Consumer Market Research on the Health Protection Scheme

Report of Focus Group Study

Prepared for

Food and Health Bureau

Hong Kong Special Administrative Region Government

BY

CONSUMER SEARCH

Content

Introduction

Research Background (1)

- The Government published the second stage public consultation document on healthcare reform on 6 October 2010, under which a government-regulated, voluntary Health Protection Scheme (HPS) was proposed for public consultation for three months till 7 January, 2011. The HPS aims to enhance the long-term sustainability of the healthcare system by better ensuring the quality and value-for-money of the private health insurance and private healthcare services. It also aims to ease the pressure on the public healthcare system, thereby benefiting those who depend on the public system for their healthcare. The Government will consider making use of the $50 billion set aside from the fiscal reserve to support healthcare reform to encourage the public to participate in the HPS.

Research Background (2)

- The Food and Health Bureau (FHB) commissioned Consumer Search Hong Kong Limited to conduct a consumer market research in order to collect and analyze the views of consumers on the design of the proposed HPS as set out in the second stage public consultation document on healthcare reform .

- This report presents the findings of the qualitative analysis in this Consumer Market Research on the HPS ("this study" hereafter). Findings of the quantitative analysis are presented in another report separately.

Research Objective

- This study is mainly aimed to generate qualitative analyses on :
  - (i) the degree of general public's acceptance and preference from consumer angle towards various design features and options of the HPS; and
  - (ii) how these results relate to their willingness to subscribe or migrate to the scheme by socio-economic profile.;
- The design features and options to test participants' response include benefit coverage, health insurance policy terms and other key features, DRG-based packaged charging and calculation of insurance benefit levels, clinical control and claims arbitration mechanism, High-Risk Pool industry reinsurance mechanism, no-claim discount, illustrative premium levels, premium adjustment mechanism, government incentives, etc.
- It is important to note that by virtue of this study's objective and methodology, the views of participants collected in this exercise primarily pertain to specific scheme features and options, and do not bear direct relationship with their willingness to join the HPS and support the relevant government policy in overall terms.

Research Methodology (1)

- In this qualitative research, 10 focus group discussion sessions lasting for about 1.5 hours each were conducted to collect views of participants on design of the HPS. The discussions were primarily based on the information provided in the second stage public consultation document on healthcare reform.
- The recruitment pool of Consumer Search, containing around 300 recruiters, was used in the recruitment process. Screening was conducted on all the referrals from the recruiters to ensure they met the participant requirements. The participants were basically those who could decide to purchase private health insurance products for themselves and/or family members.
- A discussion guide was prepared in consultation with FHB to facilitate formulation of ideas and test responses. The discussion guide encompasses major scheme details and illustrative examples/assumptions provided in the second stage public consultation document for concept testing. Three in-depth interviews were conducted as a pilot test for improving the discussion guide and stimuli used in the focus groups.

Research Methodology (2)

- Following the three pilot interviews conducted on February 15, a total of 10 focus groups were conducted at the facilities of Consumer Search between February 17 and 25, 2011. Each group consisted of eight persons, resulting in a total of 80 participants.
- These groups were segregated according to whether or not the participants were paying out-of-pocket for private hospitalization insurance, their age bands and income levels. The non-paying participants comprised those who did not have hospitalization insurance at the time of interview (62.5%) and those with insurance coverage financed by family members or employers (37.5%).
- Both genders were represented and in each group, there were one to four participants suffering from some chronic disease.

Research Methodology (3)

Composition of Focus Groups

	Descriptions
Group 1	Age 20-35, Paying Out-of-pocket
Group 2	Age 20-35, Not Paying Out-of-pocket
Group 3	Age 36-49, Paying Out-of-pocket, Higher Income
Group 4	Age 36-49, Paying Out-of-pocket, Lower Income
Group 5	Age 50 or above, Paying Out-of-pocket, Higher Income
Group 6	Age 50 or above, Paying Out-of-pocket, Lower Income
Group 7	Age 36-49, Not Paying Out-of-pocket, Higher Income
Group 8	Age 36-49, Not Paying Out-of-pocket, Lower Income
Group 9	Age 50 or above, Not Paying Out-of-pocket, Higher Income
Group 10	Age 50 or above, Not Paying Out-of-pocket, Lower Income

Research Methodology (4)

- The 10 focus groups were facilitated by a group moderator who has extensive experience in consumer research of health insurance products. All sessions were fully audio-taped and verbatim transcribed. The moderator identified key concepts and themes through systematic reviews of the data collected.
- We would like to issue our normal caution that for all qualitative research, the projected figures are based on selective, and usually rather small samples. These figures are not meant for statistical inferences but should be used for supplementing the qualitative analysis with regard to the views and underlying rationales expressed by the focus group participants. Statistical inferences should rely on the telephone survey results provided in another report separately, which do not necessarily tally with indicative figures in this report.

Executive Summary

Executive Summary (1)

Awareness and Understanding of the HPS

- There was a high level of awareness about the existence of HPS among the participants. A majority of participants stated that they had heard or read about HPS through the media in the preceding few months. Some of them could also correctly describe the scheme in general terms.
- However, the participants' understanding of some specific scheme features was not complete and occasionally inaccurate. Some participants explained that the concepts underlying certain scheme features, such as the charging method based on diagnosis-related groups (DRG) and claims arbitration mechanism, were a bit too complex to them. Yet after clarification and explanation by the moderator, a lot of participants, especially the younger and higher income groups, could grasp the key concepts and gist quite quickly.
- While most participants supported the stated objectives of HPS to enhance consumer choice and increase market transparency, some of them had reservation regarding the practicability of achieving these objectives. A few participants in particular questioned the feasibility of guaranteeing coverage for the elderly and high-risk population.

Executive Summary (2)

Benefit Coverage of the HPS Standard Health Insurance Plan

- Most participants considered the benefit coverage of the HPS Standard Health Insurance Plan (hereafter “the HPS Standard Plan”) adequate because the Plan covered mainly inpatient and ambulatory care which matched with the expectation that health insurance should primarily target at unanticipated and expensive treatments. This was notwithstanding some reservation about certain fine details, such as the ceiling on the number of claimable pre-admission and post-operative specialist consultation visits.
- A few participants suggested extension of scheme coverage to long-term care and outpatient services not related to hospitalization treatments, but the support to these ideas dwindled after the discussion led to awareness of the substantial extra premium needed to cover these more predictable needs in reality.
- After the premium concern was well discussed, the mainstream thinking also turned more pragmatic in favor of grouping the relatively less costly and less necessary services, such as general dental care and better room accommodation, under coverage of top-up plans instead of the HPS Standard Plan.

Executive Summary (3)

DRG-based Packaged Charging and Insurance Benefit Structure

- Despite some difficulties to understand fully the technicalities related to DRG in the first instance, many participants managed to grasp the underlying rationales and principles after explanation. Some of them were also keen to know more about the technical details.
- The idea of using DRG as the basis for healthcare pricing and setting of insurance benefit levels under the HPS was well received in the discussions. Many participants appreciated this idea for allowing simplified billing, predictable charges and certainty in out-of-pocket payment for both uninsured and insured patients. They also felt that this feature was potentially a unique selling point and an added value to the HPS.
- As regards itemized pricing widely adopted nowadays, some participants found it more difficult to estimate in advance how much the final bill would be. They stated that this uncertainty might discourage them from choosing private healthcare services.

Executive Summary (4)

DRG-based Packaged Charging and Insurance Benefit Structure

- However, the participants were ambivalent towards the possible pros and cons of DRG-based packaged charging in practice. Some participants expected that DRG-based packaged charging could help reduce incidents of higher pricing and ordering of less necessary services by private hospitals and doctors for the insured patients, and hence help keep long-term insurance premium rise in better check. On the other hand, some participants worried that the quality of treatment and medicines prescribed for packaged services would be compromised when the charges were fixed and all-inclusive. There was also a concern on whether the packaged charges could cover the extra cost if a treatment was more complex than average.
- A tendency observed in the discussions was noticeable as it was consistent with moral hazard behaviors common in insurance market. When the discussions came to the point about insurance-induced medical inflation, some participants admitted that they would be inclined to seek “more rather than less” treatments so long as the treatment was safe and the cost was well covered by insurance, and that they would tend to neglect and even ignore the issue of medical necessity in this case.

Executive Summary (5)

DRG-based Packaged Charging and Insurance Benefit Structure

- Some participants believed that DRG-based packaged charging would facilitate patients' comparison of charges between private hospitals. However, some others disagreed and doubted whether time would allow patients to do so when they urgently needed medical interventions.
- Some participants worried about the risk of maximized charging by which the healthcare providers might mark up their charges to reach the benefit limit, resulting in higher out-of-pocket payment due to co-insurance.
- Some participants also worried that not all private hospitals and doctors would be willing to adopt DRG-based packaged charging, and that their choice of healthcare providers would be limited in consequence.
- It appeared to be a consensus among the participants that even without HPS and regardless of the choice of packaged or itemized pricing method, the Government should exercise more control over how the healthcare providers, especially private hospitals, charge their customers because the charges were often diverse and not transparent.

Executive Summary (6)

Clinical Control and Claims Arbitration

- The participants generally claimed that they did not have the expert knowledge to comment on the topic of clinical control, but they were willing to share their perception and thoughts.
- Most participants had a good impression about the professional and service standard of private hospitals and private doctors in Hong Kong. However, some participants were discontent with high service charges but limited time and attention that some doctors spent in communicating with the patients about the treatment details.
- As regards claims arbitration, only a minority of the participants had the experience of making insurance claims on hospitalization expenses. Most of these participants were satisfied with their previous claim experiences but a few were discontent about the reimbursement amount. Yet in general, the participants with or without claims experience welcomed a more active role of the Government and a more established mechanism in settling claim disputes.

Executive Summary (7)

Clinical Control and Claims Arbitration

- Some participants considered that in the presence of effective claims arbitration mechanism, their confidence in joining HPS would greatly increase for two reasons: (1) the arbitration process would be simpler and less costly than legal litigation; (2) it would help balance the interest between the consumers, the health insurers and the healthcare service providers through proper representation. Yet some of them felt doubtful about the effectiveness of such a mechanism in avoiding dispute settlement at court level if the amount of money involved was big. In that case, they would prefer to have their days in court.

