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USAID Health Finance and Governance Activity

Diagnostic Study of Selected Public Insurance Payers: Equity and Sustainability

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Background

This diagnostic report encapsulates four of HFG's main analysis from year one to ensure greater equity and sustainability in the public health sector.

In the last few years, an emerging interest in health sector sustainability and equity has emerged globally. It represents a significant, but largely overlooked aspect of health sector reform efforts especially in Jordan. As a result, USAID Health Finance and Governance Activity (HFG) supports and works with the health sector's stakeholders both public and private, civil society, and donors to support Jordan moving systematically towards its goal of universal health coverage (UHC). HFG does this by using a health systems strengthening approach aimed at correcting structural and system-related weakness and improving efficiency within Jordan's health finance landscape, and improving public sector health governance. Through HFG technical support, policy reform, and systems development, stakeholders are able to better respond to current needs and challenges facing Jordan.

The changing demographics in Jordan pose great strain on Jordan's public services and resources, including health care. Between 1979 and 2015, the population grew from 2.1 million to 9.5 million. In addition to this, recent increases in refugees from Iraq and Syria have pushed the population to approximately 10 million today and it is expected to exceed 13.2 million in 2040 without consideration of additional regional conflict which could push this number much higher. Such a high-density population has led to the increased demand for health care services, along with overcrowding in many health care facilities across the Kingdom. The refugee crisis has also contributed significantly to the existing burden of disease. In brief, there is considerable pressure on the health system and its resources.

Unfortunately, increased population has not brought a corresponding increase in government revenue. This has created a health system that struggles to meet the needs of the population and within the public sector is continuing to see increased cost and accumulating debt. Debt within the Ministry of Health exceeded 440 million JOD at the end of 2017. Coupled with this, the primary public insurance providers (Civil Insurance Program and Military Insurance Program) are operating without a clear strategy to cover costs and require large government subsidies to support them. They continue to operate with annual loss that is a major contributor to increased public debt. This creates an unsustainable situation for health care provision in Jordan and establishes a critical need for reforms and systems strengthening in order to reduce financial risk for the health care system.

HFG has emphasized the need to improve the financial and institutional sustainability and equity of Jordan's public health system throughout its work in order to meet the increased demands of the growing population. This diagnostic study helps in defining a framework for interventions and change that can help to promote UHC and increase financial sustainability of public health insurance. This study summarizes recent work by HFG and provides a collective set of recommendations for public insurance providers and the legal and administrative system impacting on insurance.

1. Health Sector Key Stakeholder Interviews Applied Political Economy Analysis (April 2017)

The political economy analysis aimed at providing a qualitative dimension to areas of importance to the work of HFG. The qualitative study distinguished between several areas of inequity in Jordan that focuses primarily on public insurers, namely: (1) regional disparities in service coverage across

areas in Jordan, (2) women's care being reduced to reproductive care, (3) non-workers or those in the informal sector are left uncovered, (4) and finally those categories of senior civil servants who benefit disproportionately from very generous coverage.

Furthermore, the qualitative study identified a number of concerns that affect the sustainability of health coverage in Jordan. (1) Thought leaders expressed the need to increase premiums, (2) at the same time reforming the basis of offering Royal Court support to those in need. Finally (3) The leaders usually agree with the concept of a single public insurer.

The qualitative study unveiled a particular misconception about thought leaders regarding the Essential Benefits Package. There are views benefits packages, in general, are relevant to the private sector only. Some interviewees were concerned that the Essential Benefits Package will limit services in the public sector. The qualitative study concludes that there is a need for capacity building around Essential Benefits Package.

2. Jordan Association for Medical Insurance Conference Participant's Opinions on Governance and Financing Issues in Jordan (May 2017)

HFG utilised the platform of the 2017 Annual Comprehensive Health Insurance Conference held by the Jordan Association for Medical Insurance (JAMI) May 2017, to conduct a brief quantitative survey to capture what participants perceived to be the most significant priority areas in Jordan.

HFG held an interactive session to assess participants' opinions, reactions, and thinking on 11 health sector governance and financing statements related to advancing UHC in Jordan. The insights gained from the session can help HFG sequence and prioritize work, allocate resources appropriately to tasks, and develop approaches to controversial topics that will maximize the opportunities for success and minimize avoidable roadblocks.

The main conclusion from the survey is that there are two statements on which there was overwhelming agreement—the need to unite all public schemes into a single public health insurer, and that all people in Jordan should be required to have health insurance. Both statements are hugely important and concern the fundamentals: most importantly, they can be categorized into two main pillars: equity and sustainability.

