MINISTRY OF HEALTH
SINGAPORE

Public-Private Health Insurance Partnership in Singapore

Monday 7 June 2010

Singapore

Resident population : **3.73m (2009)**
- 17.9% below 15 years
- 73.3% aged 15-64 years
- 8.8% aged 65 years and above

Land Area: **710 sq. km**

GDP per capita: **S$53,143 (2009)**

Life expectancy at birth (2009):
79 for males, 83.7 for females

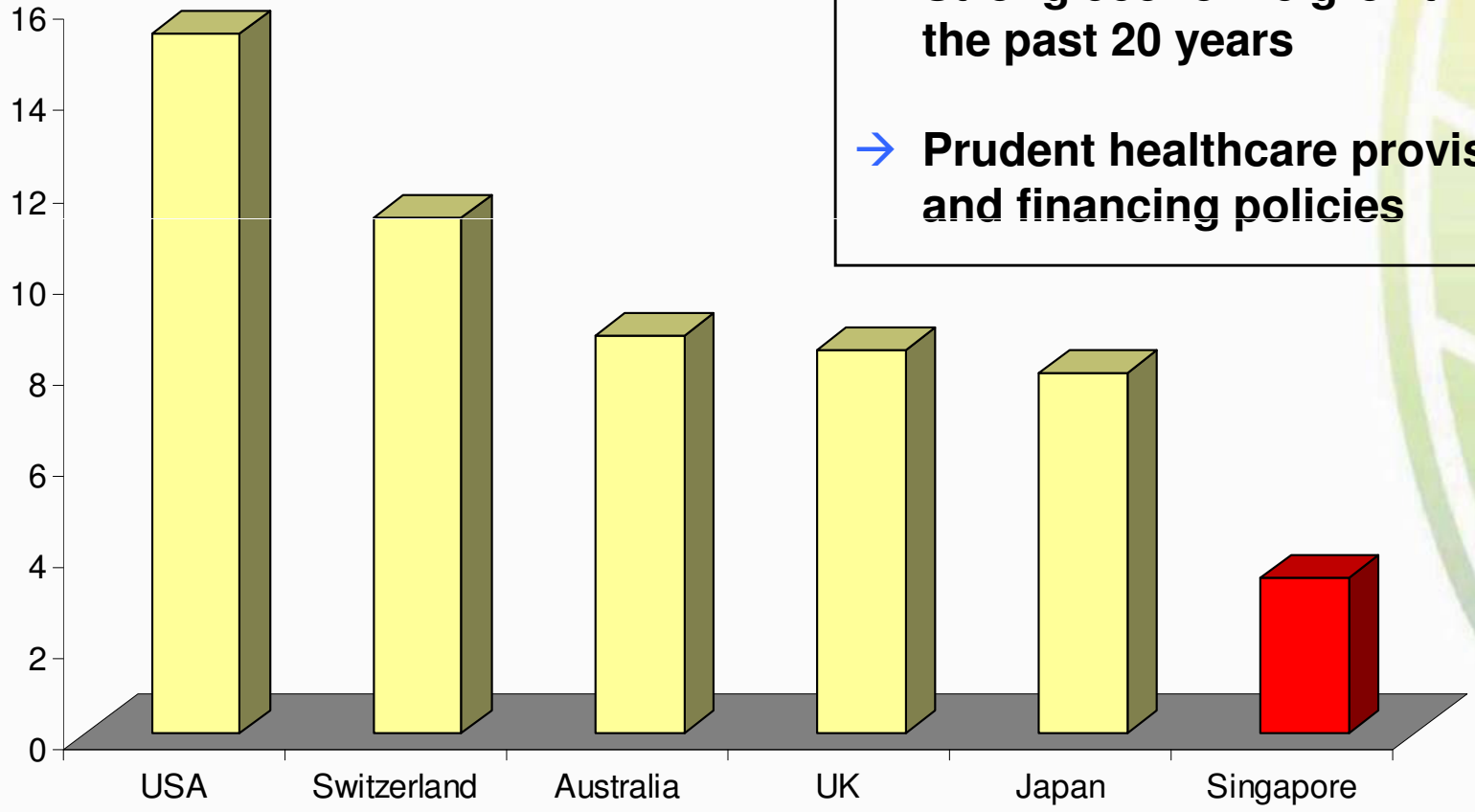
Unemployment rate: **3.3% (2009)**

Healthcare expenditure as % of GDP: **4%**

Sources: Singapore Ministry of Health; Department of Statistics

NHE low compared with others

Total Health Expenditure as % of GDP (2006)



- → **A relatively young population**
- → **Strong economic growth over the past 20 years**
- → **Prudent healthcare provision and financing policies**

But with good outcomes…

Internationally recognised for good outcomes, coverage and financial sustainability:

