Singapore Actuarial Society
Annual Report on Healthcare Provision and Financing

National Medical Programme for All Singaporean Citizens and Permanent Residents

The **MediShield Scheme** was launched for Singaporean citizens and PR's on July 1990 who were members of the Central Provident Fund, and who could pay premiums using funds in their CPF MediSave accounts. For 15 years, MediShield's coverage/benefit limits and premium rates were unchanged. In view of medical inflation, the current benefit limits were inadequate to cover costs for hospitalisation. In addition, the CPF Board, which underwrites this insurance programme, was sustaining losses due to increasing medical claims while maintaining the same premiums and, at the same time, the Scheme was suffering from 'cherry-picking' of good healthy lives by the private insurers. Therefore, the government made a bold decision to cover all lives, including those in the private insurers' pools in order to prevent 'cherry-picking'. In addition, the CPF Board increased the basic Medishield benefit limits and premium rates in order to ensure that the Medishield Scheme, together with the members' MediSave funds, could cater to the cost of hospitalization of members who are admitted to either public or restructured hospitals class B2 or lower wards. The other key consideration was to ensure that the MediShield plan continued to cover catastrophic medical treatment that entailed long duration stays in hospitals.

This change took effect from 1st July 2005 and all private insurers who wish to participate in this **Integrated Private Medical Insurance Scheme (IPMIS)** must abide by the rules and regulations governing this programme. The MediShield plan will provide the basic cover to all who purchase any policy approved under the IPMIS; while the private insurers will offer enhancement plans. These enhancement plans offer more comprehensive coverage to cater for stays in a higher class wards of government or restructured hospitals, or even in private hospitals. The premium for a policy under the IPMIS may be paid from the members' CPF MediSave accounts, and the excess of the premium over the then current limit of $660 per annum may be paid using cash.

One of the changes made to the MediShield Scheme benefits was the imposition of pro-ration factors. These pro-ration factors are applied to actual medical charges to ensure equity in benefit payment if members stay in a higher ward class than that for which the Medishield Scheme was designed and priced for. The approach is to pro-rate the claimable medical charges downwards before applying the benefit limits. The pro-ration factor for the MediShield Scheme is 28% of private hospital or class A ward charges, and 35% of class B1 ward charges.

Some key requirements for a private insurer's medical insurance plan to be approved under the IPMIS or the integrated MediSave-approved medical insurance scheme, as it is sometimes known as, are as follows:

1. The plan must be bundled together with the MediShield Scheme and offered as a single integrated plan.
2. Policyholders of the integrated plans will be reimbursed the higher of the benefits computed under the integrated plan or under the MediShield Scheme.
3. Co-insurance must not be less than 10%
4. Deductibles will be based on type of ward rather than plan type. The required minimum deductibles are as follows:
    - Private Hospitals or Ward A of public/restructured hospitals - $3,000
    - Ward B1 of public/restructured hospitals - $2,000
    - Ward B2 of public/restructured hospitals - $1,500
    - Ward C of public/restructured hospitals - $1,000
5. Policy must be guaranteed renewal, but premiums need not be guaranteed.
6. There will be no waiting period for the treatment of both sickness and accident injuries.

There were 4 insurers participating in the IPMIS prior to the revision. With this new joint insurance arrangement with the CPF Board, one insurer decided not to participate in the IPMIS, while two other insurers joined in. Details of the participating insurers' plans (as at **1 May 2006**) are given in in **Appendix 1** and can also be found on this website:

www.moh.gov.sg

All members covered under the existing scheme must convert their policies into policies under the IPMIS by 30th Jun 2007 . Otherwise , these members will have to pay the premiums on their existing policies in cash rather than from their CPF MediSave accounts.

In order to meet the needs of the aging population as well as address the problems of increasing longevity, the Ministry of Health announced further changes to how CPF Medisave funds can be used to finance insurance under the IPMIS. Starting from 1st Jan 2006, the maximum amount that can be withdrawn from an individual CPF Medisave account was raised from $660 to $800. In addition the maximum age at which premiums may be paid out of CPF Medisave accounts was increased from 80 to 85 years (on age next birthday basis).

There are currently an estimated 2.7m lives insured under all policies approved under the IPMIS.

The premiums for all basic medical insurance plans underwritten by both life and general insurers are subject to Goods and Service Tax (GST). The current GST rate is 5%. In addition, almost all private medical bills are also subject to the 5% GST. This implies that policyholders will have to pay taxes on both the premiums and claims; resulting in a double taxation effect. This goes against the government objective of promoting individual health insurance plans and, at the same time, further increases the medical inflation. If health insurance premiums are not subject to GST, I believe the promotion and marketing of health insurance will be further enhanced and this will make Singapore a key regional player in healthcare.

