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The current state of the health insurance market of the United Arab Emirates and recommendations for improvement

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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?

In 2023 the sustainability of the health insurance market in the United Arab Emirates (UAE) will reach a tipping point. Analysis has shown that the vast majority of health insurers are losing money, market conduct is largely unregulated, consumers are not happy with their plans, employers are reducing benefits to contain costs and the current system of sub-optimal pricing is unsustainable.

The author has produced this paper to be a talking point and source of reference to enable regulators and market participants to collectively improve the situation.

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.

It also does not provide a technical assessment of the revenues and profitability of UAE health insurance businesses. Such analysis can be found in the excellent reports published by Badri Management Consultancy (badriconsultancy.com)

Disclaimer

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

What is the state of the UAE health insurance market right now?

To critically review this article you need to understand the current landscape. To assist you, here are the headlines:

- Almost 50 insurers (including branches of foreign insurers) are marketing health insurance to a population of c.8mn expatriates (UAE nationals are covered under various state programs). Compare that to Saudi Arabia with around half the number of health insurers and a slightly higher expatriate population estimated at c.10mn people
- There are also a number of foreign insurers who are not licensed to operate in UAE but do so by using a locally licensed insurer to "front" their products with the local insurer ceding the majority or all of the risk back to the foreign partner
- Almost all the 28 publicly listed insurers are losing money on their health portfolios. Perhaps only 3 are profitable
- The market is dominated by 3 or 4 insurers who hold significant market share
- The Third Party Claims Administrator market has reduced from 25 companies (2013) to just 6 with two of these holding the majority market share and thus holding great negotiating power with healthcare providers
- The healthcare provider market is fragmented but two or three vertically integrated groups wield significant power when it comes to negotiating tariffs and discounts with healthcare payers although not so much with the top two TPAs because of their own market dominance
- The regulatory landscape is also fragmented. The Central Bank of UAE (CBUAE) subsumed the former Federal Insurance Authority (FIA) in 2020. Separate emirate level laws applying specifically to the health insurance business line also exist in the Emirates of Abu Dhabi and Dubai where the regulators are the respective health authorities of each emirate: Department of Health – Abu Dhabi (DoH) and Dubai Health Authority (DHA). The five other "northern emirates" have no health insurance laws and have no "health authority" except in the case of Sharjah which has Sharjah Health Authority. The other emirates in terms of healthcare as opposed to health insurance are regulated by the Federal Ministry of Health and Prevention (MOHaP)
- The approach to regulation is also piecemeal. The CBUAE (and the former FIA) focuses on prudential regulation of the insurance market in general, mainly capital adequacy and solvency matters. There is and has been almost no attention paid to market conduct regulation. Regulating market conduct goes a long way to avoiding solvency issues. Meanwhile, with no mandate to oversee insurers' prudential positions, DoH and DHA continue to focus on managing the health insurance market from a population health management perspective, although there are some market conduct rules in place in relation to the selling of health insurance in these emirates.

How did we arrive where we are?

Quite simply, the fragmented nature of the regulatory system in a country with a relatively small population, with a federal regulator without complete oversight and with two emirate level health authorities assuming the role of a financial services regulator but for health insurance only, coupled with a highly competitive, overcrowded insurance market have resulted in a market where the largest market participants dominate (both payers and providers), where healthcare system financial

leakage due to fraud, waste and abuse is significant and where most payers of health claims are losing money whilst healthcare providers appear to make good profits.

What has this created and what are the consequences?

The system has created an environment where payers seek to minimize claims costs, providers seek to maximise revenues from patients holding insurance cover and insurance brokers (who dominate the mandatory, employee financed health benefits market) seek to maximise commissions and retain their employer clients who themselves seek to minimize their health insurance spend. This also results in brokers continually acting at the behest of their employer client to find a cheaper alternative at scheme renewal date. This can be done in only one of two ways: reducing benefits or switching to a different insurer willing to take on the client at a premium which is not technically sound. The result of this scheme "churn" is that most payers of insurance benefits see no incentive to introduce wellness, lifestyle behavioural change and preventive initiatives for their scheme members. Their view is "why should we bother if in the medium to long term they will not be our members?" There are some exceptions, notably Cigna being one of these.

