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The World Bank Health Nutrition and Population MENA

Policy Note

Automatic Health Insurance Enrollment for Vulnerable Individuals:

Opportunities for Egypt's Universal Health Insurance System

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Acronyms

ELE	Express lane eligibility
GFATM	The Global Fund to Fight Aids, Tuberculosis and Malaria
MOSS	Ministry of Social Solidarity
NOSI	National Organization for Social Insurance
TKP	Takaful and Karama Program
UHC	Universal Health Coverage
UHIA	Universal Health Insurance Agency
UHIS	Universal Health Insurance System
UNR	Unified National Registry

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Executive Summary

The Universal Health Insurance System (UHIS) in Egypt has been implemented in four governorates. The law provides for subsidized UHIS coverage for underprivileged individuals registered with one of six public benefits programs categories. Category 1 includes the Takaful and Karama Program (TKP), the flagship social assistance program managed by the Ministry of Social Solidarity (MOSS). The other five categories consist of public programs that assist the unemployed without income, vulnerable children, people with disabilities, people living in disaster areas and other impoverished groups. By June 2024, nearly 1 million beneficiaries have been registered in these six program categories in the four UHIS governorates. They are all eligible for subsidized UHIS coverage, but only 56 percent of them have been insured so far. The fiscal impact of the insurance subsidy has been small with a government transfer of EGP 1.95 billion to the UHIS, accounting for about 0.014 percent of GDP in 2024.

Despite laws mandating subsidized enrollment in health insurance, vulnerable groups often remain uninsured in many countries. The low enrollment rate among these groups suggests that financial incentives through subsidies along with laws promoting subsidized coverage do not guarantee that agencies will effectively facilitate the enrollment process for the poor. This poses challenges for governments striving to achieve Universal Health Coverage (UHC) for their populations.

Administrative complexity, lack of resources, and inadequate information systems are significant barriers to enrollment. Many eligible individuals are unaware of their right to free insurance or are deterred by a complicated enrollment process. The administrative burden to enroll in a benefits program can be challenging for poor individuals, especially if it involves extensive documentation and in-person visits. Data systems are often not integrated to streamline enrollment through interagency data sharing. Other barriers may include the location and operating hours of enrollment offices.

Similar issues have impacted subsidized UHIS enrollment in Egypt. Real-time eligibility checks are not available, so beneficiaries still need to present substantial information for manual eligibility verification. Enrollment involves providing extensive documentation and evidence of vulnerability, as well as face-to-face interviews at several agency staff. Additionally, a visit to health facilities is required to get empaneled with a provider and complete the UHIS registration process.

The insurance enrollment of individuals who are eligible for public benefits programs could be made automatic based on the eligibility determination of these other programs. Automatic enrollment would provide insurance coverage to public program applicants without requiring them to actively apply for insurance coverage. It would require digital integration across agencies, establishing an express lane eligibility function to allow insurers to use eligibility findings from other public programs and obtain data from other government databases. Investing in real-time eligibility determination would substantially reduce the wait-time for applicants to access public program and health benefits.

Automatic enrollment in public benefits programs is not widely implemented in low- and middle-income countries. Information systems are often lacking to transfer relevant data across agencies. Automatic enrollment would require governments to modernize their enrollment systems, invest in digital integration, and introduce administrative easing across agencies to ensure that eligible individuals can access public benefits. Automatic enrollment can significantly reduce the uninsurance rate among vulnerable groups.

This note offers insights on how Egypt can move forward to achieve automatic UHIS coverage for vulnerable groups. Automatic enrollment would help eliminate barriers to UHIS coverage, get rid of long queues for applicants, decrease the administrative burden on employees and applicants during enrollment, and reduce the time and effort required for applicants to prepare necessary documents.

As a first step, a capacity assessment of administration and information technology within relevant agencies and the UNR could be conducted to identify the current situation and compare it to the future vision of automatic enrollment. This would allow the identification of possible investment scenarios for administration, information technology, and financing needs across agencies. Once agreed upon by the government, implementation plans can be developed and put in action. Based on the current assessment, this note proposes selected recommendations towards achieving this vision.

