

INSURANCE & REINSURANCE

Thailand's Implementation of New "Copayment" Clauses in Health Insurance Policies Starting from 20 March 2025 – What You Need to Know

Background

With effect from 20 March 2025, insurance companies will be able to introduce a copayment clause that will apply to health insurance policy renewals and new policies.

The insurance industry in Thailand is undergoing this significant transformation in March 2025 due to rising health insurance premiums, medical inflation, and unnecessary medical expenses. The copayment policy was developed by Thailand's Office of Insurance Commission ("**OIC**") in collaboration with the insurance sector, under the New Health Standard pursuant to OIC Order No. 14/2564 RE: Criteria for Approval of Standard Forms and Wording of Health Insurance Riders for Life Insurance Companies and OIC Order No. 15/2564 RE: Criteria for Approval of Standard Forms and Wording of Individual Health Insurance Policies for Non-Life Insurance Companies ("**OIC Orders**"), which have been in effect since November 2021.

To control rising medical costs and reduce unnecessary claims that impact premium rates, the OIC Orders have introduced the development of alternative health insurance products to manage healthcare expenses while safeguarding insured rights. The key measures include:

1. developing alternative health insurance products to reduce unnecessary medical expenses; and
2. encouraging self-medication for minor illnesses or obtaining prescriptions to purchase medicine directly from pharmacies.

The copayment policy is a targeted solution designed to address these concerns. This claims model aims to slow down premium increases and ensure the long-term sustainability of voluntary health insurance.

Get Ready for the Implementation of Copayment Policy Starting on 20 March 2025

Under the OIC Orders, the copayment means an insured pays a part of his medical bills, while his insurance company covers the rest. For example, if your hospital bill totals THB1,000, the insurance company may cover THB700, and you would be responsible for paying the remaining THB300. In other words, it is a joint responsibility between an insurance company and a beneficiary of the medical expenses. The application of this policy depends on your status as the insured, as detailed below:

Status of the Insured	Copayment Implementation
New insured (Copayment from the start of the health insurance policy)	The insured voluntarily agrees to share the cost of all medical expenses claimed under the policy. Typically, the copayment is set as a percentage of the medical expenses as specified in the insurance policy.
Renewal condition insured (Copayment applied upon renewal of the insurance contract)	Scenario 1: A copayment of not exceeding 30% applies if all conditions below are met. 1. There were claims made for inpatient treatment due to simple diseases (e.g. upper respiratory tract infection, influenza, acute diarrhea, vertigo, and other minor diseases as announced by the insurance company), with no medical indications requiring hospitalisation; 2. There were at least three claims (excluding Outpatient Department (OPD) claims, even if they are claims related to simple diseases); and 3. Individual claim ratio of the insured in a given policy year exceeds 200% of the covered expenses.
	Scenario 2: A copayment of not exceeding 30% applies if all conditions below are met. 1. There were claims made for inpatient treatment due to general illnesses, excluding critical illnesses and major surgeries; 2. There were at least 3 claims; and 3. Individual claim ratio of the insured in a given policy year exceeds 400% of the covered expenses.

However, **the total copayment in all cases cannot exceed 50% of the covered expenses in a given policy year**. Additionally, if the insured no longer meets the copayment criteria in subsequent years, the copayment policy will not apply in the following policy year. Therefore, even if your insurance policy is approved after the copayment policy takes effect, it does not mean you will always have to make a copayment for every medical expense.

Additionally, the premium rate under the copayment policy will be lower than that of the normal policy. As a result, the insured will benefit from this.

According to the OIC Orders, the insurance company must prepare documents related to premium rates and standards for the copayment policy and present them to the insured at least 15 days before

the policy's due date. Therefore, the insured must now prepare for the new health standard: "copayment."

Conditions for Applying for a Copayment Insurance Policy

If an insurance company wishes to introduce a new policy product with a copayment condition, the OIC Orders require the insurance company to submit the policy for review and obtain approval before offering it to the insured.

However, if an insurance company issues and sells an insurance policy with a copayment condition that differs in wording from the version approved by OIC, the insured will have the following options:

1. Hold the insurance company liable under the issued insurance policy with the copayment condition; or
2. Hold the insurance company liable under the version of the insurance policy with the copayment condition as approved by the OIC; or
3. Terminate the insurance policy with the copayment condition and receive a refund of the premiums paid.

The insured may choose the option that provides him with the greatest benefit under the copayment insurance policy.

Conclusion – Who will be Affected?

The copayment policy will primarily impact individual insured whose insurance policies are issued on or after 19 March 2025. However, the primary goal of this policy is to serve as a risk management tool to control medical costs, reduce unnecessary insurance claims, and stabilise premium rates, ensuring the long-term sustainability of voluntary health insurance.

While the insured will share a portion of medical expenses, the policy is designed to prevent excessive premium increases, ultimately leading to more stable and affordable insurance over time. To prevent potential customer dissatisfaction, insurers must clearly communicate the benefits of copayment, ensuring the insured understands how it contributes to long-term affordability.

As for hospitals, this policy may lead some patients to reconsider visiting hospitals for minor illnesses, as they will be responsible for part of the cost. Instead, they may opt for self-medication or seek alternative treatments, potentially reducing hospital revenue from outpatient services.

If you have any queries or need clarifications on the above, please contact our team below.

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