Guideline on Medical Insurance Business ("GL31")
Frequently Asked Questions

The Insurance Authority ("IA") issues these frequently asked questions ("FAQ") with the aim of providing further guidance to authorized insurers and licensed insurance intermediaries in respect of the Guideline on Medical Insurance Business ("GL31").

This FAQ is not intended to be a comprehensive guide and does not constitute legal advice. Authorized insurers and licensed insurance intermediaries are advised to seek professional legal advice if they have any questions in relation to the application or interpretation of the relevant provisions of the GL31.

This FAQ does not have the force of law and should not be interpreted in a way that would override the provision of any law. The IA reserves the right to review and update this FAQ from time to time. Unless otherwise specified, words and expressions in this FAQ shall have the same meanings as given to them in GL31.

Q1. What types of insurance products does GL31 apply to?

A1. GL31 applies to all medical insurance products within the definition of "medical insurance business" as set out in paragraph 2.1(f) of GL31, including individual and group insurance policies. Examples of such products include hospital cash coverage, critical illness coverage and Certified Plans under the Voluntary Health Insurance Scheme ("VHIS"). For the avoidance of doubt, GL31 applies to any medical insurance contract belonging to Class 2 (sickness) business (prescribed in Part 3 of Schedule 1 to the Insurance Ordinance (Cap. 41)) that is in the form of:

- a standalone policy; or
- a rider attached to a long term business policy.

(Reference: paragraphs 2.1(f) and 3.2 of GL31.)

Q2. Are all requirements in GL31 applicable to group medical insurance policies?

A2. GL31 aims to provide sufficient safeguards for fair treatment of customers in relation to all medical insurance business. The principle of fair treatment of customers applies irrespective of whether the customer is an individual policy holder or a group policy holder, so the majority of the requirements in GL31 are applicable to both individual and group medical insurance policies. For example, the interests and needs of different types of customers should be taken into account in product design, adequate product information should be provided to customers to enable them to make informed decisions, key features and terms and conditions of medical insurance policies should be clearly explained to customers in plain language for their easy understanding, claims should be handled fairly and promptly, etc. However, certain requirements are not applicable to group medical insurance policies because they relate to VHIS-compliant policies which are individual medical insurance policies (e.g. paragraphs 6.3(h), (k) and (l), 6.5(e), 6.7 and 11). Similarly, the requirements on offering of gifts to customers (paragraphs 6.8 to 6.11) only apply to individual customers.

(Reference: paragraphs 5.1, 6.3, 6.5, 6.7, 6.8 to 6.11, 7.1 and 11 of GL31.)

Q3. How should the board of directors ("the Board"), the individual appointed as controller and the senior management of an authorized insurer demonstrate their commitment to fair treatment of customers?

A3. Commitment to the fair treatment of customers can be demonstrated by putting in place measures which encourage attitudes and behaviour of the insurer's staff and licensed insurance intermediaries (if any) to consider matters from the customer's viewpoint. For example, when presentations are made to the Board on business performance, the Board should ask questions that go beyond the numbers, enquiring of management how the customer's viewpoint has been taken into account in the design of the product, its marketing and any product training that is rolled out. The Board should also take an interest in trends that relate to fair customer treatment, such as (i) number of complaints and their root causes, (ii) policy lapse ratio (or renewal retention rate), (iii) rejection rate on claims etc. The controller should make the same enquiries of the senior management team and this should be cascaded throughout the company. Other ways of demonstrating such commitment, for example, is to ensure employee's variable remuneration factoring in qualitative matters on fair treatment of customers (and not only quantitative targets). Further, throughout the year individual staff members who exemplify fair customer treatment in their work can be singled out for recognition. Please also refer to paragraphs 10.3, 10.4 and 10.6 of the Guideline on the Corporate Governance of Authorized Insurers ("GL10"). Proper policies and procedures regarding servicing of customers should be established and, as indicated above, the Board, controller and senior management should be able to demonstrate how management information is used to enhance, where appropriate, the policies and procedures on fair treatment of customers. They should also monitor the implementation of those policies and procedures and properly remedy any deficiencies identified.