11 Statements of the JAMI Survey (May 2017)

- Jordan should have a single, public health insurer.
- Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care.
- All individuals should be required to participate in a public or private health insurance scheme.
- All individuals should be required to register with primary care clinics.
- There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less.
- Funds used by the Royal Court to pay for healthcare of the uninsured should be used instead to pay to insure the uninsured.
- The Prince Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals.
- Ministry of Health primary health clinics should be allowed management autonomy.
- In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider.
- The MOH and RMS providing subsidized health insurance to private sector businesses is a model Jordan should expand.
- It is urgent the government finds ways to raise revenue to cover the growing public health

3. Health Financial Flows, Revenue, and Cost Optimization: *Efficiency Strategies to Support Financial Sustainability of the Health System in Jordan* (April 2018)

This background paper zooms into financial sustainability by focusing on 11 cost drivers and 5 revenue drivers of the public healthcare system in Jordan. The overview includes identification of key strategic interventions that would lead to an optimised cost structure and revenue enhancement within the Jordanian healthcare sector.

The analysis of the current financial flows, revenue, arrears and the identification of some areas of inefficiency in the health sector show that the financial outlook of the health system is threatened by several internal and external factors including:

1. Increasing demand of health services due to demographic impact from a rapid migration influx;
2. Scaling costs to provide recurrent treatment for chronic conditions due to insufficient focus of preventive services and growing prevalence of noncommunicable diseases (NCDs)
3. Poor performance of the health system due to outdated managerial practices, fragmentation, duplication of functions and well-known inefficiencies; and
4. A cumulative debt of the public health system estimated as more than JD 400 million that represents a third of the entire public health 2018 budget.

SUMMARY OF REVENUE AND COST DRIVERS, INTERVENTIONS AND RELATIVE IMPACT

Revenue Drivers	Potential Strategic Interventions	Potential Impact
1) Medical Tourism	• Implement a marketing strategy for Jordanian health services • Implement laws and regulations that protect patients and providers (Medical Mal practice law) • Collaboration with businesses that will benefit from tourism (airlines, hotels) • Internationally recognized accreditation of facilities to increase brand value • Simplify visa and entry process for foreigners seeking medical care	MEDIUM
2) Optimize Insurance Premiums	• Increase monthly contributions to the public-sector insurance pools • Incorporate a model for insurance that includes a risk pool approach and is linked to actuarial analysis to set premiums and service prices	MEDIUM TO HIGH
3) Expanding Insurance Coverage	• Incorporate a model for insurance that includes a risk pool approach and is linked to actuarial analysis to set premiums and service prices • Encourage the SSC to play a bigger role in insuring employees and their families Limit the categories of people that are not required to have insurance • Expand categories of people where insurance is mandatory • Grey market workers (informal sector) are encouraged to register with CIP	VERY HIGH
4) International and Local Donations Supporting Vulnerable Populations	• Increase donations from local and international agencies supporting refugees and vulnerable families	MEDIUM
5) Regulations and Laws to Right-size Revenue	• Revisit legislation on healthcare pricing: codes, fee schedule • Expand revenue from sugar tax, tobacco tax, and alcohol tax	MEDIUM

Cost Drivers	Potential Strategic Interventions	Potential Impact
1) Medicine Cost	• Implement clinical protocols to reduce over prescription • Establish a rationalized drug list • Improve supply chain management • Shift to generic instead of branded where possible	MEDIUM
2) Traffic Re-engineering	• Shift utilization to increase patient use of PHC services • BCC activities to influence patients' behavior to increase clinic use • Improve quality of PHC • Incorporate financial disincentives (fees) to use secondary services without referrals	LOW TO MEDIUM HIGH TO VERY HIGH LONG - TERM
3) Capital Expenditures Projects	• Base strategy and decisions on mapping of needed services and facilities • Use service contracting to the private sector and other public partners to fill service gaps	HIGH TO VERY HIGH
4) Electricity Cost	• Shift to solar panels & apply energy saving methods	LOW MEDIUM LONG-TERM
5) Regulation and Laws to Optimize Cost	• Ensure that insurers use a risk pool approach and actuarial models to determine eligibility and pricing • Revisit legislation on healthcare pricing: codes, fee schedule • Force insurers to provide an Essential Package of Services	MEDIUM
6) e-Health & Digitization	• Hakeem Initiative for Computing Patients' Medical and Financial Files • Program for Smart Management of Care Providers • Disease Monitoring Program • Paperless Government Initiative	MEDIUM TO HIGH
7) Human Resources Efficiency	• Improve staff through training • Improve selection criteria of staff and link ongoing employment to certification and continuing education and development • Linking performance to compensation • Increase investment in PHC staff • Invest in systems to improve efficiency and automate administrative process to reduce staff levels where applicable	MEDIUM
8) Quality Control & Treatment Protocols	• Demand that providers deliver services that adhere to diagnostic and treatment protocols approved by professional societies and meet international best practice standards	MEDIUM TO HIGH
9) Reduce Impact of NCDs	• Improve PHC capacity to diagnose and treat NCDs Community education & awareness on NCDs (behavior change) • Incorporate improved mental health services at the PHC level	LOW TO MEDIUM HIGH LONG - TERM
10) Improving Public Health Governance	• Incorporate a payor model based on best practice and that is applicable to all public providers • Strengthen the HHC to coordinate interventions, monitor, and set policies for the health system • Support decentralization programs (both national and subnational levels) • Improve information systems and strengthen decision support	MEDIUM
11) Strategic Purchasing	• Separate roles of provider and purchaser • Adopt purchasing models that link payment with performance • Promote PPPs to contract out for services to meet surge demand • Apply best practices in volume purchasing for drugs and consumables	MEDIUM

