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PROJECT AGAINST CORRUPTION IN ALBANIA (PACA)

TECHNICAL PAPER

IMPLICATIONS FOR CORRUPTION CONTROL OF LAWS AND REGULATIONS GOVERNING HEALTH INSURANCE IN ALBANIA

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October 2012

ECU-PACA-18/2012

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Introduction

Under Activity 1.2 of the Workplan for the PACA extension period (March-December 2012), the project is to 'follow up as necessary with risk assessment beneficiaries to develop anti-corruption workplans/policies based on the risk assessments conducted previously.' Specifically, it was envisaged that PACA will support the Ministry of Health to implemented selected recommendations of the PACA risk assessment, which had been completed in 2011. Following discussions with the Ministry of Health from March to June 2012, it was agreed that PACA would provide an opinion on the legal framework – specifically, the currently in force Health Insurance Law, the Health Insurance Law scheduled to come into effect in March 2013, and relevant by-laws (sub-legal acts).

The objective of this Technical Paper is to identify weaknesses in the statutory or regulatory structure of the Albanian National Health Insurance system that provide opportunities for corruption by insurance officials or health care providers or suppliers. In particular, identify places where clarification of statutory or regulatory language might reduce the risk of illegal or informal payments made by beneficiaries in order to obtain covered services.

While the author has benefitted from discussions with Prof. Taryn Vian and her studies of informal payments in Albania, he has no first-hand knowledge of the current operations of the health insurance system in the country. This analysis is based on the review of the Albanian laws and regulations listed below (1-9)[1], provided in English translation by the PACA Team, as well as the author's experience with health financing systems in former Communist countries (Russia, Vietnam, Armenia, Georgia) and his experience with public health insurance programs (Medicaid) in the United States. The author is also grateful for the opportunity to review an English translation of the contract between the Health Insurance Institute and Durres Hospital, provided by Julian Simidjiyski from the USAID Equitable Health Reforms project.

The mandatory health insurance scheme in Albania provides for coverage for primary care visits, out-patient drugs and hospital services, including specialist care and diagnostic care. Most of the population qualifies for the program through employment or because they fit into categories such as children, pensioners and veterans that are not required to make wage-related contributions. Although recent amendments to the insurance law require the Health Insurance Institute (HII) to publicize the rules governing eligibility, benefits, payments and patient obligations, the statutory structure is a patchwork of successive laws and regulations that leave some patient obligations poorly defined, and offer only limited scope for punishing providers that collect unauthorized charges from patients.

[1] In the text of this memorandum, references to a document use the number in which it is listed in the bibliography, followed by the appropriate section or subsection of the document

The analysis which follows looks at the available laws and one current hospital contract, identifies gaps and deficiencies, and suggests improvements in the legal structure for the program. These findings and recommendations are summarized in Table 1. (References to legal documents use the numbering system in the bibliography). Specific language to remedy these problems---for statutes, regulations, provider contracts or patient education materials---can be developed using models from other social or private insurance systems.

1. Summary of findings and recommendations

Table 1 summarises the main problems identified by this opinion, and lists the recommendations forwarded in order to address them.

Table 1 Recommended Improvements in Statutory and Regulatory Structure of Albania Health Insurance System

	Source	**Recommended Action**
No specific ban on patient payments in excess of those authorized	3,8,9, 10	1. Make compliance with rules on patient charges a specific condition of provider participation in the insurance program 2. Require return of unauthorized charges to patients 3. Impose substantial penalties for charging violations 4. Authorize termination or denial of contract for charging violations 5. Authorize HII to deny contract to public providers with record of charging violations
Language on covered hospital benefits particularly vague	5,7,8,10	Amend hospital laws and hospital contracts to make clear what, if any, patient charges associated with in-patient services are allowable.
No ban on charging the patient for a referral	6,7	All physician and hospital contracts should have an explicit ban on charging for referrals. Violations punishable by fine and loss of contract.

