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THIRD PARTY PAYMENT MECHANISMS IN HEALTH MICROINSURANCE

Pascale Le Roy and Jeanna Holtz

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PREFACE

The primary goal of the International Labour Organization (ILO) is to contribute with member States to achieve full and productive employment and decent work for all. The Decent Work Agenda comprises four interrelated areas: respect for fundamental worker's rights and international labour standards, employment promotion, social protection and social dialogue. Broadening the employment and social protection opportunities of poor people through financial markets is an urgent undertaking.

Housed at the ILO's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low-income families to help them guard against risk and overcome poverty. The Facility, launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation, supports the Global Employment Agenda implemented by the ILO's Employment Sector.

Research on microinsurance is still at an embryonic stage, with many questions to be asked and options to be tried before solutions on how to protect significant numbers of the world's poor against risk begin to emerge. The Microinsurance Innovation Facility's research programme provides an opportunity to explore the potential and challenges of microinsurance.

The Facility's *Microinsurance Papers* series aims to document and disseminate key learnings from our partners' research activities. More knowledge is definitely needed to tackle key challenges and foster innovation in microinsurance. The *Microinsurance Papers* cover wide range of topics on demand, supply and impact of microinsurance that are relevant for both practitioners and policymakers. The views expressed are the responsibility of the author(s) and do not necessarily represent those of the ILO.

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Employment Sector

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EXECUTIVE SUMMARY

Some health microinsurance (HMI) schemes require that patients pay cash at the time of receiving health care services, and then seek reimbursement from the insurer at a later date. For low-income households, this can be a severe financial barrier. One common way to alleviate this barrier is to set up a third-party payment (TPP) mechanism with selected health care providers.

A TPP mechanism is a model for claims payment in which insured patients are not required to pay the entire cost of health services covered by the HMI scheme at the time the services are rendered. With the exception of any cost sharing (e.g. co-payment, deductible), an insured patient has no out of pocket payment at the time of use of services, and a third party (the HMI scheme or another entity on behalf of the HMI scheme) pays the health care provider for the services provided to the patient.

HMI schemes with a TPP mechanism need to establish and maintain minimum standards for each participating provider and for the overall network of providers. These standards should address the adequacy of three key dimensions: access to care, cost and quality of care.

ENSURING ACCESS TO HEALTH CARE

The first dimension relates to access to services through the selection of health care providers. As with regular HMI schemes, the regulatory environment, and the location and service offerings of health care providers must be assessed to evaluate which health care providers could be relevant partners for the HMI scheme.

MANAGING COST

Once potential health care providers have been selected, the success of a TPP mechanism depends on implementing an appropriate payment method and aligning financial incentives to encourage proper care. With a TPP mechanism, HMI schemes usually pay contracted health care providers according to a pre-determined method of payment. Four common payment methods include: retrospective payment on a fee-for-service basis, retrospective case-based payment, retrospective payment per day, and prospective payment by capitation. Each method gives different incentives and disincentives for providers to control the cost and quality of services.

Payment methods that transfer some financial risk to health care providers (case-based, per day or capitation) have greater potential to contain costs than fee-for-service payment, but require additional measures to control for quality of care. These methods are usually more difficult to negotiate with health care providers. Mixed payment methods may be suitable in many respects

(i.e. capitation for primary health care providers/services and per case for hospital cases), but often complicate administration and increase management costs.

In order to manage costs, the HMI scheme also needs to manage moral hazard and fraud risks for both health providers and clients. Moral hazard and fraud are standard challenges associated with health insurance. Since insured patients in HMI schemes with a TPP mechanism do not bear the cost of health care at the time of service, the incidence of moral hazard can increase as clients may view the care as free and use additional services that may be unnecessary. Similarly, health care providers can view the insurer as having a greater financial capacity and thus may see an increased opportunity to deliver services that are covered, but which may not be medically necessary.

MANAGING QUALITY UNDER A TPP MECHANISM

Quality of care may be defined using objective and subjective criteria and can be measured with clinical and non-clinical or service indicators. Clinical outcomes, such as infection rates, are examples of objective indicators. Since clinical outcomes data and benchmarks for protocols are often not available, other criteria may be used as a next best alternative. For example, the credentials of health care providers are often evaluated as a proxy for clinical quality. Sometimes claims data can be mined to develop retrospective assessments of quality, using health care professionals to analyse treatment patterns. Service quality, defined by indicators such as hours of operation or scope of services offered, may also be measured.

Subjective quality of care, sometimes referred to as the patient experience, typically reflects patients' perspective as to how they feel about the health care they received. Subjective views may be measured through surveys or focus groups on a range of topics such as comfort of facilities, perceived attitudes of health care providers, value for money, etc.

HMI schemes cite numerous lessons learned about TPP mechanisms:

- Successful contracting with health providers requires a long-term approach to a partnership. Health care providers may agree to alternative payment mechanisms such as capitation, provided they perceive the terms to be sufficient to allow them to cover costs and make a fair profit.
- The ability of the HMI scheme to manage moral hazard, fraud, claim and administrative costs and to provide timely service will heavily depend on the quality and efficiency of its information system and processes.
- Approaches that encourage better objective quality of health care may be summarised as follows:
 - Assessing the extent to which insured patients receive appropriate health care services according to diagnosis and health status.
 - Auditing the quality of care in contracted health facilities according to standard indicators.
 - Implementing and monitoring compliance with standard treatment protocols.
- Approaches to improve perceived quality of health care include:
 - Locate a liaison officer at contracted health care providers to support admissions and discharge planning.
 - Monitor simple and measurable indicators of perceived quality of care, such as hours of service and patient satisfaction.
 - Set up a 24/7 help line (ideally, toll free).
- Payment methods that transfer some financial risk to health care providers (case-based, per day or capitation) have greater potential to contain costs than fee-for-service payment, but require additional measures to manage quality of care. These methods are usually more difficult to negotiate with health care providers.
- Capitation payment may be an appropriate way to cover high frequency/low cost (i.e. more predictable) health events, including primary (outpatient) care without jeopardizing the financial viability of the health care provider or burdening claims management, and seems better adapted to contexts where a critical mass of enrolment can be achieved with providers.
- HMI schemes that pay claims based on fee-for-service may be tempted to restrict care covered in order to limit the number and cost of claims. This may be in response to health care providers reacting to a financial incentive to deliver more care under a fee-for-service arrangement.

Implemented properly, TPP mechanisms can increase value for low income clients and healthcare providers, while contributing to the sustainability of HMI schemes.

1 > INTRODUCTION

Some health microinsurance (HMI) schemes require that patients pay cash at the time of receiving health care services, then seek reimbursement from the insurer at a later date. For low-income households, this can be a severe financial barrier that significantly decreases client value. One common way to alleviate this up-front cash payment is to set up a third-party payment (TPP) mechanism with selected health care providers. A TPP mechanism can be defined as:

A model for claims payment in which insured patients are not required to pay the entire cost of health services covered by the HMI scheme at the time those services are rendered. With the exception of any cost sharing (e.g. co-payment, deductible), an insured patient has no out of pocket payment at the time of use of services, and a third party (the HMI scheme or another entity on behalf of the HMI scheme) pays the health care provider for the covered services it provided to the patient¹. TPP mechanisms encompass terms of payment negotiated between the third party and the preferred health care providers, and usually include components to manage medical care (such as pre-authorizing admissions for hospital care).

The TPP mechanism is not new in health insurance, and its pros and cons are relatively well known and documented. However, setting up and managing a TPP mechanism for a HMI scheme presents unique challenges, and so far no study has been conducted on lessons that relate specifically to experience with TPP mechanisms in the HMI sector.

Therefore, the ILO's Microinsurance Innovation Facility (the Facility), and the Microinsurance Network's working group on health insurance launched a joint study to examine the pros and cons of various TPP design elements, drawing from the experiences of HMI schemes in developing countries. Using a practice-based approach, this study focused on lessons related to the set-up and management of TPP mechanisms to provide "cashless" (see Box 1) access to **insured persons**.

Box 1: Understanding the vocabulary: "Cashless" and TPP mechanism

TPP mechanisms can also be referred to as: cashless HMI schemes, cashless claims arrangements, cashless systems, cashless benefits, etc.

