G.N. 7212

INSURANCE ORDINANCE (Chapter 41)

Pursuant to section 133(1) of the Insurance Ordinance (Chapter 41), the Guideline on Medical Insurance Business (GL31) is published by the Insurance Authority.

This Guideline shall take effect from 23 September 2020.

29 November 2019 Clement CHEUNG *Chief Executive Officer, Insurance Authority*

GL 31

GUIDELINE ON
MEDICAL INSURANCE BUSINESS

Insurance Authority

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1. Introduction

1.1 The Insurance Authority ("IA") issues this Guideline pursuant to section 133 of the Insurance Ordinance (Cap. 41) ("the Ordinance"), its principal function to regulate and supervise the insurance industry for the protection of existing and potential policy holders and its function to promote and encourage the adoption of proper standards of conduct and sound and prudent business practices by authorized insurers and proper standards of conduct by licensed insurance intermediaries. This Guideline also takes account of the Insurance Core Principles, Standards, Guidance and Assessment Methodology ("ICP") promulgated by the International Association of Insurance Supervisors, in particular ICP 19 which stipulates that the conduct of the business of insurance should ensure that customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied.

2. Interpretation

2.1 In this Guideline, unless the context otherwise specifies:

(a) "Certified Plans" means individual indemnity hospital insurance plans ("IHIP") certified by the Food and Health Bureau of the Government of the Hong Kong Special Administrative Region ("FHB") as Voluntary Health Insurance Scheme ("VHIS")-compliant, including the Standard Plans and Flexi Plans.

(b) "customer" bears the same meaning as policy holder or potential policy holder, as those terms are used in the Ordinance.

(c) "Flexi Plan" means any individual IHIP under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the policy holder and the insured person, subject to the certification by the FHB. Such plan should not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by the FHB from time to time.

(d) "Gift" may include any kind of gift, incentive, enticement or inducement, whether financial or non-financial, but does not include:

(i) the payment of fees or commissions to licensed insurance intermediaries; or

(ii) any discount of premiums, fees or charges payable under a contract of medical insurance (i.e. medical insurance policy):

(A) provided that the discount is expressly stated in the quotation, offer letter, promotional materials, medical insurance policy or the policy schedule issued by the authorized insurer; or

(B) where the discount is being given by a licensed insurance broker company discounting its commission due in respect of a medical insurance policy it arranges, provided that the discount 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.

(e) "individual appointed as controller", in relation to an authorized insurer, means the individual appointed as controller of the insurer after being approved by the IA under section 13A of the Ordinance.

(f) "medical insurance business" refers to:

(i) contracts of insurance in Class 2 (sickness) of Part 3 of Schedule 1 to the Ordinance ("Class 2 (sickness) business"); and

(ii) the coverage under a contract of insurance which by its nature is Class 2 (sickness) business, where that contract of insurance is within paragraph 3 of Part 1 of Schedule 1 to the Ordinance (i.e. a contract of insurance which combines long term

business with additional business which by its nature is Class 2 (sickness) business).

In this Guideline, a reference to a "medical insurance policy" or a "medical insurance product" is to a contract of insurance within the definition of "medical insurance business".

(g) "Permitted Gift" means a gift listed in the Annex to this Guideline.

(h) "rebates" means:

(i) in relation to premiums, any repayment made as a gratuity directly or indirectly to a customer of an amount of premium previously paid by a customer; or

(ii) in relation to commissions, any payment made as a gratuity directly or indirectly to a customer by a licensed insurance intermediary of part of the commission received by the licensed insurance intermediary.

(i) "senior management", in relation to an authorized insurer, refers to individuals, headed by the individual appointed as controller of the authorized insurer, who are responsible for managing the insurance business of an authorized insurer on a day-to-day basis in accordance with strategies, policies and procedures set by the insurer's board of directors.

(j) "service provider" means a provider of services engaged by an authorized insurer to provide services, whether that provider is located in or outside Hong Kong. A service provider includes an independent third party contractor of the insurer, a service provider which is a company within the same group of companies as the insurer (e.g. a subsidiary of the insurer), and a service provider which is a unit of the insurer (e.g. head office or overseas branch).

(k) "Standard Plan" means the insurance plan with terms and benefits equivalent to the minimum compliant product requirements of the VHIS, which are from time to time published and subject to regular review by the FHB.

(l) "Scheme Documents" means the following documents issued by the FHB under VHIS:

(i) Registration Rules for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme;

(ii) Voluntary Health Insurance Scheme Certified Plan Policy Template;

(iii) Product Compliance Rules under the Ambit of the Voluntary Health Insurance Scheme; and

(iv) Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme.