Executive Summary (8)

High-Risk Pool

- Many participants, regardless of age and health status, indicated that they were willing to accept the proposed high-risk pool arrangement under HPS whereby the basic premium for all insured persons was increased moderately (by 7% as an illustrative assumption) so as to allow the scheme to accept enrollees with higher health risks and pre-existing illnesses subject to a waiting period and a cap on premium loading applied to them (at 200% of basic premium as an illustrative assumption).
- Some participants with good health status elaborated that although the high-risk pool arrangement was disadvantageous to them currently, they would take the turn to benefit from the arrangement when they grew old or their health condition deteriorated. They also supported the idea because it served the societal value of helping the needy and disadvantaged people.
- On the other hand, a few participants voiced their unwillingness to indirectly subsidize people with higher health risks through the high-risk pool arrangement. They considered it unreasonable for other people to share one's health risk.

Executive Summary (9)

High-Risk Pool

- Many participants irrespective of their attitude towards the high-risk pool voiced their concern over feasibility of the pool due to adverse selection behaviors. They worried that the high-risk pool would attract more people with higher health risks to participate in the scheme while discouraging people with lower health risks from joining, and that financial sustainability of the HPS as a whole would be threatened as a result.
- There was a suggestion that the insured persons should be given the choice between accepting exclusion clauses for pre-existing illnesses in lieu of premium loading to cover pre-existing illnesses. The rationale was that recurrence of pre-existing illnesses was often related to chronic diseases that required long-term care and hence higher expenses that might exceed the insurance benefit limit. In order to avoid the out-of-pocket payment beyond the benefit limit, the patients might not be willing to choose private healthcare services even if insured. As such, inclusion of pre-existing illnesses in the insurance coverage would become irrelevant to some of them.

Executive Summary (10)

No-Claim Discount

- Most of the participants, with the notable exception of those with chronic diseases, felt that no-claim discount (NCD) was an attractive feature because they considered this a fair and efficient pricing method. They also believed that this could be a good selling point of the HPS.
- However, the participants with chronic diseases were generally lukewarm to the idea of NCD. Although they could potentially save more in absolute terms through NCD due to higher premium level (after loading), they envisaged their chance of making no claim would be low. Also, they considered the discount too limited a relief compared with the substantial premium loading required to cover their pre-existing illnesses.

Executive Summary (11)

Containment of premium increase pressure

- Most of the participants were confident that the basic premium of the HPS Standard Plan could be under better control compared with common existing health insurance products for two major reasons. First, they opined that the Government should and could proactively control the premium adjustment and deter unreasonable increase. Second, they thought that the standardization design of the HPS, if coupled with a sizeable pool of participants, could allow better use of technology and other cost-savings means to lower the operating cost.
- On the Government's role in premium setting, the moderator attempted to facilitate the discussion by presenting 4 possible approaches in ascending order of stringency in government control. In response, the participants mostly did not agree with the two relatively less stringent approaches that only required the participating insurers to report and disclose cost and price data without direct government control on the HPS premium level. They thought that these approaches relied exceedingly on self-discipline of the participating insurers and could not render adequate protection to the consumers.

Executive Summary (12)

Containment of premium increase pressure

- By contrast, most of the participants supported more stringent approaches by the Government towards premium setting under the HPS. They considered proactive government control justified because of the inherent nature of HPS as a government regulated and initiated scheme. Compared with the idea of having a mechanism to approve premium rise applications from individual insurers, the idea that the Government fixed the premium level was even more popular among these participants. Some of them also opined that it could be more straight-forward for the Government to directly provide the health insurance and even healthcare services under the HPS instead of resting with the private sector and exercising control concurrently.
- On the other hand, some participants had reservation regarding active government intervention in premium control and service provision. They feared that market competition would be limited and consumer choice reduced in consequence.

Executive Summary (13)

Containment of premium increase pressure

- As regards the potential of using cost cutting initiatives to contain the upward pressure for the HPS premium, the participants appeared to be cautiously optimistic. They mostly agreed that if the scheme could attract a sizeable enrolment, there should be room to introduce technological and other cost-savings means to streamline day-to-day scheme operation. Some of them also thought that since the HPS Plan was standardized, the consumers could rely less on the middleman services provided by insurance agents so that the service charges could be lowered. Nevertheless, some participants valued the agent services considerably and opined that there should be a choice of using agent services or not under the HPS.

Executive Summary (14)

Willingness-to-pay

- The participants were shown the illustrative key features and age-bracketed basic premium table for the HPS Standard Plan (as extracted from the second stage public consultation document on healthcare reform) so that they could have an idea of roughly how much of insurance premium they would have to pay in joining HPS (in conjunction with the possibilities of premium loading of up to 200% of basic premium for high-risk individuals, NCD and agent commission).
- A majority of the participants, particularly those with higher income and including those with chronic disease, responded that the illustrative premium levels were attractive for them to consider joining the HPS. Some would also consider including their family members in enrolment, though they were mindful of the budget involved. However, there was a common concern about the steep rise in premium for the old-age. Some participants worried that they might not afford the premium when retired.
- A few participants considered the premium level too high to afford at individual or family level. This view was more common for the participants with lower income and currently uninsured.

Executive Summary (15)

Willingness-to-pay

- When provided an option of selecting deductible in exchange for lower premium, most participants refused to consider because their mindset did not go for substantial expenses out-of-pocket for medical treatment after paying the insurance premium. This inclination was more apparent for those with chronic disease.
- The tendency to pay extra premium for top-up components was not popular throughout the discussion sessions. Only a few participants, mainly those with chronic disease, showed such an inclination.

Executive Summary (16)

Government Incentives

- As aforesaid, most participants thought that the proposed scheme features of the HPS Standard Plan introduced so far were attractive subject to the illustrative premium. When asked to respond if financial incentives were provided by the Government to encourage joining the HPS, they naturally showed even greater interest. Those who had refused/hesitated to consider buying also stated that they were willing to re-consider if the incentive amount was attractive.
- No consensus was observed regarding the desired amount and mode of financial incentives, though.

報告撮要(1)

對醫療保障計劃的認識和了解

- 大多數參加者都察覺到醫療保障計劃 (以下簡稱 “醫保計劃”) 的存在，他們在過去數月曾在媒體聽過或看過有關該計劃的資料，部分人更能準確地概述計劃的主要內容。
- 然而，參加者對於計劃中某些特點的理解未算全面，偶爾甚至有些誤解。就此，部分參加者表示計劃中的一些特點，例如按症候族羣分類訂定醫療收費模式和索償仲裁機制等安排涉及的概念，對他們來說是有點複雜的。不過，經主持人闡述和說明後，不少參加者，特別是較年輕及收入較高的人士，都很快能掌握有關的主要概念及要旨。
- 大部分參加者均支持透過醫保計劃增加消費者選擇及提高市場透明度的具體目標。不過，部分參加者對於計劃能否實踐上述目標則有保留，少部分人對計劃要保證長者及高風險人士受保的可行性，尤其存有疑問。

報告撮要(2)

醫保計劃標準醫療保險的保障範圍

- 大部分參加者覺得醫保計劃提供的標準醫療保險 (以下簡稱 “標準醫保”) 的保障範圍足夠，因爲已主要包括住院治療和非住院手術，正好切合他們認爲醫療保險應針對不可預見及昂貴治療的期望。儘管如此，部分人對計劃中某些細節，例如住院和手術前後所需的專科門診診症的受保次數上限，依然有所保留。
- 少數參加者建議將計劃的保障範圍擴展至長期護理及跟住院或手術無關的門診服務，但經討論後，他們理解到上述附加保障由於屬較易預料的醫療需要，故此所需要的額外保費會甚高， 對有關建議的支持度因而有所下降。
- 當醫保計劃的保費這個環節經過較深入的討論後，各小組的主流意見普遍傾向務實，不少參加者贊成將一些相對較便宜及非必要的醫療服務，例如一般牙科護理及較高檔次的病房設施，歸入爲醫保計劃的附加保障項目，而不包括在標準醫保內。

報告撮要(3)

按症候族羣分類訂定套餐式收費模式和保險賠償結構

- 雖然部分參加者初時未能完全掌握按症候族羣分類的具體做法，但經主持人解釋後，很多人都能夠理解背後的理念及原則，部分人更希望進一步了解有關的技術細節。
- 在討論中，參加者普遍歡迎醫保計劃根據症候族羣分類作爲訂定醫療服務收費及保險賠償水平的基礎。他們認爲無論對於已受保及未受保的病人來說，這個做法皆有助簡化醫療收費程序，亦方便病人預計所需費用總額及須自行支付的數額。一些參加者更加覺得，這個特點可令醫保計劃更具吸引力，並且成爲一個重要賣點。
- 至於現時市場廣泛採用的逐項式收費模式，部分參加者認爲在這種收費模式下較難事先預計最終收費總額，這個不明確因素可能會減少他們有需要時選用私營醫療服務的意慾。

報告撮要(4)

按症候族羣分類訂定套餐式收費模式和保險賠償結構

- 不過，參加者對於以症候族羣分類爲基礎的套餐式收費模式在實行上可能帶來的正面和負面影響，持有不同的意見。部分參加者預期這種收費模式可減少私家醫院及醫生對已受保的病人收相討對較高費用及提供不必要服務的情況，從而對保費的長遠上升壓力具紓緩作用。然而，部分參加者擔心收費一旦固定及全包，套餐服務的治療和用藥質素會有所下降。對於某些較一般情況複雜的病案，參加者亦關注到在套餐式收費以外會否有額外費用。
- 小組討論中一些參加者的言談反映一種傾向，與目前保險市場普遍存在的道德風險行爲甚爲相符。當討論提及醫療保險會否加劇醫療通脹的問題時，部分參加者承認只要醫生建議的治療程序是安全及可獲得保險足額賠償，他們傾向以“寧多勿少”的心態選擇接受，而不理會有關程序是否必要。

報告撮要(5)

