

COMMUNITY- BASED HEALTH INSURANCE DIRECTIVE NO.1092/2017

The Ethiopian Health Insurance Service has issued this Directive pursuant to the power given to it by sub-article 2 of Article 31 of the Community-Based Health Insurance Proclamation No. 1273/2022.

CHAPTER 1

GENERAL PROVISIONS

1. Short title

This Directive may be cited as “**Community-Based Health Insurance Directive No.1092/2025**”.

2. Definitions

In this directive, unless, the context otherwise requires:

- 1) "Council" means the National Community-Based Health Insurance Council.
- 2) "Woreda Community-Based Health Insurance Implementing Body" means the government unit executing community-based health services at the Woreda level.
- 3) "Higher Level Pool" means a pool established at the zone or regional level by consolidating Woreda level pools.
- 4) "Tertiary Hospital" means a health facility that provides the country's highest Health.
- 5) "Clinical audit" means a quality improvement audit that seeks to confirm the provided health care services are in line with the national standard treatment guideline
- 6) "Claim audit" means a systematic prepayment audit conducted to verify and validate claims submitted by health facilities against contractual agreement.

- 7) "Capitation" means a prospective provider payment mechanism that primary health care providers receives capitated amount based on the number of beneficiaries assigned to the health facility.
- 8) "Proclamation" means the Community-Based Health Insurance Proclamation No. 1273/2014.
- 9) "Regulation" means the Community-Based Health Insurance Regulation No. 535/2015.
- 10) The definitions given in the Proclamation and Regulation shall also apply to this Directive.
- 11) Any expression in the masculine gender includes feminine.

CHAPTER 2

MEMBERSHIP REGISTRATION, CONTRIBUTIONS, AND MEMBERSHIP ID

3. Membership Registration and renewal

- 1) Membership registration and renewal shall be made only within the time limit outlined in the Proclamation and Regulation.
- 2) Household heads or persons applying for membership shall submit the documents specified under Article 7 of the Regulation at the time of registration.
- 3) The regional government should identify and enroll all households living below the poverty line as indigents.

4. Issuance of ID cards

- 1) Pursuant to Article 3 of this Directive, registered members shall be issued a single ID per household upon submission of a current photograph of themselves and their family members taken within six months prior to the registration period.
- 2) Notwithstanding the provisions of sub-article 1 of this Article, submitting a photograph of children under two years of age is not mandatory.

However, they shall be entitled to health care services under the household membership.

- 3) The Woreda administration shall bear the cost of photographing an Indigent household or person.
- 4) Notwithstanding the provisions of sub-article 1 of this article, a household may be issued more than one ID when the member submits a request to the Woreda Community-Based Health Insurance Implementing Body, and the request is accepted based on the following reasons:-
 - a) In situations where the household head spends time away from their residential area due to the nature of their work,
 - b) When a beneficiary in the household receives treatment away from their residence based on the referral system.
- 5) IDs issued under this Article shall be valid for five years; upon the expiration of this period, the photograph of the family members may also be replaced.
- 6) The Woreda Community-Based Health Insurance Implementing Body shall issue IDs within 15 days of receiving the family photograph.
- 7) The Woreda Community-Based Health Insurance Implementing Body that fails to issue IDs within the time frame provided under sub-article 6 above shall facilitate the member to get health services by only showing the receipt for the payment of the membership contribution. This interim measure shall not continue for more than one month.

5. Management of Member or Beneficiary Data

- 1) The membership data of members and beneficiaries shall be kept both at the Kebele and Woreda levels.
- 2) The data collected at the Kebele level shall be entered in a register, and the Woreda Community-Based Health Implementing Body shall keep both a manual register and a digital copy of the documents.

6. Membership Contribution

- 1) Membership contributions shall be paid based on the sliding-scale contribution schedule approved by the Council.
- 2) Based on sub article 1 of this article, sliding-scale implementation system will be designed to identify and categorize the community based on their ability to pay.
- 3) Membership contributions shall be paid in a lump sum at the time of registration.
- 4) In addition to the membership contribution, a registration fee shall be paid pursuant to sub-article 1 of Article 17 of the Proclamation.
- 5) Regional governments shall determine the amount of the registration fee payable under sub-article 3 of this Article.
- 6) Receipts shall be issued for contributions and registration fees paid in accordance with this Article.
- 7) The amount of the Targeted Subsidy budget allocated by the region in accordance with sub-article 5 of Article 15 of the Proclamation shall fully cover the contributions of the indigent segment of the society based on the nationally determined regional poverty index.