In consideration of these factors and following an analysis of cost and revenue drivers, it is clear that the GOJ must adopt a comprehensive strategy to promote a financially sustainable health system. This strategy should include a high-level understanding of the need for accurate and timely information to inform decision makers. To achieve this, the GOJ must:

1. Establish accurate and responsive systems to collect timely data on health care utilization, health care spending, and revenue sources
2. Build capacity of staff and systems at the national and subnational levels to support, finance and governance, strategic planning, and decision making.

Coupled with the recognition of decision support gaps and investing in improvement in the above areas, we propose the following as interventions that can provide the largest return on investment in support of a strengthened public and private health system:

1. Increase efficiency and coverage of public and private insurance programs. This includes shifting systems to inclusion of risk pooling and setting premiums and payment for services based on actuarial studies and best practice models. Initiatives to expand inclusion of a broader segment of the population will promote sustainable universal health coverage.
2. Incorporate a master planning system that maps health needs (services, facilities, personnel) to inform all decisions related to allocating resources and investing in health care expansion. The mapping of health needs will also help identify inefficiencies and setting baseline performance indicators.
3. Invest in shifting utilization toward primary health care and in public health initiatives and education to promote PHC clinic use, improve health, and reduce the incidence of noncommunicable diseases.

Item one above is a fundamental problem with the Jordanian public insurance system and further underscores the huge impact that this has on MOH arrears. Intervention in this area is critical to improve the overall functioning of the public insurance system as well as having a major impact on government debt.

4. Health Insurance Operations Review Report of Public Insurers (May 2018)

This IOR report was able to measure operations of public insurers from the perspectives of equity and sustainability. In addition, it was able to showcase the extent to which public insurers' operations are aligned with international best practices by focusing on the following competencies: eligibility, enrolment and satisfaction); providers (credentialing, contracting and satisfaction); and claims (receipt, adjudication and payment) as well as supporting services (information technology, insurance organizations and staffing).

Highly functioning health insurers provide value to the health sector, economy and society overall. They can perform beneficial functions by pooling money to pay for healthcare, fostering equitable access to health care, ensuring the appropriateness and quality of care delivery, identifying and preventing fraud and abuse, managing financial and clinical risk, among others. Health insurance serves as a check and balance on the healthcare delivery system. It develops standard and equitable products that provide access to necessary medical coverage ideally including preventive care. It provides oversight of the delivery system to make sure its insured members receive proper clinical care and quality of service.

The IORs will be used to inform the following:

- Improving insurance operations and contribute to more efficient use of resources
- Standardize operations between different public payers, which will enhance operations systems in the public sector toward a more sustainable insurance model
- Provide the evidence for decision making to advocate for a sustainable insurance model

Three core operational areas were assessed (member services, provider services, and claim processing) followed by assessment of two general areas (information systems/technology and cross cutting such as HR management, communications, training, and administration). The assessment includes a review of several standards within each operational area and measures the level that each organization has met these standards. If the organization does not have systems in place that focus on a given standard then this standard was considered not applicable to the organization for the purposes of the assessment.

