Medical Reform

Healthcare Protection Scheme

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Call for Articles or Views for the next issue of Newsletter

While all articles are welcome, we would especially like to receive articles for the Feature Articles and Knowledge Sharing section. If you read any interesting articles from other actuarial organization(s), please feel free to let us know. We will try to reprint it in our newsletter to share with our members. For the above issues, please e-mail your articles or views to Simon Lam by email at slam@munichre.com or ASHK's office by email at actsoff@netvigator.com.

ACTUARIAL SOCIETY of HONG KONG 香港精算學會

ASHK Newsletter

VOLUME 03 Oct 2013

Editorial

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Dear Readers,

Welcome to 2013's third's newsletter!

In this newsletter, we continue to share with you regarding the feature articles and knowledge sharing.

With the recent discussion of Health Protection Scheme in Legislative Council, Healthcare reform becomes a hot topic in Hong Kong nowadays. In this issue, we are happy to have interviews with David Alexander, Elaine Chan, Vivian Choi, The Actuarial Society of Hong Kong Healthcare Working Group and Food and Health Bureau, The Government of the Hong Kong Special Administrative Region to share with our members their views on this topic. Besides, Sam Yeung has contributed an introduction write up regarding the overview of the coming healthcare reform for our better understanding towards the current circumstances.

For the knowledge sharing section, we are happy for Dicky Lui to contribute an article regarding the Role of Reinsurance in an Economic Perspective. As we target to reprint an interesting article from the other actuarial publications to share among our members, in this issue, we will have Jim Filmore's article from Society of Actuaries' Product Development Section regarding Life Insurance Acceleration Riders. In the future, our members are highly encouraged to share an article with us through the coming newsletters.

Here, we would express our deepest appreciation towards their contribution for this newsletter and the effort from both of our publication committee members and ASHK's colleagues. We do hope that you will enjoy this newsletter.

Last but not least, our committee is open for any recommendations towards both membership and publication matters. Please feel free to contact me by slam@munichre.com or ASHK's office by actsoff@netvigator.com regarding any recommendations. We are happy to listen.

Simon Lam
EDITOR

ACTUARIAL SOCIETY of HONG KONG 香港精算學會

ASHK Newsletter

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The Riddle of Healthcare Reform

Health is a touchy topic – is it insurance or entitlement, or both? While as actuaries we are keenly aware that life itself is ultimately a fatal condition, it seems human nature not to pay for health protection until the need arises, albeit sometimes too late. Healthcare reform is a journey that brings profound impacts to the public, medical service providers, and insurers. This process also increases public awareness of healthcare needs and private health insurance protection. As Hong Kong contemplates healthcare reform, will the government learn from other countries and manage to avoid their missteps?

Prolonged debate about healthcare reform in Hong Kong dates back to the 1980s, but has picked up momentum since the latest public consultation in 2010. To alleviate financial burden on the public health system, the government plans a voluntary insurance scheme to steer more middle-class citizens to private wards. A cornerstone of the scheme is the Health Protection Scheme (HPS), a standardized medical reimbursement product whose features include guaranteed acceptance, guaranteed renewal, individually portability, and coverage of pre-existing conditions. To better manage medical costs, the government proposed that private hospitals use Diagnosis Related Groups (DRG), a Prospective Payment System that classifies inpatient cases, to offer packaged prices for clinically similar procedures. A HKD 50 billion fund was set aside to help finance a High-Risk Pool (HRP) and to encourage the purchase of HPS.

Public opinions differ on the proposed reform. There is widespread concern that HPS may not attract enough participation and balanced risks to become sustainable. The government's proposal did not mention any common underwriting standards for HPS, or any mechanism to contain the expenditure on HRP. Some private medical providers claim that HPS's benefit design neglects primary care, a critical component for the aging population, and that packaged fees are undesirable. Meanwhile, the insurance sector is wary of potentially stringent regulation and pricing controls that may induce insurers to quit the market.

Unfortunately, it has been evident that many key stakeholders lack a good understanding of the medical insurance business. For example, some legislators may perceive an overly rosy picture of insurers' profitability because the available premium and claim figures do not fully account for sales and administration expenses, medical panel fees, third party administration, claim reserves, and policy reserves. Other stakeholders fail to understand that the value of health insurers includes not only processing claims and financing care for insured members, but also enhancing the efficiency of medical resource allocation for individuals in need of care. It is thus critical that policymakers properly position private medical insurance to optimize the health delivery system.

Since the latest consultation, the government has started to plan execution and has continued to modify HPS's features. According to recent papers submitted to the Legislative Council, the government has dropped plans to implement DRGs. Instead, insurers will have to individually negotiate with physicians, clinics, and hospitals to obtain pre-admission quotations. The government stipulates HPS to become the minimum requirement that individuals and groups must obtain before they purchase additional medical benefits. In addition, the government has indicated that HPS might not include no-claims discount and savings account as originally proposed in the second consultation paper.

In essence, HPS is equivalent to a base benefit scheme that is trying to appeal to younger and usually healthier generations. The proposed core benefits of HPS include hospital admission, ambulatory procedures, chemotherapy, radiotherapy, and associated specialist and advanced diagnostic imaging services. The government's latest plan prohibits lifetime benefit limits and places an annual cap on out-of-pocket expenses. While full details of HPS implementation will become available later this year, the government will unlikely address price transparency and quality assurance of private medical practices in the near future.

It is unclear at this stage whether HPS can be realized as planned. The product features and associated requirements will inevitably affect the existing private medical insurance. If HPS and the supplemental schemes are not sufficiently attractive to insurers, the private medical insurance market would dwindle, with the government left holding the bag for both public hospitals and a loss-making scheme that benefits private hospitals and a small number of specialists. An ill-designed HPS could hurt policyholders and jeopardize public finance over the long term.

With all these uncertainties, issues and questions surrounding the healthcare reform, the public will undoubtedly wonder: will this round of consultation result in any effective healthcare policy implementation and benefits?

Healthcare reform has been mixed with myths, perceptions, and ideologies in almost every country. While private health insurance has blossomed in Hong Kong without government intervention, it is tempting for politicians and bureaucrats to pursue public or clandestine agendas. We as actuaries are uniquely qualified to assess each proposal and its likely impacts on consumer behavior and on the public and private health systems. Given the resources that the government is devoting to healthcare reform, an agreeable solution has to be not only financially sustainable but also socially equitable to support generations of Hong Kong citizens.

Sam Yeung participates in the Hong Kong Federation of Insurers' (HKFI) - Task Force on Health Care Reform, HKFI Medical Insurance Association, and ASHK Healthcare Working Group.

The views expressed in this article are entirely his own.

Interview with David Alexander on Health Protection Scheme

Interviewee: David Alexander – Chairman, Task Force on Health Care Reform
The Hong Kong Federation of Insurers (Represented by DA below)

Interviewer: Simon Lam – Chairperson, ASHK Publications Committee
Mary Kwan – Member, ASHK Publications Committee
Sam Yeung – Member, ASHK Healthcare Working Group
(Represented by ASHK below)

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ASHK: Could you kindly share with us more about Health Protection Scheme (HPS)?

DA: The HPS is part of a broader healthcare reform that was aimed to reduce the government's cost burden and to manage future healthcare needs of the overall population. The timeline for this broader healthcare reform can be 10-20 years or even more. This reform includes:

- Public-Private-Partnership (PPP)
- Reform of the Hospital Authority
- Primary care and preventive measures
- Electronic Health Record (EHR)
- Efforts to ensure adequate supply of private hospital beds and doctors
- Healthcare financing

HPS is part of the Healthcare financing scheme. There are different dimensions of HPS to be determined. The scheme can be mandatory or voluntary, or as part of a savings scheme or insurance scheme. Through public consultation, a voluntary scheme is preferred. There are also other factors to consider, such as whether or not there is guaranteed issue at acceptance.

ASHK: Do you think if HPS is necessary in Hong Kong and why?

DA: This is a good question as Hong Kong never has a government endorsed health protection scheme. The private health insurance industry has evidently done a good job in expanding coverage and choices of products, as shown by statistics that during the past 5 years the number of insured lives (taking up private health insurance) has increased by more than 1 million.

Having said that, it is noticeably that there are good suggestions in the proposed HPS. HPS helps to standardized benefit definitions and policy provision with government endorsement. This helps to guide members of the public to a reasonable level of coverage as well as to reduce ambiguity of coverage and likely disputes. Overall it helps to increase the transparency in terms of comparing prices of standardized products from different insurance providers.

