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SHOPS Strengthening Health Outcomes *through* the Private Sector

A PLAYBOOK FOR CAPITATION

LESSONS LEARNED FROM HEALTH INSURANCE COMPANIES IN KENYA

Today, 1.6 million Kenyans are living with HIV. Kenya needs to rapidly expand HIV testing, care, and treatment to meet the **90-90-90 goals** set for 2020— of all Kenyans living with HIV, 90 percent will know their status, 90 percent will be accessing ART, and 90 percent will be virally suppressed.

With donor resources shrinking, the challenge will require Kenya to leverage its domestic resources—for example, through improved insurance programs that generate more resources for health care through premiums, copays, and risk pooling (cost sharing for health care). With insurance coverage, patients are more likely to seek regular care—including regular HIV testing and treatment. Expanded insurance programs can increase the number of available and affordable providers, thus expanding clients' choices independent of donor funding. This is especially important for Kenya as the government considers adopting policies to provide earlier treatment following HIV diagnosis (i.e., at higher CD4 thresholds).

Expanding health insurance coverage may require new models that promote efficiency and lower costs, making it more widely affordable. Such innovative models were the focus of a collaborative project implemented by Strengthening Health Outcomes through the Private Sector (SHOPS) and partners from the Kenya health insurance industry. The SHOPS project is a five-year global project, funded by the United States Agency for International Development (USAID).

The **capitation model** presented in this playbook is one of the outcomes of the project. It has relevance for insurers and stakeholders as they consider implementing the capitation approach, to reduce costs and expand membership in developing country contexts.

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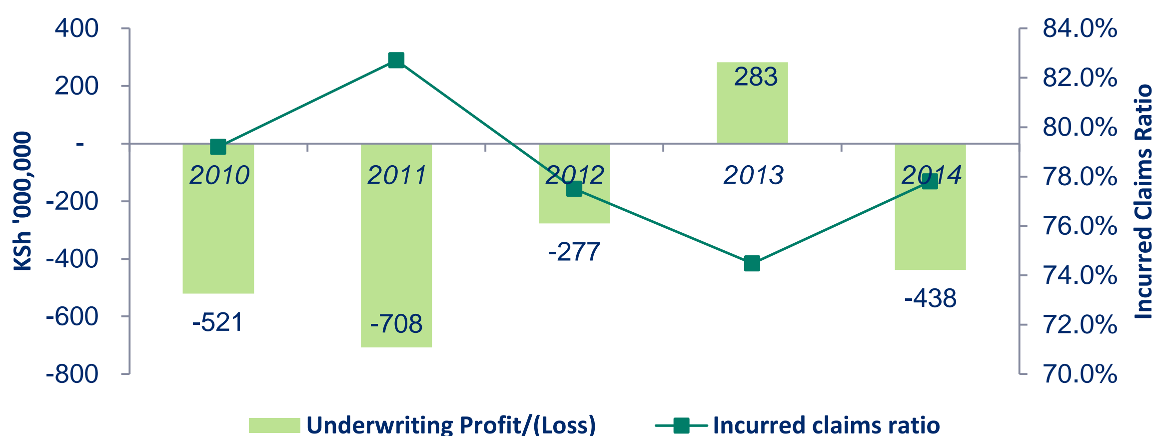
1. BACKGROUND

In the past decade, Kenya has experienced significant economic growth, with improvements in key health indicators such as child mortality and life expectancy. More recently, the country faces shifting donor funding, along with a rising burden of disease. Medical costs are increasing faster than the rate of inflation, estimated at 14.5 percent for 2014, compared to overall inflation at 6.6 percent (Towers Watson, 2014). This escalation threatens the viability of private health insurance schemes, hindering Kenyans' access to private sector health care. Meanwhile, the government of Kenya has looked to the private sector to play a greater role, in response to decreasing donor funding. Private health insurance schemes represent opportunities to increase domestic financing, especially for HIV and AIDS.

However, private health insurers struggle to remain profitable in the face of inflation. In only one of the past five years has the industry shown a net profit, and claims never dipped below 74 percent of earnings (Figure 1).

