POLITEKNIK MALAYSIA

KEMENTERIAN PENGAJIAN TINGGI

KOLEJ KOMUNITI MALAYSIA

MEDICAL AND HEALTH INSURANCE

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MEDICAL AND HEALTH INSURANCE

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Preference

This eBook: **MEDICAL AND HEALTH INSURANCE** is designed as an initiative for students and academics to use as a reference by providing information on medical and health insurance (MHI) covering MHI insurance concepts, products, Risk assessment and management, underwriting and claims. To provide clarity, this eBook provides questions and exercises that can be used as discussion topics in addition to providing examples that are appropriate to the current situation. Recognizing the relevance of MHI for all of these groups, this eBook can be used as a reference to show how this product is implemented, taking into account the roles of insurance companies, hospitals, and third-party administration. As a result, this e-book is particularly useful as an online learning material for conducting remote teaching and learning.

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5 HEALTH CARE PROFESSIONALS

1.1 NATURE & DEVELOPMENT OF MHCS

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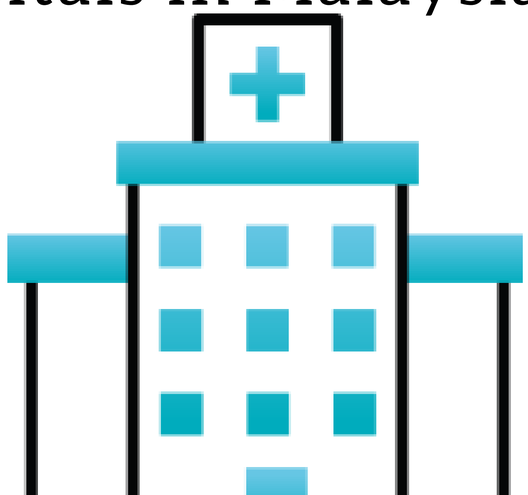
1.1.1 HISTORY OF MALAYSIA HEALTHCARE SYSTEM(MHCS)

INTRODUCTION

International Living recognized Malaysia as the “best nation in the world for healthcare” from 2015 to 2019 and ranked the nation as the seventh-best place to retire in 2020. Healthcare in Malaysia is highly affordable, said Azli, and therefore, it is very competitive compared to the Western world.

HISTORY OF MHCS

- The history of healthcare in Malaysia started before the independence period.
- Early pre-colonial day, medical care was confined to TRADITIONAL remedies among local populations.
- Advent colonial, western medical practice came in and Hospital built. However, at early stage their main concern was to encounter infection diseases such as Malaria, dengue fever and other dangerous tropical diseases from spreading.
- After independence, transformation occurred in the healthcare system in Malaysia.
- At the time of independence in 1957, there was only 65 hospital in Malaysia, but by 2019 there were around 154 government hospital and 250 private hospitals in Malaysia



1.1 NATURE & DEVELOPMENT OF MHCS

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THE MALAYSIA HEALTHCARE SYSTEM

- MHCS is the responsibility of the government under the Ministry Of Health
- MHCS operates at **TWO (2)** levels known as **Public Hospital (Universal healthcare system) and Private Hospital (Private Healthcare System)**
- THE Ministry Of Health is responsible to control all the activities of all public and private hospitals in Malaysia and the focus of the ministry is more on providing equitable, accessible, and quality health facilities.
- With economic development and the improvement of the health status of the population, mortality and morbidity shifted from communicable diseases to non-communicable diseases. However, communicable diseases still remain a concern.
- Communicable disease (Ebola, Flu, Hepatitis A, Hepatitis B, HIV/AIDS)Non
- communicable disease (heart diseases, stroke, cancer, diabetes)
- For the development of the healthcare system, the Government through the Ministry Of Health has also been trying to promote Malaysia as a healthcare destination both regionally and internationally.

1.1 NATURE & DEVELOPMENT OF MHCS

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1.1.2 STRUCTURE OF THE MHCS

The MHCS in Malaysia is regulated by the Ministry of Health and the public and private systems co-exist side by side

Service Provided:

Public sectors provide: 82% of in-patient care
: 35% ambulatory care

Private Sector provides: 18% of in-patient care
:62% ambulatory care

SERVICE PROVIDED BY PUBLIC HOSPITAL

- Comprehensive range (health promotion, disease prevention, and rehabilitative care)
- through Clinics, Hospitals, and Special institutions for long-term care as other related services.

SERVICE PROVIDED BY PRIVATE HOSPITAL

- Generally in Urban
- through a private physician, private hospital, diagnostic laboratories and private ambulance services

SERVICE PROVIDED BY NON-GOVERNMENTAL ORGANIZATION

Healthcare services for a particular group (Traditional medicine such as Malay and Chinese practices)

CONCLUSION

- Primary and Preventive Care: delivered by government clinics, health centres and private general practitioners
- Secondary and Tertiary Care: delivered by Public Hospital dan Private Hospital

1.1 NATURE & DEVELOPMENT OF MHCS

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1.1.3 AIM, PURPOSE AND SCOPE OF THE MHCS

MALAYSIA HEALTHCARE SYSTEM

Aim: "A nation working together for better health"

Mission: "Lead and work in Partnership"

Purpose:

- To facilitate and support people to:
- Fully attain their potential in health
- appreciate health as a valuable asset,
- take individual responsibility and positive action for their health

2. To ensure a high-quality health system given to customers which are:

- **equitable**
- **affordable**
- **efficient**
- **technologically appropriate**

Scope:

- Professional, caring, and teamwork
- Respect human dignity
- Community participation

1.1 NATURE & DEVELOPMENT OF MHCS

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1.1.4 MHCS DELIVERY SERVICES

INTRODUCTION

- Primary healthcare is the thrust of the Malaysia Healthcare System (MHS).
- Supported by Secondary Care and Tertiary Care.
- The organizational structure of the Ministry Of Health (MOH) has THREE (3) levels:

1. Federal
2. State
3. District

- There is decentralization in MHS
- Purpose: Ensure efficiency in reaching out to the public at large
- Hierarchical level determine (authority, information flow, accountability, and supervision)

1.1 NATURE & DEVELOPMENT OF MHCS

1.1.4 MHCS DELIVERY SERVICES

DIFFERENCE

The following are the difference between the size of the Hospital and service provided:

Size Of Hospital	Service provided
Small district	1. General Medical 2. Nursing care 3. Manpower: • Medical officer • Other personnel
Larger district/Regional	1. Wide range of specialist service 2. Easy access 3. Utilization healthcare service
Private	1. Fee for every services 2. Located in urban area 3. Smaller hospital in small town 4. None in rural and remote area

1.1 NATURE & DEVELOPMENT OF MHCS

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1.1.4 MHCS DELIVERY SERVICES

INTRODUCTION

Types of healthcare delivery services are as follows:

OUTPATIENT CARE

- Condition or course of treatment which DOES NOT require admission and overnight stay.
- Provided by primary care physicians and medical specialist

Types of O/P care:

- Primary O/P care
- Doctor's office or outpatient department of the government hospital
- Types of care provided: (Preventive, Diagnostic, and therapeutic assessment)
- Includes the coordination and continuity of healthcare services provided by other providers (specialist, medical facilities)
- Include HOME VISIT to a patient

2. Specialised O/P care

- Requires the services of a medical specialist (for example surgeon, cardiologist, internist, etc)

3. Stationery care

- Provided to patients whose medical condition requires repeated daily outpatient treatments.

SOME FACTS

In the case of emergency no doctors can refuse to see patients

Individuals have the right to visit a specialist without first seeing their primary care physician

1.1 NATURE & DEVELOPMENT OF MHCS

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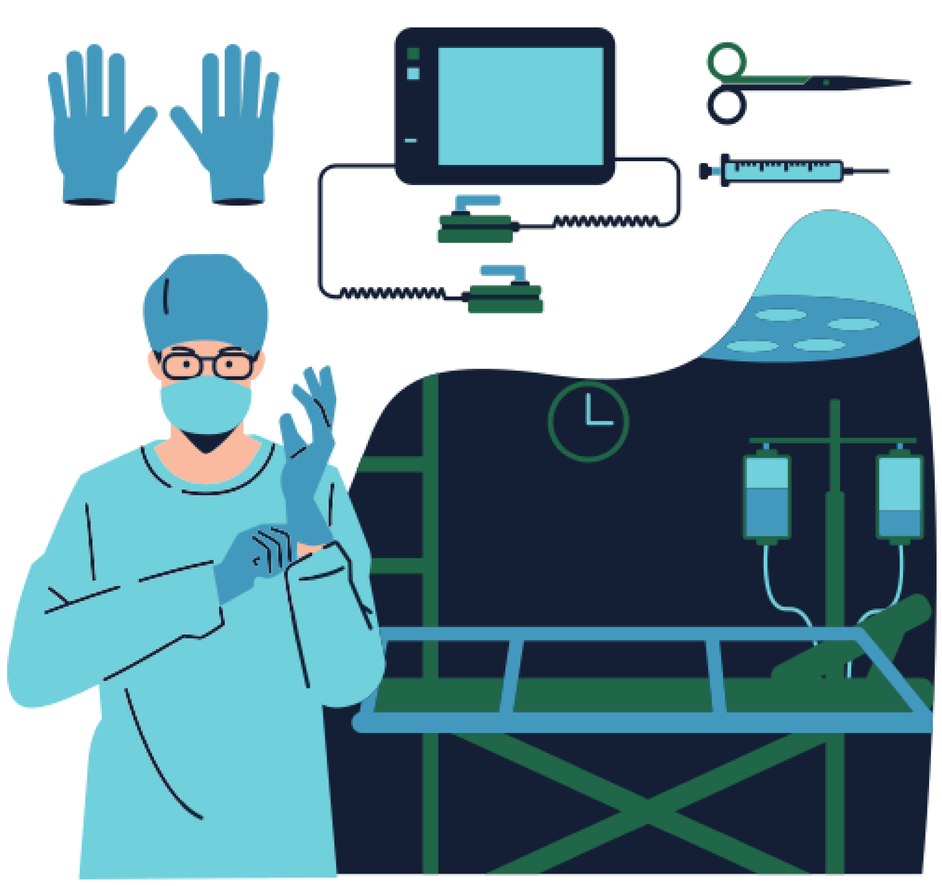
1.1.4 MHCS DELIVERY SERVICES

INTRODUCTION

Types of healthcare delivery services are as follows:

INPATIENT CARE

- Provided to the patients who are recommended by a primary care doctor or O/P specialist to be ADMITTED for treatment in a hospital.
- Can not provide on an O/P basis requires to be hospitalized in order to provide the patient with the necessary course or type of treatment.



Types of I/P care

1. Standard acute care

Patient with a sudden illness or sudden deterioration of a chronic illness but does not lead directly to a failure of vital bodily function

2. Intensive I/P care

Patient in a situation in which there is a sudden bodily malfunction or a sudden threat to bodily function in which the malfunction can be reasonably EXPECTED to occur.

1.1 NATURE & DEVELOPMENT OF MHCS

M H

1.1.4 MHCS DELIVERY SERVICES

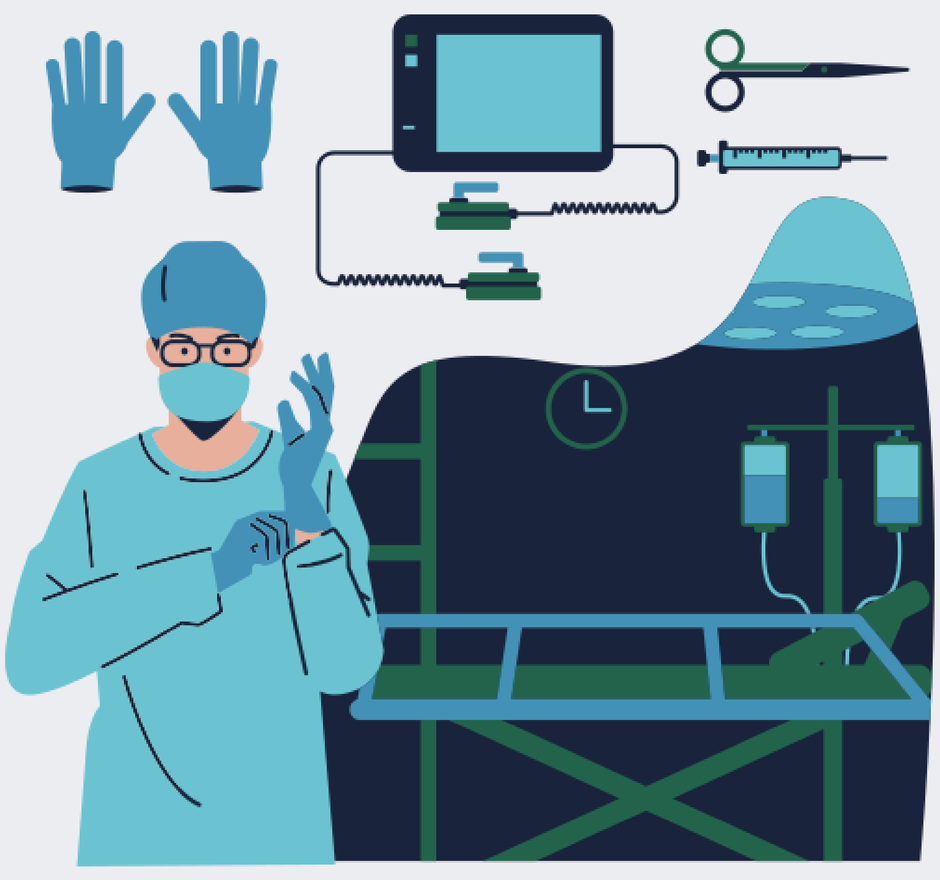
INPATIENT CARE

3. Follow-up I/P care
Provided to patients whose medical condition requires follow-up care or some type of therapeutic rehabilitative care.

4. Long-term I/P care
Provided to patients whose medical condition can not be significantly improved by medical treatment or intervention.
Also, provide patients who require ongoing nursing care to prevent their condition from worsening
Also, provide to patients who impaired basic bodily function.

ACTIVITY

- Identified the services provided under Long-term In-patient care.
- Define communicable diseases and communicable diseases.



1.2 PRIMARY AND PREVENTIVE CARE

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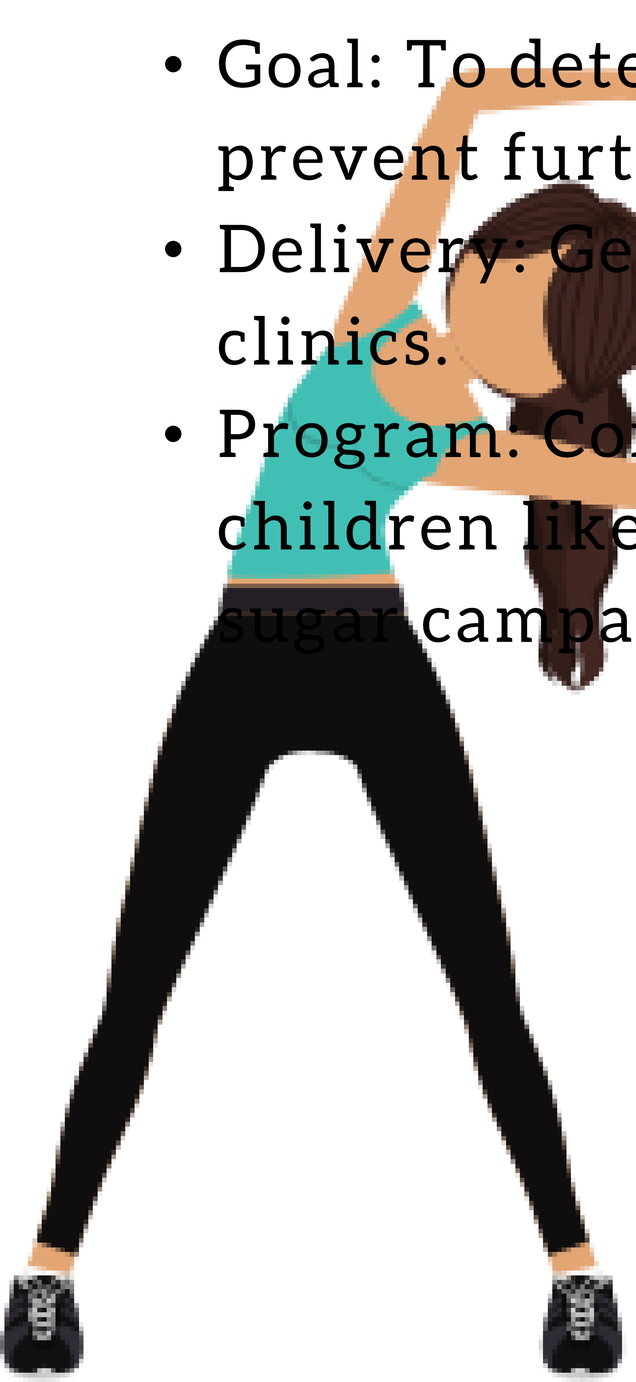
- Healthcare Services are categorized into **THREE(3)** main levels namely primary and preventive care, Secondary care and Tertiary Care.
- Preventive wellness care is administered by general practitioners, pediatricians, or nurse practitioners.
- Objective: To decrease the risk of individuals within a community setting
- Services offered:
    1. General Physical examination
    2. Patient education
    3. Vaccinations
    4. Diet moderation
    5. Exercise programs
    6. Stress reduction techniques



- Goal: To detect illness in its early stage and expedite treatment to prevent further deterioration of the illness.
- Delivery: General Practitioners (GP) Clinic or Government outpatient clinics.
- Program: Compulsory immunization program for babies and young children like hepatitis B, diphtheria, anti-smoking campaign, less sugar campaign

1.3 SECONDARY AND TERTIARY CARE

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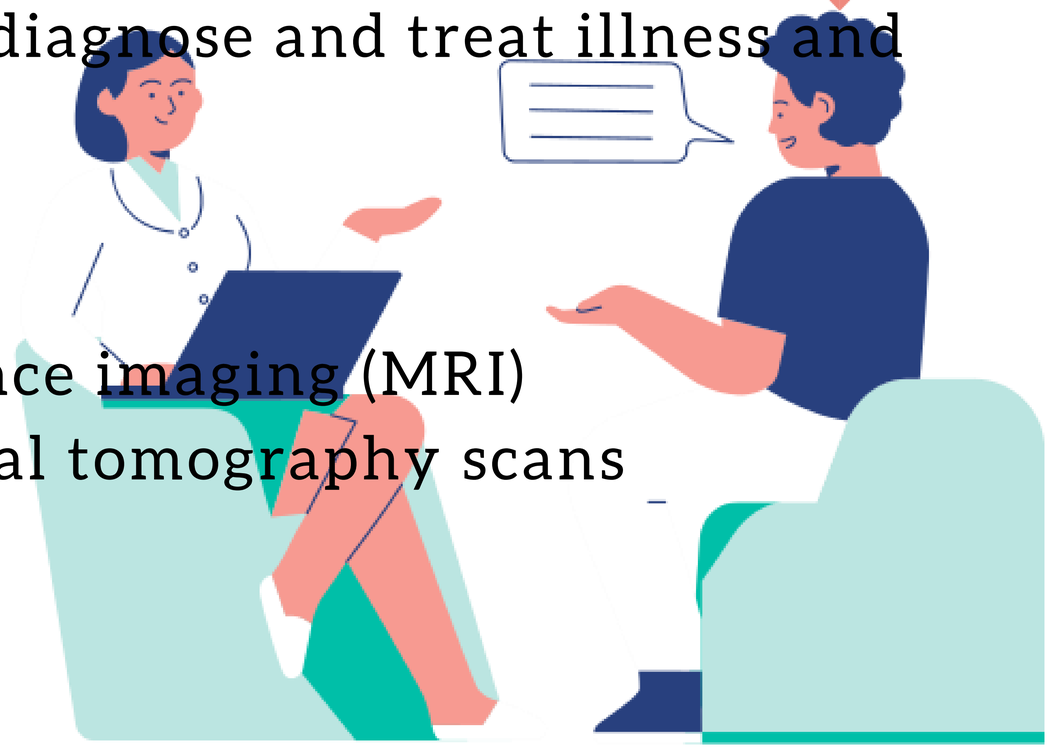
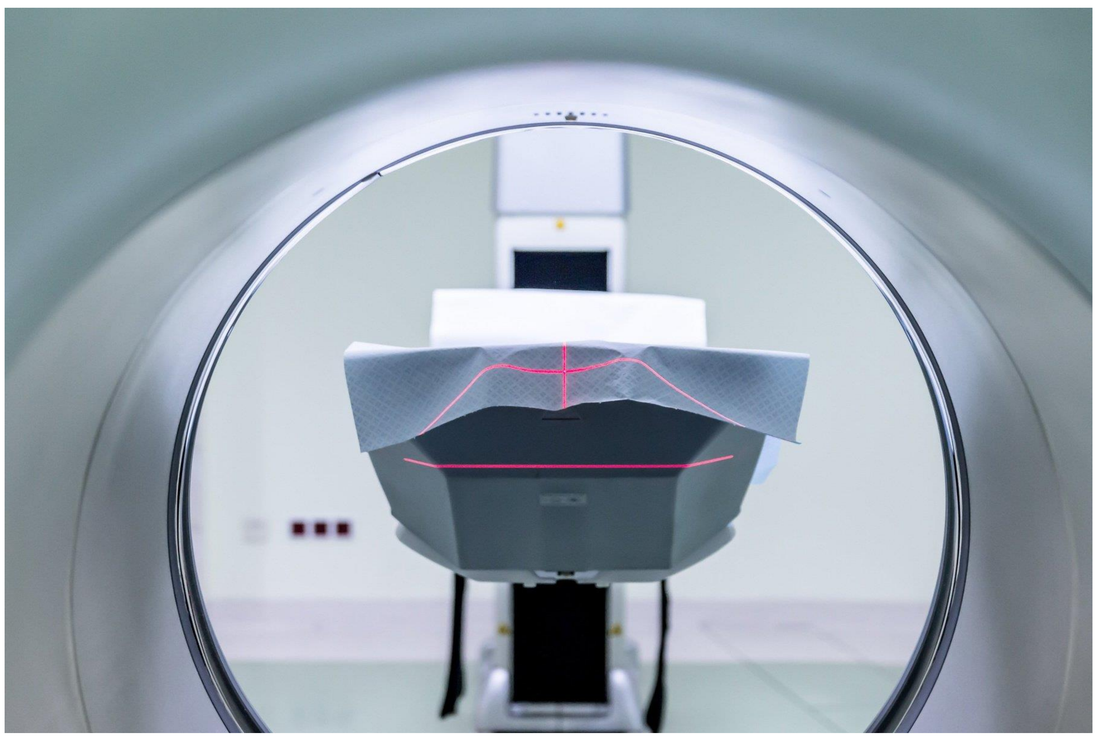
- Secondary Care is established to diagnose and treat illness and disease.
  Services offered:
    1. Colonoscopy
    2. Magnetic resonance imaging (MRI)
    3. computerized axial tomography scans
    4. Mammograms
    5. Surgery



- Tertiary Care is restorative and rehabilitative care designed to restore
  an individual back to an optimal level of health.
- Objective: decrease the risk of permanent disability related to the illness or disease.
- Service offered:
    1. Physical therapy
    2. Occupational therapy
    3. Speech therapy
    4. Respiratory therapy

- Both deliveries are either public or private hospitals and are generally referred to the primary care physicians for further treatment.



