Parliamentary QA

INTEGRATED SHIELD PLAN RIDER FRAMEWORK

12 January 2026

NOTICE PAPER NO. 310

NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON 12 JANUARY 2026

Name and Constituency of Member of Parliament

Mr Yip Hon Weng

MP for Yio Chu Kang

Question No. 962

To ask the Coordinating Minister for Social Policies and Minister for Health regarding the new Integrated Shield Plan rider requirements (a) whether there will be an absolute cap on patients' out-of-pocket costs; (b) whether insurers can retain older policies with higher coverage; and (c) what measures will be implemented to prevent insurers from unilaterally reducing coverage for ageing policyholders on existing plans.

NOTICE PAPER NO. 339

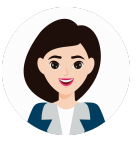
NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON 12 JANUARY 2026

Name and Constituency of Member of Parliament

Ms Poh Li San

MP for Sembawang West



Question No. 1038

To ask the Coordinating Minister for Social Policies and Minister for Health in view of the Ministry's move to curb rising healthcare insurance premiums by April 2026, how will families facing hefty medical bills be supported if their out-of-pocket expenses for co-payments become unaffordable.

NOTICE PAPER NO. 363

NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON 12 JANUARY 2026

Name and Constituency of Member of Parliament

Dr Hamid Razak

MP for West Coast-Jurong West GRC

Question No. 1158

To ask the Coordinating Minister for Social Policies and Minister for Health regarding the new Integrated Shield Plan rider, (a) whether the policy design anticipates that policyholders will continue to access private healthcare despite higher cost-sharing; (b) if so, what is the policy basis; and (c) what contingency measures have been developed to support restructured hospitals should there be increased patient volume due to shifts from private to public healthcare.

NOTICE PAPER NO. 356

NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON OR AFTER 13 JANUARY 2026

Name and Constituency of Member of Parliament

Ms Mariam Jaafar

MP for Sembawang GRC

Question No. 1144

To ask the Coordinating Minister for Social Policies and Minister for Health whether the Ministry can provide details on how it will monitor the impact of the revised Integrated Shield Plan rider framework on (i) private healthcare utilisation and (ii) public hospital waiting times.

NOTICE PAPER NO. 330

NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON 12 JANUARY 2026

Name and Constituency of Member of Parliament

Mr Kenneth Tiong Boon Kiat

MP for Aljunied GRC

Question No. 988

To ask the Coordinating Minister for Social Policies and Minister for Health given that the Monetary Authority of Singapore primarily regulates solvency, whether the Ministry intends to establish a dual-regulation framework to oversee the (i) healthcare outcomes (ii) panel selection criteria and (iii) loss-ratio efficiency of private insurers to ensure they align with national health goals.

NOTICE PAPER NO. 345

NOTICE OF QUESTION FOR ORAL ANSWER

FOR THE SITTING OF PARLIAMENT ON 12 JANUARY 2026

Name and Constituency of Member of Parliament

Dr Hamid Razak

MP for West Coast-Jurong West GRC

Question No. 722

To ask the Coordinating Minister for Social Policies and Minister for Health what specific indicators of sustainability in private health insurance premiums and claim levels were used in formulating the new design requirements for Integrated Shield Plan riders that take effect on 1 April 2026.

Name and Constituency of Member of Parliament

Dr Hamid Razak

MP for West Coast-Jurong West GRC

Question No. 723

To ask the Coordinating Minister for Social Policies and Minister for Health (a) whether the Ministry has modelled changes in out-of-pocket spending for typical hospital cases under the new Integrated Shield Plan rider design as compared to the current design; and (b) if so, what are the projected figures.

Answer

1 Mr Speaker, may I have your permission to answer Questions 1 to 4 together? My response will also address written PQs raised by Dr Hamid Razak in today's Order Paper and a similar question raised by Ms Mariam Jaafar scheduled for subsequent sitting. If the MPs are satisfied with the response, they may wish to withdraw their questions after this session.

2 Let me try to put everyone on the same page. Over the past few years, patient load has been shifting from private hospitals to public hospitals. In 2010, the split between private and public was 15:85. In 2020, it became 12:88. Now, it is 10:90.

3 There are many reasons. The issue of insurance and insurance riders is not the reason why patient load is shifting from private to public. This has been happening for the past 15 years, and there are many reasons. Part of it is that as people get older, some of them prefer public hospitals where there are more disciplines and more holistic care. But another key reason is the escalating cost of private healthcare that is in turn fueled by Integrated Shield Plan (IP) riders, which provide overly generous health insurance coverage, and that leads to a greater tendency for over-servicing and over-consumption of healthcare services. Higher private healthcare cost is translated into higher private hospital IP rider premiums and IP premiums for private hospitals have been growing at an average rate of 17% annually for the past three years, and is double that of IP premiums, and even higher compared to MediShield life premiums.

