SINGAPORE ACTUARIAL SOCIETY

PRELIMINARY COMMENTS on GOVERNMENT PROPOSALS for the REVIEW the MEDISHIELD SCHEME (to be re-named "MEDISHIELD LIFE")

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INTRODUCTION and SUMMARY of PRELIMINARY COMMENTS

Introduction & Call for Views

This brief discussion paper lays out the preliminary comments from the Singapore Actuarial Society on proposals for the review of the Medishield Scheme (to be re-named "Medishield Life") announced by representatives of the Government, and on comments made by other parties interested in these proposed reforms.

The preliminary comments have been grouped into the following 6 areas:

A. **Moving to Universal Coverage**
B. **Premium Rates and Pre-Funding**
C. **Sharing the Healthcare Cost**
D. **Managing the Healthcare Cost**
E. **The Role of the Medisave Account**
F. **Impact on Integrated Shield Plans**

This paper does not represent the official response of the SAS to these proposed reforms, but is meant to contribute to the public discussion of these reforms. While members of the Health Insurance Committee has been mindful of presenting a balanced view of these reforms, it is acknowledged that the comments may not represent the views of the general membership. **ALL members are welcome to submit their own views. Please send them to: MedishieldLife_WP@actuaries.org.sg**

The SAS intends to engage with the Ministry of Health and other government bodies involved in the review of the Medishield Scheme on a more concrete basis, and SAS representatives will wish to present as wide a range of views of members as they can, and **it will be helpful if you can submit your views by 31 Jan 2014**.

You are also welcomed to join the SAS Medishield Life Review Response Working Party which will be formed to represent the SAS on this matter of national significance.

Summary of Preliminary Comments

A summary of the preliminary comments is set out below.

A. Medishield: Moving to Universal Coverage

A.1 Universal Coverage: Maintaining Continuity an Issue

SAS commends the Government for making health insurance coverage universal for all residents. Having insurance will ensure that residents will have the financial means to meet the cost of, and have access to, healthcare services.

However, there is a requirement on the part of the individual resident to fulfil a financial commitment, that of paying insurance premiums, for this access. **There will be challenges to ensuring that coverage remains universal at all times**. What happens when an individual fails to pay the premium due for his insurance or for insurance for his dependants? The Prime Minister and Minister for Health have alluded to the likelihood that the Government will help residents who do not have sufficient assets to meet their premium commitments.

Voluntary lapse and reinstatement of insurance coverage should only be allowed under very strict rules or, otherwise, the scheme will be exposed to anti-selection risk. Lapse of insurance coverage changes the risk profile of the insured membership, and the premium rates calculated might prove to be inadequate.

A.2 Adequacy of Savings to Meet Future Premiums

For a resident to be assured of continuity of coverage under the scheme, especially at his or her advanced ages, he or she will have to make adequate provisions for meeting future premium payments.

A.3 Impact on Premium Rates

The impact of the extension of the scheme to residents aged 90 and above will depend on whether there will be any cross-subsidy of the cost of insurance from the younger residents to the older ones. **Extension of the scheme to cover pre-existing conditions will result in increases in the premium rates**, unless the claims arising from these conditions are met by other sources of funding. **Extension of the scheme to residents who had opted out may or may not result in an increase in the premium rates. It depends on the risk profile of these residents** and how it compares with the risk profile of all those already insured.

Improving the benefits will naturally result in increases in the premium rates.

A.4 High-risk Pool: Issues

There have been suggestions that the claims arising out of pre-existing conditions be managed in a high-risk pool, which may or may not be subsidised by the Government. **The conditions for which claims will be allocated to the high-risk pool will have to be clearly defined**. The total claim payable out of the pool each year will be volatile, meaning that **the premium allocated to the pool may have to contain a margin to build up a reserve to manage** this **volatility**.

As pre-existing conditions will only be identified when a claim is submitted, it is not possible to charge additional premiums only on residents with pre-existing conditions when they join the scheme. **There will be a general increase in premiums to cover the additional claims cost**.

If a high-risk pool is set up, **there is the question of who can manage the pool most efficiently** – the Government, a reinsurance company, a single insurer or a consortium of insurers? The principal consideration for the pool underwriter is whether it has the expertise and financial capacity to manage the volatility of claims experience of the pool.

A.5 Will the Lifetime Benefit Limit Be Removed? Can the Annual Benefit Limit be Removed Also?

SAS assumes that the lifetime benefit limit will now be removed or, otherwise, residents may lose their insurance coverage just when they need it most.

While annual limits are useful in stabilising the claims experience by reducing the impact of extra-ordinarily large claims, the medical expenses incurred in excess of these limits can be financially devastating. As the number of such claims should be small, **there could be a consideration for the expenses in excess of thresholds set at the annual limits to be managed under a high-risk pool** as well.

B. Medishield: Premium Rates and Pre-funding

B.1 Impact on Medishield Scheme Premium Rates of Proposed Changes to the Scheme

B.1.1 Extension to Residents Aged 90 and Above

The extension of the scheme to residents aged 90 and above will not in itself affect the premium rates for residents below that age, unless there is an element of cross-subsidy across ages in the premium rates.

However, at the moment, **the correct amount of premiums to charge at the higher ages cannot be based on empirical experience which is very limited**, and estimates will have to be made of the claims experience of this group using proxy data. Also, as the group of residents which is aged 90 and above is currently very small, **the actual claims experience can also be expected to be highly volatile**. **The errors in estimation and the volatility may be managed by including margins in the premium rates** (however, the margins themselves will necessarily be estimates), whether for the older cohorts or for all insured residents, or with funds from other sources.

B.1.2 Extension to Cover Pre-existing Conditions

Unless the additional claims arising from this extension is met by external funding, premium rates will have to be increased for all insured residents, as it will not be possible to identify residents with pre-existing conditions until they submit claims arising from these conditions.

B.1.3 Extension to Cover Opt-outs

It is **uncertain at this stage, without further analysis, as to whether the inclusion of residents who opted out previously will affect the premium rates favourably or unfavourably**.

B.1.4 Changes in Benefit Payment Terms and Conditions

What is certain is that any **enhancements to the benefit payment terms, and conditions**, like the lowering of the deductible and of the co-insurance percentages **will immediately cause the premium rates to rise, as the claim amounts payable will naturally rise** due to the higher benefit entitlement; **and the lower financial commitment required of residents when they seek medical treatment can change their behaviour in a way which is unfavourable** to the scheme.