The system has also created a malignant consumer behaviour where many insured members misuse their health cover by seeking the most expensive providers and going straight to a consultant or specialist simply because their coverage allows them to do so at little cost to themselves. There are no products in the UAE to the author's knowledge which use a Primary Point of Access (PPA) model which requires an insured member to first seek a consultation with a family physician (physically or via a teleconsultation) before being able to access a specialist or consultant. In the UK and the USA this is known as "gatekeeping" but the author dislikes this term as it implies control or restrictive access which is not the intention.

The absence of controls over premium pricing also results in egregious behaviour by some insurers in pricing renewal terms for individual/family policies by simply adding the value of claims suffered in one policy year to the following year's renewal premium and in the case of group policies simply undercutting the competition to acquire business at loss making rates.

This system is unsustainable. Most insurers continue to lose money on their health insurance business line. The only respite came during the pandemic lockdown period in 2020 when people were unable to make so many visits to clinics and hospitals which resulted in a significant drop in out-patient claims.

The result is that employers have been continually cutting back on scheme benefits, copays are rising, access is being restricted, payers are increasingly seeking to deny claims while healthcare providers continue to find ways around the tariffing system (increasingly Diagnosis Related Groups or DRGs) in order to maximise their revenues.

Why should we care?

We should care because the result of all the above is a reduced level of population health due to insured members seeing benefits reduced, access curtailed, genuine claims being denied and, worryingly, over treatment, over prescribing, incorrect prescribing (primarily antibiotics for viral infections) and exposure to unnecessary tests. Added to this is the fact that there is very little focus

on education, prevention and self-help to assist people to better manage personal health and lifestyle behaviors.

Can it be fixed and how?

Yes, it can be fixed. But it requires political will, leadership and collaboration between the various regulatory authorities, health insurers and healthcare providers. In the author's 16 years living in UAE and working in its health insurance market he has seen little of this but remains hopeful. He believes that the only way that such collaboration will happen is by agreement amongst the most senior members in government.

Below are what the author believes are some solutions

Dealing with insurer losses and unsustainable premium pricing

Insurers are losing money because they are desperate for business in an overcompetitive market and will take on or retain business knowing that they will probably make a loss. Many outside the region find this incredible. "Why" they ask "would any insurer take on or retain business knowing that they may make a loss?" The reason offered is that there is a greed to simply acquire the client to achieve "top line" results to keep shareholders happy and that by accepting the risk the insurer could win or retain other corporate business with that client or at least not lose it or lose the chance of acquiring it.

It is the author's belief that shareholders have been oblivious to the way that their insurance companies have been managed by their C-suite. They have been looking only at "top line" or market share as a measure of success. Remember, many of these UAE publicly listed insurance companies are small and often just an add-on to the major shareholders' other, far larger conglomerate businesses such as construction, automobile franchises, transport, retail and property portfolios.

In the search for "top line", executives and their sales staff have accepted business at non-technical pricing levels which inevitably leads to losses.

In the absence of local insurers adopting a mature approach to their pricing and accepting business only on technically sound underwriting principles there are only two options:

a) Reinsurers withdraw capacity from those local insurers who continue to underprice, or
b) Regulators introduce a system of premium regulation (see further below)

In respect of b) the author worked with market participants during his time at DHA and provided models for this which would suit the UAE market. However, regulatory ears remain deaf.

The regulatory landscape

As mentioned above, the regulatory landscape in UAE is fragmented. But this fragmentation is compounded by the fact that there is a federal level regulator overseeing all insurance business lines yet there are also two emirates (Abu Dhabi and Dubai) which have their separate mandatory health insurance laws and which are overseen not by a financial services regulator but by the respective health authorities.

A way to fix this would be to transfer oversight of the health insurance market in the emirates of Abu Dhabi and Dubai to the federal regulator (CBUAE). DoH and DHA should then focus on managing population health which is where their main expertise lies. However, there would need to be close coordination with CBUAE since DoH and DHA have more experienced than CBUAE in managing health insurance as a health system financing tool.

