Life Insurance Association Singapore
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THE LIFE INSURANCE ASSOCIATION, SINGAPORE'S POSITION STATEMENT ON INTEGRATED SHIELD PLANS: COLLABORATION REQUIRED TO ENSURE AFFORDABLE, QUALITY HEALTHCARE FOR SINGAPOREANS TODAY AND THE FUTURE

Thursday, 1 April 2021 **-** The Life Insurance Association, Singapore (LIA Singapore) provides more context and perspective on four key areas below with reference to the Singapore Medical Association's (SMA's) Position Statement on integrated shield plans (IPs) released on 25 March 2021.

- Recommendations put forth by the Health Insurance Task Force (HITF) in 2016[1] to bring down the rate of claims cost inflation so that premium increases can be moderated and kept sustainable
- The role of panel doctors in ensuring continued affordable, quality healthcare
- Contributing factors to increases in overall cost and, consequently, premiums
- Complaints resolution for policyholders seeking to make appeals

HITF recommendations: Constant adjustments needed to balance the interests and trade-offs for policyholders, patients, and healthcare providers

From 2010 to 2015, IP insurers recorded rapid increases in claim costs.

As noted, contributing factors include the introduction of first-dollar cover riders in 2006, as well as withdrawal of the SMA Guidelines on Fees in 2007. The rapid pace of claim cost growth led to the HITF being established in 2015, and subsequent publication of the HITF report in 2016.

Insurers can compensate for claim increases by increasing premiums, and this is the simplest action to take. However, passively passing on double digit cost increases is not in the best interest of policyholders and would lead to healthcare being unaffordable for the next generation.

Therefore, the main aim of the HITF recommendations was to slow down the rate of claims inflation so that rapid premium increases would not be necessary.

The HITF recommended two types of mechanisms:

- The re-introduction of co-pays to give consumers "skin in the game",
- The setting up of panels, pre-authorisation, and fee benchmarks to nudge positive changes in healthcare providers' behaviour.

[1] *Managing the Cost of Health Insurance in Singapore (Oct 13, 2016) Health Insurance Task Force, Singapore. Available at https://www.lia.org.sg/media/1521/managingsingaporehealthinsurancecost_hitf_20161013.pdf*

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After the publication of the HITF report, insurers and the Ministry of Health (MOH) worked to implement its various recommendations. IP panels started to be introduced from 2016 onward.

Four years since implementation, is it now possible to do away with panels for IPs?

The simple answer is "Yes." But there are implications for doing so.

Removing panels as a control measure means that insurers would have to seek other ways to compensate. These would likely take the form of increased premiums, increased co-pays, and/or stricter application of pre-authorisation.

The question really is, what balance should be struck between various cost containment measures?

The honest answer is that LIA Singapore and individual insurers do not have a definitive answer as to what the right balance of measures is.

Different insurers have taken different approaches to the implementation of panels, pre-authorisation, and co-pays. Insurers will need to observe and analyse how policyholders and healthcare providers respond and adjust accordingly.

It will need to be an iterative process, because there will be trade-offs between the interests of policyholders, patients, and healthcare providers that all parties need to accept. Insurers are in the middle trying to seek the best balance to this equation in a sustainable manner.

Preferred Healthcare Provider Panels: Priority is to provide the best value for policyholders

Preferred healthcare provider panels are not new.

They have been a longstanding feature within the employee benefits space in Singapore. Most people in the workforce would be familiar with the idea of seeing the company doctor. In overseas markets, many insurers specify that insured individuals are required to seek care from an appointed provider network for full benefits to apply.

As applied to cost containment, the underlying concept of a panel is to use the insurer's bargaining power to negotiate preferential rates from healthcare providers in exchange for higher volumes. This is the way panels work in the employee benefits space in Singapore, and in multiple markets overseas. It is no different from the use of group procurement in industries outside healthcare.

So long as a reasonable fee is left on the table for the doctor, and savings are passed on to policyholders in the form of lower premiums, this is a reasonable approach to take. Insurers are playing the role we should in stretching the healthcare dollar for policyholders.

Panels Complement the MOH Fee Benchmarks: Provide an enforcement mechanism

The use of panels in this way is complementary to the MOH Fee Benchmarks because they address two issues that the benchmarks themselves are not able to.