Hospital penalties too low	9,10	1. Hospital contracts should include a substantial penalty (e.g.; 100 times the standard consultation fee) for a single incident of inappropriate charging. For a pattern of such violations, the penalty should be a multiple of this amount. 2. Contract language should make it clear that contract can be terminated for continued violations.
Exemptions from co-payments loosely defined. No reimbursement indicated.	3,8,9	1. Define eligibility for co-payment exemption more precisely (relate to other benefit statutes, if possible). 2. Issue Government identification for those entitled to co-payment exemption. 3. Develop compensation mechanism for co-payment revenue foregone.
No language defining when a contracted provider is "unavailable" so that a patient can be reimbursed for use of a non-contracted provider	2,9	1. Regulatory language defining "availability" of providers, such as distance or travel time. 2. Readily accessible (on Internet) list of currently contracted providers.
Regulations unclear on allowable charges at the primary care level	5,7,8,10	1. Clear regulatory statement on allowable charges for exempt, and non-exempt, patients for primary care services. 2. Clear guidance in information provided to insureds
Regulations unclear on what hospital in-patient services are chargeable to the patient	3,5,8	1. Issue regulations defining what (if anything) may be charged to referred (or emergency) patients for routine in-patient care (nursing services, room and

		board), medical management, procedures (deliveries, anesthesia, surgery), drugs issued while an in-patient, and drugs issued on discharge. 2. Define which if any of these charges which are to be waived for exempt categories of patients.
Therapeutic classifications used for drug reference pricing system not clearly defined. Basis for approving additional allowances for other drugs in the therapeutic class not clear	2	1. Specify in regulation the therapeutic classification system (and method for amending it). 2. Specify in legislation the criteria for allowing payment in addition to the reference price for another drug in a therapeutic class. 3. Make current therapeutic classification system and price list readily available to insureds over the internet. Specify amounts payable with and without exemption.
Improved patient education required to navigate complex system	9	1. Develop Internet based system for communicating identity of contracted providers, chargeable services, current prices and allowable exemptions. 2. Require providers (initially high volume, ultimately all) to provide Internet access terminals in waiting rooms and cash points to that patients may query this system.

2. Background/Structure of the Health Insurance System in Albania

The overall structure of the Albanian national health insurance system is quite similar to that in several other post-Communist societies. Employers and employees

contribute to the mandatory scheme, with nearly all citizens eligible for membership in the scheme, and the Government expected to pay the costs associated with the inclusion of non-working members of society. The revised health insurance law effective in 2013 provides for voluntary enrolment in the national scheme by the few individuals who are not employed and not listed in the categories of "economically non-active individuals," such as pensioners and children, who are included in the scheme and supposedly funded by the Government. (#9, Article 2.) Voluntarily insured persons must wait six months to receive benefits, one year if they have delayed more than three months in applying for voluntary cover after leaving employment.

The law permits Albanians to insure on a voluntary basis for "expensive medications and treatments that are not covered by the mandatory insurance, or for other additional benefits." Citizens may insure themselves for "direct payment of drugs, prices of prostheses and optical glasses, dental services and other out-patient services that are not covered by the mandatory insurance." (#2, Article 7). Thus, the law seems to anticipate a substantial range of services, including drugs and some physician services, which would NOT be covered by mandatory health insurance.

3. Defining Covered Services

The health insurance law provides for the coverage of "a part of the drug prices in the open pharmaceutical net, costs of the services provided by a general practitioner or family physician (and) hospital health services adopted by the Council of Ministers." (#2, Article 4.2) The subsequent article of the same law states that the State shall fund "preventive health measures, visits and examinations for purposes of diagnosis by a specialist physician, hospital health care and other cases defined by law, and emergency services." (#2, Article 5.1). Thus, there appears to be overlap between health insurance payments and the Government budget in the financing of hospital services, and potentially in some preventive services offered by general practitioners or family physicians

4. Defining Covered Providers

In the earlier health insurance law, all state-run drugstores and "public" family physicians or general practitioners shall be considered contracted providers in the mandatory insurance scheme by default. (#2, Article 26). This seems to imply that these public providers are automatically included in the insurance program unless specific action is taken to remove them. The same article allows for contracts between the insurance program and private drug stores and private family physicians and general practitioners. In the new law, private providers contracting with the insurance scheme must be properly licensed (#9, Article 29.4).