ASHK: What do you think about the minimum mandatory requirement of the scheme? Can this really help the Hong Kong public?

DA: A minimum standard of benefits would eliminate consumer choice for policyholders with limited budget. The portion of HPS that covers the standard risks will likely be sustainable. However, it is uncertain how the government can fund the High-Risk Pool as HRP will likely be very costly. To funding of HRP will decide if HPS as a whole is sustainable, and if the guaranteed issue approach proposed by the government is feasible.

ASHK: What are cost and benefit implications from HPS towards government, insurance industry and citizens?

DA: For the Government, it is a long-term financial planning to make sure there is not a heavy burden on the citizens from taxes. This encourages people who can afford insurance to take it up and reduces the financial burden on the Government. It also gives increased choice and transparency which was a concern.

In terms of insurance industry, there is an opportunity to serve more customers and this might lead to more profits for the shareholders.

For the people in Hong Kong, there will be more choices of insurance cover and again more transparency of the products is good for the public.

ASHK: How does proposed scheme compare to that in other countries?

DA: International comparison is less important than the actual suitability for the local context.

In local context the potential issues are around guaranteed acceptance and cost of the high risk pool. The problem is whether the government is ready to fund this cost. If it is too expensive then it will become the burden for tax payers and an underwriting scheme could then be considered. There might be political implications. LegCo should be given the more complete picture to evaluate the cost implications of an underwritten schemes versus a guaranteed issue schemes to ensure a conscious and informed decision is made.

ASHK: What do you think about the sustainability of the scheme at the rates suggested by the government's consultant?

DA: While there are valid reasons why the government needs its consultant to estimate HPS premium levels, such references would most like be quite different from the actual premiums consumers will face due to market dynamics and other commercial factors.

ASHK: What are your thoughts around areas of improvement for the scheme?

DA: There are three main areas of improvement:

1. Customer's choice – The scheme should give customer the choice, so there should be no minimum standard. This mean there can be one standard level of government approached scheme, but let the insurance company offer that product as well as a wider range of products so customer can choose according to their budget.
2. High Risk Pool – The government should present the full picture to LegCo to decide between an underwriting scheme versus a guaranteed issue scheme with costs of high risk pool. This needed to be done as the coming step.
3. Contribution from health care profession – The medical service providers (MSP, i.e. private hospitals, doctors) should also contribute to the success of the scheme. This includes more transparency in terms of the costs and quality of their services and acceptance of packaged pricing based on Diagnostic-Related Groups (DRG).

ASHK: What do you think is the key success factor for HPS?

DA: That's about getting the consensus from all the stakeholders including the public, LegCo, insurers, healthcare providers. The current decision-making process involves multiple working groups formed by the Food and Health Bureau, under the help of consultant, and discussions and lobbying behind the scene between parties. Everyone will need to make some compromises. Getting everyone to agree could be the most difficult part!

ASHK: How would you assess the success or failure of HPS?

DA: The measure of success should be the total number of insured by any sort of medical insurance, for example the number of insured goes up within the next 10 years. This can be adjusted for the natural organic growth of the industry. The key point is that we are not focusing on the number of people taking up HPS, but on the total market take-up rates for all medical insurance, as they will help the state to release the burden on medical care.

ASHK: What are other possible aspects the government can consider?

DA: The government should consider the issue of elder healthcare. This is about people at retirement and how to keep individuals get cover after leaving an employer group coverage. The government has proposed individual portability as a solution though this could be an expensive option for individuals.

ASHK: So far what is the feedback from industry?

DA: The industry has been very supportive to the scheme for more than 10 years and has helped to educate the government about market and product design etc.

ASHK: What is the way forward for the scheme?

DA: We have come a long way and have come to an agreement on many aspects. There still remain areas where there are some differences. The industry will continue discussion as a partner with the government to try to find solutions and get the scheme working.

David Alexander
Chairman, Task Force on Health Care Reform
The Hong Kong Federation of Insurers

Interview with Elaine Chan on Health Protection Scheme

Interviewee: Ms. Elaine Chan - Deputy Chairman, Task Force on Health Care Reform, The Hong Kong Federation of Insurers (Represented by EC below)

Interviewer: Simon Lam – Chairperson, ASHK Publications Committee
Sam Yeung – Member, ASHK Healthcare Working Group
(Represented by ASHK below)

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ASHK: Could you kindly share with us more about Health Protection Scheme (HPS)?

EC: The government is proposing HPS as the minimum requirement for all future medical insurance products. The major requirements are reflected in the following three areas:

1. Benefit features including room & board, surgery, doctor's visit, chemotherapy and radiotherapy, etc. and corresponding minimum benefit amount, such as HKD 650 for room & board.

2. Packaged pricing which was supposed to be led by the government. However, the government is planning to ask individual insurers to directly negotiate with private hospitals and physicians. This will likely lead to inconsistencies in the minimum standard coverage because larger insurers and smaller insurers will likely obtain different prices (larger insurers have greater bargaining power) and the resultant "known gap" will vary from one insurer to another.

3. Terms and conditions would include:

   - Guaranteed acceptance, with a High-Risk Pool to cover those in poor health condition.
   - Guaranteed renewal – which is not an issue as many products already have this feature.
   - Step-wise coverage of pre-existing conditions with one-year waiting period, 25% in Year 2, 50% in Year 3, and 100% afterwards. Coverage of pre-existing conditions is only a practice for some group plans, and is non-existent in the current individual market.
   - Portability that allows an individual to switch insurers without underwriting. When this happens, the new insurer cannot place the individual into the High-Risk Pool if this person has been covered by a group plan for one year, or has been claim-free under an individual plan for three years.

The above three minimum requirements would apply to both individual plans and group plans. While the government has informally indicated "flexibility" for group plans, there is much uncertainty how the government would handle employer groups and address their concerns.

ASHK: Do you think if HPS is necessary for Hong Kong?

EC: It would be good to have a benchmark but not a mandatory product. The government should allow different products to sell side by side and may offer incentives to these products that satisfy a minimum requirement. If HPS is attractive, we would reasonably expect, as we see in the current market, that other insurers will follow. However, we cannot expect that HPS would fit everyone's needs so if this is the only voluntary product in town then the market would definitely shrink as a shift of market.

There are some merits behind HPS's design. For example, standardized policy provision but the insurance industry can work on these in the absence of HPS. The standardized portion includes terms and conditions and claim practices, but not benefit features or benefit limits.

ASHK: How does HPS differ from relevant schemes in other countries?

EC: There is no direct comparison as we need to review HPS in light of the local tax structure, social insurance scheme, healthcare provision and other factors across countries. The current HPS is a blend from different markets but it might neglect some of the other relevant factors. For example, HPS is a voluntary product but the government may have copied features of a mandatory product from another market.

ASHK: What are the cost and benefit implications of HPS?

EC: Statistics indicate about 1.9 million individual medical policies and 1.7 million group plans in 2012. We would expect that not every individual can afford HPS and not every employee would be offered "standard" coverage. The minimum requirement would therefore take away consumer choice and cause membership to decrease. If the government intends to reduce the financial burden on public hospitals, HPS should help the market expand faster than the current rate of 150,000 new members per year.

ASHK: What are the challenges for HPS?

EC: There are four major challenges in HPS implementation:

1. Guaranteed acceptance together with the High Risk Pool.

2. Portability requirement means that larger portfolios will likely attract more unhealthy individuals. For example, a cancer patient may not have claims for three years but that individual should rightly belong to the High-Risk Pool. If a risk pool attracts many such unhealthy individuals, the cost will be transferred to other healthier individuals who underwent underwriting.

3. Migration to HPS would leave insurers with closed blocks of pre-HPS products. These blocks will inevitably shrink and experience "death spiral".

4. Packaged pricing which was supposedly led by the government. With the government walking away from its involvement with medical service providers, the "known gap/no gap" approach would become inconsistent among insurers.

ASHK: How would you evaluate the success or failure of HPS after its implementation?

EC: I would consider three aspects:

1. Would HPS enhance consumer choice and help expand private health insurance faster than the current rate of 150,000 new members per year?

2. Sustainability of HPS, which will be affected by how the government finance and manage the High -Risk Pool.

3. Should the government better direct the earmarked HKD 50 billion to public hospitals or other more efficient projects?

ASHK: What is the next step for HPS? How would you incorporate the industry's feedback into the consultation process?

EC: We would expect the third public consultation in the first quarter of 2014. Meanwhile, HKFI Healthcare Reform Task Force will continue to liaison with the government and discuss various issues such as portability, migration, consumer choice, and packaged pricing.

