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DRAFT COMPREHENSIVE REPORT

23 APRIL 2021

TO: Chief Executive Officer, The Insurance Regulatory Authority

SECOND DELIVERABLE FOR THE DEVELOPMENT OF A COMPREHENSIVE LEGAL AND REGULATORY FRAMEWORK FOR REGULATION, SUPERVISION AND DEVELOPMENT OF HEALTH INSURANCE IN KENYA FOR THE INSURANCE REGULATORY AUTHORITY

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List of Abbreviations

AKI	Association of Kenyan Insurers
CHE	Current Health Expenditure
CPT	Current Procedural Terminology
DRG	Diagnostic-Related Groups
EHBP	Essential Health Benefit Package
FCR	Financial Condition Report
GDP	Gross Domestic Product
GGE	General Government Expenditure
GNI	Gross National Income
GP	General Practitioner (GP) Doctor
HISP	Health Insurance Subsidies Program
IAIS	International Association of Insurance Supervisors (IAIS)
HMO	Health Maintenance Organisations
HSSP	Health Sector Service Fund
IAIS	International Association of Insurance Supervisors
ICD	International Classification of Diseases
ICPs	Insurance Core Principles (issued by the IAIS)
IFC	International Financial Cooperation
ILO	International Labour Organisation
IRA	Insurance Regulatory Authority (of Kenya)
JCI	Joint Commission International
KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic and Investment Plan
KMPDC	Kenya Medical Practitioners and Dentist Council
MCR	Minimum Capital Requirements
MDGs	Millennium Development Goals (MDGs)
MIPAK	Medical Insurance Providers of Kenya
MOH	Ministry Of Health
NHIF	National Hospital Insurance Fund
OECD	Organisation for Economic Co-operation and Development (OECD
OOP	Out-of-pocket expenditure
PCR	Prescribed Capital Requirements
PHI	Private Health Insurers
PHS	Public Health System
RIA	Regulatory Economic Impact Assessment
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
TCF	Treating Customers Fairly
TPA	Third Party Administrators
UHC	Universal Health Coverage
VHI	Voluntary Health Insurance
WHO	World Health Organisation

List of Definitions

Term	Definition
Age dependency ratio (% of working-age population)	Age dependency ratio is the ratio of dependents--people younger than 15 or older than 64--to the working-age population--those ages 15-64. Data are shown as the proportion of dependents per 100 working-age population.
Catastrophic health expenditure.	Out-of-pocket payments for health services that exceed a given fraction of total household expenditure
Employment in services	Employment is defined as persons of working age who were engaged in any activity to produce goods or provide services for pay or profit, whether at work during the reference period or not at work due to temporary absence from a job, or to working-time arrangement. The services sector consists of wholesale and retail trade and restaurants and hotels; transport, storage, and communications; financing, insurance, real estate, and business services; and community, social, and personal services, in accordance with divisions 6-9 (ISIC 2) or categories G-Q (ISIC 3) or categories G-U (ISIC 4). In the context of this project, employment is demarcated between formal and informal employment. Formal employment is defined as employment in the formal sector both the employers and employees are regulated government. Informal employment covers diversified economic activities in sectors outside of the regulatory purview of the government and is often characterised by unprotected jobs.
Formal employment	Formal employment is defined as employment in the formal sector both the employers and employees are regulated government. Employers typically operate in the formal domain in a formalised form, that is, they are registered and provide protected employment on a structured and contractual basis.
IAIS	"The International Association of Insurance Supervisors (IAIS) Established in 1994, the IAIS is a voluntary membership organization of insurance supervisors and regulators from more than 200 jurisdictions, constituting 97% of the world's insurance premiums." For more information, please see www.iaisweb.org
Informal employment	Informal employment is characterised by 'unstructured' employment and engagement in a variety of income-generating activities that are outside of the formal sector and formal structures. This definition of informal employment includes 'unprotected employment.'
GNI	GNI per capita (formerly GNP per capita) is the gross national income, converted to U.S. dollars using the World Bank Atlas method, divided by the midyear population. GNI is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. GNI, calculated in national currency, is usually converted to U.S. dollars at official exchange rates for comparisons across economies, although an alternative rate is used when the official exchange rate is judged to diverge by an exceptionally large margin from the rate actually applied in international transactions. To smooth fluctuations in prices and exchange rates, a special Atlas method of conversion is used by the World Bank. This applies a conversion factor that averages the exchange rate for a given year and the two preceding years, adjusted for differences in rates of inflation

	between the country, and through 2000, the G-5 countries (France, Germany, Japan, the United Kingdom, and the United States). From 2001, these countries include the Euro area, Japan, the United Kingdom, and the United States.
Gross Domestic Product (GDP) per Capita in PPP Int. $	This indicator provides per capita values for gross domestic product (GDP) expressed in current international dollars converted by purchasing power parity (PPP) conversion factor. GDP is the sum of gross value added by all resident producers in the country plus any product taxes and minus any subsidies not included in the value of the products. conversion factor is a spatial price deflator and currency converter that controls for price level differences between countries. Total population is a mid-year population based on the de facto definition of population, which counts all residents regardless of legal status or citizenship.
Life expectancy at birth	Life expectancy at birth is defined as how long, on average, a new-born can expect to live, if current death rates do not change. However, the actual age-specific death rate of any particular birth cohort cannot be known in advance. If rates are falling, actual life spans will be higher than life expectancy calculated using current death rates. Life expectancy at birth is one of the most frequently used health status indicators. Gains in life expectancy at birth can be attributed to a number of factors, including rising living standards, improved lifestyle and better education, as well as greater access to quality health services. This indicator is presented as a total and per gender and is measured in years.
Loss ratio (claims ratio)	The ratio of claims incurred to earned premiums that provides an indication of how well the pricing of an insurer matches the risks taken in the insurance contracts (may be reported either gross or net of reinsurance).
Out-of-pocket (OOP) payment	Direct payment made to health-care providers by individuals at the time of service use, i.e., excluding prepayment for health services – for example in the form of taxes or specific insurance premiums or contributions – and, where possible, net of any reimbursements to the individual who made the payment.
Poverty gap at $5.50 a day (2011 PPP) (%)	Poverty gap at $5.50 a day (2011 PPP) is the mean shortfall in income or consumption from the poverty line $5.50 a day (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.
Retrocessionaire (with regards to reinsurance)	Reinsurance Business means the business of undertaking liability to pay money to insurers or reinsurers in respect of contractual liabilities in respect of insurance business incurred by insurers or reinsurer and includes a retrocession
Tax Revenue	Tax revenue refers to compulsory transfers to the central government for public purposes. Certain compulsory transfers such as fines, penalties, and most social security contributions are excluded. Refunds and corrections of erroneously collected tax revenue are treated as negative revenue.
Universal health coverage	Universal health coverage means all people receiving the health services they need, including health initiatives designed to promote better health (such as antitobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation, and palliative care

	(such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship.
World Bank Country Income Group Classification (The World Bank, 2021)	Low-Income economics: $1 035 or less Lower-middle income economies: $1 036 to $4 045 Upper-middle income economies: $4 046 to $12 535 High-income economies: $12 536 or more

(IAIS Glossary, 2019)

Executive Summary

(Please note that the terms medical insurance and health insurance are used interchangeably in this report. The Insurance Act refers to medical insurance, however in the market and global context references are made to health insurance and therefore these terms are referred to interchangeably in this report.)

Various reports and reviews have highlighted concerns with regards to the applicability of Kenya's current health insurance regulatory framework and its ability to address the risks in health insurance. Furthermore, these reports and reviews have also provided key recommendations concerning the reformation of Kenya's health insurance regulatory framework. Subsequently, the Project Implementation Unit of the National Treasury & Planning issued a call for proposals for the development of a comprehensive legal and regulatory framework for the regulation, supervision, and development of health insurance in Kenya.

The focus of this document and the aim of the policy proposals and recommendations is the creation of a legal and regulatory framework that will support the growth and development of private insurance in Kenya while enabling its appropriate regulation and supervision. This will enable the private sector to contribute to achieving the Government's goal of Universal Healthcare (UHC). Once the policy framework is agreed, amendments to the Insurance Act and new Health Insurance Regulations will be drafted as part of phase III of this project. This report also includes proposals for the updating by the Insurance Regulatory Authority (IRA) of its circulars and guidelines, as well as considering how other Acts and regulators that impact the delivery of health insurance could be updated. The implementation of agreed policy with respect to other regulators is not part of the terms of reference for this Project.

This comprehensive report is the second deliverable within this project and is submitted by i3Actuaries and the consulting team. The project consulting team is composed of 8 team members who have a combined wealth of experience in the insurance sector across the world, including the field of health insurance.

The development of a comprehensive legal and regulatory framework for health insurance forms part of the larger Financial Sector Support Project. Thus, the main outputs from this project are a policy paper and draft regulations for private health insurance in Kenya. The beneficiary under this project is the Insurance Regulatory Authority (the IRA). This report will only consider the regulation and supervision of bodies outside the IRA to the extent that a collaboration framework is required to support in the delivery of efficient private health insurance.

Summary of the comprehensive report

Structure of the report

Section 2 gives a summary to the current state of private health insurance in Kenya. The increasing low level of PHI penetration, and low levels of overall UHC in Kenya, is the reason for reviewing and updating the Insurance Act and Regulations. Section 3 gives and overview of the current regulatory framework and identifies gaps that should be covered in the new draft regulations. Section 4 defines the key components that could form part of a medical insurance system and gives the benefit and drawbacks of implementing various possible

options. By explaining the available options, the final proposals will be clearly understood by all parties. Section 5 includes a benchmarking exercise of other countries with private and public health insurance systems to explain why certain components were selected from these countries. Section 6 summaries the relevant policy proposals identified in past research papers on health insurance in Kenya. Section 7 gives the policy proposals and explains how they will impact the Insurance Act and regulations and well as other related Acts and regulations.

Overview of healthcare in Kenya

The Kenyan health system consists of a diverse mix of public (the state, the National Health Insurance Fund or the NHIF) and private stakeholders (private health insurers and private healthcare providers) with an equally diverse set of interests and outcomes.

The government's administration of healthcare and health services, the Kenyan health system, is based on a highly tiered and decentralised system. Under this decentralised system, counties are responsible for the oversight and administration of healthcare in their respective jurisdictions. It is foreseen that such a decentralised system facilitates equitable and efficient delivery of services through stimulating innovation at county level and in the wider health system thereby improving access to and equity in the availability of needed healthcare services.

Healthcare in Kenya is financed by a combination of direct government expenditure, contributions to the NHIF and private health insurance, with the government being the main funder. .With only 29% of Kenyans having any form of insurance - with the most recent available information from 2016 indicating that only 20% has any form of health insurance - the remainder and majority of the population is entirely dependent on the state for their healthcare. Furthermore, those reliant on the state to finance their healthcare (that is, most of the Kenyan population) have limited or no ability to pay for healthcare services using direct out-of-pocket (OOP) payments. The financial burden of healthcare is a reality for most Kenyans and thus advancing UHC is imperative.

Private healthcare in Kenya is characterized by high costs of care that are driven by a recurring high rate of cost escalation (medical inflation) especially at leading private hospitals. This is reported to have hampered the development of low-cost health insurance products. Furthermore, insurers reported that attempts to develop low-cost products have also been partly hampered by the low quality of care in low-cost hospitals.

Based on the World Health Organization (WHO) health cube, a quantifiable model measuring Kenya's progress in advancing UHC was built across 3 main components and dimensions, namely:

1. **Financial coverage of the population** – Approximately 20% of the population has any form of health insurance coverage (NHIF, private insurance or community cover).
2. **Expansion of financial risk protection mechanisms -** The combined analyses of all the various indicators show that 63% of the Kenyan population has access to adequate services (as shown by the list of health services listed in the promotion/preventative and treatment indicators). The Kenyan Universal Health Coverage Policy aims to expand the services offered through ensuring that the

population access a wide range of service areas including a renewed focus on primary health care services.

3. **Establishment of financial risk protection mechanisms -** This dimension measures the percentage of Kenyans who are at financial risk due to health costs. The Kenyan health-care financing system has a relatively high level of OOP expenditure at approximately 24% of total health expenditure.

The ideal (which has not been achieved even in high-income countries) is universal coverage for 100% of the population for 100% of the services available and for 100% of the cost – and with no waiting lists. (World Health Organisation, 2015). Taking these 3 dimensions into consideration, Kenya's overall score was 53% meaning. One of the main objectives of this project is to develop a regulatory framework that supports Kenya's efforts in advancing UHC.

Analysis on current legal and regulatory frameworks of medical insurance

The analysis of the health insurance legal and regulatory framework took the following key factors into consideration:

- International principles and standards including the International Association of Insurance Supervisors' (IAIS) Insurance Core Principles (ICPs).
- Benchmarking and comparative analysis with other regional and international jurisdictions.
- The various stakeholders and players in the medical insurance ecosystem and the role they play.

Typically, and as is the case in Kenya, the healthcare market consists of multiple players, institutions and stakeholders who all play a role in the medical insurance ecosystem as summarized in Table 1 below:

Table 1. Various stakeholders in the Kenyan healthcare market

Player	Role in the market	Kenyan player/stakeholder
The government	The government plays a significant role in the provision and financing (carrying the cost burden) as healthcare is seen as a social good.	The Government of Kenya
The regulator	Ensure the health market operates in an efficient manner ensuring the appropriate levels of protection for insured lives.	Insurance Regulatory Authority (IRA), Ministry of Health, Non-defined regulator
Insurers	Third-party player in the relationship between the provider and the insured. However, the insured carries the financial burden of the cost of care.	Various medical insurers (Jubilee Insurance, Heritage Insurance, UAP Old Mutual – among others)
Providers	Are experts in the provision of care and are separately regulated from the insurers.	Including public providers, private-non-profit (faith-based organisations etc.) and private for-profit
Provider groups	Most healthcare providers are members of healthcare societies and as such they are subject to certain standards of care. To a very limited extent, provider group societies oversee standards of care and issues of professional services	Oasis Healthcare Group, Aga Khan Hospital - among others
Insured	The insured enters into a contract with the insurer for the provision of health insurance. However, the care is often received from a party who is independent to the commercial relationship with the insurer (the healthcare provider).	Kenyan population

The various players in the Kenyan market can also be placed in the insurance value chain. The value chain is a breakdown of the various activities and processes that facilitate the insurance transaction from underwriting through to client acquisition. Various players in the Kenyan medical insurance value chain are:

- **Community Based health initiatives** - Community based initiatives are not regulated by the IRA. They can either be initiated by health facilities, NGOs, local communities or cooperatives and can be owned and run by any of these organisations.
- **Medical insurance providers** – Typically act as brokers but may also provide additional services. These additional services may include the management of outpatient funds where outpatient benefits are not insured but covered by the sponsor. MIPs are typically registered companies.
- **Agents and Brokers** – According to the insurance act, agents and brokers and brokers are defined as those who solicit and procure insurance business in return for a commission. The IRA keeps a list of the various registered agents and brokers.
- **NHIF –** The NHIF is the state entity mandated to offer health insurance coverage for both in-patient and outpatient visits. The NHIF is not registered with the IRA as it is not legally mandated to offer commercial insurance. However, recent amendments to the Insurance Act provide provisions for social insurance schemes such as the NHIF.
- **Health Maintenance Organisations (HMOs)** – HMOs deliver health maintenance treatment services to a group of enrolled persons who pay pre-negotiated fixed payments. An HMO is a grouping of facilities, physical and other healthcare personnel into a single system that provides a full range of medical services to a specifically enrolled population for a fixed fee paid in advance. In Kenya, HMOs

offer health packages but are not regulated as insurance companies offering health services and they are regulated by the Ministry of Health in terms of the medical services they provide.

- **Self-funded schemes** - Self-funded schemes are schemes where no form of insurance cover is purchased, but rather the employer/sponsor sets aside a fund for the payment of medical expenses incurred by staff members and their dependants.
- **Medical insurance** - The IRA's mandate covers the regulation of all major lines of insurance business of which medical insurance is one such class. Currently medical insurance is regulated and reported as a class of general insurance.
- **Third Party Administrators** - Third party administrators (TPAs) are organisations that are responsible for accepting and processing health insurance claims from doctors, hospitals, and pharmacies. Their services can however also extend to assistance with empanelment, beneficiary enrolment, pre-authorisation management, fraud detection, etc. TPAs are currently not regulated by the IRA.
- **Reinsurance intermediaries** - Reinsurance Intermediaries are brokers who act as intermediaries between reinsurers and ceding companies. For the reinsurer, intermediaries operate as an external sales force. They also act as advisers to ceding companies in assessing and locating markets that meet their reinsurance needs. Reinsurance intermediaries are regulated by the IRA.

A regulatory gap analysis was conducted to assess where additional legislation and clearer guidance may be required within the current regulatory framework. A summary of the regulatory gap analysis is presented below in Table 2.

Table 2. Regulatory gap analysis

Area or entity concerned	Regulatory gap
Foreign medical insurers in the local market	Section 19 of the Insurance Act effectively prohibits a foreign insurer from "carrying on insurance business in Kenya". This language is similar to the language used in many jurisdictions. However, subject to any Court decisions not known at the time of writing, the scope of what constitutes "carrying on insurance business in Kenya" is unclear. In any event, any provision that seeks to place a prohibition on a foreign insurer with no presence in Kenya is effectively unenforceable, as the insurer is outside the jurisdiction of the IRA and the Kenyan courts. Section 20(1) of the Insurance Act prohibits the involvement of Kenyan insurance intermediaries in actively placing Kenyan health insurance business with a foreign insurer, without the approval of the Authority, but it is unclear whether a Kenyan resident who (without the involvement of a registered intermediary) purchases health insurance from a foreign insurer, is covered by section 20. This is a problem that affects all classes of insurance business. With respect to medical insurance, there are both consumer protection and market development issues.
Entities involved in the provision of medical insurance where the IRA does not have regulatory oversight.	• Community based health schemes - Currently, the IRA does not have oversight into the functioning of community-based health groups. • Third Party Administrators and their interaction with insurers are currently not regulated by the IRA. • Healthcare providers are separately regulated from the insurers. However, the standards, range of services, price directly impact the type of insurance that can be offered and the ability to ensure the quality and control the cost of insurance.
Health Medical Organisations (HMOs)	Health Maintenance Organisations provide what is, in substance, medical insurance to their members by providing access to medical care at a fixed pre-paid amount, or a capitation fee. However, despite carrying insurance risk, HMOs are not currently regulated by the IRA and are not deemed to provide medical insurance. HMOs do not, therefore, fall within section 19 of the Insurance Act as they are not considered to carry on insurance business.
Participation, minimum benefits and coverage limits	The Insurance Act, regulations, circulars and guidance contain no provisions on participation in medical insurance, minimum levels of benefits and coverage limits.
Definitions and explanations of medical insurance terms and concepts	Given that the regulatory framework contains few provisions that are specific to medical insurance, there is no necessity for medical insurance terms and concepts to be defined or explained. This will be a significant gap in relation to the introduction of prescribed minimum benefits, standardised product offerings and other policy proposals made in Section 7.
Policyholder protection	The Insurance Act may need to expand its list of definitions or provide additional guidance in its policyholder protection rules to enable uniform adoption and implementation of a number of medical insurance specific items.
Treating customers fairly	The IRA has started requiring insurance companies to self-assess their treatment of policyholders and beneficiaries in line with the IRA's mandate and best practice. The IRA has also initiated initiatives to develop the industry's education with regards to TCF and its implementation within the regulatory environment. These requirements could be further strengthened.

Area or entity concerned	Regulatory gap
Medical insurance ombudsman	The establishment of the medical insurance ombudsman that interacts with citizens, oversees if their rights have been respected and provides policy recommendations could help improve trust in the medical insurance sector.

Benchmarking

Part of developing a comprehensive regulatory framework also requires benchmarking against other jurisdictions and countries. These comparisons offer the possibility of exploring new and different options; the potential for mutual learning and even policy transfer; and the opportunity to reconsider and reformulate national policy. As the policy objective of this regulatory framework is advancing universal healthcare and supporting the development of the private insurance market, the benchmarking process and outline is aligned to this aim.

The benchmarking process for this project involved comparing the relevant comparative statistics in identified jurisdictions. The comparative countries were identified in collaboration with the IRA as the implementing lead of the proposed regulatory framework. The IRA selected these countries on the basis that each of them has achieved some of the key objectives pursued in the forthcoming health insurance regulatory framework. The identified comparative countries are Israel, Ghana, Germany, Netherlands, and South Africa. The major benefit of such comparisons is their potential to provide a snapshot comparison of different experiences and the lessons that can be learnt and applied.

Key areas where comparative analysis was conducted include (among others):

- Country statistics
- The health systems
- Private health insurance
- Treatment of foreign insurers
- Indemnity, fee-for-service and capitation
- Strategic purchasing
- Affordability and prescribed minimum benefits
- Pricing guidelines

Overview of recommendations in literature

Several recommendations have been made concerning revisions to the Kenyan health insurance regulatory framework to ensure the advancement of universal healthcare. Recommendations that have previously been made in various sources of literature (including reports, documents among others) were then analysed according to key thematic areas as shown in the Table 3 below:

Table 3. Summary of literature review

Key thematic area	Proposed recommendations
Development of a comprehensive insurance regulatory framework	The development of a comprehensive health insurance regulatory framework that incorporates various suggested elements (including): • Guidelines for MHIs • Redefining risk pooling and prepayment mechanisms • Expanding the role of the IRA to regulate and supervise the provisions of health insurance • The introduction of a medical insurance ombudsman • Develop a regulatory framework that supports the growth of the private health insurance sector.

Regulation and management of the NHIF	Some of the suggested recommendations concerning the regulation and management of the NHIF and cover various areas (including):
	• The standardisation of provider payment
	• Improved design of the NHIF benefit package
	• Suggested reforms to the forthcoming NHIF Bill
	  ○ Structuring registration fees according to the level of care in order to avoid over-utilisation
	  ○ Understanding the role of stakeholders' interests in the specific design elements with regards to the implementation of the NHIF Bill
	  ○ Continuous process of building trust in creating transparent governance structures.

UHC and the expansion of PHI	In order to expand UHC, it is recommended that: • Government needs to consider prioritizing investments in community level and primary healthcare • Interventions that facilitate lowering of healthcare costs • Aggregation of risk pools to maximise efficiencies • Understand the low-income market and exploring opportunities to expand PHI in that market
Strategic purchasing	• Development of a policy and regulatory framework for strategic purchasing • Incorporate strategic purchasing within the broader health financing strategy • Develop a strategic policy where purchasers can choose who they contract with.

These key thematic areas were referred to on multiple occasions across various sources implying their significance. These various recommendations were incorporated and considered in the drafting of the proposed regulatory framework.

Outline of the proposed draft regulatory framework

The section of the report outlines the policy proposals for the development of a comprehensive health insurance regulatory framework for Kenya. Following each policy proposal, an indication is given, in broad

terms, of how the proposal would impact the current legal regulatory framework and the changes that would be required to the legal and regulatory framework to implement the proposal.

Table 4. Outline of the proposed draft regulatory framework

Area of concern	Policy proposal
Market structure and uniform definition of medical insurance	• No changes are needed with respect to health insurance products sold into Kenya by foreign insurers on a cross border basis. • Commence the process of bringing Community based health within the regulatory ambit of the IRA. • HMOs should be licensed and regulated by the IRA as a new licence category. • Third Party Administrators should be licensed and regulated by the IRA as a new licence category. • Medical insurance to remain a separate class within the General Insurance Business. • Continue with the process of bringing the NHIF within the regulatory ambit of the IRA.
Participation, minimum benefits and coverage limits	• Implement open enrolment where insurers are mandated to accept all lives who can afford cover. • Insurers should only offer Indemnity cover with co-payment and benefit caps. Stated-benefits cover should not qualify as health insurance products. • Implement a prescribed minimum benefits (PMB) package for all health insurers. • There should be provision for regular review and amendment to the PMB package to adjust for changes in affordability and the overall disease burden.
Benefit design	• Permit insurers to reject claims made outside of referral pathways, provider networks, policyholder elected GPs, pre-authorization processes, managed care and treatment protocols. • All policyholders should have access to the same policy options and be included in the same risk pool, i.e. group benefit and individual product offerings and prices should be standardised across the insurer and form part of the same risk pool.
Risk sharing mechanisms	• A risk equalisation fund should be established and managed by the IRA.
Premium and underwriting rules	• All benefit options should be approved by the IRA. The IRA currently requires this for retail products but this requirement includes both group and retail products. • Engage with Actuarial and Insurance professionals to provide professional guidance on actuarial and insurance certification of new options. • Mandatory regular reporting to the IRA on the performance of options and groups. The IRA should have the power to enforce corrective measures on market players who are setting unreasonably low premiums. • Insurers should be allowed to risk rate based on age however maximum differences between the highest and lowest premium rates between lives on the same product should be introduced. The initial recommendation is a 200% differential between the highest and the lowest rate. • No premium loadings are allowed for any condition identified during the underwriting process to support the principle of open-enrolment. The benefit caps, co-payment amounts, and exclusions cannot vary based on the underwriting outcome. Any benefit caps should reset on policy renewal and excessive claims in one year cannot impact the maximum claims allowed in a following year.

Area of concern	Policy proposal
	• Insurers should be allowed to apply reasonable general waiting periods. A three month general waiting period is recommended. • Insurers should be permitted to apply condition specific waiting periods which are clinically appropriate for the specific condition e.g. 9 months for pregnancy. However, these waiting periods should not exceed 24 months. No lifetime waiting periods may be implemented. • While waiting periods on maternity benefits may be imposed, a new-born (even if born prematurely) must be immediately included as a dependant under the policyholder. • Insurers should not be permitted to apply lifetime exclusions or impose waiting periods on PMBs and the underwriting of PMBs at policy inception or renewal should be prohibited. Benefit caps or exclusions that apply to the normal benefit cannot be applied to the PMB. • An insurer may not impose new waiting periods if the policyholder confirms that: • The policyholder previously had a policy with another insurer within the last three months of applying for new cover; and • The policy benefits under that previous policy provided cover in respect of similar risks relating to the same lives insured as those covered under the new medical insurance policy; and • The policyholder had completed the waiting period in respect of that previous policy. • An insurer underwriting the new policy may impose a waiting period equal to the unexpired part of the waiting period under a previous medical insurance policy if: • The waiting period of the policyholder or member under the previous policy had not expired at the time that the policyholder enters into the new medical insurance policy; and • The new policy provides cover in respect of similar risks relating to the same lives insured as those covered under the new medical insurance policy. • Condition specific waiting periods can be carried over when consumers move from one insurer to another subject to the same conditions specified for general waiting periods above. There should be guaranteed policy renewal for all policyholders.
Financial soundness and regulatory supervision	• Enhance the current annual reporting requirements to include a budget for the next period. • Quarterly reporting should be enhanced to include reporting of monitoring the membership size of insurers and product as well as changes in the risk profile of products.
Policyholder protection mechanisms	• Require insurers to file marketing material to the IRA for approval along with the benefit design approval. The material should be simple for consumers to understand and signed off by a senior manager or a person with appropriate authority to whom the responsibility has been delegated. • Intermediaries should be required to keep records of the advice they give. • Insurers should be required to ensure that policy documents specify the complaint mechanisms available to policyholders.
Relationships with providers	• Establish an independent accreditation body to carry out accreditation process of all healthcare providers in the industry. Accreditation is separate from empanelment, which should remain the function of the separate health insurers.

Area of concern	Policy proposal
	However, insurers may only empanel a provider what has been accredited as a health care provider. • This body should be created with the engagement of all other provider bodies in the industry such as (but not limited to) the Kenyan Medical Practitioners and Dentists Council, clinical officers council, nursing council of Kenya, pharmacy and poisons board and Ministry of Health. • Implement DRG's for In-hospital re-imbursement. • For the purposes of developing DRGs, claims need to contain - ICD coding & CPT procedural coding. The claims must also be linked to the age and gender of the patient. • Only allow providers to engage in capitation arrangements subsequent to checks on providers quality of care and ability to meet some level of minimum capital requirements. The ultimate liability to provide benefits set out in the medical insurance policy remains with the insurer. • Insurers are required to demonstrate how they are measuring the quality of care their policyholders are receiving. • In conjunction with provider bodies, minimum standards of quality reporting should be developed, and providers must demonstrate how they are measuring and improving the care they give. • Requirement for hospitals to provide summarized data to IRA on admissions and to publish patient-outcome based metrics.
Data standards	• Mandate requirement for ICD coding and CPT procedural coding on all claims (necessary for DRG development). • Draft a list of medication specific codes (not necessary for development of DRGs) which will be required on all claims for medicines. • Draft a set of unique provider/practice numbers. • Claims data should also be accompanied by the unique practice/provider number of the provider administering care. • Stipulate that health insurers must maintain records of monthly membership details with age and gender information. The income band should be noted if related to the premium calculation.
Independent Insurance Ombud	• Establishment of an independent insurance ombudsman
Partnering with other bodies	Establish a memorandum of understanding with other healthcare system regulators and bodies including: • Central Board of Health who are advisors of the Ministry of Health. • Medical Practitioners and Dentists Board which registers and licences. • Clinical Officers Council, which assesses qualifications of clinical officers and register and license them. • Nursing Council of Kenya, which maintains proper standards of nursing care in health institutions. • Pharmacy and Poisons Board which regulates the profession of pharmacy. • The local Actuarial Society • The NHIF
Other considerations	• Allow for flexibility to amend regulations to deal with unusual events such as COVID-19. • Establish a process for health technology assessment.

Area of concern	Policy proposal
	• Insurer's should have access to the IRA's regulatory sandbox.

Outline of the regulatory economic impact assessment

The quantitative (and qualitative) impact of proposed policy recommendations in the outlined health insurance regulatory framework is an important factor to consider when assessing the cost of implementing these proposals.

An exact estimate of the numerical impact of proposals on the Kenyan health sector is not possible due to a lack of quantitative data on private health insurance available in Kenya. Therefore, the section analyses the impact in two ways: firstly, estimates that are relative to the impact of the proposals on the three dimensions of the health cube (as discussed in Section 0 and secondly, estimating the impact of through considering the data available in other African countries where similar proposals are quantified. Implementing policy recommendations may lead to a trade-off due to the finite resources available, An implemented policy proposal can increase one dimension while resulting in a decrease in other dimensions, for example – increasing expenditure on one dimension will lead to decreased resources available to another dimension. Other proposals may cause a decrease in a dimension while supporting and enabling another proposal that will result in an increase in another dimension.

The aim is therefore not always for each proposal to increase the cube in all directions, but that the overall impact of the policy proposals results in an increase in the health-cube. The combination of proposed regulations and amendments made in this report is therefore expected to increase the health-cube for Kenya. An increase in the health cube would mean an increase in Kenya's progress towards achieving UHC by reducing OOP, increasing the number of lives covered and an increase in the benefits covered.

Outline of next steps

This report is the second deliverable to be submitted to the IRA and following the submission of this draft Comprehensive Report on Friday 23 April 2021, the next steps and timelines are:

1. **Deliverable: Comprehensive Report including the Health Policy Paper and the Regulatory Economic Impact Assessment (RIA)**
    - The draft Comprehensive Report includes
        - *Health Policy Proposal* - draft of the forthcoming health insurance regulations.
        - *The Regulatory Economic Impact Assessment (RIA)* - measuring the impact of the regulatory proposals
    - The IRA to review the first draft of the Comprehensive Report (including the RIA and the Health Policy Paper) submitted – 23 April to 30 April 2021.
    - The IRA to submit comments and feedback concerning the draft Comprehensive Report – 30 April 2021.
    - Meeting to discuss the IRA's feedback and comments concerning the Comprehensive Report – 12 May 2021.

- Technical Working Group workshop.
- Stakeholders' validation workshops.

2. **Deliverable: Draft Health Insurance Regulations**
    - To be finalised with input, feedback and comments from various stakeholders at the forthcoming stakeholders' validation workshop in line with the process outlined in section 7.15.
    - In addition to recommended changes to the Insurance Act and regulations, this step will include a *Collaborative framework* – outlining the collaboration required between the key regulators and stakeholders in health insurance and healthcare to ensure comprehensive oversight, supervision and regulation of the sector.
3. **Deliverable: Action Plan**
    - To be developed in consultation with various stakeholders at the forthcoming stakeholders' validation workshop where the Comprehensive Report will be finalised. The action plan will outline the implementation path for the forthcoming health insurance regulations.
4. **Deliverable: Final report**
    - At the stakeholders' validation workshop, feedback and comments concerning the Comprehensive Report will be discussed. Following the workshop, the feedback and comments will be considered and incorporated to produce the final report.

Additional steps and processes that will continue for the duration of the project:

- Regular engagement with the IRA.
- Regular engagement with the technical working group.

1. Report introduction

This comprehensive report is one of the key deliverables within a broader project whose objective is the development of an appropriate and comprehensive policy paper and draft regulations for health insurance in Kenya. The main beneficiary of this project is the Insurance Regulatory Authority of Kenya (IRA) which is charged with the regulation, supervision, and development of insurance.

1.1. Broader objectives and scope of work

The objectives of this project reflect the agreed objectives stated in the project contract titled 'DEVELOP A COMPREHENSIVE LEGAL AND REGULATORY FRAMEWORK FOR REGULATION, SUPERVISION AND DEVELOPMENT OF HEALTH INSURANCE IN KENYA FOR THE INSURANCE REGULATORY AUTHORITY (FSSP/PIU/IRA/44/2018-2019).'

All the additional outputs and project objectives are focused on supporting the main project output, namely, a comprehensive regulatory framework that enables the supervision and development of health insurance in Kenya in a viable and efficient manner. The development of this regulatory framework considers the factors that curtail the provision of health insurance in Kenya such as affordability, market fragmentation and inflation linked cost of health insurance.

Additional information concerning the supporting project outputs and the related sub-objectives include:

i. A review of the Kenyan health care provision landscape which includes a broad analysis of the nature and needs of the uninsured population, the individuals covered by the National Hospital Insurance Fund (NHIF) and the private health insurance. market. This broad analysis identifies gaps in current health care provision and provides recommendations on possible future interventions to assist Kenya to move towards achieving the provision of Universal Health Care (UHC).
ii. An in-depth review of the private healthcare insurance landscape, including an analysis of the current Kenyan regulatory landscape (a review of the various regulations including the Insurance Act, the NHIF Act and related policies), the health insurance market and health insurance underwriting practices. The aim of this review is to identify gaps in the current regulatory framework by benchmarking it against international best practice and providing a comparison of the different options and approaches adopted by the selected benchmark countries. The Insurance Core Principles (ICPs) issued by the International Association of Insurance Supervisors (IAIS) do not specifically refer to health insurance and the IAIS has not issued any Standards, Issues Papers, Application Papers or other documents or guidance that relate directly to health insurance.
iii. Providing appropriate recommendations concerning the development of a comprehensive health insurance regulatory framework will require an evaluation of health system financing in Kenya. This evaluation will consider the role of health insurance and the extent to which, and how, health insurance can meet the financing needs of the Kenyan population.
iv. A Regulatory Economic Impact Assessment (RIA), that provides an overview of the impact of the proposals on the Kenyan Health Cube.

v. An analysis of the feasibility of a collaboration framework that will facilitate cooperation and collaboration between the IRA and other regulators and supervisors of health service providers (such as the Kenya Medical Practitioners and Dentist Council or the KMPDC), to consider issues relating to the provision of health services under health insurance contracts. This does not extend to detailed recommendations or to the drafting of the necessary legal and regulatory framework for health service providers as the focus is on the provision of health insurance - the focus of the document is regulation of private health insurance and not the regulation of health providers.

vi. An additional output is the creation of a centralised database for the monitoring and reporting of health insurance in Kenya. This will support the improvement of the quality and effectiveness of medical procedures in Kenya, and thereby increase the accessibility and affordability of health insurance. The centralised database includes guidelines that provide guidance on the standardisation of care and the associated expected cost.

vii. The development of an action plan that will outline the roadmap towards the implementation of the proposed comprehensive regulatory framework and the recommendations therein. The action plan will also incorporate the necessary outcomes, the require stakeholders and proposed timelines.

viii. The perspectives and views of stakeholders in the Kenyan health insurance and healthcare sector will be incorporated at stakeholder workshops to validate the following project related outputs:

    a. **The comprehensive report** – Key findings from the comprehensive report will be discussed with stakeholders to consider any information gaps and additional information that should be incorporated.

    b. **The proposed draft regulatory framework** – The draft legal and regulatory framework will be discussed and inputs from various stakeholders will be considered.

    c. **The proposed action plan** – The stakeholder workshops will also facilitate the development of an action plan that will support the implementation of the proposed recommendations and the draft regulatory framework.

The comprehensive report, draft regulatory framework and proposed action plan will be finalised once input and feedback from various stakeholders (including the IRA) has been incorporated.

1.2. Outline of broader project deliverables

The terms of reference within the contract were used to determine the deliverables of this project, including this comprehensive report.

The contract sets out the following project deliverables as shown in the table below:

Table 5. Overview of project deliverables

Project deliverable		Progress to date and timelines
Inception report	An overview of the proposed methodology and approach to the project. The report also presents preliminary findings and hypotheses based on an initial literature review.	The inception report was initially presented to the IRA on the 7th of September 2020 and was accepted on the 20th of November 2020.
Draft comprehensive report (the current report).	This report is a key deliverable and reference document for the subsequent policy paper and draft private health insurance regulations. Includes the Draft health insurance policy paper.	29 June 2021
Draft health insurance regulations	Draft regulatory framework on medical insurance and collaborative framework in the draft legislation that can be adopted between the insurance regulator and the healthcare regulator	Forthcoming: 4 October 2021
Action plan	To be developed at the forthcoming stakeholders' validation workshop. The action plan will outline how to implement the proposed recommendations.	Forthcoming: 25 October 2021
Final report	Following the stakeholders' validation workshop, the comprehensive report will be finalised	Forthcoming: 25 October 2021

Due to the COVID-19 pandemic and the related national lockdowns, there have been unforeseen delays in the project timelines. Despite the challenges posed by the pandemic, every endeavour has been made to ensure that this project is completed and the agreed timelines and deadlines are met.

1.3. Outline of the comprehensive report

The remainder of this comprehensive report is structured as follows:

Section 2 - Overview of healthcare in Kenya

- Review of the current regulations and statutory instruments concerning healthcare in Kenya.
- Overview of the public and private health insurance in Kenya.

Section 3 - Overview of the health insurance regulatory landscape

- Overview of the current health care landscape and the health insurance value chain.
- Summary of the regulatory bodies that play a role in regulating and overseeing the provision of health insurance in Kenya.
- Description of the gaps in the current health insurance regulatory framework.

Section 4 - Definition of key health insurance terms and concepts

- A comprehensive explanation and definition of the key concepts concerning health insurance.

Section 5 - Benchmark and comparison of the Kenyan healthcare system against other countries

- Comparison of current health resources and outcomes, including the total health expenditure in selected countries.
- Health insurance policy objectives.
- Implementation of key health insurance components.

Section 6 - Literature review

- A review of key findings and recommendations found in literature concerning the regulation and supervision of health insurance in Kenya.

Section 7 - Health insurance policy proposals

- Health policy framework that reflects the suggestions given in the literature review and the identified approaches in the benchmark exercise.
- Indication in broad terms of how the proposals would impact the current legal regulatory framework and the changes that would be required to the legal and regulatory framework to implement the proposal.

Section 8 – Regulatory Economic Impact Assessment (RIA)

- Quantifying the impact of possible regulatory proposals on the outcome of healthcare in Kenya.
- The qualitative element is included in the policy proposals.

Section 9 – Next steps

2. Healthcare in Kenya

The health system of any country consists of a diverse mix of public and private stakeholders with an equally diverse set of interests and outcomes. This mix of stakeholders has a direct impact on the structure, functioning and health outcomes recorded by any given system, considering the manner in which the 6 building blocks of the health system (i.e. stewardship/leadership, health financing, pharmaceuticals and related consumables, health information systems, health services delivery and human resources for health) are layered and how the inadvertently interact with each other.

A health system is defined as all the organizations, institutions, resources, and people whose primary purpose is to improve health and this includes all efforts to improve health outcomes and even direct health interventions (World Health Organization (WHO), 2010). Examples of such institutions, organizations resources and people include the Ministry of Health, private health insurance providers, the NHIF, third party administrators (TPAs), and the IRA, among others. All these various entities and components in the Kenyan health system (as it pertains to private health insurance) may also be referred to in the Kenyan health insurance value chain discussed below in Section 2.1 below.

The Kenyan health system is based on a highly tiered and decentralised system that was implemented in 2010 with the promulgation of the new Constitution which led to the implementation of a restructured governance framework that allows for national government structures and the creation of 47 semi-autonomous counties. The Kenyan national government has devolved policy and implementation powers to the lowest levels of government to support equitable distribution of resources at a grassroots level.

Kenya's devolved government structure resulted in the formation of autonomous county governments. Each county has a county executive that is led by an elected county governor. Additionally, each county has a county assembly where representatives are elected from the various wards.

The impetus to move towards a devolved health system was spurred by a number of government objectives specifically to create an environment that supports the equitable and efficient delivery of services; to stimulate innovation at the local level and in the wider health system and thereby improving access to and equity in the availability of needed healthcare services. Furthermore, the development of healthcare system that promotes accountability and transparency in service delivery was the core principle behind the decision to decentralise the healthcare system.

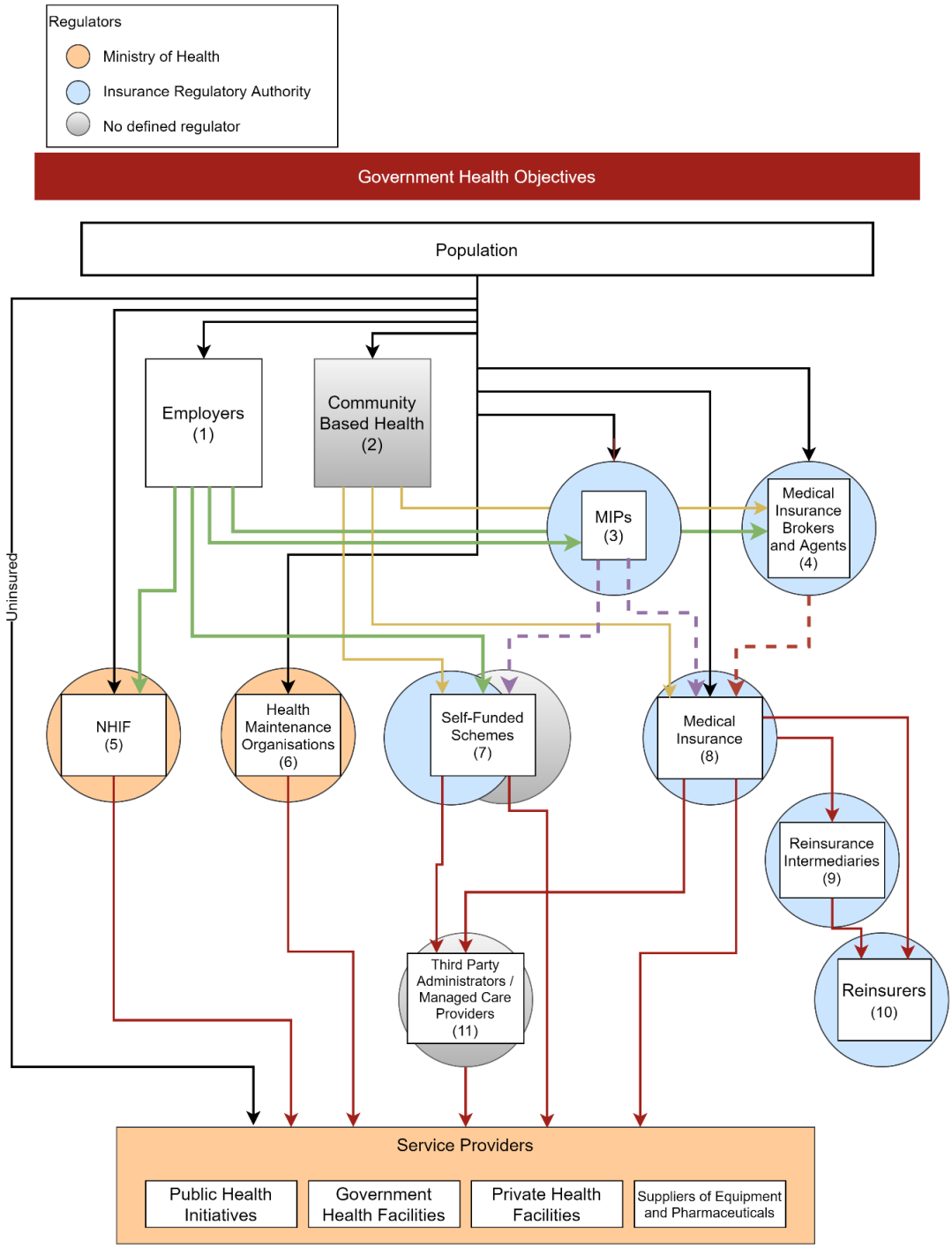
Section 2.1 provides an overview of the Kenyan health insurance value chain and the various players therein. Section 2.2 summarises policy documents issued by the Kenyan government that set out key strategies that will be followed at a national level to achieve the goal of improved access to healthcare and in turn advance universal healthcare.

Section 2.3 summarises the various healthcare financing options currently available in Kenya, including private health insurance and the public or government led healthcare packages. This provides context to the recommendations concerning private health insurance.

2.1. Kenya Health Insurance Value Chain

This section sets out each of the key players in the value chain as understood following the initial stakeholder engagement.

Figure 1. Overview of Kenyan Health Insurance Value Chain



Medical insurance is only one component of a complex medical market. However, within the insurance portion of the medical market there are more players involved than only insurers and an understanding of the entire value chain is important when considering legislation and regulation that should be developed for medical insurance. Figure 1 above provides a high-level overview of the Kenyan insurance value chain with the various players involved. Health financing is either obtained out-of-pocket, through pre-funding via the NHIF, health maintenance organisations (HMOs), self-funded schemes or through medical insurance. Often, for those with pre-funded arrangements, a combination of the above-mentioned methods is used to finance medical related expenditure. Figure 1 highlights the different routes taken to finance health care expenditure. The discussion below links the various entities to the value chain diagram as shown in Figure 1 with the relevant entity cross referenced with the number it is referred to in the diagram in brackets.

Community based health (2)

Community based initiatives are not regulated by the IRA. They can either be initiated by health facilities, NGOs, local communities or cooperatives and can be owned and run by any of these organisations. These can be informal agreements between community members to support each other's medical needs as they arise or they can be formal arrangements which can offer health benefits to its members based on a fixed annual fee. Larger communities have some form of fund management however this may also not necessarily be formal. Larger schemes may purchase health insurance to help cover obligations that may arise.

Medical Insurance Providers (MIPs) (3)

Section 2(1) of the Insurance Act Cap 487 defines a medical insurance provider as *"an intermediary, other than a broker, concerned with the placing of medical insurance business with an insurer for, or in expectation of, payment by way of a commission, fee or other remuneration."*

As intermediaries, MIPs are subject to registration and supervision by the IRA under the Insurance Act. Although the definition of a MIP excludes brokers, MIPs provide services equivalent to brokers, but limited to medical insurance, and may also provide additional services. These additional services may include the management of outpatient funds where outpatient benefits are not insured but covered by the sponsor. MIPs must be companies registered under the Companies Act, 2015.

Insurance Brokers and Agents (4)

The Insurance Act defines an agent as *a person, not being a salaried employee of an insurer who, in consideration of a commission, solicits or procures insurance business for an insurer or broker."*

The Insurance Act defines a broker as *"an intermediary concerned with the placing of insurance business with an insurer or reinsurer for or in expectation of payment by way of brokerage, commission, for or on behalf of an insurer, policy-holder or proposer for insurance or reinsurance and includes a health management organisation; but does not include a person who canvasses and secures reinsurance business from or to an insurer or broker in Kenya so long as that person does not undertake direct insurance business and does not have a place of business, or a resident representative, in Kenya".*

Brokers and agents are subject to registration and supervision by the IRA, which publishes a list of registered brokers on an annual basis.

In order to register as an agent, the applicant must pass or been exempted from Certificate of Proficiency (COP) examination for Insurance Agents and be East African citizen.

National Health Insurance Fund (NHIF) (5)

The NHIF is a State entity mandated to offer health insurance coverage for both in-and outpatient visits at the over 8,000 private and public NHIF contracted hospitals countrywide.

The Insurance (Amendment) Act No. 11 of 2019 amended the definition of insurance business to include social insurance schemes. Although the term "social insurance scheme" is not defined in the Act, the amendment is intended to provide for the regulation and supervision of the NHIF, which is characterised as providing social insurance business. The NHIF has applied for registration as an insurer under the Act and the IRA is working on the development of regulations for the registration and supervision of social insurance, which will include a definition of social insurance.