1.4 PUBLIC AND PRIVATE HEALTHCARE SERVICE

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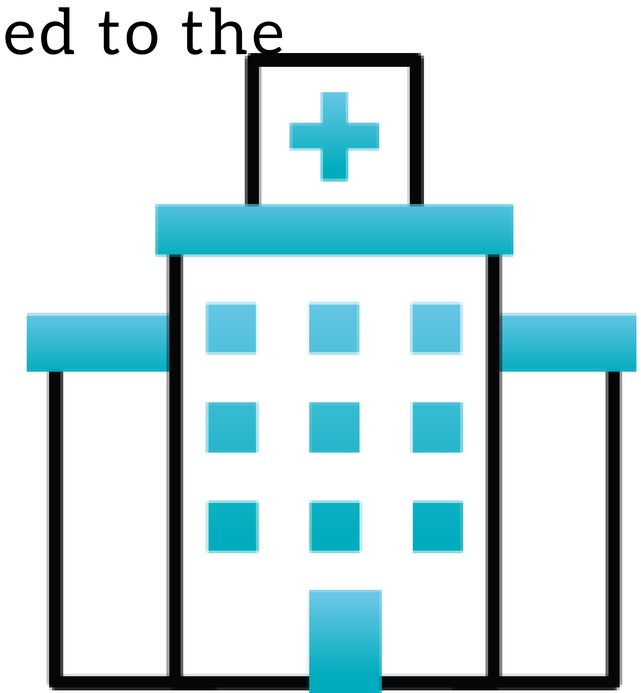
1.4.1 SERVICE OFFRED BY PRIVATE,PUBLIC HOSPITAL AND CLINIC

PUBLIC HOSPITALS

- Objective: Provide universal access to the public for healthcare facilities and services.
- Administered by the Ministry of Health
- Services provided a complete range of primary and preventive care, secondary and tertiary care.
- Services offered:
    1. Disease control of communicable disease
    2. Family health development
    3. Health education programs
    4. Nutrition programs
- Funded by the government through the consolidated Revenue Fund under the Ministry Of Finance, which is funded through taxation and general revenue.
- This system of financing is directed towards the public whereby the nominal sum of RM1 is charged for every patient at the outpatient department of the Government general hospital, hospital, and polyclinic in accordance with the Fees **Act 1951-Fees (Medical) order 1982.**
- For Secondary and tertiary healthcare there is a referral system involved from the primary care level.
- A patient has to go to the primary care level of the outpatient department and only upon referral will be escalated to the secondary care or tertiary care level.

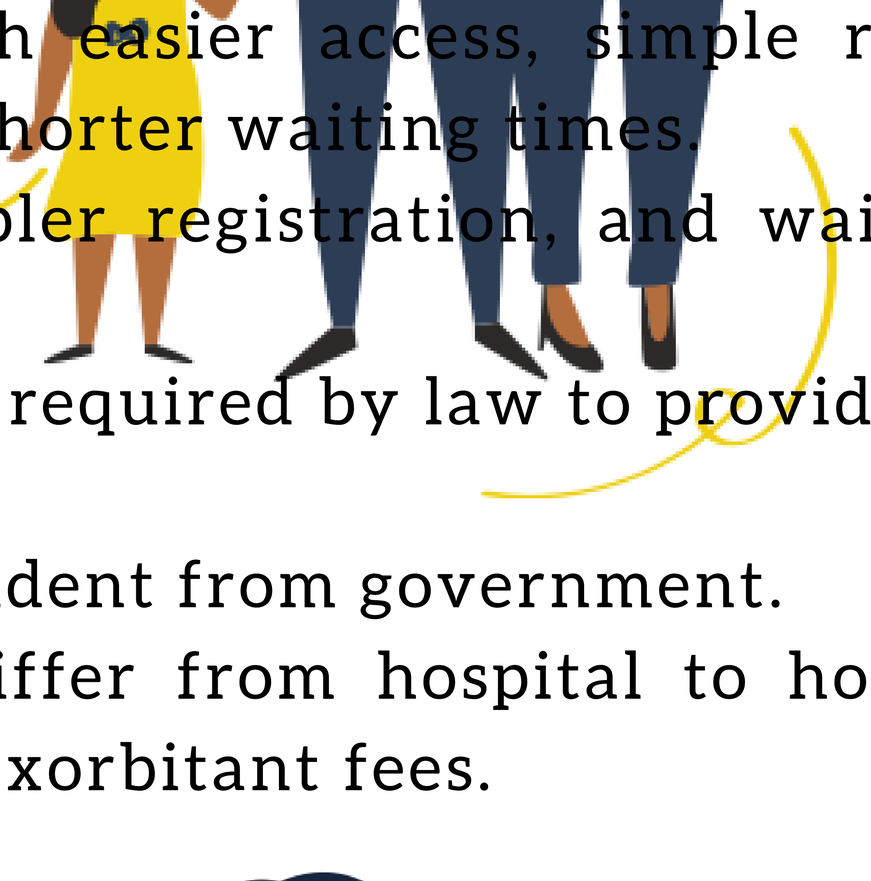


1.4 PUBLIC AND PRIVATE HEALTHCARE SERVICE

1.4.1 SERVICE OFFRED BY PRIVATE,PUBLIC HOSPITAL AND CLINIC

PRIVATE HOSPITALS AND CLINICS

- Concentrate in urban areas due to demand by the affluent community.
- Services offered are on a fee-for-service basis from primary to secondary and tertiary care.
- The range of service is not comprehensive due to specific objectives of the setup of the hospitals.
- Services are curative and diagnostic health services, which are selective in nature.
- Primary care is provided by private general practitioners who provide an alternative to the general public for consultation and treatment with easier access, simple registration, and appointment with shorter waiting times.
- Direct access, simpler registration, and waiting time much shorter
- Profit-oriented and required by law to provide quality care to the patient.
- Financially independent from government.
- Hospital charges differ from hospital to hospital and some prestigious charge exorbitant fees.



1.4 PUBLIC AND PRIVATE HEALTHCARE SERVICE

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1.4.2 OTHER HEALTCARE PROVIDERS

PHARMACEUTICAL SERVICES

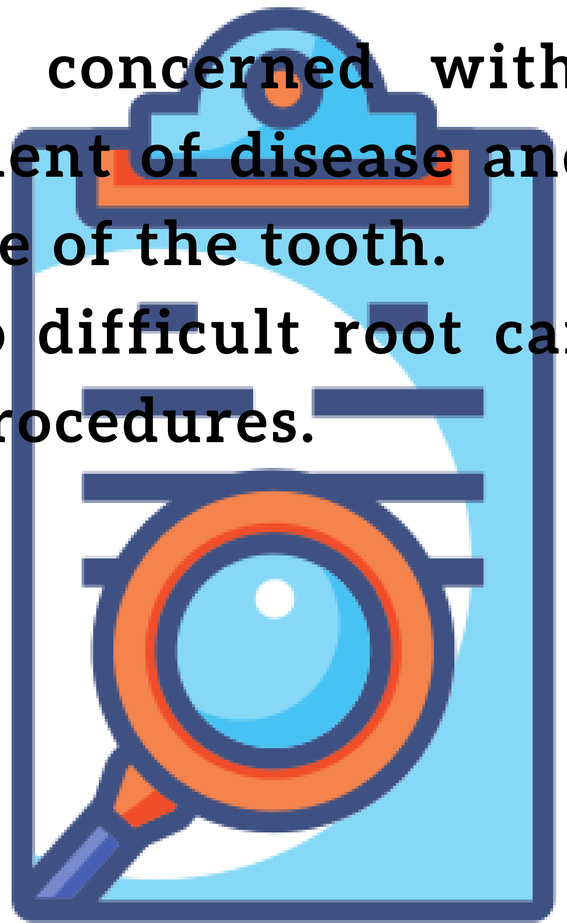
- Health professionals who are an expert on drug therapy
- Primary professionals that optimize the use of medication for the benefit of patients
- Mission: Ensure that the Malaysian public can have access to quality, safe, and efficacious pharmaceutical and healthcare products including advice in using them rationally. (Pharmaceutical service Divison)
- Pharmacy legislation is enforced by the Ministry of health under the Pharmaceutical service Divison to ensure all pharmacies comply with the legislation before drug therapy is provided.

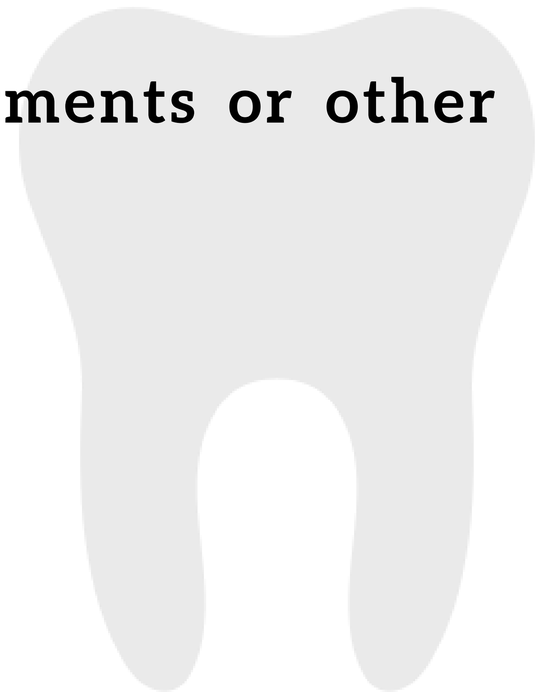
DENTISTS AND OTHER HEALTHCARE PROVIDERS

- GENERAL DENTIST
- Primary care dental provider
- Diagnoses treat and manage the overall oral health care needs, including gum care, root canals, veneers, bridges, and preventive education.

2. ENDODONTIST

- Dental specialists are concerned with the cause, diagnosis, prevention, and treatment of disease and injuries of the human dental pulp or the nerve of the tooth.
- may perform simple to difficult root canal treatments or other types of surgical root procedures.





1.4 PUBLIC AND PRIVATE HEALTHCARE SERVICE

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1.4.2 OTHER HEALTCARE PROVIDERS

3. NURSING HOME OR PRIVATE NURSING

- Flourished lately in urban areas.
- need to care for the aged and convalescence that requires nursing care.
- Services: resident care and resident support, resident attendants, dieticians, and resident physicians.
- Nurses are required by law to be licensed as regulated under the Private Healthcare Facilities and Service Act 1998 [Act 586, Law Of Malaysia].

THINK?

WHY DO YOU THINK THAT MOST OF THE PRIVATE HOSPITAL OFFER SECONDARY OR TERTIARY CARE SERVICES?

1.5 ROLES OF OTHER HEALTHCARE PROFESSIONALS

1.5.1 MAIN PROFESSIONALS INVOLVED IN DELIVERY HEALTH CARE SERVICES

HEALTHCARE PROFESSIONALS

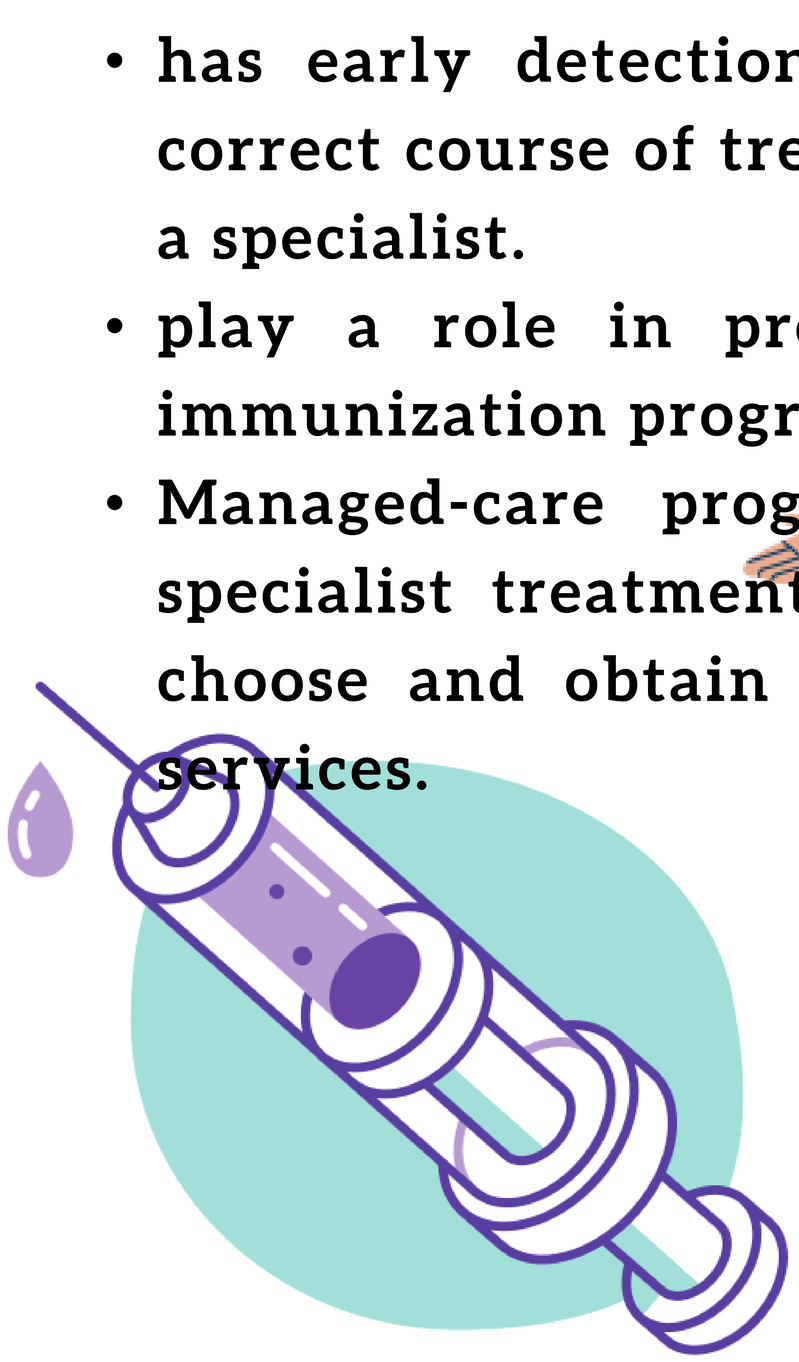
- **Highly skilled workers in their professionals.**
- **requires extensive knowledge, including university-level study, leading to the award of a first degree or higher education.**
- **often work in hospitals, healthcare centers, and other service delivery points also in academic training, research and administration.**
- **also regulated and required to register formally with the regulators and must apply for a practicing license to practice.**
- **The earliest legislation was the Nurses Act 1950 (act 14) amended in 1985, followed by the registration of Pharmacists Act 1951 (Act 371).**
- **Ministry will ensure only competent professionals with adequate and recognized qualifications get into the healthcare system and provide licensed professionals exclusive rights to practice.**
- **The purpose of licensing is to ensure the safety and right of patients are duly protected.**

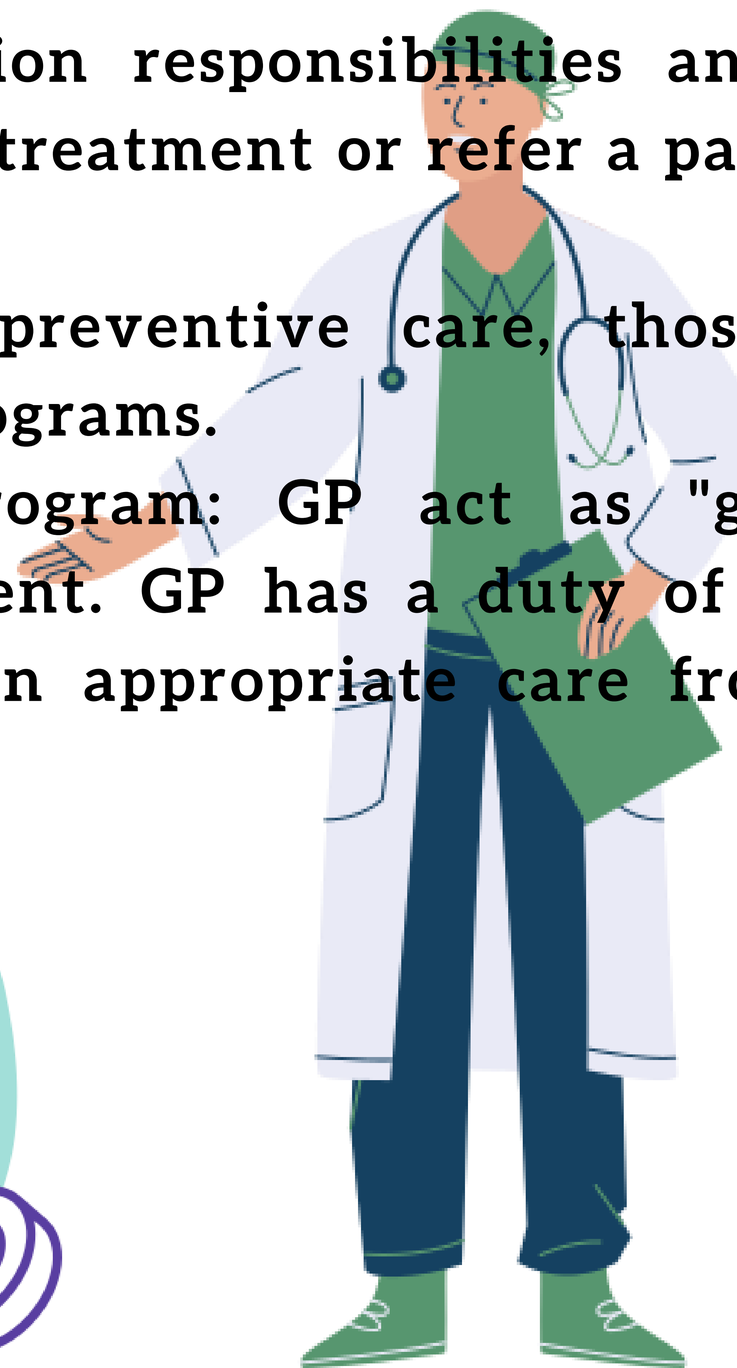
1.5 ROLES OF OTHER HEALTHCARE PROFESSIONALS

1.5.1 MAIN PROFESSIONALS INVOLVED IN DELIVERY HEALTH CARE SERVICES

- **GENERAL PRACTITIONERS [GP]**

- **Work either with the public sector or private sector**
- **Public Sector: Practice in the outpatient department of the government hospitals.**
- **Private Sector: Own clinics and the majority are in urban areas that provide easy care for common ailments and simple trauma/injury management for a fee for service.**
- **Medical doctor is responsible for diagnosing and treating a variety of injuries and diseases under the 'general practice' category.**
- **Diagnose patients by examining them and performing tests using medical equipment and instrument.**
- **Aim: Take into consideration the biological and physiological and social factors relevant to the care of each patient's illness.**
- **has early detection responsibilities and is able to determine the correct course of treatment or refer a patient with serious diseases to a specialist.**
- **play a role in preventive care, those of health education and immunization programs.**
- **Managed-care program: GP act as "get-keepers" in referrals to specialist treatment. GP has a duty of care to help the patient to choose and obtain appropriate care from the available healthcare services.**





1.5 ROLES OF OTHER HEALTHCARE PROFESSIONALS

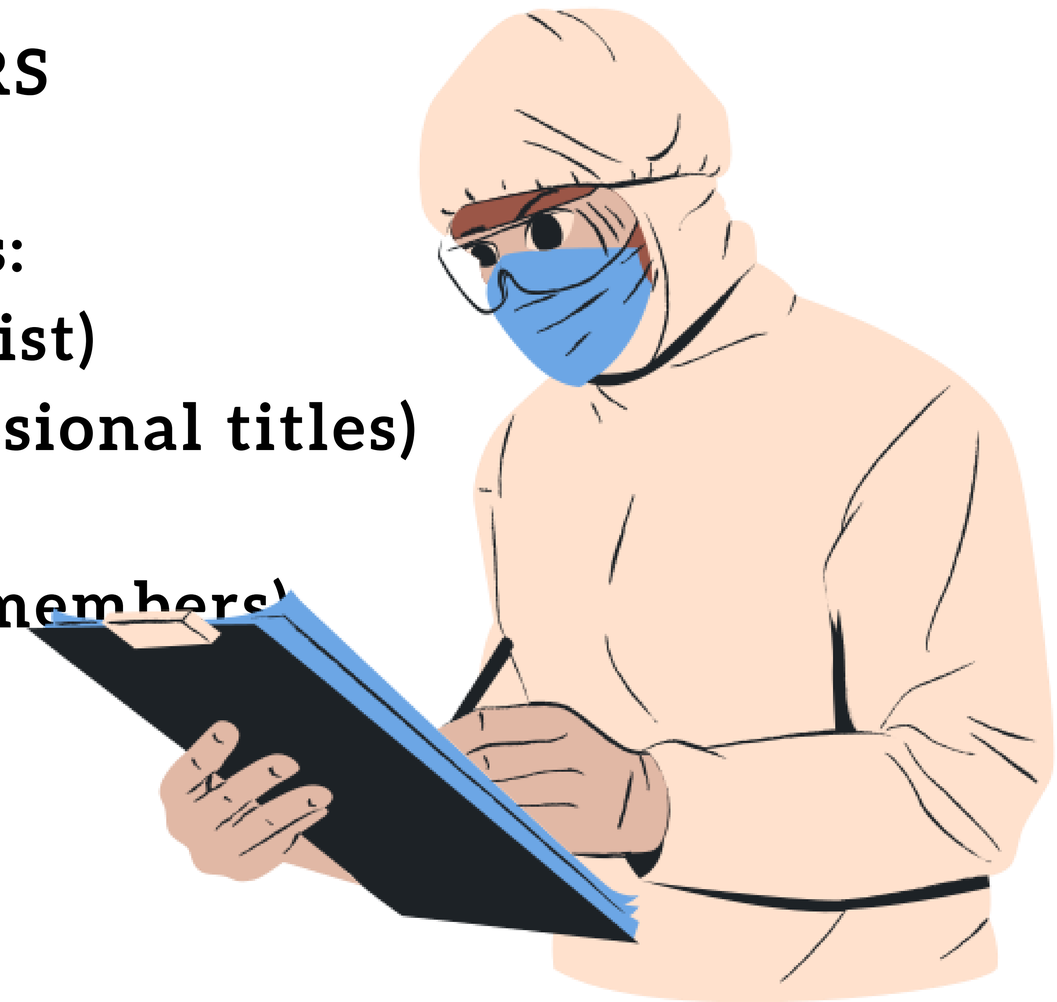
1.5.1 MAIN PROFESSIONALS INVOLVED IN DELIVERY HEALTH CARE SERVICES

2. CONSULTANT

- Involved in the secondary and tertiary aspects and they are either with the public or private sector.
- Private sector: associate with the hospital or they can own private clinics independently or with other group professionals.
- Medical specialists and are qualified and well-trained.
- Normally referred to by the primary care doctors with the specific referral of the patient's condition to their specialty.
- Patients can direct access and private sector specialist services are for a fee.
- Fees are higher and regulated under the "thirteenth schedule" of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities)(Amendment)order 2013.