按症候族羣分類訂定套餐式收費模式和保險賠償結構

- 一些參加者相信按症候族羣分類制訂的套餐式收費模式可讓病人較容易比較不同私家醫院的收費，但有其他參加者不同意此說法，認爲當病人急需診治時，未必有足夠時間去搜集價格資料。
- 部分參加者擔心按症候族羣分類制訂的保險賠償水平會推高醫療收費的風險，因爲醫療服務提供者可能刻意將套餐式收費提高至保險賠償上限，令在醫保計劃的共同保險安排下，受保人需負擔較多的自付金額。
- 一些參加者亦擔心會有私家醫院及醫生不願意採用按症候族羣分類制訂的套餐式收費，因而減少受保人就醫療服務提供者的選擇。
- 參加者似乎一致認爲，無論會否實行醫保計劃及無論是採用套餐式或逐項式收費的情況下，政府都應對醫療服務提供者，特別是私家醫院，在收費方面作出更多的管制，所持的原因普遍是認爲現時私營的醫療收費項目繁多及欠缺透明度。

報告撮要(6)

醫療質素監管及索償仲裁機制

- 參加者普遍表示他們沒有專業知識去評論醫療質素監管這個題目，但願意分享有關的感覺和想法。
- 大部分參加者對香港私家醫院及私家醫生的專業及服務水平有良好印象。然而，有些參加者不滿部分醫生向病人解釋診治細節時，未有給予足夠的時間和注意力，儘管其收費甚爲昂貴。
- 至於索償仲裁方面，僅少數參加者曾向保險公司索取住院賠償，當中大多都滿意以往的索償經驗，但亦有一些參加者不滿意獲賠償的金額。整體上，無論是否有索償經驗，參加者普遍歡迎在醫保計劃下設立更完善的仲裁機制，並且期望政府在該機制中能扮演積極的角色。
- 部分參加者認爲有效的索償仲裁機制會增加他們參加醫保計劃的信心，原因有二：(1) 仲裁過程較法律訴訟簡單及省錢；(2) 機制如能由各方代表適當參與，可以平衡消費者、受保者及醫療服務提供者三方面的利益。不過，有些參加者懷疑機制是否可避免把巨額糾紛訴諸法庭解決，因爲在這情況下，他們寧可將有關案件交予法庭裁決。

報告撮要(7)

高風險分攤基金

- 不少參加者，包括不同年齡及健康狀況的人士，均表示願意接受醫保計劃下設立高風險分攤基金的安排，即稍爲增加所有受保人的基本保費 (討論中假設上調7%作爲說明)，讓計劃可以承保較高風險人士及在等候期後承保所有投保前已有的病症，並提供附加保費的上限(討論中假設爲基本保費的200%作爲說明) 。
- 部分健康情況良好的參加者指出，儘管高風險分攤基金目前對他們不利，但他們當年老時或者健康情況轉差時，也可受惠於這個安排。此外，他們對有關基金的支持，亦建基於可以惠及有需要人士及弱勢社群的社會價值觀。
- 不過，少數參加者表明不支持高風險分攤基金，因爲做法等同要較低健康風險的人士間接資助較高健康風險的人士。他們認爲將個人健康風險由其他人攤分的做法並不合理。
- 儘管參加者對高風險分攤基金的看法分歧，不同意見的參加者均憂慮到有關安排會誘發逆選擇的市場行爲，即會吸引較多高風險人士參加計劃，但令低風險人士卻步。他們認爲若這種情況出現，將會削弱醫保計劃在財政上的可持續性。

報告撮要(8)

高風險分攤基金

- 有建議認爲醫保計劃應容許高風險的投保人士可選擇接受投保前已有病症不屬於保障範圍內，以替代附加保費的安排。他們認爲復發的病症往往是涉及長期護理的長期疾病，所需的費用可能會超出保險的賠償限額。爲免自付額外的費用，病人即使已受保，仍可能不願意選用私營醫療服務。因此，提供投保前已有病症的保障對部分長期病患者來說，未必有實際幫助。

報告撮要(9)

無索償折扣

- 除了那些患有長期疾病的人士外，其他參加者普遍認爲無索償折扣是公平及有效的價格安排，能增加醫保計劃的吸引力和成爲計劃的一個重要賣點。
- 另一方面，患有長期疾病的參加者普遍對無索償折扣的建議並不熱衷。他們認爲雖然他們的保費基準較高(因連附加保費)，從無索償折扣可節省的金額理論上可以較大，但實際上他們不索償的機會較低，故此不容易享用有關的優惠。此外，相對於爲保障已有病症而需支付的附加保費而言，他們認爲無索償折扣能提供的紓緩作用有限。

報告撮要(10)

紓緩保費上升的壓力

- 相比現時市面上的醫療保險產品，大部分參加者相信醫保計劃下標準醫保的基本保費，會較容易控制於合理水平，因爲他們認爲政府應該並且能夠主動對保費調整進行有效監管，並且杜絕不合理的加幅出現。此外，他們認爲醫保計劃的劃一標準設計，只要配合一定的參加人數，就可以有效引入高科技及其他節省成本的方法，降低營運開支。
- 爲引發有關政府在制定保費上的角色有更多討論，主持人向各小組展述了四種按嚴厲程度排序的政府管制可能方法。多數參加者的反應是不認同兩種相對較寬鬆的方法，即僅要求承保機構匯報及公開營運成本和保費的數據，而政府不會直接干預醫保計劃的保費水平。他們覺得以上方法過度依賴參與醫保計劃的承保機構之自律性，未能爲消費者提供足夠的保障。

報告撮要(11)

紓緩保費上升的壓力

- 相反，大部分參加者傾向支持政府使用較嚴厲的方法去監管醫保計劃的保費。他們認爲既然醫保計劃本身由政府監管及推動，政府是有足夠理據去主動監管保費。在兩類較嚴厲的管制方法中，由政府制定單一保費表的建議，較設立機制去審批各承保機構加價申請的建議，更受這些參加者支持。與此同時，部分參加者也建議可考慮由政府直接參與醫保計劃，提供計劃下的醫療保險服務，甚至醫療服務。他們認爲這種做法比起依賴私人市場提供服務又同時由政府規管的做法，更爲直截了當。
- 另一方面，一些參加者對政府主動對保費水平及服務提供作出積極干預的有關建議有所保留，他們憂慮這樣會窒礙市場競爭，減少消費者的選擇。
- 小組討論亦觸及用減低成本措施去紓緩醫保計劃保費上升壓力的可能性。就這方面參加者普遍持審慎樂觀的態度。他們大多同意若計劃有一定人數參加，就可以適當引入高科技及其他節省成本的方法，以簡化計劃的日常營運。部分參加者亦認爲既然醫保計劃標準醫保產品是劃一標準化的，消費者可以較少依賴保險經紀提供的中介服務，從而令服務收費下降。然而，部分參加者重視保險經紀提供的服務，認爲醫保計劃應讓投保人自由選擇是否需要有關服務。

報告撮要(12)

對參考保費水平的反應

- 小組討論嘗試測試參加者對醫保計劃下標準醫保的估算保費水平之反應。爲方便參加者能有較具體的資料作爲參考，主持人向他們展示醫保計劃標準醫保的各主要特點及不同年齡組別的基本保費表 (摘錄自醫療改革第二階段諮詢文件) 。該保費表不包括可能適用的高風險人士的附加保費(最高爲基本保費的200%)、無索償折扣及經紀佣金。
- 大部分參加者，特別是較高收入及患有長期疾病的人士，認爲提供作參考的估算保費水平會吸引他們考慮參加醫保計劃。部分人更有興趣投保時加入家庭成員，儘管他們表示會謹慎考慮所需的保費總額。不過，參加者普遍關注到保費在年老時會大幅增加，部分人擔心自己退休後可能沒有能力繼續負擔保費。
- 不過，一些參加者認爲作爲參考的估算保費水平對他們來說，不管是在個人或家庭層面，都昂貴得難以負擔。此看法在較低收入及現時未受保的參加者中，較爲普遍。
- 當主持人提出可以選擇接受墊底費以獲取較低保費時，多數參加者却表示不會考慮這個安排。他們認爲既然已經購買保險，就想避免再爲醫療服務自行承擔費用。此意向在患有長期疾病的參加者中尤其明顯。
- 在討論過程中，參加者對支付額外保費以獲取附加保障項目的建議，普遍反應未見踴躍，只有少數參加者，主要是長期病患者，對此有興趣。

報告撮要(13)

政府提供的誘因

- 如上述所言，大多數參加者覺得以作爲參考的估算保費水平來看，醫保計劃下標準醫保的設計對他們是具吸引力的。當被問及若政府提供財務誘因以鼓勵市民參加醫保計劃時，這些參加者自然對參加計劃表示更大的興趣。對於較早前表示不願參加或對計劃有猶疑的人士而言，如果津貼金額吸引的話，他們也表示願意重新考慮。
- 至於政府若提供財務誘因應以什麼模式和多少金額發放，討論中意見不一，未能達成共識。

Findings

– Part 1 –
Awareness and Understanding of the HPS

Awareness and Understanding of the HPS (1)

- There was a high level of awareness about the existence of the HPS among the participants. A majority of participants indicated that they had heard or read about the HPS through the media in the preceding few months. Some of them could correctly describe the scheme in general terms.
- Examples of their description on HPS are:
  - Participation is voluntary.
  - It aims to cover everyone regardless of age or history of illness.
  - It aims to lower public healthcare expenditures or provide relief to public hospitals.
  - It may come with some form of government subsidy.
  - It is a government program.

Awareness and Understanding of the HPS (2)

- However, the understanding of certain specific scheme features was incomplete and occasionally inaccurate. For instance, some participants misunderstood that pre-existing illnesses were not covered at all in the first 3 years of joining the scheme, while the actual fact was that they were partially covered in the 2nd and 3rd year before full coverage in the 4th year.

> *"I learned about the HPS from a brochure I picked up at a hospital…. people with chronic disease will not be covered for the first 3 years!" (Young, paying, with chronic disease)*

> *"It covers the old people and people with pre-existing conditions so they can go to private hospitals and get treatment without a long waiting period." (Old, non-paying, low income)*

- Some participants thought that the concepts underlying certain scheme features as the charging method based on diagnosis-related groups (DRG) and claims arbitration mechanism were a bit too complex for them to comprehend fully. Yet after clarification and elaboration, a lot of participants, especially the younger and higher income groups, managed to grasp the key concepts and gist quite quickly.

