

Governance in the design and review of health benefits plans.

Case study: Review and adjustment of Health Benefits Plan/HBP in Suyan¹

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Health System Context. Suyan is a upper-middle income country of 12 million people. Under its universal health insurance scheme, management, funding, and supervision are the responsibility of the state, while health insurance is administered by one large public health insurance entity and several private health insurance companies, both for- and not-for-profit. The public insurer contracts care with the public network of providers while private insurance companies contract care with both private and public providers. The poor and informal sector are affiliated to the public insurer while the formal sector can choose among the many private companies and the public insurer. The insurance system is financed with a combination of payroll taxes and direct taxes paid to a common fund called Solidarity Fund; this fund pays an annual risk adjusted premium of US\$300 to insurance companies to guarantee the delivery of services included in the health benefits plan (HBP). The poor and the informal sector are financed through taxes while the formal sector makes its contribution through a mandatory payroll tax amounting to 10% of salaries.

By year 2016, seventy per cent of Suyanians had insurance and were entitled to a single, wide-ranging explicit benefits plan that covers all levels of care.

Stakeholder Roles in Adjusting the HBP. The Regulatory Health Council is responsible for putting forth proposals to the Board of Directors for HBP adjustment and for monitoring that the services covered by the plan are actually delivered. It is authorized to request and receive information from the insurance companies (on services provided, amounts paid, claims data, etc.), which then allow it to propose adjustments and monitor delivery of the benefits plan. The Regulatory Health Council can sanction insurance companies for any breach in contracted coverage.

Decisions on adjustment of the plan and the premium paid to insurance companies are taken by the Board of Directors (BOD), led by the Ministry of Health and comprised of representatives of different key stakeholders. A first group, consisting of the Ministry of Health, workers, and business leaders, can vote on any adjustment proposal; they can also veto any proposal to adjust the plan or its premium. The business leaders' representative has demonstrated a substantial capacity to influence decisions, and tends to take positions that are favorable to the private insurance companies. A second group represents other stakeholders, including health professionals, people with disabilities, professionals, and technicians; these representatives can also vote on the adjustment proposal, but do not have veto authority.

An HBP adjustment proposal is first drawn up by the Regulatory Council; it is next reviewed by a Permanent Strategic Review Team (PSRT) within the BOD before approval by the full Board of Directors (BOD). The PSRT is responsible for evaluating the HBP and premium proposed by the Regulatory Council; verifying delivery conditions and technical and financial viability; and making recommendations to the BOD to facilitate approval. It can arrange for any technical support it deems necessary.

Lastly, there is a Claims and Ombudsman Unit (COU), which receives and processes claims from citizens when they have difficulties in accessing the services covered by the HBP. The COU submits reports and recommendations to the BOD to inform adjustments to the HBP and its implementation.

¹ A fictional country. Suyan is an indigenous girl's name meaning "hope".

History of Adjustments to Suyan's HBP. The first HBP was approved in 2007 after much discussion and conflict. The regulatory framework establishes that the HBP's purpose is to "guarantee access to those health services corresponding to the country's health priorities", but does not define criteria for explicit prioritization. The regulatory framework also establishes that the plan and premium should be adjusted each year. Between 2007 and 2012, only minor and sporadic adjustments were made.

Since 2007, citizens have lodged thousands of complaints through the COU and courts related to insufficient coverage, refusal of approved services, and irregular and extortionate co-payments charged by the insurance companies. For example, the HBP covers hemodialysis but does not cover attachment of the device to the forearm, which is indispensable in carrying out the procedure; it covers insertion of a double-J catheter in urinary obstruction cases, but not its removal once the obstruction has been corrected. Other complaints include the lack of up-to-date coverage for very common procedures. For example, the only option for cataracts is intracapsular surgery, which has not been performed in the country since the 1980s; simple cornea transplants are excluded despite being the most common. There are also complaints about the lack of final protection to guarantee the HBP and the existence of informal payments.

In light of these complaints, in 2012 the BOD requested that the Regulatory Council submit a proposal to better fit the needs of the population. One year later, the Regulatory Council submitted a proposal to the BOD suggesting coverage of a broader list of services and requesting a significant increase in the annual premium. The proposal did not come with any justification, report, or technical study to support its recommendations. The proposal was evaluated by the Permanent Strategic Review Team (PRST) with help from specialists and technical cooperation agencies; the PRST also discussed the proposal with local interest groups including public and private insurers, providers, and other government stakeholders. It concluded that the proposal did not meet the specifications and showed major methodological weaknesses. In addition, over 60% of the newly added services were within a single surgical area favoring a particular medical specialization; other services with greater demand and higher impact were excluded without explanation. Likewise, the Regulatory Council had proposed to add over 200 medications that were already included, plus several others that had been withdrawn from the market due to obsolescence. For these reasons the BOD rejected the Regulatory Council's proposal.

2015-2016 Benefits plan adjustment process. Given the situation described above, the PRST asked the Regulatory Council to reconsider its proposal. It expressly refused to do so, claiming that it had done its job and had nothing further to add. The PRST subsequently decided, under its direct coordination, to propose an HBP adjustment that would meet the needs of the population, with the hope of doing so in the shortest time possible. With this decision, it also decided to bypass the rule that assigns responsibility for reviewing the HBP to the Regulatory Council.

To carry out the review and to formulate the new proposal, the PSRT established five general guidelines: 1) the construction of the new plan would be done with the active participation of stakeholders; 2) obsolete technologies should be excluded; 3) inclusion of new services or medicines should be aligned with existing protocols and clinical guidelines, and should take into account evidence about their effectiveness, comparative effectiveness, and cost-effectiveness; 4) the new plan and its structure should be understandable to everyone, thus preventing refusal of services due to biased interpretations; 5) it should effectively respond to national health priorities, and, importantly, 6) the proposal should include integral, comprehensive cover for a limited number of prioritized health problems.