Health Maintenance Organisations (HMOs) (6)

HMOs deliver health maintenance and treatment services for a group of enrolled persons who pay pre-negotiated fixed payments. HMOs accept responsibility for the organisation, financing and delivery of health care services for its members. One of the unique aspects of an HMO is that it need not be an organisation in the conventional sense. An HMO is a grouping of facilities, physical and other health personnel into a single system that provides a full range of medical services to a specifically enrolled population for a fixed fee paid in advance. In Kenya, HMOs offer health packages but are not regulated as insurance companies offering health services (Mwagwi, 2004).

HMOs are regulated by the Ministry of Health with respect to the medical services they provide. Although HMOs can offer health packages that include pre-funding mechanisms they are not regulated as insurance companies that offer health services. As a result the same policyholder protection mechanisms, including prudential standards with regards to capital requirements, are not placed on HMOs resulting in an uneven playing field as between HMOs and insurance companies.

Self-funded schemes (7)

Self-funded schemes are schemes where no form of cover is purchased, but rather the employer/sponsor sets aside a fund for payment of medical expenses incurred by staff members and their dependants. Employers who choose to sponsor medical expenses of staff through a self-funded arrangement would be required to hold reserves for these expenses in line with accounting standards. Where the funds of a self-funded scheme are administered by MIPs the IRA requires MIPs to provide audit certificates confirming that separate accounts are kept for clients' funds and a list of clients whose accounts they manager. No regulation is placed on self-funded schemes of Community Based Health Organisations.

Medical Insurance (8)

The IRA's mandate extends to the regulation and supervision of all major lines of insurance business, of which medical insurance is one class. Currently medical insurance is regulated as a class of general insurance (class 12) and health/medical expenses insurance (where separate policies are issued) is included in class 9 (Personal Accident Insurance) and is reported on as any other class of general insurance.

Part B of the Third Schedule to the Insurance Regulation defines medical insurance business as *"the insurance business of paying for medical expenses, including the business of covering disability or long-term nursing or custodial care needs."*

Reinsurance Intermediaries (Including brokers) (9)

As "insurance business" is defined in the Insurance Act to include reinsurance business, reinsurance brokers are included within the definition of "broker". Reinsurance brokers are therefore insurance intermediaries for the purposes of the Act and must be registered by the IRA. A reinsurance broker acts as an intermediary between reinsurers and ceding insurers. For the reinsurer, reinsurance brokers operate as an outside sales force. Reinsurance brokers also act as advisers to ceding companies in assessing and locating markets that meet their reinsurance needs.

Reinsurers (10)

Reinsurers and reinsurance business are both defined within the Insurance Act as follows, *"Reinsurer means a person who carries on reinsurance business and includes a retrocessionaire"* and *"Reinsurance Business means the business of undertaking liability to pay money to insurers or reinsurers in respect of contractual liabilities in respect of insurance business incurred by insurers or reinsurer and includes a retrocession".*

Third Party Administrators (TPAs) (11)

Third party administrators (TPAs) are organisations that are responsible for accepting and processing health insurance claims from doctors, hospitals, and pharmacies. Their services can however also extend to assistance with empanelment, beneficiary enrolment, pre-authorisation management, fraud detection, etc. TPAs are currently not regulated by the IRA.

2.2. Government policy regarding healthcare

Kenya has made a commitment to achieve universal health coverage by 2022 and this commitment has been the primary impetus behind the various healthcare policy and regulatory initiatives.

Kenya's health financing and broader health sector reforms are influenced by international resolutions and agreements that the Country is party to. In 2005, the World Health Assembly of member-states of the World Health Organisation (WHO) passed a resolution on universal health financing coverage. In addition, Kenya has committed to allocate 15% of its budget targets to health spending as stated in the Abuja declaration, as well as work towards achievement of the Millennium Development Goals (MDGs).

Kenya's health sector strategies and policies are guided by the provisions of four primary documents, namely:

i. The Constitution of the Republic of Kenya 2010;
ii. The Kenya Health Policy 2014 – 2030;
iii. The Kenya Health Sector Strategic and Investment Plan 2014-2018 and,
iv. Draft Kenya UHC Policy 2020-2030.

These documents provide the overarching frameworks within which the country implements several health sector initiatives directed at implementing the core provisions of the Constitution concerning healthcare, as well as meeting local, regional and international commitments on matters such as accelerating the realisation of the principle of universal health coverage (UHC) for the Kenyan population.

The lifespan of the various primary documents that guide health sector strategies and policies is inferred from their title as some are set for a predetermined time-period. For example, the Kenya Health Policy 2014 – 2030 implies that policy is for the duration of that specified time. Furthermore, the implementation of the goals and objectives outlines in the above-mentioned policy and strategy documents are supported by adjacent documents and frameworks; for example, the Kenya Health Sector Strategic And Investment Plan (KHSSP) is supported by compliance to Kenya Quality Model for Health.

2.2.1. Kenya Health Policy 2014 – 2030

The devolution/decentralisation process of healthcare is outlined in the Kenya Health Policy 2014 – 2030. This policy framework provides the parameters within which the devolution process should occur through strategically identifying and outlining the core activities linked to Constitutional imperatives and international health commitments (Ministry of Health, 2014).

The Kenya Health Policy 2014 – 2030, themed "Towards attaining the highest standard of health" was developed out of a participatory process involving several stakeholders, including and supported by the international donor community. It considers the functional responsibilities between the two levels of government (county and national) with their respective accountability, reporting, and management lines. It proposes a comprehensive and innovative approach to harness and synergise health services delivery at all levels and engagement with all actors, signalling a radical departure from past approaches in addressing the health agenda.

The key governance objectives at the County levels of the Kenya Health Policy are:

- The ability to deliver efficient, cost-effective, and equitable health services to the population.
- The further decentralization of health service delivery, administration, and management to the community level.
- The ability to maintain operational autonomy as the oversight of healthcare services is devolved.
- The ability to maintain efficient and cost-effective monitoring, evaluation, reviewing and reporting systems.
- The implementation of a smooth transition from current to proposed devolved arrangements.
- Complementarity efforts and interventions between the national and county healthcare systems.

In the new decentralised system healthcare facilities are organised into four interlinked components at various levels ranging from levels 1 to 4 in ascending order, as summarised in the table below:

Table 6. Overview of the National Referral Health facilities

Healthcare Facility	Description
Level 1: Community health services	This level comprises all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector.
Level 2: Primary care services	This includes dispensaries, health centres and maternity homes for both public and private providers.
Level 3: County referral services	These are hospitals operating in and managed by a given county and consist of the former level 4 and district hospitals in the county and include public and private facilities.
Level 4: National referral services	This level comprises facilities that provide highly specialized services and includes all tertiary referral facilities. The units include national-level semi-autonomous agencies and shall operate under a defined level of self-autonomy from the national health ministry, allowing for self-governance.

A National Referral Health Facility (level 4) is the highest level of health care which provides highly specialized health care services. It links up with other national and international health care providers. The functions of a National Referral Health Facility include:

1. Provision of highly specialized services.
2. Setting national norms and standards for quality patient care in consultation with other levels of health and social care (levels 1 to 3).
3. Provide specialist outreach and reference support services to lower level health facilities.
4. Provide clinical and practical training for attached students.
5. Conduct scientific and operational research.
6. Monitor, evaluate and review the functioning of the referral system; and
7. Conduct consultative meetings with private health care providers and establish referral procedures including air transportation of clients.

Investing in public facilities is one of the many ways to advance and improve access to healthcare services. Under this devolved governance structure, counties can improve access to an expanding package of basic healthcare services through investing in underlying health infrastructure, service preparedness and supporting the improvement of health workers' skills (which in turn will lead to improved competence). Counties can also explore contracting out or otherwise purchasing services from private providers, which is currently infrequently done (Dutta *et al.*, 2018).

2.2.2. Kenya Health Sector Strategic and Investment Plan 2014 – 2018 (KHSSP)

The Kenya Health Sector Strategic and Investment Plan 2014 to 2018 (KHSSP) outlines the country's path to attaining accelerated progress in the realization of universal health coverage. Although this plan has expired no up-to-date plan could be identified. To achieve the goal of UHC, 6 policy objectives are defined:

1. **Accelerate the reduction in communicable diseases.** Reducing the burden of communicable diseases until they are no longer a public health concern.
2. **Reverse the rising burden of non-communicable conditions.** Ensuring clear strategies for implementation to address all the identified non-communicable conditions in the country.
3. **Reduce the burden of violence and injuries.** Through directly putting in place strategies that address each of the causes of injuries and violence at the time.
4. **Provide essential health care.** Ensuring that healthcare services provided are affordable, equitable, accessible, and responsive to client needs.
5. **Minimize exposure to health risk factors.** Through strengthening health promoting interventions which address risk factors to health, as well as facilitating the use of products and services that lead to healthy behaviours in the population.
6. **Strengthen collaboration with health-related sectors.** Adopting a 'Health in all Policies' approach, which ensures the health sector interacts with and influences the design, implementation and monitoring processes in all health related sector actions.

The KSSPH also outlines the Kenya Essential Package for Health (KEPH), a comprehensive healthcare package that will form a key component of Kenya's healthcare policy. The KEPH defines health services and interventions to be provided for each Policy Objective. The benefits provided in the KEPH are summarised in Annexure D: Summary of Kenya Essential Package for Health.

It is envisaged by focusing on the 6 interrelated objectives, the KHSSP will positively lead to the attainment of universal health coverage through the implementation of the KEPH. The KHSSP aims to achieve the following service outputs as shown in the table below:

Table 7. Objectives of the KHSSP

KHSSP service output	Sub-goals
Improvement in physical access	• Ensure 100% of KEPH services are being provided in special settings. • Upgrading 40% of dispensaries to full primary care units. • 100% of model health centres to fully functional primary care facilities. • 100% of facilities have 80% of their infrastructure functional.
Improvement in financial access	• Free point-of-use maternity, primary care, and emergency services. • Free point-of-use services addressing the main causes of morbidity and mortality (HIV, TB, malaria etc.) • Voucher system for population at risk of catastrophic health expenditure.
Improvement in socio-cultural access	• 100% of required KEPH available to those at risk from cultural barriers - (Women, disabled, elderly and children and marginalised groups).

KHSSP service output	Sub-goals
	• 100% of required KEPH available to those at risk from social barriers - Health Workers, Commercial Sex Workers. • 100% of required KEPH available to those at risk from congregated barriers - prisons, IDP camps, schools, refugee camps, army barracks.

Priority actions focused on improving the quality of care that are outlined in the KHSSP and include the supervision and accreditation of systems via compliance to Kenya Quality Model for Health as the framework for quality improvement. The current referral services tool and guidelines will also be updated.

2.2.3. Draft Kenya Universal Health Coverage (UHC) Policy 2020-2030

Kenya's draft UHC policy includes the introduction and implementation of various healthcare strategies, policies and packages that will extend healthcare coverage and advance UHC through providing the full complement of basic healthcare services. The UHC policy document is still in draft format and its conclusions and final recommendations are still to be publicized.

The key healthcare packages that form a key part of the Kenyan draft UHC policy include:

- **Kenya Essential Package for Health (KEPH)** - A comprehensive healthcare package that will form a key component of Kenya's healthcare policy.
- **Essential Health Benefit Package (EHBP)** - The KEPH is the basis for the proposed EBHP which is yet to be formally released however initial costing of the package has been completed.
- **Afya Care Universal Health Coverage (UHC) Pilot Program** – The Afya Care – the UHC pilot program aims to provide access to quality health care services and limit the financial hardship that arises from the cost of accessing healthcare. The UHC pilots/Afya Care program is being used to test the provision of such a package. The 4 pilot counties – Isiolo, Kisumu, Machakos, and Nyeri – were selected because they are characterized by high incidence of both communicable and non-communicable diseases, maternal mortality, and road traffic injuries.

Although the KEPH aims to expand access to healthcare, it is not guaranteed through financing reforms and therefore it is not universally available. For more information see 13Annexure D: Summary of Kenya Essential Package for Health. The availability of services varies significantly across health areas and geography.

The Kenyan Government has also enacted several policies dedicating government resources to advance universal health coverage and support the implementation of KEPH. In 2013, for example, the government instituted free maternal healthcare (Linda Mama project) and abolished user fees for primary healthcare at public facilities, with funds transferred through the Health Sector Service Fund (HSSF). The number of health facilities providing KEPH services increased from 41% to 55% between 2013 and 2016 (Wangia and Kandie, 2018). Therefore, the KEPH does not yet represent a full UHC project as the number of facilities that provide

the full spectrum of services under the KEPH need to increase to ensure extensive coverage across the country to achieve UHC.

Taking the above mentioned into consideration, Kenya has a draft UHC Policy 2020-2030, with the goal "to ensure all Kenyans have access to essential quality health services without suffering financial hardship." The policy has four objectives as shown in the table below:

Table 8. Overview of Kenya's Universal Health Coverage Policy Objectives 2020-2030

Kenya draft UHC Policy Objectives	The related goals and objectives
Policy Objective 1: Strengthen access to health services	Ensuring Kenyans have access to needed health services, that is, a set of integrated cost-effective interventions addressing common health needs and illnesses. These health services include promotive, preventive, curative, rehabilitative and palliative health services as defined in the **Essential Health Benefit Package (EHBP).**
Policy objective 2: Ensure quality of health services	Health services provided are efficient, safe, timely, acceptable and effective standards as described in the relevant health sector policies, guidelines, norms and standards for the desired health outcomes.
Policy objective 3: Protection from the financial risks of ill health	Protecting Kenyans from financial risks associated with ill health (excessing out of pocket expenditure or catastrophic expenditure arising from health-related expenses). Mechanisms for raising revenues for the health system will need to be fair and sustainable and this also includes mandatory prepaid sources. Resource utilization will need to be improved to obtain the maximum level of health outcomes given the available health system inputs.
Policy objective 4: Strengthen the responsiveness of the health system	Ensuring the Kenyan health system can adequately address the reasonable demands of the Kenyan population and that it is prepared for and respond to emerging health or wellbeing threats through enhancing the resilience of the health system.

(Ministry of Health, 2020)

The push to achieve and advance UHC implies an expansion of healthcare provided beyond the benefits and services offered in the KEHP, KHSSP and NHIF . Achieving these objectives will require cooperation with, and influence the operation of, any private health insurance.

The goal of private health insurance is to assist Kenya achieve its goal of universal healthcare, and therefore the targets set out for each of the six policy objectives and the KHSSP targets for Access and Quality of Care improvements. The policy recommendations made in this document builds on the KEPH and flagship investments, especially the Service Delivery Systems and Health Information System.

2.3. Overview of Healthcare financing

2.3.1. Healthcare financing in Kenya

There are several ways in which healthcare is financed in Kenya, with the government being the main funder for the majority of services accessed by the population. The percentage of the Kenyan populations with health

insurance coverage is low, resulting in high out-of-pocket health expense payments. The Kenyan government has not yet managed to implement the Abuja Declaration's target of 15% of government's budgeted expenditure being specifically earmarked for health programmes and interventions. As at 2018 the value was 5.2%, which is significantly below the envisaged target.

Out-of-pocket expenditure (OOP) is a significant portion of healthcare expenditure, with current estimates stating it accounts for 24% of total healthcare expenditure (World Health Organization (WHO), 2019). This is due to the low level of health insurance coverage (as only 29% of the population has any form of insurance coverage, including NHIF cover, according to the FSDKenya (FSDKenya, 2019), low level of benefits even when covered by health insurance, and the current KEPH packages not being comprehensive enough or available at all healthcare facilities.

2.3.2. National Hospital Insurance Fund

The NHIF was established 54 years ago as a department in the Ministry of Health to provide health insurance exclusively for those in formal employment. In 1972 an amendment was made to allow for inclusion of membership in the informal sector (that is for those who are not employed in the formal sector. The Fund was then transformed into a state parastatal through an Act of parliament, the NHIF Act No. 9 of 1998 (Republic of Kenya, 2012). The governance and management structures of the NHIF are arranged as per the recommended international best practice for semi-autonomous insurance funds. The NHIF Fund is governed by a board as provided for in sections 4 to 9 of the NHIF Act. The NHIF is a state entity.

In July 2015, the NHIF commenced outpatient services together with extended benefit packages that ease the financial burden of members suffering from chronic illness including cancer, chronic kidney disease (CKD), among others. According to the 2017/2018 financial year results the NHIF provided both in and outpatient health insurance to over 7.6 million households with 25 million Kenyans are covered. The total revenue was KSh 48 billion and total benefits and claims was KSh 38 billion (NHIF, 2018).

The core functions of NHIF, as set out in the NHIF Strategic Plan 2018-2022, are to:

1. Receive all contributions and other payments required by this Act to be made to the Fund.
2. Make payments out of the Fund to declared hospitals in accordance with the provisions of this Act.
3. In consultation with the Minister, to set the criteria for the declaration of hospitals and to declare such hospitals in accordance thereto for the purposes of this Act.
4. Regulate the contributions payable to the Fund and the benefits and other payments to be made out of the Fund.
5. Protect the interests of contributors to the Fund.
6. Advise the Minister on the national policy to be followed with regard to national health insurance and to implement all Government policies relating thereto; and
7. Perform such other functions as are conferred on it by this Act or by any other written law.

The NHIF is critical in helping Kenya achieve its goal of UHC. It also assists private health insurance by:

- Providing essential services to reduce the burden of communicable and non-communicable diseases.

- Expanding health infrastructure beyond urban areas.
- Providing healthcare quality and accreditation beyond public sector healthcare providers, as measured by the MOH standards & Norms and the KQMH system.

In 2013 the NHIF, with financial support from the International Finance Corporation (IFC) and technical support from the PharmAccess Foundation, introduced the SafeCare quality improvement system. SafeCare aims to support basic health care providers in resource restricted settings to go through stepwise structured improvement programs to deliver safe and quality-secured care to their patients according to internationally recognized standards (Barasa *et al.*, 2018).

NHIF accredits and contracts public as well as private non-profit and for-profit facilities. It requires accreditation before contracting with facilities. Accreditation covers the range of health services provided by the facility, the number and type of health personnel, bed capacity, infrastructure, and equipment.

After accreditation, facilities are contracted as one of three categories — A, B, or C — depending on the type of facility. Category A includes government hospitals where all services, including maternity services and surgery, are fully paid by NHIF. At Category B facilities (private and mission hospitals, generally in rural or underserved areas), members also receive a full range of covered services but may have to pay a co-pay for surgical services (NHIF, 2017a). Members are also limited to KSh 432,000 at Category B facilities annually. Category C includes private hospitals, where NHIF covers only a specified daily rebate (NHIF, 2020).

The NHIF is mandated to offer health insurance coverage for both in- and outpatient visits at the over 8,000 private and public NHIF contracted hospitals countrywide. These services are under the National Scheme called **'SUPA COVER'** for those who are registered and remit monthly contributions. Rates for the informal sector are at a fixed amount of KSh 500 a month and for those in the formal employment the rates are at graduating scale between KhS150-1700 monthly. The health benefits covered by the Fund are outlined below:

i. **Outpatient benefits:** include consultation, laboratory investigations, day care procedures, drugs and dispensation, health education, wellness and counselling, vaccines immunization as per the Kenya Expanded Programme on Immunisation schedule.

ii. **Specialized treatment:** includes renal dialysis, radiology and chemotherapy for cancer treatment, surgical procedures, maternal care and reproductive health services, emergency road evacuation, overseas treatment and rehabilitation for drug and substance abuse.

iii. **Services specifically for the disadvantaged**: These are provided for through government-sponsored programs. The programs are:

    a) ***Linda Mama Program***, a health insurance cover for expectant mother and their new-born children with no other form of insurance. The program offers ante-natal, delivery care, postnatal care, referral, and infant care.
    b) ***Edu-Afya the Secondary School Cover*** whereby the government launched and rolled out a free comprehensive medical cover for all students in public secondary schools.
    c) ***Health Insurance Subsidy Programs*** for the poor, orphans and vulnerable children (OVC) as well as those targeting old and persons with severe disabilities (OPSD).

A detailed summary of the benefits provided by the NHIF is given in

Annexure C: Summary of NHIF Plans.

2.3.3. Private Health Insurance

Private insurance in Kenya covers private health insurance companies and community-based health financing initiatives. Based on the IRA 2018 annual report, the total Medical Insurance Gross Direct Premiums were KSh 40 billion and Claims Incurred were KSh 20 billion. There are no up-to-date figures on the number of Community-based health schemes. As of 2013 these schemes were estimated to be covering approximately 1.3% of insured lives.

According to an analysis by the Association of Kenyan Insurers (2018), premium growth has been significant, more than quadrupling between 2011 and 2016. However, profitability has been low, with a loss ratio of ~75% across the industry. Therefore, creating a regulatory environment that supports the continued and sustainable growth of private health insurance while still ensuring value for money and high-quality service is becoming increasingly important.

The review of the 2017 – 2019 annual statistics published by the IRA for medical insurance companies provide a high-level overview of development in the industry over this period. In recent years, the number of insurers in the market has remained stable. However, the average annualised increase in gross premiums for the same period is 5.1%. The growth in gross premiums suggests that the level of coverage has recently stagnated as the increase in premiums is only reflective of inflationary increases as average inflation for 2017 to 2019 was 6%.

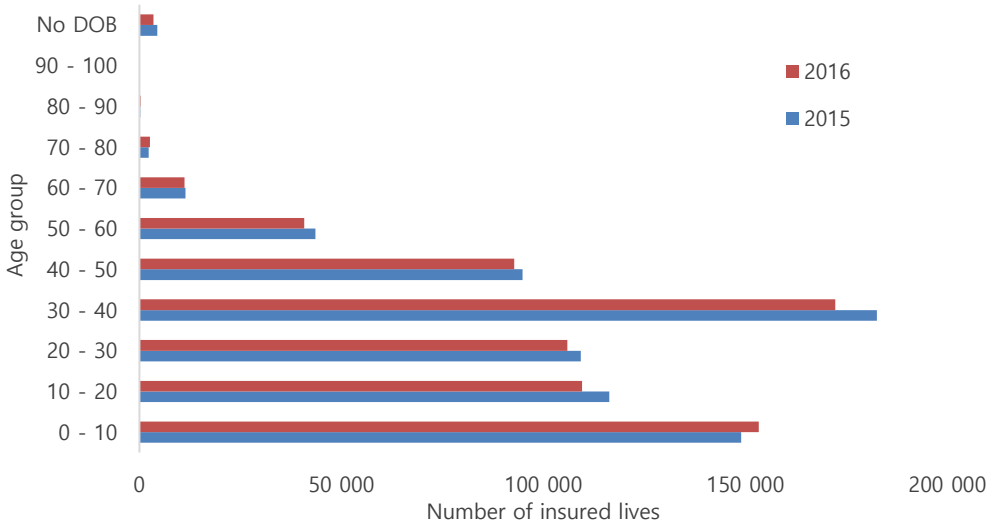
Additionally, the total claims incurred from 2017 to 2019 decreased by 1% reflecting a real reduction of the claims private insurers are paying and hence a real reduction in healthcare costs being financed through private insurance. Therefore, according to the IRA 2018 annual report medical insurers have continued to incur underwriting losses, with 7 out of 22 making a profit. Allowing for investment income, the industry made a marginal profit.

According to the Association of Kenyan Insurers (2018), insured lives are distributed roughly evenly by gender, as shown in Figure 2 below. The largest group of covered lives is the 30 to 40 years age group, while the 20 to 30 years old age group is under-represented, compared to the overall population age distribution.

The number of covered lives reduces drastically after age 60. There are two possible reasons. firstly, since the premium rates are based on age-rates, subsequently premium rates increase significantly for policyholders older than age 60. This has resulted in very Kenyans taking private health insurance cover once they reach 60 years of age and leaves a significant cover gap in the Kenyan health insurance market. Secondly, private health insurance focusses on employer groups, where many policyholders leave once, they retire.

Figure 2. Distribution of insured lives by age

The number of 20-30 and 60+ year olds are under-represented in the population covered by PHI



Premiums charged in the private health insurance market for five major benefit categories, namely, inpatient treatment, outpatient treatment, maternity, dental and optical were also analysed.

Table 9 gives a summary of the findings:

Table 9. Average annual office premiums charged per benefit category per covered life

Outpatient cover is more expensive than inpatient cover

Benefit category	Average premiums in KSh		% change
	2015	2016	
Inpatient	15 803	16 771	6.1%
Outpatient	17 663	18 288	3.5%
Maternity	12 840	13 061	1.7%
Dental	3 021	3 007	-0.5%
Optical	3 047	3 020	-0.9%

Outpatient benefits cost higher than inpatient benefits. This is expected as administration expenses associated with outpatient claims are higher, and each covered life is highly likely to make at least one outpatient claim. Insurers handle a much larger volume of outpatient claims. Moreover, premiums for each benefit category increased by no more than 6.1%, whereas medical inflation was assessed to be around 14%. More granular analysis is needed, considering different insurers and benefit designs.

Table 10. Comparison of average office premiums for group policies versus individual policies

Group premiums are significantly less expensive than Individual premium which reflects undercutting in the groups business market.

	2015		2016		
	Average premiums	Proportion of covered lives	Average premiums	Proportion of covered lives	% increase in premiums
Group	33 511	93.40%	42 995	91.10%	28.30%
Individual	45 098	6.60%	59 584	9.00%	32.10%

Table 10 shows that group covered lives were charged roughly three quarters of individual policy premiums. Premiums for individual policies are expected be higher, as there is a higher risk of anti-selection and administration expenses are likely higher. However, this magnitude of premium discount for group policies reflects the high level of competition and undercutting in group business. Over 90% of business in private health insurance is group business.

Fee-for-service is the predominant mode of provider payments for outpatient care with no notable efforts by PHIs to move towards capitation. The benefit packages by PHIs are largely outlined in terms of Outpatient and Inpatient limits. Outpatient limits range from KSh 30,000 to KSh 300,000. In most cases this included: Consultation, Nursing services, Laboratory, Pharmacy, Specialist, Dental and Optical service. Inpatient limits range from KSh 100,000 to KSh 10M (Association of Kenyan Insurers, 2018).

Most packages apply waiting periods to a range of benefits, including maternity cover and chronic disease cover.

Private health care in Kenya is characterized by high costs of care that are driven by a recurring high rate of cost escalation (medical inflation) especially at leading private hospitals. This is reported to have hampered the development of low-cost health insurance products. Furthermore, insurers reported that attempts to develop low-cost products have also been partly hampered by the low quality of care in low-cost hospitals.

An industry-wide framework for assessing and implementing quality of care standards in the country is not present. A few providers have adopted different mechanisms with some of the leading hospitals adopting international accreditation such as Joint Commission International (JCI), ISO and Safecare. It is the perception of Private health insurers (PHIs) that a lack of such a common framework causes public perception to be that only top facilities provide high quality of care and has resulted in these top hospitals having a monopoly over these markets (World Bank Group, 2018).

2.4. Universal Healthcare

2.4.1. Measuring progress towards universal healthcare

One of the main challenges faced in supporting UHC-oriented reform is the perception on the part of some decision-makers that UHC is too diffuse a concept, and UHC-related progress unquantifiable.

Broadly defined, UHC means all people receiving the health services they need, including health initiatives designed to promote better health (such as anti-tobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation, and palliative care (such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship (World Health Organisation, 2010).

Thus, the UHC comprises three main components:

1. Financial coverage over to the whole population.
2. Quality, essential health service coverage.
3. Direct costs proportion of the cost covered.

Three dimensions are typically represented in what has come to be known as the coverage or health cube. This health cube helps quantify the level of UHC achieved and in which dimension a country should focus to expand UHC coverage.

While there are debates around how each of these dimensions should be measured and how to source the required data, the choice of indicators should, as far as possible, be based on objective considerations such as relevance and quality, there will also be trade-offs between keeping the number of indicators small, manageable (and understandable) and employing enough to capture the full breadth of health services within a UHC programme. A key consideration here is simplicity, since understandable "tracer" indicators to monitor progress can be a powerful way of galvanizing efforts to move towards UHC (World Health Organisation, 2015).

2.4.2. Success in Kenya in terms of international standards

The section below shows the three key dimensions to consider when moving towards universal coverage and has been adapted to the Kenyan context based on an analysis of data from various reports and sources to reflect the current state of pooled funding available in Kenya.

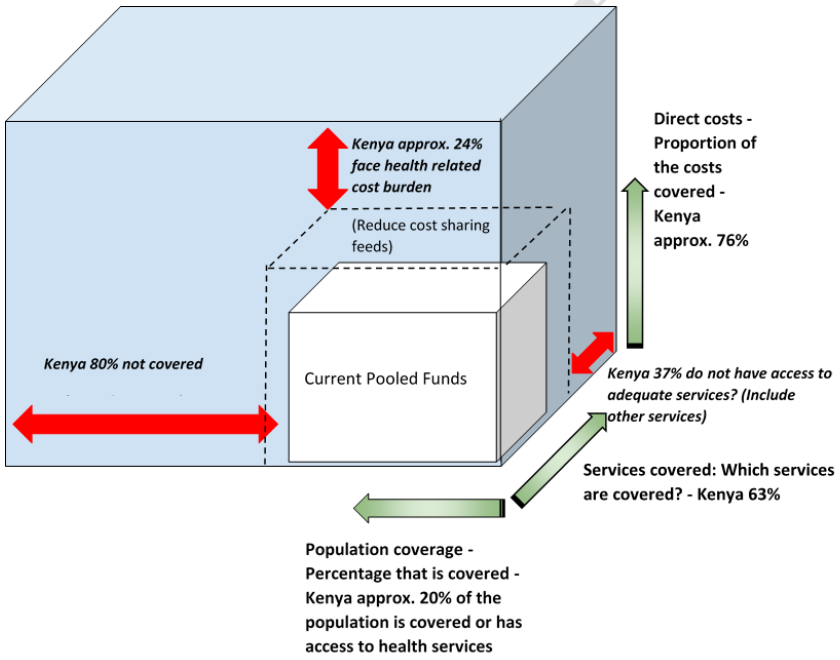
The health cube summarises the goal behind universal coverage - progressively expanding access to comprehensive health care while reducing the financial burden and cost of catastrophic health expenditure. This goal also implies a trade-off between the 3 dimensions. The health cube is illustrated in Figure 3.

The ideal (which has not been achieved even in high-income countries) is universal coverage for 100% of the population for 100% of the services available and for 100% of the cost – and with no waiting lists. (World Health Organisation, 2015).

The overall result for Kenya gives a score of 53%, which is the average of:

- 20% of the populations has health insurance coverage.
- 63% of essential services are available to the public.
- 76% of healthcare related financial expenses are covered (OOP is 24%).

Figure 3. Kenya's progress towards universal healthcare as measured with a health cube



For more detail on how the dimensions were calculated, see Annexure D: Summary of Kenya Essential Package for Health.

Individual countries fulfil the box in their own way as they follow their own individual paths to universal coverage through trading of the proportion of services and the proportion of the costs to be met from the available pooled funds.

An analysis of the 3 dimensions according to the Kenyan context was conducted to assess the country's progress in advancing universal coverage based. The dimensions and sub-dimensions of the Kenyan health cube were taken from the WHO's suggested framework in the 2015 first global monitoring report tracking universal health coverage. Sources include Dutta *et al.*, (2018), World Health Organization (2019) and Barasa *et al.* (2018).

1. **Expanding the population covered** - Approximately 20% of the Kenyan population has health insurance coverage (NHIF, Private or Community cover). This number conflicts with the FSDKenya figure of 29% insurance coverage over all types of insurance, and the NHIF record of 25 million Kenyan covered, but is the only figure we could identify. This infers that a vast majority of the population is currently uninsured and this will have implications for other dimensions. For instance, the uninsured are more likely to have limited access to essential health services and are also more likely to incur higher direct costs and out of pocket expenditure. Kenya aims to expand the population covered through extending health service coverage to vulnerable and marginalized groups and prioritizing the expansion of existing prepaid mechanisms (including insurance, subsidies and direct funding).

2. **Expansion of services offered through a single essential health benefit package** - The Kenyan service coverage dimension was calculated using various promotion/preventative and treatment indicators. Examples of promotion/preventative measures include antenatal coverage, family planning coverage among others while examples of treatment indicators include antiretroviral therapy coverage and tuberculosis treatment. The combined analyses of all the various indicators shows that 63% of the Kenyan population has access to adequate services (as shown by the list of health services listed in the promotion/preventative and treatment indicators). The Kenyan Universal Health Coverage Policy aims to expand the services offered through ensuring that the population access a wide range of service areas including a renewed focus on primary health care services.

3. **Establishment of financial risk protection mechanisms** - This dimension measures the percentage of Kenyans who are at financial risk due to health costs. Public spending as a percentage of GDP, catastrophic health expenditure as a percentage of household expenditure and OOP expenditure as a percentage of THE were used to gauge the extent to which direct health costs are covered (thus reducing the financial risk from health costs). For this dimension OOP expenditure as a percentage of THE were used.

   The Kenyan health-care financing system has a relatively high level of OOP expenditure - approximately 24% of THE. This reinforces the low insurance as only 20% of the population has health insurance thus meaning the bulk of the population will incur out of pocket expenses. OOP payments are inequitable, inefficient and a significant barrier to access for the poor. Any health system with a huge reliance on direct payments and vertically funded donor programmes undermines the entrenchment of the principle of financial risk protection and income cross-subsidization, which are critical for the country's progress towards universal health coverage.

3. Overview of the legal and regulatory framework for medical insurance

(In this section the term medical insurance is utilized to be consistent with the definition in the Insurance Act).

This section provides an overview of the current legal and regulatory framework for medical insurance in Kenya. Section 3.4 provides a factual overview of gaps and weakness highlighted by the IRA and Section 3.5 highlights areas in the current regulatory framework where additional legislation or guidance may be required.

The focus of the section is solely on medical insurance and therefore an overview of regulations with regards to healthcare providers (hospitals, doctors, etc.) is not included as it is outside of the scope of this project. This section does however provide an overview of the professional bodies and regulators of healthcare providers as collaboration with these organisations may be required to achieve some of the recommendations set out in Section 7 of the Report.

Section 3.1 applies the relevant Insurance Core Principles (ICPs) issued by the International Association of Insurance Supervisors (IAIS). This is then followed by an analysis of the Insurance Act and the related statutory instruments in Section 3.2. The analysis of the Insurance Act also includes guidance and circulars issued by the Insurance Regulatory Authority (IRA) that support the objectives of the act. An exhaustive list of guidance and circulars has not been provided, however, the regulatory analysis will consider the circulars that impact on or are relevant to the discussion and analysis.

Section 3.3 provides and overview of the medical market players from a broader market perspective. The aim of this section is to provide insight into the complexity of the market and the interaction between these general players as well as provide context of the role of medical insurance within this market.

An analysis of the changes required to the legal and regulatory framework required to implement recommendations is included in Section 7 of the Report.

3.1. Insurance Core Principles (ICPs)

The Insurance Core Principles (ICPs) issued by the International Association of Insurance Supervisors (IAIS) provide a globally accepted framework for the regulation and supervision of the insurance sector. The ICPs do not specifically refer to health insurance and the IAIS has not issued any Standards, Issues Papers, Application Papers or other documents or guidance that relate directly to health insurance. However, where relevant, the recommendations are framed so as to be consistent with the general regulatory and supervisory standards and guidance issued by the IAIS

Table 11 below discusses a paper issued by the IAIS where references to medical insurance are discussed or mentioned.

Table 11. IAIS Papers references to health insurance

IAIS Paper	Reference to medical insurance
Issues Paper On Conduct Of Inclusive Business In Insurance	In Tanzania, social health insurance schemes like the NHIF fall under the compulsory sales business model. This model is defined as insurance products that are required by regulation. At times, these compulsory schemes are partially subsidized by the government.
	"Differentiation between life, non-life and health products, and to what extent different elements may be bundled in one policy, as well as the conditions for embedded products, are further important product-related issues for supervisors in inclusive insurance markets."
	"How health insurance is classified is a particularly relevant issue in a number of countries. For example, where regulation excludes health insurance from the ambit of insurance or is not clear on the definition, it may create a grey area for informal operators outside the jurisdiction of the insurance supervisor. In other instances, strict demarcation between the business of medical schemes and that of other insurers, coupled with prescribed minimum benefits for medical schemes, may reduce affordability and inhibit innovation in the low-income health insurance space. The grey area in the case of the supervision of health insurance could not only occur if medical services firms are unregulated or unsupervised but also if there is an additional supervisor in this area."

3.2. Medical insurance regulatory framework

This section provides an overview of the Kenyan current medical insurance regulatory framework.

3.2.1. Insurance Act

The Insurance Act establishes the IRA and specifies its objects and functions, which include the licensing (which is used in the Act synonymously with registration) of insurers and insurance intermediaries, including medical insurers and medical insurance intermediaries. The Act provides the IRA with the powers that it needs to regulate and supervise the insurance sector, although regulations must be made by the Cabinet Secretary under section 180 of the Act.

The registration requirements for an insurer are detailed in sections 30 and 31 of the Insurance Act. The registration requirements for insurance brokers, including reinsurance brokers and MIPs are detailed in sections 150 to section 156 of the Act, which also cover other types of insurance intermediary, including:

- Insurance investigators
- Loss Adjusters
- Insurance surveyors / risk managers
- Claim settling agents

An insurance customer may lodge a written complaint with the Commission under section 204A of the Act, which gives the IRA (through the Commissioner) the power to determine disputes.

The IRA's regulatory function is exercised through the issuance of circulars and guidance. Although the Act does not refer expressly to circulars, section 3A(1)(g) of the Act specifies as an object and function of the IRA, the issuance of "supervisory guidelines and prudential standards for better administration of the insurance

business of persons licensed under the Act". Unless they can be regarded as "prudential standards", circulars have the status of guidelines.

3.2.2. Schedule on Minimum Capital Requirements

The Schedule on Minimum Capital Requirements sets out basic minimum capital requirements applicable to insurers. Section 23(2) of the Act gives the IRA the power to amend this Schedule.

3.2.3. Insurance Regulations

The Insurance Regulations are made by the Cabinet Secretary under section 180 of the Act. The Regulations include:

- Provisions covering the application for registration as an insurer.
- Forms of accounts.
- The actuarial valuation of liabilities.
- Rules for the calculation of the value of liabilities.
- Limitation of expenses of management (including commission).
- Maximum brokerage, commission or other intermediary procuration fees payable.
- Mandatory reinsurance cessions.
- Broker professional indemnity policy requirements.
- A number of forms for the purposes of the Act.

3.2.4. Guidance

The IRA has issued various guidelines to the insurance industry. Table 12 provides a high-level overview of the guidance with a focus on those applicable to medical insurance.

Table 12. Overview of the guidance with a focus on those applicable to medical insurance

Guidance Name	Date issued	Applicable to	Categorisation	Overview
Corporate governance guidelines for insurance and reinsurance companies	June 2011	Insurance & Reinsurance Companies	Prudential	The aim of these guidelines is to enhance good corporate governance practices by insurers which is critical to the stability of the insurance industry. The insurers are required to develop appropriate policies that will give effect to prudent management of their affairs. The prime focus of corporate governance is the protection of the interest of the shareholders, policyholders and all stakeholders of the insurers which promotes confidence in the insurance industry.
Market Conduct guidelines for insurance intermediaries	June 2011	All insurance stakeholders	Market Conduct	The guidelines set the minimum standards for proper conduct of intermediaries in performing their duties. The aim of these guidelines is to enhance best practices in the conduct of insurance business and to improve the image of the insurance industry. To enhance consumer protection and professionalism in conduct of insurance business, insurers are required to ensure that their agents or other intermediaries adhere to the set guidelines.
Guidelines on insurance products for insurance companies and intermediaries	June 2012	Reinsurance & Insurance companies Insurance intermediaries	Market Conduct	These guidelines aim to ensure that insurance products sold by insurance companies and intermediaries are suitable to consumers, fairly priced and function as intended. The guidelines offer guidance on principles to be adhered to in product design, pricing, marketing, disclosures and how applications for issuance of new and repackaged insurance products should be made to the IRA.
Guidelines on claims management for the insurance industry	June 2012	Reinsurance & Insurance companies Insurance intermediaries	Market Conduct	These guidelines aim to enhance efficiency, transparency, disclosure of information to policyholders during claims processing and increase consumer satisfaction. The IRA envisaged that efficient claims management processes would result in improved service delivery to the public which would in turn create confidence and hence improve the image of the insurance industry.
Guidelines on risk management and internal controls for insurance and reinsurance companies.	February 2013	Insurance & Reinsurance Companies	Prudential	The guidelines aim to ensure that insurance and reinsurance companies are managed in a sound and prudent manner by having effective systems of risk management and internal controls. The insurer's risk management framework must provide reasonable assurance that the insurer's risks are prudently managed.

IRA/PG/18 Guideline to the insurance industry on market conduct for insurance	June 2013	Insurance & Reinsurance Companies	Market Conduct	The guideline aims to offer guidance on principles to be adhered to in conduct of insurance business by insurers with a primary focus on fair treatment of customers. Fair treatment of customers encompasses concepts such as ethical behaviour, acting in good faith and the prohibition of abusive practices.

3.2.5. Circulars

The IRA issues circulars annually to the insurance industry. This includes an annual circular to MIPs - "Renewal of registration as a medical insurance provider" – which amongst other requirements specifies the requirements on MIPs when dealing with client funds. Specially the circular states the following: "*The circular provides information on the registration process of MIPs, information required to be submitted to the IRA and registration fees payable. The circular also requires that MIPs who manage funds are required to provide audit certificates confirming that separate accounts are kept for clients' funds and a list of clients whose accounts they manager. The circular also requires that MIPs must submit a list of products they offer with the terms and conditions of those products. MIPs are required to submit statements from major hospitals showing outstanding payments. The circular further requires that where business could not be placed locally the Medical Insurance Provider should seek approval from the IRA to place business overseas with International Medical Underwriters.*"

3.2.6. Broader legislation which impacts medical insurance and medical insurance regulation

There are several broader legislative requirements that impact on medical insurance and medical insurance regulation and should be borne in mind when developing new or amending existing legislation or legislative instruments. These include:

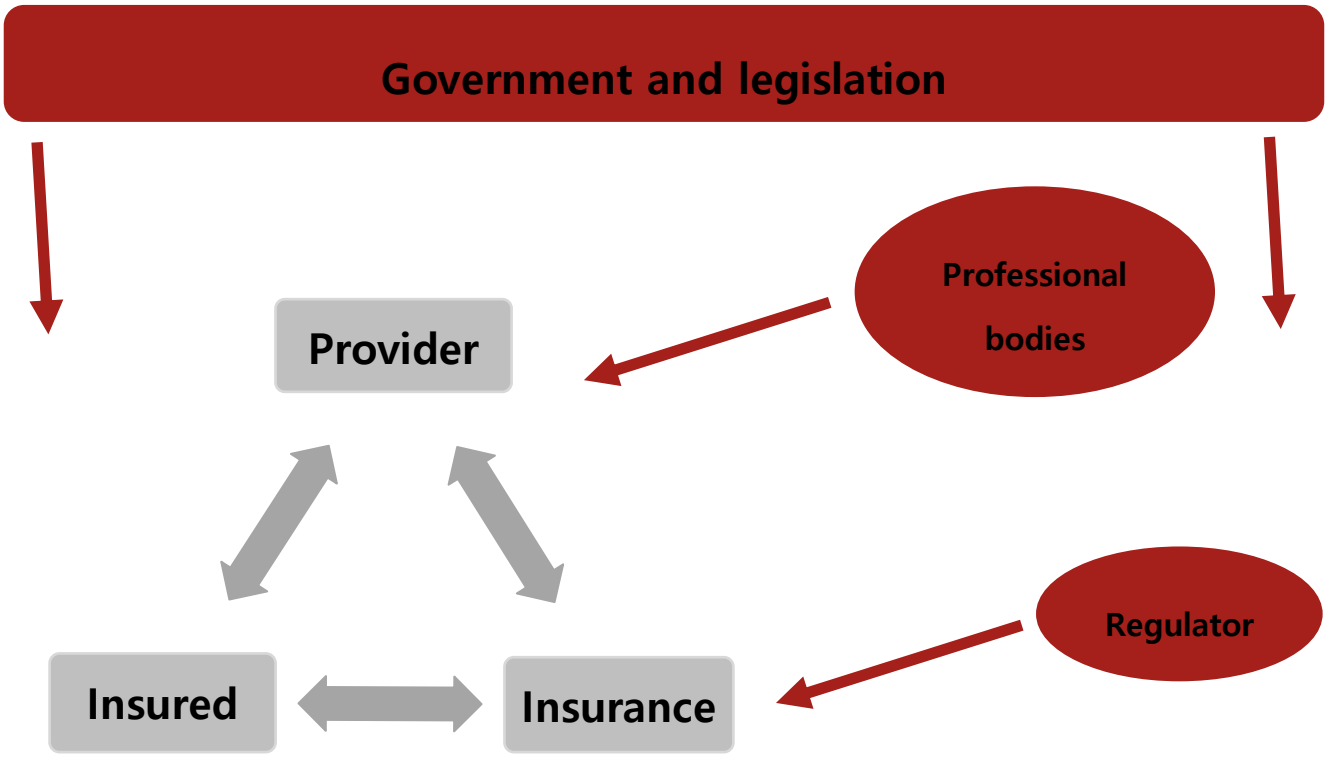
- Data protection Act, 2019
- Competition Act, 2010
- Consumer Protection Act, 2012
- Public Procurement and Asset Disposal Act 2015
- Finance Act No.15 of 2017

These will be considered, as far as relevant and applicable during the drafting stage of this Project.

3.3. Medical Market and Medical Insurance Overview

The figure below illustrates the medical market players from a broader market perspective.

Figure 4. Overview of Medical Market and Medical Insurance Overview



- **Government** – Medical insurance is viewed in many countries as a social good and as such the role government plays in the healthcare market is more pronounced than in other insurance markets. For example, the government may subsidize or partly fund public health insurance under national or social health insurance initiatives.

- **Insurance regulator** – The role of the insurance regulator is to ensure that the medical insurance market operates in a fair, safe, and stable manner and that the interests of insured persons are appropriately protected. Insurers, MIPs, Agents, Brokers and Reinsurers are regulated by the IRA as described in Section 3.2.
- **Healthcare provider regulators**: There are a number of health care provider regulators that oversee different types of healthcare providers. Firstly, the Ministry of Health (MOH) is responsible for building a progressive, responsive and sustainable health care system for accelerated attainment of the highest standard of health to all Kenyans. The MOH's mandate includes health policy, health regulations, national referral health facilities, capacity building and providing technical assistance to counties (Ministry of Health, 2021). Medical practitioners and dentists as well as health institutions are subject to regulation by the Kenya Medical Practitioners and Dentists Council (KMPDC). The KMPDC ensures the provision of quality and ethical health care through appropriate regulation of training, registration, licensing, inspections and professional practice (Kenya Medical Practitioners and Dentists Council, 2021). The Pharmacy and Poisons Board (PPB) is the Drug Regulatory Authority established under the Pharmacy and Poisons Act, Chapter 244 of the Laws of Kenya. The PPB regulates the Practice of Pharmacy and the Manufacture and Trade in drugs and poisons. The PPB aims to implement the appropriate regulatory measures to achieve the highest standards of safety, efficacy and quality for all drugs, chemical substances and medical devices, locally manufactured, imported, exported, distributed, sold, or used, to ensure the protection of the consumer as envisaged by the laws regulating drugs in force in Kenya (Pharmacy and Poisons Board, 2021). The Nursing Council of Kenya (NCK) is a statutory body established by the Nurses Act Cap 257 of the Laws of Kenya to ensure the delivery of safe and effective nursing and midwifery care, to the public, through quality education and best practices (Nursing Council of Kenya, 2021). It is the only professional regulatory body for all cadres of nursing and midwives in Kenya.
- **(Re)Insurers** – Insurers and reinsurers are third-party players in the relationship between the provider and the insured. However, the insured carries the financial burden of the cost of care[1]. Insurers and by extension their agents and brokers who sell products on their behalf are regulated by the IRA. The NHIF and community insurers are not regulated by the IRA.
- **Providers** – Providers of care and are separately regulated from the insurers. However, the standards of care, range of services, provider pricing guidelines and allowable payment methods directly impact the type of insurance that can be offered and the ability to ensure the quality and control the cost of insurance.
- **Professional bodies**– Most healthcare providers are members of healthcare societies and as such they are subject to certain standards of care. To an extremely limited extent, professional bodies oversee standards of care and issues of professional services.
- **Insured** – The insured are the persons who are entitled to benefits provided under a health insurance contract entered into between an insurer and a policyholder. The insured is often the policyholder, but may not necessarily be so for example children covered under a parent's policy. However, the care is often

[1] Although the insured carries the burden of the cost of care the government also carries the burden for the cost of care of the for the population with regards to providing and financing public health facilities.

received from a party (healthcare service provider) who is independent to the commercial relationship with the insurer. Furthermore, the information asymmetry which exists between the insured and the provider are such that the insured is seldom able to objectively evaluate the cost versus quality of care they will receive.

