DEVELOPMENTS IN THE MEDICAL AND HEALTH INSURANCE SECTOR

Medical inflation, an increase in the utilisation of medical services and the changing demographics have spawned significant developments in the medical and health insurance (MHI) sector in Malaysia. Total expenditure on healthcare has continued to experience an increasing trend, with a greater number of Malaysians turning to the private insurance industry to finance their healthcare expenditure. Structural changes have also taken place, most evidently in the broadening range of MHI products and providers, and the emergence of managed care organisations as an increasingly important feature in the financing and delivery of healthcare.

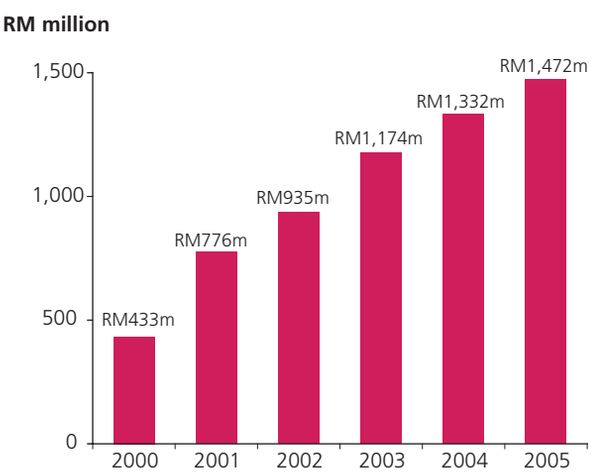
This article reviews these developments together with the regulatory initiatives that have been implemented to achieve an appropriate balance between enhancing access to healthcare through private insurance, and containing costs to promote the long-term sustainability of the private health insurance sector. Some of the key challenges for public policy in achieving this balance moving forward are also considered.

Growth and Profile of the MHI Sector

MHI products have been sold in Malaysia since the 1970s. However, public reliance on private insurance to finance healthcare expenditures remained limited for a long time to the benefits that were provided under the personal accident, workmen's compensation and motor (third-party bodily injury) insurances.

Sales of MHI policies only surged in the mid 1990s after the introduction of personal income tax relief for the purchase of MHI policies in 1996 and following policy relaxation to allow life insurers to sell standalone MHI policies in 1997. In the recent five years, annual premium income generated from yearly renewable MHI policies has increased by an average annual rate of 28% to RM1.5 billion in 2005. Including long-term MHI policies, total premium income in 2005 amounted to RM2.4 billion or 10.2% of the insurance industry's total premium income. About

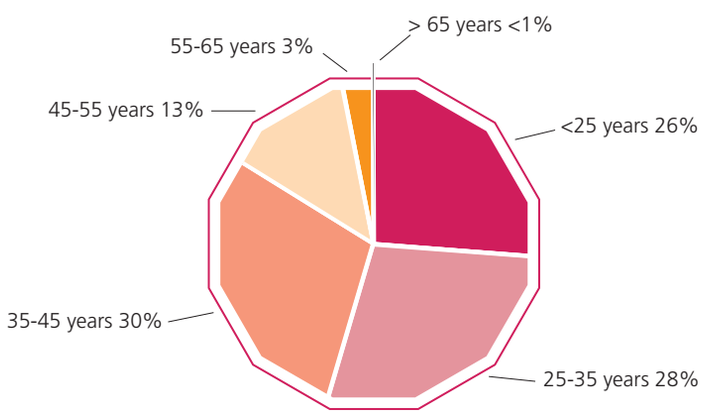
Chart 1:
Premium Income from Yearly Renewable MHI Policies



80% of MHI business was written by life and composite insurers, mainly through extensions to life insurance policies.

Individual policies accounted for more than 80% of total MHI policies sold in 2005, mainly driven by an increased awareness among individuals of the need to make adequate provisions for their personal healthcare expenditure, the growing preference for better private healthcare

Chart 2:
Distribution of Individuals Covered by MHI Policies by Age

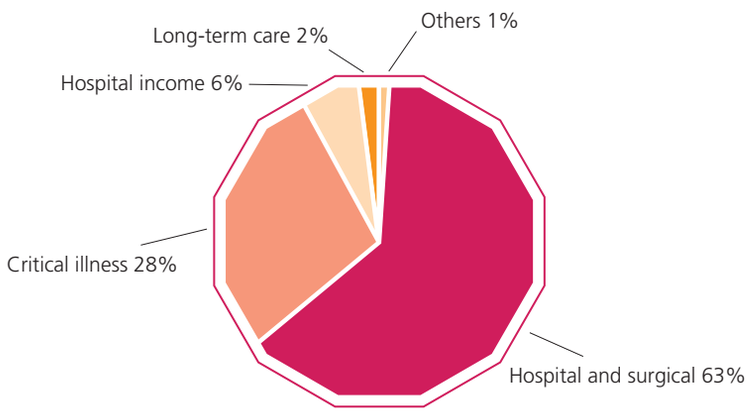


services and rising healthcare costs. Notwithstanding this, sales of group MHI policies have significantly outpaced that of individual policies in recent years with health benefits being provided more widely as part of compensation packages offered by employers. Between 2003 and 2005, net premiums generated from group MHI policies grew at an average annual rate of 30%, compared with the growth of 10% recorded for individual policies.

