided such information. Bearing that the one who lodged complaint may not be the complainant himself/herself in some cases, the figures may represent only part of the complaint situation related to elderly consumers.

Some quotes extracted from the insurance companies' notices:

Medical inflation

"... medical costs and other health related expenses continue to rise... premium increase is something we must do in order to continue to provide you with the quality service you expect."

(Company 1, premium increased 25% in 2016; the same notice was served to a different policyholder in 2017)

Benefits enhancement

"In order to ensure you enjoy the most comprehensive benefits in xxx Plan, starting from the new policy year, the Company will provide you with the enhanced benefits at premium adjustment. Please kindly refer to the enclosed Enhanced Benefit Table and new Premium Table for more details."

(Company 2, premium increased 18% in 2017)

"As part of our commitment to continued improvement, we have recently upgraded your policy's coverage to better suit your needs. Major enhancements include..."

(Company 3, 1.2% premium increased in 2016)

Grievances of the Complainants

The complainants, particularly the elderly, were generally dissatisfied with the increase in premium. They found it unexpected and unfair for the following reasons:

- No option to refuse upgrade and stay with status quo: They found the enhancements were neither necessary nor suitable for them, but the insurance companies did not offer an opt-out option. The policyholders could reluctantly either accept the upgraded policies with premiums increased or choose to let the policies lapse (case study 1).
- Uncertainty of future premium levels: The adjusted premium levels were substantially different from those written in the premium tables provided during the sales process. These new premiums are beyond the policyholders' original budget and create anxiety about future premium expenses (case study 2).
- Misinformed by insurance agents: insurance agents or staff of the insurance companies told policyholders during the sales process that premiums would not change except for age adjustments (case study 3).
- Suspected imposition of premium loading after making claims: Some complainants suspected the increases of premium loading by the insurance companies were a consequence of previous claim settlements (case study 4).
- Lack of understanding about insurance: Regarding explanations about overall claim record of policyholders in the past year leading to increasing premiums, policyholders found it unfair as they either did not make any claim in the past year or even did not make any claim since the policy purchase (case study 5).

Case study 1 – Unexpected premium increase and reluctant acceptance

Ms Wong purchased a medical insurance plan in 2008 when she was 57 years old. In the first three years, she paid HK$3,849 as the annual premium. When she entered into a higher age group (60-64) in 2011, there was an expected approximate 50% premium rise (HK$5,686); this was in accordance with the premium table provided and within her budget. In 2015 at age 64, upon policy renewal, the insurance company informed Ms Wong via written means that enhanced benefits would be offered to her with an adjusted premium. This 26% rise (HK$7,165) in annual premium included emergency outpatient treatment and family care services (e.g. domestic home care services, baby-sitter or child-care, pet care). In 2016 at the age of 65, Ms Wong expected the premium increase to be 26.8% as written in the brochure, but it turned out to be a massive surge of 58.6% (HK$11,361) due to another adjustment. The explanation given by the insurance company in the renewal letter said premium increases were necessary to provide quality service as medical costs and other health related expenses increased.

In Ms Wong's case, her premium has skyrocketed 195% in a ten-year period, much higher than her expectation of 87.4% from the premium table she received at time of first purchase. Although Ms Wong did read "the insurance company reserves the right to adjust the premium table from time to time" written in the brochure, she found it hard to accept because she never imagined an increase of that scale.

Though Ms Wong did not need the enhanced benefits, she did not reject or negotiate with the company as she thought there was no room for negotiation. In addition, it was difficult for her to switch policies.

Ms Wong also expressed discontent with the unchanged and maximum reimbursement limit compared to the ever-increasing premium. Facing these problems, Ms Wong reluctantly still chose to stay with the same policy as she worried about shifting to another insurance company. Though she was unsatisfied, she did not file a complaint.

「我無諗過保費會加到咁誇張，睇返嗰時提供的保費表都無諗過咁誇張，但又唔可以唔買。因為隨著年紀大……我真係唔敢斷保，斷咗搵第二間公司會有困難，所以佢加幾多錢我都要接受，都係要畀。」

Case study 2 – Unexpected enhanced benefits and premium vastly different from expectation

The 67 year old complainant was informed by the insurance company through written means that the policy terms would be changed to offer enhanced medical cover. This was given without seeking complainant consent nor providing an opt-out option. Subsequently, upon the annual renewal date, the complainant was informed of an adjusted premium at an amount much higher than the past year. He found it unreasonable and beyond his expectation as the adjusted premium was significantly different from the policy reference table. He had based expectations on this table when he entered into the contract. According to the complainant, the annual premium had more than doubled over the past four years, from HK$21,280 to HK$42,880. He lodged a complaint to the insurance company stating this. The insurance company argued the enhancement aimed to provide better protection to customers and that their brochure stated "premiums stated are non-guaranteed and subject to revision by the company from time to time"; and the "revision of benefit structure and/or limitations" clause in the policy stated that "the company reserves the right to revise, amend or modify the benefit structure and/or restrictions/limitations and/or the premium".

The complainant found the insurance company's premium unacceptable and filed a complaint.

With the Council's intervention, the complainant reached a settlement with the insurance company.

"*This is outrageous because this is not a suitable policy for me anymore, and I do not have a chance to say no to the policy [changes upon policy renewal]... Also, when I bought the insurance in 2013, the reference table shown to me was materially different from the proposed charged amount even at the progressive rates taking into account of inflation and age. I have relied on that information... the premium which I am now paying is materially different to what was presented to me in 2013.*"

Case study 3 – Misinformation given by insurance agent and unexpected increase in premium

Mr Leung said he purchased medical insurance around the age of 63 after his retirement, through an insurance agent who was his friend's son. In the initial sales stage, the insurance agent showed two printed documents side by side. These showed two types of premium levels of the same insurance plan with the same benefits coverage; unchanged or adjusted every year. Mr Leung chose the fixed premium policy and paid approximately HK$15,000 as an annual premium. Upon the second renewal year, the insurance company notified him in a letter that his coverage was upgraded with an adjusted premium.

Mr Leung was shocked and he wrote to the insurance company insisting that he did not need any upgrade. In the letter, he enclosed a cheque with the original amount of premium in an attempt to hold his existing plan. However, the insurance company cashed the cheque and replied in writing, that his coverage only span half the year unless he paid the remaining balance. In their correspondence, the insurance company also mentioned Mr Leung's existing plan was no longer offered so the upgrade was mandatory. After that, Mr Leung lodged a complaint to the HKFI but the organisation did not consider his claim substantial. Mr Leung also mentioned that he had not filed a complaint against the insurance agent concerned as he was acquainted with him.

A month later, the insurance agent contacted Mr Leung and refunded the cheque. Mr Leung thus let the policy lapse.

「當時代理介紹兩個保險計劃畀我，一個係佢（保險公司）可以調整保費嘅，另一個就話明佢永遠唔會加嘅，係固定保費（fixed premium）。第二次續保時……當時我已經寫封信通知佢，話唔需要提升計劃嘅保障範圍，我就畀返原本嘅保費，依舊要返以前嘅保障範圍便可以了。但佢就兌現咗我張支票，之後寄封信嚟通知，話我嘅保障只得半年，因為繳交不足保費……最終佢話我購買嘅保險計劃已經不存在或終止提供。這種隨時可以改變的做法對嗰啲已買了保險的消費者有咩保障呢！」

Case study 4 – Imposing substantial premium loading after claim

The complainant purchased a medical insurance policy in 1999. As he recalled, his premium at time of purchase was appropriately correspondent to other men his age. In 2014 and 2015, he paid a premium of HK$6,130 and HK$6,620 respectively. He received insurance payments for two eye operations in 2015 and 2016 for HK$35,685 and HK$80,216 respectively. In 2016, his premium was increased from HK$6,620 to HK$11,772. In 2017, the premium further surged to HK$18,024. A 300% loading was added upon the renewal.

Subsequent to the complainant's complaint about the heavy increase, the insurance company revised the premium down to HK$15,095, which was still a loading of 235% as indicated on the revised renewal letter. The complainant suspected it was due to his claim record and he worried that the premium would become unaffordable in the future.

"Now I am paying extra loading of 300% for my medical policy only because I made claim 2 years ago... I felt like I am now actually paying the premium to cover my claim made before, not the insurance company. It is not the insurance to cover for my unforeseen medical cost and the purpose of insurance protection is defeated."

Case study 5 – Lack of understanding about insurance concept

The complainant had been paying for his medical insurance policy for four to five years. Upon renewal in 2017, the premium surged from about HK$15,000 to HK$19,000, which was roughly a 27% increase. He consulted the agent who explained the adjustment was based on inflation and claim records. The complainant considered it unfair as he himself had not filed any claims at all since he purchased the policy. He also found the inflation of 27% unacceptable. However, he could only accept the increase reluctantly.

Exclusion of Items Imposed on Policy

In some complaint cases under review, the insurance companies excluded certain items from policy contracts based on the medical conditions of the complainants. These exclusions are based on medical check-up results, medical history as reported by the complainants or contracts revised by companies after the complainants filed treatment claims. Usually, grievances arose when insurance companies and the complainants did not agree on the insureds' health conditions and the interpretation of "full recovery" (case study 6). In some of these cases, the insurance companies might set conditions on the removal of an excluded item (e.g., when there is proof of full recovery or no recurrence of the medical conditions in question within a certain time period).

In the case of elderly consumers, excluding certain items at any point reduces the usefulness of insurance coverage. Decreased coverage means the elderly do not get protection where they most need it – access to affordable medical treatment when they are at the highest risk. Medical coverage can be viewed as a type of financial protection to the elderly, who are more vulnerable to increased financial needs as they are out of the workforce and no longer earn an income. Usually, they have no choice but to reluctantly accept the excluded items (case study 7), or they choose to let the policy lapse when they find it does not give them enough coverage anymore. Both choices put the elderly' health and financial protection at risk.

Case study 6 – Disagreement over interpretation of "full recovery"

During policy application, the complainant was required by the insurance company to undergo a medical check-up at a designated clinic and was diagnosed with idiopathic pulmonary fibrosis. Given this result, the insurance company imposed an exclusion clause in the policy which excluded all sicknesses related to the lungs. The complainant said the insurance company indicated at that time the exclusion clause could be waived if she could provide proof that there was no problem with her lungs afterwards.

Two months later, the complainant went to another doctor for examination. The medical certificate stated the examination showed no evidence of idiopathic pulmonary fibrosis, instead the complainant suffered from bronchitis caused by bacterial infection and was treated with antibiotics. It further stated the complainant "should make a full recovery with no complication". The complainant showed the medical certificate to the insurance agent. However, the insurance agent claimed the certificate did not show there was absolutely no problem with her lungs and refused to waive the exclusion clause.

Case study 7 – Imposing excluded items within effective policy dates

On 7 July 2014, the complainant signed a renewal form for the policy period of 21 August 2014 to 20 August 2015. Approximately a month after signing (13 August 2014, which was still within the previous policy period), the complainant was admitted to a hospital for treatment related to anal illness. Afterwards, he filed a claim application for the treatment and was reimbursed. Then, the complainant was admitted to the hospital again from 11 September to 6 October 2014 due to anal polyp, after the new policy period had started. On 15 September 2014, he was asked by the insurance company to sign a revised agreement form which excluded treatments relating to anal illness for the renewed policy starting 21 August 2014. After discharging from the hospital, the complainant filed a claim application but was rejected by the company.

「他們（保險公司）已完成核保及保單已正式生效，但他們仍單方面中途提出更改……保險公司加入不合理條款而不賠，這是對消費者不公平。」

Policy Application Refusal or Policy Termination

Two other issues identified are application refusal or policy termination by insurance companies based on the individual's medical history, medical conditions (case study 8), and the lack of clarity regarding reasons for rejection (case study 9). In the case of elderly consumers, the rejection by insurance companies would undermine their chance to get insurance protection.

Case study 8 – Difficulty obtaining insurance protection due to medical history

Mr Chan looked for a medical insurance plan after retirement in 2012. At first, he approached an insurance company and submitted a proposal which provided information on his medical history for a premium quotation (medical history includes asthma, removal of colon polyps, hospital confinement due to sudden faintness which was diagnosed as hypoglycemia). The company replied in writing that it regarded Mr Chan as a high risk applicant unsuitable for any kind of quotation, so it rejected his insurance application. Then Mr Chan consulted another insurance company and it offered a policy with 20% – 30% premium loading and excluded treatments for illnesses related to colon (including colorectal cancer) and cardiovascular diseases. Having no other choices available, Mr Chan reluctantly accepted the offer.

「喺回覆報價時話我有啲病歷係高風險，保險公司唔受保，唔接受我申請。」

Case study 9 – Lack of clear reasons for policy refusal by insurance company

In April 2017, the complainant received a letter from the insurance company regarding her reinstatement application, as the policy had lapsed since October 2014. In the insurance company's letter, it stated one of the general procedure reinstatement requirements was the policyholder should complete a health declaration form as attached. The complainant followed the instructions. Afterwards, the complainant was informed by the insurance company that her reinstatement application was rejected due to "medical reason", but the complainant said the insurance company did not clarify the specific medical conditions/circumstances leading to the decision.

Application of Policy Terms

Within the complaint cases relating to "application of policy terms", the main disputed terms referred to are "medically necessary" and "waiting period".

Medically Necessary

"Medically necessary" is a common term in almost all medical insurance policy contracts. For medical insurance, it usually means the need to have a specific medical service to treat an illness covered by insurance.

On some occasions, the insurance companies declined a hospitalisation claim on the basis that hospitalisation was deemed unnecessary, either because no treatment had been applied during hospitalisation or the diagnostic tests/treatment conducted during the hospital confinement could be performed in an outpatient establishment. On another occasion, an insurance company declined a treatment claim because it did not consider the treatment related to the illness (case study 10).

However, there could be a gap between the understanding by the insured and the interpretation/decision by the insurance company on the definition of "medically necessary" (case study 11). From the consumer's perspective, he/she needs treatment when something feels wrong, and the attending doctor considers the diagnostic tests and treatment should be done in the hospital setting as part of the treatment. From the insurance company's view, it has its own interpretation on what is "medically necessary", despite proof from the attending doctor regarding the necessity to first admit the patient to the hospital, then run diagnostic tests and lastly give treatment based on the diagnostic tests that should be done in a hospital setting.

In these cases, the insurance company could create confusion and uncertainty to the consumer regarding the circumstances in which his/her medical expenses would, and to what extent, be covered by insurance. Consumers may also doubt who has the final say and judgement on what is deemed "medically necessary".

Case study 10 – Condition not considered an "illness" by insurance company

One day, a claimant found a painful granule on her back. She went to a dermatologist who ran an x-ray on her. The results showed a fat granule growing under her skin, big enough to compress a nearby nerve, thus causing pain. That same day, the claimant underwent micro-surgery to remove the granule in the clinic (outpatient surgery was covered in the policy). A later diagnostic test of the fat granule tissue found it was benign, not malignant. Afterwards, she filed a claim to the insurance company and found it rejected. The insurance agent said her situation was not considered an "illness" by the company. The claimant said the written notice from the insurance company only stated that the claim was rejected but did not mention about the reason nor did it quote any relevant clause of the policy contract.

「它弄到我的神經線疼痛，便同意醫生的建議，立即進行手術……怎料最終保險代理告訴我這個不是病，最後說不能獲得索賠。」

Case study 11 – Different interpretations of "medically necessary"

The complainant involved fell on the street, sustained injuries on her left shoulder, right palm, rib cage and both knees, and was admitted to the hospital. She stayed in the hospital for 8 days and she filed an insurance claim after being discharged. Despite the attending doctor declaring in-patient physiotherapy was recommended and it was not possible for the complainant to be discharged earlier, the insurance company only settled the claim for the first 3 days of hospital confinement. It stated the remaining 5 days of confinement were "not medically necessary and physiotherapy can be done as an outpatient".

The complainant had filed the complaint to various parties including the Consumer Council, the then OCI and the then ICCB.

After half a month, the complainant obtained reimbursement of the remaining 5 days of confinement.

「保險公司漠視註冊醫生的診斷，對 8 天的住院理賠申請只賠償其中 3 天，一句沒有住院需要便拒絕賠償其餘住院日數，實在霸道無理，欺負弱小消費者，繳付多年的保費卻換不到合理的保障。」

Waiting Period

A waiting period in medical insurance usually refers to the period of time specified in a policy before some or all of the insured's health care coverage can take effect; the duration of the waiting period and the scope of diseases excluded in the waiting period may vary from policy to policy.

In some policies, there may also be a pre-existing condition exclusion period. It is a type of waiting period that involves those who have a condition during a certain period, specified by the insurance company, prior to signing up for medical insurance. This type of waiting period means the insured's insurance coverage can limit or exclude for any pre-existing condition. Issues involving pre-existing conditions will be discussed further in this Chapter.

In some cases, claim applications were rejected by insurance companies; they stated the treatments in question were conducted within the policy waiting period. In consumer grievances, the most commonly cited reasons were:

- Waiting period not openly disclosed or made known to consumers: The policyholders were frequently unaware of their policy's waiting period, declaring the insurance agents and customer service staff failed to mention the clause before and during the policy purchase (case study 12).
- Inaccurate information given by customer service staff: The policyholders said the insurance agents or customer service staff had provided inaccurate information when answering enquiries. In these cases, the insurance agents or staff only provided general information such as whether a treatment was covered by insurance plans when inquired. They overlooked highly relevant information such as the limitation or waiting period for treatments as stipulated in the policy of individual policyholders (case study 13).

Case study 12 – Failure to give clear information prior to treatment

Two months after the complainant purchased medical insurance, he was admitted to a hospital for malignant lymphoma nasopharynx. Before admission, he called the insurance company to inquire about the surgical classification of the treatment and the amount that could be claimed for it. The complainant said the staff replied the treatment was classified as small surgery and could be reimbursed according to the surgical operations schedule. After getting discharged, the complainant filed a claim to the insurance company, but was rejected as the treatment occurred within 12 months of the medical coverage commencement date. In the rejection letter, the insurance company cited the policy contract which stipulated "(the insurance company) shall not be liable to pay expense for treatment directly or indirectly arising from or consequent upon ... cataracts, endometriosis, tumours (except skin), diseased tonsils requiring surgery, hemorrhoids, hyperthyroidism, pathological abnormalities of nasal septum or turbinates and sinus condition requiring surgery within 12 months from the coverage commencement date".

With the Council's intervention, the insurance company settled the claim two and a half months later.

「手術之前我也打電話問過保險公司這些手術是哪類型，同時可賠償多少，他們也答覆我是小手術，可作出小手術的賠償。完成手術後……所得的回覆是完全沒有賠償……他們說是因為未到一年，所以未能作出任何賠償。那麼第一年的保費便是白白送錢給這間保險公司？……他們說是寫在條款上的，但我從沒有留意有這條款和寫在哪裏……買這份保險時，也沒有保險職員或保險推銷員提及到有這條款。」

Case study 13 – Inaccurate verbal information given by customer service staff

Five months after the complainant purchased medical insurance, she was diagnosed with cataracts. Her daughter called the insurance company hotline to inquire if cataract surgery was covered in the policy. During the call, she provided the policy number and emphasised that the policy commencement date was five months ago. The complainant said the hotline staff replied cataract surgery was covered. Two months later, she undertook cataract surgery and filed the claim. However, her claim was rejected by the insurance company, declaring there was a 12-month waiting period for cataract surgery.

Non-disclosure

Non-disclosure arises when an applicant of an insurance policy fails to disclose medically-related material facts within his/her actual or presumed knowledge on the application form. The information disclosed on the application or health assessment form greatly impacts the insurance company's underwriting assessment. From the information given, the insurance company identifies high-risk features and decides whether to offer coverage and at what premium and terms and conditions. Often, non-disclosure disputes are related to the medical history of the applicants.

When an insurance company deems there is non-disclosure of material facts, it may lead to claim rejection or policy termination; this is irrespective of whether the non-disclosed information has a direct relationship with the illness or subject matter of the claim concerned. From the insurance company's point of view, this information may have influenced its prudent underwriter in accepting or declining a risk or in determining the premium or terms and conditions of the contract.

From the consumer's perspective, however, the non-disclosed fact(s) may not be within his/her knowledge, or it may not be one(s) which he/she could reasonably be expected to disclose. The following arguments were usually involved in complaint cases/claimant interviews related to non-disclosure.

- Different interpretations of "illness": The complainants and insurance companies did not agree on what constituted an "illness". The insurance companies would consider an item an "illness" or "health impairment" while complainants' medical practitioners would list an item not as "health impairments", but as findings of a medical check-up to which no treatment or medicine was recommended (case study 14).
- Inaccurate advice from insurance agents given verbally: During the application process, the complainants said insurance agents declared there was no need to report illnesses/treatments that they considered minor on the application form, saying it would not affect the underwriting or claim decision (case study 15).
- Knowledge gap in knowing what to disclose: The complainants thought the medical history listed as non-disclosure material facts were minor illnesses/treatments. In some cases, the illnesses and treatments took place years prior with full recovery; the complainants were not aware they should report those illnesses/treatments in the application forms (case study 16).

Case Study 14 – Policy terminated due to non-disclosure

Two years after the complainant purchased medical insurance, she was diagnosed with stage 1 breast cancer, subsequently receiving surgery and radiotherapy. Her hospitalisation and surgical claims were rejected by the insurance company. In the rejection letter, the insurance company indicated the complainant had health impairment in the form of breast lumps that was not disclosed on the policy application. Due to this, the insurance company offered the complainant reimbursement for her paid premiums in order to terminate the policy contract.

The complainant was shocked as she had disclosed all annual check-up routines and reports to the insurance agent, filling out the application form question by question according to the agent's advice. The complainant then went to her doctor for advice. Her doctor issued a medical report stating the "breast lumps" were not "health impairments" nor were they precancerous; the complainant had no "health impairment" that she had not disclosed to the insurance company. Despite receiving this medical report, the insurance company upheld its rejection decision.

"This was a big shock and surprise to me. I don't understand why they just found these 'impairments' at time of my claim but not at time of my application submission. In fact, I have been paying the policy for 3 years without knowing that my policy is actually invalid and I was not insured."

Case study 15 – Disagreement over the term "material disclosure"

During an interview, a claimant shared that a few months after he purchased a medical insurance plan, he dislocated his arm while playing sports. He was admitted to the hospital for a surgery. The insurance company rejected his claim on the grounds he had not disclosed his medical history of being admitted to the hospital before. The insurance company refunded the 1-year premium and terminated the policy.

The claimant said the hospital admission was to the Accident & Emergency (A&E) Department, due to an arm injury and he was discharged on the same day. He also said he was told by an insurance agent he did not need to disclose the hospital and the A&E admission in the policy application form; it had happened long time ago and the claimant himself could not remember the exact time. The claimant complained to the HKFI; the HKFI turned down his complaint stating he had no evidence to prove the insurance agent's dishonesty.

「在簽單的時候，我有提及我的手曾受傷，但是我沒有因此而住院，沒有做過任何手術……他（保險代理）問我還有否再弄傷，我說沒有，然後他又問我，距離上次弄傷的時間，相隔了多久，他說不用寫進去……保險公司說因為我沒有誠實報告我之前弄傷，所以不獲索賠。」

Case study 16 – Information not requested in policy application form

The complainant was diagnosed with breast carcinoma and had a surgery to remove the tumor. Her claim was rejected by the insurance company citing alleged missing information as she had undertaken breast augmentation a year before her application and failed to disclose this information. The insurance company claimed this knowledge would have affected the approval of her policy application. Moreover, she was requested to accept amended terms of the insurance policy; it excluded coverage of breast diseases and any related treatments. She was also told to reply in two weeks or the policy would be rescinded.

The complainant opined that in the signed policy application form, there was no relevant field specifying or requesting her to fill in information related to plastic surgery. The application form fields were titled "medical consultation", "treatment", "details of diagnosis", "onset date" and "date of last symptom". As such, the complainant's view was she had duly filled out the forms according to what was specified or requested. She thought the insurance company had made the false accusation that she left out information as she did not consider cosmetic surgery an illness when there was neither diagnosis nor symptom.

Apart from the Council, the complainant also lodged a complaint to the then ICCB. Approximately two months later, the insurance company agreed to settle all insurance claims and keep all policy terms unchanged at her request.

"*It is the insurance companies' responsibility to clearly specify in the application forms the information they need for approval instead of laying the responsibility on the customer.*"

In case study 16, the complainant was not aware plastic surgery should be reported in the policy application form. She was of the opinion "plastic surgery" should not be considered a "treatment", "diagnosis" or "consultation" — the terms used in the questions on the application form. This situation may imply there is room for improvement on the application form and health questionnaire, to ask more specific questions and set clearer instructions as to which kind of information should be provided to mitigate future claim disputes.

