Health Insurance and the Law in Kenya

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Introduction

Insurance is a contract or policy by which an insurer indemnifies a person (called the insured) against losses from specific contingencies and/or perils. In the case of health or medical insurance, the contract requires the insurer to pay some or all of the insured's healthcare costs in exchange for the payment of a premium. The insured makes an advance payment of the premium to the insurer. In return, the insurer will pay a health service provider some or all the direct expenses incurred when the insured utilizes a health service. Health insurance covers some or all of the costs of consultation, hospitalization, emergency care, and medicine. Its objective is to meet unforeseen costs relating to illness. Typically, premiums are based on the incidence of diseases and utilization of services and are thus related to the insured's risk, irrespective of income.

Health insurance provides a means by which society may share the costs of public health care: those who do not fall sick but participate in insurance schemes contribute towards the expenses of those who fall sick, while they are guaranteed that in times of illness their care will be paid for by a third party.

Health insurance in Kenya has seen many developments in the recent decade, which impact the provision of health care. These developments have included devolution and the categorization of health facilities. Following the promulgation of the Constitution of 2010, Kenya's health system is now organized around two administrative levels. On the one hand, the national level is primarily responsible for policy, regulation, and national referral facilities. On the other hand, the county level is responsible for service delivery. Further, health facilities are categorized into tiers ranging from community to tertiary care.

At present, the main providers of health insurance are the government's National Health Insurance Fund (NHIF), private insurers, and community-based health insurance schemes. These providers offer both inpatient and outpatient services, based on the cover or plan that an insured has selected or is eligible for.

This article examines the regulation of health insurance in Kenya and its implications for healthcare providers. The article is organized as follows. Part II discusses the economics of health insurance. Part III examines how the law regulates the provision of health insurance in Kenya. Part IV concludes by offering some lessons on how health care providers can ensure the provision of health insurance works for them.

The economics of health insurance

Health care is a good that possesses unique characteristics, which need to be considered if the provision of health insurance is to be regulated effectively.

First, health care is a "merit good" in the sense that it is a commodity that society considers everyone should have because it is beneficial, and their ability or willingness to pay for it does not matter (1). This is one of the main reasons why governments frequently finance healthcare.

Second, some forms of health care constitute "public goods" given that one person's consumption does not reduce the amount available for others to consume. The prevention and treatment of communicable diseases are good examples. Consumers cannot be excluded from public goods: if they are made available to anyone, they are available to all. Since people can consume such public goods without having to pay for them, their production will always be less than socially optimal. To ensure socially optimal production of such goods, they must be financed by government or some other non-market alternative.

Third, the provision of health care is characterized by the problem of asymmetric information between the patient and the provider. Thus, for example, patients may be able to describe their symptoms but not know what ails them or what further action to take. In this scenario, visits to doctors may be driven by just as much by a desire for extra information as for curative health-care services. In any case, visits to health care providers often occur when patients are feeling sick and vulnerable, and will thus accept any decision that the health care provider takes. Unfortunately, because health care providers have their own needs and preferences, such decisions may not always be in the interests of the patients. For example, the health provider may prescribe unnecessary or expensive

procedures or drugs. This explains why governments often seeks to regulate the conduct of health care providers to deal with the problem of asymmetric information.

Fourth, the demand for health care is derived. People do not demand health care for the sake of it, but because they desire improved health status; health care is a means to achieving this end. Thus, much demand for health care cannot be planned in advance but is contingent upon deterioration in health status. Moreover, while health care costs may be very high, most people are risk averse and do not want to incur large costs at unforeseeable points in the future. For these reasons, insurance or risk sharing for health care becomes important. Under insurance or risk-sharing schemes, individuals or households pay a premium in advance – which may or may not be related to their actuarial risk of illness – in return for free or subsidized health-care coverage if they fall ill."

But insurance creates a "moral hazard" problem. Since insurance is a contract by which someone other than the patient agrees to pay for his or her health care, the insured has an incentive to indulge in health risks that otherwise would have been avoided or consuming more health care than otherwise. When that happens, the cost of insurance is likely to rise in order to accommodate the increased demand. Further, insurers will be reluctant to insure high-risk individuals unless they can charge them premiums that reflect their high chance of becoming ill. Alternatively, insurers may seek to deter high-risk individuals from registering with them. In these circumstances, governmental intervention may be required to ensure optimal consumption of health care and coverage for high-risk individuals.

The market for health care, therefore, has unique characteristics, which justify varying degrees of public financing and provision, and governmental regulation of private provision. To recap, there are three distinct economic justifications for government intervention in the health care market: to ensure the optimal production of public goods, to subsidize poor consumers, and to correct or offset failures in the market for health insurance. The first two justifications explain why many governments often finance and manage health care systems. Indeed, governments often establish social security systems to manage health care and finance risk pooling in the social security systems using formal sector payroll taxes.

