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Malaysia: New Policy Document on Medical and Health Insurance/Takaful (MHIT) business

On 29 February 2024, Bank Negara Malaysia (BNM) issued a new Policy Document on MHIT business (Policy Document). MHIT products refer to the following insurance or Takaful products, which may be offered on a standalone basis or as a rider to an insurance/Takaful policy:

- Medical reimbursement
- Critical illness or dread disease
- Long-term care
- Hospital income
- Dental

This update, which replaces guidelines introduced in 2005 (2007 for Takaful business), builds upon the Exposure Draft on MHIT business issued in December 2022. The revised requirements aim to address a number of significant developments in managing MHIT business which have contributed towards an increase in the utilisation of medical services and the magnitude of claims. The Policy Document also outlines BNM's increased expectations for insurance companies and Takaful operators (ITOs) with respect to product innovation and breadth of coverage.

Key areas of updates and enhancement include:

- A requirement for ITOs to have at least one individual medical product with co-payment features, with a minimum co-payment amount of no less than 5% co-insurance and/or MYR 500 deductible per policy or certificate year
- The establishment of an industry-wide central medical claims data platform
- Detailed requirements on repricing policies and procedures for MHIT products
- Revised product disclosure sheets, including disclosure of historical medical inflation and claims ratios
- A requirement for ITOs to conduct a needs-based assessment, including obtaining a list of minimum information that must be obtained from consumers
- Prohibition on concluding sales through the telemarketing channel

This e-Alert summarises the key changes in the Policy Document, with a focus on new requirements for the management of MHIT business.

Introduction of co-payment features

The new Policy Document requires ITOs to have at least one medical reimbursement insurance/Takaful product with a co-payment feature of at least 5% of total claimable expenses (subject to a maximum co-payment limit set internally by each ITO) and/or MYR 500 deductible per policy year, as well as offer a range of other co-payment amounts for its medical reimbursement products. The requirement for a co-payment feature will also apply to all new individual medical reimbursement products, where the definition of new product includes products where changes have been made to benefits or limits of an existing product as at 29 February 2024.

However, the co-payment requirement does not apply under the following circumstances:

- Emergency treatment, including accident cases
- Outpatient treatment for follow-up treatments arising from critical illnesses such as cancer or kidney dialysis
- Treatment sought at a government healthcare facility

ITOs will need to offer at least one medical reimbursement product with a co-payment feature by 1 September 2024, and must not offer any add-ons to reduce or waive the co-payment portion.

This requirement aims to promote responsible healthcare usage and encourage positive consumption behaviour. In addition, ITOs will need to record and monitor the take-up rate and experience of these medical reimbursement products with a co-payment feature on an annual basis, and report them to BNM on 31 January every year commencing from 31 January 2025.

Central medical claims data platform

In an effort to enable greater industry-wide analysis of medical claims data, a central medical claims data platform will be established by ITOs in collaboration with industry associations. The new Policy Document describes the requirements on the data platform, and ITOs will need to submit MHIT claims data to this platform (including claims data for 2023 and 2024) beginning 1 January 2025.

Additionally, the operator of the data platform needs to be able to perform industry-wide analysis yearly, which must be made available to BNM by 1 July each year, starting from 1 July 2025. The analysis includes:

- The three-year average medical inflation rate
- The three-year average claims ratio
- The average medical bill amount (e.g., by surgical and nonsurgical treatments, by cashless and non-cashless claims, by length of stay, by geographical regions)
- The average bill breakdown by types of benefit (e.g., hospital room and board, surgical, operating theatre)
- The top 10 diagnoses for medical treatments by frequency and severity

Repricing policies and procedures

Although ITOs are currently required to have internal policies and procedures for repricing in place, the new Policy Document provides more specific requirements around the repricing of MHIT products. In particular, internal repricing policies and procedures will need to address practices which may be regarded as unfair to consumers. The Policy Document provides the following examples of practices which are regarded as unfair:

- ITOs are not allowed to revise rates of medical reimbursement products for reasons that are not due to the underlying medical claims experience, for example to achieve a higher profit margin than the initial pricing basis or due to a change in expense allocation methodology resulting in higher expenses being charged to the product.
- The changing of rating factors during repricing (e.g., adding new rating factors that were not considered in the initial pricing) would not be fair to consumers for both guaranteed yearly renewable products (i.e., policies where the renewability on its anniversary is at the option of the policyholder and ITOs are obligated to continue coverage) and long-term medical reimbursement products (i.e., policies with a term exceeding 12 months).

Revised product disclosure sheets

Requirements for product disclosure sheets (PDS) have also been enhanced. By 1 January 2025, ITOs must include disclosures of:

- The three-year industry average medical inflation rate reported by the industry central medical claims platform referred to above
- An illustration of the projected premium or Takaful contribution, or cost of insurance (COI) or Tabarru', using this three-year industry average medical inflation rate
- The three-year industry average claims ratio for medical reimbursement products (expressed as claims per MYR 1.00 premium).

The PDS must also not exceed two and a half A4 pages in order to promote easy reading and facilitate consumers' decision-making process.

Needs-based assessment

The new Policy Document also requires ITOs to obtain minimum information from potential policyholders to assess their needs prior to providing any advice and product recommendation(s). This information includes the consumer's:

- Financial objectives, needs and priorities
- Financial situation, including sources and amount of income
- Existing MHIT coverage
- Employment status and whether MHIT coverage is provided by the consumer's employer

Similar requirements also apply to MHIT products sold via direct distribution channels, where ITOs will need to provide tools for self-assessment (e.g., needs analysis calculator and financial budget calculator), and where consumers may only proceed with the transaction after providing key information in mandatory fields.

Prohibition on concluding sales through the telemarketing channel

Although ITOs may continue to market MHIT products through telemarketing channels, the sales of these products may no longer be concluded over the phone. Instead, telemarketers must refer interested consumers to intermediaries who are qualified to conduct the needs-based assessment.

Conclusion and next steps

The new Policy Document acknowledges a number of significant developments and challenges in managing MHIT business, such as the rise in noncommunicable diseases, growth of private healthcare services and medical inflation. The Policy Document also aims to address escalating medical inflation by introducing mandatory co-payment features in new MHIT products and enhanced monitoring of MHIT products via industry-wide annual analysis based on data submitted to a centralised data platform.

Recognising the growing awareness of MHIT products as a risk mitigation tool, the new Policy Document also encourages ITOs to innovate to meet consumers' needs and to ensure sustainability of MHIT business in Malaysia. The Policy Document requires ITOs to consider the changing demographics and healthcare needs of society when designing and innovating MHIT products. In addition, the Policy Document encourages ITOs to provide value-added services such as wellness programmes and preventive care services in order to promote better long-term health outcomes of its policyholders and hence manage the underlying risks being underwritten by the ITO.

From an insurer or Takaful operator's perspective, MHIT business presents a valuable opportunity to access a deep and diverse market, given the growing demand for medical cover from almost all segments of society, while careful product design and pricing will ensure sustainability of this block of business.

Our consultants have extensive expertise in helping insurers and Takaful operators in managing their MHIT business, covering the entire value chain (i.e., underwriting, claims, pricing, provider management, products etc.), drawing on our experience in other markets across the region. This experience includes product design and benchmarking, pricing analysis, and monitoring and troubleshooting in-force blocks of MHIT business.

For further information, please contact your usual Milliman consultant or those listed below.

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