- **Legislation** – Healthcare is one of the most regulation intense sectors due the number of players. Insurers are subject of regulation due to the class of business they sell. In most jurisdictions, insured lives are protected by insurance legislation, general consumer protection legislation and, indirectly, by legislation governing the provision of healthcare. Providers are subject to laws in respect of their various disciplines around care, standards of treatment and qualifications. Over and above this, is national policy on medical insurance.

3.4. Regulatory concerns identified during initial stakeholder discussions

During the initial stakeholder consultation process a number of areas were highlighted where additional regulation or guidance is required within the medical insurance ecosystem. For a number of these items departments within the IRA are currently working on developing guidance for the industry others may however require collaboration with other regulatory bodies to implement. The section provides a summary of areas highlighted by the stakeholders as well as the proposed recommendations of stakeholders, where applicable, and are not in all instances representative of the recommendations of the report as set out in section 7.

- There is no uniform pricing model applied to either the pricing of medical services or medicine. Insurers are charged different rates at the same providers and as a result it is difficult to predict claims accurately. There is a need in the market for harmonisation of pricing models used by various providers which could be done through the creation of standardised packages or DRG groupers. Any initiative to address this issue would however require collaboration between various regulators, i.e. the IRA and the MOH or KMPDC.
- There are not uniform treatment protocols applied which in some cases lead to excess testing and increased claims. The implementation of standard treatment pathways could also help to improve cost management. Any initiative to address this issue would however require collaboration between various regulators, i.e. the IRA and the MOH or KMPDC.
- A number of stakeholders raised issues with regards to moving providers from competing on brand recognition to competing based on service provision and health outcomes. Different methods of addressing this issue were raised including rewarding better-quality services through the reimbursement process, establishing outcomes based metrics with a requirement for public reporting on of these metrics or through an accreditation process.
- Data quality received from providers is a concern and hospitals are using different coding methods to capture procedures. There is a need for regulation that would make the use of ICD coding compulsory to improve data quality. Such regulation would however require collaboration with medical provider regulators.

- There is no fixed medical insurance pricing regulation, for example community rating as a result medical insurance for older ages becomes difficult to access or is not always available and is prohibitively expensive.
- Key areas of concern are waiting periods, exclusions are pre-existing conditions. A large portion of the complaints that the Consumer Protection Division of the IRA receives relates to waiting periods for consumers with chronic and pre-existing conditions. These waiting periods range between 12 and 24 months whereas the policy term is generally only a year. When individuals move between insurers, they sometimes never gain access to benefits as waiting periods are reinstated at the new insurer. Individuals would have to remain with the same insurer to eventually have access to benefits excluded by initial waiting periods.
- A number of procedures require pre-authorisation, however, the IRA have received complaints where the insured individual obtained pre-authorisation to be admitted but post admission the insurer then refused to pay the claim as the condition that triggered the admission would be an excluded condition. Clearer documentation is required at point of admission to ensure that insured individuals are aware of the possible risk on non-payment by the PHI.
- Across the industry policy definitions are not standardised. The IRA is currently working on creating a standard list of terms and definitions.
- Currently, pre-mature babies are not covered by all PHIs in the market. Clear definitions of dependants are required and potential rules to allow coverage for children at birth.
- Clarity on lapse rules are required. Currently, the party responsible for triggering the lapse is not clearly defined.
- A forum needs to be developed where challenges in the health insurance ecosystem can be raised, shared and discussed between the various parties involved in the ecosystem.
- There is a need for an independent Ombud.
- The majority of policy wording currently specifies that insured lives have to follow an arbitration process when there are complaints. However, the IRA's Consumer Protection division is also an avenue available to insured lives. There should be a requirement that policy terms and conditions need to clearly indicate all dispute/complaint mechanisms available to insured lives.
- The IRA is currently working on the standardisation of medical insurance policies and trying to improve market education. This would include the development of a standard policy with standard exclusions.

3.5. Regulatory analysis

This section highlights areas in the current regulatory framework where additional legislation may be required or where clearer guidance may be required.

3.5.1. Foreign medical insurance providers and products

Section 19 of the Insurance Act effectively prohibits a foreign insurer from "carrying on insurance business in Kenya". This language is similar to the language used in many jurisdictions. However, subject to and apart from any Court decisions not known at the time of writing the report, the scope of what constitutes "carrying

on insurance business in Kenya" is unclear. For example, while a foreign insurer which actively sells insurance into the Kenyan market probably carries on insurance business in Kenya, it is far from clear that this would extend to a foreign insurer that, without actively soliciting Kenyan insurance business, sells an insurance policy to a Kenyan resident at the resident's request.

Section 20(1) provides that:

"No insurer, broker, agent or other person shall directly or indirectly place any Kenya business other than reinsurance business with an insurer not registered under this Act without the prior approval, whether individually or generally, in writing of the Commissioner."

This prohibits the involvement of Kenyan insurance intermediaries in actively placing Kenyan health insurance business with a foreign insurer, without the approval of the Authority, but it is unclear whether a Kenyan resident who (without the involvement of a registered intermediary) purchases health insurance from a foreign insurer, is covered by section 20. In any event, any provision that seeks to place a prohibition on a foreign insurer with no presence in Kenya is effectively unenforceable, as the insurer is outside the jurisdiction of the IRA and the Kenyan courts.

The only other requirement relating to the placing on medical insurance outside Kenya is in a circular issued by the IRA to MIPs which requires approval from the IRA before medical insurance business can be placed outside the country. While these provisions should significantly restrict the ability of foreign insurers to sell health insurance into the Kenyan market, there remains the problem that the requirements do not clearly prohibit or control the direct purchase by Kenyan employers of group medical insurance for their employees and the direct purchase by Kenyan residents of medical insurance on an individual basis.

Clearly this is a problem that affects all classes of insurance business. With respect to medical insurance, there are both consumer protection and market development issues.

The consumer protection issues include the following:

- Kenyan policyholders cannot be sure whether the foreign insurers that they purchase, or are intending to purchase, medical insurance from are legitimate, licensed medical insurers.
- Insurance contracts issued by foreign health insurers may be subject to foreign law, which may be very different from Kenyan law and which may not contain the provisions necessary to protect insured lives.
- If a foreign insurer refuses or fails to pay a claim, the policyholder may have little option but to take legal action in the insurer's home country, which is likely to be difficult and expensive. Enforcement outside Kenya may not be practical for Kenyan policyholders, especially consumers, and even for commercial policyholders, may be uneconomic.
- Foreign insurers that are not subject to supervision by the IRA may not conduct their business with appropriate market conduct standards, including policyholder protections, with a risk that Kenyan policyholders purchase insurance contracts that do not meet their needs, do not provide value or include unfair contractual terms.

- Without some assurance that a foreign health insurer is subject to adequate prudential regulation and supervision in its home country, there is a risk that it will not be able to meet its obligation to pay claims.

The market development issues include the following:

- Foreign insurers that conduct business on a cross border basis can impact the Kenyan market to the detriment of local insurers. In particular, by avoiding the costs of registration and supervision in Kenya and the costs of establishing a physical presence, foreign insurers may be able to offer health insurance at a lower cost than local insurers, which would distort the market and be unfair competition to Kenyan insurers.
- Allowing individuals or groups to place their insurance risk outside of the country reduces the insurance pool within the local market which is sometimes exacerbated by the fact that lives opting to take out insurance from a foreign insurer may be younger, healthier lives potentially reducing cross-subsidisation that would otherwise apply.

On the other hand, foreign insurers may provide insurance capacity which is not available within the local market and there are a number of potential benefits that may arise when allowing foreign insurers to place business in the local market. Requiring a foreign insurer to establish a registered branch or a Kenyan subsidiary would most likely be uneconomic for those foreign insurers. Therefore, an outright prohibition on the sale of medical insurance into Kenya would not be considered optimal.

The ICPs provide that an insurer licensed in one country may be permitted to conduct cross-border insurance activities without a physical presence in that country, but requires the host supervisor to consult the home supervisor, as necessary, before allowing such activities.

In section 5.6, an overview of the treatment of foreign insurers in each of the countries included within the benchmark is provided. This varies from no specific legislation to requirements to register as insurers but being subject to home country legislation or requirements to establish local branches.

Section 7.2.1 explains the policy proposals regarding the use of foreign insurers.

3.5.2. Community based health insurance

As indicated above, section 19 operates to prohibit persons from "carrying on insurance business in Kenya". If community based health schemes could be said to "carry on insurance business" they would already fall within the Act. However, it is generally accepted that they do not fall within section 19 and the IRA does not therefore currently have oversight of them. As community based health groups are not required to be registered, they do not report to the IRA and the true quantum of cover offered by these schemes as well as the number of these schemes in existence is not definitively known.

These schemes are arrangements which provide mechanisms for communities to pool funds to cover the unexpected medical expenses of the community. As such these groups are providing self-insurance to their members and, given in particular the risk that a community based group may not be able to meet the

unexpected medical expenses, there is an argument for bringing these groups within the regulatory and supervisory ambit of the IRA.

If community-based groups were to be regulated as commercial insurers, it is unlikely that any such groups would be able to meet the capital requirements and would not be able to continue in operation. If it is considered that community groups provide value and should be preserved, they would have to be subject to a lenient regime.

The treatment of community-based health initiatives within insurance regulation is not addressed in the benchmarking section, as such initiatives may not be prevalent in all jurisdictions included in Section 5. However, such a regime could include requirements:

- in relation to the handling of the group's funds, which could be similar to those prescribed for MIPs who are managing client funds.
- that a community based group either obtain medical insurance (i.e. effectively transform into an insurance intermediary) or register as an insurer should the total risk pool of the Community based health scheme reach a pre-specified level.
- that, in relation to small community based groups, are similar to the less onerous requirements applied to micro-insurers.

However, there is insufficient information on community based health insurance schemes and therefore a phased approach to bringing them within the formal sector is recommend. This is discussed further in Section 7.

3.5.3. Regulation and Supervision of Health Maintenance Organisations (HMOs)

The Third Schedule to the Insurance Regulations defines medical insurance as the *insurance business of paying for medical expenses*. Circulars issued by the IRA provide that MIPs are not permitted to carry medical insurance risk and that, should they wish to do so, they would have to be apply to the IRA for registration as an insurer. However, as described in section 3.3, Health Maintenance Organisations provide what is, in substance, medical insurance to their members by providing access to medical care at a fixed pre-paid amount, or a capitation fee. However, despite carrying insurance risk, HMOs are not currently regulated by the IRA and are not deemed to provide medical insurance. HMOs do not, therefore, fall within section 19 of the Insurance Act as they are not considered to carry on insurance business.

Consequently, although HMOs target similar markets to medical insurers, they are not subject to the same regulatory obligations as medical insurers resulting in an unlevel playing field. There are also consumer protection concerns as HMOs are not subject to market conduct standards designed to protect policyholders and HMOs are not subject to any prudential requirements. The Act includes health management organisations within the definition of "broker", but the activities of a broker are very different from those of an HMO. HMOs operate as risk carriers, not intermediaries.

It is therefore important that HMOs are brought within the regulatory scope of the IRA. This could be done by requiring HMOs to register as insurers. However, it is most unlikely that many, if any, HMOs would be able to meet the capital and other prudential requirements applicable to insurers. Furthermore, the HMO business

model is completely different to that of an insurer and the regime for the regulation and supervision of insurers is not necessarily appropriate for HMOs.

An alternative way of bringing HMOs within the regulatory regime would be to create a new HMO licence and subject HMOs to their own tailored regulatory and supervisory regime. This is considered further in Section 7.

3.5.4. Third party administrators (TPAs)

Third Party Administrators are not regulated or supervised by the IRA, despite their important role within the health insurance market, particularly with respect to claims administration.

TPAs can play an important role in the smooth delivery of medical insurance services. They act as an intermediary between insurers and medical insurance policyholders by processing claims and settling payments. TPAs assist with processing of pre-authorisation, scrutinising hospital bills and documents for their veracity, help in the processing of the claim and can also assist with the identification of fraud. TPAs may also provide value-added services like ambulance, helpline facilities for knowledge sharing and can also assist with the empanelment of hospitals for an insurer's network as well as the monitoring of the quality of service provided to policyholders. Additionally, TPAs can also assist with the issuing of policies to the policyholders, through validation of new applications and issuing of health cards. This is also discussed in section 2.3.3.

The Insurance Act defines "claims settling agent" as a form of intermediary. Claims settling agents are therefore required to be registered under the Act as intermediaries. However, despite their role in claims administration, third party administrators do not really sit comfortably within the definition of "claims settling agent" in the Act. In any event, their role within the health insurance market is considerably broader extending to assistance with empanelment, beneficiary enrolment, pre-authorisation management and fraud detection.

The importance of independent claims administrators was highlighted in the literature review (section 6.2.8) and their use within India to assist in standardising and improving the data quality of the industry (Association of Kenyan Insurers, 2018).

Given the important role that third party administrators play in the medical insurance market, their omission from the regulatory regime is both a regulatory gap and a weakness. This is discussed further in Section 7.

3.5.5. Participation, minimum benefits and coverage limits

The Insurance Act, regulations, circulars and guidance contain no provisions on participation in medical insurance, minimum levels of benefits and coverage limits. Proposals to address this gap are discussed in Section 7.

3.5.6. Definitions and explanations of medical insurance terms and concepts

Given that the regulatory framework contains few provisions that are specific to medical insurance, there is no necessity for medical insurance terms and concepts to be defined or explained.

This will be a significant gap in relation to the introduction of prescribed minimum benefits, standardised product offerings and other policy proposals made in Section 7. Definitions or explanations in guidance will

be required, for example, with respect to allowable waiting periods, the application of waiting periods when members move between insurers, allowable exclusions, cover of new-born / premature children, the use of age rating or community rating as well as indemnity (in the medical insurance context) versus fixed sum. These matters are considered further, where relevant and appropriate, in Section 7.

3.5.7. Conduct Risk

Additionally, the Insurance Act may need to expand its list of definitions or provide additional guidance in its policyholder protection rules to enable uniform adoption and implementation of several medical insurance specific items. This includes the definitions and descriptions of allowable waiting periods and application of waiting periods when members move between insurers, allowable exclusions, cover of new-born / premature children, the use of age rating or community rating as well as indemnity (in the medical insurance context) versus fixed sum. These items are currently either not defined or clear guidance on the use is not given and may be required to ensure a level playing field while still improving product design and protections for policyholders.

The IRA has started requiring insurance companies to self-assess their treatment of policyholders and beneficiaries in line with the IRA's mandate and best practice. The IRA has also initiated initiatives to develop the industry's education with regards to TCF and its implementation within the regulatory environment. Additionally, the IRA has issued two guidance notes enhancing product pricing, design, marketing and disclosure rules to further strengthen TCF principles with the market. These requirements could be further strengthened by issuing guidelines or circulars to specify:

- Disclosure in product terms and conditions of a list of all dispute resolution pathways available to policyholders and their beneficiaries.
- Clear rules with regards to the termination of policies and the requirement of insurers and intermediaries to notify to policyholders and their beneficiaries of the termination of cover.

The guidance notes do not refer specifically to medical insurance.

3.5.8. Product development and pricing guidelines

The IRA provides guidelines with regard to insurance products and the pricing of insurance products. These require that product pricing should include the reflection of emerging experience and profit and loss analyses. Medical insurers would be able to meet these requirements for retail products that they develop and price based on their retail portfolios and target markets, however, for corporate groups this may not be possible as there currently does not exist clear guidance with regards to the sharing of historic claims and exposure information between insurers when a group requests a quotation from an insurer. This could partly explain some of the under-cutting observed within the medical insurance market where quoting insurers are not required to submit products to the IRA for approval and using historic information of each group to determine appropriate rates may not be possible.

One potential approach to address this potential weakness the would be for the IRA to issue guidance on standardise forms to be supplied when quotations are requested at re-broking stage. The standardised forms

will aim to assist with capturing accurate and reliable data to be provided for use in group quotations. This would facilitate competition and is to the benefit of consumers as well as insurance companies where a more appropriate estimation of the underlying risk can be made. This could be further strengthened by requiring the submission of accepted quotes along with the bases used in the derivation of the proposed premiums to the IRA in an attempt to ensure the soundness of group premiums.

Another approach would be to require the sign-off of all group products by an individual with appropriate knowledge and skill to do so.

A last approach would be to require retail and group medical insurance product options to be made consistent. Therefore, insurers should not be allowed to customise the benefit and price of their group products. This will ensure that the product approval requirements that apply to retail products also apply to group policies. It will also create larger risk pools per product and reduce the extent to which under-cutting of premiums can occur within the group space. Such a requirement can be reviewed once market fragmentation has reduced.

Section Premium and underwriting rules7.4 explains the policy proposals that impact the approval process for group and individual policies. Section 7.6.2 explains the policy proposals regarding the standardisation of group and individual policy design.

3.5.9. Medical providers

Providers are separately regulated from the insurers. However, the standards, range of services, prices etc directly impact the type of insurance that can be offered and the ability to ensure the quality and control the cost of insurance.

3.5.10. Medical Insurance Ombudsman

Ombudsman institutions (OIs) have become a common feature of most countries' institutional frameworks. However, their role, mandate and scope of intervention can differ from one country to another as they take into account different political, institutional and historical contexts. Since the establishment of the first ombudsman institution in Sweden in 1809, the mandates of ombudsman institutions have evolved based on countries' specific needs (e.g. following civil wars, independence, consolidation of democracy, the evolution of international human rights law etc.) (OECD, 2018b) (The Ombudsman for Short-Term Insurance, 2007).

Kenya has an established Office of the Ombudsman which has a two-fold mandate extending to both national and county government. Firstly, the Commission has the mandate of tackling maladministration (improper administration) in the public sector. In this regard, the Commission is empowered to, among other things, investigate complaints of delay, abuse of power, unfair treatment, manifest injustice or discourtesy. Secondly, the Commission has the mandate of overseeing and enforcing the implementation of the Access to Information Act, 2016. (Commission on Administrative Justive (Office of the Ombudsman), 2021). The current mandate of the Office of the Ombudsman therefore only relates to the public sector and not the private sector. A large portion of the Kenyan healthcare environment would therefore not fall within the ambit of the Ombudsman.

The establishment of an independent medical insurance ombudsman would be highly desirable for private insurance as well as the NHIF. As an institution that interacts with citizens, oversees if their rights have been respected and provides policy recommendations an independent medical insurance ombudsman can help to improve trust in the medical insurance sector.

The medical insurance ombudsman could be a function of an insurance or broader financial services sector ombudsman.

3.5.11. Risk based capital guidelines

The purpose of capital is to protect the insurers against adverse claims experience, avoid insolvency and ultimately protect policyholders. To assess the appropriateness of the capital insurers hold, regulators generally specify minimum capital requirements. The Insurance Act currently mentions risk-based capital as one of the possible minimum requirements for capital. General insurers are required to hold the higher of:

- KSh 600 million
- Risk based capital determined from time to time
- 20% of net earned premiums of the preceding year

Risk-based capital adequacy guidelines were introduced in 2017 in Legislative Supplement No 16 (Legal Notice No. 37). A risk-based capital framework encourages insurers to operate in a manner that will protect insurance policyholders, focuses supervisory attention on the most significant risks and aligns capital requirements with the underlying risks of the insurer.

The guidelines set out the prescribed capital requirement (PCR) as well as the minimum capital requirement (MCR). The guidelines further provide information with regards to the tiering of available capital and inadmissible assets for determining capital adequacy. The risk-based capital requirement takes into account market risk, credit risk, operational risk as well as insurance risk. Insurance risk is calculated such that the insurer shall hold capital against fluctuations in the premium reserves and claim reserves. The guidelines also set out the supervisory strategy with regards to breaching of capital requirements.

3.5.1. Financial condition reporting

The 2013 guidelines to the insurance industry on the actuarial function (IRA/PG/13) provide an overview of the requirements with regards to Financial Condition Report (FCR) that the Appointed Actuary has to produce on an annual basis. The Appointed Actuary is required to, amongst others, include the following information in the annual FCR:

- An FCR must identify and comment on the past profitability of the insurer, including consideration of significant features or trends in the insurer's recent experience, over a period of at least three previous years, to the extent that such experience exists. This assessment must consider premiums, claims, expenses, commissions, investment return, and profits/losses, including any abnormal features.

- An FCR must consider the adequacy of premiums, and must outline, consider and comment on material issues arising from the insurer's pricing processes and underwriting and claim management practices.
- An FCR must consider whether expected future profitability arising from the assessment of premium adequacy is materially in line with the insurer's plans.
- The Actuary must consider and comment on the insurer's capacity to meet its MCR and its capital targets over at least the next three years.

4. Discussion on key health insurance terms

The section below defines and discusses key health insurance concepts which are referenced throughout the document. The explanations will give a wider understanding of the options available when designing health insurance and ensure a clear understanding of the meaning of each term when recommendations and policy proposals are made.

The inclusion of each concept and theme reflects the inputs from the stakeholder engagements, regulatory overview, and the benchmarking and literature reviews done in the subsequent sections. The policy proposals set out in section 7 considers each of the concepts explained below.

4.1. Indemnity cover vs stated benefit

Indemnity cover refers to a form of insurance where the insured person is indemnified for their medical care expenses. The cover may not always pay the full cost, but the payment is related to the cost of the medical expense incurred. For example, if a policyholder is admitted to hospital and their policy provides indemnity cover then the benefit that they will receive will be related to the cost of providing the cover.

A stated benefit refers to a form of insurance where the insured person receives a pay-out of a fixed benefit amount on the occurrence of a defined event. For example, upon admission to a hospital, a policy may pay out a single fixed amount or an amount for each day in hospital. The stated benefit is not related to the actual cost of healthcare and could also be limited in the number of times it pays out over the contract period.

In general terms, indemnity cover assures the policyholders that all or most of their healthcare expenses will be covered and that they will avoid out-of-pocket payments (excluding co-payments). Providing indemnity cover does not exclude the ability for insurers to add maximum payment caps for certain or all benefits. Therefore, an insurer can still manage its total risk exposure by limiting the maximum payments. However, all expenses up to the payment cap (excluding co-payments) must be paid by the insurer.

On a stated benefit policy, the policyholder will not be able to determine the size of their out-of-pocket expenditure as the benefit is fixed, but the cost of cover is variable and could exceed their insurance cover.

Indemnity cover providers much greater certainty to the policyholders as the claims cost risk is passed to the insurer. This reduces the risk of out-of-pocket expenses and therefore a requirement to achieve full UHC. However, these generally come at a higher price.

Indemnity cover does pose a greater risk to the insurer as both the frequency and severity of claims paid are uncertain. Whereas for a stated benefits policy, it is typically only the frequency risk which is passed to the insurer.

4.2. Inpatient vs outpatient cover

Inpatient cover provides benefits which cover the cost of medical services where the policyholder is admitted to a hospital. Admissions typically require a doctor to formally write to the hospital for a patient to be admitted.

Inpatient cover generally provides for treatment which is needed for more serious illnesses or injuries where the patient needs to stay overnight in a healthcare facility for one or more days.

Outpatient cover provides benefits which cover the cost of medical services that do not require an overnight stay at a hospital or care facility, and it is often referred to as day-to-day cover. This includes services such as acute medication received at a pharmacy, routine GP visits or surgical procedures done in a doctor's room.

The cost of inpatient medical services is usually significantly higher than outpatient services per event as patients requiring admission to hospital will generally have more serious conditions and will utilize beds at the facility as well the time of medical professionals. Outpatient cover is used more frequently by policyholders, but the cost per event is generally significantly lower.

4.3. Fee-for-service vs capitation

Fee-for-service and capitation arrangements refer to manner in which the providers of healthcare are remunerated by the funders of healthcare benefits. Therefore, it refers to how the risk is passed between the funder and the provider, and not between the funder and the policyholder.

Fee-for-service means providers (GPs, specialists, hospitals etc.) receive a payment every time they service a member, and this payment varies by the type of service provided. Fee-for-service arrangements run the risk of not being sustainable in the long run as the fee-for-service model rewards providers for increased utilization. That is, the more tests, treatments, drugs or resources used the higher the provider can charge as they charge for each individual service. This discourages efficient rationing of healthcare resources among providers.

A capitation arrangement refers to an arrangement where a health provider (or provider group) receives a fixed fee for each individual (or "per capita fee") in a specified population. In exchange for receiving this fixed fee, the provider is responsible for providing healthcare services for the specified population over the agreed time period.

Capitation also includes arrangements whereby the insurer will pay the provider a fixed fee for a defined service, irrespective of the underlying cost of the service. For example, an insurer can agree a fixed fee per day in hospital with hospital providers, where the fee does not vary based on the reason for admission to the hospital.

Capitation arrangements between providers and insurers can also be facilitated through a third party. It is common for managed care organizations (or provider groups) to engage in capitation arrangements with insurers. For example, contracting with a managed care organization which specializes in handling oncology treatment. In these cases, the insurer and managed care organization is engaged in a capitation arrangement where the insurer pays a per capita fee to the organization who, in turn, provides healthcare benefits for the insurer's policyholders. These organizations often rely on their own network of providers who they deem to be the most efficient in treating members.

Capitation arrangements are a way for insurers to transfer risk to a third party – most often the healthcare provider. Capitation has the benefit of making healthcare expenditure more predictable for the insurer. Since

a fixed fee is paid per active life, the cost of relevant healthcare expenditure is only dependent on the number of covered lives. The third party carries the risk that the cost of healthcare that all the policyholders need is greater than the amount charged to the insurer. The insurer has the risk that the cost of healthcare is significantly lower than the fee paid to the third party, which is why these contracts should be monitored carefully.

It is worth noting that a capitation arrangement covering one area of medical benefits may impact other areas of healthcare expenditure. For example, if primary care is managed through a capitation arrangement and these providers are inefficient (make referrals for cases they could manage or make admissions where not necessary) this could result in larger major medical claim expenditure in areas where the insurer pays on a fee-per-service model. This drawback but can be managed by monitoring the costs incurred by their providers on the provider networks.

4.4. Passive vs strategic purchasing

Purchasing refers to the process where pooled funds are paid to providers to deliver a specified or unspecified set of health interventions. Passive purchasing is where bills are paid as they are presented while strategic purchasing requires a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how and from whom. Under strategic purchasing, interventions must be chosen which are expected to achieve the best performance for individuals and the population by means of selective contracting and incentive plans.

Capitation fee arrangements are an example of strategic purchasing. Under a typical capitated arrangement, the insurer has contracted with a provider/s (or managed care organization) by pre-paying for healthcare interventions for policyholders for their current period of cover.

Health insurers may negotiate for volume discounts to control costs in a fee-for-service environment. Volume discounts are negotiated agreements between insurers and healthcare providers. This is often applied to purchasing care from hospitals in which agreement a hospital agrees to charge for healthcare services at a defined discount rate if the number of policyholders utilising the hospital reach a stated threshold. The volume discount agreement may also specify a class of treatments covered. For example, a volume discount agreement may specify a minimum number of hospital admissions for hip replacements. The use of volume discount models may also mean that the insurer restricts provider choice for policyholders, to ensure that the discount threshold is reached for a specified provider or group of providers.

As part of a volume discount agreement, the insurer may also include additional requirements from providers. The insurer may require minimum efficiency and quality standards to encourage providers to provide quality care while actively searching for ways to contain costs. Requirements may also include minimum data quality standards and periodic utilisation reviews and benchmarking.

4.5. Underwriting

Underwriting refers to the manner in which the premiums are differentiated between different policyholders and to the process of accepting new policyholders. The concepts of underwriting were grouped into five sections, each of which is discussed below.

4.5.1. Enrolment for new members

A common concept used in health insurance is open enrolment. This refers to an environment in which a health insurer may not decline to cover an individual. This will improve insurance coverage (i.e. increase the number of residents that can access cover) in the population. However, the coverage will depend on how insurers opt to price the individual's premiums and manage the quality of the risk pool and therefore the affordability of premiums across the healthcare system.

Open enrolment should, therefore, be considered in conjunction with risk rating. If insurers are allowed to apply unlimited risk rating, then they can effectively exclude certain individuals from cover by quoting unaffordable premiums, based on a certain risk factor that they have identified. This will, in turn, neutralise the benefits and impact of open enrolment. Therefore, if open enrolment is applied, then the regulations should also make provision for community rating, or limited risk rating only.

The complete opposite of open enrolment would occur if insurers can decline members on account of their age or health status. This practice will protect the health of the risk pool as a whole as insurers will only allow healthy individuals to join, however it will result in many members not having access to cover, especially at times when these individuals might need the cover the most.

Insurance coverage may be mandated as opposed to an open enrolment environment. Mandated cover creates a legal requirement for specified individuals to be to purchase prescribed insurance cover. The minimum type of cover that needs to be purchased would be specified and individuals may be liable to pay fines should they not have the required cover in place. Mandated cover increases the price of being uninsured thereby causing more people—particularly healthier ones—to obtain coverage. This may in turn help to manage cost, affordability and sustainability.

The type of enrolment applied should, in addition to risk rating considerations, also take into account of the interaction between public and private health insurance specifically the type of coverage offered by private health insurance, i.e. supplemental versus complementary cover. These ideas are discussed further in Section 4.15.

Open enrolment should be considered in conjunction with risk rating. If insurers are allowed to apply unlimited risk rating, then they can effectively exclude certain individuals from cover by quoting an unaffordable premiums, based on a certain risk factor that they have identified. This will, in turn, neutralise the benefits and impact of open enrolment. Therefore, if open enrolment is applied, then the regulations should also make provision for community rating or limited risk rating.

4.5.2. Risk rating vs community rating

Health insurance premiums may be differentiated, through underwriting, by factors such as age, gender and health status. The goal of underwriting is to ensure that risks are separated into broadly homogeneous sub-groups so that premium rates are appropriate to the experience of each risk group, and hence are broadly equitable between the policyholders in different risk groups.

Risk rating means premiums are determined based on the risk you pose to the insurer. In the context of health insurance, this would generally result in very high premiums for new-born dependants and pensioners and low premiums for young and healthy policyholders. Although risk rating has its merits in most classes of insurance, within healthcare there are additional considerations. For instance, risk-rating would not be desirable as many vulnerable groups, for example, older individuals may not be able to afford cover as their premiums are higher than the younger policyholders' premiums.

Community rating means everyone is charged the same premium regardless of age or state of health. If paired with appropriate tools for risk mitigation, community rating can be an effective tool to ensure affordability and equality. However, this requires cross-subsidization of premiums from younger, healthier lives to the older, sicklier lives. The consequence here is that younger individuals might choose to remain outside the healthcare system as their premiums are much higher than the value (or perceived value) that they derive from the healthcare funding system.

The ideal system lies between the two as both systems have desirable and undesirable elements.

Even if risk-rating factors are allowed, practical considerations limit the extent to which these are used. For example, the insurers might not have enough information on a specific individual to apply effective risk rating. In systems where rating factors are used, there is still a risk of the actual claims experience being different from what was assumed – due to claim volatility and miss-pricing of the risk group. For instance, although child dependants are not expected to claim as much as adults, a child dependant could be involved in an accident and hence claim more than even a pensioner. Such risk events give rise to the need for pooling and cross-subsidisation.

Outside of risk rating, the principal of social solidarity requires that premiums should be priced according to the ability to pay and healthcare should be provided according to need. This requires cross subsidization from the healthy to the sick and from higher income individuals to low-income individuals. This means that premiums rates will vary according to the income earned by each individual policyholder.

It is very important to ensure that the pricing principle is applied consistently across the industry as this will ensure that all market participants will be able to compete against each other on a level playing field.

4.5.3. Waiting periods and exclusions

Health insurers may supplement risk rating (where this can be applied) imposing waiting periods, pre-existing condition exclusions and maximum ages at entry onto new applicants. These measures are typically used in

cases where the insurer's underwriting scope is limited, for example when the insurer is restricted from accessing full personal information about each applicant.

A waiting period is a length of time at the beginning of an insurance policy during which the policyholder is required to pay premiums but may not receive any benefits under the policy. A waiting period may also be applied partially to existing health conditions at the application stage. For example, an insurer might impose nine months waiting period on pregnancy and pregnancy-related conditions, while full health insurance cover is available for other healthcare needs.

One can consider exclusions on new-borns as an example. While waiting periods on maternity benefits (such as pre-natal consultations and scans) may be imposed, further exclusions on or protocols regarding the new-born's access to benefits may be regressive in the context of UHC. A new-born baby (including babies born prematurely) can be considered as their own individual requiring health insurance cover. However, if any restriction is placed on the new-born's access to health insurance benefits this could have serious consequences for the health of the child. While it is reasonable for health insurers to expect dependants to be registered and paying premiums to access benefits, it becomes an unnecessary hurdle in the case of new-borns, particularly considering that the date of birth is still unpredictable.

Waiting periods and exclusions can be advantageous to insurers by preventing anti-selection and reducing the unpredictability of healthcare costs for the covered lives. This in turn prevents unpredictable increases in insurance premiums. However, the drawback of these measures mean that people may be refused health insurance coverage when they need it most.

Insurers should not impose these on policyholders with the intention of simply limiting the claims they pay. This will only increase out-of-pocket expenditure (even in cases where policyholders are not trying to select against the insurer) and reduce the level of benefits a product offers which impedes the ability to achieve UHC.

Waiting periods can therefore provide necessary protection for insurers, however the scope of these measures should be limited and regulated to provide reasonable access to policyholders and to consequently, increase access to healthcare funding.

4.5.4. Late-joiner penalties & age restrictions

In addition to waiting periods, late joiner penalties may be applied to the portion of a member's premium related to the principal member or a dependant who purchases health insurance after a certain age. This should however only be applied if the insurer cannot apply risk rating and vary the premiums by age.

The purpose of the late joiner penalties and age restrictions is to serve as an incentive for individuals to take up personal health insurance cover earlier on in life and to remain covered till old age. This in turn, will improve the quality of the risk pool and generally lower premiums for the whole industry.

4.5.5. Transferring between insurers

Various rules may be imposed on switching health insurance providers or transferring an existing policy to another insurer. The main goal is to allow policyholders the freedom to change insurance providers while

ensuring that the switches are not anti-selective. For example, members might move between insurers based on the size of different benefits to try to access the best benefit in all cases, in which case, insurers will not be able to reasonably manage their risks.

Limitation of the ability to apply these rules should be put in place as many policyholders may desire to change insurance providers due to price differences, customer care levels, or seeking an insurer with the lowest likelihood to dispute claims. If insures have full discretion to apply various restrictions to limit anti-selection when policies are switched, it may result in a non-competitive industry as members will not move between providers as they will lose all or some of their cover.

Some health insurers restrict the timing of switches, allowing them only at the expiry of the existing insurance policy, which may be on an annual basis. Insurers may also accept policyholders switching from previous insurers on a like-for-like basis, while upgrades to a more comprehensive benefit package require full underwriting, similar to a new policy application.

Premiums under the new policy may be set at standard premium rates for the new insurer, or they may be loaded considering claims experience under the old policy. Waiting periods may be waived under the new policy, or the balance of the waiting period on the old policy might still be applicable.

4.6. Prescribed minimum benefits

Prescribed minimum benefits (PMBs) refer to a minimum level of benefits all insurance providers are required to provide on all health insurance products. PMBs aim to ensure that the insurance offered covers certain minimum health services regardless of what product is purchased and to provide people with continuous care to improve their health and well-being while still being affordable.

PMB simplifies the product offering as there is a common basis of benefits and promotes consumer confidence in health insurance as a reasonable level of cover is always provided. Consumers should be able to spend less time (and require less expertise) understanding the complexities between different insurance plans because they understand that all policies will provide a minimum level of benefit. This will also allow individuals to make price comparisons more easily across insurers.

The benefits covered under PMB regulation needs to be considered carefully while considering the trade-off between affordability and comprehensiveness of cover. PMBs ensuring all products provide consumers with a level of benefit that meets their basic expectations. This increases consumer confidence in the insurance market, which increases take-up by policyholders.

However, having a minimum benefit forces insurer to design products that may be more onerous than the insurer wants to provide, resulting in higher minimum premiums and a higher barrier of entry into the funding system. If the PMBs are defined as a list of hospital centred benefits, then insurers will not be able to offer other low-cost benefit options which may focus on covering primary healthcare needs. This may result in the product excluding low-income policyholders, reducing insurance take-up in the market.

4.7. Pricing guidelines

Where pricing guidelines are used, the regulatory authority (or other suitable body) is responsible for outlining the pricing guidelines of health insurance products and typically most insurers will use these guidelines to reimburse the healthcare service providers. The pricing guidelines are generally re-assessed on an annual basis.

The purpose of setting pricing guidelines is to ensure consistent and reasonable pricing across the healthcare servicing industry and to aid the fairness of competition between insurers. Insurers with more policyholders (and more potential patients) have greater negotiating power with providers compared to smaller insurers. If the regulator wants to avoid insurers with larger risk pools to gain a pricing advantage, then the regulator can consider allowing for price guidelines.

The challenge with pricing guidelines is that these are often considered to be pricing floors and providers will charge members at least this amount, or insurers will consider this to be the lowest acceptable reimbursement level. This could hamper competition as some providers might be willing to charge a lower fee in the absence of such guidelines.

As an example, telemedicine has become increasingly popular with technological advancements. It can provide access to qualified healthcare personnel at a convenient time and location and serves as a reasonable substitute for GP visits. Telemedicine can be offered at a reduced cost but if a price floor is in place (this might be the case as there is no pricing guideline for remote consultations), then regulation has priced this out of the market and limited the ability for innovation.

4.8. Risk equalisation

4.8.1 Principles of risk equalisation

Premiums will differ across insurers based on their geography, demographic profile, and number of insured lives. Insurers who can attract a healthier demographic profile can charge lower premiums. The regulator might want to avoid a situation where insurers with healthier lives and healthier demographic profiles can dominate the market. Instead, the regulator might want to impose regulations which promote competition based on the quality of care, innovation of products and rigorous negotiation. A mechanism for risk equalisation amongst insurers may assist in achieving this. Risk equalisation effectively introduces risk pooling at an industry level.

Risk equalisation is especially useful in countries with open enrolment and community rating (refer to sections 4.5.1 and 4.5.2 above). This is because the cost of providing the cover to individuals are not reflective in the income from that individual and insurers do not have a mechanism to protect itself against itself against high-claiming individuals or anti-selection. This will also apply in situations where insurers have limited opportunity to apply risk rating.

A risk equalisation fund will ensure that the whole industry carries the additional risks of open enrolment and limited risk rating and that this risk will not be shifted onto one or a few insurers. If one or two dominant

insurers are able to attract the younger and healthier individuals into their risk pools, then these will likely end up dominating the insurance landscape.

Additionally, in a market where open enrolment and limited risk rating applies, then insurers will be competing to attract younger and healthier members. The insurers will try to avoid providing cover for the less-healthy individuals and these individuals might find it difficult to obtain cover, which in turn, will degrade the principle of open enrolment through higher premiums.

If insurers compete purely on the ability to attract younger and healthier members, this might limit competition and innovation. Insurers should be encouraged to compete on other areas that will drive innovation in the management of care and in providing cost effective and quality care. For more information see Armstrong *et al.*, (2004)

4.8.2 Risk equalisation mechanisms

Risk equalisation can work by creating a mechanism whereby the insurers with healthier risk pools should cross-subsidise insurers with less healthy risk pools. This type of equalisation regulation should aim to promote competition based on quality of care, innovation of products, efficient claims management and negotiation with providers and thereby avoiding competition to attract only healthy individuals.

The mechanism can be set up as a separate fund that is administered by the regulator, or by a dedicated entity. The fund will charge the insurers with a better quality risk pool a fee, and this fee will then be distributed to the insurers with a lower quality risk pool. The fee will typically be based on a defined set of measures that would generally determine the quality of a risk pool. These will include, but not limited to, age and chronic disease burden. The equalisation will also generally be limited to the PMBs or compulsory benefit packages provided by all insurers to ensure that it is not impacted by different levels of benefits provided by insurers.

This mechanism requires more frequent and detailed data collection and reporting by insurers to the manager of the risk equalisation fund, and the ability of this manager to investigate, verify and enforce the accuracy of the data provided by the insurers.

Countries have applied different risk equalisation mechanisms some with annual risk sharing and others where the regulator has the right to trigger the risk equalisation mechanism only if deemed necessary. The exact formula and mechanism should be investigated as part of a separate study.

4.9. Referral systems in the healthcare system

A referral system refers to a process where higher levels of healthcare can only be accessed upon referral from a lower level. For example, admission to a hospital must be approved by a primary care provider or specialist. Primary health care providers include general practitioners (GPs), nurses, pharmacists, and allied health providers like dentists.

The main function of a referral system is to improve efficiency of the healthcare system and to efficiently ration resources. The healthcare system within a country has a finite number of resources available. There is a limited number of GPs, specialists, hospital beds and high care and ICU facilities etc. within the healthcare system. To

ensure these resources are allocated in a cost-effective and efficient manner, referral systems can be implemented to prevent over-utilization and utilization at the incorrect level of care.

However, it is possible for a referral system to have the opposite impact if abused by providers. In a fee-for-service environment, providers increase their income by performing more services (which may not always be clinically necessary). Providers may also be incentivized to refer patients to specialist colleagues where a case may not be deemed complex enough to warrant the need of a specialist.

In other countries this is mitigated to some extent by the implementation of provider networks (for example, GP and specialist networks) where benefits are not funded if claimed for by out-of-network providers. Only efficient providers are included in the network. Additionally, the ongoing monitoring of providers in fraud, waste and abuse investigations can assist in identifying inefficient providers.

4.10. Quality Assurance and Accreditation

Regulatory bodies are in place to ensure providers offer consistent, safe and quality healthcare for all. Additionally, the regulatory body will be responsible for providing all health establishments (clinics, hospitals, doctor practices, auxiliary healthcare providers etc.) with the accreditation certifying that they are well equipped to offer quality healthcare to users. This is vital in ensuring users of the healthcare system receive a minimum standard and quality of care.

A set of norms and standards is defined by the body which outlines what is required of healthcare establishments to be compliant and receive accreditation. This may cover areas such as:

- User rights - information given to users, ability to access care.
- Clinical governance and clinical care - health records and management, clinical management, infection prevention and control programmes, waste management.
- Clinical support services - medicines and medical supplies, diagnostic services, blood services, medical equipment .
- Facilities and infrastructure – management of buildings, engineering services, transport management, security services.
- Governance, human resource management and occupational health and safety.
- Adverse events and waiting time.

Insurers may opt to only re-imburse claims from accredited healthcare facilities. This ensures policyholders are receiving care consistent with industry standards. It is critical that the correct regulatory bodies are employed to design and manage these standards and accreditations. Insures could be assisted by the KMPDC who would have the required knowledge and skill to help develop these accreditations standards in line with their own.

A publicly communicated accreditation systems is needed to provide the trust needed for a referral system to be implemented and followed.

4.11. Standardised care

Insurers will want to ensure the care policyholders receive is of a good quality and is provided in the most cost-efficient manner possible. This is in the interest of protecting policyholders, maintaining confidence in their products, ensuring the healthcare products provide is value for money and creating affordable health insurance products through clinical cost management systems. Examples of mechanisms insurers may use to achieve this are treatment protocols, managed care co-ordination, referral pathways and the use of designated service providers and provider networks. Insurers may turn to reporting of quality-of-care metrics as a method to measure quality and compare across different providers. The effective implementation of standardised care is subject to buy-in from clinical oversight bodies.

Treatment protocols refer to a set of guidelines which are to be followed when providing care for certain diseases/injuries. Care co-ordination is where different providers (treating the same patient) collaborate and share information to achieve the best outcome for the patient. This would typically be implemented by a managed care organisation which has created its own network or teams of providers. Referral pathways serve as a cost management mechanism to ensure the correct level of care is accessed by patients and that higher levels of care within the healthcare system are only accessed when deemed necessary. This often requires using primary healthcare providers as a gatekeeper.

Insured lives may be required, by the insurer, to elect a GP as their primary care provider. The number of visits allowed at other GPs may be limited or not funded. By ensuring primary healthcare for the individual is managed by the same provider, a more consistent level of care is achieved.

A designated service provider or provider network refers to a list of insurer approved providers who insured lives must visit. Insurers would place providers who they have verified as offering cost-efficient and good quality levels of care on their network. The use of out of network providers is typically not covered or covered at a reduced rate.

These interventions can be effective for rationing resources, preventing unnecessary utilization of costly resources, establishing a standard level of care, ultimately improving consumer confidence in health insurance products and containing healthcare related costs.

4.12. Diagnosis Related Groups (DRGs)

A diagnostic related grouper is a tool with which to classify hospital admissions into statistically homogenous and clinically intuitive risk categories. An example of a DRG is a "tonsillectomy" or "cataract procedure". These basic DRGs can be further refined into cases with or without complications such that all cases within a DRG are expected to require similar levels of resource utilisation. Diagnostic related groupers typically require clinical data such as ICD diagnosis codes, CPT procedural codes (discussed in section 4.18) as well as the age and gender of the patient. A diagnostic related grouping can utilise the different combinations of clinical codes in conjunction with the patient's information to allocate the admission to a reasonable DRG.

The main benefit of introducing DRGs is that it allows an easier and objective comparison of efficiencies between different hospitals and providers. Being able to allocate admissions to a specific DRG provides the

option for provider re-imbursement on the basis of DRGs. This can result in better control of medical costs over time if an industry cost per DRG is established. Additionally, DRGs improve the transparency of hospital admissions such that trends in hospital experience can be observed over time and standards for quality-of-care metrics for specific DRGs can be established. This can allow easier standardisation of care across providers using DRGs to compare quality of care on a like for like basis. That is, the types of admissions dealt with by different providers can be accounted for when attempting to benchmark them against peers.

Additionally, trends in hospital experience can be observed over time which can assist in better management of hospital costs. Assigning a DRG to an admission allows providers, and not only insurers, the means to assess their efficiency in treating patients for specific admissions. The spend for the admission can be disaggregated across the different service providers. For example, the costs attributable to different specialists (anaesthetist, surgeon, radiologists etc.) and for the facility (hospital bed, ward fees, theatre & equipment costs etc.) can be identified and compared to other admissions for the same DRG. The DRG also allows for easier identification of outlier admissions. That is, admissions of a significantly different severity which may be a contributing factor to significantly higher costs for an admission.

4.13. Claims/Cost management

The total claims health insurers will have to pay is largely influenced by two factors, that is, the average cost of claims and the utilization (frequency of claims) of healthcare services. Insurers have several mechanisms which can be used to limit these factors and to limit the overall cost. These will be discussed below.

4.13.1. Changing claiming behaviour

Introducing methods to change claim behaviour is one way to limit overall cost. Co-payments are one such method and refers to requiring a member to pay the provider directly for certain healthcare services. The co-payment can be a stated fixed amount or a percentage of the total amount charged by the provider. For example, it is common for insurers to impose a co-payment on diagnostic procedures like gastroscopies. This reduces the risk of unnecessary diagnostic tests as the insured life has an interest in preventing the claim. Co-payments also influence health provider behavior - it encourages the provider to not require large or unnecessary costs, since the patient will also have to pay for part of it.

Benefit limits may also be imposed on specific sub – categories. For example, an insurer may fund all acute medication claims up to a fixed amount. Any claims exceeding this threshold will have to be funded by the insured, out of pocket. This also sets a limit on the maximum an insurer can expect to pay, for a life, in respect of the benefit category, which reduces the cost of offering the benefit.

The insurer may allocate a portion of the premium raised to a medical savings account (MSA) which is designated for primary healthcare needs. The insured gives monthly contributions to the insurer that go into both savings and risk pots. The savings pot is used to fund specific medical costs and outpatient expenses until the savings are depleted. The risk pot contributes towards normal insurance. The savings not used in a year can be carried over to the next year or taken out at no additional cost. This incentivizes policyholders to

minimize their claim costs and discourages abuse of day-to-day benefits such as over-the-counter medication. The use of medical savings transfers some of the responsibility for rationing healthcare to the policyholder.

Another option is to require claims to be approved by the insurer first through pre-authorization. The requirement for pre-authorization allows the insurer to check if the correct managed care and treatment protocols are being followed, the correct network of providers is being used and that the services (or devices in the above example) are in line with what the insurer has approved for use. That is, it is a cost-efficient claim being made in line with the plan and treatment protocols. This requirement ties in with the referral system, where pre-authorisation will only be given then a claim is correctly referred.

