Asia e-Alert

Malaysia's Base MHIT: A growth opportunity on a compressed timeline

Learnings from Singapore's 20-year Integrated Shield Plan journey

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Introduction

In January 2026, Bank Negara Malaysia (BNM), the Ministry of Finance and the Ministry of Health jointly published the White Paper on the Base Medical and Health Insurance/Takaful plan ("Base MHIT"), known as MediAsas. This is part of RESET,[1] Malaysia's national healthcare reform programme launched in 2025 after public outcry over steep 2024 MHIT premium hikes.

From January 2027, every licensed life insurer and family takaful operator writing medical and health business in Malaysia will need to offer the standard Base MHIT plan, MediAsas Teras, alongside existing MHIT plans; the standard-plus Base MHIT plan, MediAsas Fleksi, is optional. A Klang Valley pilot programme began running from the end of July 2026 and will conclude in October 2026, with six participating life insurers and family takaful operators, ahead of nationwide implementation.

In Malaysia, MHIT products are offered by both life insurers/family takaful players and general insurers/general takaful operators. This e-alert focuses on the life insurance and family takaful segment in Malaysia.

Although existing MHIT products are not being replaced, new MHIT offerings will be shaped by the standards set for the Base MHIT plan. For many insurers, this is not an incremental product change; it resets the economics of the largest protection line in the market.

This e-alert discusses three critical questions:

- Growth: How large is the addressable medical opportunity after allowing for structural constraints?
- Profitability: How did product-design and pricing levers impact Singapore's Integrated Shield Plans (IPs) claims ratio?
- Product strategy: What are the implications following the introduction of Base MHIT plans on product development for all MHIT plans (Base MHIT and other MHIT plans) and overall company-level product strategy over the next 12 to 18 months?

FIGURE 1: CURRENT VS NEW BASE MHIT

	CURRENT MHIT	BASE MHIT
Product structure	Predominantly unit-deducting riders (UDR) attached to investment-linked products; non-standardised plans varying by insurer; coverage can lapse if underlying investment underperforms	Standalone, standardised MediAsas Teras and MediAsas Fleksi plans across insurers; premiums fund medical coverage only, not investment
Hospital cost structure	Fee-for-service hospital payments, with charges varying by utilisation	Phased move to Diagnosis-Related Group (DRG) hospital payments, with target prices set by diagnosis and severity level
Cost-sharing	Co-payment or deductible required on newly designed medical reimbursement products; co-pay option must be offered at sale and renewal from September 2024 'As-charged'/last-dollar designs persist in the in-force book, fuelling claims inflation and over-utilisation	Mandatory deductible and two-tier co-payment built in from the outset (zero for in-network and 20% for out-of-network capped at RM3,000 per disability)
Re-pricing structure	Steep re-pricing every 2 to 3 years; premiums not standardised Historically, insurers have controlled repricing, subject to regulatory requirements and approvals; BNM's interim measures require MHIT premium increases arising from medical claims inflation and effected from 2024 to 2026, to be spread over at least three years	Risk-rated premiums on a standardised pricing and underwriting framework, with oversight by a Governance Board; policyholders facing repricing can switch to MediAsas with their existing insurer without new medical underwriting Premiums published are indicative only, with final pricing to be confirmed before the January 2027 rollout.

Source: Base MHIT White Paper, January 2026

1. RESET: Revamp MHIT, Enhance price transparency, Strengthen digital health system, Expand cost-effective options, Transform provider payment mechanisms.

Growth opportunity in Malaysia

Malaysia's MHIT penetration rate (premiums as % of GDP) was 0.8% in 2025, against Singapore's 2.2% for IPs. Both countries provide universal access to heavily subsidised public healthcare, so private cover is an upgrade and not a necessity in many cases. The ~3× gap is indicative only, as there are structural constraints. Malaysia has roughly one quarter of Singapore's GDP per capita (PPP), near-free public care at the point of use and no national health insurance layer to anchor private cover.