The HKFI Health Care Reform Task Force is considering a comparison of existing products and a survey among insurers to help assess the impact of having HPS as the minimum coverage requirement.

Elaine Chan
Deputy Chairman, Task Force on Health Care Reform
The Hong Kong Federation of Insurers

Interview with Vivian Choi on Health Protection Scheme

Interviewee: Ms. Vivian Choi - Chairman, Medical Insurance Association
(Represented by VC below)

Interviewer: Simon Lam – Chairperson, ASHK Publications Committee
Sam Yeung – Member, ASHK Healthcare Working Group
(Represented by ASHK below)

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ASHK: Could you kindly share with us more about HPS?

VC: HPS is part of the healthcare financing, one of the six pillars under the healthcare reform initiative. The HPS includes features like minimum benefit requirements, guaranteed acceptance, high risk pool and portability.

ASHK: Do you think HPS is necessary for Hong Kong?

VC: Currently, around three million people in Hong Kong are covered by private health insurance either with group or individual medical products. The membership has been growing in past years.

The objective and its expected outcome of HPS have to be clearly specified. HPS would further increase awareness of the need of medical insurance and also attract young people to take up medical insurance earlier.

ASHK: What are HPS's cost and benefit implications to the government, insurance industry, and citizens?

VC: To the government, it would be the management of High-Risk pool and the financial implication of the High-Risk Pool. In addition, it would be the effectiveness of HPS of diverting the usage of medical service to private hospitals.

To the insurance industry, it would be the positive effect to drive the development of medical insurance market.

To the public, it would be whether HPS is the effective solution of healthcare financing or would there be any alternative solution.

ASHK: How does the proposed scheme differ from relevant schemes in other countries?

VC: Comparison of the insurance schemes alone would not be sufficient to assess whether the proposed scheme would deliver the same outcome of other countries in comparison. There are components in healthcare system like health care service provisions, source of funding in other countries.

ASHK: Is there any area of improvement for HPS?

VC: I am concerned about the following three major issues:

- Minimum benefit requirement -- The intention of minimum benefit is to ensure insured get adequate cover from the medical insurance scheme. However, with minimum benefit would make HPS become unaffordable for some customers.
- Guaranteed issue, High-Risk Pool and portability -- The operation and management of the high risk pool need to be articulated clearly. In addition, allowing portability would further complicate the risk management process of insurers. Insurers will need to establish some sort of mechanism to manage it.
- Medical cost containment -- Packaged pricing like DRG was originally included in the design of the scheme, however, not much progress so far.

ASHK: How do you foresee the trend of product strategy in medical insurance with the implementation of HPS?

VC: Products like top-up benefits, additional benefit items for preventive care, post-treatment … etc may be developed depending on the needs.

ASHK: **What will be the key success factors for HPS?**

VC: I am thinking of three items:

- The sustainability of HPS -- HPS has to be financially sustainable and people won't have to drop off the scheme because of huge premium increase.
- Cost and quality transparency of medical service providers -- transparency of medical service cost, treatment and procedures for common diseases is the key.
- Implementation of other pillars of healthcare reform on a timely basis.

ASHK: How would you assess the success or failure for HPS after its implementation?

VC: The key questions I would consider including:

- How does HPS attract young and healthy individuals who are currently not insured?
- How sustainable is HPS?
- Are individuals covered by HPS better off than alternative products?

ASHK: What will be the next step for HPS? And what will be the action plan for your committee towards the development of HPS?

VC: There should be third consultation for the public. The HKFI is supportive of the initiative and will continue liaising with the government on the issues identified.

The Medical Insurance Association is undertaking the initiative to work on the proposed standardized policy provisions including definitions, terms & conditions, and claims practices.

Vivian Choi
Chairman, Medical Insurance Association

Interview with ASHK - Healthcare Working Group on Health Protection Scheme

Interviewee: Dr. Wolfgang Droste on behalf of ASHK Healthcare Working Group
(Represented by HWG below)

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ASHK: Could you kindly share with us more about HPS?

HWG: The Hong Kong Government commissioned a team from the Harvard University School of Public Health in November 1997 to review Hong Kong's health care system. At the time, it already became clear that Hong Kong as one of the fastest aging societies in the world would run into problems financing the government subsidized health care system. One and a half decades have passed and numerous committees have pondered the issue how best to solve the problem. While, on the one hand, there is an understanding that, ideally, a funding mechanism should be created to support the health care costs of the older generation in future (after all Hong Kong's population of those aged 80 and above will count more than a million by 2050), on the other hand, any prefunded insurance scheme would be considered an additional tax and is therefore politically unpopular. The latest proposal tries to blend features of various health systems but in our view is unlikely to adequately address the issue. It requires guaranteed acceptance but is not mandatory which could possibly lead to anti-selection and leaves the burden of funding a pool of bad risks to the government.

ASHK: Do you think that HPS is necessary in Hong Kong and why?

HWG: The Hospital Authority has done a splendid job providing world-class health care to the Hong Kong population. Obviously, with aging of the society their funding needs will increase and, as already mentioned by the Finance Secretary, this will likely result in additional demands on taxpayers. Currently, Hong Kong has a very small tax base so there could be many avenues to provide additional financing. From an actuarial perspective many of the options work out to be equivalent so we cannot really comment on the appropriateness of one scheme as compared with another one. With HPS being designed as a voluntary scheme, there is no certainty that it will solve Hong Kong's future health care financing problems.

ASHK: What are the cost and benefit implications from HPS towards government, insurance industry and citizens?

HWG: As mentioned above, the proposed HPS will likely still leave a significant burden of payment to the government. There could be anti-selective behavior (even though the current design will have some gatekeepers). It will not replace the Hospital Authority which will continue to be the major treatment deliverer.

For the insurance industry, the proposed HPS might offer opportunities, notably an increased awareness on the part of the population of the need for cover. Considering that many features have not yet been decided, it is difficult to comment on the final impact on the industry. As individual and possibly even group cover will have to comply with HPS minimum requirements, it will definitely have a major effect on the industry.

For citizens the proposed HPS could possibly result in more treatment options due to more available funds for payment of medical procedures. Currently, for elective procedures, as in many other countries, there can be long waiting lists.

ASHK: How does the proposed scheme differ from the relevant schemes in the other counties?

HWG: One of the major differences is that the scheme is not mandatory. In some other countries where schemes are not mandatory, significant tax benefits try to entice citizens to take out cover but then in Hong Kong this tool cannot really be applied effectively. It is also interesting to know that Singapore, which has had the Shield Plans for about 8 years, is now contemplating to make those mandatory to ensure universal coverage for its population.

ASHK: What will be the major challenges to implement HPS?

HWG: Obviously, this will be one of the major challenges. A further challenge will be the absence of any prefunding mechanism. So, as learned by the Singapore population, health insurance products can become rapidly unaffordable at high ages. The reason why the Singapore's Prime Minister addressed this in his National Day speech last month contemplating forms of prefunding or generational sharing.

ASHK: What will be the key success factors for HPS?

HWG: A critical issue in Hong Kong is affordability of care. Hong Kong's private medical sector is known for one of the highest charges in the world. The proposed scheme tries to address this by introducing agreed pricing for DRGs. At this stage, it seems that the private medicine sector is not yet buying into that concept.

Dr. Wolfgang Droste
On behalf of Healthcare Working Group
Actuarial Society of Hong Kong

Interview with Food & Health Bureau on Health Protection Scheme

Interviewee: Chris Sun (Head, Healthcare Planning and Development Office)
Sheung-Yuen Lee (Deputy Head, Healthcare Planning and Development Office)
Cheng Tak Chi (Actuary - System Development, Research Office)
Hoi-Shan Cheung (Senior Administrative Officer, Healthcare Planning and Development Office)
(Represented by FHB below)

Interviewer: Simon Lam – Chairperson, ASHK Publications Committee
Sam Yeung – Member, ASHK Healthcare Working Group
(Represented by ASHK below)

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ASHK: Could you kindly share with us more about HPS?