4.13.2. Provider negotiations

The above interventions are mainly focused on changing policyholder behavior and reducing their utilization. To effectively manage average costs, insurers need to engage with providers to negotiate specific tariffs and provider re-imbursement rates. A tariff refers to the price charged by a provider for a specific healthcare service. The negotiating power of the insurer in setting tariffs/provider rates (and future tariff/price increases) is influenced by the number of lives on their book. An insurer with more lives would have greater bargaining power than a smaller insurer.

Insurers will also be concerned of the impact fraud, waste and abuse may have on claims costs. The analysis of claims experience is a key risk-management function. Analyses should enable insurers to identify policyholders and providers who are submitting fraudulent claims or abusing benefits. This highlights the need for collection of claims data with relevant fields of information which can be used to approve/reject claims and perform detailed analyses on, which would include a comparison across providers. An insurer's ability to accept/reject claims reliably requires efficient claims administration platforms which are automated to check if a claim is in line with the insurers benefit and clinical rules. The coding of healthcare data is discussed in a subsequent section.

In order to improve negotiations hospitals and insurers should be using similar data and metrics when making decisions. A standardized data base, coding and health metrics could improve the transparency of the negotiating process. Additionally, there is a need to ensure that providers and insurers understand the potential benefit of agreeing to work together to reduce costs e.g., through standardized tariffs, packages or DRGs.

To improve the dialog between insurers and providers individuals involved in the process should be knowledgeable to improve the interaction between the parties and reduce information asymmetry. Insurers could consider using the services of retired doctors to improve the interaction between hospitals and the insurers. Collaboration between the insurance industry and the KMPDC would be required to improve the negotiation process.

4.14. Non-healthcare expenses

On top of healthcare claims, insurers have additional expenses which need to be covered by premium income. This includes items such as fees paid to administrators (or the cost of administration if self-administered), statutory and association fees, fidelity guarantee and professional indemnity premiums, legal and audit fees,

broker commissions, management and healthcare services provided by managed care organizations and bad debts.

Items such as managed care management and healthcare services are typically proportional to the number of policyholders on the product. Remaining overheads need to be spread across the premiums the insurer charges and hence the fixed costs are spread across the number of policies. By writing more policies the insurer can achieve lower premiums which also implies that the fewer policies an insurer sells, the less likely it is premiums will be sufficient to cover overheads. The insurer will have to consider the impact these expenses have on its financial stability, profitability and solvency position.

4.15. Interaction between contributory public- and private health insurance

The way contributory public health systems and private health insurance work in the same environment is an important consideration, particularly where there is an overlap of the benefits covered. In the case of Kenya, the NIBF is a contributory public health insurance scheme.

In most cases, it is expected that private insurance (PHI) offers richer benefits than what is available through the public health system (PHS). And hence, private insurance typically adds an additional layer of insurance cover over and above the PHS. In some countries, the PHS offered runs parallel to private insurance. That is, private insurers offer the same or similar benefits as PHS. Where both PHS and PHI are offered it is typical for all citizens to contribute to PHS regardless of whether they utilize the benefits or not.

Allowing individuals to opt-out of contributing to PHS depends on how the PHS of a country is funded. The PHS may rely on contributions from all citizens, who can afford to, to contribute towards the scheme. Allowing citizens to opt out means a lower premium income will be generated which could have an impact on the financial sustainability of PHS. It is possible for government to alleviate this through subsidizing the PHS or applying other tax reforms which generates revenue to fund healthcare.

Whether or not to allow opt-outs of PHS also depends on a country's prioritization of UHC. It is possible to allow for individuals to opt-out in instances where individuals can afford PHI cover. However, if individuals opt out of both PHS and PHI this impedes progress towards UHC. Hence, some countries allow individuals to opt out of PHS where they are able to afford private cover and where that PHI at least covers the same benefits under PHS. If UHC is a focus of policy, then some form of health insurance coverage may be made mandatory. The extent to which individuals would decline PHS in favour of PHI depends on the benefits covered by both. If regulation only allows for top-up cover by private insurers, then it is less likely for individuals to opt-out of PHS as they will likely still want these benefits to be covered. PHI may offer additional benefits such as coverage at different facilities not covered under PHS benefits.

PHS and private insurance should be considered as two tools to be used to achieve UHC. In instances where an individual is covered through PHS and PHI it may be unclear who is responsible for paying claims. It is possible for the private insurer to pay the full portion of the claim and claim the PHS benefit back. However, it may not be prudent for insurers to allow for this in their pricing as it is not guaranteed (in practice) that the insurer can reliably recover this amount. The insurer assuming responsibility for the lives it insures is more

likely to result in better outcomes for policyholders. If insurers opted not to pay the claim policyholders are at a risk of being forced to make out-of-pocket payments which erodes the value they derive from purchasing private insurance. Individuals who can afford private insurance should purchase it while individuals who cannot afford it should rely on PHS.

4.16. Definitions of insurance products

There are currently overlapping definitions of different classes of business in the Insurance Act. The definition of "medical insurance business" (class 12 of Part C of the Insurance Regulations), includes "*the business of covering disability or long-term nursing or custodial care needs*". This is not appropriate for a general insurance product. In addition, health/medical expenses insurance (where separate policies are issued) is included in class 9 (Personal Accident Insurance), which is not clearly demarcated form medical insurance business. The Insurance Act defines "Long Term Insurance Business" as including the class of permanent health insurance. However, the term permanent health insurance is not defined.

In order to remove any scope for ambiguity and uncertainty, the classes of health and disability products that may be provided by Long Term and General Insurers must be clearly defined to ensure that there is clear demarcation from medical insurance products that are offered under General Insurance. Examples of definitions are provided below:

- Medical Insurance business should be defined as an annually renewable indemnity products that cover the cost of medical care, in line with the proposals made in this section. Therefore, both the premium and the cover are only for a year.

- Personal Accident Insurance should be defined as stated benefit cover. Therefore, the cover provided, and benefit paid, will not aim to provide indemnity cover and are not related to the actual value of medical expenses incurred.

- Long Term Care products should be classified under Life Insurance and should defined as annuity type benefits that continue to provide a benefit beyond the year in which the claim is incurred and covers the cost of nursing-home care, home-health care, and personal or adult daycare. These types of benefits should not be covered under Medical insurance business. These products can be used to fund the premiums required for Medical Insurance, but should not directly provide indemnity for the cost of any medical expenses.

- Lastly, Permanent Health Insurance should include disability and long term sickness benefits that provide either a lumps sum or an annuity benefit for any of loss of income incurred by the policyholder, irrespective of the medical expense related to the disability event.

4.17. Centralised database

The IRA's mandate involves the regulation of all major lines of insurance business of which health insurance is one such class. Currently health insurance is regulated as a class of general insurance and as such is reported on in a similar manner. The IRA collects financial and other insurance related data from all the and publishes a consolidated set of annual statistics with an annual report for companies across the insurance industry. The results are limited to the financial data contained in the financial statements of a medical insurer. While the financial data is useful, healthcare data is complex and there is a vast amount of additional data that can be collected and used to improve the ability of the regulator to supervise the healthcare industry.

There are also numerous other sources of information for different aspects of the healthcare sector of Kenya that is not being collected by the IRA.

Therefore, a centralised database will allow the regulator to collect all the data from the health insurance industry.

The aim of creating a centralized database is to aid the regulator in performing its main functions. A centralised database will allow the IRA to:

- Better understand the market dynamics within the health sector and improve efficiency of the healthcare system.
- Measure its progress in achieving universal health coverage and adjust its strategy accordingly.
- Consider and evaluate changes to needed to health insurance regulations e.g. the introduction of prescribed minimum benefits.
- Improved financial monitoring of health insurers.
- Better assess the solvency and financial position of insurers.
- Increase consumer protection against of health insurance products.
- Motivate insurers to implement more efficient ICT platforms and claims processing systems to meet the requirements of the centralised database.
- Promoting confidence in the industry through better management and regulation .
- Assist in reducing financial crime, fraud and waste.
- Provide insights into the quality of care policyholders receive.

The collection of detailed claims, membership and premium data from health insurers can assist the regulator in identifying trends in healthcare expenditure, identifying gaps in cover and assessing the risk profile of policyholders in the health insurance industry. This allows the regulator to better understand the drivers of healthcare expenditure in Kenya and the recurring high rate of cost escalation which can hinder the development of low-cost health insurance products. Products which could assist in improving healthcare coverage of individuals in lower socio-economic groups.

For example, data collected on the incidence of chronic diseases helps to focus on what the underlying burden of disease is amongst insured lives. This can assist in drafting future regulations/reforms to help alleviate the

impact of the disease on the population. For example, if a large proportion of lives suffer from diabetes the IRA may want to encourage insurers to promote cover accordingly and engage in managed care initiatives.

Additionally, the overview of the insured population can assist in identifying differences to the uninsured population. The average premiums paid across the different products can be considered in relation to the average salary and level of income inequality present in the country. This could guide the regulator in its attempt to improve access and affordability of these products.

The Deloitte Consulting, (2011) report on prepaid schemes notes that a better understanding of prepaid schemes and challenges affecting their growth is important in determining how medical insurers can contribute towards achieving universal health coverage. A key outcome of the creation of a centralised database is a tool with which the IRA can apply evidence-based decision making.

The recommended data reporting requirements are further explained in section 4.18.

4.18. Coding of data

An agreed industry standard used for the coding of healthcare claims/admissions must be applied to ensure the reliability and usefulness of data supplied.

The International Classification of Diseases (ICD) codes are an internationally used classification system for injuries, physical and mental illnesses and is published by the World Health Organisation. All member states of WHO are expected to adopt the latest version of the ICD codes. The detailed monitoring of patients' health would allow for more efficient allocation of healthcare resources through evidence-based decision making.

Currently, ICD-10 (the tenth revision) is being used. However, ICD-11 will be implemented on 1st January 2022. A version of ICD-11 has already been released by WHO for countries to translate and prepare for the implementation of the revised ICD coding.

Current Procedural Terminology (CPT) codes, developed by the American Medical Association, are used in conjunction with ICD codes. While ICD codes provide detail on the disease or injury being treated, CPT codes provide detail on the treatment or service provided by the healthcare professional. The two sets of codes provide detail on the overall service rendered and is used by insurers in many countries internationally.

Establishing the use of ICD and CPT coding will require collaboration between insurers and the MOH as well as the KMPDC as reliance will be placed on the regulatory bodies governing medical professionals to set it as an industry standard. As such, it is recommended for Kenya to adopt ICD codes as its standard for classifying healthcare claims. All providers should supply this information on all patients seen and insurers should receive this information with all claims submitted.

The adoption of ICD and CPT coding on claims can assist hospitals in assigning diagnostic related groups (DRGs) to hospital admissions. The DRG is determined by considering the diagnosis, procedures performed, co-morbidities and complications as well as the patient's age and sex. This allows for comparison of hospital admission across diagnostic groupings and allows for more detailed analyses of hospital admissions.

An additional set of codes for products such as pharmaceuticals, surgical and healthcare consumables should be adopted. That is to identify the product, strength (drugs) and pack size of the consumables used. This will provide more detail on what specific drugs or consumables are being billed for and can improve insurers' ability to detect fraud waste and abuse. An example of these codes is the National Pharmaceutical Product Index (NAPPI codes) used in South Africa. These were designed uniquely for the South African market and so it is not recommended for Kenya to simply adopt the same coding system for consumables. It is recommended that the IRA, in collaboration with healthcare and pharmaceutical professional bodies, raise the issue of creating a similar coding system for the Kenyan market.

The adoption of ICD, CPT and a Kenyan variant of NAPPI codes will enable detailed breakdowns of costs to be provided to patients, when being billed, and may lead to a clearer understanding of what costs were incurred. Providing this detail to insurers will help with the identification of fraud where costs on similar procedures can be compared and over-expenditure can more easily be identified.

The KMPDC publishes a national registry of all licenced healthcare professionals which includes a unique practice number for each individual healthcare practitioner and also records their specialty. This unique practice number must be recorded on every claim or patient seen so that it can always be linked back to the healthcare professional administering care. A national standard for discipline codes of healthcare professionals must be established. It is recommended that Kenya adopts the list of specialties published by the Board of Healthcare Funders (BHF) in Africa as this is already used by African countries such as South Africa.

4.18.1. Data collection by Insurers

To ensure health insurers can supply the centralised database with all required fields of data an industry standard must specify what data health insurers should collect in daily operations. The detail below is a reasonable standard of what data insurers should collect, even if the IRA does not expect the submission of all the data to the centralised database.

If the NHIF is regulated by the IRA, then the NHIF will have to comply with the same standards. Similarly, requirements for community based schemes to be registered will also require data to supplied by them. This will ensure a more complete and accurate view on the level of UHC achieved in Kenya.

The following membership data is required for all policyholders and dependants for each month of cover:

- Unique Membership number of the principal member (unique to each family) and a number for the dependant in the family (Unique to each dependant within the family. This is coded in such a manner to allow an individual's claims to be tracked.
- Date of birth of each member and dependant and therefore the age.
- Gender of each member and dependant.
- Relationship of dependant to member, e.g. spouse, child, aged parent, etc.
- Date at which cover commences in respect of each member and dependant.
- Date of end of cover, where applicable, in respect of each member and dependant.
- Details of the benefit option in which each member and his/her dependants participate in.

- Details of salary or income bands for contribution calculation purposes, where applicable.
- Monthly contributions payable in respect of the policyholder's family.
- Member's location (county).
- Details of any waiting periods imposed.

The following claims data must be maintained for each beneficiary and each claim:

- A unique reference number for each claim.
- The membership number and dependant number
- Date of service.
- Receipt date, processing date and date of payment for each claim.
- The applicable ICD and CPT codes for the claim.
- Providers practice number and discipline code of referring / attending practitioner (where applicable).
- If the claim relates to an admission (in-hospital) or outpatient service.
- If the claim is an admission, detail on the type of ward admitted to should be included. That is high care, ICU or general ward.
- Amount charged by provider for each line item and benefit awarded.
- Where a benefit has been modified, for example, by imposition of a maximum, a levy or a limit, or if a benefit has been disallowed, an explanation by way of rejection code or other means should be reflected on the claims record.
- Where a claim has been adjusted after assessment or payment, full details of the adjustment must be shown. Where the adjustment results in a debt due by the member, details of the amounts owing must be calculated and reflected.
- Total of claims to be deducted from savings accounts.
- Total of claims to be deducted from benefit limits.
- Any portion of the claim paid by NHIF cover.

The last item in the list above stems from the need to reconcile health insurer payments and any portion of the claim that may have been funded by NHIF cover where a member has both private health insurance and NHIF cover. This item is of value for insurers to avoid insurers paying providers out in full on every claim. It relies on establishing a system which allows private insurers to link policyholders with NHIF cover with claims paid out by NHIF in respect of these policyholders. While this is not a necessary aspect for the centralised database, it does provide a means to prevent waste and abuse in the healthcare system and if not implemented now should be a future consideration.

The insurance industry would have to collaborate with the medical regulators, the MOH and the KMPDC, in order to enforce the minimum claims data requirements as specified above.

4.18.2. How can medical insurers use data to better manage claims?

A health insurer is a third-party player in the relationship between the insured and the healthcare service provider. This relationship is further complicated by the wide range of services which can be provided. Hence

to effectively evaluate the validity of a claim, insurers place great reliance on data which is submitted by providers in relation to the care they provide to insured lives. Without this data, accurately evaluating claims would be almost impossible.

However, by receiving such data insurers can:

- Evaluate the validity of the claim
- Understand the burden of disease of insured lives
- Identify fraud, waste and abuse
- Benchmark providers
- Derive the quality of care provided by providers
- Monitor and improve benefit design

The data submitted will allow for the calculation of quality-of-care metrics that can provide an indicator of the value of care policyholders receive from providers. These include metrics such as:

- Re-admission rates (within 7 days, 8 to 30 days or 31 to 90 days of discharge)
- Neonate birth related injury rates
- Surgical site infection rates
- Surgical mortality rate (deaths arising from surgery)
- Level of preventative care
- Hba1c test results

4.18.3. Data to be submitted to the IRA

Currently the IRA publishes an annual insurance sector report with an accompanying set of annual statistics.

While this information gives a high-level overview on the financial performance of health insurance companies, it does not show results for the individual products sold. Additionally, health insurers have additional data that can assist the IRA. The additional data health insurers should be required to submit per product sold is:

- Financial information
    - Gross, reinsurance and net premiums written
    - Reserves
    - Incurred claims
    - Net commissions, management expenses, investment income and profit for the period
- Premiums written, split by appropriate risk cell (financial month, population type, age-bands, gender, county, chronic status).
- The number of members (exposure), split by appropriate risk cell (financial month, age-bands, gender, county, chronic status).
- Number of lives on product for more than 1 year and joining in last year split by population type.
- Number of lives with waiting periods, pre-existing condition exclusions and late-joiner penalties.
- The average age of lives as well as the proportion of lives who are pensioners.
- Claims data

- Total amount claimed and paid, number of claiming beneficiaries and total visits split by:
  - Relevant age bands
  - Gender
  - County
  - Chronic status (whether the member has a chronic condition or not)
  - Discipline of healthcare provider
  - In- and outpatient claims
- For medicine and consumable claims – number of items dispensed, total amounts claimed and paid split by:
  - Relevant age bands
  - Gender
  - County
  - Chronic status (whether the member has a chronic condition or not)
  - Discipline of healthcare provider
  - In- and outpatient claims
  - Consumable or medicine
- For hospital claims data – the number of unique lives admitted, number of admissions, total inpatient days, total amounts claims split by:
  - Relevant age bands
  - Gender
  - County
  - Chronic status (whether the member has a chronic condition or not)
  - ICD code on discharge
  - Day-case or hospital admission
- Additionally, the claimed and paid amounts for hospital claims above should be further sub-divided by amounts claimed and paid (from risk/savings) in respect of:
  - Radiologists and pathologists
  - Professional fees
  - Hospital fee
  - Other fees

The data outlined above should be collected on a quarterly basis.

5. Benchmarking

5.1. Objectives and scope of work

There are various challenges when considering a template for international best practice in the regulation of health insurance due to the diverse measures adopted by individual countries to fit the context. Countries have diverse health system organisations and funding arrangements serving different portions of the population. However, most health systems have similar goals and face similar challenges, such as demographic change, limited resources, and rising costs. Countries have applied diverse strategies to address these challenges, as summarised in the tables below. Therefore, there is no 'iron-cast' template for international best practices in health insurance regulation (European Parliament, 1998).

The major benefit of international comparisons is their potential to provide a snapshot comparison of different experiences and the lessons that can be learnt and applied. These comparisons offer the possibility of exploring new and different options; the potential for mutual learning and even policy transfer; and the opportunity to reconsider and reformulate national policy (World Health Organisation, 2013).

Section 5.2 outlines the country selection process and relevant data sources that were utilised. Section 5.3 provides relevant statistics for each of the countries included in the benchmarking section as well as comparative figures for Kenya. This provides input into the progress made by each country in their efforts to achieve UHC as well as insight into the health care spending and development of their respective healthcare markets. The information provides important background of the context and peculiarities of each country to aid the understanding of the measures adopted by these individual countries. Section 5.4 provides an overview of the health system for each of the countries included in the benchmarking section. From this part onwards Kenya is no longer included as the details with regards to the Kenyan health system is set out in section 2. Section 5.5 to 5.12 provide descriptions of how the countries approach the following themes:

- Provider payment methods
- Provider agreements and contracts
- Affordability and prescribed minimum benefits
- Pricing guidelines
- Referral systems
- Foreign insurers
- Quality assurance and accreditation
- Coding, centralised data and reporting.

5.2. Country selection and data sources

The countries selected for the benchmarking include two countries identified during interviews with the IRA, namely South Africa and Israel. Additionally, Ghana has also been included since it has a similar level of economic, social and political development to Kenya. Both Ghana and South Africa are actively pursuing the realisation of universal health coverage as key policy and legislative framework objectives. Lastly, Netherlands and Germany were included as examples of developed countries with two different predominant systems of

health care finance, but which have both achieved high levels of UHC. Germany's health care system is predominantly funded by compulsory social insurance which is supplemented by private voluntary insurance, direct payments, and public taxation. The Netherlands provides universal coverage through multiple private insurers in regulated competitive markets.

Due to the lack of a uniform data sources, quantitative data on health services is based on a variety of different sources. These include the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF) and the World Bank's World Development Indicators were included as they provided the required data.

5.3. Country statistics

5.3.1. Population statistics

The table sets out high level population statistics for each country included in the benchmarking section as well as comparative figures for the Kenyan population.

Table 13. Benchmarking – population statistics

The average age of the Kenyan and Ghanaian populations is younger than those of the other countries included in the benchmark with roughly 40% aged 14 and below as at 2017. South Africa and Israel have comparable age distributions while the Netherlands and Germany have similar age distributions. The percentage of the population living within urban centres is only 26.56% in Kenya while the second lowest is Ghana with roughly double that of Kenya at 55.41%. The age distribution of a population as well as the percentage of the population who live within in urban areas may impact the prevalence of diseases and may also impact the access to health care services of a population.

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
Population (in thousands), 2017	49 700	28 834	56 717	8 322	17 082	82 522
Population, male (% of total population), 2017	49,68%	50,67%	49,33%	49,67%	49,75%	49,28%
Age distribution, 2017	0-14: 40,19% 15-64: 57,39% 65 and above: 2,42%	0-14: 37,78% 15-64: 59,13% 65 and above: 3,09%	0-14: 28,95% 15-64: 65,63% 65 and above: 5,42%	0-14: 27,46% 15-64: 60,33% 65 and above: 12,21%	0-14: 15,54% 15-64: 64,85% 65 and above: 19,61%	0-14: 12,26% 15-64: 65,18% 65 and above: 21,56%
Age dependency ratio (% of working-age population), 2017	74,23%	69,12%	52,37%	65,76%	54,19%	53,42%
Urban population (% of total population), 2017	26,56%	55,41%	65,85%	92,34%	91,08%	77,26%
Unemployment (% of total labour force) (modelled ILO estimate), 2017 (International Labour Organization, 2020)	2,69%	4,22%	27,07%	4,22%	4,84%	3,75%

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
Employment in agriculture (% of total employment) (modelled ILO estimate), 2017	55,91%	31,99%	5,28%	0,99%	2,27%	1,28%
Employment in services (% of total employment) (modelled ILO estimate), 2017	37,09%	47,91%	71,37%	84,65%	81,21%	71,32%
Employment in industry (% of total employment) (modelled ILO estimate), 2017	7,01%	20,10%	23,35%	17,36%	16,52%	27,40%
Informal employment (% of total non-agricultural employment) (index mundi, 2019)	82,7% (2014) (Kenya National Bureau of Statistics, 2014)	83,18% (2015)	35,15% (2018)	Not available	Not available	Not available

5.3.2. Economic overview

The table below provides an overview of key economic indicators for each of the countries in the benchmarking section as well as comparative figures for Kenya.

Table 14. Benchmarking – economic overview

Kenya and Ghana are classified as Low-Mid income countries according to the Word Bank while South Africa is classified as Up-Mid and the remaining benchmark countries as high. Countries such as Israel, the Netherlands and Germany may therefore have more funds available within their fiscal envelope to spend on health care and the provision of health care related services resulting in improved health outcomes for the country. However, it should be noted that although countries may have more funds available this may not necessarily translate in higher health care expenditure. The prioritisation of heath care, as seen in section 5.3.4, together with the availability of funds will ultimately determine the level of health care expenditure within each country.

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
World Bank Country Income Group	Low-Mid	Low-Mid	Up-Mid	High	High	High
Gross national income per capita US$ (GNI), 2017 (World Bank Group, 2020a)	1 750	2 220	6 040	43 290	53 200	48 520
Gross Domestic Product (GDP) per Capita in US$, 2017	1 595	2 046	6 153	42 452	48 624	44 754
Gross Domestic Product (GDP) per Capita in PPP Int$, 2017	3 293	4 502	13 531	40 697	54 581	52 660
Tax Revenue (% of GDP), 2017 (World Bank Group, 2020b)	15,09%	12,57%	27,47%	23,07%	23,04%	38,2% (2018) (Bradbury and Harding, 2019)
Poverty headcount ratio at $1.90 a day (2011 PPP) (% of population)	37,1% (2015)	13% (2016)	18,7% (2014)	0,2% (2016)	0,2% (2017)	0,0% (2016)
Poverty gap at $5.50 a day (2011 PPP) (%)	49,4% (2015)	25% (2016)	29% (2014)	0,8% (2016)	0,2% (2017)	0,2% (2016)

Population living in slums (% of urban population)	46,5% (2018)	30,40% (2018)	25,60% (2018)	Not available	Not available	0,01% (2018)

5.3.3. Key health expenditure indicators

Table 15. Benchmarking – health expenditure indicators

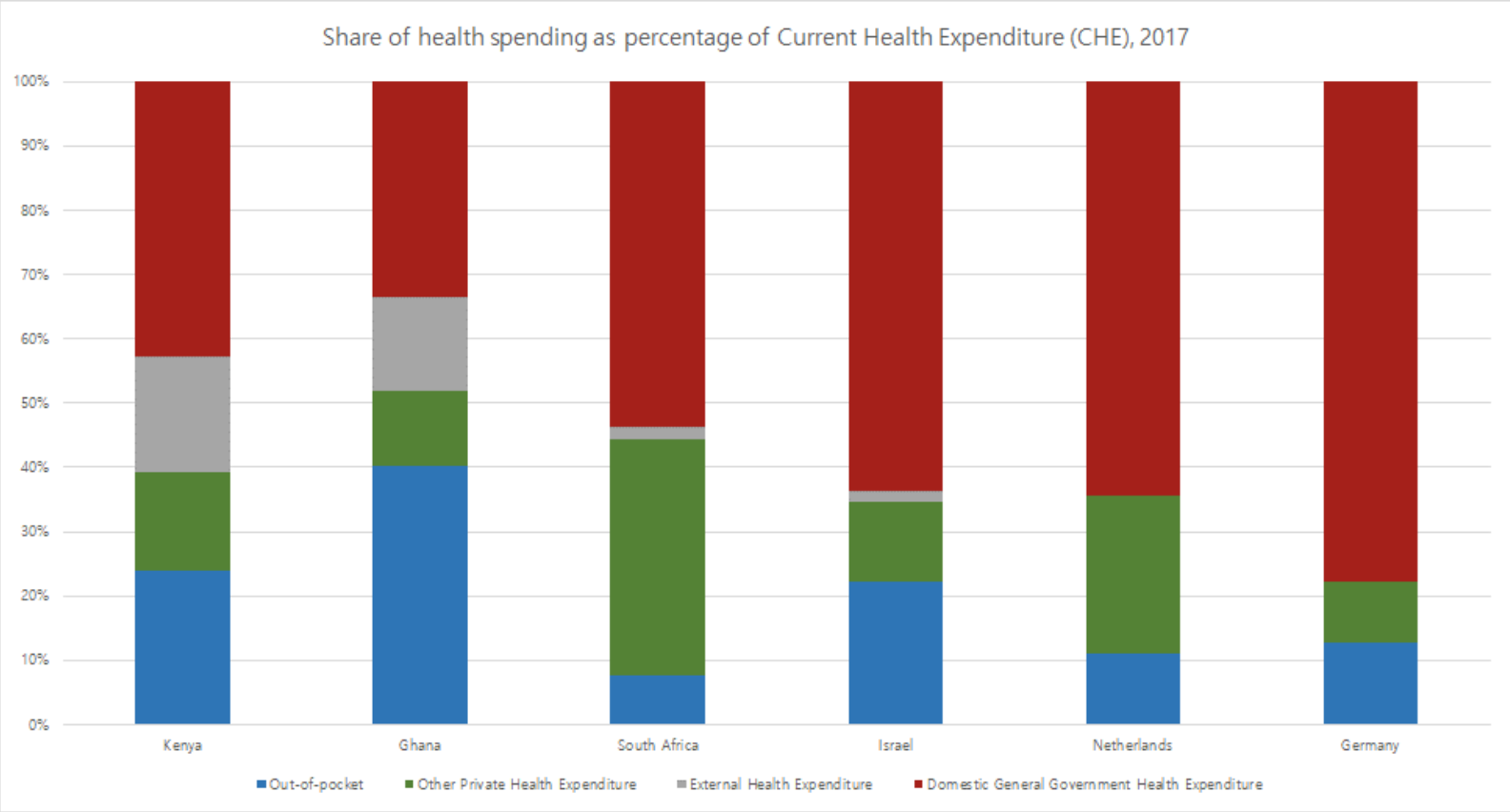
Across low-income countries, the average health spending was only US$ 41 a person in 2017, compared with US$ 2,937 in high income countries – a difference of more than 70 times. High income countries account for about 80% of global spending on health care, but the middle income countries' share increased from 13% to 19% of global current health expenditure (CHE) between 2000 and 2017 (World Health Organization (WHO), 2019).

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
CHE as % Gross Domestic Product (GDP), 2017	4,80% (5.2% in 2018)	3,26%	8,11%	7,41%	10,10%	11,25%
CHE per Capita in US$, 2017	76,61	66,75	499,24	3144,63	4911,44	5033,45
CHE per Capita in PPP, 2017	158,16	146,87	1097,82	3014,65	5513,10	5922,64
External Health Expenditure (EXT) as % of CHE	17,87%	14,50%	1,96%	1,76%	0,03%	0.0%
OOP as % of CHE, 2017	24,04%	40,29%	7,77%	22,25%	11,09%	12,67%
OOP per Capita in US$, 2017	18,42	26,89	38,78	699,71	544,53	637,89

In 2017 external donor funding still contributed a relatively large portion to current health expenditure for both Kenya and Ghana, 17.87% and 14.50% respectively. For the low-mid income countries out-of-pocket expenditure remains a significant portion of current health expenditure when compare to higher income countries. High levels of out-of-pocket spending is known to increase the burden and barriers faced by households and individuals when they have to access required health services. Out of pocket payments are inequitable, inefficient and a significant barrier to access for the poor. Any health system with a huge reliance on direct payments and

vertically funded donor programmes undermines the entrenchment of the principle of financial risk protection and income cross-subsidization, which are critical for the country's progress towards universal health coverage.

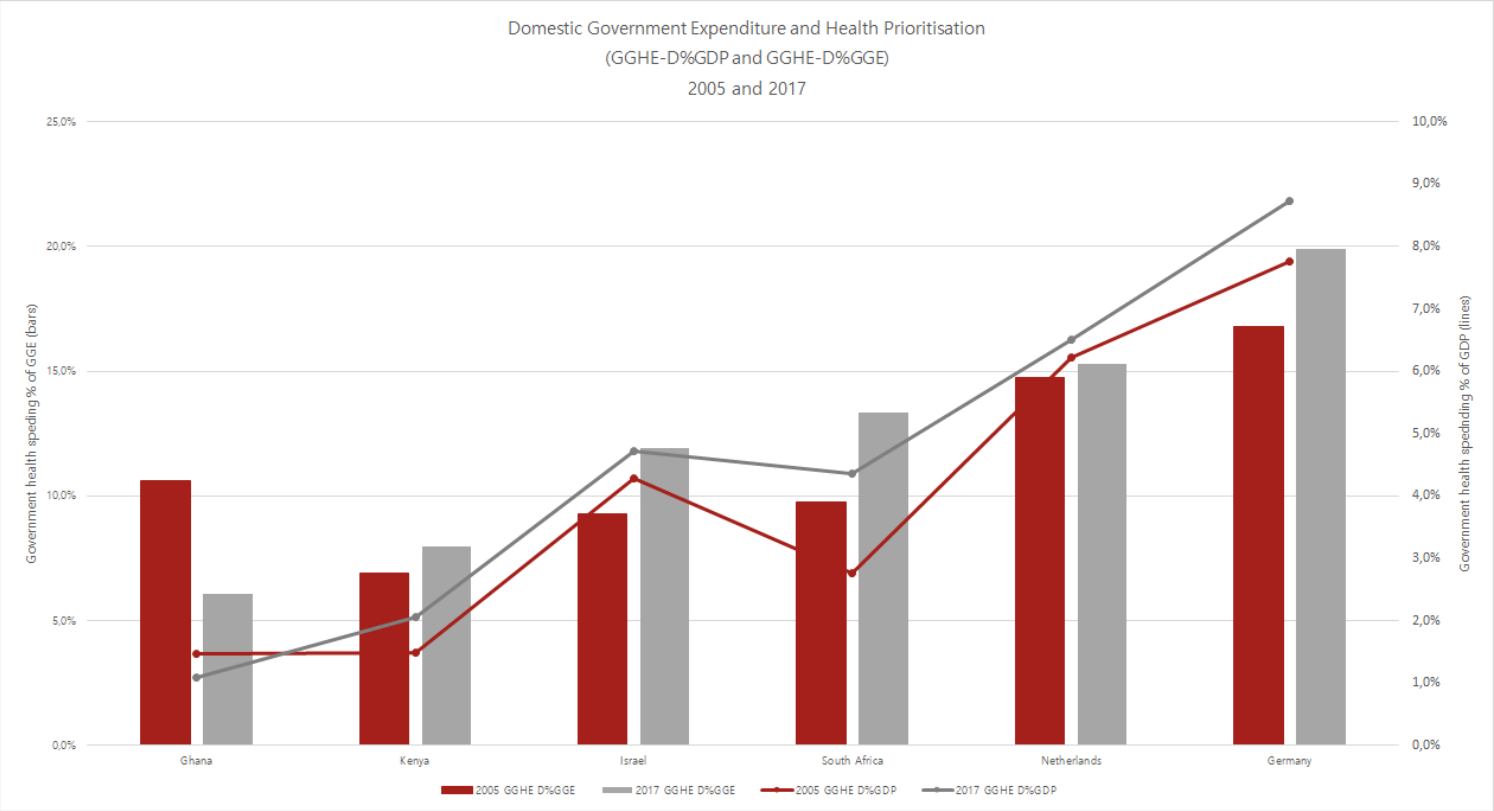
Figure 5. Benchmarking - Share of health spending as a percentage of Current Health Expenditure (CHE)



5.3.4. Government prioritisation of health spending

Figure 6. Benchmarking – Domestic Government Expenditure and Health Prioritisation

For all countries, included in the benchmark section, excluding Ghana the domestic government expenditure on health care as a percentage of both GDP and general government expenditure (GGE) increased between 2005 and 2017. In Ghana this was replaced by other private health expenditure including spending on private health insurance schemes. The Abuja Declaration set a target of 15% of government expenditure budget being specifically earmarked for health programmes and interventions. As seen in the graph below, as at 2017 only the Netherlands and Germany met the Abuja Declaration target.



5.3.5. Healthcare supply

Table 16. Benchmarking – healthcare supply

The WHO recommends a ratio of ten doctors per every 10 000 population (Mulaki and Muchiri, 2019). As seen in the table below, Israel, Netherlands and Germany exceed this recommended ratio of doctors with Ghana and Kenya both having less than 2 doctors per 10 000 population. The 2006 World health report developed a method for estimating health worker needs that was based on the density necessary to achieve 80% coverage of essential health services (such as births with a skilled health worker and immunization), finding that a health worker density of 23 skilled health workers (physicians and nurses/midwives) per 10 000 population was generally necessary to attain high coverage. In a 2016 report which extended the range of health services to include those required by the Sustainable Development Goals (SDGs) agenda the WHO estimated that an indicative minimum density of 44.5 doctors, nurses and midwives per 10 000 population is required as a minimum (Richard Scheffler, Giorgio Cometto, Kate Tulenko, Tim Bruckner, Jenny Liu, Eric L. Keuffel, Alexander Preker, Barbara Stilwell, Julia Brasileiro, 2016). As seen in the table below only Israel, Netherlands and Germany meet either of these minimum requirements.

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
Hospital beds (per 10 000 population) (World Health Organisation, 2020)	14,0 (2010)	42,0 (2018)	23 (2010)	29,8 (2018)	31,7 (2018)	80,0 (2017)
Medical doctors (per 10 000 population)	1,6 (2018)	1,4 (2017)	9,1 (2017)	46.3 (2018)	36,1 (2017)	42,5 (2017)
Pharmacists (per 10 000 population)	0,19 (2018)	0,25 (2017)	2,72 (2016)	8,01 (2017)	2,1 (2017)	6,47 (2017)
Nursing and midwifery personnel (per 10 000)	11,7 (2018)	42,0 (2018)	13,1 (2017)	57,0 (2017)	111,8 (2017)	132,4 (2017)

5.3.6. Health indicators

Table 17. Benchmarking – health indicators

The Universal Health Coverage effective coverage index aims to represent service coverage across population health needs and how much these services could contribute to improved health. The UHC effective coverage index improved from 1990 to 2019 for all countries included in the benchmarking exercise. All countries have similarly also shown improvements in maternal mortality, infant mortality and life expectancy at birth between 2000 and 2017.

Indicator	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
Maternal Mortality Ratio (MMR; maternal deaths per 100,000 live births), 2017	342	308	119	3	5	7
Infant mortality rate (per 1000 live births), 2017	33,90	36,10	28,20	3,10	3,40	3,30
Life expectancy at birth, 2017	65,91	63,46	63,54	82,55	81,76	80,99
Births attended by skilled health personnel (%) (World Health Organisation, 2020a)	2014: 61,8	2017: 78,1%	2016: 96,7	Not available	2003: 100	2017: 98,7
UHC effective coverage index (Global Burden of Disease Collaborative Network, 2020)	1990: 43,0% 2010: 42,0% 2019: 51,6%	1990: 29,5% 2010: 41,6% 2019: 49,1%	1990: 48,7% 2010: 40,7% 2019: 59,7%	1990: 59,5% 2010: 78,6% 2019: 81,4%	1990: 69,8% 2010: 87,6% 2019: 89,6%	1990: 66,5% 2010: 83,5% 2019: 86,2%

5.3.7. Causes of death

Table 18. Benchmarking – causes of death

The table below provides the top 10 causes of total number of deaths in 2019 for all ages combined. For Kenya, Ghana and South Africa communicable, maternal, neonatal, and nutritional diseases were the largest contributors to deaths in 2019. For Israel, Netherlands and Germany non-communicable diseases were the largest contributors to deaths in 2019. (Institute for Health Metrics and Evaluation, 2020).

2019 Ranking	Kenya	Ghana	South Africa	Israel	Netherlands	Germany
1	HIV/AIDS	Malaria	HIV/AIDS	Ischemic heart disease	Ischemic heart disease	Ischemic heart disease
2	Lower respiratory infection	Stroke	Ischemic heart disease	Stroke	Lung cancer	Stroke
3	Diarrheal diseases	Lower respiratory infection	Stroke	Alzheimer's disease	Stroke	Lung cancer
4	Neonatal disorders	Neonatal disorders	Lower respiratory infection	Chronic kidney disease	COPD	Alzheimer's disease
5	Stroke	Ischemic heart disease	Diabetes	Diabetes	Alzheimer's disease	COPD
6	Tuberculosis	HIV/AIDS	Tuberculosis	Lung cancer	Colorectal cancer	Colorectal cancer
7	Ischemic heart disease	Tuberculosis	Road injuries	Colorectal cancer	Lower respiratory infection	Chronic kidney disease
8	Cirrhosis	Diarrheal diseases	Interpersonal violence	Lower respiratory infection	Breast cancer	Hypertensive heart disease
9	Malaria	Diabetes	Neonatal disorders	COPD	Falls	Lower respiratory infection
10	Diabetes	Cirrhosis	Diarrheal diseases	Breast cancer	Prostate cancer	Diabetes

5.4. Health system overview

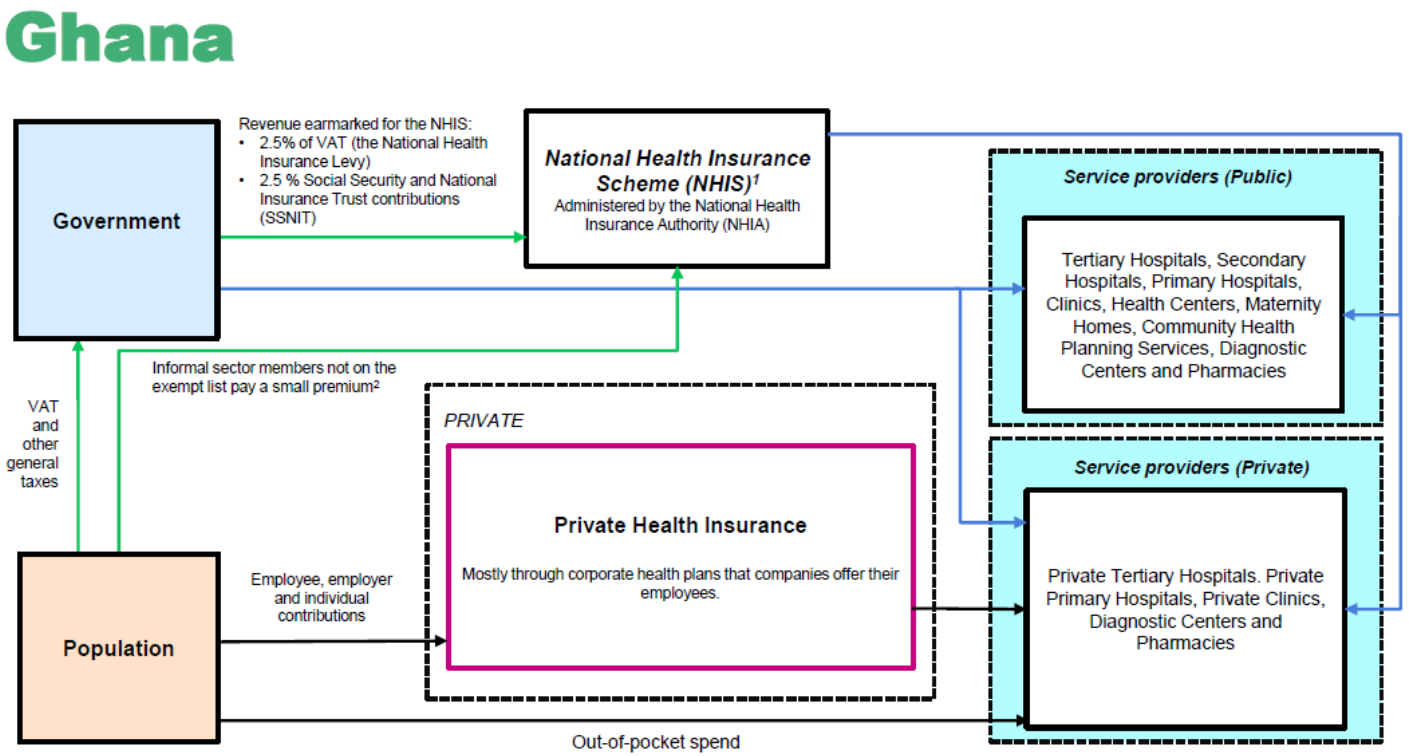
The following sections only include details with regards to the five countries included in the benchmarking exercise as details with regards to Kenya's healthcare system and health insurance is set out in earlier parts of the report.

Table 19. Benchmarking – health system overview

Ghana	South Africa	Israel	Netherlands	Germany
The Ministry of Health in Ghana is responsible for policy and overseeing the health sector. The actual health service delivery, is headed by the Ghana Health Service and the regional and district health management teams. This delegation of power is part of the government's efforts to decentralize. Ministry of Finance supports policy development and implementation through budgetary allocations.	National Ministry of Health with 9 semi-autonomous Provincial Departments of Health (with a total of 52 health districts across the country) are responsible for policy and implementation. The National Ministry of Health is responsible for setting sectoral policy and some direct programme implementation e.g. HIV/AIDS and TB programmes; Health Facility Infrastructure programme; etc.	Israel has a universal statutory healthcare system since the introduction of a progressively financed statutory health insurance system in 1995. All citizens can choose from among four competing, non-profit-making health plans (HPs). These HPs must provide their members with access to a statutory benefits package. Non-resident workers are not eligible to receive NHI but employers are obliged by law to purchase private health coverage for non-resident workers. (OECD, 2011)	The health insurance systems in the Netherlands provide universal coverage through multiple private insurers in regulated competitive markets. In 2006 a new Health Insurance Act replaced the two-tier system with a single system in which all residents are required to obtain basic coverage from a private insurer which may be for-profit or non-profit, including insurers that previously operated as sickness funds. The government stepped back from direct control of volumes and prices to a more distant role as supervisor of these markets (though planning of medical professionals remains by limiting the number of doctors trained).	Germany has a universal multi-payer health care system. It encompasses both statutory health insurance for people who earn less than a certain salary, as well as private health insurance for those who earn more and choose to purchase their own. It is based on the principles of social solidarity, decentralisation and self-regulation. The role of the central government is limited to providing the legislative framework in which health services are delivered while much of the executive responsibilities lies with the administrations of the individual states.

The diagrams below illustrate the models of health care funding used by each of the benchmark countries as set out in the Internal Health Care Funding report of the IAA (American Academy of Actuaries, International Actuarial Association and Society of Actuaries, 2020).

Figure 7. Benchmarking – overview of Ghana's health system



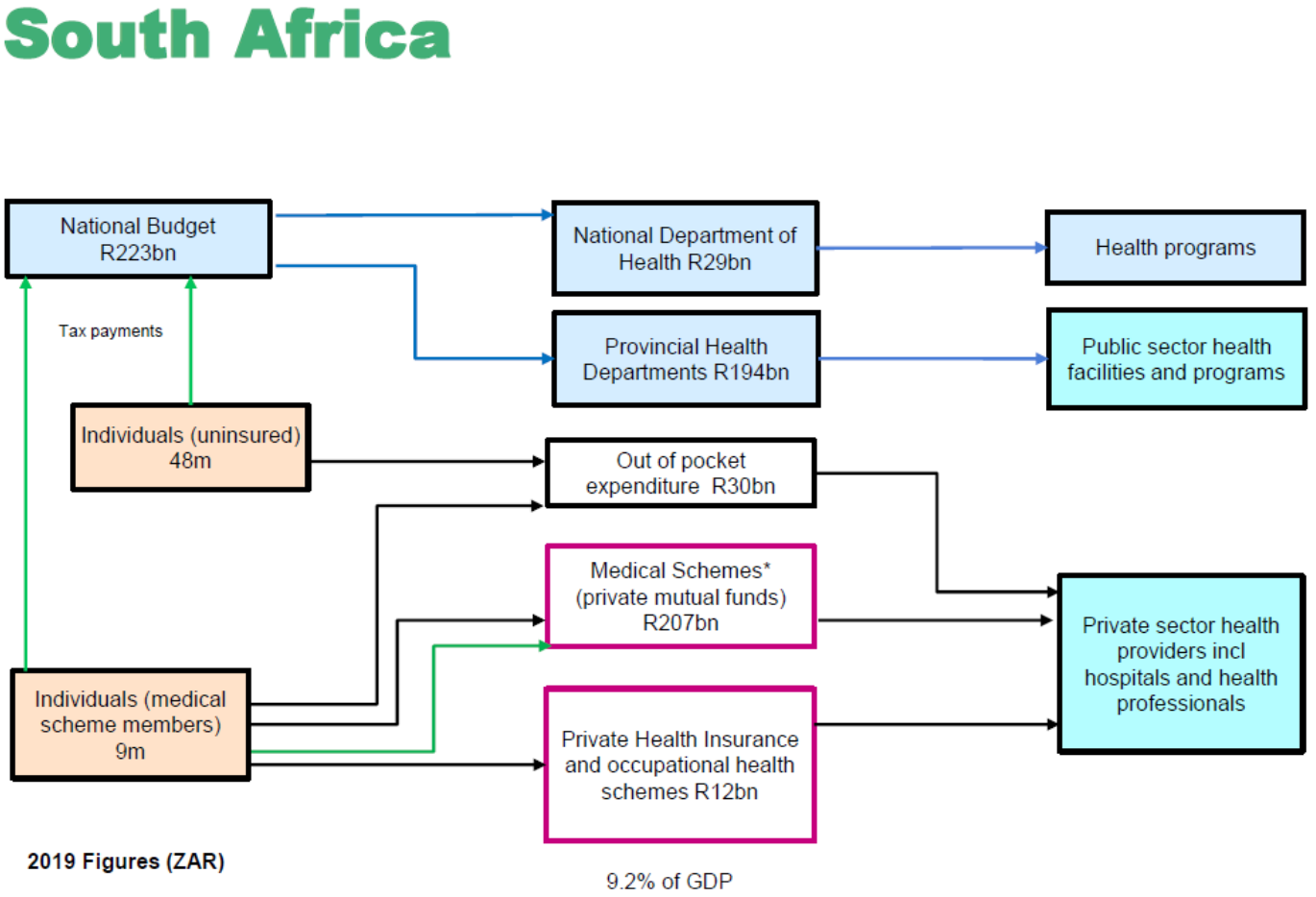
Health sector is administered by the Ministry of Health. Ghana Health Services is another agency that reports to the MOH and is a major player in service delivery.