3. OTHER HEALTHCARE PRACTITIONERS

- Grouped into a number of professions:
  - a. Medical (including GP and specialist)
  - b. Nursing(including various professional titles)
  - c. Midwifery(including Obstetrics)
  - d. Dentistry(including dental team members)
  - e. Allied health professions
  - f. Health Scientists

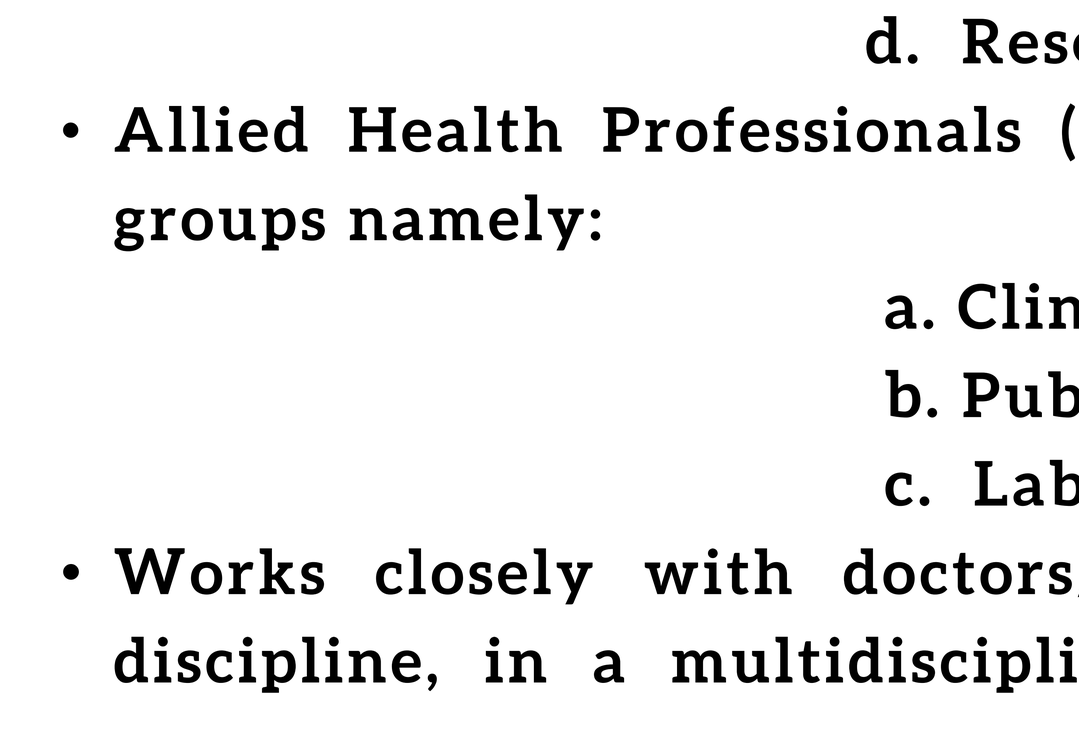


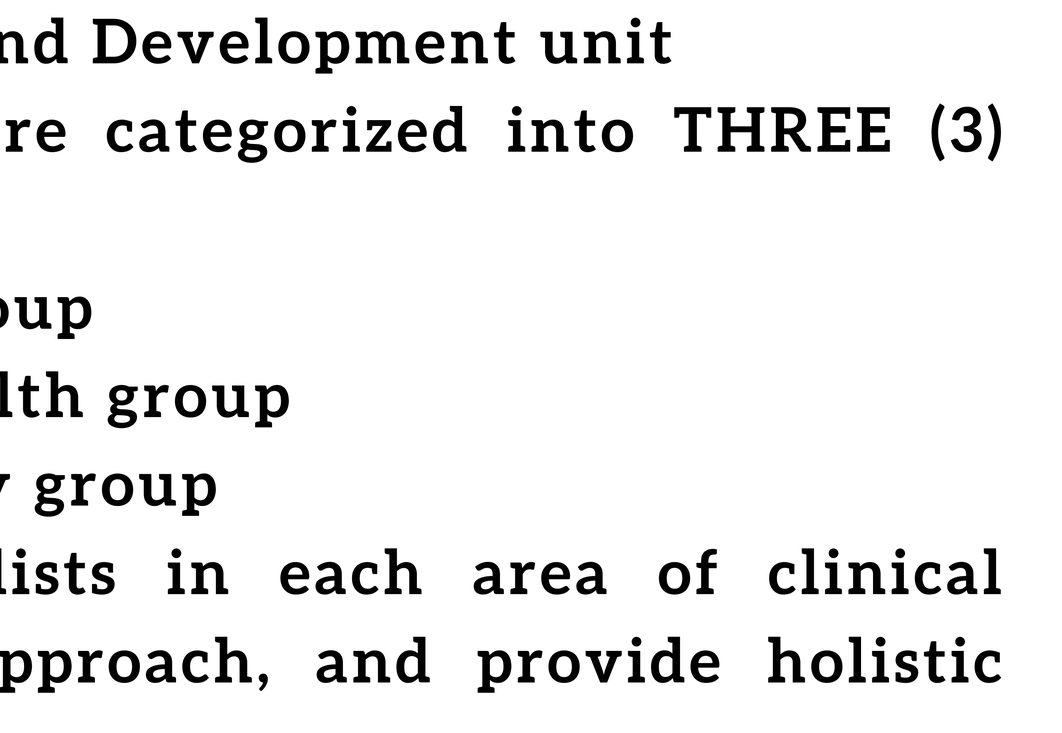
1.5 ROLES OF OTHER HEALTHCARE PROFESSIONALS

1.5.1 MAIN PROFESSIONALS INVOLVED IN DELIVERY HEALTH CARE SERVICES

4. ALLIED HEALTH PROFESSIONALS (AHP)

- **Referred to as "health associate professionals" in the International Standard Classification of occupation, support implementation of healthcare, treatment, and referral plans.**
- **usually established by medical, nursing, and other healthcare professionals.**
- **Comprises of FOUR (4) units namely:**
  a. **Administration unit,**
  b. **Professional development unit,**
  c. **Quality Unit,**
  d. **Research and Development unit**
- **Allied Health Professionals (AHP) are categorized into THREE (3) groups namely:**
  a. **Clinical group**
  b. **Public Health group**
  c. **Laboratory group**
- **Works closely with doctors/specialists in each area of clinical discipline, in a multidisciplinary approach, and provide holistic care.**





QUESTIONS

a) State FIVE (5) tertiary care services provided by the Malaysia healthcare Services (MHCS).

_____

_____

_____

b) Describe TWO(2) current healthcare systems in Malaysia?

_____

_____

c) Outline some other healthcare providers.

_____

d) In which area of care are consultants normally involved?

_____

Congratulations you have covered chapter 1

CHAPTER 2
PRIVATE MEDICAL INSURANCE (MHI) PRODUCTS & PRINCIPLES

1 PRIVATE MEDICAL INSURANCE (PMI) POLICIES

2 EMPLOYEE BENEFITS SCHEME

3 INTERNATIONAL POLICIES

4 FUNDING METHODS IN MHI

2.1 PMI POLICIES

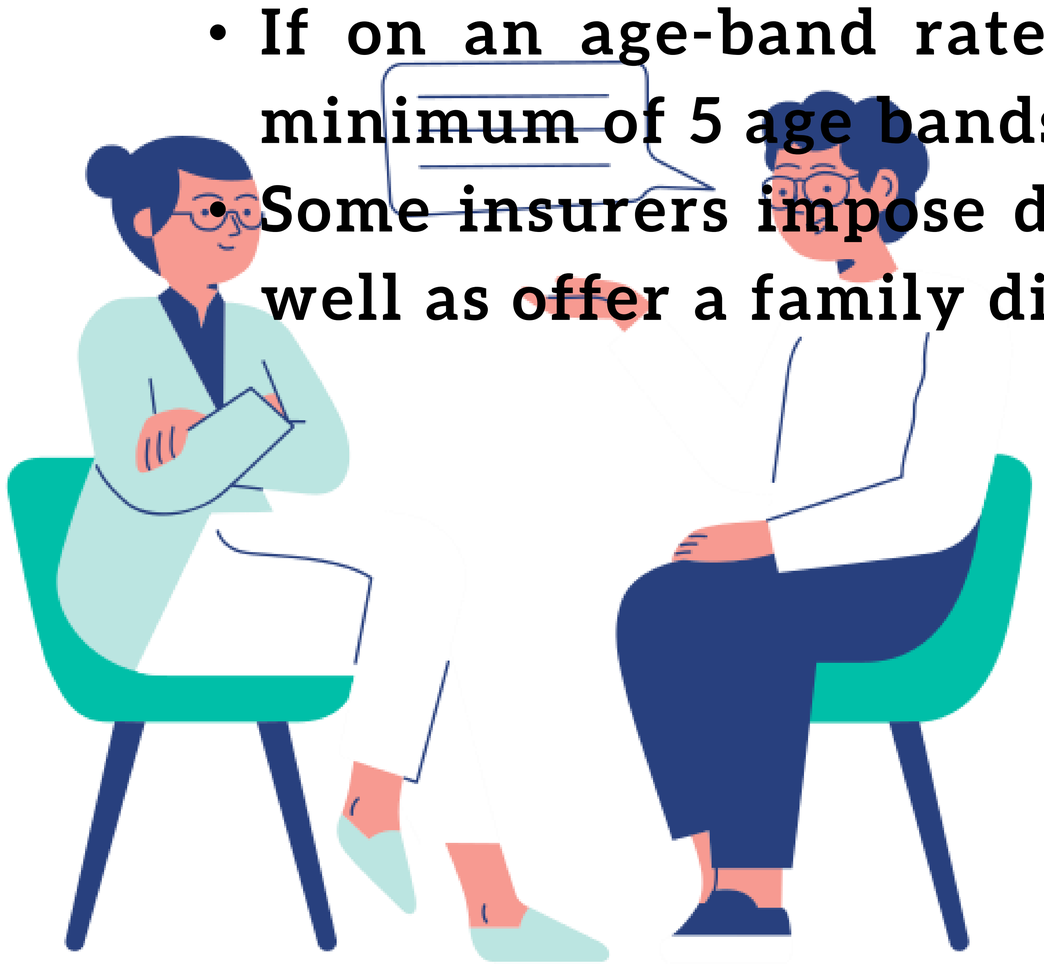
2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

A. INDIVIDUAL MARKET

- Generally arrange to provide protection against an individual on a single, married, or with-child/children basis
- Coverage can be through agents or directly with the companies
- The minimum entry ages vary among different PMI individual products and generally before 60 years and coverage up to a minimum of 70 years and more
- For children, the eligible coverage age is generally 30 days
- Premium paid can be yearly or monthly.
- The premium is individually rated according to age or on an aged-band rate basis
- Example age-band

You pay RM460 every year from age 25 to 35 and RM550 from age 36 to 45. Age 25 to 35 is an age band and age 36 to 45 is another age band. Generally, the premium is lower at a younger age and increases as the age increase.

- If on an age-band rate, the individual product will have a minimum of 5 age bands for differentiation.
- Some insurers impose differing premiums between gender as well as offer a family discount for more family members.



2.1 PMI POLICIES

2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

INDIVIDUAL MARKET

- For a family of four members or more, in the same policy, a family discount from 5%-15% is given.
- Individual PMI products offered a FIXED and cannot be varied.
- An individual health declaration is required for underwriting consideration and payment of premium is Cash Before Cover.
- Renewable either 'yearly' or 'guaranteed renewable', subject to the age coverage and the limits stipulated but the premium can not guarantee as per regulatory guideline
- Termed know as “self-funding” or “self-pay” or “self-insurance”.

ACTIVITY

Collect Some Product Broucher from several Insurance Companies and perform a comparison on the benefits offered in the individual market

2.1 PMI POLICIES

2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

INDIVIDUAL PRODUCT

- **Cater for the individual customer who takes responsibility for arranging their own PMI cover and paying their own premiums**
- **Cover will usually be arranged on a single, married, one parent with child/children or family basis**
- **Customers will be usually offered the choice of annual, quarterly, and monthly period**
- **Methods of payment are: Cash/ cheque, Credit card, Variable direct debit and Standing order (in some cases)**
- **An insurer will give a discount between 5% and 7.5% for annual payment**
- **An insurer will decide on what basis the premium is to be calculated**
- **Range of personal PMI products divided into;**

COMPREHENSIVE, BUDGET, STANDARD, AND INTERNATIONAL

2.1 PMI POLICIES

2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

COMPREHENSIVE POLICY

- flagship" product
- Sometimes referred to as "full cost" or "full refund" policies
- Expensive to purchase because they offer the widest range of benefits and services to members
- Cover cost of private inpatient, outpatient, and day-case treatment of eligible medical conditions

BUDGET POLICY

- Lower premium
- Some budget policies are a six-week scheme
- Only available when waiting list longer than six weeks for NHS treatments
- When a customer decides to receive treatment as an NHS patient, the insurer may pay a cash benefit
- The six-week scheme can be difficult to understand because waiting lists vary from area to area and even by the hospital or individual consultant
- Offer customers the opportunity to buy cover for only the more important and/or expensive types of treatment for example inpatient and day-case costs

2.1 PMI POLICIES

2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

BUDGET POLICY

- **A current trend in budget policies is to offer *modular* or *menu* policies**
- **Modular or menu policies: allow customers to choose which benefits to cover**
- **For example, customers may exclude out-patient treatment or excluded heart and cancer treatment, arguing that such treatments are now covered very well by the NHS**
- **Policy excess, no claim discount, and reduced hospital list can help tailor cover to match the available budget**
- **Scope of cover is limited and customers are not automatically cover for all private medical treatment**

STANDARD POLICY

- **Similar to and offer many of the benefits available from comprehensive**
- **However, certain benefits are reduced, or excluded completely, in order to contain treatment costs and to reduce premiums**
- **Required patient to received treatment in a pre-specified hospital, which the insurer has negotiated favorable rates for accommodation and services**
- **Outpatient benefits available only when the course of treatment directly related to an inpatient stay or day case episode**
- **Peripheral benefits such as repatriation, ambulance services, optical care and NHS cash payment are usually EXCLUDED**

2.1 PMI POLICIES

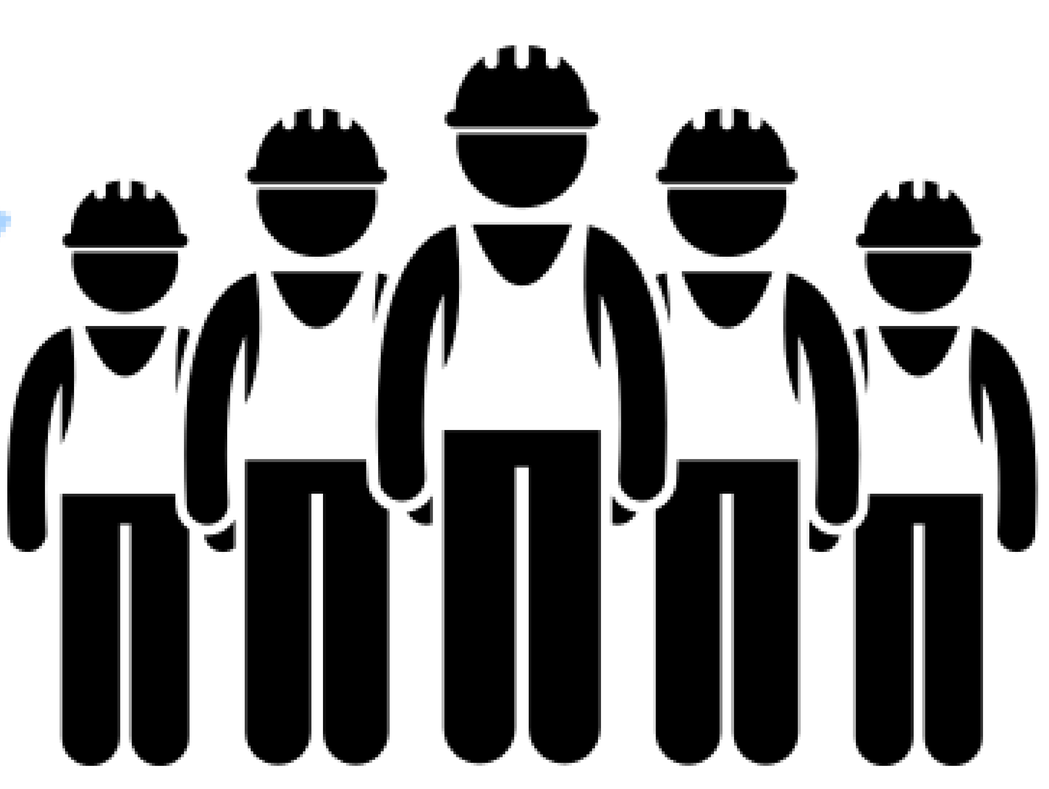
2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

INTERNATIONAL POLICY

- Cater for more those who travel frequently or reside outside the country and require a local policy to be issued.

B. COMPANY AND CORPORATE GROUP MARKET

- Refers to employers providing group PMI for their employees and can also be a part of the employee benefits scheme.
- Premium is paid by the employer and coverage may extend to the dependents of the employees.
- A fast-growing segment in the industry as providing PMI cover for employees and now provide a corporate social responsibility rather than something good to have.
- The Products for the group market can be divided into:
- Small group : refers to less than 50 members and the benefit generally less than large group
- Large Group:refers to the size above 50 members and the benefits company can negotiate with the insurer for the coverage desired.



2.1 PMI POLICIES

2.1.1 PMI MARKET AND ITS RELATED PRODUCTS

C. VOLUNTARY GROUP MARKET

- usually, a group policy, whereby an association, organization, club, or employer wishes to offer PMI cover but does not pay for the premium or partly subsidies the premium.
- Product benefits are based on individual products found in the market or have some alteration or be exclusively tailor-made for the group's need.
- Premium based on group size, claim experience, and risk exposure.
- Premium may be 'age band' or 'level premium" regardless of age.
- Members or employees are responsible for the premium, fully or partly, depending on the arrangement of sponsorship of the scheme.
- Mode of premium payment can be on monthly basis by way of salary deduction or by quarterly or annual premium, depending on the group size and the negotiation terms.
- Personal health declaration may be imposed or waived depending on the group size and terms.
- Renewal is on yearly basis subject to underwriter consideration and the terms and premium may alter during renewal, depending on the experience and changes of the group size.

2.1 PMI POLICIES

2.1.2 BENEFITS ASSOCIATED WITH HOSPITAL AND SURGICAL INSURANCE POLICIES

- For this policy, it's mandatory to use the standardized wording contained in the glossary of terms in all policies, certificates where such definitions, descriptions of benefits, conditions, and exclusions are used.
- The benefit offered generally are categorized as:

a) Traditional with inner limit benefits

b)'As charged' basis, subject to the overall annual limit/lifetime limit

a) Traditional with inner limit benefits

- There is a limit specified in every benefit stated in the policies.
- The payment is on a "per disability" basis

Hospitalization & surgical	Plan			
	1	2	3	4
a) Daily room & Board (up to 120 days)	350	230	160	100
b) Surgeon Fees without surgical	350	350	350	350

Table 1.1 Schedule of Benefit-Inner Limit Per Disability Basis

2.1 PMI POLICIES

2.1.2 BENEFITS ASSOCIATED WITH HOSPITAL AND SURGICAL INSURANCE POLICIES

- Anyone disability refers to a single disability and its complication that result in the insured person/participant/covered person being hospitalized one or more times.
- All hospitalization shall be considered to be from the same disability if the insured person has not completely recovered and is still under treatment for that disability and its complication.
- Hospitalization is considered as if the insured person's new disability has fully recovered and does not require any treatment for the disability for a period more than 90 days following the date of discharge from the last hospitalization.

b)'As charged' basis, subject to the overall annual limit/lifetime limit

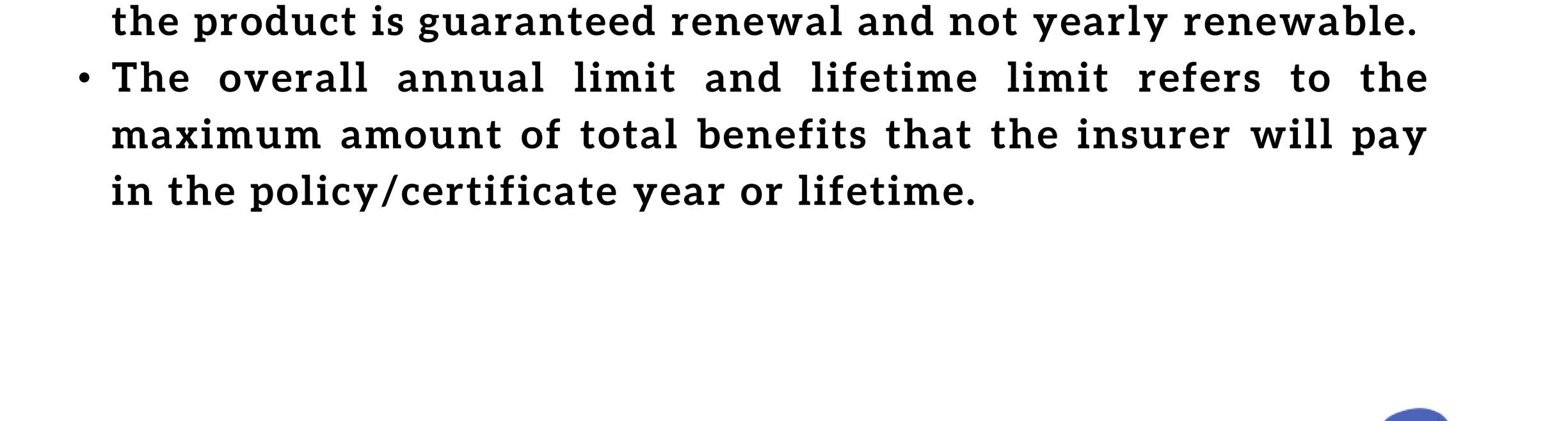
Hospitalization & Surgical	Plan		
	A	B	C
a) Daily Room & Board (up to 120 days)	350	350	350
b) Intensive Care Unit (up to 20 days)	AC	AC	AC
c) Surgeon Fees	AC	AC	AC
Overall Annual Limit	70,000	50,00	30,000

Table 1.2 Schedule Of benefit-"As Charged Basis"

2.1 PMI POLICIES

2.1.2 BENEFITS ASSOCIATED WITH HOSPITAL AND SURGICAL INSURANCE POLICIES

- In the 'as charged basis plan, the room & board is capped as stated in the plan, whereas all the other charges are 'as charged', subject to being medically necessary and reasonable.
- customary charges as stated in the definition will be applicable for what is medically necessary and reasonable.
- A lifetime limit is generally for individual products, whereby the product is guaranteed renewal and not yearly renewable.
- The overall annual limit and lifetime limit refers to the maximum amount of total benefits that the insurer will pay in the policy/certificate year or lifetime.