(Reference: paragraph 4.2(a) of GL31.)

Q4. Please elaborate on the requirements for the management information ("MI") framework in relation to fair treatment of customers.

A4. As alluded to in A3 above, the Board, the individual appointed as controller[1] and the senior management of an authorized insurer should be provided with relevant, accurate and timely MI that enables them to measure and monitor the performance of the insurer and its licensed insurance agents with respect to fair treatment of customers. The MI concerned should reflect the outcome of delivering services in line with the principle of fair treatment of customers. To obtain such information, the insurer could, depending on its own circumstances, take appropriate measures such as the following:

a) monitor the number and type of customer complaints and their root causes;
b) conduct surveys to gauge customers' satisfaction and feedback;
c) conduct mystery shopping programmes; and
d) prepare compliance reports at regular intervals (e.g. reports to evaluate the compliance status of internal procedures regarding fair treatment of customers).

(Reference: paragraphs 4.2 (b) and (c) of GL31.)

[1] "individual appointed as controller" is defined in para. 2.1(e) of GL31.

Q5. Could the Board and senior management of an authorized insurer delegate any of the activities or tasks associated with its own roles and responsibilities to designated committees, groups of persons or key persons in control functions?

A5. Yes. Despite any delegation made, however, the Board retains the ultimate responsibility for maintaining general oversight over the implementation of measures in compliance with GL31 and for ensuring fair treatment of customers. Please also refer to paragraphs 4.3(b) and 6.6 of GL10. Where the Board makes any delegation, it should ensure that the delegation:

a) is appropriate with regard to the delegated tasks and the capabilities of the persons to whom such tasks are to be delegated;
b) avoids any undue concentration of powers;
c) is made under a clear mandate with well-defined terms and is supported by adequate resources; and
d) can be effectively monitored, assessed and withdrawn if the delegated tasks are not properly carried out.

Where the senior management makes any delegation, there should be clear lines of accountability and reporting.

(Reference: paragraph 4.2 of GL31.)

Q6. How should authorized insurers, licensed insurance agencies or licensed insurance broker companies monitor their selling processes of medical insurance products to ensure fair treatment of customers?

A6. Authorized insurers, licensed insurance agencies and licensed insurance broker companies should adopt monitoring measures that are appropriate to their own circumstances. For example, they could monitor the number and type of complaints they receive to ensure such complaints are addressed efficiently, identifying and addressing any root causes. They could proactively obtain and record the feedback from customers to monitor and analyse trends, if any. For example, they could monitor policy lapse rate, rejected claim ratio, sales volume of different types of medical insurance products as well as any other internal control measures on the sales processes, etc.

(Reference: paragraph 6.1 of GL31.)

Q7. How should authorized insurers and licensed insurance intermediaries assess the insurance needs of customers and recommend suitable medical insurance products to them?

A7. Authorized insurers and licensed insurance intermediaries have an obligation to collect adequate information to place themselves in a position whereby they can perform reasonable assessments before making any insurance recommendation. This should be done in accordance with any applicable rules, codes, circulars, guidelines, etc. issued by the IA and other regulatory bodies from time to time and their own internal policies and procedures which should be commensurate with their nature of business, scale of operations and particular circumstances of the customers.

Group Medical Insurance Policies

Customers for group medical insurance are mainly corporates seeking medical insurance for their employees. The needs of the corporate, in this respect, are its objectives in sourcing medical insurance, which may include (a) offering the insurance as part of a competitive employee benefits package (versus its competitors in the same industry); (b) ensuring employees can access medical treatment when needed thereby reducing sickness absence and underpinning productivity (as well as staff morale); and (c) sourcing a health insurance coverage available within specific budgetary parameters. In these circumstances, the suitability assessment is regarded to have been completed upon obtaining the essential information about the corporate and its employees during the application process (e.g. nature of the business, total number of its employees, employee demographic and any particular objectives for the health insurance which the corporate highlights).