The PSRT stated that the proposal must be finished within six months, as general elections were approaching. Releasing the proposal before a change in government would mitigate disruption, including turnover among those taking part in the review and adjustment process.

The PSRT quickly realized that an in-depth adjustment of the HBP would require a great technical effort and considerable time, and that it would be impossible to do it so quickly without external support. It therefore mobilized international experts to support review of the plan. The PRST instructed the experts to avoid an academic study and instead emphasize participation of different interest groups, helping build their knowledge and capacity.

The PRST organized over 20 focus groups to inform the experts' contract and the specific aims of the new HBP. It found, for example, that one major concern was the lack of comprehensive services offered by the current plan. The experts' work was coordinated by a Technical Coordination Team (TCT) and led by the PSRT. Many stakeholders participated continuously in the process, including doctors' groups, private and public insurance companies, and the COU. Other stakeholders (academia, NGOs, patient groups, among others) were included in different phases of the process according to their interests and skills. From the start, the PSRT established a methodology for mobilizing effective and active stakeholder participation. As a consequence, all information was socialized with each of the groups, a large number of key players participated in the discussion, many meetings and workshops were held, diverse publications were written, and input received from the interested parties was taken into account.

At the start of the work, the Regulatory Council decided not to participate in this new review effort despite its mandate. Shortly thereafter, however, the head of the Regulatory Council was replaced; the Regulatory Council joined the process once its new leader took office.

Information sources. As a first step, the team of experts went in search of the information and methods used during the initial HBP design in 2007 and the Regulatory Council's subsequent partial adjustments. However, the experts found almost no documentation on the processes in the past. The team was informed that the documentation from the technical studies was probably in a drawer somewhere in the Regulatory Council, but no one knew exactly where. Likewise, it was impossible to find technical information on the methods and studies used to partially adjust the HBP over time.

The team ended up using existing information from the Ministry of Health, Regulatory Council, COU, and other national and international studies. However, they identified weaknesses in the sufficiency, validity, availability, and quality of information, requiring them to significantly delay the work and exert a significantly greater effort. First, Suyan lacked an explicit statement of its specific health goals, and Health Ministry officials did not appear to have a consensus in this regard. Nor was there up-to-date information available about the epidemiological profile of the Suyanians; the last health survey had been held over a decade before. For some diseases it was impossible to identify use of services, incidence, prevalence, mortality, or morbidity; for example, there was no credible, up-to-date information about the number of patients with breast cancer or prostate cancer, nor was it known how many people were receiving care for mental health problems. It was thus necessary to estimate incidence and prevalence from national and international secondary sources. The information that insurance companies gave to the Regulatory Council about the quality and price of services was also full of problems. For example, there was no standard format to record medications, e.g. by name, quantities, dosage, main ingredient, units system, solution type, etc. It was impossible to know if the information for prices and quantities provided by an insurer corresponded to a tablet, a box, or a doctor's prescription. As for costs, there was no system or credible information available. There were extreme disparities in the prices paid by insurers for the same service, for example a 10x difference in the price paid for MRIs. Also, the information sent by insurance companies to the Regulatory Council had registered services that were not included in the benefits plan. For example, impregnated mosquito nets and aesthetic surgeries. Lastly, there was no information on effective cover of services covered in the benefits plan.

Agreements and Results. Given the limited timeframe and the fact that Suyan does not have technology evaluation units, external sources were used and adapted where possible. For example, the clinical practice guides from the National Institute for Health and Care Excellence (NICE) were used, as were the baskets of technologies constructed for prioritized diseases in Chile. This information was then reviewed by local specialists. For cost estimates, the team used the 2013 Chile Benefits Plan, the International Medications Price Guide, and other international references. The results of the costing exercise generated discontent among some stakeholders, who argued that it did not reflect the reality of the Suyanian context. Nonetheless, all stakeholders recognized the lack of better local information.

After concluding the work and paying US\$200,000 to the team of high-level experts, and after months of intense, collective work, the final review studies were abruptly stopped as the Regulatory Council manifested its content with the proposal and the country entered into the election process of a new government. . Once the government changed, the PRST proposal was no longer discussed, nor was it submitted to the BOD. After the change of government, the Regulatory Council started to speak about a new proposal, emphasizing the need to offer comprehensive coverage for health problems. Some voices argued that the remit of the BOD should be restricted, and that a new institutional framework should be developed to adjust the benefits plan.

Externalities of the process. Despite the fact that the benefits plan adjustment proposal is on hold, stakeholders have absorbed several key principles as nonnegotiable for future efforts, including the importance of accounting for comprehensive care when choosing services and the need for transparent prioritization. Consequently, the BOD ordered some partial adjustments to the existing plan, including the obligation to provide comprehensive coverage for surgical and high-cost services. For example, all insurers are now obliged to cover the implanting of the arteriovenous fistula in patients who require it for hemodialysis. The process of reviewing the HBP also motivated action from other stakeholders. For example, it encouraged the Health Ministry to update the Essential List of Medications (ELM). It generated incentives among various groups, especially patients and doctors, to share their preferences and feedback for proposed adjustments. It even mobilized public opinion to demand that the BOD be streamlined and conclude the review, bringing the new coverage into effect. Various patients' groups also expressed their understanding of the need to prioritize, given the financial limitations, but emphasized the need for transparent processes. Finally, the process raised stakeholders' awareness of the difficulties of the HBP adjustment process in Suyan and documented the challenges for any future adjustment process. These challenges include the weaknesses of available information, institutional weaknesses in evidence-based decision making, the high prices paid for some medications, the absence of a standardized codification of procedures, and the limitations of monitoring processes.