First, the fee benchmarks do not include an enforcement mechanism. The benchmarks provide guidance as to what are considered acceptable charges. However, doctors are not required to abide by them and can charge above the upper bound should they feel the need to do so[2].

This issue of enforcement can be addressed through the appointment of panels, within which doctors sign on to enforceable contracts, and are therefore legally bound to charge within the agreed fee range.

Second, where to charge within the range of the fee benchmark can be unclear. The average difference between upper and lower bound is 1.8 times (though only approximately two per cent of procedures have the upper bound at 4.2-6.3 times the lower bound).

Many procedures do not have descriptors for when a doctor should charge toward the upper end and when a doctor should charge toward the lower end. This means that doctors have considerable discretion to decide where to charge within the range of the fee benchmarks.

Through panels, insurers can help address this by setting a default fee below the upper bound, as well as allowing charges above the default for cases which are more complex than the norm. So long as insurers are fair in allowing deviations, this should be a reasonable way to conduct panels. Some cases will be more complex than the norm and should be compensated as such, but it cannot be that every case is complex.

Claims data indicates that insurers are fair in practice. Panel claims from IP insurers have surgeon fees which span the full range of the MOH's fee benchmarks, and even have claims which are above the upper bound of the fee benchmark range. This indicates that insurers do give due allowance for cases that are more complex than the norm. The data is shown in **ANNEX A**.

Panel sizes have and continue to expand: Comprehensive panel is to the benefit of policyholders and insurers alike

Insurers have been expanding their panels and will continue to do so. It is in the interest of insurers to ensure that panels are comprehensive, to avoid policyholders having to consult non-panel doctors which likely incur higher costs.

Current IP panels range from 250-400 private specialists (noting that this range excludes the public sector doctors which some insurers also list on their websites). This is comparable to the typical size of an employee benefits private specialist panel. They should grow beyond this size over time.

Significant effort and cost on the part of insurers is needed to vet and monitor panel doctors, inadvertently imposing limits on the rate of panel expansion and the ultimate size that a panel can be. Insurers remain open to engaging stakeholders on the ideal size of a private specialist panel.

All insurers' panel fees are within the MOH Fee Benchmark ranges: Fees need to be set judiciously because of potential escalation in claims costs and, consequently, premium increases

LIA has been informed that all insurers have set their panel fees within the MOH Fee Benchmark ranges for the 218 procedures where these are available. Given that the upper bound is, on average, 1.8 times of the lower bound, setting panel fees at the upper bound of the MOH Fee Benchmarks will likely lead to escalation in claims costs and, as a consequence, premiums.

[2] *Although doctors are supposed to explain to insurers why they need to charge higher than the benchmark range, in practice, it is difficult for an insurer to question a doctor's assertion that a case is complex.*

Transparency in selection criteria of panel doctors: Due diligence to ensure the quality of healthcare services provided

As part of its constant review and update of guidelines, LIA Singapore has recently issued guidance to insurers that they should publish the general criteria for selection of panel doctors as a best practice.

Insurers would typically review the prospective panel doctor's past claims to see if the historical charges have been reasonable, whether there are any red flags in terms of volume of suspicious claims, and available markers of quality (e.g. re-admission rate).

The process may also include looking into doctors' overall reputation, doctors' training records and credentials, as well as checks on whether there are any disciplinary issues with the Singapore Medical Council (SMC). Insurers will work with stakeholders to better communicate their criteria to doctors.

IP Financials: Deeper analysis required to inform further actions that ensure the sustainability of IPs as a healthcare financing tool

Mathematically, claim cost increases, on a per life basis, are either due to increases in cost per claim, or due to increases in claim rate (the number of claims for every 100 policyholders, also referred to as claims incidence).

As noted, based on MAS data, the average cost per claim went down by one per cent from 2016 to 2019. Claim rate for IPs has been growing at approximately 9% year on year, which is close to MediShield Life's claim rate growth of 10%.

That IP claim rate trends are similar to MediShield Life's claim rate trends are not surprising and implies nothing about whether or not the claim rate inflation is excessive.

70% of MediShield Life policyholder have IPs. As all IP claims are also MediShield Life claims, the claim rate for MediShield Life will be very close to the claim rate for IPs because the two populations have a very high overlap.