Individual Medical Insurance Policies

For authorized insurers and licensed insurance intermediaries, in addition to the personal information of individual customers (e.g. age, sex, health condition and coverage of existing medical insurance policy of the customer), they would need to obtain sufficient information from the customer so that a suitable medical insurance product can be recommended. The minimum scope of information to be collected for suitability assessment of the individual customers may include the following:

a) the customer's objectives of purchasing a medical insurance product (e.g. getting insurance protection for future healthcare needs, increasing expenses for medical and healthcare services or loss of income during hospital confinement, etc); and
b) the customer's insurance needs in respect of any medical insurance product, including types of the products (e.g. indemnity/non-indemnity/combo product).

Authorized insurers and licensed insurance intermediaries should recommend medical insurance products that suit the customer's objectives and insurance needs. For example, if the customer expects an insurance product that reimburses medical expenses for hospital confinement, medical insurance products with medical expenses reimbursement/ indemnity features should be recommended; if the customer looks for income protection during hospital confinement, medical insurance products with hospital cash feature should be advised.

Save for the prescribed types of benefits and/ or circumstances in A8 below, suitability assessment covering the above minimum scope of information should be conducted for every application for a new medical insurance policy.

As for licensed insurance intermediaries, they should also make reference to the General Principle 6 – Suitability of Advice stated in the Code of Conduct for Licensed Insurance Agents or the Code of Conduct for Licensed Insurance Brokers (as the case may be). For example, a licensed insurance intermediary should take reasonable steps to understand the client's circumstances and take into account the client's circumstances when giving regulated advice to the client and have a reasonable basis for such advice.

(Reference: paragraph 6.2 of GL31.)

Q8. For i) critical illness accelerated benefit[2], ii) refundable medical insurance policies without substantial savings component, or iii) medical insurance policies without cash value which is/ are embedded in a life insurance policy or added to the policy as a supplementary benefit rider, is it necessary to assess the medical insurance needs of customers?

A8. In this case, upfront disclosure of the key features and terms and conditions[3] of the benefit(s) concerned[4] is required. Authorized insurers and licensed insurance intermediaries should clearly explain to customers, in plain language, the key features and terms and conditions of the above benefit(s). Suitability assessment in relation to the basic life insurance policy or medical insurance policy/ rider should have been conducted at the point of sale according to the applicable guidelines (e.g. GL16), rules, regulations, codes, circulars or any other specific requirements issued by the IA and other regulatory bodies from time to time. For the avoidance of doubt, other than the above prescribed types of benefits and/ or circumstances, insurers have to obtain information specified in A7 for any other medical benefits/ policies/ riders embedded in or added to the life insurance policy.

(Reference: paragraph 6.2 of GL31.)

Q9. Do authorized insurers and licensed insurance intermediaries selling medical insurance products through digital channels need to comply with the requirements of GL31?

A9. Yes, customers should be treated fairly regardless of the distribution channels through which they purchase medical insurance products.

While most of the customers are typically self-directed when purchasing medical insurance products through a digital channel, authorized insurers and licensed insurance intermediaries should make upfront disclosure[5] to ensure that customers are aware of the nature, features and coverage of the medical insurance products before the customer arrive at a purchase decision. Adequate product information (including relevant types of product(s) for customers' selection and clear explanation of the key features and terms and conditions of medical insurance policies) should be directed to the customers' attention before completion of selling process. Meanwhile, authorized insurers and licensed insurance intermediaries should handle enquiries properly before, during and after the point-of-sale.

Authorized insurers and licensed insurance intermediaries may use online questionnaires to assess the insurance needs of customers. This may involve having an automated mechanism which analyses a customer's information inputted in response to a questionnaire, which then (based on the information) screens out the available medical insurance product(s) for the customer's consideration and selection.

