

Insurers want all patients to pay part of hospital bills

They appeal to MOH to tweak rider regime in Shield plans, even for existing policyholders

The days of getting insurers to pay your entire medical bill may be drawing to a close.

The six companies selling MediShield Life-linked health insurance have appealed to the Ministry of Health (MOH) to make it compulsory for existing as well as new policyholders to pay part of their hospital bills, even if they buy riders that now cover the entire amount.

This dovetails with a suggestion from the Health Insurance Task Force (HITF) that patients pay part of their bills to keep claims from ballooning. The HITF had cautioned, however, that existing policyholders should not be disadvantaged.

Insurance companies said patients who do not have to bear any part of the cost not only make more claims, but their claims are also 20 to 25 per cent higher than those of people who pay part of their bills.

The large claims end up pushing up premiums for everyone.

Some 1.3 million people out of the 2.7 million covered by private Integrated Shield Plans (IPs) have riders that guarantee they pay very little or nothing towards their hospital bills. IPs incorporate MediShield Life - which covers subsidised treatment - but offer coverage for higher classes of care.

The insurers have asked that MOH require patients with full riders to pay a small part of their bills.

The Straits Times understands the figure is likely to be 5 per cent to 8 per cent, with a safety net written in to protect patients against really large bills. This safety net is a specified maximum amount patients need to pay in any given year.

Asked if the ministry would intervene, its spokesman said MOH supports the HITF's recommendations. The task force was set up to address the spiralling cost of medical insurance.

Healthcare inflation rose by 30.6 per cent in the 10 years from 2005 to 2015, compared with a 21.7 per cent increase in general inflation.

In 2016, to slow escalating insurance premiums, the task force recommended that all patients pay part of their bills to encourage prudent spending. It said people who do not pay a cent of their medical bills "may lack the incentive to manage their health and medical costs, translating to higher insurance claims".

It noted cases where private hospitals and doctors "overcharged patients by inflating certain components of the bill, unbundling certain routine laboratory tests for higher total billing or charging excessive amounts for consumables".

Patients who have to pay would likely question such charges. The task force suggested doing away with blanket coverage, with the caveat that any move not "disadvantage" existing policyholders.

The spokesman said: "MOH has been working with insurers on implementation of the task force recommendations. We will share more details in due course."

In 2008, NTUC Income tried offering only riders with partial coverage - but reinstated full-cover riders in 2015 after losing market share to its competitors.

Several insurers The Straits Times spoke to said no insurer is willing to suffer the same fate as Income. But they also cannot agree to stop selling riders for fear of falling foul of the Competition Act. Faced with underwriting losses, they turned to the MOH for help.

The problem has only deepened as riders become increasingly popular. In 2011, only 19 per cent of people here had riders. By 2015, 32 per cent did - with more than three in four having the most expensive, private hospital insurance plans.

Mr Oo Wooi Cheng, a finance executive who has an IP but no rider, and has seen his premium going up, hopes the ministry will step in.

He said: "I think a move by MOH would make sense and will help instil better responsibility in consumers of healthcare services. Otherwise, it could be subject to abuse."

QUESTIONABLE CLAIMS FROM PATIENTS

The Health Insurance Task Force noted that patients who did not have to pay for their medical treatment often racked up large bills at private hospitals.

In fact, insurers have been bombarded with questionable claims from patients with riders who were treated in private hospitals, The Straits Times has learnt. Here is a sampling:

- A 37-year-old woman stayed seven days in hospital for abdominal hernia repair. Of the \$46,000 bill, the surgeon's share was \$31,900, or five times the norm. It transpired that while in hospital, she also had her breast augmented, and a tummy tuck with the fat transferred to her buttocks, but since these are not covered by insurance, none of this was stated in the bill.
- Another patient who needed cataract surgery opted to be admitted to hospital, instead of having it done as a day procedure, which would have taken no more than an hour or so. His one-day stay each time for each eye amounted to a total bill of \$21,000. The median private hospital bill for cataract surgery of one eye is \$5,000.
- A patient with fungal growth in her nail stubbed her toe, causing the nail to fall out. She was admitted for two days and was billed \$6,000.
- A patient complaining of stomach and chest pains was admitted to hospital, and underwent gastroscopy and colonoscopy procedures to check his stomach and intestines. He was also referred to a heart doctor, a dermatologist for skin rash and an ophthalmologist for blurred vision. The total bill for his one-day stay was \$14,000.

- A patient was admitted for 16 hours for inflammation of the gall bladder. The tests showed no inflammation and no treatment was needed. However, the patient was given a series of unrelated screening tests, including an electrocardiogram, a magnetic resonance imaging scan and a computerised tomography scan. Screening is not covered by insurance. The bill came to \$11,000.
- A woman was warded for 42 days for cervical sprain and strain (or pain in the neck) but received treatment only on seven days. She was given physiotherapy and painkillers for the other 35 days, something that could have been done as outpatient treatment. The bill was \$84,000.
- A 40-year-old man was warded for four days for pain and swelling in his big toe, chalking up a bill of close to \$6,000. The bill was rejected after the insurer checked with the doctor, who said the patient was admitted at his own request and that the treatment would otherwise normally be done in the clinic.

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