Chapter 5

Health Insurance Policies

Chapter Objectives

Students must be able to:

- Define Health Insurance
- Describe the Typeso f Health Insurance
- Understand the Problems of Healthcare in the Country
- Compute Disability Income Need
- Compare the Different Health Plans
- Analyze and Select Health Insurance Policies

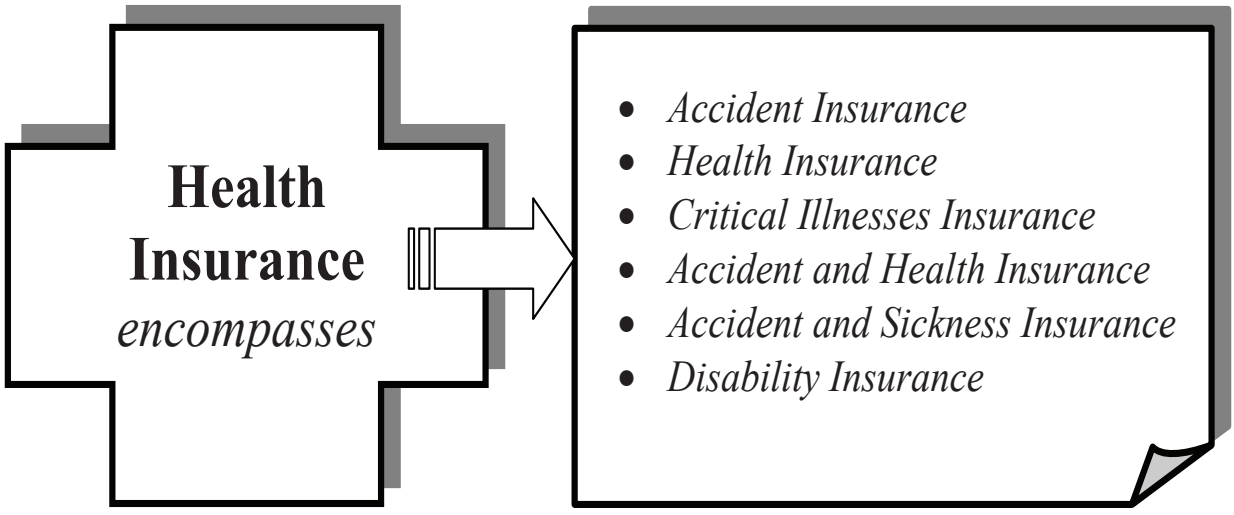
Chapter 5

Health Insurance Policies

Introduction

No one can be assured of permanent good health. In a personal risk management program, the risk associated with health deterioration should be given a high priority. Each year, thousands of people go in and out of hospital, and this can emplace a heavy financial burden on them and their dependents. This becomes even more contingent with the continued escalating costs of medical treatment and hospitalization.

In Malaysia, the health insurance sector is growing rapidly and the number of health insurance policies offered is also on the increase. Many new health policies, hybrid-health policies and medical arrangements are currently being introduced in the market. It would be accurate to say that such growth was a result of an increased level of awareness in relation to the increasing medical and associated treatment costs. It is therefore imperative that the financial planner be conversant with the major types of policies so that they can advise their clients on the appropriate protection cover.



Health Insurance is a generic term that encompasses several types of insurance contracts. These contracts are related but each provides coverage against different types of risks. Even the term health insurance has raised much discussion as to what is the right term to use for slightly different policies. Some of the common terms that are used in the past include accident insurance, health insurance, accident and health insurance, accident and sickness insurance, and disability insurance. Recently in the United States, all these terminologies are converging into a general term called *health insurance*. For the purpose of this chapter, we shall adopt the term health insurance to include all types of health-related and accident policies in the local market.