[1] The NHIS was established in 2003. The National Health Insurance Authority which licenses, monitors and regulates the operation of health insurance schemes in Ghana. The NHIS covers about 95% of diseases in Ghana. The benefit package includes outpatient, inpatient, dental, optical, maternity and emergency services.

[2] Those exempt from premiums include: Pregnant women, Indigents, Categories of differently-abled persons determined by the Minister responsible for Social Welfare, Persons with mental disorder, SSNIT contributors, SSNIT pensioners, Persons above seventy years of age (the elderly), Other categories prescribed by the Minister

[3] As of May 2020, the NHIS covered around 40% of Ghana's population. (roughly 12.3 million people).

Figure 8. Benchmarking – overview of South Africa's health system



*Medical schemes are regulated mutual funds that are required to cover prescribed minimum benefits but can also offer supplemental cover

Figure 9. Benchmarking – overview of Israel's health system

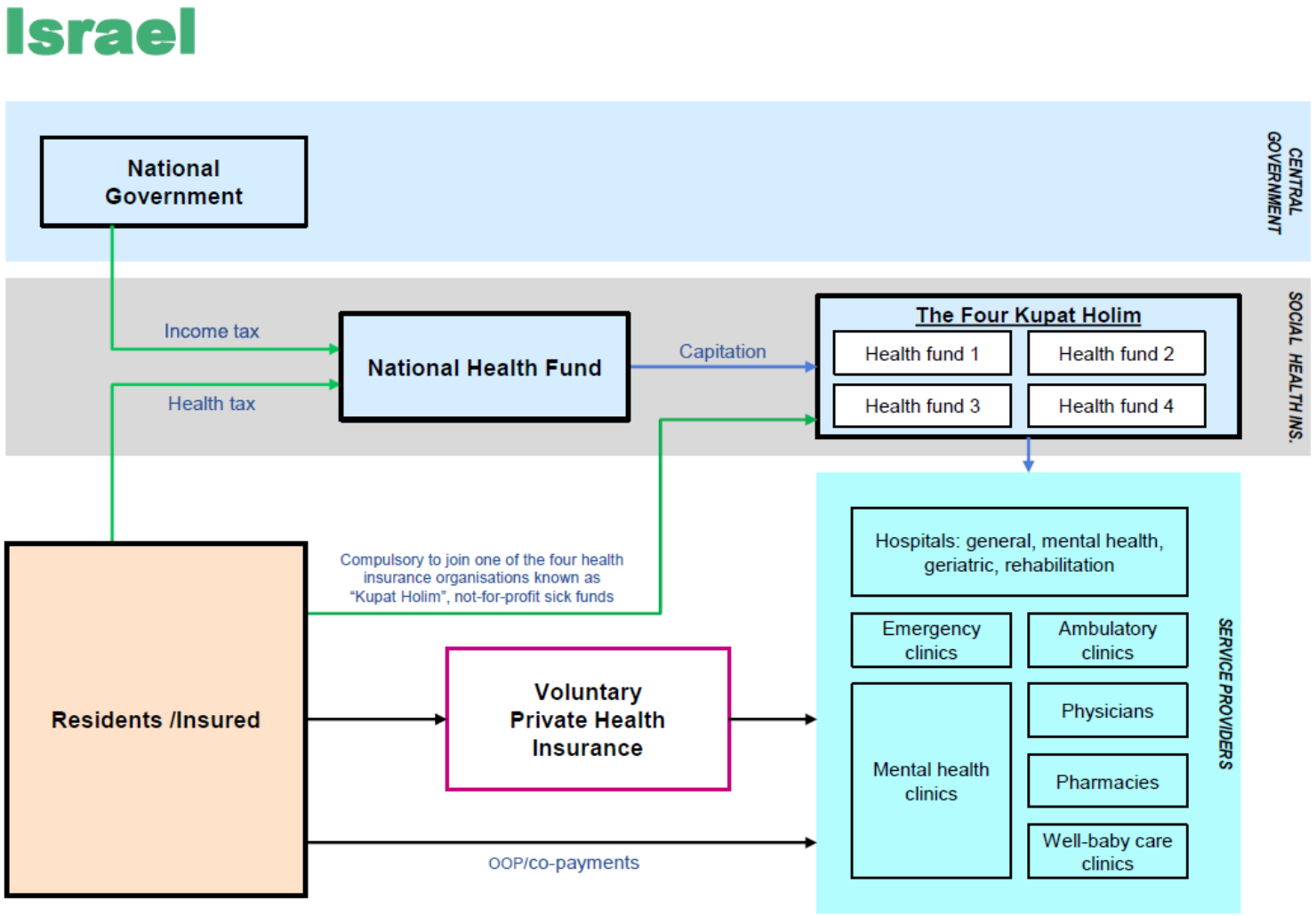


Figure 10. Benchmarking – overview of Netherland's health system

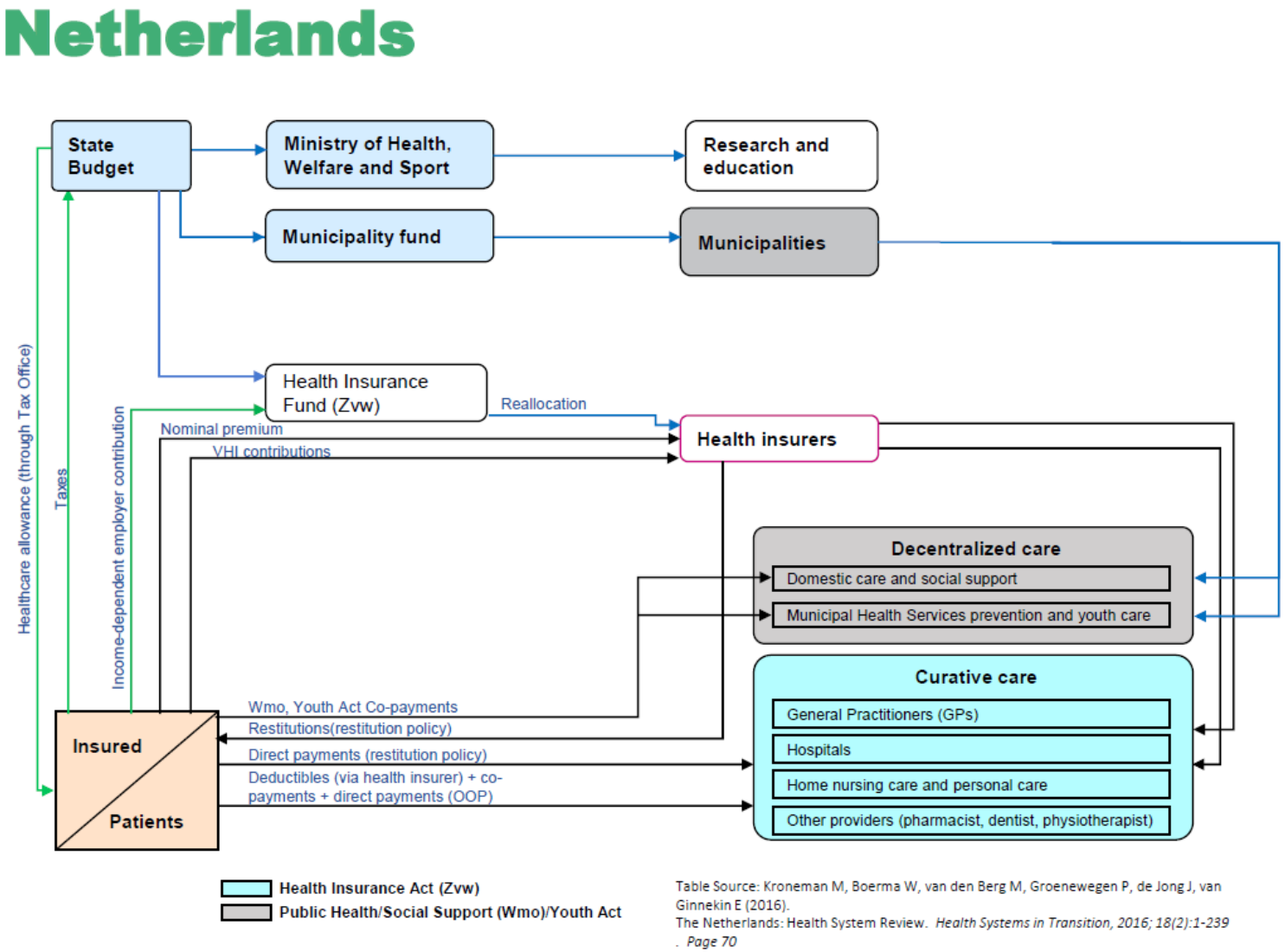
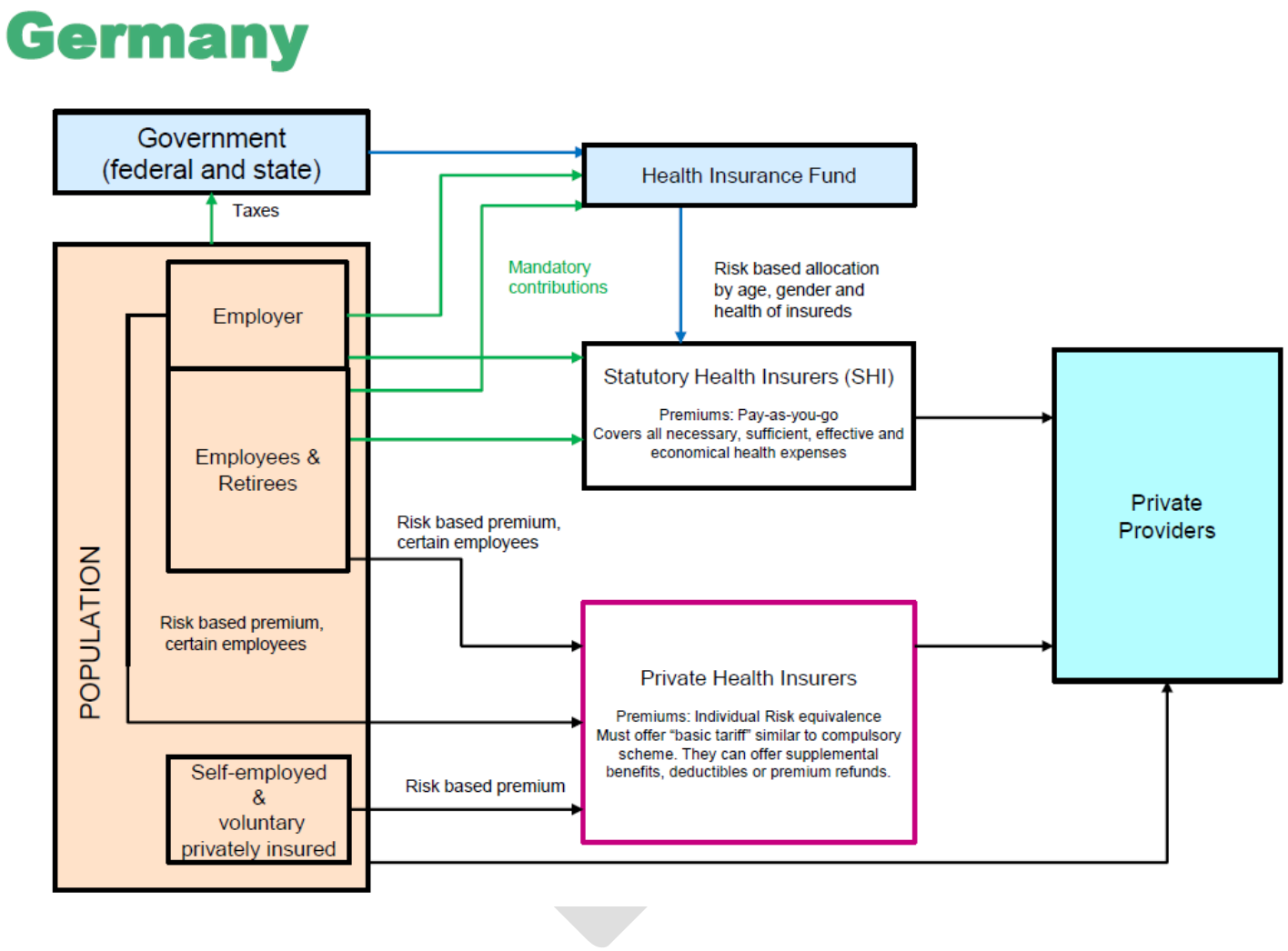


Table Source: Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J, van Ginnekin E (2016).
The Netherlands: Health System Review. *Health Systems in Transition, 2016; 18(2):1-239 . Page 70*

Figure 11. Benchmarking – overview of Germany's health system



5.5. Private Health Insurance Population Coverage

The WHO/World Bank framework specifies a target of a minimum 80% coverage of quality, essential health services, regardless of economic status, place of residence or sex (World Health Organization and The World Bank, 2015).

Table 20. Benchmarking – public system coverage

Ghana	South Africa	Israel	Netherlands	Germany
As of May 2020, the NHIS covered 40% of the population. It is compulsory for all citizens to join the NHIS or a different medical scheme. However, since there is no penalty for opting not to, this is not enforced strictly.	The public system in South Africa is funded by general taxation and all citizens and legal residents have access to the public health system. Users of the public health system are required to pay for services based on a means test, but in practice, these fees are generally waived. Around 83% of the total population is dependent on the public health system. Government employees receive subsidies and the majority of these employees are members of the Government Employees Medical Scheme through which they will have access to the private healthcare system. Around 50% of the total healthcare expenditure is allocated to the public healthcare system. In addition, all employees have access to the Compensation Fund which funds medical expenses resulting from occupational injuries and all motorists have access to the Road Accident Fund which funds medical expenses resulting from road motor vehicle accidents.	All Israeli residents are eligible and 95% of the population is covered through mandatory insurance funded through income and health taxes, provided by four private non-profit plans. Private coverage for foreign workers, army and prison health services: 3% (Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic, 2020)	All residents are required to purchase statutory health insurance from private insurers, which are required to accept all applicants. Financing is primarily public, through premiums, tax revenues, and government grants. The national government is responsible for setting health care priorities and monitoring access, quality, and costs.	85% of the population is covered under Social Health Insurance (SHI) through either mandatory or voluntary cover. (Busse and Blümel, 2014)

Table 21. Benchmarking - Types of private coverage

Ghana	South Africa	Israel	Netherlands	Germany
Private health insurance is offered through two types of entities – private mutual health insurance schemes (PMHIS) and private commercial health insurance schemes. PHIS may offer the following policies: • Duplicate cover – this cover includes benefits included under the NHIS benefit package. The individual still remains covered by NHIS but opts to buy private insurance instead. However, the cost of healthcare when using PHIS services is fully borne by the private insurer. • Supplementary – benefits offered by PHIS that are not covered by NHIS. Cost of healthcare is fully borne by PHIS. • Complementary – covers all or part of cost of benefits not covered by NHIS. Members can use either their NHIS card (for NHIS benefits) or PHIS card (for PHIS benefits).	South Africa has a private healthcare system that currently services around 17% of the total population. Most of these people access the private healthcare system through membership of a medical aid scheme which are mutual funds. This includes all government employees. Medical aid schemes are highly regulated and have to provide a set of minimum benefits. In addition to the medical aid schemes, a very small proportion of people access the private healthcare system through "for-profit" healthcare insurance which generally offers more limited benefits compared to medical aid schemes. The healthcare insurance market is being phased out by regulators due to the limited benefits and ability to apply strict underwriting for new applicants. Lastly, a small number of members access the private healthcare market through OOP funding. Around 50% of the total healthcare spend in South Africa is spent in the private healthcare system. Private healthcare funders, including medical aid funds and health insurance generally provides full or partial indemnity to their members or policyholders.	Supplemental health insurance cover is offered by health plans (HPs) and cover offered by Commercial insurers is called voluntary health insurance (VHI). These plans are available to adults aged 22 and older for adult dental care, faster access to and greater choice of providers and improved amenities. VHI offered by the health plans are regulated by the Ministry of Health while commercial VHI is regulated by the Insurance Commissioner.	Most health insurers offer voluntary packages in combination with the basic benefit package. Unlike the basic benefit package insurers are free to define which risks are covered. In the Netherlands VHI can be characterized as complementary as it provides cover for services that are excluded or not fully covered by the Health Insurance Act (Zvw). Health insurers offer a variety of complementary VHI that may cover all kinds of extra care or out-of-pocket payments. (Kroneman *et al.*, 2016).	PHI has two facets in Germany: (1) to fully cover a portion of the population (substitutive PHI) and (2) to offer supplementary and complementary insurance for SHI-covered people (Busse and Blümel, 2014). Most people who are covered by substitutive PHI fall into one of three groups (who are excluded from SHI) (1) active and retired permanent public employees who are excluded from SHI; (2) self-employed people who are excluded from SHI unless they have been a member previously (except those who fall under mandatory SHI cover such as farmers); (3) employees whose earnings exceed or exceeded the opt-out threshold. Supplementary insurance might cover extra amenities like hospital rooms with one or two beds or treatment by the head-of-service. Complementary health insurance covers co-payments for benefits that are not – or not fully – covered by the main insurer of an insured.

Table 22. Benchmarking - Population covered by Private Health Insurance

Ghana	South Africa	Israel	Netherlands	Germany
It is understood that private health insurance coverage is very low in the country. Based on the 2013 annual report published by NHIA, private insurers covered 144 620 members (0.6%) of 2013 population. It is unclear if this refers to policyholders or total insured lives. There are no updated published statistics on private health insurance coverage.	Around 16.6% of total population are covered through medical aid schemes and less than 1% of the total population access the private healthcare system through private health insurance.	**Complementary cover**: 84% covered by voluntary health insurance (VHI) offered by health plans (as at 2016) and 57% covered by commercial insurance (as at 2016)	In 2015, 84% of the insured purchased complementary VHI. The number of people purchasing complementary VHI decreased gradually over the years: in 2006, 93% of the insured purchased VHI. Most health insurers offer free complementary VHI for children. In practice the child is covered for the same complementary VHI as the parent (Kroneman *et al.*, 2016).	Private health insurance covered roughly 11% of the population as at 2012 (Busse and Blümel, 2014).

5.6. Treatment of foreign insurers

As seen in the section below, all countries in the benchmarking section, with the exception of Ghana have regulation with regards to foreign insurance companies transacting business is the local market.

Table 23. Benchmarking – treatment of foreign insurers

Ghana	South Africa	Israel	Netherlands	Germany
In Ghana individuals are allowed to purchase private medical insurance from international insurance companies without a requirement for the international insurer to have a local branch.	A foreign insurer or reinsurer may not conduct insurance business in South Africa, unless it is licensed under the Insurance Act To conduct insurance business in South Africa, a foreign insurer must incorporate and license a local insurance subsidiary in South Africa. Similarly, all medical insurance schemes conducting business in South Africa must be registered under the Medical Schemes Act.	Insurance companies in Israel may either be incorporated in Israel or a foreign insurance company registered in Israel as a foreign company, which is subject to supervision by a regulator in its country of incorporation. Writing insurance business in Israel requires a license and foreign companies cannot write insurance business in Israel, but Israeli citizens may buy insurance abroad. The Commission of Insurance is authorised to license a foreign company if the latter is registered in Israel and subject to regulation in the country of origin. In a unique act, the Israeli Government enacted regulation exempting Lloyd's Underwriters from the stipulations of the law of Controlling Insurance Services. The main practical effect of this is that Lloyd's underwriters are permitted to write business directly in Israel. (International Comparative Legal Guides, 2021b)	Health insurance in the Netherlands is mandatory for individuals who stay in the Netherlands on a long-term basis and is designed to cover the cost of medical care. As a rule, all expats must have Dutch health insurance even if they are already insured for healthcare in their homeland (with a few exceptions)	In order to write German insurance and reinsurance business, foreign insurers and reinsurers need to comply with preconditions of German insurance regulatory law. Under the EU single passport regime, EEA-insurers and reinsurers are permitted to write German insurance/reinsurance business either through a domestic branch or under the freedom to provide cross-border services without requiring separate authorisation in Germany. In contrast, primary insurers and reinsurers from third countries, i.e. countries that are not EU Member States or signatories to the Agreement on the EEA, are subject to authorisation by BaFin and must as a general rule, establish a German branch office if they wish to carry on primary insurance or reinsurance business in Germany. (International Comparative Legal Guides, 2021a)

5.7. Fee-for-service and capitation

Table 24. Benchmarking - Provider payment methods

Ghana	South Africa	Israel	Netherlands	Germany
Provider payment mechanisms in use in Ghana are: • Itemized fee-for-service. This is mainly for non-insured individuals for both services and medicines; • Diagnostic related groupings (DRGs) for insured clients only (only services); and • Capitation arrangements. Insurers may use a mix of the above reimbursement methods. Ghana has also created its own Ghana DRGs to assist in DRG re-imbursement.	In the public healthcare system, most citizens and legal residents have access on a no fee basis. Some users will be required to pay on a fee-for-service basis subject to a means test. Private healthcare funders generally use a variety of payment mechanisms which will include fee-for-service and capitation. Capitation is often used as a mechanism to reduce the cost of healthcare and therefore are most often used for products and options that provide less comprehensive benefits.	Most of the physicians working with health plans are paid via capitation and/or salary arrangements, thereby largely avoiding the cost-promoting effects of fee-for-service reimbursement. The government publishes maximum-price lists for inpatient care and sets hospital revenue caps to contain hospitals' income increases. The maximum prices that pharmacies are allowed to charge consumers in direct sales to them are centrally set. HPs purchase inpatient care from hospitals through 50 differential per diem fees, and activity-based payments based on procedure-related groups (PRGs). Hospitals and HPs are however allowed to negotiate alternative reimbursement contracts.	For care for which negotiation is not feasible (around 30% of hospital care), such as emergency care (not plannable) or organ transplantation (too few providers), the Dutch Healthcare Authority establishes maximum prices. Hospitals are paid through an adapted type of diagnosis-related group (DRG) system: Diagnosis Treatment Combinations. GPs are paid by a combination of fee-for-service, capitation, bundled payments for integrated care, and pay-for-performance (focused on issues such as accessibility and referral patterns). (Kroneman *et al.*, 2016)	The payment of health personnel is organised differently between SHI and PHI. For all acute hospitals SHI payments use the German modification of the Australian Refined DRG system. The DRGs are meant to cover medical treatment, nursing care, pharmaceuticals and therapeutic appliances as well as board and accommodation, but not capital costs. Payment of SHI affiliated physicians follows a complicated three step process. For private delivery and PHI for physicians and dentists, the catalogues for private tariffs are valid in ambulatory as well as inpatient care. They are based on fee-for-service and are determined by the Federal Ministry of Health, which is advised by the professional bodies concerned. The catalogue lists the requirements for reimbursement, such as duration, performance, documentation or limits concerning the combination of several tariff numbers (Busse and Blümel, 2014).

Strategic purchasing

Table 25. Benchmarking - Selection of available benefits

Ghana	South Africa	Israel	Netherlands	Germany
The NHIS includes a nationally standardized and comprehensive benefits package. This is intended to cover 95% of Ghana's burden of disease and includes primary, tertiary and pharmaceutical goods and services. The National Health Insurance Act of 2012 stipulates that the benefits offered under NHIS are to be decided by the Minister of Health under the advisement of the National Health Insurance Authority (NHIA) Private insurance schemes may offer duplicate, supplementary or complimentary benefits to the NHIS.	The public healthcare system provides access to comprehensive services through its own network of clinics and hospitals. Medical aid funds have to provide a minimum set of benefits which is set at a reasonably comprehensive level. Medical aid funds can use strategic purchasing to limit the cost of the minimum benefit package. In addition, medical aid funds are not allowed to limit access to the minimum benefit package to new entrants, although limited waiting periods and late joiner penalties are allowed. Health insurance products are not required to provide a minimum set of benefits.	All health plans are legally mandated to provide the same benefits package, which is specified and periodically changed by the government. This is done via a formal process established in 1998. Government sets budget to be allocated to new additions. HPs, pharmaceutical companies, the IMA, patient organizations and other groups submit recommendations, along with supporting analytic material. These proposals are reviewed by a staff unit within the Ministry of Health, which analyses the likely costs and benefits of each proposal. This background material is brought before a public commission that recommends to the Ministry and the government which new technologies should be adopted, given the previously determined budget constraints. Considerations include number of patients whose care will be improved, extent of improvement in terms of duration and quality of life, amongst others.	The Healthcare Insurance Board uses the following criteria to assess the content of the basic benefit package: 1. Care should be essential: Does the illness, disability or the care needed justify a claim on solidarity within the existing cultural context? 2. Effectiveness: Does the intervention do what it is expected to do? In other words: it is proven to be effective and evidence based. 3. Cost-effectiveness: Is the ratio between the cost of the intervention and the outcome acceptable? 4. Feasibility: Is it feasible to include the intervention in the basic package, now and in the future?	The Federal Joint Committee and the contractual partners (sickness funds and providers) define the benefit catalogues for the Statutory Health Insurance in the framework of Social Code Book V. Unlike other countries, the German federal government limits its regulatory role to defining procedures that determine the scope of Statutory Health Insurance services. The explicitness of the benefit catalogues varies greatly between different sectors. While benefits in outpatient care are rather explicitly defined, benefit definitions for inpatient care are vague.

Table 26. Benchmarking - Prescribed minimum benefits

Ghana	South Africa	Israel	Netherlands	Germany
There is no stipulated level of minimum benefits required to be offered by PHIS. PHIS may offer duplicate, supplementary, or complementary cover to the NHIS. The set of benefits offered under NHIS is determined by the Minister of Health under the advisement of the NHIA. Currently this is said to cover 95% of disease burden.	Medical aid funds have to provide a minimum set of benefits which is set at a reasonably comprehensive level. The minimum benefit package has been a contributing factor to the high cost of medical aid funds and this is contributing to the low coverage of the population by medical aid funds. Health insurance products are not required to provide a minimum set of benefits.	Private health insurance packages are regulated by the Ministry of Finance's Commissioner of Insurance.	National benefit standards specify a comprehensive basic benefit package for acute care. Most of the Dutch purchase supplementary insurance that covers some services omitted from the basic package, such as adult dental care.	All policyholders must have access to the standard tariff policy.

Table 27. Benchmarking - Provider agreements and contracts

Ghana	South Africa	Israel	Netherlands	Germany
Any healthcare provider may apply to be credentialed to provide services to beneficiaries of the NHIS. The NHIA requires minimum standards of quality and capacity for each healthcare facility before credentials are issued. The NHIS then has uniform reimbursement models for all providers including FFS, capitation and per G-DRG case billing. PHI providers are free to negotiate on price and quality of care for their members.	The public healthcare system provides access to healthcare services directly and there is limited ability for strategic purchasing. The government does use its bulk purchasing power to obtain external items, specifically medicines, at reduced prices. The private healthcare funders employ strategic purchase agreements to reduce the cost of providing the benefits. These arrangements can be between the private funder and private (or public) hospitals and networks of providers (for example general practitioners or pharmacies). Strategic purchasing has become more important to reduce costs since a set of benchmark tariffs were abandoned and it has generally benefitted the larger healthcare funders. By law, no one may be denied emergency medical treatment. People reliant on state healthcare are also often taken to the casualty ward of private hospitals to be stabilised, but those without medical aid are transferred to state hospitals for further treatment, once their condition is stable enough for them to be moved. The private healthcare funders generally have a range of plans to choose from these can either be network or non-network options. Network options have a	Most of all sales of services to HPs are governed by contracts that are built on the official government reimbursement prices and mechanisms. In return for guaranteeing a minimum service revenue stream, HPs are given additional price discounts. No laws prohibit HPs from channelling patients to particular hospitals. To limit the extent of the channelling, the Ministry of Health has decided that each HP will have to pay to each hospital 95% of what they paid to them in the previous year, even if the HP reduces consumption at a certain hospital by more than 5%. By virtue of its role as the owner of the government hospitals, the Ministry of Health reviews and approves all contracts with the government hospitals	Health insurers and providers negotiate on price and quality of care.	Sickness funds responsibilities include negotiating prices, quantities and quality assurance measures with providers of health care services. Regulation (SGB V) set out guidelines for negotiations between SHI physicians and dentists and the sickness funds, specifying the categories of benefits and the scope of areas to be negotiated. These negotiations determine the conditions of remuneration and the specific items in the ambulatory benefits package. As a general rule, both areas are regulated in great detail in the German ambulatory sector, whether through legislation or through negotiations between providers and the sickness funds. (Busse and Blümel, 2014).

	list of network providers that charge only the agreed upon tariff. If a network plan is chosen individuals can utilise services providers specified on the list of network providers. Visits to network providers generally require no out-of-pocket payments with minimal or zero co-payments.			

5.8. Affordability and prescribed minimum benefits

Table 28. Benchmarking - Benefit packages available and service needs

Ghana	South Africa	Israel	Netherlands	Germany
The benefits package under NHIS includes: • outpatient care – general and specialist care, radiology and pathology, day procedures, physiotherapy, medication; • in-patient care; • oral health – basic dentistry; • eye-care; • Maternity care; and • Emergency care, The NHIS places exclusions on: • cancer treatments (except cervical and breast cancer); • Dialysis for chronic kidney failure; • Medicines not on NHIS list; • Organ transplants; • Appliances and prostheses; • Cosmetic surgeries; • Treatment abroad; • Mortuary services; • Echocardiography; • angiography; and	Medical aid funds offer a wide ranges of benefit packages, all of which much include the minimum benefits. The minimum package will include the following: • Any life-threatening condition; • A defined set of 270 diagnosis; and • 27 chronic conditions. In addition to the minimum benefits, some medical aid fund options will offer additional benefits and freedom of choice (where the minimum benefits are provided through specific providers resulting from strategic purchasing). Health insurance does not have a minimum set of benefits and most of the products provide limited benefits, or specific targeted benefits (for example, a product aimed at dental benefits only).	Benefit packages as set out in NHI Law. The health basket includes, for example, physician services, hospitalization, medication, diagnostic examination and in vitro fertilization treatment, dental care for children (introduced in 2010) and mental health care (starting in mid-2015). Institutional LTC, preventive care, dental care for adults, contraception and alternative medicine are not included in the package (mid-2015). Mother and baby preventive care is funded by the Ministry of Health and provided by the Ministry of Health, the municipalities and HPs. The Ministry of Health provides needs-based assistance for institutional LTC. The remaining non-NHI care can be purchased privately either through VHI or OOP payments. The mandated NHI benefit package includes the following: • hospital care • primary and specialty care • prescription drugs • certain preventive services • mental health care	The basic benefits package includes GP care, maternity care, hospital care, home nursing care, pharmaceutical care and mental healthcare.	The following types of benefits are included in the SHI benefit package: • prevention of disease, health promotion at the workplace • disease screening • treatment of disease (ambulatory medical care, dental care, drugs, care provided by allied health professionals, medical devices, inpatient/ hospital care, nursing care at home, and certain areas of rehabilitative care, sociotherapy) • dental prostheses and orthodontics • emergency and rescue care • certain other benefits such as patient information and supporting self-help groups

Ghana	South Africa	Israel	Netherlands	Germany
• Government provided services such as ARV treatment and immunization.		• dental care for children and the elderly aged 75+ • diagnostic exams • maternity care • allied medical care (physiotherapy, occupational therapy, nutrition, speech therapy) • some durable medical equipment (wheelchairs, orthopaedic aids) • limited coverage of palliative and hospice services. The insurance commissioner has introduced a standard benefit package with uniform coverage with cover for private operations forming the main cover offered. The intention is to offer low-risk people a cheaper policy with unique basic coverage		

Table 29. Benchmarking - Risk sharing mechanisms

Ghana	South Africa	Israel	Netherlands	Germany
There is no evidence of risk sharing mechanisms in place between government and insurers or amongst the private insurers.	The public health system does not employ any risk sharing mechanisms on a wide scale. Medical aid schemes and health insurers carry their own risks without sharing between providers. Some of these funders will have risk sharing arrangements (for example capitation agreements) with service providers. Healthcare insurers can use reinsurance arrangements to achieve risk sharing.	There are effective mechanisms for risk sharing between the government and the main providers/ purchasers of care, through: • financing of HPs primarily via prospective payments based on a capitation formula with simple and objective risk adjusters; and, • supplementary HP funding via retrospective payments based on performance and the prevalence of outlier costly diseases. Risk adjusters include age, gender and place of residence of the HPs members	Insurance market rules and oversight, including risk equalisation funds, seek to focus insurance competition on quality and cost performance (value) and limit opportunities to gain or lose by health risk selection.	PHI contracts include an option to impose a surcharge to pay for premium cap on standard tariff package, but this option has not been invoked. Insurers participate in a risk equalisation scheme for standard tariff policies, as the number of aged insurees varies across companies. The authority has a right to trigger the risk equalisation mechanism that would require certain privately insured to cross-subsidise some of the cost of coverage of the elderly under the standard tariff policy although to date this has not been deemed necessary. (Tapay, 2004) For the basic substitutive policy premiums are reduced by 50% if a person can demonstrate they cannot afford to pay the full premium; if this reduced premium is still unaffordable, individuals receive a state subsidy under the social benefits scheme (covering up to 100% of this reduced amount) (Sagan and Thomson, 2016)

Table 30. Benchmarking - Portability and cover protections

Ghana	South Africa	Israel	Netherlands	Germany
In theory, all citizens are to join the NHIS (or another scheme) but this does not happen in practice. Members of the NHIS may also purchase cover through a private insurer and hence can have NHIS and PHI cover at the same time. If an employee is on a scheme due to an employer, they may elect to transfer their accrued benefits to another registered scheme when changing employment. Under law, both the previous employer and trustees of the scheme are obliged to comply in effecting the transfer. There are no other clearly stated rules governing the transfer of policies between insurers. Membership at a scheme is for a given period and has to be actively renewed.	All citizens and legal residents have access to the public healthcare system with no limitations, however some geographical restrictions may apply. Medical aid funds must apply open enrolment and cannot deny cover to new applicants. Limited general and condition specific waiting periods can apply to new applicants. Medical aid schemes can also apply late joiner penalties if an individual joins the medical aid fund system for the first time after a specific age. Individuals are generally free to choose any medical aid fund, however some employers might restrict membership to one or more than one medical aid scheme. Movements between medical aid schemes are regulated and individuals can move, subject to a 90 day limit, between medical aid schemes without any additional restrictions. Healthcare insurers does not have any limitations on underwriting and are not subject to open enrolment.	All Israelis are free to choose their HP and HPs must accept all applicants. In the past, transfers were limited to specific periods of the year, but anyone who has been in a plan for at least six months may transfer at any time. Residents are allowed to switch between plans any time, up to twice a year. No resident can opt out of the NHI system.	Basic Benefit Package: All health insurers are obliged to accept all applicants and to charge each individual applicant the same nominal premium for the same policy. Members are they have the option to switch healthcare providers and choose a better (or less expensive) health insurer every year. (VWS, 2016) Insurers are prohibited from terminating a VHI contract if a person switches to another insurer for mandatory health insurance.	Effectively, for substitutive cover, it is offered on a lifetime basis. For other types of coverage, cancellation by insurer is prohibited after a certain number of years. Insurers are required to build up ageing reserves to cover age-related increases in costs and slow the increase of premiums later in life. In 2007, the government introduced new regulation to facilitate portability; from 2009 ageing reserves have been fully portable for all new VHI policyholders. Existing policyholders could transfer their reserves if they switched private insurer between January and June 2009, but the ageing reserve could not be transferred if an individual switched from private to publicly financed cover. (Sagan and Thomson, 2016) If moving from social to private insurance limits on general waiting periods and specified limits on coverage exclusions for certain conditions apply.

5.9. Pricing guidelines

Table 31. Benchmarking - Underwriting and premium setting rules

Ghana	South Africa	Israel	Netherlands	Germany
Underwriting practices vary across different health insurance schemes. The NHIS is not allowed to underwrite under NHIS law. NHIS premiums are income rated and range from 7.20 - 48 Ghana Cedi. Certain groups are exempt from paying premiums such as Individuals aged 70 and older. No underwriting is done at private mutual health insurance schemes. Private commercial health insurance schemes have limited underwriting practices. Insurers may request a medical report and may request medical tests be conducted as part of the application process. Due to a very limited demand for private insurance, underwriting is not well developed. Insurers rely on exclusions, waiting periods and benefit limits to mitigate risks. Group health insurance is more competitive - this is attributable to employers traditionally providing healthcare benefits for employees. There is no restriction on the premiums insurers may charge but is decided by the market.	No underwriting or pricing occurs in the public healthcare system. Medical aid funds must apply open enrolment and cannot deny cover to new applicants. Limited general and condition specific waiting periods can apply to new applicants. Medical aid schemes can also apply late joiner penalties if an individual joins the medical aid fund system for the first time after a specific age. The pricing of the benefit options is determined by each medical aid scheme however, the pricing is subject to approval by the regulator, the Council for Medical Schemes. Premiums are community-rated: variations by age, sex, or health status are prohibited. Health insurers can apply their own underwriting rules and they can determine their own pricing and they are only limited by the requirements to treat customers fairly.	Commercial insurance premiums may be set using risk rating. Factors used for individual commercial insurance include age, gender and pre-existing conditions. Commercial voluntary health insurance use a number of factors to select healthier lives including waiting periods, exclusions of pre-existing conditions, risk-rated premiums, rejection of applicants and coverage limits. Voluntary health insurers provided by HPs may not deny coverage to any member applying and they are prohibited from excluding pre-existing conditions. Premiums are solely determined based on age. Government sets rules with regards to the extent and nature of co-payments, whether voluntary health insurance packages can include coverage for life-saving pharmaceuticals and choice of hospital-based physician. A related issue that is also regulated is whether the HPs can use their VHI programmes to cross subsidize their core activities (i.e. those related to the basic benefits package), or vice versa	For the basic benefit package premiums are community-rated: variations by age, sex, or health status are prohibited. For complementary VHI, unlike with basic health insurance, health insurers are free to set premium levels and use risk selection (for example, based on medical criteria or other risks).	Substitutive cover must be offered on a lifetime basis; premiums determined by age of entry and gender (and benefits); health status risk surcharge may be imposed (except for civil servants switching from public cover to standard tariff). New entries may not be charged less than already insured of same age (not including ageing reserve). There is a premium cap applied to substitutive coverage.

5.10. Referral systems

Table 32. Benchmarking - Formularies and standard treatment guidelines

Ghana	South Africa	Israel	Netherlands	Germany
In theory, under the NHIS, services at regional and tertiary hospitals are accessed through referrals from lower-level services. Members are expected to follow treatment pathways. However, in practice, most hospitals accept direct patients for outpatient and inpatient services.	The public healthcare system in South Africa has formularies and treatment guidelines in place. In addition, there is a referral system whereby the initial contact would be at a primary healthcare or general practitioner level. The private healthcare funders make extensive use of formularies and treatment guidelines. These are either implemented by the administrators of the private funders or through third-party managed care providers. The private healthcare funders generally have a referral process in place, however where the members or policyholders have more comprehensive cover in place, they are able to access the healthcare system at specialist level.	HPs work as managed care organizations with gatekeeping, and some cost sharing from patients for visits to specialists and for medications.	Residents have to register with a GP and there is a compulsory referral system from primary care to specialist doctors i.e. GPs act like gatekeepers to specialist and hospital care. In 2008, the government introduced an annual mandatory deductible of EUR 150 for insured people 18 and over (which has since been increased to EUR 360 in 2014). GP services are exempted from the mandatory deductible in order to support the role of the GP as gatekeeper. (European Comission, 2016)	SHI have set treatment pathways that must be followed to access reimbursed care. Family practitioners are not gate-keepers in Germany, although their coordinating competencies have been strengthened in recent years.

5.11. Quality assurance and accreditation

Table 33. Benchmarking - Private Health Insurance Service Provider Accreditation Mechanisms

Ghana	South Africa	Israel	Netherlands	Germany
PHIS are required (by the NHIA) to only use services of healthcare providers or facilities which have been licensed by the relevant agency and credentialed by the authority. As per the National Health Insurance Act of 2012, the NHIA is expected to collaborate with the relevant agencies to ensure healthcare providers operating under the NHIS implement policies that guarantee quality healthcare to members of the Scheme and carry out clinical audits. The policies are to include the granting of credentials, undertaking service utilisation reviews and technology assessments. The Health Institutions and Facilities Act of 2011 established the Health Facilities Regulatory Agency to license facilities for the provision of public and private healthcare services.	All private healthcare practitioners must have a practice code number to submit claims as per the Medical Schemes Act, 131 of 1998. The Practice Code Numbering System ("PCNS") is administered by the Board of Healthcare Funders who has been appointed by the Council for Medical Schemes to issue these numbers. The providers themselves are regulated by the Health Professions Council of South Africa.	The government regulates hospital licensure and oversees the authorization process for opening a new hospital or department. The number of hospital beds is regulated, along with their distribution in terms of ownership, specialty and location, as is major capital expenditure. The Ministry of Health sets the requirements for licensure as a physician, nurse or other health care profession and assesses whether individual applicants meet those requirements. The licences granted to hospitals are valid for one to three years, depending on the results of the latest inspection. The licences are very detailed. They refer to a specific number of beds by department, as well as specifying the types of outpatient clinic the hospital is authorized to operate. A large and growing number of Israeli hospitals have been accredited by the Joint Commission International, with many additional hospitals currently under review.	A process of selective contracting enables health insurance companies to control the effectiveness and quality of the care provided by healthcare providers. They do this through careful negotiation and selective contracting based on the large amount of (anonymised) data to which they have access regarding issues such as quality, effectiveness and customer experiences. Members of the public, in turn, also have some degree of control over this process, since they are given the opportunity every year to switch healthcare providers and can influence the policies of health insurers and health institutions.. (VWS, 2016)	Accreditation and contracting general rules are set out in federal law (SGB V). In 1999, an independent, voluntary accreditation program for hospitals, the Kooperation für Transparenz und Qualität im Krankenhaus, or KTQ, was established with the collaboration of the federal medical chamber, insurers, and the board of the German Hospital Federation. Because the program expanded to include primary care, it changed its name in 2004 from Krankenhaus to Gesundheitswesen The Kooperation für Transparenz und Qualität im Gesundheitswesen, or KTQ-GmbH, is totally independent from the government and is an organization with limited liability, in conjunction with the appointment of a full-time chief executive (INDIGOMED, 2020). This certification procedure, which is an active program without legislation, concerns: hospitals, doctors' surgeries, dental surgeries, psychotherapy centers, rehabilitation centers, inpatient (including partly inpatient) health care facilities, ambulatory care services, hospices, alternative residential arrangements. This procedure provides hospitals with the impetus for implementing new

Ghana	South Africa	Israel	Netherlands	Germany
				elements in quality management based on analysis and further development of existing structures and working processes (increased motivation). Self-assessment is the first step; this is carried out by the hospital or the institution that seeks KTQ certification. Immediately after self-assessment, it can decide to take any measures needed to improve certain methods or processes, or it can directly seek KTQ certification. External assessment is conducted via on-site inspection, on-spot employee interviews, and a study of documents. KTQ visits are carried out by renowned experts with proven knowledge, and assessment takes several days to complete. KTQ certification is the ultimate goal, proving that the hospital or clinic has satisfactorily fulfilled the quality control tests. KTQ certification is valid for a certain period, and hospitals' names and quality reports are published on its website. The quality reports contain all parameters used in decision making. KTQ certification is not compulsory – but it is seen as a good measure of infrastructure and performance. To earn the certification, the hospital must: • Attain at least 55 percent of the "adjusted" total point score per category,

Ghana	South Africa	Israel	Netherlands	Germany
				• Demonstrate participation in external quality-assurance procedures required by law, and Ensure publication of the KTQ quality report

Table 34. Benchmarking - Complaint mechanisms

Ghana	South Africa	Israel	Netherlands	Germany
The NHIS employs accredited agents to whom patient and provider complaints can be submitted to. The District Mutual Health Insurance Scheme (DHMHIS) handle the day-to-day operations of the NHIS at the district level. Complaints are made to the NHIS agents or directly to the DMHIS. If complaints are not handled within two months, it can be escalated to the Health Complaint Committee.	Members and policyholders of medical aid funds and private healthcare insurers respectively have access to various complaint mechanisms. All medical aid funds and insurance companies must have internal complaints procedures. Once this process has been exhausted, then medical aid fund members can submit a complaint to the Council for Medical Schemes. Policyholders of private healthcare providers can direct complaints about the insurer to the Financial Services Conduct Authority. All users of the healthcare system, including users of the public healthcare system and the private healthcare system, can submit complaints about the healthcare service providers to the Office of the Health Ombud.	All major Israeli health care institutions (such as HPs and hospitals) are required to assign a designated person as responsible for handling patient complaints. The Ministry of Health itself operates several units to which patients can send complaints regarding problems they encounter anywhere in the health system, both clinical and administrative. Both the Ministry and the providers try to respond to the complaints at two levels: by trying to better meet the specific needs of the individual who submitted the complaint, and by analysing aggregate complaint data to identify and then address problems that are prevalent and systemic in nature. Additionally, the Ministry of Health has an ombudsman's office which handles consumer complaints about the HPs; the complaints are addressed at both the individual and the systemic levels. The ombudsman can address both clinical/malpractice issues and patient financial rights/ administrative issues; the ombudsman can enforce the withholding of funds from noncompliant HPs.	People can exercise control over health insurers' policies through various representative bodies. If they are dissatisfied with the implementation of the Health Insurance Act or with the care services received, there are several independent organisations they can contact. (VWS, 2016)	At the state level, the professional chambers of physicians, dentists and pharmacists are urged to establish complaint systems and arbitration boards for the extrajudicial resolution of medical malpractice claims. An ombudsperson is responsible for arbitrating disputes between patients and companies that offer private health and long-term care insurance, and for addressing the needs of patients and individuals with disabilities. Patients harmed by negligent actions on the part of health care providers or manufacturers of pharmaceuticals or medical devices have the right to compensation according to tort law. They may address their complaints free of charge to the above-mentioned arbitration boards, which are staffed by independent physicians and lawyers. Sickness funds also support patients through the SHI Medical Review Board, which provides counselling and can draft expert reports to help resolve malpractice claims.

Table 35. Benchmarking - Policyholder protection mechanisms

Ghana	South Africa	Israel	Netherlands	Germany
PHIS are required to provide a procedure for settlement of complaints from its members and healthcare service providers. This includes the recording, investigation and process for settling complaints received from members and providers. The scheme is also required to inform members of the existence of the Adjudication committee set up by the Minister of Health which unsettled or unsatisfactorily settled claims can be submitted to.	The medical aid schemes are regulated by the Council for Medical Schemes and the conduct of medical schemes are prescribed in many areas. Members have access to a complaints procedure if they feel that the medical aid funds are not in compliance with these requirements. Policyholders on private healthcare insurers receive protection through the policyholder protection rules issued by the Financial Services Conduct Authority. Both of these entities are required to provide members with the details of these complaints procedures.	Policy holder satisfaction is carefully monitored by the Capital Market Insurance and Savings Division (CMISD). The CMISD's Consumer Ombudsman Unit regularly processes public complaints relating to insurance companies, insurance agents as well as pension funds and provident funds. This data constitute a key indicator of policyholder satisfaction.	By law health insurers have a duty of care: they must guarantee that healthcare is available in the basic package for all their policyholders. (VWS, 2016)	Policyholders on private healthcare insurers receive protection through policyholder protection provisions issued by the Federal Financial Supervisory Authority (BaFin).

5.12. Coding, centralised data and reporting

Table 36. Benchmarking - Coding rules and guidelines

Ghana	South Africa	Israel	Netherlands	Germany
There is no enforced industry standard for coding on clinical data or claims submission. Private facilities are more likely to submit incomplete claims information. A 2017 study by the World Bank Group noted that among private clinics that submit claims without GDRG information, 42% do not have the relevant diagnosis information to assess if the claims expenditure is eligible for re-imbursement. Ghana has introduced a Ghana Diagnosis Related Grouping (G-DRG) for services and standard itemized fees. This is also expected to assist.	The Medical Schemes Act, 131 of 1998 requires that all claims to medical aid schemes must include ICD 10 coding in order to be considered valid claims. No such requirement exists for claims submitted to private healthcare insurance providers however, the same practice generally applies.	No coding requirement exists for claims submitted to private healthcare insurance.	No coding requirement exists for claims submitted to private healthcare insurance	In Germany, the attending hospital physician is legally responsible for documentation and coding of the hospital inpatient/outpatient admissions. All physicians are compelled to code according to the International Statistical Classification of Diseases and Related Health Problems, 10th revision, German Modification (ICD-10-GM), according to the Statutory Health Insurance. The classification is in use since 2004 in the same version for inpatient and outpatient care. Special coding guidelines are to be used for inpatient care. For electronic use the index is published with a unique identifier (so called Alpha-ID). This enables electronic communication of diagnosis on a more granular level than the broad categories of ICD-10.