Awareness and Understanding of the HPS (3)

- While most participants agreed to the stated objectives of HPS to enhance consumer choice and increase market transparency, some of them had reservation regarding the practicability of achieving these objectives. A few participants in particular questioned the feasibility of guaranteeing coverage for the elderly and high-risk population.

> *"I have a concern over the funding of this scheme especially if it covers pre-existing conditions." (Young, non-paying)*

> *"It's a good idea to cover the high-risk group, but private hospitals are so expensive, how can the HPS cover them all?" (Young, non-paying, with chronic disease)*

> *"I would question universal coverage. It sounds unrealistic." (Young, non-paying, with chronic disease)*

> *"The concept of the HPS looks very good on paper. How it can be put into practice remains to be seen." (Old, non-paying, high income)*

– Part 2 –
Benefit Coverage of the HPS Standard Plan

Benefit Coverage of the HPS Standard Plan (1)

- Most participants considered the basic benefit coverage of the HPS Standard Plan adequate because the Plan covered mainly inpatient and ambulatory care which matched with the expectation that health insurance should primarily target at unanticipated and expensive treatments.

> *"It depends on your viewpoint. If you feel that HPS should provide total protection, i.e. you can rely on the government 100%, this core coverage is inadequate. However, if you feel that the purpose of HPS is to protect you from financial disaster due to major medical expenses, then this core coverage is adequate." (Middle age, non-paying, low income)*

Benefit Coverage of the HPS Standard Plan (2)

- This was notwithstanding some reservation about certain fine details, such as the ceiling on the number of claimable pre-admission and post-operative specialist consultation visits.

> *"Three visits to specialists per case are not enough. It will take at least five." (Middle age, non-paying, low income)*

- A few participants suggested extension of scheme coverage to long-term care and outpatient services not related to hospitalization treatments, but the support to these ideas dwindled after the discussion led to awareness of the substantial extra premium needed to cover these more predictable needs in reality.

> *"The core coverage is definitely inadequate. It does not cover people with chronic disease who need outpatient care and prolonged medication." (Young, paying, with chronic disease)*

> *"Physiotherapy should be included. It can be prolonged and become very expensive." (Old, non-paying, high income)*

Benefit Coverage of the HPS Standard Plan (3)

"It will cost too much to cover everything!" (Middle age, non-paying, high income)

- After the premium concern was well discussed, the mainstream thinking also turned more pragmatic in favor of grouping the relatively less costly and less necessary services, such as general dental care and better room accommodation, under coverage of top-up plan instead of the HPS Standard Plan.

"Upgrading to better room accommodation is not necessary. Those covered in the HPS Standard Plan are necessary for curing your illness, but better room accommodation is just for better service and environment." (Old, paying, high income)

"I just go to the dentist for scaling once a year, which costs a thousand or less, it is not necessary to be covered." (Young, paying)

– Part 3 –
DRG-based Packaged Charging and Insurance Benefit Structure

DRG-based Packaged Charging and Insurance Benefit Structure (1)

- Despite some difficulties to understand fully the technicalities related to DRG, many participants managed to grasp the underlying rationales and principles after explanation. Some of them were also keen to know more about the technical details.
- The idea of using DRG as the basis for healthcare pricing and setting of insurance benefit levels under the HPS was well received in the discussions. Many participants appreciated this idea for allowing simplified billing, predictable charges and certainty in out-of-pocket payment for both uninsured and insured patients. They also felt that this feature was potentially a unique selling point and an added value to the HPS.

> *"I don't need to pay the whole sum first and then file a claim. I like that very much!" (Old, non-paying, high income)*

> *"DRG is attractive to people who don't have the money to pay the hospital upon discharge." (Young, paying)*

> *"DRG pricing gives me peace of mind knowing the cost in advance." (Old, non-paying, high income)*

DRG-based Packaged Charging and Insurance Benefit Structure (2)

- As regards itemized pricing widely adopted nowadays, some participants found it more difficult to know in advance how much the final bill was and this uncertainty might discourage them from choosing private healthcare services.

> *"I went to a hospital once because of a leg injury. The hospital bill was quite a shock! I could not imagine those charges! There was no transparency at all! I had insurance coverage from my employer and it was all paid for, but I don't think this is fair. What if I am not working or my employer does not provide insurance coverage? I can be ruined financially even by something that is considered minor." (Young, paying)*

DRG-based Packaged Charging and Insurance Benefit Structure (3)

- However, the participants were ambivalent towards the possible pros and cons of DRG-based packaged charging in practice. Some expected that DRG-based packaged charging could help reduce incidents of higher pricing and ordering of less necessary services by private hospitals and doctors for the insured patients, and hence keep long-term insurance premium rise in better check. On the other hand, some participants worried that the quality of treatment and medicines prescribed would be compromised when the charges were fixed and all-inclusive. There was also a concern on whether the packaged charges could cover the extra cost if a treatment was more complex than average.

> *"At lease there would be a fixed charging for the DRG, which can lead to the competition between the hospitals." (Old, not paying, high income)*

> *"With packaged charging, the doctors will just do what is necessary in the operation, and will save all those which are not necessary. (Middle age, paying, low income)*

DRG-based Packaged Charging and Insurance Benefit Structure (4)

"Now different hospitals charge differently and we tend to think that price equates quality. With DRG pricing, some hospitals might have to lower their quality so as to stay profitable." (Middle age, paying, high income, with chronic disease)

"With DRG, the hospital will use the cheapest drugs possible and discharge you as soon as possible." (Middle age, paying, low income)

"For example, for a surgery of Appendicectomy, usually the patient can leave after four to five days. But after the surgery, the intestine is not function, so you need a further surgery and finally in-hospital for a month. Will the packaged charges cover this kind of situation?" (Old, paying, high income)

DRG-based Packaged Charging and Insurance Benefit Structure (5)

- Moreover, a notable tendency exhibited in the discussions was consistent with moral hazard behaviors common in insurance market. When the discussions came to the point about insurance-induced medical inflation, some participants admitted that they would be inclined to seek “more rather than less” treatments so long as the treatment was safe and the cost was well covered by insurance, and would tend to neglect and even ignore the issue of medical necessity.

> *“It is a common practice that the doctor will ask if you have any insurance. They will then charge you to the insurance benefit limit.” (Middle Age, Paying, High Income)*

> *“Last year, I received a treatment in a private hospital, which could actually be done in any clinic. I had to do so in order to be eligible for reimbursement under my insurance policy.” (Middle Age, Paying, High Income)*

DRG-based Packaged Charging and Insurance Benefit Structure (6)

- Some participants believed that DRG-based packaged charging would facilitate price comparison between private hospitals. However, some others disagreed and doubted whether time would allow patients to do so when they urgently needed medical interventions.

> *"It allows me to compare prices. It's clear and less hassle." (Middle age, non-paying, low income)*

- Some participants were concerned that if the DRG-based benefit limit exceeded the packaged charges by the healthcare providers, some providers would be induced to mark up the charges to reach the benefit limit. To the extent that the insured has to bear co-insurance, their out-of-pocket expenses would be increased. In the longer term, this phenomenon would also aggravate medical inflation.

> *"Private hospital is running a business. For example, suppose a surgery costs less than $18,000, but as the Government says the packaged benefit limit for the surgery is $18,000, the private hospital will charge you $18,000." (Young, paying)*

DRG-based Packaged Charging and Insurance Benefit Structure (7)

- Some participants also worried that not all hospitals and doctors would be willing to adopt DRG-based packaged charging, and that their choice of healthcare providers would be limited in consequence.

> *"The best hospitals might choose not to offer DRG pricing. This will limit our access to these hospitals!" (Young, paying, with chronic disease)*

> *"I am afraid service quality will suffer because the best doctors will choose not to participate in DRG." (Middle age, non-paying, low income)*

DRG-based Packaged Charging and Insurance Benefit Structure (8)

- It appeared to be a consensus among the participants that even without HPS and regardless of the choice of packaged or itemized pricing method, the Government should exercise more control over how the healthcare providers, especially private hospitals, charge their customers because the charges were often diverse and not transparent.

> *"'Free market' is a poor excuse for the government not to get involved in controlling the high cost of private hospitals." (Middle age, paying, high income)*

> *"Private hospitals do not list all their prices. You have to ask for the price for each item. It lacks transparency." (Young, paying, with chronic disease)*

> *"Government oversee can put a lid on the cost of private hospitals." (Middle age, paying, with chronic disease, high income)*

DRG-based Packaged Charging and Insurance Benefit Structure (9)

- Some participants were eager to learn more about the operation of DRG-based packaged charging. Numerous questions have been raised on the service coverage, price setting and quality assurance of this payment method.

> *"I would like to know more details on what it covers. There might be different procedures for the same surgery. For example, does it cover laparoscopy or only open surgeries? Does it cover local or general anesthesia? There might even be different drug regiments for the same disease. How about the different grades of stent for angioplasty? This needs to be spelt out clearly in the DRG pricing so we don't get short-changed at a hospital. We don't want the doctors/hospitals to economize on their choice of treatment, drugs or material." (Young, non-paying)*

> *"What will happen if there are complications during surgery or if there is co-morbidity?" (Young, paying)*

– Part 4 –
Clinical Control
and Claims Arbitration

Clinical Control and Claims Arbitration (1)

- The participants generally claimed that they did not have the expert knowledge to comment on the topic of clinical control. Yet many of them were willing to share their impression, perceptions and thoughts.
- Most participants had a good impression about the professional and service standard of private hospitals and private doctors in Hong Kong. However, some participants were discontent with high service charges but limited time and attention that some doctors spent in communicating with the patients about the treatment details.