Excluded Items

Most, if not all, insurance contracts contain an "exclusion" section which lists all the losses, perils, hazards, situations, conditions or circumstances excluded from the policy coverage. As additional cover may warrant an additional charge in the premium, the purpose of exclusions is to limit the coverage to risks the policies are intended to cover at the agreed premium. Generally excluded items include confinements/treatments related to pregnancy, war, attempted suicide, cosmetic treatment, experimental/unconventional medical technology/procedure, health check-ups, dental treatment, congenital/inherited disorder, mental disorder, etc. Claim disputes often arise when the policyholder neglects or is unaware of these exclusions.

In addition to the generally excluded items stipulated in policy contracts, insurance companies may also impose more excluded items on an individual's policy based on the underwriting decision or claim record of the individual.

In some complaint cases, the complainants blamed the insurance agents or customer service staff for overlooking the excluded items of their policy contracts and failing to provide accurate information to them upon enquiries. These complainants had explicitly asked whether specific treatments were covered before they received it, but the misinformation from the insurance agents or customer service staff led to the failure of claim applications (case study 17).

There were also cases where arguments between the insureds and the insurance companies focused on whether the treatments undertaken were considered a specified excluded item, such as whether the treatments should be defined as "plastic surgery" or "dental surgery", both of which were on the list of exclusions (case study 18).

Case Study 17 – Excluded items not listed in product brochure

The complainant had suffered a ski accident in Japan. She was transferred back to Hong Kong and admitted to the hospital. Her hospitalisation claim was declined by the insurance company on the ground that "winter sports" was an excluded item under the Exclusion Provisions in the policy contract.

The complainant stated that such exclusion was not indicated in the product brochure made available to her when she made the decision to purchase the medical insurance plan in question.

Case study 18 – Treatment deemed cosmetic surgery despite attending doctor's medical report

The claimant shared that one day she found a scar on her belly after a surgery which caused her discomfort when wearing trousers. She underwent surgery to remove the scar. Her claim for the surgery was rejected by the insurance company on the grounds that it was considered plastic surgery, an excluded item in the policy. The claimant found the insurance company's decision unreasonable as she felt the scar affected her daily life and the surgery was not for cosmetic purpose. The attending doctor also stated in the medical report the scar affected the claimant's everyday wearing of clothes. However, the claimant did not make any appeal nor lodge any complaint.

「我是有原因才去除掉它，不是愛美，也不是為了穿游泳衣；醫生也寫清楚這道疤痕，可能讓我日常在穿衣時會有影響；醫生已經這麼說，保險公司還說我是因為醫學美容而不批核，我也實在無話可說。」

Pre-existing Conditions

"Pre-existing conditions" are commonly found in medical and hospitalisation policies to exclude injuries or sicknesses which occur, exist or present signs or symptoms before the policy commencement. Grievances often arise when there are different views between the insureds and insurance companies on whether signs or symptoms of the illness are present before the policy effective date.

Case study 19 shows some insureds may not be aware of the pre-existing condition clause in their policies. They could not get the protection from the policies when they needed treatments related to conditions with pre-existing signs or symptoms, leading to negative outcomes for the insureds.

Case study 19 – Non-coverage of pre-existing condition

The complainant was admitted to the hospital due to a stroke. After being discharged, he filed a claim to the insurance company but was declined. In the letter, the insurance company explained they had reviewed his medical report provided by the admitted hospital. He had had a history of hypertension, hyperlipidaemia and a ischaemic stroke prior to the policy effective date, and it was stipulated in the Exclusions of the Policy the insurance company shall not pay any claims in respect of Pre-existing Medical Conditions. Therefore, the company could not honour his claim on that occasion. According to the complainant, he had disclosed his medical history to the sales person during the sale process via phone.

Amount of Indemnity

A schedule of benefits sets the maximum limit of indemnity for each item of hospital and surgical benefits per insured person. Usually, the maximum indemnity limit of surgical, anesthetic and operating theatre fees are subject to the complexity of the surgical procedure, as often specified in the schedule of surgical operations. The schedule of surgical operations is usually not included in the sales brochure — there are occasions that the schedule is even not available in the sample policy contracts. That means consumers may not be privy to detailed information regarding the maximum amount of indemnity for individual treatments, either before or at the stage of application/purchase (case study 20).

Complaint cases related to indemnity amounts often arise when there are gaps in insureds' knowledge of the maximum indemnity amount of the various treatments covered in their insurance policy contracts (case study 21).

It is also common for hospitalisation insurance contracts to have the "Reasonable and Customary" clause (R&C clause), which is to prevent potential abuse of overcharging for medical fees and control costs for the ultimate benefit of all. An insurance company's estimation of R&C charges may be based on its internal claim statistics, the industrial fee survey and the schedule of fees published by the government, relevant authorities or recognised medical association in the locality. In some cases, insurance companies used this clause to limit their settlement amounts, even if the amount had not exceeded the maximum indemnity amounts as specified in the schedules of benefits.

In recent years, there has been a rise of premium hospital plans which claim to offer comprehensive "full cover" benefits provided to most types of medical expenses. Policyholders may expect their medical expenses to be fully covered as long as total hospital charges do not exceed the specified annual policy limit. However, the possibility that the insurance companies may apply the R&C clause to limit the claim application's indemnity amount should not be overlooked.

Case study 20 – Expectation gap in claim limits

The claimant found a keloid behind the ear and was admitted to the hospital to undergo a surgery to remove it. Prior to that, she had sought the advice of her insurance agent on whether the surgery was covered and the expenses could be fully reimbursed. At that time, the insurance agent said it should be fully reimbursed under normal circumstances. However, it turned out the claimant only got 80% reimbursed. Upon enquiry, the insurance agent verbally explained it was due to the policy terms restricting the maximum claim to 80% of the particular type of surgery in question. The claimant said she was not aware there were maximum claim limits for different surgical operations. In the past, she had successfully received full reimbursement for hospitalisation. As a result, she had thought she was entitled to full reimbursement with her policy so long as she was hospitalised.

「保險代理跟我說，你照去做手術吧……正常來說，應該可以全包括的……後來才告訴我因為細節條款……指那種手術類型(賠償上限)是百分之八十，還是百分之九十。其實我以前也曾經作出索賠……讓我認為只要我住院，我便可以100%全數索賠成功，我想不到不能全數索賠的。」

Case study 21 – Overlooked maximum indemnity limits

The complainant was admitted to the hospital for Percutaneous Coronay Intervention. The surgical fee was HK$92,056, and he received a settlement amount of HK$24,131 from the insurance company. He was not satisfied as the settlement was much less than the medical expense incurred.

In response to the complaint, the insurance company issued a reply letter enclosed with the schedule of benefits to the Council. According to the information provided, the complainant's policy's maximum limit for surgical fees was HK$38,610, subject to individual surgical operation. As for Percutaneous Transluminial Coronary Angioplasty, the maximum payout was 62.5% of the maximum limit. The insurance company advised that it had already fulfilled its payout obligation by paying the maximum limit of indemnity (i.e. HK$38,610 x 62.5% = HK$24,131).

In this case, the complainant was not aware of the maximum limits of reimbursement in his policy and may have overlooked the maximum payout limit included in the policy.

4.4 Other Observations

Administrative or Service Issues

The following provides a summary concerning other administrative or service quality issues identified in the complaint cases.

- Premium charged after policy termination – Some complainants said they had applied for policy termination, but the insurance companies still charged the premiums from their bank accounts or credit cards.
- Auto-renewal of premium without explicit consent – Some complainants were not satisfied the insurance companies auto-renewed the policies without their explicit consent, incurring auto-transaction of premiums (consent was only given at initial sale stage).
- Administrative delay in delivering medical cards – Some complainants said they had waited for a long time (e.g. 4 months in an extreme case) and had not received the medical cards or renewed policies from the insurance, potentially affecting them in time of need.
- Poor service quality – Some grievances were about the poor service quality of insurance company staff, such as inefficiency of hotline staff or unhelpful or incorrect information given by them.

Role of Insurance Agents

Verbally given advice has been a repeatedly raised issue and is one of the major causes of consumer complaints. From Chapter 3, consumer research suggested most respondents consulted insurance intermediaries (61%) when purchasing PHI (Figure 9). From the Council's complaint cases and in-depth interviews with the claimants and the elderly consumers, it is observed that consumers rely heavily on the information and advice provided by the insurance agents during the purchasing stage or after the effective policy date. Advice sought include

coverage of the insurance plans, medical history to be reported in the policy application form, indemnity amounts, surgical class of different treatments/operations, etc. Some complainants and interviewees said as the insurance agents were referred by their personal network (e.g. friends, relatives), they tended to trust and rely on the information given by the agent, especially at purchasing stage.

On one hand, insurance agents should have the responsibility to provide quality and professional services by offering accurate and personalised information and advice rather than misrepresenting the product. Currently, there are industry codes[40] which advise insurance companies to provide sufficient training to insurance agents. The Council is of the view that such training should be improved.

On the other hand, consumers also have a responsibility to understand the features and policy terms, i.e. coverage and exclusions, before and after purchase of the insurance plans.

Some quotes from the in-depth interviews with consumers:

「（買的時候）代理說一般來說，是可以全數索償的，但過往幾次都不行。」

"(At sales stage) The agent said full reimbursement could be obtained in general situations, but I could not get full reimbursement in last few claims."

「代理跟我說，你照去做手術吧……正常來說，應該可以全包的……（到索償被拒後）然後，他說，我這種手術是屬於某一個什麼類型的，理賠的數額不會是 100%的。」

"The agent told me to go ahead with the surgery as in normal situation it should be fully covered... (after claim rejected) then he said the surgery was classified as a type of treatment which could not be 100% claimed."

「就算你喺電話問啲代理，佢都係講得好大概畀你聽，唔係咁全面。」

"Even though you asked the agent over the phone, he only explained roughly and not so complete."

「我覺得究竟個代理自己有無睇清楚嗰份咁厚嘅保單……」

"I'm having doubts about whether the agent himself had read the many pages-policy contract thoroughly..."

Non-transparent Private Medical Costs and Uncertain Out-of-pocket Amount Required

In an interview, the elder expressed she was concerned with the non-transparent medical costs of private hospitals. She felt the expenses charged by private hospitals were unpredictable, and the actual cost might be much higher than the quotation made available before admission. Even though she owned a medical insurance plan, it was difficult for her to predict the out-of-pocket money required of medical expenses. Therefore, as she got older and had limited savings, she terminated her policy and returned to public healthcare services.

[40] The Code of Conduct for Insurers issued by HKFI: Clause (36) Insurers should provide their insurance agents with sufficient support facilities and materials as will enable the insurance agents to properly advise and inform members of the public concerning the insurer's products and services. The Code of Practice for the Administration of Insurance Agents issued by HKFI: Clause (28) A Principal shall provide to each of its insurance agents sufficient training where a reasonable person receiving such training: (a) shall be familiar with the requirements of the Ordinance and this Code; and (b) would thereby be able to competently undertake the duties of an insurance agent in accordance with the requirements of the Ordinance and this Code.

Vulnerability of Elderly Consumers

Before engaging with a medical insurance plan, elders may encounter difficulties in finding a suitable medical insurance plan with an affordable premium and reasonable benefit coverage. As discussed in the above case studies, insurance companies might impose excluded items in the policy contract or apply premium loading based on medical history and underwriting results.

When elders engage with a medical insurance plan, they may face a substantial cost increase compared to the younger consumers. As a retired person with no income and limited savings, such uncertainty could incur great financial pressure.

When elders are unsatisfied with their existing policy contract, they find it difficult to make a decision to quit one policy and switch to another insurance plan offered by a different company as they may be requested for re-underwriting. Moreover, once the elderly quit, they can in most cases, only fall back to public healthcare services.

Different List/Definitions in Relation to Exclusions and Restrictions

There are a number of complaints where the consumer feels a hospital benefit has been incorrectly restricted or excluded. These complaints often involve a misunderstanding or disagreement over the wording of a policy term and whether the treatment needed fits within that definition.

For example, where a policy states benefits for "minor eye procedure" are paid at a higher level than a "restricted" "major eye procedure" – a complaint can form because the insurance company has a list of what it considers minor and major eye procedures that differs from the definitions used by a patient's ophthalmologist. Furthermore, a consumer's reading of the policy terms and understanding of what constitutes a minor/major eye procedure could also differ from that of an insurance company.

4.5 Summary

In summary, the review of complaint cases and interviews with the claimants and elderly consumers points to the major sources of consumer grievances:

- Knowledge gap of consumers/policyholders on the coverage and provisions listed in the policy contracts.
- Trade practices of insurance companies, in terms of the fairness of policy terms and conditions, transparency of underwriting procedure, premium/loading adjustments and claim settlement decisions.
- Quality and professionalism of insurance agents and customer service staff of the insurance companies in providing accurate and personalised information and services.

It is understandable that disputes will occur from the many transactions insurance companies administer each day. However, a certain proportion of complaints seem to be preventable by improving practices in the sales and application processes, assessing claims and importantly, clarifying decisions to policyholders. More work can be done by insurance companies to promote good practices in the medical insurance industry, enhance consumer protection and empower consumers to expand their knowledge of medical insurance.

Table 7 recaps the problems and consumer grievances in the policy application, renewal and claim stages, along with possible areas for improvement.

Table 7: A summary of problems and consumer grievances

Problems	Consumer Grievances	Possible Areas for Improvement
Policy refusal/ termination	• No clear explanation given to insured on application rejected reasons	• Providing a clear statement of reasons in written form
	• Difficulty for elderly to get medical insurance protection	• Extend entry age limit
	• Being charged despite policy termination	• Improve administrative process
Premium increase	• Lack of confidence that premium increase is justifiably necessary	• Provision of justifications and premium table on an on-going basis; enhance premium transparency
	• Premium out of expectation or more than the average for their insurance company or industry average; uncertainty of future cost	
	• Upgraded benefits not needed; no option to refuse upgrade	• Offer opt-out option to remain status quo
	• Substantial loading added after claim; outcome not negotiable	• No re-underwriting after claim
Benefits reduced (exclusion)	• Excluded items added unilaterally by insurance company; insureds have no option to reject	• No re-underwriting after effective date of policy/upon renewal[41]
	• Change of benefits unilaterally by insurance company while policy has been in effect	• No change allowed unless mutually agreed upon
	• Information not known; excluded items not in brochure	• Improve information availability and ease of understanding (key information)
Amount of indemnity fall short	• Received less than the anticipated amount for a treatment	• Consumer education (misunderstanding of terms) • Bring in independent assessment (disagreement of a policy term)

[41] No re-underwriting after effective date of policy/renewal, except special reasons such as change in occupation or place of residence of the insured, if the insurance company has taken into account these issues in underwriting before policy inception.

Refusal of claims (non-disclosure, medical necessary, pre-existing, waiting period)	• Insurance company disregarded the opinion of the treating doctor	• Bring-in independent assessment
	• Failure to clearly stated which signs/symptoms were relied upon in assessing and rejecting a claim	• Provision of clear statement of reasons to justify with appropriate reference in written
	• Had filled-in the application requested information; not known what else are expected	• Improve application form to ask more specific and time framed questions
Information gap	• Not knowing policy details (e.g. benefit limits and claim limits) because not being provided or informed during the sales stage	• Improve information availability and ease of understanding
	• Not covered for a treatment that they had assumed was included in the policy	
	• Inaccurate information/oral advice (e.g. surgical coverage, waiting period) being given by insurance agents	• Improve training & monitoring, impose penalty for inaccurate information/advice given
	• Lack of understanding in insurance concept	• Consumer education
Service issues	• Delays associated with processing request to handle payments and medical cards delivery	• Improve administrative process and impose a service pledge
	• Poor frontline staff quality in insurance companies (consumer misunderstanding their benefits during telephone calls and conversations with their agents)	• Improve training and quality management system

5 Study of Terms and Conditions of PHI Policies

Main problems identified in PHI policy contracts include the followings:

- Insurance companies may use ways to limit their liability and payout amounts, such as applying the clauses of "Medically Necessary", "Excluded Items", "Double Insurance" and "Reasonable and Customary".
- Key policy terms vary from insurance company to insurance company and even from policy to policy within the same insurance company, making it difficult for consumers to properly compare policies and their coverages.
- There is a lack of understanding by consumers of the meaning of policy wordings, which are not clearly or extensively defined; and these are open to interpretation by the insurance companies.

Consumers should observe the general legal principles applied to PHI policy contracts, such as:

- Duty of disclosure: Under the common law principles, there is a duty imposed on a person to reveal all material facts of which he/she is aware prior to the entering into the contract.
- Entire agreement clause: This clause aims to prevent the party relying on it from being liable for any statements or representations (including pre-contractual representations) except as expressly set out in the agreement. Therefore, if an insurance company has specified and a policyholder has acknowledged that he/she has not relied upon any oral or written representation made to him/her by the company or its employees or agents in clear terms in the policy contract, it is likely that the policyholder will be precluded from arguing that he/she relied on the oral or written representations made to him/her which is not included in the contract if disputes subsequently arise and turn on these representations.
- Significance of clauses relating to unilateral variations on terms, double insurance and pre-existing conditions: It is common for PHI policies to include clauses specifying that the insurance companies have the right to revise the terms, premium and/or the benefit schedule upon renewal; in case of combinations of double insurance clauses, the policyholders, depending on the wording/combination of the policy wordings, may not be able to claim under the policy at all; pre-existing condition is a common exclusion in PHI policies, its definition varies among different policies, some policy wordings provide that pre-existing conditions of which the policyholder was aware before the effective date of the policy are excluded from coverage, while others are less specific on the awareness, and a few explicitly state that pre-existing conditions are excluded irrespective of whether the signs or symptoms were known by the policyholder prior to the policy effective date.

As for the insurance companies, the court has emphasised a duty to deal with claim in good faith. The duty of good faith requires an insurance company to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its policyholders.

The Council commissioned a legal consultancy team to carry out research on specific terms and conditions of PHI policies, with a view to delivering a legal opinion to draw attention to any highly disputed and problematic areas arising from policy wordings which may lead to consumer detriment. This Chapter presents the highlights of the legal opinion, referencing relevant findings from other parts of the Study to facilitate comprehension. The legal opinion identifies the main problems of common PHI policy contracts that may undermine consumer interests. General principles under the Common Law legal system as applied to PHI policy contracts are also discussed, as are problematic terms and conditions commonly found in disputes.

5.1 The Legal Research

18 PHI Policy Contracts under Review

The legal research reviewed 18 PHI policies from 14 key insurance companies commonly providing PHI products in Hong Kong, collected from the market in 2017 and 2018. To reflect the features of the policies available for the vast majority of the general public, the 18 PHI policies selected were sample policies of common individual-based hospitalisation insurance plans with coverage for general ward (for more details of the selection criteria, please refer to the Legal Analysis section in Chapter 1).[42]

Very often, insurance companies may have more than one PHI plan. In order to review if there are variations among the policies of different PHI plans from the same insurance company, and if so, the significance of the variations, more than one PHI policies[43] from some shortlisted insurance companies were selected for the Study.

The 18 PHI policies are listed as follows:[44]

- AIA Super Good Health Medical Plan 2
- AXA FirstCare Medical Insurance
- AXA Smart Medical Insurance
- AXA SmartCare Executive
- Blue Cross Super Medical Insurance
- BOC Medical Comprehensive Protection Plan
- Bupa Care HealthNet
- Bupa CarePro
- Chubb HealthProtector Hospital & Surgical Plan

[42] Plans of the following natures: private ward and critical illness were not selected as they were not within the scope of this Study.
[43] These policies are different in benefit coverage, benefit levels and premium levels.
[44] The coding of the insurance companies and policies of the examples quoted in this Chapter is irrespective of the alphabetical order of this list.

- CIGNA HealthFirst Choice Medical Plan
- CTPI HealthCare Individual Insurance
- CTPI Hospital Care Protection Plan
- FWD Embrace Medical Plan
- Generali GenHealth Medical Insurance
- Liberty MediLink Medical Plan
- Manulife ManuGuard Medical Plan
- Prudential PRUmed Lifelong Care Plan
- Zurich HealthMultiple Medical Insurance Plan

Of the 18 PHI policies, 4 of them were sample policy contracts downloaded from the websites of the respective insurance companies or banks (for cases where the bank acted as an agent of the insurance company). For the rest of the 14 policies, sample policy contracts were not available online and they were either obtained through enquiries to the customer service of the relevant insurance company or by field workers recruited by the Council contacting insurance agent assigned by the relevant insurance company.

Key Policy Terms and Provisions

A review of consumer complaints relating to PHI policies helped identify which specific terms and conditions should be included in the legal research. Difference in interpretation over the terms "Medically Necessary", "Reasonable and Customary", "Non-disclosure", "Pre-existing Conditions"; and the clauses related to "Entire Agreement", "Other Insurance"[45] and "Unilateral Change of Policy Terms" is the crux of most disputes.

Other Common Law Jurisdictions Referenced

The legal research also referenced the judicial interpretations of these terms from four other Common Law jurisdictions, namely Australia, Canada, Singapore and the United Kingdom (UK). It also considered and reviewed insurance law literature and regulatory regimes in these jurisdictions.

In Hong Kong, there is not much guidance from the Courts specifically regarding the terms and conditions of PHI policies. Therefore, the scope of the legal opinion and this Chapter do not provide any such reference.

[45] Also known as "Double Insurance".

5.2 Main Problems Identified in PHI Policy Contracts

Scope of Insurance Policy

According to the legal opinion sought, the scope of medical coverage differs from policy to policy. The documents which form part of the policy can be lengthy, complicated, confusing and difficult to understand. Indeed, a policyholder may not fully understand the terms and conditions when signing the policy. Failing to properly understand the significance of certain clauses and terminology/definitions can result in a policyholder having no protection when a claim is made, despite the high premiums paid. One reason for this is that the significance of certain terminology/definitions is usually buried away in very small print in the footnote of the promotional materials or at the end of the policy, and can be easily missed. Further there may be cross referencing to other parts of the policy (or related documents), which can make it confusing for a consumer.

For example, the insurance plan may cover Hospital and Surgical Benefits. In the sales brochure, there is a case illustration which provides "Maximum Limit for Surgical Expenses (complex) of $65,000", with a footnote. The footnote has a separate heading called "Remarks". Under "Remarks" it is stated "For the classification of operations, please refer to the Simplified Schedule of Operations of the policy provisions." Therefore the policyholders will then have to look for the "Simplified Schedule of the policy provision" which will usually be found at the end of the policy. The significance (i.e. the limiting/exclusion effect) which may be contained in a policy can therefore be easily missed.

There are numerous insurance companies providing private medical healthcare in Hong Kong and other jurisdictions. In Hong Kong, insurance companies attract consumers by using words in marketing materials, such as "*guaranteed lifetime renewal*", "*provides a comprehensive range of products and services*", "*success in insurance products and services is reaffirmed by numerous awards and accolades*", "*the plan provides you with an access to our quality medical network with expanded cover*", "*a comprehensive medical plan that offers the most attractive range of inpatient and outpatient surgery benefits, together with guaranteed whole life renewability*", "*comprehensive medical protection during your deepest need*" and "*you need not bother about high medical costs or limited health services provided by public hospitals….you have the peace of mind to focus on your speedy recovery*."

As a result, a policyholder is under the misapprehension that they will be covered, and protected when they make a claim. It is noted that important points frequently only appear in the "*footnote*" or "*remarks*" or "*important note*" section of a sales brochure. For example, a sales brochure may provide a list of benefits under "*Comprehensive inpatient coverage*". However, two of the benefits stated therein may have a footnote in the brochure which then goes on to limit such coverage by stating that it is "*Applicable to designated plans only*."

Attempts by Insurance Companies to Limit Liability

According to the legal opinion, insurance companies have different ways to limit liability. It is opined that in Hong Kong, an insurance company may limit liability by stating *"The Company shall pay Medical Benefits for Medically Necessary expenses in accordance with the scope of cover provided herein below but each Insured Person's benefit shall be subject to the maximums (or maximum percentage), the limits, the respective covered benefits of the Insured Plan as applicable and as specified in the Schedule and the "Limit of Indemnity" table of this Policy."*

Another technique used is to limit liability under the heading of *"General Exclusions"* or *"Major Exclusions"*, which is usually drafted very broadly. Further, definitions provided by the insurance company provide for terms such as *"medically necessary"*, and *"reasonable and customary"* and *"pre-existing condition"* which have the effect of limiting the amount a policyholder can receive.