Healthcare Issues in Malaysia

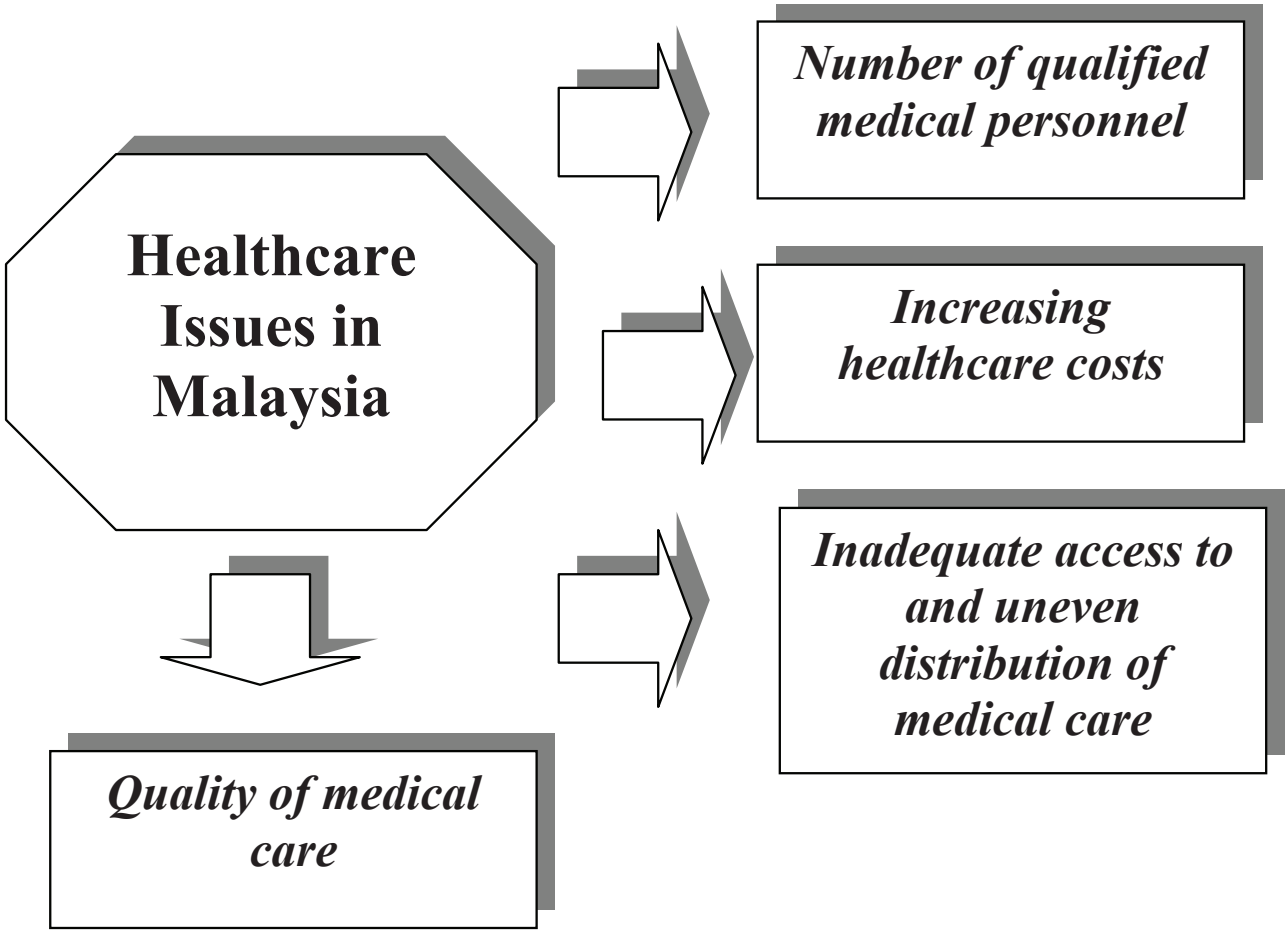
Over the years, improved healthcare and other factors have contributed to the increased life expectancy and enhanced general health condition of Malaysians. Yet, there are several areas that need attention to improve healthcare provision in the country. These areas include

- **Number of qualified medical personnel** – the growing population and the demand for high quality health care has created a need for more medical personnel and higher qualified practitioners. The increase in demand for such expertise is currently exceeding our ability to produce the number of qualified medical practitioners in all specialized areas.

- **Increasing healthcare costs** – Inflationary and other factors are driving medical costs upwards.

- **Inadequate access to and uneven distribution of medical care** – Most of the best medical facilities are found in the major cities and towns like Kuala Lumpur and Johor Baru when compared to the medical care and facilities available in the rural areas.

- **Quality of medical care** – Again due to the availability of funding, especially in the private medical centres which are based in larger towns, the quality of medical expertise aided by technology vary according to geographic location.



Types of Individual Health Insurance Plans

In recent times, introduction of innovative individual health insurance coverage by both general and life insurers has been on the rise. Some of the more important ones are listed below:

- **Critical Illnesses Insurance**
- **Hospital and Surgical Insurance**
- **Long-term Healthcare**
- **Major Medical Insurance**
- **Disability Income Insurance**

Dread Disease/Critical Illnesses Insurance

The first dread disease product appeared in South Africa in the 1980's and was marketed as a rider in response to the relatively high incidence of these illnesses and diseases. The product was described as a genuine innovation, providing "immediate cash benefits to policyholders stricken by heart attack, stroke, coronary disease requiring surgery, or cancer".

Critical illnesses cover was first issued in Malaysia as an additional feature of life insurance. It began with five illnesses, and was later expanded to cover thirty-six illnesses. For critical illness contracts, the face amount of the policy is paid out the moment one of the covered dread diseases is contracted. The insured does not need to fulfill any criterion for disability as it is not designed to indemnify the insured against any loss of earnings. Once the disease is diagnosed and confirmed to be one of those defined in the policy, the face amount is paid out.

Normally, coverage for critical illness stops at age 65 or 70 although there are some plans in the country that cover the insured for life. The premiums charged will be in accordance with the client's age, gender and may be in the form of level premium throughout life or abased on an age range (say, 30 to 35 years) and such premiums will be adjusted at the next age range (say, 35 to 40 years) and so forth.

Dread disease cover incorporates a waiting period of 60 or 90 days from inception of the policy. This is to avoid anti-selection. The imposition of such a waiting period may give rise to genuine policyholders feeling unhappy about buying the policy and having to wait 60 or 90 days before their coverage takes effect. In order to reduce the negative impact of such requirement, some insurers choose only to impose a waiting period on chronic conditions such as cancer or multiple sclerosis.

There is also a requirement that the insured survives a specified period, commonly 30 days, after the diagnosis of the covered dread disease. The policy may also provide for a premium waiver. In this instance, upon the happening of a covered event, the insurer agrees to waive all future premiums payable after an initial pre-payment.

Dread disease policies may incorporate an acceleration rider or an additional benefit rider or a combination of both.

- Under an *acceleration rider*, the sum insured is accelerated in whole or in part of the proceeds of the basic life insurance policy to which the rider is attached.

- Under an *additional benefit rider*, the dread disease sum insured is paid out without affecting the insured person's rights on the basic policy.

A combination of both incorporates the dread disease benefits within a term life rider. The rider sum insured is payable on death or when the dread disease is diagnosed.

Special dread disease-only health insurance covers were later introduced by general insurers to tap the growing demand for such protection. Conceptually, the cover is identical to the life version except that it covers fewer illnesses, has no cash value and is renewable on a year to year basis.

