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USAID Health Finance and Governance Activity

Health Insurance Legislative Review in Jordan:

Civil Health Insurance Fund, Military Insurance Fund, Jordan University, Jordan University for Science and Technology and Select Private Health Insurance Companies

2017

Submission Date: January 16, 2018

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This document was produced for review and approval by the United States Agency for International Development / Jordan (USAID/Jordan).

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Abbreviations

AOI: Arab Orient Insurance

CHIF: Civil Health Insurance Fund

CBJ: Central Bank of Jordan

HFG: Health Finance and Governance

HIA: Health Insurance Administration

ID: Insurance Directorate

JPMC: Jordan Phosphate and Mining Company

JU: Jordan University

JUST: Jordan University for Science and Technology

MIF: Military Insurance Fund

MOF: Ministry of Finance

MOH: Ministry of Health

MOITS: Ministry of Industry, Trade and Supply

RMS: Royal Medical Services

TPA: Third Party Administrators

WHO: World Health Organization

UNRWA: United Nations Relief and Works Agency

USAID: United States Agency for International Development

UHC: Universal Health Coverage

Executive Summary

The Health Finance and Governance (HFG) Activity initiated a targeted review of the legislative health insurance environment in Jordan. The purpose was to undertake a systematic assessment of strengths and weaknesses of selected health insurance laws from the perspective of resiliency, sustainability and efficiency in their broader sense. The analysis covered international conventions, laws, regulations, instructions, bilateral agreements, Cabinet decisions and directives and their impact upon the health insurance environment.[1]

The goal is to assist decision-makers in understanding the legislation across the public and private sectors and put forward considerations required to bring legislative compatibility and relevance into a health insurance system that is capable of delivering universal health coverage.

The findings demonstrate that legislation creates additional barriers and contributes to a fiscally unstable health system which cannot be responsive to the needs of the population in a fair and equitable way. If Government desires to continue with an insurance-based health model, applying sound insurance criteria is an important part of creating a sustainable and efficient health system. A number of priority areas for consideration have been listed enabling Government to design and implement laws that support a highly functional health insurance system.

To ensure that legislation was evaluated uniformly and consistently for the public and private health insurers, a set of five measures, with sub-indicators were developed. These cover principles relating to equity, access and affordability and are as follows:

a) Supervisory and Institutional Structures
b) Access to Insurance
c) Health Coverage
d) Beneficiary Funding
e) Consumer Protection

Major problematic legal issues have been identified and outlined in this report. Until each of these areas are strengthened and legislation drafted in a strategically coordinated manner, progress in attaining Jordan's health insurance coverage goals will be difficult.

The Public Sector

The public sector provides legislative foundation for coverage for the poor and vulnerable groups. The last few years demonstrate a strong commitment to insure other categories such as over 60 years and persons with disabilities.[2] The Public sector regulations also reveal an absence of discrimination, this particularly the case for the civil health insurance and that of RMS. Moreover, the review reveals that there is some recognized importance of the need for financial independence, as determined in the

[1] This report would not have been possible without the support of the following entities: Ministry of Health, Health Insurance Administration, and the Insurance Directorate at the Ministry of Industry and Trade.
[2] Also, coverage of the poor and persons with disabilities.

military health fund. The most encouraging conclusion, however, is in the existence if a policy moment to improve legislation of public health insurance towards greater sustainability and resilience. Examples of deficiencies from the review include:

- There is no national regulatory body that oversees public health insurers. Accountability is undermined on the basis that insurers are not held responsible to an independent, impartial supervisory agency. There is no overarching, uniform insurance legislation that demarcates and guides institutions in their roles, responsibilities and functions.
- Public health insurers are not licensed and operate in several different institutional capacities. There are no minimum reporting requirements on management and financial activities. Solvency cannot be objectively assessed. It is unclear whether insurers are capable of meeting their liabilities. Budgets are not independent. Premiums are not actuarially calculated. Some insurers openly discriminate by applying significantly higher premiums for women if they are the main subscriber. Premium subsidies are not currently assessed on an individual's ability to pay. A benefit package(s) has not been assessed on either its cost-effectiveness or responsiveness to health priority needs. Despite a comprehensive benefit package, it is applied unfairly. The volume of eligibility categories has resulted in unequal benefit entitlements across members, unknown benefits for others and fewer benefits for those in need.
- The public health sector has not implemented mechanisms to resolve disputes. This has led to unfair and inequitable practices for consumers, impacting quality and efficiency in the public health system. Consumers are unable to build trust in legislative authority.

The Private Sector

The report also unveils of legislative strengths in the private sector. For example, the existence of a health regulator that works towards the financial stability of private health insurance companies. Moreover, there is a unified legislation that regulates private health insurance companies in Jordan with some minimum levels of consumer protection and conflict resolution. Increasing coverage through the private sector is attainable when insuring employees in the formal and informal sectors. The report also reveals that self-insured companies can be regulated. The report clearly underlines the opportunities of exchanging expertise between the public and private sectors to enhance sustainability and resilience. The points below capture the main challenges in the private sector.

- Private insurance companies are governed by an insurance regulatory body, namely the Insurance Directorate (ID). Nonetheless, certain private sector entities, which are not insurance companies, but provide or purchase insurance on behalf of their employees or members, are not regulated or supervised—these consumers are totally unprotected because of the regulatory vacuum.
- The principle of guaranteed access is not mandated in the private sector. Insurance companies attract the young and healthy and shift unwanted risk onto the public sector. They apply excessive mechanisms to protect themselves from poor risks. Despite this sector growing annually, legislation is too broad to effectively shape this market and regulate

its contribution towards national health policy goals. Insurers should be competing on the basis of quality, efficiency and innovation.

In both sectors, voluntary enrollment has not brought about economies of scale and inhibited access for marginalized groups. Accordingly, insufficient revenue is collected and cannot be allocated to subsidize poorer groups. In contrast, some individuals receive subsidies without assessment of their ability to pay.

Consumer protection is closely linked to strengthening the governance of the health insurance sectors. It increases the level of information available for the insured and supports comprehensive, informed decision making. Health information disclosure is not currently regulated and instructive on consumer rights and responsibilities. Consumers are neither engaged nor empowered, leading to greater confusion, administrative inefficiency, dissatisfaction and stakeholder practices that deviate from legislative provisions. There is opportunity in both sectors to issue industry guidelines on comparative benefits and pricing to improve understanding and promote consumer awareness.

Structured dialogue and cooperation between the public and private health insurance sectors can yield many advantages in the pursuit of national policy goals. This report advances a framework which better aligns with achieving equity, financial protection and access regarding the delivery of quality health services and products. Below are short and longer term legislative priority areas to be evaluated and comprehensively addressed in Government's National Health Strategies and reform efforts to sustainably and efficiently introduce UHC:

- Agree on the form and substance of an independent regulatory body for the public sector, its oversight mandate in who it will regulate and level of involvement with public insurers.
- Capacitate the regulatory agencies and develop a structured coordination between the public and private health insurance agencies to jointly pursue national health policy goals.
- Recognize and implement the agency function of the third-party payer (insurers) in the public sector by separating the insurer and provider functions.
- Enforce the ID's jurisdiction over entities that are currently governing themselves in the private sector, for example, self-insured employers, to close the regulatory vacuum.
- Require the establishment of management boards (with qualified experience), licensing processes and minimum solvency levels. Budgets should be independent, and funds allocated for qualifying expenses. Annual reports should be made public.
- Draft and implement a comprehensive national law that replaces and/or repeals the existing volume of legislation issued by each insurer. The national law should set out clear objectives, minimum standards and rules relating to the governance of health insurance. Main issues to be covered include insurer incorporation and management of insurers, eligibility, premiums, co-payments, benefits, continuation and suspension of membership, provider arrangements and consumer protection.
- Establish whether public and private insurers should compete against each other. Whether insurers in the same sector should compete with one another and the basis upon which they compete.

- Eliminate voluntary membership for those who can afford it by making participation compulsory. This would serve to increase revenue collection and reduce practices of moral hazard.
- Consolidate risk pools to share the financial burden in a fair and efficient way, specifically as the demographic population ages and co-morbidity increases with non-communicable diseases. Where there are multiple payers, and therefore multiple risk pools, there is financial fragmentation, administrative inefficiency and higher costs in the health insurance system. The positive effects of cross-subsidization are diluted. Insurers should have minimum membership numbers.
- Direct subsidies towards premiums for qualifying individuals and not treatment fees.
- Redefine and simplify eligibility categories and create standardized definitions and terminology for all insurers.
- Review premium methodology and base it upon income rather than gender or health risks.
- Design and cost a minimum benefits package for both sectors. Alternatively, mandate a negative list, i.e., identify medical conditions that may be excluded from coverage. Ensure that exclusions are based on fair and equitable principles for the whole population to avoid discrimination against marginalized groups.
- Individual exemptions, i.e. the Royal Court paying for an individual's medical treatment, should be structured, in the interim, and eventually phased out to avoid unnecessary subsidies that lead to financial wastage in the health insurance system.
- Assign actuarially calculated premiums to a particular benefit package for a benefit year.
- Publish health benefits and pricing information and ensure the material is distributed and explained to consumers and providers.
- Implement dispute resolution mechanisms in the public sector to provide consumer protection.
- Legislate patient confidentiality and privacy rights.

Health Insurance Legislative Review: Introduction

Jordan's financing in the delivery of health services closely resembles a health insurance system when aiming to protect its population against catastrophic health expenses.[3] A health policy goal is to close the gap of uninsured individuals and achieve a 95% health insurance coverage rate by 2025.[4] The estimated number of insured, according to various surveys ranges from 64% to 85%[5]. A prerequisite for achieving this objective is strengthening the governance and financing of the health insurance system.

This report focuses on the legislative environment for health insurance in Jordan[6]. Evaluation of the legislation revealed the difficulties and challenges at a much broader scale. The application of these laws creates additional barriers to a fiscally unstable health system which cannot be responsive to the needs of the population in a fair and equitable way. As the subsequent pages illustrate, health insurance laws need to be designed and implemented against a wider set of measures. Scrutiny of the regulatory and supervisory framework, from the perspective of resilience, sustainability and efficiency in their broader sense shows that the health insurance system is hampered by significant legislative deficits covering the following areas:

1. Supervisory, institutional and management structures
2. Enrollment and eligibility requirements
3. Revenue collection and pooling approaches
4. Resource allocation and purchasing policies
5. Information disclosure and dispute resolution mechanisms

Until each of these areas are strengthened and legislation drafted in a strategically coordinated manner, progress in attaining Jordan's health insurance coverage goals will be difficult. This report serves as a diagnosis by identifying the major problematic legislative issues. It highlights important principles that contribute towards sustainability and efficiency.

Health insurance systems are complex and extremely technical. They continue to evolve based on a number of variables such as technology, changes in demographic and disease profiles and macro-economic contexts. An analysis of the historical development of the Jordanian health insurance legislation does not form part of this report. Emphasis has been on the contemporary suitability of the laws, given the Government's ambition towards universal health coverage (UHC). Nonetheless, there is

[3] Health systems are broadly divided into public service type models and insurance type models. Insurance type models can either have a single or multiple payer system. The payer is an insurance entity. It is beyond the scope of this work to discuss the different classifications of national health systems and the appropriate model for Jordan. Public and private legislation in Jordan makes references to insurance funds, premiums, subscribing members and other terms assigned to insurance models. The legislation has therefore been assessed against the criteria of health insurance principles and insurance-based health systems.

[4] Jordan 2025 A National Vision and Strategy: Key Performance Indicators – Healthcare.

[5] There is no single reliable source of number of insured in Jordan. For the purpose of this report, the numbers of the Department of Statistics are used.

[6] Preliminary findings outlined in this report are a result of assessing legislation publicly available or provided to HFG. Not all legislation and/or agreements of the selected insurers was accessible. There are insurers operating in the public and private sectors which did not form part of the review. Findings are not conclusive as it did not evaluate the health insurance legislation of all insurers.

an urgency and opportunity for policy makers to constructively assess the interconnection between the social, political and economic processes relating to health insurance.

Policy changes need to strive towards equity, financial protection and access to quality health services and products. If the Government desires to continue with an insurance-based health model, applying sound insurance criteria is important. Otherwise, implementation of national health policy goals will be slow, complex and unsustainable. Essentially, all insurers collect premiums for the purpose of reimbursing either the insured(s), or the provider for the incurred medical expenditures/losses. This establishes the legal contractual insurance relationship. For (health) risks to be insurable, certain important principles must be fulfilled, including, but not limited to: defining an uncontrollable risk; creating a direct relationship between the insured and the insurable risk; the insurer being able to calculate a fair premium and the value of the risk being calculable.