According to the Base MHIT White Paper, most of Malaysia's private health spend is out-of-pocket self-pay, as roughly four in five Malaysians hold no private cover at all. The Base MHIT plan aims to convert that self-pay pool, the able-to-afford uninsured and policyholders downgrading from re-priced plans into more structured and sustainable coverage.

FIGURE 2: KEY METRICS COMPARISON

	MALAYSIA	SINGAPORE
Local population (Citizens and Permanent Residents) with private medical cover (2025)	~22%	70% have IP, 100% have MediShield Life (mandatory)
New Business (NB) medical premium CAGR (2022–2025)	2.0%*	11.2%
Industry-level medical claims ratio (2025)^	Standalone: 87% Riders: 96% Industry-level: 94%	80%

Source: Base MHIT White Paper; MAS forms, Industry statistics
*Medical premiums are represented by Investment Linked Plan (ILP) riders and medical and health policies. This includes both conventional and takaful (but excludes general insurance and general takaful).
^Malaysia's data includes conventional insurance, not the takaful market.

Despite 70% of Singaporeans and Permanent Residents (PRs) already holding an IP, medical NB premiums still grew 11.2% per annum over the last three years, against Malaysia's 2.0%. High penetration has not capped growth in Singapore, which suggests real headroom for insurers and takaful operators in Malaysia, even after allowing for the structural constraints above.

Public–private medical layer comparison

FIGURE 3: PUBLIC-PRIVATE LAYERS COMPARISON

PUBLIC–PRIVATE MEDICAL LAYERS	MALAYSIA	SINGAPORE
Public healthcare	Near-free public healthcare	Heavily subsidised public healthcare, with subsidies of up to 80%
Medical savings	EPF withdrawals for approved medical expenses and insurance/takaful premiums	MediSave account within Central Provident Fund (CPF)
National health insurance	None	MediShield Life (Administered by CPF Board)
Private insurance	Base MHIT and existing MHIT plans	IPs and riders above MediShield Life

Source: MediShield Life 2024 Review Council Report, Ministry of Health Singapore, Employees Provident Fund; Health White Paper for Malaysia, Ministry of Health Malaysia, 2023.

The two systems align most closely at the public healthcare, medical savings and private insurance layers. The key difference is the national health insurance layer: Malaysia has no equivalent to MediShield Life, so Base MHIT and existing MHIT plans sit more directly above the public healthcare and EPF framework, whilst Singapore's IPs sit above compulsory national insurance. Singapore remains a useful reference for product design and cost-control lessons, but is not a like-for-like comparison.

Singapore plan design and profitability

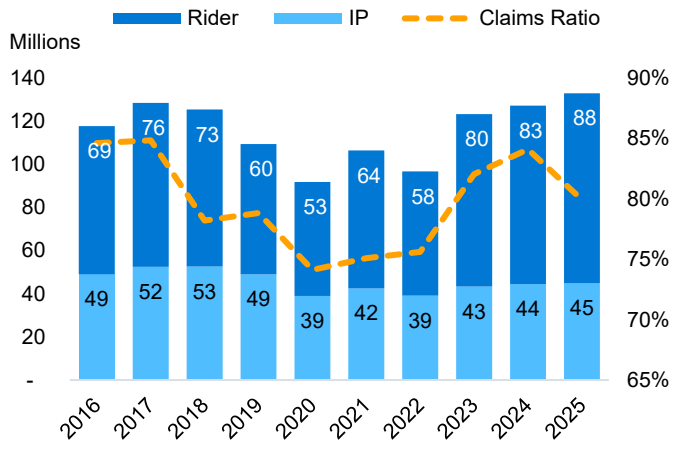
Singapore introduced low-cost basic health cover in the early 1990s with MediShield, funded through MediSave, the dedicated medical account within CPF.