Table 37. Benchmarking - Regulatory reporting

Ghana	South Africa	Israel	Netherlands	Germany
All PHIS are required to register with the NHIA and to comply with the extensive list of registration requirements. This includes submission of the proposed minimum premiums/benefits package to be signed off by a qualified actuary. The methodology and assumptions used in determining premiums is to be disclosed. PHIS are required to submit quarterly and annual reports including financial statements to the Authority for review. Quarterly reports are to be submitted within one month of the end of the quarter and annual reports within three months after 31st December of the preceding year. In addition to financial statements the authority requires an annual operational report covering corporate governance, comprehensive analysis on enterprise risk management, stakeholder relations, operations and outsourcing activities. PHIS apply for renewal of their licence every two years.	Medical aid funds are required to submit detailed data to the Council for Medical Schemes ("CMS") on a quarterly and an annual basis to allow the CMS to monitor the industry and to present annual industry reports and statistics. In addition, medical aid schemes are required to submit annual pricing reports to the CMS to allow for the approval of such increases. Healthcare insurance providers are required to submit quarterly and annual solvency statements to the Prudential Authority.	Capital Market Insurance and Savings Division (CMISD) sets reporting requirements for insurers.	The Dutch health insurance authority requires that health insurance companies report the performance indicators of entities from which they procure health services. This information is put in the public domain to inform consumers when making health insurance purchasing decisions. The Dutch Health Care Performance Report describes three dimensions. These performance dimensions are quality, access, and affordability. There are 125 performance indicators underlying the performance dimensions. The performance indicators support the policy principles of transparency and accountability. (Council for Medical Schemes, 2019)	Private Health Insurers report to the Federal Financial Supervisory Authority (BaFin). In Germany, the Federal Insurance Office regulates statutory health insurance funds. Private health insurers are required to annually submit reports to BaFin which includes reports of their activities during the year, financial statements and budget plans for the following year. (OECD, 2018a).

Table 38. Benchmarking - Centralised health insurance data

Ghana	South Africa	Israel	Netherlands	Germany
The NHIA does not currently require any submission of data beyond reports, financial statements and projections (stated above) from other insurers in the industry. The NHIA does collect data from the NHIS as part of its function of managing the NHIS.	No centralised health insurance database is maintained.	The Ministry of Health has made transparency one of its main goals and it has made major strides in increasing the public's access to comparative data on quality, finances and patient satisfaction. These advances in transparency have also facilitated greater accountability, both to the government and to the general public. There are sophisticated information systems within all the HPs and hospitals that aggregate data on services and quality of care; data are also combined from across providers to support broad policy decisions and to monitor and analyse overall national developments.	In order to improve access and reduce the waiting time for hospital surgery, authorities have obliged hospitals and mental healthcare providers to give information to an integrated central and nationwide information system on patients on a waiting list. This information can be used by insurers and their insured to choose between hospitals. The publishing of this information is designed to encourage providers to increase activity and reduce waiting times. Data on patients' experience of care is published by the government, the insurers and NGOs. Comprehensive data exists, which enables information on physician and hospital activity and quality and patient care utilisation to be published. This information is used by insurers and patients to choose providers and by providers to improve their own activity. Surveys are conducted on patient's experience and satisfaction with the care provided. A general health care sector performance report is published on a regular basis using a comprehensive set of indicators. (European Comission, 2016)	No centralised health insurance database is maintained.

6. Literature review

This section is the literature review component of the report. and it provides a synopsis of key reports, documents and research concerning the Kenyan health insurance sector. The main objective is to provide a:

- Snapshot of recommendations concerning the health insurance regulatory framework based on the evidence gathered during the research and consultation stages.
- Overview of various recommendations concerning the improvement of the Kenyan health sector with regards to attaining UHC and the management of the NHIF.
- Overview of the latest global and regional developments and trends concerning the regulation of health insurance.

The literature for this review was based on reports into the Kenyan healthcare market that were sponsored by various organisations, including the USAID, World Health Organization and the World Bank Group. Furthermore, documents and reports from Kenya (and written by Kenyan authors and institutions including the University of Nairobi and the KEMRI Wellcome Trust) were also reviewed to provide a deeper and more contextual understanding of the health sector market and health insurance market dynamics.

6.1. Approach to literature review

Literature reviews typically review key authors, thought leaders, research and documents within a particular field to ensure an adequate grasp of the subject matter at hand. Moreover, a literature review gives insight concerning 'knowledge gaps' and the additional research required within a particular research area. The same applies within this project with the focus and subject matter being the Kenyan health insurance regulatory context.

The documents reviewed provide numerous recommendations concerning the development of a health care and insurance. The focus and approach of this literature review is to consider key recommendations from authors regarding health insurance given the primary focus of this project is the development of a private health insurance regulatory framework.

In reviewing the individual reports and the various recommendations provided, several key themes where often repeatedly mentioned and identified. Examples of key emerging themes that arose from the literature review include recommendations pertaining the health insurance regulatory framework, strategic purchasing, capitation, and quality of care. A thematic approach to the literature review was therefore adopted to group together similar recommendations and avoid repetition of the same recommendations.

While alternative methodologies were considered, focusing the literature review on recommendations as they pertain to the development of a comprehensive health insurance regulatory framework ensures diverse views are considered and incorporated in the process of developing the health insurance regulatory framework.

Each theme contains a conclusion, in the introduction or with the individual suggestions, that explains to what extent the recommendation has been included in the final policy proposals.

Some of the recommendations surveyed fall outside of the scope of a health insurance regulatory framework and may not necessarily require regulation. Also, some recommendation may require regulation, but the responsibility should not be with the health insurance regulator. Such recommendations are still considered as they indirectly impact on or feed into the health insurance policy paper and impact how the health insurance regulator should collaborate with other regulators. Examples of themes whose recommendations fall outside of the scope of the regulation of health insurance include enforcement of contracts, coding, accreditation, and certain intermediaries (payment platform providers, technical service providers) etc.

6.2. Themes and recommendations impacting health insurance

The main themes that emerged from the literature review are:

- Health insurance regulatory framework
- Regulation and management of the NHIF
- UHC and the expansion of PHI
- Strategic purchasing of health insurance
- Accreditation and Quality Assurance
- Affordability and prescribed minimum benefits
- Collaboration between different regulators
- Consumer awareness and protection

These themes and the recommendations made under each are explained in more detail below.

6.2.1. Health insurance regulatory framework

Recommendations concerning the Kenyan health insurance regulatory framework were the most predominant theme in this literature review. While some of the recommendations have already been implemented by the IRA and other stakeholders, it is important that any future regulations incorporate the learnings from the past.

The key theme discussed with whether and to which extent a regulatory authority should supervise both private and public insurance providers (the NHIF), and if this authority should be separate or be part of the existing Insurance Regulatory Authority (IRA). The overall recommendation is that by creating a single framework for regulating PHI and the NHIF, overall standards for both can be improved, since many key aspects for both are currently unregulated. There are also recommendations to consolidate the PHI market to create bigger and more profitable risk-pools.

Table 39 - Literature review recommendations concerning the health insurance regulatory framework

Overall recommendation	Summary of recommendation and impact on the recommended proposals
Need for a new insurance law	Kenya lacks a specific health insurance law and regulatory framework (Munge *et al.*, 2019). (Gitonga, 2012) also shares a similar view and recommends the development of a comprehensive health insurance law either under a new entity or a revamped division of the Insurance Regulatory Authority (IRA). **Past research papers have concluded that the Insurance Act and regulations will need to be updated for the private health insurance market to grow significantly.**
Guidelines for contribution rates, selection of providers and PMBs	(Munge *et al.*, 2019) recommends: • Guidelines on contribution rates (and the corresponding or minimum benefit package). • Guidelines and indications for selecting providers. • Some of the health insurance aspects that are not covered in the Insurance Act are that "there are no guidelines on contribution rates and corresponding or minimum benefit package, nor are there any general indications for selecting providers". • Diverse forms of provider payment mechanisms may also require appropriate regulation or financial management requirements (Munge *et al.*, 2019).

Overall recommendation	Summary of recommendation and impact on the recommended proposals
	The policy proposals include recommended limits on the range of premiums an insurer can charge, the needed for an industry minimum benefit package, the need for independent accreditation, and the use of DRGs to control payments and therefore the cost of insurance claims.
Integration of Micro Health Insurers	Adequate policy, legal and regulatory frameworks are required that support strategic purchasing practice in Kenya. Specific to Micro Health Insurers, the frameworks should support the integration of Micro Health Insurers into the broader health financing system in a way that would enhance progress towards Micro Health Insurers. This is a more significant problem for Micro Health Insurers , which operate under a variety of labels, mandates, motivations, and even sectoral context. (Munge *et al.*, 2019). **The policy proposals include the requirement for community-based health insurers to be licenced as a Micro Health Insurer.**
Risk pooling, prepayment mechanisms and setting of benchmarks	(Gitonga, 2012) recommends: • Redefinition of the various types of risk pooling and prepayment mechanisms to support efficient underwriting, for example organizing various risk pools into uniform groups to ensure efficient administration and underwriting. • Redefinition of various health insurance vehicles and capitalisation. • Performance benchmarks for health insurers (coverage breadth, depth, height, pay-out ratio, admin expenses, efficiency etc) • Regulation of healthcare quality and cost-effectiveness (supply side) **The policy proposals include the methods of improving the risk pools by reducing the extent to which underwriting can be used and prices adjusted for each pool. Proposals also recommend how collaboration with the PMPDC will assist with accreditation and measurement of care.**
Expand role and capacity of IRA to regulate and supervise health insurance (and independent health benefits authority) and create an Independent	Private medical insurance falls under the regulatory purview of the IRA while the NHIF falls under the MOH. To date, there is no independent regulatory authority or entity to safeguard the interests of contributors, enforce minimum standards and provide a grievance channel for customers. It is suggested that the health insurance regulatory framework should make provision for an independent ombudsman or regulatory authority. The current structure with oversight from the IRA for the private sector and MOH for the NHIF does not provide full oversight. An independent health benefits authority provides the best solution (Deloitte, 2012).

Overall recommendation	Summary of recommendation and impact on the recommended proposals
medical insurance ombudsman	(Gitonga, 2012), (Munge *et al.*, 2019) and (Deloitte, 2012) all recommend that a review of the health insurance regulatory framework will require an expansion of the role of the IRA as the current regulatory framework does not provide adequate oversight. Countries with social health insurance models like Kenya's NHIF have independent regulators to safeguard and protect the interests of contributors, enforce minimum standards and provide a grievance channel for customers. These countries include Chile and the Netherlands which have independent ombudsmen. It is suggested that the health insurance regulatory framework make provision for an independent regulatory authority or ombudsman (Deloitte, 2012). **The policy proposals require the NHIF to be regulated by the IRA. This will ensure consistency in standards between the NHIF and PHI. The policy proposal also requires the creation of a health insurance focussed Ombudsman to address any complaints in the industry.**
Strengthening the health insurance regulatory framework to support the growth and development of the private health insurance sector and its contribution towards UHC. **Closer cooperation and integration of PHI and the NHIF, which can be achieved through the creation of a**	There are concerns that the current health insurance regulatory framework and the gaps therein that limit the growth and the role PHIs can play in the health sector. For example, some of the updated laws governing PHIs are largely focused on financial sustainability (including actuarial analyses to monitor financial health). "However, there lack of clarity on how the laws will guide or support PHIs to increase coverage of health insurance" (World Bank Group, 2018)**.** Strengthening the regulatory framework for private health insurance is pivotal to the growth and sustainability of the sector and to building its role in contributing towards the attainment of UHC. The ways in which the regulatory framework can be strengthened to support the growth of private health insurance and its contribution towards UHC include: • Strengthening the role of the IRA with regards to health insurance capacity • Strengthen existing laws with focus on managing health insurance • Create common inclusive framework that enables intersection of Health care providers and insurers (including a framework for collaboration between PHIs and the NHIF).

Overall recommendation	Summary of recommendation and impact on the recommended proposals
uniform regulatory framework.	• Framework to support automation of claims processing • Involve PHIs in the national health financing policy. Advancing UHC will require a working partnership between PHIs and the NHIF and "PHIs playing a complementary and supplementary role would serve to mobilize more resources towards UHC". This would require: • "Designing a framework/platform to support dialogue and partnership between NHIF and PHIs. • Explore Synergistic and mutually beneficial partnerships to support achievement of UHC. • Establish a data sharing mechanism across the industry: both among the PHIs and with NHIF" (World Bank Group, 2018) **Similar to the recommendation above, the policy proposal require the IRA to regulate both the NHIF and PHI. Common requirements will improve the standards of the NHIF create a regulatory environment that support the goal of achieving UHC through the cooperation of public and private interventions.**
Supporting growth of private health insurance sector through addressing standards	A health insurance regulatory framework also considers how best regulation can support the growth and development of private health insurance. "To optimize penetration and growth of private health insurance in Kenya there is need to develop a regulatory framework that intersects between Health care providers and private health insurers (PHIs)". The framework must cover: • **Quality of care** – PHIs are largely reliant on licensure by regulatory bodies which normally focus on licensing but have limited resources available to continuously monitor quality of care on an on-going basis. • **Pricing** – There are limited guidelines concerning pricing. • **Provider panel management** (World Bank Group, 2018) **The policy proposals make specific recommendation to address these issues**

6.2.2. Regulation and management of the NHIF

While the NHIF falls under the purview of the public sector through the Ministry of Health – it is still important to consider key recommendations with regards to the NHIF as a dominant player in the health sector. This is needed if the NHIF and PHI are both to be regulated by the IRA under a uniform framework.

The recommendations below are all addressed via the inclusion of the NHIF under the IRA's regulatory ambit. Specific policy proposals address these issues for both the NHIF and PHI.

Table 40. Literature review recommendations concerning the regulation and management of the NHIF

Overall recommendation	Suggested element or aspect to be included
Standardisation of provider payment rates	• NHIF should adopt similar provider payment rates for similar services to minimize the generation of perverse incentives (Barasa *et al.*, 2018). • Tight management, effective contracting, and appropriate provider payment arrangements are of critical importance to successful implementation of health insurance (Kimani, Muthaka and Manda, 2014). **Along with earlier suggestions creating DRGs for private health insurance, the NHIF should also standardised their services and procedures. This will then allow standard pricing rates to be determined by the NHIF and their providers**
Better planning needed in the design of the NHIF package, considering the need of the beneficiaries	• It is important to have a thorough design and planning stage, which draws on international experience and where all stakeholders are consulted. • The results have shown that the link between the beneficiaries and the NHIF is weak. This manifests itself in various ways including in a benefit package that deviates not only from policy design for access to care but also from burden of disease patterns. Thus, there is need for a greater link between beneficiaries and the NHIF. (Kimani, Muthaka, & Manda, 2004). • "The recommendation is that the NHIF's new package should be critically examined to whether it reflects the needs, preferences and values of Kenyan citizens and fits with national priorities and goals" (Munge, Mulupi, Barasa, & Chuma, 2017).

Overall recommendation	Suggested element or aspect to be included
	Need for a proper costing of the benefit package (for the then proposed NHIS Bill) (Abuya, Maina and Chuma, 2015) **The NHIF should be run more like an insurance company, with actuarial analysis required for the pricing and customer input on the product design**
Suggestions for future reforms to the NHIS Bill	• Having registration fees structured by levels of care to prevent over-utilization • Initial exclusion of long-term illness • Cost containment through quality management • Mortuary charges limited to three days • Special review procedures for expensive drugs • Understanding various stakeholders' interests on specific design elements of the forthcoming bill may facilitate implementation • Develop a continuous process of cultivating the spirit of trust over time through governance structures that promote accountability. Investing in administrative efficiency and transparency such as use of efficient electronic system of payment may facilitate trust. Having proper accountability channels include mechanisms for members to raise complaints related to the insurer is also critical • Future reforms in health care financing towards UHC in Kenya, should not only focus on the design of a viable national health insurance but also devise ways of building trust to existing health care systems, the public and institutions mandated to provide leadership in the reform process • Active sensitization and engagement of key players through a well-organized leadership. Public engagement and encouraging public dialogue on key issues from the early design stage is key to success • Assess specific design barriers • "Future reforms process should focus on how to garner support from large employers by persuading them that the proposals would reduce their workforce costs. The win-win situation is critical for future implementation." (Abuya, Maina and Chuma, 2015)

Overall recommendation	Suggested element or aspect to be included
	Although the NHIS Bill was never passed, many of the learnings and recommendations are still valid and should be incorporated in any new regulations
Reporting by the NHIF	Performance monitoring reports must be made public - The NHIF's accountability framework was also undermined by the absence of a regulatory and policy framework in support of strategic purchasing practice (Munge *et al.*, 2018).
Fraud and the needed for better accreditation and referral systems	Weak financial accountability led to fraud by healthcare providers, NHIF officials and NHIF beneficiaries: Say you have high capacity to get high payment, but then give low delivery. Several system weaknesses had led to this, including self-assessment process - whereby health facilities could assess their own structural capacity prior to contracting. Ways to address this include: • Online notifications for inpatient admissions • Centralised authorisation (letters of undertaking) for surgical procedures and specialised imaging studies • Introduction of biometrics for identification of beneficiaries (Mbau *et al.*, 2020) **The use of an accreditation body independent from the NHIF that is used by both the NHIF and PHI, and separate from the individual empanelment process, will aim to improve performance and reduce fraud**

6.2.3. UHC and expansion of private health insurance

Any private health insurance will have to interact with existing public healthcare and public health insurance and assist Kenya in achieving its UHC goals. A key regulatory decision is whether PHI should form a supplementary or complementary role to the NHIF, and to which extent portability of coverage or opting out of the NHIF should be allowed.

Table 41. Literature review recommendations concerning UHC expansion of private health insurance

Overall recommendation	Suggested element or aspect to be included
Steps needed to enable UHC and support PHI	To make universal health care work requires the following: 1) Prioritizing investments in good quality primary and community health services; increase resources for health from general revenue, and, where appropriate and feasible, obligatory health insurance contributions from those with the ability to pay. 2) Drastically lower operational costs, both in insurance administration and health service delivery (e.g., via mHealth and telemedicine), to offer affordable premium. 3) Avoid too many pools, possible diseconomies of scale. 4) Include Co-payment systems, including mechanisms to exempt the poor and vulnerable . (World Bank Group, 2019). **Policy proposals are made to reduce the number of risk pools and allow more Kenyans to qualify for PHI by requiring consistency between Group and Individual products and removing the ability to change the product price based on underwriting questions.**
Allow portability of coverage	Problems with Private Health insurance if there is a lack of portability of health insurance coverage where health insurance is provided for some of the population by employers or is geographically based, with respect either to enrolment or care delivery sites (World Bank Group, 2019).

Overall recommendation	Suggested element or aspect to be included
	Policy proposals reduce the impact of waiting periods and underwriting to allow movement between insurers. The existence of Prescribed Minimum Benefits also make the comparison of different products easier.
Increase in PHI take-up	Improved take-up of PHI requires: • Restructuring and some form of consolidation to form larger more efficient and sustainable risk pools. • Implementation of some measures to improve efficiency of pooling and purchasing. • Implementation of consumer protection mechanisms. • Need to create incentives and better regulatory environment. • Redesigning products to cater to broader market and not just high-end clients. • Build wider provider network & work on provider payment mechanisms. • Understand low-income market. • Build relationship with NHIF. (World Bank Group, 2018) **All these recommendations have been incorporated in the policy proposals**
Cooperation between PHI and NHIF	Some PHIs reported that here had been some discussions between NHIF and PHIs on forging partnerships though no formal partnerships have been formed. Whilst incentives and benefits for PHIs in working with NHIF are clear to due to the latter's expanded benefit package, the potential benefits for NHIF is also not very clear. To increase the target market to include low-income and informal groups, PHIs need to: o Understand these segments and their needs, behaviours and perceptions o Explore sustainable partnerships with NHIF and other partners o Expand provider network: explore partnerships with franchises, chains of providers etc

Overall recommendation	Suggested element or aspect to be included
	(World Bank Group, 2018)
Clarify the role of PHI and consider opt-out of NHIF premium	Clarify role of private schemes in providing mandated national health insurance. Either to continue playing a supplementary and complementary role only. Or in addition to above, be part of providing mandated social health. Consider Opt-out option with social tax on premiums (Gitonga, 2012), (World Bank Group, 2018) **The policy proposals allow for the opt-out of the NHIF to ensure there is competition between the NHIF and PHI and avoid unnecessary duplication of cover and premiums**
Integration of PHI and NHIF claims management	Private health insurers must develop methods to ensure the NHIF are billed for the part of the claim that relates to their coverage, instead of having the private insurer pay the full claim amount (Association of Kenyan Insurers, 2018). **Policy proposal addressing the data capture and reporting requirements will improve the ability to separate NHIF and PHI claims and support better cooperation between the two types of cover.**

6.2.4. Strategic purchasing of health insurance

Several recommendations were made with regards to strategic purchasing (which includes capitation and other methods of purchasing) by PHIs. If the IRA also regulates the NHIF, the same standards will apply to the NHIF purchasing. The policy proposals recommend ways to improve the cooperation of private health insurers and the KMPDC and give suggestions of proposals to include in the Health Act. A key recommendation is the use of diagnostic related groups.

DRGs will impact how insurers price benefits and remunerate providers. Health financing should therefore move away from fee-for-service and capitation. However, it will require an industry wide approach with standardisation needed to ensure improved health outcomes.

Table 42. Literature review recommendations concerning strategic purchasing of health insurance

Overall recommendation	Suggested element or aspect to be included
Role of NHIF in Strategic purchasing	The absence of a policy and regulatory framework for strategic purchasing in Kenya was exacerbated by a lack of clarity at the MOH about the centrality of the NHIF to health financing reforms, for example in negotiating price or even service delivery structure. Furthermore, the absence of a policy and regulatory framework is "exacerbated by a lack of clarity at the MOH about the centrality of the NHIF to health financing reforms". Specifically, we recommend the development of a policy and regulatory framework for strategic purchasing practices. This would lay the ground for strategic purchasing practice for the NHIF (Munge *et al.*, 2018).
Regulatory guidelines and framework for strategic purchasing	(Munge *et al.*, 2018) make suggestions for incorporating strategic purchasing into a policy and regulatory framework and these include: • A regulatory framework that supports person-centred evidence-based benefit package design. • A strategic purchasing policy framework will have policy that gives purchasers room to choose who they contract with, provider payment mechanisms and payment rates. • A strategic purchasing policy and legislative framework that would be embedded in a wider health financing strategy and health sector regulatory framework that identifies clearly with local contexts. "Included in this framework would be key provisions that would address the shortcomings on the three principal-agent relationships. On the government-purchaser axis, the framework should support the development and implementation of policy and regulations that support strategic purchasing"

Overall recommendation	Suggested element or aspect to be included
Provider payment rates and avoiding "purchaser capture"	The determination of provider payment rates should be informed by evidence generated from rigorous costing and actuarial analysis, rather than recommendations from health care providers. The NHIF should avoid 'purchaser capture' - where health care providers exert a high influence on provider payment rates, resulting in inflated costs of services, that benefit providers but compromise the sustainability of the NHIF. Appropriately costed provider payment rates will enhance the financial sustainability of the NHIF (Barasa *et al.*, 2018). **Many of the policy proposals made later specifically aim to reduce "purchaser capture" and widen the access to accredited and affordable health providers to reduce the cost of providing healthcare.**
Frameworks for strategic purchasing that support system-wide approaches	Health insurers can take steps to ensure their suite of incentives and sanctions align with broader health system arrangements and goals. However, government can also undertake to provide frameworks for strategic purchasing that support system-wide approaches to introducing new provider payment mechanisms, other incentives and sanctions, and contractual relationships between purchasers and providers (Munge *et al.*, 2018).
With regards to the NHIF specifically and adopting diagnostic related groups (DRG) approach	NHIF as a social health insurer should be focused on getting the best benefit possible for its members. To this end, purchasing of Health care should be strategic and optimised. "Currently, the NHIF is using a basic 'rebate' system, though there are plans to move to more sophisticated purchasing methods using 'diagnostic related groups' (DRGs) to drive purchasing decisions. This process should be expedited and given full priority" (Deloitte, 2012). **The proposal is extended to also cover PHI**
NHIF benefit packages supporting standardisation	With regard to purchasing, and related to risk pooling, consolidation of the risk pools has to be accompanied by harmonization of benefit packages. We recognize that this might be politically difficult, especially if it means reducing benefits that certain groups, such as civil servants, are entitled to. However, schemes with comparable benefit packages could be harmonized initially and a policy decision

Overall recommendation	Suggested element or aspect to be included
	made not to introduce new benefit packages but rather to progressively review and update the existing ones toward harmonization (Barasa *et al.*, 2018).
With regards to private health insurance providers	There is the need for PHIs to reform provider payments that geared towards cost control and improved health outcomes. To achieve these, there is need to embrace: • Industry wide approaches towards payment mechanisms such as capitation or DRGs • Value-based payments • Price controls and transparency among providers • Bulk purchasing and volume discounts by providers (World Bank Group, 2018)
Need monitoring of provider performance and accreditation to support strategic purchasing	In the context of strategic purchasing, the literature suggests this is best done by setting clear guidelines and putting strong systems in place to monitor provider performance and curb corruption. Since providers in both Ghana and Kenya value their accreditation status, our data suggests that providers would be motivated to charge correctly if their relationship with the SHIs was partially dependent on this performance measure (Suchman, 2018).
Ensure wider geographic spread of hospitals – use of referral system	Several options to help ensure strategic purchasing across geographic regions exist including steps to train, attract and retain health workers in underserved areas; and to discourage the over-supply of services in certain geographical areas. MHIs could also influence the pattern of distribution by leveraging on member location to influence provider location and service type. (Munge *et al.*, 2018)
Move away from Fee-for-payment and adoption of Capitation	Fee-for-service is the predominant mode of provider payments for outpatient care with no notable efforts by PHIs to move towards capitation. Adoption of capitation models is still hampered by several factors such as: • PHIs being apprehensive about the likelihood of provision of poor quality of care by providers;

Overall recommendation	Suggested element or aspect to be included
	• Low understanding of capitation by providers; and • Clients not being willing to be under capitation. As a result, PHI's largely ascribe their inability to manage and predict costs of care and resultant high loss ratios incurred in outpatient schemes to fee-for-service being the main provider payment mechanism in the industry (World Bank Group, 2018).
Lack of central database or bargaining limits ability to move away from fee-for-service	Currently each insurer has service level agreement with providers, making it hard to control costs across the industry. An integrated information system could help with the development and roll out of true risk pooling mechanisms and strategic purchasing mechanisms such as capitation and Diagnostic Related Grouping (World Bank Group, 2018). **The better sharing of data via the IRA and a centralised database will also lower cost solutions to be discovered and implemented by the industry**
Steps to implement strategic purchasing	Key strategic purchasing actions in relation to providers: • Select (accredit) providers considering the range and quality of services, and their location. • Establish service agreements/contracts. • Develop formularies (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines. • Design, implement and modify provider payment methods to encourage efficiency and service quality. • Establish provider payment rates. • Secure information on services provided. • Monitor provider performance and act on poor performance. • Audit provider claims. • Protect against fraud and corruption. • Pay providers regularly. • Allocate resources equitably across areas. • Implement other strategies to promote equitable access to services. • Establish and monitor user payment policies. • Develop, manage, and use information systems.

Overall recommendation	Suggested element or aspect to be included
	Key strategic purchasing actions in relation to citizens or population served: • Assess the service needs, preferences and values of the population and use to specify service entitlements/benefits. • Inform the population of their entitlements and Obligations. • Ensure population can access their entitlements. • Establish effective mechanisms to receive and respond to complaints and feedback from the population. • Publicly report on use of resources and other measures of performance. Key strategic purchasing actions by government to promote strategic purchasing: • Establish clear frameworks for purchaser(s) and providers. • Fill service delivery infrastructure gaps. • Ensure adequate resources mobilised to meet service entitlements. • Ensure accountability of purchaser(s). (Busse, 2014) **Although many of these suggestions are addressed in the policy proposals, cooperation with the KMPDC and changes to the Health Act is needed to ensure that all these can be implemented**
Steps to implement strategic purchasing (2) – standard treatment guidelines (DRGs)	Strategic purchasing actions for the Government-Purchaser relationship • The government should have policy and legislative frameworks for purchasing activities. • The government should ensure the accountability of purchasing organizations. Strategic actions for the Purchaser-Provider relationship • The purchaser should choose and contract health service providers based on their capabilities including the services offered and their geographical location.

Overall recommendation	Suggested element or aspect to be included
	• The purchaser should establish mechanisms to ensure service quality including formularies, standard treatment guidelines and essential drug lists. • The purchaser should utilise provider payment mechanisms to incentivise efficiency, service quality and promote equitable access. Strategic purchasing actions for the Citizen-Purchaser relationship: • The purchaser should develop benefit packages based on an assessment of the needs, preferences and priorities of the target population. • The purchaser should establish mechanisms to obtain and respond to complaints and feedback from the population. (Munge *et al.*, 2018)
Avoiding Capitation and use DRGs	The data outlined above suggest that capitation may not be the best strategy if both the NHIA (in Ghana) and NHIF hope to reach low-income patients with affordable Health care. While this system may be easier to manage on the government end and should generate higher quality Health care through increased competition, in reality we found that small private providers struggled to understand and implement a system of financial risk pooling within their own facilities, often charging patients on top of their SHI coverage as a result. However, patients were rarely aware of which charges were appropriate and which were not, and SHI officials did not appear to monitor these practices. These findings align with other findings that capitation works best in a health system with a well-functioning and agile bureaucracy that can effectively monitor program implementation. Other forms of purchasing, such as the Diagnosis Related Group (DRG)-based payment system currently found in Ghana, may be a more effective way for government to purchase health services from private providers in such a scenario. A DRG-based payment system creates more efficiencies than a fee-for-service payment option while also allowing risk pooling at the national level, where it can best be managed (Suchman, 2018).

Overall recommendation	Suggested element or aspect to be included
	The use of DRGs is a critical component the policy proposals and is expected to make a significant impact on the purchasing by PHIs and the NHIF.
Use of Capitation and need to make calculation process public and the use (DRG) for purchasing	Capitation was guided in part by the likelihood of over-servicing that theoretically results from fee-for-service and per diem payments. While evidence from interviews suggested the use of costing studies and actuarial analysis of NHIF utilisation data in developing capitation rates, these analyses were not in the public domain and it was unclear whether their development included stakeholders. The result was that providers, particularly private ones, were reluctant to be contracted to provide services to the NHIF owing to the low capitation rate which they felt could not cover the cost of care (Munge *et al.*, 2019). Most recommendations suggest that Kenya moves towards a strategic purchasing approach (such as the diagnostic related groups or DRG) rather than a passive purchasing approach. A strategic purchasing approach will help "enhance the equity, efficiency and quality of Health care service delivery" (KEMRI Wellcome Trust , 2019). **Consistent with the recommissions above, the policy proposals encourage better reporting and the greater use of DRGs. This will help ensure that customers are not billed for unnecessary procedures, which will increases costs and can result in higher out-of-pocket expenses**
Use of Co-payments	Modest co-payments are necessary in order to curtail overuse of medical services, as shown in the various country case studies contained in this study. In some cases, it is important to set the level of co-payment differently across medical care institutions to curb the concentration of medical services in large urban hospitals (Kimani, Muthaka and Manda, 2014). **Co-payments will still be allowed but is not a central policy proposal**
Inefficiencies in the current Empanelment of health	- Select hospital panel by using data analytics to reduce overcharging and fraud - Standardised data provided by providers will allow better comparisons between providers on costs and service standards - Need real-time analytics to compare a claim against average cost of treatment and length of stays per disease

Overall recommendation	Suggested element or aspect to be included
providers reduced through better use of data	(Association of Kenyan Insurers, 2018) **Policy proposal require better data collection, report and then communication of the quality of care by providers to the public. This will allow the public to make more informed decisions on which provider to use.**
Cost containment	Explore the use of medical savings accounts and co-payment as methods to contain costs associated with outpatient services. These measures increase awareness of healthcare costs for covered lives. They also noted the move towards preventative healthcare and encouraging healthy lifestyles as a viable cost containment measure (Association of Kenyan Insurers, 2018). **Medical savings accounts can be introduced in the future but are not part of the current policy proposals.**
Use of independent claims administrators	Use of independent claims administrators in India has assisted in standardising and improving the data quality in the industry (Association of Kenyan Insurers, 2018). **Policy proposals include the licencing and regulation of Third party claims assessors by the IRA.**

6.2.5. Accreditation and Quality Assurance

Quality assurance plays a critical role in improving access to quality health care through enforcing the standardisation and quality of care which in turn results in increased uptake of health insurance products.

A key requirement identified for successful strategic purchasing is the accreditation of healthcare providers. Accreditation is currently being done separately by the NHIF and private health insurers, which have resulted in different standards and a lack of the required access in certain geographical areas. An independent and reliable accreditation system is required to support a referral system and reduce the monopoly power of the leading providers. The Accreditation should also be done separately from the NHIF to allow the PHIs develop independent providers and referral systems. These recommendations dove-tail with recommendations made earlier for the management of the NHIF and strategic purchasing.

Table 43. Literature review recommendations concerning accreditation and quality assurance

Overall recommendation	Suggested element or aspect to be included
There are multiple accreditation standards, leading to uncertain standards and monopoly power by the leading providers.	There exist several modalities of quality assurance: 1. Accreditation of public health facilities by the NHIF in relation to the awarding of rebates to health facilities 2. Activities of the Kenya National Accreditation Services (KENAS) in relation to the accreditation of certifiers and laboratories are also voluntary processes. 3. Private standards such as ISO and SafeCare certification/accreditation of mainly private health facilities. (Wangia and Kandie, 2018) In 2013, the NHIF, with financial support from the IFC and technical support from the PharmAccess Foundation, introduced the SafeCare quality improvement system. to deliver safe and quality-secured care to their patients according to internationally recognized standards.

Overall recommendation	Suggested element or aspect to be included
	This differs from traditional quality assurance mechanisms that have a dichotomous approach to quality standards and hence allows small, poorly resourced health care facilities to implement a quality improvement plan with the goal of meeting the required standards for accreditation and contracting by the NHIF to provide health care services (Barasa *et al.*, 2018). There still lacks an industry-wide framework for assessing and implementing quality of care standards in the country. A few providers have adopted different mechanisms, with some of the leading hospitals adopting international accreditation such as Joint Commission International (JCI), ISO and Safecare. PHIs reported that the lack of this common framework has led to the perception that only top facilities provide high quality of care and hence further creating some form of monopoly for them (World Bank Group, 2018).
Independent Accreditation is needed separate from the NHIF	Need independent accreditation since the NHIF does not enforce standards. The NHIF contracting process undermined equity. It was reported that the rigorous 'accreditation' disadvantaged some regions, which were historically marginalized, thus undermining geographical access. However, there was documentary evidence of de-gazettement (effectively contract cancellation) of health facilities including publicly owned ones for not adhering to NHIF standards. We propose that the NHIF take urgent measures to review its quality assurance mechanisms, and in particular consider the incentives generated by its mix of provider payment mechanisms, monitoring capabilities and contractual requirements. (Munge *et al.*, 2018) Explore the possibility of making accreditation a semi-autonomous independent agency, separate from the various service delivery functions (Wangia and Kandie, 2018) Accreditation consists of four basic components: 1. Development of an accrediting organization; 2. Development of accreditation standards and the criteria to meet these standards; 3. Implementation of a survey process;

Overall recommendation	Suggested element or aspect to be included
	4. Incentives and disincentives (Suchman, 2018)
Use of referral system	While it's a positive trend that primary care facilities were utilized extensively, the county and sub-county health management should strengthen this level of care to reduce dependence of higher level facilities by e.g. ensuring allocation of resources according to need and demand (Ngugi *et al.*, 2017).
Accreditation should also impact Private Health Providers	Governments purchasing health services from private providers in Low and Medium Income Countries should determine ahead of time how much quality needs to be monitored depending on each private facility's level of independence; with increasing levels of autonomy, private facilities should be more closely monitored (Suchman, 2018).
Standardised coding requirements	Enforcing data standardisation by using of the following standard codes: o ICD codes provided by the World Health Organisation to categorise diseases; o Provider unique identifiers - consider the use of NHIF provider codes; o Unique national identifiers - consider use of national identification numbers; and o Medication codes (Association of Kenyan Insurers, 2018)
Insurers must publish provider performance lists and recommend providers to policyholders	In India insurers create preference rating of providers as a way to manage them. Their costs and quality of service determine if an insurer recommends a provider to a policyholder (Association of Kenyan Insurers, 2018).

6.2.6. Affordability and Prescribed Minimum Benefits and pricing controls

Affordability relates to one's ability to purchase or take-up a particular good or product (in relation to another good or product). Within the context of health insurance and UHC, affordability will determine uptake and utilisation. Affordability may fall outside of the scope of regulation and may not be regulated but rather, government could provide guidelines.

Table 44. Literature review recommendations concerning affordability, PMBs and pricing controls

Overall recommendation	Suggested element or aspect to be included
Premium subsidies for the poor and vulnerable to increase uptake	To improve uptake of health insurance products, the government should consider finding "innovative ways of financing premiums for the poor, elderly, people with disabilities, unemployed and those in the informal sector in a bid to leave no one behind. This can be done through specific allocation of general government revenue" (Mbau *et al.*, 2020). **The policy proposals do not include any government subsidies or support as the PHIs should be able to operate sustainable and independently from the Kenyan Government.**
What to exclude from PMBs	To maintain financial stability and appropriate standardisation of benefits, the health insurance programme should have some limiting conditions by excluding some items from coverage, such as treatment for simple fatigue, cosmetic surgery, treatment of addiction to narcotics, physical examination without any symptoms, bodily harm suffered while committing criminal acts or from intentional accidents, among others (Muthaka *et al.*, 2004). **The design of the PMBs will require a separate investigation but the cover should be limited to avoid increasing the cost of PHI unnecessarily, making it unaffordable for most of the population. Otherwise PMBs will defeat the purpose of helping PHI increase the total UHC coverage.**
Interaction between KEPH and PHI	In order to increase numbers of KEPH interventions being provided, the sector will scale up insurance arrangements, particularly for those interventions whose use is associated with catastrophic health expenditures. Coverages for these shall primarily be through social

Overall recommendation	Suggested element or aspect to be included
	health insurance mechanisms (restructuring of NHIF), with additional coverage assured through private health insurance mechanisms (Ministry of Health, 2018). PMB and NHIF's benefit package must be guided by KEPH: For example the KHP does not mention the NHIF at all, while the KHSSP limits its mention of the NHIF to specifying its mandate to "provide quality social health insurance" (Munge *et al.*, 2018). **The policy proposals require the PMB to be linked to the current NHIF benefit to ensure consistency between NHIF and PHI benefits. However, this can be changes in the future as benefits included in the KEPH and NHIF changes.**
Benefits to include	Almost all the product documents reviewed showed that care for HIV treatment was covered. However, there was varying coverage and limitations on services available for chronic diseases such as hypertension and diabetes which some product having some waiting periods. Some products also had waiting periods for coverage of maternity services. Dental and Optical services were treated as separate benefits and were not available for all products as they were considered to be associated with high costs of care (World Bank Group, 2018). **These give possible suggestions of what should be included as a PMB package**
Standardised Pricing is required	Price regulation does not exist in Kenya. However, the Kenya Medical Practitioners and Dentists Council (KMPDC) published in 2016 guidelines for fees to be charged for different services (Suchman, 2018) KMPDC has published recommendations on pricing of health services, there lacks documented evidence of consensus between PHIs and providers of these costs as well as documentation of legal enforceability of the prices care (World Bank Group, 2018) **The policy proposals support better cooperation between the PHI and the KMPDC and give recommendations of changes to the Health Act.**

Overall recommendation	Suggested element or aspect to be included
Reduce undercutting of premium rates in group medical insurance business	Publicise premium rates annually to mitigate under-cutting. This should emphasised competition based on service levels, rather than premium rates. (Association of Kenyan Insurers, 2018). **One way to reduce undercutting and emphasised competition based on service levels is by introducing a Risk Equalisation Fund. However, the policy proposals do not require this. The use of a Risk Equalisation Fund can be reconsidered in the future.**
Expand the market to 20-30 year olds	The regulator should do periodic pricing studies to monitor price in more detail as more granular data becomes available. Specifically focus on the need for targeted marketing to capture the untapped market of young adults aged 20 to 30 years old, as this group is highly underrepresented in the population of medical insurance covered lives (Association of Kenyan Insurers, 2018). **There are no specific recommendations covering this suggestion. However, the policy proposals try to avoid discouraging the 20-30 year target market from joining by allowing aged-based pricing to be applied.**

6.2.7. Collaboration between different regulators

Collaboration within the context of this project refers to the interaction between different players within the health sector. This collaboration can be between private and public sector or between various government departments within the health sector. This recommendation is tied to another deliverable within this project, namely, the collaboration framework.

Several key recommendations that fall outside of the scope of health insurance regulation will require cooperation with other regulatory entities. For example, the regulation and supervision of technical service providers (e.g. providers of payment platforms) in the health insurance value chain will require cooperation between the insurance regulator and the respective payment platform regulators or supervisory authorities to ensure sufficient oversight of the insurance value chain.

The collaborative framework will be further developed as part of the next phase of the project.

Table 45. Literature review recommendations concerning collaboration

Overall recommendation	Suggested element or aspect to be included
Facilitate various forums through which key stakeholders in the health sector can engage	• Establish a working group of NHIF, MOH and stakeholders to determine health insurance changes that accrue in the new Constitution and the Health care financing strategy that will be adopted for the health sector (Deloitte Consulting, 2011). • Develop public-private partnerships for private facility networking and contracting with the GOK and NHIF (Dutta *et al.*, 2018). • The IRA, under whose remit health insurers and insurance regulation fall, is answerable to the Ministry of Finance, with limited engagement, if any of the Ministry of Health (MOH). This arrangement potentially contributed to weak policy coordination between the IRA and the MOH. The intersection of financial and health sectors presents an opportunity for collaboration and coordination that would allow health insurers to contribute to health financing arrangements (Munge *et al.*, 2019). • Using evidence-based approach to engage with various stakeholders (Mwaura *et al.*, 2015).
Collaboration between PHIs and the NHIF in pursuing	In advancing UFC partnership between NHIF and PHIs is paramount. PHIs playing a complementary and supplementary role would serve to mobilize more resources towards UHC. This could be achieved by: • Designing a framework/platform to support dialogue and partnership between NHIF and PHIs.

Overall recommendation	Suggested element or aspect to be included
UHC (public private sector collaboration)	• Explore Synergistic and mutually beneficial partnerships to support achievement of UHC. • Establish a data sharing mechanism across the industry: both among the PHIs and with NHIF (CYGNUS, 2018). • Develop public-private partnerships for private facility networking and contracting with the [MOH] and NHIF (Dutta, Maina, Ginivan, & Koseki, 2018). • Inequities in health and access to care spring from complex socio-economic dynamics that are beyond the scope of health policies. Multi-sectoral approaches at the local, regional and national level are necessary to address the root causes of social inequity and reduce poverty and persistent disparities between socio-economic groups. To this end, the universal health coverage policy agenda should be embedded into a larger multi-sectoral collaboration (including both private and public stakeholders) focused on addressing the determinants of health and health equity (Ilinca *et al.*, 2019).
Multi-sectoral approach, in dealing with challenges that fall outside of the scope of health insurance	"Poverty-related determinants of infectious diseases such as malnutrition and under-nutrition, lack of access to safe drinking water and sanitation and inadequate availability of water for hygiene are pervasive in this poor rural community. Addressing these determinants will require a multisectoral approach between the county government, development partners and other stakeholders." (Ngugi *et al.*, 2017).
Sector wide collaboration to mitigate fraud (in supporting private health insurers)	There is need for sector-wide collaboration to mitigate against fraud amongst providers. This will involve: • Data sharing and analytics amongst PHIs as well as between PHIs and NHIF • Common standards and practices amongst providers • PHIs and their regulator to explore partnership with provider regulators (World Bank Group, 2018).
With regards to the NHIF	• Implementation of Government of Kenya NHIF Task Force (Dutta *et al.*, 2018) • Government through the MOH needs to embrace its stewardship role in health, while recognizing the multiplicity of actors given Kenya's devolved context. Relatively recent decentralisation reforms present an opportunity that should be grasped to rewrite the contract between the government, the NHIF and Kenyans in the pursuit of UHC (Munge *et al.*, 2018).

Overall recommendation	Suggested element or aspect to be included
With regards to supporting the broader health insurance regulatory and policy framework	Development and implementation of various health insurance regulatory or policy frameworks will require coordination across various sectors (Munge *et al.*, 2018).

6.2.8. Consumer awareness and protection

Consumer awareness is central to building trust and thus increasing uptake of insurance products. None of these recommendations are directly addressed by the policy proposals. However, the proposals do aim to improve trust and take-up of PHI.

Table 46. Literature review recommendations concerning consumer awareness

Overall recommendation	Suggested element or aspect to be included
Using simplified language to reach the low-income sector	There is a need to simplify the language used in communication of the benefit packages and adopt communication strategies that reach low-income, less educated, rural population groups such as visits to homes and public places such as markets and places of religious worship (Mbau *et al.*, 2020).
Using simplified language to reach the informal sector	"The idea of insuring against risk is not well understood in Kenya and this undermines the sustainability of the new scheme. Therefore, marketing and education to the informal sector is vital in order to encourage people to see the advantages of joining and for them to understand how insurance works" (Kimani, Muthaka and Manda, 2014)
In building trust	"The need for transparency and citizens' engagement in successful reform - availability of information and data to the public builds trust" (Mwaura *et al.*, 2015).

7. Health Insurance proposals

7.1. Introduction

This section of the report outlines the policy proposals for the development of a comprehensive health insurance regulatory framework for Kenya.

Each section explains in broad terms the impact of the proposals on the current legal regulatory framework and the changes that would be required to the legal and regulatory framework to implement the proposals. While many of the proposals can be fully implemented through amendments to the Insurance Act, the proposed new Health Insurance Regulations and circulars and guidelines issued by the IRA, some of the proposals will not be capable of implementation without the amendment of other non-insurance legislation and regulations. Although a more detailed assessment of the impact of the proposals and their implementation will be undertaken during the drafting stage of the legal and regulatory framework, once the final policy recommendations have been agreed, this Section provides a high-level indication of the legislation that will need to be amended for each proposal and the extent to which the proposal can be amended through circulars and guidance.

The Insurance Act will have to be amended to enable the IRA to make Health Insurance Regulations. The enabling power should be drafted to include the many issues that will need to be covered by the new Regulations. Where this section recommends that a matter should be covered in or provided for under the Health Insurance Regulations, care will need to be taken to ensure that the enabling power in the Insurance Act is sufficiently widely drawn to cover the matter.

As indicated in Section 3, circulars appear to us to have the status of guidelines. To the extent that the proposals require the imposition of enforceable obligations on insurers and insurance intermediaries, it would be preferable for these obligations to be included in the Health Insurance Regulations.

Several factors have been considered in forming these proposals. These are discussed briefly below:

- The proposals have been developed to assist Kenya in achieving the goal of UHC. An approach where both the NHIF and private insurers cover the population will assist Kenya to achieve UHC sooner.
- The current legal and regulatory framework have been taken into consideration. The proposals are designed to build on and supplement this framework rather than suggest its wholesale replacement. Building on the current framework will provide the IRA with the most efficient way to enable the development of private health insurance in support of UHC.
- Insurance penetration is relatively low with less than 2% of the population covered by private health insurance. The proposals have been designed to assist the IRA and insurers to expand the reach of private insurance to more segments of the population.
- The proposals take account of the need for the IRA to monitor compliance. Experience across several markets has shown than ease of monitoring is an important consideration as it reduces the financial and administrative burden on the regulator as well as the compliance cost to the industry.

- It is essential to ensure that the regulatory framework promotes the development of a sustainable and efficient health insurance market that is accessible to a wide range of consumers. Furthermore, the proposals take cognisance of the IRA's functions of protecting customers and the promotion of consumer confidence in the market. In addition to striving for UHC, these proposals aim to promote a fair, safe and stable insurance sector.
- Prior research undertaken into the Kenyan health insurance environment has been taken into account. Interviews and workshops with key industry players have been conducted to assist in the formation of these proposals.
- Global practices have been considered and the proposals incorporates the aspects of other health markets which is expected to improve the current regulatory framework.