CHAPTER 3

POOL ESTABLISHMENT AND TRANSFER OF FUNDS

7. Criteria for Establishing a Primary Pool

- 1) The minimum criteria to establish a Primary Woreda level pool shall be:-
 - a) a membership threshold of 80%,
 - b) have a minimum of 5,000 households.
- 2) If the number of households required to establish a Primary Pool is below the criteria set under sub-article 1 of this article, the Woredas in the Zone shall form a Zonal Higher-Level Pool.

- 3) Notwithstanding the provisions of sub-article 2 of this Article, if two or more Woredas fail to meet the criteria, they may agree to form a Woreda Primary-level pool by pooling their resources.

8. Establishment of Higher level pool

1. To ensure the financial sustainability of the community-based health insurance system, a system will be established in which existing Primary pools will form and administer a zonal or regional Higher-Level Pool.
2. The Ethiopian Health Insurance Service shall prepare a comprehensive pooling manual to guide the establishment of Higher-Level Pools.

9. Federal Pool Establishment process

- 1) The Ethiopian Health Insurance Service shall open a bank account designated to the federal pool and notify the regional implementing body.
- 2) Only primary pools that are fully operational in the year of establishment of the federal pool are eligible to contribute to the federal pool.
- 3) The regional implementing body shall collect the share of the Federal Pool from the primary pools and transfer it to the federal pool's bank account.
- 4) The Ethiopian Health Insurance Service, after ensuring all funds of the federal pool are deposited, shall inform regions through the chairman of the Council that the federal pool is ready for operation.
- 5) The Ethiopian Health Insurance Service shall commence purchasing health services from tertiary hospitals upon establishing the federal pool.

10.Pool Percentage distribution

- 1) The contribution share of each region to the federal pool may vary depending on the Council's decision.
- 2) The pool distribution of the different pools shall be determined by considering the health service cost of each health facility tier.
- 3) Pool share distribution rates between the Federal and regional pools may be revised annually.

11. Transfer of pool share and reserve fund

- 1) The Ethiopian Health Insurance shall request the Ministry of Finance to issue accounting codes for transactions of the federal pool and inform regional governments.
- 2) In addition to the accounting codes under sub-article 1 of this article, the Ethiopian Health Insurance Service shall, upon the approval of the Ministry of Finance, print and issue receipts for the collection of pool and reserve fund shares of the federal pool.
- 3) The zonal pool office or the regional implementation body shall issue receipts for the pool share and reserve fund share they receive from the primary pool office.

12. Bank Accounts

- 1) Community-based health insurance contributions shall only be deposited to a government-owned bank.
- 2) Notwithstanding the provisions of sub-article 1 of this article, the regional government may decide to engage one additional bank to deposit membership contributions.

CHAPTER 4

CONTRIBUTION COLLECTION, RECEIPTS, AND PAYMENTS TO CASH COLLECTORS

13. Contribution Collection System

- 1) The kebele administrator shall collect registration fees and contributions from paying members, document membership data, and transfer it to the primary pool's database.
- 2) Although it may vary according to local circumstances, the kebele administrator may divide the responsibilities under sub-article 1 of this Article among the following bodies: -
 - a) Members of the Kebele leadership

- b) Kebele Managers
 - c) Got leaders
 - d) Health extension workers and
 - e) Other representatives of relevant institutions
- 3) The Woreda Community-Based Health Insurance Implementing Body or the Woreda finance office, as appropriate, shall hand over the receipts for the collection of contributions members to the kebele administrator and acquire a signature proving receipt of the documents.
 - 4) The kebele administrator shall distribute the cash collection receipts to the bodies mentioned under sub-article 2 above and acquire a signature proving receipt of the documents.
 - 5) The persons assigned by the kebele administrator shall make daily deposits of the collected contributions in areas with a bank service and deposit on the last day of the week in areas without bank service nearby.
 - 6) When depositing the members' contributions, The cash collectors under sub-article 5 of this article shall also submit the second copy of the cash collection receipts and the bank deposit slip to the Woreda Community-Based Health Insurance Implementing Body.
 - 7) The Woreda Community-Based Health Insurance Implementing Body shall issue a summary receipt to the cash collectors upon receiving the documents mentioned under sub-article 6 of this article.
 - 8) The cash collectors shall collect the contributions for the basic family and the additional contribution for additional family members.
 - 9) upon receiving the compiled payment documents from the kebele administrator, the Woreda Community-Based Health Insurance Implementing Body shall reconcile the total number of members in the basic family, the additional family and the sliding-scale contribution level with the total contribution collected and deposited by the cash collectors.