(m) "VHIS" means the Voluntary Health Insurance Scheme, being a policy initiative introduced by the FHB concerning IHIP offered to individuals, with voluntary participation by authorized insurers and customers.

2.2 Unless otherwise specified, words and expressions used in this Guideline should have the same meanings as given to them in the Ordinance.

3. Purpose, Application and Status of this Guideline

3.1 Fair treatment of customers is a vital principle which reinforces public trust and confidence in the insurance sector. According to ICP 19, fair treatment of customers encompasses achieving outcomes such as:

(a) developing, marketing and selling products in a way that pays due regard to the interests and needs of customers;

(b) providing customers with information before, during and after the point of sale that is accurate, clear, and not misleading;

(c) minimising the risks of sales which are not appropriate to customers' interests and needs;

(d) ensuring that any advice given is of a professional standard;

(e) dealing with customer claims, complaints and disputes in a fair and timely manner; and

(f) protecting the privacy of information obtained from customers.

ICP 19 also indicates that fair treatment of customers encompasses concepts such as ethical behaviour, acting in good faith and the prohibition of abusive practices.

3.2 This Guideline applies to all authorized insurers underwriting medical insurance business, and all licensed insurance intermediaries carrying on regulated activities in respect of medical insurance business. This Guideline applies in respect of all medical insurance business, including individual and group business, Certified Plans under the VHIS and any other types of medical insurance business. This Guideline provides guidance on the standards and practices which are expected to be met in order to ensure fair treatment of customers across all aspects of medical insurance business.

3.3 This Guideline does not have the force of law, in that it is not subsidiary legislation, and should not be interpreted in a way that would override the provision of any law. A non-compliance with the provisions in this Guideline would not by itself render an authorized insurer or a licensed insurance intermediary liable to judicial or other proceedings. A non-compliance may, however, for example reflect on the IA's view of the continued fitness and properness of (i) the directors, controllers or key persons in relevant control functions of the insurers to which this Guideline applies and (ii) the licensed insurance intermediaries to which this Guideline applies and (in the case of licensed insurance agencies and licensed insurance broker companies) their directors, controllers or responsible officers. The IA may also take guidance from this Guideline in considering whether there has been an act or omission likely to be prejudicial to the interests of policy holders or potential policy holders (albeit the IA will always take account of the full context, facts and impact of any matter before it in this respect).

3.4 This Guideline should be read, where appropriate, in conjunction with the relevant provisions of the Ordinance and all other relevant rules, codes, circulars and guidelines issued by the IA or other regulatory bodies, including but not limited to the following:-

(a) Guideline on the Corporate Governance of Authorized Insurers (GL10) issued by the IA;

(b) Code of Conduct for Licensed Insurance Agents issued by the IA; and

(c) Code of Conduct for Licensed Insurance Brokers issued by the IA.

4. Responsibilities of Board of Directors, Individual appointed as Controller and Senior Management

4.1 Authorized insurers should put in place policies and procedures on the fair treatment of customers in relation to medical insurance business and they should ensure that the principle of treating customers fairly is an integral part of their business culture.

4.2 The board of directors of an authorized insurer (the "Board") is responsible for maintaining general oversight over the implementation of measures in compliance with this Guideline and is ultimately responsible for ensuring fair treatment of customers. The individual appointed as controller of the insurer is responsible for ensuring that applicable requirements set out in this Guideline are observed throughout the life cycle of a medical insurance policy. The senior management of the insurer is responsible for formulating relevant business practices for the fair treatment of customers. This involves putting in place measures which encourage attitudes and behaviour of the insurer's staff and licensed insurance intermediaries (if applicable), such that they consider matters from the customer's viewpoint. Such measures should include:

(a) demonstrating the commitment by the Board, the individual appointed as controller and the senior management to the fair treatment of customers;

(b) devising a management information framework for the Board to measure the performance of the insurer and its licensed insurance agents with respect to fair treatment of customers;

(c) establishing mechanisms and controls to ensure that deviation from corporate policies and procedures, or any other acts or omissions that may jeopardise the fair treatment of customers, are promptly identified, escalated to the appropriate level of management and remedied;

(d) providing appropriate and regular training to the relevant licensed insurance intermediaries and the insurer's staff so that they can exercise care, skill and diligence in carrying on regulated activities in relation to, and are competent to provide regulated advice on medical insurance products; and

(e) implementing a performance evaluation and remuneration structure that includes, as one of its benchmarks, the fair treatment of customers (so as to encourage such fair treatment).