The legal consultancy team also advised that the significance and effect of such definitions and limitations/exclusions only become apparent to a policyholder when a claim is made. Once a policyholder makes a claim to recover expenses incurred, the insurance company will possibly then argue that the expenses are not medically necessary/reasonable and customary, and withhold payment, even though the words *"shall pay"* appear in the policy. In some of the policy clauses, there is an express provision which states, *"we (the insurance company) reserve the right to determine..."*, which allows an insurance company to easily find that certain fees are not recoverable as it is within their discretion to determine.

The legal consultancy team further opined that in most cases, the terms/phrases used in policies are not clear or extensively defined. For example, what does "*generally accepted standards of medical practice*" or "*with professional and prudent standards of medical practice*" or "*not be rendered primarily*" or "*good patient medical practice*" or "*general level of charges being charged by the relevant service providers or suppliers of similar standing in the locality.*" or "*equivalent circumstances of quality and economic consideration in the same area..*" mean? How is a policyholder going to understand what these phrases mean when he/she signs a policy? At times, it is questionable as to whether the insurance agent explaining the policy would know either.

To explore the ease of understanding of the information provided under different medical insurance plans, the Council studied and compared the 18 PHI policy contracts, focusing on the highly disputed and problematic terms and conditions. As discussed in Chapter 4, according to the Council's complaint statistics in recent years, "application of policy terms" (e.g. medically necessary) and "excluded items" (e.g. pre-existing conditions) are two of the top three reasons giving rise to PHI related claim disputes. Some examples are also provided below to illustrate the complexity of these policy contracts and the steps which have to be taken by a policyholder just to find out if a medical treatment will be covered by the PHI policy contract, or the coverage amount (See also Chapter 4 – case studies 20 and 21).

Example 1: (Insurance Company A)

Product Brochure *provides that Benefits of Surgical Charges depend on the* ***Class of Surgery*** *(Complex, Major, Intermediate, Minor).*

Coverage[1] 保障項目 [1]	Maximum benefit per insured person per disability (HKD) 每名受保人每宗傷疾之最高賠償額（港元）		
	Essential Plan 精選計劃	Advanced Plan 特級計劃	Deluxe Plan 尊貴計劃
Core benefits 基本保障			
Section 1 – Room and board 第1節 — 房租及膳食費用			
1.1 Room and board 房租及膳食費			
Maximum number of days 最高日數	182 days 日	182 days 日	182 days 日
Maximum limit per day 每日最高限額	750	1,580	3,100
1.2 Room and board for intensive care unit 深切治療部房租及膳食費			
Maximum number of days 最高日數	15 days 日	15 days 日	15 days 日
Maximum limit per day 每日最高限額	2,000	3,000	4,000
1.3 Accompanying bed benefit 陪伴床位保障			
Maximum number of days 最高日數	60 days 日	60 days 日	60 days 日
Maximum limit per day 每日最高限額	400	500	600
Section 2 – Surgical cover 第2節 — 手術費用保障			
2.1 In-hospital doctor's call fees 醫生巡房費			
2.2 Hospital sp 醫院雜費			
2.3 Surgical ch 手術費			
Minor 小型	5,625	7,500	11,250

2.3 Surgical charges 手術費

Complex 複雜	46,000	62,000	93,000
Major 大型	27,000	36,000	54,000
Intermediate 中型	11,250	15,000	22,500
Minor 小型	5,625	7,500	11,250

The ***Class of Surgery*** *is specified in a* ***separate*** *Schedule Of Surgical Operations available at the end of the* ***Policy Contract****.*

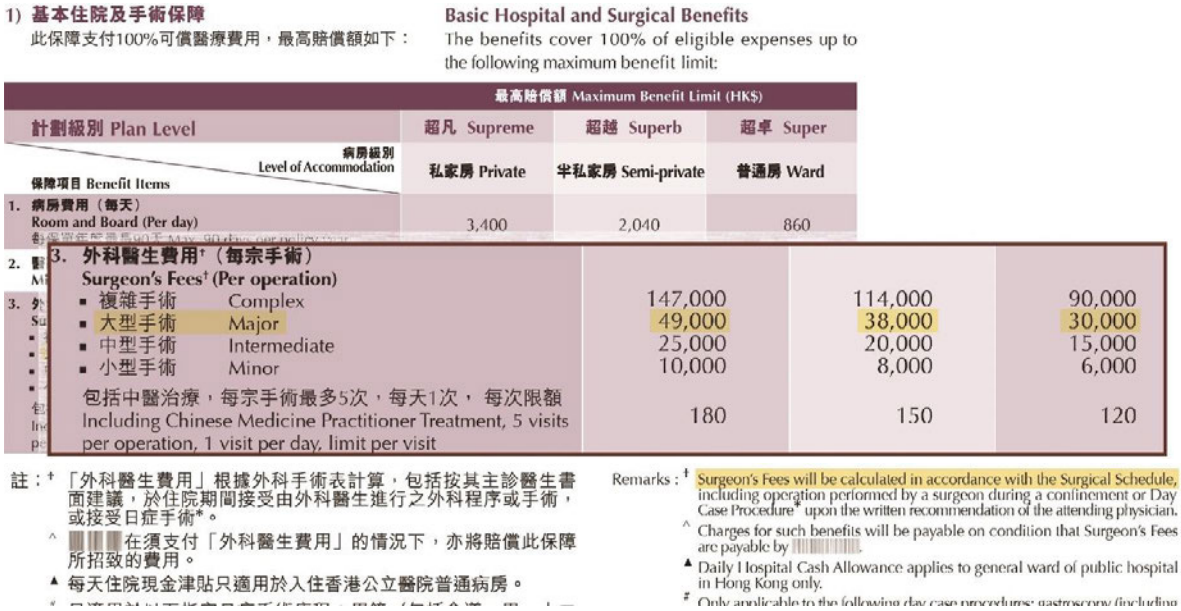
Schedule Of Surgical Operations 手術項目表

For operations not listed in this *Schedule of Surgical Operations* and not expressly excluded herein by any other condition of the policy including all the *relevant documents* , *we* will pay a benefit using a classification at *our* discretion depending on the complexity of the surgery involved.
凡手術未列於此「手術項目表」內，同時亦未有任何保單條款包括「有關文件」及細則明確表示屬保障範圍以外，「本公司」將根據有關手術之複雜程度，酌情決定手術分類而作出賠償。

Body Region	Surgical Operation		Classification
Skin and Breast 皮膚及乳房			
Skin 皮膚	Excision of skin lumps or tumour of subcutaneous tissue, including lipoma, neurofibroma or its variants, sebaceous cysts, pilonidal cyst, malignant melanoma, and naevus etc.	皮膚硬塊或皮下組織腫瘤切除，包括脂肪瘤、藏毛囊腫、神經纖維瘤或其變異體、皮脂腺囊腫、惡性黑色素瘤及痣等	Minor
	Suture of wound on skin	皮膚上作傷口縫合	Minor
	Drainage of subungual haematoma or abscess	指甲下血腫或膿腫引流	Minor
	Skin grafting or keloid operation	皮膚移植或疤痕疙手術：	Minor
	Incision and/or drainage of skin abscess	皮膚膿腫切口及引流	Minor
	Incision and/or removal of foreign body from skin and subcutaneous tissue	乳房囊腫的細針活檢	Minor
	Wedge resection of toenail (unilateral or bilateral)	甲楔切除 (單側或兩側)	Minor
	Curettage/cryotherapy/cautierisation/laser treatment of lesion of skin	皮癌或皮下病變組織切除/ 冷凍治療 / 電灼治療 / 激光治療	Minor
Breast 乳房	Incisional breast biopsy	乳房切口活組織檢查	Minor
	Fine needle aspiration of breast cyst (FNA)	乳房囊腫細針活檢	Minor
	Breast tumor / lump excision or excisional biopsy	乳房腫瘤切除或切除性活組織檢查	Intermediate
	Duct papilloma excision	導管乳頭狀瘤切除	Intermediate
	Partial or simple mastectomy	部份或簡單乳房切除手術	Intermediate
	Partial or radical mastectomy with axillary lymphadectomy	部份或徹底乳房切除手術連同軸向腋下淋巴結切除手術	Major

Example 2: (Insurance Company B)

Product Brochure *provides that Benefits of Surgeon's Fees depend on the* ***Surgical Category*** *(Complex, Major, Intermediate, Minor). Under the table, there is one remark indicating that the Surgeon's Fees will be calculated in accordance with the* ***Surgical Schedule****.*



1) 基本住院及手術保障
此保障支付100%可償醫療費用，最高賠償額如下：

Basic Hospital and Surgical Benefits
The benefits cover 100% of eligible expenses up to the following maximum benefit limit:

計劃級別 Plan Level	最高賠償額 Maximum Benefit Limit (HK$)		
	超凡 Supreme	超越 Superb	超卓 Super
保障項目 Benefit Items / 病房級別 Level of Accommodation	私家房 Private	半私家房 Semi-private	普通房 Ward
1. 病房費用（每天） Room and Board (Per day)	3,400	2,040	860
3. 外科醫生費用†（每宗手術） Surgeon's Fees† (Per operation)			
▪ 複雜手術 Complex	147,000	114,000	90,000
▪ 大型手術 Major	49,000	38,000	30,000
▪ 中型手術 Intermediate	25,000	20,000	15,000
▪ 小型手術 Minor	10,000	8,000	6,000
包括中醫治療，每宗手術最多5次，每天1次，每次限額 Including Chinese Medicine Practitioner Treatment, 5 visits per operation, 1 visit per day, limit per visit	180	150	120

註：† 「外科醫生費用」根據外科手術表計算，包括按其主診醫生書面建議，於住院期間接受由外科醫生進行之外科程序或手術，或接受日症手術*。
^ [redacted]在須支付「外科醫生費用」的情況下，亦將賠償此保障所招致的費用。
▲ 每天住院現金津貼只適用於入住香港公立醫院普通病房。

Remarks : † Surgeon's Fees will be calculated in accordance with the Surgical Schedule, including operation performed by a surgeon during a confinement or Day Case Procedure* upon the written recommendation of the attending physician.
^ Charges for such benefits will be payable on condition that Surgeon's Fees are payable by [redacted].
▲ Daily Hospital Cash Allowance applies to general ward of public hospital in Hong Kong only.

The ***Policy Contract*** *also specifies that "the Surgeon's fees shall be paid subject to the…* ***Schedule of Benefits****…".*

> 3. **Surgeon's Fees** – the fees payable for a surgical procedure or operation performed on an Insured by a Surgeon during a Confinement or Day Case Procedure upon the written recommendation of his attending Physician.
>
> The Surgeon's fees shall be paid subject to the maximum benefit limits specified in the Schedule of Benefits with reference to the relevant surgical category and percentage payable for such operation under the surgical schedule. If an operation performed is not included in the surgical schedule, the Company reserves the right to determine its surgical category with reference to the gazette issued by the Hong Kong government, relative value units or any other relevant publication or information such as the schedule of fees recognized by the local government, relevant authorities and medical association.

However, the Surgical Schedule is not available in the sample policy contract. As the fieldworkers did not further request information from the insurance company or the agent, the Study cannot determine if the Surgical Schedule is provided in the actual policy contract when a consumer confirms the purchase; or when a consumer makes an enquiry with the insurance company or agent.

Different Definitions of Key Policy Terms in Contracts

PHI policy contracts are usually lengthy, complicated and full of technical terms. Without knowledge of contract language and technical terms, contracts may be difficult for ordinary consumers to comprehend and understand. It can become even more complicated as the structure and terms of PHI policy contracts are not standardised; contracts can differ from company to company, it can also differ within different plans from the same company. Each policy is set out in a different format and definitions of some key policy terms vary among different plans and insurance companies.

By way of example, below are seven different PHI contract excerpts, taken from six different insurance companies. All of the contracts, including the two different PHI plans from the same insurance company, have used different definitions for "Medically Necessary" and "Reasonable and Customary".

Medically Necessary

Below are sample provisions from different policies highlighting the factors the insurance companies use to decide whether a treatment or service is considered "medically necessary". These factors are lumped together in a list of items which may vary in:

(1) **wording** (e.g. most cost-efficient manner and setting, reasonably cost-effective manner, the least costly setting);

(2) **conditions** (e.g. in accordance with generally accepted medical practice, consistent with the diagnosis and customary medical treatment, not for the convenience of the Insured, not rendered primarily for diagnostic tests); and

(3) **determining parties** (e.g. in the Company's opinion, the recommendation of Physician or Surgeon), from contract to contract.

As to who determines whether a treatment or service is medically necessary has been an area of contention as shown in the Council's complaints review exercise (See Chapter 4 – case studies 10 and 11).

The legal consultancy team advised that the Canada Health Act 1984 (CHA)[46] refers "medically necessary" under the definition of "hospital services" in section 2, but it does not go so far as to provide definition on "medically necessary".

Insurance Company C

"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.

[46] In Canada, healthcare is publicly funded and administered under the Canada Health Act 1984 (CHA), which is applicable provincially and territorially. The CHA only refers to "medically necessary" under the definition of "hospital services" in s2 of the CHA.

Insurance Company D

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 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.

Insurance Company E

Medically Necessary: means the necessity to have a medical service which are:

(1) consistent with the diagnosis and customary medical Treatment for the condition; and
(2) in accordance with standards of good and prudent medical practice; and
(3) not for the convenience of the Insured, the Insured Person, or any person coming within the meaning of General Definition items 30 and 34 below; and
(4) performed at a Reasonable and Customary charge on Treatment of a covered Disability.
(5) Performed in the least costly setting required for Treatment of a covered Disability. Experimental, screening test and preventive services or supplies are not considered Medically Necessary.

Insurance Company F

Medically Necessary shall mean the necessity to have medical service which:

(a) require the medical expertise of the medical practitioner;
(b) is consistent with the diagnosis and customary medical Treatment for the condition;
(c) is rendered in a reasonably cost-effective manner;
(d) is not rendered primarily for diagnostic tests, diagnostic scanning purpose, imaging examination, laboratory tests or physiotherapy without medical Treatment.

Insurance Company F (another policy)

Medically Necessary: In respect of Confinement, treatment, procedure, supplies or other medical services, medically necessary means such Confinement, treatment, procedure, supplies or other medical services which:

(1) are required for the diagnosis or direct treatment of the Insured's Disability; and
(2) are appropriate and consistent with the symptoms and findings or diagnosis and direct treatment of the Insured's Disability; and
(3) are in accordance with generally accepted medical practice; and
(4) are not associated with treatment, procedure, supplies or other medical services of an experimental or investigative nature unless it is in the Schedule of Surgical Fees; and
(5) cannot have been omitted without adversely affecting the Insured's medical condition.

Reasonable and Customary Charges

Similar to the observations made of the definitions of "Medically Necessary", the determining factors of what is "Reasonable and Customary" may vary from contract to contract. Factors may include:

(1) the amount of charges made at a location;

(2) average fees charged under similar conditions;

(3) industrial treatment or service fee survey results;

(4) internal claim statistics; and/or

(5) schedule of fees published by the Government.

On top of that, in some contracts, specific clauses (see Insurance Company C below as an example) indicate the insurance companies reserve the right to determine whether an expense is a "Reasonable and Customary" charge. However, contracts without such a specific clause do not explicitly state if they will take only the items listed in the policy contract into consideration. This uncertainty in interpretation may allow the insurance companies to potentially apply other factors not known to a policyholder.

Insurance Company C

"Reasonable and Customary" in relation to a fee, a charge or an expense, means any fee or expense which

(a) is charged for treatment, supplies (inclusive of medication) or medical services that are Medically Necessary and in accordance with standards of good medical practice for the care of an injured or ill person under the care, supervision or order of a Registered Medical Practitioner;

(b) does not exceed the usual level of charges for similar treatment, supplies (inclusive of medication) or medical services in the locality where the expense is incurred, which for the avoidance of doubt, shall not exceed the level of such charges applicable to the relevant Room Type…; and

(c) …

The Company reserves the right to determine whether any particular Hospital/medical charge is a Reasonable and Customary charge with reference but not limited to any relevant publication or information made available, such as schedule of fees, by the government, relevant authorities and recognized medical association in the locality. The Company reserves the right to adjust any and all benefits payable in relation to any Hospital/medical charges which in the opinion of the Company's medical examiner is not a Reasonable and Customary charge.

Insurance Company B

"Reasonable and Customary" shall mean a charge for medical treatments, services or supplies, which does not exceed the general level of charges being charged by the relevant service providers or suppliers of similar standing in the locality where the charge is incurred for similar treatments, services or supplies to individuals of the same sex and age, for a similar disease or injury. ….

In determining whether an expense is 'Reasonable and Customary', the Company may make reference to the following (if applicable):

a) the gazette issued by the Hong Kong government which sets out the fees for the private patient services in public hospitals in Hong Kong;

b) industrial treatment or service fee survey;

c) internal claim statistics;

d) extent or level of benefit insured; and/or

e) other pertinent source of reference in the locality where the treatments, services or supplies are provided

Insurance Company F

Reasonable and Customary Charges shall mean charges for medical care which shall be considered by the Company or its medical advisers to be Reasonable and Customary to the extent that they do not exceed the general level of charges being made by others of similar standing in Hong Kong Special Administrative Region, when furnishing like or comparable Treatment, services or supplies to individuals of the same sex and of comparable age for a similar Disease, Illness, Sickness, Accident or Injury and which in accordance with accepted medical standards, could not have been omitted without adversely affecting the Insured Person's medical condition. Any scales of charges which may be agreed from time to time between the Company and Hospitals and Physicians shall also be indicative of such Reasonable and Customary Charges. The Company accepts the Schedule of Fees provided by the Hong Kong Medical Insurance Association as Reasonable and Customary scale.

Insurance Company F (another policy)

Reasonable and Customary Charges: The charges for Confinement, treatment, procedure, supplies or other medical services which are Medically Necessary but do not exceed the general level of charges at the location for such Confinement, treatment, procedure, supplies or other medical services.

Insurance Company G

Normal and Customary: In relation to fees, means a sum not exceeding a reasonable average of the fees charged under similar conditions by persons of equivalent experience and professional status in the area in which the service was provided; and in relation to material or services, means a sum not exceeding a reasonable average of the charges for similar material or services in equivalent circumstances of quality and economic consideration in the same area as that in which any such material or services were obtained.

According to the legal opinion, an insurance company may consider their own internal claims experience or their medical advisers' opinion when deciding what is "reasonable and customary". Again, this leads to inconsistency between policies depending on the definition given by the insurance company or their own internal experience. In some cases, "reasonable and customary" may be defined differently by the same insurance company for different types of policy coverage, which may confuse consumers, and may wrongly lead consumers to think that one policy provides more coverage than another, without fully understanding the limiting effects and consequences of the policy itself.

Further, the legal consultancy team noted that the Common Law jurisdictions under study (Australia, Canada, Singapore, UK) do not provide statutory definitions and there is no judicial guidance as to the terms "medically necessary" and "reasonable and customary".

Australia and Singapore have used approaches such as product design to encourage the use of medically necessary and appropriate treatment paths (see Chapter 6, Section 6.5 Latest Development).

Lack of Understanding by Consumers about the Meaning of Policy Wordings

Apart from the fact that policy terms and conditions vary among PHI plans, in most cases, these terms are not clearly or extensively defined, which may lead to consumer confusion. Taking the above policy samples as an example, consumers may not understand how the terms below are applied in real practice, or that these terms are open for interpretation by the insurance companies during claim settlements:

- "generally accepted standards of medical practice";
- "with professional and prudent standards of medical practice";
- "not be rendered primarily";
- "good and prudent medical practice";
- "general level of charges being charged by the relevant service providers or suppliers of similar standing in the locality"; and
- "equivalent circumstances of quality and economic consideration in the same area".

5.3 General Legal Principles Applied to PHI Policy Contracts

Utmost Good Faith and Duty of Disclosure

Duty of a Consumer Entering into an Insurance Contract

According to the legal opinion, Hong Kong follows the common law position. The common law principles regarding disclosure were laid down in Carter v Boehm (1766) 97 ER 1162, 1164, which imposed a duty on a person to reveal all material facts of which he is aware prior to the entering of the contract. In deciding whether the information was material or not, it was held that this would be determined by considering whether the information which had not be disclosed or misrepresented would have *"influenced the judgment of a prudent insurer" when assessing the risk. It was also held that the phrase "influenced the judgment of a prudent insurer" denotes an "effect on the thought processes of the insurer in weighing up the risk, quite different from the words which might have been used but were not such as "influencing the insurer to take the risk.""* Material facts will include a policyholder's claim history and events which may give rise to future claims. It is quite common for policies to exclude liability for non-disclosure of earlier events which arise from circumstances known to the insured.

Further, the legal consultancy team noted that the United Kingdom previously followed the common law position, until the enactment of the Consumer Insurance (Disclosure and Representations) Act 2012 (the 2012 Act), which applies to consumer contracts. Under the 2012 Act, there is *"a duty by the consumer to take reasonable care not to make a misrepresentation to the insurer."*

The position in Australia has also changed with statutory provisions governing the duty of disclosure, since the enactment of the Insurance Contracts Act 1984 (ICA). Under s21 ICA, there is only the requirement *"to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that: (a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or (b) a reasonable person in the circumstances could be expected to know to be a matter so relevant, having regard to factors including, but not*

limited to: (i) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and (ii) the class of persons who would ordinarily be expected to apply for insurance cover of that kind." [47]

As these statutory provisions will not apply in Hong Kong, unless a similarly worded statute is enacted, common law principles will continue to apply.

It is observed that terms related to "non-disclosure" are commonly included in policy contracts, though the definition and the sections/headings where it locates vary; for example, some may come under the sections/headings called "misrepresentation/fraud", "non-disclosure", "material disclosure", "misstatement" or "conditions precedent to liability". The following provides some examples of such "non-disclosure" clauses:

Insurance Company F

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.

Insurance Company A

Misrepresentation or Non-disclosure
If you or the insured person, or anyone acting for you or the insured person make(s) a statement in the enrollment form and declaration or in connection with any claim knowing that the statement to be false, or fail to disclose pre-existing conditions or fail to act in utmost good faith, we will not be liable for the claim and all cover under this policy shall cease immediately. We will not be liable to refund any premium paid.

Insurance Company C

THE POLICY CONTRACT
If your application omits facts or contains materially incorrect or incomplete facts, we have the right to declare the Policy void.

Consumers should be cognisant of this duty and fill out the application form/health declaration document with due care. They should also ensure that they respond to questions with information of which they are aware. That said, when it comes to disputes relating to non-disclosure clauses, consumers may argue they were confused or that they held different views as to what information was required be provided or disclosed. This was observed in the Council's complaint cases and also during in-depth interviews (see Chapter 4 – case studies 14, 15 and 16). For example, some insurance companies had rejected claim applications citing that the complainants did not report an "illness" in their health declaration. The complainants did not agree with the insurance companies, and

[47] However, for life insurance policies regarding non-disclosure and misrepresentation by insured, there are changes as a result of the Insurance Contracts Amendment Act 2013 in Australia, for example s27A (Certain contracts of life insurance may be treated as if they comprised 2 or more separate contracts of life insurance); s29 (Life Insurance); s30 (Misstatement of age) and s31A (non-disclosure by life insured).

argued that results of routine medical check-ups or minor sicknesses which happened a long time ago from which they made full recovery, should not be considered an "illness".

Below are excerpts of the application forms of Insurance Company F and Insurance Company A, for which some health questions may be considered as too general, vague and not specific enough, having the possibility of causing confusion to consumers. For instance, there is a lack of definite timeframe; the phrases "any disease" and "respiratory system" may be too broad; and consumers may be confused by whether A&E admissions happened in the past which did not involve follow-up treatment is considered as "admission to hospital" and whether a visit to a general practitioner for a minor illness which had been recovered is considered as having "received medical advice" and thus whether such information is expected by the insurance companies to be disclosed.

Insurance Company F

- Has any person to be insured been admitted to a hospital or received any surgery, medical advice, treatment or examination including X-ray/imaging/ECG/MRI/laboratory test, etc.? [If "Yes", please provide a copy of the original medical report(s)]
- Has any person to be insured suffer from any disease not mentioned above?

Insurance Company A

- Have you ever been admitted into hospital or sanitorium, or undergone or been recommended to undergo surgery (other than that associated with a full term pregnancy)?
- Have you ever suffered from or been treated or do you foresee to consult with a medical practitioner for any of the following disorders or diseases?
  (i) ...
  (ii) The respiratory system (e.g. tuberculosis, asthma, chronic bronchitis) or other related symptoms/diseases?
  (iii) ...