> *"They spent only a few minutes with you during which they asked a few questions. They hardly ever examined you before they called in the next patient." (Middle age, paying, low income)*

> *"Private doctors charge very high fees and yet spend very little time with the patients." (Middle age, non-paying, low income)*

Clinical Control and Claims Arbitration (2)

- As regards claims arbitration, only a minority of the participants had the experience of making insurance claims on hospitalization expenses. Most of these participants were satisfied with their claim experiences while a few were discontent about the reimbursement amount. Yet in general, the participants with or without claims experience welcomed a more active role of the Government and a more established mechanism in respect of claims dispute settlement.

> *"The claim process was fast. My claim could be settled within a month after submitting invoices to the insurer." (Middle age, paying, high income)*

> *"Insurance companies are profit-oriented and they handle claims from business angle. For the sake of justice, government intervention is needed to settle dispute." (Old, paying, high income)*

Clinical Control and Claims Arbitration (3)

- Some participants considered that in the presence of effective claims arbitration mechanism, their confidence in joining HPS would greatly increase for two reasons: (1) the arbitration process would be simpler and less costly than legal litigation; (2) it would help balance the interest between the consumers, the health insurers and the healthcare service providers through proper representation.

> *"Claims arbitration will restore some balance to the system. It will enhance public confidence." (Middle age, paying, high income)*

> *"Arbitration is necessary. It offers one more venue for consumers to seek help." (Young, paying)*

> *"Claims arbitration helps balance the consumers' right against the insurance companies and hospitals." (Middle age, paying, low income)*

Clinical Control and Claims Arbitration (4)

- Yet some of them felt doubtful about the effectiveness of such a mechanism in avoiding settlement at court level if the amount of money involved was big. In that case, they would prefer to have their days in court.

> *"I believe claims arbitration is a good idea, but I am not sure how effective it will be." (Young, paying, with chronic disease)*

> *"I would rather take my case to the courts. They are more effective." (Middle age, non-paying, high income)*

– Part 5 –
High-Risk Pool

High-Risk Pool (1)

- Many participants, regardless of age and health status, indicated that they were willing to accept the high-risk pool arrangement under the HPS whereby the basic premium for all insured persons was increased moderately (by 7% as an illustrative assumption) so as to allow the scheme to cover people with higher health risks and pre-existing illnesses subject to a waiting period and a cap on the premium loading applied to them (at 200% of basic premium as an illustrative assumption).

> *"The illustrated assumption of 7% is acceptable. It is not too high. I can afford it and also it will not only benefit others but will also benefit myself." (Young, non-paying with chronic disease)*

> *"It's fine for me to pay extra 7%, as I will grow older, and will benefit from this in the future." (Middle age, paying, high income)*

High-Risk Pool (2)

- Some participants with good health status explained that although the high-risk pool arrangement was disadvantageous to them currently, they would take the turn to benefit from the arrangement as they grew old or their health condition deteriorated. They also supported the idea because it served the societal value of helping the needy and disadvantaged groups.

> *"I am healthy now, but this might change without any warning. This high-risk pool may benefit me someday. It's acceptable to me." (Old, paying, low income)*

> *"This is acceptable. Sooner or later I will become old and high risk." (Middle age, paying, high income)*

High-Risk Pool (3)

- On the other hand, a few participants voiced their unwillingness to indirectly subsidize people with higher health risks through the high-risk pool arrangement. They considered it unreasonable for other people to share one's health risk.

> *"I will not want to subsidize those who are at high risk, unless the premium turns out to be the same or lower than similar products." (Young, paying)*

High-Risk Pool (4)

- Many participants irrespective of their attitude towards the high-risk pool voiced their concern over feasibility of the arrangement due to adverse selection behaviors. They opined that the high-risk pool arrangement would attract more people with higher health risks to participate in the scheme while discouraging people with lower health risks from joining, and that financial sustainability of HPS as a whole would be threatened as a result.

> *"For those who are healthy, high-risk pool does not sound attractive. For those who are high risk, this is great! So what will happen if only the high-risk group buy this plan?" (Young, non-paying)*

> *"Smart people will wait until they are ill before they join HPS!" (Young, paying, with chronic disease)*

High-Risk Pool (5)

- There was a suggestion that the insured persons should be given the choice between accepting exclusion terms for pre-existing illnesses in lieu of premium loading to cover pre-existing illnesses. The rationale was that recurrence of pre-existing illnesses was often related to chronic diseases that required long-term care and hence higher expenses that might exceed the benefit limit. In order to avoid the out-of-pocket payment beyond the benefit limit, the patients might not be willing to go private even if insured. Inclusion of pre-existing illnesses would become irrelevant to them in this situation.

> *"At first the coverage of pre-existing conditions under the HPS sounded very good. But now that I know there's a waiting period, it is not that good anymore. I'd prefer my current private insurance which excludes heart disease…and the premium is very reasonable. I have a history of heart disease, so when it recurs, I can always go to a public hospital. (Young, paying, with chronic disease)*

– Part 6 –
No-Claim Discount

No-Claim Discount

- Most of the participants, with the notable exception of those with chronic diseases, felt that no-claim discount (NCD) was an attractive feature because they considered this a fair and efficient pricing method. They also believed that this could be a good selling point of HPS.

> *"NCD is very appealing, especially for people who are healthy. It will also prevent minor claims. It works similar to auto insurance." (Old, non-paying, high income)*

- However, the participants with chronic diseases were generally lukewarm to the idea of NCD. Although they could potentially save more in absolute terms through NCD due to higher premium level (after loading), they envisaged their chance of making no claim would be low. Also, they found the discount too limited a relief compared with the substantial premium loading to cover their pre-existing illnesses.

> *"I have to pay high loading. NCD or not, I am still paying very high premium!" (Young, paying, with chronic disease)*

– Part 7 –
Containment of Premium Increase Pressure

Containment of Premium Increase Pressure (1)

- Most of the participants were confident that the basic premium of the HPS Standard Plan could be under better control compared with existing health insurance products for two major reasons. First, they opined that the Government should and could proactively control the premium adjustment and deter unreasonable increase. Second, they thought that the standardization design of the HPS, if coupled with a sizeable pool of participants, could allow better use of technology and other cost-savings means to lower the operating cost.

> *"The government should exert more control on the premium level of HPS. Otherwise, it will go up and get out of control like all the other plans in the market." (Young, non-paying)*

> *"I believe the government can work with the insurers to come up with a standard rate that is reasonable, one that the consumers can afford and the insurers can operate with some profit." (Old, non-paying, low income)*

Containment of Premium Increase Pressure (2)

- On the government's role in premium setting, the moderator attempted to facilitate the discussion by presenting four hypothetical approaches in ascending order of stringency in government control.
  1) The government to require participating insurance companies to report and disclose their operating, financial and pricing data for HPS business.
  2) The government to provide benchmark indicators on the HPS Standard Plan's premium, such as the market average and range.
  3) The government to approve individual premium rise applications from each participating insurance company before an increase can become effective.
  4) The government to fix the premium levels which all participating insurance companies must follow without deviation.
- In response, the participants mostly did not agree with the two relatively less stringent approaches 1 and 2 without the Government directly controlling the HPS premium level. These two approaches were considered to rely exceedingly on self-discipline of the participating insurers and could not render adequate protection to the consumers.

Containment of Premium Increase Pressure (3)

- By contrast, more of the participants supported the more stringent approaches 3 and 4 by which the Government controlled the premium levels of the HPS Standard Plan in a direct manner. They considered this intervention justifiable because of the inherent nature of HPS as a government-regulated scheme.

> *"Because HPS is a Government-regulated scheme, the insurer should follow what the Government sets, and it should not be based on the free-market concept. (Young, Paying)*

- Compared with the approach 3, the approach 4 received even greater support for being more straight forward and simple.

> *"A standard price set by the government will be most effective. Insurers will then compete on service, not price. And consumers will select insurers based on their service quality. The government can do this if it's determined." (Young, non-paying)*

Containment of Premium Increase Pressure (4)

- Furthermore, some participants proposed that in order to safeguard consumer interest, the Government might directly provide health insurance and even healthcare services under the HPS instead of resting with the private sector and exercising control concurrently.

> *"The government can't really control the insurance companies. It will be difficult to even expect insurance companies to open their books! The only way for the government to control premium level is to run it itself!" (Middle age, paying, low income)*

> *"The government should set up an 'insurance department' to run HPS. If they can run a revenue department, they can surely run an 'insurance department'!" (Middle age, non-paying, low income)*

> *"Outsourcing HPS to insurance companies is not a good idea. Look at MPF…it's a bad example of government outsourcing to banks and insurance companies. They charged high fees and failed to perform to our expectations." (Middle age, non-paying, low income)*

Containment of Premium Increase Pressure (5)

"It's best that it runs HPS internally. I don't buy health insurance because I have heard horror stories about insurance companies refusing to pay claims. If the government runs HPS, I will buy!" (Middle age, non-paying, low income)

- On the other hand, some participants had reservation regarding active government intervention in premium control and service provision for fear of hindering market competition and reducing consumer choice in consequence.

"Hong Kong is a free market. It's best to let insurers compete on their own merits." (Old, non-paying, low income)

"Standard pricing might lead to complacency among the insurers." (Old, non-paying, low income)

Containment of Premium Increase Pressure (6)

- As regards the use of cost cutting initiatives to contain the HPS premium pressure, the participants appeared to be cautiously optimistic. They mostly agreed that if HPS could attract a sizeable enrolment, there should be room to introduce technological and other cost-effective operational arrangements. Some of them also agreed that since the HPS Plan was standardized, they could rely less on the middleman services provided by insurance agents so that the resultant savings in agent commission could translate into more affordable premium.

> *"I would be happy to buy directly from the insurance companies. In fact, I bought my present coverage at a bank without going through an agent." (Middle age, paying, low income)*

- Nevertheless, some participants valued more the agent services and opined that there should be a choice of using agent services or not under the HPS.

> *"Insurance agents are very helpful when you have to file claims." (Middle age, paying, low income)*

– Part 8 –
Willingness-to-pay

Willingness-to-pay (1)

- The participants were shown the illustrative key features and age-bracketed basic premium table for the HPS Standard Plan (as extracted from the second stage public consultation document on healthcare reform) so that they could have an idea of roughly how much of the premium they would have to pay in joining HPS (in conjunction with the possibilities of premium loading of up to 200% of basic premium for high-risk individuals, NCD and agent commission).
- Most participants, especially those with higher income and inclusive of those with chronic disease, found the illustrative premium levels attractive for them to consider joining the HPS. They would also consider including their family members in enrolment, though mindful of the budget involved.