"What Singapore Can Teach the White House"—*WSJ, Oct 19 2009*

*In Singapore, by contrast, they already have **universal coverage**. They also have **world-class quality care at world-competitive prices**… Singapore's example might have something to teach them about the kind of reform Americans really need.*

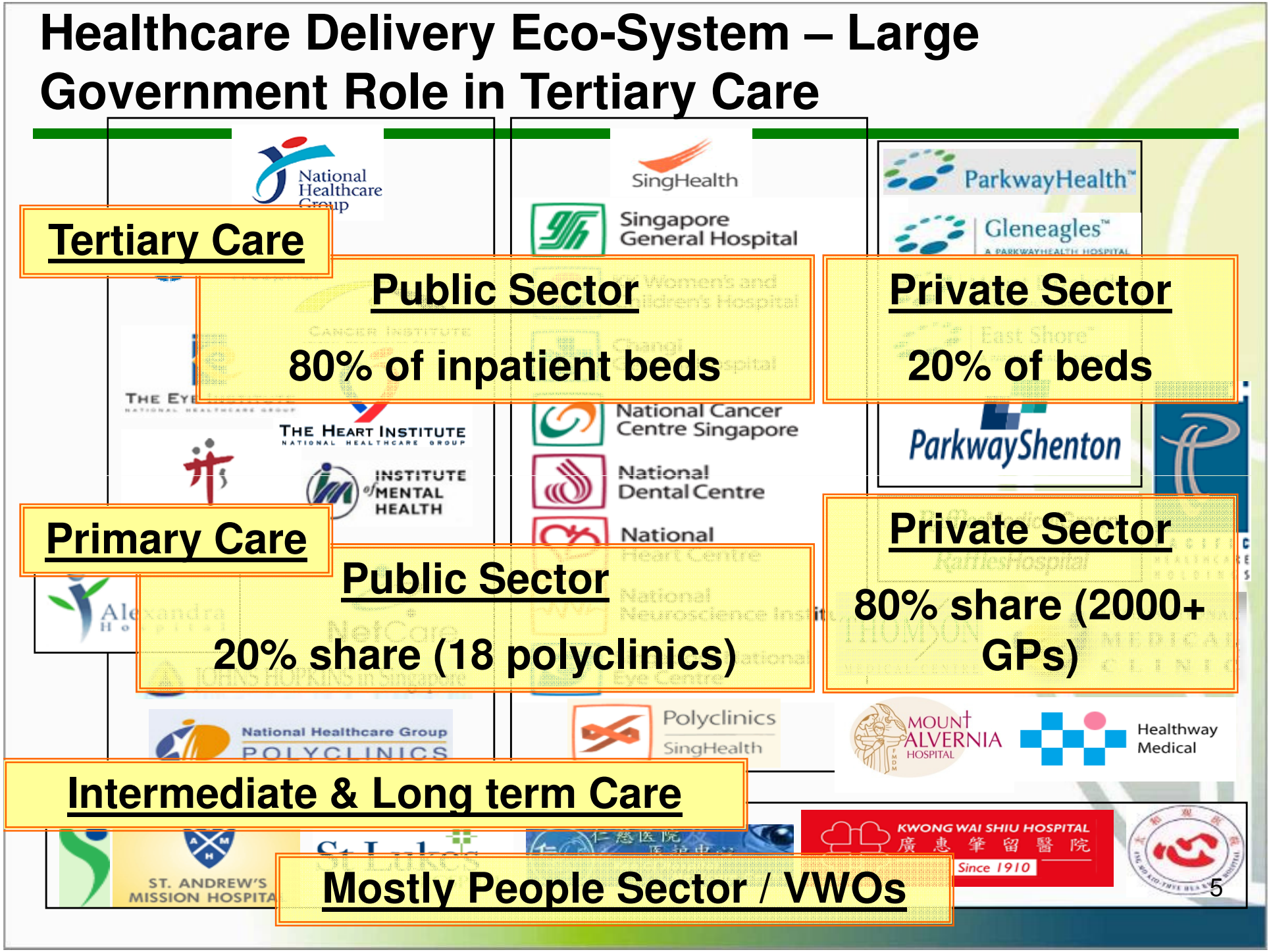
"What we can learn from Singapore's health-care model"—*Washington Post, Mar 3 2010*

*We interrupt Washington's feud over the president's "way forward" for a brief word on a path not taken, courtesy of **the only rich nation that boasts universal coverage with health outcomes better than ours** while **spending one-fifth as much per person on health care**. Introducing (drum roll please): Singapore.*

"Universal healthcare in Australia may become unaffordable"—*The Age, Mar 15 2010*

Two ways greater competition could be introduced into our health system without compromising care would be to change Medicare to a **health-savings-based system** and to **allow public and private hospitals to compete for patients** irrespective of their insurance status. Singapore has such a system and spends less than 4 per cent of GDP on health - far less than Australia (9.7 per cent) and the US (15.4 per cent).