● Hospital and Surgical Insurance

This type of cover is widely offered by insurers here. Both the general and composite insurers have such plans introduced in the market with differing levels of coverage. These plans usually cover routine medical expenses that are linked to hospitalization. The most complete versions of such plans usually cover the following items:

- *Hospital expenses* – The hospital and surgical policy covers medical expenses while the individual is in hospital. Generally, such policies cover **daily room and board** and **miscellaneous hospital expenses**.

- *Surgical expenses* – There are essentially two common methods to cover the surgical costs :-

  - **The schedule method lists the various surgical operations in a schedule, and a maximum monetary amount is paid for each procedure.**

  - **Another method is the relative-value schedule method where units or points are attached to each operation based on the degree of difficulty. A conversion factor is then used to convert the relative value of the operation into a Ringgit amount that is attributable to the surgeon's services.**

- Outpatient diagnostic X-ray and lab expenses – Many modern plans offered by general insurers cover outpatient diagnostic X-rays and lab expenses. The Ringgit capping of plans offered by different companies varies in amount.

- *Physician's in-hospital expense benefit* – Many current plans provide some level of **physician's in-hospital benefits**. The benefit pays for non-surgical treatment provided by the physician to a patient while in the hospital. The maximum amount paid for each visit is limited and there is usually a capping on the number of visits on any single day during the individual's hospital stay.

● Long-term Healthcare

With age comes a reduced ability to take care of one-self. Estimates in the United States suggest that some 40% of elderly will require nursing home care at some point in their lives. By age 75, the odds of requiring some long-term care increases to 60%. This type of plan is growing in popularity in the United States and other countries but is hardly available in Malaysia at the moment.

Long-term care (LTC) refers to a broad range of supportive medical, personal, and social services needed by people who are unable to meet their basic living needs for an extended

period of time because of accident, illness, or frailty. Long-term care involves receiving the assistance of another person(s) to perform the essential activities of daily living when these tasks can no longer be performed independently. Long-term care, therefore, is more than nursing care, it also includes home care and community care.

Essentially, such plans pay a daily or monthly benefit for medical or custodial care received in a nursing facility, hospital, or at a home.

This type of policy typically covers skilled nursing care, intermediate nursing care and custodial care.

- *Skilled nursing care* is medical care ordered by a physician and provided by a registered nurse, licensed practical nurse or licensed therapist 24 hours a day.

- *Intermediate nursing care* is medical care for a stable condition that demands daily care except that the patient does not require or receives 24 hours nursing surveillance. The care is instructed by a doctor and is supervised by a registered nurse. The duty is less specialized and focuses more on personal care.

- *Custodian care* is the most basic level of nursing care. It supports the patient with daily living activities, such as assistance in bathing, eating/feeding and dressing and other areas of personal care, although the care must be ordered by a physician and supervised by a nurse.

Two other evolving forms of community care are:

(i) the Assisted Living Facilities , which have been popular in the Scandinavian countries. These provide supervision, assistance, and limited health services to relatively healthy senior citizens.

(ii). Continuing care centers, also called life care centres, provide a range of sensitive living arrangements and services that reflect each person's level of needed care and assistance – individuals purchase the right to live and receive support in the centre.

General contract provisions of the long-term care policies include:

- Premiums : the premiums are determined based on the applicant's age, sex, medical Condition and the benefits provided. Issue age vary widely by company, such as 50-84, 55-79, 40-79 and 20-74.

- Renewability: Virtually all individually issued LTC policies are guaranteed renewable but the company retains the right to revise the rates on a class basis – that is, for all the insureds in the same class.

- Non-forfeiture options : Example is the conversion to a paid-up policy.

► Coverage limitations: Common exclusions include restriction on pre-existing conditions, that is sickness that started or injuries that occurred prior to the issuance of the policy. The most common pre-existing condition is for six months (some policies for 12-24 months).

● Major Medical Insurance

Major medical insurance is designed to pay a high proportion of the covered expenses of a catastrophic illness or injury. This type of plans is often sold in conjunction with a hospitalization and surgical plan, and is aimed at covering costs that a normal hospitalization plan does not cover.

There are generally two of major classes of these plans:

(a) Supplemental Major Medical Plans : It is a plan that is superimposed on a basic plan provided by an insurer or another company such as Blue Cross and Blue Shield. The insured is reimbursed for the charges covered under the reimbursement formula in the basic plan. Deductibles (see below) are applicable for this plan, thus the claimant shares in the claims cost to the extent of the deductibles.

(b) Comprehensive major medical plans : These cover all types of medical care services and supplies. The reimbursement formula applies to the total covered expenses subject to a deductible.

Most of these plans include the following features:

- ***Extensive Coverage*** – Usually the major medical insurance coverage is wide and includes all the reasonable and essential medical expenses and other related expenses from a covered illness or injury.

- ***Generous Maximum Limits*** – Many of such plans offered overseas have generous lifetime limits ranging from $300,000 to a million or even more. Locally, the limits offered are often less, but still considered high relative to the cost of major illness treatments. A high limit is necessary because the purpose of having such plans is to cover catastrophic losses that a normal hospitalization plan does not cover.

- ***Benefit Period*** – A **benefit period** is the length of time that the plan's benefits will be paid after the deductible is satisfied. At the end of the benefit period, the insured has to satisfy a fresh deductible in order to establish a new benefit period. The purpose of the benefit period is to grant a definite period within which qualified medical expenses for a particular disease or injury must be incurred in order to be reimbursed under the policy.