Based on aggregate amounts, cost per claim has not risen in recent years[3]. However, IPs have been around for many years now, and 2016-2019 is a relatively short part of this history. We should therefore take a longer-term view to understand the fuller picture. For that, it is useful to look at the IP insurers' annual returns to the Monetary Authority of Singapore (MAS)[4]. Note that these returns contain other long-term health products, but about 77% were IPs based on 2018 data[5].

The graph below shows the trends in claim rate (number of claims registered divided by the number of lives covered) and the cost per claim (gross claims settled divided by number of claims registered).

As can be seen, cost per claim rose very sharply from 2010 to 2014, but has plateaued since then, and actually fell between 2017 and 2018. This could possibly be because insurers started implementing cost containment measures after the HITF report release in 2016. However, claim rate rose considerably from 2013 to 2017, and has continued to climb since.

[3] The Singapore Actuarial Society's paper highlighted the need for detailed data analysis. Cost per claim depends on many factors, including diagnosis mix, provider mix, procedure mix, and the way claims are booked in the system.
[4] There are some anomalies in the MAS data due to factors such as reinsurance, but these do not affect the overall conclusions.
[5] Medishield Life 2020 Review: SAS Comments. Prepared by the Singapore Actuarial Society.

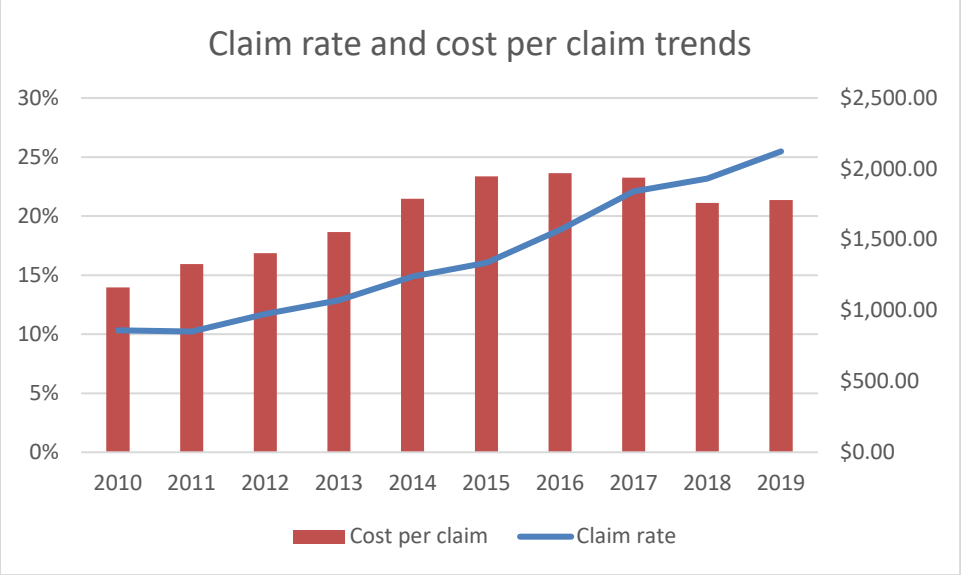


FIGURE 1: Claim rate and cost per claim trends for long term health portfolios of IP insurers[6]

Even if cost per claim remains constant, claim rate growth of 9-10% year on year implies that total claim costs per life assured will rise at 9-10% year on year.

The key question, which remains unanswered, is whether a 10% Compound Annual Growth Rate (CAGR) in claim rate is appropriate and manageable. The implications of continued claim rate inflation of this magnitude are potentially serious.

Claim rate is currently at about 20-25%; i.e. 20-25 claims for every 100 policyholders. If claim rate continues to climb at a CAGR of 10%, it will reach about 30-40% in 5 years, and 50-65% in 10 years. At some point, the risk pooling effect may break down.

In addition, 10% year on year increase in claim cost per life assured is likely to be many multiples of income growth, which means that affordability will become a concern.

This is a complex issue that requires much deeper analysis, including segmentation by policyholder groups, and an assessment of what types of claims are driving the increase in claim rate.

Management expenses and distribution costs: Initial investments to implement HITF recommendations for a more sustainable way forward

It was said that management expenses and distribution costs, rather than claims, are primarily responsible for cost increases experienced by IP insurers. While LIA Singapore agrees that it is important to control non-claim expenses, it is important to recognise that claims are still the main source of overall cost increases.