"Compared to the premium I am paying now, HPS premium is much lower…and I like its transparency." (Middle age, paying, high come, with chronic disease)

"I don't think we should rely on the government for free healthcare. We should see if this HPS can provide basic coverage at a price comparable to other plans. If it can, I will surely buy." (Middle, non-paying, low income)

Willingness-to-pay (2)

- However, there was a common concern about the steep rise in premium for the old-age which some participants considered probably not affordable when they retired.

> *"This premium level is way too high, especially when we get older and are near retirement." (Middle age, non-paying, low income)*

> *"The government should waive our premium when we retire!" (Middle age, non-paying, low income)*

- A few participants considered the premium level too high to afford at individual or family level. This view was more common for the participants with lower income and currently uninsured.

> *"This premium is expensive, especially if there are several members in the family!" (Middle age, paying, low income)*

Willingness-to-pay (3)

- When provided an option of selecting deductible in exchange for lower premium, most participants refused to consider because their mindset did not accept substantial expenses out-of-pocket after already paying for the insurance premium. This inclination was more apparent for those with chronic disease.

> *"People buy insurance so they don't have to pay out-of-pocket. Deductibles will defeat the purpose of insurance." (Middle age, high income, with chronic disease)*

- The tendency to pay extra premium for top-up components was not popular in the discussion. Only a few participants, mainly those with chronic disease, showed such an inclination and they largely opted the lowest deductible amount.

– Part 9 –
Government Incentives

Government Incentives

- As aforesaid, most participants thought that the proposed scheme features of HPS Standard Plan introduced so far were attractive subject to the illustrative premium. When asked to respond if financial incentives were provided by the Government to encourage joining the HPS, these participants naturally showed keener interest. Those who had refused/hesitated to consider buying also stated that they were willing to re-consider if the incentive amount was attractive.

> *"The HPS is not attractive to me as I am insured already. If the Government would like to encourage people like me to purchase the HPS, it should provide some subsidies to attract us." (Old, paying, high income)*

- No consensus was observed regarding the desired amount and mode of financial incentives, though.

> *"It's unreasonable to ask for 100% incentives from the Government. I think the incentive should be around 30% of the premium." (Old, non-paying, low income)*

Appendix 1
Participants' Profile

Participants' Profile (1)

- **Total Number of Participants = 80**

- Gender (N=80)

Male	Female
50.0%	50.0%

- Age (N=80)

Aged 20-35	Aged 36-49	Aged 50 or above
20.0%	40.0%	40.0%

- Paying Out-of-pocket for Comprehensive Health Insurance Owned (N=80)

Paying Out-of-pocket	Non-paying Out-of-pocket
50.0%	50.0%

Participants' Profile (2)

- Owning / Not Owning Comprehensive Health Insurance Purchased by Employers and Family Members for Non-paying Group (n=40)

Owning Comprehensive Health Insurance		Not Owning Comprehensive Health Insurance Purchased by Employers and Family Members
From Employers	From Family Members	
32.5%	5.0%	62.5%

- Household Income (N=80)

Higher Income ($20,000 or above)	Lower Income (Below $20,000)
57.5%	42.5%

- Chronic Disease (N=80)

With Chronic Disease	Without Chronic Disease
35.0%	65.0%

Participants' Profile (3)

- Occupation (N=80)

Clerks	28.8%
Associate professionals	22.5%
Professionals	12.5%
Managers and administrators	11.3%
Service workers and shop sales workers	10.0%
Housewife	5.0%
Retired	5.0%
Plant and machine operators and assemblers	2.5%
Craft and related workers	1.3%
Elementary occupations	1.3%

Participants' Profile (4)

- Claim Experience for Those Paying Out-of-pocket (n=40)

With Claim Experience	Without Claim Experience
42.5%	57.5%

- Martial Status (N=80)

Single	Married	Divorce/ Widowed
23.8%	71.3%	5.0%

- Number of Children (n=61)

0 Child	1 Child	2 Children	3 Children	4 Children
14.8%	36.1%	42.6%	4.9%	1.6%

Participants' Profile - Hospitalization Insurance Ownership (1)

Important note: Since the participants were recruited according to the desired characteristics, the percentages shown hereafter are not representative of the general population .

- Ownership of Hospitalization Insurance (N=80)

Owners	Non-Owners
68.8%	31.3%

Base: All participants (N=80)

- Purchaser of the Hospitalization Insurance Owned (n=55)

Participants Themselves	Employers	Family Members
72.7%	65.5%	5.5%

Base: Hospitalization insurance owners (n=55)
Remarks: Participants might own more than 1 policy

- Coverage of Out-patient (n=55)

Out-patient Covered	Out-patient Not Covered
58.2%	41.8%

Base: Hospitalization insurance owners (n=55)

Participants' Profile - Hospitalization Insurance Ownership (2)

- Purchasing Hospitalization Insurance for Family Members (n=55)

Yes	No
34.5%	65.5%

Base: Hospitalization insurance owners (n=55)

- Reasons of Not Purchased Hospitalization Insurance for family Members (n=36)

	Overall
Family members purchased policy for themselves	61.1%
No such need / Family members said they did not have such need	13.9%
Family members were too old to be insured	8.3%
Family members had chronic disease and rejected by insurer	8.3%
No extra money to purchase for family member	5.6%
The employer of the family members provided hospitalization coverage	5.6%
Too expensive	2.8%

Base: Those hospitalization insurance owners who did not purchase hospitalization insurance for their family members (n=36)

Participants' Profile - Hospitalization Insurance Ownership (3)

- Monthly Premium Paying for Hospitalization Insurance (n=55)
  - Average = $704

- Reasons of Not Purchased Hospitalization Insurance (Top 5) (n=25)

	Overall
No extra money to purchase	28.0%
Did not need the coverage	16.0%
With chronic disease, rejected by the insurer or with high premium	12.0%
Too old to be insured or with high premium	12.0%
Healthy and did not need insurance	8.0%
Public hospital can satisfy me if needed	8.0%
Able to afford the medical expense and no need to purchase insurance	8.0%

Base: Hospitalization insurance non-owners (n=25)

Appendix 2
Discussion Guide

Focus Group Discussion Guide

引言及介紹 (5 minutes)

1. 歡迎及多謝被訪者
2. 主持人自我介紹
3. 解釋市場研究公司的中立性
4. 解釋答案沒有對錯的重要性
5. 介紹座談會流程及目的
6. 錄音及觀察目的 – (強調錄音及觀察只為寫報告，報告以不記名形式作記錄)
7. 被訪者作簡單自我介紹 (如姓名、職業等等)

Section 1 – 個人綜合住院保險的經驗、態度和看法 (Pre-group questionnaire)

(請在工作紙上填寫答案)

1. 請問你現時有冇持有任何住院保險呢？
2. 如果有住院保險，係邊一個人俾錢買架呢？ [自己 / 家人/ 公司]
3. 可唔可以講吓你份保單嘅保障範圍呢？ [住院 / 門診/ 兩者都包括]
4. 你份保單有冇保障埋你嘅屋企人呢？ 或者你有冇為你嘅屋企人額外買住院保險呢？ [點解有 / 冇幫佢哋買呢?]
5. 你每個月嘅住院保險保費係幾多錢呢？
6. (限於沒任何住院保險的被訪者) 請問你唔購買住院保險嘅原因係咩呢？

Section 2 – 對醫療保障計劃的認知 (5 minutes)

1. 請問你有冇聽過政府最近建議嘅自願性醫保計劃或者閱讀過相關嘅資料呢？
2. 你最記得醫保計劃嘅什麼特點呢？可唔可以簡略講吓？
   [主持人追問：保單的條款及定義標準化；套餐式收費；索償仲裁機制]
3. 你對於醫保計劃嘅整體印象係點呢？

[主持人介紹醫保計劃 (Slide 1)]

Section 3 – 對醫保計劃保障範圍的意見 (10 minutes)

[主持人介紹保障範圍 (Slide 2-3)]

1. 醫保計劃建議嘅基本保障範圍，對你是否足夠和具吸引力? 點解呢?
   [主持人解釋：核心項目主要包括需要住院治療或接受非住院手術的病症，也包括住院/手術所需的專科門診及先進診斷成像服務（例如磁力共振掃描、電腦斷層掃描）和為癌症進行的化療或放射治療，因為這些醫療服務的費用較高、出現次數較少，可預見性亦較低，相對切合醫療保險的功能。]

2. 對於政府建議大部分非住院服務不被納入為醫保計劃的核心項目，你接受嗎?
   [主持人解釋：非核心項目建議包括普通科門診、一般專科服務、一般身體檢查、分娩服務，牙科護理、洗腎服務或長期療養（例如長期糖尿病和高血壓），因為這些醫療服務的費用較低、出現次數較多，可預見性也較高，因此醫療保險的效用較低，保費也較高。]

3. 你會否願意支付額外保費，為那些非核心項目提供附加保障呢？

Section 4 – 對套餐式收費的意見 (20 minutes)

[主持人介紹套餐式收費 (Slide 4-6)]

[主持人解釋：和現時市場上普遍根據逐項收費計算賠償的模式比較，醫保計劃建議的套餐式收費賠償安排特點有以下好處：

- 方便消費者確切預知醫療費用的數額(和賠償額)。
- 方便消費者比較不同服務提供者的收費。
- 減少醫療服務濫用的情況，舒緩保費上升的壓力。

[如被追問：所揀選的服務提供者如果沒有提供套餐式收費，投保人仍可以逐項收費模式獲得賠償。]

1. 假設套餐式收費賠償安排能適用於起碼一半的治療和手術上，令索償的投保人起碼有一半機會受惠於有關安排，你覺得這個特點吸唔吸引？對你考慮會否參與醫保計劃的決定影響大唔大？
2. 上述套餐收費的幾個主要好處，有邊一個你特別認同和覺得重要？點解呢？
3. 你對於套餐式收費有其他意見和關注嗎？