- ***Deductible*** – A **deductible** is a specified amount of initial medical cost that must be borne by the participant before any costs are paid by the plan. If a plan has a deductible of say RM200.00, then the plan participant must pay the initial RM200.00 and the plan will then pay any excess according to the plan provisions. The purpose of deductibles is to

eliminate small claims that pose a relatively high processing cost to the insurers. This will help insurers keep the premiums for major medical plans reasonable.

Deductibles can be classified as all cause, per cause, corridor and integrated. These are elaborated as follows:

(i) Under the *all cause deductible*, all expenses incurred are accumulated to satisfy the deductible regardless of the number of diseases or accidents giving rise to the expenses.

(ii) Under the *per cause deductible,* all expenses incurred because of the same or related causes are accumulated to satisfy the deductible.

(iii) A *corridor deductible* is use din connection with a supplemental major medical plan and it applies after the basic plan benefits have been exhausted.

(iv) The *integrated deductible* is defined as the greater of (a) a fairly high amount, such as RM500 or (b) the basic plan benefits. For example, if the basic plan paid RM600 and the stated value of the deductible was RM500, the deductible would be deemed to have been met and the supplemental major medical benefits would be payable.

- ***Co-Insurance*** – A **co-insurance provision** is a policy provision that requires the insured to pay a certain percentage of the eligible medical expenses in excess of the deductible. The purpose of this clause is to reduce premium and prevent over-utilization of policy benefits. Since the insured has to pay part of the bill, premiums can be offered at cheaper rates. Another purpose of this provision is to discourage the patient from simply choosing the most costly medical services while lower-cost versions are available and are just as good. In some plans the term percentage participation is used instead of co-insurance.

- ***Exclusions*** – Like all types of insurance policies, major medical plans contain exclusion clauses. Some of the common exclusions that are found in such plans are as follows:

  - **Expenses incurred as a result of war or military conflict**
  - **Optional cosmetic surgery**
  - **Normal dental care**
  - **Pregnancy and childbirth, except for complication that arises as a result of childbirth**
  - **Experimental surgery**

To further control cost, **internal limits** are sometimes imposed on the plan. There may be in the form of annual or lifetime limits on the amount paid for certain diseases.

● Disability Income Insurance

Disability insurance is the oldest type of health insurance and has been in existence for over a century. Everyone who works for a living knows that to be disabled and to suffer the inability to earn an income for even a relatively short time can bring about financial and emotional stress. It is thus important for the financial planner to include disability cover in a financial solution.

The individual disability income policies have been called loss-of-time insurance because of the occupational definitions used to qualify the insured as a disabled. A disabled person under these policies is presumed to have suffered a loss of income because he or she cannot work.

Disability income insurance or *permanent health insurance* (PHI) is a plan that provides monthly benefits to replace lost income when the insured is unable to work due to a sickness or accident. As the purpose of the plan is to replace earnings, the insured amount is relative to the earnings of the insured. In practice, this is often defined as the inability to perform in an occupation. To prevent over-insurance and to reduce moral and morale hazard, the amount of disability income is often limited to two-thirds or three-fourths of the insured's income.

Disability plans can be issued on an individual or group basis. Polices sold to individuals are typically issued on a guaranteed renewability basis. It is non-cancelable and the insurer cannot (a) cancel the policy, (b) refuse to renew it, or (c) unilaterally change the premium charged during the policy term. Generally, the insurer is not allowed to cancel the plan solely on the premise of adverse claims experience.

Definition of Total Disability

Since payment of policy benefits is triggered by the provisions in the policy, and that each insurer may define total disability differently, it becomes important to know the definition in each plan. The tightness or liberality of the definition depends on the intensity of market competition as well as the reputation and strengths of the insurers. Here are some of the important definitions of total disability that can be found in a disability income policy:

Total disability is defined as when "a person cannot perform the major duties of any gainful occupation that his education, training or experience makes him suitably suited for". A second definition is "a person is totally disabled when he cannot perform the major duties of his regular occupation". Sometimes there is a restriction prohibiting the insured to work in any other occupation. Insurers normally also add that the insured (disabled person) must be under the care and attendance of a physician.

Some key terms that need to be understood include:

- ***Disabled from performing all duties of the insured's occupation*** – This is the *most liberal* definition of total disability you can find in such plans. Example, a heart surgeon has two of his right-hand fingers crushed in an accident, he will no longer be able to perform surgery and would qualify for disability income under this definition, even if he were to work in some other capacity.

- ***Disabled from performing the duties of any occupation that the insured can reasonably be expected to perform as a result of his past training, education and experience*** – This definition is *more restrictive*. Using the above instance, the surgeon will not be able to claim as he is still able to lecture in a medical school or give medical consultation to patients which are consistent with his training, education and experience.

- ***Disabled from performing the duties of any gainful occupation*** – This is the *most restrictive* of the various disability definitions found in policies. The insured must not be able to work in any gainful occupation at all to qualify under this definition.

- ***Income-loss approach*** – The income-loss approach is the *newest approach* to defining disability. It moved away from the traditional approach of defining disability in terms of cause of the loss. Instead, the definition focuses on the *outcome* of the disability, i.e. **the loss of income**. This approach simply provides for the payment of benefits when the insured suffers a loss of income due to illness or injury, and the loss continues for the elimination period.

  - ***Definition of Injury***

    In most policies, injury is defined as accidental bodily injury, which implies that the injury must not be intentionally inflicted and must be unforeseen or unexpected. Some policies use the definition *bodily injury by accidental means*, which requires **both** outcome and cause of the injury be accidental in nature. For example, a person who deliberately jumps off a building and injures himself or herself would certainly not be covered under the accidental means clause.