Again, looking at the longer-term trend offers more insights as IPs have been around for some time and various actions have been implemented to manage claims cost.

[6] *Note: One insurer was removed from the data for this chart due to anomalies in number of claims registered for 2010-2014 which may be due to errors. This does not affect the overall results.*

The following chart shows the growth in total claims, management expenses, and distribution costs from 2010 to 2019. The data comes from the annual returns which insurers submit to MAS.

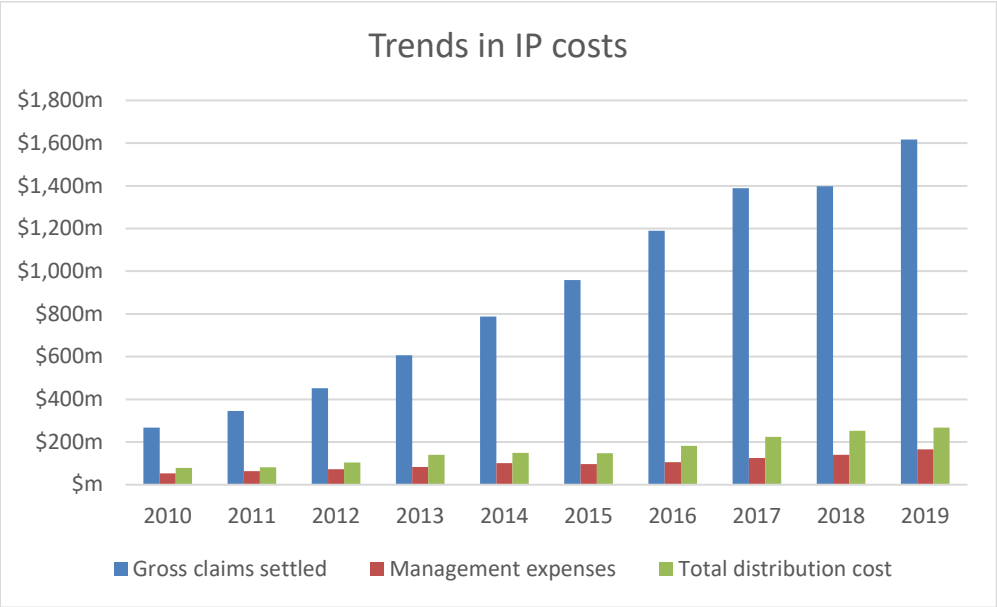


FIGURE 2: Gross claims settled, management expenses and total distribution cost for long term health portfolios of IP insurers

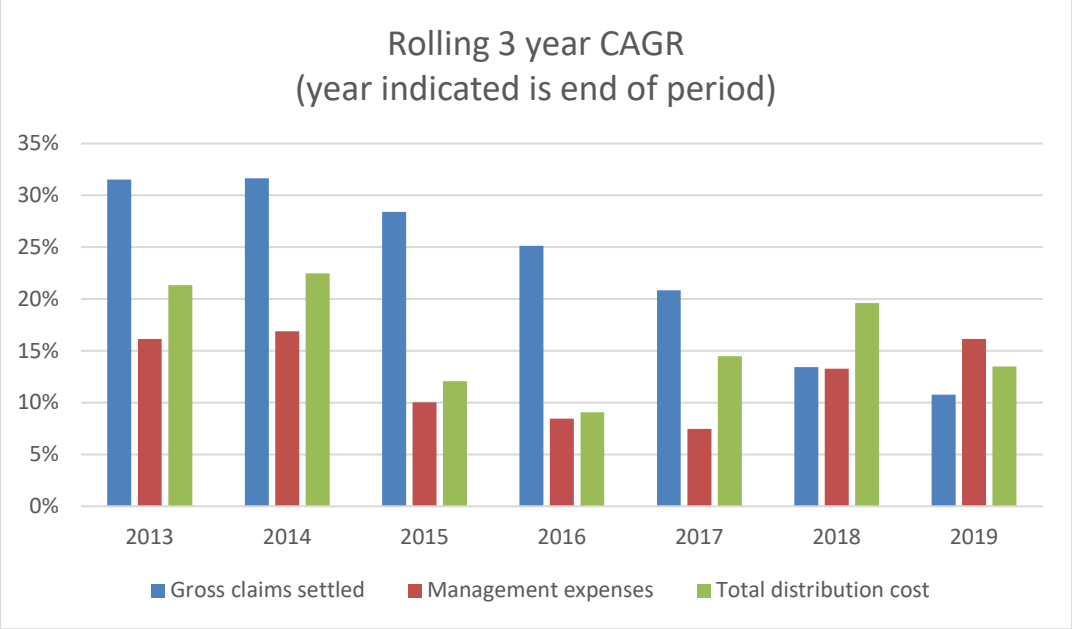
Total claims grew from $267m to $1.6b (a 6-times increase) from 2010 to 2019.