1. **Administrative simplification for improved insurance coverage**

The UHIS communication strategy would need to outline the information process about automatic UHIS enrollment. UHIA would inform individuals about their eligibility and facilitate their insurance enrollment. MOSS, NOSI and health providers could assist UHIA by informing their beneficiaries about their eligibility for subsidized UHIS coverage. Mobile phones could be used to invite people to apply for coverage. Teachers could be asked to assist children and their caretakers with enrollment.

Consolidating the six public benefits categories (Figure 2) into fewer public programs along with streamlined eligibility determination would simplify the enrollment process for applicants and staff.

Eligibility determination would occur when individuals apply for a public program category at MOSS or NOSI, or at UHIA. Individuals in Category 6 could be enrolled during their MOSS application, if they are poor but did not qualify for TKP but qualify for Category 6 enrollment based on specific criteria.

Agencies would need to establish policies and procedures for the simplified processes, including how to handle incomplete information and obtain data from other databases. Application and renewal forms should be standardized across agencies to facilitate data transfer.

An auto-empanelment policy would automatically assign applicants to the nearest health provider if they do not specify a preferred provider during the public program application process. Once empaneled, individuals could then have the option to switch providers if desired.

Egypt could consider providing enrollees with a single benefits card that identifies them as beneficiaries of public programs and UHIS. It would eliminate the need for multiple cards.

Performance management practices supportive of increased take-up could be considered. Performance indicators could include UHIS enrollment rates by category and wait time for enrollment. Staff would be rewarded for achieving higher enrollment rates.

MOSS, NOSI and UHIA should produce and publish quarterly reports, based on timely monitoring and evaluation of enrollment across programs and governorates. This would allow for the identification of areas with low enrollment and addressing any potential barriers to UHIS enrollment. UHIA could conduct focus group discussions to identify issues affecting low enrollment.

Additional analysis could focus on pertinent policy questions, such as the efficiency of the enrollment process, and the impact of UHIS coverage on enrollees' health care seeking behavior and out-of-pocket payments. The results will be valuable in raising awareness and informing policy decisions regarding the design, financing, and procedural aspects of the UHIS. Think tanks could be engaged to regularly analyze the UHIS effectiveness and publish reports to inform policy decisions.

2. **Digital integration to enable seamless enrollment across agencies**

Digital integration across MOSS, NOSI, and the UHIS is recommended to improve data flow. This may involve upgrading eligibility and enrollment systems at the MOSS, NOSI, UHIA and in health facilities, investing in digital integration across agencies, implementing express lane eligibility and real-

time eligibility determination, and enhancing consumer-friendly features of online applications. An interagency agreement may be needed to allow electronic data transfer across agencies.

With express lane eligibility (ELE) UHIA can rely on MOSS or NOSI's eligibility findings and obtain data from other public databases such as the UNR. ELE processes could be implemented for individuals in all public program categories. Successful data matching between agencies would necessitate standardized forms and electronic file structure to guarantee consistency in data reporting across files (including name, address, date of birth, national ID number, etc.).

Real-time eligibility determination could streamline the application process for public programs and UHIS coverage with results ideally available within 24 hours. Application platforms could be made available at the MOSS, NOSI and UHIA registration points, where staff would assist applicants with data entry. Applicants would enter their data into the portal and receive immediate confirmation of their eligibility. Eligibility could be verified through electronic data accessed through the government's data services hub, the UNR, and private data services (e.g. telecom). Applicants unfamiliar with the online application process may still require in-person assistance.

Real-time eligibility determination can also be offered to individuals living with disabilities (category 4), people living in disaster areas (category 5), the poor registered with MOSS who fail to meet their basic needs (category 6), as well as individuals who qualify for a public program (category 4) but have not been enrolled yet. To prevent duplicate enrollment, UHIA can match individual data against the public program datafile and the UHIS enrollment database.