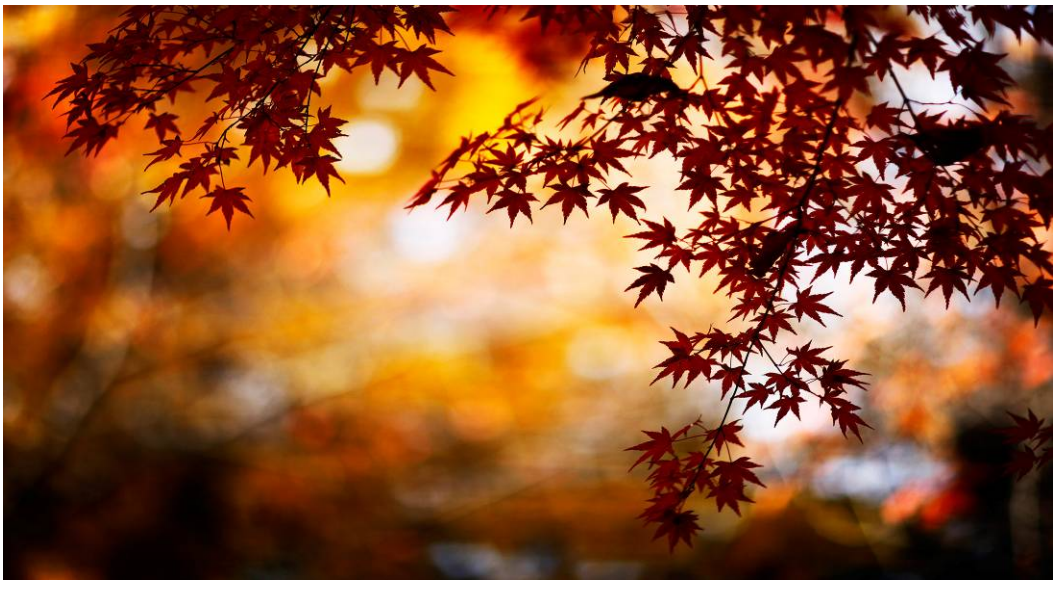
FHB: We are now at a critical stage of formulating detailed proposals for the HPS, which is a voluntary, government-regulated private health insurance scheme.

In Hong Kong, we have a dual-track healthcare system which has served us well over the years. The public system is the cornerstone of our healthcare system and safety net for all Hong Kong people. The private sector, on the other hand, could complement public healthcare by offering choice to those who can afford and are willing to pay for healthcare services with personalised choices, enhanced privacy and more accessible services. It is our aim to continue to maintain and ensure the balanced and sustainable development of the dual-track system.

The HPS is not intended as a total solution to the problems of our healthcare system. As a supplementary financing tool, the HPS is one of the control knobs for adjusting the balance of the public-private healthcare sectors, together with other turning knobs such as public-private partnerships and electronic health record platform. Currently, the public healthcare sector is the dominant secondary level service provider in Hong Kong, providing about 90% of in-patient services to Hong Kong people in terms of bed days. The objective of HPS is to empower the middle class by providing them value-for-money private health insurance products, thus facilitating them to choose to use private healthcare services.

Under our current proposal, individual-based indemnity hospital products offered after the launch of the HPS must meet a set of Minimum Requirements, including guaranteed acceptance, coverage of pre-existing conditions, guaranteed renewal, minimum benefit coverage and limits, standardised policy terms and conditions, etc. The aim is to enhance consumer protection by improving the access, continuity and quality of the insurance protection of consumers through these Minimum Requirements.

In doing so, we aim to rationalize the utilisation of public and private healthcare services. The public sector can then focus more on servicing its target areas, thereby enhancing the long-term sustainability of our healthcare system as a whole.



ASHK: Do you think if HPS is necessary in Hong Kong and why?

FHB: Yes, I think HPS will be a positive step towards enhancing the long-term sustainability of our healthcare system.

As you may agree, our public healthcare system has been one of the most equitable and accessible in the world, and our health indicators rank among the best in the world in terms of infant mortality rate and life expectancies. Yet we are also facing a number of major challenges similar to those experienced by other advanced economies. Longevity brings with it the challenges of an aging population and a rising demand for healthcare services. At present, the proportion of elders in our population is about one in seven. According to the Census and Statistics Department, this figure will become one in three by 2041. In particular, in about two to three decades' time, we will witness the emergence of a middle class elderly who will be more affluent, better educated and have higher expectation of healthcare services. Advances in medical technology, while lengthening and improving our quality of life, contribute to the escalating medical costs that we have witnessed in recent decades.

Confronted by these challenges, the Government has substantially increased its investment in public healthcare over the years. The annual Government recurrent expenditure on healthcare now reaches almost HKD 49 billion, accounting for 17% of total recurrent expenditure of the Government. Nevertheless, the rising health expenditure, which grows at a rate faster than that of the economy, indicates clearly that we must develop measures to ensure the sustainability of our healthcare system in the long run. I believe the HPS is a right step towards the goal.

Overall, the HPS will provide much-needed relief to public healthcare so that it could better focus on its target areas, meet the increasing need of the middle class for value-for-money private healthcare services, and to cater to challenges brought about by the ageing population. We aim at reinforcing confidence in both the public and private healthcare sectors among our citizens.

ASHK: This sounds like a very good idea. Where did this idea come from?

FHB: As you may recall, healthcare reform is no news to Hong Kong. In fact, discussions on healthcare reform and healthcare financing began as early as in 1990s. Since then, we have conducted several rounds of public consultations on healthcare reform and financing, the most recent ones being the First and Second Stage Public Consultation on Healthcare Reform conducted in 2008 and 2010 respectively.

What we have learnt from this journey is that any reform or financing arrangement suitable for Hong Kong must take into account our own distinct economic, social, cultural and political characteristics. In these rounds of public consultation, we have put up various financing options similar to those adopted in overseas countries, including a savings account and mandatory health insurance. It was clear from these rounds of consultation that the public does not welcome any supplementary financing option of a mandatory nature. As a result, we have developed the HPS proposal in the Second Stage Public Consultation on Healthcare Reform along the principle of voluntary participation. The outcomes of this Consultation showed that the public in general supported our healthcare reform direction. We have been working on the detailed proposals for the HPS based on the outcomes of the Consultation.

ASHK: How does the proposed scheme differ from the relevant schemes in the other counties?

FHB: In fact, the proposal of introducing the Minimum Requirements is in line with international experience. In countries where private health insurance plays a significant role in health financing (e.g. Australia, the United States, Switzerland, the Netherlands, Ireland), the governments have prescribed a set of basic requirements for private health insurance products for the sake of protecting consumer interests.

On the other hand, as I mentioned above, we cannot merely replicate the system of other countries because the local circumstances of a society very much shape the particular structure of its healthcare system as well as the direction for reform. An important factor shaping our healthcare reform direction is our dual-track healthcare system. Since our public healthcare service is highly-subsidised and available to all, it would be very difficult to put forth a mandatory health insurance scheme as in the United States, Switzerland or the Netherlands. At the same time, a robust public system means that we may need to actively encourage people to enroll in a voluntary health insurance scheme like the HPS.

We have appointed a Consultant to help us develop detailed proposals for the HPS, including measures to encourage young and healthy people to take up HPS plans. For instance, we are also considering the feasibility and desirability of offering tax incentive to those who purchase HPS plans. Another option is to lower the entry age limit for the guaranteed acceptance feature of HPS plans. In Australia, people are encouraged to take out private health insurance early as those who do so after the age of 30 would be charged a loading on the insurance premium.

ASHK: What are cost and benefit implications from HPS towards government, insurance industry and citizens?

FHB: For the Government, the objective of the HPS is to provide a choice to those who are able to and willing to use private healthcare services, thereby enabling the public sector to focus its resources in the target areas. As for the costs, a major area requiring public funding would be the proposed High-risk Pool. To enable high-risk individuals to have access to health insurance protection at an affordable premium, we have proposed to set up a High-risk Pool to accept policies of HPS Standard Plan of high-risk individuals, provided that their premium loading is assessed to be 200% or more of standard premium charged by the insurer. If necessary, the Government will consider injecting funding to ensure the High-risk Pool's sustainability. Our Consultant is working on the projected fiscal impact of the High-risk Pool and will provide the estimated figures in the final report.

For consumers, they would be able to enjoy enhanced insurance protection provided by the Minimum Requirements, including guaranteed acceptance, coverage of pre-existing conditions, guaranteed renewal, standardised policy terms and conditions, etc. We expect that the premium for HPS Standard Plan would likely be higher than the current market average – the Consultant's estimation is that the average premium of the HPS Standard Plan would be around HKD 3,600, as compared to the market average of about HKD 3,300. Nevertheless, we will introduce a number of transparency measures, such as publishing of premium and product information for HPS plans, in order to facilitate consumer choice, drive market competition and bring better value to consumers.