The new health insurance law (#9, Article 29.5) coming into effect in 2013 provides that the Health Insurance Fund can "interrupt the contract with a service provider in cases when the analysis of the performance shows that this provider do(es) not fulfill

the criteria" laid out in Article 29., which provides for procedures and criteria to "stimulate access to service, efficiency cost, and service quality growth." This language suggests some gap in the translation. The intent seems to be to have the Insurance Fund and its Administrative Council develop "Conditions of Participation" which would be incorporated into provider contracts. These conditions presumably include offering the covered services for which the provider is licensed at an adequate level of quality. However, there is no specific mention in this section of adherence to rules on co-payments, or bans on charging for covered services, and such rules may not automatically be included in the contracts. Without specific reference to adherence to charging rules as a Condition of Participation, then charging patients" under the table" would not, per se, be cause for "interrupting" (terminating) the contract and ejecting the provider from the insurance system.

Insured persons will be reimbursed for services obtained from providers who are not contractors to the Fund only if there are no contracted health providers available. (#9, Section 30.2). This does provide a powerful incentive to contract with the Fund, unless the provider is confident there are no competing providers with Fund contracts, and his patients are able to pay fees "up front." Such "non-contracted" providers can presumably charge patients in excess of approved rates for covered services. Sanctions which may be applied against contracted providers could NOT be applied to these non-contracted providers.

The language which provides that state run drug stores and primary care public family physicians are automatically included in the insurance program is of some concern. This concern may be partly resolved by the language in the new insurance law which provides "the Fund signs contracts with the providers of public health services, licensed by the competent authority and which covers all the services provided by the providers that are included in the service packet." (#9, Article 29.3) While the Fund "can" sign contracts with private providers, implying the Fund's discretion in doing so, it would appear that public providers are still automatically contracted. The language is clearly an improvement on the earlier law, but it should be clearer that a contract can be withheld from a licensed public provider for specified reasons, including unauthorized charges.

5. Defining Patient Payment Responsibilities

The new health insurance law provides that "insured persons participate in the partial payment of the health service provided. The rate, the service and the direct payment manner are case by case defined by the Council of of Ministers" Based on the "social policies of the Government," the insurance program may exclude from "direct payment specific categories of the individuals based on the capability to pay." (#9, Article 11.2) This language contemplates the waiver of co-payments for certain vulnerable populations, presumably with the Government in some way making up for the loss of the co-payment revenue, perhaps as is done by the Medicaid system for poor Medicare beneficiaries in the United States. However, there is no clear statement in this law of how individuals entitled to such waiver will be identified.

The Council of Minister's decision of 2004 (#3, Section 2b) provides for a co-payment exemption (100% payment) "for children 0-12, totally disabled persons, war invalids, veterans and persons suffering from TBC (tuberculosis) and CA (cancer)." This appears to apply to the schedule of payments listed for diagnostic procedures. While those qualifying for the childhood exemption may be apparent (if birthdate is known), the other categories would need some form of identification. If the other groups are entitled to receive cash payments from the Government, perhaps they are issued identification cards that can be shown to providers when requesting the co-payment exemption. Ideally, the agency determining the eligibility of an individual for cash benefits would also determine the eligibility for co-payment exemption, and have the responsibility for educating these groups about the particular co-payment exemptions which apply to them.

Language defining exempted groups does not appear in the more recent, and more extensive, procedure and fee list issued in 2009. This document (#8) includes allowable charges for primary care visits and procedures, as well as a much more extensive list of diagnostic procedures. However, it does not provide any further information on co-payments, or the categories of beneficiaries who are exempted from such co-payments.