Within the public health insurance sector, there is a significant lack of overall data and the application of the abovementioned principles of insurance. A majority of the insurers that formed part of the evaluation are not necessarily capable of determining the expected losses and calculating the fair value of insurance premiums. Benefits are poorly defined, membership is unpredictable, the frequency and amount of member claims is unavailable, provider fees are not published, and risk pools are not managed. Premiums do not reflect the true cost of health care. In contrast, private health insurers operate according to insurance principles. However, they depend on reliable policy interventions, transparent information and correct data inputs from the public sector.

Legislation should be effectively redrafted to implement sound insurance practices that lead to fairness, equity and consumer protection. It then balances the rights and entitlements of diverse stakeholders to attain policy objectives.

I. Methodology: Selection of Insurers and Legislative Analysis

1.1 Public and Private Health Insurance Sectors

The public sector is the primary source of health insurance coverage for the Jordanian population. The National Strategy for Health Sector[7], states that the largest health insurer is the Civil Health Insurance Fund (CHIF), established by the Ministry of Health and covers approximately (44%) of individuals.[8] It is followed by the Military Insurance Fund (MIF), managed by the Royal Medical Services and covers approximately (38%)[9]. The third largest insurers are Jordan University Health Fund (JUHF), implemented by Jordan University and the King Abdullah Health Insurance Fund (KAHF), established by Jordan University of Science and Technology (JUST).

Additional financial assistance for health treatment is provided to non-insured individuals through the Royal Court and international donor agencies such as UNRWA. These institutions play important

[7] National Strategy for Health Sector in Jordan 2015-2019. Note that percentages of insured individuals vary according to different sources. There is no national agreement on actual percentages.
[8] *Id.*
[9] *Id.*

societal roles, including the financing of health services. However, they are not insurers and are not established for the purposes of performing insurance services. Accordingly, these institutions, and their governing laws, did not form part of the analysis, except for instructions relating to exemptions applied under CHIF.

The private health insurance sector comprises life and non-life insurance companies and self-insured employers. There are 24 private insurance companies registered with the ID and 23 have been issued with a health license to provide health products.[10] According to the Jordan Insurance Federation Annual Report[11], the largest insurer is Arab Orient Insurance (AOI), which holds 39.01% of the market share in health. Its closest competitor trails at 8.24%. Accordingly, AOI formed part of the analysis. In addition, the ID regulates and licenses Third Party Administrators (TPAs). These organizations provide services such as medical claims management, provider network contracting and billing services to public and private insurance companies. Employers that self-insure their employee health benefits also require TPA support services.

The analysis also incorporated the review of Jordan Phosphate and Mining Company's (JPMC) health By-laws, to illustrate the governance applied by a self-insured employer. The governance and legislation of professional associations, which purchase health insurance on behalf of their members, did not form part of the review.

1.2 Legislative Overview and Analysis Process

The public health insurance legislative environment consists of Cabinet decisions, By-laws, Regulations and Instructions.[12] There is no national health insurance act that regulates public health insurers. Each public health insurer publishes their own by-law.

The private health insurance sector is governed by the Insurance Act No 31 of 1999 (the Act). Regulations, Directives and Instructions are issued by the ID. The ID is the regulatory body for the private insurance sector and is under the Ministry of Industry, Trade and Supply[13]. Private insurance companies enter into a group or individual policy with insured(s) that sets out additional terms and conditions relating to the health services delivered and reimbursed.

Employers self-insuring the health costs of their employees (and possibly the employee's dependents), are not supervised by the ID. Instead, self-insured employers issue their own by-laws[14] relating to the governance and financing of their employee health care There has been a regulatory failure to actively incorporate this segment, and others, such as professional associations and unions under their

[10] Annual Report Insurance Business in Jordan 2016. Issued by Jordan Insurance Federation July 2017.
[11] *Id*
[12] Furthermore, the Ministry of Health has entered into agreements with public and private health insurers which stipulates the basis upon which CHIF members are transferred to hospitals outside the MoH and can receive medical treatment.
[13] The ID will be moving from MoITS to the Central Bank of Jordan during the course of 2018 and fall under their jurisdiction.
[14] The term by-law used by self-insured employers can be misleading. It is necessary to distinguish between regulations issued by the Council of Ministers (by-law) and the policies adopted by companies and non-governmental organizations. The latter may be called a by-law or regulation but is not legislation. Instead it is considered a policy adopted by the company.

jurisdiction. Entities that either self-insure their employees or provide insurance but are not established as an insurance company, are operating in a regulatory vacuum.

Jordan is also a signatory to several international conventions that impact on its obligations in the financing and provision of health services to its nationals. There are provisions in the by-laws of the public insurers that contravene these international conventions. These have been noted, but an in-depth analysis of international conventions did not form part of this scope.

To ensure that legislation was evaluated uniformly and consistently for all insurers, a set of five measures, with sub-indicators were developed. They cover a number of principles relating to equity, access and affordability. The principles can be evaluated from different angles in the sub-indicators. The findings demonstrate the effectiveness and efficiency, or lack thereof around the current legal framework in terms of achieving UHC.

	MEASURES	INDICATORS
1	Supervisory and Institutional Structures	Regulatory Body, Insurer Management and Licensing, Financial Reporting, Solvency Requirements, Dissolution of a Fund
2	Access to Insurance	Eligibility and Enrollment Mandates, Waiting Periods, Membership Continuation, Portability and Termination
3	Health Coverage	Benefit Packages and Exclusions, Pre-authorization and provider arrangements
4	Beneficiary Funding	Premiums, Co-insurance, Deductibles, Late Joiner Penalties
5	Consumer Protection	Information Disclosure, Dispute Resolution Mechanisms, Patient Privacy and Member Confidentiality

It is important to highlight that some participants unilaterally interpret the laws and adapt them to their own context. This may be attributed to the volume and silo nature of legislation in the public sector. In some cases, the provisions of the laws are disregarded by public providers, insurers and patients because they are either too unclear, discriminatory or conflicting. This assessment focused primarily on the content and inherent gaps of the law and not stakeholder practices that have developed to supplement the laws. However, this is a clear manifestation that the current legislative framework is for the most part no longer perceived as being relevant or most importantly, capable of achieving goals that lead to equity, fairness and protection.

There is recognition at national and ministerial levels that changes are needed. The Government has explicitly identified several areas of improvement in its pursuit of the Sustainable Development Goals Agenda of 2030 and the Jordan 2025 Vision. Key aspects include: *"Improving the quality of health services, improving the institutional framework in the health sector, developing an effective health insurance system,*

strengthening partnerships and cooperation, improving education of medical professionals and controlling the emergence or re-emergence of infectious diseases". [15]

Difficult and transparent decisions are required by policy-makers for the health insurance system to operate at a high functioning level and benefit everyone, especially the poor, vulnerable and marginalized groups.

2. Main Findings

Jordan's health insurance regulations are hampered by five key deficits that are defining features for the public and private sectors. There are significant differences in the type and extent of failures that are occurring in each sub-sector which have been called out separately.

2.1 Supervisory, institutional and management structures

The regulatory framework and institutional structures are crucial elements of a resilient health system. Shortcomings in accountability and governance will lead to weak, ineffective structures and management. Governance in the health sector is defined by the WHO as referring "…to a wide range of steering and rule-making related functions carried out by governments/decision makers as they seek to achieve national health policy objectives that are conducive to universal health coverage".[16]

> Public insurers act in multiple capacities. They each issue by-laws and regulations, in addition to acting as providers, funders and accreditors, which may lead to conflicts of interest.

From this definition, there is an emphasis on active supervision, coordinated legislation and rule-making, and continual oversight required to ensure a well-performing health insurance system. Structured coordination is especially needed where there are multiple supervisory bodies or agencies involved in the monitoring and guidance of the system. This ensures sector alignment in national objectives and the design of laws.

Public sector

HFG analysis revealed a significant gap in the governance of health insurers. There is no national regulatory body that oversees public health insurers. They are self-governed. Accountability is not only undermined on the basis that insurers are not held responsible to an independent, impartial supervisory agency. There is no overarching, uniform insurance legislation that demarcates and guides institutions in their roles, responsibilities and functions. Insurers issue their own by-laws and regulations according to their own standard-setting criteria and procedures. Any new regulations or instructions that may be issued by an insurer, are not necessarily carried out according to an established, transparent public procedure. Consequently, no long-term decisions by the public at large can be made as there is not much assurance that rules will not change or, at least, not change arbitrarily.

[15] The Hashemite Kingdom of Jordan: "Jordan's Way to Sustainable Development". First National Voluntary Review on the Implementation of the 2030 Agenda"

[16] http://www.who.int/healthsystems/topics/stewardship/en/

Undermining the stability of the public health insurance sector is that the incorporation of some funders is legally insufficient to establish them as juristic entities with legal personality. The legal status of insurers affects the decision-making structures because it establishes boundaries around what an insurer is allowed to do or is restricted from doing. Currently, insurers are not licensed, and they operate in several different capacities.

By-laws do not mandate the constitution of management boards or boards of trustees. Technical committees may be formed to address specific, ad-hoc issues. For example, committees authorize the approval of medical treatment for members outside the Kingdom of Jordan in certain cases, which is paid by the fund. Without appointed management boards guiding the strategic performance of the insurers, public funding entities have become bureaucratic, task-oriented organizations. Lack of ownership makes it impossible to hold the institution accountable, in whatever capacity it operates. By-laws are also silent on individuals possessing the requisite range of skills, expertise and knowledge to act as a board member of a health insurer.

There are no minimum reporting requirements on management activities or the financial functioning of insurers. There is currently no objective way to assess the solvency of public insurers or whether they are capable of meeting their liabilities. No transparency exists on how the contribution income of beneficiaries is allocated, invested and used for their best interests. It is not possible to measure how effectively insurers fulfill their mandates in providing members with access to health services and thereby financial protection. Fraud and corruption cannot be successfully controlled, and abuse is more likely to occur when budgets and financial statements cannot be reviewed, and management held accountable. Actuarial analysis, claims management and health cost projections are lacking. The consequences for not calculating premiums correctly and the lack of data at macro and micro levels is highlighted at the beginning of this report. The ability for consumers to decide the value of health care, and whether or not premiums are a fair reflection of accessing quality health care, is not possible.

Combined, these issues are causing sustained failures in the sector. They are preventing the establishment of financially sound insurance entities and stifling the development of managerial and technical skills capable of meeting national goals.

Private sector

Insurance principles are applied, and greater predictability and stability exists within private insurance companies. One national law exists —the Insurance Regulatory Act No. 33/1999. There are a number of Regulations and Instructions that have been issued by the ID.[17] A key departure point of the private sector is that legislation is generated openly. Decision-making follows a transparent process. The rule of law is promoted, and discretionary actions are limited.

Prudential regulation follows international best practice. Insurers are legally incorporated, management boards with demonstrated experience and qualifications are required, licensing (and annual renewal)

[17] There is a draft insurance law that is in the process of finalization. It is expected to repeal the Act of No. 33/1999 and be implemented during 2018.

processes are mandated, solvency and audited financial reports are annually published, actuarial skills are legislated. Consumers are more assured that insurance companies are capable of meeting their liabilities.

Despite the strong emphasis on governance, existing legislation is too broad to effectively shape the private health insurance market and its contribution towards national health policy goals. Health insurance is one of several product lines offered by insurance companies. There are no stand-alone private health insurers. Their role is important as products provide duplicate and supplementary health coverage. Statistics released by the Jordan Insurance Federation confirm that the private health insurance market is growing annually.

The ID has not yet fully developed the in-depth technical expertise required for balancing the profit-nature of insurance companies and protecting consumers, specifically individuals who are older and at higher health risk. No rules exist regulating market peculiarities inherent with health insurance e.g. moral hazard and adverse selection. A much greater proportion of individuals should be allowed guaranteed access to private health insurance on fair and transparent terms. At present, insurance companies attract the young and healthy and burden unwanted risk onto the public sector. They also delist high cost health services from benefit plans which has the effect that there is no reimbursable medical treatment available to sicker individuals. They are forced to seek treatment in the public sector. Insurers should be competing on the basis of quality, efficiency and innovation. However, they have no mandate or incentive to expand their role in a manner that is complimentary to the public sector.

As mentioned earlier in the report, the ID regulates private insurance companies, but it does not regulate self-insured employers that provide health coverage to their employees and dependents. Unions and professional associations that purchase insurance on behalf of their members are also unregulated. Political interests have prohibited the ID from exercising their mandate to the fullest extent in the private health insurance sector. Structured dialogue and cooperation between the public and private health insurance sectors would yield many advantages in the pursuit of national policy goals.