The term "cashless" reflects the perspective of an insured client, and not that of the HMI scheme or the health care provider. Cashless arrangements are made by HMI schemes to enable insured clients to access health care services with no (or relatively little) out of pocket costs. The term cashless can apply regardless of whether the insured patient's access is truly cashless or whether it involves some cost sharing, e.g. co-payment or deductible.

¹ ILO/STEP/ GIMI glossary: <http://www.ilo.org/gimi/ShowIndexGlossary.do>

1.1 METHODOLOGY

The paper is based on data collected through four complementary sources:

- **A literature review** (published and unpublished) of TPP mechanisms in health insurance and in HMI.
- **An online survey of HMI practitioners.** A survey conducted in April-May 2009 polled practitioners in 21 countries who were affiliated with several HMI networks in Africa, Asia and Latin America related to the Facility, the ILO's former STEP programme or the Microinsurance Network's working group on HMI.
- **A series of interviews with HMI experts.** Nineteen experts were interviewed by telephone or in person: eight practitioners, six researchers and five consultants (Annex 2). Following a standard interview guideline, experts were asked to share lessons from their experience and to identify HMI schemes with TPP mechanisms that could be candidates for a case study.
- **A series of short case studies** (Annex 1). Seven HMI schemes were selected to detail lessons on designing and managing a TPP mechanism. The selection criteria for inclusion of an HMI scheme as a case study included its contribution toward geographic diversity, and its size (minimum 10,000 insured persons) and longevity (in operation for at least 3 years). Each case study followed a standardized methodology including interviews with key stakeholders involved in the claim process². The seven HMI schemes that met the criteria and contributed data for the case studies are summarized in Table 1.-

The first half of the paper presents the different claims models available to HMI schemes and the pros and cons of using a TPP mechanism among these models while illustrating the current situation in HMI schemes surveyed. The second part presents key issues to address when establishing and managing a TPP mechanism as well as tips and solutions collected from cases studies and experts' interviews.

² Three case studies included a field trip while three were conducted based on phone interviews with the manager of the scheme and exchange of data by email. The Yeshasvini HMI scheme was studied from existing literature with updated statistical information when available:

<http://www.yeshasvini.org/html/statistics.htm>.

Table 1: Summary of Case Study Information

	AFRICA		ASIA				LATIN AMERICA
Name of scheme	Microcare ³	UMSGF	Yeshasvini	CBHI	SKY / GRET	FMiA	Solsalud (Zurich Bolivia and Bancosol)
Country	Uganda	Guinea	India	Lao PDR	Cambodia	Pakistan	Bolivia
Type of HMI Scheme	Commercial insurer	Community based	Community based	Community based	Community based	Insurer + distribution partner	Insurer + distribution partner
No. covered (end 2008)	29 000	16 120	3 060 000	65 000	39 000	19 000	13 000
Provider payment method	Fee for service with fixed fee schedule	Case-based payment and drugs	Case-based payment	Capitation	Capitation and case-based payment	Fee for service with fixed fee schedule	Capitation payment / Fee for service and case-based payment
Funds transfer method	Electronic transfer or checks.	Cash	Checks	Electronic transfer	Cash	Checks	
Health svcs. Covered	Hospital and primary care	Hospital and primary care	Surgery	Hospital and primary care	Hospital and primary care	Hospital and voucher for 1 consultation	Hospital and primary care (drugs excluded)
Number of providers contracted	150	53	295	24	63	4 hospitals and 25 first line health facilities	
Member Cost Sharing	Claims in excess of benefits	Small deductible	Claims in excess of benefits	None	None	Claims in excess of benefits	Co-payment and claims in excess of benefits
Claims admin outsourced?	No	No	Yes (Family Health Plan Limited)	No	No	No	Yes (PROVID)

³ Microcare ceased operations in late 2009 due to a mix of political and regulatory reasons. Nevertheless, the lessons from this scheme are relevant for this paper.

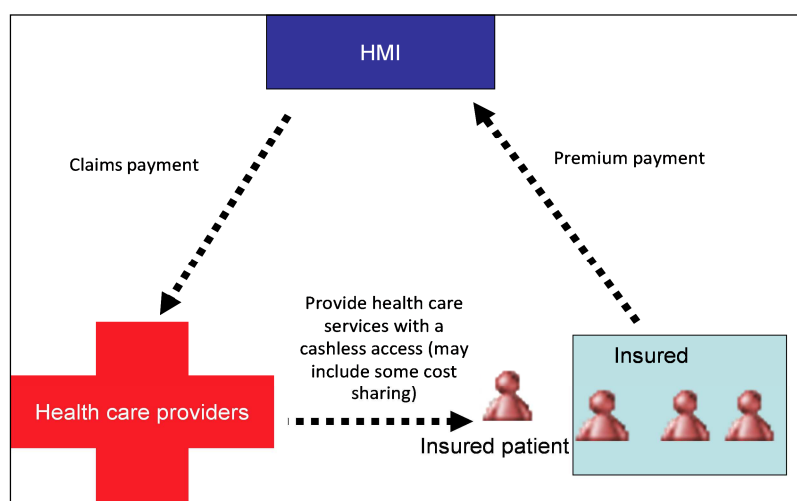
2 > TPP MECHANISM: DEFINITION AND CURRENT STATE IN HMI SCHEMES

2.1 CLAIMS MODELS FOR HMI SCHEMES

When designing a HMI scheme, practitioners must define the conditions to access health care, and the mechanism and entity responsible for claims submissions and payment. TPP mechanisms are one of three major claims models prevalent in HMI (Churchill ed. 2005). Two of these models provide cashless access to insured patients, while the other uses reimbursement of claims.

TPP mechanism: With a TPP mechanism, the HMI scheme arranges direct payment to the healthcare provider on behalf of the insured patient for covered services (Figure 1). With the exception of any cost sharing (e.g. co-payment, deductible), an insured patient has no out of pocket payment at the time of service. As such, TPP mechanisms are frequently cited as one tool to increase value of insurance to low-income persons who may otherwise face significant debt burden to fund the cost of health care, even for a short period.

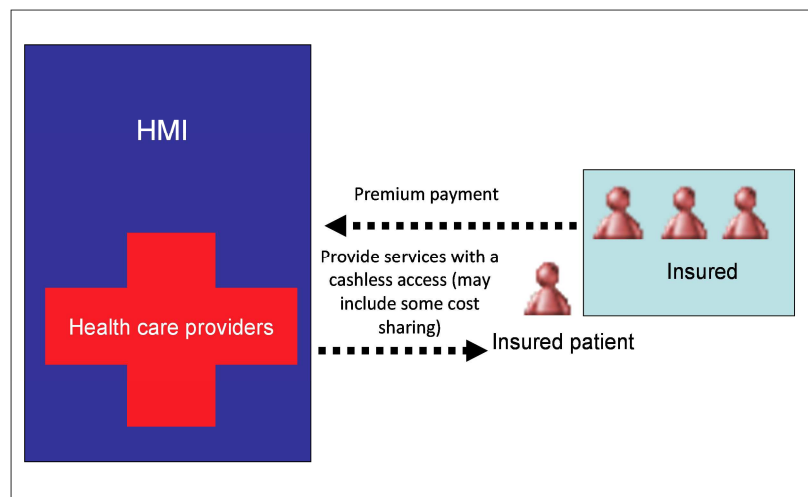
Figure 1: TPP mechanism



Integrated care and financing model: HMI practitioners may own and manage health care facilities (usually to provide primary health care), or health care providers may start HMI schemes, thereby integrating insurance with health care delivery (Figure 2). This is most common when the supply of health care providers is insufficient. In an integrated model, health care providers collect the premium from the insured and provide health care services according to the terms of the insurance policy. The premiums collected in advance by health care providers are expected to cover the cost of the services delivered to insured

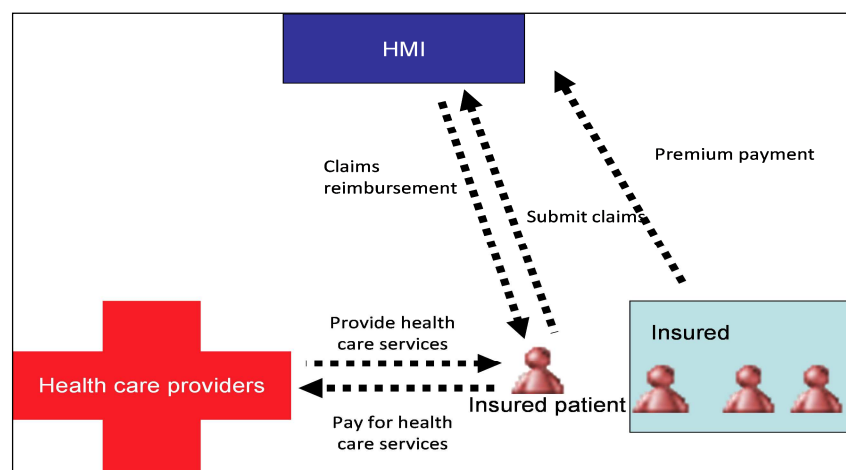
patients. In this situation, insured patients do not have to submit claims. As with a TPP mechanism, in the integrated claim model, insured patients have access to care without paying out of pocket or only paying a moderate part when cost sharing is in place.