Automated renewal would allow UHIA to renew coverage without requiring an individual to fill out a renewal form. Data can be consistently verified through information exchange with other agencies and against the unified national registry. This will minimize paperwork for both individuals and staff.

3. Medium-term expenditure planning to boost subsidized UHIS enrollment

The rollout of UHIS will necessitate an increase in government transfers to subsidize UHIS coverage. Subsidizing UHIS enrollment for all 970,964 beneficiaries currently registered in public programs in the four governorates would require an annual transfer from the MOF to UHIS equivalent to 0.025 percent of GDP in 2024. Subsidizing UHIS enrollment for 30 percent of the population nationwide by 2028/29 will likely increase annual government subsidies to about 0.4 percent of GDP. The UHIS would need to provide regular analysis on its impact on population health in return for the subsidies.

The UHIS health benefits package should be designed based on a prioritized list of medical conditions and treatments provided in Egypt's health sector. The financial implications of the benefits package for all payers, including the government and individuals, will need to be analyzed regularly. If the basic package covered by the UHIS should include more services, then the budget for financing it would need to be increased. This will have fiscal implications for the government who subsidizes the UHIS enrollment of vulnerable groups. The UHIS should aim to maximize the amount of UHIS revenue spent on healthcare and minimize its administrative costs.

Introduction

Many people do not receive the health insurance coverage for which they are eligible, even when enrollment is free. Their low enrollment rates suggest that financial incentives through subsidies combined with laws on subsidized coverage do not guarantee that administrative agencies will facilitate the enrollment process for eligible groups. This can be problematic for governments that aim to achieve Universal Health Coverage (UHC) for their populations.

Administrative complexity, insufficient resources, and inadequate information are key barriers to subsidized insurance enrollment. The process of enrolling in a benefits program can be challenging for individuals. Government agencies that primarily serve the poor often lack the necessary resources, such as qualified staff, technology, facilities, and commitment to client service compared to agencies that serve a broader public.[1] Often information systems are not ready to transfer relevant data between agencies. Other barriers may include limited outreach efforts to educate individuals about their eligibility, the location of enrollment offices, and complicated enrollment procedures. Additionally, the limited availability of government resources to subsidize insurance coverage can deter applicants. Some people may not enroll because of the perceived high transaction costs associated with enrollment.[2]

People who are eligible for subsidized insurance are often also eligible for various public benefits programs. Their insurance enrollment could be made automatic based on the eligibility determination from other public programs. Automatic enrollment would provide insurance coverage to eligible individuals without requiring them to actively apply for coverage. Setting up real-time eligibility determination would reduce the wait time and administrative burden for applicants and agency employees. Digital integration across agencies and establishing an express lane eligibility function would allow insurers to rely on findings from other public programs and receive data from government databases to enroll eligible individuals. An interagency agreement would ensure that the agency determining eligibility for the public program can transfer electronic data of beneficiaries across agencies.

Automatic insurance enrollment could significantly decrease the number of uninsured eligible for subsidized coverage. It would involve investing in digital integration, updating enrollment systems, and streamlining administrative processes across agencies. Governments would also need to allocate the necessary resources to enroll a greater number of eligible individuals.

In Egypt, the law mandates that all Egyptians must enroll in the Universal Health Insurance System (UHIS).[3] The Universal Health Insurance Law was enacted in December 2017 to provide guidance for the government-managed UHIS. The Universal Health Insurance Agency (UHIA), an independent off-budget authority that reports to the Prime Minister, is responsible for administering the UHIS, which is being implemented in six phases over a 15-year period. Phase 1 began in 2018 in Port Said governorate and has since expanded to Luxor (2021), Ismailia (2022), and South Sinai (2023), with a pilot rollout in Aswan and Suez. The government provides subsidized UHIS enrollment for underprivileged groups. However, the challenges of enrolling these underprivileged individuals in the UHIS have not been analyzed yet.