Priority Issues for Consideration:

- Agree on the form and substance of an independent regulatory body for the public sector, its oversight mandate in who it will regulate and level of involvement with insurers.
- Capacitate the regulatory agencies and develop a structured coordination between the public and private health insurance agencies that jointly pursue national health policy goals.
- Recognize and implement the agency function of the third-party payer (insurer) in the public sector by separating the insurer and provider functions.
- Enforce the ID's jurisdiction over entities that are currently governing themselves in the private sector, for example, self-insured employers, to close the regulatory vacuum.
- Develop a unified health insurance law for the public sector that sets out public health insurance objectives, coordinates with the private sector Act and establishes minimum standards to affirm consumer protection.

2.2 Access to Insurance

Enrollment of uninsured individuals into the CHIF has remained stagnant for several years.[18] This is partly attributed to a number of factors such as the limited benefits for voluntary members, an alternative of seeking medical exemptions which dis-incentivizes insurance enrollment, in addition to institutional deficiencies and that voluntary membership figures are not increasing.[19] There are no mechanisms to encourage voluntary members to join and remain members of the CHIF at a time when they are a lower health risk. Individuals who are considered higher health risks (e.g. older individuals and pregnant women) can join the CHIF at any time and they would not have necessarily contributed, via premiums towards the cost of their treatment even though they had the financial means to do so.

Entitlement and obligatory participation for some members across all public funders arises on the basis of employment. However, membership suspension occurs on arbitrary grounds (such as when on leave or during secondment) not linked to evidence of abuse, fraud, misrepresentation or non-payment. This prevents participation and premium contribution into the public health insurance system.

In the private sector, enrollment is voluntary. Insurers protect themselves against high risk by applying waiting periods[20], pre-existing conditions[21] and premium loading. Voluntary enrollment has not brought about economies of scale. Namely, there is an insufficient number of individuals that are young and healthy that are contributing towards the medical treatment costs of individuals who are older and/or less healthy.

A strategy needs to be developed for compulsory membership and how the uninsured can be identified and covered in a way that is fiscally sustainable. Legislation must be clear which government agency or regulatory body will enforce compulsory membership for the population segments. Three conflicting pieces of legislation currently authorize different agencies to mandate compulsory membership demonstrating the lack of coordination and integration with policy makers and legislators.[22]

Eligibility and enrollment are closely tied to health financing and has to be considered as part of the larger health insurance strategy.

Public sector

Consumer demand for inclusion into CHIF is low. There are many reasons, including poor institutional management and strategy, the consumer's perceived lack of quality in public health facilities, minimal educational material and an individual's ability to voluntarily join the fund when they choose. There are

[18] General Budget Law (2017), MoH Budget Chapter 2701.

[19] It is worth noting that the HIA serves the subscribers, beneficiaries, retirees, and free categories such as the poor and the disabled who are usually the categories that seek insurance. HIA was not set up to recruite members. Adding to that the administrative burden.

[20] Waiting periods are a delay in the period before an individual is covered for any health services that he or she receives after the effective date of joining the insurer.

[21] Pre-existing medical conditions is the delay when an insurer is obliged to begin paying a member's health expenses that are related to a particular medical condition and which existed before they applied for health insurance.

[22] Article 31 of the Civil Health Insurance Regulation, No. 83 of 2004, Article 3 of The Social Security Law No. 1 of 2014 and Article 99 of the Insurance Act No 31 of 1999

also several entities[23] that grant exemptions to applicants allowing them not to pay towards any treatment costs despite not having previously contributed premiums. To date, the inclusion of groups into CHIF is unstructured and random. There are over 70 categories of eligibility groups. No rationale exists for why there are so many groups. Eligibility is classified according to many criteria and is duplicated. Organ or blood donors are granted membership for a limited time period and can simultaneously fall into another eligibility category, such as the poor, a dependent spouse etc. Eligibility is also assigned to geographical areas. Goals to widen eligibility will cause greater confusion and administrative complications.

There is a need for a comprehensive strategy that outlines eligibility criteria, enrollment processes and timing to provide health insurance coverage to the Jordanian population. There has not been any such public policy approach which has resulted in the:

> The public sector lacks a clear policy to provide comprehensive health insurance. While in the private sector serious inequity considerations are raised.

1. Creation of national financial risks. Categories of groups are exempted from paying premiums, not on their ability to pay, but other criteria, such as age. Not raising revenue from members capable of paying, or those deciding not to join who could contribute when health treatment is not required, limits fiscal ability. Therefore, Government cannot extend insurance coverage to those truly qualified and who require a premium subsidy.
2. Nominal increase of members into the CHIF over the past 13 years. Voluntary membership lowers participation and only attracts individuals to membership when they are older and at higher risk. This reduces the ability to raise sufficient revenue over the life-cycle of an individual.
3. Duplication of eligibility groups and inconsistency in membership terms. Standardized terms are not used and therefore an individual can fall into several groups. For example, reference is made to the poor, the non-wealthy, the individual receiving aid from the National Aid Fund; the social safety net and the poorest. "Subscriber" and "Dependent" are not statutorily defined. This creates administrative inefficiencies and an inability to collect accurate data.
4. Encouragement of moral hazard. Individuals can rejoin their respective insurer without the imposition of waiting periods. Individuals that lose or terminate insurance are encouraged to rejoin the fund only at the point at which they realize they require insurance coverage.[24] Voluntary membership is usually accompanied by waiting periods. This protects insurers from members joining the fund at the point at which they require medical treatment. This is a tool the CHIF has not implemented.

<u>Private sector</u>

Group insurance coverage is more viable for individuals that are older or unhealthier and form part of a younger healthier employer group. Unless individuals are wealthy, obtaining affordable coverage as an

[23] Examples of entities that grant exemptions are the Royal Court, Prime Minister, Ministry of Health, Members of Parliament.
[24] Some members, who have cancelled their membership are required in terms of Article 13 of the CHIF by-law to pay past premiums when they submit a new subscription application.

individual will be difficult, especially as guaranteed access is not a legislated principle. Insurers are entitled to deny individuals access to a health insurance product based on their age. Insurers have discretion to admit individuals over 50 years and automatically deny coverage for individuals over 65 years.

Waiting periods are excessively applied, facilitating the practice of insurers attracting and covering viable health risks only. Without portability provisions, individuals are not assured of continued coverage when changing insurers and that their access to previous benefits can be retained. As a result, they may be re-underwritten at a time when they are older and potentially less healthy and have pre-existing conditions applied by the new insurer. Risk selection in the private health sector creates inequity as insurers are able to reject members, exclude pre-existing conditions and unilaterally cancel contracts. While risk selection is profitable for insurers, it makes health care less accessible in the private sector and shifts the burden back to the public sector. Risk selection undermines solidarity-based sharing of risk across the population.

Priority Issues for Consideration:

- Establish whether the public and private insurers should compete against each other and if insurers in the same sector should compete with one another. Determine the basis upon which insurers compete (price, provider networks, benefit packages, application and standardization of waiting periods, pre-existing conditions etc.).
- Eliminate voluntary membership (i.e. make participation compulsory for those individuals that have the financial means to pay) to increase revenue collection and reduce practices of moral hazard.
- Evaluate the different ways to enroll segments of the population in a fiscally sustainable manner.
- Redefine and simplify eligibility categories. Create standardized definitions and terminology.
- Remove explicit risk underwriting and require insurers to renew policies.

2.3 Beneficiary Funding

Significant work is yet to be carried out around actuarial costing to cover the uninsured and provide a sustainable benefit package. The lack of data impedes the ability to do cost projections within the public health sector. Calculating the revenue to be collected for benefits will be difficult and potentially underestimated.

There are multiple payers, and therefore multiple risk pools, in the health insurance system causing fragmentation, administrative efficiency and higher costs. The positive effects of cross-subsidization are reduced. There is no risk-equalization fund that can level the playing fields and redistribute revenue to insurers that have a poorer risk profile. Duplication of coverage frequently occurs, and insurers are unable to restrict double claiming further decreasing revenue for legitimate claims.

Legislative analysis did not consider macro-economic options to dedicate specific funding towards policy goals. The review focused upon premiums, the risk-rating methodology used by each insurer and

individual out-of-pocket payments for purposes of equity.

Failure to design and price premiums according to benefits received will continue to undermine the health system.

Public Sector

Discriminatory provisions exist as some insurer by-laws levy substantially higher premiums on the principal member if they are female—premiums are unfairly loaded according to gender.

Government subsidies for the CHIF are directed either towards premiums or treatment fees. Optimum use of subsidies should be targeted towards premiums only.[25] If subsidies are directed towards treatment fees, the member is not necessarily informed of the cost of treatment. Cost is therefore not known or understood by the consumer and the value of the subsidy is not recognized. Hidden subsidies may lead to an increase in fraud, waste and over-consumption. Legislation also permits subsidized medical treatments regardless of the financial ability to pay.

The high level of member co-insurance for inpatient treatment in the public sector contributes to a significant number of insured individuals applying for medical exemptions when they are most ill. Treatment costs (and coinsurance) is at its highest due to treatment being received when medical conditions are at their worst and public subsidies are significantly costlier.

Private Sector

The private sector currently engages in the risk concept of mutuality and not solidarity relating to contributions. Mutuality entitles the insurer to charge applicants a premium that relates to their particular risk at the time of application. Premiums are subsequently pooled with other applicants; however, the applicant pays a premium that is attributable to their personal risk. Solidarity on the other hand, does not determine the premium based on the risks of the individual but on criteria that is not linked to health, gender and age, but on different criteria, namely, the ability to pay. The information required from applicants is closely related to the rating method used to set premiums. Insurers use health status as a variable for risk rating premiums and require applicants to complete a medical questionnaire leading to higher premiums. This may disadvantage people of all ages but particularly older, poorer and sicker people.

Priority Issues for Consideration:

- Review premium methodology and base it upon income rather than gender or health risks.
- Consolidate risk pools to share the financial burden in a fair and efficient way, specifically with future demographic population changes and increases in non-communicable diseases.
- Direct subsidies towards premiums for qualifying individuals and not treatment fees.

[25] Only under Article 30, that subsidies are directed towards premiums.

2.4 Health Coverage

Inequity is more pronounced when assessing benefits from a legislative perspective. The CHIF provides an overly generous benefits package in the public sector. This package has not been assessed on either its cost-effectiveness or responsiveness to health priority needs. Despite this comprehensive benefit package, it is applied unfairly. The volume of eligibility categories has resulted in unequal benefit entitlements, unknown benefits for others and fewer benefits for those in need. Individual exemptions, i.e. the Royal Court paying for an individual's medical treatment, should be structured, in the interim, and eventually phased out to avoid unnecessary subsidies that lead to financial wastage in the health insurance system.

On the other hand, health coverage in the private sector is varied. There are many policies on the market, with a range of policy benefits and exclusions, coinsurance and provider arrangements. This increases complexity for the consumer as comparisons are difficult.

Without regulatory tools and a legally defined benefit and cost-sharing package, wide variations in plan designs are occurring in both sectors. This encourages risk selection, moral hazard[26] and adverse selection[27].

Public Sector

Insurers have participated (unintentionally) in their own form of risk selection by limiting benefits for vulnerable groups and providing more comprehensive benefits to groups of individuals that are wealthier and have a higher employee rank. CHIF by-laws have also created the effect that uninsured individuals are able to access benefits without delay, at no cost, while insured categories need to apply for exemption and in certain cases have co-payments. Where exemption is granted, benefits are more comprehensive for an uninsured than an insured. Benefits are poorly defined. There is no application of a benefit year—a 12-month period where premiums are payable by or on behalf of the insured and medical services are delivered to the member. Insurers are therefore unable to clearly guide beneficiaries regarding their benefit entitlements.

Private Sector

Annual benefits vary according to the benefit plan selected and varied benefit designs are common. It is difficult for consumers to compare the value of benefits for the premium paid. Without a mandated benefits package, insurers have full discretion in the variation of benefits annually. Generally, benefit

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[26] Moral hazard is when a consumer changes behavior to the detriment of an insurer by increasing consumption of health services after obtaining insurance coverage. Insurers manage their exposure to higher claims by imposing copayments or benefit exclusions.

27 Adverse selection means that a consumer has more information than the insurer about their health and more likely to claim insured benefits. Those consumers who most need health insurance will subscribe, and consumers who do not need it, don't purchase it.

exclusions are targeted towards high cost medical treatments, such as cancer and HIV/AIDS, which are covered under the public health insurance sector at a much lower cost.[28]

Priority Issues for Consideration:

- Reduce existing CHIF benefit packages and assign them to the simplified eligibility groups
- Assign actuarially calculated premiums to a particular benefit package for a benefit year.
- Design and cost a minimum benefits package for both sectors. Alternatively, mandate a negative list, that is, identify medical conditions that may be excluded from coverage. Ensure that exclusions are based on fair and equitable principles for the whole population to avoid discrimination against marginalized groups.

