Office of the State Comptroller
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Ministry of Finance

Regulation of the Commercial Health Insurance Market

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Background

The purpose of health insurance is to minimize the financial damage caused to an insured as a result of a health problem. Commercial health insurance policies in Israel, which are being sold by commercial health insurance companies, serve as a second and third layer of coverage, in addition to the coverage provided by virtue of the National Health Insurance Law, 5754 – 1994 and the Additional Healthcare Service plans (Supplementary Insurance) being sold by the HMOs. The government authority in charge of regulating and supervising insurance companies is the Capital Market, Insurance and Savings Authority (hereinafter: the Authority or the Capital Market Authority).

Key figures

ILS 11 billion

total premiums paid for commercial insurance policies and for Additional Healthcare Service plans[1] in 2018, compared to ILS 6 billion in 2009.

53.4%

of people with per-capita income[2] of at least ILS 4,001 have a commercial health insurance policy, compared to 11.5% of people with per-capita income of less than ILS 2,000.

39%

average refund rate[3] in individual policies between 2009 and 2018, compared to the refund rate of 87% in group policies.[4] The difference in the refund rate in relation to each insured is estimated at about ILS 500 per annum and reaches hundreds of millions of shekels for all insureds holding individual policies.

More than 90%

of the insureds under commercial health insurance policies are also members of Additional Healthcare Service plans.

82% increase

total payments to pensioners in 2019 by in the number of complaints regarding health insurance policies that were handled by the Capital Market Authority in 2018 (2,710 complaints), compared to the number of complaints it handled in 2017.

63.7%

of the insurance agencies marketing health insurance policies to the public received more than 90% of the commissions in 2018 in respect of sales of health insurance policies from a maximum of two insurance companies.

1 Not including long-term nursing care.
2 Average per-capita household income (gross per month).
3 According to Capital Market Authority data. The refund rate is calculated according to the Capital Market Authority's calculation methodology, and it reflects the ratio between the insureds' gross claims and the total premiums they paid to the insurance company.
4 With private insurance policies, the insured purchases an insurance policy from an insurance company for himself and for his family, largely through an insurance agent. Group insurance policies are for a group of at least 50 insureds (for example: insurance policies arranged in large organizations having a common denominator, which jointly purchase a policy under identical terms.

Audit actions

From March to December 2019, alternately ,the Office of the State Comptroller audited various aspects of commercial health insurance policies: economic and consumer aspects of the Capital Market Authority's supervision of commercial health insurance policies; the handling of public complaints about commercial health insurance policies; the regulation of insurance agents' activities relating to commercial health insurance policies; the service provided to the public of insureds under commercial health insurance policies and the publication of service indicators. The audit was conducted in the Capital Market, Insurance and Savings Authority.

Key findings

- **Redundant insurance policies** – the plethora of information, the differences in the components of the insurance companies' insurance policies and the lack of uniformity in policies all make it difficult for the public to examine the degree of overlap between the various insurance policies. In particular, it is difficult to differentiate between an additional insurance cover that may be beneficial to an insured and unnecessary redundant insurance coverage that imposes unnecessary costs on the insured.

- **Data collection and analysis** – as a result of an incomplete database, the Capital Market Authority is inadequately performing material analyses to support the regulatory authority's work. For example: the Authority lacks complete information about the volume of redundant insurance and about the overlap with the Additional Healthcare Services plans, or information about the effectiveness of its actions.

- **The refund rate in individual insurance policies** – the refund rate in group insurance policies is more than double the refund rate in individual insurance policies (87% compared to 39% on average between 2009 and 2018). Although the Authority identified the low refund rate in private insurance policies as a key failure in the category, it does not have a quantitative examination (after 2012) of the causes of this gap, including the sums of the surpluses[5] that accumulated in the insurance companies.

- **The 2016 reform** – the Authority failed to fully analyze the degree of success of the 2016 reform, which was designed to empower insureds by making the insurance products simple, clear and comparable. For example: the reform's impact on the premium prices was analyzed, but its impact on the refund rate to insureds and the expense breakdowns of the commercial insurance companies were not analyzed.

5 The unexplained gap remaining after deducting the direct expenses from the total premiums received in the category.

- **Procedure for handling public inquiries** – the procedures established in 2014 regarding the Capital Market Authority's handling of public inquiries are partial and do not relate to an entire work process in this regard.

- **The Capital Market Authority's handling of complaints** – the complaint-handling process in the field of health insurance policies in 2018, which the Authority determined were justified, continued for about 290 days. This duration of complaint handling may reduce the public's confidence in the Authority. Furthermore, since most of the complaints are being handled by an administrative team in the Authority and only a small portion thereof (about 8.7%) were determined to be justified or unjustified by professionals in the Authority, then, from a systemic perspective, complaints are not being optimally and efficiently handled.

- **Regulation of the status of insurance agents in the health insurance category** – the Authority has not yet completed regulating the standing of insurance agents in the health insurance category, as it did in the pension insurance category, even though several public committees and the Authority itself have discussed various failures in the agents' activities, such as benefits being given to them in respect of achieving sales targets, and aspects of their activities that raise concerns about inherent conflicts of interest between the best interests of the agent and the best interests of the customer.