(Reference: paragraphs 6.2, 6.4 and 6.5 of GL31.)

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[2] A critical illness accelerated benefit enables a policy holder to accelerate and receive a portion of the death benefit before his/her death under a life insurance policy. Instead of paying out only upon death, the policy provides a benefit if the insured is diagnosed with one of several specified critical illnesses.

[3, 5] The upfront disclosure should include objective(s), type and nature of the policy (e.g. indemnity/non-indemnity/combo product), and where applicable, target benefit period, payment period, level of premiums payable, etc.

[4] Including critical illness accelerated benefit, refundable medical insurance policies without substantial savings component, and medical insurance policies without cash value.

Q10. What are the "sales materials" for the purposes of paragraph 6.3(a) and 6.3(m) of GL31?

A10. Sales materials contain products information or any promotional information in which the products or promotional information are contained and presented to the customers to enable them to make informed decisions with respect to whether the products are suitable for their needs. Product brochure and online promotional information are just two examples of "sales materials" given in paragraph 6.3(a). They are non-exhaustive. Examples of other "sales materials" are: product and promotional leaflets, other presentation materials, quotation, offer letters or written proposals, etc. in which products information or promotional information is contained and presented with the objective of enabling the customers to make informed decisions with respect to whether the relevant products (including tailor-made group medical insurance policies) are suitable for their needs.

(Reference: paragraph 6.3(a) and (m) of GL31.)

Q11. Should authorized insurers include all exclusions in the product information in relation to each of their medical insurance products?

A11. The product information should include key or unusual exclusions of the medical insurance products.

A key exclusion is one that would tend to affect the decision of customers generally to buy a medical insurance policy being recommended. An example is the effect of pre-existing condition (i.e. any sickness, disease, injury, physical, mental or medical condition. or physiological degradation (including congenital condition) in respect of the insured that has existed prior to the policy issuance date or the policy effective date, whichever is the earlier) to the coverage of the medical insurance products.

An unusual exclusion is one that is not normally found in comparable medical insurance policies. For example, if non-surgical techniques such as balloon angioplasty (i.e. a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart, known as coronary arteries) or laser angioplasty (i.e. a medical procedure in which a catheter that can send out laser to vapourize plaque is used to open coronary arteries blockage) are excluded, this information should be included in the product information.

Authorized insurers and licensed insurance intermediaries should also ensure that a clear explanation of the key features and terms and conditions is provided to customers in plain language for their easy understanding.

(Reference: paragraphs 6.3(e) and 6.5(b) of GL31.)

Q12. What is meant by full disclosure in response to an insurer's question?

A12. Full disclosure generally refers to the disclosure of all "material facts" which are the facts, information or circumstances, in particular medically-related facts, e.g. medical history, smoking status, etc., that would influence the judgment of a prudent insurer in setting the premium, or in determining whether to insure the risk. Applicants should be made aware (in the application form or product information etc.) that if they are uncertain as to whether or not a certain piece of information is material, it would be best for them to take a cautious approach and disclose it to the insurer.

(Reference: paragraph 6.5(h) of GL31.)

Q13. What are excesses, deductibles, retentions or coinsurance in a medical insurance policy?

A13. Excesses, deductibles or retentions generally refer to the amount of medical expenses that the policy holder needs to bear him/herself, before the medical insurance policy starts to cover such expenses. Coinsurance is similar in nature but is usually represented as a percentage of the medical expenses that the policy holder needs to bear with the remaining percentage of the expenses covered under the policy. Authorized insurers are generally expected to demonstrate these features (if any) as examples in their product information (e.g. product brochure/online promotional information).

(Reference: paragraph 6.5(i) of GL31.)

Q14. What is the arrangement for migrating an individual indemnity hospital insurance plan ("IHIP") policy to a VHIS-compliant policy?