2.5 Consumer protection deficits

Consumer protection is closely linked to strengthening the governance of the health sector. It increases the level of information available for the insured and supports informed decision making. There are significant deficits in consumer protection guarantees and allowing for mechanisms to resolve disputes.

<u>Public sector</u>

The level of information disclosure by both the insurer and the insured is not regulated and instructive on their rights and responsibilities (medical history information, benefit options and changes, provider networks, process for dispute resolution, premium terms and conditions etc.). Good quality information creates a competitive advantage for the holder of that information but is non-existent in the public health sector. Generally, very little information is provided by public insurers. Consumers are not empowered to understand their benefits. Navigating the public sector is mostly intuitive and based on previous experience or input from the member's family or friends. The lack of information disclosure causes greater confusion, administrative inefficiency, dissatisfaction and stakeholder practices that deviate from legislative provisions.

Patients have very little bargaining power with medical service providers. This is influenced mainly by patients' lack of choice, access and information regarding providers and also their understanding of the various disease states and appropriate care options.

Failure to implement successive mechanisms to resolve disputes leads to unfair and inequitable practices for consumers impacting quality and efficiency in the health system. The volume of laws, regulations, instructions and directives make it impossible for consumers to be aware of, and act on their rights. Consumers cannot build trust in the legislative authenticity in either dispute resolution mechanisms or the health insurance system.

<u>Private sector</u>

[28] See, Articles 17 and 18 of the Health Insurance Regulation.

Lack of accessible information limits the ability of insureds to take meaningful advantage of choices in health insurance products as it is often difficult to compare insurer offerings by price and benefits. Issuing industry guidelines on comparative benefits and pricing ensure minimum levels of information that promote consumer awareness and engagement.

Information between insurers and providers is key in any negotiation process and impacts on quality outcomes of healthcare. The private health insurance sector is better positioned to collect and analyze provider information but not necessarily the consumer.

Insured's have access to the ID to resolve and mediate disputes and legislation outlines a comprehensive process for the arbitration and mediation of disputes.

Priority Issues for Consideration:

- Promote transparency and fairness in insurance policy transactions between consumers, insurers and providers.[29]
- Increase consumer awareness and education relating to health insurance in both sectors.
- Design a dispute resolution mechanism to resolve complaints and provide protection to consumers
- Legislate patient confidentiality and privacy.

3. Conclusion

HFG's review and findings of health insurance legislation in Jordan illustrates that laws do not support the design and delivery of health insurance services according to the needs of the population, specifically vulnerable and marginal groups, in a fair and equitable way. They are creating barriers resulting in a fiscally unstable health system and large governance deficits.

In the public insurance sector, health insurance laws are complex, voluminous and confusing for stakeholders. A regulatory and supervisory failure exists as there is no independent statutory body that provides oversight and monitoring for all public insurers. Accountability is lacking on the part of insurers and its management. Solvency margins are not legally required. Audited financial and management reports should be made public on a consistent basis. There is a legislative need to define eligibility, membership and benefits in simple, clear terms to protect consumers and contribute towards a

[29] Closely linked to the previous point on simplifying and reducing the number of categories.

sustainable, more efficient health insurance system.

The private insurance sector is monitored and held accountable by the Insurance Directorate and the Insurance Act. Insurer solvency margins are required by law. Management information systems must be properly implemented. Consumers also have recourse to dispute resolution mechanisms. Despite the strong prudential regulation that exists, legislation is too broad to effectively shape the private health insurance market and its contribution towards national health policy goals. As a result, health insurance is largely inaccessible for individuals at lower income levels, who are older or have chronic conditions. Legislative interventions are needed to regulate market peculiarities inherent with health insurance and make it available on fair and transparent terms. Insurers should be competing on the basis of quality, efficiency and innovation.

The findings and priority issues for consideration are intended to facilitate dialogue on legislative health insurance principles and practices that strengthen the governance of a health insurance system and ensure consumer protection. The report can be used to broadly inform policy-makers on the legislative modifications required to support the implementation of a sustainable, efficient and resilient health system.

Annex I: Findings of Assessment

1. Regulatory oversight of health insurers

1.1 Description, Feature and Indicators

Statutory regulatory body created with the mandate to control and coordinate the functioning of insurers in order to protect consumers. Responsibilities vary and may cover a wide variety of supervisory and administrative tasks in the delivery and financing of health care, such as the: design of the minimum benefit package(s); disclosure of information; approval of premiums; investigate complaints and settle disputes; make regulations, rules and guidance notes to support health policy and health insurance law(s).

1.2 Findings

Public Sector
No insurance regulatory body The various Insurers (CHIF, MIF, University Insurers etc.) act in multiple capacities; providers, insurers and accreditors, which leads to conflicts of interest. Each issue their own by-laws and regulation. There is no clear accountability for the different institutions in addition to administrative inefficiencies.

Priority Issues for Consideration For the Public Sector: Identify an independent regulatory body (or bodies) that focus on the supervision and regulation of insurers. Ensure the regulatory structure reinforces the agency function of the third-party payer and empowers the consumer of health insurance and healthcare. Assess the required financial, technical and administrative needs of the body to effectively manage and monitor health insurers. Agree on the form and substance of the regulatory body/ies, its oversight mandate in who it will regulate, level of involvement and accountability (MoF, MoH, Central Bank etc.).

The below table captures the main findings of from the Private Sector.

Private Sector
Insurance Regulatory Body is the Independent Directorate(ID). Currently under the Minister of Industry Trade and Supply. Moving to Central Bank in 2018. ID has a corporate status and is financially and administratively independent. Its mandate relates to private health insurers, Third-Party Administrators (TPAs) and brokers. ID does *not* regulate self-insured employers, unions or professional associations that purchase insurance on behalf of their members, or other entities that deliver care. ID capacity, level of expertise and skill relating to health insurance is limited.

Priority Issues for Consideration For the Private Sector: Investigate the viability to broaden the ID mandate. Enforce its jurisdiction over entities that are currently governing themselves, for example, self-insured employers. This will create equitable market conditions for consumers. Examine the structure and operations of insurers to create more stability and maturity in the health sector. Currently, insurers are established with multiple lines of business.

2.Uniform, transparent insurance legislation

2.1 Description/Central Feature and Indicators

Written, publicly disclosed insurance laws adopted and enforced in accordance with established procedure and made available to the public in a user-friendly manner.

2.2 Findings

Public Sector
No unified published Insurance Act to govern public health insurers. Approximately 150+ by-laws, instructions, directives and agreements issued by different insurers. Laws are incomplete and ambiguous. Issuing of legislation occurs frequently and not through an established, public procedure. Cabinet decisions on eligibility and coverage are not always published in the official Gazette making some laws unavailable and difficult to access. (Example: writers' association). Agreements between Insurers and Providers are incomplete and may not be in full compliance with governing legislation (Judges were granted first class insurance regardless of their rank). HIA staff have difficulty in understanding legal provisions/decision and explaining them to the public.

Priority Issues for Consideration For the Public Sector: Draft and implement a comprehensive national law that replaces and/or repeals the existing volume of legislation issued by each insurer. The national law should set out clear objectives, standards and rules relating to the governance of health insurance such as eligibility, premiums, co-payments, medical treatment.

The below table captures the main findings of from the Private Sector

Private Sector
Insurance Regulatory Act lacks specific provisions relating to the governance of the health businesses of insurers. Act is publicly available and accessible and sets minimum standards relating to the prudential regulation of insurers. The law does *not* deal with specific health related issues that impact on consumers, for example, minimum benefit inclusions/exclusions, type and nature of health information to be disclosed, privacy and data management, premium regulation. Note - a new insurance law has been proposed and drafted by the ID. HFG will offer its opinion on the draft on areas that can strengthen the governance of health insurance and consumer protection.

Priority Issues for Consideration For the Private Sector: Review draft proposed ID insurance law to determine additional governance mechanisms that can be incorporated for health insurers. Examples include open enrolment and guaranteed access, portability of health coverage, standardizing information disclosure etc.

3.Legal status and Licensing of Insurance Entities

3.1 Description/Central Feature and Indicators

Process of standard-setting by regulatory body to determine whether an insurer's operations meets acceptable prudential standards. The legal status of insurers affects the decision-making structure because it establishes boundaries to what an insurer can and cannot do, including the degree of liabilities and responsibilities of the board of management/trustees.

3.2 Findings

Public Sector
Not all public insurance entities have been incorporated with full juristic legal status and personality. This casts legislative uncertainty into the ownership of assets, their ability to enter into contracts with other entities and the relationship between the insurer and the consumer.

Priority Issues for Consideration For the Public sector: Determine the nature and incorporation (profit, not-for-profit etc.) of insurers as legal entities, its vested powers, constitution of ownership, rights and duties. Establish if there will be a single payer or multiple payers (insurers) in this sector. Special attention on insurers is needed to assure public accountability and avoid undue political interference.

The below table captures the main findings of from the Private Sector

Private Sector
All insurers are required to be licensed prior to operating their business and annually renew their license. Re-issuing of the license is conditional upon the insurer complying with specific provisions around management, solvency, reporting etc. Insurers receive a sub-category license "8821" for health. Third Party Administrators, while they are not risk bearing entities, are also required to be licensed by the ID.

Priority Issues for Consideration For the Private Sector: Evaluate the viability of stand-alone health insurers in the private sector, specifically where the role of insurers will continue to provide important levels of coverage to the population. Consider in this regard the future role of private health insurers and the types of coverage they can deliver to consumers and whether it will duplicate, supplement or complement the public insurers. Subsequently, the ID can encourage and facilitate the growth and maturity of the sector in an organized and controlled manner.

Agree on insurer exemptions for unique groups e.g. UNRWA and charities.

4.Management of Insurers and Penalties for Non-compliance

4.1 Description/Central Feature and Indicators

Board representatives who are elected and responsible for the proper management of the insurance entity and held accountable for the supervision and compliance of insurance operations.

4.2 Findings

Public Sector
By-laws do not require appointed management/oversight boards that direct and monitor the operations and performance of the insurer for purposes of *balancing the interests of beneficiaries and providers*. Operational managers have unfettered discretion in their decision-making process because there is no objective statutory standard setting. No penalties exist, and therefore no accountability, for management boards that fail to meet standards or comply with regulatory provisions. No minimum requirements for board members/individuals to have the requisite range of skills, expertise and knowledge when operating a health insurer.

Priority Issues for Consideration For the Public Sector: Agree upon legislative provisions that require every insurer to have a management board. Define their fiduciary duties, terms of appointment, ethical standards, compensation, the permitted degree of independence and incentives to properly guide the health insurance business. Once criteria have been established set out the individual and collective penalties and consequences for failing to carry out fiduciary duties or non-compliance with the law.

The below table captures the main findings of from the Private Sector

Private Sector
Insurance Act mandates the composition of the Board. Legislation sets out the required education, competence and experience to qualify as a board member, the events disqualifying board members and what constitutes a conflict of interest. Penalties are implemented for non-compliance by the board or its member for not fulfilling legislative requirements. For example, the insurer's license can be cancelled or the ID can levy a fine (not less than one thousand dinars, and not exceeding ten thousand dinars). The penalty is doubled if the violation is repeated.

Priority Issues for Consideration For the Private Sector: Existing management boards oversee the entire operations and business of insurers which includes life and non-life product lines. Examine opportunities to establish minimum standards for all private sector entities that engage in health insurance, for example, employer health insurance funds. Incentivize management to act in ways that improve efficiencies in the private health market and protect beneficiaries.

5.Financial Solvency and Reporting

5.1 Description/Central Feature and Indicators

Independent, objective evaluation of the financial reporting processes and reserving levels for sustainability determined by the calculation of a solvency ratio (amount of capital relative to the payment risks on behalf of insureds).

5.2 Findings

Public Sector
There are no legislative mandates relating to solvency, reserving or financial reporting. For those insurers that do provide some information, reporting does not relate to the overall management of the funds, strategic objectives or measurement against consumer indicators. No annual report is consistently made publicly available providing an overview of an insurer's activities and economic situation. Insurer objectives and priorities cannot be linked to specific activities, responsibilities, and budgets. Budgets are required to be independent in terms of legislative provisions, but in practical terms there is a blending of budgets with other entities, such as the budgets of providers, which makes insurance costs difficult to identify and calculate. Payments for expenses are not limited to legitimate expenses that relate to meeting the treatment liabilities of beneficiaries. For some insurers, where surpluses exist, they can be repatriated out of the fund.

Priority Issues for Consideration For the Public sector: There is a critical policy need to establish minimum financial requirements for assuring solvency. This should be supported by accurate and reliable financial statements, systems and forecasts. Regular public reporting must be made available for review and scrutiny to assure financial protection for consumers, reduce the occurrence of fraud, waste and corruption and promote financial and operational efficiency of insurers.