Section 5 – 對醫保計劃規管事宜的意見 (10 minutes)

1. 請問你對現時個人住院保險產品嘅服務和收費情況滿意嗎？
   [主持人追問：保費？ 產品內容？索償經驗？保障是否足夠？...]
2. 請問你對現時私家醫院嘅服務和收費情況滿意嗎？
   [主持人追問：收費是否合理和具透明度？服務水準是否適切？]
3. 請問你覺得現時私家醫生嘅服務和收費情況滿意嗎？
   [主持人追問：收費是否合理和具透明度？服務水準是否適切？]
4. 為確保自願醫保計劃的運作，你贊成政府對私營承保機構及醫療服務提供者加強監管嗎？

[主持人展示醫療保險索償仲裁機制(Slide 7)]

5. 對於呢個受政府監管嘅索償仲裁機制，你贊成其設立嗎？點解呢？你有其他意見嗎?
6. 呢個仲裁機制係咪可以增加你對醫保計劃嘅信心，同吸引你去購買醫保計劃呢？

Section 6 – 對高風險分攤的意見 (10 minutes)

[主持人展示高風險分攤的方式 (Slide 8)]

1. 醫保計劃建議保障埋投保之前已有嘅疾病，呢個做法可以幫助社會上年老及身體狀況欠佳的人受惠(任何人現在或將來都可能受惠)，但可能需要提高所有參加者嘅保費大約 7%和政府資助。你對呢個提議有咩意見呢？

Section 7 – 對無索償折扣的意見 (10 minutes)

[主持人展示無索償折扣的方式 (Slide 9)]

1. 政府建議醫保計劃提供最高 30%嘅無索償折扣，如投保人一旦索償，下次續保時無索償折扣會重設於 0%，若之後無提出索償，則每年有 10%的無索償折扣，如連續三年無索償，最高可獲 30%嘅無索償折扣。你喜歡這個安排嗎? 你對呢個提議有咩意見呢？
   [主持人解釋無索償折扣的運作]

Section 8 – 對保費訂定事宜的意見 (10 minutes)

[主持人解釋：醫保計劃有以下特點協助降低保費水平和紓緩保費上升壓力，令消費者更有保障：

- 標準化的保單條款和定義，可減輕經紀在解釋產品和跟進索償的工作量，令保費中的佣金部份有下調空間。
- 標準化的保單條款和定義，可方便引進電子化或高科技的運作平台(例如處理索償)，令行政效率得以提升，減低行政成本。
- 套餐式收費有助減少醫療服務濫用的情況，令保險成本得以更好控制。

1. 你覺得上述好處有幾大程度上增加你參加醫保計劃的信心？點解？

[主持人展示監管醫保的建議 (Slide 10)]

2. 你認為政府應唔應該監管醫保計劃的保費？對你是否參加計劃有幾大影響？
3. 如果你認為政府應該監管醫保計劃的保費，你對以下不同的安排有什麼意見？
   - 要求保險公司公開營運數據和保費水平。
   - 政府根據市場數據及其他考慮提供保費的指標水平供市場參考。
   - 保險公司增加保費的幅度需各自事先向政府申請進行審批。
   - 政府制定單一保費表予所有參與保險公司跟從。

Section 9 – 對醫保計劃保障特點的整體意見 (20 minutes)

[主持人展示醫保計劃的所有主要特點 (Slide 11)]

1. 在醫保計劃中，有什麼特點係你最喜歡嘅呢？請揀最喜歡嘅三個。點解揀呢三個呢? (請在工作紙上選擇適當答案)

Section 10 – 對醫保計劃保費水平的接受程度(10 minutes)

[主持人展示保費 (Slide 12-14) 及請被訪者在工作紙上選擇適當答案]

1. 醫保計劃嘅收費大概係表列嘅價錢，你會否有興趣購買或者轉過嚟醫保計劃呢？
2. 假設醫保計劃有另一個選擇，如果肯俾部分免賠額（或索償墊底費）（每次入院計），就可以減低保費嘅話，假設有三個免賠額 ($5 000, $10 000, $15 000)，舉例 30-34 歲人士的保費可下減約 2 成至 5 成，請問你會揀邊一個，定係唔會揀有免賠額？
3. 你覺得免賠額的安排對你是否參加醫保計劃的決定是否重要？
4. 假設將保障範圍擴大到包括門診服務，保費會升兩至三倍，你會唔會有興趣投保埋門診服務呢？

Section 11 – 對政府提出誘因的意見 (5 minutes)

1. 無論任何形式，你覺得係唔係要有政府提供保費津貼，計劃先有吸引力呢?
2. 如果政府提供保費津貼，但津貼額要到年老或退休後先至發放，並且只限於醫療用途，津貼要等同保費幾多百分比先有吸引力呢? (請在工作紙上選擇適當答案)
   [主持人追問： 假設 30%如何?]

Section 12 – 總結 (10 minutes)

1. 整體上，你對於這個由政府規範及監管嘅自願醫療保障計劃是否支持呢？你覺得它可行嗎？
2. 假如你的僱主轉用自願醫保計劃來提供員工醫療福利，你會歡迎嗎？點解?
3. 你對醫保計劃有其他建議嗎？

[完: 120 minutes]

Appendix 3
Focus Group Stimuli

自願醫療保障計劃


醫療保障計劃
持續而可靠的保障
醫療保險
人人受保
保證續保
全面可攜
保費透明
消費者保障
私營醫療
增加服務量
質素保證
良性競爭
收費透明
消費者信心

保障範圍


附加項目
較佳病房設施及
更高保障限額
需要住院治療
或接受非住院
手術的病症
核心項目
住院/手術所需
的專科門診
及先進診斷
成像服務
為癌症進行
化療或
放射治療
附加項目
標準醫保未包括的
其他服務，例如
普通科門診、
牙科護理、
分娩服務等
附加項目
一般專科服務及
先進診斷成像服務

保障範圍

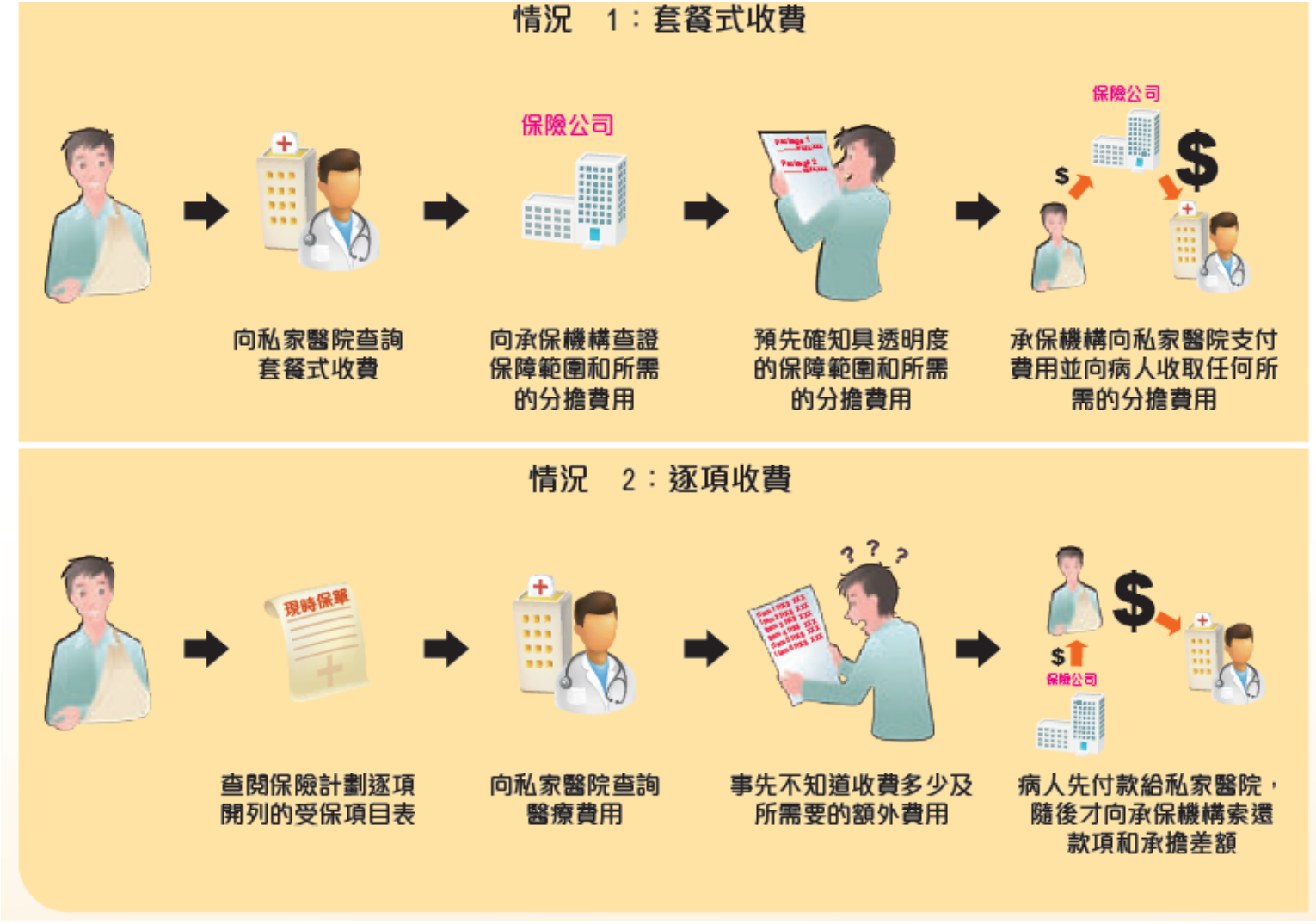
核心項目(必須提供的項目):

- 住院（以普通病房計）及日間手術和療程
- 住院/手術所需的專科門診診症/檢查
- 所需的先進診斷成像服務（例如磁力共振掃描、電腦斷層掃描等）
- 癌症化療或放射治療

附加項目(自行提供的項目):