2.1 PMI POLICIES

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2.1.4 OTHER PMI PRODUCTS AND ADDITIONAL BENEFITS

- Popular medical expenses cover available as additional benefits are coverage for chronic illness of:
- Outpatient cancer treatment
- Outpatient kidney dialysis treatment
- Organ Transplant

- OUTPATIENT CANCER TREATMENT
- defined as any malignant tumor characterized by the uncontrolled growth of malignant cells and invasion of tissue.
- "Malignant tumor" may also include leukemia, lymphoma, and sarcoma.
- The insurance policy will pay eligible medical expenses for radiotherapy or chemotherapy for outpatient treatment.
- The benefit payable can be on monthly basis or annual basis on a predetermined fixed amount specified in the plan

2.1 PMI POLICIES

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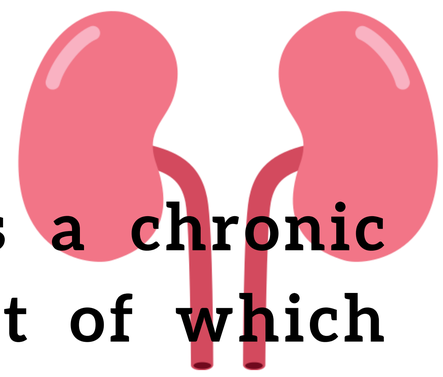
2.1.4 OTHER PMI PRODUCTS AND ADDITIONAL BENEFITS

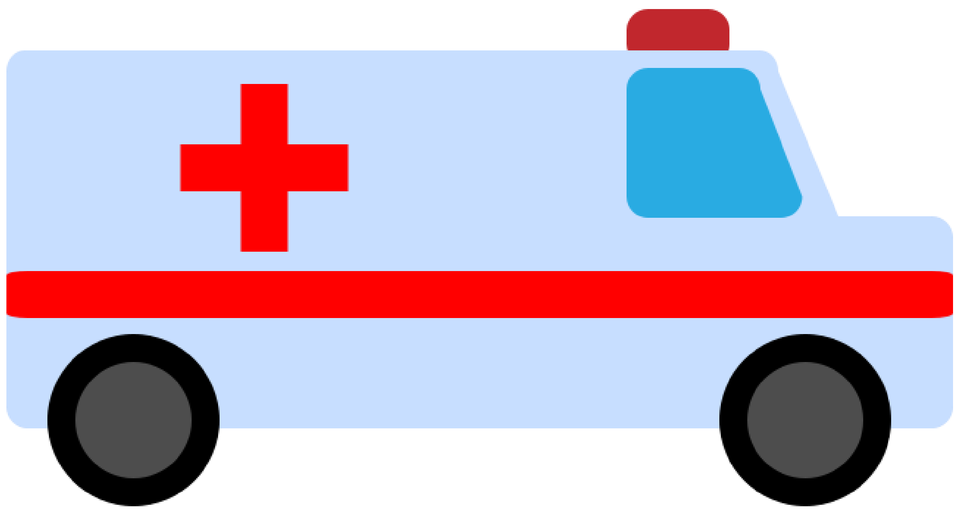


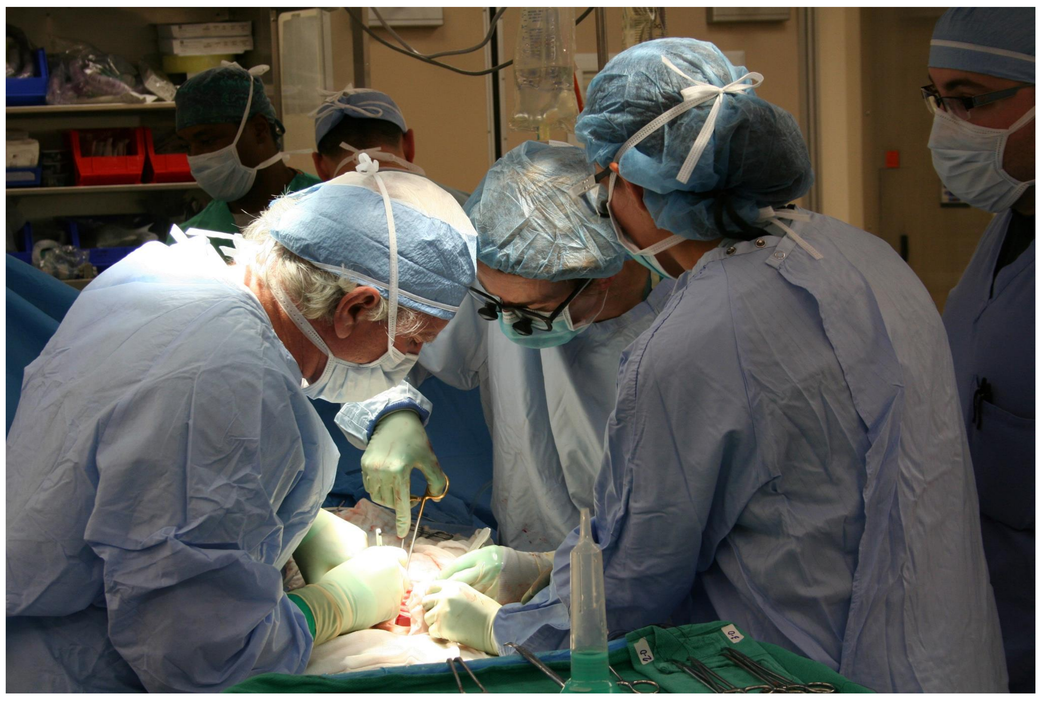
2. OUTPATIENT KIDNEY DIALYSIS TREATMENT

- Refer to end-stage renal failure presenting as a chronic failure of both kidneys to function as a result of which renal dialysis is initiated.
- Insurance pay for the eligible incurred expenses for kidney dialysis perform at a registered kidney center or hospital

3. ORGAN TRANSPLANT

- Insurance pay for the eligible incurred medical expenses or transplantation surgery for the insured being the recipient of the transplant of a kidney, heart, lung, liver, or bone marrow.
- payment of benefits is applicable only once in a lifetime and subject to the limit as specified in the plan.
- The cost of acquisition of the organs all costs incurred by the donors are not covered.



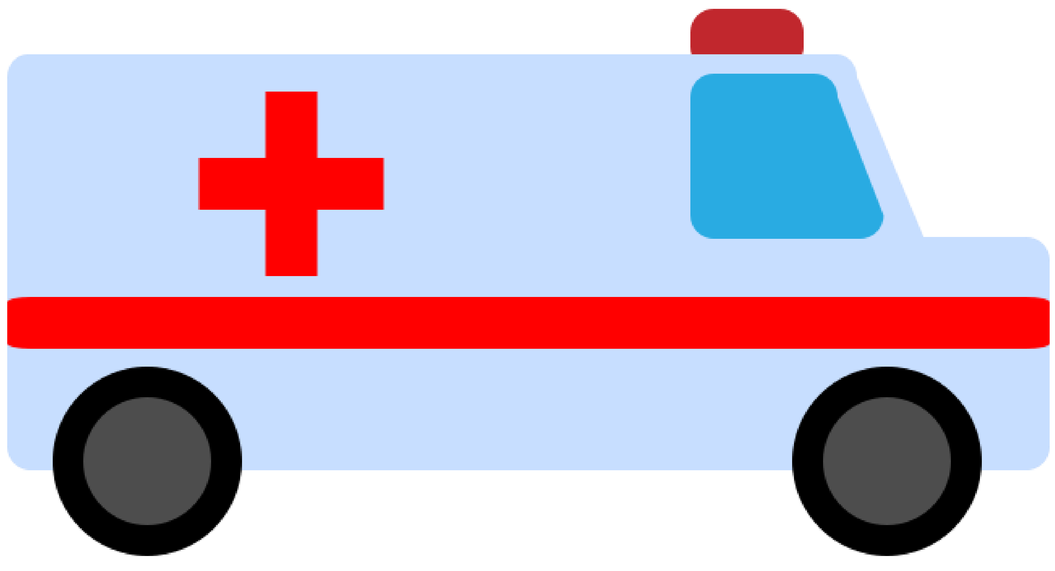


2.1 PMI POLICIES

2.1.4 OTHER PMI PRODUCTS AND ADDITIONAL BENEFITS

OUTPATIENT CLINICAL INSURANCE

- Usually a rider to a group Private Medical Insurance [PMI] policy for the large group under employee benefits scheme.
- Cover outpatient services provided by primary care physicians of the company's panel clinic for treatment arising out of illness, sickness, disease, or injury.
- Benefit:
- Consultation and treatment for the usual outpatient ailments
- Supply of prescribed drugs for the necessary treatment
- diagnostic test, including laboratory tests and X-rays
- Extend cover non-panel clinics



2.1 PMI POLICIES

2.1.4 OTHER PMI PRODUCTS AND ADDITIONAL BENEFITS

OUTPATIENT SPECIALIST

- A written referral from the primary physicians and from the company's panel clinics
- Benefit :
- Consultation and treatment for the referred ailments
- supply of the prescribed drugs for the necessary treatment
- diagnostic test, including laboratory test and x-ray
- Direct access to specialists is not covered to prevent abuses and an insured has to go through the primary care gatekeeper.

CRITICAL ILLNESS INSURANCE

- Sold as an optional rider to a life policy or a standalone life or health insurance policy
- Lump-sum payment if the insured is diagnosed with one of the critical illnesses listed in the policy.
- Policy automatically terminated upon payment of the sum assured and no further cover or sum will be payable if death occurs subsequently.

Activity

Find out the 39 critical illnesses offered by the insurance companies and identify why does the regulator fix only 36 critical illnesses to be sold, instead of 39.

2.2 GROUP EMPLOYEE BENEFIT SCHEME

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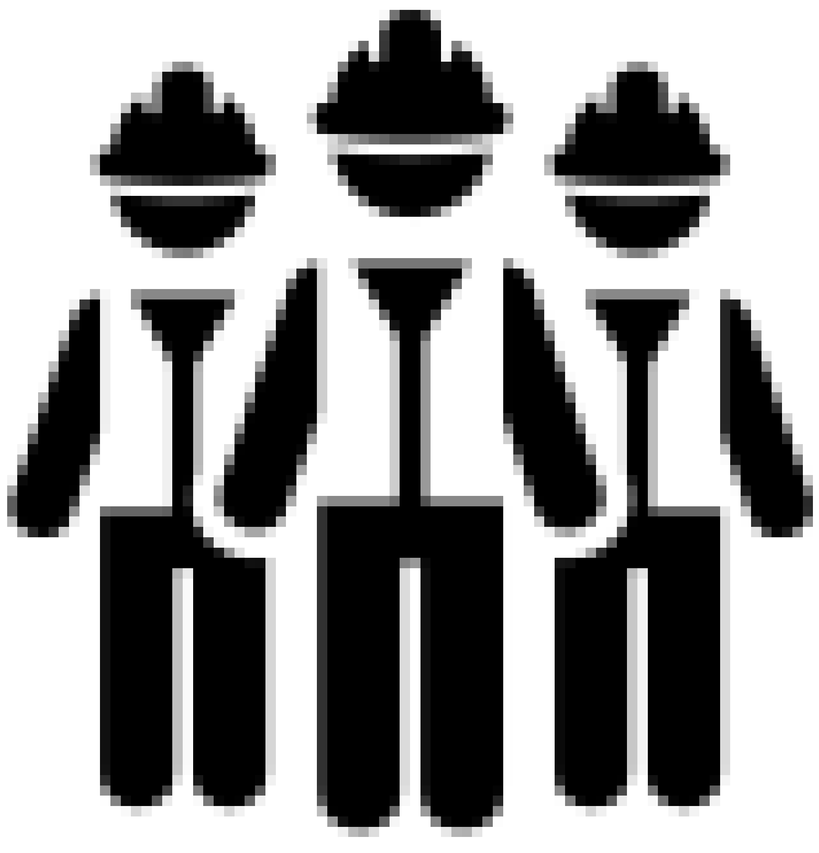
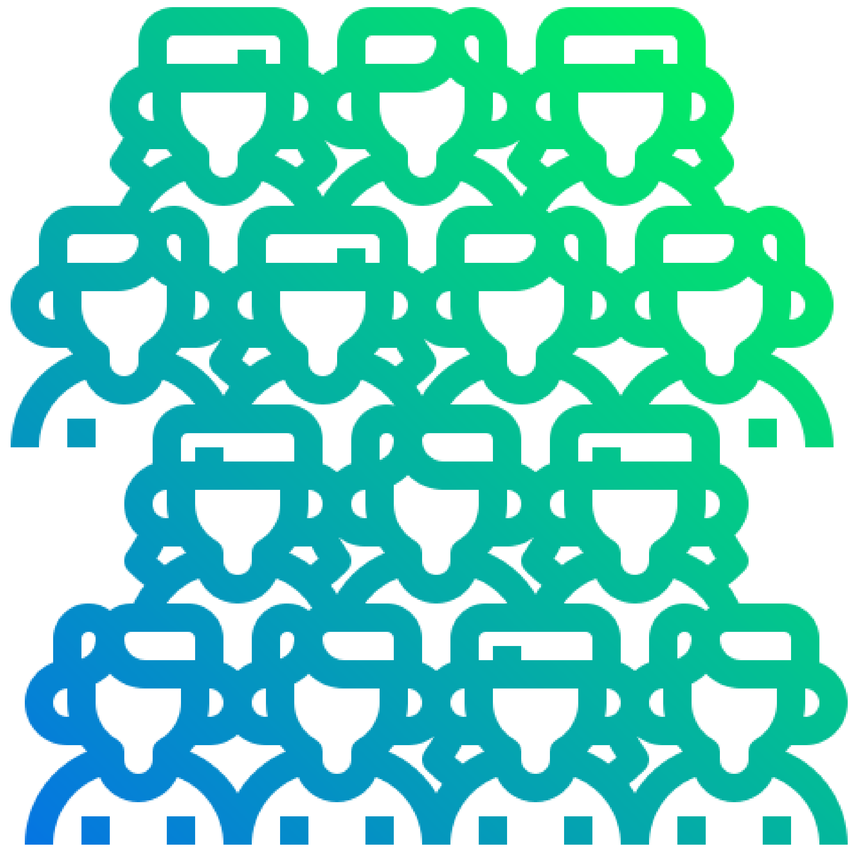
2.1.4 OTHER PMI PRODUCTS AND ADDITIONAL BENEFITS

- **Arranged by the company for its employees' welfare**
- **May arise because of:**
- **Union bargaining for health protection benefits from the employer**
- **Staff retention strategy to ensure the stability of the workforce for the company**
- **The employer is responsible for the payment of the premium and may extend to cover the dependents of the employees as well.**
- **The employer can choose and provide protection based on different categories of staff with different levels OF PMI coverage subject to their job/position.**
- **Insurer generally classifies group market into:**
  a. **Small Group**
  b. **Large Group or Corporate Scheme**

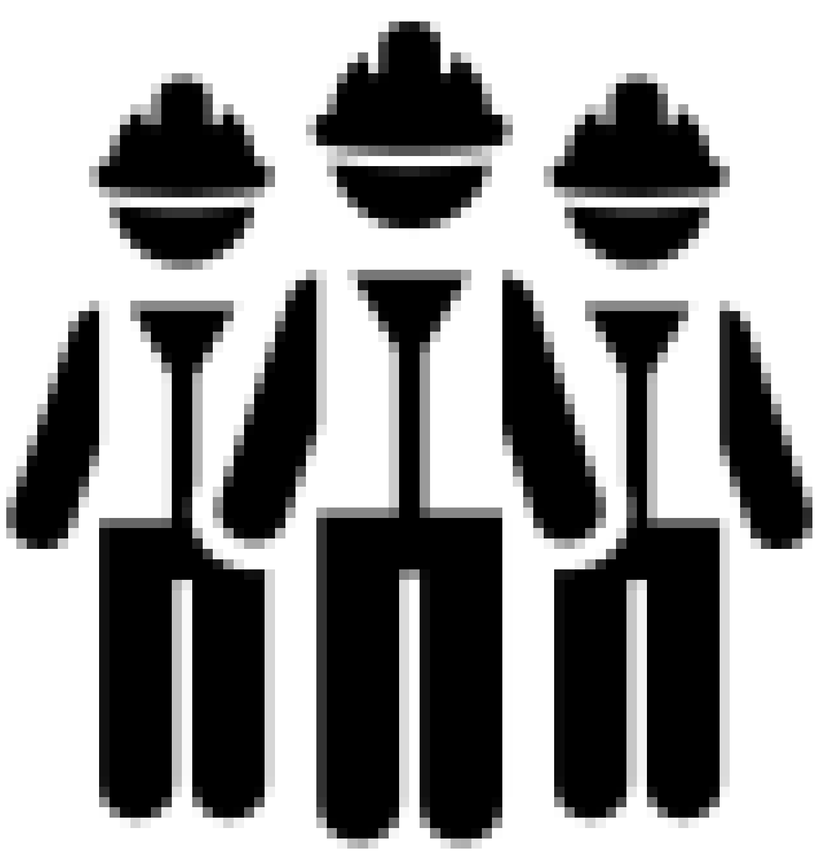




2.2 GROUP EMPLOYEE BENEFIT SCHEME

2.2.1 SMALL GROUP SCHEME POLICIES

- Normally offered to a small group ranging from 10-50 members
- Plans may be pre-fixed and employers can select the plan offered according to their affordability.
- Described also as SME plans to cover small and medium-sized enterprises.
- Some insurers may have tailor-made group policies and price them accordingly.
- For these policies, insurers are not allowed the flexibility of the benefit structure and choice of the range of additional services as compared to those offer with a large group scheme
- A personal declaration is required and the underwriting process imposes exclusions on the pre-existing condition which totally excluded and not covered by the additional premium.
- Premium charge based on age band or level premium regardless of age.
- Premium payment is on an annual basis



2.2 GROUP EMPLOYEE BENEFIT SCHEME

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2.2.2 LARGE GROUP/ SCHEME POLICIES

- Normally offered to a large group ranging from 50 and above members
- Policies are tailor-made according to the group's need, generally comprehensive in cover, and competitive in pricing due to the large premium generated from the large group.
- The premium is level premium across all ages and can be 3 0r 4-tiers of categories as follow:
  a. 3-tier premium categories: Employee, spouse, and child
  b. 4-tier categories: Employee, Employee, and spouse, employee and children, Employee and family.
- Premium computed on experience rating also known as "community pricing".
- Payment of premium is on an annual basis or half-yearly or quarterly depending on what is negotiated.
- An experience refund is given to encourage good claim control and utilized to offset renewal premium as a form of business retention.
- Renewal is on yearly basis, terms and considerations as well premium rating may be altered, depending on the experience and changes of the group size.

2.2 GROUP EMPLOYEE BENEFIT SCHEME

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2.2.3 EXPERIENCE-RATED AND COMMUNITY-RATED GROUP SCHEME

- In the derivation og group pricing
- under these scheme premium is computed according to the group's claim experience called as 'experience rating'. This rating taking claim experience over 12 month or more.
- If insurer have to cost the administrative charges with the projected claim for the period covered, level premium, regardless age or gender this rating known as "community rating"
- This scheme only applicable for large group scheme and excluding individual and small group products.

2.2 GROUP EMPLOYEE BENEFIT SCHEME

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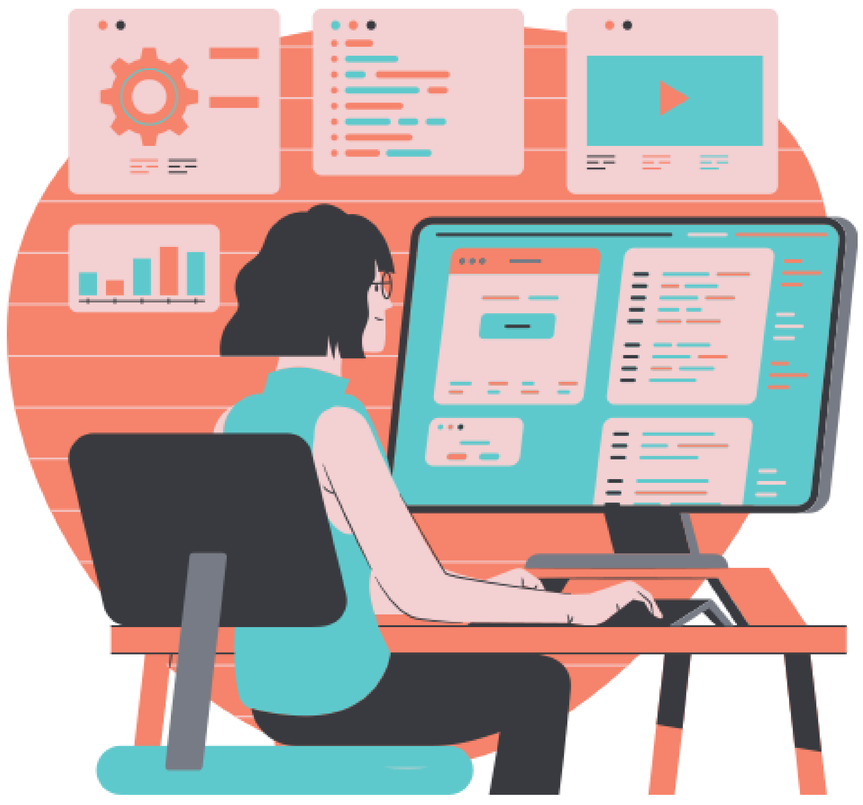
2.2.4 CONTRIBUTORY AND NON-CONTRIBUTORY SCHEME

- In the Group Employee Benefits Scheme
- Non-contributory scheme: PMI policy's premium payment fully paid by the employer
- Contributory scheme: Premium may partially be paid by employees in terms of contributory which is salary deduction.
- If by contribution, it may be voluntary for employees to include their dependent to enjoy rate as an extension to cover.
- Voluntary contribution insurers may require a minimum participation of generally 75% as a grant to be cover on a group policy.

2.3 INTERNATIONAL POLICIES

- Cover insured who travel outside Malaysia for working or living abroad.
- cover high costs of overseas treatment where local PMI cover may not sufficient.
- Local PMI policies generally have "Residence overseas" policy condition whereas insurer will not cover any medical treatment received outside Malaysia if the insured resides or travel Malaysia more than ninety (90) consecutive days.
- Yearly renewable policy
- option to cover family
- payment of claim arranged in local currency of the country of residence
- insurer facilitates the local panel hospital and clinics for ease of claims servicing.