Private insurers have offered MediSave-approved plans integrated with MediShield since 1994, with 'as-charged' designs entering the market from 2005. In 2015, MediShield Life replaced MediShield as compulsory universal cover for Singaporeans and PRs, with no lifetime limit and pre-existing conditions covered, and IPs were re-based onto it as bundled plans providing additional coverage on top.

FIGURE 4: RECENT DEVELOPMENTS IN SINGAPORE MEDICAL INSURANCE MARKET

YEAR	DEVELOPMENT	IMPACT ON MARKET
Pre-2018	IP riders reimburse 'as-charged' to the last dollar (zero co-pay)	Strong NB premium growth
2017–2018	Prudential launches the first claims-based-pricing (CBP) rider (2017); mandatory ≥5% co-pay on new IP riders capped at S$3,000 with panel/pre-authorisation (2018)	Prudential's NB premiums grew 35% in 2018, whilst its claim ratios dropped from 82% to 69%; market-wide NB premiums fell in 2019 and 2020 (Figure 5)
2021–2023	AIA and Great Eastern launch CBP riders; Singlife Health Plus introduces a flat 15% no-claim-discount (NCD) rider; MOH introduces Cancer Drug List (CDL) and the corresponding MediShield Life and MediSave limits IP claim limits still set by private insurers.	Positive NB premium growth but limited claims ratio impact No IP premium hikes for base plan from September 2022 to August 2024 when CDL introduced Steep increase in IP Rider take-up rate from 2023 after CDL, where riders have been re-designed to cover non-CDL
2025–2026	MediShield Life annual claim limit raised from S$150k to S$200k; riders covering the minimum deductible prohibited; minimum co-pay cap raised from S$3,000 to S$6,000	MediShield Life premium increases capped at 35% and phased evenly from April 2025 to March 2028 NB growth expected to slow

FIGURE 5: TOTAL IP AND IP RIDER MARKET NEW BUSINESS PREMIUM AND INDUSTRY CLAIMS RATIO IN SINGAPORE



Source: MAS Forms.

In Singapore, the industry medical claims ratio has hovered around 75% to 85% in the last five years, which is significantly lower than Malaysia's industry claims ratio of 94% in 2025. Malaysia's high claims ratio may partly reflect BNM's December 2024 interim measures, which require medical-claims-inflation-related premium increases to be spread over at least three years.

The average claims ratio for the top-three medical insurers (~77% market share) in Malaysia was 95% in 2025 versus 82% for Singapore's top-three (~72% market share). This concentration sits over a much longer tail in Malaysia, with 24 life insurers and family takaful operators writing MHIT against seven IP insurers in Singapore.

Unlike Malaysia's typical past market practice of repricing every two to three years, repricing of IP and riders in Singapore is frequent—often an annual exercise—and is a key driver of the lower experienced claims ratio compared to Malaysian insurers. Even with the government-agreed moratorium in place post-CDL, insurers could adjust the IP premiums for riders.

Implications for product strategy

COST-SHARING AND NETWORK STEERING

Cost-sharing is already required on newly designed medical reimbursement products, and network-based MHIT products also exist in the market, so neither feature is new to the market in MediAsas. The key changes are zero co-payment in-network against 20% out-of-network, capped at RM3,000, and a phased move to DRG-based hospital reimbursement with regulator-set target prices and broader cost-containment initiatives. The revamp combines provider management and reimbursement with product design.

Singapore's experience indicates cost-sharing was effective, but it took many years for the benefits to reach the whole book. The 2018 minimum co-payment covered only new riders; existing full-rider policyholders were grandfathered and largely migrated from 2021. For the riders with cost-sharing, claims incidence growth was close to zero, against 9% to 15%[2] per year for full riders (riders which cover co-pay), varying by hospital type.

The mechanism also requires recalibration over time. In 2025, MOH prohibited deductible-covering riders from April 2026 and doubled the co-payment cap to S$6,000. The mandatory deductible, as imposed by the Base MHIT plan, is in effect starting from where Singapore has arrived. Insurers should treat RM3,000 as a starting parameter and build pricing and in-force projections to pressure-test against re-tightening.