> **The manager of one insurance company insists:**
> **"Switching to capitation payments is not just an option. It must be the future for our industry's survival."**

FIGURE 1. HEALTH INSURANCE: NET PROFIT COMPARED TO CLAIMS (2010–2014)



Source: Insurance Regulatory Authority of Kenya

Note: Profit/loss is given in million Kenya shillings (KSh).

Can capitation help control the rising costs of health care?

From January to December 2014, SHOPS designed and tested a capitation model for primary and outpatient medical care, as a supplement (not replacement) for the existing fee-for-service provider payment method. During this 12-month period, the SHOPS team supported:

- An actuarial analysis, to develop a capitation rate for selected primary care services
- Negotiations between private insurers and health care providers
- A monitoring and evaluation plan for pilot testing
- A forum to bring together private insurers and health care providers, to discuss design and implementation

This playbook captures best practices, reflecting the experiences of SHOPS's insurance partners, to help inform other insurance companies and development partners considering capitation plans to control medical costs.

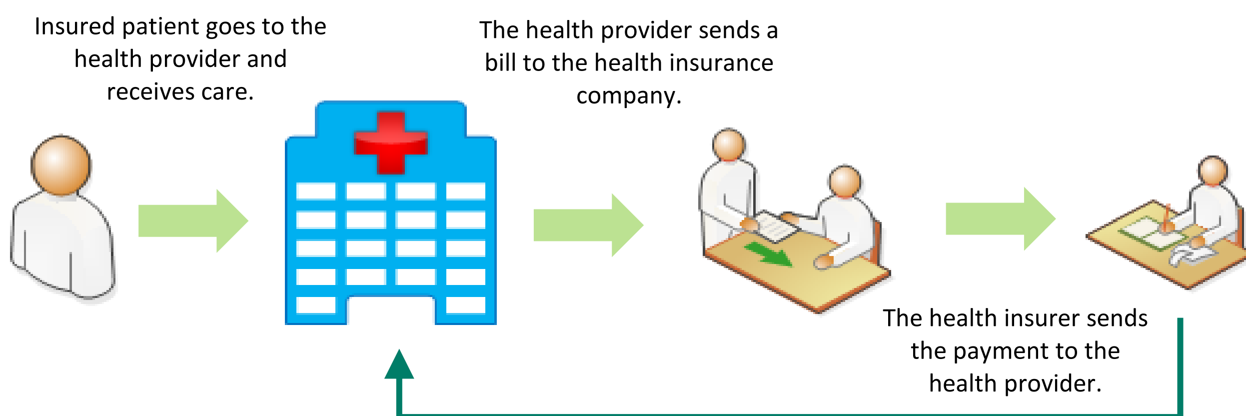
2. WHY CAPITATION?

How do fee-for-service payment models differ from capitation models?

2.1 FEE-FOR-SERVICE MODELS

In fee-for-service insurance, a health care provider submits a claim to a health insurer for each itemized service delivered to a patient—an office visit, test, or procedure. The health insurer processes each claim and reimburses the health care provider, either partially or in full (Figure 2).