Figure 2: Integrated care and financing model



Reimbursement model: With the reimbursement claims model, the insured member pays for health care services at the time of use and then submits claim documents and receipts from health care providers to the HMI scheme to request reimbursement (Figure 3).

Figure 3: Reimbursement model



Practitioners often use a mix of the different claim models depending on contracts with providers and services covered (see Box 2)

Box 2: Claims models in HMI schemes surveyed

The online survey conducted by the Facility in April-May 2009 confirms that the majority of HMI schemes use TPP mechanisms.

Among the 65 HMI schemes that answered the question related to their claims model:

- 52% use a TPP mechanism;
- 22% used reimbursement models. Most of these are in Asia;
- 18% use a mix of TPP mechanism and claims reimbursement (depending on services covered or type of health care providers); and
- 8% use an integrated care and financing claim model.

Among the HMI schemes using only a TPP mechanism (52%), one out of four had not implemented any cost sharing (e.g. co-payment, deductibles) or benefit limits.

Some regional patterns emerge. In Central and West Africa, TPP mechanisms appear to be a standard feature of health mutuals, for which the UMSGF case study is a representative example.

In India, Devadesan et al. (2003) report that only two out of 12 schemes studied were using TPP mechanisms (including the Yeshasvini health care trust, one of the case studies). Five other schemes were integrated into health care providers, and offered cashless access to services. In Pakistan, the National Rural Support Programme started with a reimbursement model and is evolving towards a TPP mechanism based on clients' feedback. All schemes that were developed by First Microinsurance Agency (FMiA), another case study in this paper, use TPP mechanisms.

In Cambodia, Lao PDR and Vietnam, TPP mechanisms are a common feature amongst HMI schemes since they tend to rely less on the integrated care and financing model and since national health financing systems are oriented toward social health insurance with TPP. This is illustrated by two cases in this paper. In Lao PDR, only one Community Based Health Insurance (CBHI) network has developed so far, under the supervision of the Ministry of Health, with a TPP mechanism. In Cambodia, all five existing CBHI schemes use TPP mechanisms. The Ministry of Health has issued guidelines regarding key design features allowing TPP mechanisms with capitation to be negotiated with public health facilities for both primary and hospital care at the district level. At the provincial level, HMI schemes typically pay hospitals on a fee-for-service basis according to a fee schedule.

Responses to the survey from Latin America are too limited to gather a fair picture of claims models used in that region. Five schemes from Bolivia, Colombia and Mexico responded to the survey. Three of these have adopted TPP mechanisms, including *Sol Salud* health care insurance services from *Zurich Bolivia* and *Bancosol*, one of the case studies in this paper.

2.2 ADVANTAGES AND DISADVANTAGES OF USING A TPP MECHANISM

Compared with reimbursement or integrated models, a TPP mechanism has both potential advantages and disadvantages (see Table 2) that differ according to the parties involved:

Table 2: Possible advantages and disadvantages of TPP mechanisms

Party	Possible Advantages	Possible Disadvantages
Insured Clients	<ul style="list-style-type: none"> Eliminate or reduce cash payment at the time of service Enhance access to health care services Reduce delay or avoidance to seek health care Reduce or eliminate administrative burden (e.g. no claims to submit) 	<ul style="list-style-type: none"> Restrict choice of providers Require authorization prior to admission Health care providers may perform unnecessary services that can increase health risk and out of pocket costs
Insurers	<ul style="list-style-type: none"> Simplify claim management (e.g. batch settlement versus claim by claim) Depending on the provider payment method, can align incentives for providers to provide efficient, appropriate care Enable transfer of financial risk (all or part) to health care providers Support market expansion (turn-key operations) Improve quality of care Increase efficiency to collect payments from clients 	<ul style="list-style-type: none"> Increase moral hazard by health care providers and members to provide/seek unnecessary services if member has no financial responsibility when seeking care Contracting health care providers may be difficult and time consuming Some providers may be unwilling to contract if they do not have excess capacity and do not face competition Increase administrative costs and processes, especially in IT Increase claims costs
Health care providers	<ul style="list-style-type: none"> Increase utilization and therefore generate additional revenue Reduce uncollectible amounts from patients Stimulate quality of care (and therefore enhance reputation) Depending on the payment method, can generate <ul style="list-style-type: none"> a) a financial gain b) a stable flow of revenue 	<ul style="list-style-type: none"> Create additional administrative burden to verify eligibility and submit claims Increased patient volume may not offset any discounts or additional costs Increase compliance requirements for quality of care Pressure to eliminate informal charges including bribes Depending on the payment method and utilization, can generate a financial loss Depending on the payment method, it may increase time for payments

3 > PRACTICAL TIPS AND SOLUTIONS TO ESTABLISH AND MANAGE A TPP MECHANISM

The way in which a HMI scheme contracts and manages health care providers under a TPP mechanism can ultimately determine the success or failure of the scheme. It is critical that HMI schemes with a TPP mechanism establish and maintain minimum standards for each participating provider and for the network of providers overall. These standards should address the adequacy of three key dimensions: access to care, cost and quality of care.

3.1 ENSURING ACCESS TO HEALTH CARE SERVICES: SELECTING AND CONTRACTING HEALTH CARE PROVIDERS

The first dimension relates to access to services for members of the HMI scheme through the selection of health care providers. As with regular health insurance schemes, the regulatory environment and location and service offerings of health care providers must be assessed to evaluate which health care providers could be relevant partners for the HMI scheme.

CONTRACTING HEALTH CARE PROVIDERS

Contracting health care providers to participate in a TPP mechanism is most successful when the negotiations are transparent and collaborative, and there is recognition of the objectives of both parties. Endorsements from existing participating health care providers can help a HMI scheme recruit new partners. HMI schemes often seek health care providers that agree to:

- Meet minimum standards for the quality of health care, ideally with the oversight of a medical advisor from the HMI scheme;
- Conduct regular monitoring of quality of care, both internally and/or by external health care professionals;
- Agree to receive payment for services provided under the terms agreed to, and use rational fee schedules;
- Utilize transparent billing and accounting systems;
- Establish an acceptable procedure to verify insured patients' eligibility;
- Share information with the HMI scheme regarding insured members' utilisation of health care services; and
- Potentially support the presence of help desk staff on-site to assist members of the HMI scheme.

Commitments from the HMI scheme to contracted health care providers can include:

- Financial guarantees (e.g. a minimum annual payment until an enrolment threshold is reached, or placing a maximum on potential revenue lost under a capitation arrangement - GRET-SKY);
- Minimum or sufficient member enrolment (Microcare, FMiA);
- A cash advance (UMSGF);
- Tools or support to identify insured clients and determine eligibility for covered services (Microcare, FMiA); and
- Agreeing to a regular review of results under the HMI scheme (volume of patients, revenues, costs, etc.) with the potential to renegotiate terms.