For the insurance industry, we recognise that the proposed Minimum Requirements would imply compliance costs. There will be administrative costs in product design, registration, migration of existing policies, etc. On the other hand, the Minimum Requirements will enhance consumer confidence in purchasing and using private health insurance coverage, which will be conducive to the healthy development of the private health insurance market.

ASHK: What will be the key success factors for HPS? And what will be the major challenges to implement HPS?

FHB: A key challenge is to strike a fine balance between protecting consumer interests on one hand, and ensuring the viability of the HPS on the other hand. We understand that some of the Minimum Requirements are designed for social cause and will have cost implications, such as guaranteed acceptance and coverage of pre-existing conditions. Our intention is to work with the insurance industry and other stakeholders to put up a practical and sensible proposal that can best meet the needs of the community. Our principle is to set the basic rules for the good of our society and enable insurers to innovate and meet market demands through flexible arrangements in the form of Flexi Plans and Top-up Plans.

We have been engaging stakeholders from various sectors in the past one or two years in formulating the detailed proposals for the HPS. We have set up a Working Group and Consultative Group on HPS under the Health and Medical Development Advisory Committee (HDMAC) to tender a detailed recommendation on the HPS. The Working Group and Consultative Group comprise representatives from the insurance industry, healthcare service providers, employers' associations, academics and the civil society. As with other policy initiatives, we have to seek the public and the Legislative Council's support before we can implement the HPS.

ASHK: How to assess the success or failure for HPS after the implementation?

FHB: We are developing a set of indicators for assessing the impact of the HPS, such as take-up rate of private health insurance and utilisation of public and private services. On the other hand, measuring the impact of the HPS may not be as straightforward as it seems because there are other factors at play. For instance, it would be difficult to say in a quantitative way how far the HPS could help alleviate pressure on the public system, because the demand for public healthcare services is dynamic and may likely increase in future years due to the aging population. Moreover, some of the benefits of the HPS are intangible and may not be easily measurable by quantitative parameters, such as greater confidence in using private health insurance and private health services.

ASHK: What will be the next step and the target timeline for the coming consultation and implementation?

FHB: The Working Group on HPS is expected to tender its recommendation to the HMDAC later this year. Upon its endorsement, we plan to conduct a public consultation exercise early next year before proceeding to necessary legislative work.

ASHK: We heard from the industry that they would like to learn a bit more regarding the details of High Risk Pool, could you kindly share with us regarding this?

FHB: The Consultant's recommendation is that a centralised High-risk Pool (HRP) should be established under the HPS agency established to supervise the HPS. The daily operation of the HRP could be contracted out to a specialist claims manager through a tender process. If, at the opinion of the insurer providing coverage, the premium loading of policies of HPS Standard Plans of high-risk individuals is assessed to equal or exceed 200% of standard premium charged by the insurer, the insurer may transfer these policies to the HRP by surrendering the premium collected for these policies after deducting a nominal administrative fee to be prescribed by the HPS agency. The insurer will continue to be responsible for the administration of the policies, but the premium income (net of administrative fee), claims/liabilities and profit/loss of these policies would be accrued to the HRP instead of the insurer concerned.

The Consultant is working on the estimated fiscal impact of the HRP, including its cost to the Government. The estimated figures will be included in the Consultant's final report.

ASHK: We understand that there is a request from HKFI to exempt group medical insurance from HPS's requirement. Could you kindly share with us the latest update on this issue?

FHB: In the long run, it would be desirable for group-based indemnity hospital insurance products to comply with the Minimum Requirements for individual-based products for better consumer protection. On the other hand, we need to take into account the local characteristics of our group market, our economic and labour structures, as well as employers' affordability. We are prepared to consider flexible arrangements for group plans in this regard.

Food & Health Bureau
The Government of the Hong Kong Special Administrative Region

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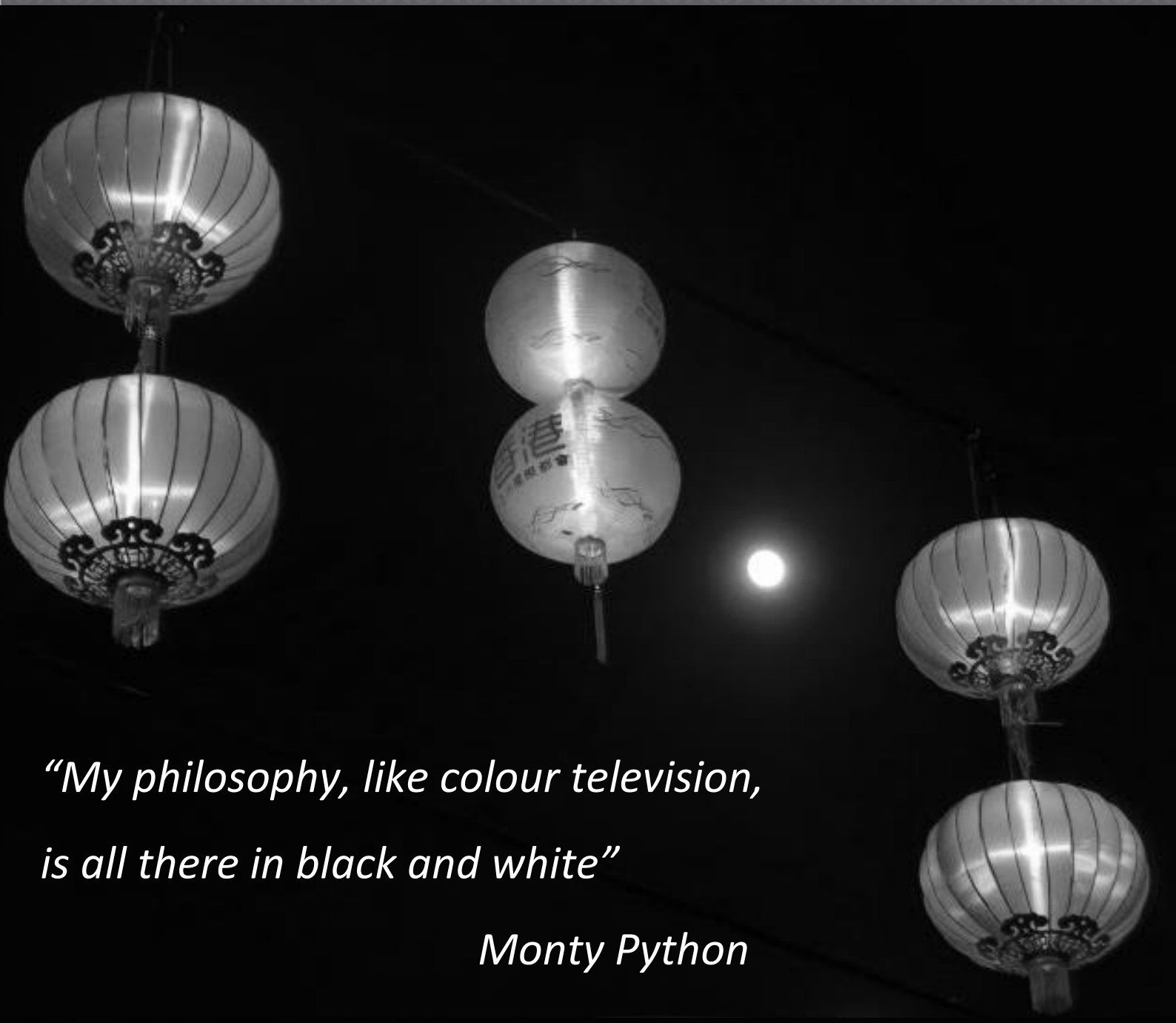

"My philosophy, like colour television,

is all there in black and white"

Monty Python

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Life Insurance
Acceleration Riders

This article was previously published in the Society of Actuaries June 2013 "Product Matters!" and July 2013 "Reinsurance section newsletters". Reprinted with permission.

Historically, life insurance companies in the United States have given the policyholder the option to accelerate a portion of their death benefit in the case of terminal illness. In those circumstances, terminal illness was typically defined to be where a physician certified that the applicant has a life expectancy of less than 12 months (24 months is used in some states).

In recent years, life insurance companies have started offering acceleration of a portion of the face amount of the life insurance policy to those who are chronically ill or critically ill. This article discusses the more common form of the chronic illness riders found in the U.S. marketplace today as well as considerations to control the risks under that rider.

Definitions

For the purpose of this article, we will be using the following definitions:

1. A **terminal illness rider** is one that allows the policyholder to accelerate a portion of their face amount when they have a life expectancy of less than X months. X is typically 12, but is 24 months in some states.