It is unclear whether other Government programs would actually reimburse a provider for the exempted co-payment, or if the provider is simply expected to absorb the loss of revenue. Since public primary care practices and hospitals apparently receive direct Government subsidies in addition to insurance payments, it is possible that there is no reimbursement mechanism for this lost revenue. But if there is no reimbursement mechanism for the lost revenue, then private providers in the insurance program may feel entitled to illegally take co-payments, or may refuse to treat patients in the exempted categories.

a. Primary Care

The basic health insurance law seems to anticipate that primary care physicians will be paid on some form of capitation basis. It says that the costs of services by a general practitioner or family physician "shall be covered in proportion to the number of persons registered with that physician." (#2, Article 14). However, the Minister's Order of 2009 (#8) specifies fees "payable by patients" for such services as a visit to a family physician (1,000 lek) and an injection (150 lek), so it does appear that primary care providers are expected to obtain service payments in addition to any capitation. The way in which the fees are presented suggests that the patient, not the insurer, pays these fees. Unlike the 2004 document, there is no indication of exempted categories. However, when read with the other laws, the inference is that insured persons pay 10% of the approved fees for these primary care services unless they are in an exempt category. However, no statute clearly states that primary care visits require a co-payment of 10% of the approved visit or service charge. If this is

the intent, there should be an explicit statement of the primary care fees to be paid by non-exempt patients.

b. Specialist Care

Payments to specialists are clearly anticipated in the 2009 fee schedule (#8), which provides for a 1,500 lek fee for a patient seeing a specialist in an out-patient clinic, 2,000 lek for a specialist in a regional hospital and 3,000 for a specialist in university hospitals. These are all classified as "tariffs payable by patients." The implication again is that insured patients pay 100% of these amounts if not properly referred, 10% if referred and not in an exempt patient category, and nothing if they are in such a category. Clearer language in a single statute or regulation would be preferable.

c. Hospital Services

The Council of Ministers decision of 2008 (#5) appears to be the operative document on hospital funding, at least of those documents provided. This decision provides for contracts between hospitals and the Insurance Fund (HII) that define the services a particular hospital can provide, the manner of payment and the methodology for calculating costs. However, unlike the list of out-patient services and diagnostic tests, there is no fee schedule, and no clear indication of what the patient is expected to pay. The hospital shall "charge fees for the paid services defined by the Council of Ministers." (#5, Section 11). It is not clear if the fee schedule in the 2004 document (#8) is an exclusive list of the services for which hospitals can charge. The listing of "Hospital HII-Funded Services" (#5, Appendix 1a) is extensive, and probably includes most of the medical services that could be obtained in Albania. However, there is no indication in this, or any other document, of whether hospitals might charge for any aspect of these services, other than physician visits and diagnostic tests. Read together with the Medical Service Charges (#8) and the Hospital Referral Rules (#7), the documents imply that emergency patients and those who are properly referred would not be charged for per diems, laundry, food, or other necessary items included in in-patient and out-patient services. Greater clarity is clearly required to specify exactly which fees a patient can expect to pay when using a hospital facility upon proper referral or in an emergency.

It is also unclear if drugs required for hospital services are subject to the rules on charging for drugs, or are included within the scheme for hospital financing. Article 6 of the Durres Hospital contract (#10) provides that drugs recommended on discharge should comply with clinical practice guidelines and clinical practice protocol, and be on the "list of Reimbursed Drugs…and exceptions of this list." The prescription should include the generic name for drugs on the "reimbursement list." Interestingly, prescriptions for veterans should show the brand name as well, suggesting that this group may be entitled to additional reimbursement for brand name drugs.