7.2. Market structure and uniform definition of medical insurance

Proposal:

- **No changes are needed with respect to health insurance products sold into Kenya by foreign insurers on a cross border basis.**
- **Commence the process of bringing Community based health within the regulatory ambit of the IRA.**
- **HMOs should be licensed and regulated by the IRA as a new licence category.**
- **Third Party Administrators should be licensed and regulated by the IRA as a new licence category.**
- **Clarify the definitions of different classes of insurance. Medical insurance should remain a separate class within the General Insurance Business**
- **Continue with the process of bringing the NHIF within the regulatory ambit of the IRA.**

7.2.1. Foreign insurers

In summary, the current legal and regulatory framework restricts the sale of medical insurance into the Kenyan market:

- By prohibiting foreign insurers from carrying on insurance business in Kenya (s. 19 of the Act).
- By prohibiting registered insurance intermediaries (and other persons) from placing any Kenya business with an insurer not registered under the Act without the prior approval of the IRA (s. 20 of the Act).
- By requiring MIPs to apply to the IRA for approval of medical insurance business placed outside the country (s. 20 of the Act and Circular).

However, as indicated in Section 3, there remains the concern that these provisions do not adequately prevent or control the direct purchase of medical insurance by Kenyan employers or Kenyan residents. Section 3 sets out the consumer protection and market development concerns.

As indicated in Section 3, any prohibition against a foreign insurer will most likely be unenforceable. To be effective, control must be against persons within the jurisdiction of the Kenyan courts. The position with respect

to the purchase of individual medical insurance policies, is even more difficult. A policy may cover medical costs in more than one country or may be purchased when the resident is outside the country.

Because the number of foreign individual cover policies are not expected to be significant, it is currently not considered worthwhile to increase the regulatory requirements on the purchase of group and individual policies. If the use of foreign medical insurance for group insurance increases, possible recommendations could include:

- Expressly prohibiting a person from purchasing a group policy from an insurer that is not a registered insurer without the consent of the IRA.
- Given the consumer protection concerns, any purchase of group medical insurance should be placed only through a registered insurance intermediary and should be subject to Kenya law.

Therefore, no changes are recommended to the current Insurance Act or Regulations

7.2.2. Community-based health insurance

As discussed in Section 3, community-based health insurance schemes are not currently regulated and supervised as insurers or insurance intermediaries. The IRA therefore has very little information on their numbers, the amount of risk pooled within the market or on how they operate. As it would be impracticable to bring all community-based health insurance within regulatory scope straight away, a phased in approach is recommended.

As a first step, it is recommended that all community-based health insurance schemes should be required to register with the IRA. It is expected that at this stage registration would be a notification process rather than an approval process.

This would enable the IRA to require all community-based schemes to report to the IRA, which would provide the IRA with the information it needs to better understand the impact of the schemes on the market and how they should be regulated and supervised.

Given that community-based health insurance schemes most likely do not fall within section 19 of the Act as they do not "carry on insurance business", this would require an amendment to the Act. It is expected that the amendment would be straightforward, requiring all community-based health insurance schemes to notify their existence to the IRA. The Act would also be amended to enable the detailed regulatory regime to be set out in Regulations[3]. At this stage, the Regulations would extend only to reporting obligations.

In the future, consideration could be given to extending the Act to convert the registration process from a notification regime to a licensing regime and to extending the Regulations to provide for the proportional regulation and supervision of community based schemes. The need for regulations could be made dependent

[3] Community-based health insurance could be covered either through separate Regulations or through a separate Part in the Health Insurance Regulations.

on the size of the community based schemes, either based on the size of their membership of value of the funds they administrate. The Regulations are expected to include:

- Prudential requirements, including governance.
- Requirements concerning the safeguarding and handling of funds, which could be based on those applicable to MIPs.
- The registration of smaller community-based health schemes as micro insurers and setting the thresholds which would trigger a requirement for a community-based health scheme to register as a micro insurer, with reduced prudential and other obligations.
- Requirements for schemes to obtain medical insurance on a group basis to cover their risks, effectively converting them to intermediaries.
- Market conduct requirements

The Regulations would be supported by circulars and guidelines.

7.2.3. Health maintenance organisations

As discussed in Section 3, HMOs carry insurance risk but are currently outside the regulatory ambit of the IRA. They are currently regulated by the Ministry of Health.

The business undertaken by an HMO is viewed as so different to the business of a commercial insurer, that it would not be appropriate to require HMOs to register as insurers. Therefore, the creation a new category of HMO licence is proposed. All HMOs would be required to register as HMOs and a new regulatory regime tailored to HMOs would be established.

This would require amendments to the Insurance Act to create the new category of licence, provide for the application process, set out high level obligations and enable the detailed requirements to be specified in regulations issued by the IRA (HMO Regulations). In summary, all HMOs would be subject to consumer protection and funds handling obligations, and those HMOs that carry insurance risk would be subject to additional prudential requirements focussed on capital adequacy and solvency.

It is recommended that the HMO Regulations include the following:

- Application process and requirements.
- Capital and solvency requirements, unless an HMO transfers its insurance risk to a registered insurer.
- Governance and reporting requirements.
- Requirements relating to the administration of the HMO’s business and its interface with registered insurers.
- Consumer protection requirements (that in some respects would mirror those applicable to registered insurers but would include additional requirements appropriate for the HMO business model).

The Regulations will be more fully developed during the drafting phase.

Requirements with regards to the provision of capitated fee structures to insurers are described in section 7.9.

7.2.4. Third party administrators

As discussed in Section 3, third party administrators fulfil an important function within the health insurance market and should therefore be regulated and supervised by the IRA.

It is recommended that a new category of intermediary licence is created to cover the activities of third-party administrators. This will require amendments to the Insurance Act to define "third party administrator", to include third party administrators within the definition of "insurance intermediary", to specify the activities permitted that a third party administrator is entitled to undertake, to ensure that third party administrators are covered by other sections of the Act that apply to insurance intermediaries (as appropriate) and to enable the detailed requirements to be specified in regulations issued by the IRA and circulars and guidelines.

The IRA has issued guidelines to the industry with regards to claims management with the aim of enhancing efficiency, transparency, disclosure of information to policyholders during claims processing, the protection of data and increase consumer satisfaction. These guidelines could be adjusted and strengthened and issued as Regulations applicable to third party administrators. This would also enable to IRA to enhance policyholder protection by developing a clear understanding of the services provided by Third Party Administrators and the impact on medical insurance. Regulations could also stipulate maximum administration charges that may be levied by third party administrators.

7.2.5. Clarify definition of medical insurance business

As a short-term (annual) policy, it is recommend that medical insurance remain a class of General Insurance business. However, the reporting and risk-based capital requirements should be expanded to reflect the specific requirements of this class of business, as set out in section 3.5.11 and Section 7.7.

In order to remove any scope for ambiguity and uncertainty, it is recommended that the classes of health and disability products that may be provided by Long Term and General insurers be clearly defined to ensure that there is clear demarcation from medical insurance products that are offered under general insurance. Examples of definitions are provided in section 4.16.

7.2.6. NHIF

As mentioned in Section 2.1 the Insurance (Amendment) Act No. 11 of 2019 amended the definition of insurance business to include social insurance schemes. Although the term "social insurance scheme" is not defined in the Act, the amendment is intended to provide for the regulation and supervision of the NHIF, which is characterised as providing social insurance business. The IRA should continue with its work on the development of regulations for the registration and supervision of social insurance, which will include a definition of social insurance and bring the NHIF into the ambit of the IRA.

7.3. Participation, minimum benefits and coverage limits

Proposal:

- **Implement open enrolment where insurers are mandated to accept all lives who can afford cover.**
- **Insurers should only offer Indemnity cover with co-payment and benefit caps. Stated-benefits cover should not qualify as health insurance products.**
- **Implement a prescribed minimum benefits (PMB) package for all health insurers.**
    - **The NHIF benefits could be used as a starting point for the PMB package.**
    - **The PMB package should be refined around the burden of disease and impact on affordability.**
- **There should be provision for regular review and amendment to the PMB package to adjust for changes in affordability and the overall disease burden.**

Participation in an insurance market as well as risk management are concepts which go hand in hand. It is important to ensure that access to the insurance market as well as risk management are considered in a manner which allows expanded coverage as well as adhering to general insurance principles. Although these proposals will likely increase the cost of the benefits for - and therefore premium required by – insurers, it will increase the trust and accessibility of health insurance, which in turn will increase take-up rate of health insurance.

7.3.1. Open enrolment

Insurers are currently free to decide whether or not to sell an insurance policy, of any type, to a particular prospective policyholder. This enables an insurer to decline cover if it considers that the risk is too high or otherwise does not fit within its underwriting criteria. Alternatively, insurers can provide cover at a premium or on terms that, from a practical perspective, amount to a declination of cover. In the context of health insurance, this is likely to result in the exclusion of older and high-risk policyholders.

Consideration was given to both open enrolment and mandated cover (described in section 4.5). Within Kenya, NHIF cover is already mandated for those employed in the formal sector. Additionally, a large portion of Kenya's workforce is in the informal sector which may restrict the ability of the regulator to enforce mandated cover. The policy proposal is therefore that open enrolment and not mandated cover should apply to private medical insurance.

Although open enrolment will apply only to registered insurers who have voluntarily submitted to the regulatory regime, open enrolment is such a significant interference in the contractual rights of an insurer, that it should be mandated in the Insurance Act, with the details specified in the Health Insurance Regulations.

As indicated above, the regulations would need to protect against insurers circumventing the open enrolment requirements by setting unreasonably high premiums or specifying unattractive policy terms so as to dissuade prospective policyholders that the insurer does not wish to cover from purchasing a policy.

7.3.2. Indemnity cover

Insurers should only offer Indemnity cover type products. Insurers can require co-payments and apply benefit caps to individual or overall treatment types and exclude certain types of medical treatment or procedures to reduce their risk, and the expected claim amounts. However, insurers should also implement better strategic purchasing to better manage the cost of their claims instead of just relying on benefit caps.

Future regulations could potentially require the removal of some or all benefit caps to ensure that out-of-pocket expenses are minimized and UHC is fully achieved .

Stated benefits cover products should not fall under the medical insurance class of business, as explained in section 7.2.5.

7.3.3. Prescribed minimum benefits (PMB)

It is proposed that prescribed minimum benefits should be put in place. These would ensure that all medical insurance policies provide a certain specified minimum level of cover.

The need for defined minimum benefit packages and insight into the potential structure of such benefits was highlighted in various pieces of literature including Munge *et al.* (2019) and Muthaka *et al.* (2004).

The design of the actual PMB package must minimize the drawbacks which can accompany PMBs as described in section 4.6. Most notably, that PMBs set a price floor for insurance products and in doing so set a boundary on those persons who can and cannot afford medical insurance. This is a crucial point given the low level of health insurance coverage in the lower income levels in Kenya as highlighted in section 2.3.3.

Individuals are likely to perceive the NHIF benefit package as a minimum level of benefit and the IRA may consider this as a starting point for the creation of the PMBs. It is suggested that the PMB package place greater focus on primary care considering the impact PMBs have on affordability and the cost of cover. An alternative to using the NHIF benefits as a basis PMB is using the KEPH, as discussed by Munge *et al.* (2018) and Ministry of Health (2018) in section 6.2.6.

UHC can be achieved through the use of one monopsony fund and private insurance as top-up cover or alternatively through using a combination of national and private medical insurance. The implementation of PMBs linked to the NHIF benefit package would result in the latter approach being taken.

It is considered that the Insurance Act enables prescribed minimum benefits to be required through Regulations, without the need for amendment of the Act itself. The Regulations should be updated from time to time to account for changes in disease burden and affordability levels. It is not considered appropriate for PMBs to be covered though a circular.

7.3.4. NHIF Opt-out

Based on the interviews with industry stakeholder, the understanding of the future development with regards to the NHIF and UHC is that the NHIF will provide supplemental coverage to a base UHC. This has impacted the proposal that a combination of national and private medical insurance would then be used to achieve

improvements in UHC. Given this approach as well as the mandated NHIF cover for individuals who are formally employed the option to opt-out of the NHIF may be required. Section 4.15 sets out factors that should be taken into account when deciding on whether or not to allow for opt-out of NHIF.

As described in section 5.5, German medical insurers can provide cover that is substitutive for social health insurance (SHI) as well as supplementary and complementary insurance for SHI-covered people. Individuals are allowed to opt out of the SHI but have to purchase substitutive private medical insurance coverage. If moving from social to private insurance, limits on general waiting periods and specified limits on coverage exclusions for certain conditions apply. There are also a number of rules governing the ability of individuals to opt back into SHI to protect the SHI risk pool.

Gitonga (2012) and the World Bank Group (2018) suggested the use of an opt-out option with social tax on premiums should insurers provide similar benefits to mandated social health. An opt-out option may also help to address the insurers concern with regards to ensuring the NHIF are billed for the part of the claim that relates to their coverage, instead of having the private insurer pay the full claim amount as highlighted by Association of Kenyan Insurers (2018).

Individuals may however choose to "stay in" the NHIF on a voluntary basis even if they are allowed to opt out of the system. To protect the NHIF risk pool, there needs to be clear criteria specifying both when individuals are allowed to opt-out as well as when they would be allowed to opt back into the NHIF.

A NHIF opt out option would have to be included in primary legislation and could not be covered in subsidiary legislation alone. There are two possible options. The first option is to provide for the opt out in the National Hospital Insurance Fund Act. Alternatively, the option could be included in the Insurance Act. Given that the opt out would primarily impact the NHIF, it is considered preferable that the opt out be included in the National Hospital Insurance Fund Act.

7.4. Premium and underwriting rules

Proposal:

- **All benefit options should be approved by the IRA. The IRA currently requires this for retail products but due to the proposal in section 7.6.2 this requirement now includes both group and retail products. This also covers the marketing material, as explained in section 7.8.1.**
  The product approval process would include submission of the following data:
  - **Demonstration of financial sustainability of the option as well as the entire book.**
  - **Demonstrate the impact benefit design changes are expected to have on the option and insurer.**
  - **Demonstration of sufficient capital to sustain the option.**
  - **Demonstration of adherence to PMB's.**
  - **Actuarial certification by a qualified fellow with the requisite skill to perform the work.**
- **Engage with Actuarial and Insurance professionals to provide professional guidance on actuarial and insurance certification of new options.**

- **Mandatory regular reporting to the IRA on the performance of options and groups. The IRA should have the power to enforce corrective measures on market players who are setting unreasonably low premiums.**
- **Insurers should be allowed to risk rate based on age however maximum differences between the highest and lowest premium rates between lives on the same product should be introduced. The initial recommendation is a 200% differential between the highest and the lowest rate.**
- **No premium loadings are allowed for any condition identified during the underwriting process to support the principle of open-enrolment proposed in section 7.3. The benefit caps, co-payment amounts, and exclusions cannot vary based on the underwriting outcome. Any benefit caps should reset on policy renewal and excessive claims in one year cannot impact the maximum claims allowed in a following year.**
- **Insurers should be allowed to apply reasonable general waiting periods. A three month general waiting period is recommended.**
- **Insurers should be permitted to apply condition specific waiting periods which are clinically appropriate for the specific condition e.g. 9 months for pregnancy. However, these waiting periods should not exceed 24 months. No lifetime waiting periods may be implemented.**
- **While waiting periods on maternity benefits may be imposed, a new-born (even if born prematurely) must be immediately included as a dependant under the policyholder.**
- **Insurers should not be permitted to apply lifetime exclusions or impose waiting periods on PMBs and the underwriting of PMBs at policy inception or renewal should be prohibited. Benefit caps or exclusions that apply to the normal benefit cannot be applied to the PMB.**
- **An insurer may not impose new waiting periods if the policyholder confirms that:**
    - **The policyholder previously had a policy with another insurer within the last three months of applying for new cover; and**
    - **The policy benefits under that previous policy provided cover in respect of similar risks relating to the same lives insured as those covered under the new medical insurance policy; and**
    - **The policyholder had completed the waiting period in respect of that previous policy.**
- **An insurer underwriting the new policy may impose a waiting period equal to the unexpired part of the waiting period under a previous medical insurance policy if:**
    - **The waiting period of the policyholder or member under the previous policy had not expired at the time that the policyholder enters into the new medical insurance policy; and**
    - **The new policy provides cover in respect of similar risks relating to the same lives insured as those covered under the new medical insurance policy.**
- **Condition specific waiting periods can be carried over when consumers move from one insurer to another subject to the same conditions specified for general waiting periods above.**
- **There should be guaranteed policy renewal for all policyholders.**

All of the above proposals, explained in more detail below, can be accommodated in the new Health Insurance Regulations or in circulars, as indicated under the specific proposals below. As indicated in section 7.1, the Insurance Act will first have to be amended to enable detailed Health Insurance Regulations.

It is noted that there are few provisions in relation to group insurance contracts generally. These will need to be covered in more detail in the Health Insurance Regulations as they relate to medical insurance.

7.4.1. New products and current benefit options

In order to assist the IRA to perform this role, it is proposed that health insurance products require sign-off from a qualified actuary who is sufficiently skilled to perform the work as well as IRA approval before it may be sold. This would require current and future products in the market to be evaluated by an actuary and for a formal report to be submitted to the IRA for approval. The requirements and standard of the annual report to be compiled by the actuary should be established by the IRA with the input from the local actuarial and insurance profession. As this is part of the approval process, it could be covered in a circular.

7.4.2. Annual sustainability reporting

Insurance companies are required to provide the IRA with product performance reports for at least three years after the approval of new or repackaged products. Additionally, the Appointed Actuary is required to annually submit a FCR which includes an assessment of the adequacy of premiums charged. The FCR also includes an assessment of whether expected future profitability arising from the assessment of premium adequacy is materially in line with the insurer's plans.

It is recommended that the detail of the future profitability assessment included in the FCR should be at a sufficiently granular level to demonstrate the long-term sustainability of all medical insurance products and options with reasonable premium increases. This will require reporting in sufficient detail such that the regulator can evaluate the long-term sustainability of each of the medical insurance products an insurer sells. The IRA should have the power to enforce corrective measures on market players who are setting unreasonably low premiums. As a reporting requirement, this can be covered through an amendment to the reporting templates and a circular.

7.4.3. Risk rating

Currently, Kenyan medical insurers can underwrite and price premiums on any number of risk factors. This is a contributing factor to the low health insurance coverage within Kenya. The increases applied to premiums to account for old age and chronical illness are particularly detrimental to the improvement of health insurance coverage. For example, individuals who have been covered by an insurer for many years should not be forced to resign cover due to increasing premiums as they age (Association of Kenyan Insurers, 2018).

As described in section 4.5.2 there are benefits to risk rating. However, the ideal system lies between the two opposing concepts of risk rating and community rating in a system where cross subsidisation is allowed. It is therefore recommended that risk rating by age be allowed to continue. To allow for cross subsidisation between younger and older lives it is proposed that a maximum difference between the highest and lowest premium

rates between lives on the same product should be introduced. The main aim of this regulation is to prohibit exorbitantly high premium increases for older individuals such that they are forced to lapse medical insurance coverage. The differentiation between highest and lowest premiums is generally around 600%. The differentiation between lives in-between these extremes is roughly 400%. The initial recommendation is therefore a factor of 200%, half-way to the differentiation ignoring the extremes. This is a very judgemental factor and should be chosen to allow for enough cross-subsidisation while allowing companies to still apply risk management. Therefore, this factor should be reviewed in the future based on the success achieved in making health insurance more affordable to older lives.

As risk rating will only be allowed based on age insurers will have to utilise further underwriting tools, effectively, to efficiently manage the pool of lives. The implementation of the risk equalisation fund will help to spread the risk of poorer lives, which would previously have been risk rates, among the various insurers.

Risk rating will need to be covered in the Health Insurance Regulations.

7.4.4. Underwriting, waiting periods & exclusions

While underwriting is meant to serve as a tool for insurers to better assess and equitably price the risks they are insuring, in the context of health insurance this can become a barrier to improving insurance coverage. This in turn hinders progress towards achieving UHC as insurers can at times exclude the elderly and people in poor health. Minimum requirements should be imposed on health insurers with respect to underwriting potential policyholders for the purpose of pricing, the extent to which exclusions and waiting periods on benefits can be imposed, how underwriting may operate when policyholders transfer between insurers and what penalties insurers can impose on high-risk individuals or individuals where the risk is uncertain.

Benefit caps and co-payment amounts can also not vary depending on the underwriting outcome of policyholder and should be the same for all policyholders with the same benefit plan. If the benefits are limited to a certain amount per year, this limit must be reset the following year to ensure the policyholder's cover continues. PMBs aim to ensure that policyholders have continuous healthcare for the prescribed benefits. As a result this means that even if a policyholder has reached their annual benefit cap the medical insurer has to pay for the treatment of PMB conditions.

In particular, insurers should only be permitted to impose waiting periods on benefits where the potential policyholder has no history of prior medical insurance coverage or where they have a lapse in cover of three or more months. The reasoning of not allowing waiting periods before three months of cover have lapsed is to give consideration to policyholders lapsing cover for a brief period due to affordability issues (e.g.: retrenchments or a sudden loss of income). Furthermore, it is unlikely that an individual would be able to select against an insurer within a three month timeframe by lapsing and then purchasing cover in the subsequent month.

The purpose of allowing the insurer to impose a waiting period is to give the insurer a mechanism to prevent anti-selection. A three month general waiting period is a generally accepted global standard. A waiting period on all benefits longer than three months may be detrimental to both the insurer and policyholder. A potential

policyholder (without prior coverage) could perceive lengthier waiting periods as eroding the value of purchasing cover and hence insurers may experience significant difficulty in attracting previously uncovered lives. This would impede progress towards UHC.

Health insurers should be permitted to set condition specific waiting periods on individual policyholders who have no prior health insurance coverage and should be subject to a medical evaluation when purchasing cover. This is to discourage individuals from seeking cover only when they are much more likely to claim and conversely it encourages individuals to purchase medical insurance coverage as early as possible. Condition specific waiting periods should only be imposed up to a maximum of two years as it is unlikely that future medical treatment can be planned for such a lengthy period of time.

While medical insurers may be allowed to impose waiting periods on maternity benefits (subject to the defined list of PMBs), insurers should not be allowed to impose any restriction on the benefits new-borns may access as described in section 4.5.3. This is irrespective of whether a new-born is born prematurely or not. All new-borns should automatically be registered as dependants under the policyholder's policy from the month of birth. Policyholders should also be allowed a grace period of 30 days to formally register their new-born as a dependant, with premiums being payable from the month after birth.

Lifetime exclusions on any benefits should be strictly prohibited. Additionally, insurers should not be allowed to impose waiting periods and exclusions on PMB claims.

The above proposals will support the portability of policyholder benefits between insurers, are commended by World Bank Group (2019).

Given their impact on policyholders, it is recommended that the requirements concerning waiting periods and exclusions should be set out in the Health Regulations. In order to enable enforcement, minimum underwriting requirements will need to be set out in the Health Insurance Regulations, but these can be amplified in Guidelines issued by the IRA.

7.4.5. Late joiner penalties

As described in section 4.5.4, late joiner penalties should be applied if the insurer cannot apply risk rating and vary the premiums by age. Given the proposals to continue to allow the use of age rating as well as the introduction of the risk equalisation fund, the proposals do not require the introduction of late joiner penalties.

7.4.6. Policy renewal

Within this framework policyholders should be able to assume guaranteed annual renewal of their insurance products. This is in line with the concept of open enrolment. Furthermore, insurers should be prohibited from underwriting PMBs upon policy inception or renewals but they may adjust premiums considering past claims experience of the insurer and the benefit option. Changes and shifts in underlying risk when individuals are moving between insurers should be covered within the risk equalisation fund. Therefore, the claims experience of a member cannot impact the level and type of cover received in a following year, including benefit caps or co-payment requirements.

In order to ensure enforcement, it is recommended that policy renewals should be included in the Health Insurance Regulations.

7.5. Risk sharing mechanisms

Proposal:

- **A risk equalisation fund should be established and managed by the IRA.**

A medical insurance environment which prescribes open enrolment also needs a mechanism for risk equalisation between medical insurers in the market. As set out in section 5, both the Netherlands and Germany have used risk equalisations funds as part of their efforts to improve UHC and promote competition based on the quality of care and innovation of products.

The risk equalisation calculation should be completed on an annual basis and should be derived so that insurers with good risk contribute into the fund and insurers with poorer risk draw from the fund. The risk equalisation fund should only apply to the experience of the PMB component of the medical insurance product.

For the reasons specified below, the establishment and management of the equalisation fund must be provided for in the Insurance Act:

- A risk equalisation fund would significantly impact the property rights of insurers as funds that one insurer is entitled to under law could be transferred to another insurer;
- As the Fund would be managed by the IRA, the establishment of the Fund and the principal obligations and duties of IRA in relation to the Fund cannot be included in regulations issued by the IRA itself.
- The exact formula used to apply the risk equalisation should still be finalised once the details of the PMB are finalised.

However, the detailed rules and requirements, so far as they are imposed on insurers, and details of the risk equalisation calculation can be included in the Health Insurance Regulations. Any functions, obligations, duties or powers of the IRA must be included either in the Insurance Act or in Regulations made by the Minister.

The IRA should be given the discretion to decide when to activate the use of the risk equalisation fund. It will only be required if the IRA determines that insurers are not competing on quality of care and innovation but instead on targeting lower risk policyholders.

7.6. Benefit design

Proposal:

- **Permit insurers to reject claims made outside referral pathways, provider networks, policyholder elected GPs, pre-authorization processes, managed care and treatment protocols.**
- **All policyholders should have access to the same policy options and be included in the same risk pool, i.e. group benefit and individual product offerings and prices should be standardised across the insurer and form part of the same risk pool.**

Consumer confidence and understanding of health insurance has been identified as a contributing factor to low private medical insurance coverage. This may be attributable to the complex nature of medical insurance products. The Association of Kenyan Insurers (2018) report indicated that out of hospital consultations and services have been a contributor to some of the overall poor financial experience of the sector.

Given the impact on policyholders and to enable enforcement, these matters should be included in the Health Insurance Regulations.

7.6.1. Referral pathways, networks, managed care protocols and treatment protocols

Claims expenditure and cost control is a key aspect of improving the affordability of health insurance coverage. The reliance on higher levels of care without adequate referral processes is a contributing factor to the high cost of healthcare in the country. There needs to be efficient rationing of healthcare resources and to achieve this, the IRA should require health insurers to implement claims management protocols such as clinical referral pathways into their benefit design. Insurers should only allow policyholders to access higher levels of care (such as specialist and in-patient benefits) when referred by a primary care provider. This makes exception for emergency medical conditions. Failure to comply with appropriate referral pathways may result in a claim not being paid. Additionally, insurers should be expected to demonstrate that in-patient benefits are managed through a pre-authorization process. A gatekeeping system for benefits more comprehensive than primary care is expected to reduce unnecessary utilization of costly benefits which will in turn reduce the premium insurers need to charge to cover the cost of healthcare.

Insurers should also be permitted to use managed care protocols, provider networks, treatment protocols and policyholder elected GPs. Similar to referral pathways, insurers should be permitted to reject claims made outside of these systems. However, should insurers opt to implement strict provider networks and reject claims outside of the stipulated care protocols, they should have to provide sufficient evidence that their product is generating savings compared to a traditional product with the same benefits.

The development of treatment protocols and clinical referral pathways should be done in collaboration with the KMPDC taking into account guidance provided by the council and its members.

Although the proposals could be implemented by imposing requirements on insurers to include appropriate terms and conditions in their medical policies through regulations or other subsidiary legislation, given the significant impact on policyholders, it would be preferable for this to be enabled in the Insurance Act, the detail being included in the Health Insurance Regulations.

7.6.2. Standardised product offerings across insurers

As described in section 2.3.3, roughly 90% of medical insurance business is sold as group cover. This has resulted in many insurance products being tailored for specific groups. While this has the benefit of creating products which cater to the specific needs of individuals, it results in further complicated medical insurance products and increases the regulatory burden of supervising these products. This also results in a larger number of smaller risk pools within companies, i.e. different risk pools for separate groups as well as retail business.

It is therefore proposed that the same medical insurance product options should be available to groups as well as retail policyholders and all lives on similar options (irrespective of group or retail policies) should be pooled together. This will allow for the creation of larger risk pools and improve cross-subsidisation over the market. Therefore, groups should not have access to bespoke benefits and not have separate prices from those assessable to the public. This will encourage insurers to compete for group business through customer service and not through undercutting of prices, as recommended by Association of Kenyan Insurers (2018).

A number of different pieces of literature highlighted the need to avoid too many risk pools and the associated diseconomies of scale introduced by fragmented risk pools. Gitonga (2012) provided an example of organizing various risk pools into uniform groups to ensure efficient administration and underwriting. This was echoed by the World Bank Group (2018) which suggested the restructuring and some form of consolidation to form larger more efficient and sustainable risk pools. The suggested pooling of group and retail products is expected to achieve these recommendations.

The requirement to standardise group and individual policies can be relaxed once the market grows sufficiently in size to ensure that the underlying risk pools can be separated without diseconomies of scale impacting the profitability of insurers. This is likely only possible once the IRA has certainty that the underwriting income is profitable and sustainable across the medical insurance industry.

As discussed in Section 3, the IRA already provides guidelines regarding insurance products and the pricing of insurance products. These would need to be expanded to include medical insurance policies, which the IRA has already started working on. This recommendation can, therefore, be implemented without the need for amendment to the Insurance Act or for specific Regulations.

7.7. Financial soundness and regulatory supervision

Proposal:

- **Enhance the current annual reporting requirements to include a budget for the next period.**
- **Quarterly reporting should be enhanced to include reporting of monitoring the membership size of insurers and product as well as changes in the risk profile of products.**

Financial soundness and long-term sustainability are an essential part of a functional regulatory framework. The regulator should evaluate the financial position of medical insurers as well as the long-term financial sustainability. There has been a concern that certain players have been undercutting premiums in a manner which is not sustainable. The regular reporting and demonstration of financial soundness is expected to restrain market players from engaging in such practices.

The proposals relating to additional annual and quarterly reporting can be readily implemented by expanding the current reporting requirements and do not need additional Regulations or amendments to the Insurance Act.

7.7.1. Annual submissions of financial sustainability

In addition to current annual Financial Condition Reporting requirements, it is proposed that annual submission should also include a proposed budget for the following year reflecting expected premium, claims, investment income and expenses on which the premium calculations were based, as well as a justification of the budget based on the actuarial report.

The expectation is that the submission will assist the regulator to assess the financial performance as well as financial sustainability of medical insurers. As this is an addition to the current FCR reporting requirements, it is recommended that it is provided for in one or more circulars issued by the IRA.

7.7.2. Quarterly submissions for regular monitoring

Given the dynamic nature of the medical insurance market, it is recommended that, in addition to the quarterly reporting, the requirements should be enhanced to assist the IRA in monitoring the membership size of insurers and products as well as changes in the risk profile of products. The requirements are set out in section 4.18. This can be implemented through a circular, without the need for a change in the Insurance Act or the Regulations.

7.8. Policyholder protection mechanisms

Proposal

- **Require insurers to file marketing material with the IRA for approval along with the benefit design approval. The material should be simple for consumers to understand and signed off by a senior manager or a person with appropriate authority to whom the responsibility has been delegated.**
- **Intermediaries should be required to keep records of the advice they give.**
- **Insurers should be required to ensure that policy documents specify the complaint mechanisms available to policyholders.**

7.8.1. Marketing and marketing material

Mbau *et al.* (2020) highlighted the need to simplify language used in the communication of benefit packages and the adoption of communication strategies to reach low-income, less educated, rural population groups. Kimani, Muthaka and Manda (2014) also highlighted the importance for marketing and education to the informal sector to encourage individuals to take up medical insurance as well understand how it functions.

The benefits offered by medical insurers need to be transparent and as simple as possible for consumers to understand. This is not only important for the purposes of consumer protection and awareness but also to allow consumers to make comparisons across different products.

It is proposed that the marketing material used by medical insurers should be provided to the IRA for approval. Insurers need to ensure that marketing material complies with the standards of consumer protection and treating customers fairly set by the IRA. An insurer must have documented policies and procedures for the

approval of marketing material by a senior manager or a person with appropriate seniority to whom the senior manager has delegated the approval. As described in section 7.4.1, the final benefit design for a product (and changes in subsequent years) should have actuarial sign-off and be approved by the regulator.

It is recommended that a requirement to provide the IRA with marketing material on a file and use basis should be included in the Health Insurance Regulations.

7.8.2. Intermediaries

Intermediaries such as insurance brokers and MIPs act as sales agents for health insurance products. These parties provide financial advice to prospective policyholders and assist in choosing the most suitable health insurance products for individuals. They are currently operating under the regulation and guidance of the IRA. Currently, intermediaries have to meet extensive criteria in order to register to conduct business. This includes but is not limited to having sufficient capital, business-plan, a degree or diploma in insurance from a recognized institution and evidence of at least five years' experience in the insurance industry. The IRA has also issued extensive market conduct guidelines for insurance intermediaries however one aspect this does not cover is the recording of advice given to policyholders. The guidelines make provision for the secure and confidential record-keeping of information obtained from clients but does not stipulate that a record of the advice given be maintained. This would be beneficial in improving levels of consumer protection and hence consumer confidence in utilising intermediaries. It would also provide the IRA with records to verify that the advice provided was sound and objective.

The requirement on intermediaries to keep records of the advice that they give should be included in the Health Insurance Regulations.

7.9. Relationships with providers

Proposal:

- **Establish an independent accreditation body to carry out accreditation process of all healthcare providers in the industry. Accreditation is separate from empanelment, which should remain the function of the separate health insurers. However, insurers may only empanel a provider what has been accredited as a health care provider.**
- **This body should be created with the engagement of all other provider bodies in the industry such as (but not limited to) the Kenyan Medical Practitioners and Dentists Council, clinical officers council, nursing council of Kenya, pharmacy and poisons board and Ministry of Health.**
- **Implement DRG's for In-hospital re-imbursement.**
- **For the purposes of developing DRGs, claims need to contain - ICD coding & CPT procedural coding. The claims must also be linked to the age and gender of the patient.**
- **Only allow providers to engage in capitation arrangements subsequent to checks on providers quality of care and ability to meet some level of minimum capital requirements. The ultimate liability to provide benefits set out in the medical insurance policy remains with the insurer.**

- **Insurers are required to demonstrate how they are measuring the quality of care their policyholders are receiving.**
- **In conjunction with provider bodies, minimum standards of quality reporting should be developed, and providers must demonstrate how they are measuring and improving the care they give.**
- **Requirement for hospitals to provide summarized data to IRA on admissions and to publish patient-outcome based metrics.**

As described below a number of these proposals would have to be implemented through the Health Act and would require buy-in from health providers and their industry associations to be successful. Therefore, the abovementioned proposals would require collaboration between the IRA and amongst others (but not limited to) the MOH, the KMPDC and the PPB.

7.9.1. Accreditation of providers

Healthcare is a good and as such consumer's need to be assured that the good they are purchasing is of a sufficient quality and standard. Many possible agencies have been suggested, with the NHIF being the main agency currently implementing accreditation. However, accreditation through a semi-autonomous independent agency, separate from the various service delivery functions, was recommended by Wangia and Kandie (2018) to be responsible for the accreditation of all healthcare facilities and providers. The requirements are set out by Suchman (2018).

It is proposed that medical insurers may only engage with and pay claims to providers who have been given official accreditation to offer healthcare services. The accreditor will also be able to assess if the rate being charged for services is in line with industry pricing and standards. This may be an efficient method for better controlling rising healthcare costs in the market. Empanelment is a separate issue from accreditation. Insurers should be free to empanel any provider if the provider has been accredited by the independent accreditation body.

An accreditation process will boost consumer confidence in the healthcare policyholders can access. Policyholders will also feel confident in accessing levels of care which are not at the most expensive and prestigious hospitals in the country. This is expected to improve health insurance coverage and reduce costs.

As this proposal goes beyond health insurance, it is not appropriate for it to be covered in the Insurance Act. It is suggested that, regardless of which body is ultimately responsible for accreditation, the most appropriate legislation to provide for accreditation is the Health Act No. 21 of 2017.

Section 112 of the Health Act enables the Cabinet Secretary to make regulations and paragraph (r) covers the grading of health facilities in consultation with the county governments. Although this could possibly be stretched to include accreditation, it would be much preferable for accreditation to be enabled in the Act, perhaps in Part XIII (Private Sector Participation). The details would be set out in regulations made under section 112.

The Health Insurance Regulations would reference accreditation under the Health Act.

Accreditation (termed "declaration of hospitals") is currently a function of the NHIF under the NHIF Act (section 5(1)(c). However, the accreditation function is to be performed for the purposes of the NHIF Act only. This is reflected in section 30 of the NHIF Act which enables the Board to declare any hospital, nursing home or maternity home to be a hospital for the purposes of the Act (in consultation with the Minister and the chairman of the Medical Practitioners and Dentists Board). If, against the recommendations made in this section, accreditation is to be undertaken by the NHIF for other purposes, including for the purposes of the Insurance Act, the NHIF Act would need to be amended to establish the NHIF to operate as the accreditation authority for the healthcare sector more generally. As the interests of the private insurance sector would not align with those of the NHIF, the NHIF Act would have to be amended to expand the functions of the NHIF and to specify a considerably more detailed accreditation process. The NHIF Act would need to be supported by detailed regulations covering accreditation.

7.9.2. Provider reimbursement

The model used for provider re-imbursement is an important aspect of containing health expenditure costs. It is recommended that the methods for re-imbursing inpatient and outpatient claims be considered separately due the difference in cost and nature of the claims that are typically incurred under both.

Fee-for-service is currently used in hospitals for provider re-imbursement. As described in section 4.3, this may not be a sustainable long run solution as the fee-for-service model rewards providers for increased utilization. It is therefore recommended that inpatient claims be paid based on a DRG re-imbursement model. The benefits of a DRG re-imbursement model are set out in section 4.12 and as explained in the benchmarking section this is currently the approach adopted in Ghana. Most recommendations suggested that Kenya moves towards a strategic purchasing approach (such as the diagnostic related groups or DRG) rather than a passive purchasing approach as highlighted throughout section 6, including Deloitte (2012).

This suggestion relies heavily on the use of clinical coding and good quality data standards implemented by provider hospitals and insurers as these need to be in place to create a DRG grouper. It is proposed that a Kenyan specific DRG grouper be created which can allocate in-hospital admissions to homogenous diagnosis groups such that the typical utilisation of hospital resources is the same for all admissions within that group. This will provide transparency around the costs charged for different services in-hospitals and with case-mix adjustment will allow objective benchmarking across providers. Additionally, it provides a method for analysing trends in the quality-of-care patients receive. This would introduce a more competitive environment for providers and create an opportunity for robust negation between the funders and providers of healthcare. This will serve as a mechanism for controlling costs within the industry.

In Kenya, outpatient claims are typically managed through fee-for-service (Suchman, 2018). As stated above, this is not conducive towards controlling costs. An alternative which could better manage claims costs is through the implementation of capitation fee arrangements with providers. As described in section 4.3, (Suchman, 2018) highlighted that private medical insurers are hampered in their adoption of capitation fee arrangements due to concerns on the quality of care policyholders will receive, a low understanding of capitation on part of the providers or a general unwillingness by providers to be under capitation.

This method of re-imbursement assists the insurer by transferring risk to the provider. If a move towards capitation fee arrangements is made, then the providers who are eligible to engage in these should be limited to providers who are financially able to accept the transfer of risk. That is, if the services providers are required to provide is greater than the capitated fee charged, the provider should not be at risk of defaulting on the arrangement or compromise their financial sustainability by fulfilling the arrangement. The provider should have sufficient capital to engage in the arrangement. The ultimate liability for the provision of benefits under insurance contract however remain with the insurer.

It is recommended that insurers should have the right to use both reimbursement methods and no regulatory prescription should be applied. However, quality control should be applied.

Given that the recommendations to move to a strategic purchasing approach using DRGs goes beyond medical insurance, it is recommended that this should be provided through appropriate amendments to the Health Act, supported by more detailed regulations made under section 112 of that Act.

7.9.3. Measurement of quality of care

Medical insurers act as a third party to the doctor-patient relationship. However, they are facilitating policyholder's access to healthcare and as such have a duty to monitor the care being provided through the use of their products. This is also beneficial for improving consumer confidence in medical insurance products as they will want to have some reassurance that health insurers are monitoring the standard of benefits (and therefore care) policyholders are afforded and provides assurance to policyholders that their product is providing good value for money.

Both Gitonga (2012) and the World Bank Group (2018) recommended that regulation with regards to healthcare quality should be developed.

While insurers do not have the ability to physically observe the care each policyholder receives at every interaction with the health system, they do have access to individual claims data. This, along with improved data standards, would enable the insurer to monitor the level of care at different providers. There are countless numbers of quality measures which are used in healthcare around the world a few of these are mentioned in the benchmark section. However, the exact quality metrics need to be determined considering the aspects of quality needed to be measured. In the context of quality of care insurers would be concerned, primarily, with mortality (and other poor outcome) measures, patient safety (or preventable harm) measures as well as patient related outcome measures. Providers should also be expected to demonstrate how they have monitored the quality of care they provide but this does rely on collaboration with other professional bodies who monitor providers in the market.

It is recommended that the IRA work with the regulators of healthcare services to develop simple patient outcome-based metrics and require hospitals to publish these at least annually. This would encourage competition on the basis of patient outcomes instead of just price.

The Association of Kenyan Insurers (2018) highlighted the approach adopted in India. The proposal could be used to develop a similar preference rating of providers in Kenya. This could be used by medical insurers to provide objective criteria to policyholders for recommending a provider.

As accreditation, this may be better implemented through the Health Act than the Insurance Act. However, the use of the quality of care metrics and reporting to the IRA can, once the Health Act has been amended, be covered in the Health Insurance Regulations and through circulars.

7.10. Data standards

Proposal:

- **Mandate requirement for ICD coding and CPT procedural coding on all claims (necessary for DRG development as set out in section 7.9.2).**
- **Draft a list of medication specific codes (not necessary for development of DRGs) which will be required on all claims for medicines.**
- **Draft a set of unique provider/practice numbers.**
- **Claims data should also be accompanied by the unique practice/provider number of the provider administering care.**
- **Stipulate that health insurers must maintain records of monthly membership details with age and gender information. The income band should be noted if related to the premium calculation.**

The successful implementation of the proposals requires that the health insurance industry captures the recommended level of data specified in section 4.18. This could be facilitated directly through the insurer's own administration system or through the use of third-party administrators. Insurers should be expected to maintain accurate records of membership. Recording of claims data would also rely on buy-in from the provider supervisory bodies in the country as it will depend on the ability of providers to provide clinical coding on all claim submissions. Medical insurers should also be required to maintain records of all hospital pre-authorizations. With the buy-in of provider supervisory bodies the IRA could require insurers not to pay claims which lack complete information.

Medical insurers should be required to record monthly snapshots of policyholders and their dependants' details. This should provide demographic detail such as individuals age, insurance product, gender and their chronic status. The membership detail should provide anonymized detail which can be reliably linked to their corresponding claims data – that is, insurers should be able to link claims to the individuals making the claims. Collaboration of industry bodies would assist in the drafting of a list of unique provider numbers which will be stated on all claims. The pre-authorization data insurers keep should, similarly to the membership and claims data, be able to link to the specific individuals authorized for admission. Details to be included would be a unique admission number, the authorized admission and discharge date.

Collaboration with provider bodies may assist in enforcing regulation that ensures all admissions are accompanied with a set of admission and discharge ICDs which may also be kept in the insurers pre-

authorization data. As described in section 5.12, both Germany and South Africa have regulation that support the use of standardised coding.

A minimum standard would require all claim submissions to be accompanied with relevant ICD coding and procedural coding (if a procedure was performed). All claims are expected to have ICD coding as it pertains to the reason for providing treatment (i.e. the diagnosis). A set of medicine specific codes would also be beneficial. The recording of this data is also critical for the development of a diagnosis related grouper and the establishment of a DRG based re-imbursement model.

The abovementioned recommendations are in line with those proposed by the Association of Kenyan Insurers (2018).

The introduction of coding, although discussed in the context of health insurance, would have wider implications for the health sector. Therefore, it is suggested that Coding would be better provided for through the Health Act 2017. This would require support from the MOH (probably through the Director-General appointed under section 16 of the Health Act) as well as the KMPDC and the PPB.

Once coding is established, obligations could be imposed on health insurers in relation to the use of Coding, claims data and record keeping. This would need to done through the Health Insurance Regulations. Increased reporting to the IRA could be facilitated through circulars.

7.11. Independent Insurance Ombudsman

Proposal:

- **Establishment of an independent insurance ombudsman**

As set out in section 3.5.10 the establishment of an independent medical insurance ombudsman would be highly desirable for private insurance as well as the NHIF. The Deloitte (2012) report also recommended that the health insurance regulatory framework make provision for an independent regulatory authority or ombudsman. The Office of the Ombudsman established under the Commission on Administrative Justice is a public sector ombudsman with the dual mandate of tackling maladministration in the public sector and overseeing and enforcing the implementation of the Access to Information Act, 2016. Given the public sector focus, the functions of the Office of the Ombudsman are completely different from the functions of a private sector ombudsman.

It is therefore recommended that a dedicated insurance sector, or wider financial services sector, ombudsman is established to improve trust in the medical insurance sector.

The establishment of an independent insurance ombudsman could be implemented either through the Insurance Act (if the role of the ombudsman were to be limited to medical insurance or as part of a wider insurance sector mandate) or through separate legislation (if the ombudsman is intended to operate more widely across the financial services sector).

7.12. Partnering with other bodies

Proposal:

Establish a memorandum of understanding with other healthcare system regulators and bodies including:

- **Central Board of Health who are advisors of the Ministry of Health.**
- **Medical Practitioners and Dentists Council which registers and licences medical and dental practitioners as well medical facilities.**
- **Clinical Officers Council, which assesses qualifications of clinical officers and register and license them.**
- **Nursing Council of Kenya, which maintains proper standards of nursing care in health institutions.**
- **Pharmacy and Poisons Board which regulates the profession of pharmacy.**
- **The local Actuarial Society**
- **The NHIF**

The health insurance environment is a complex landscape with a number of different stakeholders. While the IRA has the mandate to monitor and regulate insurance providers there needs to be collaboration with the other industry bodies invested in the same environment. Regulation for the supply-side of healthcare, or lack thereof, has been referenced as a problem in the industry. This has limited the extent to which quality of care and accreditation can be effectively monitored in the industry. Better collaboration of the industry bodies would also allow for engagements on issues such as methods of re-imbursements and standards of clinical coding.

The IRA needs to collaborate with professional bodies regulating the providers of healthcare. While they IRA may prescribe regulation for insurers there needs to be collaborative regulation to better govern the interaction between all stakeholders – that is, the policyholders/patients, the health insurers and the providers. A memorandum of understanding should be drafted between the IRA and relevant professional bodies governing providers. This will lay the foundation for engagement and collaboration between the regulators within the healthcare environment and will assist the IRA in implementing measures to better regulate the supply side of the market.

This is an operational matter and amendments to legislation would not therefore be required.

7.13. Other considerations

Proposal:

- **Allow for flexibility to amend regulations to deal with unusual events such as COVID-19.**
- **Establish a process for health technology assessment.**
- **Insurer's should have access to the IRA's regulatory sandbox.**

The IRA should also have the flexibility to make changes to the requirements of what is needed to be submitted by health insurers. Changes in healthcare can occur suddenly and the regulator should have the flexibility to request additional information in light of current events.

The healthcare environment is also subject to developments in health technology. This could be the advancement in drugs, procedures or medical equipment. A process for health technology assessment should be implemented to evaluate the properties, effects and impacts of these new developments to aid in policy decision making.

The IRA has the power to amend regulatory instruments that it has issued.

Furthermore, the IRA would be able to cover additional reporting and provide guidance through circulars and guidelines.

It is important for insurers to be able to test the development and distribution of new private health insurance products and insurers should, therefore, have access to the IRA's regulatory sandbox (Insurance Regulatory Authority, 2020).

7.14. The National Hospital Fund (Amendment) Bill, 2021

On 13 May 2021, a Bill to amend the National Hospital Insurance Fund Act was submitted to the National Assembly. The Bill (the National Hospital Insurance Fund (Amendment) Bill, 2021) proposes a number of significant amendments to the NHIF Act that seek to establish the National Health Scheme and to enhance the mandate and capacity of the NHIF to facilitate and deliver UHC. The Bill aims to achieve some of the objectives identified in the draft UHC document that was reviewed in section 2. The main difference is that the proposed UHC cover will be achieved through the expansion of NHIF cover, instead of a separate EHBP that is proposed in the Draft UHC policy.