4 Hence, every year, about 100,000 policyholders cancel or downgrade their IP rider policies, and I suspect amongst them, many switched from private to public hospitals.

5 To Dr Hamid's question on the indicators that we used as a basis to decide policies, the data and signs have been clear and the situation is not ideal, and not sustainable. We have been actively expanding healthcare infrastructure and expanding manpower, in order to cope with rising workload and manage wait times. Our plans are significant, I have made them public before and I will not repeat here.

6 To Mr Yip's question, the new requirements for IP riders will only affect policyholders who purchased riders on or after 27 November 2025. Individual IP insurers will decide on their approach for rider policyholders who purchased their plans before 27 November 2025.

7 As for affected IP riders, these are the new ones, we should expect the following changes:

8 First, IP rider premiums under the new design should be lower. On average, 30% lower compared to existing policies with maximum coverage, and this is a significant recurrent savings.

9 Second, the new IP rider policies will not cover the minimum IP deductibles and require higher co-payment. We share Members' concerns about patients' out-of-pocket costs, especially for large medical bills. But this is precisely the main aim of the rider changes – preserve the protection against very large and unexpected medical bills, but disallow coverage of the minimum deductible, which is a fixed sum, which users of private hospitals tend to be able to afford. This would help restore health insurance to its original objective, which is to provide assurance against large, infrequent, often unexpected healthcare bills, rather than the small bills.

10 For a rider plan designed with the new requirements, there will still be a cap of 5% co-payment up to $6,000 a year, in addition to the deductibles. In reality, these need not be out-of-pocket cash payments because patients can tap on their MediSave. We project that six in ten rider claimants should not have to pay cash out-of-pocket after

MediSave. For the remaining four in ten, majority of those with cash out-of-pocket would pay $1,000 or less, and practically all would pay $3,000 or less.

11 We should bear in mind that all of these numbers I am talking about pertains to private hospital patients. Their IP rider premiums have been driven up so high that under the new design, many can expect significant premium savings which can more or less offset the higher co-payment. In short, the current design of IP riders may no longer make financial sense for many policyholders, and this change will help redress the situation.

12 Let me give you an example. A 60-year-old on a private hospital IP and rider with maximum coverage can now save about $1,600 a year in premiums by switching to the new rider. Over three years, he would have saved $4,800 in cash, which would be more than sufficient to offset the increase in co-payment for a typical procedure – for instance, $3,300 for a knee joint replacement surgery in a private hospital.

13 Ms Poh asked about support measures for families facing unaffordable out-of-pocket expenses. Patients should consider their financial and healthcare needs when choosing where to seek care, including seeking subsidised care in public hospitals should affordability become an issue.

14 Third impact, there should be in the medium to long-term, changes in the respective utilisation of private and public care and wait times. As I explained earlier, this change is part of our efforts to mitigate the shift of patients from private to public healthcare that has happened over the last 10 to 15 years, by putting the private healthcare sector and health insurance on a more sustainable path and ensuring private care remains accessible to Singaporeans in the long-term.

15 However, in the short-term, as a few members have expressed concern about, some individuals on the new riders may choose to seek care at public hospitals to reduce their co-payment. We will monitor this closely. Efforts to expand public health capacity – both in terms of hospital beds and outpatient capacity - are already ongoing to support the demands of an ageing population. If need be, we may need to implement surge capacity for selected treatments.

16 On Mr Kenneth Tiong's question relating to the regulation of IP insurers, MOH and the Monetary Authority of Singapore (MAS) work closely together in exercising regulatory oversight of IP insurers, to ensure that policyholders' interests are protected and the products are sustainable.

17 MOH's key role is to oversee the development and operation of the public healthcare system and ensures universal access to healthcare. For individuals who prefer private healthcare and purchase private insurance, we should not micro-manage or prescribe the market practices. Instead, we set requirements pertaining to the key parameters of IPs and riders, such as co-payment and deductible requirements, to ensure that the schemes are sustainable. We only step in when we see a serious market failure emerging, which is why we have intervened in this case, to tighten the design of IP riders.

18 Doctor panels are an example of cost-management measures put in place by the market, the insurers, in response to rising private healthcare bills and claims. MOH has been, and will continue to work with key stakeholders including insurers, healthcare providers, hospitals, medical professionals, and consumer representatives through the Multilateral Healthcare Insurance Committee (MHIC) on these matters, to strike a balance between the interests of all stakeholders.

19 To sum up, we must take a long-term and balanced view of this issue so that we can put private healthcare and insurance on a more sustainable path.

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