The below table captures the main findings of from the Private Sector

Private Sector
Insurance Act requires insurers to periodically report on the financial condition of the business, including the maintenance of minimum capital requirements and solvency margins certified by the appointed auditor. New insurer applicants are required to submit various documentation and data to establish and operate the company, which includes a business plan for the first 3 financial years, actuarial certificates approving the calculation of premium rates, details of the management board and key employees, agreements with reinsurers and brokers, projected financial statement for 3 years and proposed financial statement for 5 years based on a sensitivity analysis. These requirements relate to the entire insurance business across a variety of segments such as motor, general accident, fire, life etc. If insurers were licensed to operate only in the medical segment, the minimum financial requirements and annual reporting could be reassessed and adjusted to facilitate governance and growth specific to this industry.

Priority Issues for Consideration For the Private Sector: There is a level and frequency of financial reporting required by insurers. Consider opportunities for insurers to provide expanded reporting in the health segment that covers information over and beyond prudential

regulation such as utilization patterns, enrolment, claims experience, quality of care, trends in provider and consumer behaviour.

6.Eligibility

6.1 Description/Central Feature and Indicators

Eligibility defines the individuals that can join the fund, the basis of their membership, rights and duties, the categories of beneficiaries, enrolment procedures, processes and timing.

6.2 Findings

Public Sector
In the CHIF there are 70+ categories of eligibility. The volume of eligibility groups makes it difficult to clearly determine who is entitled to membership and the basis for their eligibility. It is extremely difficult to align eligibility with the amount of financial resources needed for the different groups (i.e. determining the amount that qualifying individuals should contribute and those entitled to a premium subsidy). Eligibility is duplicated as individuals can be classified in more than one group (e.g. the poor, the non-wealthy, the individual receiving aid from the National Aid Fund; the social safety net, remote regions; the poorest). Participation is compulsory for some groups and voluntary for others. Eligibility is not always assigned to natural persons but includes geographic regions. Uninsured individuals are able to access benefits without delay, and at no cost, while insured categories need to apply for exemption and in certain cases have co-payments. Where exemption is granted, the benefits exceed the benefits provided to an insured. Examples include: full coverage in all hospitals with no co-insurance; treatment abroad; receiving non-prescribed medication; the right to choose the hospital etc. "Subscriber" and "Dependent" are not statutorily defined and the term is used inconsistently confusing its practical application. For other insurers, eligibility is determined, for the most part, on the basis of employment. Duplicate membership exists as some insurers do not disallow members from joining two insurers. By not defining benefits, and a benefit year, insurers cannot instruct beneficiaries in the timing and information relating to enrolment.

Priority Issues for Consideration For the Public sector: Define and simplify eligibility categories. Simple, clear eligible definitions and terms promote consistency, standardization and administrative ease. Assign eligibility to natural persons. Avoid eligibility on the occurrence of an event, for example, to individuals that donate blood or organs. Review the need for exemptions once eligibility has been correctly defined and the ability for individuals to pay premiums has been determined.

The below table captures the main findings of from the Private Sector

Private Sector
Eligibility for individuals can be through employment. Some private sector employers purchase group insurance on behalf of their employees. Individuals can also apply for membership to a private health insurer. The principles of open enrolment and guaranteed access are not applied. Open enrolment is a principle that requires every health insurer to accept as a member or dependant any and

every person who wishes to join the insurer as a member. The principle of open enrolment and guaranteed access ensures non-discriminatory access to healthcare financing. Every person who applies for membership, as well as any member who applies for the membership of a dependant, is guaranteed membership. Applicants should be accepted regardless of factors such as their age or past and present medical history.
Currently, insurers are entitled to deny individuals access based on their age (Insurer has discretion for individuals over 50 years and automatically denies individuals over 65 years). For individuals who do apply for membership, insurers can engage in risk selection and underwrite younger, healthier individuals. Premiums are loaded according to age, gender and health risks.

Priority Issues for Consideration For the Private Sector: Assess policy opportunities to make eligibility compulsory for private sector employers and employees. Enforce regulations that remove explicit risk underwriting by insurers and can unilaterally deny access in their sole discretion to individuals who apply for membership.
General: Examine at a national level the basis upon which eligibility will be determined in both the public and private sector a) mandatory participation in a single insurance fund b) mandatory participation but freedom for individuals to choose across alternative insurers c) mandatory participation by the conditions of employment. Achieving equity is easier and more direct when individuals are grouped into fewer insurance pools because it facilitates cross-subsidies across individuals and simplifies eligibility criteria. Legislative provisions should be clear on insurance membership and provide that no person can be i) a member of more than one insurer (ii) be admitted as a dependent of more than one insurer and claim or accept benefits in respect of himself or herself or any dependent from any insurer other than the insurer of which he or she is a member.

7.Continuation of Coverage and Suspension, Termination of Membership

7.1 Description/Central Feature and Indicators

Defines the period in which the insured belongs to the insurer and events that trigger suspension or termination of membership

7.2 Findings

Public Sector
In the CHIF, membership terms vary significantly across eligibility groups—6 months to 5 years. Responsibility is on the insured to renew their membership card after the term of expiry. Failure to do so results in the insured carrying the full medical treatment costs until a new card is issued even if premiums have been paid during the period after the card has expired. This can lead to financial impoverishment. If the principal member died during their term of employment as a civil servant, future contributions are exempted for surviving beneficiaries regardless of their financial ability or not to pay. In other cases, the eldest child becomes the principal member and is responsible to pay the premium. Some consumers engage in behaviour known as adverse selection. They can join and terminate their membership voluntarily which exposes the insurer to financial risks. Some subscribers are requested to pay the premiums they would've paid had they remained a member of the insurer. Other public insurers apply excessive and unreasonable conditions for suspension of membership e.g. suspension is triggered if the insured is on academic leave. Events that trigger termination of membership are not clearly outlined in majority of public insurer by-laws. There are no requirements for insurers to provide written notice to the insured to enable them to remedy their default within a given time period.

Priority Issues for Consideration For the public sector:
Regulatory and administrative tools can support the effectiveness of access through renewability requirements. Renewability is a useful and fairly straightforward means of promoting continuity of coverage and strengthened risk pooling. Suspension of membership should allow insureds the opportunity to remedy their breach of contract or access dispute mechanisms prior to termination of their membership. Design penalties for consumers misusing health insurance.

The below table captures the main findings of from the Private Sector.

Private Sector
Annual renewal is automatic unless the policy is cancelled or the following events occur; Death of the insured, the insured reaches 65 years or the individual loses the status of legal dependent. Insurers have the right to unilaterally cancel the medical policy on 30 days' written notice. Insurers are entitled to cease coverage of the insured within 7 days in the event of non-payment by the insured on the due date or there is abuse, misrepresentation and fraudulent information submitted or carried out by the insured.

Priority Issues for Consideration For the Private Sector: Prevent unilateral cancellation of policies by private health insurers (except for fraud, misrepresentation and abuse). Mandated renewability requirements can promote risk pooling because the enhanced coverage security

provided is an incentive for individuals of lower health risk to purchase health insurance. It also ensures that policies are not cancelled on the basis of claims experience or other health status related factors which could undermine both continued access to coverage and the intended risk pooling function. Implement terms for continuation of coverage and the permitted length of a coverage gap prior to attracting the imposition of waiting periods, penalties or pre-existing condition exclusions.

8. Member (Beneficiary) Cost sharing

8.1 Description/Central Feature and Indicators

Amount payable by the Insured with respect to any requested tests, services and treatment covered under the health insurance plan. Types of member cost sharing used by insurers:
Coinsurance: A portion of the medical cost an insured must pay after the deductible has been met and to access benefits under the health insurance plan. Coinsurance is a way that the insurer and the insured pay a share of qualifying costs that add up to 100%.
Co-payment: A flat fee that an insured must pay at the point in time the health service is accessed or the medication is purchased. Co-payments cover the insured's portion of the cost of a doctor's visit or medicine.
Deductible: A deductible is the amount an insured must pay each benefit year for eligible medical services or medicines before they are entitled to claim from their insurance plan.

8.2 Findings

Public Sector
Coinsurance and copayments are predominantly towards medication (5%, minimum amount of JOD 0.250 – JOD 10). This amount is low for individuals have the financial means. For treatment of emergency cases and direct admission to hospital there is a coinsurance of 20% or higher for some other insurers. The high level of co-insurance for inpatient treatment in the public sector contributes to a significant number of insured individuals applying for medical exemptions. Treatment costs and therefore cost sharing, is at its highest due to treatment being received when medical conditions are at their worst and in turn, public subsidies are not significantly costlier. In practice, individuals receive exemptions from entities such as the Royal Court, which contravene legislation as providers transfer the patient after their admission to the hospital in order to be treated as a transfer, not an emergency.

The below table captures the main findings of from the Private Sector

Private Sector
Cost sharing varies according to benefit design and is generally a coinsurance that is directed towards outpatient coverage (approximately 20%). Currently, cost sharing structures do not direct individuals to proper care. Furthermore, the extent of benefit exclusions applied by insurers result in the insured bearing the full cost of treatments and medications on an out-of-pocket basis.

Priority Issues for Consideration

General: Insurers use cost sharing with the insured to prevent moral hazard. Though cost sharing may be a small portion of the actual cost of the medical service, it is meant to prevent people from seeking medical care that may not be necessary. The underlying philosophy is that with no cost sharing insured's will consume much more health treatment than they otherwise would if they were paying for all or some of it. However, cost sharing may also discourage people from seeking necessary medical care and may result in the non-use of essential medical services and prescriptions, forcing the individual to be effectively uninsured as they cannot afford the cost sharing requirement. A balance should be achieved namely, where cost sharing

is high enough and deters unneeded expenses but low enough so that insureds do not seek the appropriate care as soon as possible.

9.Information Disclosure

9.1 Description/Central Feature and Indicators

Provision of complete, standardized and accurate health information to the consumer from the Insurer, Provider or Broker.

9.2 Findings

Public Sector
There are no regulatory safeguards resulting in a lack of transparency and protection of the beneficiary's right. Minimum disclosure on the type, frequency and extent of health information by the insurer to the insured is not currently legislated. Consumers are not empowered to understand their health coverage. Examples of information can relate to benefit options, exclusions and changes, provider networks, processes relating to dispute resolution, amount and timing of premiums payable etc. By-laws are not instructive on the insured's rights and responsibilities as a member. Insurer decisions, agreements and fee lists are not published and made available to the public. It is difficult to obtain this information. There is no comprehensive legislation protecting the privacy and confidentiality of the health of insureds. The lack of information disclosure causes greater confusion, administrative inefficiency, dissatisfaction and encourages stakeholder practices that deviate from legislative provisions. Patients do not have bargaining power with providers because of their lack of information and understanding of the various disease states and appropriate care options.

Priority Issues for Consideration For the public sector: Implement measures to promote transparency and fairness in transactions between consumers and insurers. Explore ways to increase consumer awareness and education relating to their health and the health insurance sector. Information between insurers and providers is key in any negotiation process and impacts the quality and outcomes of healthcare. Good quality information creates a competitive advantage for the holder of that information which is non-existent in the public sector.

The below table captures the main findings of from the Private Sector

Private Sector
Insurance Act requires minimum information disclosure on the contractual rights of the policyholder. For example, each policy sets out the process to lodge a complaint with the insurer or the ID, the due date for payment of premiums, the date the contract comes into force between the insurer and insured, the terms upon which membership is suspended or cancelled. The Act does not require that insurers provide any benefit information disclosure, Insurers have full discretion on the frequency and extent of information provided for their consumers. There is no provision for the protection of the privacy and confidentiality of insureds in the Insurance Act.

Priority Issues for Consideration For the Private Sector: If the private sector continues to grow and it is agreed that it will play a greater role in fulfilling national health policy objectives, various benefit designs and products are likely to emerge. Consumers often find it difficult to compare products across insurers. Disclosure requirements can be used to promote consumers' understanding of complex product options and help promote meaningful choice within the market. The content of health policies should be clearly understandable and user-friendly for consumers.
Legislative provisions around patient confidentiality and privacy.

10. Dispute Resolution

10.1 Description/Central Feature and Indicators

Any dispute which may arise between a beneficiary, insurer and provider relating to the service, treatment and payment/reimbursement coverage under the health plan.