This note explores automatic enrollment as a possible option for the UHIS. It reviews the experiences from Egypt and other countries and draws from interviews with key-informants to assess possible factors affecting insurance enrollment for those entitled to subsidized coverage in Egypt. It analyzes these key

[1] Fox et al. 2020.
[2] Fossett and Thompson 2005.
[3] Egypt UHIS Law. 2018.

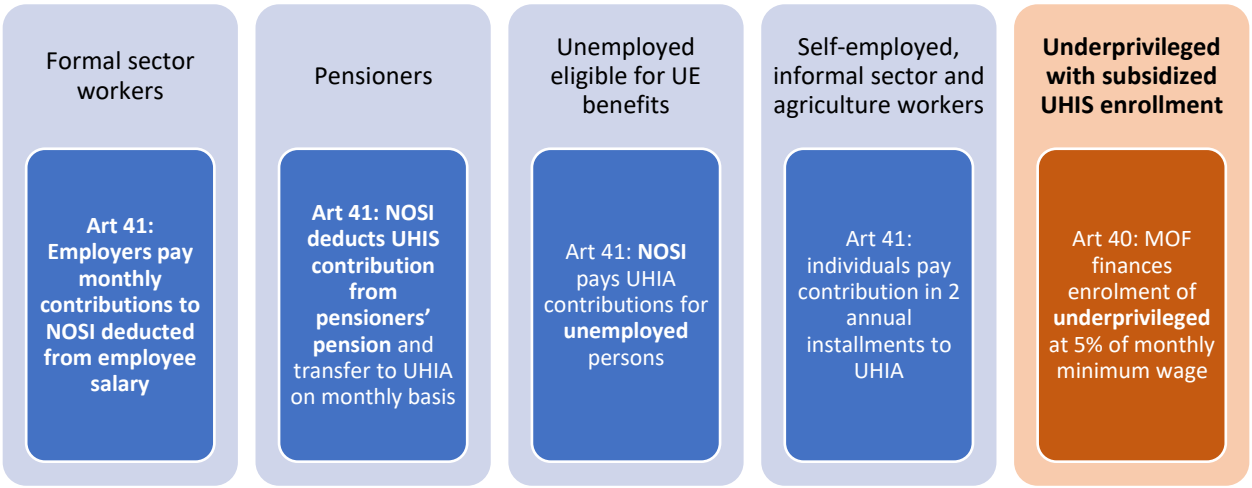
factors in the context of the UHIS. The findings can assist the government in addressing enrollment barriers and exploring opportunities for automatic UHIS coverage for eligible individuals.

Egypt's experience with health insurance enrollment

Five main UHIS enrollment categories

There are five main UHIS enrollment categories based on individuals' socio-economic and demographic situation. Enrollment is financed by contribution payments and government subsidies (Figure 1). The National Organization for Social Insurance (NOSI) plays an important role in the enrollment and contribution collection for the first three categories, including formal sector workers, pensioners, and the unemployed eligible for unemployment benefits. Formal sector workers pay a 1 percent payroll tax to enroll, an additional 3 percent for their spouse and 1 percent for each dependent. NOSI must transfer contributions collected on behalf of these groups to UHIA within 30 days. The fourth category, which includes the self-employed, informal sector workers, and agricultural workers, enroll and pay contributions of 5 percent of their wage as declared on their tax statement directly to UHIA. The government subsidizes the enrollment of underprivileged groups in the fifth enrollment category. The UHIS enrollment subsidy is a government transfer from the Ministry of Finance (MOF) to UHIA, set at 5 percent of the monthly minimum wage of EGP 6,000. This results in a monthly premium subsidy of EGP 300 per person, or EGP 3,600 per person per year.

Figure 1: Five UHIS enrollment categories in Egypt:



Source: UHIS Law Articles 40 and 41.