5. Product Design

5.1 Authorized insurers should take into account the interests and needs of different types of customers when developing medical insurance products. Before launching a medical insurance product to the market, insurers should carry out a diligent review of the product by making reference to their business models; the applicable law, regulations and rules (including but not limited to the Product Compliance Rules under the Ambit of the VHIS published by the FHB); and their risk management approach. In particular, insurers should put in place appropriate policies, procedures and controls to enable them to:

(a) design a medical insurance product that seeks to meet the identified needs and the expectation of the target customer base;

(b) price a medical insurance product reasonably taking into account the sustainability of the product; and

(c) adopt channels of distribution which are aimed at targeting the identified target customers.

6. Sales Process

6.1 After launching any medical insurance product (i.e. making a medical insurance product available for purchase by customers), an authorized insurer should monitor the processes by which the product is distributed against the requirements set out in this section, with a view to ensuring customers are treated fairly during the selling process. Licensed insurance agencies and licensed insurance broker companies should also monitor the processes by which they distribute medical insurance products against the requirements set out in this section, with a view to ensuring customers are treated fairly during the selling process. If, through these monitoring processes, the insurer, licensed insurance agency or licensed insurance broker company (as the case may be) identifies any shortfall from the requirements in this section, they should take appropriate remedial action(s).

Recommending Products that Suit Needs of Customers

6.2 Authorized insurers and licensed insurance intermediaries should assess the insurance needs of customers and recommend suitable medical insurance products to them.

Providing Product Information to Customers

6.3 Authorized insurers should ensure their product information in relation to each of their medical insurance products contains clear and adequate information to enable customers to make informed decisions with respect to whether products are suitable for their (i.e. the customers') needs. The information should include, without limitation, the following:

(a) a statement displayed at a prominent position in the sales materials (e.g. product brochure, online promotional information) stating that

the product information does not contain the full terms of the policy and the full terms can be found in the policy document;

(b) the name of the insurer;

(c) the type of medical insurance product (e.g. critical illness, long term care benefit or IHIP) and its coverage;

(d) key features including but not limited to benefits of the product (e.g. the principle of indemnity, waiting period, etc.);

(e) key or unusual exclusions (e.g. pre-existing conditions, specific medical procedures, etc.);

(f) period of cover;

(g) price information (e.g. VHIS premium schedule);

(h) customers' rights under cooling off period, if any;

(i) existence and duration of the right of cancellation;

(j) renewal of the policy (e.g. circumstances under which guaranteed renewal is granted, insurer's right to revise the terms and conditions, etc.);

(k) migration arrangement from a non-VHIS-compliant policy to a VHIS-compliant policy, if applicable;

(l) eligibility for tax deduction (only applicable to VHIS-compliant policies); and

(m) option for customers, if any, to purchase the medical insurance product as a standalone plan instead of bundling with other type(s) of insurance product. Similar to (a), this information should be displayed at a prominent position in the sales materials.

6.4 Authorized insurers and licensed insurance intermediaries should ensure that product information is communicated to customers before and at the point of sale in a clear and fair manner and in a way that is not misleading.

Explaining Key Features and Terms and Conditions of Policies

6.5 Authorized insurers and licensed insurance intermediaries should ensure that a clear explanation of the key features and terms and conditions of medical insurance policies is provided to customers in plain language for their easy understanding. Examples of the key features and terms and conditions include, to the extent applicable:

(a) coverage under the policy;

(b) key or unusual exclusions (e.g. pre-existing conditions, specific medical procedures, etc.);

(c) benefits and features including healthcare provider networks;

(d) potential increase in premiums, factors leading to such increase, frequency and timing of premium adjustment and/or potential changes to benefits or other policy terms at renewal;

(e) implication on pre-existing conditions and other implications when switching from one policy of an insurer to another including switching from a group plan to an individual plan and from a non-VHIS-compliant policy to a VHIS-compliant policy;

(f) any requirement for obtaining pre-approval from insurers before receiving medical consultations or treatments;

(g) procedures for making claims and terminating policies;

(h) requirement to make full disclosure in response to an insurer's questions and the consequences of not making full disclosure;

(i) limits of indemnity for benefits, "Reasonable and Customary" clause, amounts of excesses, deductibles, retentions, coinsurance or other policy/benefits limits and how these features will be applied; and

(j) other significant insurance clauses (e.g. double insurance, medically necessary and termination clause), if any.