As discussed previously and in Chapter 6, under the 2012 Act, an insurance company has to ask the consumer specific questions to obtain information about his/her circumstances when he/she buys insurance. The 2012 Act also gives the consumer legal protection if he/she unknowingly gives incorrect or incomplete information to the insurance company.

The UK position may provide insight into how the application form/health declaration document could be improved. For example, in the Implementation Recommendations issued by the Association of British Insurers, a suggested question set for a motor insurance related question was "Have you had or caused any accidents, claims or damage involving any motor vehicle (including car, motorcycle or van) in the past 5 years, whether or not a claim was made, and regardless of blame?". The way that such a question is phrased may give clearer instructions to consumers as they are specifically asked to disclose any accidents, claims, losses or damages to any vehicle in the past 5 years for all drivers on the policy, whether or not a claim was made, and regardless of blame. Asking specific questions may facilitate consumer clarity and lead to clearer answers and provide the necessary information for underwriting. This may result in avoiding disputes based on non-disclosure clause and post-claim underwriting.

The Code of Conduct for Insurers issued by the Hong Kong Federation of Insurers provides some guidance on the disclosure of material facts in policy proposals. In general, when a proposal form is used, the proposal form should ask questions in plain language and, if appropriate, explain how the questions should be answered. If a proposal form calls for the disclosure of material facts, a statement should be included in the form explaining the consequences of a failure to disclose all "material facts" (i.e. facts relevant to the insurance company's decision whether or not to provide coverage). The form should also highlight that in addition to the specific questions asked in the proposal, an insurance applicant must also include any facts that an insurance company would regard as likely to influence the insurance company's assessment and acceptance of the proposal. Also, there should be a statement warning that if the applicant is uncertain as to whether or not particular information is material, these facts should be disclosed in any event. Furthermore, for matters which insurance companies consider to be material, they should be the subject of clear and specific questions in the proposal form and questions should be avoided which would require a knowledge of certain facts which the average applicant would be unlikely to possess.

However, the Code of Conduct for Insurers may be too general in this respect. For instance, how would the applicant know what is an important consideration for the insurance companies? Also, the wordings that "if the applicant is uncertain as to whether or not particular information is material, these facts should be disclosed" puts all the responsibility on the consumers. To close this understanding gap, the Council considers that there is much room for improvement.

Duty of an Insurance Company to Provide Insurance Protection

On the insurance company's part, it has a duty to deal with claims in good faith.

According to the legal opinion, in Canada, the duty of utmost good faith has been set out by the court as follows: *"The relationship between an insurer and an insured is contractual in nature. The contract is one of utmost good faith. In addition to the express provisions in the policy and the statutorily mandated conditions, there is an implied obligation in every insurance contract that the insurer will deal with claims from its insured in good faith Whiten v. Pilot Insurance Co. (1999), 1999 CanLII 3051 (ON CA), 42 O.R. (3d) 641 (Ont. C.A.). The duty of good faith requires an insurer to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its insureds.... The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. It must not deny coverage or delay payment in order to take advantage of the insured's economic vulnerability or to gain bargaining leverage in negotiating a settlement. A decision by an insurer to refuse payment should be based on a reasonable interpretation of its obligations under the policy."*

Referencing the complaint statistics received by the Council, "delay in claim settlement" ranked as the second most frequent complaint between 2015 – 2018. The Council is of the view that this could be an area of improvement for the insurance companies and that they should commit to the duty to provide insurance protection and act promptly and fairly when dealing with claims made by the policyholders.

Interpretation of Insurance Contracts

The legal consultancy team advised that a party who relies on a clause exempting him from liability can only do so if the words of the clause are clear on a fair construction of the clause. The Hong Kong courts, when interpreting the policy wording where a party is trying to exclude or limit his liability, will consider all the relevant terms, whether the policy words are clear, and will adopt a meaning which a reasonable person having all the background knowledge would conclude.

Entire Agreement

The Policy Contract Contains the Whole Agreement

It is common for the PHI policy contracts to have a clause to state that the signed contract represents the entire agreement between the insurance company and the policyholder, regardless of whether any other written or verbal agreements have been made to the policyholder by representatives of the insurance company. However this may not be the understanding of the ordinary consumer. The policy contracts under the Study commonly have this clause, though located in various sections of the policy contracts, such as under "The Contract", "Entire Contract and Changes", "Policy/Whole Agreement", "Insuring Clause" or "Policy Conditions", etc.; and wordings vary among policies and most are unclear (see examples below). Only two policies (Insurance companies F and H) explicitly state that the policyholder should not rely on any representation or promise made by agents if it is not written in the policy contract.

Insurance Company E

This Policy, including the Schedule, endorsements, "the Classifications Schedule", appendix and amendments (if any), will constitute the entire contract between the parties. Any change in this Policy is not valid unless evidenced by the Company's endorsement or amendment.

Insurance Company F

This Policy contains the whole agreement between the parties and the Policyholder acknowledges that the Policyholder has not relied upon any oral or written representation made to the Policyholder by the Company, its employees or agents.

Insurance Company H

The application for this Policy, any medical evidence form and any written statement and answers furnished as evidence of insurability, together with the Policy, constitute the entire contract.
The Company will not be bound by any promise or representation heretofore or hereafter made by or to any agent or person other than as specified above.

The legal opinion advised that whether the entire agreement clause excludes liability for misrepresentation would depend on the construction of the clause and its effect. In HIH Casualty & General Insurance Ltd v Chase Manhattan Bank the court held that a contracting party cannot exclude liability for its own fraud and, if it wished to exclude the liability for the fraud of its agent, it must achieve that by using clear and unmistakable terms on the face of the contract.

From a legal perspective, Insurance Company F, from the sample above, has clearly specified that the "Policyholder acknowledges that the Policyholder has not relied upon any oral or written representation made to the Policyholder by the Company, its employees or agents". Therefore once the policyholder signs the contract, it is unlikely that he/she can rely on the oral or written representation made to him/her which are not included in the contract by the insurance company or the agent as an argument in any dispute.

That said, in the interests of fairness and consumer rights, the Council considers that the insurance companies and intermediaries should provide oral or written representation to consumers which are: 1) Accurate at any period of time according to the policy contract; and 2) Free from representation not in line with the policy that could be misleading or confusing to consumers, including but not limited to benefit coverage, benefit level and policy terms and conditions.

The IARB receives and handles complaints related to the conduct of a Registered Person (e.g. insurance agent). According to its statistics, "making inaccurate or misleading declaration/representation" was the number one reason in substantiated allegations from 2015 to 2018, comprising 16% of the total substantiated allegations. It should be noted that this figure represents complaints against all types of insurance products and not just an individual figure for PHI products only. However, it is quite an indication that misleading representation is a common malpractice among the insurance agents.

Possible Discrepancies between Sales Materials and the Policy Contract

Other than representations made by the insurance company or the agent, consumers usually rely heavily on the sales materials such as the sales brochure, which in their opinion offers comprehensive and comprehensible information, before making a purchase decision. Comparing the sales brochures and the policy contracts of insurance companies, the Council notes that there are cases where discrepancies were commonly found between the information listed in the former and the latter documents, such as terms relating to premium adjustment. Taking Insurance Company I below as an example, determining factors for the premium adjustment stated in its brochure including "claims and persistency experience, medical price inflation, projected future medical costs…". However, more lenient terms stating that the company "reserve the right to review and adjust the premium" was found under the "Premium adjustment" section of its policy contract, without further reference to any determining factors.

The Council is of the view that such differences, which offer greater flexibility and room for manoeuvre to the insurance company, increase the uncertainty to be faced by consumers regarding premium increases, which is often one of their essential concerns. If a consumer does not read the policy contract carefully, he/she may wrongly believe that the future premium will only be adjusted based on the factors set out in the brochure, which in fact may not be the case.

Insurance Company D

Premium adjustment [Under the Sale Brochure]
The premium is non-guaranteed and will be determined annually based on the age of the Insured on his or her next birthday at the time of renewal. The premium may increase significantly due to factors including but not limited to age, claims experience and policy persistency.

Renewal
It is clarified that the premium rates for each renewal are determined based on the age of the Insured at the next birthday, are not guaranteed and are subject to change at the sole discretion of the Company.

Insurance Company I

Remarks [Under the Sale Brochure]
Premium rates are yearly adjustable… at the time of policy application/renewal which are not guaranteed. We will determine the relevant premium rates based on several factors, such as our claims and persistency experience, medical price inflation, projected future medical costs and any applicable changes in benefit.

Premium adjustment
We reserve the right to review the premium rates at each renewal and adjust the premium rates accordingly across a particular risk class.

Unilateral Variation

As observed from the Council's complaint cases and in-depth interviews, consumers' grievance also arose when changes in policy provisions were unilaterally imposed by the insurance companies. Two common examples are (1) benefit enhancements leading to a premium increase that was unwanted, out of expectation, and over the budget of the policyholder; and (2) imposition of excluded items upon renewal or while the policy was in effect (see Chapter 4 – case studies 1, 2, 3 and 7).

Insurance Company F

Change in the Premium Rate of this Policy
The Company shall have the right to change the rate of the premiums payable on this Policy and on any supplemental provisions on the Expiry Date or anniversary of the Effective Date, whichever is the earlier.

Renewal
Renewal is arranged automatically and is guaranteed for life. The premium payable upon renewal and the terms of any renewal may not be the same as for the expiring Policy and will be determined by the Company.

Insurance Company J

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.

Premium Payment

The Premium is calculated by reference to the Age, sex and Class of Risk of the Person insured on the Commencement Date and at the time of renewal of this Policy...

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.

Insurance Company J provides factors that are considered for the calculation of premium at the time of renewal (e.g. age, class of risk). This is in contrast to Insurance Company F, where a general statement gives the insurance company the right to make unilateral changes on premium and terms. In this case, it is apparent that Insurance Company J provides more references to consumers than Insurance Company F.

In the below example, Insurance Company A explicitly states that it has no obligation to provide policyholders with the rationale for the variation of the premiums and terms. There is no doubt that such practice undermines consumers' right to know. Consumers in this case are not able to make an informed decision on whether it is worth renewing the PHI policy given the revised premiums and terms.

Insurance Company A

Renewal

...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...

We will not be obligated to reveal our reasons for such amendments.

As for the scope to which these variations apply, there are some insurance companies (e.g. Insurance Company G) which clearly state in its terms that such changes to the premiums and/or terms apply to ***all*** policyholders under the policy. This implies that such changes are not based on an individual policyholder's own conditions (e.g. health conditions or claim records). Out of the 18 policies studied, only 3 policies have such similar wording. The implication may be that (i) the variations reflect the overall changes in the aggregated risk of the pool; and (ii) under this clause, the insurance company is not able to cherry-pick healthy consumers by significantly increasing premiums on or imposing limitations on benefits to individual policyholders with claim experience that the insurance company considers unfavourable to it.

Insurance Company G

The Contract

...may amend the rate of Subscription, Benefits, terms and conditions of the Contract from time to time subject to prior written notice to the Subscriber, provided that such amendments apply to all members of the same age under the same product and upon renewal...

For the other PHI policy contracts, there is no explicit wording stating that the same change will apply to all policyholders. Instead, there are clauses in these insurance companies' contracts which reserve the right to apply these variations either to ***specific groups*** of policyholders or to ***individual*** policyholders. The policy terms of Insurance Company K below states that for all of the plans, the company reserves the right to adjust the premium and terms "in respect of like categories of Insured Person(s)". As for the example of the latter scenario, in its policy terms Insurance Company H reserves the right to revise the premiums and benefits of "this Policy", which refers to the contract between an individual policyholder and the insurance company. This kind of terms may offer latitude for insurance companies to compensate costs or eliminate risks generated from policyholders of higher risk in the pool.

Insurance Company K

PART IV – PREMIUM
The Company reserves the right to adjust the premium and/or terms of this Policy in respect of like categories of Insured Person(s), such as Age or health conditions for all the Insured Plans in the Scheme specified in the Schedule.

Insurance Company H

Renewal and Revisions
…The Company reserves the right to revise the terms and conditions of this Policy including the premiums and the benefits upon policy renewal.

From a legal perspective, the legal opinion advised that it is common for insurance companies to unilaterally include exclusion terms while the policy is in effect, and as a result reject a claim when submitted. Consumers usually do not read or pay attention to such provisions. Generally, in case of an ambiguity in a contract which specifies a variation (where one party unilaterally changes or amends the terms and conditions of the contract), the clause will be construed in favour of a construction which would limit/restrict the scope of the clause. The court will however, also look at the intention of the parties to create legal relations.

The legal consultancy team supplemented that in RTS Flexible Systems Ltd v Molkerei Alois Mueller GmbH and Co KG (UK) Productions, at paragraph [45] it was stated: *"Where there is a binding contract between the parties and, if so, upon what terms depends upon what they have agreed. It depends not upon their subjective state of mind, but upon a consideration of what was communicated between them by words or conduct, and whether that leads objectively to a conclusion that they intended to create legal relations and had agreed upon all the terms which they regarded or the law requires as essential for the formulation of legally binding relations."* Further, the intention to enter into legally binding relations will be determined objectively, and one should not enquire into the state of minds of the parties, as context is all-important. The burden of proving a lack of intention to create legal relations would be on the person seeking to rely on the variation.

The legal consultancy team therefore advised that if a policyholder signs the policy with the full knowledge that the insurance company reserves the right to make unilateral alterations to the terms, then it will be difficult to argue that the term should not be enforced against the consumer. In this context, unilateral notification of a term without notifying the other party, and without that parties' agreement, will not be considered a variation.

In the example considered below, the legal consultancy team was of the view, the effect of the wordings is that the insurance company maintains the right to amend the terms and conditions of the policy at any time. Further, the widely drafted clause of the automatic guaranteed renewal for successive periods of twelve months provision, allows the insurance company to make changes to the policy terms on the issuing of the new policy, and on payment of the premium. The amount of premium in such cases will also be determined by the insurance company. Therefore, if a consumer does not read the terms carefully, the insurance company may automatically renew the policy on different terms and possibly, higher premiums, and change the Benefit Schedule. The insured will then have to comply with the new policy terms at their own risk.

Insurance Company J

Policy Changes
We reserve the right to amend the terms and conditions of this Policy at any time whilst this Policy is in force pursuant to any applicable legislation effective at the Commencement Date or during the term of the Policy.

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 "Plan", 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.

Implications to the Limitation on Guaranteed Renewal

Guaranteed renewal is one of the most essential features of a PHI policy as it provides continuous protection to policyholders. In most of the policies, as long as policyholders are willing to pay the premium, which is subject to amendment by the insurance company as set out in the policy contract, they have a guaranteed right to renew their policies. However, in the below examples the policy contracts show that the right to cancel or terminate a policy are reserved by the insurance companies. The term of Insurance Company L is more restrictive than that of Insurance Company A, as the former only allows for termination of a policy in the event that the whole plan is no longer offered by the insurance company. In contrast, Insurance Company A is entitled to cancel a policy provided that an advance notice is given to the policyholder.

For avoidance of doubt, the Council suggests that, in instance where the insurance company reserves the right to terminate the policy even when there is no breach from the policyholder, such fact should be clearly stated and prompted to the insureds upon contract signing and at the time of renewal.

Insurance Company A

Cancellation
We have the right to cancel this policy or any section or part of it by giving thirty (30) days' advance notice in writing by registered post to your last known address.

Insurance Company L

Commencement and Renew
The Plan may also be terminated by the Insurer with effect from any Due Date by giving one month's prior notice in writing of the intention not to renew the Plan if the pool is ceased to offer by the Insurer.

Double Insurance

A policyholder may think taking out more than one PHI to cover the same risk/interest will ensure he/she is well protected. This is known as double insurance. In reality, this could have the opposite effect as different policies will limit or exclude liability by relying on an "Other Insurance" clause. There is a possibility that the policyholder may obtain no reimbursement from any policies at all for the same risk leaving him/her totally unprotected.

Most PHI policies contain an "Other Insurance" clause. There are three types of "Other Insurance" clauses, (1) excess clause; (2) escape clause; and (3) rateable proportion clause. There is another way of expressing such clauses under the umbrella of "Other Insurance". PHI policies in Hong Kong usually contain excess clauses, meaning the insurance company will only be liable to pay for any excess not covered under another policy. It should be noted that different policies provided by the same insurance company may also contain different types of "Other Insurance" clauses. Within the 18 policies collected for the Study, by looking at the wording, 14 of them contain an excess clause, while 3 of them contain escape clauses or a rateable proportion clauses. One of them does not have an "Other Insurance" clause or similar provision.

Below are examples of excess clauses, escape clauses and rateable clauses:

Insurance Company B
(Excess clause)

Other Insurance or Sources
In the event that an Insured is entitled to recover all or part of the expenses from any other insurance or sources, the Company will only be liable for such amount in excess of the amount payable under such other insurance or sources.

Insurance Company M
(Excess clause)

LIMITATION OF CLAIM
When the Insured is entitled to Benefits payable under another insurance policy or reimbursed through any other means, the Benefits under this Basic Plan shall be limited to the lesser of
a) the balance of expenses not covered by Benefits payable under another insurance policy or any other means; or
b) the maximum limits of each Benefit as specified in the Benefit Schedule.

Insurance Company F
(Escape clause)

BENEFIT LIMITATION
We will not pay any benefit in respect of any Disability for which compensation is payable under any law or for which a benefit is payable under any medical program or other insurance policy except to the extent that the relevant medical expenses are not reimbursed by such law, medical program or insurance policy.

Insurance Company F (another policy)
(Rateable clause)

Other Coverage and Co-ordination of Benefits
In the event that a benefit covered or payable under the other contract or plan and/or such extension benefits provisions exceeds the amount payable for the benefit under this Policy, the Company will only be liable for a rateable proportion of any such claim.

According to the legal opinion, for there to be double insurance, the following factors must be present, and the policy must cover the following: (1) same insured; (2) same subject matter; (3) the same risk; (4) same interest; and (5) same period of time.

The legal consultancy team further advised that complications can arise if both policies have a combination of "Other Insurance" clauses. The law on double insurance is unclear. Different combinations of "Other Insurance" clauses may have different effects. Conclusion of each and every case will be subject to the actual circumstance and its own merits. For example, generally where there is a combination of an escape clause, the effect could be that they may be self-cancelling. This means that the policyholder may have no cover at all. In the case of a combination of an excess clause, the usual effect would be they may not be self-cancelling and both insurance companies may be liable.

Consumers should note that in either event, based on the concept of indemnity,[48] the policyholder will not receive reimbursement from different insurance companies at a total amount that is more than what he/she has actually lost for the same insured item.

Pre-existing Conditions

In Australia, there is a provision under section 47 of the ICA (excerpt below) which deals with pre-existing sickness or disability. In effect, the insurance company cannot avoid liability to unknown pre-existing conditions, i.e. pre-existing conditions the policyholder was not aware of prior to the policy effective date.

[48] PHI is usually a kind of indemnity insurance, which is a contractual agreement in which the insurance company guarantees compensation for actual losses sustained by the policyholder.

Section 47 of the ICA

Pre-existing sickness or disability

(1)This section applies where a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.

(2)Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.

According to the legal opinion, in *Asteron Life Ltd v Zeiderman*, Spigelman CJ stated: "…Where exclusion is based on the state or condition of the subject matter of the insurance, the insurer should not be able to rely on that exclusion if the insured proves that, at the time the contract was entered into, he did not know, and a reasonable man in his circumstances would not have known, of the existence of the relevant state or condition."

Eight out of the 18 PHI policies studied have such wordings, and provide that pre-existing conditions that the policyholder was aware of before the effective date of the policy are excluded from coverage (see below example). This may imply that pre-existing conditions with signs or symptoms of which the policyholder was not aware of are covered by the policy.

Insurance Company D

Pre-existing Conditions - shall mean Disability which existed before the Effective Date in respect of the Insured and which presented signs or symptoms of which the Insured or the Policy Owner of this Policy was aware or should reasonably have been aware.

Exclusions

The Company shall not be liable to pay any benefits under this Policy in respect of hospitalization, surgical and other medical fees and expenses incurred directly or indirectly caused by:

1. …
2. …
3. Pre-existing Conditions.

Insurance Company K

Pre-existing Conditions – means any Medical Condition or Related Condition for which the Insured Person have received medical Treatment or had signs or symptoms of which the Insured Person was aware or should reasonably have been aware prior to …

PART 3 – EXCLUSIONS

The Company will not be liable for any loss in respect of :

1. Pre-existing Conditions;
2. …

However, 9 PHI policies are less specific and more limiting and do not mention whether the signs or symptoms of pre-existing conditions, nor whether the policyholder's awareness matters. The policy wordings simply state the insurance company will not pay any benefit in respect of any pre-existing conditions prior to the policy effective date. Please see below example.

Insurance Company F

Pre-Existing Condition
We will not pay any benefit in respect of any pre-existing conditions or recurrence of chronic pre-existing conditions prior to the Policy Date or any date of reinstatement, whichever is later.

One PHI policy explicitly states that pre-existing conditions are excluded irrespective of whether the policyholder was aware of the signs or symptoms prior the policy effective date (see Insurance Company N as example).

Insurance Company N

"**Pre-existing Condition**" shall mean any disease, illness or condition (a) for which the Insured Person has received medical treatment or has been attended to by a Registered Medical Practitioner or has been prescribed drugs; or (b) the symptoms of which occur (regardless of whether they are known or unknown to the Insured Person or the Policyholder) prior to the latest of the Date of Issue, the Effective Date or the effective date of reinstatement of this Policy.

Section 5 – Exclusions
The Company shall not be liable to pay any benefits under this Policy in respect of Hospital Confinement or expenses incurred directly or indirectly caused by or under any of the followings:
1) …
2) Pre-existing Conditions.

With regard to the issue of pre-existing conditions, the Council has the following views:

(1) Coverage of unknown pre-existing conditions (when policyholders were not aware of symptoms and signs prior to effective policy date)

The Council upholds the principles adopted by the Australian courts. As a matter of fairness, pre-existing conditions which (1) presented signs or symptoms of which the policyholder was not aware of and; (2) a reasonable person in the circumstances could not be expected to have been aware of prior to the policy effective date, should be covered by the policy.

(2) Principle used to determine a policyholder's awareness of the pre-existing conditions

When an insurance company establishes whether a policyholder was aware of the signs or symptoms prior the policy effective date, or whether such signs or symptoms are associated with the sickness which the claim is meant to cover, the Council is of the view that the decision should be based on the principle of what is fair in all the circumstances and taking into account various matters, including:

- the nature and severity of symptoms suffered by the policyholder;
- the timing of the sequence of events;
- the insured's medical history; and
- the level of medical consultation and/or investigation undertaken.

5.4 Summary

According to the legal opinion, the main problems with private medical insurance are (1) the lack of standardised wordings in contracts; (2) complex language adopted by insurance companies; (3) lack of understanding by consumers of the significance of policy wordings; and (4) attempts by insurance companies to limit/exclude liability.

A policy contract is an important document which specifies all the provisions agreed upon between the insurance company and the policyholder, which includes the following:

- the scope of coverage of the insurance product;
- the level of benefits;
- the circumstances/conditions in which the policyholder is entitled to reimbursement;
- the circumstances/conditions in which the insurance company has the right to cancel the policy;
- items excluded from the coverage; and
- provisions for renewal.

Accordingly consumers should carefully read the policy contract so that they are aware of the significance of the key policy terms before taking out the policy. The Council advises consumers of PHI policy contracts to:

- Always read and rely on what is written in the policy contract; not on the sales materials or oral presentation of insurance intermediaries.
- Not rely on the attractive wordings in sales materials such as "guaranteed renewal" or "comprehensive medical plan". Carefully read the policy contract for details of any limitations. Check if the policy will suit their needs. If they are uncertain of any of the wordings, they should seek clarification with the insurance company and best in written form.
- Read through the whole contract document as important provisions, such as the Exclusions and Schedule of Operations, may be set out near the end of the contract; also some clauses under exclusions may cross-reference with other clauses in the contract.
- Fill out the application form/health declaration form with due care; a person entering into an insurance contract has a duty of disclosure.
- Bear in mind the insurance company may have the right to vary the policy contract provisions; the clause related to unilateral variation is currently included in most policy contracts.
- Take note of the significance of the "Other Insurance" clause; a combination of two or more "Other Insurance" clauses could result in no medical coverage at all.