By June 2024, over 3.13 million people were enrolled in the UHIS, representing an all-time high of 81 percent of the population in the four Phase 1 governorates. UHIA does not publish enrollment results for each of the five categories. Enrollees include 2.59 million individuals enrolled in the four contribution-paying UHIS categories, and 542,973 underprivileged individuals with subsidized enrollment,[4] representing 17.3 percent of all UHIS enrollees. The UHIS law establishes a limit on subsidies, stating that up to 30 percent of the population can receive subsidized enrollment. Currently, about 14 percent of the population in the four governorates benefit from subsidized UHIS enrollment**.**

[4] World Health Organization independent verification reports (June 2024).

Beneficiaries of public benefits programs are eligible for subsidized UHIS enrollment

The relevant public benefits programs were classified into six categories (Figure 2) by a recent Prime Minister Decree.[5] All beneficiaries of these public program categories are eligible for subsidized UHIS coverage; however, they must first qualify for one of these public programs. Category 1 includes the Takaful & Karama Program (TKP), which is the signature social protection program managed by the Ministry of Social Security (MOSS). The TKP was introduced in March 2015 to provide cash transfers to poor families with children under 18 years, poor elderly aged 65 years and above and persons with disabilities. TKP applicants' data are cross-checked against Egypt's Unified National Registry (UNR) covering the entire population of Egyptian citizens. By June 2024, the TKP covered approximately 4.67 million households nationwide (about 20 million TKP individuals). Women represent 74 percent of beneficiaries. TKP uses proxy means testing to target support for the poorest. In 2022, the TKP covered 27.7 percent of poor households in Egypt. TKP demonstrates strong targeting performance with 81.1 percent of beneficiaries being poor, 12.5 percent being near poor, and a relatively low leakage rate at 6.4 percent.[6]

Figure 2: Six categories of public benefits programs

Source: UHIS Law (2018) Article 2 and Prime Minister Decree #4586 (2024).

An impact evaluation conducted in 2018 found that TKP improved the wellbeing of poor households. TKP increased household consumption and reduced the probability that a household is poor by 11.4 percentage points. A follow up evaluation conducted in 2022 found that TKP increased households' investments in assets and reduced their debt burdens. TKP households reported better school enrollment and attendance. However, the TKP enrollment had no impact on maternal and child health and nutrition, except for a reduction in wasting for young children.[7] This highlights the importance of ensuring access to health care for TKP beneficiaries through subsidized UHIS coverage.

MOSS manages the large public benefits programs. As of June 2024, MOSS had registered over 1.68 million individuals in categories 1 and 3 in the six UHIS governorates, with most of them being TKP

[5] Egypt Prime Minister Decree 4586 from 2024.
[6] World Bank 2022.
[7] El-Enbaby et al. 2022

beneficiaries. Information on the number of unemployed individuals registered with NOSI (category 2) and the number of individuals living with disabilities registered with MOSS (category 4) is unavailable. There is also no information on the number of individuals residing in disaster areas who qualify for assistance under category 5 as defined by the Prime Minister. Category 6 includes individuals who are considered poor and are unable to meet their basic needs but did not qualify for TKP benefits. In June 2024, category 6 included 352 individuals living in Port Said and Luxor who were confirmed by the UHIA committee (Table 1).

Table 1: Beneficiaries of Public Programs in Categories 1-6 living in UHIS governorates, June 2024

Beneficiaries of public programs		Governorates					Pilot Governorates		Total 6 Gov.
		Port Said	Ismailia	Luxor	South Sinai	Total 4 Gov.	Aswan	Suez	
Cat. 1 MOSS	TKP head of household	39,346	194,551	385,798	12,414	**632,109**	417,950	44,619	**1,094,678**
	TKP Dependent	19,959	105,402	192,560	6,945	**324,866**	215,397	24,610	**564,873**
	Social Security	1,230	4,715	5,356	739	**12,040**	7,363	1,426	**20,829**
	Child Pension	103	46	11	106	**266**	54	19	**339**
Cat. 2 NOSI	Unemployed without UE benefits	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cat. 3 MOSS	Social Care	501	516	252	62	**1,331**	171	290	**1,792**
Cat. 4 MOSS	Disabled	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cat. 5 PM	Disaster area	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cat. 6 UHIA	Income insufficient	179	0	173	0	**352**	0	0	**352**
Total beneficiaries		**61,318**	**305,230**	**584,150**	**20,266**	**970,964**	**640,764**	**70,674**	**1,682,863**