FIGURE 2. FEE-FOR-SERVICE INSURANCE MODEL

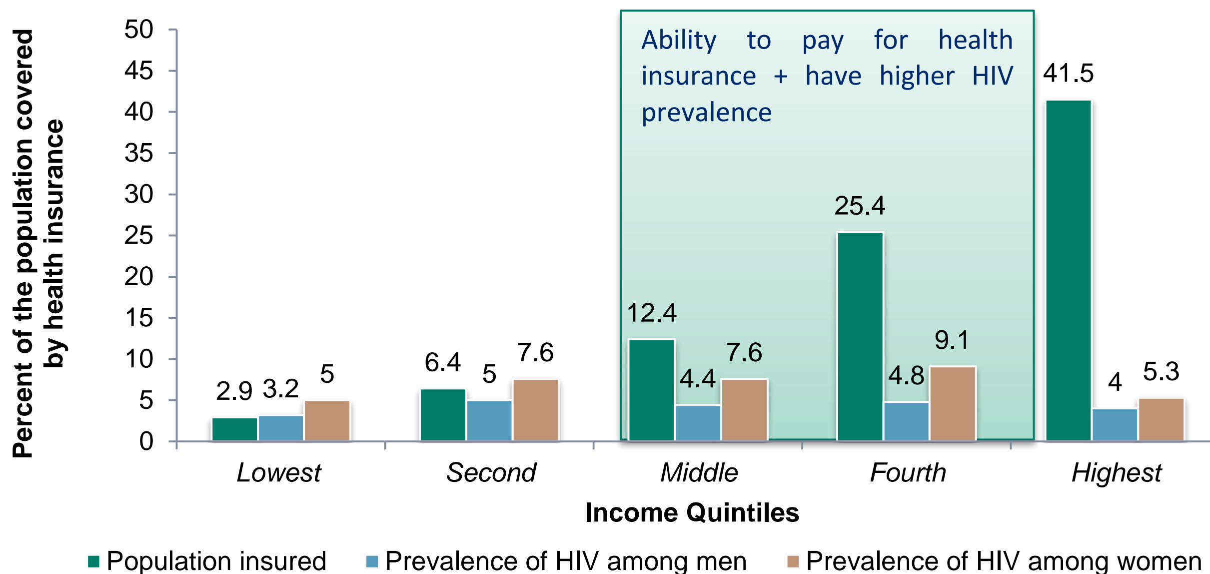


When paid through fee-for-service, health care providers have been shown more likely to provide health services that are not medically necessary (Hirunrassamee, 2009; Mills, 2000; Jegers, 2002). Since increased costs of providing services results in higher reimbursements, health care providers have little incentive to deliver cost-effective medical care. In short, because health care providers are paid by volume, the fee-for-service model tends to drive up health expenditures that are not necessarily correlated with improved quality of care. With more procedures per client and higher costs per procedure, claim costs increase for health insurers. As we saw in Figure 1, the ratio of health insurance claims to premiums (income) received is quite high in Kenya, at 77.8 percent.

Moreover, fee-for-service mechanisms have high administrative costs in Kenya, due to inefficient claims processes, high volume, and the risk of fraudulent claims by health providers. SHOPS found that the average cost of processing each claim, for the thousands received each month, is KSh 69 (USD $0.79) for outpatient services and KSh 252 (USD $2.90) for inpatient services (Chuma, 2015).

Over-utilization of health services perpetuates rising medical costs. Nevertheless, insurers compete for clients by underpricing their health insurance products, endangering their viability. Insurers are unable to develop innovative products that can reach low income or vulnerable populations with historically low health insurance penetration, such as people living with HIV (Figure 3). Thus, it would benefit health insurers to consider alternative methods of payment such as capitation, to control their costs. And in the process, insurers may be able to reach groups in the middle and fourth income quintiles that also have higher concentrations of HIV (Figure 3).

FIGURE 3. PERCENT OF POPULATION INSURED AND PREVALENCE OF HIV (BY INCOME QUINTILE)