The hospital contract appears to anticipate creation of individual bills for services received: "the hospital….shall calculate the expenses of the benefited services from

each patient based on the clinical file for the time being in the hospital." (#10, Section 4c7). But it is not clear in the contract what happens with this "bill." Under the Durres Hospital contract, the facility "shall provide inhabitants with free (ambulatory) services based only on General and Family Doctor's recommendations."(#10, Section 4d3). This clearly authorizes the hospital to charge for non-referred out-patient services. The same section (#10, Section 4d9) provides that the "hospital shall apply the system of co-payment for particular categories of insured patients foreseen in Council of Ministers Decision # 383" (#3). Thus, patients not in an "exempt" category should be paying 10% of the approved fees for diagnostic and specialist services if properly referred, 100% if not.

What, if anything, patients should pay for in-patient services remains unclear. The Durres Hospital contract provides (#10, Article 5.1) that the Health Insurance Institute "shall fund the provision of hospital health services" including wages, health and social insurance, and goods and other services. (Article 6.1) Subsequent sections of this article provide for budgeting and HII funding against an approved budget, which suggests that the hospital is being paid on a global budget, not on the basis of individual services provided to covered beneficiaries, even though (Article 7), the hospital is required to calculate the costs incurred for a particular patient and file these in the patient record. While the contract requires the hospital to stock adequate drugs and follow procurement regulations, it is notably silent on whether these are a "chargeable" service, as is the case with specialist and diagnostic services. It would be logical to assume that hospital-dispensed prescriptions are subject to the same co-payment rules (co-payment proportional to approved cost) as out-patient prescriptions, but it might also be intended that hospital-provided prescriptions are part of the service covered by budget support from the Health insurance Institute (HII). A clear statement is needed of just what hospital services a properly referred patient should pay for, both inpatient and outpatient, and how the applicable fees can be determined by the patient.

d. Testing and Laboratory Services

The statutory structure is perhaps clearest for these. The 2009 price list is extensive, and specifies an amount "payable by patients in the primary specialized and hospital health care." There is no language in this document differentiating patient co-payments and insurance system payments. However, if we read the language of the short 2004 fee schedule to apply to the procedures in this later price list, then insured persons with the proper referral pay a 10% co-payment unless in an exempt category. Unreferred patients must pay the full amount on the charge scale. This seems to be confirmed by the referral procedures (#6 and 7) and the Durres Hospital contract (#10).

e. Drugs

The only direct patient payment referred to in the basic health insurance law is for "a part of the drug prices in proportion to the amount paid by HCII" (#2, Article 6). HCII is the Health Care Insurance Institute, the manager of the Health Insurance

Fund. This language anticipates a patient co-payment for covered drugs that is proportional to the approved amount of the payment by HCII for the drug (presumably a percentage of the approved cost). The amount paid by the insurance scheme for drugs is to be determined by the HCII each year. Where "several alternative drugs are used in a case, with the same effect, HCII shall cover the lowest price. More expensive drugs may only be insured subject to conditions" determined by HCII. (#2, Article 15) This seems to provide for a reference pricing system, where the HCII payment is limited to the lowest price for any drug in a therapeutic class, but where the insurance program has the authority to selectively approve payment for more expensive (and more effective) drugs. The ability to specially approve more expensive drugs in a therapeutic class could be an invitation to pharmaceutical companies to corrupt the drug selection, classification, and pricing process. However, such discretion may be necessary to permit additional payments for drugs that have improved performance or reduced side effects in some populations. A transparent system for approving an increased price for a drug within a therapeutic class could offset this risk. Ideally, it would require clear identification of the types of patients who would benefit from the specially priced drug, and submission and publication of international data on the alleged benefits of a drug requesting higher prices.