  - ***Definition of Sickness***

    Commonly, the definition of sickness is used to exclude pre-existing conditions in the individual health policy. Sickness means sickness or disease that first manifests itself while the policy is in force. Some insurers define sickness as sickness or disease that is first diagnosed and treated while the policy is in force. In either case, the intention is to cover only sickness that is first contracted after the policy takes effect.Group health policies may be more liberal and do not exclude pre-existing illnesses.

Partial and Residual Disability

Apart from total disability, a policy will also cover payments for partial and residual disability. These are elaborated below.

Payments for Partial Disability

Partial disability may be defined as the inability of the insured to perform some, but not all of the important duties of his or her occupation. Or it could also be defined as the inability to engage in his or her regular occupation for longer than (say) one-half of the time normally spent in performing the usual duties of the regular occupation. Partial disability does not base

its benefits on the reduction of the insured's income. It is based on the inability of the insured to perform the specified percentage of the functions that constitute the insured's normal job. The typical partial disability is 50% of the monthly indemnity for total disability and is payable for up to 6 months or, if less, for the remainder of the policy benefit after a period of total disability that was compensated. period when the insured has returned to work on a limited basis

● Payments for Residual Disability

A residual disability benefit provides coverage for partial disabilities, but unlike the partial disabilities benefits, it focuses on income lost rather than on the physical inability to perform work. There are essentially two types of residual disability benefits. The first type measures the loss of earnings only. The second type measures loss of earnings but also requires that the insured is unable to perform some of the functions of his regular work due to the disability. The claims will be paid in proportion to the reduction in earnings and for a certain period of time only, as specified in the policy contract.

The common formula employed to compute the proportionate benefits is :

$$\text{Residual Indemnity} = \frac{\text{Loss of income}}{\text{Prior income}} \times \text{Monthly indemnity benefit}$$

Here the loss of income means the difference between the insured's prior income and the insured's current income. Prior income is usually defined as the average monthly income for the year, while the current income is defined as the earned incomein each month while the insured is residually disabled.

Example

Let's assume that Mr.A, who is residually disabled, is receiving an income of RM1,500. He had a prior income of RM3,000. If the monthly indemnity is RM2,500, then under the residual benefit the, the residual indemnity will be :

$$\text{Residual Indemnity} = \frac{\text{RM3,000 – RM1,500}}{\text{RM3000}} \times \text{RM2,500}$$

Residual Indemnity = RM1,250.00

It is common to include a definition of *presumptive disability* in policies that provide benefits for total disability. Under the presumptive disability clause, an insured is always considered totally disabled, even if the person is at work, if sickness or injury results in the loss of both eyes, the hearing in both years, the power of speech, or the use of any two limbs. Usually, the insurer begins the benefit payments immediately upon such loss and waives the medical care requirement. The insured can work in any occupation and full benefits will be paid to the end of the policy's benefit period, while the loss continues.

Individual Health Insurance Contractual Provisions

● Exclusions Clauses

Apart from the limitations imposed by the definition of disability, the disability income contracts also contain a moderate number of exclusions. The common exclusions include war, self-inflicted injuries and normal pregnancies (complications are usually covered). In some contracts, pre-existing conditions are not covered by virtue of an exclusion clause rather than by the definition of illness. For group policies, the number of exclusions are usually fewer when compared to the individual policies.

● Benefit Period

The *benefit period* is the stretch of time that the disability benefits are to be paid after the waiting period has expired. The client has a choice of benefit periods, such as 2, 10 or 15 years, or up to age 55. Studies done in some countries have indicated that most disabilities are of a relatively short duration. According to one report, most disabilities are recovered within one year. However, it was found that the longer the disability lasted, the chance of recovery dropped. Thus, because of the uncertainty concerning the duration of disability, the client should select a longer benefit period, for instance, one that pays benefits until age 55. The longer the benefit period, the higher the premiums.

Another issue related to the period of benefit is the inclusion of a provision with regard to consecutive or recurrent episodes of disability. Here the company will have to determine whether the disability is due to a new cause or whether the disability is continuing. Generally, the recurrent periods of disability from the same cause is regarded as one continuous period of disability, unless each period is separated by a recovery of six months or more.

● Deferred or Elimination Period

The *deferred period* which is sometimes called the *elimination* or *waiting period*, is the period from the start of the disability where the policy benefits are not paid out. Its aim is to exclude the inconsequential illness or injury that disables the insured for only a few days. Depending on the insurers, the deferred period varies according to the insurers and sometimes for different health conditions in the same policy. The common deferred periods are the first month, six months or twelve months of disablement. Premiums are cheaper for policies with longer elimination periods.

● Waiver-of-Premium

A waiver-of-premium provision stipulates that if an insured is disabled after a certain period of time, say 90 days, future premiums will be waived as long as the insured remains in the disabled condition. Some policies may provide for a refund of the premiums paid during the initial period before the provision has taken effect. If the insured recovers, premium payment resumes.

- ***Terms of Renewability***

  Some policy contracts are renewable and some may function on a year to year basis with the renewal option entirely at the prerogative of the insurer. If a client wants to have a policy that allows continuity, then it will be good to ensure that the policy contract guarantees the renewal of the policy or a non-cancelable policy should be purchased. Policies with this feature will be more expensive than those that are not renewable.

Computing the Disability Income Need

The amount of disability income needed can be computed by using the format shown below. It takes into account the monthly income and expenses, and the amount of current disability benefits available to the client. The format also enables the financial planner to calculate the number of months of reserve available for the client in the event a disability strikes.