Lowering either the deductible or the co-insurance percentages should be considered carefully, as doing so **may induce demand for additional healthcare services**. **A more sophisticated structure may be adopted, for example, to differentiate the deductible and co-insurance percentages** for expenses incurred in a private hospital and for expenses incurred in a community hospital, to encourage more cost-effective behaviour.

B.2 Ageing of Population: No Direct Effect on Premium Rates

The ageing of the population in itself will not directly cause premium rates to rise, if residents are charged premiums according to risk they contribute at their respective ages. However, if there is an element of cross-subsidy across ages, then the premium rates for the younger ages will rise at a faster rate as the population ages than if there is no cross-subsidy.

B.3 Medical Cost Inflation

The **strongest pressure on premium rates across the board will be medical cost inflation**. Where the ageing of the population has an effect on premium rates is the impact it will have on the demand for healthcare services.

B.4 Premium Pre-funding or "Front-loading"

The Government has mooted the idea of pre-funding of premiums, or "front-loading", as described by some members of the Government. However, the form this pre-funding will take is unclear.

B.4.1 Pre-funding by Personal Accumulation of Assets

The simpler model is where the resident pre-funds his own future premiums, either for insurance on himself or herself or on his or her dependants. **The** only issues **to deal with are the medium for the accumulation of his or her pre-funding premiums or contributions, and the adequacy of the accumulated amount**.

The Government may consider allowing residents to pre-fund their health insurance premiums through media other than the Medisave account, e.g. life insurance policies.

B.4.2 Pre-funding by Cross-subsidy from the Younger Generation to the Older Generation

The other form of **pre-funding where the premiums for older residents are subsidised by additional margins included in the premiums for younger residents poses** other **challenges**. **As the population ages, the margin in the premiums for younger residents to provide the subsidy will grow more rapidly than medical cost inflation**, unless the level of subsidy is scaled down.

There will be a loss of transparency in the medical expenses incurred at different ages, as the differential in the amount of medical expenses incurred by younger and older residents will be masked.

A balance may have to be struck between equity (pre-funding by making personal provisions) and collective social responsibility (pre-funding by cross-subsidy of premiums). If there is to be no cross-subsidy, the **Government's announcement that it is considering subsidising the premiums payable by older residents is welcomed. SAS assumes that such subsidies will continue to be provided until such time when it is deemed that residents will have had the opportunity to adequately pre-fund their premiums**.

B.5 Medishield: Can It Be an Insurer of the First Resort? Or Should It Remain as Insurer of the Last Resort?

In pricing the revised Medishield scheme, it may be noted that the **historical claims experience of the scheme may not be reflective of the true cost of the benefits because the scheme is currently treated as the insurer of the last resort**, paying benefits only after the resident has exhausted his or her claims on other forms of health insurance, e.g. his or her employer's group health insurance plan. This order of claim preserves the resident's lifetime limit on Medishield benefits.

If the lifetime limit is removed, the Medishield scheme could be designated the insurer of the first resort. **This** will remove the distortion of the claims experience arising from benefits payable under other health insurance plans. **This will stabilise its claims experience** and make the calculation of premium rates more reliable, as the claim amounts payable will not be subject to the proportion of insured residents who are entitled to benefits under their employers' health insurance plans.

However, making Medishield the insurer of the first resort will result in an immediate increase in premiums, and will have an impact on the group medical insurance business.

B.6 One-time Premium Rate Increase: To Be Phased In?

There will a **one-time increase of the Medishield premium rates due to the proposed changes**, and this adjustment **can be substantial**, and the **Government may have to look into phasing the premium increases** required. **Residents in the lower-income groups may require financial assistance** to meet these premium increases.

B.7 Exemption of Premiums from Goods and Services Tax Liability

As the Medishield scheme will become universal and compulsory, the premiums could be exempted from Goods and Services Tax (GST) liability. Exempting the premiums from GST liability will also make the premium rate increases more palatable.

C. Sharing the Healthcare Cost

C.1 Residents' Personal Responsibility

It is still a keystone of Government healthcare financing policy that the individual resident takes personal responsibility for paying at least part of his or her healthcare expenses. The resident can buy health insurance, but must still make provision for meeting expenses which fall outside the insurance net.

The **resident will have greater confidence in the adequacy of his healthcare expenses provision if the uncertainty in the share of healthcare expenditure the Government will assume, the amount of the expenses he or she may incur which will not be met by payment of insurance benefits, and medical cost inflation can be minimised**.

C.2 Government Subsidies to Healthcare Providers Affect Insurance Premiums

Direct Government subsidy of the expenditure of public hospitals and other public healthcare facilities have a direct impact on the expenses which are eligible for benefit payment under health insurance plans, especially the Medishield scheme, and health insurance premiums.

While the allocation of Government revenue is a matter of Government policy, health insurers will benefit from greater transparency in the Government's policy on its subsidy of public healthcare facilities, in managing their insurance portfolios.

C.3 Government Subsidies to Residents

SAS acknowledges that **means-tested subsidies provided to residents are more targeted approaches to providing financial assistance to residents who need it most**, rather than general subsidies provided to public healthcare providers.

C.4 Government Share of Healthcare Expenses: Should It Be Pre-funded?

There is an argument for the Government itself to pre-fund the subsidies it intends to provide directly to residents, to offset either healthcare expenses or insurance premium payments, so as to reduce the tax burden on the working population in the future, which will decrease in size relative to the size of the retired population.

D. Managing the Healthcare Cost

D.1 Drivers of Medical Cost Inflation

The key to keeping health insurance premiums affordable is to control medical cost inflation, which is driven by, principally, **inflation of the underlying cost of delivering healthcare services**, and **increasing utilisation of healthcare services by each resident**.

D.2 Ageing Population

The ageing of the population will raise the demand for healthcare services which will, in turn, lead to increases in healthcare cost for each resident unless supply can be raised to meet the increasing demand. The Government has taken steps to keep supply in line with demand.

The Government is also implementing programmes to re-structure the delivery of healthcare services so that patients migrate from the most cost-intensive facilities (acute care hospitals) **to less cost-intensive facilities** (e.g. community hospitals) and finally to the least cost-intensive facility, the home. It has also **encouraged residents to take up preventive measures** like regular health screenings and follow-up visits to doctors for long-term conditions by, for example, providing subsidised services; and allowing withdrawal from the Medisave account to pay for these services.

The **question is whether health insurance plans can be re-designed to support these Government initiatives**. **Medishield can take the lead** in this area. By setting the terms and conditions for providing benefits which pay for step-down care and preventive measures, Medishield can provide a template for private insurers to follow suit.