Source: MOSS and UHIA data from June 2024

Only the TKP reports on its administrative performance. Member satisfaction with the TKP has declined from 89 percent of households being very satisfied or somewhat satisfied in 2018 to 76 percent in 2022. Satisfaction was affected by long queues for program applications, insufficient help from social workers explaining the process, the substantial time and effort needed to prepare the relevant documents to register with TKP, and the limited working hours of administrative units that delivered benefits.[8] The government has introduced measures to address these complaints. Similar administrative hurdles may affect enrollment in other program categories (Figure 2). Addressing them will increase enrollment in public programs and expand the number of people eligible for subsidized UHIS coverage.

Across these public programs, each with distinct eligibility rules and enrollment procedures, individuals bear the administrative burden of enrolling. This burden becomes more complex if people transition between eligibility for different programs (Figure 2). At key transitional moments, such as a change in family status or if a person becomes disabled or faces a disaster, individuals must actively enroll in a new program and apply for UHIS coverage again. Individuals who wait to requalify for a different program or

[8] El-Enbaby et al. 2022

get lost in the process risk sliding into uninsurance. This suggests that administrative easing including streamlined eligibility determination and consolidating all six public benefits categories as possible, could simplify the enrollment process for eligible individuals and for staff working in these agencies.

There are substantial variations in subsidized UHIS enrollment across governorates and time

Subsidized UHIS enrollment varies across governorates ranging from 45.2 percent of eligible individuals in South Sinai to 59 percent in Luxor and Port Said. The UHIS reported more than half a million subsidized enrollees in the four Phase 1 governorates: Port Said, Ismailia, Luxor, and South Sinai by June 2024, reflecting 56 percent of eligible individuals (Table 2). The UHIS is yet to fully commence operations in Aswan and Suez governorates. UHIA does not report information on subsidized UHIS enrollment by category 1 to 5 (Figure 2). However, since the TKP is the largest public benefits program, most subsidized UHIS enrollees are TKP beneficiaries. The actual UHIS enrollment rate could be lower if the number of people registered with public benefits programs is under-reported based on the available data (Table 1). UHIS enrollment could be substantially increased if the government were to subsidize coverage for all eligible beneficiaries across governorates.

Table 2: Subsidized UHIS enrollment among eligible public program beneficiaries, June 2024

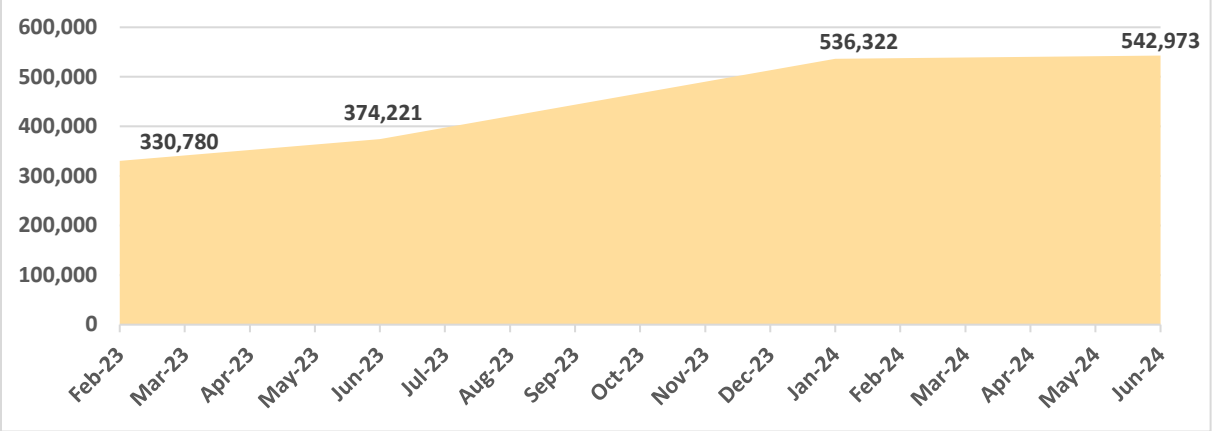
Enrollment	Governorates					Pilot Governorates		
	Port Said	Ismailia	Luxor	South Sinai	Total 4 Gov.	Aswan	Suez	Total 6 Gov.
Eligible: Number of beneficiaries in public programs (cat. 1-6)	61,318	305,230	584,150	20,266	**970,964**	640,764	70,674	**1,682,863**
Actual: Number of subsidized UHIS enrollees	35,783	153,771	344,267	9,152	**542,973**	0	0	542,973
Enrollment rate: % of eligible individuals enrolled with UHIS	**58.4%**	**50.4%**	**58.9%**	**45.2%**	**55.9%**	**0%**	**0%**	**32.3%**