2.3 INTERNATIONAL POLICIES

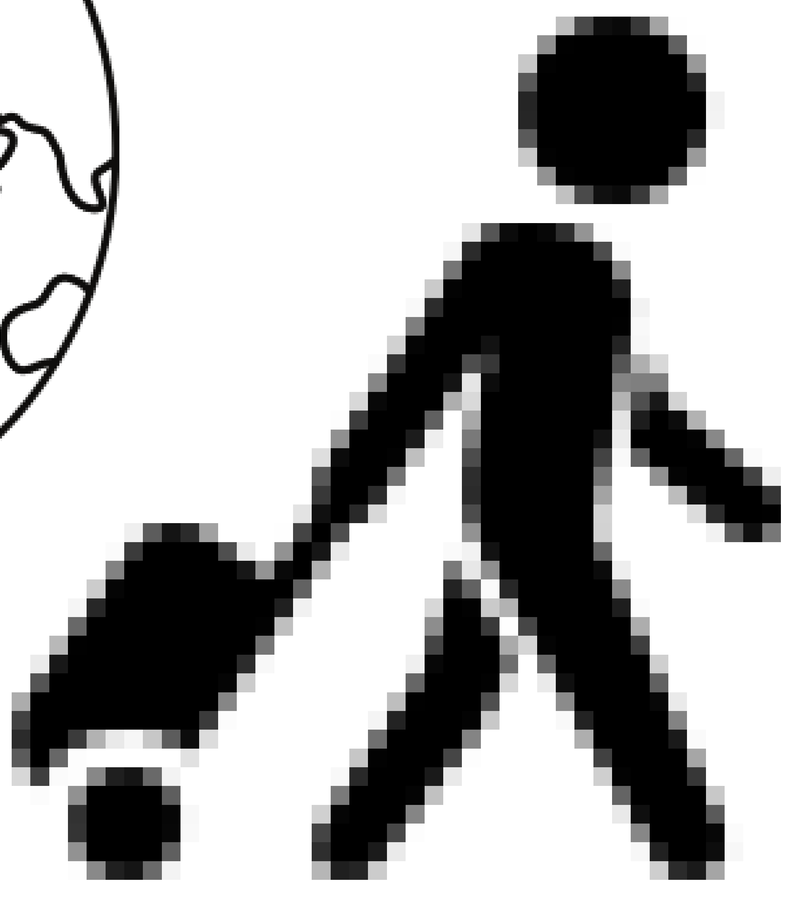
2.3.1 SCOPE OF COVER

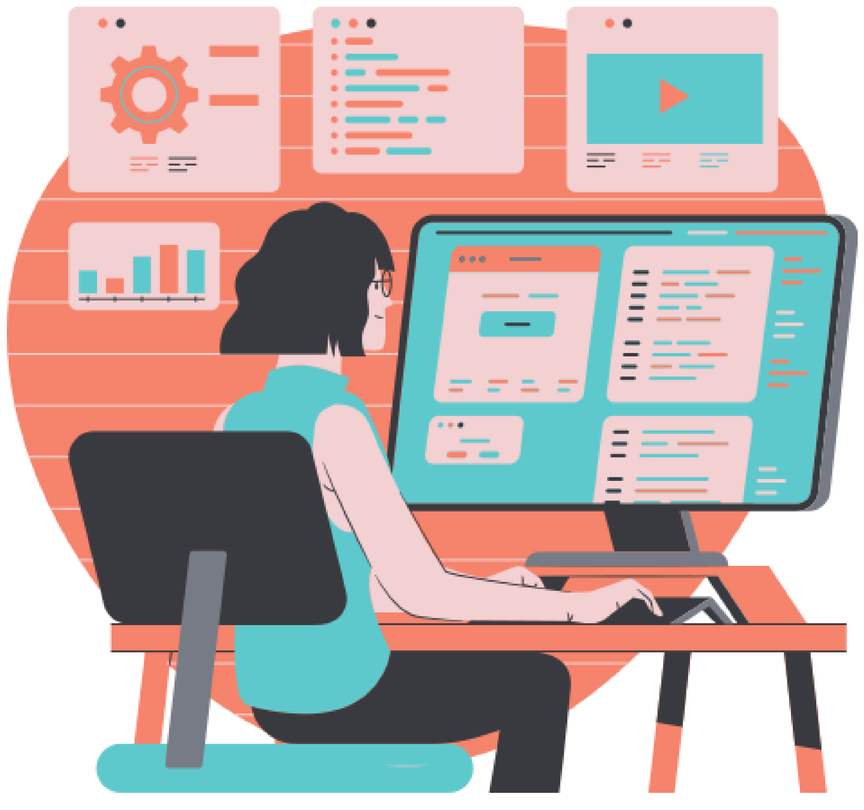
- **Similar to those of Hospital and Surgical insurance products.**

- **cover medical treatment and service up to a predetermined amount as specified in the plan of coverage, comprehensive or standard plan.**

- **the comprehensive plan generally extends to cover outpatient clinical, with the local network panel clinic abroad and co-payment or deductible may be applicable, depending on the plan of choice.**

- **additional benefits would be benefits of evacuation and repatriation back to Malaysia, including mortal remains as well as the full range of travel assistance services.**





2.3 INTERNATIONAL POLICIES

2.3.2 EXCLUSIONS AND LIMITATION

Similar to the local policies in Malaysia except at times it may extend to cover certain benefits that may be considered as necessary in the locality and should not be excluded for example pregnancy.

Activity:

In Group find out the General Exclusion for PMI product applicable to all PMI policies.

2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

a. Fully insured

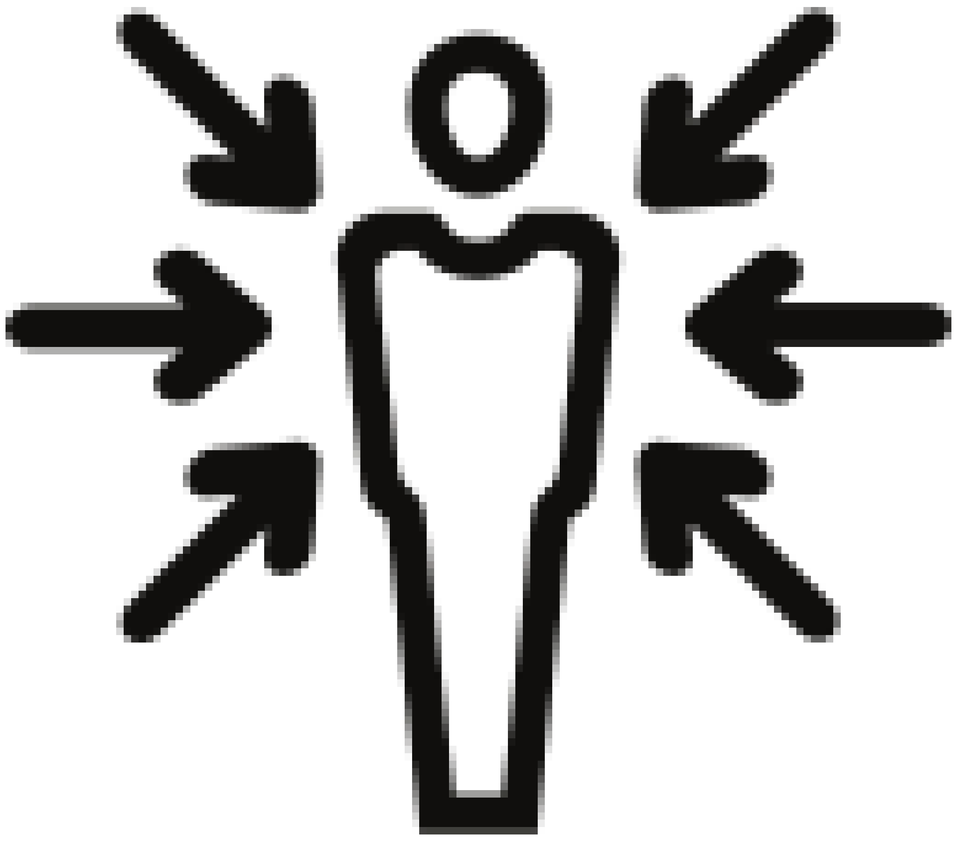
-Individual and corporate bodies transferring their risk to the insurer through purchase an individual or group PMI policy.
-Insurer bears the risk of an unexpectedly high claim during the period of insurance, which premium had been fixed and will not be affected by the high claim.
-subject to the product or plan offered by the insurer and subject to insurance policy terms and conditions and exclusions of the limits of cover purchased.
-less flexibility in terms of plan design or coverage and subject to negotiation with the insurer
-Insured is not exposed to the variability of high and low claims experience and they can budget their expenses and cash flow.

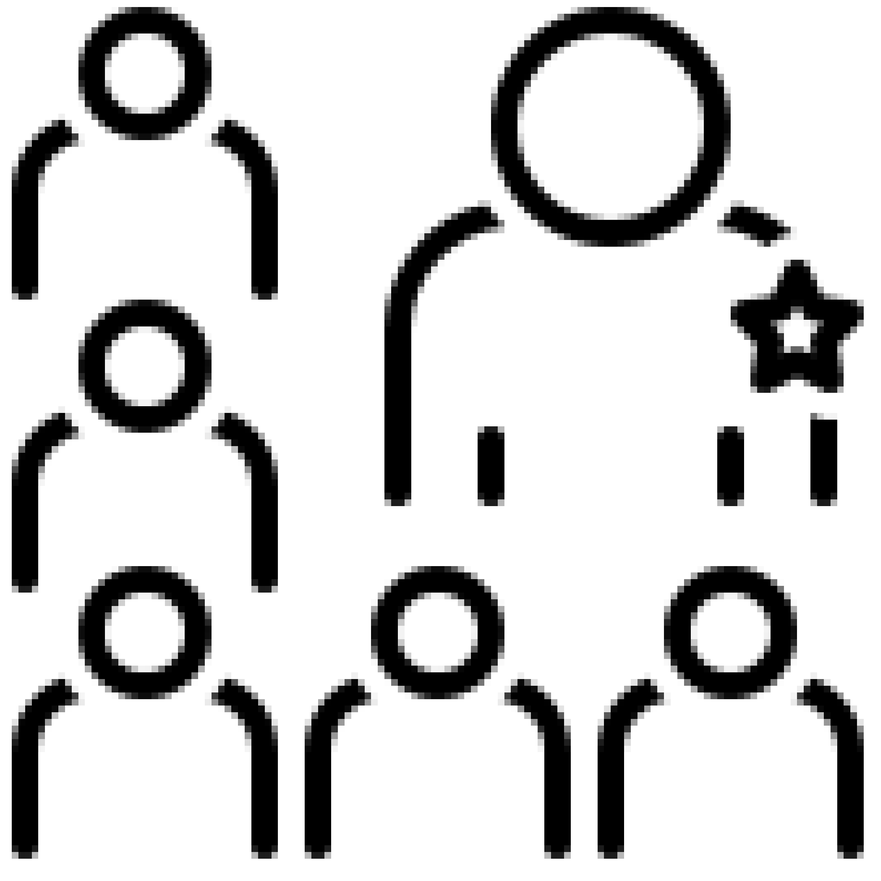
2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

b. Individual and Group scheme

-Group schemes are generally categorized into small and large groups depending on the size of the group.
-Premium is paid by the employer and it's also part of the Employee Benefits Scheme.
-The dependent of the employees may also be included to enjoy group scheme benefits.
-Premium rating and adjustment as follow:
a. Experience rating-The group claim experience is collated over a period of 12 months or more. Premium calculated based on group claim experience.
b. Community rated-Group experience will be pooled with other groups within the community and the insurer will charge a fixed rate for all members within the community depending on community experience.





2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

C. Risk Sharing

-Can be occurred in TWO (2) Situation:

- Insured wish to share the insurer's profit if the claim is low, which is termed as " good claim experience refund". The incentive for the insured to maintain a healthy life and to have control, ensuring that the risk is profitable. Applicable for group PMI policies.
- For individuals usually on the losses, policyholders will bear a certain proportion of the losses, whereby the insurer bears the higher portion.

-The advantage will be a lower premium charged compared to the full risk to be borne by the insurer.

2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

D. COST PLUS PLANS

-arrangement to provide facility for payment of medical expenses, of which the expenses can be:
a. excluded and not covered by the insured benefit program
b. on a self-funding basis.
-Premium calculated will be the cost claim expected to be paid, plus an administrative charge for administering the scheme and all other related costs.
-Premium adjustment: Insurers must first determine the future claim cost and add in the administrative fee for managing the scheme, to arrive at the premium.

2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

e. Self Funding

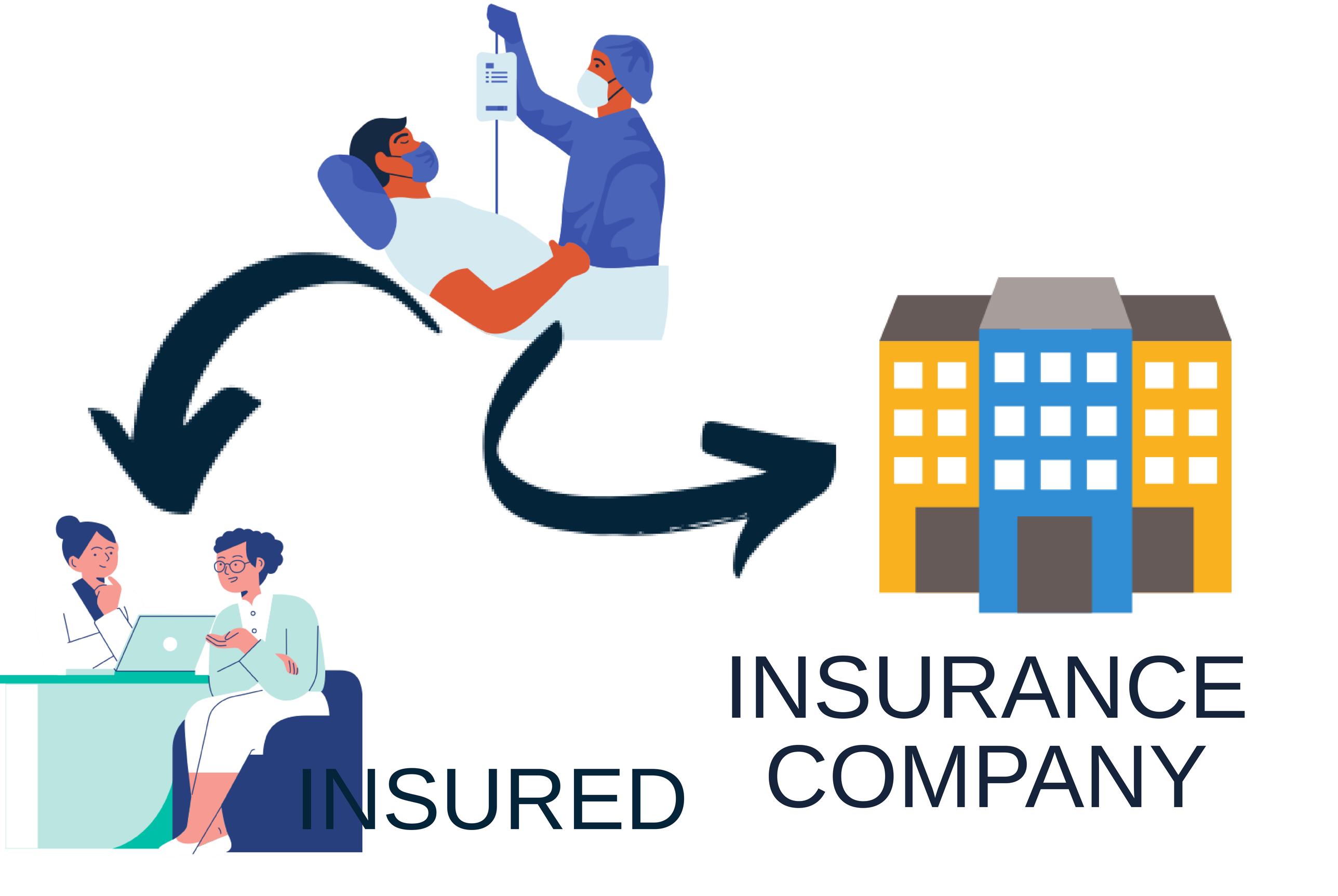
-Individuals or corporate bear the risk and undertake all costs incurred.
-Funding through individual saving or paid out of company general expenses account or reserve.
-Greater flexibility in terms of plans design and coverage and not limited to the offering of standard plans by the insurer.
-In the event of an unexpected high claim there would be a potential inability to meet claim expenses when they arise.

2.4 FUNDING METHOD IN MHI

2.4.1 FUNDING METHODS IN RELATION TO INDIVIDUAL AND GROUP SCHEME

F. Co-Funding

-Type of arrangement where insured will bear a portion of the claims and the insurer, the balance
-Quite common, especially in major medical insurance whereby the insured will bear 20% of the claim and the insurer the balance 80%.



CHAPTER 3
RISK ASSESSMENT & MANAGEMENT

1 ASSESSMENT & UNDERWRITING

2 COST CONTAINMENT IN MHI

SELF-BELIEF AND HARD WORK WILL ALWAYS EARN YOUR SUCCESS

Virat Kohill

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.1 PRINCIPLE OF ASSESSMENT AND UNDERWRITING

DEFINITION OF UNDERWRITING

Definition: Process by which an insurer seeks to **assess** the risk posed by a pre-existing medical condition and where necessary, excluded this risk by imposition of a 'special condition' to the term of the policy.

Risk assessment has TWO (2) basic elements:

- **Underwriting the risk**
- **Adequately pricing the risk**

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.1 PRINCIPLE OF ASSESSMENT AND UNDERWRITING

- For individual PMI the basic risk selection falls under FOUR (4) categories:

1. Medical Factors
2. Financial factors
3. Occupational Class
4. Age factors

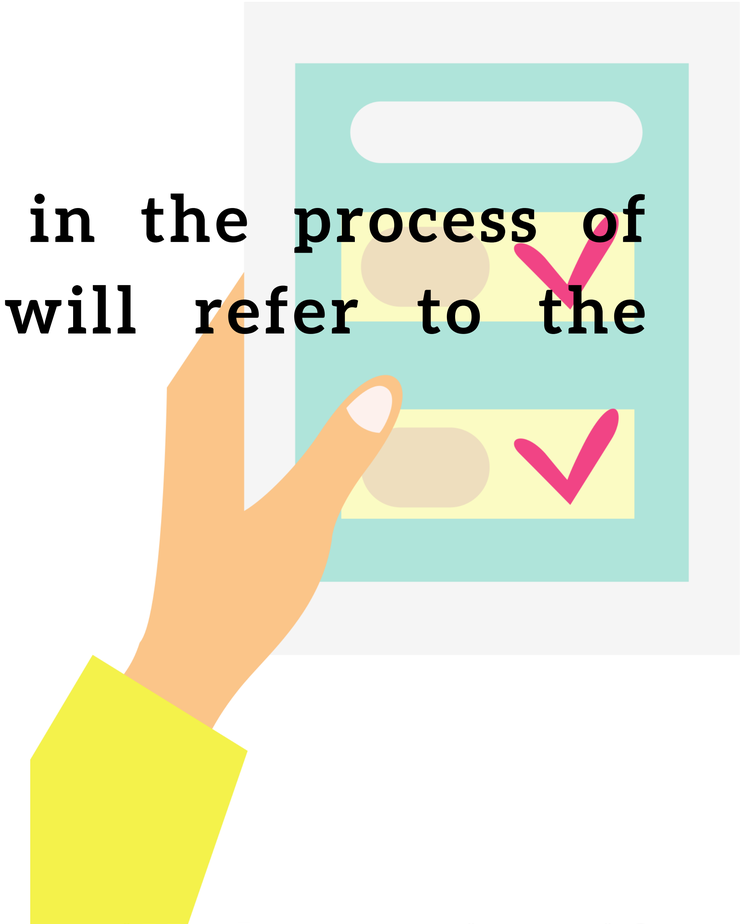
- For Group risk selection factors are:

1. Group Size
2. Occupation of the group
3. Age distribution
4. Level of participation

- Underwriter will work with the actuarial department and medical personal of the company to establish criteria for evaluating an application for insurance coverage, determine risk factors represented by the proposed insured.
- Premium rate calculated based on mortality or morbidity rates of the company.

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.1 PRINCIPLE OF ASSESSMENT AND UNDERWRITING



-The underwriter will select those risks and in the process of selecting and classing of risk underwriter will refer to the information which is from:

a. application form

b.medical history and the examination report

c.hospital medical record

d.agent's statement

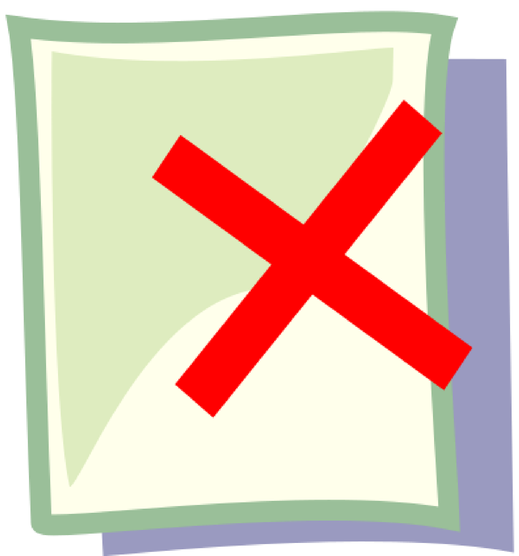
-upon evaluating the proposal, the underwriter will determine if the application for insurance be:

a. accepted as the preferred basis

b.accepted as a standard basis

c.accepted as substandard basis

d.rejected



3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.2 PREMIUM LOADING AFTER CLAIM AND PREMIUM CALCULATED

-Loading factors differs between individual and the group PMI policies and also whether it is a yearly renewable policy or guaranteed renewal policy, on portfolio re-pricing.

-In the event of portfolio re-pricing, generally applicable for guaranteed renewable individual PMI policies, it has to be actuarially certified and the new pricing would be applicable to all policyholders within the pool, irrespective of the policyholder having made claim or otherwise.

-In the event adverse claim, there will be no premium loading for portfolio pricing guaranteed renewable product, for each respective claimant.

-Re-pricing is done if the pool is no longer viable to sustain future claims and the new pricing would apply to the existing and new prospective policyholders.

-Yearly renewable products, policyholder premium will be subject to premium adjustment or premium loading after an adverse claim.

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.2 PREMIUM LOADING AFTER CLAIM AND PREMIUM CALCULATED

-For an individual policy for any adverse claim experience, maximum loading should not exceed 50% of the policy premium prior to the claim set in The Guidelines on MHI Business [revised] on 1 January 2010 by Bank Negara Malaysia.

-In a group PMI policy, normally it would be experience-rated and the insurer would project the future costs of expected claim to be paid together with the projected medical inflation, the acquisition costs, and the desired margin to arrive at the group premium loading after an adverse claim situation.

Activity:

In Group find out the loading factors applicable in MHI

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.2 PREMIUM LOADING AFTER CLAIM AND PREMIUM CALCULATED

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In Group find out the the loading factors applicable in MHI

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.2 PREMIUM LOADING AFTER CLAIM AND PREMIUM CALCULATED

How Premium Calculated?

- **The Guidelines On Medical and Health Insurance (MHI)Business (Revised) on the sales of MHI products came into effect on 1st January 2010 by Bank Negara Malaysia.**

- **A premium of an insurance policy is made up of TWO elements, namely:**
- **The risk premium, which is the part intended to pay for the anticipated claim of a policy**
- **The expenses loading, which must provide for:**

a. Acquisition and maintenance expenses,
b. A margin of profit
c. Contingency or security against statistical fluctuations; and
d. Taxation and regulatory costs

- **Premium calculated based on pricing analysis of various factors affecting the outcome of the product.**

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.3 MEDICAL UNDERWRITING & OTHER RISK ASSESSMENT

- A medical declaration is mandatory for Individual PMI applications to be underwritten.