Providing step-down care benefits can result in lower health insurance premiums if residents are persuaded to move from higher-cost acute care settings to lower-cost settings. In **Part B**, it was suggested that a more sophisticated deductible and co-insurance structure may be adopted, for example, to differentiate the deductible and co-insurance percentages for expenses incurred in a private hospital and for expenses incurred in a community hospital, to encourage more cost-effective behaviour. **Providing "wellness" discounts will increase premium cost in the short-term until the desired positive insured resident behaviour translates into lower healthcare cost per resident**.

D.3 Induced Demand and Managed Healthcare Systems

It is **well known that the presence of health insurance may induce demand for healthcare services** and increase their utilisation and, hence, the amount of expenses incurred for such services. Where healthcare cost had risen, **managed healthcare systems** have been developed. However, these systems **have had mixed results in controlling healthcare services utilisation**. **In a more controlled environment like Singapore**, where the public sector manages a significant share of healthcare services provided (e.g. it manages more than 75% of hospital beds in the country) and with only a small number of major players in the private healthcare sector, **it may be possible to develop a system which controls utilisation without denying any resident essential medical attention and treatment**, and which allows both the public and private sectors to maintain their viability.

E. The Role of the Medisave Account

E.1 Competing Demands on the Medisave Account

Medishield premiums will increase if changes to the Medishield scheme proposed are implemented. If pre-funding is also introduced, **Medisave contributions may have to be increased to maintain adequacy of the balance to meet all future premium payments**.

At the same time, the Government is expanding the range of healthcare expenses for which a resident can withdraw from his or her Medisave account to pay. Even higher Medisave contributions will be required.

E.2 Adequacy of the Account Balance

The Government will have to communicate with residents on the adequacy of their Medisave account balances, which may include revisions of the various caps and floors imposed on the account balances, providing residents with more information on the impact of paying insurance premiums on these balances and developing tools for residents to project the movement in these balances on realistic assumptions.

E.3 Increasing Medisave Contributions

Medisave contributions should not be raised at the expense of residents' general retirement financial security (e.g. by reducing the contributions to the Ordinary and Special accounts), and the **increases would likely have to be made at the expense of current consumption or savings for other purposes (e.g. housing)**.

F. Impact on Integrated Shield Plans

F.1 Universal Coverage

Insurers of Integrated Shield policies are unlikely to be able to offer universal insurance coverage, in terms of coverage of full benefits for all medical conditions, especially **pre-existing conditions**. Take up of these policies will remain voluntary and anti-selection against the insurer, by residents with such conditions, is a major risk. The insurer must underwrite.

As **an insurer of an Integrated Shield plan** acts as an agent for the Central Provident Fund (CPF) Board in collecting Medishield premiums and paying Medishield claims, it **will have to increase the premiums for its plan to cover the increase in Medishield premiums it has to transfer to the CPF Board**, regardless of the high likelihood that the residents it insures (who will have been underwritten) will not benefit from this extension of the Medishield scheme to cover pre-existing conditions.

F.2 Premium Rates and Pre-funding

If changes in the Medishield benefits result in any reduction in the benefits which an insurer has to pay under its Integrated Shield plan, in excess of the Medishield benefits, such a reduction will provide some offset against the increase in premiums it has to transfer to the Board.

Pre-funding by cross-subsidy has implications for the Integrated Shield plans. The likelihood is that the age profile of residents insured under Integrated Shield plans will be lower than that of all residents insured under the Medishield scheme. As such, **Integrated Shield plan insurers may transfer more in premiums, which include the cross-subsidy margins, to the CPF Board than it receives in claims from the Board**.

F.3 Sharing the Healthcare Cost

The **premiums for Integrated Shield plans designed to meet the cost of medical attention received in public hospitals are sensitive to changes in the Government direct subsidies to public hospitals and other medical institutions**.

End of Summary

The following sections set out the full discussion of the preliminary comments, together with abstracts of the proposals for revisions of the scheme made to date, and some comments made by interested parties on these proposals, as sourced from the press.

A. MEDISHIELD: MOVING to UNIVERSAL COVERAGE

Government Proposals

The Government proposes to extend Medishield scheme to cover:

- *All residents, including:*
  - *Those aged 90 and above; and*
  - *Those who had previously opted out of the scheme, as membership will be made compulsory for all eligible residents; and*
- *All medical conditions, including those which exist when the resident joins the scheme, i.e. pre-existing conditions.*

These proposals were first announced in the Prime Minister's National Day Rally on 18 Aug 2013.

This will make the scheme universal in coverage, without any gaps through which a resident can fall through and incur large medical expenses which he or she has to bear all by himself or herself. Currently, Medishield covers 92% of all eligible residents.

The Government has also announced that the benefits under the scheme will be improved, most likely by reducing the deductible and co-insurance liability of insured residents.

SAS Preliminary Comments

A.1 Universal Coverage: Issues of Maintaining Continuity

SAS commends the Government for making health insurance coverage universal for all residents. Healthcare may be regarded as a basic need, and access to healthcare should not be denied simply because a resident does not have the financial means to meet the cost. Having insurance will relieve the resident of a substantial worry.

In countries which provide universal access to healthcare, this access is arranged either by financing healthcare services out of general tax revenue, or through a national insurance scheme. With the former, there is no requirement on the part of the individual resident to fulfil any financial commitment, like paying insurance premiums, for this access. With the latter, there is this commitment.

SAS assumes that all residents, including all those who are unemployed, will be provided with a Medisave account, to facilitate payment of premiums.

There will be challenges to ensuring that insurance coverage remains universal at all times:

- What happens when an individual fails to pay the premium due for his insurance or for insurance for his dependants?
- What will the rules be for continuation of insurance?
- Will there be a legal mechanism which allows the Government to access the assets of the resident to collect the premium due?
- What about the individual who has insufficient assets to meet the premium payments? The Prime Minister and Minister for Health have alluded to the likelihood that the Government

will help these residents to meet their premium commitments. The affected residents will be interested to see how this financial assistance is structured.

Voluntary lapse and reinstatement of insurance coverage should only be allowed under very strict rules, e.g. only when the resident moves to another country and proves that he or she is fully insured under a different insurance scheme. Allowing gaps in the continuity of insurance coverage of an individual resident poses problems in management and pricing:

- The scheme will be exposed to anti-selection risk, where the resident who allows his insurance coverage to lapse will apply to reinstate it only when he or she needs the insurance. A private insurer manages this risk by underwriting, or by imposing special terms and conditions on reinstatement. However, these risk management methods pose two problems:
    - It increases the administration cost, that of the actual underwriting and of monitoring the statuses of reinstated residents, in the event that restrictions are imposed on their insurance benefits; and
    - More importantly, the principle of universal coverage may be breached, if terms and conditions restricting the scope of the resident's insurance will have to be imposed upon reinstatement.
- Lapse of insurance coverage changes the risk profile of the insured membership:
    - The premium rates calculated might prove to be inadequate, depending on the profile of the members who are allowed to lapse their insurance coverage.