6. Referrals

The intent of the statutory structure is to require primary care referral for non-emergency hospital and specialist care, a reasonable approach to improving the efficiency of the health system. This is accomplished by requiring patients to obtain a referral if they are to receive insurance payment for the service. Order #526 of 2009 (#6), requires that "every person in need of receiving a service in public health institutions must first see the family physician he/she is registered with." (#6, Article 1). This referral requirement applies to "laboratory and imagery examination" (#6, Article 2) and specialized consultation (#6, Article 3). Patients without the required primary care referral must pay "the prescribed tariff." (#6, Article 4). This law also requires that referral be obtained from a specialist physician for treatment in a regional hospital, and that regional hospitals approve referrals to University hospital. Hospitals are required to post the tariffs applicable to services received by a patient who is NOT referred. (#6, Article 9). Article 12 of this order provides that "all persons who fail to apply the referral system shall be provided services on payment of health service tariffs adopted by the Minister of Health, and posted in the public health institutions. " Thus, unreferred services are subject to the insurance price list. The law does contain an exception to the referral requirement for true medical emergencies, although these are not defined, which creates room for unwanted discretion: for example, how serious does a medical situation have to be to be classified as an emergency?

This Ministerial Order provides for penalties of 10,000 leks "in case the medical staff at all service levels fail to apply the medical referral system." A fine of 30,000 leks can be imposed in case of repeated violations. (#6, Article 14). The law further

provides for appeal of these fines, and for "administrative measures….against the director of the health institution" in "cases of repeated breaches." (#6, Article 16). Because hospitals usually have a local monopoly, it may not be feasible to revoke the contract for such violations, but the penalties should definitely be larger, since they only amount to a few times the standard consultation fee.

These requirements are accompanied by an additional order (#7, On the Registration, Identification and Referral of a Patient Inside Health Institutions) that provides for pre-payment of fees at health institutions by patients who are not insured and by insured patients who do not have the appropriate referral . When a patient is referred within the institution for a diagnostic test, s/he must return to Reception with the referral and get a note that the test is a covered referral before proceeding for the test. Otherwise, the patient must prepay. Thus, there seem to be reasonable "teeth" enforcing a requirement that patients obtain a referral, and that higher level providers not charge the insurance system when providing non-emergency care unless there is a referral.

However, this system provides an opportunity for corruption at the level of the referring physician or institution. The benefit of insurance coverage is substantial, and it would be economically rational for a patient who desires medical care at a higher level institution to pay for the referral. Primary care physicians might also be tempted to refer (and obtain under the table payment) even when they could treat the patient effectively. Since the primary care contract was not reviewed, the author does not know if there is a specific enforceable provision against charging for a referral, but there should be. A ban on charging to make a referral should be incorporated in hospital primary care and specialist physician contracts.

7. Patient Education and Notification

The law going into effect in March 2013 (#9 Public Disclosure #1) specifically obligates the fund to "inform the public at large, via the media and websites, magazines and brochures published by the Fund…..on….

iii) benefit packets
iv)co-payment and tariffs

This rightly puts the burden on the Health Insurance Program to educate insurance beneficiaries about their entitlements and obligations. This must be done in a way that is clear, logical and transparent, and must indicate the services and groups subject to exceptions to the usual rules for payment and co-payment.

8. Sanctions for Unauthorized Charges

There is nothing specific in the laws and regulations reviewed that penalizes a provider for collecting unauthorized charges or under-the table payments. As noted

above, the law does give the Insurance Scheme power to "interrupt" a contract, and provides for a process for the provider to challenge the decision. However, unless the provider contract provides that collection of unauthorized fees is a forbidden activity for which the contract can be revoked, the provider could argue that this activity is not covered by the contract. Even if the necessary language on adherence to rules on charging is included in the contract, the provider might claim that the current statutory language (#9, Section 29.5) does not authorize a contractual ban on inappropriate charging. In general, revoking a provider contract is the most direct and immediate method of disciplining a provider. It would appear that cash flow from the insurance program will be of great importance to all hospitals and most primary care physicians or pharmacies. Except in the wealthiest areas, it will be difficult for providers to attract patients if the patient cannot benefit from an insurance payment - even if the provider collects additional amounts from the patient. Revoking, or refusing to renew, a provider contract should be easier than attempting to remove the provider's license. In the case of a hospital, or a physician or pharmacy with a local monopoly, it may be impossible to close the provider. But the threat of loss of insurance revenue can be a powerful bargaining chip in addressing charging abuses and under-the-table payments.