As for the insurance companies, the Council is of the view that they should set out provisions in a fairer and more equitable manner and commit to its duty to deal with consumer claims in good faith. Insurance intermediaries should also be under responsibility of accurately

and clearly explaining the provisions and the significance of key policy terms to consumers/policyholders. The Council advises the PHI industry to:

- Provide sample policy contracts on a publicly accessible platform, so that consumers can have the chance of studying the terms and conditions, exclusions and benefit schedule, etc., before committing the purchase.
- Improve the design of application forms to ask questions in a more specific way, so as to minimise disputes related to "non-disclosure" clause.
- Devise and adopt standardised definitions of key policy terms to facilitate consumers to make comparison between policies.
- Provide coverage for unknown pre-existing conditions, which would enhance certainty of protection to policyholders.
- Enhance transparency on change of policy terms, benefit and premium, for instance where the insurance company reserves the right to make unilateral revisions to the terms and conditions, such fact and the factors which trigger the revisions should be clearly stated and prompted to prospective policyholders before they commit the purchase.
- Enhance training to insurance intermediaries. The requirements on the responsibility of insurance intermediaries in providing accurate information regarding PHI plans (e.g. coverage, benefit limits, exclusions) and clear explanations regarding significance of key policy terms to consumers/ policyholders could be set out in industry code for insurance companies/ intermediaries to follow.

6 Review of PHI in Selected Jurisdictions

In six jurisdictions where PHI plays a similar role to Hong Kong, Council desktop research on their regulatory approaches demonstrates various measures have been adopted to promote consumer protection and sustainable development of the PHI sector.

- Addressing certainty of coverage and quality of PHI products, there are examples of standardised level of benefits and definitions for treatments.
- Looking at promotion of accessibility, affordability and continuity, examples are found on the coverage of pre-existing conditions, available option to switch to a more affordable plan, guaranteed access, renewal and portability.
- Regarding enhancement on disclosure, transparency and choice, there are examples of standardised information sheet of product summaries as well as specified information which insurance companies should disclose to consumers at different stages. The UK has a legislation which deals with a consumer's duty of disclosure and representation to an insurance company. Some authorities also set up assessable platforms to facilitate product comparison.
- All jurisdictions under review provide a cooling-off period by mandate or common practice.

Some new initiatives taking place in the jurisdictions under review include the categorisation of hospital insurance products, introduction of clinical categories, provision of switching options to policyholders for terminating products, introduction of pre-authorisation framework and panel of preferred healthcare providers.

This Chapter highlights certain key features of PHI in six jurisdictions selected for study as the role of PHI in Australia, Ireland, Mainland China (the Mainland), Malaysia, Singapore and the United Kingdom (the UK) is similar to Hong Kong. It describes the regulatory structures, approaches and requirements of these jurisdictions in various aspects of consumer interests, including PHI product design (standard level of benefits and standardised definitions for key policy terms), guaranteed acceptance, renewal and portability, treatment of pre-existing conditions, disclosure requirements on insurance companies and consumers, complaint handling mechanism and cooling-off period, as well as the approaches to encourage PHI take out.

New developments in PHI regulations are also discussed. The information contained in the Chapter is based upon desk research of the readily available sources in the public domain as a benchmark to the current status in Hong Kong and is not meant to be a comprehensive review of the PHI markets under study.

6.1 The Role and Structure of PHI Markets[49]

Across the globe, the role of PHI in the healthcare system can be classified into three general groups, namely "primary" (e.g. the United States),[50] "supplementary" (e.g. Australia and Hong Kong), and both "primary and supplementary" (e.g. Netherlands and Switzerland).[51] For the goal of enhancing consumer protection, reference is drawn from Australia, Ireland, the Mainland, Malaysia, Singapore and the UK as, like Hong Kong, PHI is supplementary/ voluntary in these countries.

In these jurisdictions, total healthcare expenditure is predominantly funded by government, from general tax revenue, earmarked income tax and/or employment-related insurance contributions. PHI plays a supplementary role in the healthcare system financing. People can choose to voluntarily purchase PHI from the private sector to give themselves a wider range of healthcare service options, more choice of healthcare providers, faster access for non-emergency services and/or more comprehensive coverage. Table 8 shows the role of PHI and regulatory of PHI in these jurisdictions.

Table 8: Role of PHI and regulator of PHI in selected jurisdictions

Jurisdiction [1]	Government Role on Health System	Supplementary Role of PHI (Voluntary) [2]	Legislation and Regulator of PHI
Australia	Regionally administered universal public medical insurance programme, Medicare, funded through income taxes for public hospitals	About 47% bought complementary (e.g., private hospital and dental care, optometry) and supplementary coverage (increased choice, faster access for non-emergency services)	• Private Health Insurance Act 2007 (PHIA) • Private Health Insurance (Prudential Supervision) Act 2015 • Australian Prudential Regulation Authority (APRA)
Ireland	Health Service Executive (HSE)	45% of the population was insured	• Health Insurance Act 1994 • The Health Insurance Authority (HIA)

[49] Part of the content of this section was referenced from: The Commonwealth Fund. (2017)International Profiles of Healthcare Systems.

[50] In jurisdictions where PHI plays a primary role, for instance in the United States, residents are mandated by law to purchase health insurance from private insurance companies. Total expenditure on healthcare is predominantly funded by premiums being paid directly to insurance companies. Under the Patient Protection and Affordable Care Act of 2010, individuals (except those qualify for one of the several exemptions) are required to obtain PHI coverage starting from 2014. Individuals failing to do so may pay a fee called the individual shared responsibility payment (sometimes called the "penalty"). However, the President Donald Trump signed on December 2017 a tax bill that repeals the Act's tax penalty by zeroing out the fines, effective in 2019.

[51] In some jurisdictions, PHI plays both a primary role and a supplementary role, such as the case of Netherlands and Switzerland. For instance, residents in Netherlands are legally obliged to take out standard health insurance to cover the cost of, for example, consulting a general practitioner, hospital treatment and prescription medication. The government decides on the cover provided by the standard package. All insurance companies offer the same standard package. Healthcare insurance companies are obliged to accept anyone who applies for the standard insurance package and must charge all policyholders the same premium, regardless of their age or state of health. On top of that, 84% of people in Netherlands also opt to take out voluntary additional insurance to cover healthcare that is not covered by the standard package, for example, physiotherapy or dental care. In this case, insurance companies are not obliged to accept everyone who applies for additional insurance. The Commonwealth Fund. (2017) International Profiles of Healthcare Systems.

The Mainland	Supervision by health authorities (Health and Family Planning Commissions) at the national, provincial and local levels; some direct provision through public ownership of hospitals	Complementary to cover cost-sharing and gaps, as well as better health care quality and/or higher reimbursements; no data on coverage, but growth has been rapid	• Measures on Administration of Health Insurance 2006 [3] • China Insurance Regulatory Commission (CIRC)
Malaysia	Government-run universal healthcare service	About 24% bought supplementary coverage (for hospitalisation and surgical expenses, critical illness and cash benefit)	• The Insurance Act • Guideline on Medical and Health Insurance Business issued by the Central Bank, Bank Negara Malaysia • The Central Bank, Bank Negara Malaysia
Singapore	Government subsidies at public healthcare institutions Medisave: mandatory medical savings program for routine expenses MediShield Life: catastrophic health insurance (run by the Central Provident Fund (CPF) Board) Medifund: government endowment fund to subsidise healthcare for low-income and those with large bills	Medisave-approved Integrated Shield Plans(IPs) (provide additional private insurance coverage component run by the insurance company) supplement MediShield Life coverage to provide catastrophic health coverage for additional ward classes; there are also non-IP plans; private insurance also provided by employers; no data on coverage	• Insurance Act • Monetary Authority of Singapore (MAS)
The UK	National Health Service (NHS)	About 11% bought supplementary coverage for more rapid and convenient access (including to elective treatment in private hospitals), with the bulk of it provided through employers	• Insurance Act 2015 • Consumer Insurance (Disclosure and Representation) Act 2012 • Prudential Regulatory Authority (PRA) • Financial Conduct Authority (FCA)

Hong Kong	The public sector is the predominant provider of secondary and tertiary healthcare services. Secondary healthcare encompasses specialised ambulatory medical services and general hospital care that are curative in nature. Tertiary healthcare refers to highly complex and costly hospital care.	46.7% of the population were entitled to medical insurance (i.e. medical benefits provided by employers/companies or covered by medical insurance purchased by individuals or had both kinds of medical protection	• Insurance Ordinance • Insurance Authority

Remarks:

[1] Source of information of the table taken from the Commonwealth Fund. (2017) *International Profiles of Healthcare Systems.*

[2] Some rounding of figures are done for presentation purpose. PHI in this table refers to medical insurance, irrespective of whether it is purchased by individuals or provided by employers.
Sources of enrolment rate of PHI for
- Australia and UK: The Commonwealth Fund. (2017) *International Profiles of Healthcare Systems.*
- Ireland: The Health Insurance Authority, Ireland. (2018) *Annual Report & Accounts.*
- Malaysia: Ministry of Health, Malaysia. (2016) *Malaysia Health Systems Research Volume I.*
- HK: Census and Statistics Department, Hong Kong. (2017) Thematic Household Survey Report No. 63.

[3] The current regulation was enacted in 2006. In November 2017, the authority published consultation on the proposed new Measures on Administration of Health Insurance.

6.2 Regulatory Approach and Requirement

Although PHI is voluntary in the selected jurisdictions, some of them have specific legislation, administrative measures, guidelines, codes and/or policies in place to promote PHI purchase rates and good practices of this market. For instance, Australia, Ireland and the Mainland have specific legislation in place for private health insurance, namely Private Health Insurance Act 2007, Health Insurance Act 1994 and Measures on Administration of Health Insurance 2006, respectively.

Malaysia, Singapore and the UK have general insurance legislation (e.g. Acts or Regulations related to insurance) which apply to PHI, with some of them also including specific provision(s) for PHI. For example, the Insurance (General Provisions) Regulations in Singapore stipulates the free-look period (i.e. 14 days cooling-off period) for life policies and accident and health policies.

The sections below will explore some of the regulatory requirements aimed at enhancing PHI consumer protection in the selected jurisdictions, and the learnings that Hong Kong may benefit from.

Providing Certainty and Quality

Standardised Definitions for Key Policy Terms

As discussed in previous chapters, different interpretations of key policy terms such as "Medically Necessary", "Reasonable and Customary Charges", are a problematic area of PHI, as observed from consumer complaints. Based on the research findings, most of the

jurisdictions under study do not have any standardised definitions on these important policy terms, though some observations were found.

In 2005, the Bank Negara Malaysia (BNM) issued the Guidelines on Medical and Health Insurance Business; one of the requirements under the Guidelines was the "use of standard definitions for key policy terms and conditions where applied to facilitate comparability between products and minimise public confusion over coverage due to variations that may not be apparent to policy owners at the point of purchase".[52] It is found that some key policy terms (e.g. Hospitalisation, Medically Necessary, Pre-existing Illness and Reasonable and Customary Charges) are very similar amongst different PHI policies of different insurance companies in the Malaysian market, which may be a result of this Guideline requirement.

Although the legislation in Singapore does not have a provision regarding definitions of policy terms, the Ministry of Health in Singapore encourages insurance companies to be transparent and upfront with their customers by keeping their terms and conditions simple and clear. Where necessary, the Ministry may require an insurance company to amend its contract if any of the terms and conditions are ambiguous.[53]

For more discussions about the definition issue from the legal perspective, please see those presented in Chapter 5.

A Standard Level of Benefits

In Australia and Ireland, a standard level of benefits is adopted. In Australia, it is mandated by law[54] that all PHI hospital plans must cover at least 25% of the surgical fees, according to the Medicare Benefits Schedule[55] for private patients. From April 2019 onwards, the implementation of the Australian Private Health Insurance Reforms will require insurance companies to categorise PHI hospital products as Gold/Silver/Bronze/Basic, and use standardised definitions for treatments to make it clear to consumers what is and what is not covered in their policies. More information about this new development is given in this Chapter (See section 7.5 on the Latest Development).

In Ireland, it is mandated by law[56] that insurance companies that are offering cover for in-patient hospital services must offer a minimum level of benefits. They must provide a minimum level of cover in respect of the following aspects: daycare/in-patient treatment; hospital out-patient treatment; maternity benefits; convalescence; psychiatric treatment and substance abuse. The minimum accommodation level is semi-private in a public hospital. The law specified a list of special procedures and corresponding procedure benefits. For instance, it is stipulated that the prescribed minimum payment of a procedure shall be 35% of the procedure benefit as specified, for health services provided by a private hospital.

[52] Bank Negara Malaysia. Insurance Annual Report 2005. The Guidelines on Medical and Health Insurance Business is not available for public review.

[53] Ministry of Health, Singapore. (2009) Parliamentary QA No:145: Health Insurance Regulation.

[54] Private Health Insurance Act 2007.

[55] The Medicare Benefits Schedule lists a wide range of consultations, procedures and tests, and the Schedule fee for each of these items. The Schedule fee is the amount the Australian government considers appropriate for one of these services.

[56] Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996.

Promoting Accessibility, Affordability and Continuity

Coverage of Pre-existing Conditions

In Australia and Ireland, it is unlawful for PHI insurance companies to refuse consumers with pre-existing conditions; PHI should provide coverage for pre-existing conditions, subject to a waiting period.

Under the Private Health Insurance Act 2007 in Australia, insurance companies are not allowed to exclude coverage of pre-existing conditions after the insured has served the waiting period, which is up to 12 months for hospital benefits. This requirement applies to new and existing members upgrading their policy to higher level benefits. The legal definition of a pre-existing condition refers to any ailment, illness or condition where signs of symptoms existed at any time six months before the insurance contract commences, in the opinion of a medical adviser appointed by the insurance company. The example presented in the following box illustrates the application of a waiting period for pre-existing conditions.

> An insured was experiencing nausea and abdominal pain a month before she took out hospital insurance from a health insurance company. She consulted her GP about the problem shortly after joining the insurance company. Her GP referred her to a specialist, who diagnosed gallstones and recommended surgery. The doctor appointed by the health insurance company determined that symptoms of the insured's condition were in existence in the 6 months before she joined the insurance company. Although the insured's GP had not diagnosed gallstones initially, the symptoms of nausea and pain had been present for some time before the insured saw him or joined the health insurance company. The insurance company advised the insured she would not be eligible for benefits for treatment of the gallstones for the first 12 months of her membership.
>
> (Source: Excerpt from the brochure "Waiting periods for private health insurance" published by the Private Health Insurance Ombudsman (PHIO) in Australia)

In Ireland, the Health Insurance Act 1994 (Open Enrolment) Regulations 2015 stipulates that the maximum waiting period an insurance company may impose on a pre-existing condition is five years. The definition of a pre-existing condition is an ailment, illness or condition where the signs or symptoms existed at any time six months prior to the policy commencing. After such waiting period, the insurance company must cover the insured for any other illnesses once the initial waiting period[57] has expired.

In Malaysia, the Guidelines on Medical and Health Insurance Business to Enhance Policy Owner Protection issued by the authority (BNM) specifies that exclusion of coverage for pre-existing conditions must relate to medical conditions a policy owner ought to have been reasonably aware of at the time of health insurance policy purchase.

[57] Initial waiting period refers to 52 weeks for maternity benefits and 26 weeks for other conditions that did not exist at the time the insured person started insurance.

Community Rating

In Australia[58] and Ireland,[59] PHI premiums are community-rated by law. This means each insurance company is only allowed to charge all its customers a flat premium for the same product and level of services/benefits, regardless of age and health risks. In principle, this control can prevent insurance companies from using prohibitive premium loading to drive away high-risk enrollees without breaching the guaranteed issue requirement. It is noted that insurance companies are still allowed to set their own premium levels for their products, and a Risk Equalisation System is implemented to off-set market competition imbalances and further protect consumers.

Risk Equalisation System

Because of the guaranteed issue requirement and community-rating of insurance premium, an insurance company may have a relatively older and less healthy customer profile compared with its competitors. This will put the financial position of the insurance company concerned and hence the interest of their consumers at risk, and will distort market competition. In order to enable level playing and maintain financial viability of the PHI funds, the Australian and Irish governments introduced a risk equalisation system which transfers and shares costs across all insurance companies according to their risk profiles. In a nutshell, the system transfers payment from those with lower-than-average risk exposure to those with higher-than-average risk exposure.

Premium Approval

According to the Measures on Administration of Health Insurance of the Mainland, insurance companies shall submit drafted insurance clauses and premium rates for health insurance to the CIRC for examination and approval or filing according to relevant stipulations of CIRC.

Option to Switch to a More Affordable Plan

In Singapore, insureds under IPs are given the option to switch to a more affordable plan should they consider the premium of the current plan unsuitable for them. The Monetary Authority of Singapore (MAS) requires insurance companies to highlight in the product summary and premium notification letter that the policy owner has the option to switch to another IPs with lower coverage and premium, in case affordability is a concern for the policy owner.[60]

Guaranteed Access, Renewal and Portability

In both Australia and Ireland, private health insurance companies are required by law to accept applications, with no right of refusal in handling new enrolments and renewals of insurance contracts. Moreover, no premium loading except Lifetime Health Cover (LHC in Australia) or Lifetime Community Rating (LCR in Ireland) is allowed[61] and the entry age is not restricted. This enables consumers to enjoy guaranteed access to PHI regardless of age and health status.

[58] Private Health Insurance Act 2007.

[59] Health Insurance Act 1994.

[60] Monetary Authority of Singapore. (2015) Notice 120 Disclosure and Advisory Process Requirements for Accident and Health Insurance Products.

[61] LHC and LCR are loading introduced by the Australian Government and Irish Government respectively, to promote young population to take out PHI. See section 7.4 Approaches to Encourage PHI Take Out for more details.

PHI coverage is guaranteed for life. Insurance companies do not have the discretion to cancel insurance contracts or refuse their renewals so long as premium payments are not overdue.

For portability, the insureds can move from one insurance company to another without barriers. The new insurance companies must provide continuity for the waiting periods that the insured have already served, and cannot impose additional waiting periods except for the extra benefits in the new PHI plans. In Ireland, the continuity of the waiting period should be provided for if the switch of insurance company takes place within 13 weeks.

In Malaysia, the Guidelines on Medical and Health Insurance Business specifies that an insurance company should not refuse to renew a PHI policy solely on the grounds of a previous claim made by the policyholder. Also there are initiatives which introduced take-over policy clauses, meaning that insured individuals are allowed to continue their PHI coverage with a different insurance company without being subject to the underwriting scrutiny and benefit limitations applied to new PHI purchasers.[62]

As for the right of insurance companies that can apply in renewal policy contract, the Measures on Administration of Health Insurance of the Mainland restricts the insurance companies' right to adjust liabilities. The Measures stipulates that there should be no specification providing that insurance companies have the right to adjust insurance liabilities and scope of exclusions at the time of renewal shall be made for health insurance products containing a guaranteed renewable clause.

Enhancing Disclosure, Transparency and Choice

Requirements for Disclosure by Insurance Companies

Australia, the Mainland, Malaysia and Singapore have regulatory measures requiring insurance companies to provide specific information to their prospective insureds; however, each jurisdiction differs in the scope and methods of disclosure.

In Australia, health insurance funds are required by law[63] to provide a Standard Information Statement (SIS) with each policy they offer. It is a summary of the benefits and limitations of a health insurance policy and allows a consumer to see the policy's key features at a glance. The consumer, if necessary, will need to contact the health fund to get all the details about the product. The SIS should contain the following aspects of information: services covered, exclusions, restrictions, waiting periods, excesses and co-payments, out-of-pocket expenses and other features. From April 2019 onwards, following the implementation of the Private Health Insurance Reform (see section 7.5), a Private Health Information Statement (PHIS)[64] will replace the SIS as the regulated method insurance companies use to provide information to consumers. The default method for providing a PHIS to a person who asks for information is by post.[65]

In the Mainland, it is stipulated by the Measures on Administration of Health Insurance that insurance companies, when selling health insurance products, shall explain the contents of insurance contract to the applicant and make written representations on the following matters, which are to be acknowledged by the applicant through signing: (1) insurance

[62] Bank Negara Malaysia. Insurance Annual Report 2005.

[63] Private Health Insurance Act 2007; Private Health Insurance (Complying Product) Rules 2015.

[64] Australian Government Department of Health. (2018) Private health insurance reforms: Information provision.

[65] The PHIS could also be sent by other methods, e.g. email or text, or via a webpage, if it is so requested by the person seeking the information.

liabilities; (2) exclusions; (3) elimination period; (4) hesitation period of insurance contract and relevant rights and obligations of the applicant; (5) whether to provide guaranteed renewal and valid time of renewal; (6) claim procedure and document requirements for claim; (7) insurance term of each product in package health insurance; and (8) other matters specified by the authority.

In Malaysia, the authority requires a PHI information sheet containing key product features be provided to policy owners at the point of sale; the information includes but not limited to terms of issue, major benefits, limitations and indicative premium rates.[66]

The MAS issued a notice[67] to insurance companies in Singapore prescribing mandatory requirements on the disclosure of information and provision of advice to policy owners for health and accident policies. It also stipulates detailed items of information that should be disclosed in respective documents, such as (1) product summaries (e.g. benefits, premiums payable for all age bands based on no pre-existing condition, option to downgrade); (2) proposal forms (e.g. risks and limitations of switching or upgrading); (3) acceptance letters (e.g. start of policy coverage), conditional letter of offer (e.g. loading imposed by the insurance company); (4) premium notification letters (e.g. list of policies due for renewal); (5) termination letters (e.g. reinstatement period) and (6) claims settlement letters (e.g. breakdown of claims paid out).

It is worth noting that the MAS notice clearly states that insurance intermediary/representative shall disclose to a policy owner the following information (in which items (a) and (b) should be provided in writing, and items (c) and (d) should be provided in respective documents as mentioned above):[68]

(a) All remuneration, including any commission, fee and other benefits that it has received or will be receiving for providing advice on, or arranging insurance contracts or both, in respect of any health and accident policy;

(b) Any actual or potential conflict of interest arising from any connection to or association with any insurance company;

(c) Option to downgrade an existing integrated shield plan, in the product summary and premium notification letter;

(d) Risk-loading factor to be imposed to the premium, in the conditional letter of offer;

(e) Contractual rights and obligations; and

(f) Risk of the policy (whether the insurance company may alter the terms; decline to renew the policy or unilaterally terminate the policy).

Requirements for Disclosure by Consumers

In UK and Malaysia, there are legislative and administrative requirements in place, respectively; they specify the responsibility of the insurance companies to ask consumers specific questions to obtain relevant information when the consumers submit application proposals for underwriting purposes.

[66] Bank Negara Malaysia. (2005) Guidelines on Medical and Health Insurance Business to Enhance Policy Owner Protection.

[67] Monetary Authority of Singapore. (2004, latest revised on 2015) Notice 120 Disclosure and Advisory Process Requirements for Accident and Health Insurance Products.

[68] As for items (e) and (f), there is no specification on whether they should be provided in writing or in specified document.

In 2013, the Consumer Insurance (Disclosure and Representations) Act 2012 of the UK came into force. The Act makes provision about disclosure and representations by a consumer to an insurance company before a consumer insurance contract (including PHI contract) is entered into or varied. It removes the duty on consumers to disclose any facts that a prudent underwriter would consider material and replaces this with a duty to take reasonable care not to make a misrepresentation. One of the factors to be taken into account when determining whether or not a consumer has "taken reasonable care", is whether or not the questions asked of them at policy inception were clear and specific. In other words, an insurance company has to ask the consumer specific questions to obtain relevant information about his/her circumstances when he/she buys insurance. The Act gives the consumer legal protection if he/she unknowingly gives incorrect or incomplete information to the insurance company. This means that the insurance company is not able to decline a claim on the grounds of non-disclosure unless the consumer carelessly or deliberately lied or misrepresented his/her circumstances. Concepts of "careless", "deliberate" and "reckless" are described in the Act.

In Malaysia, the Guidelines on Medical and Health Insurance Business to Enhance Policy Owner Protection stipulates that proposal forms must include reasonable and specific questions to prompt prospective policy owners to provide relevant information to an insurance company for underwriting purposes before an insurance company can repudiate a claim on the grounds of non-disclosure.

In Singapore, consumers are reminded of their responsibility to provide the facts they know in a proposal form. By law,[69] a warning must be prominently displayed on the proposal form, that if a proposer (prospective policy owner) does not fully and faithfully give the facts as he/she knows them or ought to know them, he/she may receive nothing from the policy.

Platform for Product Comparison

In Australia and Ireland, there are easily assessable platforms set up by the authorities to facilitate product comparison.

In Australia, a website[70] is set up by the PHIO under legislation[71] and every insurance company is required to provide up-to-date information about coverage and premium of each policy on the website (i.e. SIS). Consumers can compare policy features from different insurance companies to help them to choose a PHI policy that best meets their needs.