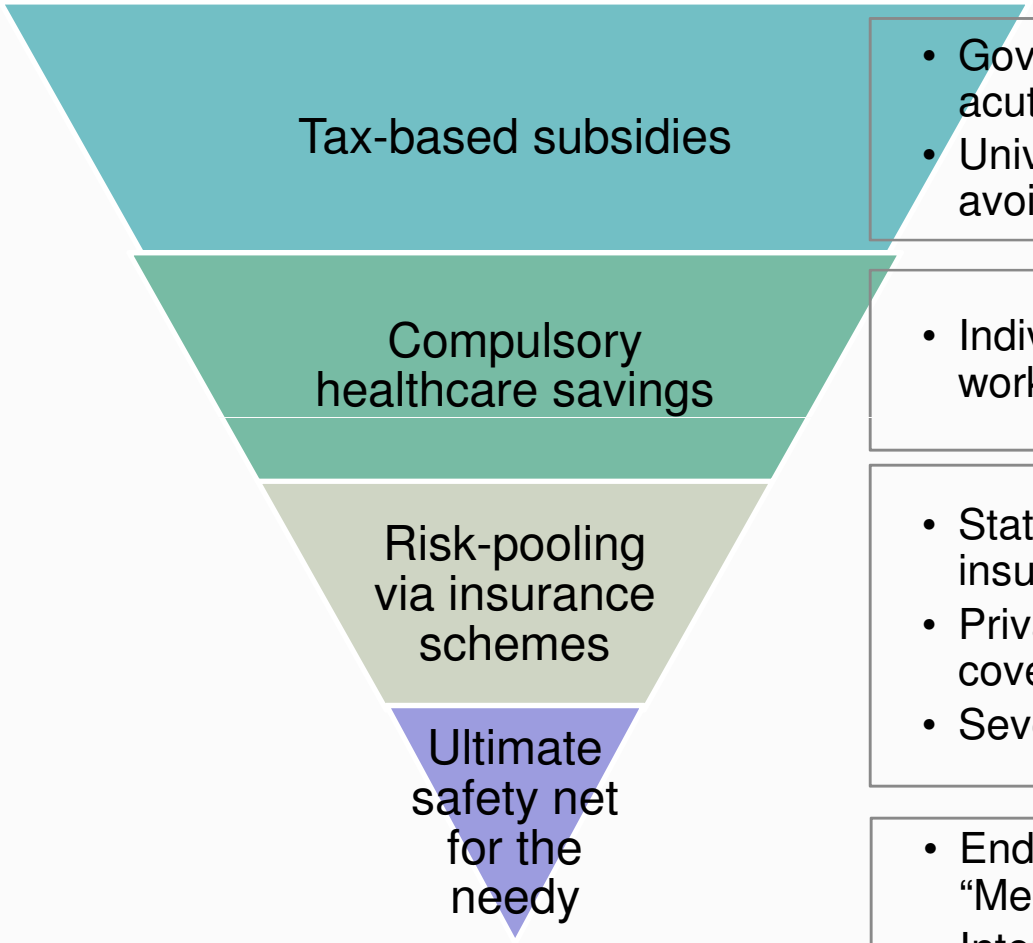
Healthcare Delivery Eco-System – Large Government Role in Tertiary Care



Singapore's healthcare financing philosophy

- **Universal healthcare coverage, anchored on twin philosophies of:**
  - ***Affordability and accessibility of basic healthcare***
    - Heavy subsidies for basic services (primary, acute and step-down care)
  - ***Individual responsibility***
    - Co-payment by individuals
    - Risk-pool for catastrophic illnesses, without undermining the need for individual responsibility and patients' desire for choice.
- **Minimise market distortions**, allow market mechanism to function
  - Private and public sector provision in all healthcare sectors
  - Free choice of providers

Universal coverage through multiple layers of protection



- Government subsidies across primary, acute, rehabilitative and nursing settings
- Universal access, but no 100% subsidy to avoid over-consumption

- Individual medical savings accounts for all workers – “Medisave”

- State-run, low-cost catastrophic health insurance scheme – “MediShield”
- Private health insurance for additional coverage – “Integrated Shield plans”
- Severe disability insurance – ElderShield

- Endowment fund set up by government – “Medifund”
- Interest income generated goes towards assisting the most needy

Government Subvention

- Means-tested subsidies of up to 80% in acute setting, up to 75% in step-down setting (e.g. community hospitals, nursing homes)
- S$2.2 b for direct patient subsidies for FY10
- Means-testing introduced so that subsidies are better targeted at lower-income group
  - Acute means-testing introduced in Jan 2009, step-down means-testing introduced in 2000
  - But acute patients retain choice of ward class