Based on a recent survey conducted by the Bank, it is estimated that about 15% of the total population have MHI protection. Demographically, 84% of individuals covered under MHI policies are below the age of 45 years. Those above 55 years old accounted for less than 4% of the individuals covered, reflecting the relatively young Malaysian population with only 8% of the total population above this age. This distribution pattern of individuals covered by MHI is also not unexpected given the relatively new growth of the domestic MHI sector and more expensive cost of coverage at later entry ages. Over time, however, a larger proportion of insured individuals in the higher age groups is expected in line with the ageing population.

Hospital and surgical insurance (HSI) policies, which provide for the reimbursement of medical, hospitalisation and surgical expenses incurred by consumers, continued to be the most dominant type of MHI coverage purchased, accounting for 63% of total MHI premiums written. In recent years, however, critical illness (CI) policies, which provide lump sum benefit payments to policy owners upon the diagnosis of insured illnesses, have become increasingly popular, accounting for a significantly higher share of 28% of total MHI premiums in 2005 from only 10% in 2002. Hospital income and long-term care policies mostly make up the balance of premiums written.

Chart 3:
Distribution of Premiums by Types of MHI Covers



The MHI market remains largely oligopolistic. The top three insurers in this sector have continued to account for more than 60% of the business during the recent five years. Despite the apparent concentration however, signs of a more competitive market evolving is evident from the growing number of insurers progressively increasing their individual market shares. This has resulted in a more dispersed distribution of MHI business across the industry with the market share of MHI premiums by the top 10 MHI insurers correspondingly declining from 86% to 83% between 2001 and 2005.

Emergence of Managed Care Organisations

Managed care organisations (MCOs) which specialise in the management and administration of healthcare schemes have gradually assumed a larger role within the MHI market with the significant growth in MHI business. Insurers, to a certain extent, have relied on the services of MCOs to increase administrative efficiencies and curb rising claims costs by exercising some form of control over the utilisation of medical services by policy owners to conform to normative or clinical-based standards.

As at end 2005, 22 insurers engaged MCOs to administer their MHI claims. MCOs are required to register with the Ministry of Health and are not directly regulated by the Bank. However, an insurer must obtain the approval of the Bank to engage the services of an MCO for the management of its MHI claims which is regarded as a core insurance activity. Under almost all of these arrangements, MCOs do not have the authority to approve or settle claims.

The prior approval of such arrangements has enabled the Bank to institute regulatory measures to ensure proper dealings between insurers and MCOs, and by extension, policy owners. In 2001, insurers were prohibited from selling group MHI policies to MCOs which covered their members under multi-level marketing schemes. The move followed reports of MCOs which had failed to remit premiums received from their members to insurers, hence depriving members of cover which they thought they had purchased. The sale of MHI insurance policies bundled together with other healthcare services provided by MCOs under medical card facilities which were offered to the public were also prohibited. This was aimed at ensuring transparency in

price and benefits relating to MHI covers purchased and eliminating the forced sale of MHI policies.

Product Trends

The increasing intensity of competition in the MHI sector has prompted substantive changes made by insurers to the features of MHI products offered in the market in order to sustain the long-term viability of the business.

Reflective of trends observed in more developed MHI markets in the Asia Pacific, North American and European regions, these changes include:

- an increase in the maximum insurable age from 60 to 70 years for HSI policies, and from 70 to 100 years for CI covers to meet the increasing demand from older consumers;
- the emergence of new products with variable levels of benefits tailored to individual needs and income levels, and with features specifically tailored for targeted segments of the population. More recent product launches have included products designed exclusively for females to provide coverage for female-related illnesses, and juvenile cancer riders to provide protection against critical illnesses common among children;
- a distinct shift towards non-guaranteed premium rates, notably for CI policies, as part of moves by insurers to better manage risks associated with higher than expected losses, particularly in light of the increasing withdrawal of reinsurance support for premium guarantees; and
- the introduction of cost-sharing arrangements (under which consumers bear a portion of the medical costs incurred) as a disincentive against the over-utilisation of medical services which in turn drives up claims costs.