There should also be a concerted effort to extend mandatory health insurance to the Northern emirates under a federal mandate. Ideally, a consolidation of the Abu Dhabi and Dubai laws within such a federal law would make the lives of all market participants and consumers far easier, provide uniformity, clarity and help towards creating a far more efficient market, not to mention improving population health.

However, repeating from above, the only way that such consolidation and collaboration will happen is by agreement amongst the most senior members in government.

Prudential supervision and oversight of market conduct

As mentioned earlier, the focus of the FIA was always on prudential supervision to see that licensing was in order and that insurer solvency was assured. There was very little attention paid to market conduct apart from setting tariffs and maximum discounts on motor insurance. Ensuring proper market conduct will help to prevent insurance companies from writing business at unsustainable, non-technical levels which will in turn go a long way to preventing the solvency issues.

This is one reason why the so-called "Twin Peaks" model was adopted in countries such as Australia and the UK. Twelve years ago, the UK broke apart the Financial Services Authority to create two separate entities: the Prudential Regulation Authority (focusing on solvency and related matters of governance) and the Financial Conduct Authority (regulating market conduct).

The UAE should consider adopting a similar model. This could be under the overall purview of CBUAE. However, within a market conduct branch there should be separate departments for banking and other financial services and for insurance. The two types of business are very different, the former being largely short term and transactional while the latter combines both short and long term business with the added complication of risk assessment (underwriting). By way of example, underwriting or assessing a loan is very different to underwriting a group health insurance risk or a group life insurance scheme that may involve thousands of lives. The two lines of business require very different skillsets and experience, yet we still see the regulation of insurance business "tacked on" to banking and run by banking professionals who have limited or no experience of insurance.

We did see some action on market conduct from DHA in 2013 by way of its permit application requirements (Health Insurance Permit (HIP) for insurers and TPAs and Health Insurance Intermediaries Permit (HIIP) for brokers and other intermediaries selling health insurance in or into the emirate of Dubai). These actions included that companies should produce documented evidence of training and competence schemes, policies on client confidentiality, codes of conduct and complaints handling procedures.

At the time and from initial responses received and reviewed by the author in his role at DHA it was clear that most insurers, TPAs and brokers did not even understand the elements of a training and competence scheme, had no policy on client confidentiality, did not understand the elements of a code of conduct or its purpose and had no documented complaints handling procedures. DHA's approach changed all that, providing guidance and education for companies on all four aspects. The

fact that most companies also operated in other emirates meant that DHA raised standards in other emirates by default.

Market consolidation

One reason that so many insurers accept health insurance business knowing that they will probably make a loss is fear. They fear that if they do not provide this business line to their corporate clients, they risk losing other business lines such as property insurance or fleet insurance to the insurer that will in fact cover the client's health insurance needs. Managements have largely justified this by using profits on their motor business to subsidise their losses on their health portfolios. But recent years have shown motor profits also under pressure, not to mention dwindling "other comprehensive income" which mainly consist of returns on investment portfolios. The advent of IFRS17 will fully expose this issue.

Market consolidation will result in several benefits:

- Fewer insurers competing on price
- Greater economies of scale
- Improved allocation of resources for technological enhancements
- A reduction in staffing levels in the overall insurance sector thereby reducing costs
- A reduction in other operational costs such as office space and overheads

Market consolidation has been forecast by many consultancy firms every year for a decade or more but it never happened. But why did it never happen? Largely it was due to the fact that shareholders were reluctant to reach out to other shareholders of competing companies for fear of being seen as "weak" or "losing face". That was the case until 2022.

We have now seen small market participants in the Takaful market begin to merge and seen the largest takaful operator assume part of the portfolio of another takaful operator. We also very recently saw one of the largest conventional insurers take a 90% share in another small takaful business. So the market consolidation ball is rolling. It should continue. There is no room for 50 companies selling health insurance in the UAE market.

We have also seen in Saudi Arabia that increased capital adequacy requirements have forced some mergers or exits. It is unclear if this will transpire in UAE. But perhaps IFRS17 will further expose the inadequacies in profitability and solvency.