By comparison, management expenses grew from $53m to $166m (a 3.1-times increase), while total distribution cost grew from $79m to $267m (a 3.3-times increase). Therefore, over this longer period, claims accounted for 81% of the growth in costs experienced by IP portfolios.

The following graph shows the rolling three-year CAGR for claim costs, management expenses and distribution costs for IP insurers. Growth in management expenses and distribution costs have generally lagged that of claims. However, after 2017, there is an increase in the CAGR for management expenses alongside continued decline in the CAGR for claims.

One possible explanation is that insurers started implementing the HITF recommendations, and incurred management expenses for doing so. At the same time, the implementation of these recommendations may have had the effect of moderating claims growth. If this is true, then on an overall basis, the HITF recommendations have had the beneficial effect of moderating overall cost growth.

Another factor to consider is that 2016 and 2018 saw new entrants into the IP market. As new entrants have relatively small portfolios, they will tend to have higher management expenses as a fraction of premiums. In addition, distribution costs are higher for policyholders in the first year of a policy, as considerable work is involved in the inception of IP policies.



LIA Singapore is in the process of working with local academics to further analyse the drivers of IP cost increases and will share these findings publicly.

Medical Loss Ratio regulation: For regulators to review feasibility and value of implementation for policyholders

Medical Loss Ratio (MLR) regulation, where insurers are required to spend above a defined percentage of premiums on claims, is found in the US and some other markets. Applying this to Singapore's IP market is not, in and of itself, an unreasonable suggestion. However, it is important to note that the market environment for Obamacare plans is quite different from the market environment for Singapore IPs. Hence, it may not be appropriate to directly transplant the Obamacare regulatory requirement of an 80-85% loss ratio to the Singapore context.

Insurers in the US operate at a much larger scale than insurers in Singapore. US health insurers such as Cigna, United Health, and Blue Cross Blue Shield, cover over 10 million lives each, more than the population of Singapore. Health insurance premiums are also much higher in the US than in Singapore which makes it easier to cover management costs at a lower percentage of premiums. Finally, healthcare costs are generally much higher in the US than in Singapore.

In addition, the evidence on the effectiveness of MLR regulation in the US is mixed. Some research has suggested that it does not result in a decrease in premiums but leads insurers to reduce cost containment efforts to allow claim costs to grow to meet the MLR target[7].

LIA Singapore will defer to the relevant regulators to make a more detailed analysis and determination on the feasibility and value of introducing MLR regulations for policyholders.

[7] *Cost of Service Regulation in U.S. Healthcare: minimum Medical Loss Ratios (April 2017) National Bureau of Economic Research. Available at https://www.nber.org/system/files/working_papers/w23353/w23353.pdf*

Complaint resolution: Policyholders are advised to continue to use established processes including FIDReC

LIA Singapore's understanding is that the SMA's Complaints Committee is primarily intended to be a channel for complaints from doctors.

Policyholders seeking to make appeals on their cases are advised to continue to use their insurer's established appeal process, or, failing that, bring the case to the Financial Industry Disputes Resolution Centre Ltd (FIDReC) for adjudication. FIDReC is the duly appointed entity for such matters.

Way Forward: All parties to work collaboratively to achieve better outcomes for all

Managing healthcare costs is a complex issue for which there are no simple solutions. At the same time, doing nothing is not an option because the current trajectory of healthcare cost increases in Singapore raises real sustainability concerns.

