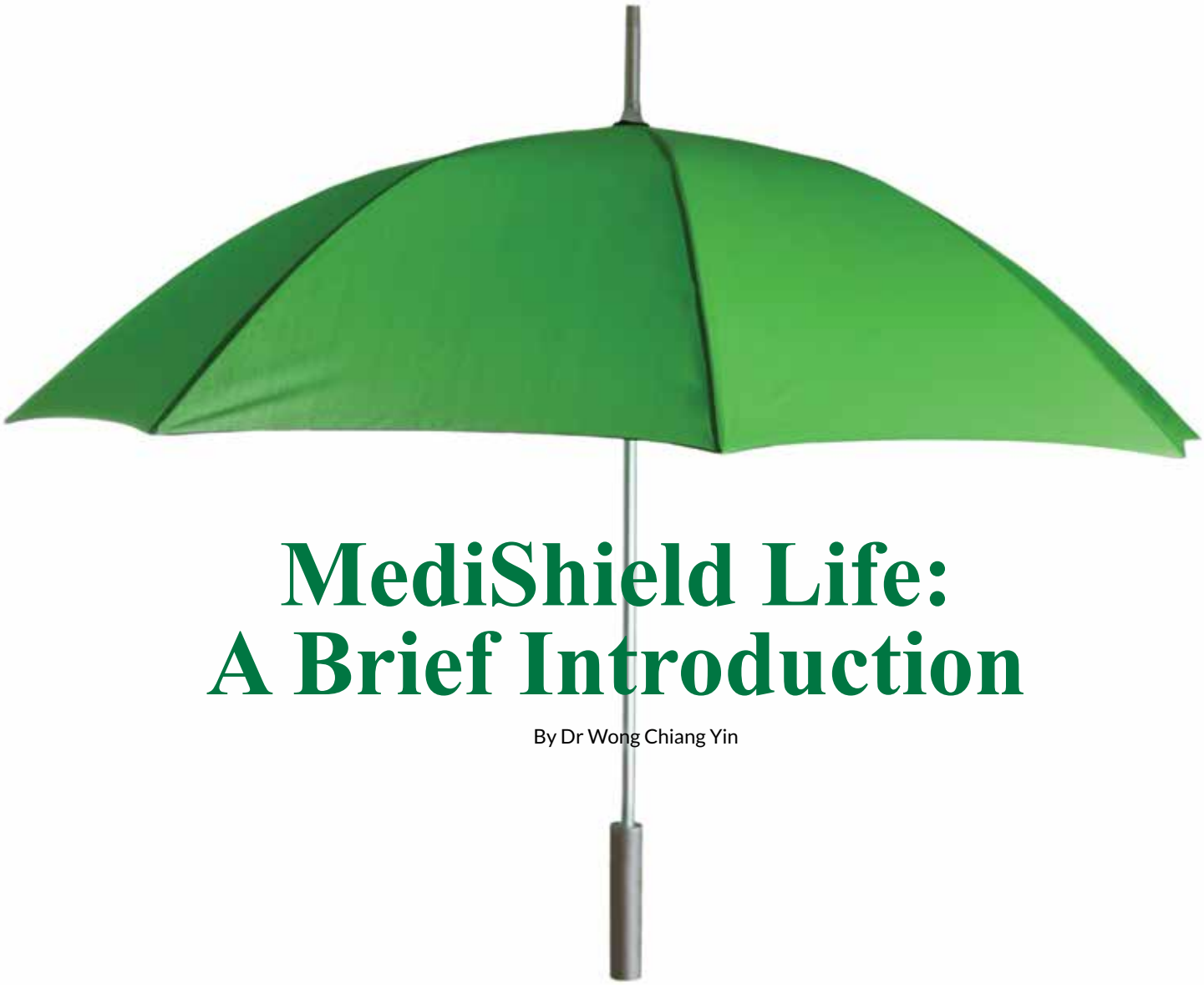

MediShield Life: A Brief Introduction

By Dr Wong Chiang Yin

IN NOVEMBER 2013, the MediShield Life Review Committee was formed, and released its recommendations in June this year. The Ministry of Health (MOH) announced last month that it has accepted the Committee's recommendations.