The contract with Durres Hospital (#10), which presumably follows the same model as contracts between the Health Insurance Institute and other Albanian hospitals, does provide for specific sanctions for violations of the contract terms. The hospital is required to reimburse the Health Insurance Institute for misuse of insurance funds, or for unnecessary or inappropriate care. (#10, Article 12) Under the agreement, fines can be imposed for inadequate reporting, "provision of services not in accordance with professional and ethical standards" and "non observance of criteria decided by the Ministry of Health in relation to determination of patient state related to their hospitalization according to extreme need." (#10, Article 13). But it is not clear if "extreme need" refers to medical need, or to financial need.

The next section of the contract (#10, Article 14) does provide for fines "in case not making available to the public and not applying the tariffs approved for the health service." In "case of personal responsibilities of its staff," the hospital shall pay a fine of 1,000 Albanian leks. This fine seems extremely low (similar to the amount payable for a consultation), and there is no requirement for restitution to the patient for an unauthorized payment. This language is a good start, but should be expanded to indicate the types of unauthorized charges that will be punished, stiffen the fines, and provide for revocation of the contract or much larger fines if a pattern of charging abuse is proven. Hopefully, other provider contracts contain similar language on "not applying the tariffs," and all should be modified to provide for restitution to the patient and significant fines where a pattern of unauthorized charging is apparent.

9. Analysis

For beneficiaries, the greatest corruption risk in the Albanian heath insurance system is that they will be charged amounts not contemplated by the insurance statutes. This can happen in several ways:

- Paying for benefits covered by the scheme, either
  - Because the patient does not realize that the service is a covered benefit, or
  - Because the provider tells him/her that the service is not covered

- Paying amounts in addition to authorized co-payments for covered services. This could occur in several ways:
  - The provider simply demands (or passively accepts) additional "under the table" payments.
  - The patient and/or the provider do not understand that the patient is eligible for waiver of co-payments.
  - The patient and/or the provider do not understand the relevant price on which the co-payment for a drug is determined:
    - The patient may not be aware of the therapeutic category in which the drug falls.
    - He may not be aware of the applicable "base" price set by the insurance system which would determine the co-payment, or
    - He may not understand that the drug in question is actually eligible for a higher level of reimbursement, and is asked to pay the full amount in excess of the payment set for a therapeutic class.
- For a hospital service, the patient does not understand the nature of the procedure and/or does not have access to the approved fee schedule.
- The patient is told that certain aspects of in-patient services are not insured, even though the Health Insurance program is providing a budget to the hospital to cover these costs

In addition, the referral requirement for specialized services may encourage providers to charge the patient for a referral, since this will greatly reduce the cost of using a higher level provider.

The new insurance law does put an obligation on the insurance fund to educate beneficiaries about benefit packages, authorized fees and co-payments. How this

provision is implemented will be extremely important, but additional regulatory and statutory language is not required. Recommended public education options include:

- Regular mailings of updated information on fee schedules and benefit packages.

- A website with a well developed query function that permits beneficiaries to find out if a procedure is covered, what the insurance scheme will pay, and what the patient is obligated to pay in addition. Such a web site would also be a good way for patients to learn the therapeutic category into which a drug falls, the drug in the category which sets the reference price, and the legitimate indications (if any) for a more expensive drug which falls into the therapeutic category.

- A web site that indicates the providers which have contracts with the insurance scheme. This should enable patients to choose a contracted provider that is bound to accept the approved payments and co-payments. Some providers may attempt to charge patients (who seem to have adequate resources) in full by claiming they are not in the insurance scheme. As noted above, beneficiaries can only recover the insured amount for payments to these providers if there is no contracted provider in the region. There is no limit to what these non-contracted providers can charge.

