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The case for health insurance premium regulation in the United Arab Emirates

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About the author?

The author of this paper has 31 years' experience across all forms of insurance, including health insurance, in many countries. His last 10 years have been specifically focused on health system financing in developing countries in the Middle East and Africa. The author's work has included working for two UAE based health insurance brokers, being a senior manager with a "Big 4" advisory firm, being a key contributor to the development and implementation of the Health Insurance Law No 11 of 2013 of the Emirate of Dubai including being the architect of its regulatory framework. He has also provided *pro bono* advice to other regulators in the Middle East and Africa and contributed to the implementation of the eClaims platform of the Kingdom of Saudi Arabia known as "nphies". He has also provided health system financing and regulation advisory and consulting services to clients of other global consulting companies.

Why this paper?

The issue of regulating health insurance premiums is a thorny one which very few people seem willing to grasp or discuss. This article argues the case for premium regulation in some Middle East countries, specifically the United Arab Emirates (UAE), where governments or other authorities have mandated compulsory health insurance, mainly aimed at protecting their large expatriate populations. It argues that without such regulation the health insurance market will remain unprofitable for many insurers leaving the mandatory system unsustainable. The current unregulated market (in terms of premiums) also serves to deny individuals the benefits of "risk pooling", a key principle of insurance for the wider public good. It also leads to severe price "undercutting" for corporate health insurance business leaving insurers taking on business at unprofitable rates which then leads them (or their TPAs) towards cost containment measures that adversely affect the insured member's access to services.

Limitations on scope

This paper does not represent a full assessment of the various healthcare financing systems in the Middle East. Its primary focus is on the position in the United Arab Emirates but comparisons can be drawn with other countries and some lessons transferred.

Disclaimer

All views expressed and statements made in this paper are those of its author.

A statement of general principle by the author

Where a government (or any of its regulatory bodies) imposes an obligation on the population to purchase certain services, the government has a moral duty to also put in place measures to protect the population from unfair and discriminatory pricing practices by the providers of such services or their intermediaries. It also has a duty to ensure a sustainable market for providers of such services and one that is not detrimental to the recipients or users of such services.

Why is this principle so important for health insurance in the Middle East where mandatory health insurance exists?

Residents (generally meaning expatriate workers holding residency visas) of territories such as the Emirates of Abu Dhabi and Dubai, the Kingdom of Saudi Arabia and soon the Kingdom of Bahrain, the Sultanate of Oman and the State of Qatar have no "opt-out" clause. They or their employers must purchase health insurance, often as a condition of maintaining their residency status.

Unlike drivers of vehicles who have control over their driving behaviour, individuals do not have complete control over their health issues. People with genetic or non-lifestyle related conditions can be penalized as "bad risks" through no fault of their own (unlike "bad drivers" who can control their behaviour and therefore should be penalized for bad driving). This means that such people will be forced to pay higher premiums. The absence of the application of the "risk pooling" principle can make health insurance unaffordable for many such individuals. Yet, motor insurance premiums are often regulated while health insurance premiums are not.

What are the impacts of not regulating health insurance premiums?

For individuals who incur higher than expected claims, the insurer is free to load the renewal premium to recoup losses on the individual policy. This contradicts the principle of "risk pooling". Individuals may be subjected to unaffordably high premiums based upon an individual risk assessment which again contradicts the principle of "risk pooling". Individuals may effect a policy for the purpose of obtaining a residence visa and then cancel because of the high premiums leaving them without cover for medical expenses.

For employer groups, the competitive broker driven environment results in price undercutting to the extent that premiums received by insurance companies do not meet claims resulting in underwriting losses for insurers. To compensate, insurers (and their third party administrators) seek to contain claims costs with denials of coverage, often to the detriment of the health of the insured member. The "race to the bottom" in terms of group pricing leads to a continual switching between insurers leaving insurers no incentive to introduce "preventive" health schemes for the long term health benefit of their insured members

Overall, none of this is good for the health of the population or the health of the economy.

Arguments for and against health insurance premium regulation

Arguments against health insurance premium regulation include the "free market" works better, that regulation can distort the market, that it increases compliance costs or creates barriers to entry. Others say that it is simply too complicated or that regulators don't understand the business and would impose an unworkable system.

The arguments for health insurance premium regulation are that it creates stability for insurance companies, improves underwriting performance and provides a greater incentive for insurers to introduce preventive schemes. Regulation will also provide financial protection for individuals and, with less pressure on cost containment caused by unsustainably low group premiums, result in unfettered access to medical plan benefits. All of which will lead to a healthier health insurance business and a healthier population and workforce

What are the methods of premium regulation?

There are several options but these all need to be weighed against the principles of equity and the fact that the target populations are transient, often not spending more than a few years as expatriate workers.

The tariff system

Firstly, there is the tariff system where the regulator sets premiums or a range of premiums based upon certain criteria. This is a mechanism often applied to motor insurance but in relation to health insurance it is crude.

Limiting premium increases at renewal by a set percentage

A second method is limiting premium increases at renewal by a certain percentage. However, this is again a crude method which does not allow insurers the scope to adjust renewal premiums based upon actual claims experience.

Community rating

Thirdly there is community rating where everyone with the same insurer pays the same premium regardless of age or risk. Whilst workable for the countries in focus, this requires a sophisticated “risk equalisation” mechanism under which insurers with inherently “impaired life portfolios” are compensated by insurers with better performing portfolios. Such a mechanism is complicated. For example, in the Netherlands the regulator has built such a system over 28 years which now includes over 150 factors to arrive at the end result in terms of risk equalisation between insurers.

Age related community rating

Fourthly, and similar to the above, there is age-related community rating (everyone in a specific age band pays the same premium). Ireland employs this method.

Fixed lifetime premium

Fifthly, there is the option of a lifetime fixed premium (based on age at first scheme entry). This is used in Germany but given the transient populations in the countries under discussion it would not work here.

Risk and benefits related banding system

Finally, there is a risk and benefits banding system. This involves the insurer setting an “index rate” for each product in its portfolio (crudely, an “average” premium) and then adjusting individual premiums based upon individual risk factors, network coverage and add-on services. This is the basis used in many states in the United States. This method would involve significant actuarial work, product rationalization, standardisation of policy benefit definitions and other matters. However, this would also be the most appropriate method for Middle East countries which have mandatory health insurance and large , transient populations of foreign workers.

The key challenges for regulators

Health insurance products have diverse benefits, limits and exclusions making premium regulation difficult without the product rationalization and standardization mentioned above. There is a lack of centralized data and/or a lack of data sharing. The countries under discussion are subject to a largely broker driven corporate market open to manipulation. Also, the healthcare provider network system is "price driven" and not "quality driven". Without any published "quality of outcomes" index, individuals and employers tend to equate "quality" with "price" which only fuels premium inflation and the revenues of the more expensive healthcare providers.

Low insurance company scheme retention rates with regular scheme switching between insurers is another challenge, brought about by a lack of premium regulation. In some countries such as the United Arab Emirates which is a federation of emirates, securing "buy-in" from and implementation in all emirate level authorities may be challenging.

Development time, costs and implementation of a system of premium regulation are also a challenge and should not be underestimated but where there is the political will to act it is easily achievable. However, whatever system is adopted, monitoring and enforcement will be key to its success.

Conclusion

Without a system of premium regulation, employers will continue to complain about rising premiums and seek to reduce benefits to compensate, individuals will remain subject to cynical renewal pricing based on their claims, insurers will continue to lose money and complain about other insurers' predatory pricing practices and all the time the health of the economy and the individual will suffer.