The below table summarizes the IORs findings in the public sector:

Public sector IORs results					
Operations Area	**Standards Assessed**	**Met %**	**Partially met%**	**Not met%**	**Not Applicable%**
Members	22	79%	5%	16%	14%
Providers	18	47%	6%	47%	26%
Claims	20	73%	13%	14%	13%
IS/IT	9	59%	24%	18%	6%
Cross Cutting	19	54%	16%	30%	0%

From this assessment several key gaps were identified that were consistent across public insurance providers and pose significant risk in these provider's ability to effectively and efficiently manage an insurance operation. Two major challenges that exist within this group of providers is a lack of a clearly defined service package and the inability to properly determine cost and price for services. These two standards represent the core of any efficient insurance system and when addressed will force changes in many other operational areas. At a secondary level, many standards will be addressed and systems and processes improved to improve sustainability and equity. Some of these standards are described in the Table below:

Area	**Not met Standards**	**Impact**
Areas Pertaining to Sustainability	Process for controlling utilization through prior authorization and defining medical necessity	Prior authorization process is part of the provider contract and rights and responsibilities are included in provider training. Lack of standardization may lead to increasingly subjective decisions which are inconsistent. This reduces trust in the system and negatively affects efficiency
	Standardized claims management process	Increased standardization is fundamental to reducing administrative errors. The more standardized the forms, codes and processes,

		the greater the transparency and the lower the costs associated with adjudicating claims.
Areas Pertaining to Equity	Members materials: providing newly enrolled members with information about their coverage	If there are insufficient member explanations, individuals may access the product incorrectly leading to denied services. A key criterion to measure the effectiveness of a health insurance product is member satisfaction. If members are not educated on the coverage and access requirements, it will negatively impact member satisfaction rates.
	Process to prepare, review and authorize all provider contracts.	The greater the transparency between payer and provider, the higher the trust among stakeholders. For example, if a claim is denied the provider may not understand the reason and simply seek other coding approaches to be reimbursed. Creating transparent processes increases provider trust in the system.
	Process for credentialing the healthcare professionals and delivery organizations with whom it contracts such as hospitals, laboratories, clinics and groups of providers.	Credentialing is the foundation of any clinical management or network management process. Network management positively effects member satisfaction levels and quality of care. This increases the potential for a positive medical outcome.

HFG developed a separate report for each public insurer identifying findings and recommendations. Following are main recommendations for improvement of public insurer operations in the short-term. These recommendations will support a unified and strengthened foundation for insurer operations that will allow subsequent interventions and higher level policy and legislative changes to be more quickly and effectively implemented.

1. Support development of essential service packages.
2. Improve capacity to cost and price health services.
3. Develop a unified process to capture the members satisfaction for the health care service providers/facilities.
4. Integrate pre-authorization process and link it to claims payment system.
5. Standardize and implement re-credentialing process to verify any changes in the initial credentialing process, and to include member satisfaction, member complaints and resolution, medical and quality management reviews and communication process.
6. Maintain a process to prepare, review and authorize all network provider contracts.
7. Standardize claims management process among different public insurers. The government may consider requiring that all licensed providers submitting bills use standard claims forms and coding and if not, claims will not be reimbursed. This stipulation should be included in provider agreements.
8. Advocate at a high level for the third-party liability, where the Insurer must share information regarding its members having multiple coverages with the other payers and is fully responsible for coordinating benefits with the third party to maximize the use of third-party coverage.

9. Standardize and expand the MIS system so that it is sufficient to cover all functional areas including the provider network management, which is still not covered in the system.

5. Health Insurance Legislative Review (January 2018)

The legislative review traces the origins of some of these complications found in the IORs through an in-depth analysis of laws, regulations, procedures, and other policies dictating the health system (See Annex 5: The Health Insurance Legislative Review). Five principles were conceptualized to measure the health care system to better its prospects for sustainability and equity.

The findings of the legislative review demonstrate that legislation creates additional barriers and contributes to a fiscally unstable health system which cannot be responsive to the needs of the population in a fair and equitable way.

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

The three principles of supervisory and institutional structures, beneficiary funding, and consumer protection offer important insights as to how the health care system could be better structured and financed in order to maximize resources, including those from the public sector. The final two principles of access to insurance and health coverage offer greater insight into the gaps existing throughout the health care system that disproportionately affect women, refugees, displaced persons, individuals with disabilities, and other vulnerable Jordanians. Women in Jordan, for instance, have a significantly more difficult time accessing health care than men, and oftentimes do not receive benefits or services recommended by established international standards.