But what failures can arise in the market for health insurance? As we have noted, the moral hazard problem tends to be common in health insurance, as consumers use too much care thereby escalating its costs. Second, insurers are often reluctant to cover high-risk individuals, such as chronic patients, with the result that a significant segment of the population may not be covered. Third, unregulated health insurance may lead to excessive medicalization as health care providers seek to maximize their profits. And in developing countries such as Kenya, the population coverage is limited because of their large informal sectors and urban bias. The resolution of these efficiency and equity problems requires governmental regulation. In addition, policymakers have introduced community-based health insurance schemes, which target self-employed populations.

Regulating health insurance in Kenya

The National Hospital Insurance Fund (NHIF) covers the majority (or 88%) of Kenya's insured population (2). The rest are covered by private health insurance (9%), employer-based medical schemes (3%) and community-based health insurance (<1%) (2).

The NHIF provides contribution-based health insurance services to formal and informal sector workers. It is compulsory for the former but voluntary for the latter. Thus, the NHIF is financed principally through premium contributions from its 5 million registered members. It also receives some funding from the government. It contracts both public and private health care facilities to provide services, consisting of a benefits package, to registered members.

The NHIF's benefits package embraces preventive and curative care comprising consultation, laboratory investigations, drug administration and dispensation, dental healthcare services, radiological examinations, nursing and midwifery services, surgical services, radiotherapy, and physiotherapy (3). Further, subscribers are entitled to specialist care in hospitals for hospitalization (or in-patient care) when needed and referral to specialists where necessary. In-patient benefits are linked to the category of a hospital, hence access to essential surgical services – for example – following a road traffic accident – may be constrained (4).

The NHIF contracts hospitals through a four-step process: application for accreditation, inspection, gazettement and contracting (5). A facility that has applied for accreditation is inspected for the availability of infrastructure, facilities, equipment, staff, and services such as ambulances. Where the inspection recommends accreditation, the NHIF board of directors gazettes the health facility (6). A contract is then signed between the NHIF and the health facility, specifying the category of the health facility, payment mechanisms and rates, and other terms of engagement (6). The accreditation process also serves as a basis for quality assurance. During the initial inspection, the NHIF establishes standards of care and contracted facilities are thereafter regularly inspected for compliance with those standards. The NHIF has established a benefits and quality assurance management committee and an organizational department to handle this task.

The NHIF pays contracted health service providers using capitation, case-based payments and fee-for-service for specific services such as renal dialysis and radiology services. It uses capitation to pay for outpatient services and fee-for-service for both outpatient and inpatient services. The NHIF is supposed to negotiate the payment rates with the service provider (7). In practice, it pays a fixed annual rate per enrollee. Thus, it pays KES 1200 (US$10) per year for an enrollee under its general scheme and KES 1500 (US$13) under its civil servants' scheme (8). Private providers receive KES 2850 (US$25) per year (8). A challenge with capitation is that it often compels service providers to compromise on the quality of services when the number of visits from enrollees increases (8). So that capitation may lead to the under-provision of health services. In addition, capitation works better for public health service providers since they "receive line-item budgets, medical supplies, drugs, equipment and staff salaries from county governments" (8). However, it might lead to losses for private health services providers as they must procure drugs, medical equipment and pay salaries. These costs, therefore, need to be factored in when calculating the cost of health services.

Above all, health providers should be involved in the establishment of capitation rates. Unfortunately, the experiences of health care providers are not always considered when designing provider payment methods such as capitation and fee-for-service (9). For example, public health providers have "complained of receiving lower capitation rates per enrollee as compared with private and faith-based providers and that the rates were not set in consultation with them" (9).

The NHIF uses capitation mainly to pay for outpatient health services. Under this arrangement, the enrollee selects and registers at a healthcare provider where he or she will receive services. The provider then receives capitation payments for that enrollee on a quarterly basis to provide a pre-determined set of outpatient services, as specified in the benefits package. Where a service is not available in the health facility, it is required to outsource the service at no cost to the patient. Further, the NHIF pays fee-for-service reimbursements after claims are submitted in accordance with the contracts signed with the providers.

While the NHIF's provider payment methods are predictable and providers, therefore, know in advance how much to expect, they impose complex reporting requirements on the providers. The NHIF requires providers to complete claims forms, upload them onto an online system, and present paper copies to its offices for verification and approval (9). Claims are rejected where the details on the online system do not tally with those on paper copies. Providers are thus confronted with double reporting that they consider unnecessary (9). In addition, providers are required to promptly notify the NHIF through the online system that enrollees have sought care from their facilities, otherwise they risk not being reimbursed (9). The NHIF, therefore, needs to simplify its claims and reporting processes.

The Insurance Act regulates the provision of private health insurance. It regulates health insurance as a class of general insurance. It defines medical insurance as "the insurance business of paying for medical expenses, including the business of covering disability or long-term nursing or custodial care needs". The Insurance Act sought to separate the businesses of medical insurance and health care provision, to avoid conflicts of interest (10).