10)The kebele administrator shall monitor and ensure the activities of the cash collectors are aligned with this Directive, remove the cash collectors that are not adequately fulfilling their responsibilities, and, in case of violation of the law, shall refer the case to the relevant legal authorities for further actions.

11)Notwithstanding the provisions of sub-article 2 of this article, in areas with no kebele structure, the registration of members, collection of contributions, and receipt-related tasks shall be undertaken with bodies with equivalent responsibility.

14.Receipt Distribution and Collection

- 1) The Regional implementing body or the Regional Finance Office shall distribute the printed receipts to the Woreda Community-based Health Insurance Implementing Body in accordance with the applicable distribution procedure for government financial documents.
- 2) The Woreda Community-Based Health Insurance Implementing Body shall deliver the receipts to the kebele administrator one week prior to the start of the membership registration and renewal period.
- 3) The kebele administrator shall collect the used or unused receipts distributed as per sub-article 2 of this article and return them to the Woreda Community-Based Health Insurance Implementing Body within 15 days of the end of the registration and renewal period.
- 4) Notwithstanding the provision of sub-article 3 of this article, fully used cash collection receipt pads shall immediately be returned to the Woreda Community-Based Health Insurance Implementing Body within the membership registration and renewal period.
- 5) The relevant community-based health insurance implementing bodies at each level shall keep an organized and detailed record of the cash collection receipts and report to the appropriate authorities.

- 6) A cash collector who lost a cash collection receipt shall be liable for up to the amount collectible from the receipts.

15. Payment to Cash Collectors

- 1) Cash collectors' fees may be paid under the following circumstances:-
 - a) When used or unused cash collection receipts have been returned within the time limits set forth in sub-article 3 of Article 13 of this Directive,
 - b) When the cash collected has been deposited to the scheme's bank account within the time limit set forth.
 - c) When it's verified that the second copy of all the cash collection receipts, bank deposit slips, and a completed new members' application form has been submitted within 15 consecutive days following the end of the membership registration and renewal period.
- 2) In the event that cash collection has been outsourced to a private financial service provider, the service fee may be paid from funds set aside for minor expenses.
- 3) If the amount determined as a minor expense is not sufficient to cover the expenses, the regional implementing body shall cover the expense from its budget.

16. Printing of Receipts

- 1) The regional government budget shall cover the cost of printing receipts for the collection of members' contributions.
- 2) Receipts shall be printed at the regional administration level. However, a sub-regional government office may, as appropriate, be granted the responsibility to print the receipts.

CHAPTER 5

PURCHASE OF HEALTH SERVICES AND PROVIDER PAYMENT MECHANISMS

17. Purchase of Health Services

- 1) Health services shall be provided to beneficiaries by a health service provider that entered into a negotiation-based contract with the federal or regional implementing body.
- 2) The federal or regional implementing body may enter into a separate contract with selected laboratory, diagnostic imaging, and pharmaceutical service providers in order to provide complete services to beneficiaries.
- 3) The Ethiopian Health Insurance Service shall develop detailed procedures for the participation of non-profit and for-profit private health service providers in the health insurance system.

18. Emergency Treatment

- 1) An emergency patient who is a member of a community-based health insurance system is not required to follow the referral system provided under the proclamation and Regulation. The cost of health services may be covered by health insurance in the following cases.
 - a) The health service provider where the beneficiary received services has entered into a contract with a health insurance provider,
 - b) When the claim request for the payment is submitted according to the accepted claim request procedures and
 - c) The health services provided are included in the insurance system benefits package.
- 2) A health service provider that has provided emergency medical services in accordance with this article shall, within one month of giving the emergency treatment, submit a claim request to the pool office where the beneficiary is a registered member.

- 3) The relevant provisions on claim audit provided in this Directive shall apply to the claim request entered under this article.