10.2 Findings

Public Sector
No processes are outlined for consumer complaints and mechanisms for dispute resolution in the by-laws of the insurers. Under the CHIF By-Law, the only "dispute" provision is for the non-approval of emergency cases and the refusal of treatment outside Jordan. Grievances are escalated to the Minister of Health without any mechanism for objecting or appealing before the courts. Failure to implement successive mechanisms that can resolve disputes between stakeholders can lead to unfair and inequitable practices for consumers. This in turn negatively impacts the quality and efficiency in the health system

Priority Issues for Consideration For the Public Sector

Design mechanisms which initially allow disputes to be resolved internally between the insurer and beneficiary to enable a process that allows for quick and more cost-effective resolution of disagreements where possible. Should this mechanism fail, establish an independent third-party process for the resolution of disputes. Third-party review bodies should be independent and have the necessary expertise relating to medical insurance issues for the purpose of conciliating and improving services in the public health sector. Provide consumers with information on the process to lodge a complaint and enforce that insurers advise their members on the process and necessary information on how it will deal with the complaint. The nature of complaints can provide insights on where the health insurance system and the information published can be improved, strengthened and communicated.

The below table captures the main findings of from the Private Sector

Private Sector
Insured's have access to the Insurance Directorate to resolve and mediate disputes. Comprehensive process around arbitration and mediation of disputes. Committee allows both parties (insurer and insured) to present their case and supporting documents within a published timeframe.

Priority Issues for Consideration For the Private Sector

Legislation is clear on the process around dispute resolution and the service charges to be collected. Beneficiaries are a vulnerable party because they are less equipped to adequately challenge or negotiate with an insurer's denial of claims. Requiring claimants to pay fees in advance can deter individuals with a valid case from escalating claims to be resolved. The ID is equipped to identify the major complaint categories received by consumers, the number of complaints and the key issues of concerns. This enables it to design strategic responses to reduce complaints by educating consumers on their areas of grievances. All grievances should be acknowledged and reported on a standard basis, and this information should be made publicly available.

11.Provider Arrangements

11.1 Description/Central Feature and Indicators

Contractual agreements between an insurer and third-party for the delivery of specified health services and/or treatment at a specified fee.

11.2 Findings

Public Sector
Provider arrangements are a mechanism to enhance the quality of healthcare provision. Little information is made available on the procurement terms and conditions when negotiating and contracting with providers to deliver care to members of the CHIF. The issue is further complicated by legislation not demarcating the role, functions and responsibilities of the insurer from providers and the vertical integration of insurer/provider models in the public sector. Discussions with private providers indicate that the agreement terms with MoH have not been revised since 2008 leading to private providers opting out of the agreement and potentially causing a gap in coverage for CHIF insureds. Insurers assume a passive purchase role encouraging revenue-enhancing practices by providers that result in the oversupply of equipment, procedures, and drugs. A major source of inefficiency.

Priority Issues for Consideration:
Assess the separation of funder and provider models and identify the bargain power between the different groups. Consider drafting regulatory provisions that create alignment of choice and costs between the interests of patients and encourage providers to deliver high quality health services to improve population health outcomes. Include provider arraignments for marginalized groups located in remote areas who may be susceptible to worsened health risks due to delayed treatment. Vulnerable insured groups may incur higher co-payments to access the services with providers not forming part of a network.

The below table captures the main findings of from the Private Sector

Private Sector
The Insurance Act does not regulate the terms and conditions of the agreements between insurers/TPAs and providers or the payment methods that incentivize the delivery of high quality care to the insured's. Insured's are provided with insufficient information on provider arrangements, including payment terms. Optimal provider payment systems and incentives need to be designed when private insurers contract with public or private providers.

Priority Issues for Consideration For the Private Sector: Payment by insurers to providers are generally agreed between the parties through a process of commercial negotiation. Policy should decide on the level of regulatory intervention in managing agreements

between insurers/TPAs and providers. Clarify the legal relationship that exists between the TPA and the Insurer.

General: Insurers should be the contracting party with providers for the treatment of health services of their members and the terms and conditions agreed to in writing. Arrangements between insurers and providers ensure the proper delivery of medical services to beneficiaries. Insurers should demonstrate that they have carried out an assessment of providers to ensure the availability of quality services. Encourage strategic purchasing by insurers and that providers are remunerated in ways that encourage the delivery of an appropriate set of health interventions to members. Insurers should continually search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom through selective contracting and incentive schemes to drive quality in the system.

12.Member Benefits (covered and excluded)

12.1 Description/Central Feature and Indicators

Medical services and/or treatments available (guaranteed) to the insured during their term of membership. Some benefits may be subject to a maximum amount (annual or lifetime) that an insurer will pay towards the medical services or treatment.

12.2 Findings

Public Sector
For most categories, benefits are not listed in the various by-laws of funders. Random benefits are mentioned, i.e. benefits are not identified under inpatient, outpatient or pharmaceutical categories. The CHIF has a comprehensive benefit package, but it is applied unfairly across eligible groups. For example, certain eligible categories are not entitled to prescribed, unavailable medicine while other eligible categories are provided with treatment abroad at no cost and there is a daily per diem for the patient and their companion. The volume of eligibility categories has strangely led to benefit entitlements for some, unknown benefits for others and fewer benefits for those in need. An ex-parliament member qualifies for first class coverage allowing access to non-prescribed medication whereas pregnant women, the elderly and disabled persons cannot obtain prescribed medicine that is unavailable which is usually easier and cheaper than the non-prescribed medicine. Uninsured individuals are able to access benefits without delay, and at no cost (e.g. Royal Court), while insured categories need to apply for exemption and in certain cases have co-payments. Where exemption is granted, the benefits exceed the benefits provided as an insured. Some public insurers continue to provide excluded benefits. Benefit years are not defined by some public insurers. Leading to confusion and financial volatility for the fund. By not defining benefits, and a benefit year, insurers cannot instruct beneficiaries in the timing and information relating to enrolment. Annual or lifetime limits are not applied by the CHIF.

Priority Issues for Consideration For the Public Sector: Review premium setting from an equity perspective. Setting premiums according to individual income and not on the basis of age, health risk or gender is a more equitable approach across the population. Any subsidies

provided by government should be directed at the premiums for qualifying individuals and not towards the treatment fees.

The below table captures the main findings of from the Private Sector

Private Sector
Without a legally defined benefit and cost-sharing package, variations in plan design are occurring in both sectors and encouraging risk selection. Benefits offered by private health insurers are unregulated, leaving insurers free to determine the size and scope of the packages they offer. There are specific exclusions that do not support health policy objectives. For example, treatment for HIV/AIDS, mental health services, dialysis, cancer and preventative care. Insurers have the discretion to annually exclude more benefits. Individuals, who have contributed in previous years, cannot rely on future treatments and medications that they contributed towards in previous member years. By setting annual limits for coverage, the private sector shifts the risk back onto the insured, who may not be able to afford the out-of-pocket costs. These insureds either have to fund their own medical costs or rely on the public sector. Essentially, the private sector pushes high risk individuals back onto the public sector. Private sector has initiated pre- approvals which can support insureds accessing the correct health care services.

Priority Issues for Consideration For the Private Sector: The level of coverage provided by private health insurers is largely determined by the level of coverage in the public system and the extent to which the public health system provides timely and comprehensive benefits of good quality. It is important that the private health insurance market be responsive to consumer needs and complement the public health sector. Reliance on market dynamics may be insufficient and regulation can enforce minimum standards to ensure consumer protection.

General Considerations: Implementation of a mandated benefits package structurally reduces discrimination on the basis of health status, age, gender etc. and strengthens risk pools. A benefits package prevents the unnecessary splitting of risk pools through varied, multiple benefit designs. Mandated benefits that are applied for all insurers avoids the shifting of poor health risk from one insurer to another and individuals have a minimum level of protection.

13.Premiums

13.1 Description/Central Feature and Indicators

Amount payable to the insurer by or on behalf of the subscriber.

13.2 Findings

Public Sector
Contributions are determined randomly. Premiums are not based on actuarial calculations and cover a small share of health services. Failure to design and price premiums according to benefits covered undermines the entire health insurance system. Government subsidies are directed towards the provision of care in public facilities rather than the cost of premiums. Therefore, the value of subsidies is hidden and perceived value is not understood. This can contribute to fraud, waste, and over-consumption. Legislation permits subsidized treatments to a majority of categories, regardless of the insured's financial ability to pay. The voluntary environment in both sectors results in higher risks being borne by fewer individuals. Legislation set premiums that vary from JOD 0 – 150, or 3% of salary up to a max of 30 JOD (that is a maximum of 360 JOD a year for higher level ranks of employees). Premiums are either based on category, age, gender or employee rank. Premiums are inequitably determined as factors such as employee category and gender are used. The public sector is attracting poorer risk through subsidization and supporting the private sector retaining the healthier risk. Allowing risk-based calculation by private insurers results in significantly higher premiums for older and unhealthier individuals

Priority Issues for Consideration For the public sector:
Review premium setting from an equity perspective. Setting premiums according to individual income and not on the basis of age, health risk or gender is a more equitable approach across the population. Any subsidies provided by government should be directed at the premiums for qualifying individuals and not towards the treatment fees.

The below table captures the main findings of from the Private Sector

Private Sector
Premiums are determined according to gender, health risk(s), age. The information required from applicants is closely related to the rating method used to set premiums. Insurers that use health status as a variable for risk rating premiums will require applicants to complete a medical questionnaire and as a result the insured may be subject to higher premiums. This may disadvantage people of all ages but is a significant barrier for older and sicker people. The Insurance Act does not set standards or guidelines on the method of calculating premiums or premium increases.

Priority Issues for Consideration For the Private Sector: Ensure that the legislative framework guides the private sector on setting premiums that are not based on the risk they represent. This will allow for equitable access to health insurance and facilitate the spreading of risks across all insurers.

General: A critical policy step is to create pre-payment pools across the entire population and share the financial burden in a fair and efficient way, specifically as Jordan's population ages and co-morbidity increases with non-communicable diseases.

14. Pre Existing Conditions and Waiting Periods

14.1 Description/Central Feature and Indicators

Period during which an insured is not entitled to claim any benefits or not entitled to claim benefits in respect of a specific medical condition for which medical advice, diagnosis, care or treatment was recommended.
Pre-existing medical conditions: There is a delay when an insurer is obliged to begin paying an individual's health expenses that are related to a particular medical condition and which existed before they applied for health insurance.
Waiting periods: A delay in the period before an individual is covered for any health services that he or she receives after the effective date of joining the insurance fund.

14.2 Findings

Public Sector
No waiting periods or limits on pre-existing medical conditions are applied. Individuals can join and re-join CHIF at any time without waiting periods being imposed upon them and at the point at which they know they have a medical condition without having contributed, via premiums, to the cost of their condition. Individuals should demonstrate previous health coverage (with another insurer) in order to re-join the CHIF without penalties. Waiting periods need not apply in mandatory environments unless individuals do not enrol within the mandated period. In these events, individuals could be penalized with late joiner penalties. Waiting periods support cross-subsidization and funding projections (stability).

Priority Issues for Consideration For the public sector:
Introduce regulatory provisions that allow for the application of pre-existing conditions and/or waiting periods to prevent adverse selection.
For the Private Sector: Place limitations on insurers ability to impose exclusions on coverage of pre-existing conditions for a period exceeding 12 months. Disallow the imposition of exclusions and waiting periods if individuals can demonstrate that they have maintained continuous health insurance coverage.

The below table captures the main findings of from the Private Sector

Private Sector
Private health insurers, in the absence of mandatory membership, are applying pre-existing conditions clauses, policy exclusions, and possibly post-claims underwriting to back up underwriting requirements and limit their risk. Waiting periods vary significantly with a minimum of 6 months up to 24 months for specific procedures.

General considerations: Waiting periods and limits on pre-existing medical conditions are defined in order to inform consumers of the implications and clearly guide insurers in what they can and cannot do.

15.Continuation of Coverage and Suspension, Termination of Membership

15.1 Description/Central Feature and Indicators

Defines the period in which the insured belongs to the insurer and events that trigger suspension or termination of membership

15.2 Findings

Public Sector
Events that trigger termination of membership are not clearly outlined in the majority of by-laws. Continuation of coverage is permitted (except where employment is terminated with the employer). Future contributions are exempted from paying by surviving beneficiaries if the principal member died during their term of employment despite their ability or not to pay for contributions. In other cases, the eldest child becomes the principal member and is responsible to pay the premium. Mandated renewability requirements can promote risk pooling because the enhanced coverage security provided is an incentive for individuals of lower health risk to purchase health insurance. It also ensures that policies are not cancelled on the basis of claims experience or other health status related factors which could undermine both continued access to coverage and the intended risk pooling function. Conditions for suspension of membership are excessive e.g. unreasonable in that suspension is triggered if the insured is on academic leave, unpaid leave etc.

Priority Issues for Consideration For the public sector:

Design penalties for consumers misusing health insurance.

Prevent unilateral cancellation of policies by private health insurers (except for fraud, disorientation and abuse).