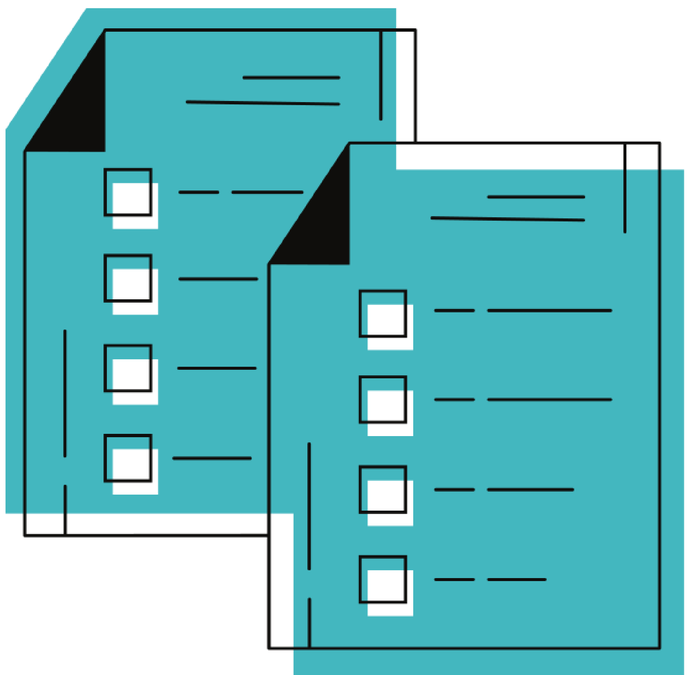
- Done through the application form, whereby medical history would be declared by the proposer.

- In the medical history declaration, complete information and the current status of health are obtained from the proposer as stated in the proposal form.

- Proposal form design to:
  a.question designed to extract the state of health of the proposer and pre-existing condition
  b.Underwriter will be able to assess the risk

- A specific medical report is required in order to assess risk, to know the frequency of treatment and prescription of the dosage of drugs taken. Additional report cost is borne by the proposer.

- Medical underwriting is also applicable to small group policies, health declaration required, and not waived.



3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.4 MORATORIA UNDERWRITING

MORATORIUM UNDERWRITING

- Often referred as "point of claim underwriting" which enables the PMI policy to be purchased with a minimum of formality
- Cost of treatment for pre-existing conditions are excluded
- Applicant does not have to declare their medical history at the time of joining the scheme
- Lends to direct selling, applicant may be covered immediately rather than subject to underwriting medical history
- Administrative easy, underwriting new application is not required at the point of joining
- Pre-authorization required by insurer upon claim
- Helpline facility provided

3.1 ASSESSMENT & UNDERWRITING IN MHI

3.1.4 MORATORIA UNDERWRITING

MORATORIUM UNDERWRITING

Advantage	• ease administration attract customer
Disadvantage	• can not control claim cost

3.2 COST CONTAINMENT IN MHI

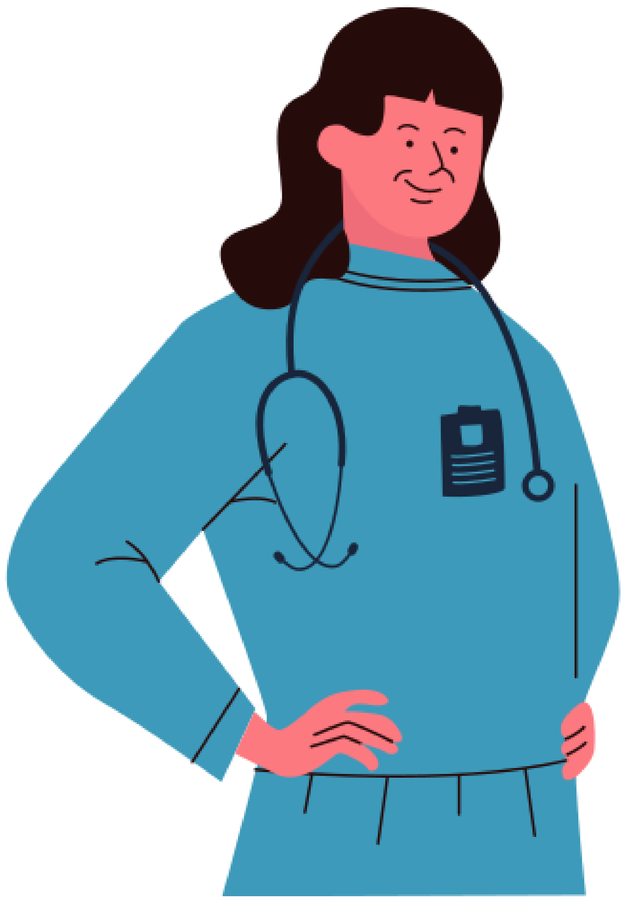
3.2.1 METHOD OF COST CONTAINMENT

a. No Claim Discount

- **Borrowed from Motor insurance, that is the renewal premium will be discounted if there is no claim in the previous year.**
- **Policies that offer NCD, normally offer an initial discount for the first year policy and subsequent year of discount up to the maximum amount that can be allowed.**
- **Example NCD:**

No of years renewal	% discount allowed
2nd year	10%
3rd year	10%
4th year	15%

Table 1.3 NCD for individual policy



3.2 COST CONTAINMENT IN MHI

3.2.1 METHOD OF COST CONTAINMENT

a. No Claim Discount

- It can be seen that the maximum NCD allowed is a total of 35% by the 4th year of renewal, provide no claim is made.
- The pricing structure will directly encourage policyholders to be cautious and responsible for their health to avoid claims and enjoy low premiums.
- only applicable to individual PMI products and not group products.
- Not widely used by insurers in Malaysia.

b. Loyalty Discount

- **Not a 'no claim bonus' but tagged to the policyholder as an incentive to continue insuring with the existing insurer.**
- **Improve the company's renewal rate and increase the pool of the risk premium to sustain any claim loss**
- **Neither popular nor used in PMI insurer**
- **Reason: insurers did not want to encourage the aging group and adverse health condition policyholder to remain in the pool.**

3.2 COST CONTAINMENT IN MHI

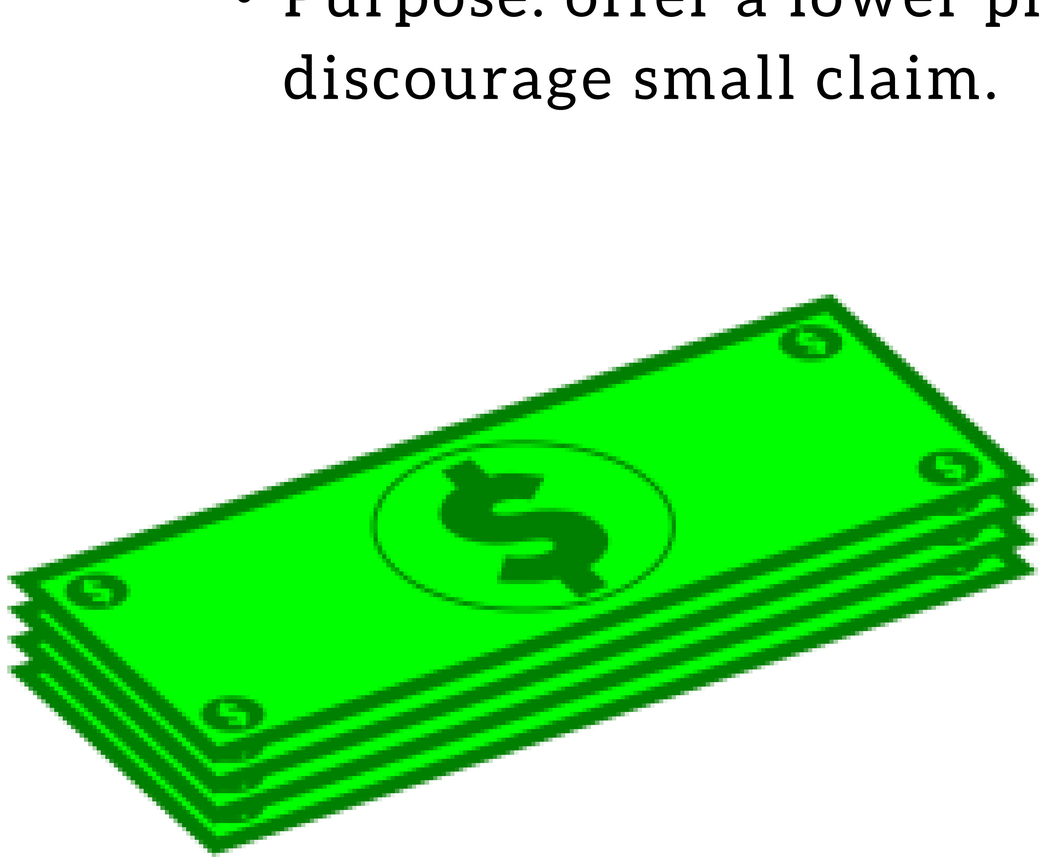
3.2.1 METHOD OF COST CONTAINMENT

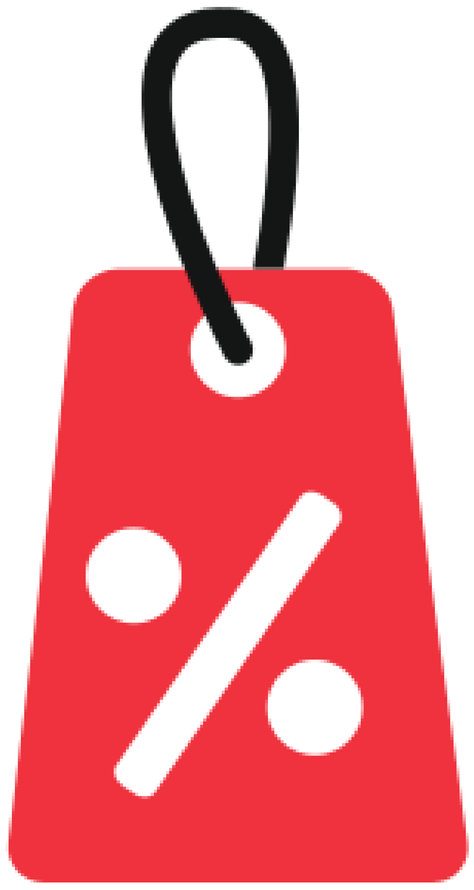
c. Payment Method Discounts

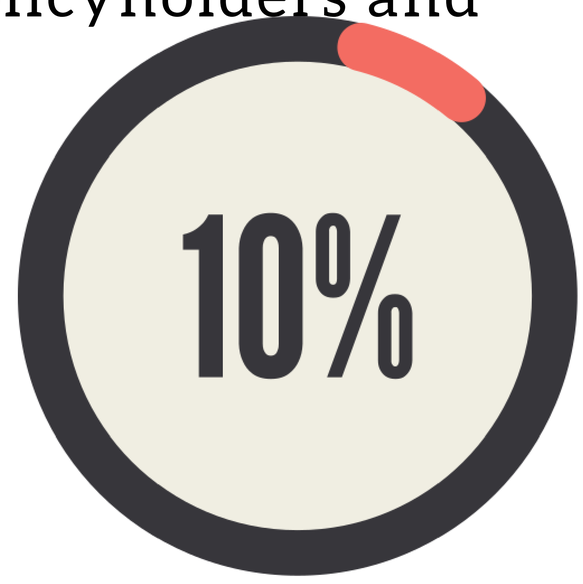
- Discounts negotiated with providers, on bills or invoice amounts at a certain percentage.
- Providers generally do not give discounts on hospital supplies and services and the only discount is given is on room and board charges which are an average of 10%.
- Insurers generally pass discounts to the claimant to reduce the overall claim cost so that the overall loss ratio can be maintained with minimal adjustment of premium in the next renewal policy.
- Professional fees were not involved and cannot be discounted.

d. Excess/deductible

- A fixed amount that policyholder must pay first regardless of the total cost of an eligible benefit.
- If deductible Rm 5,000 means policyholder have to pay the first RM5,000 and the remaining balance will be paid by the insurer
- Purpose: offer a lower premium for the policyholders and discourage small claim.







3.2 COST CONTAINMENT IN MHI

3.2.1 METHOD OF COST CONTAINMENT

e. Good experience refund scheme

- Applicable for group PMI policies
- Encourage policyholders to play an active part in ensuring a good claim experience and participate in the profit made by insurers.
- Good retention strategy to encourage good policyholders to continue with the insurer and enjoy refund as it is used to offset the renewal premium.

f. Co-insurance

- also known as cost-sharing
- applied more frequently as a cost-containment measure for both, individual and group PMI policies. Insurers normally took a higher percentage of the co-insurance, usually up 80% while insured may up to 20%.
- The proportional percentage may also applicable depending on the product design.
- Fixed price generally not subject to co-insurance.

3.2 COST CONTAINMENT IN MHI

3.2.1 METHOD OF COST CONTAINMENT

g.Benefit Limit

- vary among insurers.
- The higher the benefits, the higher would be the premium-priced
- In the "as charged" policies with an overall annual limit, the insurer will reimburse the actual cost charged if charges being reasonable and customary.

h. Exclusions

- Generally applied after full medical underwriting has been done for certain disabilities, not within the risk acceptance level of the insurer.
- Assist in eliminating the risk that has a high probability of occurrence or which may expose the insurer to a significant loss.
- Usually done for individual and small group PMI policies
- Also can be applied for hazardous occupation risks or hazardous sports activities that may increase the incident rate or injury.
- Besides exclusions insurers also can charged loading to accept risk.

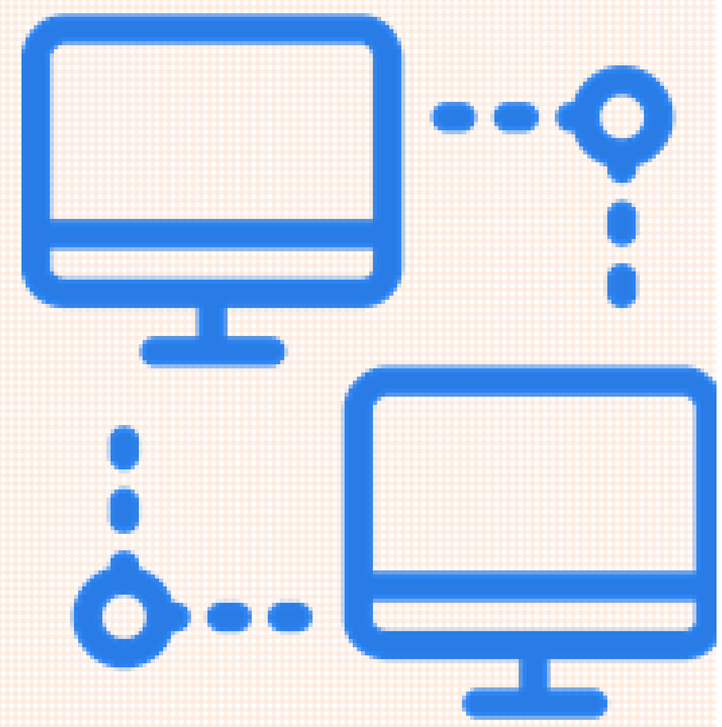
3.2 COST CONTAINMENT IN MHI

3.2.1 METHOD OF COST CONTAINMENT

i. Provider Network

ELECTRONIC DATA INTERCHANGE

- Recent innovation
- Hospital, specialist enters details of the claim and their cost/fee on a computer terminal situated in their own premises
- Data will transmitted directly to PMI company computerized claim system to be processed
- Advantages: Whole process become speedier, reduce mistake, improve quality and paperwork is eliminated



3.2 COST CONTAINMENT IN MHI

3.2.1 METHOD OF COST CONTAINMENT

i. Provider Network

PROVIDER HELPLINE

- Can use to:

Confirm benefit available for treatment

Discuss details of a particular case

Enquire about settlement of claim

Discuss shortfall which the consultant or hospital wish to clarify

Discuss cases where the patient has already settled the bill and the insurer should have reimbursed the customer rather than the provider

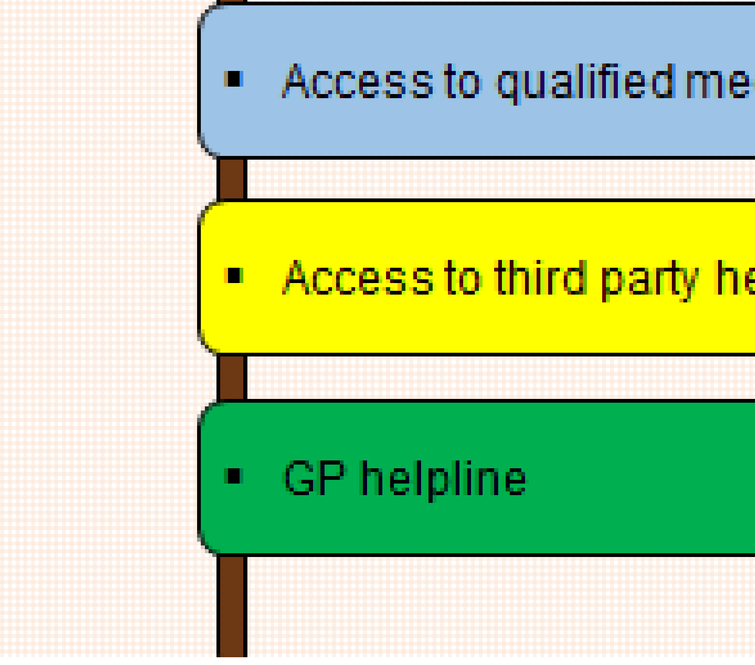
3.2 COST CONTAINMENT IN MHI

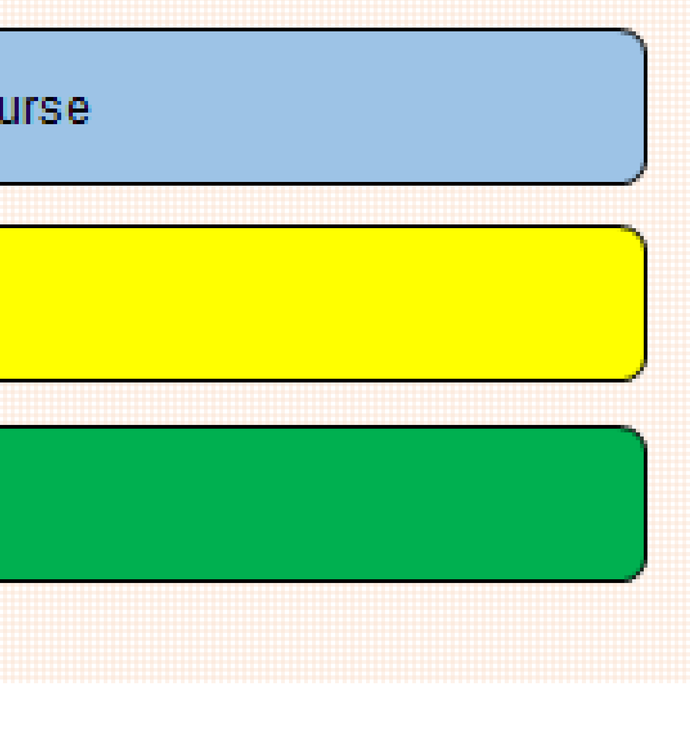
3.2.1 METHOD OF COST CONTAINMENT

i. Provider Network

PATIENT HELPLINE

- Using for pre-authorize claim
- Form:
  - Pre-recorded tapes giving information about particular medical condition
  - Access to qualified medical person-usually nurse
  - Access to third party helpline services
  - GP helpline





CHAPTER 4
MEDICAL UNDEWRWRITING

1 MEDICAL UNDERWRITING CONSIDERATION

2 UNDERWRITING OF MEDICAL HISTORY

3 SPECIAL CONSIDERATION FOR GROUP UNDERWRITING

4.1 MEDICAL UNDERWRITING CONSIDERATION

M H

4.1.1 PRE-EXISTING CONDITION

Definition:

- means disabilities before the effective date of insurance.
- Disabilities considered as condition which:

a. The insured person had received or is receiving treatment

B .Medical advice, diagnosis ,care or treatment has been recommended

c. Clear and district symptoms are or were evident or,

d. It existence would have been apparent to a reasonable person in the circumstances.

- policy exclusion for individual policies means insurer would not be expected to pay for this kind of illness or injury.
- For small group policies pre-existing are classified as standard policy exclusions.

Group Activity:

Find out cases related to pre-existing condition where the insurance company rejected the claim. State the reason.

4.1 MEDICAL UNDERWRITING CONSIDERATION

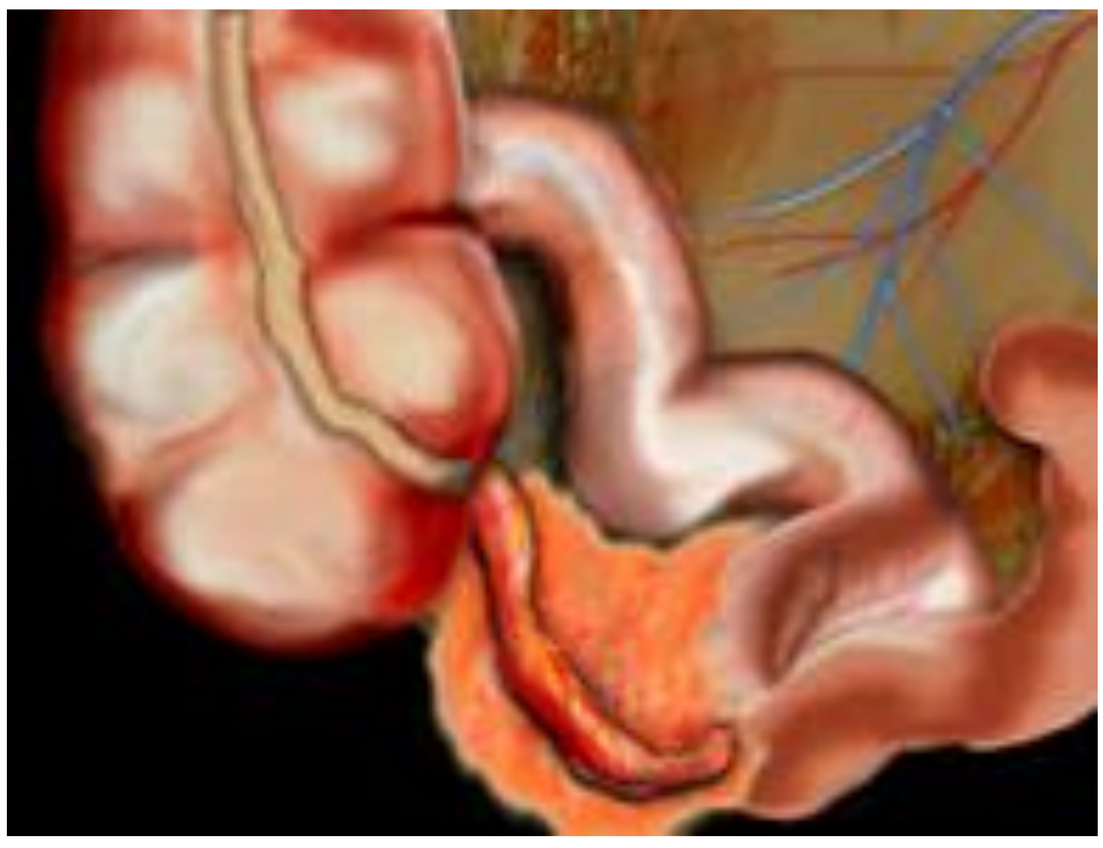
M H

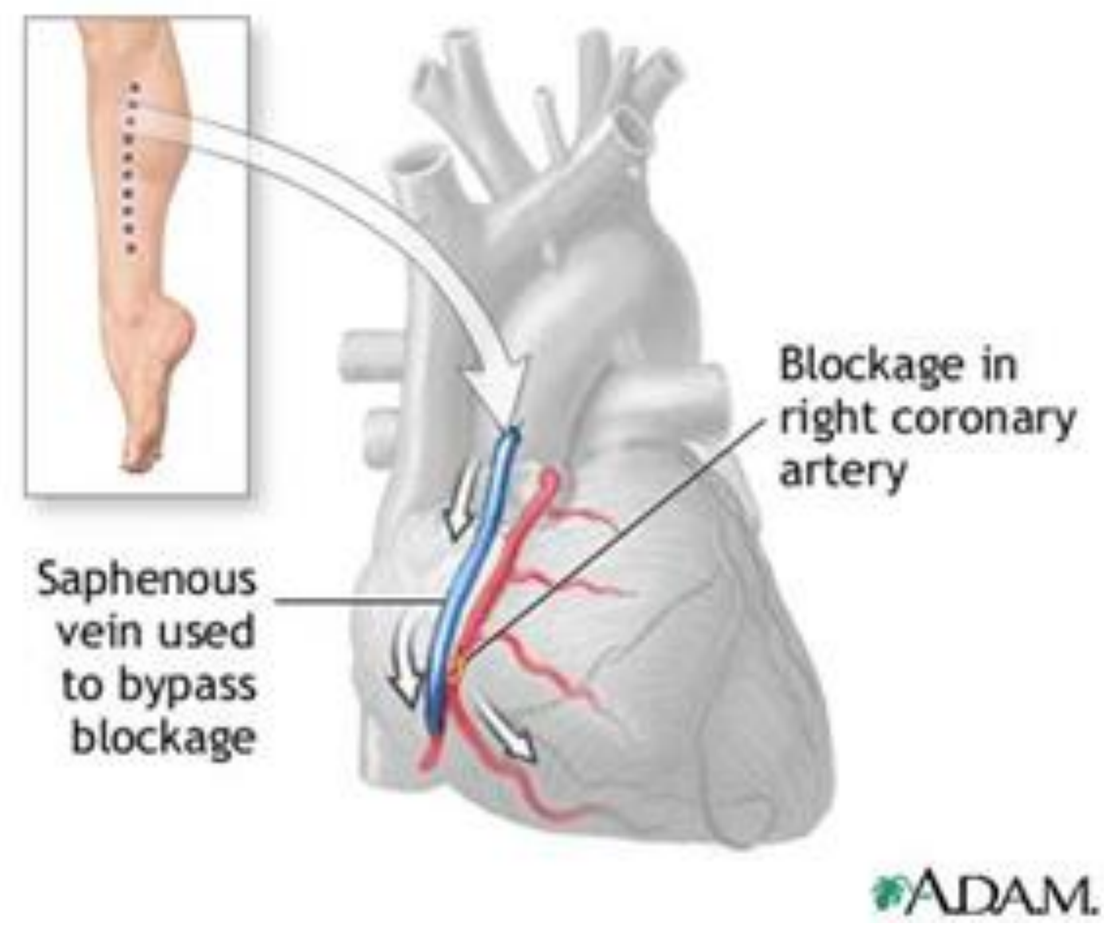
4.1.2 Acute and Chronic Illness

ACUTE ILLNESS

DEFINITION: A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

- **The term also include condition resulting from chronic illness but which can be CURED, or substantially cured (sometimes called an acute episode of a chronic condition.**
- **Example: Hip replacement or heart bypass surgery**