- Use of community organizations (funded at least in part by the insurance scheme) to advise patients - particularly those not skilled in the use of the Internet or medical terminology - in determining their rights under the insurance scheme. Such organizations should be readily reachable by cell phone or text/email so questions may be asked at the time that medical care is required

10. Conclusions

The statutory language is confusing, and although the general outlines of the insurance system are quite clear, it is very difficult to determine precisely what a patient should pay for any particular service. Drug prices will change and fee schedules must be adjusted, with the addition of some new drugs and diagnostic tests. What providers and patients need is a clear and consistent categorization of services and beneficiaries so that a beneficiary in a class can determine what percentage of an approved fee s/he must pay for a particular service or drug, and which routine services are excluded from coverage. If an in-patient is expected to

pay for food, linen, prescription drugs or any other services, this must be explicitly indicated, in both provider contracts and patient education materials. Properly structured, perhaps as a matrix, with beneficiary status on one axis and service category on the other, this set of rules can then be applied to any approved tariff to determine the patient payment responsibility.

The system of exemption from co-payments of patient charges should be more clearly defined in the health insurance laws, with specific reference to laws defining the groups exempt from specific types of patient payments or co-payments, and the way in which persons with these exemptions can be identified..

All providers in a particular category (pharmaceutical sales, physicians, hospital), whether public or private, should be covered by contracts which incorporate similar requirements for charging only authorized amounts to the patient and the insurance company. The manner in which the provider is to verify the patient's eligibility for an exemption is not stated, nor is it clear how the provider is to recover the patient payments which are waived. For hospital services, perhaps the hospital budgets provided by the Health Insurance program are expected to compensate for exempted co-payments. However, private pharmacies and physicians would not have this source of funding. If the provider is simply expected to provide the service at a discount by not collecting the co-payment, then this should be clear, and the contract must specifically indicate if the provider can refuse to provide a drug or service when the co-payment is waived. For drugs, at least, this would seem to be necessary, unless another agency of Government will make up the co-payment.

The law underlying provider agreements should be amended to clearly empower the health insurance system to deny a contract, or terminate an existing contract, if a provider violates charging rules - whether the violation is an overcharge of the insurance system or the patient. If the patient is overcharged, the provider should be obligated to return the proven overcharge or illegal payment. For providers in a monopoly situation (such as hospitals), the fines for violation of charging rules should be substantially increased, since it would be difficult to terminate the contract. In addition, the hospital should clearly be responsible for unauthorized or under-the-table payments taken by its staff, and required both to return the inappropriate payment and pay substantial fines for a pattern of violations. Any payment taken to induce a doctor to give an insurance referral or prescription should be subject to repayment and fines in a similar manner. To the extent possible, the provider contracts should be carefully drafted to indicate that continuance of the contract is conditioned on adherence to charging rules.

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2. Law on Health Insurance (currently in effect). (Translation does not contain articles 17-25, 27, 28 and 30-33).

3. On the Adoption of Procedures, Tariffs and Extent of Coverage of Unique, Tertiary Examining Services, Included in the Health Insurance; Decision #383, June 19, 2004
4. On the Administration and Reimbursement of the Costs of Refundable Prescriptions; Decision #87, February 15, 2006
5. On the Funding of Hospital Health Services by the Mandatory Health Care Insurance Scheme; Decision #1661 December 29, 2008. (Including Appendix 1a, List of Hospital HII-Funded Services).
6. On the Implementation of the System of Patient Referral in the Health Service; Order #526, October 12, 2009
7. On the Registration, Identification and Referral of a Patient Inside Health Institutions, Pursuant to the System of Referral; Order #558, October 26, 2009.
8. Medical Service Tariffs Payable by Patients in the Primary Specialized and Hospital Health Care; Order #559, October 26, 2009.
9. Law on Compulsory Health Insurance 2012 (Goes into effect March 2013). *NB: translation seems to be missing the requirement for public disclosure by the Fund, Articles 31-42.*
10. The Contract of Durres Hospital S/2011