Computing the Disability Income Need

1. FORECASTED MONTHLY EXPENSES

Mortgage/Rent	_____
Utilities	_____
Miscellaneous domestic expenses	_____
Loan payments	_____
Food	_____
Clothing	_____
Insurance payments/expenses	_____
Medical and dental expenses	_____
Miscellaneous (holiday, entertainment, etc.)	_____
Education	_____
Transportation	_____
TOTAL	_____

2. FORECASTED MONTHLY INCOME

For Singles:

Present monthly take-home pay	_____
Subtract investment income	_____
TOTAL	_____

For Married:

Present monthly take-home pay	_____
Subtract investment income	_____
Subtract spouse's pay	_____
TOTAL	_____

3. PRESENT BENEFITS

SOCSO/Workers compensation	_____
Group disability income insurance	_____
Individual disability income insurance	_____
TOTAL	_____

4. AMOUNT OF DISABILITY INSURANCE NEEDED

If the total from 3 is greater than the total from 2, the coverage is adequate. But if the total from 3 is less than the total in 2, subtract total 3 from total 2. This is the amount of additional monthly coverage needed.

5. PERSONAL RESERVE ACCOUNT

$$\frac{\text{Amount from savings account that is spendable}}{\text{Total expenses - short-term disability Benefits provided by employer}} = \text{The number of months that the person can survive without long-term disability coverage}$$

Selecting the Health Insurance Policy

Often, the more extensive the coverage of the health plan, the more expensive it will be. It is important to bear in mind that the objective of purchasing such a policy. It is pointless to purchase a cheaper coverage if the policy does not provide sufficient coverage against risks that should be transferred.

Below are some of the guidelines that should be followed if a meaningful coverage is to be obtained.

● Cover Catastrophic Loss

One of the most important rules in risk management is for the client to cover himself against losses that can devastate him financially. Many of the critical illnesses, such as cancer, heart disease and kidney problem can be expensive to treat. Without adequate financial reserves or an adequate health plan, these potential expenditures can be very threatening to the individual concerned. Thus, the client should cover himself with a high quality plan, which also has features that limit out-of-pocket expenses. For major medical policies, make sure it has a stop-loss limit that requires the insurer to pay all covered expenses in excess of the stop-loss limit.

● Evaluating Existing Sources of Coverage

The income need of the client should be determined and then the resources to meet the need are identified. The disability income program should be considered as a potential flow of income, capable of replacing the income lost as a result of the inability to work. One of the first factors to be considered is whether any group health plans is in place or is available. It is possible to participate in a group health plan sponsored by the employer, the professional association or other sources. In recent times, many credit card companies have been aggressively promoting such plans to their members.

Although it is nearly impossible to determine in advance the length of the period of disability, protection should be designed based on the worst-case scenario – a disability that is permanent in nature. It would be best if the coverage provides for benefits for life or until retirement age of the client in an amount that will permit the individual to continue the accumulation of a retirement program in the same way as if he or she had not been disabled.

● Study the Restrictive Policy Provisions

The restrictive provisions in a health plan are the “small prints” that may deny the client certain coverage or level of coverage and hence care should be taken to ensure these excluded risks are taken care of in some ways. The two common restrictive clauses are the *pre-existing-condition clause* and the *exclusionary rider*. Most planners recommend that any policy with a pre-existing condition clause longer than one year should be avoided. An exclusionary rider is one, which excludes certain conditions where the client has been treated for the ailments before, such as cancer and heart surgery.

- **Select a Reputable Insurer**

  It is also important to check the service and claims background of the insurer before any recommendation is made to the client. Most reputable insurers will made fast payments and not frustrate the policyholder by delaying their payment or worst still fight the claim. The strength and the amount of claims paid by the insurer may be used as two of the indications when making the selection. A strong insurer is in a stronger position to pay claims and is less likely to delay claims.

- **Check the Price and Benefits with Several Insurers**

  The benefits and prices of similar policies can vary considerably. Hence, the planner should check with several insurers before a selection is made. Because of the intense competition amongst these companies, it can be assumed that newer policies will contain more innovative features and are more competitively priced.

Comparing Health Plans

	Plan A	Plan B	Plan C
The Costs Factor			
• Premiums payable			
• Deductible (amount insured has to bear)			
• Doctor visitation (% insured has to bear)			
• Prescriptions			
• Emergency (% insured has to bear)			
• Out-Patient Treatments (% insured has to bear, if covered)			
The Protection Factor			
• Doctor visitation			
• Outpatient tests & procedures			
• General preventive care			
• Women's preventive care			
• Maternity			
• Annual check-ups			
• Hospitalization			
• Emergency Care			
The Convenient Factor			
• Manner of making claims – e.g. reimbursement or guarantee			
• Accessibility of customer service			
• Any limit to the use of specialists			

Appendix

Minimum Standard on Product Disclosure and Transparency in the Sale of Medical and Health Insurance Policies

Introduction

In view of the complexity and wide variety of medical and health insurance (MHI) policies, it is important that consumers have a reasonable understanding of the policies before they make any purchases. Sufficient and essential information should be disclosed to enable prospective policy owners to adequately assess whether an MHI policy being purchased meets their needs and resources. This would reduce the likelihood of termination of MHI covers due to policy owners' inability to pay future premiums and lack of understanding of the product features. The minimum standard on product disclosure and transparency in the sale of MHI policies stipulates the disclosure requirements that all insurers underwriting MHI business must comply with for MHI products. It also provides prospective policy owners some perspective as to the information that should be disclosed to them by insurers before they make a commitment to purchase an MHI policy.