The competitive landscape: striking a balance between oligopoly and a free market

Having made the case for consolidation, we must be cautious. Too much consolidation can result in an oligopolistic market. This is evident in the TPA market where we now have just two companies holding a majority market share with only four other active TPAs. It has to be admitted that the number reduced because many of the other 19 TPAs went out of business due to either mismanagement or the ending of the capitation scheme rather than as a result of market

consolidation. This was not a bad result. However, regulators must keep a careful eye upon the market conduct of the remaining market participants.

The author believes that there will not be wholesale consolidation as far as insurers themselves are concerned. Vested shareholder interests will continue to sway them against mergers although there may be some more aggressive actions in terms of acquisition attempts by larger insurers. But the question for these larger insurers remains "why should I acquire a smaller competitor when I can simply run them out of business?"

But turning specifically to health insurance, the author believes that some insurers should consider exiting the health insurance business and focus on other business lines. They can overcome the "fear" mentioned above if they are confident that by providing a superlative service on their employer client's other business requirements they will keep this other business even if they no longer offer health insurance to that client.

On the other hand, as two of the most successful insurers in UAE and Saudi Arabia are monoline health insurers, perhaps some insurers should consider exiting all business lines except health insurance!

Reform of the network provider system and the need for quality of care indicators

The author has already written a 3,400-word paper on this matter entitled "Reasons why the private health insurance provider network system needs reform" which is available without charge at www.consilient.ie so that content will not be repeated fully here.

A price-driven network system is detrimental to access to and affordability of quality care and desirable health outcomes. Inclusion of a healthcare facility in a network of providers should be based on *quality* not on *price* of services or "perceived" quality linked to price.

However, the headlines from that paper are summarised here:

- A price-driven rather than a quality-driven network system distorts the market and adversely affects population health
- Health insurance policies should be redesigned with access based on the quality of outcomes of the healthcare provider, not on the price of services
- To do so would require regulators to publish quality of outcome indicators. However, due to pressures from other areas of government, some regulators appear reluctant to do so.

More of the above is explained in the paper mentioned but here are listed the benefits of the reforms proposed in that paper:

- Firstly, it would provide transparency in the quality of outcomes of healthcare providers and negate the myth that "price equates to quality"
- Secondly, it would allow insured members to access any provider on the basis of quality of outcomes (subject to the premium which they pay) rather than being restricted to a list that may not be geographically or otherwise convenient.
- Thirdly, it would go some way to reducing the oligopolistic tendencies of the current network system.

- Fourthly, it will remove the focus of individuals to want the “best” providers in their network based upon the “price equates to quality” myth and to remove the tendency for employers to restrict access based upon the price of provider services.
- Fifthly, it would provide the comfort of standard payer-provider contracts but with as much flexibility as regulators wish to allow (Saudi Arabia already has a standard payer-provider contract).
- Sixthly, it will allow insurers to design contracts that meet the needs of insured members’ and employers’ financial resources which are based upon quality of outcomes rather than the quality of the curtains!

Primary Point of Access (PPA) products

The term “gatekeeping” is widely used in the UK, USA and some other countries to describe the process whereby patients must first seek the opinion and a diagnosis from a family physician or GP before being given a referral to a specialist or consultant. However, the author dislikes this term as it has connotations with restricting access to care which is not its intention. He has therefore coined the phrase “Primary Point of Access” and encourages everyone to adopt this term.

DHA was the first regulator to promote a PPA approach in relation to insured members’ access to healthcare services on the basis that seeking a diagnosis at a primary healthcare facility through a GP or family physician would reduce unnecessary costs. Referrals to specialists would be made by the PHC physician based upon his or her diagnosis.

However, insurance companies themselves ignored this recommendation. Instead they were telling clients “Sign up with us and your employees can go straight to a specialist or consultant. No need for a GP visit first”. This was all due to the focus on winning business at any cost. It was also a great example of insurers shooting themselves in the foot.

Insurance companies must introduce products which require an insured member to approach a GP or family physician in the first instance. This will reduce claims costs considerably and avoid the insured member being subjected to unnecessary tests. However, this requires insurers to have a better understanding of their own business and how they can make it both more attractive to employers (lower premiums) and more profitable (lower claims costs).