If the rules for allowing residents to lapse their insurance coverage are stringent, then the majority of insured members whose insurance coverage will lapse will be those on the basic Medishield scheme, and their insurance coverage lapses because of their inability to pay premiums, and the number of residents who lapse their coverage on a voluntary basis should then be small.

A.2 Adequacy of Savings to Meet Future Premiums

For a resident to be assured of continuity of coverage under the scheme, especially at his or her advanced ages, he or she will have to make adequate provisions for meeting future premium payments.

The tool for enabling all eligible residents to make such provisions already exists – the Medisave account. The issue of how to ensure, as far as possible, that each resident's Medisave account balance will always be adequate to meet all future insurance premiums will be discussed in **Part B, Section B.4.1**.

A.3 Impact on Premium Rates

The impact of the extension of the scheme to residents aged 90 and above will depend on whether there will be any cross-subsidy of the cost of insurance from the younger residents to the older ones.

Extension of the scheme to cover pre-existing conditions will result in increases in the premium rates, unless the claims arising from these conditions are met by other sources of funding. If external funding is considered, the cost of these claims must be identified clearly, and a number of commentators have proposed the setting up of a high-risk pool to manage these claims (see below).

Extension of the scheme to residents who had opted out may or may not result in an increase in the premium rates. It depends on the risk profile of these residents and how it compares with the risk profile of all those already insured.

Improving the benefits will naturally result in increases in the premium rates.

Premium rates will be discussed in more detail in **Part B**.

A.4 High-risk Pool: Issues

There have been suggestions that the claims arising out of pre-existing conditions be managed in a high-risk pool, which may or may not be subsidised by the Government. While simple and elegant in concept, a high-risk pool raises issues of its own:

- The conditions for which claims will be allocated to this pool will have to be clearly defined.
- As claims arising from these conditions will form only a small subset of the total claims under the scheme, the total claim payable out of the pool each year will be volatile, and the premium allocated to the pool may have to contain a margin to build up a reserve to manage this volatility (however, this will be less of an issue if the Government is willing to mitigate this volatility itself).

It is assumed that, from the date the scheme is made universal and compulsory, no medical condition will be regarded as pre-existing for new members (at the time they join the scheme), and that the claims arising on them will fall into the general experience, regardless of whether the conditions leading to the claims existed at the time they join the scheme or not. In which case, the high-risk pool, measured by the number of residents whose claims will be allocated to it, will be a diminishing pool, and its claims experience will become extremely volatile at some stage. However, this volatility can be managed by pre-funding, either out of premiums paid or from an external source. Alternatively, the Government may wish to assume this liability, which will be finite.

There is also the question of how this high-risk pool will be funded. As pre-existing conditions will only be identified when a claim is submitted, it is not possible to charge additional premiums only on residents with pre-existing conditions, i.e. conditions which are present when they join the scheme. There will have to be a general increase in premiums to cover the additional claims cost, where a portion of each premium will be allocated to the pool.

A resident with a serious pre-existing condition may not earn sufficient income (due to his or her condition), or have sufficient assets, to pay the additional premiums required to fund the claims arising in a high-risk pool. This exacerbates the financial strain on residents with pre-existing conditions.

If a high-risk pool is set up, there is the question of who can manage the pool most efficiently – the Government, a reinsurance company, a single insurer or a consortium of insurers? There may be other options. The principal consideration for the pool underwriter is whether it has the expertise and financial capacity to manage the volatility of claims experience of the pool. Due to the uncertainty in the claims experience of this pool, especially in the early years, some Government funding may be required (e.g. it may provide the initial capital which will be returned only if the pool becomes self-sustaining).

A.5 Will the Lifetime Benefit Limit Be Removed? Can the Annual Benefit Limit be Removed Also?

SAS assumes that the lifetime benefit limit will now be removed or, otherwise, residents may lose their insurance coverage just when they need it most. This has implications for the order of reimbursement of medical expenses from different insurance sources, as will be discussed in **Part B**.

While annual limits are useful in stabilising the claims experience by reducing the impact of "tail claims" or extra-ordinarily large claims, the medical expenses incurred in excess of these limits (together with the deductible and co-insurance obligations) can be financially devastating. As the number of such claims should be small, there could be a consideration for the excess expenses to be managed under a high-risk pool as well, which may again require the Government to manage the

volatility of its claims experience. The alternative would be to remove the annual limit and to manage all claims under the scheme. However, this change will have implications for the Integrated Shield plans.

B. MEDISHIELD: PREMIUM RATES and PRE-FUNDING

Background

The Government has acknowledged that the proposed extensions to the Medishield scheme and the enhancements of the benefits under the scheme will result in increases in the premium rates. As stated in his National Day Rally, citizens above the age of 60 ("the pioneer generation") will be provided with financial assistance to cope with these increases.

Members of the Government have also alluded to the likelihood of pre-funding (or "front-loading") of premiums. However, the form that pre-funding will take is at the moment unclear. There are indications that it will involve some cross-subsidy by younger residents of older residents' premiums. Some commentators have questioned whether such a cross-subsidy will be acceptable to the younger residents.

SAS Preliminary Comments

B.1 Impact on Medishield Scheme Premium Rates of Proposed Changes to the Scheme

B.1.1 Extension to Residents Aged 90 and Above

The extension of the scheme to residents aged 90 and above will not in itself affect the premium rates for residents below that age, unless there is an element of cross-subsidy across ages in the premium rates (which will be discussed below). The theoretical amount of premium a 95-year old has to pay will be the same, regardless of whether the residents aged 90 and above form 2% or 20% of the total population, if the premium amount is based on the expected claims experience of 95-year old residents as a group, assuming that this experience can be projected fairly accurately.

However, at the moment, the correct amount of premiums to charge at the higher ages cannot be based on empirical experience which is very limited, and estimates will have to be made of the claims experience of this group using proxy data. The experience may be extrapolated from the experience at the lower ages, or by inference from the general population (the majority of whom are uninsured) experience, but it will still be an estimate. Any premium rate decided for residents in this age group must necessarily be subject to a high degree of uncertainty.

While the Ministry of Health would have data on hospitalisation of, and utilisation of other medical services by, residents who are aged 90 and above, it is unlikely that the data will be sufficiently large to be statistically reliable. Also, this data will be on residents who are unlikely to be insured. Being covered by insurance may change the behaviour of these residents in terms of utilisation of medical services.