4.1 MEDICAL UNDERWRITING CONSIDERATION

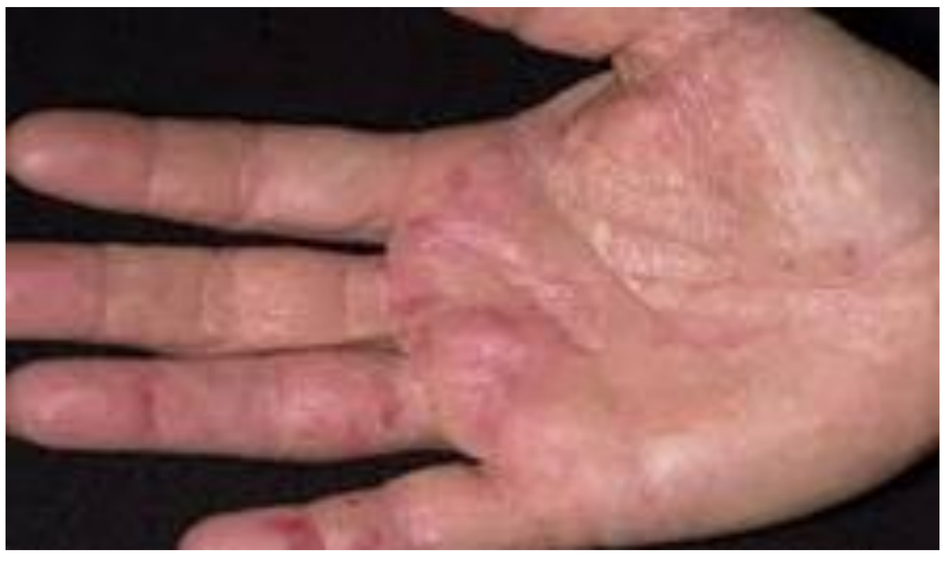
M H

4.1.2 Acute and Chronic Illness

CHRONIC ILLNESS

ABI Definition of a chronic condition is:

- A disease, illness or injury that has one or more of the following characteristics ."
- It needs ongoing or long-term monitoring, through consultation, examinations, check ups, and/or tests
- It needs ongoing or long-term control or relief symptoms
- It requires your rehabilitation or for you to be specially trained to cope with it
- It continues indefinitely
- It has no Known cure
- It comes back or is likely to come back
- This term is used to describe condition which is current medical knowledge, treatment can alleviate but not cure.
- EXAMPLE:



4.2 MEDICAL HISTORY

MH

4.1.2 Medical Underwriting

- Popular for individual underwriting for PMI products.
- Based on application or proposal form with a declaration of present or past medical condition.
- Underwriter will examine the severity of medical condition and the possibility of recurrence or relapse of the condition or related condition.
- Full medical history information and current state of health are obtained from the applicant
- Questions ask to determine the severity of any pre-existing conditions.
- Factors of medical condition consider by underwriter are:

a. age

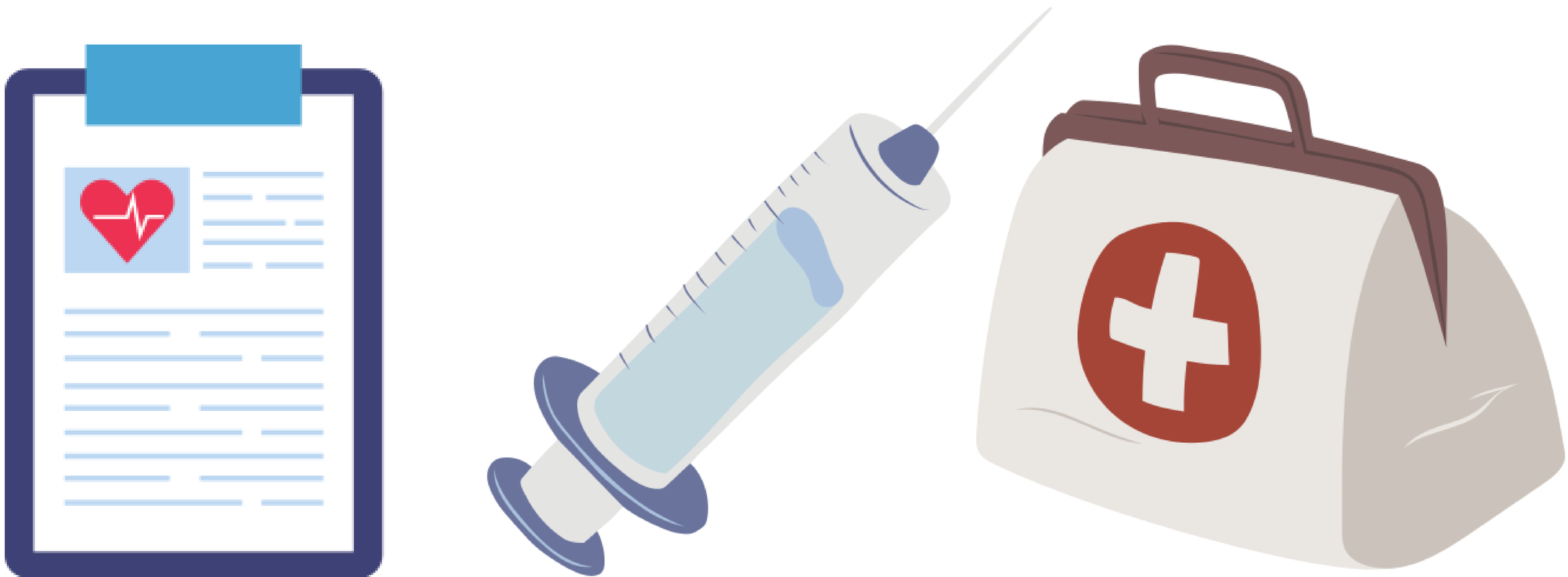
b. gender

c. start date of illness, duration and severity

d. frequency of symptoms

e. type of treatment received

f. present state of health that is fully recovered or still under treatment.

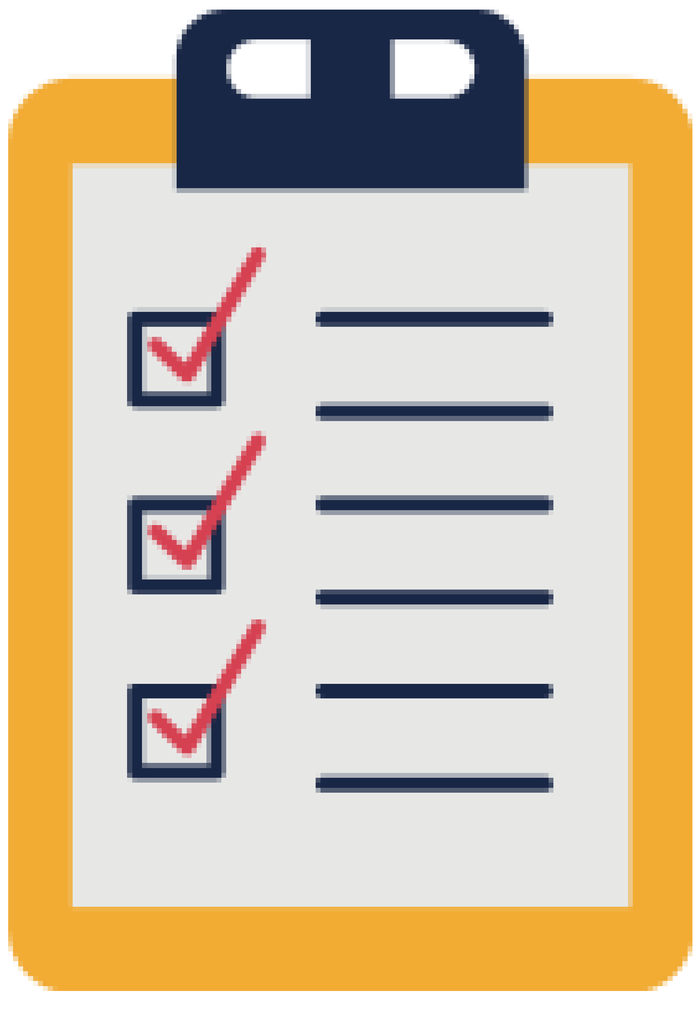


4.3 SPECIAL CONSIDERATION FOR GROUP MEDICAL UNDERWRITING

M H

4.1.2 Provider Network

- Policyholder have an option to choose their provider network either self funded or reimbursement from insurer later.
- If guarantee letter provided, there will be listing of panel hospital provided.
- Hospital charges vary among hospital based on their locality and specialty offered.
- For group medical underwriting, if there are request for high-end providers which are not within the panel list, insurer may given special consideration and price it accordingly.

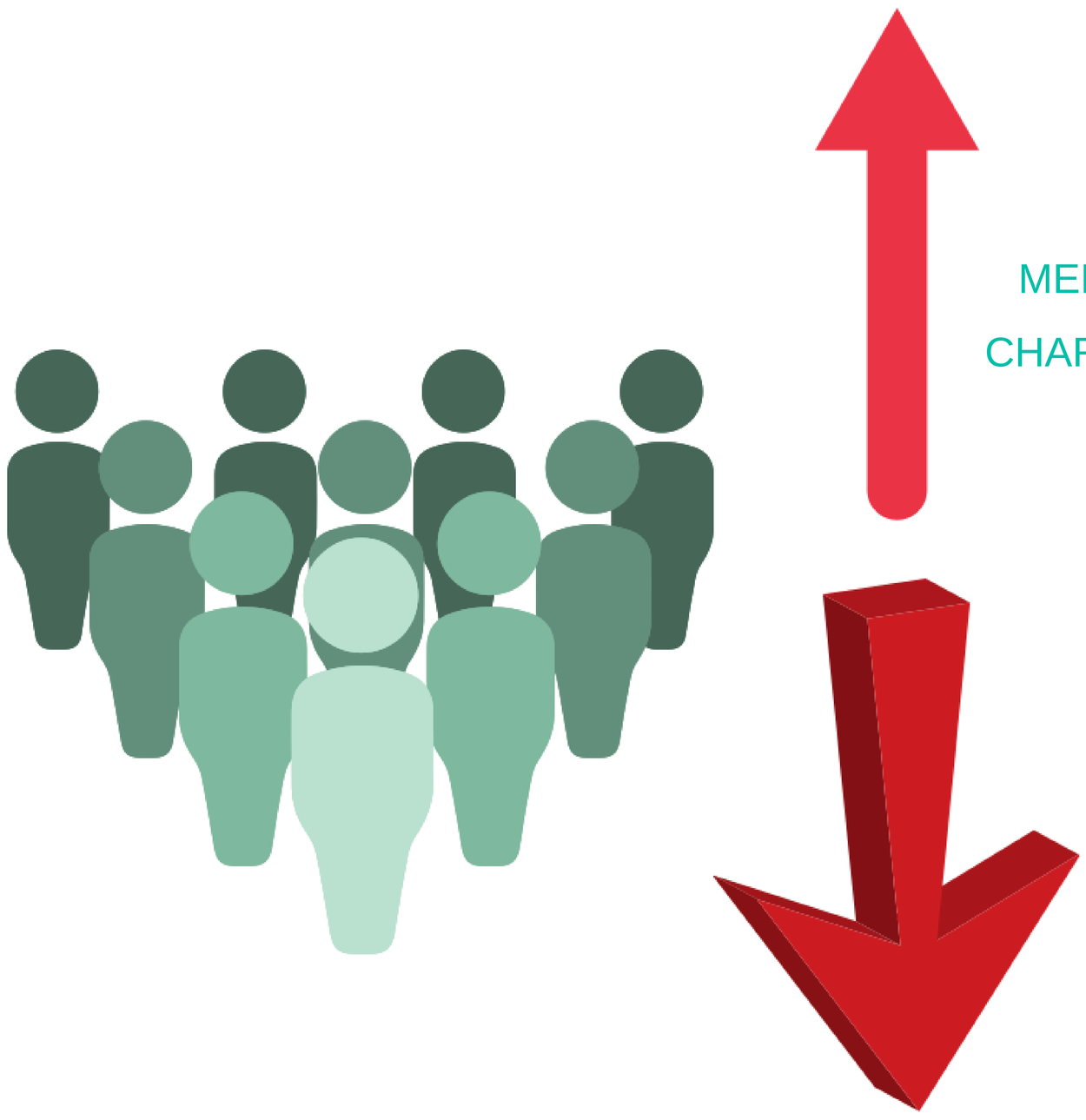


4.3 SPECIAL CONSIDERATION FOR GROUP MEDICAL UNDERWRITING

M H

4.1.3 Claim Experience

- Most medical underwriting based on past claim experience to underwrite also known as "EXPERIENCE RATING".
- Purpose: to analyzed and able to project the future trend of the claim for the group.
- Trend projection required skill and experience of the underwriter.
- If loss high: Premium will adjusted to cater loss, taking into consideration medical inflation, administrative charges and profit margin.
- If loss low: Group premium rating will be adjusted to reflect favorable past claim experience.



4.3 SPECIAL CONSIDERATION FOR GROUP MEDICAL UNDERWRITING

M H

4.1.4 Health, wellness, occupational and safety Compliance

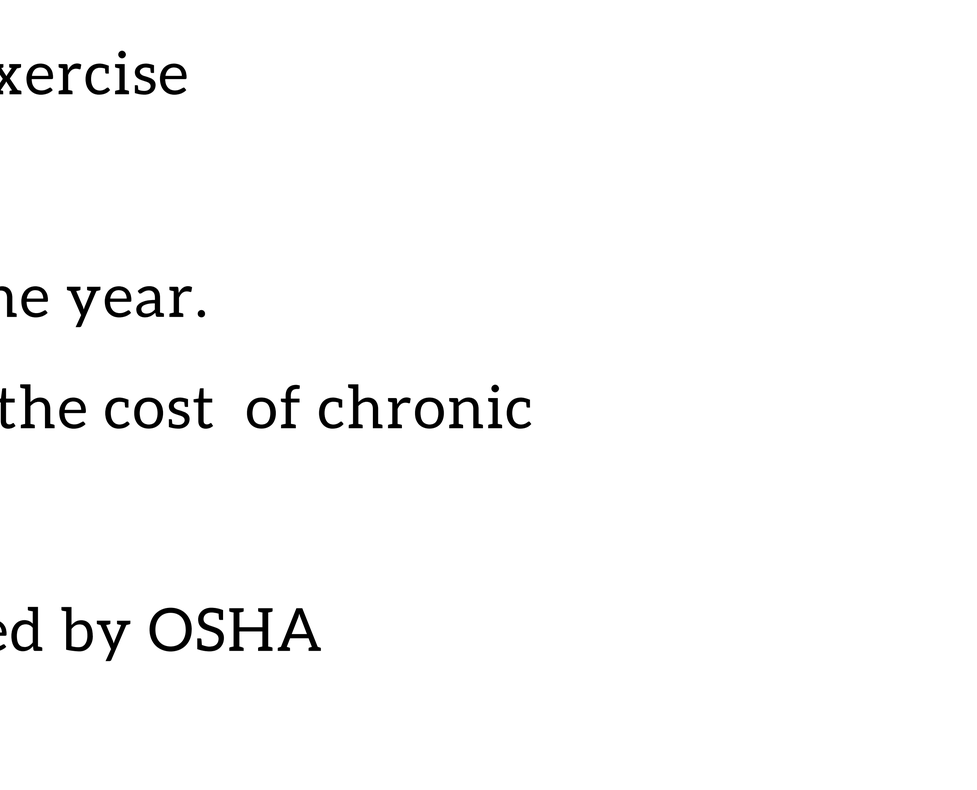
- Responsibility of employer if group policies provided.
- If group policies provided by employer all employees are subject to pre-employment check-up and must be suitable with employment before employment is offered.
- Employees must be screened for major illness and less likely to incur a claim during the first year of cover.
- For wellness program generally company make an effort to create healthy workplace. Example

a. subsidies gym subscription fee for their staff to exercise

b .organize regular games and outdoor activities

c. organize health talk at regular intervals during the year.

- Wellness program proven much cheaper than the cost of chronic treatment of illness.
- Occupational and safety compliance is governed by OSHA
- There are penalty for non-compliance of Act.
- Purpose: To create safety in workplace.



4.3 SPECIAL CONSIDERATION FOR GROUP MEDICAL UNDERWRITING

M H

4.1.5 Utilization review

- Important to detect if reasonable and customary charges are charged medically necessary procedures to avoid abuse and overcharging by providers.
- Done by following methods:

a. Pre-authorization(submit details prior to admission)

b. Case Management (high cost, complex treatment or major surgery and not to common day to day cases.

c. Co-current review (review to ensure the inpatient and all procedures medically necessary)

d. Take over Scheme (Switching to another insurer)

CHAPTER 5 CLAIMS AND POLICY ADMINISTRATION

1 MHI CLAIMS PROCEDURES

2 PRE-AUTHORIZATION

3 MHI SCHEME MANAGEMENT

4 TRANSFERING OF BUSINESS IN MHI

5.1 MHI CLAIMS PROCEDURES

5.1.1 Principle and Practice of claim under MHI

- Insured required to comply the claim procedures as part of policy term and condition in the insurance contract.
- Claim procedures for MHI are:
  a. Notification or report of claim
  b. Registration
  c. Full documentation required as a proof of claims
  d. Claim assessment process
  e. Payment
  f. Claim recovery
  g. Repudiated claim

5.1 MHI CLAIMS PROCEDURES

5.1.1 Principle and Practice of claim under MHI

- Claim procedures for MHI are:

a. Notification or report of claim

- received from intermediaries or direct client stating the full particulars of such event, including all original bills/invoice, receipt and medical report stipulating medical condition being treated.
- Notice must be within 30 days from the day of loss or hospitalization.

b. Registration

- Register the claim notification received within 7 working days from the date notification is received.
- Issue acknowledgment letter and request full document if there are incomplete documents.
-ensure sufficient reserve is provided as per company's receiving policy.

5.1 MHI CLAIMS PROCEDURES

5.1.1 Principle and Practice of claim under MHI

- **Claim procedures for MHI are:**

c. Full documentation required as a proof of claims

- The full documents as follows:

i. Claim form with medical report

ii. Original invoice/bills and receipt

iii. Referral letter, if any

iv. Police report, if due to motor vehicles accident

d. Claim assessment process

i. Process claims against benefits entitlement using set parameters of the policy.

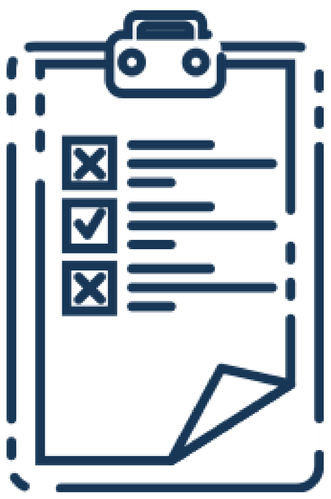
ii. Request further medical information if necessary.

iii. Check the reasonable and customary charges

iv. Question the hospital charges or 'not medically necessary' procedures.

v. Check if premium have been settled, especially on group PMI policies.

vi. Determine the liability and submit for payment approval.



5.1 MHI CLAIMS PROCEDURES

5.1.1 Principle and Practice of claim under MHI

- Claim procedures for MHI are:

e. Payment

- Ensure cheque is issue to the respective payee as describe in a claim form.

-Notify payee of the payment.

f. Claim recovery

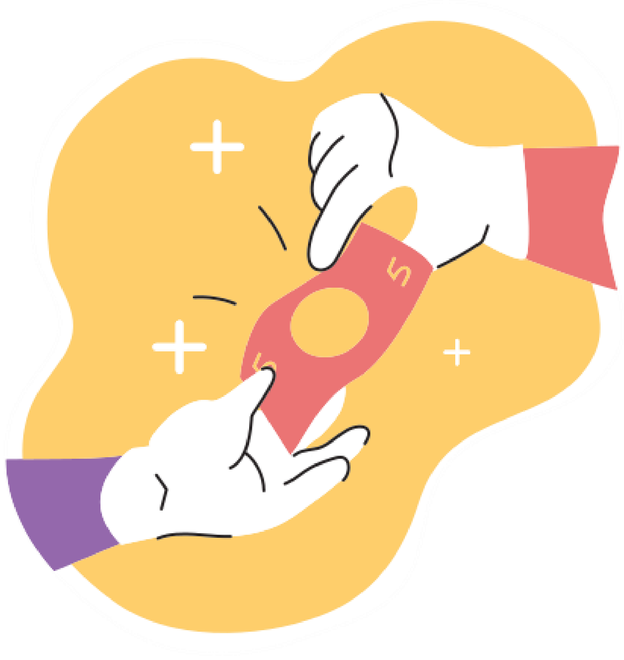
- Raise Debit note for recovery on non-guaranteed disability or non-eligible expenses during hospitalization, whereby guarantee letter was issued for the admission.