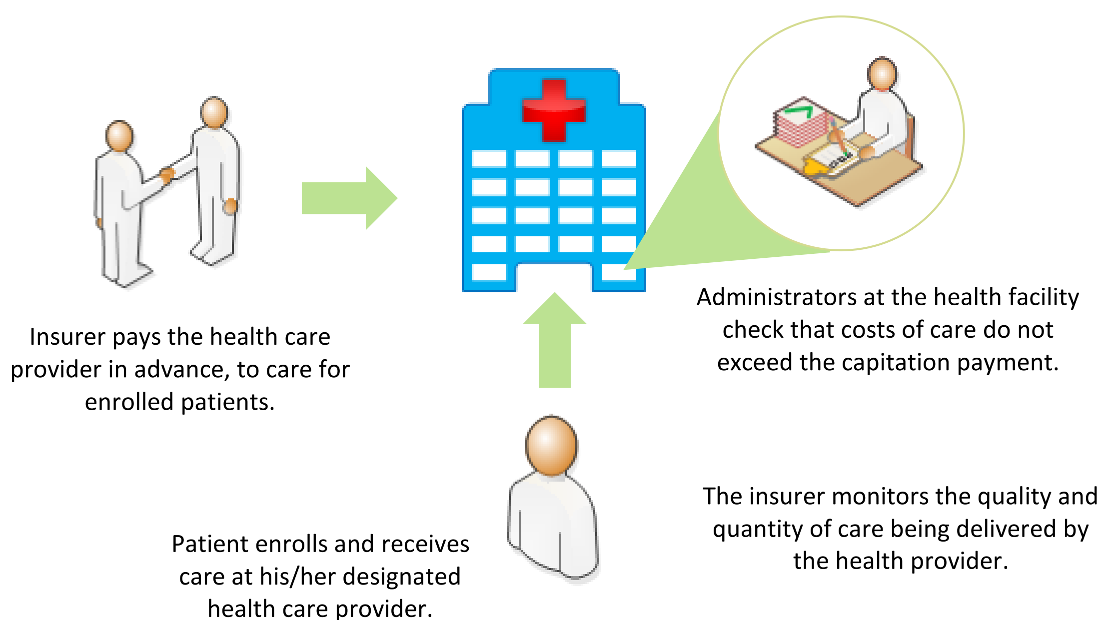


Source: NASCOP, 2014; Ministry of Health, 2014

2.2 CAPITATION AS AN ALTERNATIVE

In a capitation model, a fixed amount of money is paid *in advance* to the health care provider for each enrolled client, to cover a defined period of time. This method is most often used for primary care, because those services are generally lower in cost and more predictable than inpatient care (WHO, 2010). Under these plans, a client enrolls with a health care provider, either through self-selection or by assignment; in many cases they may be enrolled only during select periods. This form of prospective payment mechanism, if implemented well, can reduce both medical costs and administrative costs.

FIGURE 4. CAPITATION PAYMENT MODEL



3. THE CAPITATION RATE

The capitation rate paid to the provider is determined by many factors, including: services covered, number of clients enrolled, and the period of time the payment covers.

For insurers, the capitation model can reduce both administrative costs and excessive claims, as compared to retrospective, fee-for-service payment methods. Providers have fewer incentives to deliver excess health services, use additional resources, or file fraudulent claims (Jegers, 2002). Administrative costs are reduced by eliminating the claims process associated with retrospective payment mechanisms.

By setting capitated payments in advance, financial risk is shifted from health insurers to providers. Insurers are thus better positioned to predict and control costs (Figueras 2005; Langenbrunner et al., 2005; Barnum, Kutzin & Saxenian, 1995). Health care providers, however, will have to manage their resources more efficiently.

For providers who deliver care efficiently, capitation offers a stable revenue stream and may reduce administrative costs associated with filing claims (Langenbrunner et al., 2005; Barnum, Kutzin & Saxenian, 1995).

Clients, too, can benefit through reduced premiums and cost sharing as well as more comprehensive health insurance benefits.

If implemented carefully, capitation can

- **expand access to medical care**
- **help control claim and administrative costs**
- **improve insurance scheme viability**

Converting to capitation requires that products are well-designed, that rates are negotiated using the best available evidence, and that all parties—clients, health-care providers, and insurers—understand and support the implementation plan (section 4).

Calculating a capitation rate requires (1) selecting the services that will be included under capitation, (2) estimating the cost and frequency of those services, and (3) negotiating with providers the rate and administrative details of operating under capitation. This section presents the recommended approach for calculating a capitation rate, along with strategic lessons learned.