6.6 Where an authorized insurer directly distributes its medical insurance products through digital channels (e.g. webpage/mobile apps), the insurer should be in a position to demonstrate to the IA upon request that the requirements of this Guideline are complied with.

6.7 With regard to the sale of VHIS-compliant policies, authorized insurers and licensed insurance intermediaries should, in addition to the information referred in paragraphs 6.3 to 6.5 above, provide a clear explanation to customers in relation to the following:

(a) unique product features of VHIS-compliant policies;

(b) differences between a Standard Plan and a Flexi Plan, where both types of plans are offered to customers;

(c) eligibility for tax deduction for the relevant premiums paid under VHIS Certified Plans[1]; and

(d) migration arrangement from a non-VHIS-compliant policy to a VHIS-compliant policy, if applicable.

Offering of Gifts to Customers

6.8 Authorized insurers and licensed insurance intermediaries should not directly or indirectly offer Gifts to individual customers when marketing, promoting or distributing medical insurance products, unless the requirements in paragraph 6.9 are satisfied.

6.9 A Gift for the purposes of paragraph 6.8 may be offered or made to an individual customer only if, according to a reasonable assessment made by the authorized insurer or licensed insurance intermediary, the Gift would not distract the customer from making an informed decision on whether or not to purchase the medical insurance product. Accordingly, the responsibility lies with an authorized insurer and licensed insurance intermediary to make an assessment as to whether, in their reasonable

[1] Care should be taken not to give undue emphasis on this feature to avoid distracting customers' attention from the suitability, features and risks of VHIS Certified Plans.

opinion, the proposed Gift would distract a customer from making an informed decision. In making such assessment, the authorized insurer or licensed insurance intermediary should take account of all the circumstances in which the Gift is proposed to be offered or made (including the value of the Gift relative to the amount of premium payable by the customer in relation to the product and the manner in which the Gift is to be marketed or offered). This assessment may be made either on a case-by-case basis or, if Gifts are to be offered or made as part of a marketing campaign or programme, at the time the marketing campaign or programme is formulated.

6.10 The restrictions in paragraphs 6.8 and 6.9 also apply:

(a) in relation to the marketing, promotion or distribution of a range, group or collection of insurance products, where one or more of those insurance products is a medical insurance product; or

(b) in relation to the offering or provision of any Gift by an authorized insurer to a licensed insurance broker representing a customer.

Permitted Gifts

6.11 As an exception to paragraphs 6.8 to 6.10 above, authorized insurers and licensed insurance intermediaries which offer medical insurance products may offer Permitted Gifts as shown in the Annex, provided that the criteria referenced in the Annex in relation to each Permitted Gift is strictly adhered to.

Premium Rebates and Commission Rebates

6.12 Rebates of premiums or commissions should not be offered or paid to customers in relation to medical insurance products.

6.13 Paragraph 6.12 does not apply:

(a) in relation to any rebates of premium which are recorded in the contract of medical insurance, whether in the medical insurance policy, the policy schedule, the quotation or offer letter, or in any promotional material (the terms of which are incorporated by reference into the contract of medical insurance); or

(b) in relation 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.

Ensuring Competency of Licensed Insurance Intermediaries

6.14 An authorized insurer, licensed insurance agency and licensed insurance broker company should:

(a) ensure that persons (including staff) who carry on regulated activities (as specified in Part I of Schedule 1A to the Ordinance) in relation to the insurer's medical insurance business should comply with the statutory licensing requirements (i.e. if they carry on regulated activities they should either be licensed or fall within one of the exemptions stated in the Ordinance);

(b) ensure that their staff and licensed individual insurance agents, licensed technical representatives (agent) or licensed technical representatives (broker) (as the case may be) have the knowledge and skills in relation to the medical insurance products in order to provide quality and timely advice to customers; and

(c) provide quality and ongoing training on medical insurance business and product features to such persons as referenced in paragraph 6.14(a) above.

7. Claims Handling

7.1 When dealing with claims from policy holders, authorized insurers should:

(a) handle and settle claims fairly and promptly; and

(b) provide customers with sufficient information and timely advice about the claims-handling process and clear explanations in plain language on claim results.

7.2 Where claims handling has been outsourced, authorized insurers should ensure that:

(a) the service providers are aware of and fulfil the insurers' obligations to treat customers fairly including but not limited to fulfilling the obligations referred in paragraph 7.1 above; and

(b) the insurers have appropriate systems and controls in place to monitor the service standards of the relevant service providers with respect to the compliance of this Guideline and the Scheme Documents issued by the FHB from time to time.