This article will discuss briefly the following questions:

1. What is MediShield Life?
2. How is MediShield Life different from MediShield?
3. What is MediShield Life trying to achieve?
4. What does MediShield Life mean for the doctor?
5. What does MediShield Life mean for the doctor as a patient?
6. Other issues?

What is MediShield Life?

To answer this, we need to remind ourselves what the original MediShield scheme is all about. This quote from the MOH website summarises its intended purposes:

MediShield is a low cost basic medical insurance scheme. Introduced in 1990, the government designed MediShield to help members meet large Class B2/C hospitalisation bills, which could not be sufficiently covered by their Medisave balances. To avoid problems associated with first-dollar, comprehensive insurance leading to unnecessary over-consumption of healthcare services, MediShield operates with co-payment features such as co-insurance and deductible where patients share part of the responsibility for his medical expenses. The co-insurance and deductible can be paid using Medisave or cash.[1]

As stated in the preceding paragraph, the key elements of MediShield are:

1. Low cost;
2. Basic medical insurance;
3. Meet large B2/C class hospitalisation bills and selected subsidised specialist outpatient bills (eg, cancer treatment) that are not adequately covered by Medisave (note: not sized for A/B1 wards or private hospitals, and not for outpatient treatment); and
4. Co-insurance and deductibles.

Most of these remain in place for MediShield Life, which is an improved version of MediShield.

MediShield Life also represents one of the Government's three recent significant shifts in health financing. The other two are: increasing its share in healthcare spending (from 33% to 40% of total healthcare expenditure) and enhancing flexibility in Medisave.[2]

How is MediShield Life different from MediShield?

The Review Committee announced on 5 June this year that MediShield Life should be enhanced in the following aspects:

1. Remove the lifetime claim limit of $300,000.
2. Those with pre-existing diseases should also be covered. The additional costs of covering individuals with pre-existing conditions will be mostly borne by the Government. These individuals will also help to co-share these additional costs through higher premiums (additional 30% for ten years).
3. Increase the policy year claim limit by 40% from $70,000 to $100,000.
4. Increase the daily claim limits for normal wards and intensive care unit wards by up to 55%.
5. Increase the claim limits for surgical procedures by between 25% and 93%.
6. Increase the daily claim limits for community hospitals by 40% from $250 to $350.
7. Substantially increase the claim limits for outpatient cancer chemotherapy and radiotherapy treatments, to better cover the cost of subsidised cancer treatment.
8. Lower co-insurance rates from the current range of 10% - 20% to 3% - 10%.
9. Start premium rebates earlier, from age 66, instead of 71.

Hence, the main ways MediShield Life differs from MediShield can be summarised as:

1. Life-long coverage (as opposed to up to the age of 80 and the subsequently raised limit of 92 years);
2. No more lifetime limit;
3. Raised withdrawal limits for a range of claims;
4. Coverage of pre-existing diseases;
5. More "front-loading" of premiums so that people pay more when they are younger and less when they are older (ie, premium rebates start earlier) and
6. Co-insurance substantially reduced, especially for large bills.

But what hasn't changed (and this is extremely important to note) are:

1. MediShield Life, like MediShield, aims to address the problem of paying for large bills in B2 and C class wards.
2. The deductible remains at $$2,000 and $1,500 for B2 and C class hospitalisation bills respectively (which is the amount you must pay before MediShield payouts kick in).

What is MediShield Life trying to achieve?