Also, as the group of residents whose members are all aged 90 and above is currently very small, the actual claims experience can also be expected to be highly volatile. If the actual claims experience is worse than anticipated, the excess amount of claims will have to be recovered from future premiums, whether those payable by residents aged 90 and above only, or by the whole insured population. If the residents aged 90 and above have to bear these increases themselves, the premium rates at the higher ages will rise even faster than the premiums at the lower ages. Some consideration could be given to providing for these excess claims either:

- By including margins in the premium rates (however, the margins themselves will necessarily be estimates), whether for the older cohorts or for all insured residents, or
- With funds from other sources, for a period of time until the claims experience can be estimated more reliably.

B.1.2 Extension to Cover Pre-existing Conditions

The increases resulting from the coverage of pre-existing conditions which are currently excluded has been discussed in **Part A, Section A.4** in some detail, with reference to the proposal for the setting up of a high-risk pool.

Unless the additional claims arising from this extension is met by external funding, premium rates must be increased for all insured residents, as it will not be possible to identify residents with pre-existing conditions until they submit claims arising from these conditions.

B.1.3 Extension to Cover Opt-outs

It is uncertain at this stage, without further analysis, as to whether the inclusion of residents who opted out previously will affect the premium rates favourably or unfavourably. There is no prima facie evidence that SAS is aware of which suggests that those who opted out are in better or worse health than those who chose to remain in the scheme.

B.1.4 Changes in Benefit Payment Terms and Conditions

What is certain is that any enhancement to the benefit payment terms, and conditions, like the lowering of the deductible and of the co-insurance percentages will immediately cause the premium rates to rise. Premium rates will go up for a couple of principal reasons:

- All else remaining the same, the claim amounts payable will naturally rise due to the higher benefit entitlement; and
- The lower financial commitment required of residents when they seek medical treatment can change their behaviour – they may, for example, elect for additional examinations and tests to be conducted – resulting in increases in the amount of expenses incurred which will be eligible for benefit payment under the scheme.

Lowering the deductible may actually make the claims experience less volatile and future claims experience (and, hence, future premium rates) easier to estimate. However, lowering either the deductible or the co-insurance percentages should be considered carefully, as doing so may induce demand for additional healthcare services, and aggravate medical cost inflation.

A tiered co-insurance structure, with different percentages applying to different bands of the total eligible expense for each claim, the percentage reducing as the expense crosses to the next higher band, is already in place under the Medishield scheme. However, a more sophisticated structure may be adopted, for example, to differentiate the deductible and co-insurance percentages for expenses incurred in a private hospital and for expenses incurred in a community hospital, to encourage residents to adopt more cost-effective behaviour.

B.2 Ageing of Population: No Direct Effect on Premium Rates

The ageing of the population in itself will not directly cause premium rates to rise, if residents are charged premiums according to their ages, which are commensurate with the level of risk contributed by residents in each age group to the general pool of risks. However, if there is an element of cross-subsidy across ages, then the premium rates for the younger ages will rise at a faster rate as the population ages than if there is no cross-subsidy. Cross-subsidy will be discussed later in this Part.

B.3 Medical Cost Inflation

The strongest pressure on premium rates across the board will be medical cost inflation. If this inflation rate is higher than the rate of increase of the Consumer Price Index, or even of wages, the premiums will take up an increasing share of either the resident's wages or of his accumulated savings. The key to controlling health insurance cost lies in managing healthcare expenditure, which will be discussed in **Part D**.

Where the ageing of the population has an effect on premium rates is in the impact it will have on the demand for healthcare services. If the supply of these healthcare services cannot cope with the increasing demand, cost (especially, human resource cost – healthcare is still a highly human resource-intensive industry) will rise.

B.4 Premium Pre-funding or "Front-loading"

The Government has mooted the idea of pre-funding of premiums, or "front-loading", as described by some members of the Government. However, the form this pre-funding will take is unclear. Some statements indicate that each resident will have to make provision for his or her future premium commitments, while others appear to indicate some form of cross-subsidy from the younger residents to the older ones, on the basis that the current younger generation will benefit from the subsidy by residents who will be younger than them when they age.

B.4.1 Pre-funding by Personal Accumulation of Assets

The simpler model is where the resident pre-funds his own future premiums, whether only for insurance on himself or herself or for insurance on his or her dependants as well. The only issues to deal with are the medium for the accumulation of his or her pre-funding premiums or contributions, and the adequacy of the accumulated amount:

- The Medisave account is the natural medium for accumulating these contributions: this may require the account to be further sub-divided into sub-accounts, with one designated for these contributions, to be drawn down only for payment of Medishield premiums.
- The determination of the adequacy of the balance in the sub-account is highly subjective, as it should allow for the resident's future Medisave contributions if he or she is still earning wages, the rate of growth of his or her wages (which will determine the rate of growth of his or her Medisave contributions), the interest to be earned on the Medisave account balance and the inflation of Medishield premiums. The resident may be provided with a range in which to maintain his balance, and will be required to maintain at least the minimum balance in the range in his pre-funding sub-account but be allowed to increase the balance in his sub-account to the maximum balance in the range, e.g. by transferring funds from other sub-accounts or by making voluntary contributions. The determination of these minimum and maximum account balances has to take into account factors other than just the technical ones, especially competing demands on the use of the resident's wages and assets.

The Government may consider allowing residents to pre-fund their health insurance premiums through media other than the Medisave account, e.g. life insurance policies. In which case, it could consider granting the same tax allowances for contributions to these other media (e.g. premiums on life policies) as it does to contributions to the Medisave account. This will make the options tax-neutral to the resident.

B.4.2 Pre-funding by Cross-subsidy from the Younger Generation to the Older Generation

The other form of pre-funding where the premiums for older residents are subsidised by additional margins included in the premiums for younger residents poses other challenges:

- As the population ages, the margin in the premiums for younger residents to provide the subsidy will grow more rapidly than medical cost inflation, unless the level of subsidy is scaled down:
    - If the level of subsidy is not scaled down, there will be a convergence of the premium rates across the ages, and the scheme will take on the appearance of a community-rated scheme, where all insured residents pay the same amount of premium. There may be resistance by younger residents to the scheme then.
    - If the level of subsidy is scaled down to maintain premium rate differentials across ages, the premium rates at the older ages may begin to appear unaffordable, if the rates increase at a rate which is higher than that of general inflation. The current younger residents may then feel hard done by when they reach the higher ages, as they will enjoy a lower level of subsidy than that which they provided to the generations before them.
- There will be a loss of transparency as the differential in the amount of medical expenses incurred by younger and older residents will be masked, and residents may fail to make adequate provision for healthcare cost over and above that which is covered by insurance.