Source: UHIA data from January 2024. Note: UHIS enrollment data by category not available

There have been significant changes in subsidized UHIS enrollment over time. The most substantial increase occurred between June 2023 and January 2024, when the UHIS gained an additional 162,000 subsidized enrollees within six months. This number is considerably higher than the 6,000 newly subsidized UHIS members added in the first six months of 2024 (Figure 3). This rapid increase demonstrates that agencies have the capability to greatly boost UHIS enrollment in a short timeframe. However, enrollment has been slow for applicants in category 6. Between March 2020 and 2024, the UHIA committee received 232 applications for category 6, reviewed 205 applications (88% of all applicants) and approved 104 applications (50.7% of those reviewed).

Little is known about the causes of enrollment variations over time, across governorates and categories. They could be attributed to several factors, such as improved data sharing between MOSS and UHIA, additional government subsidies or funding from alternative sources, enhanced administrative capacity to streamline enrollment processes, and different outreach activities aimed at informing eligible groups. By analyzing the administrative enrollment process, data transfer procedures, and financial status, it may be possible to identify and address the underlying reasons for these variations.

Figure 3: Total number of subsidized UHIS enrollees in 4 governorates, February 2023 – June 2024



Source: UHIA data.

Lessons from other countries: Factors affecting subsidized health insurance enrollment

Uninsurance is a significant issue in low- and middle-income countries.[9, 10] Many vulnerable individuals are unaware of health insurance, their right to free coverage, and how to enroll. Lengthy enrollment processes, administrative barriers, restricted opening hours, and documentation requirements can discourage them from enrolling. Individuals without identification documents are most affected by these challenges. Geographical accessibility to enrollment centers can also be a barrier, particularly in rural areas. Lack of trust in the government can further hinder enrollment. Misconceptions may arise from negative experiences with the healthcare system or insurance programs. The perceived value of insurance may be low if limited benefits lead to high co-payments, or if concerns arise about the quality and availability of healthcare covered by insurance, long wait times or insufficient health providers.[11]

Low-income individuals make up a significant portion of the uninsured population, even when their enrollment is subsidized. Several factors contribute to low coverage among subsidized groups, including a lack of administrative responsiveness from agencies, inadequate data to assess eligibility for subsidized coverage, and insufficient resources to finance enrollment. Some governments have addressed low enrollment rates by introducing automatic insurance enrollment, streamlining administrative processes across agencies, investing in digital integration to ensure eligible individuals can access relevant public programs and insurance, and allocating enough resources to subsidize coverage for eligible groups. This section discusses these reforms to provide insights for Egypt's UHIS.

[9] Osei Afriyie et al. 2022.
[10] Global Financing Facility and World Bank 2019.
[11] James and Acharya 2022.