The design and implementation of MediShield Life had to strike a good balance between several competing demands, which includes:

1. The need for MediShield Life to be financially sustainable so that there is no intergenerational transfer of liabilities, ie, our children and grandchildren ending up paying for our elderly's healthcare costs, other than those within the same family unit.
2. To preserve the original aim of MediShield, which is to pay for large healthcare bills encountered in B2 and C wards, while leaving smaller bills to be paid for by other means, like Medisave, out-of-pocket payments, employee benefits, and so on. MediShield Life rightly pays more than MediShield for big bills.
3. To avoid the two main pitfalls of private insurance schemes – adverse selection and moral hazard (in layman terms respectively: "cherry picking" by insurers and "buffet mentality" by the insured). The scheme is all-inclusive, even for those with pre-existing diseases; deductibles and co-payments remain as key features.
4. To give Singaporeans peace of mind – there are now no lifetime limit caps, and annual and daily limits of payouts have been substantially raised.
5. To keep MediShield Life premiums affordable, and well within what the vast majority of working Singaporeans pay in terms of Medisave contributions, so that out-of-pocket payments will not be needed to fund MediShield Life premiums.
6. To foster a spirit of collective welfare through healthy Singaporeans funding a small portion of the additional premiums of less healthy Singaporeans, in order to achieve universal coverage.

It is very important to note that MediShield Life by design will not suffer from mission overreach. The deductible of $2,000/$1,500 is quite a high threshold when you consider

the substantial subsidies that B2/C classes receive. It is estimated that about one in three bills will cross this deductible threshold. The target subsidy rates for B2 and C wards are 65% and 80% respectively. In other words, if we take a C class patient who only pays about 20% of the true cost of treatment, MediShield Life only kicks in when the total bill exceeds $7,500 and he pays the 20% of $1,500. For a B2 patient, the total unsubsidised bill must exceed $6,000 before he pays $2,000.

What does MediShield Life mean for the doctor?

MediShield Life will give patients a payout, where applicable, regardless of which hospital or ward they chose to stay in. This is an essential point to note. But as also mentioned above, the payout would be pegged to a simulated equivalent subsidised bill.

Hence, MediShield Life will impact public and private sector doctors differently. For the public sector doctor, whose patients are mainly B2 and C class patients, it would mean that most patients would not have to worry about large bills. Many of us may not be aware that many bills for B2 and C patients do not exceed $2,000/$1,500, hence MediShield Life will not kick in. For example, in the latest bill size data released by MOH for the period 1 June 2013 to 31 May 2014, the 90th percentile bill size for a laparascopic cholecystectomy for B2 patients in general hospitals ranged from $2,065 to $3,141. The corresponding numbers for C class bills were $1,502 to $2,779.

In other words, MediShield Life will be quite irrelevant to most laparascopic cholecystectomy patients, even if they opt for B2/C class beds, because the vast majority of subsidised patients with this condition incur bills that do not exceed the $2,000/$1,500 deductible significantly. They will pay with Medisave instead.

For A/B1 and private hospital patients, because the high bill sizes are pegged to the equivalent subsidised bill sizes before the MediShield Life payout is computed, MediShield Life will not alleviate largely the expenses they face. These patients should still rely on Integrated Shield Plans (IPs) to meet their needs.

Another example would be cataract surgery. The MOH bill size data states that the 90th percentile for cataract surgery for subsidised day cases in the public hospitals and centres ranges from $1,015 to $1,340. Again, since payouts are linked to these subsidised patient bill size numbers, even if the patients were private day surgery cases MediShield Life will not be relevant to ALL cases of cataract surgery due to the deductible requirement.

The positive impact of MediShield Life will be felt in larger bills incurred during catastrophic diseases, such as cancer surgery and acute myocardial infarction (AMI) with stenting. In the example given by MOH, a B2 patient only pays $2,595 out of a subsidised bill of $11,500 after MediShield Life kicks in for an AMI hospital stay. Under the existing MediShield scheme, the patient would have had to pay $6,156. A bill of $11,500 after government subsidy would be a very large B2 class bill at the 98th percentile.