A balance may have to be struck between equity (pre-funding by making personal provisions) and collective social responsibility (pre-funding by cross-subsidy of premiums). It should be noted that the pre-funding by making personal provision is still an applicable strategy even if there is cross-subsidy of premiums. Regardless of the amounts of premiums required to be payable at the higher ages, a resident may find them to be onerous financial burdens when he attains these ages if he does not pre-fund them.

The Government has announced that it will consider subsidising the premiums payable by older residents, which SAS assumes will continue until such time when it is deemed that residents attaining the higher ages will have had the opportunity to adequately pre-fund their premiums. These subsidies will be particularly helpful if there is to be no cross-subsidy of premiums from the younger residents to the older residents.

B.5 Medishield: Can It Be an Insurer of the First Resort? Or Should It Remain as Insurer of the Last Resort?

In pricing the revised Medishield scheme, it may be noted that the historical claims experience of the scheme may not be reflective of the true cost of the benefits provided under the scheme, if the scheme had been operated in isolation.

This is because the scheme is currently treated as the insurer of the last resort, paying benefits only after the resident has exhausted his or her claims on other forms of health insurance and, in particular, on his or her employer's group health insurance plan. This order of claim was decided upon largely to preserve the resident's lifetime limit on Medishield benefits.

If the lifetime limit is removed, the Medishield scheme could be designated the insurer of the first resort:

- This will remove the distortion of the claims experience arising from benefits payable under other health insurance plans.
- This will stabilise its claims experience and make the calculation of premium rates more reliable, as the claims amounts payable will not be subject to the proportion of insured residents who are entitled to benefits under their employers' health insurance plans, and also to the benefits provided under these plans. If the status quo is maintained, this proportion will fall progressively as the population ages, and the increase in claims cost will be accelerated, as the subsidies from employers' plans, in the form of benefits payable under these plans, become proportionally smaller over time. The "subsidy" of MediShield claims

by employers' medical expense insurance plans depends on the influx of younger workers into the employers' workforce.

However, making Medishield the insurer of the first resort will:

- Result in an immediate increase in premiums, even if there are no other changes made to the scheme. The premium increases will apply to all residents insured under the Medishield scheme, regardless of whether they are covered under employers' group insurance plans or any other insurance plans, or not. These increases will add to the increases necessitated by the changes to the scheme proposed.
- Have an impact on the amounts of benefits payable under group medical insurance plans and, therefore, the premium rates charged on these plans.

B.6 One-time Premium Rate Increase: To Be Phased In?

There will a one-time increase of the Medishield premium rates due to the following:

- Extension of the scheme to cover pre-existing conditions;
- Extension of the scheme to residents aged 90 and above if, at the same time, cross-subsidy of premiums is introduced;
- Increases in the amounts of benefits payable under the scheme; and
- Making Medishield the insurer of the first resort, if this step is taken.

This adjustment can be substantial, and the Government may have to look into phasing the premium increases required. Residents in the lower-income groups may require financial assistance to meet these premium increases.

B.7 Exemption of Premiums from Goods and Services Tax Liability

As the Medishield scheme will become universal and compulsory, the premiums could be exempted from Goods and Services Tax (GST) liability. The premium will no longer be a consideration of contract which the resident voluntarily enters into, albeit by not exercising his or her opt-out option. The premium payable is, in effect, a national health insurance contribution. Exempting the premiums from GST liability will also make the premium rate increases more palatable.

C. SHARING the HEALTHCARE COST

Background

How healthcare expenditure is shared among residents, the Government and insurers (including the CPF Board, as insurer of the Medishield scheme) will have an impact on health insurance.

The Government has indicated that it will increase its share of the national healthcare expenditure from the current 30% to 40%, and that it will provide more subsidies to residents when they incur outpatient medical expenses. The Government still expects residents to pay a part of their medical expenses and to take "responsibility to keep healthy, make wise decisions on treatment and save up for rainy days".

One commentator noted that the Medisave account would have to be expanded to cover the additional expenses for which residents would be eligible to withdraw from the account to meet, and for paying higher premiums for a more generous health insurance scheme. He hoped that "the new policies will not lead to greater moral hazard and excessive consumption of health care in the future".

SAS Preliminary Comments

C.1 Residents' Personal Responsibility

It is still a keystone of Government healthcare financing policy that the individual resident takes personal responsibility for paying at least part of his or her healthcare expenses. The resident can transfer some of the risk of incurring these expenses to insurers, but must still make provision for meeting expenses which fall outside the insurance net, and which is in excess of any Government subsidies he or she may receive to offset these uninsured expenses, as well as for future health insurance premiums.

The resident will have greater confidence in the adequacy of his provision if the uncertainty in the following can be minimised:

- The share of healthcare expenditure the Government will assume in the future (i.e. the subsidies are not expected to be reduced);
- The amount of the expenses he or she may incur which will not be met by payment of insurance benefits (i.e. the health insurance benefits remain largely constant relative to the expenses incurred (after allowing for Government subsidies)); and
- Medical cost inflation, relative to the inflation of other costs (e.g. if medical cost inflation can be managed to be a fairly constant margin over the CPI inflation rate over the long term).

C.2 Government Subsidies to Healthcare Providers Affect Insurance Premiums

Government subsidy of the expenditure of public hospitals and other public healthcare facilities has a direct impact on the expenses which are eligible for benefit payment under health insurance plans, especially the Medishield scheme, which cover the expenses incurred by residents admitted to the most highly subsidised wards. Hence, the levels of subsidy will also affect health insurance premiums.

While the allocation of Government revenue is a matter of Government policy, health insurers will benefit from greater transparency in the Government's policy on its subsidy of public healthcare facilities. The Minister of Health indicated that the Government's share of healthcare expenditure would go up from 30% to 40%. Insurers may be interested to know as to how much of this increase

will go to development (which may have a long-term knock-on effect in balancing the demand and supply of healthcare services), and how much will go to meeting operational cost, especially in the form of direct subsidies to public healthcare service providers.

While it is acknowledged that the formulation of Government policy cannot be rigid and must adapt to circumstances, there could be regular dialogue between the Government and insurers, so that insurers can manage their insurance portfolios better, e.g. by anticipating the changes required to their plan benefits.

C.3 Government Subsidies to Residents

SAS notes that the provision of Government subsidies to residents' to offset their healthcare expenses and insurance premium payments appears to be a circuitous route to the Government assuming a higher share of healthcare expenditure. However, SAS acknowledges that these subsidies are more targeted approaches to providing financial assistance to residents who need it most.