- 較佳病房設施及更高保障限額
- 一般專科服務及先進診斷成像檢測（非關手術和療程）
- 其他服務，例如：普通科門診、牙齒護理、分娩等

套餐式收費 vs. 逐項收費



套餐式保障例子

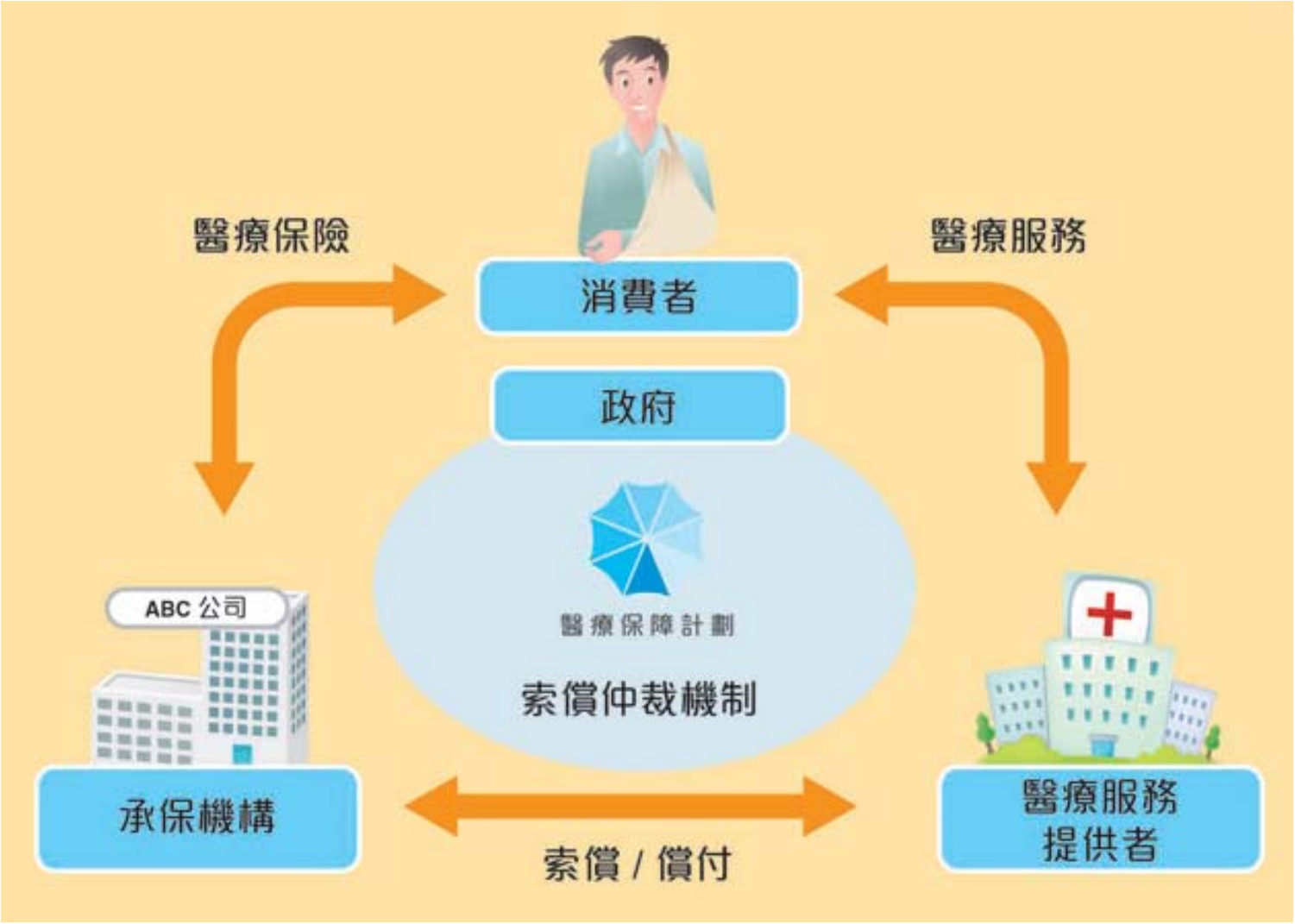
	賠償限額
套餐式保障	
住院手術	
疝氣手術	２２，０００元
痔瘡手術	３０，０００元
切除盲腸手術	３５，０００元
經腹腔鏡膽囊切除手術	４０，０００元
經皮冠狀動脈腔內成形術（俗稱通波仔手術） （支架費用將於手術植入物保障項目獲得額外保障。在本說明例子中，有關支架的賠償限額是每個 ２２，０００元。）	９０，０００元
經腹腔鏡前位切除直腸及大腸造口手術	１１２，０００元
非住院手術	
痔瘡手術	７，０００元
經內窺鏡逆行胰膽管造影治療（ＥＲＣＰ）	１０，０００元
白內障手術	１３，０００元
疝氣手術	１３，０００元
體外衝擊波碎石治療（ＥＳＷＬ）	１５，０００元
每次住院／非住院手術的共同保險（首1 萬元／次9 萬元／其後）	２０％／１０％／０％

非套餐式保障例子

	賠償限額
非套餐式保障（在沒有適用的醫療套餐收費的情況下應用）	
住宿及膳食上限(每天)， 最多１８０天	５５０元
醫生巡房費(每天)	６５０元
深切治療部住宿及膳食上限(每天)	２，０００元
每次手術上限(外科醫生、麻醉科醫生、手術室)	５０，０００元
每次住院的專科醫生費	２，０００元
每次住院的住院雜項開支	８，０００元
手術植入物(須視乎認可的植入物而定)	按植入物收費表
每次住院／非住院手術的共同保險（首1 萬元／次9 萬元／其後）	２０％／１０％／０％

與住院治療或受保的非住院手術相關的門診服務	
每次專科醫生診症(每項手術最多三次)	６００元
專科門診檢查（按每項手術計）	５，０００元
先進診斷成像檢測（按每項手術計）	５，０００元
共同保險	２０％
費用高昂的門診服務	
化療或放射性治療（按每症計）	２００，０００元
共同保險	２０％

醫療保險索償仲裁機制



讓較高風險人士參與計劃

- **如何承保投保前已有的病症？**
  - ✓建議設有一年等候期，第二年可獲償付25%，第三年為50%，三年後則為100%。
- **如何讓高風險人士參加？**
  - ✓建議保費上限為已公布保費的三倍，並通過高風險再保險機制，分攤額外風險。
- **如何讓高齡人士亦可參加？**
  - ✓建議65歲或以上人士可在計劃推行首年投保，惟不設保費上限。

無索償折扣

- 如投保人一年內無提出索償，下次續保時可獲10%的保費折扣，按年增加，如連續三年無索償，折扣最高可達30%。

- 投保人一旦索償，下次續保時無索償折扣會重設於0%，之後需逐年累積。

監管保費的建議

- 要求保險公司公開營運數據和保費水平。
- 政府根據市場數據及其他考慮提供保費的指標水平供市場參考。
- 保險公司增加保費的幅度需各自事先向政府申請進行審批。
- 政府制定單一保費表予所有參與保險公司跟從。

	醫保計劃下 的醫療保險	市場上一般 私人醫療保險
保證終身續保	有	約半數保險公司有提供
承保投保前已有的病症	等候期後會提供逐步增加的保障	個人保單 絕大多數不受保
保單可攜	可以	不可以
明確而預知醫療保障和收費	可以（按症候族群分類(DRG)提供套餐式收費）	不可以 (只提供逐項收費)
高風險再分攤	有	沒有
無索償折扣	有	沒有
保費調整	有公開指引依據	並無準則
劃一保單條款	有	沒有
由政府監管的索償仲裁機制	有	沒有

免賠額範例

個案 1： 疝氣

- 1a：實際收費低於保險賠償限額。
- 1b：相同個案，但投保人所投購的保險設有 10,000 元免賠額。

		個案 1a	個案 1b
收費與保險賠償限額	實際收費	20,000 元	20,000 元
	保障限額	22,000 元	22,000 元
核准額 [1]		20,000 元	20,000 元
由投保人支付	免賠額	不適用	10,000 元
	共同保險	3,000 元 [2]	1,000 元 [3]
	超出保障限額的收費	不適用	不適用
	總額	3,000 元	11,000 元
由承保機構支付		17,000 元	9,000 元

註：

1. 核准額以實際收費或保障限額的較低者為準。
2. 共同保險：10,000 x 20% + (20,000 - 10,000) x 10% = 3,000
3. 共同保險：(20,000 - 10,000) x 10% = 1,000

不設免賠額的保費

年齡	無計及無索償折扣 免賠額 0 元	計及 30%無索償折扣後 免賠額 0 元
00-01	2,070	1,450
02-04	1,570	1,100
05-09	1,000	700
10-14	790	550
15-19	1,140	800
20-24	1,570	1,100
25-29	1,710	1,200
30-34	2,000	1,400
35-39	2,360	1,650
40-44	2,930	2,050
45-49	3,500	2,450
50-54	3,930	2,750
55-59	4,570	3,200
60-64	5,570	3,900
65-69	6,710	4,700
70-74	7,710	5,400
75-79	9,500	6,650
80-84	12,570	8,800
85+	15,000	10,500

(不包括佣金及其他購置成本)

設免賠額的保費

年齡	無計及無索償折扣			
	免賠額 0 元	免賠額 5,000 元	免賠額 10,000 元	免賠額 15,000 元
00–01	2,070	1,360	1,000	710
02–04	1,570	1,070	790	640
05–09	1,000	710	570	500
10–14	790	640	500	430
15–19	1,140	860	710	570
20–24	1,570	1,210	930	790
25–29	1,710	1,360	1,070	860
30–34	2,000	1,570	1,290	1,070
35–39	2,360	1,860	1,570	1,290
40–44	2,930	2,360	2,000	1,640
45–49	3,500	2,860	2,360	2,000
50–54	3,930	3,140	2,710	2,290
55–59	4,570	3,790	3,290	2,790
60–64	5,570	4,640	4,070	3,570
65–69	6,710	5,640	5,000	4,290
70–74	7,710	6,500	5,710	4,930
75–79	9,500	7,930	7,000	6,070
80–84	12,570	10,430	9,140	7,860
85+	15,000	12,430	10,790	9,140

（不包括佣金及其他購置成本）

End of Report