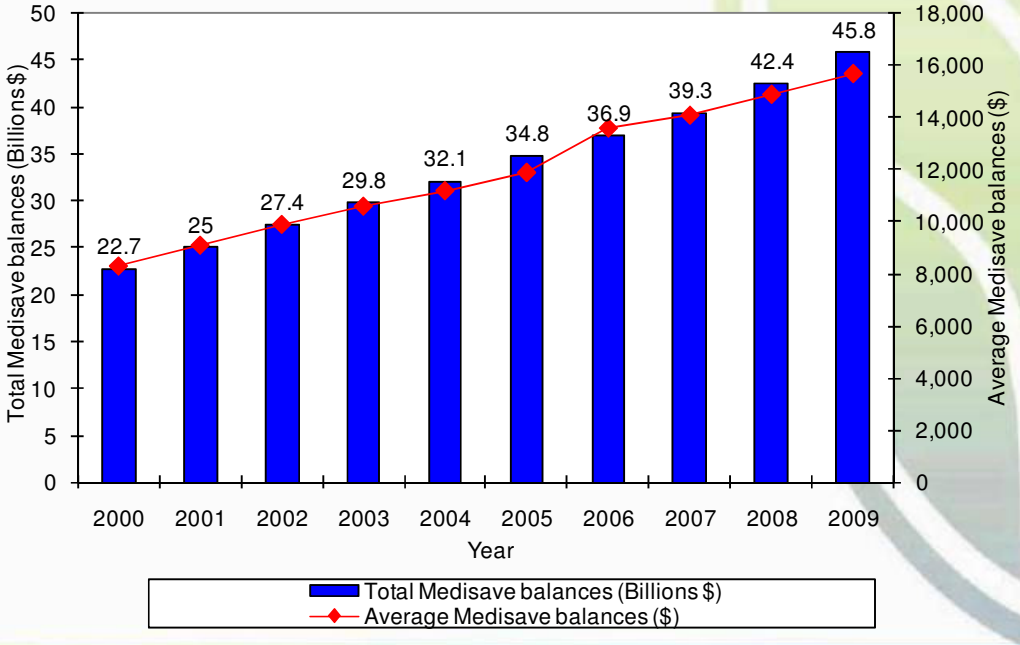
Monthly Income	Class C Subsidy	Class B2 Subsidy
$3,200 and below	80%	65%
$3,201 - $3,350	79%	64%
$3,351 - $3,500	78%	63%
…	…	…
$5,001 - $5,100	67%	52%
$5,101 - $5,200	66%	51%
$5,201 and above	65%	50%

Medisave

- Compulsory medical savings scheme introduced 1984
- Everyone who works will have a Medisave account, part of CPF system
  - 6.5% ~ 9% of monthly salary goes into individual accounts, not pooled
- Singaporeans have set aside $46 billion in Medisave Accounts, around $15,700 per person

$15,700 can pay for:

- **10 x Class B2 hospitalisations, or**
- **11 x Class C hospitalisations**



Medisave

- Can be used to cover personal or immediate family's medical expenses after applicable subsidies, reducing out-of-pocket payments
- Earns annual interest rate of 4%
- Medisave can be used for:
  - **Hospitalisation charges**
  - **Step-down care**, e.g. community hospitals, hospices)
  - **Expensive outpatient treatment**, e.g. chemotherapy, renal dialysis
  - **Chronic disease management and vaccinations**
  - **MediShield/ElderShield premiums**

MediShield

- State run, low-cost, catastrophic insurance
  - Focus on subsidised care coverage
  - Additional coverage for middle/upper-income through private Integrated Shield Plans (IPs)

- Covers hospitalisation expenses and expensive outpatient treatment (e.g. kidney dialysis, chemotherapy, radiotherapy)

- Do not cover routine care, unlike most social health insurance schemes
  - Extremely affordable premiums, encourage Singaporeans to keep healthy rather than claim against insurance

Basic MediShield Premiums

Age Next Birthday	MediShield Yearly Premiums (S$)
1 to 30	33
31 to 40	54
41 to 50	114
51 to 60	225
61 to 65	332
66 to 70	372
71 to 73	390
74 to 75	462
76 to 78	524
79 to 80	615
81 to 83	1087
84 to 85	1123