In Ireland, the HIA provides a comparison tool of the health insurance plans available on the market,[72] giving information on coverage and premium.

For reference, the website[73] set up by Singapore's Ministry of Health provides information regarding IP plans (i.e. with MediShield Life component run by the CPF Board) such as coverage, premiums and sample policy contracts of various insurance companies. Though the platform is not for other private health insurance plans (i.e. non-IP plans).

[69] The Statutes of The Republic of Singapore. (2002) Insurance Act.

[70] See privatehealth.gov.au

[71] Private Health Insurance Act 2007.

[72] See www.healthinsurancecomparison.ie

[73] See www.moh.gov.sg/medishield-life/about-integrated-shield-plans/comparison-of-integrated-shield-plans

Providing Redress

Cooling-off Period

In the Mainland, Malaysia, Singapore and the UK, there are legislation or industry requirements which specify the duration of the cooling-off period, in the range of 10 to 15 days (Table 9).

By legislation, insurance companies in Singapore[74] are mandated to provide a cooling-off period of at least 14 days for new PHI policy owners to review the terms of the policy.

In the UK, the Insurance Conduct of Business Sourcebook (ICOBS) issued by the Financial Conduct Authority, the conduct regulator for financial services firms (including insurance companies) in the UK, stipulates that a consumer has a right to cancel a health insurance contract, without penalty and without giving any reason, within 14 days.[75]

In Malaysia, the mandated cooling-off period is 15 days[76] from the date of issue. A consumer will be entitled to a refund of the full premium, after deducting administrative expenses incurred by the insurance company for issuing the policy. These expenses shall be RM50 or 10% of the gross premium paid, whichever is lesser.

In the Mainland, the mandated cooling-off period for long-term health insurance is not less than 10 days in the current legislation.[77] In 2017, the authority conducted consultation on the proposed new legislation, which proposed the cooling-off period be extended to not less than 15 days.

A cooling-off period is not mandated in Australia and Ireland but is considered common practice. According to the Private Health Insurance Code of Conduct[78] in Australia, insurance companies are encouraged to allow any consumer who has not yet made a claim to cancel their PHI policy and receive a full refund of any premium paid within a period of 30 days from the commencement date of their policy. As for Ireland, it is a general practice that all insurance companies will provide a 14 day cooling-off period from the commencement of the contract, during which time the consumer may cancel and get a full refund. No claims will be paid in respect of these 14 days.[79]

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[74] This applies to accident and health policies with a duration of one year or more. The free look period is at least 14 days after the date of receipt of the policy by the policy owner. Any expense incurred by the insurance company in underwriting the policy shall be recoverable by the insurance company from the policy owner. Monetary Authority of Singapore. (2004) Insurance (General Provisions) Regulations.

[75] Association of British Insurance companies. (2017) Are you buying private medical insurance?; Financial Conduct Authority. (2016) Insurance Conduct of Business Sourcebook.

[76] Bank Negara Malaysia. Insurance Annual Report 2005.

[77] Under the Measures on Administration of Health Insurance (In Chinese《健康保險管理辦法》), cooling-off period is called "hesitation period". "Long-term health insurance" refers to such health insurance under which the insurance term is longer than one year or, the insurance term is not longer than one year but a guaranteed renewal is provided. "Guaranteed renewal clause" refers to a clause in insurance contract providing that the insurance company must renew the policy according to the premium rate and original clauses specified in the contract upon renewal application of the applicants after expiration of the previous insurance term.

[78] The Private Health Insurance Code of Conduct has been developed and adopted by the two industry associations covering private health funds in Australia: the Private Healthcare Australia and the Health Insurance Restricted & Regional Membership Association of Australia.

[79] The Health Insurance Authority. (2018) Private Health Insurance My Rights My Choices.

Table 9: A summary of cooling-off period requirements specified in respective legislation or code in different jurisdictions

Jurisdiction	Mandate / Voluntary	Legislation / Code	No. of Days of the Cooling-off Period	The Date when the Cooling-off Period is Counted from	Deduction for Administration Fee
The Mainland	Mandate	Measures on Administration of Health Insurance	10 *	Not specified	Not specified
Malaysia	Mandate	Guidelines on Medical and Health Insurance Business, 2005	15	Date of issue of policy	Administrative expenses (the lesser of RM50 or 10% of the gross premium paid)
Singapore	Mandate	Insurance (General Provisions) Regulations, 2004	14	Date of receipt of policy	Any expense incurred by the insurance company in underwriting the policy
UK	Mandate	Insurance Conduct of Business Sourcebook	14	Date of receipt of policy	No penalty
Australia	Voluntary	Private Health Insurance Code of Conduct	30	Commencement date of policy	No deduction Full refund
Ireland	Voluntary	General practice of insurance companies	14	Commencement date of policy	Full refund

Remark:
* Applied to Long-term health insurance products only.

6.3 Complaint Handling Mechanism

All six selected jurisdictions under review have established health insurance complaint handling mechanisms, some in the form of an Ombudsman, others by the establishment of dispute resolution centres (Table 10). The responsible organisation in Australia handles only complaints related to health insurance, while those for Ireland, the Mainland, Malaysia, Singapore and the UK also receive other financially related complaints. All the organisations cover claims and non-claims disputes.

These organisations may exist in the form of (i) government agencies/public bodies (the Australia's PHIO, the Ireland's Financial Services and Pensions Ombudsman (FSPO), the Malaysia's BNM and the UK's Financial Ombudsman Service (FOS)), (ii) non-profit organisation (the Malaysia's Ombudsman for Financial Services (OFS)) or (iii) public company

limited by guarantee (the Singapore's Financial Industry Disputes Resolution Centre Ltd (FIDReC)). In the Mainland, the authority (CIRC) also receives and handles complaints by means of mediation.

While government agencies are funded by government revenue, organisations that operate in the form of public companies are usually funded by insurance companies as their "members", either by membership fees, official levy, or case fees.

The Australia's PHIO also receives complaints related to medical service providers (e.g. private hospitals or medical practitioners), so long as the complaints are about a health insurance arrangement.[80] In Australia, Ireland and Malaysia, the respective organisations require the insureds that they must first demonstrate an attempt to resolve disputes with the insurance companies before they make a complaint to these organisations.

Most of the organisations resolve disputes through mediation (and some would escalate to adjudication if mediation is unsuccessful). The decisions of the organisation in Australia is not binding, while the decisions made by the organisations in Ireland, Malaysia, Singapore and the UK are binding. It is interesting to note that whether the final decisions of the Malaysia and the UK organisations are binding are subject to the complainants' acceptance of such decisions. This gives flexibility to the consumers involved to pursue other courses of action such as arbitration or litigation if such decisions are not favourable to them.

Most of the processes do not charge the consumers any fees, at least in the first stage of complaint such as the mediation process. A fee may be payable in the second phase of complaint (adjudication/review) in some jurisdictions. In Singapore, the consumer and the insurance company concerned need to pay S$50 and S$500 respectively for adjudication. In the UK, insurance companies are entitled 25 "free" cases; a case fee applies from the 26th case onwards if the complaint becomes a chargeable case.

The organisation in Australia does not set limits for claims. However, organisations of Ireland, Malaysia, Singapore and the UK have claim limits ranging from around HK$0.5 million to HK$2.3 million.

[80] The PHIO cannot take complaints about the quality of service or treatment provided by a health professional or a hospital.

Table 10: A summary of the complaint handling mechanism applied in different jurisdictions

Jurisdiction	Organisation [1]	Legal Form	Dispute Resolution Process	Claims Limit [2]	Binding of Decision	Funding	User Fee on Complainant	Relationship with Regulator
Australia	Private Health Insurance Ombudsman (PHIO)	Government agency	Mediation	None	Not binding	Government revenue	None	Required to submit an annual report to the Minister for Health
Ireland	Financial Services and Pensions Ombudsman (FSPO)	Statutory body	Mediation (optional) and adjudication	EUR250,000 (HKD2,292,500)	Binding, subject to appeal to the High Court	Levies on financial services providers and a grant from the government	None	The governing council is appointed by the Minister for Finance
The Mainland [3]	China Insurance Regulatory Commission (CIRC)	Public institution	Mediation	–	–	Government revenue	–	CIRC is the regulator

Malaysia	Ombudsman for Financial Services (OFS)[(a)]	Non-profit organisation	Case management (mediation, negotiation or conciliation) by the OFS, and adjudication by the Ombudsman for Adjudication if the complainant or the complainant is dissatisfied with the recommendation made by the OFS	MYR250,000 (HKD477,500)	Binding if the complainant accepts the decision, otherwise the complainant may pursue his/her claim through other means, including a legal process or arbitration	Annual levy and case fee imposed on OFS's Members (financial service providers)	None	OFS is the Operator of the Financial Ombudsman Scheme appointed by BNM pursuant to the Financial Services Act 2013 and Islamic Financial Services Act 2013, while BNM is the regulator of the sector
	Bank Negara Malaysia (BNM)[(b]	Statutory body	Adjudication	MYR500,000 (HKD955,000) (except if it is related to quality of service and unfair claim handling)	Binding if the complainant accepts the decision, otherwise the complainant may take legal action (or arbitration)	Total income comprises revenue from foreign reserves management which includes interest and dividends, non-treasury income, realised capital gains or losses, and is stated at the net of amortisation/ accretion of premiums/discounts and monetary policy cost	None	BNM regulates entities which carry on insurance business, insurance broking, adjusting and financial advisory

Singapore	The Financial Industry Disputes Resolution Centre Ltd (FIDReC)	A public company limited by guarantee	Mediation and Adjudication	SGD100,000 (HKD588,000)	Binding for the insurance company	Annual membership fees from all regulated financial institutions	Mediation: free Adjudication: consumer pays S$50 and the insurance company pays S$500	FIDReC shall submit to MAS a quarterly report on complaints received
United Kingdom	The Financial Ombudsman Service (FOS)	An independent official body, established by the Parliament	Mediation and Adjudication	GBP150,000 (HKD1,530,000)	Binding if the complainant accepts the final decisions	Funded by annual levies and individual case fees payable by firms	Consumer: None Insurance company: All businesses are entitled 25 "free" cases – case fee become applicable from the 26th case onwards	The FOS is responsible for making a yearly report to the Financial Conduct Authority (FCA), which is the financial conduct regulator, on the discharge of its functions

Remarks:

[1] (a)OFS handles disputes about private health insurance, including claims and non-claims disputes (except pricing of insurance products, underwriting, fraud cases and cases that have been or are being referred to the court. (b)BNM handles disputes not in the scope of the OFS.

[2] Reference exchange rates as of January 2019: GBP1 = HKD10.20; EUR1 = HKD9.17; MYR1 = HKD1.91; SGD1 = HKD5.88.

[3] –: No information available.

6.4 Approaches to Promote PHI Purchases

Economic Incentives

The Australian, Irish, the Mainland and Malaysian Governments offer tax credit, tax rebate or tax relief to PHI policyholders in an effort to encourage their residents.

Under the Premiums Reduction Scheme, most Australians with private hospital coverage receive a rebate from the Government to help cover the cost of their premiums. The rebate is income tested.

In Ireland, a member of an approved PHI scheme may get a tax credit. The tax credit is generally granted directly by the insurance company. The insured's premium will be reduced by the amount of the tax credit so he/she will probably not even notice that he/she has got a tax credit. Since 16 October 2013, the relief is limited to the cost of the policy up to a maximum of €1,000 per adult and €500 per child. The relief is given at the standard rate of 20%.

In the Mainland, employees are able to enjoy income tax deductions for individual premiums for "qualified" commercial health insurance products. Qualified commercial health insurance products are defined by the CIRC and sold by insurance companies approved by the CIRC.

In Malaysia, insurance premium for medical benefit including not through salary deduction is entitled individual income tax relief.

Loadings and Surcharges

Apart from the above incentives, Australia and Ireland implemented a penalty approach to incentivise the public and/or the younger generation to purchase PHI.

The Medicare Levy Surcharge is a levy paid by Australian tax payers who do not have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to acquire private hospital coverage, and where possible, use the private services to reduce the demand on the public Medicare system.

To further promote private hospital insurance among younger generations, the Australian Government introduced the Lifetime Health Cover (LHC) programme in July 2000. By LHC, a person starting to take out a hospital plan after age 30 is charged a loading in addition to the base rate premium for the hospital plan. The loading is 2% for each year a person delays joining after age 30, subject to a ceiling of 70%. The loading is removed after 10 years of membership. For example, a person starting to purchase PHI at age 40 would be charged 20% above the base rate premium that applies to those starting to enroll at age 30 or below, and this 20% loading would apply until age 50.

Similarly, Ireland has applied the Lifetime Community Rating (LCR) since May 2015. If a person purchases a PHI policy for the first time at age 35 or older, he/she will pay a 2% loading on top of his/her premium for every year that he/she is over the age of 34. For example, if a person takes out a private health insurance policy for the first time at age 40, he/she will pay 12% more than someone who took out his/she cover before the grace period expired. The loading that applies when a person purchases PHI after the effective date will apply in subsequent years.

6.5 Latest Development

The following section provides the latest developments in Australia, the Mainland and Singapore's health insurance markets and regulations, potentially shedding further light on improving and understanding the problems encountered by consumers in the local PHI market.

Australia – Private Health Insurance Reforms

In late 2015, the Australian Government undertook consultations to identify how PHI may be improved to deliver better value for money for consumers by building a stronger and more sustainable private health system. The consultations aimed to consider ways to enhance the value of PHI to consumers; encourage increased efficiency of PHI; increase effectiveness of Government incentives for private health; and improve sustainability of the private health sector. In October 2017, the Australian Government announced a series of PHI reforms to make it simpler and more affordable for Australians. Different parts of the reform have been implemented in stages and the Private Health Insurance Reforms will come into full effect on April 2019.[81]

A full list of the reform is provided in Appendix 2. Three key items warrant attention: (i) categorisation of hospital insurance products into four product tiers based on the scope of coverage; (ii) the introduction of a new list of clinical categories for hospital treatment; and (iii) the improvement in consumer protection for terminating products.

(i) Categorising hospital insurance products into four product tiers (Gold/Silver/Bronze/Basic)

Starting from 1 April 2019, hospital products will be categorised into four tiers – Gold, Silver, Bronze and Basic. For each tier, there is a stipulated list of hospital treatments by clinical category that it should cover as a minimum requirement. Insurance companies can offer additional coverage in Basic, Bronze and Silver tiers, for instance:

- The Basic tier product, at a minimum, entitles consumers to three treatments (rehabilitation, hospital psychiatric services and palliative care), which may be offered on a restricted basis.[82]
- In addition to what is covered by Basic products, Bronze products include coverage of 16 more categories of hospital treatments, such as the brain and nervous system, eyes, ears, nose and throat, kidney and bladder, etc.
- Silver products cover seven more categories than Bronze, such as the heart and vascular system, lungs and chest, blood, etc.
- Gold products cover nine extra categories from Silver, such as cataracts, joint replacement and spinal fusion, dialysis for kidney disease, etc. It is also the only category that offers coverage for rehabilitation, hospital psychiatric services and palliative care without restrictions.

[81] The Department of Health, Australian Government. (2018) Private health insurance reforms: Overview.

[82] Restricted cover refers to being covered as a private patient in a public hospital. However, if the insured is a private patient in a private hospital, his/her health fund will not pay any benefits towards the theatre fees and only a small benefit towards his/her accommodation fee. This means the insured will face considerable out-of-pocket costs.

The new product tiers will give consumers greater certainty about the services covered by each type of hospital treatment products. The changes also make it easier for consumers to shop around and compare different hospital treatment products in order to find a suitable one.

(ii) Introducing a new list of clinical categories for hospital treatments

Along with the new requirement of product tiers, PHI insurance companies will be required to use standard clinical categories across all of their documentation and platforms. The Australian Government has developed a list of standard clinical categories which is consumer-friendly, easy to understand and designed to cover all hospital treatments. The standardised set of clinical categories defines inclusions and exclusions, which help consumers to make an informed choice about PHI and what different products do, and do not, cover.

For example, for the clinical category "heart and vascular system", which is one of the minimum requirements for Silver and Gold products, the list specified that it should cover "hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls". Details about the treatments that should be covered are also included in the list, for instance in this case one of the treatments covered is "Transluminal balloon angioplasty of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)".[83] This kind of specificity helps clarify insurance coverage for consumers.

(iii) Improving consumer protection for terminating products

One of the new requirements also stipulates that insurance companies must adequately inform each insured if their policy is about to terminate, how the termination will proceed and the associated transfer to a new product. If an insurance company chooses to terminate a product, they will need to provide information to affected insureds about the new policy, such as coverage, waiting period, premium and the difference between the terminating policy and the new policy. The affected insured should also be given the choice to transfer to a different policy within the same insurance company instead of the one chosen by the company.

The Mainland – Consultation on Proposed New Regulation

In November 2017, the CIRC announced a public consultation on proposed new Measures on Administration of Health Insurance. The proposal, among other things, suggested the following new measures:

- Premium rates of short-term individual health insurance products can be adjusted, and the range should not exceed 30% of the benchmark premium rate.
- For long-term health insurance products, insurance companies can provide in the contracts that the premiums would be adjusted, in which case they should specify the conditions which trigger the adjustments.

[83] "Transluminal balloon angioplasty of coronary artery" in Chinese usually refers to "冠狀動脈腔內成形術" (or in layman term "通波仔").

- When a policyholder possesses more than one effective medical insurance policies of the type of reimbursement basis, he/she can decide the order of claim applications.
- The waiting period of medical insurance should not be longer than 6 months.

At the time when this Study report was prepared, there had been no information regarding the progress of the consultation and the revision of the Measures available from the public domain.

Singapore – Recommendations by Health Insurance Task Force (HITF)

In view of the increasing pressures on the premiums of IPs, the HITF was formed in February 2016 with the objective to better understand the factors affecting IPs cost and recommend methods to moderate the escalation of future IPs premiums in Singapore. The HITF is comprised of representatives from the insurance industry, healthcare professionals and consumers in Singapore.

In October 2016, the HITF published a report which sets out a list of recommendations, with the aim to keep claims escalation in check and IPs premium levels affordable. In summary, the recommendations include: introducing medical fee benchmarks or guidelines; clarification on existing process to surface inappropriate medical treatment; enhancing insurance procedures and product features (incorporating a panel of preferred healthcare providers, co-insurance and deductibles, and pre-approval of medical treatment); and educating consumers. Details of these recommendations are provided in Appendix 3.

Some of the recommendations such as co-payment requirements, pre-authorisation framework, and panel of preferred healthcare providers have been implemented. In line with the HITF recommendations, the Life Insurance Association (LIA) had developed two best practice guidelines[84] for IPs for insurance companies to adopt in January 2018, with a view to help consumers manage their healthcare costs.[85]

(i) Pre-authorisation framework

Establishing a process for policyholders to obtain a review and approval for a medical treatment and its estimated bill size prior to the actual procedure. This serves to guard against unnecessary treatments, unexpected out-of-pocket payments, and possible denial of a claim.

(ii) Panel of preferred healthcare providers

Establishing a list of doctors which insurance companies are confident of offering appropriate and cost-effective medical services to policyholders. This initiative, common for employee benefit insurance in Singapore, is suggested to be effective at managing fees charged by healthcare providers and to keep claims within a reasonable range. As for the policyholders, they could have the assurance that their insurance company will cover their claims. In this respect, the guidelines advised the insurance companies should aim to ensure that the standard of care provided by their panel of preferred healthcare providers is consistent with customary medical treatment and is in accordance with generally accepted medical practice in Singapore.

[84] MU 70/18 – Integrated Shield Plans: Good practices on panel of preferred healthcare providers; and MU 71/18 – Integrated Shield Plans: Good practices on pre-authorisation framework/process. Life Insurance Association. (2018) IP Riders to incorporate co-payment as part of multi-prong effort to manage healthcare and healthcare insurance costs in Singapore.

[85] Life Insurance Association, Singapore. (2018) Industry news.

6.6 Summary

All the jurisdictions studied have approached PHI regulation differently. Some have legislation specific to PHI, others have guidelines, codes and regulations issued by the regulatory authorities and/or industries. It is clear that governments and regulatory authorities have taken various measures to promote consumer protection and healthy development of the sector. For example, standardised definitions for key policy terms, standardised categories of hospital insurance products for easy comparison, and a standardised list of clinical categories to facilitate consumer understanding of policy coverage.

The promotion of accessibility, affordability and continuity was also a strong theme, with examples offering consumers the option to switch to a more affordable plan and coverage of pre-existing conditions. There are also examples on the requirement of disclosure by insurance companies, in particular disclosure of detailed items of information in specific documents and provision of advice by insurance intermediaries on remuneration and conflict of interest, the requirement of insurance companies to ask consumers specific questions at policy inception, the provision of cooling-off period and available platform for product comparison. These are all valuable examples worthy for discussion and consideration among stakeholders in local to respond to issues identified in previous parts of the Study, such as consumer demand on coverage certainty, information transparency, accessibility, affordability and continuity of PHI.

7 The Value of Voluntary Health Insurance Scheme

After years of public discussion, the Government, with the aims to alleviate the imbalance between the public and private healthcare services and maintain the sustainability of Hong Kong's healthcare system, has launched the Voluntary Health Insurance Scheme (VHIS). 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 consumer protection.

To address some of the shortcomings of IHIP available in the existing market, the VHIS offers IHIP with enhanced accessibility, continuity, quality, certainty and transparency. The key features of the VHIS include:

- Extended entry limit to age 80;
- Guaranteed renewal up to age 100 without re-underwriting due to changes in health conditions;
- No lifetime benefit limit;
- Coverage of unknown pre-existing conditions;
- Cooling-off period of 21 days;
- Coverage of day case procedures;
- Minimum benefit limits;
- Coverage of prescribed non-surgical cancer treatment, prescribed diagnostic imaging tests, treatment for congenital conditions and psychiatric treatment;
- Standardised policy terms and conditions; and
- Premium transparency.

For development of the VHIS, the Council believes that the Government should take into consideration other aspects for future review of the scheme, such as to:

- Standardise application form;
- Ensure fair treatment in the underwriting process;
- Mandate written explanations; and
- Monitor the implementation.

The VHIS is a policy initiative implemented by the Food and Health Bureau (FHB) concerning indemnity hospital insurance plans (IHIPS) offered to individuals, with voluntary participation by insurance companies and consumers. Under the VHIS, participating insurance companies can offer hospital insurance plans that are certified by the FHB to be compliant with the VHIS Scheme Rules, called the Certified Plans. This Chapter provides an overview of the VHIS, including the minimum requirements of the VHIS, the institutional framework to govern compliance of the VHIS products, and ways the VHIS may address some of the problems identified from research findings and provide improvement for betterment of consumer benefits and protection.

7.1 Background and Objectives of the VHIS

In December 2014, the Government launched a public consultation on the VHIS. It set out a proposal to introduce a regulatory regime requiring insurance companies selling and/or effecting individual hospital insurance to comply with a set of minimum requirements prescribed by the Government. This regulation aimed to improve the accessibility and continuity of hospital insurance as well as enhance the quality, transparency and certainty of health insurance protection.

The Government announced in January 2017 that it would implement the VHIS through a non-legislative framework with refined minimum requirements and related proposals. Given the diverse views on the proposed establishment of the High Risk Pool, the two related minimum requirements of "guaranteed acceptance" and "portable insurance policy", which were included in the original proposal set out in the consultation paper, would be dealt with at a later stage as concluded by the Government.

In March 2018, the Government announced the details of the VHIS, including the scope of protection and policy template of the Certified Plans as well as the code of practice with which participating insurance companies ("VHIS Providers") must comply. In November 2018, the Government further published the company registration rules and product compliance rules. The VHIS was fully launched on 1 April 2019. VHIS Providers started offering their Certified Plans to consumers since then.

According to the Government, the objectives of the VHIS are to (1) enhance the protection level of hospital insurance product; (2) provide the public with an additional choice of using private healthcare services through hospital insurance; (3) relieve the pressure on the public healthcare system in the long run.

7.2 Key Features

Certified Plans

Under the VHIS, there are two types of Certified Plans, namely the Standard Plan and Flexi Plans:

- **Standard Plan** – Provides standardised basic protection according to the minimum requirements of the VHIS; and
- **Flexi Plans** – Provides flexible top-up protection compared to Standard Plan, e.g. higher benefit amount and/or more coverage.