Contracting health care providers can be time consuming, as the contract needs to be comprehensive and clear to avoid future complications. For example, at UMSGF it takes approximately three months to contract an outpatient clinic and six months to contract a hospital. Both parties need to understand what is expected of them and how the relationship will be carried out. Commitment from both administrative and clinical teams within health care providers should be obtained during the contracting process as they may have different expectations for the partnership with a HMI scheme. Above all, HMI schemes should take care to ensure that commitments that can be met, and be prepared to periodically reassess commitments in order to serve the long-term interests of all parties. For HMI schemes that contract public health care providers, involving the health authorities that supervise providers at an early stage can support the contracting process as well as enforce the contract in some cases (GRET-SKY, CBHI).

In some locations, public health care providers are the only available partners that offer health care services at affordable costs for the target population of HMI schemes (e.g. Cambodia, Lao PDR). Often the reputation of public providers is perceived as poor, but it can be possible to form productive partnerships under which quality can improve. In other contexts, public providers may not be allowed contract with health insurers (e.g. in Pakistan, where public providers are officially free of charge), pushing HMI providers to turn to private providers and negotiate costs of health care services (in order to provide affordable premiums).

One of the most difficult challenges to overcome is when there are simply not enough qualified health care providers in a service area. In this case, near-term solutions may be scarce, and it is possible that the TPP mechanism will not be relevant. Long-term approaches include working with governments, donors and other stakeholders to improve the capacity of health care delivery system. Alternatives, including mobile clinics, telemedicine and training of community health workers continue to emerge in an effort to address this dilemma.

MEASURING ACCESS TO CARE

Access to health care services, may be defined by number, type, and location of providers, and the mix of services they offer. The adequacy of a health care provider network to serve the number of enrollees can be monitored through indicators such as waiting time for appointments and the amount and type of care delivered outside of the provider network. A network of health care providers under a TPP mechanism should include providers needed to cover the insured services. For example, if eye surgery is a covered benefit, then ophthalmology providers should be included in the provider network.

Geographic access can be measured using time and distance required to access care. The results of these measurements can be compared to benchmarks such as “85% of members will have access to two or more providers within 20km distance or 90 minutes travel time.” Such standards need to be tailored to urban and rural settings, and should reflect the existing standards in the community.

3.2 MANAGING COST UNDER A TPP MECHANISM

Once potential health care providers have been identified, the success of a TPP mechanism depends on selecting the appropriate payment method and aligning financial incentives to encourage appropriate care. In order to manage costs, the HMI scheme also needs to manage moral hazard and fraud risks for both health care providers and clients.

NEGOTIATING THE PAYMENT METHOD

With a TPP mechanism, HMI schemes usually pay contracted health care providers according to a pre-determined method of payment. The payment method is critical for the scheme’s success. Four common payment methods are outlined below. Each method gives different incentives and disincentives for providers to control the cost and quality of services:

- **Retrospective payment on a fee-for-service basis:** providers are paid (a la carte) for each service performed that is covered by the HMI scheme. Fee-for-service payments can be based on a fixed fee schedule per service, group of services or on the provider’s billed charges. In the case of the latter, payments may be based on a percentage of billed charges (i.e. when a discount is negotiated). This is the most prevalent model amongst the surveyed schemes. In developed countries, discounted fee-for-service payment methods are usually associated with an increase in both the volume of services provided and overall health care expenditure (Langenbrunner et al 2009).
- **Retrospective case-based payment:** providers are paid an all-inclusive (sometimes called “global”) amount, typically for all services provided in connection with a hospitalization or an episode of care that may include pre- and post-hospitalization care. Per case payments can be constant, or

vary according to variables, such as diagnosis or age of patient, that can greatly influence the cost of treatment.

- **Retrospective payment per day:** providers are paid an all-inclusive amount per day of hospitalization. Per diems can vary by type of service or bed, such as intensive care versus surgical or medical ward services.
- **Prospective payment by capitation:** providers are paid a fixed payment per enrollee – per “head” – for a defined period, usually one year. Capitation payments are not affected by utilization of services (volume and type) by the insured; they are made prospectively (in advance) to the health care provider that the enrollee selects. Capitation may apply to a specific health care service or set of services, such as primary (outpatient) care, or capitation can apply at a “global” level, i.e. for all health care including primary, secondary and tertiary care.

It can be difficult to develop fair payments, regardless of the method used, given the wide variation in baseline charges, and the tendency for charges to not be based on cost plus a reasonable margin, or to be supported by accurate data. Another challenge with all payment methods is that health care providers may attempt to “balance bill”, or collect additional fees not reimbursed through the payment made by the TPP mechanism.

Each payment method has advantages and disadvantages as highlighted in Table 3. Measures to offset disadvantages vary depending on the method of payment chosen (ILO/ STEP, 2006; Langenbrunner, Cashin, O'Dougherty, 2009).

Table 3: Advantages and disadvantages of the different payment methods (from the perspective of a HMI scheme)

Method of payment	Advantages	Disadvantages
Per day	Simplify claims administration Transfers financial risk for cost per day to providers Encourages efficient care management (lower intensity of service per day)	Incentive to increase length of stay Incentive to reduce services that may be necessary Incentive to make unnecessary admissions
Capitation	Simplifies claims administration (no claims necessary) Steady revenue stream (pre-payment) for providers (cash-flow advantage) Allows the transfer of financial risk to health care provider	Providers generally unreceptive due to inability to manage full financial risk of care Difficult to price accurately and implement without large enrolment due to high variation in cost to care for small numbers of patients and overall lack of data Incentive to reduce care

	Encourages providers to provide more preventive care and encourage earlier and less costly treatment	Incentive to exclude high risk groups (elderly, HIV-Aids, those with pre-existing and chronic diseases. Encourages inappropriate referral to other providers for expensive cases (when some, but not all health care services are capitated) Can be difficult for HMI scheme to obtain utilisation (encounter) data to reconcile capitation payments with actual experience
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Most of the surveyed schemes with TPP mechanism use a single method for payment, though 36 per cent use a mix of two or more payment methods. The majority (69 per cent) have negotiated fee-for-service payment terms, 40 per cent use a case-based payment method, while 17 per cent have negotiated a prospective payment based on capitation.

The following lessons emerge from the case studies:

- Payment methods that transfer some financial risk to health care providers (case-based, per day or capitation) have greater potential to contain costs than fee-for-service payment, but require additional measures to control for quality of care (see section 2.3). These methods are usually more difficult to negotiate with health care providers (see Box 3).
- Capitation may be an appropriate way to compensate providers for high frequency/low cost (i.e. more predictable) health events, including primary (outpatient) care. This is because it is easier to estimate in advance how often persons will seek primary health care in a given period and the approximate cost for this. Capitation (i.e. pre-paid care) is more difficult to implement for more complicated and infrequent care such as that which requires hospitalization. Capitation can also reduce administrative costs, because claims do not need to be submitted and processed for each health care encounter (see Box 3).
- Capitation seems better adapted to contexts where a critical mass of enrolment can be achieved with a given provider. This is more often attainable when the number of health care providers is limited and/or the enrolled population is significant. Capitation payments are easier to establish and manage in settings where the full range of care can be delivered by the health care provider.

- Mixed payment methods may be suitable in many respects (i.e. capitation for primary health care providers/services and per case for hospital cases), but often complicate administration and increase management costs.

Box 3: GRET-SKY's experience with capitation

GRET SKY (Cambodia) wanted to provide free access to clients to primary health care to limit expensive hospital cases (and thereby contribute to the sustainability of the scheme) and offer an attractive benefit to clients. Capitation was felt to offer the best payment method for primary health care, in part because it could limit the administrative costs associated with the high claims frequency of primary health care and also because it limited the financial risk for the scheme.

Establishing a capitation payment arrangement required lengthy negotiations to address concerns of public health care providers to generate sufficient revenue. Several factors made this negotiation successful:

- The scheme had support from the Ministry of Health as well as the local health authority.
- The first contracted public health facilities were supported by an international NGO that was open to alternative payment methods.
- The contracted public health facilities had excess capacity and were seeking more patients.
- All calculations to determine the capitation amount were transparent to all parties.
- GRET-SKY compensated any financial loss by the provider during the first year if the charges for services rendered exceeded the capitation amount.
- When the number of insured clients was limited and providers were reluctant to participate, the capitation payment per client was "boosted" in order to guarantee a minimum amount of revenue to participating providers. This per member "capitation boost" gradually decreased as the membership increased, and then was constant.