C.4 Government Share of Healthcare Expenses: Should It Be Pre-funded?

Currently, the Government's share of healthcare expenditure (other than subsidies paid out of the Medifund) is met out of current revenue. If the Government maintains this share at a constant rate (40%, say), it will face the potential ballooning of cost due to the ageing population, just as residents and health insurers will.

There is an argument for the Government itself to pre-fund the subsidies it intends to provide directly to residents, either to offset healthcare expenses or insurance premium payments, to reduce the tax burden on the working population in the future, which will decrease in size relative to the size of the retired population. Otherwise, there will be inter-generational cross-subsidy of healthcare cost even if there is no explicit cross-subsidy of health insurance premiums.

Pre-funding of the Government subsidies provided to public healthcare providers may be less viable, given the potentially significant proportion of tax revenue which will have to be allocated to this provision. However, the Government may consider making a partial provision for the future expenditure, in its reserves.

D. MANAGING the HEALTHCARE COST

Background

The cost of healthcare emerged as a particular area of concern for Singapore in a recent consumer trends study of 28 countries. The Government has plans to expand healthcare services, e.g. by building the country's biggest healthcare complex by 2030 at Novena, to keep up with the increasing demand for such services. As the healthcare industry is human resource-intensive, wage increases will be a major driver of healthcare cost inflation. Low wage healthcare workers received wage increases of up to 10% last year.

The Government Parliamentary Committee (GPC) for Health called for rising cost to be managed through measures such as expanding the list of subsidised drugs and giving the public more information on private fees. A member of the GPC also suggested that easing the Medisave rules would stop people from using their savings unnecessarily. For example, it will discourage those who may not need to stay in hospital for a procedure from doing so to tap Medisave. One commentator suggested that people should be able to get subsidies for care programmes, rather than getting the bulk of subsidies at hospitals. Another suggested that co-payment requirements might be detrimental for promoting preventive services.

Another commentator observed that market-driven healthcare pricing has "crept into" the public sector, bringing costs up. He also said that, as the elderly population grows, the challenge is for the Government to keep the economy competitive so that it has resources to finance more healthcare without having to tax shrinking young age groups to unbearable levels.

SAS Preliminary Comments

D.1 Drivers of Medical Cost Inflation

The key to keeping health insurance premiums affordable is to control medical cost inflation, which is driven by the following principal factors:

- Inflation of the underlying cost of delivering healthcare services (e.g. wages of healthcare personnel); and
- Increasing utilisation of healthcare services by each resident (e.g. undergoing additional tests and examinations or elective procedures), thereby increasing the cost per admission or per disability. This increase in utilisation may be exacerbated by the extension of insurance coverage (see discussion on induced demand below).

D.2 Ageing Population

The ageing of the population will raise the demand for healthcare services which will, in turn, lead to increases in healthcare cost, for each procedure or for each course of treatment, unless supply can be raised to meet the increasing demand. Ultimately, these increases will result in health insurance premium rate inflation.

The Government has taken steps to keep supply in line with demand. While the physical infrastructure can be expanded, the recruitment and training of healthcare personnel remains a challenge.

It is also implementing programmes to re-structure the delivery of healthcare services so that patients migrate from the most cost-intensive facilities (acute care hospitals) to less cost-intensive facilities (e.g. community hospitals) and finally to the least cost-intensive facility, the home. It has

also encouraged residents to take up preventive measures like regular health screenings and follow-up visits to doctors for long-term conditions, like diabetes by, for example:

- Providing subsidised services; and
- Allowing withdrawal from the Medisave account to pay for these services.

The question is whether health insurance plans can be re-designed to support these Government initiatives, e.g. by providing benefits for residents who incur expenses in step-down care facilities (some of which can already be found in current Integrated Shield plans) or premium discounts for favourable insured resident behaviour (e.g. regular attendance of health screening (regardless of result) and follow-up doctor visits), which has to be documented. Medishield can take the lead in this area. By setting the parameters for these benefits, Medishield can provide a template for private insurers to follow suit.

Providing step-down care benefits can result in lower health insurance premiums if residents are persuaded to move from higher-cost acute care settings to lower-cost settings. It may be time to look at health insurance in a holistic manner, as a tool for managing the cost of financing the whole continuum of care, from acute care to long-term care for the disabled or cognitively impaired. For example, it may be cost-effective to integrate the Medishield and ElderShield schemes. Having developed in isolation from each other, integration may prove technically difficult. However, discussion should begin on the development of an insurance plan which can cover the cost of paying for healthcare services on an end-to-end basis, which does not leave gaps through which residents can fall, resulting in them having to bear large expenses which are uninsured (e.g. after discharge from hospital but still requiring care, but their conditions do not fulfil the definition of disability required for payment of long-term care benefits).

In **Part B, Section B.1.4**, it was suggested that a more sophisticated deductible and co-insurance structure may be adopted, for example, to differentiate the deductible and co-insurance percentages for expenses incurred in a private hospital and for expenses incurred in a community hospital, to encourage more cost-effective behaviour.

Providing "wellness" discounts will increase premium cost in the short-term until the desired positive insured resident behaviour translates into lower healthcare cost per resident. The effect of wellness programmes on health insurance claims has been studied in places like South Africa. These studies can be reviewed for the application of similar programmes in Singapore, with insurance as one driver for promoting wellness maintenance behaviour.

D.3 Induced Demand and Managed Healthcare Systems

It is a well-known phenomenon that the presence of health insurance may induce demand for healthcare services, and may increase their utilisation and, hence, the amount of expenses incurred for such services. The presence of deductibles and co-insurance mitigate this effect but any insurance of these elements reduces the impact of their mitigation effect.

Where healthcare cost had risen alarmingly, managed healthcare systems have been developed where, for example, utilisation of healthcare services must be pre-approved by the payor for these services (usually an insurer).

Managed healthcare systems have had mixed results in controlling healthcare services utilisation where such systems have been implemented, especially in the US. In a more controlled environment like Singapore, where the public sector manages a significant share of healthcare services provided (e.g. it manages more than 75% of hospital beds) and with only a small number of major players in the private healthcare sector, it may be possible to develop a system which controls utilisation without denying any resident essential medical attention and treatment, and which allows both the public and private sectors to maintain their viability.

E. ROLE of the MEDISAVE ACCOUNT

Background

The use of the Medisave account has been expanded to cover more long-term medical treatment of chronic conditions and preventive services, like health screening and vaccinations. The limits on withdrawals have also been raised. The Minister for Health cautioned that extending Medisave should not be at the expense of depleting savings for future usage or for paying Medishield premiums.