3.1 DEVELOPING A CAPITATION RATE

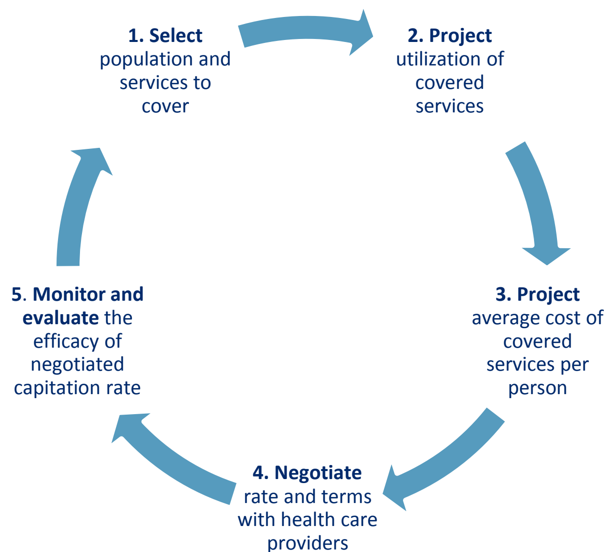
SHOPS recommends five steps to conduct an actuarial analysis for capitation—illustrated in Figure 5.

1. **Select the population and the services to cover.** Examine existing membership data and forecasted changes in membership demographics, using demographic or market data to justify assumptions for changes. Capitation is usually limited to primary care services, because they are more predictable and costs are lower in comparison to complex outpatient or inpatient care.
2. **Project the utilization rate of covered services.** Examine historic claims data, population demographics and associated health risks, and any information about new clients. Insurers should expect an initial temporary surge in use of health services among previously uninsured) clients.
3. **Project the average cost of covered services per person (i.e., *per capita*).** Use reference data on client characteristics such as age, gender, disease burden, and prior expenditures or claims costs, to estimate the per-person cost. Also, consider variation in cost to health care providers delivering the covered services, for example due to location.
4. **Negotiate the capitation rate and terms with health care providers.** Health care providers must adapt to a new payment system and also take on greater financial risk, for which they expect to be compensated. Use the rate analysis to find a mutually beneficial rate that enables both the

health care provider and the insurer to sustain their operations. In the transition period, this may require weighting the capitation rate to give providers 5–10 percent higher payments.

5. **Monitor the efficacy of the negotiated capitation rate.** Work closely with participating providers to see if the negotiated rate suffices to meet their costs. Ensure that clients are still treated with acceptable quality. Routine monitoring may include monthly health care provider visits, viewing complaints about providers, and checking in with members about their care. Conduct evaluations to assess if the capitation agreement helps control health care costs. The capitation rate may need to be revisited and the monitoring cycle repeated accordingly.

FIGURE 5: STEPS TO DEVELOP A CAPITATION RATE



3.2 STRATEGIC LESSONS IN SETTING A CAPITATION RATE

Lesson 1: Find alternative data, when patient data are not available.

When patient-level data are not available, demographic and population health data can yield rational assumptions to support an actuarial analysis. Work with an actuary who has experience in settings where data is scarce; add contingent conditions to the final capitation rate. SHOPS hired an international health actuary who worked closely with the actuarial team and the health insurance partner, while teaching the health insurer's actuarial department how to conduct the analysis.

Lesson 2: Agree on a capitation rate that is actuarially fair while taking into account providers' experience and risk preferences.

SHOPS used a three-step process to arrive at feasible capitation rates. First, SHOPS sent proposals to the targeted health care providers, requesting them to recommend a capitated rate under three different volume assumptions: 200, 500, and 1,000 clients. Based on the providers' responses, the actuary compared their recommendations to the numbers generated from actuarial analysis. The insurer then offered providers the *average* of the rate proposed by the insurer and that recommended by the health care provider. Most of the providers accepted the proposed rates.

Lesson 3: Pricing needs to allow for different menus of services for different providers.

SHOPS's actuarial analysis focused on covering commonly occurring chronic conditions, such as diabetes, hypertension, and HIV/AIDS. However, providers may not have the capacity to offer every service or may prefer to have some services paid through fee-for-service. Each service-level agreement may therefore include different covered services and terms. Through workshops,

moreover, SHOPS learned that health care providers were more willing to work with insurance providers who shared their actuarial analysis; transparency was conducive to building trust.