Once a year, GRET-SKY evaluates appropriateness of the capitation amount to achieve financial viability for both parties, and makes any needed adjustments. So far, the capitation amount has progressively decreased for many contracted health providers, as rates were initially "boosted" to encourage participation. GRET-SKY's experience showed that approximately two years was necessary to eliminate subsidy of per person capitation rates (rather than one year as initially envisioned). A critical success factor to implement capitation payments with the provider network was to set initial capitation payments at or near expected billed charges, and to reduce these slowly as enrolment scaled up.

Moral hazard and fraud are standard challenges associated with health insurance. Since insured patients in HMI schemes with a TPP mechanism do not bear the cost of health care at the time of service, the incidence of moral hazard can increase as clients may view the care as free and use additional services that may be unnecessary. Similarly, health care providers often view the insurer as having a greater financial capacity to pay than a patient who must pay directly and thus may see an increased opportunity to deliver services that are covered but which may not be medically necessary.

HMI schemes with TPP mechanisms face similar challenges regarding fraud as schemes that use reimbursement models. Fraudulent behaviour can occur when non-insured patients pose as covered persons, or insured clients seek non-covered services; providers can engage in fraudulent acts by billing for services not delivered or providing unnecessary services to generate additional revenue.

Each of the seven HMI schemes studied has implemented measures to control moral hazard and fraud through strategies to influence both the providers' and clients' behaviour.

Moral hazard by health care providers

It is necessary to monitor utilization, cost and patient satisfaction delivered under various payment approaches, each of which can generate specific types of moral hazard (see Box 4). For example, in fee-for-service environments providers have a well-known tendency to increase the number and cost of services. Examples of how schemes manage moral hazard include:

- **Product design: limit maximum total benefit per person for hospital care** (FMiA and Microcare). This can be an effective way to limit risk exposure but this limits benefits for necessary care for those who incur catastrophic claims. This in turn can reduce both real and perceived value of the HMI scheme from the client perspective, making a “right balance” difficult to achieve.
- **Claims administration: analyse claims and utilization data.** A variety of indicators related to high (or low) costs or utilisation can help identify instances of moral hazard. These include:
 - Number and cost of claims (total, segmented by client category, location, provider, type of service and category (e.g. water borne disease), etc.
 - Frequency and cost per unit (e.g. number and cost of hospital admissions per thousand members per year)
 - Average length of stay, expressed in days per admission (for hospitalisations)
 - Incurred claim ratio (Incurred claims/ earned premium)
 - Billed charges as a per cent of total capitation (for schemes with capitation)

Routine (e.g. monthly) monitoring of key performance indicators can be essential to monitor a HMI scheme's incidence and type of moral hazard. Interpreting these indicators requires access to a developed information system and knowledge to analyse data. For schemes that use a case-based payment, the focus should be on ensuring that the length of stay and provision of services during that stay are appropriate, and that providers do not claim for more complex diagnoses or treat unnecessary cases to increase revenue. In previous schemes such as FMiA, the claims at times are reviewed twice before being sent to the insurer for payment: a first review is done at the time of discharge by a sales officer, who could then refer questionable claims for a second review to a FMiA medical advisor. Schemes using a prospective payment approach such as capitation need to monitor for under provision of health care, because health care providers may restrict care to maximize profits.

- **Medical management: implement utilization management controls.** Interventions such as pre-authorisation or concurrent review can manage both cost and quality prospectively and concurrently and reduce moral hazard. However, such activities (e.g. implementing treatment guidelines) can be complex and costly to administer, and are often perceived as a hassle by providers as well as clients.

Box 4: A co-payment to limit client moral hazard induces moral hazard by providers being paid capitation: GRET-SKY in Cambodia

The HMI schemes in the case studies that use capitation do not require any out of pocket costs to be borne by clients, even for primary health care (e.g. outpatient consultations). In one scheme, GRET-SKY, a contracted provider requested that a co-payment be implemented to discourage frivolous use of health care services. What was observed, however, was that the health care provider actually encouraged additional (and potentially unnecessary) visits to supplement the capitation payments with the co-payment collected at each visit. The co-payment has since been discontinued and the provider receives compensation for care solely through capitation, while the GRET-SKY monitors utilization and patient satisfaction to assess whether access to and use of care is appropriate.

Moral hazard by clients

When access to health care is free or nearly free for patients, the risk of over-utilization, especially of outpatient services, increases. A common strategy is to include some form of patient cost-sharing (Microcare, UMSGF). Additionally, many schemes implement a gatekeeper mechanism, which requires a referral by a primary care provider to access specialist consultations or hospital services. In low-income populations enrolment in an HMI scheme often triggers an initial period of high utilization due to pent-up demand and deferred care, especially for elective procedures (e.g. hernia repair).

Fraud

Lessons from case studies show that HMI practitioners understand that a zero fraud target is not realistic.

Strategies to control fraud include:

- ***Issue a family or individual insurance card***, usually with a photo. Findings from the online survey show that 67 per cent of the schemes with TPP mechanisms use an identification card with a photo, and only 14 per cent (six schemes) use a more technologically advanced approach with a smart card that allows electronic verification of eligibility. Photo identification cards, however, present challenges and there are ways to verify identification with using cards without photos (see Box 5). Identification cards add administrative cost, so savings through fraud reduction must offset the additional cost. Cards may not be effective in controlling fraud when health care providers do not correctly use them, or if the provider is complicit in fraud, such as to receive payment from the insurer for an uninsured client who may lack funds to pay for care. Photo identification cards can also be problematic to prepare, as often the client and insured family members must obtain, pay for, and present photos to the insurer. Finally, in some locations photo identification cards may be unacceptable for religious or other reasons, particularly for females.
- ***Check identification through liaison officer and technology***: A liaison officer can foster a “client culture” by assisting clients to better understand the benefits of their scheme, and ease the burden on providers to verify eligibility. Nevertheless, the health care provider still has an important role in managing fraud, and must be trained accordingly. Having an insurance liaison inside contracted health facilities entails a risk of internal fraud that needs to be heeded. For example, Microcare rotates nurses managing the liaison function at a health care provider to limit the potential of fraud. Microcare also observed a reduction in claims of 30% when a computerized check-in desk was introduced in a clinic. The reduction was attributed to a reduction in fraud, which could occur when uninsured persons accessed care under the name of an insured person.
- ***Require pre-authorization of high cost services and hospitalisations***. A gate-keeping function to limit fraudulent health care utilisation is especially important when providers receive fee-for-service payments (FMiA, UMSGF, Yeshasvini). Typically, the insured person must request an authorization from the scheme to access health care services. Timeliness of the authorization is important to maintain client satisfaction. Authorizations of emergency cases are usually done retrospectively, within 24 hours. When possible, a toll-free telephone/fax process can be implemented to speed up the process (FMiA and Yeshasvini). With advances in and more widespread availability of technology, internet-based options using mobile phones, computers or handheld or point of service devices are being introduced. Pre-authorization remains problematic for primary health care, due to the higher frequency of services, and less clear criteria available for their use (e.g. when is it necessary to seek medical care for a headache?).
- ***Provide accurate and up-to-date lists of eligible clients*** to health care providers. This is critical for schemes with capitation payment. This is simpler for HMI schemes that limit enrolment, e.g. to once a year, but more demanding for HMI schemes, such as GRET-SKY and CBHI, that maintain an open enrolment. Both of these schemes have clear procedures and deadlines to ensure that eligibility data are provided to health facilities early each month.

Box 5: Controlling fraud without photo identification: FMiA in Pakistan

After testing a smart card with photographs that could be read at hospitals using a card reader, FMiA began using a more simple identification process that uses national identity cards with photographs. FMiA issued an insurance card without a photograph, and requests the insured to show his or her national identity card (NIC) at the time of admission. The risk of fraud remains for children who have no NIC. In cases where a NIC has not been issued or is not available, birth certificates are requested. A thumb print identification system was considered, but ultimately not implemented due to the time and cost expected to obtain thumb prints for all members at the time of registration. FMiA additionally managed fraud using a pre-authorization process and a “gate-keeping” system with FMiA staff located at contracted hospitals.