A14. According to the Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme, policy holders who have an inforce and valid individual IHIP policy before the date of the implementation of the VHIS on 1 April 2019 will be entitled to a one-off migration facilitation offered by the relevant insurer concerned. Authorized insurer should commit to offering each such existing IHIP policy holder a VHIS-compliant product option as soon as possible after the insurer has registered with the Government as a VHIS Provider. This commitment will be open for ten years since the full implementation of the VHIS on 1 April 2019.

For enquiries related to the migration arrangement, please contact VHIS Office directly. The contact details of VHIS Office are:
Tel: 2529 8900
Fax: 2529 8982
Email: vhis_enquiry@fhb.gov.hk

Please note that if the customer is an existing individual IHIP policy holder, the authorized insurer or licensed insurance intermediary should as soon as reasonably practicable inform him/her of the availability of the migration arrangement to enable the customer to make an informed decision.

(Reference: paragraph 6.3(k) of GL31.)

Q15. Should the procedures for making claims under and terminating VHIS policies be followed for all medical insurance policies?

A15. It is not necessary for the procedures for making claims and terminating VHIS policies, to be adopted for non-VHIS medical insurance policies (albeit there nothing to stop authorized insurers from adopting such procedures if they choose). It is, however, necessary for the procedures for making claims and terminating medical insurance policies to be clearly explained to customers.

(Reference: paragraph 6.5(g) of GL31.)

Q16. What information regarding claims handling should be provided by authorized insurers to their customers?

A16. Authorized insurers should provide sufficient information to customers about how to submit a claim. They are required to, amongst other matters, explain the procedures as well as information and documents required for making claims. Besides, they should provide their customers with information on the insurers' internal dispute resolution procedures and availability of the external dispute resolution channels. Customers should have access to the insurers' claims procedures via insurers' websites and mobile apps (if any) or by approaching insurers directly for information.

(Reference: paragraph 7.1(b) of GL31.)

Q17. What are the unique product features of VHIS-compliant policies?

A17. VHIS-compliant policies (i.e. the Certified Plans) are officially certified by FHB. They are subject to the requirements as specified in the Scheme Documents issued by FHB. Their unique product features include, amongst other features, standardised policy terms and conditions, guaranteed renewal up to the age of 100 years, no "life time benefit limit", cooling-off period of not less than 21 days, premium transparency and other extended coverage such as special coverage arrangement on unknown pre-existing condition. For details, please contact the VHIS Office.

(Reference: paragraph 6.7(a) of GL31.)

Q18. Are authorized insurers, licensed insurance agencies and licensed insurance broker companies required to extend the ongoing training on medical insurance business and product features to their staff?

A18. It is important that the staff of authorized insurers, licensed insurance agencies and licensed insurance broker companies (including those who are licensed individual insurance agents, licensed technical representatives (agent) or licensed technical representatives (broker) (as the case may be)) who provide services relating to medical insurance policies have the relevant knowledge and skills to provide quality services to customers. Therefore, authorized insurers (including insurers using digital channels), licensed insurance agencies and licensed insurance broker companies should provide ongoing training on medical insurance business and product features to such persons.

(Reference: paragraph 6.14(b) of GL31.)

Q19. When and how should authorized insurers and licensed insurance intermediaries assess the continued suitability of the medical insurance policy in meeting the policy holder's needs?

A19. Authorized insurers or licensed insurance intermediaries (as the case may be) should conduct a review of the continued suitability of the medical insurance policy/policies in meeting a policy holder's needs, upon the policy holder's request. They should conduct such review in accordance with their own policies and procedures. The review would generally cover, amongst other matters, insurance needs of the policy holder, coverage of the existing medical insurance policy/policies and any change in the insureds' needs for medical insurance, etc.

(Reference: paragraph 8.1 of GL31.)

Q20. Are the requirements relating to offering of gifts and rebates under GL31 similar to those stipulated in the Guideline on Offering of Gifts ("GL25")?