Suspension which is not linked to evidence of abuse, fraud and misrepresentation or non-payment should be eliminated as it is preventing participation and contribution to the health insurance system.

The below table captures the main findings of from the Private Sector.

Private Sector
Annual renewal is automatic unless the policy is cancelled under the events of death, reaches 65 or loses status of legal dependent (as well as non-payment on due date, abuse and fraudulent information, in which event, coverage automatically ceases within 7 days). Insurers have the right to unilaterally cancel policy on 30 days' notice. Without portability provisions, individuals (specifically employees) are not assured of continued coverage and that access to benefits can be retained due to the risk of underwriting and application of pre-existing conditions by other insurers.

Priority Issues for Consideration For the Private Sector: Implement terms for continuation of coverage and the permitted length of a coverage gap without imposition of pre-existing condition exclusions.

Annex II List of Legislation Reviewed

1. THE CONSTITUTION

- THE CONSTITUTION OF JORDAN, (1952) and its amendments.

2. NATIONAL LAWS, REGULATION AND DECISIONS RELATED TO GOVERNANCE

- INTEGRITY AND ANTI-CORRUPTION LAW, No. 13 (2016).
- THE COMPETITION LAW, No. 33 (2004), and amendments thereto.
- THE LAW ON THE RIGHT TO INFORMATION, No. 47 (2007), and amendments thereto.
- THE HIGHER HEALTH COUNCIL LAW. No. 9 (1999),
- *Regulations for Development of Government Services,* No. 156 (2016) issued in accordance with Article 120 of the Constitution of Jordan of 1952, and amendments thereto.
- THE LAW ON THE RIGHTS OF PERSONS WITH DISABILITY, No. 20 (2017).
- *Regulations for the Administrative Organization of the Ministry of Health,* No. 36 (2008), and amendments thereto, issued in accordance with Article 120 of the Constitution of Jordan of 1952, and amendments thereto.
- LAW OF EXEMPTION FROM PUBLIC FUNDS, No. 28 (2006).
- THE INCOME TAX LAW No. 34 (2014).
- Cabinet Decision on July 23, 2002, issued pursuant to the General Sales Tax Law No. 6 of 1994.[30]

3. HEALTH RELATED

- PUBLIC HEALTH LAW, No. 47 (2008).
- PRIVATE HOSPITAL REGULATION, No 54(2014).
- HEALTH ACCREDITATION REGULATION, No.105 (2016).
- LAW OF MEDICINE AND PHARMACY, No. 12 (2013), and amendments thereto.
- LAW OF FOOD AND DRUG ADMINISTRATION, No. 41 (2008).
- *Regulations for Licensing Pharmaceutical Institutions,* No. 75 (2014) and amendments thereto, issued in accordance with Article 24, Paragraph 3 and Article 98, Paragraph 3 of the LAW OF MEDICINE AND PHARMACY, No. 12 (2013) and amendments thereto.
- *Regulations for Licensing Medical Clinics and Centers,* No. 74 (2014), issued in accordance with Article 7, and Article 72, Paragraph 1 of PUBLIC HEALTH LAW, No. 47 (2008).
- *Regulations for Licensing Dental Clinics and Centers,* No. 52 (2016), issued in accordance with Article 7, Paragraph 1, and Article 72 of the PUBLIC HEALTH LAW, No. 47 (2008).
- *Regulations for Unified Procurement of Medicines and Medical Supplies,* No. 91 (2002) and amendments thereto.

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[30] *See* Council of Minister's decision, held on 23/07/2002 and pursuant to the provisions of Article 22/C of the General Sales Tax Law No. 6 of 1994 and Amendments thereto (the Cabinet decided to approve the following: First: the following services shall be exempted from the general sales tax as of 16/05/2002: A- Medical insurance and accident insurance).

4. LEGISLATIONS RELATED TO THE CIVIL HEALTH INSURANCE:[31]

- *Civil Health Insurance Regulation*, No. 83 (2004) issued in accordance with Paragraph C of Article 66 of the PUBLIC HEALTH LAW, No. 54 (2002) and amendments in accordance
- *Regulations of Subscription and Benefit from the Health Insurance*, issued in accordance with the *Civil Health Insurance Regulation*, No. 83 (2004)
- Terms and Conditions of Casual Laborers Subscription Instructions, No. 1 (2004) issued in accordance with the Provisions of Article (5/F) *Civil Health Insurance Regulation*, No. 83 (2004)
- Coverage of Subscriber's Family Instructions, No. 1 (2008) amending statute No. 1 (2004) issued in accordance with the Provisions of Article (8/B) *Civil Health Insurance Regulation*, No. 83 (2004).
- Coverage of Physically Disabled Beneficiaries Instructions, No. 2 (2004) issued in accordance with the Provisions of Articles (8) and (39) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Term of Health Insurance Card and the Information to Be Included Regulations No. 10 of 2007,[32] amending to the Regulations No. 3 of 2004 Issued in accordance with the Provisions of Article (9/A) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Regulations of Pregnant Women Coverage by Civil Health Insurance Regulations No. 9 of 2006 Issued in accordance with the Provisions of Article (30) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Regulations of Covering Individuals by the Civil Health Insurance Regulations No. 3 of 2010 Amending to the Regulations No. 9 of 2007 Issued in accordance with the Provisions of Article (30) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Regulations of Covering Staff of Any Company or Institution by the Civil Health Insurance Regulations No. 4 of 2010 Amending to the Regulations No. 10 of 2007 Issued in accordance with the Provisions of Article (31) of *Civil Health Insurance Regulation*, No. 83 (2004).
- Mechanism to Cover Poor Families by Health Insurance[33]
- Procedures to Cover People of Petra Development and Tourism Region by the Civil Health Insurance[34]
- Coverage of Wives and Children thereof in Deir 'Alla District by the Civil Health Insurance[35]
- Regulations Issued in accordance with the Civil Health Insurance Regulations of Treatment Instructions
- Treatment Card and Booklet Regulations No. 4 (201) Issued in accordance with the Provisions of Article (11) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Cases in which Expenses of Treatment and Medicines may Be Collected from the Subscriber, Non-wealthy Person, Disabled Person or Any Beneficiary therewith, Blood Donor and the Person Having an Organ Donor Card Regulations No. 1 (2007) amending to the Regulations

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31 *See* GUIDEBOOK ON CIVIL HEALTH INSURANCE (2016) fourth issue.

32 The letter of the Minister of Health No. 17/30/2230, dated 30/9/2007

33 Cabinet's decision No. 5157 in its meeting held on 13/08/2014; Prime Minister's letter No. 56/10/6/27375 dated 17/08/2014

34 Cabinet's decision No. 5646 in its meeting held on 17/09/2014; Letter No. 20/13/3/9923 dated 08/03/2015; Minister of Health Letter No. Z V/ 4/4/2054 dated 31/03/2015

35 Cabinet's Decision No. 12075 in its meeting on 18/10/2015

No. 7 of 2005 and Regulations No.2 of 2004 Issued in accordance with the Provisions of Article (15/B) of the *Civil Health Insurance Regulation*, No. 83 (2004).

- Terms and Conditions of Non-collection of Treatment Expenses at the Hospital or Center of Any Person or Cases Included in Article (18) of the Civil Health Insurance Regulations No. 2 (2010) amending Regulations No. 3 (2008) Issued in accordance with the Provisions of Article (18) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Terms and conditions of Treatment and Transfer of the Persons Covered by the Civil Health Insurance for the Social Safety Net Category, the Poorest Regions Category and the Remote Regions Category Regulations, No. 5 (2010).
- Regulations for Treatment of Gaza Strip Citizens in the Hospitals and Centers of the Ministry Regulations No. 17 of 2014[36] Amending to the Regulations No. 11 of 2007 Issued in accordance with the Provisions of Article (36) of *Civil Health Insurance Regulation*, No. 83 (2004) and Amendments thereof. And both Resolutions of the Cabinet No. 3859 dated 27/03/2007 and No. 4108 dated 24/04/2007
- Regulations for the Cases and Diseases Not Covered by the Civil Health Insurance Fund Regulations No. 5 (2004) Issued in accordance with the Provisions of Article (39) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Treatment of Cases Relating to Legal Proceedings Circulation of Prime Ministry Letter No. 10/11/2/27147 dated 14/8/2014
- Regulations for Emergency Cases inside the Hospitals and Centers of the Ministry Regulations No. 1 of 2005 Issued in accordance with the Provisions of Article (15) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Regulations for Emergency Cases Regulations No. 8 (2004) Issued in accordance with the Provisions of Article (24/B) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Instructions for Treatment of Kidney Patients (2011)
- Maternity, Childhood and Family Planning Services Regulations No. 3 (2008) amending Regulations No. 5 of 200437 Issued in accordance with the Provisions of Article (19/B) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- School Health Services Regulations No. 6 (2004) Issued in accordance with the Provisions of Article (19/F) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Instructions for Provision of Eyeglasses to School Students[38]
- Treatment of Ministers, Parliament Members and the First-Class Employees of the Upper Category[39] Pursuant to the provisions of Article (26) of the *Civil Health Insurance Regulation*, No. 83 (2004) and its amendments.
- Regulations for Treatment outside the Kingdom[40] Regulations No. 9 (2014) Issued in accordance with the Provisions of Article (37/B) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Instructions for Using Electronic Files and Prescriptions in Hospitals and Centers of the Ministry of 2013 Issued in accordance with the Provisions of Article (41) of the *Civil Health Insurance Regulation*, No. 83 (2004).

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[36] The letter of the Prime Ministry No. S1/9/4224, dated 01/02/2015

[37] Official Gazette, Edition No. 4673 dated 01/09/2004

[38] The Letter of the Minister of Health No. O Z/ 38/ 2/ 226 dated 11/10/1998

[39] *See* the resolution of the Prime Ministry No. 15 in its meeting on 03/04/2013, P 29

[40] Cabinet's decision No. 5747 in its meeting held on 21/09/2014

- Instructions for Rotation of the Medical File in the Hospitals of the Ministry of Health Issued in accordance with Article (41) of the Health Insurance Regulations
- Mechanism for Collection of Health Insurance Revenues in the Hospitals of the Ministry of Health[41]
- Processing the Books of Judicial Reports in the Hospitals of the Ministry of Health[42]
- The Period of Keeping Documents, Records, Books of Medical Reports and Health Certificates in the Ministry of Health[43]
- Regulations Issued in accordance with the Civil Health Insurance Regulations for Medicines and Medical Supplies
- The Regulations of Provision of Medicine to Patients Regulations No. 6 of 2010 Amending to Regulations No. 1 of 2010 and Regulations No. 7 of 2004 Issued in accordance with Article (23/D) of the *Civil Health Insurance Regulation*, No. 83 (2004).
- Circulation and provision of medical supplies in the Ministry of Health's hospitals and centers
- Treatment protocols relating the beneficiaries of Civil Health Insurance Fund

REGULATIONS AND DECISIONS ISSUED FOR EXEMPTIONS

- Processing applications submitted to the Royal Hashemite Court, Prime Ministry and Ministry of Health by uninsured citizens for purposes of exemption from the medical treatment expenses.[44]
- Processing Application of the Citizens Covered by Health Insurance for the Purposes of Exemption from All or the Proportion of Expenses Borne by the Patient according to the Terms of the Cooperation Agreement between the Ministry and Hospitals Contracted with.[45]
- Exemption of citizens transferred from the Ministry of Social Development and both National Aid Fund and Zakat Fund from examination and checkup expenses at the medical committees[46]
- Staff at Al-Akaider Landfill site.[47] The staff at Al-Akaider Landfill site shall be exempted from payment of the excess (20%) in case they visit King Abdullah University Hospital without transfer or directly as of 24/8/2014.
- Residents of Al-Akaider Town/ Mafraq Governorate[48] Residents of Al-Akaider/ Mafraq Governorate covered by the Civil Health Insurance who suffer from respiratory diseases shall be allowed to visit Ramtha Public Hospital without medical transfer from the competent health center.

[41] The letter of the Minister of Health No. O Z/ 37/2/4828, dated 18/9/2011

[42] The letter of the Minister of Health No. O Z/ 37/2/1327, dated 08/03/2011

[43] The letter of the Minister of Health No. O Z/ 37/2/3594, dated 15/05/2012

(44) The Cabinet's Decision No. 309 in its meeting held on 13/12/2011 and the Cabinet's decision No. 145 in its meeting held on 17/4/2013.