The Bill has been reviewed and the clauses most likely to impact Private Health Insurance and this policy paper identified as follows:

- Clause 10 proposes to amend section 15 of the NHIF Act (a) to require employers to make a matching contribution to the Fund, on behalf of each of its employees; (b) to provide for government to contribute to the Fund on behalf of indigent and vulnerable persons and (c) to enable any who wishes to receive an enhanced benefit to make additional voluntary contributions to the Fund.
- Clause 11 proposes to insert a new section 15A into the NHIF Act mandating every person who has attained the age of 18 years to be a member of the Fund.
- Clause 17 proposes to amend section 22 of the NHIF Act to provide that where a beneficiary has a private health insurance cover (a) The private health insurance shall be liable for payment up to the limits the beneficiary is covered; (b) the Fund shall pay the daily rebate, for inpatient; and (c) the Fund shall cover the outstanding bill where private insurance cover's limits have been exhausted subject to the Fund's applicable limits.
- Clause 22 proposes to amend section 30 of the NHIF Act to mandate the Board, in consultation with the relevant accreditation bodies, to publish in the *Gazette* the list of empanelled health care providers for purposes of the Act. The Board would be empowered to publish the empanelment of a health care provider subject to conditions relating to the fees that the health care provider may charge to any contributor to the Fund (including conditions as to the amount of the fees and requirement for

the Board's consent to any variations in fees). If the Board imposes conditions on Gazette publication, a healthcare provider would be prohibited from charging fees to a contributor contrary to the condition.

(Republic of Kenya, 2021)

As the Bill has not started its passage through the legislature, there can be no certainty as to whether it will be enacted in this form, or at all. In the circumstances, the Report has not been redrafted to take account of the proposed changes to the NHIF Act.

However, the enactment of the Bill would be likely to impact a number of the proposals and recommendations made in the Report. This will be considered further once the Bill has been enacted or, at least, once it is clear that it will be enacted and there is confidence as to its likely content. It is also recommended that the NHIF Amendment Bill be reviewed in light of the policy proposals made in this Report.

7.15. Development and drafting of a legal and regulatory framework

Legislation gives legal to the developed policy of the relevant policymakers. As this Report is intended to assist the IRA, the MOH and other stakeholders to finalise the legislative policy for medical insurance, the Report does not cover the required legislation in any detail as it would be premature to do so. However, to assist in policy development, the Report does indicate which existing legislation would most likely have to be amended and the new legislation that would be required for each policy proposal.

Once the policy has been developed, a set of legislative proposals will be required. These will summarise the main policy objectives and requirements with supporting detail. These will serve as drafting instructions.

For the purposes of preparing this Report relevant legislation has been reviewed and wider legislation that should be taken into account has been identified (as set out in Section 3.2.6), it will need to be analysed in greater depth once the legislative policy has been agreed with a view to identifying those provisions that will need to be amended. Although the drafting of amendments to legislation other than the Insurance Act are beyond the scope of the ToRs, the Final Report accompanying the draft legislation will provide an overview of the legislation that will need to be amended.

Following the agreement of legislative proposals, a summary (most likely in tabular form) of the scope and extent of the required amendments will be required together with a summary of the issues to be covered in the Regulations. This will be provided to the IRA for its agreement. This process is expected to require one or more meetings with the IRA.

The proposed amendments to the Insurance Act will then be drafted and provided to the IRA, with a brief explanatory note, for consultation and agreement.

Once the draft amendments to the Insurance Act have been agreed, the Health Insurance Regulations will be drafted and provided to the IRA with a draft explanatory note. It is possible that, as the Health Insurance Regulations are drafted, further additional amendments to the Insurance Act will be identified, or adjustments to the amendments that have already been drafted. These will be covered in the explanatory note.

It may be more efficient for the IRA to establish a committee with which to consult on the draft amendments to the Insurance Act and the draft Health Insurance Regulations. It is likely that specific issues of detail will arise during the drafting process on which the IRA would need to comment. It is therefore envisioned to be a partly iterative drafting process. The final drafts would, of course, need to go to the IRA for approval.

Following agreement with the IRA, the draft amendments to the Insurance Act and the Health Insurance Regulations will be finalised for consultation with the insurance industry and other stakeholders.

The final report will indicate in more detail those matters that can be covered through circulars and guidelines without the need for amendment to the Insurance Act or for Health Insurance Regulations.

8. Regulatory Economic Impact Assessment

This section provides a summary of the quantitative impact of the proposals discussed in section 7. The qualitative impact of the proposals was discussed along with the proposals in section 7. A synopsis of the current health-care environment has been provided in earlier sections of the report.

An exact estimate of the numerical impact of proposals on the Kenyan health sector is not possible due to a lack of quantitative data on private health insurance available in Kenya (Association of Kenyan Insurers, 2018). Therefore, this section estimates the impact of the policy proposals on the costs of providing and the likely take-up rate of PHI by looking at the data available in other African Countries where similar proposals were quantified.

8.1. Quantitative impact on other African Countries

This section aims to provide an indication of the potential cost impact these proposals may have on insurers in Kenyan. In the absence of Kenyan health insurance data, available data was used from on roughly 4 million lives from numerous African countries including South Africa.

The data used includes claims and membership data from different medical insurers and medical schemes with whom the consultants have worked with in the past. The claims data includes (but is not limited to) clinical coding for the relevant diagnosis/procedure as well as the claiming provider detail. The membership data includes (but is not limited to) demographic detail of members (such as age, gender, chronic status) and information regarding individuals' premiums/contributions. Additionally, pre-authorization data for hospital admissions and information regarding individual chronic registration has also been used.

Any analysis or cost impacts determined using this data may not translate exactly to the Kenyan market and should be viewed with caution. However, it provides an indication of the potential impact some of the proposals may have.

Open enrolment

Section 7.3.1 puts forth the proposal for open enrolment to health insurance. This implies anyone can purchase health insurance and cannot be denied cover. The proposal also highlights the importance of pricing regulation to prevent insurers circumventing this by hiking individual premiums up to unaffordable levels. If this is achieved, it is expected that a larger segment of the population will be able to purchase private health insurance coverage. With an expansion of coverage and restriction around insurers ability to reject potential policyholders it is expected that claims will increase. This increase in claims is driven by the extension of coverage to individuals of a poorer health status.

Figure 12 below compares the per life per month (PLPM) claims of three different health insurance products. Two of which have a restricted membership pool and a third which is open to any members of the public to join. The open option must accept any individual, regardless of their health status. While the restricted options cannot decline cover and membership is voluntary, the criterion for membership includes employment under a specific employer group. Hence, they are not open to the general population and so are not exposed to the

same risk profile. In some age bands, and particularly the oldest ages, the PLPM claims of the open option are markedly higher in comparison to the restricted options. This is because of individuals of poorer health status and higher risk opting to join the open scheme.

Figure 12: Comparison of per life per month claims of restricted and open benefit options

Open-enrolment is expected to increase the cost of claims across age-bands and genders by 3 to 30%.

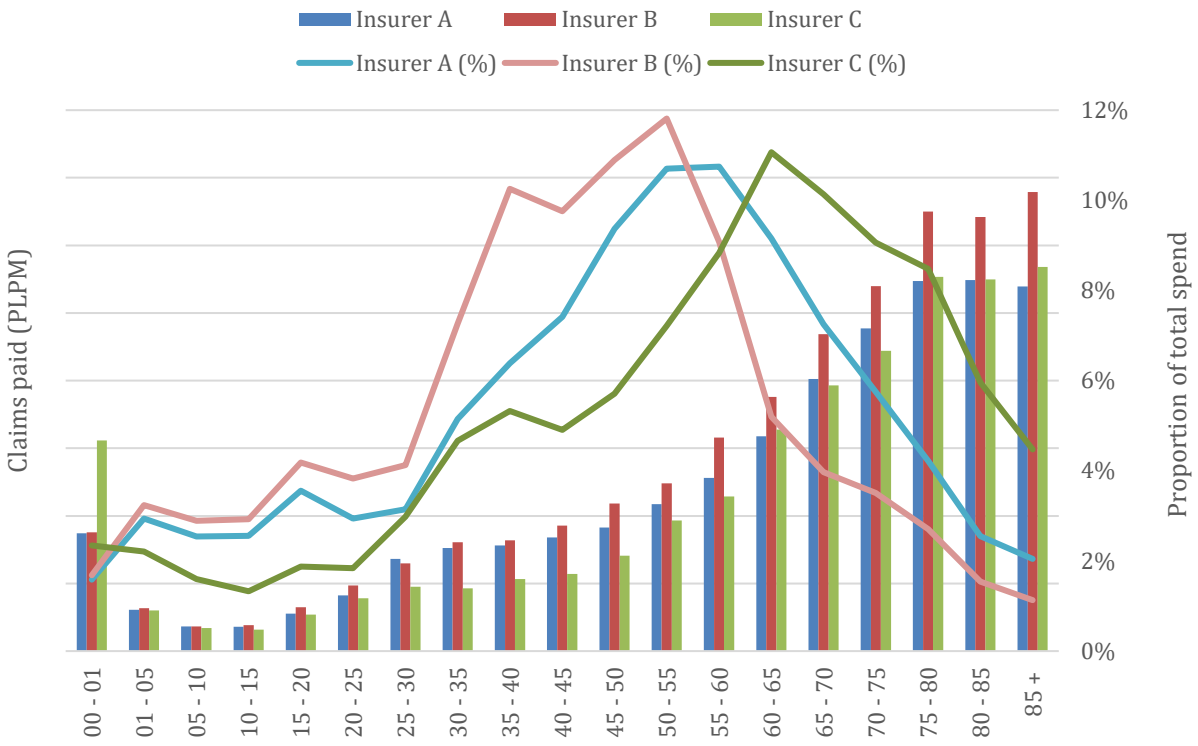
Based on the available health insurance data, the increase in claims as a result of open enrolment could range from roughly 3% to 30%. The impact of open enrolment on claims experience will vary by age. The level of this increase is also influenced by the level of underwriting applied. Applying appropriate underwriting and risk mitigation strategies such as age rated premiums and condition specific waiting periods will reduce the impact, moving closer to the lower end estimate of 3%. The exact increase in claims will depend on the change in the demographic profile of the insurer (age, gender and chronic status of members), the number of pensioners and the benefit structure of the product.

Mandated cover for new-borns

Section 7.4 of the report outlines the importance of mandatory cover for new-borns. This will expand insurance coverage but importantly, it will improve consumer sentiment towards private health insurance. This proposal is expected to increase the level of claims expenditure since more lives will be covered. Figure 13 below shows the per life per month cost of claims incurred across different age bands for four different insurers. The line graph also indicates the claims paid in each age band as a proportion of total costs incurred.

Figure 13. Per life per month claims expenditure across different age bands for different insurers

Cost of new-born babies are significantly higher than dependents agreed 1-20 years old. However, the proportion of claims are relatively low. Therefore, mandatory inclusion of new-born babies will not significantly increase claim costs for insurers.



Claims incurred in the youngest age band, 0 to 1 year old, illustrates the costs incurred for new-born dependants. This illustrates that significant costs can be incurred for new-born dependants and that there is a need for these claims to be covered by health insurers. If new-born dependants are not always covered, this expenditure will need to be funded through the main member's own funds which could be unaffordable in some cases. Since this is typically a small proportion of total claims expenditure, it is feasible and in the interest of policyholders, that new-borns (even if born prematurely) be covered. For the insurers considered above, new-born dependants account for 1.0% to 1.4% of each insurer's membership base.

The increased coverage of new-borns could result in total claims for an insurer increasing between 1.3% to 2.4%. This does not take into account the level of claims currently being covered by Kenyan insurers and so it is possible for this impact to be slightly less.

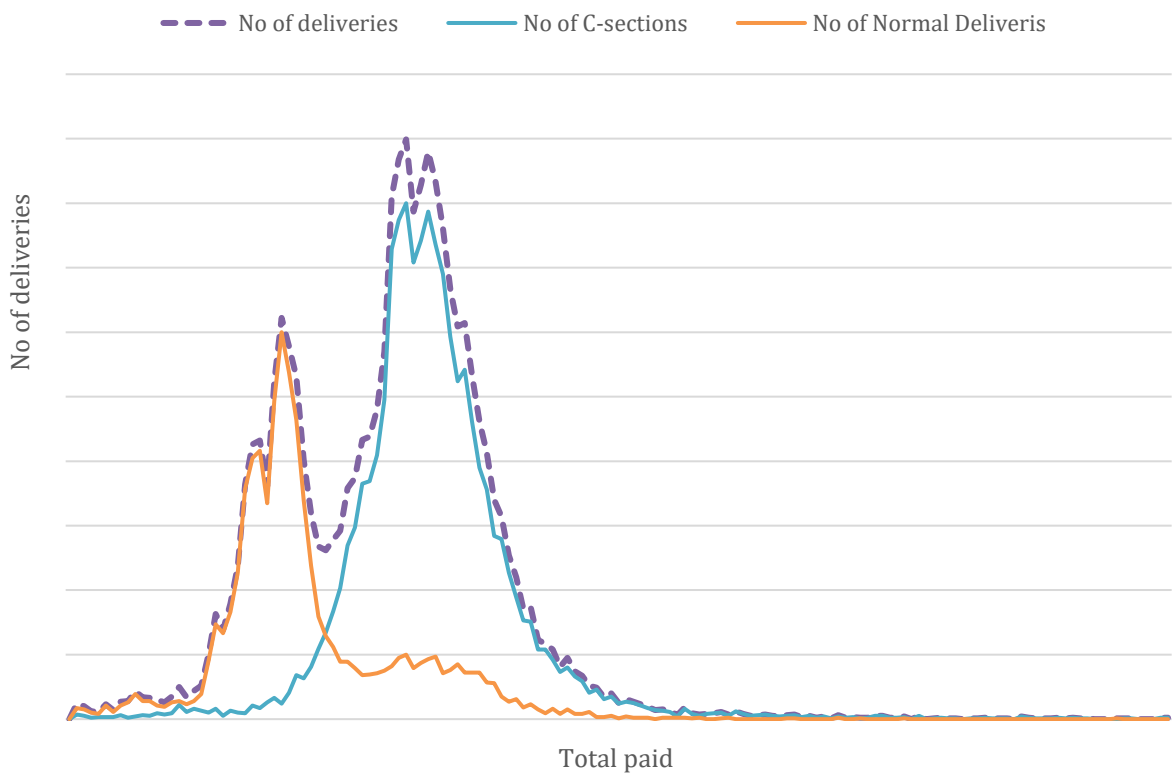
Provider reimbursement

A proposal for DRG re-imbursement for inpatient services was put forward in section 7.9.2. The main benefit of this is to allow meaningful comparison of costs incurred and care provided for homogenous types of admissions. Assigning DRGs to an admission allows the specific diagnosis of or reason for the admission to be identified. It also allows for further classification of admissions not only into homogenous diagnoses, but also to account for the severity/complexity of the admission. Childbirth is an example - the implementation of DRGs means admissions for child deliveries can be easily identified. The cost of delivery can vary significantly especially when comparing normal deliveries to c-sections, or deliveries with different levels of complications. Figure 14 below illustrates this variability. The amount paid and their frequency for deliveries are shown.

Separating the two types of deliveries gives a more accurate view of the typical cost of each. This helps to reduce the variability in costs when making comparisons across different admissions and different providers.

Figure 14. No of deliveries by total amount paid for Normal and C-section births

DRGs will help separate claim types and give better insight into the drives of the cost of claims.



The purple line in the figure illustrates the distribution of total claims paid per admission, for deliveries over the course of 2020. By assigning DRGs it is possible to not only identify admissions for childbirth but to further specify whether it was through a C-section or normal delivery. By separating the two types of deliveries a more accurate view of the typical cost of each can be observed. This helps to reduce the variability in costs when making comparisons across different admissions and different providers. Additionally, DRGs allow for case-mix to be adjusted for when measuring trends in hospital experience, that is, to account for differences in the mix and severity of admissions.

Table 47 below illustrates how DRGs can allow for better comparison of inpatient costs. The DRGs stated specify whether an admission is without complications (W/O CC), with complications (W CC) and with major complications (W MCC). The figures stated for the average paid and the standard deviation are relative to the average amount paid and the standard deviation across all deliveries.

The implementation of DRGs can assist in a like for like comparison across different providers and different admissions which can assist in managing rising healthcare costs.

Table 47. Variation of costs across different DRGs

DRG	Average Length of Stay	Relative Average Paid	Relative Standard Deviation
C-Section W/O CC	4.11	1.11	0.66
C-Section W CC	5.08	1.32	1.33
C-Section W MCC	6.85	1.76	2.87
C-Sections	**4.23**	**1.14**	**0.88**
Normal Delivery W/O CC	3.11	0.72	0.68
Normal Delivery W CC	3.62	0.90	0.86
Normal Delivery W MCC	5.26	1.44	3.91
Normal Deliveries	**3.18**	**0.74**	**0.85**

The table shows how the average costs vary across different deliveries (C-section vs normal deliveries) as well as for different levels of complication across DRGs. The implementation of DRGs can assist in a like for like comparison across different providers and different admissions which can assist in managing rising healthcare costs. The standard deviation of costs is also shown. The standard deviation is a measure of variation in the amount paid for a DRG. The standard deviation for procedures without complications is observed to be the lowest. That is, there is significantly less variation in uncomplicated admissions. Hence, admissions in this category can be expected to be more closely aligned to average costs than complicated admissions. By assigning a level of severity to the admission, outlier admissions can be more easily identified.

While DRGs aren't expected to have a direct impact on costs, over time, it will assist in better management of healthcare expenditure and hence a reduction in insurers claims expenditure by facilitating the means for improved claims management in the long run.

Setting a maximum difference between the highest and lowest premiums

Age-rated premiums, in the health insurance context, results in prohibitively high premiums for old individuals. This results in significantly reduced coverage of individuals aged 60 and older, as explained in section 2.3.3. Section 7.4 proposes a limit of 200% for the difference between the lowest and highest premium charged for a particular health insurance product. This proposal is expected to prompt insurers to create products with more affordable premiums for older age individuals, which improve coverage. Older individuals are typically a client of an insurer for a long period of time and hence contribute a significant amount to the pool of funds throughout their lifetime. If insurers are allowed to price these individuals out, it will be unfair for individuals to contribute throughout their life only to be priced out of affording insurance when they reach the age when they need it most. While this is typical of other classes of insurance, health insurance also aims to achieve UHC and provide a social good to members of the public. Hence, pricing individuals out at old age is regressive when considered in the context of achieving UHC. Furthermore, the introduction of a late joiner penalty will incentivise individuals to begin contributing to the pool of funds earlier rather than later.

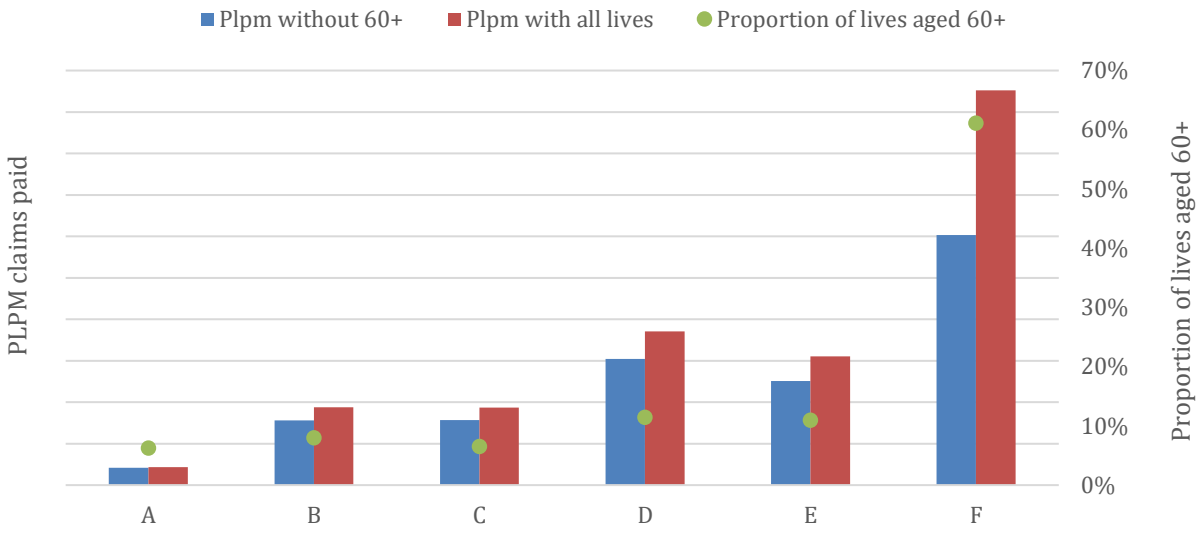
Figure 15 below shows the per life per month claims paid across different options (A – F) of an individual insurer. This is shown for claims excluding individuals older than 60 years and claims including lives of all ages,

to illustrate the impact of covering older lives. For options A to E, the increase in per life per month claims paid ranges from 2% to 24%. The increase on option F is 58% and should be viewed as an outlier, due to the large proportion of older individuals on the option and the higher comprehensiveness of cover provided.

The cost of 60+ year old policyholders is higher than those younger than 60 years. But due to the low overall number of 60+ year olds the overall increases in costs is less significant. Therefore, limiting the premium increases will significantly increase coverage of 60+ year olds while not significantly increasing the overall insurer's cost and therefore required premium.

Figure 15. Per life per month claims (Plpm) paid on different options of an individual insurer

Including lives order than age 60 does not significantly increase the cost of claims, except for option F.



The exact increase in overall claims for an insurer will depend on the demographic profile of the insurer, the number of pensioners and the benefit structure of the product. Although providing cover for these lives has the potential to increase costs, the increase is less significant that the premium increase currently being applied to lives older than 60 years. Therefore, limiting the premium increases will significantly increase coverage of 60+ year olds while not significantly increasing the overall insurer's cost and therefore required premium.

No premium loadings or exclusions for specific conditions

Currently, the Kenyan health insurance environment allows insurers to apply premium loadings and benefit exclusions for chronic conditions identified in the underwriting process. Furthermore, insurers have the ability to reject claims which are incurred as a result of excluded conditions. By removing this aspect from the health insurance market consumer confidence in health insurance is expected to improve and as a result population coverage is expected to increase. Furthermore, since insurers cannot exclude claims arising from these chronic conditions it is expected that the level of services covered will improve and the level of out-of-pocket expenditure required by members will decrease.

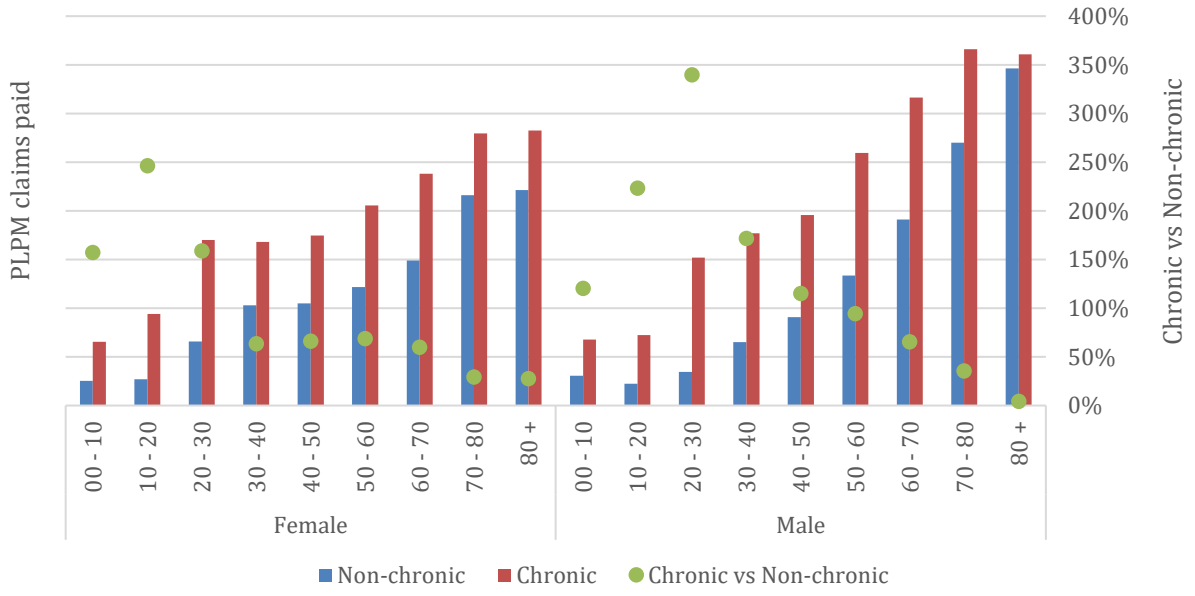
The increase on claims expenditure is difficult to estimate. Overall claims are expected to increase, but the level of this increase depends on the proportion of lives suffering from chronic conditions as well as the extent

to which these lives and their claims are currently being covered in the market. Figure 16 below considers per life per month claims incurred for a single option. This is delineated by the age, gender and chronic status of members. It illustrates that chronic lives typically claim more than non-chronic lives.

The impact on total claims for an insurer of covering chronic conditions depend on the age and gender distribution of the members, the number of chronic lives and benefit structure of their product.

Figure 16. Comparison of Per life per month claims paid of chronic and non-chronic lives

Providing cover for members with chronic conditions could significantly increase the cost of health insurance.



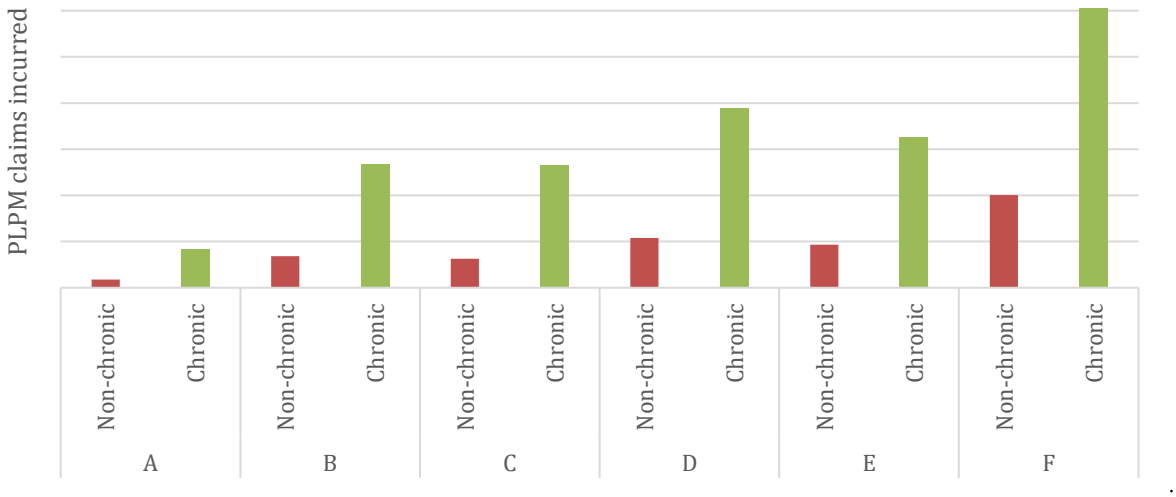
The per life per month cost of chronic lives may be 4% to 340% higher than non-chronic lives, depending on the age and gender being considered. This difference is less significant in older age groups. The impact on total claims for an insurer will depend on the age and gender distribution of the members, the number of chronic lives and benefit structure of their product.

Figure 17 below compares the per life per month cost of chronic and non-chronic lives across different options at an individual insurer. Chronic lives are observed to pose a higher cost to the medical scheme (as expected).

The impact on total claims for an insurer of covering chronic conditions depends on the age and gender distribution of the members, the number of chronic lives and benefit structure of their product.

Figure 17. Comparison of PLPM claims incurred for chronic and non-chronic lives - split by option

The cost of chronic members depending on the type of cover provided



These are ordered based on the comprehensiveness of cover with option "A" being the least comprehensive and "option F" the most comprehensive. This illustrates that the impact on overall costs will depend on the level of cover provided by the individual option, in addition to the number of chronic lives who would claim for the available benefits.

Establishing referral pathways and rejecting claims outside of these systems

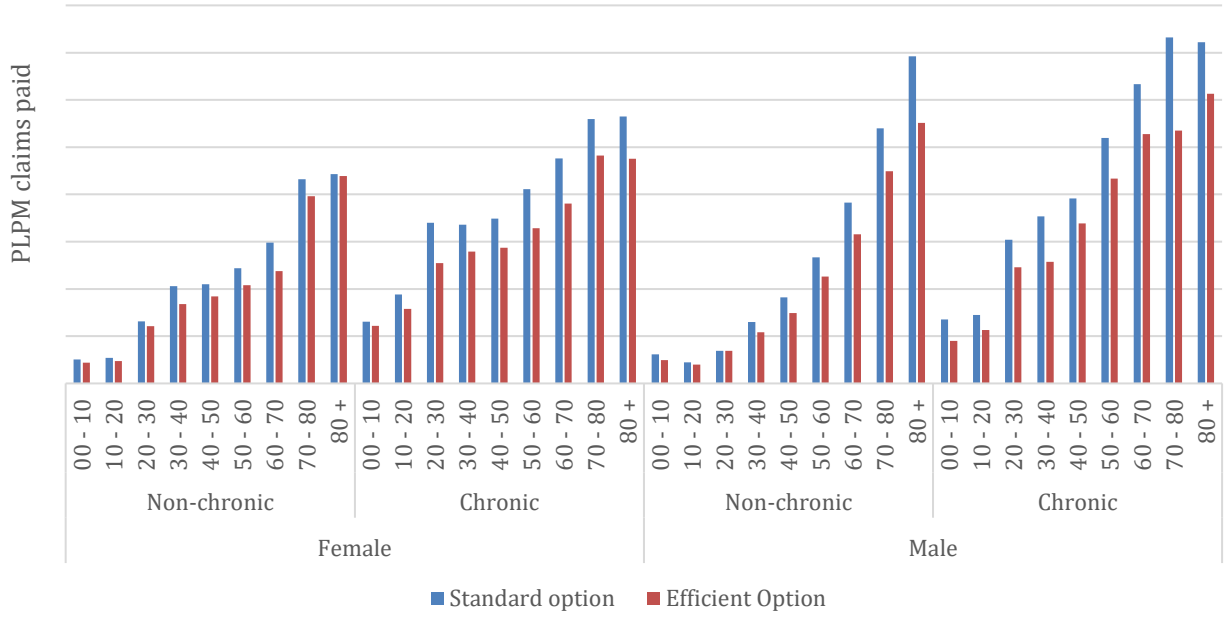
Section 7.6.1 recommends implementing a referral system in the healthcare system. This is illustrated below, by way of an example.

Figure 18 below shows per life per month costs of a standard option and an efficient option, with the same benefits, but makes use of referral pathways and care-coordination mechanisms. The per life per month claims paid figures for the efficient option are consistently lower than the standard option. The efficient option has the same benefits as the standard option but makes extensive use of care coordination mechanisms.

Implementing a referral pathway claims system can reduce claim costs by up to 15%. The reduction is more significant for Chronic conditions benefit options, indicating that the use of a referral system will reduce the impact of removing underwriting requirements on chronic conditions.

Figure 18. Impact of referral pathways on claims paid by gender, age and condition

Using referral pathways improves efficiency and reduces the cost of claims.



After adjusting for the differences in the distribution of chronic lives, age and gender, the efficient option produces claims which are 15.1% lower than the standard option. An exercise on a different insurer was conducted to see what potential impact a GP designated service provider would have on incurred claims. It was estimated that implementing a scheme approved network of GPs alone could result in savings of between 3.5% and 6.0% of incurred claims. The implementation of these care-coordination mechanisms could produce a similar reduction in claims for health insurers in the Kenyan market. The reduction is more significant for Chronic conditions benefit options, indicating that the use of a referral system will reduce the impact of removing underwriting requirements on chronic conditions,

Proposals with no quantifiable impact

The sections above provide an indicative view of how some proposals may impact the market, particularly focusing on the impact for insurers. However, Section 7 of the report does outline several proposals which do not have a direct, quantifiable impact on the market. This includes proposals or reforms for:

- Market structure and uniform definition of medical insurance.
- Standardization of insurer's products across group and individual options.
- Requiring IRA approval on all benefit options.
- Demonstrating financial sustainability, impact of benefit design changes, adherence to PMBs and requiring actuarial certification.
- Mandatory regular reporting to the IRA.
- Financial soundness and regulatory supervision.
- Policyholder protection mechanisms.
- Establishing independent accreditation bodies and engaging with provider bodies.

- Requiring insurers and providers to demonstrate how they measure quality of care and hospitals to provide data on admissions.
- Mandating ICD and CPT procedural coding, drafting a list of medication specific codes and unique provider numbers.
- Stipulation of the exact data insurers are to keep.
- Establishment of an independent medical insurance ombudsman.

9. Next steps

This report is the second deliverable to be submitted to the IRA and following the submission of this draft Comprehensive Report on Friday 23 April 2021, the next steps and timelines are:

1. **Deliverable: Comprehensive Report including the Health Policy Paper and the Regulatory Economic Impact Assessment (RIA)**
    - The draft Comprehensive Report includes
        - *Health Policy Proposal* - draft of the forthcoming health insurance regulations.
        - *The Regulatory Economic Impact Assessment (RIA)* - measuring the impact of the regulatory proposals.
        - *Collaborative framework* – outlining the collaboration required between the key regulators and stakeholders in health insurance and healthcare to ensure comprehensive oversight, supervision and regulation of the sector.
    - The IRA to review the first draft of the Comprehensive Report (including the RIA and the Health Policy Paper) submitted – 23 April to 30 April 2021.
    - Meeting to discuss the Comprehensive Report and initial feedback and the next steps with the IRA – the week of 26 April 2021.
    - The IRA to submit comments and feedback concerning the draft Comprehensive Report – 30 April 2021.
    - Meeting to discuss the IRA's feedback and comments concerning the Comprehensive Report – 30 April 2021.
    - Stakeholders' validation workshops
2. **Deliverable: Draft Health Insurance Regulations**
    a. To be finalised with input, feedback and comments from various stakeholders at the forthcoming stakeholders' validation workshop in line with the process outlined in section 7.15.
    b. In addition to recommended changes to the Insurance Act and regulations, this step will include a *Collaborative framework* – outlining the collaboration required between the key regulators and stakeholders in health insurance and healthcare to ensure comprehensive oversight, supervision and regulation of the sector.
3. **Deliverable: Action Plan**
    - To be developed in consultation with various stakeholders at the forthcoming stakeholders' validation workshop where the Comprehensive Report will be finalised. The action plan will outline the implementation path for the forthcoming health insurance regulations.
4. **Deliverable: Final report**
    - At the stakeholders' validation workshop, feedback and comments concerning the Comprehensive Report will be discussed. Following the workshop, the feedback and comments will be considered and incorporated to produce the final report.

Additional steps and processes that will continue for the duration of the project:

- Regular engagement with the IRA.
- Regular engagement with the Technical Working Group.

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11.Annexure B: Stakeholder Engagement

List of stakeholder meetings, consultations and workshops.

Date	Organisation	Meeting description	Representatives
2020/11/18	IRA	IRA meeting 1	Shamim Kimitei: General Insurance Supervision Bernard Osano: Financial Access Eric Komolo: Composite Insurance Supervision
2020/11/18	IRA	IRA meeting 2	Monica Thirima: Consumer Protection
2020/11/18	IRA	IRA meeting 3	Diana – IRA Company secretary and Legal Team Leader
2020/11/19	Dr Joan Osoro	Dr Joan Osoro	Dr Joan Osoro
2020/11/19	NHIF and UHC	James Wambugu	James Wambugu – Former UAP CEO consulting on NHIF and UHC
2020/11/19	Kenbright	Kenbright	Ezekiel Macharia
2020/11/19	Association of Insurance Consumers Kenya	AICK	Elias Sang
2020/11/19	Zamara	Zamara	Sheila Gatu, Seth, Samantha, Sandeep
2020/11/23	Swiss Re	Swiss Re	Mukami Njeru
2020/11/24	KHF	KHF	Denis Okaka Walter Obita
2020/11/25	Zep Re	Zep Re	Jephita Gwatipedza Cecilia Augustine Manka Nicholas Malombe
2020/11/25	Resolution	Resolution	Irene Mutua Micha Kasiti Bernard Githinji Alice Mwai Catherine Wamagata Timothy Kering
2020/11/25	IRA	IRA meeting 4	Kalai Musee
2020/11/25	Britam	Britam	David Obonyo
2020/12/03	IRA	IRA meeting 5	James Ndwinga

12. Annexure C: Summary of NHIF Plans

The NHIF offers a number of benefit options to meet the needs of the various target groups it covers. The main benefit option offered by the NHIF is called the SUPA COVER package. There are also several other benefit options focusing on specialised services that are offered by NHIF. In the formal sector, NHIF contributions are paid by the employee only on a sliding scale by Salary between KSh 150 and 1700 per month. For self-employed and the informal sector, the cover costs KSh 500 per month for the principal members and beneficiaries.

The Civil Servants and Disciplined Services Scheme and County Public Servant Scheme are more comprehensive packages paid for through contributions from civil servants and members of uniformed services.

The Linda Mama program covers pregnant women. Any pregnant women not covered by other insurance will be enrolled in Linda Mama whenever they contact the health system. It is fully subsidised and requires no contributions.

The Health Insurance Subsidy Program is a fully subsidized pilot program targeting poor and vulnerable households. Administered through NHIF, the program is currently supported by the World Bank.

(Dutta *et al.*, 2018)

The table below summarises the NHIF packages:

Package	Description
SUPA COVER	This is Kenya's largest, reliable, accessible and affordable medical insurance cover that enables members (and their dependants) to access a relatively comprehensive package of healthcare benefits. ● **Outpatient Services** - Consultation, Laboratory, investigations, day-care procedures, drugs and dispensation, health education, wellness and counselling, physiotherapy services, immunization,/vaccines as per the KEPI schedule ● **Inpatient Services** offered through a network of contracted facilities that provide comprehensive and non-comprehensive cover - ○ Comprehensive Cover: comprises of all government hospitals and selected Faith-based and private hospitals. Our members get to enjoy full and all-inclusive cover for all admissions provided they are fully paid up members. ○ Non-Comprehensive: comprises of some Faith-based and private hospitals. Members who choose to visit the hospitals in this category may be required to pay out of pocket for services offered. ● Maternal care - Antenatal and Prenatal care and deliveries (Normal delivery and caesarean section) ● Reproductive health services ● Renal Dialysis ● Rehabilitation for drugs and substance abuse ● All surgical procedures including transplants ● Emergency road evacuation services ● Radiology imaging services (X-rays, CT Scan, & MRI) ● Cancer Treatment ● Overseas treatment for specialized surgeries not available locally
The Civil Servants Scheme	This benefit package was negotiated by the government and NHIF and is delivered through a capitation model. The core services covered would include: ● **Inpatient services:** All necessary medical treatment and services provided by or on the order of a clinician to the Member when admitted to an NHIF Accredited Hospital offering services under levels as defined by the Kenya Essential package for Health (KEPH). The cover includes hospital bed charges, nursing care, diagnostic, laboratory or other medically necessary facilities and services, physician's, surgeons, anaesthetists', or physiotherapist's fees, operating theatre charges, specialist consultations or visits and all drugs, dressings or medications prescribed by the physician for in-hospital use.

	• **Outpatient cover:** All necessary outpatient medical treatment and services provided by or on the order of a clinical to the member when admitted to an NHIF Accredited Hospital offering services under levels as defined by the Kenya Essential Package for Health (KEPH).The outpatient cover shall include but is not limited to: ○ Consultation ○ Laboratory investigations ○ Drug administration and dispensing ○ Dental health care services ○ Radiological examination ○ Nursing and midwifery services ○ Minor surgical services ○ Physiotherapy services ○ Optical care ○ Occupational therapy services ○ Referral for specialized services ○ Any other benefit as approved by the NHIF Board of management • **Maternity and reproductive health services:** includes for Delivery and Caesarean section. For reproductive health cover includes family planning services, excluding fertility treatment. This benefit is not available for dependants other than declared spouse. • **Group life cover:** Death benefit upon demise of a member whilst in service subject to provision and receipt of full documentations. This also includes Last Expense Cover where the NHIF shall upon written notification of death of a member while this cover is in force, pay to the Client or such other person or persons as the Client may in writing direct, the amount specified in the schedule to cater for the funeral expenses.
Government subsidised targeted programmes	1. ***Linda Mama Program***, a health insurance cover for expectant mother and their new-born children with no other form of insurance. The program offers ante-natal, delivery care, postnatal care, referral, and infant care. 2. ***Edu-Afya the Secondary School Cover*** whereby the government launched and rolled out a free comprehensive medical cover for all students in public secondary schools. • This is an innovative product emanating from a partnership between the Fund and the Ministry of Education and NHIF. The partnership was formalised in April 2018 and it offers a unique Comprehensive Medical Insurance Cover for Public Secondary School Students during the duration of Study. Eligibility is for any student in a public Secondary School and is under National Education Information System

	(NEMIS), any student who is in a Public Secondary School and in NEMIS database and Registered by NHIF; and only the Student shall be covered under the scheme and not a Dependent or Parent. ● The benefit package is comprehensive in that it includes outpatient services (including specialized services), dental and optical cover plus inpatient services, emergency road rescue among many others. The package also covers treatment costs arising from a condition that warrants treatment overseas because the treatment is not available in Kenya will be covered subject to preauthorization from NHIF. 3. ***Health Insurance Subsidy Programs*** for the poor, orphans and vulnerable children (OVC) as well as those targeting old and persons with severe disabilities (OPSD).

13. Annexure D: Summary of Kenya Essential Package for Health

The Kenya Essential Package for Health defines health services and interventions to be provided for each Policy Objective, by level of care and cohort (where applicable). The tiers in the KEPH are the levels of care as defined in the Kenya Health Policy:

1. Community level: The foundation of the service delivery system, with both demand creation (health promotion services), and specified supply services that are most effectively delivered at the community. In the essential package, all non facility based health and related services are classified as community services – not only the interventions provided through the Community Health Strategy as defined in NHSSP II.
2. Primary care level: The first physical level of the health system, comprising all dispensaries, health centres, maternity / nursing homes in the country. This is the 1st level care level, where most clients health needs should be addressed
3. County level: The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package of close to client services
4. National level: The tertiary level hospitals, whose services are highly specialized and complete the set of care available to persons in Kenya.

The KEPH interventions by cohorts are defined only for those specific to a given cohort, not for all KEPH interventions. The cross cutting interventions are not aligned to any cohort. Specific KEPH cohorts are:

1. Pregnancy and the new born (up to 28 days): The health services specific to this age-cohort across all the Policy Objectives
2. Childhood (29 days – 59 months): The health services specific to the early childhood period
3. Children and Youth (5 – 19 years): The time of life between childhood, and maturity.
4. Adulthood (20 – 59 years): The economically productive period of life
5. Elderly (60 years and above): The post – economically productive period of life

The table below outlines the services offered under the KEPH and the respective objective they contribute to:

Policy Objective	Service
Accelerate the reduction in communicable diseases	Immunization
	Child Health
	Screening for communicable conditions
	Antenatal care
	Prevention of mother to child HIV transmission
	Integrated vector management
	Good hygiene practices
	HIV and STI prevention
	Port health
	Control & prevention of neglected tropical diseases
Halt and reverse burden of non-communicable diseases	Community screening for NCDs
	Institutional screening for NCDs
	Workplace Health & Safety
	Food quality & safety

Reduce the burden of violence and injuries	Pre hospital Care
	Community awareness on violence and injuries
	Disaster management and response
Minimize exposure to health risk factors	Health promotion including health education
	Sexual education
	Substance abuse
	Micronutrient deficiency control
	Physical activity
Provide essential health services	Outpatients
	Emergency
	Maternity
	In patient
	Clinical laboratory
	Specialized laboratory
	Radiology
	Operative services
	Specialized therapy
	Specialized services
	Rehabilitation
Strengthen collaboration with health-related sectors	Safe water
	Sanitation and hygiene
	Nutrition services
	Pollution control
	Housing
	Water and sanitation hygiene
	Food fortification
	Population management
	Road infrastructure and transport

The table below shows the various dimensions and sub-dimensions that were calculated as part of the analysis of the health cube in Kenya. Sources include Dutta *et al.*, (2018), World Health Organization (2019) and Barasa *et al.* (2018).

Dimension	**Indicator and sub-indicator**		**Data**
1. Population coverage (who is covered)		Percentage with health insurance coverage (NHIF or Private or Community cover)	20%
2. Services: Which services are offered	Promotion or prevention indicators	Family planning coverage with modern methods (Family planning demand satisfied with modern methods %)	76%
		Antenatal care coverage (Antenatal care, 4+ visits %)	58%
		Skilled birth attendance (Skilled delivery)	60%
		Diphtheria, tetanus and pertussis (DTP3) immunization coverage among 1-year-olds	89%
		Prevalence of no tobacco smoking in the past 30 days among adults age ≥ 15 years (Tobacco non-smoking population)	89%
		Percentage of population using improved drinking water sources (At least basic sanitation %)	30%
		Percentage of population using improved sanitation facilities	68%
		Preventive chemotherapy (PC) coverage against neglected tropical diseases (NTDs)	
	Treatment indicators	Antiretroviral therapy coverage	57%
		Tuberculosis treatment coverage (Success rate of tuberculosis treatment)	90%
		Hypertension coverage	44.0%
		Diabetes coverage	33.33%
		Cataract surgical coverage	
3. Direct costs: Proportion of the costs covered		Public spending on health as percentage of GDP	34.67%
		Catastrophic health expenditure as a percentage of household expenditure (Percentage of population incurring catastrophic health expenditure)	40.82%
		Out of pocket expenditure (OOP as percentage of THE)	76.3%

14. Annexure E: Insurance Regulatory Authority (IRA)

The IRA started operations in May 2007 as an autonomous Government institution created through an Act of Parliament. The IRA took up the functions of the former Department of Insurance and is charged with regulating supervising and developing the insurance industry in Kenya. It is headed by the Board of directors and run by the Commissioner of Insurance who is also the CEO.

Functions

The IRA has the following functions:

- To ensure effective regulation, supervision, and development of insurance in Kenya.
- To formulate and enforce standards.
- To issue licences to all persons.
- To protect the interests of insurance policy holders and insurance beneficiaries.
- To promote the development of the insurance sector.
- To ensure prompt settlement of claims.
- To investigate and prosecute insurance fraud.

How IRA Regulates & Supervises

The focus of regulation pertaining to the IRA tries to ensure that market players comply with the provisions of the Insurance Act CAP 487. Supervision relates to the oversight function which the IRA exercises over the operations of insurance companies. Among the supervisory functions are:

- Ensuring the viability of applications for licensing.
- Ensuring that all board members are fit & proper.
- Ensuring that all senior management staff are fit & proper.
- Ensuring that insurers have adequate Capital at all times.
- Approval of insurance products.
- Inspection, investigation, analysis of accounts and returns, intervention and withdrawal of licenses among others.

Specific Steps taken by the IRA to stabilize the industry

Consumer Protection

- IRA receives and handles all complaints pertaining to insurance business as raised by members of the public,
- Where necessary, meetings are held between the complainants and the providers or their agents to resolve the disputes.
- Complainants are advised accordingly about the status of their complaint (whether the claim is payable or not).
- The division calls for the necessary information regarding claims already paid by insurers through law firms and for which the claimants have not received the same.

- Complainants then pass on the details to the Advocates complaints Commission for further action.

Consumer Education

The aim of the IRA's consumer education role is to:

- Make Kenyans aware about the benefits of insurance.
- Make Kenyans aware of their rights and obligations.
- Fight the negative perception people hold towards insurance.
- Encourage Kenyans to secure the welfare of their loved ones through income protection insurance.
- Encourage Kenyans to protect their possessions through buying short term insurance.
- Encourage Kenyans to protect themselves against liabilities through buying liability insurance.
- Get the views of the public on the practice of insurance.
- Pass the right messages on insurance.

Establishment of Policyholders Compensation Fund

- The Compensation fund was established in 2004 under section 179 of the Insurance Act as a result of the collapse of a number of insurance companies in the 1970s and 90s leaving policyholders with no option but to meet claims from own sources.
- The fund pays claims left outstanding by insurers who become bankrupt/insolvent.

Establishment of Insurance Fraud Investigation Unit

- The Insurance Fraud Investigation Unit (IFIU) was established in 2011 to fight fraud in the insurance industry.
- The unit's role is to investigate and prosecute fraudulent activities within the industry.
- The Unit is manned by CID officers from the Police department.
- IFIU investigates and prosecutes fraudulent activities as well as provide training to various interest groups.