Legislative provisions that undermine the sustainability of **public insurers** include:

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

- There are no legislative mandates relating to solvency, reserving or financial reporting.
- In public insurers such as the Civil Health Insurance Fund there are 70+ categories of eligibility. The volume of eligibility groups makes it difficult to clearly determine who is entitled to membership and the basis for their eligibility. It is extremely difficult to align eligibility with the amount of financial resources needed for the different groups (i.e. determining the amount that qualifying individuals should contribute and those entitled to a premium subsidy).
- Coinsurance/co-payment are predominantly low for individuals who have the financial means, which undermines equity.
- There are no regulatory safeguards, resulting in a lack of transparency and protection of the beneficiary's right. Minimum disclosure on the type, frequency and extent of health information by the insurer to the insured is not currently legislated. Consumers are not empowered to understand their health coverage.
- No processes are outlined for consumer complaints and mechanisms for dispute resolution in the by-laws of the insurers.
- For most categories, benefits are not listed in the various by-laws of funders. Random benefits are mentioned, i.e. benefits are not identified under inpatient, outpatient or pharmaceutical categories.
- Premiums are not based on actuarial calculations and cover a small share of health services. Failure to design and price premiums according to benefits covered undermines the entire health insurance system
- No waiting periods or limits on pre-existing medical conditions are applied. Individuals can join and re-join CHIF at any time without waiting periods being imposed upon them and at the point at which they know they have a medical condition without having contributed, via premiums, to the cost of their condition. The lack of contribution to the insurance program by healthy individuals does not allow for a distribution of financial responsibility across all insured. This is a major obstacle in attaining financial sustainability of public insurance programs in Jordan.
- Events that trigger termination of membership are not clearly outlined in the majority of by-laws.

Conclusion and Recommendations

HFG's four main reports consistently underline the need to improve the financial and institutional sustainability and equity of Jordan's public health insurance system. Condensing the findings of these reports, which are included as Attachments to this document, enables the identification of a framework for interventions and change that can help to promote UHC and increase financial sustainability of public health insurance.

The following are recommendations for improving equity and sustainability of Jordan's health system through interventions targeting the health insurance system. These are the culmination of the studies presented in this document and represent an analysis of the various factors that influence the system from the perspective of HFG and its work to date. These have been categorized based on the anticipated time (short, medium, long term) for implementing interventions and realizing results:

- **Short Term (1-3 years)**

- Better inform the public of rights, benefits and entitlements within the Jordanian health insurance system and promote public insurance enrollment.
- Implement dispute resolution mechanisms within public insurers to provide consumer protection.
- Standardize insurance operations where applicable so that all public health insurers are at the same benchmark with regards to international standards of insurance operations. This is a pre-requisite for future amalgamation of public insurers, i.e. single payer model.
- Provide technical assistance to advocate for a revision of exemptions and regulations from an equity standpoint through an inclusive process of all stakeholders and strong consensus building tools.

- **Medium Term (2-5 years)**
  - Supporting the splitting of the insurer and provider functions in the public sector.
  - Provide technical assistance to establish a regulatory body to regulate public insurers.
  - Consolidate risk pools to share the financial burden in a fair and efficient way, specifically as the demographic population ages and co-morbidity increases with non-communicable diseases. Where there are multiple payers, and therefore multiple risk pools, there is financial fragmentation, administrative inefficiency and higher costs in the health insurance system. The positive effects of cross-subsidization are diluted. Insurers should have minimum membership numbers.
  - Improve management information systems supporting all insurance operations functions to reduce costs and better manage enrollment, pre-authorization, and claims processes.
  - Review premium methodology and base it upon income rather than gender or health risks.
  - Design and cost a minimum benefits package for both sectors. Alternatively, mandate a negative list, i.e., identify medical conditions that may be excluded from coverage. Ensure that exclusions are based on fair and equitable principles for the whole population to avoid discrimination against marginalized groups.
  - Support the establishment of processes within the insurance system that promote rational drug use and increase use of generics.
  - Enhance the quality and availability of data needed for analysis and decision making.
  - Develop a health finance strategy in order to promote health finance system sustainability.

- **Long Term (3-5 years +)**
  - Draft and implement a comprehensive national law for mandatory health insurance that replaces and/or repeals the existing volume of legislation issued by each public insurer. The national law should set out clear objectives, minimum standards and rules relating to the governance of health insurance. Main issues to be covered include insurer incorporation and management of insurers, eligibility, premiums, co-payments, benefits, continuation and suspension of membership, provider arrangements and consumer protection.

Annexes

Annex 1	Jordan Association for Medical Insurance Conference Participant's Opinions on Governance and Financing Issues in Jordan (HFG/USAID, May 2017)
Annex 2	Health Sector Key Stakeholder Interviews Applied Political Economy Analysis (HFG/USAID, June 2017)
Annex 3	Health Financial Flows, Revenue, and Cost Optimization: Efficiency Strategies to Support Financial Sustainability of the Health System in Jordan (HFG/USAID, April 2018)
Annex 4	Health Insurance Operations Review Report of Public Insurers (HFG/USAID, May 2018)
Annex 5	Health Insurance Legislative Review (HFG/USAID, January 2018)