Caring for the Elderly

In addition to arranging for the provision of hospitalization insurance coverage for all Singaporeans, the government also introduced an insurance scheme to provide financing for care of the elderly. This scheme called ElderShield was mentioned in the first SAS healthcare report issued in 2002.

The **ElderShield Scheme** started on 30 September 2002 and was underwritten by 2 local insurers rather than through a government body, like the CPF Board. The view was that the insurers were in a better position to handle claims and were more cost-effective and responsive. This is an opt-out programme where any eligible person over the age of 40 is automatically covered unless he writes to his assigned insurer to opt out. Only Singaporean citizens and permanent residents are eligible for insurance under this ElderShield Scheme. As this is an opt-out scheme, there is no underwriting. However, if the person opts out and later wishes to re-join the Scheme, underwriting will then be required.

The ElderShield Scheme pays monthly cash benefit of $300 for up to a maximum of 60 months if the insured is unable to perform at least 3 out of the 6 defined Activities of Daily Living. These 6 Activities of Daily Living are washing, dressing, feeding, toileting, mobility and transferring. The $300 monthly cash benefit can be used to pay for any expense such as home nursing services charges, day rehabilitation fees, medical bills, household expenses or charges for nursing home stays.

There are currently about 700,000 Singapore residents insured under the ElderShield Scheme. The initial take-up rate for this programme was around 60%, which was quite low considering that this is an opt-out scheme. The take-up rate in this context is defined as the percentage of eligible residents who did not opt out of the Scheme. One reason for the low take up rate is probably due

to residents switching between the two insurers. If a resident switches insurer (i.e. opts out from one insurer's plan), then this will reduce the take-up rate. The take-up rate for those residents who only reach age 40 after the launch of the Scheme is close to 80%, a much higher rate than that of the initial cohort.

The premium for this plan is paid using the resident's CPF MediSave account funds. Any individual over 40 years of age can either opt to pay regular premiums (which are payable to age 65) or to pay a single premium. An extract of the latest LIA report show that the number of eligible residents opting to pay lump sum single premiums is less than 1.4% of the total number of insured residents.

The regular premium is based on the entry age and does not increase automatically with attained age. The premium rates are gender and age distinct. For a male aged 40, the regular premium is $148.84 while for a female of the same age, it is $190.63. The single premium for a male aged 40 is $2,325.39 and for a female aged 40 is 3,021.75. The full set of premium rates can be found in **Appendix 2**. The premiums are not guaranteed but can only be adjusted once every 5 years based on actual claims experience. The maximum increase at any one time is 20% of the existing premium rate, if an upward adjustment is required.

Since this programme started 3 years ago, there have been about 1,400 claimants who have successfully benefited from this Scheme. The claims success rate is about 82% (that is, the percentage of those receiving claims over those who claimed). The high success rate may be attributable to the significant training and education process by the media on the eligibility of claims.

The setting up of the ElderShield programme was definitely a step in the right direction by the government to offer some cash assistance for those elderly who are unable to care for themselves. Putting the Scheme, a national programme, on an opt-out basis prevents discrimination against those who need the insurance most. At the same time, all or most lives over 40 years old will be covered individually. This is in line with government's objective of promoting personal responsibility for one's health; relying on market forces to improve services and managing the cost structure of this programme.

As mentioned in the first SAS report, the $300 monthly benefit is not sufficient to meet the needs of a disabled elderly. In fact, hiring a skilled nurse will cost more than $700 a month (not taking into account the monthly foreign workers' levy, if the nurse has to be brought in from overseas). The cost of nursing home stay ranges from $1,000 up to $5,000 per month and this monthly cost is increasing. Certainly other sources of fund, either from children, insurance, savings, or maybe social welfare, will be needed to care for the disabled elderly.

The entry age for this scheme is 40 years old. In the US, long-term care is a major growing insurance business. The average age of entry there is around 68 years old. It is also the same for UK and other developed countries. A person at age 40 may not envision the need for buying into this plan, considering the likelihood for the earliest claim would be around ages in the late 70's. This may probably explain why the take-up rates for both the initial and the on-going cohorts were less than 100%.

In view of the two issues mentioned above, there is certainly an opportunity for other private insurers to offer more comprehensive long-term care plans. These plans may well pay a higher $ amount or even cover the actual cost of nursing home stays, and may offer first time coverage to those over 65 years old when they can actually envision the need for such insurance .

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