8. After-sales Service

8.1 As part of the after-sales service, upon a policy holder's request, authorized insurers and licensed insurance intermediaries should review the continued suitability of the medical insurance policy/policies in meeting policy holder's needs and provide such review to the policy holder making the request.

8.2 Where significant changes are to be made to the features and terms and conditions including but not limited to premiums, benefits, new exclusions etc. of medical insurance policies at renewal or while the policies are in effect (if changes can be made while such policies are in effect), authorized insurers should give sufficient advance written notice to inform the policy holders of such changes prior to the renewal date of the policy or the date on which such changes become effective. Where the renewal is being

handled by a licensed insurance intermediary, the authorized insurer should also provide the licensed insurance intermediary with such advance written notice. The changes, and the reasons for the changes, as well as the alternative option(s), if any, should be clearly explained in the written notice. Authorized insurers and licensed insurance intermediaries should also properly address any follow-up queries which customers have arising from the changes.

8.3 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.

8.4 Should a policy holder make an enquiry on the eligibility of a claim and reimbursement limit according to the terms and conditions of his/her medical insurance policy before he/she undergoes a treatment or procedure, the authorized insurer and/or licensed insurance intermediary should provide timely and suitable advice to the policy holder. To this end, authorized insurers should set a service pledge on the response time to such enquiries.

9. Complaints Handling

9.1 Authorized insurers and licensed insurance intermediaries should, upon customers' requests, provide them with information on complaints handling, including the channels (e.g. the insurers', insurance agencies' or insurance broker companies' complaint hotlines (as relevant) and the contact details of the Insurance Complaints Bureau) and procedures for making complaints. Authorized insurers, licensed insurance agencies and licensed insurance broker companies are encouraged to display such information in such a way that is easily accessible by customers, e.g. on their websites.

9.2 Authorized insurers, licensed insurance agencies and licensed insurance broker companies should:

(a) have formal complaints handling policies and procedures to ensure that complaints are handled fairly, effectively and promptly;

(b) set service standards for complaints handling;

(c) review the complaints properly;

(d) properly address any problems identified in the process of handling complaints;

(e) provide their findings, complaint assessment reports, any other relevant information and/or remedial actions to the IA and other relevant regulatory authorities (where applicable) upon request; and

(f) have policies or guidelines which set out clearly the circumstances under which complaints should be escalated to the individual appointed as controller and the senior management of the insurers, or the responsible officers and the senior management of licensed insurance agencies or licensed insurance broker companies (as the case may be).

10. Proper Handling of Customers' Personal Data

10.1 Authorized insurers and licensed insurance intermediaries should, at all times, exercise due care and diligence in collecting, handling, storing, using, transferring and erasing customers' personal data.

10.2 Authorized insurers and licensed insurance intermediaries should comply with the Personal Data (Privacy) Ordinance (Cap. 486), the Guidance on the Proper Handling of Customers' Personal Data for the Insurance Industry issued by the Office of the Privacy Commissioner for Personal Data ("OPC") or any relevant rules, codes, circulars and guidance issued by the OPC from time to time.

11. Voluntary Health Insurance Scheme-Compliant Policies

11.1 In addition to the requirements in this Guideline, authorized insurers underwriting VHIS-compliant policies and their licensed insurance agents should also comply with the requirements set out in the Scheme Documents issued by the FHB from time to time.

12. Commencement

12.1 This Guideline shall take effect from 23 September 2020.

November 2019

Annex

Permitted Gifts

(a) Gifts that are offered for "relationship building" purposes and are not tied to the marketing, promotion or distribution of any medical insurance product.

(b) Gifts that can be redeemed at a later date under a customer loyalty programme through the accumulation of points provided that the number of points earned is not directly or indirectly linked to the volume or value of sales (or both) of any medical insurance product or, in the case of a licensed insurance broker, are not directly or indirectly linked to the distribution volume or a pre-determined level of sales of any medical insurance product.

(c) Provision of sponsorship and support for customer information seminars, compliance support and financial planning software. The level of sponsorship and support should not be in the form of subsidy or cash equivalents and should not be directly or indirectly linked to the distribution volume or a pre-determined level of sales of any medical insurance product.

(d) Brand building campaigns such as lucky draws that are open to all policy holders and potential policy holders and are not tied to the marketing, promotion or distribution of any medical insurance product.

(e) Ancillary services that are relevant and reasonably found in medical insurance products at no extra charge, such as medical check-ups, medical consultancy services or emergency SOS services.

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