[45] The Cabinet's Decision No. 319 in its meeting held on 13/12/2011; List of hospitals contracted with pp. 149-150

[46] The Cabinet's Decision No. 7165 in its meeting held on 21/12/2014

[47] Letter of the Ministry of Health No. V.R./4/4/6014 dated 7/9/2014

[48] The Cabinet's Decision No. 10916 in its meeting held on 2/8/2015

- Treatment expenses of domestic violence victims.[49]
- Treatment Expenses of Persons Leaving the Residential Health Care Facilities/ Non-wealthy Category.[50]
- Treatment mechanism for medical conditions of inmates at reform and rehabilitation centers[51]
- Exemption of individuals arrested for suspicion of driving under alcohol influence from blood test expenses[52]
- Arrested individuals visiting the health centers and hospitals of the Ministry of Health and Prince Hamzah Hospital for the suspicion of driving under alcohol influence from blood test expenses to indicate alcohol percentage in the blood amounting JOD 5.
- Exemption of Iraqi citizens from the list of treatment fees approved for non-Jordanians[53]
- Iraqi citizens residing in the Kingdom shall be exempted from the list of treatment fees approved for non-Jordanians. They shall be treated the same as the uninsured Jordanians as they shall pay the treatment fees pursuant to the list of fees applied to the uninsured Jordanians for the cases visiting primary care centers.
- Treatment of Syrian refugees in hospitals and health centers of the Ministry of Health[54]
- Syrian refugees shall be treated the same as the uninsured Jordanians when treated in the hospitals and centers of the Ministry of Health. Treatment expenses and financial claims shall be collected directly therefrom without preparing financial claims in this regard.
- Exemption of the non-wealthy Palestinian refugees and Gaza Strip citizens residing in the Kingdom[55]
- The Cabinet may exempt the non-wealthy Palestinian refugees and Gaza Strip citizens residing in the Kingdom from treatment expenses.
- Exemption of children of Jordanian women married to non-Jordanians[56]
- Facilities provided to the children of Jordanian women married to non-Jordanians in respect of health care[57]
- Cases Exempted from Treatment Expenses[58]

LEGISLATIONS RELATED TO THE EXECUTIVE ASPECT OF HEALTH INSURANCE:

[49] The Cabinet's Decision No. 2869 in its meeting held on 19/10/2010

[50] Cabinet's decision No. 533 in its meeting held on 27/6/2012

[51] Cabinet's decision No. 39 in its meeting held on 1/11/2011

[52] Cabinet's decision No. 1017 in its meeting held on 29/1/2013

[53] Cabinet's decision No. 5663 in its meeting held on 16/10/2007

[54] Cabinet's decision No. 6524 in its meeting held on 12/11/2014

[55] Cabinet's decision No. 5240 in its meeting held on 20/8/2014

[56] Cabinet's decision No. 5663 in its meeting held on 16/10/2007

[57] Cabinet's decision No. V.R./4/4/7900 dated 30/11/2014

[58] Cabinet's decision No. 1607 in its meeting held on 20/5/2008

- *Regulations for Medical Reports and Committees*, No. 13 (2014), and amendments thereto, issued in accordance with Article 72, Paragraph 4 of PUBLIC HEALTH LAW, No. 47 (2008), and Amendments thereto; the Central Medical Committee shall have the authority to allow treatment outside hospitals affiliated to the Ministry of Health.
- *Regulations for the National Women's Health Care Center*, No. 4 (2011), issued in accordance with Article 120 of the Constitution of Jordan of 1952 and Amendments thereto and Article 4, Paragraph 4 of the PUBLIC HEALTH LAW, No. 47 (2008) and Amendments thereto.
- *Regulations for Prince Hamzah Hospital,* No. 90 (2008), and amendments thereto.
- Instructions on Terms and Conditions of Accounting of Patients subject to the Provisions of the *Civil Health Insurance Regulations at Prince Hamzah Hospital* No. 1 (2008) and Amendments thereto.
- Instructions for Issuance of Health Insurance Cards for Pregnant Women.
- Instructions for Issuance of Health Insurance Cards for 60-and-above Age Group.
- Instructions for Subscription of Former MPs and the Beneficiaries therewith to the Civil Health Insurance No. 1 (2016) and amendments thereto.

LEGISLATIONS FOR PUBLIC INSTITUTIONS COVERED THEIR EMPLOYEES WITH THE CIVIL HEALTH INSURANCE REGULATIONS:

- THE NATIONAL AID FUND LAW, No. 36 (1986).
- Instructions for Aid and Rehabilitation No. 1 (2004).
- *Regulations for the Staff of Jordan News Agency*, No. 17 (2010) and amendments thereto as Similarly, the following legislations involved the same provision:
- *Regulations for Amman University College of Applied Engineering,* No. 27 (1991) and amendments thereto.
- *Regulations for Staff of the Higher Council for Information* No. 100 (2003)
- *Regulations for the Staff of the Royal Jordanian Geographic Center* No. 48 (1980) and Amendments thereto
- *Regulations for the Staff of the Department of Statistics* No. 85 (2008).
- *Regulations for the Staff of the Prime Ministry* No. 79 of 2004 and Amendments thereto
- *Regulations for the Staff of Petra Region Authority* No. 82 (2002) and Amendments thereto
- *Regulations for the Staff of Jordan Radio and Television Corporation* No. 33 (1978) and Amendments thereto
- *Regulations for the Staff of Jordanian Ports Corporation* No. 24 (1982).
- *Regulations for the Staff of Drinking Water Corporation* No. 54 (1980) and Amendments thereto
- *Regulations for the Staff of Audiovisual Media Authority* No. 76 (2007) and Amendments thereto
- *Regulations for the Staff of Independent Election Commission* No. 40 (2012)
- *Regulations for Municipal Staff* No. 108 of 2007 and Amendments thereto
- *Regulations for the Staff of the Special Communications Commission* No. 54 (1984)
- *Regulations for the Staff of the Jordanian Maritime Authority* No. 166 (2003) and amendments thereto
- *Regulations for the Staff of Jordan Standards and Metrology Organization* No. 26 (2004) and amendments thereto
- Instructions for Hiring Casual Laborers in Municipalities and the Joint Service Councils (2014).
- Instructions for Volunteers of the Civil Defense (2012)
- Civil Service Regulation of (2012)

- *Regulations of the Staff of the Central Bank of Jordan* No. 62 of 2001 and Amendments thereto, issued in accordance with Articles 93 and 120 of the Constitution of Jordan of 1952 and Amendments thereto.
- *Regulations for the Jordanian Diplomatic Corps* No. 68 (1993)
- Instruction for the Medical Treatment of the Diplomatic Personnel and their Family Members (1980), issued in accordance with Article 41 of Regulations for the Jordanian Diplomatic Corps No. 64 of 1979 and Amendments thereto.
- *Regulations for the Staff of Aqaba Special Economic Zone Authority* No. 7 of 2007 and amendments thereto.

LEGISLATIONS RELATED TO EXPENSES COVERED BY THE HEALTH INSURANCE FUND:

- *Regulations for Incentives of Doctors and Pharmacists* No. 32 (1992) and Amendments thereto.
- *Regulations for Technical and Specialty Allowances for Doctors, Dentists, Pharmacists, Nurses and Midwives* No. 36 (1972)
- *Regulations for Treatment of Renal Failure* No. 11 (1983) and Amendments thereto
- Instructions for Incentives of Employees of the Ministry of Health No. 2 (2006) and Amendments thereto.

MILITARY SECTOR

- JORDANIAN ARMED FORCES LAW, No. 3 (2007).
- *Regulations for Health Insurance in the Jordanian Armed Forces* No. 4 (2000) and Amendments thereto.
- *Regulations for Military Medical Committees* No. 19 of 1971 and Amendments thereto, issued in accordance with Article 80 of the Jordanian Armed Forces Law No. 11 (1964). and Amendments thereto.
- *Regulations for King Abdullah II Design and Development Bureau* No. 156 of 2003 and Amendments thereto, as Article 16 provides for:
- *Regulations for Hiring Doctors and Pharmacists in the Armed Forces and Allowances* (1970)

PRIVATE SECTOR:

- THE LABOR LAW, No. 8 (1996).
- THE SOCIAL SECURITY LAW No. 1 (2014).
- Instructions for Coverage of Staff in Any Company or Institution by Health Insurance No. 10 (2007).
- Regulations for Private Offices for Recruitment and Employment of Non-Jordanian Domestic Workers Law No. 12 (2015).
- Instructions for the Insurance Policy for Domestic Workers (2015).

INSURERS AND SERVICE PROVIDERS:

- COMPANIES LAW, No. 22 (1997) and Amendments thereto.
- CONSUMER PROTECTION LAW No. 7 (2017).
- INSURANCE REGULATION LAW, No. 33 (1999) and amendments thereto.
- Code of Professional Conduct and Ethics relating to Instructions for Insurance Companies No. 9 (2004) issued by the Board of Insurance Commission in accordance with Article 23, Paragraph J and Article 108,
- Instructions for Licensing Insurance Management Companies and Rules for Regulation and Control, No. 36 (2010).

- Decision No. 16 (2010) Forming Committees issued by the Director General of the Insurance Commission on 12/05/2010 in accordance with the provisions of Article 5 of the Insurance Company Contract and Insurance Instructions with the Providers of Medical Services No. 3 of 2010 and Amendments thereto.
- Instructions for Licensing and Regulating the Duties and Responsibilities of Insurance Agents No. 1 (2005) and amendments thereto, issued by the Board of the Insurance Commission in accordance with the provisions of Article 23, Paragraphs H and J; Article 54, Paragraph A; and Article 108, Paragraph B of Insurance Regulation Law No. 33 of 1999 and Amendments thereto.
- Instructions for Licensing and Regulating the Duties and Responsibilities of Insurance Agents, No. 11 (2005), issued by the Board of the Insurance Commission in accordance with the provisions of Article 23, Paragraphs H and J; Article 55; and Article 108, Paragraph B of Insurance Regulation Law No. 33 (1999) and Amendments thereto.
- Instructions for the Committee of Insurance Dispute Resolution, No. 5 (2004) and Amendments thereto, issued by the Board of the Insurance Commission in accordance with the provisions of Article 83, Paragraph B of Insurance Regulation Law No. 33 of 1999 and Amendments thereto.
- Instructions for Accreditation of Insurance Brokers and Dispute Arbitrators at the Insurance Commission, No. 7 (2005) and Amendments thereto, issued by the Board of the Insurance Commission in accordance with the provisions of Article 84, Paragraphs A and B of Insurance Regulation Law, No. 33 (1999) and Amendments thereto.
- Instructions for Arbitration Procedures in Insurance Disputes and Provisions thereof, No. 9 (2005) and Amendments thereto, issued by the Board the Insurance Commission in accordance with the provisions of Article 84, Paragraph A of INSURANCE REGULATION LAW, No. 33 (1999) and amendments thereto.

LEGISLATIONS ON HEALTH INSURANCE OF UNIVERSITIES (SPECIAL FOCUS ON EXAMINING THE UNIVERSITY OF JORDAN AND THE UNIVERSITY OF SCIENCE AND TECHNOLOGY):

- THE JORDANIAN UNIVERSITIES LAW No. 20 of 2009 and Amendments thereto

UNIVERSITY OF JORDAN

- *Regulations for Health Insurance for Staff of the University of Jordan,* No. 50 (2003).
- *Regulations for Staff of the University of Jordan,* No. 52 (2003) and Amendments thereto.
- Instructions for Faculty of the University of Jordan (2011).
- *Regulations for Treatment at Jordan University Hospital,* No. 45 (1983) and Amendments thereto
- *Regulations for Jordan University Hospital* No. 64 (2008)

UNIVERSITY OF SCIENCE AND TECHNOLOGY

- *Regulations for Faculty of Jordan University of Science and Technology* No. 144 (2003)
- *Regulations for Health Insurance of Jordan University of Science and Technology* No. 168 (2003).
- KING ABDULLAH UNIVERSITY HOSPITAL LAW, No. 16 (1999)

5. The International Conventions:

- International Covenant on Economic, Social and Cultural Rights (1966)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)

- Convention concerning Sickness Insurance for Laborers in Industry and Commerce and Domestic Servants, No. 24 (1927).
- Convention concerning Sickness Insurance for Agricultural Laborers, No. 25 (1927)
- Standard Minimum Rules for the Treatment of Prisoners (1957).
- Convention on the Rights of Persons with Disabilities (2008)
- Convention on the Rights of the Child (2006).
- The Arab Charter on Human Rights (2004). Article 38/1 provides for: "The State Parties shall recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the right of every citizen to enjoy free and non-discriminatory access to health services and health care centers".

6. Bilateral Agreements

- Bilateral Agreement between Ministry of Health and Royal Medical Services
- Bilateral Agreement between Ministry of Health and Jordan University Hospital
- Bilateral Agreement between Ministry of Health and Private Hospitals
- Bilateral Agreement between Ministry of Health and King Abdullah University Hospital