3.3 MANAGING QUALITY UNDER A TPP MECHANISM

In addition to access and cost, the third dimension of standards application to contracted health care providers under a TPP mechanism is quality of care. Quality may be defined using both objective and subjective criteria, and can be measured with clinical indicators as well as non-clinical or service indicators. Clinical outcomes, such as infection rates, are examples of objective quality of care indicators. Since clinical outcomes data and/or benchmarks or protocols are often not available, other criteria may be used as a next best alternative. For example, the credentials of health care providers are often evaluated as a proxy for clinical quality. Sometimes claims data can be mined to develop retrospective assessments of quality, using health care professionals to analyse treatment patterns. Service quality, defined by indicators such as hours of operation or scope of services offered, may also be measured.

Subjective quality of care, sometimes referred to as the patient experience, typically reflects a patients' perspective as to how they feel about the health care they received. Subjective views may be measured through surveys or focus groups on a range of topics such as comfort of facilities, perceived attitudes of health care providers, value for money, etc.

PROMOTING AND MONITORING QUALITY OF HEALTH CARE SERVICES

HMI schemes require members to use a defined network of participating health care providers when they implement a TPP mechanism. Thus, poor quality of care provided at network facilities – whether real or perceived – can hurt client retention and the reputation of the HMI scheme. As indicated in Table 3, HMI schemes that use capitation payment can be even more vulnerable to quality of care issues, as providers may have a financial incentive to restrict care.

Measuring quality of care

In order to promote quality of care, HMI schemes must find objective ways to measure it (Box 6). One way to do this is to compare the actual number and type of services (e.g. admissions per thousand clients; number of encounters with the primary health care provider per person per year, number of prescriptions per consultation, per cent of children immunized, etc.) to expected morbidity (sickness) and mortality (death) norms. It can be challenging to develop norms. Ultimately, with sufficient quality and quantity of data, the comparison should be possible. However, great care must be taken when interpreting the data because there can be many natural variations in clinical outcomes across patients. These variations may be explained, for example, due to nutrition, education, sanitation, occurrence of natural or man-made disasters, etc.

HMI schemes can evaluate the frequency and type of health care services being delivered to individual patients, or by specific health care providers. The HMI scheme (ideally a clinical professional from the HMI scheme) can meet with health care providers to discuss unusual cases and trends, and develop appropriate interventions.

Box 6: Monitoring the service quality of health care: the case of Bancosol and Zurich Bolivia with PROVID

Zurich Bolivia and Bancosol have a TPP mechanism in place with a third party administrator, PROVID. PROVID receives a capitation payment (and then pays contracted health care providers according to various methods of payment including fee-for-service, etc.). PROVID monitors utilization of health services and maintains claims data. PROVID also performs regular spot checks of service quality in contracted health facilities by sending its staff to pose as potential patients to test how they are received and treated.

Because Bancosol distributes the HMI product to its microfinance clients, comment boxes have been placed in Bancosol branches to allow insured clients to comment on the HMI services. It is critical for the microfinance institution to make sure that clients are satisfied with HMI scheme as otherwise it could damage Bancosol's reputation.

Setting standards for quality

In all seven case studies, the HMI schemes' provider contracts establish standards for various aspects of quality. For example, contracts often require that insured patients be treated the same as non-insured patients in terms of access to services and clinical standards of treatment. The behaviour of health care providers toward HMI scheme members should be monitored for any evidence that members receive inferior service. This can occur because of a perception that a patient not paying cash out of pocket at time of service, or who is receiving discounts or special rates, is socio-economically inferior. Some contracts under TPP mechanisms stipulate adherence to treatment protocols or care guidelines, and ensuring availability of essential drugs.

Box 7: Improving quality of care: UMSGF in Guinea

Despite collaborative relationships with health care providers, quality of care is a core challenge for UMSGF. The HMI scheme has taken a number of measures to improve the situation.

Contracted health facilities are under-financed and face significant drug shortages. To improve the quality of care (and client satisfaction) UMSGF began to cover the cost of drugs purchased in private pharmacies when prescribed by a contracted hospital. Unfortunately this initiative resulted in a rapid rise in claims costs and thus had to be stopped. Now, a revolving fund for drugs has been set up with donor support to purchase a stock of drugs that can be provided to clients when a prescription is not available directly from a contracted provider.

Additionally, financial incentives have been set up to encourage medical staff to provide appropriate care to insured patients and limit unauthorized payments by patients (e.g. bribes for drugs). More recently, a liaison officer was assigned to each contracted facility to ensure that insured patients are appropriately welcomed and served.

In other contracts, such as that of UMSGF (see Box 7), health care providers are prohibited to request additional fees beyond those established in the plan of benefits, e.g. co-payments. Such provisions exist to dissuade fraudulent practices that can be rampant in facilities where salaries are low or a culture of corruption prevails.

For some HMI schemes, a performance-based contract may be a useful solution to promote quality of care. GRET SKY is currently testing a performance-based contract with a capitation payment adjusted by utilization rates. Targets for utilization of services are set with each provider and a capitation payment is associated with this target. If the actual utilization is below target, providers receive a decreased capitation payment. When utilization exceeds the target, health care providers also receive a decreased capitation payment, but to a lesser extent. The objective is to encourage health providers to achieve an optimum (desirable) utilization, and to discourage potential over-utilization. The use of utilization as an indirect indicator of clinical quality can be useful in a context where more specific measures of clinical quality may

be unavailable. The system is currently being tested and its impact will be documented after sufficient experience is gained.

Promoting clinical quality through medical advisors

Related to clinical quality, cases studies show that medical advisors can play a key role in measuring quality of care against defined standards, especially when a health care provider is not directly engaged in claims and care management (FMiA, UMSGF, GRET-SKY, CBHI). A medical advisor monitors quality of care with health care providers, through these main functions:

- **Assessing the extent to which insured patients receive appropriate health care services according to diagnosis and health status.** This assessment can be either 1) prospective, when authorizing treatment or assessing a provider against network participation criteria, 2) concurrent, such as through case management of a hospitalization, or 3) retrospective, through analysis of claims, encounters or surveys of patients.
- **Screening and periodically auditing of the general quality of care in contracted health facilities.** Quality indicators can include simple and measurable criteria such as hours of operation, availability of medical staff, availability of essential drugs and diagnostic equipment and hygiene.
- **Implementing and monitoring compliance with standard treatment protocols.** Such protocols may be in the public domain and published by organizations like the World Health Organization or a Ministry of Health, as seen in Cambodia and Lao PDR, or they may be proprietary and developed by the HMI scheme and/or its network providers.

Promoting service quality through liaison officers

All seven case studies confirm that clients may perceive greater quality in a HMI scheme when a liaison officer assists them to access care and to submit claims. Liaison officers often perform tasks such as:

- Welcoming patients, and orienting them to the facility
- Verifying benefits and eligibility
- Registering new enrollees and collecting premium
- Visiting hospitalized patients and serving as an advocate to be sure appropriate care and services are being rendered, and helping prepare the patient and family for discharge
- Collecting feedback on patient satisfaction and outcomes through surveys or interviews

Liaison services can increase the perception of value and quality and in turn increase trust in the scheme and encourage renewals, contributing to the scheme's sustainability. They have a cost, however, so HMI schemes must evaluate when and how to efficiently provide such services. For example, the HMI scheme must decide whether to provide a liaison service for hospitalizations or to additionally be present in outpatient settings. An optimal cost-benefit arrangement may be achieved by providing a liaison at facilities that have a minimum number of clients or claims (Microcare). Another cost-efficient strategy can be for a liaison officer to cover several facilities on a rotating basis, or only during peak hours (GRET-SKY). Technology developments such as the spread of mobile phones have also stimulated development of call

centres which can remotely provide many of the liaison services desired, at a considerably lower cost (five case studies, including FMiA).

ENSURING TIMELY PAYMENT TO HEALTH CARE PROVIDERS

In a context where health care providers often struggle to maintain sufficient cash flow to fund operations, many experts interviewed commented on the importance for HMI schemes with a TPP mechanism to make timely payments to providers. Contracts with health care providers typically stipulate the terms for payment, including the maximum time allowed for payment of capitation or reimbursements. Failure to abide by contractual terms can lead to refusal to treat patients or to demand pre-payment, which can damage the HMI's reputation amongst both clients and providers, and may even result in contract termination. Managing quality under a TPP mechanism therefore includes paying health providers on time.