LIA Singapore has consistently advocated the need for collective action on the part of multiple stakeholders to tackle this issue. We remain open to engaging with other stakeholders to chart a way forward that balances the interests of policyholders, patients, and healthcare providers, and leads to better outcomes for all.

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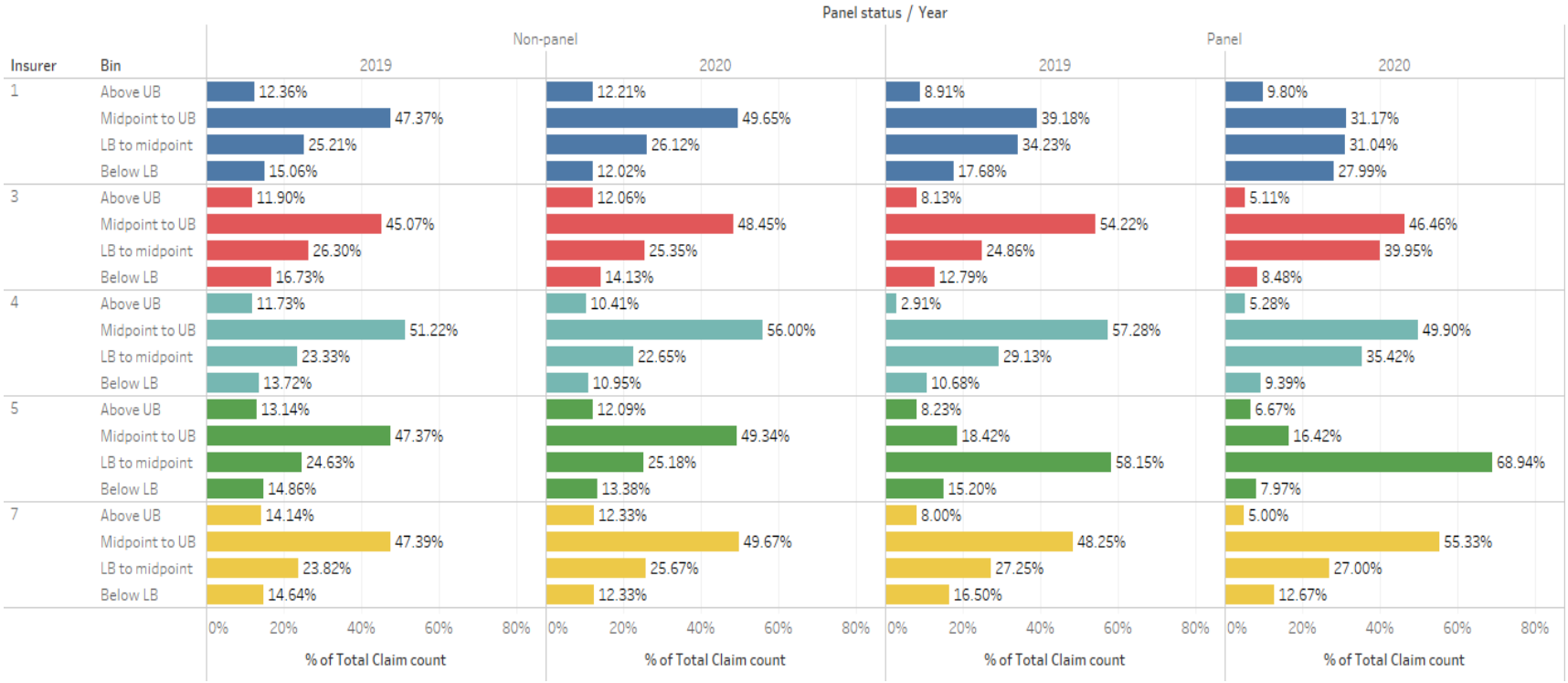
ANNEX A

Proportion of claims approved at different levels relative to the MOH Fee Benchmarks

The chart below shows the percentage of claims with surgeon fees approved below the Lower Bound (LB) of the MOH Fee Benchmark range, between the LB and midpoint of the MOH Fee Benchmark range, between the midpoint and the upper bound (UB) of the MOH Fee Benchmark range, and above the UB. Five insurers were able to provide the required data in time for this study. All five insurers have approved claims above the UB of the MOH Fee Benchmarks even if the claims came from panel doctors. This study was conducted in Nov 2020.



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