- **Centralization in the distribution of insurance company commissions to agencies** – in 2017-2018, an increase occurred in the c of the distribution of insurance agencies' commission income. In 2018, 15 agencies received about 40% of all commissions in the category, and 130 agencies received about 70% of the commissions – out of about 1,500 insurance agencies operating in the category.

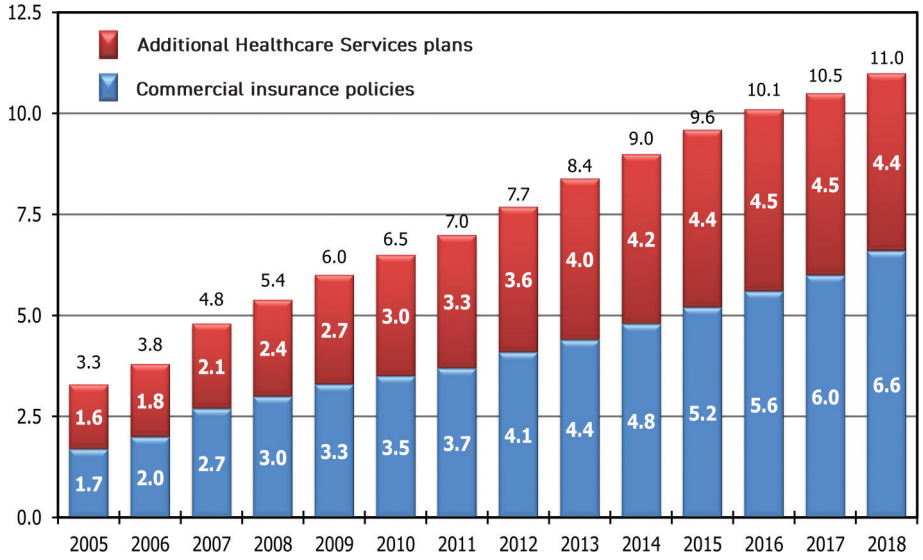
- **Usefulness of service level indicators** – although the Authority has been publishing service indicators relating to insurance companies' activities in a variety of insurance lines since 2014, it is doubtful that the public is finding these indicators useful, due to the difficulty predicting the quality of the companies' service in the medium and long range, and considering the frequently change in the ranking of the companies due to the minor differences between them.

Identification of failures and promotion of the 2016 reform – the Authority has identified and defined the key failures in the health insurance market: the low level of competition, the inherent upper hand that insurance companies have over insureds and the companies' incentivisation of insurance agents – and took measures designed to help eliminate the failures, inter alia, through the promotion of a reform in the market.

Key recommendations

- It is recommended that the Authority should analyze all causes of the significant gap in the refund rates between the individual insurance policies and the group insurance policies, while relating to the gaps in the sums of the surpluses, to the built in differences between the policies and the failures enabling the low refunds in the individual insurance policies.
- It is recommended that the Authority should consider defining key quantitative targets in its work plan, such as the refund rate per insured and the ratio of the companies' surplus sums, while performing a methodical analysis of the factors influencing them – with the objectives of examining the impact of its measures and measuring the volume of financial savings generated for the public.
- It is recommended that the Authority should take action to minimize the phenomenon of redundant insurance policies. To this end, the Authority should inform the public of insureds of this matter, explain what redundant insurance is and why it should be avoided, and it should frequently measure the extent of the phenomenon. According to its findings, the Authority should consider additional means to eliminate the phenomenon to the extent required.
- It is recommended that the Authority should consider ways to strengthen the examination of complaints by professionals in the Authority, particularly regarding complaints that can be resolved by the supervised entities, in order to provide professional responses to individuals who submit complaints,. and to professionally address the broad-impact issues raised in the complaints.
- It is recommended that the Authority should consider regulating the different types of insurance specialists and of other parties in the health insurance category and consider ways to prevent failures in their activity. It should regulate agents' modes of operation according to the various types of licenses, and should take action to encourage competition among the agents for the benefit of insurance consumers.
- It is recommended that the Authority should regularly examine, through methodological work and by taking into consideration customer surveys as needed, the components of the service level indicators, their relative weights and their impact on customers.

Expected budgetary pension payments to all State pensioners



Source: The Central Bureau of Statistics, **"National Expenditure on Healthcare 2018"**[6]

Summary

Commercial health insurance policies are a major factor in the public's ability to contend with the risks deriving from health incidents. The significant increase in the costs that the public is bearing as a result of an uptrend in purchases of these insurance policies requires the State to ensure that the value that the public is receiving from these insurance policies directly correlates to the magnitude of their investment in them. The Capital Market Authority should augment its examinations and control of the health insurance category and should ensure that the reform that it is implementing in this category, which is supposed to improve the situation for the insured public, achieves its objectives.

6 According to the Central Bureau of Statistics' definitions, commercial health insurance policy premiums include insurance policies for medical expenses, acute diseases, dental care, foreign workers, travel insurance and others. Furthermore, both private insurance policies and group insurance policies are included in these definitions.