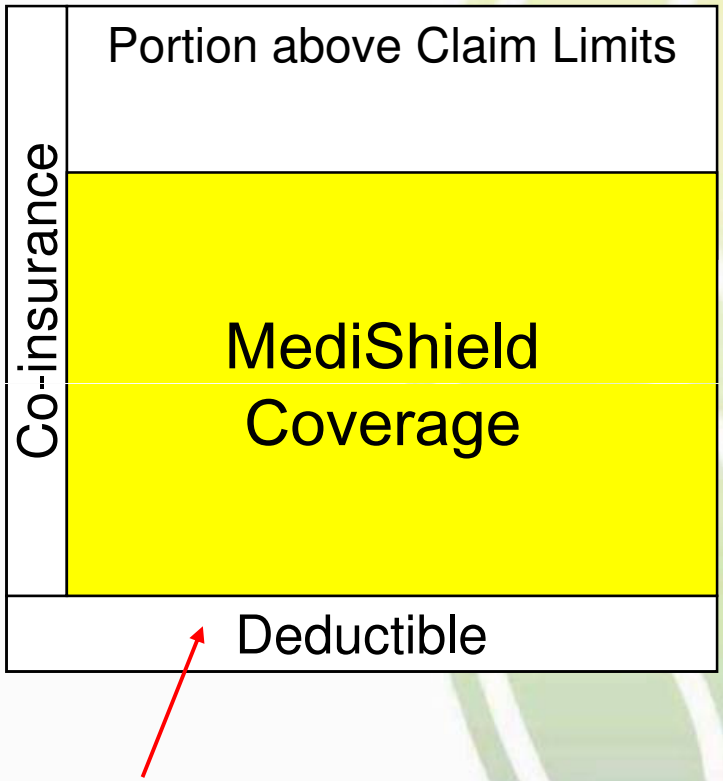
MediShield

Deductible

- Patient pays the first $1,500 / $1,000
- Pay small bills with Medisave/cash, to keep premiums affordable
- MediShield kicks in after the deductible

Co-Insurance

- MediShield pays majority of claim
- Patient pays small 10-20% co-insurance
- Reduces over-consumption and over-servicing, and avoids “buffet syndrome”



7 in 10 B2/C bills are all less than the deductible

Measures to maximise population coverage

- Facilitate automatic coverage wherever possible
  - At working age: upon first contribution to CPF
  - Marriage registration (introduced 2003): to reach out to non-working spouses (working spouse's Medisave to pay for premiums)
  - At birth (introduced Dec 2007): all newborn Singaporeans and permanent residents

Measures to maximise population coverage

- Autocover arrangement encourages participation, lowers administrative and enforcement costs of running a compulsory scheme
  - E.g. penalties for not participating, administration procedures to monitor participation

- Regular public messaging to raise awareness of benefits of MediShield and insurance

- Opt-out rates per cohort generally low, <5%

Private Medical Insurance in Singapore

- Employer Sponsored Plans (Group Plans)

- Individual Health Insurance Plans
  - Private Medisave-approved integrated Shield Plans (previously "PMIS")
  - Non Medisave-approved riders/supplements to private Shield IPs
  - Other Cash Plans

- Private Shield IPs most common
  - Strong Appeal of private Shield IPs: Key reason for popularity is the use of Medisave to pay for premiums, and portability (not tied to employer)

Development of private Medisave-approved insurance schemes

- The first Medisave-approved private insurance schemes were launched in July 1994
- Subject to a set of minimum guidelines from MOH
  - E.g. minimum deductibles to ensure focus on catastrophic expenses, co-insurance to reduce possible over-consumption
- Pre-2005 reform: growth in PMIS market from 47,000 policyholders in 1996 to 1 million in 2004

Consumer demand for private Shield plans

- Development of Integrated Shield further spurred by 2005 reforms:
  - Increased competition: resulting in wider coverage, lifetime coverage, removal of sub-limits (resulting in easier understanding of health insurance payouts)
  - Increased promotion by Government and industry

- Hassle-free electronic submission of hospital bills for Medisave, MediShield and IP claims

- Although many Singaporeans might have employer-provided insurance as well as have either MediShield or Private shield IPs
  - Reimbursement protocol in electronic claims submission process to prevent double-claiming

MediShield

MediShield Products	No. of Policyholders
Basic MediShield (without Integrated Shield Plan)	**1,370,000**
Basic MediShield + Integrated Shield Plan	**1,930,000**
Total Coverage	**3,300,000 (~88% of population)**

- Opt-out scheme; lower administrative and enforcement costs
- Those who want better insurance coverage can purchase Integrated Shield plans offered by private insurers

Policy Reforms: Evolution of MediShield and the Private health insurance market

MediShield Reform 2005

- Inadequate adjustments to MediShield
  - Erosion of benefits over time
    - MediShield payout reduced as claim limits had not been adjusted over time
    - Increasingly covering too many bills as deductibles eroded by inflation
  - 'Cherry picking' due to fragmented risk pools
    - Sub-optimal industry structure: private insurers pick and choose healthier and younger Singaporeans to insure
    - Without re-structuring, MediShield's risk pool would become progressively older and more sickly, this would give pressure to raise premiums to cover rising payouts