2. MOH Singapore parliamentary reply, February 2021; claims incidence CAGR 2015–2020.

In the near term, NB premiums may decline as policyholders downgrade or migrate from higher-cost plans. Over time, demand from the self-pay and uninsured pool is expected to offset the decline from adverse migrations.

PRODUCT INNOVATION AND FIRST-MOVER ADVANTAGE

Following the establishment of a compulsory co-payment mechanism, Singaporean insurers rapidly differentiated their offerings by introducing wellness rewards, CBP, NCD and value-added services such as telehealth and digital second opinions.

Achieving first-mover advantage on CBP, particularly with products targeted at younger demographics, can lead to improved economies of scale and a healthier risk pool. Initiating research and development efforts early is advisable, given the materiality of this portfolio, widespread business impacts and time to market. As pricing and benefits on the base plan itself are standardised, differentiation can only happen in the riders and services layered above it.

RISK POOLING

To keep the risk pool balanced, insurers will need to strengthen the product's value proposition and affordability to drive uptake, whilst managing adverse selection from higher-risk individuals moving in from costlier MHIT plans or the uninsured segment.

Broader risk pooling across participating insurers and family takaful operators, supported by risk equalisation arrangements, is expected to reduce claim volatility and support more stable premiums for the Base MHIT plan over time.

A possible way to maintain a higher mix of healthier lives is to link premium discounts or benefit enhancements to objectively measured healthy behaviours (such as CBP or NCD). This also aligns more closely with BNM's affordability goals and can still drive positive sales outcomes.

Standardised underwriting and premiums also mean insurers cannot price accurately for their own distribution mix or claims experience, which is not a constraint for Singapore's IPs since insurers there retain pricing control. Insurers whose channels attract worse-than-average risk will be exposed, making the risk-pooling design critical to product economics.

PRODUCT STRATEGY

Currently, MHIT in Malaysia is mainly sold as a UDR attached to investment-linked plans. However, given that the new Base MHIT plan must be a standalone protection plan, there is a potential for a reduction in the overall rider attachment ratio, which will impact overall product mix, profit margins and volumes.

Insurers need to recalibrate product design so that the slimmer margin on the Base MHIT plan is offset by a well-balanced suite of riders, particularly those with higher profitability, such as critical illness. With the government's signal to shift away from a fee-for-service cost structure to DRGs, consideration should be given to the operational impact of claims management. Claim costs are expected to be more predictable and ultimately provide a better cost-control framework for future MHIT offerings.

The impact on the overall ILP proposition without this rider also needs to be considered, as the medical rider was a key acquisition tool for many agents. A significant revamp of the overall product strategy is required so the new medical offering integrates seamlessly without disruption to sales volumes.

PORTFOLIO MANAGEMENT

Active portfolio management through regular monitoring of emerging claims trends and lapse experience will be crucial for sustaining both volumes and margins. There could be a significant deterioration in experience for the in-force UDRs if a larger proportion of healthier lives opt for the new Base MHIT plans. Insurers that move quickly to develop a product strategy, incentivise the right sales behaviour and proactively drive conversions to the new Base MHIT plan will be best positioned to manage in-force profitability.

Conclusion

Singapore's insurers refined the IP product construct over two decades of iterative regulations. Life insurers and takaful operators in Malaysia face a compressed timeline to the same set of decisions ahead of the January 2027 launch.

Milliman has supported Singapore insurers through each stage of the Shield journey and worked with life insurers across Asia, including Hong Kong, Thailand and Indonesia, on similar medical portfolio and product strategy challenges. We would welcome the opportunity to discuss how these regional lessons apply to your portfolio, including Base MHIT pricing, product architecture, in-force portfolio management and broader product strategy before market terms are set.

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