A20. The requirements with respect to offering of gifts in GL31 dovetail with GL25, save that the requirements in GL31 are confined to gifts that are offered to individual customers as opposed to non-individual customers such as a company which takes out a group medical insurance policy for its employees.

As regards rebates, the prohibition on rebates in GL31 does not apply to any rebate of commission given by a licensed insurance broker company in respect of a medical insurance policy it arranges, provided such rebate is expressly recorded in either the document setting out the quotation which is issued by the broker company to the policy holder, or in the premium debit note, invoice or similar document issued by the broker company to the policy holder for the purpose of collecting the premium from the policy holder (see paragraph 6.13(b) of GL31).

Please note that the scope of application between GL25 and GL31 are different (see paragraph 4.1 of GL25 and paragraph 3.2 of GL31). All authorized insurers carrying on long term business and underwriting medical insurance business or all licensed insurance intermediaries carrying on regulated activities in relation to long term business and medical insurance business, should comply with the requirements of GL31 in addition to the requirements of GL25.

(Reference: paragraphs 2.1(d) and (h), 6.8 to 6.13 of GL31.)

Q21. Paragraph 8.3 of GL31 states that where enhancements on terms and benefits to medical insurance policies are proposed to policy holders at renewal, irrespective of whether the proposed enhancements will lead to an increase of premium or not, authorized insurers should, as far as practicable, provide policy holders with the option of renewing the existing policies without enhancements. Please explain under what circumstances it would be considered impractical for an authorized insurer to provide such option to the policy holders?

A21. Authorized insurers do enhance terms and benefits to their medical insurance policies from time to time (at policy renewal or at any other time during the term of the policy) due to, for example, new treatment or therapy for specific disease which is not covered under the existing benefit or other medical advancement). Where such enhanced terms and benefits are offered at renewal, the intention of the requirement in paragraph 8.3 of GL31 is to ensure, as far as practicable, that policy holders are provided with an option to choose to renew with the enhanced terms and benefits proposed by the insurer, or alternatively to renew on the same terms as the expiring policy i.e. without the enhanced terms and benefits (as well as the alternative of not renewing at all). This should be done irrespective of whether the premium is being increased by reason of the enhancements.

The caveat "as far as practicable" suggests that there may be circumstances where the insurer does not have to offer such alternatives at renewal where it is enhancing the terms and benefits (even without increasing the premium). Examples of where this caveat may apply (i.e. where the insurer does not have to offer alternatives of renewing with the enhancements or renewing without the enhancements) because it is not practicable to do so would be as follows:

a) Where (i) the enhancements to the terms and conditions are being provided for no additional premium; and (ii) the coverage under the existing policy would still be provided under the renewed policy, albeit with enhancements (i.e. none of the existing coverage benefits are being reduced or removed on renewal and the enhancements only serve to increase these coverage benefits or broaden the policy to include other coverage benefits). In these circumstances, there would appear to be no practicality the policy holder being offered renewal without these enhancements;
b) Where the insurer decides to cease servicing the existing policies without enhancements after a certain date due to business or operational reasons; or
c) Where revision to the terms and benefits of a VHIS Certified Plan upon re-certification by FHB results in the old version of the VHIS Certified Plan being no longer available for the existing and potential policy holders of the insurer concerned. Please also refer to the Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme.

In assessing whether it is practicable to provide policy holders with an option of choosing the enhanced terms and conditions proposed by the insurer or stay with the current benefits of the policy, authorized insurers should have regard to the principle of fair treatment of customers (this is particularly the case with example (b)). Insurers should retain proper records of their decisions and reasons for the decisions and provide such records for the IA's inspection as soon as practicable upon request.

If such option could not be provided to the policy holders, authorized insurers should give sufficient advance written notice to the policy holders specifying the proposed enhancements on terms and benefits to the medical insurance policies and any change in premium as a result of the proposed enhancements prior to the renewal date of the policy or the date on which such changes become effective.

(Reference: paragraph 8.3 of GL31.)

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