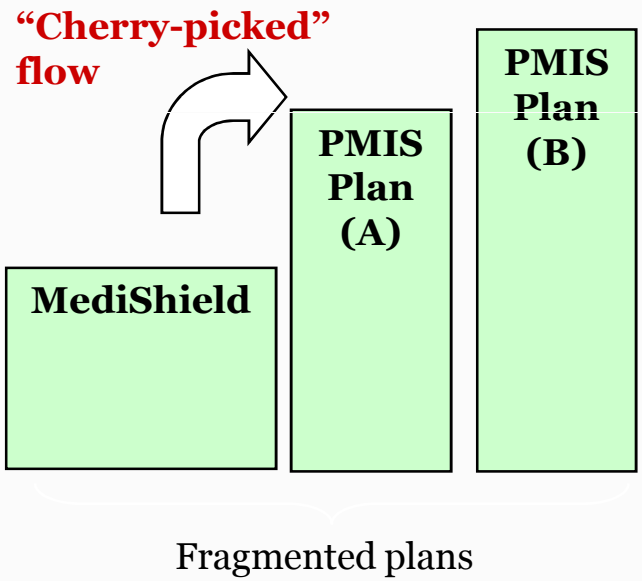
MediShield reform 2005

- Return to original purpose as a catastrophic insurance: look after large bills, and cover large bills adequately
  - Increase in claim limits
  - Increase in deductibles to refocus on large bills

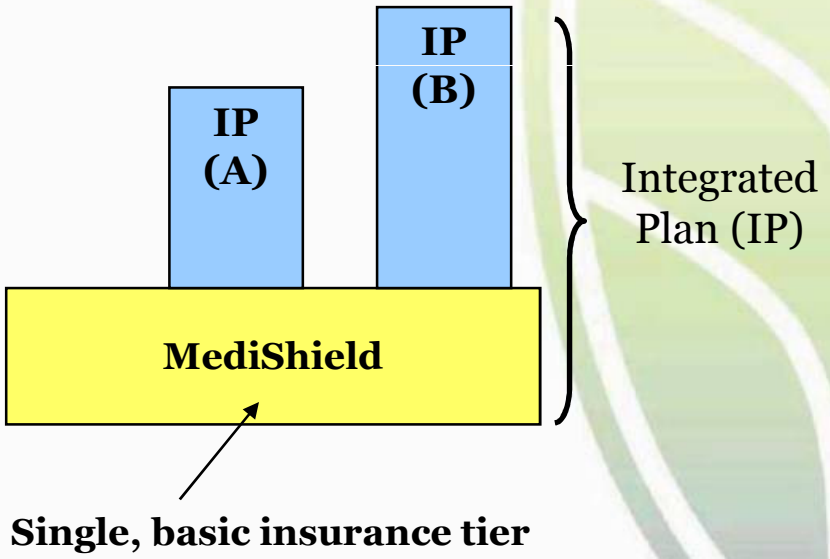
- Remove cherry picking and keep premiums affordable, but retain competitive market
  - Enlarge the pool of policyholders to maximise economies of scale and keep premiums affordable
    - Single MediShield risk pool, rather than fragmented across various insurers
  - Restructure PMIS plans as Integrated “Shield” Plans (IPs)
    - Extensive industry consultation between insurers and regulator
    - Integration with MediShield introduced as a condition for Medisave-approval of private plans
    - Maintain minimum deductibles/co-insurance for IPs so that they also focus on catastrophic expenses

MediShield reform '05 to tackle cherry-picking

Previous Sub-optimal Structure



Reformed Industry Structure



MediShield experience

Year	(A) Net Premiums Collected for the year (S$'000)[1]	(B) Claims Paid for the year (S$'000)[1]	Claims Ratio (B/A)
2001	95,503	58,838	0.62
2002	98,266	76,641	0.78
2003	98,688	76,788	0.78
2004	100,030	83,770	0.84
2005	185,902	87,739	0.47
2006	229,783	112,823	0.49
2007	238,899	137,362	0.57
2008	302,851	160,653	0.53

[1] Source : CPF Annual Report

MediShield changes in 2008

- Objective: further increase MediShield coverage from up to 60% to up to 80% of large bills of subsidised wards
- Increase in claim limits for inpatient stay, selected surgeries, implants, outpatient cancer treatment
- Further increase in premiums due to increased benefits

Public–private joint insurance arrangement

- Issues faced in 2008: first experience raising premiums for the whole MediShield market – basic and integrated parts of MediShield i.e. involving private insurers

- Changes to MediShield now affect private insurers because of the integrated structure
  - Increase in premiums for MediShield means insurers cede more of IP premiums back to CPF (due to joint insurance arrangement) because MediShield bears increased claims liability in steady-state
  - Profit margins vary from insurer to insurer – the increase in MediShield premiums affect private insurers' profitability in the short-term

Differing Perspectives

- Insurers' perspective: higher MediShield premiums erode margins
  - Affects profitability of their IPs

- Regulator's perspective:
  - Single risk pool for MediShield - both standalone MediShield as well as the basic tier of the IPs
  - With increased claim limits, MediShield fund has higher liabilities
  - Claims experience considered as a whole, all are paid from MediShield fund
  - Intent of 2005 reform to require integration of IPs with MediShield to remove 'cherry-picking'

Public-private joint insurance arrangement: Lessons learnt?