2. A **chronic illness rider** is one that allows the policyholder to accelerate a portion of their face amount when they are significantly cognitively impaired or when they are unable to perform 2 or more activities of daily living (ADL's) without assistance from another person. Activities of daily living are bathing, continence, dressing, eating, toileting, and transferring.

3. A **critical illness rider** is one that allows the policyholder to accelerate a portion of their face amount when meeting the criteria for one or more of the listed critical illnesses. An example of a critical illness is a heart attack or a stroke.

There are other related offerings such as life/LTC combination products and Long Term Care (LTC) acceleration riders that allow the policyholder to accelerate more than the face amount of the policy when meeting certain Activities of Daily Living triggers and/or when staying in a qualified LTC facility. However, those products and riders are beyond the scope of this article.

Chronic Illness Benefit Designs

Chronic illness riders are typically designed so that the rider benefit qualifies for favorable tax treatment under section 101(g) of the Internal Revenue Code. The most common chronic illness designs are the following:

i. Actuarial discounting of the face amount that is being accelerated. For example, $100,000 of the face amount may be accelerated in a particular year resulting in a payment of $80,000 to the policyholder. The other $20,000 is the actuarial discount that reflects the time value of money for the benefit being paid early along with the premiums associated with the accelerated amount that would have been required to keep the policy inforce until the projected date of death. The assumptions and methodology used in the actuarial discounting is the one of the keys to a well designed chronic illness rider.

ii. Acceleration benefit is done by holding a lien against the death benefit of the policy in the amount of the cumulative accelerated death benefit plus interest. In this design, the policyholder is still paying the premium for the portion of the face amount that is accelerated. Thus, the cost is the interest associated with the lien. The outstanding lien balance reduces the amount of cash value available for surrender or loan. The death benefit paid is reduced by any outstanding lien balance. This design is primarily utilized when the base policy is a whole life policy.

iii. A chronic illness acceleration rider which charges the policyholder an explicit additional premium at the time the rider is attached to the life insurance policy.

Risk Control Measures on Chronic Illness Acceleration Riders

Common risk control measures applied to chronic illness riders include the following:

- Use of a supplemental underwriting application for any acceleration riders. The supplemental underwriting typically consists of questions related to the applicant's medical history with respect to the triggers that are used for the acceleration benefit. For example, it will focus on conditions that may result in morbidity associated with ADL loss that may not be included in a typical life insurance application. It may also probe regarding ADL losses or currently disabilities. The supplemental application may also ask questions related to other living benefit coverage inforce (such as long-term care or other chronic illness or terminal illness acceleration riders). Those coverage questions are intended to determine if it appears that the individual is over insured for these benefits (over insurance may imply that the applicant is intending to anti-select against the writing company).
- Limiting the issue ages at which the chronic illness rider can be added and/or incorporation of cognitive testing at particular issue ages.
- Holding the accelerated amount as a lien against the death benefit and charging interest against that lien OR explicitly charging for the rider OR payment of a discounted amount relative to the face amount that is being accelerated. The discounted amount is the actuarial present value of the amount being accelerated taking into account interest and premium payments based upon a life expectancy assumed for a chronically ill individual at that gender and attained age.
- Limiting both the annual and the maximum acceleration amount to some specific dollar amount. The annual benefit amount is also often limited to ensure that the benefit receives favorable tax treatment under section 101(g) of the tax code. Often the policyholder is encouraged to consult their personal tax advisor in advance of making the decision regarding the accelerated death benefit payment so they can review the policyholder's personal circumstances to determine whether the payments qualify for tax free treatment.
- Requiring that an approved Licensed Health Care Practitioner certifies that the policyholder is unable to perform the ADL which are the triggering events for the benefit payment. The writing company often reserves the right to pay for an independent examination of the insured by a Licensed Health Care Practitioner to confirm the validity of the claim. The typical chronic illness acceleration rider trigger requires permanent loss of two or more Activities of Daily Living. Chronic illness acceleration riders often also include a benefit trigger related to severe cognitive impairment.

- Defining the loss of ADL as expected to be permanent can be an important risk control. In the absence of such as definition an otherwise healthy individual could claim under the rider when there is a situation that involves a temporary loss of ADL. Such claims are typically not consistent with the reduced life expectancy that is assumed in the discounted face amount or the additional premium payment forms of chronic illness acceleration riders.

- The rider form may have certain exclusions such as some mental or nervous disorders, alcoholism, drug addition, act of war (declared or undeclared), suicide or intentional self afflicted injury. These exclusions must mirror the base policy language in most states.

- The rider is typically only available on policies that are issued up to some maximum rating (such as Standard or Table D).

- The contestability rights for the writing company with respect to the rider typically follow that of the base policy.

- Limiting the maximum benefit to be less than 100 percent of the death benefit on the life insurance policy which could come in the form of monthly, annual, or lifetime maximums.

Reinsurance Participation on Chronic Illness Acceleration Riders

Reinsurance participation of acceleration riders can take different forms. Terminal illness acceleration riders are often considered to be standard in the United States individual life insurance marketplace. Thus, most reinsurers participate on those riders in proportion to their participation on the base policy. There is typically no additional charge for this rider and the only cost to the policyholder is a small discounting to account for loss of interest between the date of the accelerated payment and the anticipated date of death. It is common for terminal illness acceleration riders to have some cap on the overall face amount that can be accelerated.

Reinsurance participation of chronic illness acceleration riders is more varied. The first question is the product to which the rider is attached. If it is attached to a permanent policy, then one could argue that the policy is likely to ultimately result in a claim if the insured has met the triggers for the acceleration benefit. While that may not be an accurate assumption with all acceleration claims (as one could have a heart attack or stroke and survive for many years), it is not unrealistic to assume the lapse rate on the permanent policy would be at or near zero for those individuals. Thus, the question is whether the discounting used in the payment calculation appropriately takes into account the loss of premiums and interest to the direct writing company and the reinsurer based upon a reasonable life expectancy for a chronically ill individual of that gender and attained age. Reinsurers in the U.S. market today often participate on the acceleration rider if they are able to get comfortable with both the risk control measures used by the writing company at the time the rider is offered and the discounting on the back end at the time the benefit is utilized. Not all reinsurers are comfortable participating on the stream of benefit payments made to the policyholder (if that is an option to the policyholder). Consequently, a reinsurer may approve rider participation subject to a one-time payment either upon death or upon lapse of the policy. Reinsurance participation of prior accelerated amounts upon lapse of the policy essentially means that their liability has been determined once an accelerated payment has been made (as the rest is simply a timing issue).

If the chronic illness acceleration rider is attached to a term policy, then the calculations are very similar to when it is attached to a permanent policy. However, the percentage of term policies that ultimately result in a claim is significantly lower than the percentage of permanent policies that ultimately result in a claim. Thus, the cost of offering such a rider is greater on a term policy as compared to a permanent policy. In addition, the considerations in the actuarial present value calculation can be more challenging as the life expectancy for the policyholder may extend past the end of the level term period. Consequently, offering such a rider on a term policy involves greater uncertainly and potentially higher cost than offering such a rider on a permanent policy. A similar argument holds true when contemplating whether or not to allow such a rider to be included upon conversion of a term policy to a permanent policy. In that situation,

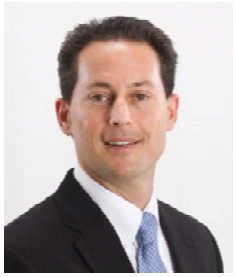
a possible risk control measure is to require completion of the rider application if the policyholder wants to convert from a term policy without the rider to a permanent policy with the rider. To date, the majority of chronic illness acceleration riders have been offered on permanent forms of life insurance. Market pressures are likely going to encourage expansion of these chronic illness acceleration riders onto term products. Market pressure may also exist to discourage use of risk control measures that may be viewed as intrusive to the applicant. As an industry, we should be careful not to offer such a benefit option without careful thought as one does not need to go back far in the history of insurance to see examples of how such product creep can be risky.

Other questions to take into consideration with respect to chronic illness acceleration riders include the following:

- If the writing company charges the policyholder for the rider, then how is the reinsurer compensated? Not all reinsurers have living benefits experience that would allow them to appropriately evaluate and price these risks.
- Should the reinsurer on a YRT basis wait until death to pay their portion of the NAR? If so, then what happens to a policy that accelerates a portion of the death benefit and then lapses (that may be a rare situation)?
- Should the rider be offered to all or a certain class of existing policyholders (such as those who purchased a life insurance policy in the past four years)? If so, then what underwriting should be done to control the risk of anti-selection?