A challenge for the PPA approach in the UAE is the lack of GPs and family physicians in relation to specialists and consultants. Some estimate that of all such only 20% are GPs or family physicians. In the UK where “gatekeeping has been in place for over 70 years this proportion is reversed. So for the PPA approach to work UAE needs more GPs or family physicians.

Premium regulation

In the absence of insurance companies adopting technically sound premium pricing and instead simply undercutting the competition to win business which will cause them a loss, the only alternatives as the author sees them as mentioned earlier are that either

a) Reinsurers withdraw capacity from those local insurers who continue to underprice, or
b) Regulators introduce a system of premium regulation

The author has written a brief 1,700 word article on "The case for health insurance premium regulation in the United Arab Emirates" which is available at www.consilient.ie so will not duplicate its content here.

However, here are summarised the disadvantages of not having some form of premium regulation.

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.

What does all the above mean for population health in UAE?

Access to care

Insured members may have access to care but pre-approvals may not be forthcoming and reimbursement claims may be denied. Employers will also continue to contain their health insurance premium costs by seeking to reduce benefits.

Quality of care

Without a published analysis detailing quality of care outcomes for healthcare providers, employers and insured members will continue to believe in the "price equals quality" myth, paying excessive prices for care when a better quality of outcome may be achieved at a lower price.

Affordability

For many of those who must fund their own or their families' health insurance, the lack of premium regulation will make health insurance unaffordable.

Preventive health

Payers of health insurance currently have no incentive to invest in preventive health programs, basing their logic on the fact that members will be with them for as little as one year due to the "churn" problem. They also lose sight of the fact that if all payers invested, population health in general would rise meaning that they would all benefit in the medium to long term.

Recommendations

Recommendation 1 - Regulatory framework

Leaders should discuss bringing regulation of health insurance within the purview of a federal level regulator. This may be CBUAE. The current expertise held within DoH and DHA should be utilised to assist the federal level regulator. The federal level regulator can focus on sustainability of the healthcare financing system (both prudential regulation and market conduct) while the health authorities can focus on population health management and advising the federal regulator on the best ways that health insurance benefits schedules can be created and how premiums should be determined.

Recommendation 2 - Publish quality of care indicators for all healthcare providers

Without this, buyers of health insurance, be they employers or individuals will be unable to assess the options available to them in terms of quality of care and will continue to be pushed towards believing the "price equals quality" myth as their only guide.

Recommendation 3 - Reform the price based network system to a quality based system

This will only be possible with the publication of quality of care indicators. It will also involve the alignment of the TPA and large payer market. This would involve significant reform of their revenue models. The volume based rebate system would need to end, but how much better would a quality based rebate system be for population health, affordability and sustainability of the system?

Recommendation 4 - Encourage the introduction of PPA products

This can easily be achieved if insurers agree on this as an approach to contain claims costs. It can also be encouraged by reinsurers offering better support for such products. This is the light touch approach. If the market cannot achieve this by itself, regulators could mandate it as a requirement that all insured members must seek the opinion of a GP or family physician before being referred to a specialist or consultant. This would need careful monitoring from a compliance perspective to avoid "under the table" agreements between GPs/family physicians and specialists/consultants.

Recommendation 5 - Introduce a system of premium regulation

The UAE insurance market (by its own admission) has proven itself incapable of writing health insurance business at sustainable, technically sound pricing levels. The author sees no reason why this will change. Therefore, the only answer is for regulatory intervention. However, such intervention needs to be based on an intelligent, intricate, actuarially sound but easily implemented

system to succeed, not the broad brush approach that we have seen applied in the motor insurance market.

Recommendation 6 - Reinforce the enforcement function

Regulators have done a limited job in enforcing what rules and regulations do exist. Market participants continue to circumvent policies and rules and often simply disobey them in the knowledge that the regulator does not have the resources to identify, investigate and sanction.

Conclusion

The UAE health insurance market can be revitalized and be profitable for payers, continue to provide revenue for healthcare providers and provide access to affordable and quality care for the population in a sustainable manner. But not without the above recommendations being adopted.

- *Robin Ali*