Voluntary Participation

As reflected in the name, participation in the VHIS by both insurance companies and consumers is voluntary. Insurance companies registered with the Government as VHIS Providers are required to make a FHB certified Standard Plan available to all consumers for new application at all times, while Flexi Plans availabilities are optional. Consumers can voluntarily choose to take out any Certified Plan(s) from any registered VHIS Provider(s). Same as the existing market practices, VHIS Providers can underwrite the insureds to assess their risk and decide whether to accept the application unconditionally, or accept the application with premium loading and/or case based exclusions, or reject the application.

Minimum Requirements

The Standard Plan and basic coverage of Flexi Plans are required to adopt a set of minimum requirements as specified under the VHIS. The minimum requirements are set out in three aspects with a view to:

(a) Improve accessibility and continuity of insurance – extension of entry age limit to 80 years old, guaranteed renewal without re-underwriting and up to the age of 100, no "lifetime benefit limit", cooling-off period of 21 days;

(b) Enhance quality of insurance protection – coverage of day case procedures on top of hospitalisation; prescribed diagnostic imaging tests subject to co-insurance; congenital conditions; prescribed non-surgical cancer treatments and psychiatric treatments; unknown pre-existing conditions subject to a standard waiting period and reimbursement arrangement (a waiting period of 3 years upon policy inception, i.e. 0% of claim amount in the 1st year, 25% in the 2nd year and 50% in the 3rd year, and full coverage from the 4th year onwards); minimum benefit limits specified; no cost-sharing by policyholders except for prescribed diagnostic imaging tests; and

(c) Promote transparency and certainty of hospital insurance products – standardised policy terms and conditions and premium transparency via posting age-banded premiums through the official websites of the VHIS Office and every VHIS Provider.

See Table 11 for details of the minimum requirements.

A Standard Plan and the basic coverage of Flexi Plans must meet all the prescribed minimum requirements. As for the flexible top-up protection offered by Flexi Plans, they still need to meet certain minimum requirements (e.g. guaranteed renewal without re-underwriting and up to the age of 100, no "lifetime benefit limit").

Scheme Documents

The VHIS is administered by the FHB. The following provides a list of scheme documents, issued by the FHB, for which VHIS Providers must comply with under the VHIS:

(a) Registration Rules for Insurance Companies under the Ambit of the VHIS – Insurance companies must be successfully registered with the FHB as VHIS Providers before they are allowed to sell Certified Plans.

(b) VHIS Certified Plan Policy Template – The policy terms and benefits of all Certified Plans, whether Standard or Flexi Plans, must be based on the standard template.

(c) Product Compliance Rules under the Ambit of the VHIS – IHIP must be certified by the FHB according to the Rules before they can be marketed as Certified Plans.

(d) Code of Practice for Insurance Companies under the VHIS – VHIS Providers must comply with the required practices stated in the Code, covering product offering, migration, sales and marketing, cooling-off period, and underwriting.

Incentive to Encourage Take Out

To provide an additional incentive for purchasing Certified Plans, the Government allows tax deduction for relevant premiums paid. Taxpayer who or whose spouse is the policyholder of a policy issued under a Certified Plan of VHIS may claim tax deductions up to HK$8,000 per insured person for the premiums paid in relation to the Certified Plan. The insured

person of the Certified Plan should be the taxpayer or any specified relatives, which cover the taxpayer's spouse and children, and the taxpayer's or his/her spouse's grandparents, parents and siblings. There is no cap on the number of policies or specified relatives eligible for tax deduction by a taxpayer.

Migration Arrangement

Under the migration arrangement, VHIS Providers are required to offer at least one opportunity for the policyholders who have signed up for existing individual hospital insurance policies before the VHIS implementation to switch to a Certified Plan. VHIS Providers are required to fulfill this commitment within the ten years since the full implementation of the VHIS on 1 April 2019. The two associated underwriting arrangements are as follows:

(a) Same plan with the VHIS features incorporated, without re-underwriting – Existing policyholders will be offered the same plan with the incorporation of the VHIS features for renewal. No re-underwriting is allowed (except in cases where the existing policy provisions do not provide renewal guarantee). If the plan offered for migration is a Flexi Plan, the VHIS Providers must provide an option to renew to a Standard Plan if the policyholders do not want to renew their policies to the Flexi Plan concerned.

(b) Different plan with the VHIS features incorporated, subject to re-underwriting – Existing policyholders will be offered a different plan incorporating the VHIS features. If existing policyholders opt to switch to the new Certified Plan, the existing policies will not be renewed. Re-underwriting is allowed which may be carried out for each policy or selected policies in the same portfolio. Policyholders who are not switching could stay insured with their existing policies according to the existing policy provisions.

7.3 Institutional Framework

The Roles of the FHB and the IA under the VHIS

Under the VHIS, the FHB is responsible for administering the scheme. As part of the FHB, a VHIS office has been set up to implement the VHIS. Its duties include registration of the participating insurers, vetting of IHIP for certification of compliance status, enforcement of scheme regulations, undertaking of publicity and consumer education programmes, monitoring of scheme performance, information dissemination and compilation of statistics, as well as handling of enquiries and complaints, etc.

As for the IA's role, it would provide guidance to the insurance industry on businesses relating to indemnity hospital insurance plans. IA would soon issue a guideline setting out the principles of fair treatment of customers for medical insurance business, which would include the compliance of VHIS Providers with scheme documents issued by the FHB.

In cases where an insurance company markets a non-VHIS-compliant product as VHIS-compliant and misleads consumers into purchasing it, the FHB may refer such cases to the IA to consider if the action amounts to a "misconduct" in the Insurance Ordinance. If the IA considers the insurance company's action a misconduct, it can consider taking appropriate disciplinary actions, including the order of a pecuniary penalty, reprimand, or even revocation or suspension of the authorisation of the insurance company.

As for dispute resolution, the policyholders can file complaints to the existing complaint channels (see Chapter 4).

7.4 Problems That VHIS May Address

In previous Chapters, discussions have been made on the problems faced by consumers or policyholders when they attempt to purchase and/or engage with a PHI product. Through consumer research, in-depth interviews and complaint cases analysis, it is revealed that major sources of consumer grievances usually stem from several areas, for instance, application refusal for elderly consumers or those with known pre-existing conditions; unexpected premium increases due to loading; benefit variations to provide mandatory enhanced protection or reduced coverage; and claim rejection or indemnity amounts fall short of expectation due to limitation or interpretation of policy terms by insurance companies.

It is expected that the VHIS, through the offering of Certified Plans, may help address some of these problems by enhancing accessibility, affordability, continuity and certainty of benefit coverage and by standardising policy terms of hospital insurance products. Table 11 provides a comparison on the VHIS features and current market situation.

Enhanced Accessibility, Affordability and Continuity on Coverage

The extended entry age limit to 80 years old and guaranteed renewal up to 100 years old with restrictions on re-underwriting and imposition of rate of premium loading of the Certified Plans, may help addressing the accessibility of aged consumers to hospital insurance products and providing certainty on continuity and affordability. In other words, under the VHIS requirements, accessibility of elders (aged 80 or below) to hospital insurance products could be ensured as their applications may not be declined simply because they have exceeded certain application age limits. In addition, coverage and affordability may be maintained for aged insureds or insureds with deteriorated health conditions as insurance companies shall neither have the right to re-underwrite the terms and benefits irrespective of any change in health conditions of the insureds nor may insurance companies impose any additional rate of premium loading or case-based exclusion upon renewal.

Enhanced Certainty on Benefit Coverage

As it currently stands, claims related to eligible expenses of treatments arising from pre-existing conditions are usually rejected by the insurance companies. Under the VHIS, "unknown pre-existing conditions" refer to any existing conditions that the policyholder was not aware and would not reasonably have been aware of at the time of submission of application (or any updates of and changes to the required information if so requested by the insurance company before the policy issuance date or they policy effective date, whichever is the earlier). The VHIS Certified Plans provide coverage for unknown pre-existing conditions subject to the specified duration of waiting period and reimbursement arrangement (see "Coverage of Unknown Pre-existing Conditions" in Table 11), which is expected to enhance the certainty of insurance protection to policyholders.

The standardised benefit coverage and minimum benefit limits of the Standard Plan and the basic requirements of Flexi Plans that are established by the FHB both facilitates product comparison by consumers and provides certainty of benefit coverage and indemnity amount for eligible expenses. As benefit enhancement may currently applied at any time, at the discretion of individual insurance companies and may come with increased premiums, policyholders may find the cost and benefits changes unnecessary. In the case of the Standard Plan, these features also prevent unilateral enhancement of benefits.

Standardised Policy Terms and Conditions

Under the VHIS, Certified Plans offered by various insurance companies must adopt the same set of policy terms and conditions covering, among others, definitions and wordings, based on the Policy Template (except that there may be variations in the case where a Certified Plan offers terms and benefits that exceed the minimum requirements that the Policy Template does not stipulate), which is expected to enable consumers to better comprehend the terms upfront and minimise disputes afterwards.

Table 11: Comparison on the VHIS features and the current market situation

	VHIS	Current Market Practice [1]
Improving Accessibility to and Continuity of Insurance		
Extended Entry Age Limit	• VHIS Providers are required to consider applications for Certified Plans in relation to persons to be insured who are: (a) Hong Kong residents; and (b) Aged between 15 days – 80 years.	• Maximum Entry Age limits vary between plans, ranging from 59 years to no upper limit • Majority set as 64 – 70 years
Guaranteed Renewal	• Guaranteed renewal up to the age of 100 with adjustment of benefits and standard premium necessarily on same portfolio basis. • No re-underwriting due to change in health conditions of individual insured persons after policy inception. [2]	• Guaranteed lifetime renewal (or guaranteed renewal up to age of 100) is common for most plans, yet subject to re-underwriting and individualised premium adjustment allowed in some plans.
No "Lifetime Benefit Limit"	• No limitation on the maximum benefit amount that a policyholder can reimburse for eligible expenses throughout his/her lifetime, although there is an annual benefit limit.	• Usually do not have "lifetime benefit limit" for basic plans/core benefits
Cooling-off Period	• During a cooling-off period of 21 days, policyholders can cancel the policies with full refund of premium.	• Common for most plans, with duration ranging from 14 to 30 days • Mostly 21 days
Enhancing Quality of Insurance Protection		
Minimum Benefit Limits	• Benefit limits for Standard Plans are at the prescribed levels with the aim of providing reasonable coverage for general ward in average-priced private hospitals. • Enhanced benefit limits are allowed to offer in Flexi Plans.	• Benefit limits vary between plans
Coverage of day case procedures	• Cover surgical procedures (including endoscopy) not conducting in hospital.	• Common in most plans
Coverage of Prescribed Diagnostic Imaging Tests	• Cover Computed Tomography (CT scan), Magnetic Resonance Imaging (MRI scan), Positron Emission Tomography (PET scan), PET-CT combined and PET-MRI combined, whether or not conducting in hospital, subject to 30% coinsurance.	• Not common

Coverage of Prescribed Non-surgical Cancer Treatments	• Cover radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.	• Common in most plans
Coverage of Treatment for Congenital Conditions	• Cover investigation and treatment of congenital conditions which have manifested or been diagnosed after attaining the age of 8, subject to the same reimbursement arrangement that applies to unknown pre-existing conditions.	• Not common
Coverage of Psychiatric Treatment	• Cover psychiatric treatments during confinement in a local (i.e. Hong Kong) hospital.	• Not common
Cost-sharing Restrictions	• No cost-sharing arrangements should be included in Standard Plan, except the fixed 30% coinsurance arrangement for prescribed diagnostic imaging tests. • Deductible or reduced coinsurance is allowed in Flexi Plans.	• Cost-sharing not common for basic coverage but for optional benefits, coinsurance and/or deductible are usually applied.
Coverage of Unknown Pre-existing Conditions	• Partial coverage during a waiting period of 3 years upon policy inception (a) 0% of claim amount in the 1st year (b) 25% in the 2nd year (c) 50% in the 3rd year • Full coverage (i.e. 100%) from the 4th year onwards.	• Claims would commonly be rejected (According to the Food and Health Bureau) [3]
Promoting Transparency and Certainty		
Standardised Policy Terms and Conditions	• Standard Plan has fixed product template ("VHIS Certified Plan Policy Template") in terms of standard policy terms and conditions, benefit coverage, benefit limits and cost-sharing arrangements. • Flexi Plans have to follow the VHIS Certified Plan Policy Template for at least the basic coverage equivalent to Standard Plan.	• Terms and conditions vary amongst plans
Premium Transparency	• Transparent information on age-banded premiums through the official websites of the VHIS Office and every VHIS Provider.	• Premium adjustment may not be clearly informed to policyholders (as observed in complaint cases/in-depth interviews)

Remarks:

[1] Based on the 18 health insurance plans collected by the Council (see Chapter 5) except otherwise specified.

[2] The insurance company shall not have the right to re-underwrite the policies due to changes in health conditions of the insured persons (including incidents of making insurance claims), and hence to apply/increase premium loadings and/or case-based exclusions upon renewal. Otherwise, the guarantee will become meaningless.

[3] Based on materials of Consultative Group on the VHIS by the FHB, October 2017.

7.5 Some Thoughts on Future Development

The Council has been actively participating in the consultation to lobby for the best possible conditions for consumers in subscribing to the VHIS. The Council believes, despite the compromise during the course of the development, the introduction of the VHIS will help reduce and resolve some of the current problems of hospital insurance plans in the market. For development of the VHIS, the Council is of the view that the following aspects should also be taken into consideration for betterment of consumer protection in the next review if not earlier.

Standardising Application Forms

Under the VHIS, each individual insurance company can issue its own application form (health declaration/underwriting questions). Consumers may be confused as to the kind of information they should disclose to individual insurance companies for the underwriting procedure. The importance of the information provided by the applicants in the application form (health declaration/underwriting questions) and its implications to the "non-disclosure" clause cannot be underestimated as it may be used by insurance companies as the ground for claim rejection. The Council is of the view that the FHB shall attempt to establish a standardised application form (health declaration/underwriting questions) for Certified Plans in the long run.

Ensuring Fair Treatment in the Underwriting Process

Consumer confusion may also be caused by different underwriting processes adopted by different insurance companies. Under the VHIS, individual insurance companies can still establish their own underwriting guidelines and make their own underwriting decisions as to whether to accept an applicant. This may cause confusion to consumers as they may be given different underwriting results by different insurance companies; this may be further complicated when the applicant has pre-existing conditions that are then subject to different premium loading rates by different insurance companies.

Overall, the Code of Practice has set out principles and requirements for application, underwriting and issuance of policies for insurance companies to follow, and it stipulates that insurance companies should practice due process in underwriting by assessing risks in a fair and objective manner consistently applied to applicants with similar risks. However, the Council suggests the FHB monitor the underwriting decisions made by different insurance companies on a regular basis after the implementation of the VHIS; this will further address any unfair practices to the detriment of consumer interests and assess if there are significant differences in the underwriting results given to persons with similar risks.

Mandating Written Explanations

The Code of Practice stipulates that insurance companies should explain application results to applicants based on the underwriting decisions and, upon applicants' request, provide written notice for such explanation. The Council is of the view that a more friendly approach is to automatically provide a written explanation with reasonable details provided as the clarity and adequacy in information through verbal explanation may not be easily comprehended and remembered by applicants or some details may be miscommunicated,

especially when it comes medical related terms and the case of elderly consumers. Therefore, the Council is of the view that insurance companies should provide such written explanations proactively to applicants irrespective of whether a request is made by the applicant.

Monitoring the Implementation

The Council suggests some VHIS implementation issues that may require close monitoring by the FHB, for instance:

- Whether accessibility and affordability of elderly consumers or consumers with pre-existing conditions to Certified Plans would be undermined by the higher level of premium for old age; or the imposition of case-based exclusions or premium loading rates for reported pre-existing conditions by insurance companies;
- Whether there are undesirable trade practices applied by insurance companies during the promotion of the VHIS Flexi Plans or bundling products; and whether insurance companies/intermediaries maintain a neutral position in marketing the VHIS and non-VHIS products;
- Whether there is confusion to the market on product design;
- Whether the premium level and premium adjustment of Certified Plans is affordable and sustainable;
- Whether sufficient insurance protection is being provided to insureds – through regular review of rate of successful claim applications and reimbursement amounts;
- Whether insurance companies will try to avoid payout obligation by using different interpretations on the policy terms (even though standardised terms and conditions are required by the Standard Plan) – through regular review of consumer disputes related to the VHIS and Certified Plans, in particular claim cases;
- The FHB should disclose information about the implementation of the VHIS, such as number of Certified Plans, subscription rate, premium levels, claim ratio, etc.; and
- The FHB should implement public education on the VHIS to ensure consumers' understanding of the features and terms of the VHIS.

7.6 Summary

Overall, the key features of the VHIS include extended entry age limit to age 80, guaranteed renewal without underwriting due to changes in health conditions, coverage of unknown pre-existing conditions subject to waiting period and reimbursement arrangement, standardised policy terms and conditions and premium transparency. These features are able to enhance accessibility, continuity, quality, certainty and transparency of PHI plans. Close monitoring and regular review on its implementation, for instance the subscription rate, premium levels and future adjustments, claim ratios and disputes on claim settlement, are crucial for the sustainable development of the VHIS.

8 Key Findings and Recommendations

From this Study, the Council identified a number of areas the PHI industry can develop to enhance consumer choice and protection. The issues identified fall under two categories:

- Apparent gap exists between consumer expectation and in reality what they could enjoy from their PHIs – Narrowing it will empower consumers to make more informed choices.
- Enhance continuity of PHI – Bringing continuity and certainty to PHI coverage will alleviate healthcare financing and improve the welfare of vulnerable consumers.

Below is a list of recommended actions the Council hopes the regulatory authority and PHI industry will consider:

- Standardise definitions of key policy terms to facilitate comparison;
- Improve the design of application forms to ask specific questions, with a view to facilitate consumers when providing information during application and to minimise disputes regarding "non-disclosure" down the road;
- Provide sample policy contracts on a publicly accessible platform, so that consumers may look into the policies before purchase;
- Enhance transparency of change of policy terms, benefits and premiums, which will help consumers make an informed choice;
- Provide clear explanations in writing and in plain language, such as details pertaining to the grounds for application rejection, imposition of exclusions at purchasing and renewal stages, claim rejections or partial reimbursement reasons; such clarity is more essential in cases where difficult medical terms and elderly consumers are involved;
- Release market and complaint statistics, so as to enhance public understanding of the nature of complaints and development of PHI;
- Improve transparency of sources of reference for "reasonable and customary" charges, such as requiring disclosure of factors that may influence the determination of reasonable and customary charges and the actual factors and statistics considered in cases of partial reimbursement;
- Provide pre-authorisation services to elective or non-emergent services, which could help give policyholders peace of mind in knowing that the services charges are within the scope of their insurance coverage;
- Enhance training of insurance intermediaries and improve administrative process, so that they could provide clear and personalised information to consumers/ policyholders in order to facilitate clearer communication and minimise disputes arising from miscommunication;
- Strengthen consumer education, which could help narrow the expectation gap;
- Extend the entry age limit to promote PHI accessibility to the ageing population;
- Offer opt-out options for non-core benefits enhancements so that policyholders have the choice to retain budgetary status quo;

- Provide coverage for unknown pre-existing conditions where the policyholder was not aware of the signs or symptoms of the conditions before policy application/inception, or should not reasonably have been aware of such signs or symptoms to enhance certainty of PHI protection; and
- Adopt a one-off underwriting practice / enhance transparency of re-underwriting policy and conditions, requiring factors that may influence re-underwriting and the possibility of a revision of terms upon renewal to be clearly specified in the policy and made known to prospective policyholders, so that they can make an informed purchase.

Through the Study, the following areas are reviewed and analysed: (1) consumer behaviour when engaging in different purchasing stages of PHI; (2) sources of consumer grievances and complaints; and (3) problematic terms and conditions which are commonly the subject of consumer disputes.

It was found that certain factors affected the accessibility, continuity and certainty of the coverage provided by PHI and 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-purchase stage.

At the pre-purchase stage and purchasing stage, consumers were in general satisfied with the services provided by the insurance companies as shown in the consumer research, 95% of the respondents were satisfied or strongly satisfied with the amount of time required to make purchase, level of information given and services of the insurance intermediary.

Insurance intermediaries and personal network played a key role when consumers looked for PHI, most of the respondents obtained information from insurance intermediaries referred by their friends or relatives (61%), and spoke to their friends or relatives about their policies (59%). Comparatively, lesser consumers shopped around; approximately one-third of the respondents obtained quotes from different insurance companies (38%) and searched for information from the internet (32%). Consumers relied heavily on insurance intermediaries. Most consumers relied on the intermediaries (46%) to fill in the health declaration form. Also, they might not pay enough attention when filling in the health declaration form as 51% of the respondents claimed that they only answered to the questions to the best of their knowledge.

Consumers purchased PHI with an expectation that it would give them a peace of mind; allow them to have a choice to use private healthcare services when in need; and premium would remain at a level affordable by them. Though some problems about the trade practices of the insurance companies and the policy terms and conditions might have affected consumers' accessibility to PHI and their understanding on significance of key policy terms. For instance, samples of policy contracts were not easily accessible; policy terms and conditions varied among policies and across different insurance companies and were not explained fully, elderly consumers might not be able to apply for PHI due to maximum entry age limit. These problems are still prevalent in the market.

At the post-purchase stage, major concerns were about continuity and whether claims could be reimbursed. As shown in the consumer research, the percentages of the respondents who were satisfied or strongly satisfied with claim-related issues (e.g. ease in making a claim; time required for handling the claim; and amount of reimbursement received) were in the range between 83% to 88%, which is a slightly lower satisfaction rate as compared with those "pre-purchase"/"purchasing" issues (more than 90%) mentioned in the previous paragraph.

Consumer grievance arose when there was unexpected premium increase and that factors causing the increase and explanations of how the amount was calculated did not make understandable to consumers. There was a gap between consumer expectations of coverage and benefit amount and the indemnity that they were actually entitled to and received.

Further study on policy terms and conditions revealed that insurance companies used different methods to limit their liabilities to avoid payout obligation or limit payout amounts. Consumers' expectation on guaranteed renewal as pledged by the insurance companies and their expectation on continuous protection provided by PHI might be disappointed by the limitation as set in the policy contract, for instance, the insurance company's right of making revision on terms, premium and benefit specified in the policy contract. Eventually, these experiences made consumers had a negative perception of PHI.

Study into regulatory framework of selected jurisdictions revealed that there are existing legislations or measures to enhance consumer protection and to promote a continued healthy development of the PHI industry. 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.

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 VHIS in April 2019. 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.

This Chapter puts forward the Council's recommendations for the consideration of the regulatory authority and the PHI industry, with the aim of narrowing the gap between consumer expectation and the actual protection received from their PHI purchase and enhancing PHI continuity. These recommendations address the issues identified in the Study and strive to enhance consumer protection.

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

Analyses of complaint cases and in-depth interviews show that consumer grievances and disputes commonly stem from an understanding gap; the gap between the information provided to consumers and their expectation regarding policy terms and conditions, benefit coverage, eligibility of reimbursement and the concept of insurance. In presenting the Council's recommendations, the coming sections recap the key identified issues and their corresponding recommendations to address these issues.

Standardise Definitions of Key Policy Terms

Chapter 5 looked at the legal study on PHI policy terms and conditions, highlighting the variation of terms and definitions in different PHI policies. This variation occurs not just amongst different insurance companies, but even within the same insurance company. No wonder consumers find it difficult and confusing to compare terms of different policies at the point of purchase due to this wide variation.

Recommendation (1): To follow the good practice in Malaysia where the Bank Negara Malaysia has issued guidelines requiring insurance companies to use standard definitions of key policy terms and conditions, the Council recommends that the regulatory authority considers setting out standard definitions of key policy terms and mandate this adoption in PHI policies. The VHIS Certified Plan Policy Template could possibly be used as a base reference for further development.

Improve the Design of Application Forms to Ask Specific Questions

Apart from the policy, the application form is another important document in a PHI contract. "Non-disclosure" is one of the policy terms commonly quoted by insurance companies for claim rejections, comprising the majority of consumer disputes. In the current situation, how questions are worded vary among policies both within the same and across different insurance companies; some may be too general, vague or broad. A typical example is that consumers could get confused as to which conditions and within what timeframes they are expected to disclose to the insurance companies.

In "The Code of Conduct For Insurers" issued by the HKFI, Section 10 suggests a statement should be included in the declaration to (1) highlight the fact that the applicant must also include any facts that an insurance company would regard as likely to influence the insurance company's assessment and acceptance of the proposal; and (2) warn that if the applicant is uncertain of a key piece of information's importance, these facts should be disclosed. This puts all the responsibilities on the shoulder of consumers.