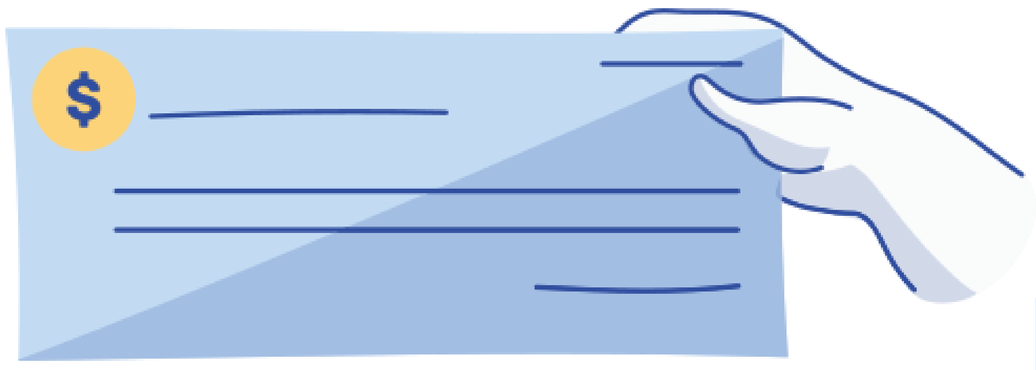
g. Repudiated claim

i. Issue repudiated letter to the claimant.

ii. Attach copy of Financial Mediation Bureau leaflet.

iii. Keep copy of documents in repudiated claims file.





5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim Process for MHI are:
  a. Notification of loss
  b. Claim registration
  c .Claim assessment
  d. Payment

5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim Process for MHI are:

a. Notification of loss

- Notify insurer immediately or within 30 day after the loss.
- Need to complete claim form and attach together the original full document.

-The claim form will contain the details of:

5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim form may also include a declaration from the member confirming that the treatment was provided under referral from their GP
- The Access to Medical Report Act 1988 requires the insurer to obtain a member's consent before asking for a medical report relating to the treatment
- For group scheme, the claim form also need to be signed by an authorized signatory of the employer example company secretary to confirm that the patient is covered by the scheme.
- The data protection Act 1998 states that the employer does not have the right to receive details of the treatment and the claim form may, be signed prior to treatment taking place
- It necessary to submit the original invoices and receipt to the insurer to minimize fraudulent claims.

5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim Process for MHI are:

b. Registration of claim

- Insurer are required to maintain Claim registered as an official record of claim.

-Purpose: to ensure proper and accurate provision are maintain and claim reserved can not be removed as long as the claim has not be settled.

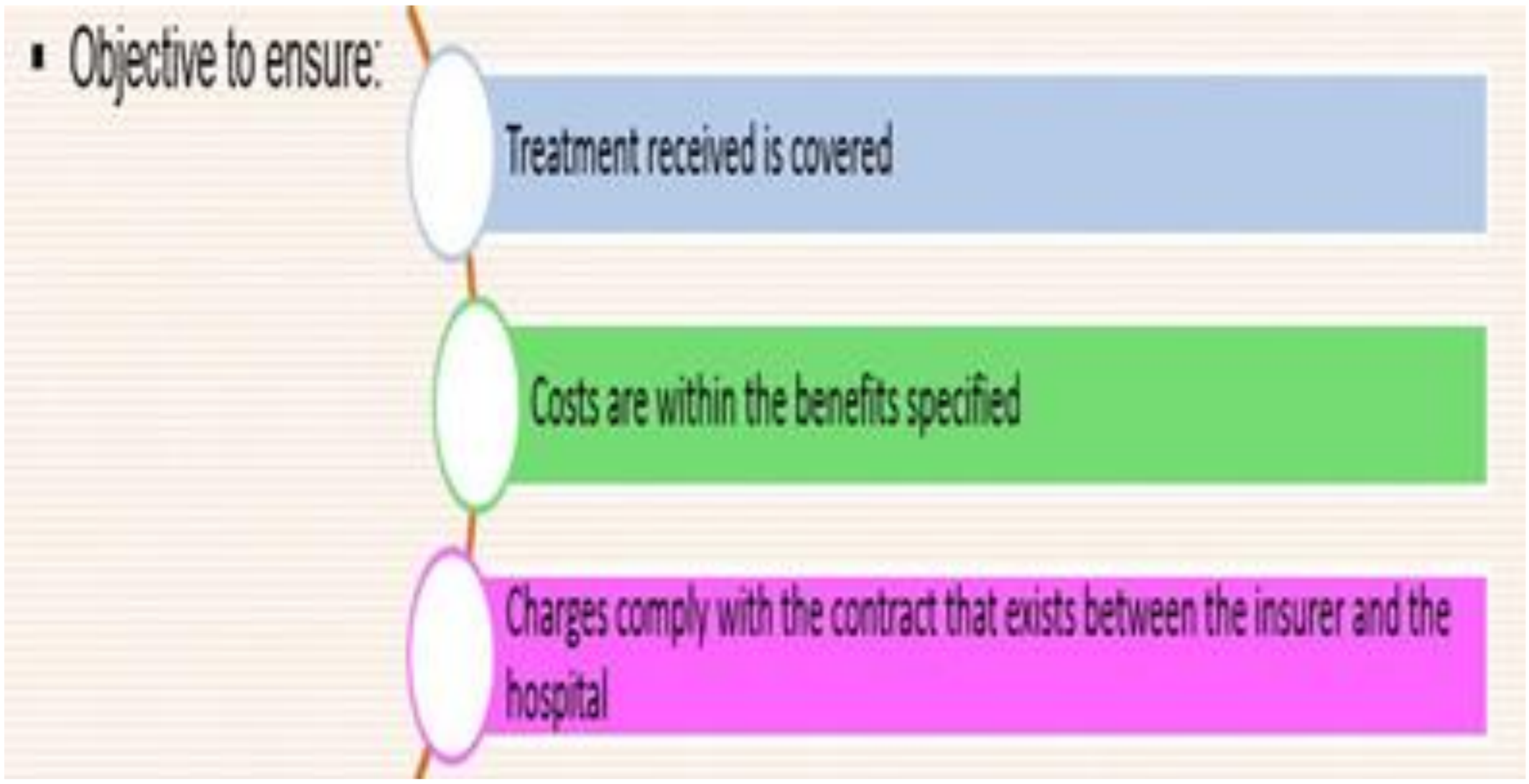
- Claim must be registered within 7 days compliance with the guidance on claim settlement practices with an acknowledgement letter to be issue to the claimant enclosing the checklist of all documents required.

5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim Process for MHI are:

c. Claim Assessment



- with the full documentation, claim assessor will do eligibility check in terms of the condition of the diagnosis treatment as follows:

5.1 MHI CLAIMS PROCEDURES

5.1.1 Claim Process

- Claim Process for MHI are:
  c. Claim Assessment
- with the full documentation, claim assessor will do eligibility check check in terms of the condition of the diagnosis treatment as follows:

- If there are doubts claim assessor will write to provider for clarification or investigation if necessary.

5.1 MHI CLAIMS PROCEDURES

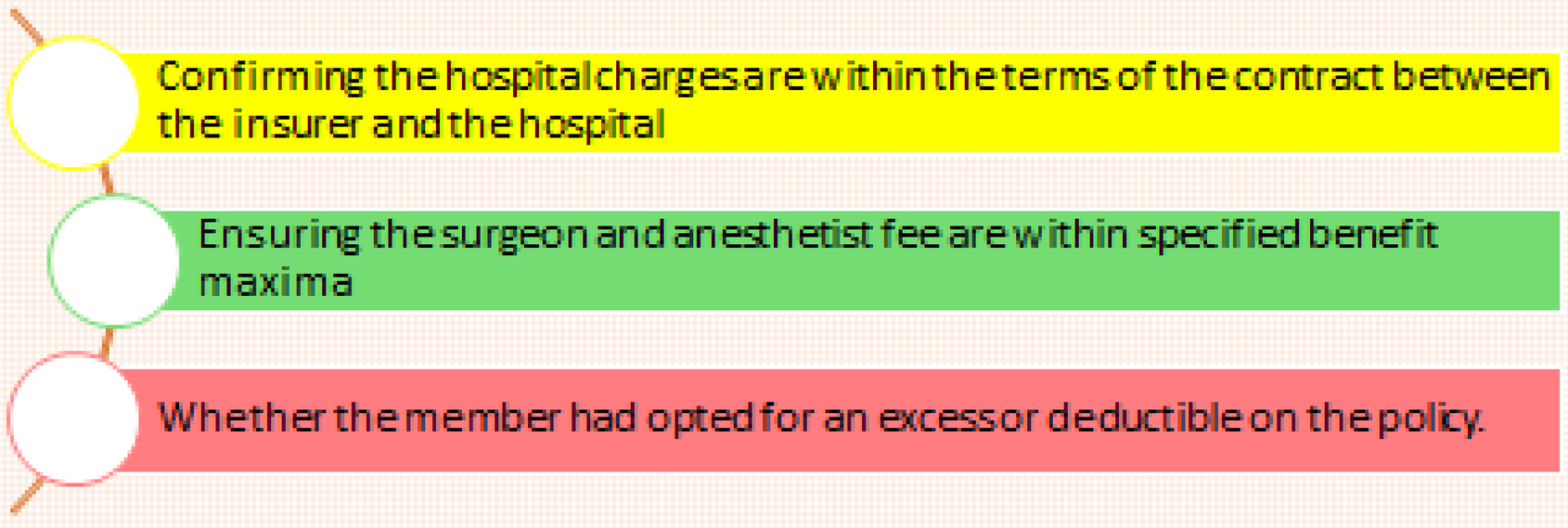
5.1.1 Claim Process

- Claim Process for MHI are:

d. Payment

PAYMENT RESOLUTION

- Having determined that the treatment is eligible, next step in the claim process is to determine the level of benefit payable:
- This involves:



- When insurer reached a decision than insurer will decided who should paid, either member or provider

- Remittance advice must provide the details of the treatment and the amount payable as entitled by the benefits.
- The details of any in eligible expenses not payable must also be shown together with reasons.

5.1 MHI CLAIMS PROCEDURES

5.1.2 Principles and practices of managed care and other claims management techniques, settlement methods, administration and coding

Managed Care

- Originated in the USA in the 1930s when the first prepaid group practiced were established.
- Health Maintance organization (HMO) were the early prepaid group introduced where there purpose:

i. Provide define, comprehensive set of health services to a voluntarily enrolled population.

ii. Limit or eliminate out-of-pocket expenses to the enrollees, as long as they seek care fro HMO panel hospital.

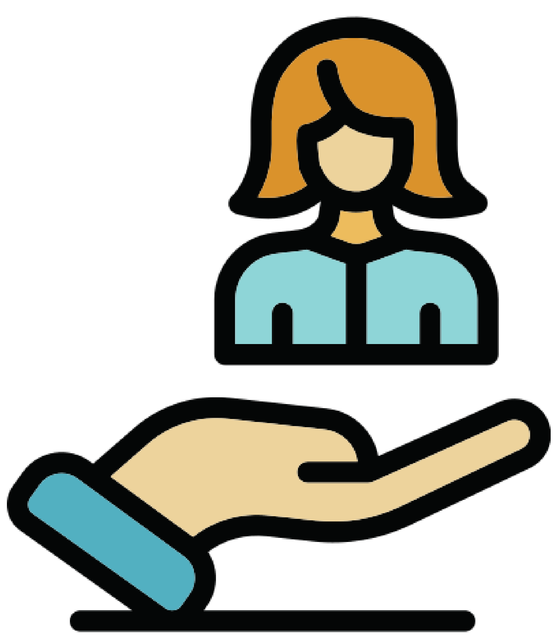
The choice of provider is usually limited to the HMO's network of hospital and physicians.

- The function of managed care at the beginning of establishment were to improve the quality and continuity of care as a means providing preventive healthcare services.
- The concern of managed care are:

i .the medically necessary appropriate level of healthcare intervention

ii. the cost-effective of healthcare,

iii. the quality of healthcare



5.1 MHI CLAIMS PROCEDURES

5.1.2 Principles and practices of managed care and other claims management techniques, settlement methods, administration and coding

Related claims management technique

- Managed care has an ability to contain cost by using certain management cost-effective cost.
- Through utilization review managed care able to manage and monitor the quantity, necessity and appropriateness of healthcare intervention.
- Utilization review is a tool used in utilization management and has a clear advantages over the traditional practice of respective claim audits.
- The appropriateness of the medical treatment required can be reviewed upfront or even before the patient admitted.
- The utilization review methods are:

i. Pre authorization or pre certification admission

ii. Case management

(used for serious and complicated illness example cancer)

iii. Concurrent review

(verified the necessity of continued hospitalization a hospital setting)

iv. Use of primary care physician as coordinator and managers of care

5.1 MHI CLAIMS PROCEDURES

M
H

5.1.2 Principles and practices of managed care and other claims management techniques, settlement methods, administration and coding

Settlement Method

- Paying for providers
- There are various types of compensation arrangement or settlement method used in managed care plans, such as:

i. Capitation (capitation amount ,especially for primary care upon the outpatient general practitioners visitation.

ii. Fee-for-service (mutual agreements of cost control through negotiated fees and global fees)

Negotiated fees: agreed fees, predetermined upfront for each service
Global fees: negotiated fees that are all- inclusive for the entire range of services provided for a specific episode or episode of care.

iii. Case rate (Contract with providers whereby negotiated fixed rate for certain specialty treatment like coronary artery bypass grafting.

iv. Per diem (Fixed rate of payment per day for services rendered generally inpatient care and limited based on length of hospital stay)

v. Diagnosis related group (DRG) (Flat rate fee for all inpatient services related to a diagnosis and a single episode of care).

vi. Free Schedule (Comprehensive list of all the fees for specific services, usually applied as the maximum limit at which the payer has to pay.

5.1 MHI CLAIMS PROCEDURES

5.1.2 Principles and practices of managed care and other claims management techniques, settlement methods, administration and coding

Administration

- The general basic administration function that the MCOs has to cater are:
    i. 24-hour helpline service
    ii. Data management system for integration with provider's and physician's network
    iii. Decision Support System

5.1 MHI CLAIMS PROCEDURES

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5.1.2 Principles and practices of managed care and other claims management techniques, settlement methods, administration and coding

Coding

CODING CLAIM

- With the introduction of computerized claim processing to support accurate assessment it became necessary to formulate coded information
- The common standard coding mechanism in PMI are:
  - International Classification od Diseases-referred to as diagnosis or impairment codes
  - CCSD or OPCS codes used for surgical procedures

5.2 PRE AUTHORIZATION

5.2.1 Meaning of of Pre-authorization of claims

Reasons FOR CARRYING PRE AUTHORIZATION:

i. To promote day case surgery against a list of procedures which are routinely carried out on a day case basis

ii. To manage areas such as psychiatry/addictions which often result in long period of inpatient admission, unless monitored carefully.

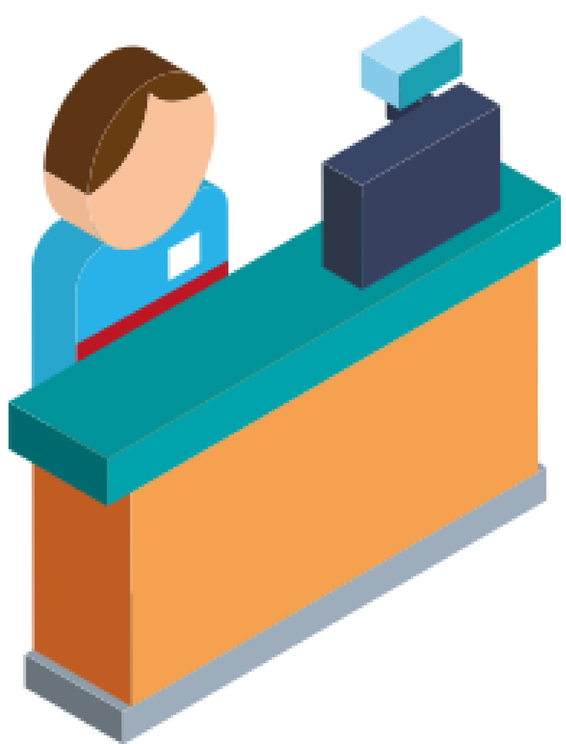
iii. To check the appropriateness of procedures which may not be medically necessary

iv. To identify closely manage high cost cases to ensure that costs are controlled and to assist with discharge planning

v. To ensure that care is given appropriate way.

vi. Enable an insurer to gather information about claims before they take place to assist financial analysis and planning

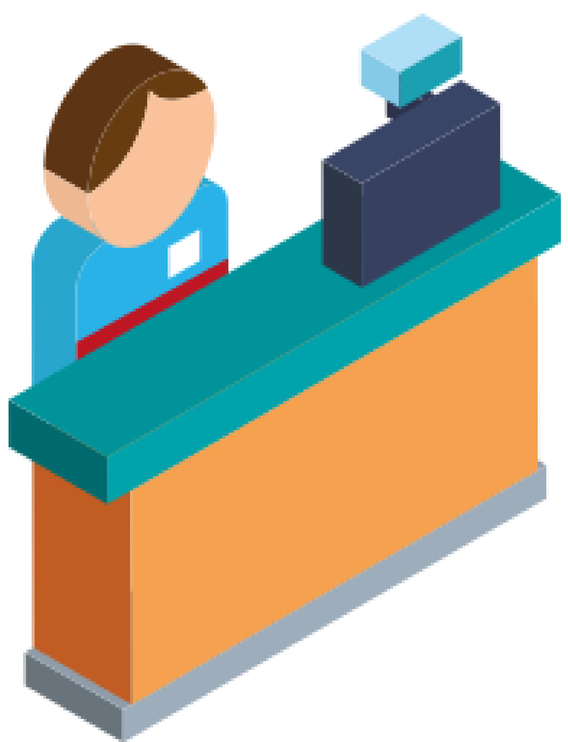
vii. If further treatment is required after the agreed period, the hospital and consultant will re-apply for further benefits and the insurer will re-assess the application



5.2 PRE AUTHORIZATION

5.2.1 Meaning of of Pre-authorization of claims

- Process of obtaining authorization from an insurer that the treatment is medically necessary and clinically appropriate, and covered by the policy
- Claimant required to contact a telephone helpline, usually run by qualified nurses
- Failure to obtain authorization may mean insurer will not pay any treatment cost or may not pay all the costs
- Pre authorization or pre certification is utilizations review tool used by managed care organization, third party administration (TPA) or insurer to manage claims costs.
- In pre authorization process , MCO/TPA and insurer requires the provider to submit pre authorization request form indicating types of medical treatment required with presenting symptoms and diagnosis and estimated cost.
- Often used to approve a hospital admission whereby a guarantee letter will provided if the medical condition is admissible to a panel hospital.



5.2 PRE AUTHORIZATION

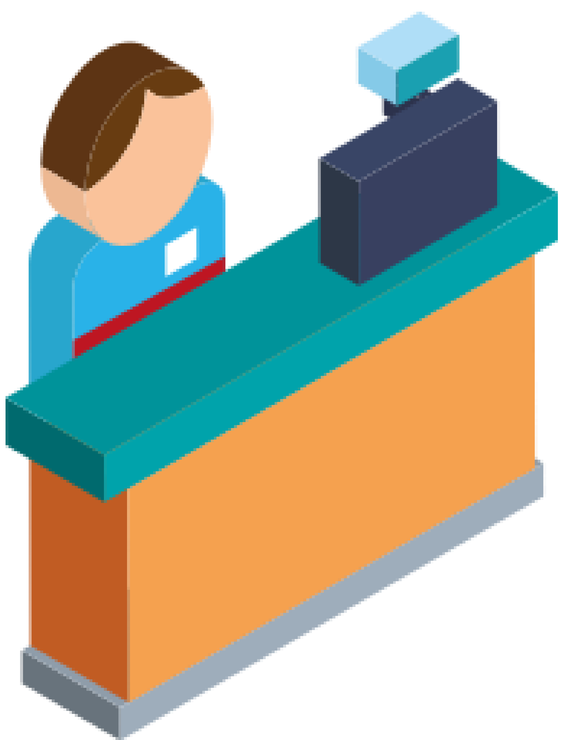
5.2.2 Process and the impact of Pre-authorization of claims

Impact of Pre authorization on patient

- Delay in admission- especially when information provided insufficient to insurer to make a decision.
- Delay in discharge-when time required for the bills to be sent from the hospital to the TPA and time taken to adjudicate the claim.

Impact of Pre authorization on insurer

- A means of cost containment to prevent abuse of admission, whereby day care or outpatient treatment can be rendered.
- Allow utilization management to be exercised on the current cases admission and not after discharge
- Loss of customer, if the service standard are not within the reasonable acceptance time frame, especially on the time taken for authorization and adjudication of claims.



5.3 MHI SCHEME

5.3.1 Basic principles of scheme management and administration

Administration

- Establish rules and procedures on how is scheme to be managed.
- Take into account:

i. Setting up of parameters on the plan and structure.
ii. Process flow of documentation and manual.
iii. Criteria on change permissible of policy condition.
iv. Data upkeep
v. Provider network record
vi. Claim processing

- For such wide role and functions, insurer appoint Chief Medical Officer (CMO) who is responsible to overall scheme management. The role of CMO are:

i. Advising and training underwriters
ii. Adjudicating on complex cases
iii. Analyzing trends and claim patterns
iv. Advising the insurer on medical trends

- CMOs usually practicing surgeons or GPs
- CMOs work more than one insurer and involves conflict interest
- Can provide additional expertise and experience for complex cases

5.4 TRANSFERING OF BUSINESS

5.4.1 Business transfer between insurers

- Can be transferred from one intermediary to another or from one insurer to another upon the request of the policyholder.
- Transfer from one insurer to another insurer is not common and the new insurer need to consider:

i. How many customers willing to switch?
ii. How profitable the business likely to be?
iii. What is the value adding new customer?
iv. Is there any consideration payment for it?
v. What is the total time frame for the total switch?

5.4.2 Option available to the new insurer

Option available to the new insurer:

- The new insurer may simply take over the underwriting and may acquire the name from the previous insurer
- New insurer may offer new terms that are identical to the old ones, at the same or a different premium
- May offer “no worse term” switch to an equivalent but not identical policy
- May offer switch, but apply re underwriting terms
- The new insurer offer new policy with new underwriting process

5.4 TRANSFERING OF BUSINESS

5.4.3 Change Of Insurer

- Policyholder have a right to choose their insurer for coverage.
- It is permissible if new insurer take over the risk to provide continuity of cover.
- The new insurer will offer the “take over policies” to assure the policyholder on the switch of insurer that in the event of claim, it would be payable for the existing disability as if there is no change.

Activity

In group find out the characteristics of “take over policies” and state the impact has the “take over condition” had on insurer?

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