Lesson 4: When negotiating with health care providers, specify expectations for quality of service and treatment protocols.

When should a patient be referred to a specialist or hospital? What is the appropriate level of staff time, drugs, and diagnostics? These quality-of-care factors drive the cost of the covered service. The insurer should openly discuss expectations, referring to formularies and specific protocols (such as the Kenya National Formulary for Primary Care Level) to ensure the highest quality service. Expectations and protocols should be included in the service-level agreements with participating health care providers (Ministry of Medical Services, 2008).

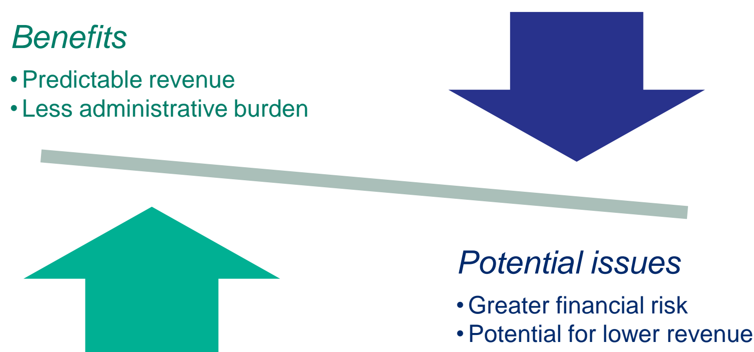
4. THE TRANSITION TO CAPITATION

Transitioning from fee-for-service to capitation requires effective communication: clients, health care providers, and insurers' staff all need to understand what will be required and what will change. Under capitation, members may select (or be assigned to) primary care providers who will serve as gatekeepers. Providers will need to maintain adequate quality of care, while being compensated a fixed amount per member per period. Because clients, health care providers, insurers, and employers have their own unique interests, it is critical to tailor strategies for each stakeholder.

4.1 HEALTH CARE PROVIDERS

Providers are likely to have the most misgivings about the transition, because they bear financial risk and could lose revenue. SHOPS emphasized the benefits that capitation could bring them and clearly communicated how to avoid potential pitfalls (Figure 6).

FIGURE 6. BENEFITS AND ISSUES FOR HEALTH CARE PROVIDERS



Benefits of capitation payment for health care providers include:

Predictable Revenue. In Kenya, under fee-for-service, providers often receive late payments and cannot predict reimbursement levels from health insurers. Under a capitation payment model,

payments are received in advance and follow the client; SHOPS's health insurance partner promised to pay capitation rates quarterly. This makes financial planning easier for health providers, who are better able to predict revenue and target investments. SHOPS found that most providers found this aspect of capitation appealing.

Reduced Administration Costs. Because capitation eliminates the process of filing individual service claims, administrative costs are lower for providers over the long term. However, because capitation methods are complex to design and implement, the transition may initially result in higher administration costs.

Issues to be addressed with health care providers include:

Greater financial risk. Capitation shifts substantial financial risk to health providers. Even when capitation rates are risk-adjusted to account for patient, provider, and market-level factors, predicting costs cannot be an exact science. Even providers who exercise caution may find that per-patient costs exceed the capitation rate—especially during the initial implementation phase, when health providers are adjusting to the transition from fee-for-service.

Lower revenue. Providers also worried that SHOPS' health insurance partner would be unwilling to negotiate a fair capitation rate. This was true particularly of providers who had negative experiences with capitation in the past, dealing with insurers who forced unsustainably low capitation rates upon contracted providers. But even in fair negotiations between insurers and providers, a lack of available data for risk adjustments can result in a capitation rate that is too low or too high.

Strategies for managing the transition with providers

SHOPS found several methods that were effective at resolving the concerns of private providers, as other researchers have also observed (Chawla, 1997; Telyukov, 2001).