The objectives of the minimum standard are as follows:

I. To protect policy owners' interest by ensuring that they are in a position to make an informed choice when purchasing MHI policies;

II. To facilitate consistency in disclosure of essential information of MHI business; and

III. To minimise the instances of mis-selling of MHI policies and ensure that policies sold are appropriate to the needs and resources of policy owners.

The minimum standard is applicable to all types of individual MHI policies, including MHI riders attached to individual life polices, and group MHI polices issued under Section 186 of the Insurance Act 1996 where the group policy owners have no insurable interest in the life of persons insured under the polices. The disclosure requirements stipulated in the minimum standard must be make to all individuals covered under such group policies. For other group MHI polices, insurers should ensure that the disclosures are made to the master policy owners.

The minimum standard shall apply to all channels through which MHI products are distributed. For the purpose of this minimum standard, 'marketing and sales materials' refers to all promotional materials and any other materials provided at the point of sale of a MHI product. Announcements

or advertisements regarding MHI products are not subject to the minimum standard. However, the announcements or advertisements should provide sufficient information to the prospective policy owners, and the information given should be clear, fair and not misleading.

The minimum standard shall take effect in respect of all MHI policies and products sold or introduced on or after 1 August 2003.

General Disclosure Principles

Insurers must improve product transparency of their marketing and sales materials, by providing sufficient details of the essentials features of MHI policies to enable prospective policy owners to make informed decisions. Important notices should also be made to prospective policy owners in appropriate wordings, such as 'you should satisfy yourself that this plan will best serve your needs' and 'you should be satisfied that the premium payable under the policy is an amount that you can afford'.

To enable them to make informed decisions in the purchase of MHI polices, prospective policy owners should be first educated on the basics of MHI. In this regard, all prospective policy owners should be advised to refer to the consumer education booklet on MHI (which is issued under the Consumer Education Programme launched by Bank Negara Malaysia in 2003). Prospective policy owners should also be advised to refer to the policy contract for the details on the important features of the polices that they have purchased. They should also be advised on the availability of such information if the information is also available from other avenues, for example the website of the insurer.

Disclosure should be communicated in simple, unambiguous and easily comprehensible language to facilitate 'public' understanding in connection with the purchase of such insurances. Insurers should be guided by the following principles in making disclosures on MHI products to prospective policy owners:-

I. Technical terms must not be used without a clear and proper explanation of their meaning to the general public, while common definitions for frequently used key terms should be properly and adequately explained. For this purpose, insurers may refer to the definitions of key terms provided in the Underwriting Guide for Medical and Health Insurance (MHI Underwriting Guide) issued by the Life Insurance Association of Malaysia (LIAM) and Persatuan Insuran Am Malaysia (PIAM);

II. Accurate, adequate and relevant information must be provided, and any claim or statement in marketing and sales materials must be clear and correct;

III. Any information which becomes misleading following any changes in circumstances must be withdrawn immediately. The existing policy owners must also be notified of the changes if the impact of the changes is deemed significant;

IV. Important features and conditions of the product, such as benefits, limitations in benefits and common exclusions, must be highlighted in all disclosures;

V. The important wordings used in the marketing and sales materials and policy contracts should not be in fine prints; and

VI. Marketing and sales materials that contain information specific to each MHI product should be produced by insurers.

Specific Disclosure Requirements

There are particular aspects of MHI product features and policy contracts that need careful explanation. Insurers and their intermediaries should therefore provide sufficient details of the essential features of an MHI policy to prospective policy owners. This would means that the important provisions of the MHI policy should be clearly and adequately explained in all its marketing and sales materials.

A. Benefits

The specific information that should be disclosed regarding the benefits of a particular MHI product includes:-

I. The form and amount of the benefits payable under the policy; and

II. Details of the events, circumstances or contingencies upon which benefits are payable.

Changes to benefits of MHI products can be made on policy anniversary or upon renewal only. All changes to critical benefits of a particular MHI product and preferably, the reasons for the changes should be notified to all policy owners of that product in writing at least one month before the change is made. This is to ensure that policy owners are aware of the changes made and are given adequate time to reassess their insurance needs and to look for alternative products, if necessary.

B. Exclusions and Limitations of Benefits, Pre-Existing Conditions, Specified Illnesses and Qualifying Period

Many policy owners do not realise that payment of MHI benefits might be excluded or limited under certain circumstances and is subject to pre-existing conditions, specified illnesses and qualifying period. Therefore, information regarding benefit exclusions and limitations, pre-existing conditions, specified illnesses and qualifying periods as defined in the MHI Underwriting Guide must be adequately disclosed and clearly explained to prospective policy owners.

All possible exclusions or limitations in marketing and sales materials should, as far as practicable, be disclosed. Disclosures should at least cover the following areas:-

I. A statement to alert prospective policy owners the fact that there are exclusions and limitations in benefits, and how and where they can get more information on the exclusions and limitations;

II. Highlighting important exclusions and limitations of benefits and circumstances in which the exclusions and limitations apply;

III. Highlighting important pre-existing conditions, specified illnesses and the qualifying periods applicable;

IV. Highlighting the waiting period, deductibles, reimbursements, co-insurance, residence overseas treatment and the circumstances in which the limitations and exclusions apply; and

V. A statement to alert prospective policy owners that the exclusions and limitations of benefits highlighted are not exhaustive and they should refer to the policy contract for further information.

Insurers may use simple examples to illustrate the above disclosures.

C. Premiums

The specific information that should be disclosed regarding premiums of a particular MHI policy is as follows:-

I. The amount, the frequency of payment and the term over which the premiums are payable to secure the benefits;

II. The premium rates table showing the premiums of the product for all ages at entry;

III. The possible conditions that would lead to the following scenarios on policy renewals:-

- A policy is renewed with a level premium;
- A policy is renewed with an increased premium; or
- A policy is not renewed.