Conclusion

Acceleration riders attached to life insurance policies are getting a lot of attention today. However, one should not be too quick to add such a rider without carefully thinking through the pricing implications. Underwriting and risk control features on most life insurance products today are focused on mortality. A shift to include living benefits requires additional analysis and risk control measures as otherwise the expected profitability the product may not be realized.



Jim Filmore
Vice President and Actuary
Munich Re, Individual Life Pricing - United States

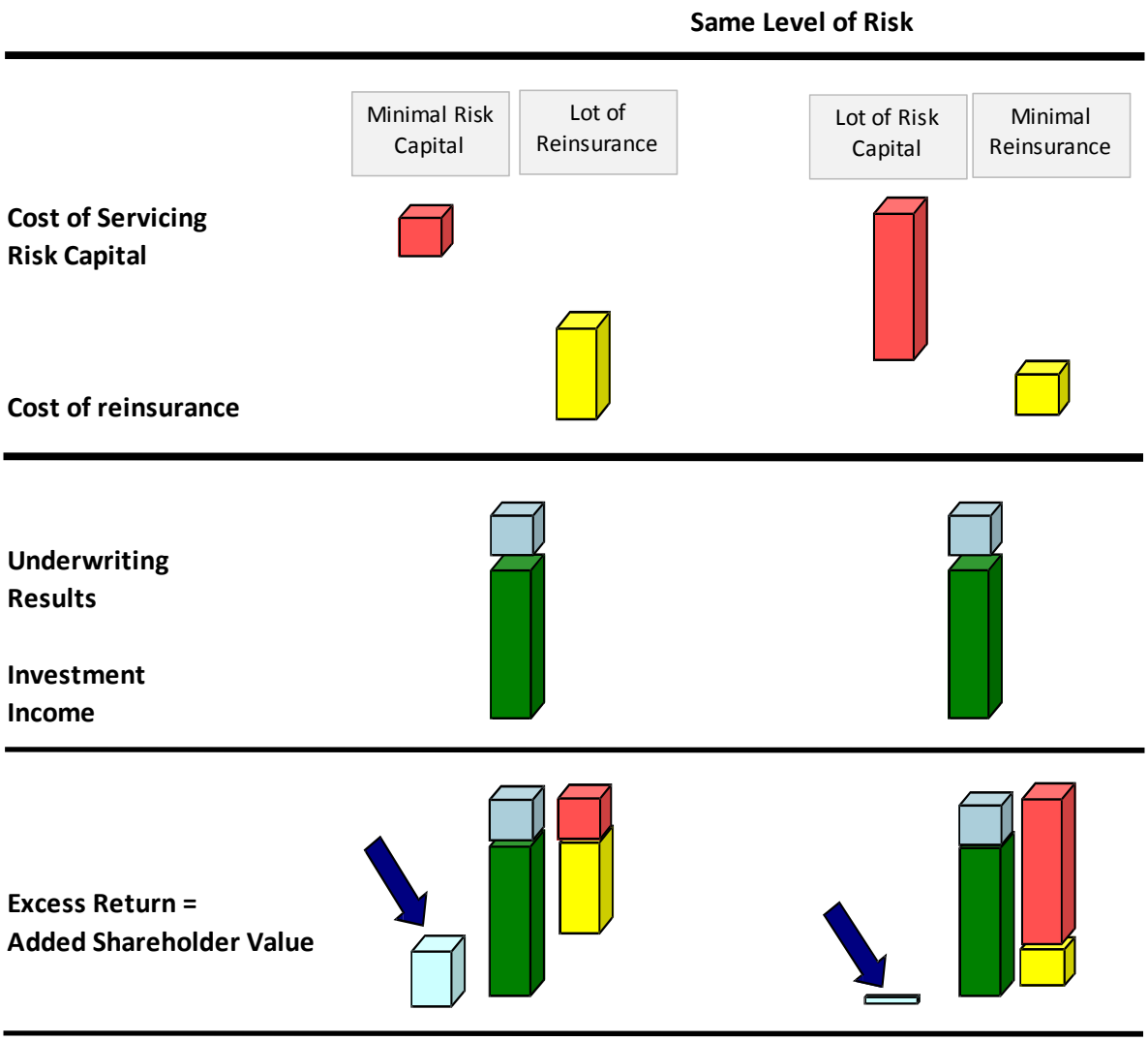
Role of reinsurance
in an economic perspective

Reinsurance: a substitute of capital

For insurance companies, capital is required for providing cushion for insolvency due to adverse events. However, capital is scarce and there is cost associated with holding the capital, as shareholders expect an adequate return for their investment. Therefore, from an economic perspective, analysis of business performance should take the cost of capital into account.

Reinsurance helps insurance companies reduce their risk, and thus helps relieve their capital requirement. Therefore, reinsurance serves as a substitute for capital. Then, the next question is whether it is economically more favorable for the insurer to support the risk by its own capital, or, to transfer the risk through reinsurance.

Figure 1: Illustration: Trade-off between Capital and Reinsurance



Efficiency of reinsurance cover

From insurer's perspective, the underwriting profit (after reinsurance) can be written as U_N=P-L-E-P*+R where P = premium, L = loss, E = expenses, P* = reinsurance premium, R = reinsurance recovery

Define the risk-adjusted capital "C" as C= -E[U|U<=F^{-1}(a)]
where F is the cumulative distribution of the stochastic variable U and "a" is a threshold (e.g. 1%, 1-in-100-year event). "C" can be interpreted as the expected shortfall of underwriting profit among the worst a% of scenarios.

Net underwriting profit (including capital cost) "Z_N" can be expressed as Z_N=U_N-r C_N
where C_N is the risk-adjusted capital after reinsurance and r is the cost of capital.

The profit distribution of Z_N is the basic quantity we are interested in. From the insurer's perspective, it characterizes the economic value of keeping risk on its balance sheet.

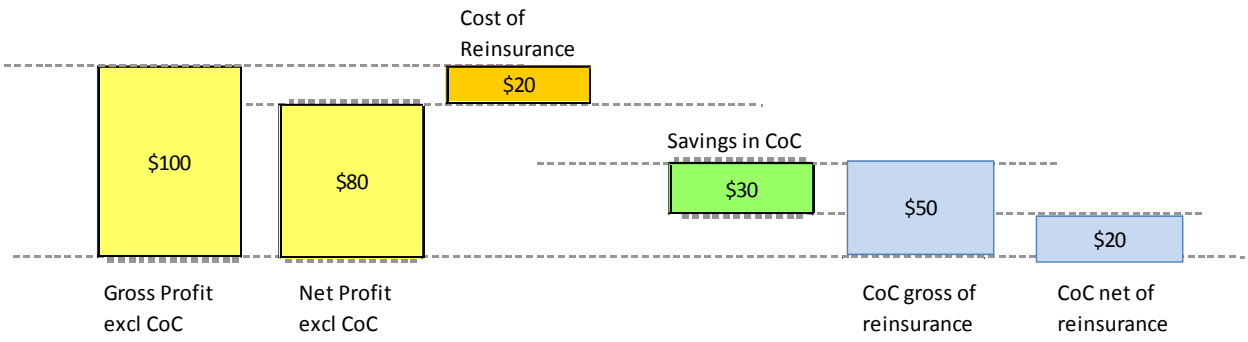
To consider the efficiency of a reinsurance cover, we compare gross and net results including capital costs. The gross result is Z_G=U_G-r C_G
where C_G is the risk-adjusted capital assuming there is no reinsurance.

For an efficient reinsurance cover, the expected net underwriting result (inc. capital costs, reinsurance premiums and recoveries) should be greater than the gross result (inc. capital costs)
E[Z_N]>=E[Z_G]

It implies that:
E[P*]-E[R]<=r(C_G-C_N)

In other words, an efficient reinsurance cover means that the **saving in capital costs of the insurer outweighs its net reinsurance outflow**.