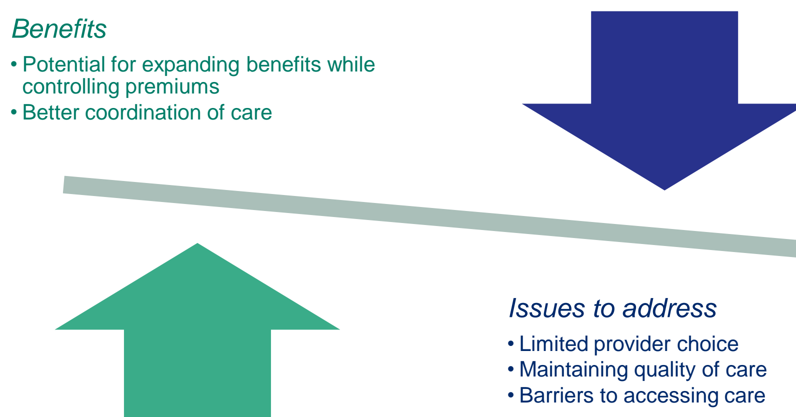
1. Reduce provider risk: start with a small pilot group, analyzing the experience and identifying lessons learned, and then consider scaling up.
2. Weight the capitation rate temporarily: provide higher payments during the initial roll-out period, to give health providers time to adapt and to assess whether payments are adequate.
3. Leverage technologies: tracking clients' use of benefits can help providers manage their care.
4. Institute a regular review process, to assess the adequacy of capitation rates.
5. Document the basis for calculating the capitation rate credibly and transparently, consulting with providers.
6. Train health providers on how capitation models work—their merits and their associated risks.

External technical assistance will be an essential part of managing a successful transition to capitation payment plans, to introduce each step and to ensure adequate communication between all stakeholders throughout the process.

4.2 HEALTH CARE CLIENTS

Figure 7 shows a summary of the benefits of capitation that should be promoted among clients, and the issues that must be addressed.

FIGURE 7. BENEFITS AND ISSUES FOR CLIENTS



Benefits of capitation payment methods for clients include:

The potential for expanding benefits or controlling premiums. SHOPS found that some clients received three to four times the level of benefits they would get through fee-for-service. (This was true for families of three or more, and for plans with maximum benefits above KES 50,000.) Cost savings can also be passed on to clients through reduced insurance premiums and cost-sharing (deductibles and co-insurance). Lower premiums can have a substantial impact on enrollment levels.

Better coordination of care. Having a designated primary care provider can align incentives to encourage preventive care, as well as improving the doctor/patient relationship. Improved care coordination may lead to better clinical decision making, less fragmented delivery of health services, and improved patient satisfaction, with increased familiarity with designated primary care providers.

Issues to be addressed with clients include:

Limited choice of health providers. Clients may fear that enrolling with a single primary care provider limits their freedom in choosing providers and accessing health services. In some cases, the principal policy holder may be based in a different location from one or more beneficiaries, who may not have access to a contracted health provider.

Maintaining quality of care. Under capitation-based payment models, providers have been known to minimize the quantity or intensity of services they provide (such as costly treatments) or to refer patients with complex cases to other providers, which can result in lower quality of care.

Barriers to access to care. Capitation can incentivize health care providers to risk-select healthier, less costly clients, limiting access to care for vulnerable populations (those with multiple co-morbidities or chronic or communicable diseases such as HIV and AIDS, as well as the elderly). Clients may also incur additional, *non-sanctioned* out-of-pocket fees, if a provider feels financially stressed.

Strategies for managing the transition with clients

The following strategies can help mitigate the issues that capitation payments may cause for clients.

1. Contract with health providers in sufficient numbers and geographic distribution, to ensure that clients and their families can access care close to home.
2. Allow clients to choose and periodically change their designated primary care provider. Based on global best practices, SHOPS recommends a waiting period of three to four months before allowing a change in provider. Most clients saw no more than two providers in a given three- to four-month period; it was helpful to communicate that this kind of waiting period would generally not impact them significantly.
3. Ensure that clients have the ability to express feedback on their providers through surveys, focus groups, or client interviews.
4. Develop quality assurance, monitoring, and reporting mechanisms to prevent and address issues related to quality. Insurers should (a) review provider referral patterns and (b) audit resources and services delivered for specific conditions, in comparison with clinical guidelines.
5. Contract with well trained and highly qualified health care providers.