A statement should also be made to alert prospective policy owners that the possible conditions disclosed are not exhaustive and that premium rates may be reviewed or policy renewal declined under other justified circumstances.

IV. Whether the premiums are level or may vary on renewal, if it has varied before, statistics on the annual increases in the standard premiums for the product over the last three years for selected sample ages at entry of 30, 40, 50 and 60 should be disclosed. There

should also be a statement to alert prospective policy owners that the past trends on the increases in premium rates do not necessarily reflect the future trend; and

V. The insurer's right to revise the premiums on policy renewals.

Changes in premiums of MHI products can be made on policy anniversary or upon renewals only. All changes in premiums of a particular MHI product and preferably, the reasons for the changes should be notified to policy owners of that product in writing at least one month before policy renewal.

D. Others

To ensure proper and adequate disclosure, insurers/intermediaries should use a checklist on the important information regarding MHI policies that should be disclosed to prospective policy owners. The checklist should be shown to prospective policy owners as it would guide them to enquire the important information regarding the policies that should be disclosed to them at the point of sale. The checklist should also incorporate the element of cross-referencing with the details of the terms and conditions in the policy contract. For this purpose, insurers should use a sample policy contract to show the standard terms and conditions. There should also be a statement to alert prospective policy owners that the actual terms and conditions will be in the original policy contract that will be delivered to them after their policies are underwritten by the insurer. The checklist should cover the minimum content as attached in Appendix I. Insurers are encourages to disclose more relevant information in the checklist.

The checklist should at least be in Bahasa Melayu and English. Insurers are encouraged to have the checklist in other languages.

Lodgement of all MHI products with the Bank

Premium rates of all MHI products and their marketing materials must be approved by the appointed actuary in the case of a life insurer and a qualified actuary in the case of a general insurer, and lodged with the Bank as least 30 days before they are used to market the MHI products.

Coverage

The minimum standard is applicable to all insurers underwriting MHI businesses and their intermediaries. Insurers are responsible to ensure that the requirements of the minimum standard complied with at all time.

Appendix 1

Checklist on Product Disclosure and Transparency in the Sale of Medical and Health Insurance Policies

Important Notice to Prospective Policy Owners is follows:-

- Before purchasing any medical and health insurance (MHI) product, a prospective policy owner is advised to seek explanation on the following from the insurer or its intermediary:-
    - Basic and salient features of MHI in general; and
    - Basic and salient features of a particular MHI product that he intends to purchase.
- The objective is to ensure that the prospective policy owner understands the basic and important features of a MHI product so that he is able to make an informed decision before purchasing the product.
- A prospective policy owner should ensure that important information regarding the policy is disclosed to him and that he understood the information discussed. Where there is ambiguity, he should seek an explanation from the insurer or its intermediary.
- Prior to making a decision to purchase any MHI policy, a prospective policy owner must satisfy himself that the policy best meets his insurance needs and resources.

Self Assessment

1. Disability Income Insurance is also called _____.

A. Disability care insurance

B. Total disability insurance

C. Permanent health insurance

D. Income loss insurance

2. How does the income-loss approach define disability?

A. It focuses on the loss of income of the insured

B. It focuses on the level of job performance of the insured

C. It focuses on the hurt to the family of the insured

D. It focuses on the length and severity of the disability of the insured

3. Heddy Chan is worried about her health in the coming years. She asks you to tell her what would be her main concerns if her health fails? Which of the following would correctly highlight her major concerns?

i. Escalating costs of medical treatment

ii. Lost in EPF contributions

iii. Loss of income

A. i only

B. i & ii only

C. i & iii only

D. All the above

4. The following insurance is classified as health insurance, EXCEPT:

   A. Accident insurance

   B. Disability insurance

   C. Life insurance

   D. Sickness insurance

5. There are several issues associated with the need to provide healthcare services in Malaysia. Identify which are some of the main concerns from the list below:

   i. Lack of qualified medical personnel

   ii. Increasing healthcare costs

   iii. Inadequate access to and uneven distribution of medical care

   iv. Consistent high quality of medical care through the country

   A. i & ii only

   B. i & iii

   C. i, ii & iii

   D. All the above

6. All of the following are health insurance schemes found in Malaysia, EXCEPT:

   A. Critical illnesses insurance

   B. Funeral insurance

   C. Major medical insurance

   D. Hospital and surgical insurance

7. Which health insurance is often issued in conjunction with a life policy and covers a list of dread diseases only.

   A. Critical illnesses insurance

   B. Healthcare rider insurance

   C. Major medical insurance

   D. Hospital and surgical insurance

8. Hospital and surgical insurance covers surgical expenses incurred by an insured. There are essentially two common methods to cover surgical costs. Select the correct combination below.

   i. Schedule method

   ii. Expense method

   iii. Relative-value method

   A. i & ii

   B. i & iii

   C. ii & iii

   D. Not found in the above

9. This method of covering surgical costs is performed by listing the various surgical operations in a schedule, and a maximum amount is paid for each procedure. This method is called the

   A. Schedule method

   B. Expense method

   C. Relative value method

   D. Listing method

10. Which of the following is true of long-term health care here?

   i. It is rarely found in Malaysia

   ii. It pays a daily or monthly benefit

   iii. It covers medical or custodial care received in a nursing facility, hospital or at a home

   A. i & ii only

   B. i & iii only

   C. ii & iii only

   D. All the above

Answers: 1- C, 2- A, 3-C, 4-C, 5-C, 6-B, 7-A, 8-B, 9-A, 10-D