19. Clinical Audit

- 1) Clinical audits may be conducted by the federal or regional implementing body for the quality assurance of medical services under the following conditions:-
 - a) A comprehensive audit before entering into or renewing a contract with a health service provider as a readiness assessment to ensure that the necessary requirements have been met.
 - b) A periodic audit to ensure that the contracted health service provider is providing quality and complete services expected at its level.
 - c) Special audits
- 2) A periodic audit shall be conducted every 6 months for 30% of the sampled health facilities.
- 3) Pursuant to sub-article 2 of this Article, the sampling for conducting periodic audits will take into account the following conditions:-
 - a) Healthcare facilities presenting exaggerated payment requests (aggregate or requested for a single user),
 - b) A high number of complaints from beneficiaries,
 - c) Unusual shortage of medical service resources or
 - d) if there are excessive claim requests compared to the previous quarter's payment requests or
 - e) more patient referrals than expected.
- 4) Notwithstanding the provisions of this article on sample periodic audits, the audit shall cover all contracted health facilities within three years.
- 5) Notwithstanding the provisions of sub-articles 3 and 4 of this article, the executive body at different levels may carry out periodical audits on all contracted health service facilities every 6 months depending on improved efficiency and capacity.

20. Provider Payment Mechanism

- 1) The following provider payment mechanisms shall apply as applicable to services provided by health facilities.
 - a) Capitation,
 - b) fee-for-service or
 - c) case-based payment mechanism.
- 2) Subject to the provisions of sub-1 of this article, the Ethiopian Health Insurance Service may study other payment methods and implement them at the national level.
- 3) The payment methods under this Article may be applied individually or in combination.

21. Claims Audits

- 1) A pre-payment audit shall be conducted on all payment requests submitted by healthcare facilities, except for healthcare facilities that are paid under the capitation payment mechanism.
- 2) Claims audit shall, as appropriate, be conducted by experts from the Federal or regional implementing body or someone represented by the implementing bodies.
- 3) Based on the findings of the claims audit, action may be taken against the health facility in accordance with the contract signed.

22. Post-service Payment for Health Services

- 1) Post-service payment requests shall be made for fee-for-service and case-based payment mechanisms.
- 2) Pursuant to sub-article 1 of this Article, the health care provider shall submit monthly payment claims.
- 3) As per sub-article 2 of this Article, payments shall be made as follows
 - a) Claims for payment shall be submitted within 10 consecutive days from the end of the month.

- b) The appropriate federal or regional implementing body shall conduct a claims audit on payment requests submitted for three consecutive months and make quarterly payments.
- c) Payment shall be made within 15 days after the end of the third month.

23. Capitation

- 1) To implement the capitation payment mechanism, beneficiaries shall be assigned to a government health center or a health post in their catchment area.
- 2) Notwithstanding the provision of sub-article 1 of this article, beneficiaries may, in the absence of a government health center, be assigned to a health center established by a charity organization or to a primary hospital.
- 3) The beneficiary mapping done pursuant to sub-article 1 of this Article shall be based on the beneficiary-to-health facility ratio prepared by the Woreda health office.
- 4) Notwithstanding the provisions of sub-article 1 of this Article, a beneficiary may be assigned to a health facility outside of its catchment area and to a health facility closer to their place of residence based on a mutual agreement between the Woreda health office and the Woreda Community-Based Health Insurance Implementing Body.
- 5) Capitation payment shall be calculated and paid on the following basis:-
 - a) The capitated amount shall be calculated annually.
 - b) The health facility shall be paid every six months.
 - c) The health facility shall send a utilization report of the assigned beneficiaries to the health insurance implementing body every 6 months.
- 6) The health facility shall provide a complete and uninterrupted service to the beneficiaries for the period for which payment is effected in accordance with sub-article 5 of this Article.

- 7) The annual capitated rate calculated in accordance with sub-article 5 (a) of this Article may be revised for the following year.

24.Payment to Health Facilities

- 1) The payments effected in accordance with Articles 20 and 21 of this directive shall be made via a bank transfer or cheque or an appropriate digital payment system.
- 2) Notwithstanding the provisions of this directive about payment, penalties for late payments and other payment-related details shall be governed by the contract signed between the implementing body and the health service provider.

CHAPTER 6

MISCELLANEOUS PROVISIONS

25.Use of Technology

The design and implementation of a digital system for membership registration, ID issuance, member and beneficiary information management, contribution collection, and claims management will be established.

26. Transfer of General Subsidy

General subsidy will be transfer after Ethiopian Health Insurance Service verifying the collected members' contribution in line with the number of core and additional family members, and the sliding-scale contribution schedule.

27.Inapplicable laws

Other directives and practices inconsistent with this Directive shall not apply to matters covered by this Directive.

28.Effective Date

This Directive shall become effective from the date it is registered by the Ministry of Justice and uploaded to its website.

Semerita Sewasew

Chair Person of Ethiopian Health Insurance Service Management Board