In addition, insurers should monitor to ensure that:

- Wait times for clients to see providers do not increase.
- Providers do not ration services for less healthy (more costly) patients.
- Providers do not charge clients any "informal" payments.
- Clients' out-of-pocket costs do not rise significantly.
- Client utilization of essential health services does not significantly decline.
- Clients have access to health facilities, in both urban and rural areas.
- Health providers have acceptable hours of operation.

4.3 INSURANCE COMPANY

Transitioning to a capitation-based payment system generates issues for the health insurance company as well. For SHOPS's health insurance partner, there were employee concerns about what a capitation-based method would mean for staffing and operations.

Employees expressed resistance to changes in organizational processes and the need to learn new methods. Efficiency gains meant that some jobs, such as claims processing, would become less important and could even disappear. For some employees, roles and responsibilities would shift, requiring training in new skills. Hiring new staff and creating new departments meant that the organization would need to develop new management structures.

SHOPS and its health insurance partner took important steps to navigate these issues, focusing on communication at all levels. Timely communication with staff and management is a critical component of transitioning to capitation plans.

Insurance company staff. The SHOPS team held a series of meetings with the company's middle managers and staff to address any misconceptions about capitation, improving their understanding of the concept and the value proposition being offered to clients—particularly important for sales teams. The company's general manager specifically addressed staff opposition and their fears of job loss. Staff learned about the changes to expect during the transition to capitation, how it would impact them, and strategies the company would take to mitigate its negative effects.

After the sessions, staff were able to express their opinions anonymously, to report areas that they thought needed improvement, challenges they foresaw, and their ideas for addressing challenges.

SHOPS's staff consolidated the feedback and forwarded this information to senior managers, to address the issues with middle managers and in departmental meetings.

Insurance company management. The general manager set up a steering committee composed of middle managers for each operational area. The committee met biweekly to discuss the progress of the actuarial analysis. It also met with health care providers and with the sales department, to discuss the capitation product. The general manager identified a champion who would lead the steering committee in his absence, while liaising with middle managers and coordinating communication to providers.

5. LESSONS LEARNED

The table below summarizes the lessons derived, in relation to each of the parties affected by the new insurance plan.

For Clients
☐ Balance the length and frequency of open enrollment periods ☐ Monitor the actions and quality of care delivered by health providers ☐ Balance quality and quantity when contracting with health providers ☐ Monitor clients' access to care, utilization of care, and health spending ☐ Open feedback channels with clients
For Health Care Providers
☐ Pilot capitation to learn what works ☐ Weight the capitation rate at first; lower it as health providers adjust ☐ In developing a capitation rate: adjust risk, use high quality data, and collaborate with health providers ☐ Train health providers to manage and monitor financial risk ☐ Review capitation rates regularly ☐ Open feedback channels with health providers
For Insurance Company
☐ Establish a steering committee on capitation ☐ Find a champion who can lead the transition to capitation ☐ Educate and train staff on capitation ☐ Open feedback channels and regularly meet with staff

6. CONCLUSION

Well-designed capitation-based payment systems can be used to control costs of care for insurers and clients; they also may improve cash flow for health insurers and health care providers. Capitation schemes can be used to control excessive medical costs, freeing up resources for illnesses, including HIV and AIDS. By improving the viability of private insurance, capitation may help to sustainably mobilize domestic resources for health.

Ensuring a successful transition to capitation requires significant technical expertise, as well as an initial financial investment. The interests of all stakeholders must be aligned and their objectives met. Sustainability, quality of care, and acceptability by all stakeholders are key objectives. Thus, managing change and using data for decision-making are essential elements for success. Despite these challenges, capitation holds significant potential for increasing and sustaining access to quality care in the private health sector, including for HIV and AIDS services.

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