One commentator was concerned that the Medisave account balance would be depleted by withdrawals to pay health insurance premiums, and might not be adequate to meet on-going uninsured healthcare expenses. On the other hand, another commentator proposed that the limits on withdrawals be raised to be sufficient to meet the premiums for at least the lowest benefit Integrated Shield plan.

SAS Preliminary Comments

E.1 Competing Demands on the Medisave Account

It is clear that Medishield premiums will increase if the changes to the Medishield scheme proposed by the Government are implemented. Medisave contributions may have to be increased to maintain adequacy of the balances in the Medisave accounts of residents to meet future premium payment. If pre-funding by personal provision is also introduced at the same time, and the Medisave account is decided upon as the pre-funding instrument, then the increases in contributions required will be even higher.

At the same time, the Government is expanding the use of Medisave account for on-going healthcare expenses, including long-term medication or treatment for additional chronic conditions, regular health screenings and vaccinations. Withdrawals from the account for these uses will erode the balance, and require even higher Medisave contributions.

E.2 Adequacy of the Account Balance

The issues of calculating the minimum balance which will be required to be maintained, to meet future premium commitments were discussed in **Part B, Section B.4.1**. The Government will have to communicate with residents on the adequacy of balances in their Medisave accounts, which may include:

- Revisions of the Medisave Contribution Ceiling (MCC, which caps the balance in the account and triggers the transfer of excess Medisave contributions to the Special Account, and of the Medisave Minimum Sum (MMS, the minimum balance which must be retained when a CPF member withdraws his account balances at age 55) – the MCC and MMS may have to be resident-specific depending on individual factors which are parameters for determining the adequacy of the balance (e.g. age, preceding year's contribution, number of dependants insured).
- Giving more information to CPF members in their CPF statements so that they will be able to estimate the impact of paying insurance premiums on their account balances.
- Developing tools for use by CPF members so that they can project the movements in their CPF account balances, based on assumptions about the future (e.g. their own wage growth rates (which will determine the amount of contributions to their CPF accounts), rates of interest credited to their accounts, future insurance premium payment amounts (which may be adjusted for inflation), retirement age (which, upon attaining, contributions cease)).

To ensure that there is always an adequate balance in the account to meet future insurance premium payments, the account may be further sub-divided with a premium sub-account which may be drawn upon only to pay insurance premiums, as discussed in **Part B, Section B.4.1**.

E.3 Increasing Medisave Contributions

Increasing the rates of mandatory contributions to CPF accounts and to the Medisave account, in particular, is subject to competing demands on the residents' wages. Enhancing a resident's healthcare financial security should not be at the expense of his or her general retirement financial security (e.g. by diverting contributions from the Ordinary and Special Accounts to the Medisave Account). It would then appear that any increase in Medisave contributions would have to be made at the expense of current consumption or savings for other purposes (e.g. housing).

Alternatively, the Government can encourage additional voluntary contributions to the Medisave account, by relaxing the limits imposed on such contributions currently and providing incentives for making additional contributions. For income tax-paying residents, an incentive is already given in the form of tax relief on these contributions. However, about 65% of residents are not required to pay income tax and the tax relief is of no financial value to these residents. One idea, which the Government may consider, is to provide matching contributions of 18% (say) of voluntary contributions (subject to a cap) less any tax relief earned on the contributions.

F. IMPACT on INTEGRATED SHIELD PLANS

Background

By its name, it is clear that Integrated Shield plans (approved under the Private Medical Insurance Scheme) will be affected by any changes made to the Medishield scheme with which these plans are integrated. The changes currently proposed will have a significant impact on these plans.

SAS Preliminary Comments

F.1 Universal Coverage

Providing universal coverage under the Medishield scheme has implications for the Integrated Shield plans. There will be even greater divergence between the Integrated Shield plan and the Medishield scheme, in terms of the terms and conditions for eligibility for payment of benefits, which has to be managed.

Insurers of Integrated Shield policies are unlikely to be able to offer universal insurance coverage, in terms of coverage of full benefits for all medical conditions, especially pre-existing conditions, as take up of these policies will remain voluntary and anti-selection against the insurer, by residents with such conditions, is a major risk. The insurer must underwrite. Unfortunately, underwriting has sometimes been described as "cherry picking". Underwriting is a fundamental risk management process for the insurance industry, and it should be understood that insurance as it is recognised today simply could not exist without underwriting.

The extension of the Medishield scheme to residents who were denied insurance due to the existence of medical conditions will also have implications for the pricing of the Integrated Shield plans, as this extension (assuming that there are no other changes made to the Scheme at the same time) will cause the cost of claims and, hence, the premium, per insured member under the Medishield scheme to rise. As an insurer of an Integrated Shield plan acts as an agent for the Government (represented by the Central Provident Fund (CPF) Board) in collecting Medishield premiums and paying Medishield claims, it will have to increase the premiums for its plan to cover the increase in Medishield premiums it has to transfer to the CPF Board, regardless of the high likelihood that the residents it insures (who will have been underwritten) may not benefit from this extension to cover pre-existing conditions.

F.2 Premium Rates and Pre-funding

Changes in Medishield benefit payment terms and conditions will affect Integrated Shield plan premiums. The insurer of an Integrated Shield plan will have to increase the premium rates for its plan to meet the additional premiums it has to transfer to the Board. However, if changes in the Medishield benefits result in any reduction in the benefits which it has to pay under its Integrated Shield plan, in excess of the Medishield benefits, such a reduction will provide some offset against the increase in premiums it has to transfer to the Board.

Pre-funding of the second form, i.e. with some element of cross subsidy from the younger residents to the older residents, has implications for the Integrated Shield plans. The likelihood is that the age profile of residents insured under Integrated Shield plans will be lower than that of all residents insured under the Medishield scheme. As such, Integrated Shield plan insurers may transfer more in premiums, which include the cross-subsidy margins, to the CPF Board than it receives in claims from the Board. This will affect the profitability of Integrated Shield plans. An insurer may have to recoup these deficits from the premiums they charge on these Integrated Shield plans to meet its profit targets, e.g. by further increasing their premium rates.

F.3 Sharing the Healthcare Cost

The premiums for Integrated Shield plans designed to meet the cost of medical attention received in public hospitals are sensitive to changes in the Government direct subsidies to public hospitals and other medical institutions.

To encourage residents to buy insurance which is adequate for their needs, the Government may consider extending the exemption from GST liability to premiums on Integrated Shield plans also, if it exempts premiums on the Medishield scheme from this liability.