- Need for open channels of communications between insurers and regulator;
  - need for mutual understanding of issues faced by the other party
- Managing public expectations on reasons for premium increases
  - With private sector involvement, there is a need to manage communications and expectations through the agency distribution channel as well
  - Eventually, decision of whether to absorb or pass on increased premiums is up to the individual insurers
- Innovation in IP product offerings by private insurers

Public-private joint insurance arrangement: Lessons learnt?

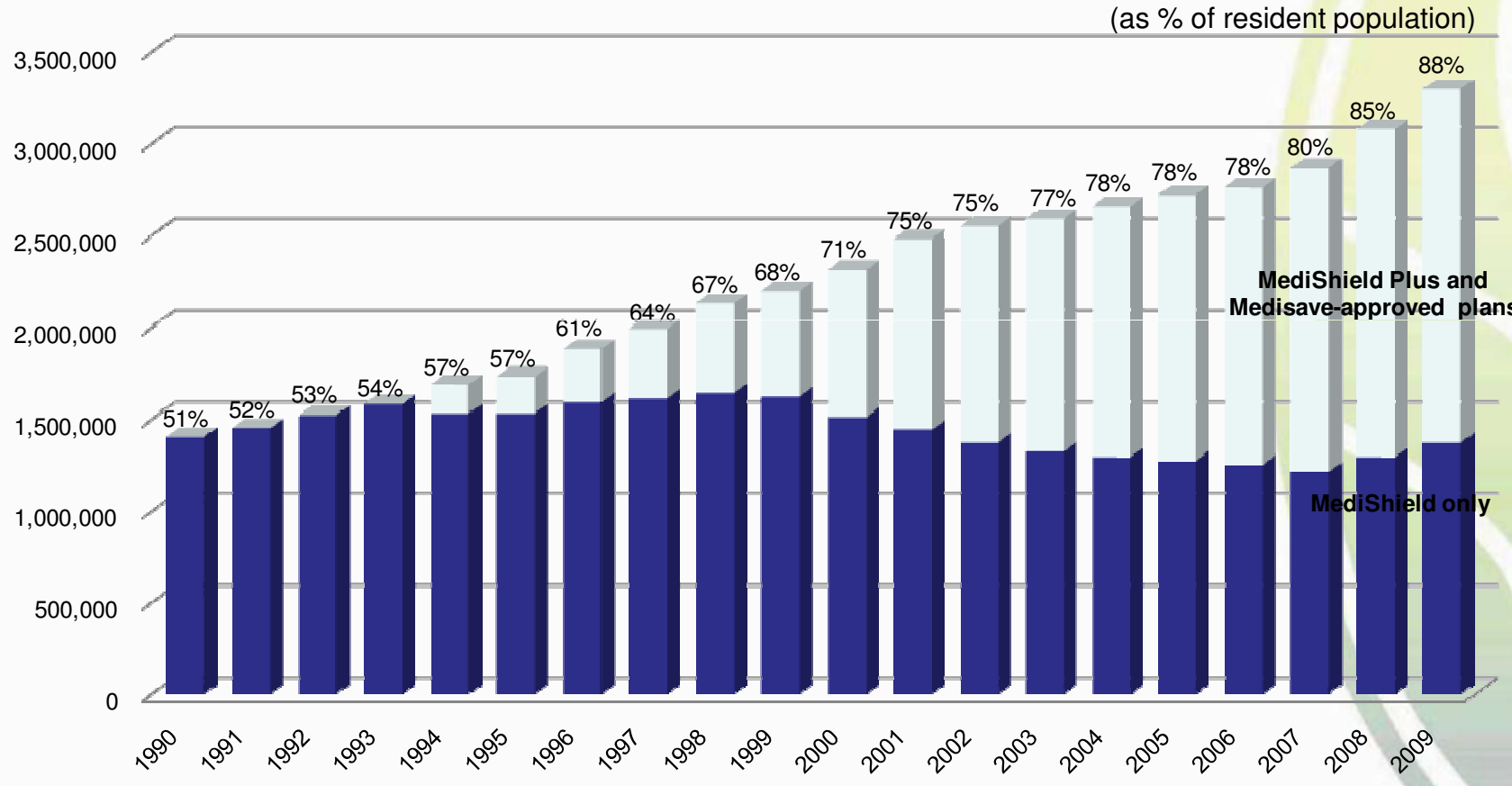
- Joint insurance arrangement means all parties must be clear of their respective scope of insurance coverage
  - MediShield focus on subsidised treatment
  - IPs encouraged to provide higher reimbursement levels for those willing to pay;
  - MOH shares in public messaging efforts to encourage mid- to higher-income groups to purchase IPs