Figure 2: Numerical example of efficient reinsurance cover



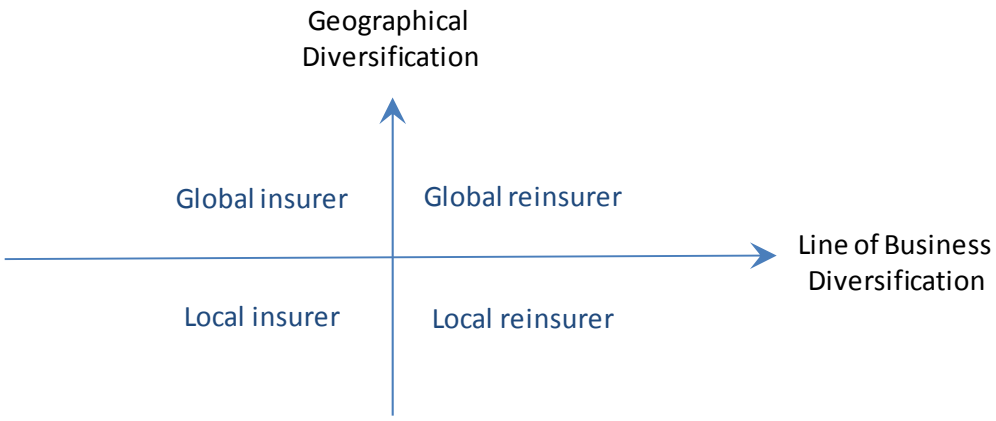
Competitive edge of reinsurers

Similar to insurers, reinsurers also need to have capital and thus need to bear the cost of capital as well. So, you may wonder why the financials can work out for reinsurers and risk transfer mechanism (reinsurance) is financially feasible in the holistic industry view.

The key is diversification. In reality, the total portfolio of (re)insurers are often divided into several sub-portfolios. There is usually some diversification effect among different sub-portfolios. The implication is that the total risk-adjusted capital in aggregate level is usually smaller than the sum of individual risk-adjusted capital for each sub-portfolio. Also, the larger the diversification effect, the lower the capital required. In terms of diversification effect, reinsurers may have some advantages when compared to direct insurers.

Large and international reinsurers have established business all over the world so generally geographic diversification effect is more significant. Moreover, reinsurers usually enjoy better diversification effect through different lines of business. Many direct insurers either focus on life insurance or focus on P&C insurance only. Nevertheless, reinsurers usually develop both life business and P&C business simultaneously.

Figure 3: Geographical and Line of Business diversification



Furthermore, determination of diversification impacts requires sophisticated capital model. “Capital model” here not only includes the modeling tool (e.g. Prophet, AXIS, Moses etc), but also the capital requirement framework prescribed by regulators. For example, sometimes local insurers can hardly recognize their diversification impact under some rule-based local capital requirement.

Optimal retention

Due to generally higher diversification of the portfolio of the reinsurers, it is feasible for both insurer and reinsurer to agree on a price such that the reinsurance cost for risk transfer may actually be lower than the cost of keeping the risk in the portfolio of the insurer. In other words, it is viable that such risk transfer would lead to a win-win situation that both insurer and reinsurer can benefit in the deal. The question is more about how to structure the deal.

In reality, there is no standard rule how much of the risk should be retained and what reinsurance structure should be adopted. Instead, the optimal retention or risk transfer would depend on various factors, for example, cost of capital, risk appetite, diversification effects, external capital constraints etc. Nevertheless, regardless of details of the reinsurance solution, **the aim is always to reach a win-win situation** and to establish a long-term relationship between different parties.

Dicky Lui
Senior Pricing Manager, Pricing & Guidelines
SCOR Global Life Asia-Pacific

Reference: **Kull A.**, 2009, Sharing risk, An Economic Perspective, ASTIN Bulletin, vol.39(2), pages 591-613.

The views expressed herein are those of the individual author and do not necessarily reflect the views of SCOR Global Life.

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Andrew Bishop
Regional Head of Human Resources Asia Pacific & India Markets
Reinsurance Group of America

RGA

Key Contacts

Jonny Plews	+852 5804 9200	jonny.plews@ojassociates.com	Toby Weston	+852 5804 9042	toby.weston@ojassociates.com
Philip Chau	+852 5804 9287	philip.chau@ojassociates.com	Joanne Lim	+852 5804 9225	joanne.lim@ojassociates.com
Gary Rushton	+852 5804 9223	gary.rushton@ojassociates.com	Leanne Leung	+852 5804 9070	leanne.leung@ojassociates.com

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Market Update

1. Revised MPF Guidelines

The Management Board of the MPFA has recently approved one set of revised Guidelines on Election for Transfer of Accrued Benefits (Guidelines IV.3). (formerly known as Guidelines on Election Forms for Transfer of Accrued Benefits).

In November 2012, the Authority announced that it will launch a program to facilitate and encourage scheme members to consolidate their personal accounts ("PAs") as one of a series of measures to address administration costs. Currently, scheme members who wish to transfer their accrued benefits from several PAs to one account would need to fill in a transfer from for each PA from which benefits are to be transferred. To facilitate and encourage consolidation of PAs, Guidelines IV.3 have been amended to include a new single transfer form approved by the Authority as the election form for transfer of accrued benefits from several PAs to one account. The title of Guidelines IV.3 has also been revised to "Guidelines on Election for Transfer of Accrued Benefits" in order to better reflect the purposes of the Guidelines.

Copies of the revised Guidelines can be downloaded from the Authority's website at http://www.mpfa.org.hk.

Membership Update

New Membership

Fellow

Kenneth	BUFFIN	Buffin Partners	FIA (1973), FSA (2000)
Simon Raymond George	FERRY	Mercer	FIA (2007)

Associate

Sheng	Di	Moody's Analytics	ASA (2008), MAAA (2009)

Student

Elizabeth Grace	Chan	Standard Life (Asia) Ltd	IoA Student
Xiaojun	LIANG	-	SOA Student

Others

10th

ASHK ANNUAL DINNER

5 November 2013

Cocktails 6:00 pm / Dinner 7:00 pm

Hyatt Regency Hong Kong, Tsim Sha Tsui

Upcoming Events

Date	Event
15 – 18 Oct	17th EAAC, Singapore
30 Oct	ASHK Evening Discussion on Statutory Body Project
5 Nov	ASHK Annual Dinner
6 Nov	ASHK Appointed Actuaries Symposium
21 Nov	ASHK Evening Talk
28 Nov	IFoA CPD Event, Hong Kong
29 Nov	ASHK/ HKFI Joint Talk
6 Dec	SOA APC, Shanghai
12 Dec	ASHK AGM

Actuaries on the move

Chan Ching Chuen
KC Chan
Tom Chan
Simon Chan
David Cheung
Simon Dai
Shirley Fong
Mary Kwan
Mario Lai
Jeff Lau
Ivan Lee
Phillip Lui
Joyce Luo
Eric Sum
Benjamin Tam
Gordon Tse

Events Highlights

Joint Regional Seminar, Hong Kong 26 July 2013

Mr. Jack Mak, ASHK President

Mr. Mark Saunders, Chair of the Organising Committee

Mr. Philip Tso, Towers Watson

Mr. Keith Walter, Towers Watson

Mr. Marco Warmelink, ING Life

Mr. Bob Cook, Manulife Asia

Mr. Ben McDermott, Towers Watson

Ms. Angela Lau, Swiss Re

Mr. Roger Steel, Sun Life Financial

Ms. Katherine Wong, SCOR Global Life

Mr. Paul Carrett, Carrett & Co

Others

Events Highlights

Joint Regional Seminar, Taipei 29 - 30 July 2013

Mr. Bond Yang, Nanshan Life

Ms. Emily Papworth and Janet Li, Towers Watson

ASHK Evening Talk 23 Sep 2013

Mr. Peter Duran and Mr. Tom Herget

Mr. Peter Duran and Mr. Simon Walpole

Prize to Give away

Solutions for Jul 2013

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Contributions to the ASHK Newsletter

We welcome members' contribution to the following sections of the ASHK Newsletter: Feature Articles, Knowledge Sharing and Industrial Update, Actuaries on the Move and Puzzle Corner.

Send correspondence to the ASHK Office at the address below. When sending in correspondence which has been created in a word processing program, when possible, email a copy of the file to either the editor's or the coordinators' e-mail address. Publication of contributions will be at editor's discretion.

Editor

Simon Lam E-mail: SLam@munichre.com

Assistant Editors

Chen Hao E-mail: hao.chen.china@gmail.com
Mary Kwan E-mail: mary.kwan@ageas.com.hk
Iris Lun E-mail: Iris.HY.Lun@prudential.com.hk
Calvin Tang E-mail: calvintangyc@yahoo.com
Sing-Yee Yeoh E-mail: singyee.yeoh@milliman.com

Coordinators (ASHK Staff)

Patricia Kum	Tel: (852) 2147 9418	E-mail: patkum@netvigator.com
Tiffany Wong	Tel: (852) 2147 9419	E-mail: actsoff@netvigator.com
Emily Lye	Tel: (852) 2147 9420	E-mail: actuaries@biznetvigator.com