However, while the Act regulates the conduct of medical insurance providers, it does not regulate health management organizations. The Act defines a Medical Insurance Provider (MIP) as an "intermediary other than a broker, concerned with the placing of medical insurance business with an insurer, for, or in expectation of, payment by way of a commission, fee or other remuneration". On the other hand, a Health Management Organization (HMO) is an entity that delivers health maintenance and treatment services for a group of enrolled persons who pay pre-negotiated fixed payments. However, while HMOs provide medical insurance to the extent that they offer health packages that include pre-funding mechanisms, the Insurance Act does not apply to them. Instead, the Ministry of Health regulates HMOs with respect to the medical services they provide. The result is that, unlike MIPs, HMOs are not obligated to adhere to policyholder protection mechanisms such as prudential standards with respect to capital requirements, creating an uneven playing field (11).

Unlike public health insurance under the NHIF, the Insurance Act does not prescribe a minimum or core benefit package (2). Requiring core benefits restrains insurers from designing packages to attract only low-risk individuals. However, most health insurance policies tend to have limited coverage of pre-existing conditions, contract exclusions and waiting periods. The goal is to discourage adverse selection and keep premiums affordable. Unfortunately, this approach leads to a situation in which most people will not be able to purchase insurance for high cost diseases such as cancer, "which are often the very conditions for which insurance is most needed" (12). A need, therefore, arises to "set boundaries on what can be excluded and for what period" (12). This will require the creation of standardized packages.

Health insurance providers also seek to discourage excessive use of health care through mechanisms such as deductibles, co-payments, co-insurance and payment ceilings (12). However, these measures may be counter-productive as they "may disproportionately

reduce service utilization among the poor and discourage people from seeking preventive services that would avoid the subsequent need for costly curative care" (12). In addition, insurance is only effective if it covers a substantial share of health service costs. A need, therefore, arises to strike a balance between providing effective financial protection and assuring affordable premiums.

Health insurance providers also use various mechanisms to manage the utilization of services, including the use of formularies with generics or negative lists of medicines excluded from reimbursement (13). The formularies list covered medicines and are updated on a regular basis, typically annually. Medicines are covered on the basis of factors such as meeting regulatory standards of quality and safety, cost-effectiveness, and availability. In some cases, the maximum reimbursement for covered medicines is capped, and their quantities may also be limited.

Monitoring medicines utilization and costs is another mechanism for managing the utilization of services. Thus, health insurance programs usually collect demographic, pharmacy, procedures, outpatient and hospitalization data. However, health care providers do not always provide quality data and hospitals use different coding methods to capture procedures (11). A standard coding method should therefore be instated if the quality of data is to improve.

In private health insurance schemes, there are two main modes of paying service providers, namely credit facilities and fee-for-service. In the former scenario, enrollees receive benefits-in-kind. And in the latter scenario, enrollees pay service providers upfront on a fee-for-service basis and claim reimbursement by submitting claims. Health insurance providers often require service providers to meet performance indicators, such as quality (9). For example, the insurance providers will not pay for complications arising from procedures such as surgeries especially when the costs have escalated. In such scenarios, the service provider is required to absorb the higher costs (9).

A common challenge with private health insurance schemes is the absence of uniform treatment protocols, which can lead to excess testing and increased claims (11). Implementing standard treatment pathways could also help to improve cost management (11).

There is also Community-Based Health Insurance (CBHI), which also contracts public and private health service facilities to provide services to members. CBHIs fall into two categories: (i) those that are formal and offer benefits to members based on a fixed annual fee; and (ii) those that are informal agreements between community members to support each other's medical needs as they arise. Both are not regulated by law.

Another key player in the health insurance industry are the Third Party Administrators (TPAs), which are organizations that accept and process health insurance claims from health service providers such as doctors, hospitals, and pharmacies. TPAs are also not regulated by law.

Lessons for healthcare providers

The health insurance industry places health service providers such as physicians in a difficult position. On the one hand, the physician is a gatekeeper for the insurance provider to the extent that the insurance contract places an obligation on the physician to control the costs of health care. Thus, the contract may require the physician to seek fewer tests and referrals. On the other hand, the physician has a professional obligation to ensure that his or her patients receive adequate health care. Physicians must therefore balance these two roles that may conflict.

Accordingly, healthcare providers need to ensure that they sign suitable contracts with insurance providers if they are to balance these roles. Key lessons for health providers include the following:

Poorly drafted contracts may place healthcare providers at great financial risk, especially when they assume the risk of providing health care. They should therefore ensure that their contracts with the health insurance providers are carefully drafted and fair, including setting reasonable reimbursement timelines, describing covered services, and setting fee schedules, and formal processes for resolving disputes relating to matters such as billing.

Negotiating fair contracts demands that health providers know their data. They should therefore endeavor to know how they perform in standard quality metrics, patient satisfaction measures, and referring physician satisfaction measures.

Health care providers should ensure they participate in the design of health insurance policies (including the development or review of capitation rates), particularly through their associations.

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