Payment by check or electronic transfer can lower risk of fraud or loss, though some schemes (e.g. UMSGF in Guinea and GRET-SKY in Cambodia) use cash. The type of payment method (i.e. retrospective or prospective) can influence results, as illustrated below.

TPP mechanisms with retrospective payment

Lessons learned from TPP mechanisms to successfully pay health care providers on time and accurately are:

- Spot checking by the claims administration team to identify problematic claims;
- Clinical review by a medical advisor focussing on problematic cases only;
- Computerized systems that provide data for prices and services covered;
- Decentralized systems to capture data directly at the health care provider level (admission and discharge);
- Payments to providers preferably by electronic transfers and/or cheques to avoid cost, time and risks associated with cash transactions.

Microcare reduced its claims payment from 30 days to 14 days with a reorganization of the claims department into five units, each specialized in one task of the claims process (see Box 8). At Yeshasvini, claims are sent by health care providers to the third party administrator which assesses the claims, with support from a medical advisor. These claims are reviewed by the Yeshasvini Trust during a monthly meeting and those that are approved are paid by check to the third party administrator, which in turn pays health care providers by check. The timeliness of payment to health care providers varies from 15 days (target) to three months. Delays in payment are usually not problematic for larger hospitals but might be problematic for smaller clinics.

Box 8: The claims administration function: the example of Microcare in Uganda

In 2009 *Microcare* divided its 12-person claims administration team into five units. Each administrative unit fulfilled the following tasks:

- Invoicing - unit matches claims with health care provider invoices (sent often in batches). Discrepancies are sent to the investigation unit.
- Data entry - data from paper claims are entered into the computerized database. The system automatically alerts *Microcare* staff when charges for key services and drugs exceed acceptable limits. A query is made to validate the appropriateness of the charge.
- Data analysis - a medical doctor reviews the appropriateness of the diagnosis and corresponding treatment, and a drug specialist checks prices and benefits allowed for drugs to identify possible occurrences of fraud or inappropriate billing. Questionable claims are queried further; approved claims are sent to reporting.
- Investigation - administrators follow up with health care providers to resolve questions about claims (e.g. missing or inconsistent information, unexplained charges, etc.).
- Reporting - approved claims are sent to a supervisor for a final review and approval, which triggers a request to the accounting department to issue payment.

TPP mechanisms with prospective payment by capitation

With capitation, the HMI scheme pays a fixed amount per insured person assigned to a health care provider. A per capita payment approach can be rather simple when enrolment information is accurate and timely and fixed for a longer period of time, such as a year. Capitation payments become complex to administer when a HMI scheme permits open enrolment, or when retroactive adjustments due to delayed or incorrect enrolment data are required. Capitation can be more difficult to administer if the per capita payments are made more frequently (e.g. monthly), and when payments by member vary by factors such as age, gender, or location (GRET-SKY, CBHI - see Box 3). Additional challenges can arise related to premium collection and policy administration rules. For example, a waiting period may be mandatory to reduce adverse selection, requiring the HMI scheme to defer capitation payments until the waiting period has elapsed; or a grace period may apply for unpaid premium before a policy is cancelled, creating challenges for the HMI scheme to make payments (see Box 9). As these complexities occur, and schemes scale up, the need for management and information systems expertise increases.

Box 9: Balancing premium and capitation payments: CBHI in Lao PDR and GRET-SKY in Cambodia

Delays or gaps in premium collection can create delays or leave a HMI scheme with insufficient capital to make prospective capitation payments to health care providers. Two schemes, CBHI in Lao PDR and GRET-SKY in Cambodia, allow a three-month grace period for members to pay monthly premiums due. In CBHI, members can avoid cancellation if they pay three months premium in arrears at the time of paying the fourth month's premium, but for many, this is unaffordable, and local scheme premium collectors are reluctant to enforce cancellations. Instead, members may pay for one month, then skip two, and then pay for another month to avoid cancellation, at least until planned health care services can be utilized. This creates additional administration and affects the schemes' ability to make timely capitation payments to health care providers, and collect adequate premiums.

To minimize such difficulty, GRET-SKY requests three months premium at enrolment to establish cash reserves for capitation payments and to reduce the occurrence of unpaid premiums. This approach has not been implemented in CBHI Lao PDR as the district schemes are not computerized and lack capacity to manage advance premium payments.

4 > CONCLUSION

TPP mechanisms were found within a majority of HMI schemes surveyed as part of this study. This finding is likely due to the **potential advantages of a TPP**, though may also be influenced by any bias in the sample selected, or in responses received. A primary advantage of implementing a TPP mechanism is to increase value for clients by eliminating all or almost all out of pocket costs for care at the time of use. A TPP mechanism also offers potential advantages to HMI schemes and can contribute to their sustainability:

- More rational and fair pricing of health care services
- Increased quality of care, potentially leading to better health outcomes
- More optimal utilisation of services, leading to better care and lower costs
- Improved administrative efficiency
- Better client service (leading to higher enrolment/retention)

Despite these potential benefits, **TPP mechanisms also create challenges** that HMI schemes must monitor and manage. These challenges include:

- Lack of quality providers to build an adequate provider network that offers clients all covered services and also choice and convenience
- Unwillingness of health care providers to contract as part of a TPP mechanism, in particular to agree to financial and administrative requirements imposed by the scheme
- Lack of information system technology; limited infrastructure (e.g. unreliable electricity)
- Insufficient know-how to monitor and manage TPP mechanisms
- Challenges to monitor and manage claims expenses and administrative costs without creating burdensome procedures (and costs)
- Dependence on the financial payment method used, risks of fraud and abuse by both clients and health care providers
- Risks associated with influencing clients to use certain providers when the client is dissatisfied or there is a poor outcome

HMI schemes cite numerous lessons learned about TPP mechanisms:

- Successful contracting with health providers requires a long-term approach to a partnership. Health care providers may agree to alternative payment mechanisms such as capitation, provided they perceive the terms to be sufficient to allow them to cover costs and make a fair profit.
- The ability of the HMI scheme to manage moral hazard, fraud, claim and administrative costs and to provide timely service will heavily depend on the quality and efficiency of its information system and processes.

- Approaches that encourage better objective quality of health care may be summarised as follows:
 - Assessing the extent to which insured patients receive appropriate health care services according to diagnosis and health status.
 - Auditing the quality of care in contracted health facilities according to standard indicators.
 - Implementing and monitoring compliance with standard treatment protocols.
- Approaches to improve perceived quality of health care include:
 - Locate a liaison officer at contracted health care providers to support admissions and discharge planning.
 - Monitor simple and measurable indicators of perceived quality of care, such as hours of service and patient satisfaction.
 - Set up a 24/7 help line (ideally, toll free).
- Payment methods that transfer some financial risk to health care providers (case-based, per day or capitation) have greater potential to contain costs than fee-for-service payment, but require additional measures manage quality of care. These methods are usually more difficult to negotiate with health care providers.
- Capitation payment may be an appropriate way to cover high frequency/low cost (i.e. more predictable) health events, including primary (outpatient) care without jeopardizing the financial viability of the health care provider or burdening claims management, and seems better adapted to contexts where some critical mass of enrolment can be achieved with providers.
- HMI schemes that pay claims based on fee for service may be tempted to restrict care covered in order to limit the number and cost of claims in response to health care providers responding to a financial incentive.

Implemented properly, TPP mechanisms can increase the value for low income clients and health care providers, while contributing to the sustainability of HMI schemes. Cases studies and experts' interviews also indicate that multiple contextual factors such as the extent to which a regulatory environment supports HMI, whether public and private (or both); adequacy of health delivery infrastructure; and availability of financing (public or private) can enable the development of HMI schemes and TPP mechanisms to support them.

Additionally, HMI schemes may be willing to engage a TPA to manage their TPP mechanism and maintain a sufficient health care provider network, especially when scaling up and expanding geographically. In most developing countries, affordable and well functioning TPA services tailored for the poor may be difficult to find (or unavailable), though this is changing with the development of internet based systems, use of mobile phones for data transfer, etc. A more in-depth review of the availability and pros and cons of Third Party Administrators of TPPs merits further attention.