MediShield Life also has significant impact on some elective procedures. For example, the median bill sizes of total knee replacement for C class ranges from $4,125 to $5,346; for B2 class, from $4,965 to $5,758. MediShield Life has lowered the co-insurance requirement for such bills from 20% to 10%, which results in much lower out-of-pocket or Medisave payments from the patients.

What does MediShield Life mean for the doctor as a patient?

Once we understand and remember the very important point of the $2,000/$1,500 deductible, and that all payouts are pegged to subsidised bills and not to the higher class or private hospital bill sizes that a patient stayed in, we can also make informed choices as potential patients.

If we see ourselves and our family members seeking subsidised care in the public hospitals, then MediShield Life will suit us just fine. But if we want to get care in A/B1 class wards or private hospitals, then MediShield Life alone will not be sufficient for our needs, unless we are prepared to pay a significant amount from Medisave (which is subject to withdrawal limits) and cash.

MediShield Life does offer us two distinct advantages over IPs and private hospitalisation insurance plans:

1. MediShield Life covers all pre-existing conditions (at a price). Most private hospitalisation plans and IPs exclude pre-existing conditions.
2. IPs do not allow for front-loading of premiums because an IP policy holder can withdraw from or join an IP anytime. There is no promise of continuity. MediShield Life, being a compulsory insurance scheme, is designed with front-loading of premiums. This means a more even re-distribution of premiums over our lifetimes, so that premiums do not rise so rapidly in one's old age.

Other issues?

What is unique about MediShield Life?

For any insurance scheme to work well, aside from relying on good actuarial practices, one has to contend with three factors, which are:

1. The size of the insurance premium;
2. The payout; and
3. The out-of-pocket portion, ie, the difference between the total healthcare bill as given by the healthcare provider and the payout.

Most healthcare insurance providers cannot control the size of the healthcare bill. They can only control the premium

and the payout. In other words, except for a very limited number of cases, the healthcare insurance provider has little control over the healthcare provider.

But MediShield Life is very different. In effect, the government controls all three aspects of the ecosystem. By pegging payouts to subsidised bills, it has implemented control and avoidance of mission overreach. The offering of B2 and C class services is essentially that of a monopoly run by restructured hospitals that are wholly owned by MOH.

Although there are many restructured hospitals offering B2 and C wards, by virtue of the funding formulas and the ownership and the appointment of board directors, the Government also has very good oversight and governance over these same hospitals.

So, with regard to systems design, there is good control over both the demand and supply sides of the equation, unlike conventional healthcare insurance in which there is little control over the supply side.

If MOH can truly exert control over how B2 and C services are scoped, delivered and subsidised, then we can be very optimistic that MediShield Life will work. However, if it is unable to do so, then two things will happen: premiums rise significantly or out-of-pocket payments by patients painfully increase. In the worst case, both will occur simultaneously and MediShield Life will fail as a healthcare funding policy tool.

Revisiting the 3M Framework

One may be surprised to know that the much vaunted 3M framework, ie, Medisave, MediShield and Medifund, only funds a purported 10% of total healthcare expenditure.

Government expenditure will soon account for 40% of total healthcare expenditure, up from 33% a few years ago. And then there is the 10% funded by the 3M framework. That leaves about half of total expenditure still funded either by out of pocket, employee benefits or other private insurance. Will this share of funding change with MediShield Life? Will the 3M framework shoulder a larger share of total healthcare expenditure in the future? This is a point healthcare policy makers should seriously mull over in the next few years.

A standard IP for B1 class patients

With the Committee's recommendation that there should be a "standardised" IP for B1 patients, should the government completely take over the running of IP for B1 patients and leave private insurers to concentrate on A class and private hospital patients? If the healthcare service product (B1 class in public hospitals) and the insurance product are BOTH standardised, then what is the role of having multiple private insurance healthcare providers? There is no room for product differentiation, and hence there is also little or any rationale for multiple insurance service providers as well, unless the standard plan is positioned as a required base for the other IP products with higher coverage. ■

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