These changes have resulted in an expanded product range to meet different consumer circumstances and greater access to MHI protection for the more vulnerable consumer groups. In the longer term, the introduction of cost-sharing arrangements and shift away from premium guarantees are also expected to promote greater individual responsibility for health spending which is essential to avoid spiraling healthcare costs and ensure the long-term viability of healthcare coverage provided by the insurance industry.

Regulation of MHI

The regulation of the MHI sector aims to continuously improve the functioning of the private health insurance market. This is achieved by focusing both on the economic aspects of MHI through prudential requirements that support the sustainability of private health insurance, as well as public policy objectives of promoting affordable coverage for the general population while meeting the needs of higher-risk individuals.

Initial regulatory initiatives focused on improving transparency in sales practices which had given rise to early public misgivings over the degree of protection which consumers had sought, and thought they had secured, under their MHI policies. In 2003, a transparency circular was issued by the Bank to raise the level of disclosures provided to consumers on MHI products. This was complemented by the publication and widespread distribution of information booklets on MHI under the InsuranceInfo consumer education programme, and specific mandatory training for agents on MHI products to equip them to provide sound and professional advice to consumers in the sales process. Insurers were also required to file product information, including sales and marketing materials, on new MHI products with the Bank prior to their sale. This was to ensure that materials used in the sales process were reasonably representative of the benefit entitlements which consumers could expect under their policies.

Reforms at a more fundamental level followed in 2005 which sought to more clearly define market rules governing terms of issue, premium ratings and benefit design of MHI products. At the heart of the reforms was the desire to achieve more equitable terms and conditions across the board for consumers that were consistent with the goals of expanded coverage and choice, without significantly impeding market innovation.

Following extensive consultations with the insurance industry, the Bank issued the Guidelines on Medical and Health Insurance Business in August 2005. Under the guidelines, the basic terms and conditions of MHI policies were reviewed to accord better protection to policy owners as enumerated in Table 1 below.

Table 1:
Requirements under Guidelines on Medical and Health Insurance Business to Enhance Policy Owner Protection

- Insurers must provide a mandatory minimum "free-look" period of 15 days for policy owners to review the suitability of a newly purchased policy before confirming their purchase.
- Use of standard definitions for key policy terms and conditions where applied to facilitate comparability between products and minimise public confusion over coverage due to variations that may not be apparent to policy owners at the point of purchase.
- Insurers are not permitted to unilaterally terminate cover during the period of insurance (for example, following a change in the health profile of a policy owner).
- Reduced waiting periods before a policy owner is entitled to claim for benefits.
- Exclusion of cover for pre-existing conditions must be in relation to medical conditions which a policy owner must have been reasonably aware of at the time of purchase of the MHI policy.
- Premium increases imposed on higher-risk individuals must be suitably moderated based on the aggregate experience of the portfolio.
- Proposal forms must include reasonably specific questions to prompt prospective policy owners to provide relevant information to an insurer for underwriting purposes before an insurer can repudiate a claim on grounds of non-disclosure.
- Information sheet containing key product features, including but not limited to, information regarding the terms of issue, major benefits and limitations and indicative premium rates, must be furnished to policy owners at the point of sale.
- Cost-sharing provisions shall not be mandatory and where applicable, shall be limited to the lower of 20% (excluding deductibles) or RM3,000 (inclusive of deductibles) on every claim, and shall not be mandatory.

Way Forward

Maintaining the delicate balance between commercial viability and greater access to healthcare continues to present significant challenges for public policy. While health insurance market regulation will continue to play an important role, the sustainable solution will entail further reforms that address several of the issues currently confronting the domestic healthcare delivery and financing system.

Among the key public policy challenges are:

- determining the appropriate means of healthcare financing for high-risk individuals over the long term;
- safeguarding the delivery of appropriate care for patients in the face of increasingly rigorous cost containment controls imposed by MCOs and insurers;

- enhancing access to reliable patient records which are needed to support more precise underwriting assessments and risk-based ratings, while safeguarding individual rights to privacy;
- mitigating insurance 'capture' by enabling insured individuals to source alternative MHI plans more easily without being subjected to the more stringent underwriting filters and benefit limitations usually imposed on newly insured individuals; and
- improving the efficiency of existing processes for hospital admissions and payments.

Several initiatives are already underway to address these challenges. These include the establishment of joint committees involving relevant stakeholders comprising insurers, healthcare providers and MCOs to streamline operating and claims management processes, and the introduction of take-over policy clauses which allow insured individuals to continue their MHI coverage with a different insurer without being subjected to the underwriting scrutiny and benefit limitations applied to first-time purchasers of MHI.

Continued persistence and the further deepening of these and other initiatives will be critical to achieve a system that adequately protects the vulnerable target groups, while expanding the choice and access to high quality healthcare for the wider population.