As a HMI scheme matures and reaches some degree of volume and complexity, investment in information technology and improved collection and analysis of data becomes increasingly necessary and cost-justified not only to manage moral hazard but also to assess quality of care, to identify ways to improve the product, etc. The deployment of information technology and expanding analysis of the scheme's performance should be part of the scheme's business plan to achieve scale and viability.

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ANNEX 1: CASE STUDY DETAILS

Table n°1: Findings from case studies / Membership, financial viability and efficiency of the claims management process

	AFRICA		ASIA			LATIN AMERICA	
Name of the HMI scheme	Microcare health insurance services	UMSGF	Yeshasvini	CBHI	SKY / GRET	FMiA (Northern areas)	Solsalud (Zurich Bolivia and Bancosol)
Country	Uganda	Guinea	India	Lao PDR	Cambodia	Pakistan	Bolivia
Starting date	2000	1999	2003	2002	1998	2007	2006
Membership (insured persons over the last 3 years)	29 000 (informal population 2009) + 50 000 (employees 2009)	15 517 (2006); 23 346 (2007); 16 120 (2008)	1 850 000 (2006) ; 2 230 000 (2007); 3 060 000 (2008)	65000 (2008)	8926 (2006);11196 (2007);34761 (2008)	6044 (2007) ; 19518 (2008); 9106 (2009)	4924 (2006); 8200 (2007);13000 (2008)
Geographic coverage	na	5,1% (2006); 6,7% (2007); 4,8% (2008)	27% (2006)	from 1% to 25% depending on the village	from 3% to 13.5% depending on the health center zones	na	na
% of women	na	na	38% (2006)	na	52% (2006 to 2008)	42% of adults (2008)	na
Renewal rate	70%	65% (2006); 87% (2007); 58% (2008)	50 -55% (2006)	na	na	47% (2009)	80-85%
Breakdown of expenditure of the scheme (or % of administration cost)	na	Premium is shared: 63% health care services; 2% guarantee fund; 17,5% Technical unit cost / Union; 4% to the management board of mutual; 4% to the manager of the mutual and 9,5% are kept for the mutual running costs. CIDR is subsidizing the functioning of the Union and its technical unit.	ACR 1.5% (2005) ; 5.5% for FHPL ?	Administration costs are limited by CBHI regulation to 10% of the premium	Since the scheme did not yet reach a sufficient scale the operational and administration costs represent 75.2% of the total expenditures and the payment to health providers represent 24.8%.	Current split of the premium: 75% is going to NUJ life and 25% is going to FMiA.	The premium is currently split in 12.5% for Bancosol and 87.5% for the insurer and health providers
Incurred expenses ratio	na	Na	na	na	The current split of the premium is 64% for health costs that fully covered and 36% for operational costs which is insufficient and operational costs remained subsidized by donors.	Currently NUJ life is absorbing the technical loss and FMiA is subsidized by Aga Khan Agency for Microfinance	No data available but the TPA is currently making reserve on the capitation received
Claim rejection ratio (claims rejected/total claims submitted)	5% sent to adjustment in 2008 and 40% may be rejected (estimate)	NA	0.3% (2006); 0.7% (2007); 3% (2008)	No rejection in capitation but few cases discussed per month	No rejection in capitation but few cases discussed per month (average of 5 cases/month).	No rejection reported so far but invoices partially rejected at FMiA level not at insurer's level	NA
Promptness of claim settlement	14 days on average and possibility of one day process	No follow up on that indicator but 2 months minimum against 15 days planned in the contract	Payment by the TPA, from 15 days to 3 months	Monthly advance payment before the 10th of the month	Monthly advance payment before the 5th of the month. Capitation payment can be suspended in case of major problem but it never happened	No follow up on that indicator but within 30 days as planned in the contract.	NA

Table n°2: Findings from case studies / Value for main monitoring indicators (when available)

	AFRICA	ASIA				LATIN AMERICA
	UMSGF	Yeshasvini	CBHI	SKY / GRET	FMiA (Northern areas)	Solsalud (Zurich Bolivia and Bancosol)
Name of the HMI scheme						
Country	Guinea	India	Lao PDR	Cambodia	Pakistan	Bolivia
Starting date	1999	2003	2002	1998	2007	2006
<i>Claims management</i>						
Incurred claim ratio (incurred claims/premium)	70% (2006); 59% (2007); NA (2008)	91% (2006); 97% (2007); 86% (2008)* with government subsidy	na	90% (2006); 75% (2007); 64% (2008)	133% (2008); the target is 65%	NA
<i>Utilization of health care</i>						
Out patient care (primary health care)	0.3 contact per insured per year (2006) ; 0.4 (2007)	Not applicable	1.1 (2008); 0.9 (2009)	4.1 (2006); 4 (2007); 2.32 (2008)	1 voucher per person/year	Claims incidence : 4.14 (2007); 3.71 (2008)
Hospital care (hospitalization)	2.9% (2006); 3.7% (2007)	2.1% (2006); 2.6% (2007); 2.4% (2008)	6.4% (2008) ; 7% (2009)	8% (2006); 17% (2007); 8% (2008)	12.5% against 5.8% expected (2008)	
<i>Average cost of health care</i>						
Out patient care (primary health care)	1.8 USD (2006); 1.2 FG (2007)	Not applicable	4 USD at district hospital and 11 USD at provincial hospital (August 09)	0.4 USD at health center (stable over years); 1.5 USD at district hospital and 2.7 USD at provincial hospital (2008)	Not applicable	NA
Hospital care (hospitalization)	16.4 USD (2006); 16.5 USD (2007)	210 USD (2006); 191 USD (2007); 174 USD (2008)	20 USD at district hospital and 96 USD at provincial hospital (August 09)	9 USD (2006); 12 (2007); 16 (2008) at district hospital and 32 (2006); 36 (2007); 41 (2008) at provincial hospital	44 USD against 40 USD expected (2008)	NA

Table n°3: Findings from cases studies/ Information related to the payment of health care providers

	AFRICA		ASIA			
Name of the HMI scheme	Microcare	UMSGF	Yeshasvini	CBHI	SKY / GRET (Rural scheme)	FMiA (Northern areas)
Country	Uganda	Guinea	India	Lao PDR	Cambodia	Pakistan
Starting date	2000	1999	2003	2002	1998	2007
Provider payment method	Fee for service with a fixed fee schedule	Case-based payment + drugs	Case-based payment	Capitation	Capitation and case-based payment	Fee for service with a fixed fee schedule
Number of providers contracted	150	53	295	24	63	4 hospitals and 25 first line health facilities
Funds transfer method	Bank wire transfers or cheques.	Cash	Cheques	Bank wire transfer	Cash	Cheques
Authorized delay of payment after claims submission	30 days	15 days	15 days	The 10th of the month	The 1st of the month and not later than the 5th	30 days
Promptness of payment	14 days	2 to 5 months	15 days to 3 months	Not monitored but around the 10th	Not monitored but before the 5th	No delay has been reported

ANNEX 2 - LIST OF EXPERTS INTERVIEWED

Name of the experts interviewed in March and April 2009 for the study on TPP

General expertise in health insurance
Aviva Ron, Specialist in social health insurance
Denis Garand, International microinsurance expert
Frank Droin, KADRIS consultant
Guy Carrin, WHO (health financing)
Jean Perrot, WHO (contracting)
Asia
Annie Asanza, International microinsurance expert, Philippines
Cédric Salze, GRET, Cambodia
David Dror, Microinsurance Academy
François Xavier Hay, Director of Political Partnership/ MACIF
Kent Ransom, WHO
Kimberley Switlick Prose, Deloitte consulting
Africa
Alain Letourmy, researcher CNRS
Bart Criel, researcher IMT Anvers
Bruno Galland, expert with CIDR
John Pott, Aga Khan Microfinance Agency
Olivier Louis Dit Guérin, ILO STEP Africa
Richard Leftley, CEO, MicroEnsure
Latin America
Lisa Beichl, independent consultant (formerly with Milliman)
Philippe Marcadent, ILO

MICROINSURANCE INNOVATION FACILITY

Housed at the International Labour Organization's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation.

See more at: www.ilo.org/microinsurance