The Council is of the view that reference may be made to the UK, which operates under the principle that an insurance company has the responsibility to ask the consumer specific questions to obtain relevant information about his/her circumstances when he/she buys insurance. 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 that the regulatory authority sets appropriate guidelines requiring insurance companies to ask specific questions, for instance which specific illnesses, treatments or diagnoses the consumers should disclose; which minor illnesses (e.g. cases without follow-up treatment or examination or long-term medication) can be exempted, if it is the case; or should insurance companies require consumers to disclose minor illnesses, they are encouraged to specify it in the questions. For the timeframe of information disclosure, the Council suggests it should be clearly specified and should not exceed 7 years (as reference from the longest timeframe applied in the policies collected under the Study).

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 samples of policies for better understanding of its content such as terms and conditions, exclusions, benefit schedule etc., before committing to the purchase. In Hong Kong, policy samples are not easily accessed by consumers and rarely found online. Even within the same insurance company, some of PHI policies are downloadable and others are not. In some cases, policy samples could be obtained from customer services through hotline enquiries while others were only available from insurance agents through face-to-face contact and explicit request only.

Recommendation (3): The Council encourages informational transparency and accessibility, recommending insurance companies provide policy samples for public access in an easy and convenient way. One example is to have policy samples conveniently available on company websites, apart from hotline request.

Enhance Transparency on Change of Policy Terms, Benefit and Premium

As revealed from complaint case analysis and in-depth interviews with elderly policyholders, consumer grievances can occur when there are unexpected premium increases. Two major reasons given by insurance companies for premium increases are "offering of enhanced benefits" and "inflation of medical cost". The former issue will be addressed in separate recommendation under Section 8.2 of this Chapter.

Shown in Chapter 5, it is common for PHI policies to guarantee renewal while also including a clause that gives insurance companies the right to unilaterally revise policy terms, benefits and/or premium at renewal. The Council considers guaranteed renewal and the right to unilaterally revise a policy to be somehow contradictory in spirit. In fact, expectation gaps may occur if consumers are only attracted by marketing phrases like "guaranteed lifetime renewal" at the time of purchase but overlook the significance of the terms that favour the insurance companies; the consumers could then be left in a disadvantageous position. Therefore, the Council is of the view that the right of insurance companies to make unilateral revisions at renewal and the factors which may trigger the revisions should be clearly disclosed to prospective policyholders, right at the purchasing stage before they enter into the contracts so that the prospective policyholder can make an informed decision at this stage.

Recommendation (4): The Council recommends that clear indication of premium increases be given to each age group/profile of the same policy plan, well in advance of the renewal date to allow ample time for policyholders to consider the renewal. In fact, premium table should be provided on an on-going basis as policyholders should have the right to know of the potential change in premium for their policy along with a clear explanation such as the data on medical inflation for justification of the premium increase. To further enhance transparency from the beginning, various and specific situations or factors that trigger premium increases should be clearly stated in the policy contract. Moreover, for the sake of clarification and to facilitate informed consumer decisions, remarks on the insurance company's right to re-underwrite and to unilaterally revise policy terms and conditions, if it is so specified in the policy contracts, should be made alongside the statement of "guaranteed renewal" at all occasions (e.g. sales brochures and contracts) and the potential effects should be 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 provided only verbal explanations of the application/claim rejections. The Council is of the view that the basic consumer right to be informed of necessary information should be well respected. Details pertaining to grounds for application rejection, imposition of exclusions at purchasing or renewal stages, claim rejection or partial reimbursement reasons should not only be verbally explained; clear and easily understandable written explanations should be provided. Such clarity is even more essential in cases where difficult medical terms and/or elderly consumers who are more vulnerable in searching for alternatives, are involved.

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

During the Study, the Council found that complaint statistics related to PHI or medical insurance in general are fragmented and hardly available for public monitoring. The ICB has provided separate data on complaints of monetary nature related to hospitalisation/medical insurance on its website but similar statistics are not published in the public domain by other channels such as the IA, IARB, HKCIB, PIBA and FDRC.

For information transparency and ease of public monitoring, the Council sees the need to have market statistics of PHI or medical insurance in general (e.g. total premiums, quantity of available plans, quantity of policies sold) be published on a regular basis and in publicly accessible platforms. Currently, the IA publishes market statistics by type of business (e.g. general business and long term business). For general businesses, the annual statistics are presented by the class of business of "Accident and Health". In other words, there are currently no specific statistics solely for PHI or medical insurance in general, but this is a very important and significant insurance category worldwide.

Recommendation (6): To enhance public understanding and monitoring of the PHI issues and development, the Council recommends relevant market and complaint statistics be published by regulator and complaint channels on a regular basis. Such data could also promote development of the PHI industry.

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

As mentioned in Chapter 5, "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 and premium increases. However, the shortcomings of the current situation are two-fold: (1) insurance companies may each have their own methods to determine what is reasonable and customary; and (2) policyholders do not understand the insurance companies' decisions as how the reasonable and customary charges are determined.

Wordings of the "Reasonable and Customary" term vary amongst different policy contracts. Some of them list factors that to which the insurance companies would make reference when determining what constitutes reasonable and customary charges, while some may not. The list of factors also varies amongst policy contracts and insurance companies. This creates uncertainty for policyholders as to what amounts to reasonable and customary charges for different treatments. The policyholders are usually not informed of these charges until after the insurance companies have made the claim decisions, e.g. after only partial reimbursement is granted.

Recommendation (7): The Council suggests that factors which may be considered by the insurance companies when determining the reasonable and customary charge be specified in the policy contracts; and in cases where this charge is the justification for partial reimbursement, the actual factor and statistics considered should be well explained to the policyholders.

In addition, the List of Private Charges as per the Gazette issued by the Hong Kong Government which sets out the fees for the private patient services in public hospitals in Hong Kong should be presented as one of the references. In the Study, 6 out of the 18 policy contracts collected have similar wordings in the policy contracts, implying this list is one of the references in determining the reasonable and customary charge.

Provide Pre-authorisation Services for Non-emergent Services

To further enhance the certainty of benefit limits and coverage, reference may be taken from the initiative of the Singapore's medical insurance industry on the pre-authorisation framework for IPs. Such practice enhances a policyholder's peace of mind as it provides affirmation of whether the services charges are within the scope of a policyholder's insurance coverage, thereby avoiding any unexpected out-of-pocket expenses. The policyholder will also be able to better manage his/her expectations if there is a possible denial of claim. Although pre-authorised reimbursement amount is not necessarily equal to reasonable and customary charges, the former would provide better certainty to the policyholders. In Hong Kong, pre-authorisation is not common for the basic category of PHI plans. Among the 18 policies collected, only 2 of them provide pre-authorisation services. Currently, it is specified in the Certified Plan Policy Template under the VHIS that respective insurance companies should provide claimable amount estimate to policyholder when it is requested.

Recommendation (8): The Council is of the view that the regulatory authority may encourage 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 or indemnity amount. At times, there were also complaints of instances where insurance agents provided inaccurate advice regarding information that needed to be disclosed in the application form; this in turn affected the validity of the policy contract and subsequent claim results. Currently, there are industry codes which advise insurance companies to provide sufficient training to insurance agents. The Council is of the view that such training should be improved to enhance the integrity and professionalism of the insurance agents and operational staff, so that confidence of consumers/policyholders in the industry can be strengthened as a result.

There were further complaints related to the less than satisfactory services of insurance companies, such as premiums charged after policy termination, auto-renewals without explicit consent and administrative delays in delivering medical cards, etc.

Recommendation (9): The Council recommends that the regulatory authority should require insurance companies to promote continuous and product-specific training to insurance intermediaries and/or frontline staff to improve service quality; this will enable better and clearer communication with consumers and reduce instances of disputes arising from misunderstandings in the long run. Areas of trainings should include how to effectively communicate sufficient, accurate, clear and personalised information to consumers/policyholders to match the situation/policy of the consumer/policyholder concerned, i.e. medical history needed to be reported in the application forms, benefit coverage and limits, general/case-based/pre-existing conditions exclusions and waiting periods.

To improve service quality, the Council suggests that the insurance companies should implement and publish a 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 PHI products, there is a general lack of concept of how insurance works as a whole, and consumers do not have the relevant knowledge when purchasing insurance products. The significance and implications of some key policy terms and clauses such as medically necessary, pre-existing conditions, non-disclosure and double insurance etc., require much stronger efforts towards consumer education to enrich overall consumer knowledge on PHI, in particular to matters of high potential for disputes. The Council proposes that more can be done by the regulatory authority and the industry in this regard.

Recommendation (10): The Council recommends that consumer education should include the following areas:

- Insurance concept, e.g. premium setting, risk pool, duty of disclosure;
- Significance of key policy terms, such as the clause regarding the right of insurance companies to revise terms, benefits and premiums at renewal, if it is so set out in the policy contract;
- Information that should be obtained and understood before signing up for a policy, e.g. benefit coverage, benefit limit, exclusions, premium level, possible premium adjustment, alteration of policy and re-underwriting arrangement; and
- Consumer rights to request information and explanations when in doubt, and to seek redress.

8.2 Enhancing Continuity of PHI

Another key observation of the Study is the consumers/policyholders' general expectation of continued PHI coverage, when in fact, coverage can be revised upon contract expiry. In the current situation, PHI policies are usually renewed annually. As stipulated in most policy contracts, upon annual renewal, insurance companies have the right to revise the policy, benefit schedule and premium. This means that policyholders face a large amount of uncertainty every year, unsure whether policy or other elements will change and most importantly, whether the revised policy will still be suitable or affordable to him/her. Such uncertainty will become more critical as the policyholders age and no longer have income. The below sections set out key findings and recommendations in relation to the promotion of continuity of PHI.

Extend Entry Age Limit

Currently, consumers who are approaching retirement or have already retired may find it difficult to purchase a PHI; one of the reasons being the maximum entry age limit set by the insurance companies. Within the policy samples collected for the Study, maximum entry age limits varied among the policies, ranging from 59 to no upper limit with the majority of them setting the limit between the ages of 64 to 70. However, considering the longevity of the Hong Kong population where life expectancies for males and females[86] are 82 years and 88 years respectively in 2017, a sizeable number of the elderly will need healthcare services and some of them can afford private healthcare services and should have be given the opportunity to purchase PHI.

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

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

As mentioned above, consumer grievances occurred when increases in premiums were "unexpected" and disruptive to the retirement plan. Given these unexpected increases, some elderly consumers have no choice but to reluctantly drop out of their policy at the time when they need protection the most. A common reason given by insurance companies to justify this increase is the imposition of "enhanced benefits" unilaterally decided by the insurance companies. The Council notices that due to medical inflation at times, insurance companies may offer enhanced benefits for some core benefits, such as surgery/treatment costs. However, as revealed from the in-depth interviews in Chapter 4, sometimes the enhancements related to non-core benefits (e.g. domestic home care service, baby-sitter or child-care, pet care) which might not be needed by the policyholders but there was no option to keep the policy coverage which suited their needs.

In Singapore, the relevant authority requests that insurance companies provide policyholders of IPs a choice to switch to a more affordable plan.

Recommendation (12): For fairness and continuity, the Council recommends that insurance companies offer policyholders the choice to retain status quo with a policy which is suitable and within their budgets, especially in cases of enhancement related to non-core benefits.

Provide Coverage for Unknown Pre-existing Conditions

In most PHI policies, "pre-existing conditions" is one of the excluded items. The significance of this term is that insurance companies usually reject claims for expenses incurred by treatments related to a pre-existing condition. The Council is of the view that in the case of known pre-existing conditions, (1) the consumer should disclose this fact to the insurance company for underwriting during policy application stage; and (2) the responsibility of asking specific questions to collect sufficient information for underwriting purposes rests on the insurance company.

[86] Life Expectancy at Birth (Male and Female), 1971-2017. Centre for Health Protection, Department of Health.

Another way to reduce disputes based on "non-disclosure" of "pre-existing conditions" may be to introduce a "pre-assessment" condition (e.g. body check) prior to policy inception. The Council is of the view that, for the reason of fairness, unknown pre-existing conditions should be covered by insurance companies if (1) the policyholder was not aware of the signs or symptoms of the condition(s) in question before policy application or inception; and (2) should not reasonably have been aware of the signs or symptoms of the condition(s) in question before policy application or inception.

In Australia, the Insurance Contracts Act 1984 stipulates that insurance companies cannot avoid liability to unknown pre-existing conditions.

Recommendation (13): The Council recommends the insurance companies to adopt 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 the case of unknown pre-existing conditions being 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 also revealed that after the policyholders filed a claim and received reimbursement, what followed sometimes was a re-underwriting of their policies which resulted in imposition of premium loading and/or excluded items. 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" or "guaranteed renewal" by insurance companies in real practice when the premium or coverage becomes unsuitable or unaffordable to them.

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 making PHI a continuous protection; for instance, re-underwriting after the inception of policy should best be avoided or minimised in order to provide a more stable marketplace for the community as a whole. The Council acknowledges that 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 deem the avoidance of re-underwriting inapplicable, the Council is of the view that information of such arrangement such as 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 and the implications explained to prospective policyholders before they enter into the policy contracts.

8.3 The Way Forward

In summary, this Chapter sets out a list of recommendations for the consideration of stakeholders, including the regulatory authority and the PHI industry. The recommendations fall under two categories: (1) the narrowing of the gap between consumer expectation and in reality what they could enjoy, and (2) enhancing continuity of PHI.

The 14 recommendations as set out in this Chapter 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's findings, the Council is of the view that it should be a priority of stakeholders to join hands and take a progressive approach by imposing clear regulatory guidance to the 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 for 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 purchase 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.

Appendix 1: Statistics on Insurance Related Complaints in Hong Kong

The following provides the complaint statistics published by the Insurance Authority (IA), the Insurance Agents Registration Board (IARB), Hong Kong Confederation of Insurance Brokers (HKCIB), the Professional Insurance Brokers Association (PIBA) and the Financial Dispute Resolution Centre (FDRC). The published figures refer to complaints or referrals of all types of insurance policies, which therefore are not comparable with the complaint figures from the ICB and the Council presented in Chapter 4. The data presented below were the latest statistics available in the public domain (unless otherwise specified) at the time when the Study Report was prepared. The IA and IARB have replied to the Council that they do not have breakdown data on complaints related to PHI or medical insurance.

Insurance Authority (IA)

On 7 December 2015, the Independent IA was established with commencement of the relevant provisions added by the Insurance Companies (Amendment) Ordinance 2015. The Independent IA is a new insurance regulator independent of the Government. The objectives of its establishment are to modernise the insurance industry's regulatory infrastructure to facilitate the stable development of the industry and provide better protection for policyholders. The Independent IA took over the regulatory functions of the then Office of the Commissioner of Insurance on 26 June 2017.

From June 2017 to the end of 2018, the IA received 1,759 complaint cases related to the insurance sector. Major complaints were related to representation of information (Table i).

Table i: Complaint statistics of the IA

Nature of Complaints	Jun-Dec 2017	2018	Total
Representation of Information (e.g. presentation of product features, policy terms and conditions, premium paying terms or returns on investment, dividend or bonus shown on benefit illustrations, etc.)	164	242	406
Claims (e.g. dispute regarding the result of claims assessment or settlement amount etc.)	113	143	256
Business or Operations (e.g. matters related to cancellation or renewal of policy, adjustment of premium, underwriting decision, or matters related to the management of insurance company, etc.)	109	289	398
Conduct (e.g. fraud, forgery, matters related to selling process, handling of client's premium or money, commission rebate, twisting, cross-border selling or unlicensed selling, etc.)	107	182	289
Service (e.g. delay in delivery of premium notice or annual statement, dissatisfaction with service standards, etc.)	72	167	239
Insurance Intermediary against Insurance company (e.g. agent's registration or deregistration, termination of appointment, terms and conditions of agency agreement, remuneration arrangement, etc.)	38	76	114
Others	45	12	57
Total	**648**	**1,111**	**1,759**

Insurance Agents Registration Board (IARB)

IARB[87] of the HKFI is responsible for handling complaints against insurance agents who have allegedly violated the Code of Practice for the Administration of the Insurance Agents. From 2015 – 2018, there were 1,641 complaints or referrals received by the IARB involving misconduct of insurance agents which were considered as substantiated allegations (Table ii). Among the cases presented to IARB for deliberation and were considered as substantiated, there were approximately 100 insurance agents subject to disciplinary action(s) on average each year. No breakdown statistics on medical insurance are available upon the Council's enquiry.

The four most common substantiated allegations for complaint cases in the said period were "making inaccurate or misleading declaration/representation", "mishandling of clients' premium or monies", "use of document containing inaccurate information" and "forgery/use of forged document".

Table ii: Complaints received by IARB on conduct of insurance agents, 2015 – 2018

Nature of Complaints	2015	2016	2017	2018	Total
Provision of inaccurate/false information [1]					
• Making inaccurate or misleading declaration/representation	20	70	52	125	267
• Use of document containing inaccurate information	15	47	15	73	150
• Forgery/use of forged document	1	12	24	112	149
Service quality not up to standard [1]					
• Failure to take reasonable effort to deliver policy within the cooling-off period	32	42	19	8	101
• Material lack of understanding of duties and ethical responsibilities of an insurance agent	20	39	30	10	99
Unclear agency identity/without authority [1]					
• Conducting insurance agency business without registration	4	3	0	39	46
• Applying policy services/Enquiring policy information without authority	8	6	0	32	46
• Effecting insurance policy without authority	1	8	19	6	34
Mishandling of clients' premium or monies	14	27	30	195	266
Others [2]	118	133	52	180	483
Total	**233**	**387**	**241**	**780**	**1,641**

Remarks:
[1] Regrouped by the Council for the purpose of this Study.
[2] Other cases involving (i) fit and proper criteria of a Registered Person, including cases of Registered Persons declared bankrupt, been controllers/directors of insolvent companies, convicted of criminal offences or found guilty or misconduct by other professional bodies; (ii) breach of the Code of Practice for Life Insurance Replacement; and (iii) breach of Requirements Relating to the Sale of ILAS Products.

[87] An insurance agent must be registered with the IARB set up by the HKFI. The IARB is empowered by the Insurance Companies Ordinance (Cap. 41) to implement and administer the Code of Practice for the Administration of the Insurance Agents. It is responsible for handling complaints against an insurance agent who has allegedly violated the Code of Practice. It conducts investigation to determine if the allegations are substantiated and if disciplinary actions are necessary.

Hong Kong Confederation of Insurance Brokers (HKCIB), the Professional Insurance Brokers Association (PIBA)

HKCIB and PIBA published the overall complaint statistics of all types of insurance products on their respective websites. Upon the Council's enquiry, the HKCIB advised there were 5 new cases of complaint related to medical insurance purchased by individual received by HKCIB in 2015 – 2018, with around 1 to 2 cases each year as told. PIBA disclosed there were 6 complaint cases related to medical insurance in 2015 – 2017,[88] with 1 to 4 cases each year.

Financial Dispute Resolution Centre (FDRC)

The FDRC was set up in November 2011 as a non-profit making company limited by guarantee. It is an independent and impartial organisation administering the Financial Dispute Resolution Scheme (FDRS) which provides a channel for financial institutions who are members of the FDRS to resolve monetary disputes with their customers through mediation and/or arbitration. As banks or brokerages may also act in the capacity of insurance agents to sell insurance products, FDRC is an alternative channel apart from the previously mentioned organisations.

Out of the enquiries received by the FDRC during the period between 2015 and 2017, 1,943 complaints were related to financial products and services (Table iii). Those related to insurance accounted for approximately one-fifth of such enquiries, with an average of almost 150 received each year. However, a large proportion of the 1,943 enquiries (including all types of financial products and services) were classified as prima facie ineligible disputes under FDRS. The major reasons include exceeding the 12-month limitation period, the maximum claimable amount of HK$500,000, or involve organisations which were not members of the FDRS. Amongst those eligible disputes handled by the FDRC, nearly 30% were related to insurance (Table iv).

Table iii: Breakdown of enquiries about financial products and services received by FDRC, 2015 - 2017

Nature of Enquiries [1]	2015	2016	2017	2015-2017
Investments	342	232	137	711
Liabilities	177	146	121	444
Insurance [2]	193	165	84	442
Assets	59	50	56	165
Others	53	56	41	150
Could not be classified	9	15	7	31
Total	**833**	**664**	**446**	**1,943**

Table iv: Breakdown of eligible disputes handled by FDRC, 2015 – 2017

Nature of Eligible Disputes [1]	2015	2016	2017	2015-2017
Investments	12	19	10	41
Liabilities	1	4	5	10
Insurance [2]	7	14	3	24
Assets	0	0	3	3
Others	1	2	3	6
Could not be classified	0	0	0	0
Total	**21**	**39**	**24**	**84**

Remarks:
[1] There are no subdivisions of nature of enquiries/eligible disputes for the listed categories.
[2] "Insurance" includes investment-linked products, life (non-investment-linked) products, general and group insurance policies. No breakdown data on private health insurance (PHI) is published by FDRC.

[88] As advised by PIBA, there was no case related to medical insurance in 2018.

Appendix 2: An Overview of the Private Health Insurance Reforms in Australia

In October 2017, the Australian Government Department of Health announced a series of reforms to PHI to make it simpler and more affordable for Australians. These include:

- Categorising hospital insurance products as gold/silver/bronze/basic, and implementing standardised clinical categories for treatments to make it clear what is and is not covered in the policies;
- Upgrading the privatehealth.gov.au website to make it easier to compare insurance products, and allowing insurance companies to provide personalised information to consumers on their product;
- Boosting the powers of the PHIO and increasing its resources to ensure consumer complaints are resolved clearly and quickly;
- Reducing costs for consumers through a 1.1 billion Australian dollars reduction in prostheses benefits under an agreement with the Medical Technology Association of Australia;
- Requiring insurance companies to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period on a once-off basis;
- Allowing insurance companies to discount hospital insurance premiums for 18 to 29 year olds by up to 10%, with the discount phasing out after people turn 41;
- Allowing insurance companies to expand hospital insurance to offer travel and accommodation benefits for people in regional and rural areas who need to travel for hospital treatment;
- Increasing the maximum voluntary excess consumers can choose under their health insurance policies for the first time since 2000;
- Removing coverage for a range of natural therapies as benefits under general treatment; and
- Continuing to support private hospitals, including transferring administration of the second tier default benefit, which provides a safety net for consumers attending non-contracted hospitals, to the Department of Health.

Appendix 3: A Summary of Recommendations by the Health Insurance Task Force in Singapore

Aspect	Recommendation
Introducing medical fee benchmarks or guidelines	• To have a set of medical fee benchmarks or guidelines to provide a range of professional fees. Benchmarks or guidelines should be calibrated to ensure the appropriate involvement and adoption by stakeholders • To address the issue of information asymmetry by providing stakeholders access to information on appropriate charges • To mitigate cases of over-charging by providers
Clarification of existing process to surface inappropriate medical treatment	• To clarify the existing escalation process which allows insurance companies to raise cases of inappropriate and excessive medical intervention to the relevant authorities • To clarify the practices amongst insurance companies when dealing with such claims so as to minimise the impact on policyholders whose cases are subject to investigation • To increase awareness of the existing avenue for insurance companies to raise cases of inappropriate and excessive medical intervention noted in their review of claims
Enhancing insurance procedures and product features	
• Panel of preferred healthcare providers	• To suggest that insurance companies consider the use of preferred healthcare provider panels, where appropriate, to manage medical costs through fee agreements. IP insurance companies should make clear to their customers that their choice of healthcare providers is not restricted by the existence of the panels, although the coverage may be affected • To enhance and ensure transparency of the arrangement (e.g. disclosures on the healthcare provider selection process) • To suggest that insurance companies consider, during the appointment of preferred healthcare providers, TPAs, and intermediaries, whether their fee arrangements are in line with SMC's ECEG
• Co-insurance & deductibles	• To encourage insurance companies to include coinsurance and/or deductible features in product design to ensure consumers' interest are aligned with managing healthcare costs • To address the risks of overconsumption due to poor product features
• Pre-approval of medical treatment	• To encourage insurance companies to approve claims for medical treatment and estimated bill size prior to the actual procedure, which provides certainty to patients on what can be claimed from their insurance policy • To address the risks of inappropriate treatment and high medical charges
Educating consumers	• To educate the public on the available options, such as the types of hospitals and wards, and the corresponding costs of their medical treatments

Remarks:
TPA refers to third party administrator
SMC's ECEG refers to Singapore Medical Council's Ethical Code and Ethical Guidelines

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消費者委員會2019年5月出版　Published by Consumer Council, May 2019