Experience of MediShield and the reformed Shield plans

Growing the IP Market

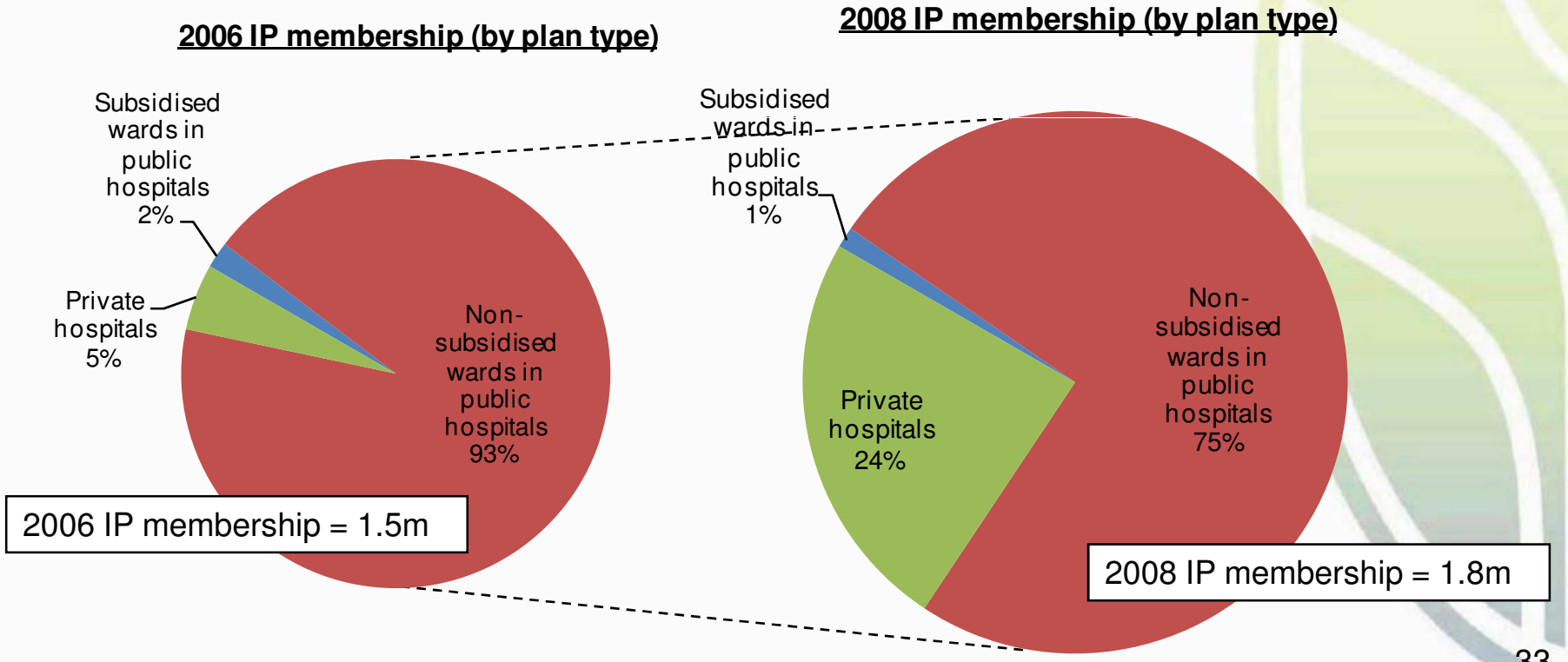
- Healthy growth in Medisave-approved private Integrated Plans (IPs) membership
- There are 3.3 million MediShield (basic + integrated) members, out of which 1.9 million (60%) have IPs
- IPs are driving growth
  - Increase in post-2005 reform IP membership from 1.45m in 2005 to 1.9m in 2009 (~33% growth) compared to 21% growth of overall MediShield+IP market

MediShield and IP membership (1990-2009)



Growth in the IP Market

- Active encouragement by MOH to middle- and high-income Singaporeans who prefer treatment in non-subsidised wards in public hospitals, or treatment in private hospitals, to enhance their coverage with IPs



Active steps to expand IP market

- IPs are a key product group for the industry
- Can reach out effectively to the masses and all players are actively marketing these plans as it is a basic protection plan that customers should have
- While it is a pure risk product which has modest premiums, most industry players see it as an opportunity to serve their customers in this area so as to expand and protect their customer base