

Taking a healthy risk?

Bob Cookson explains why obtaining health insurance for yourself and your family is a no-brainer.

In these economically challenged times, we all have to take a long, hard look at our living expenses. If you are not lucky enough to enjoy the benefit of a company-sponsored medical insurance scheme, then the cost of insuring yourself and your family against illness undoubtedly makes up a significant part of your annual expenses. And, if you and your family are generally in good health, then it is likely that the premium you are being asked to pay is far more than the amount you actually spent on medical treatment last year.

So when you write that sizeable cheque for your family medical expense insurance policy, what exactly is it that you are paying for? The answer is protection.

The principle of insurance is that when you take out an insurance policy, you are agreeing to participate in a “community” or “risk pool” of people who are similarly insured with the same insurance company.

In the case of medical expense insurance, the insured risk is that of an illness occurring in the future that requires medical treatment. So, effectively, when you buy an “individual” or “family” medical expense insurance policy, you are agreeing to share in the risk of illness in the group of individuals and families covered by your insurer.

Financial protection

The premium that you pay goes into the fund – along with the premiums paid by all those other clients – out of which the insurance company pays the medical claims for all the clients in that risk pool.

Why is this important? Clearly, since the risk pool premiums are calculated based on the claims the insurer has to pay out each year, the healthier the members of the risk pool are, the lower the claims paid out and therefore the lower its premiums should be.

If your insurer offers medical expense insurance to corporate (company) clients, then the risk pool may (or may not – if you want to know, ask them!) include companies with a small number of employees that are “community rated”.

Your insurer’s large corporate clients are almost certain to be excluded from the risk pool, as they have enough employees to have their premiums calculated on their own merits (i.e. based on the medical expenses expected for just the employees of each specific company).

Whatever the make-up of the particular risk pool, you would be forgiven for assuming that most of what you pay will go towards paying for the medical bills incurred by the community of insured members.

In order to make a profit, however – and let’s face it, insurance companies are not charitable organisations – your insurer has to calculate the premiums it charges so that the total premium paid into the risk pool by the community of its members is sufficient

to pay for the claims made over the course of the year by all the members of the community plus its internal organisational and administrative costs, commissions to brokers and agents and, of course, an allowance for the profits its shareholders expect.

So, your premiums will be affected both by how healthy the risk pool is in any given year and how much of the premium fund the insurer spends on administration and other costs.

You might be surprised to learn, therefore, that the risk pool into which your premium has been paid may pay out in the form of claims only 60-70 per cent of the total premium collected.

So why not just pay for my medical treatment costs myself and get 100 per cent value for money, you may ask?

Well, apart from the fact that the renewal of your visa requires a valid health insurance policy (or, of course, a medical card), you would be forgoing the financial protection of the risk pool.

In addition, insurance companies add value by negotiating reduced rates with their network of doctors and hospitals so that when you receive medical treatment “in network”, the cost is less than what you would pay yourself if you went directly to the doctor. The benefit of the reduced rates is passed on to the risk pool in terms of reduced claims costs. This is why your insurer may penalise you in some way for going for medical treatment “out of network”.

So, if it’s not advisable for me to insure my own risk, how can I make sure that I am getting value for money for the premium I am paying into the risk pool?

With any insurance pooling arrangement, you are agreeing to share in the total risk of the pool – but are you subsidising other members who claim for higher amounts or more frequently?

Most insurers offer a range of options to reduce the premium you pay by bearing a portion of your own medical expenses. So, if you consider yourself to be a generally healthy person, then you could consider taking a share of your own “risk” by moving to a plan with a higher excess option or a plan with a so-called deductible or coinsurance.

Savings achievable

Medical expense policies typically have either a “per medical condition” excess where you pay a fixed amount for each new medical condition, a per claim or per visit excess where you pay a



fixed amount for each visit to the doctor or an annual deductible where you pay all of your medical expenses for the year up to an agreed amount after which the insurance policy takes over.

A co-insurance means that you pay a percentage of the total cost of the medical treatment yourself and can be combined with one of the excess or deductible options explained above.

As a comparison of the savings achievable with one of the major international medical expense insurers operating in the UAE, the difference in annual premium for worldwide cover for a typical family of four (mum and dad in their 40s with two children) between a policy with a zero excess and one with an excess of just US\$100 per medical condition is US\$7902.

If the same family took a US\$250 excess, then the annual savings would be US\$9726.

The same insurer's regional plan shows savings of US\$2259 for a US\$100 excess and US\$3144 for the US\$250 option.

Be aware, however, that once you have moved to a higher excess or deductible, your insurer will not allow you to reduce the excess – at least for ongoing medical conditions that have occurred since you made the switch. Check carefully with your insurer on this point before making any change.

If you tend not to need to visit the doctor on an outpatient basis very often and are prepared to pay the whole amount when you do but want to be covered for in-patient hospital treatment, then you could consider taking out a “major medical” or inpatient-only plan.

With a major medical plan, only treatment on an in-patient basis in a hospital is covered (although most plans cover outpatient follow-up treatment after a hospital stay). The savings offered by purchasing such a plan can be substantial.

The difference between the premium for our typical family for a fully insured regional plan with nil excess and a major medical option also with nil excess is a whopping US\$8134.

Once again, be aware that most insurers will allow you to downgrade from a fully insured plan to a major medical or inpatient-only plan. Once there, however, you cannot re-upgrade if you have claimed for a non-routine medical condition. You will also be required to make a new medical declaration, so as with moving to a higher excess option, check carefully first with your insurer before making a decision.

Finally, if you do opt for a major medical plan, then you should seriously consider putting some (if not all) of the premium saved into a savings account where it will generate some additional interest, which you can break into if a costly course of outpatient treatment is required in the future.

If you want to save money in these hard times, then perhaps it is time to take a healthy risk.

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