Administrative responsiveness is a key enabler for automatic insurance enrollment

Administrative responsiveness includes marketing, enrollment processes, and performance management. A review of agencies' performance in these three areas (box 1) revealed that agencies in the United States with high insurance enrollment among subsidized groups excelled in improving enrollment processes. Previously, eligible individuals could not apply by phone or online for subsidized health insurance enrollment under Medicaid in the United States. They typically had to visit the relevant office to submit documentation and endure long wait times to receive an eligibility determination.[12] Agencies have implemented administrative simplifications to overcome these challenges. Measures include marketing strategies to educate individuals about their eligibility for subsidized coverage, as well as simplified enrollment and renewal procedures for both applicants and agency staff. Furthermore, they have implemented robust performance management practices to increase enrollment among marginalized groups and have made investments in information technology.

Box 1: Agencies' administrative responsiveness in health insurance enrollment

Marketing - officials went out of their way to publicize their programs:

- agencies used mass media, accepted available government monies for outreach, and solicited the collaboration of health providers, various community groups, and private firms to enhance take-up.
- agencies creatively used public schools to reach uninsured children.

Enrollment and renewal processes - getting enrolled and then staying insured:

- administrative coordination across different social programs.
- how agents deal with incomplete application and renewal forms, how they obtain the necessary information or process applications in its absence to facilitate enrollment.
- the elimination of a means-test for potential beneficiaries.
- the elimination of requirement for a face-to-face interview to apply for or renew enrollment.
- to grant continuous eligibility for one year enrollment and automatic renewal.
- the use of standardized application and renewal forms to ease enrollment.

Performance management – with goals for organizational behaviors in agencies:

- agencies use "enrollment rate" as a performance indicator, monitored enrollment carefully, and rewarded employees for fostering greater take-up of eligible individuals.
- the extent to which administrators disregard eligibility errors.

Source: Fossett and Thompson 2005.

Agencies improved information about program benefits and streamlined enrollment and renewal processes through coordination with other agencies. They have also reduced the amount of data and documents required from applicants, eliminated face-to-face interviews, standardized application forms

[12] Fox et al. 2020.

across agencies, and introduced automatic renewal and prepopulated forms (box 1). These reforms have helped minimize paperwork for individuals and reduce workloads for staff. Policies have been introduced to facilitate data sharing across agencies and further reduce paperwork. Additionally, agencies have implemented performance management practices that support enrollment by rewarding staff for higher enrollment rates. Proactive leadership from the governor has been a key catalyst for administrative responsiveness and enrollment, shaping the organizational cultures of agencies and the professionalism of staff.[13] Regular monitoring and evaluation can help identify and address such barriers.

Digital campaigns can generate awareness. Countries such as Namibia, South Africa, Brazil, Pakistan, and Togo have successfully utilized digital platforms to invite applications for emergency relief through mobile phones, WhatsApp or their websites.[14] Similar digital campaigns can be used to encourage low-income individuals to apply for health insurance and public benefits programs.

Reforms were supported by evidence-based analysis produced by non-governmental groups. In the United States, think tanks unleashed a steady stream of analyses on the factors involved in facilitating enrollment.[15] The Robert Wood Johnson Foundation invested over US$50 million in its ''Covering Kids'' initiative aimed at helping agencies in simplifying the application process for public programs, aligning administrative regulations across programs, and conducting outreach to enroll low-income families. These efforts helped reduce the number of uninsured children by more than 2 million.[16]

Digital integration enables a coherent enrollment process across public programs

Investments in digital integration are crucial for data sharing across agencies and automatic enrollment. In the United States, agencies have replaced or upgraded outdated eligibility and enrollment systems and expanded consumer-friendly online applications. Digital integration has enabled the launch of real-time eligibility determination with presumptive eligibility, express lane eligibility to automatically enroll beneficiaries based on other program eligibility determinations, and automatic renewals. Insurers use electronic data to renew coverage without requiring individuals to fill out a renewal form or provide documentation. Policies and procedures have been implemented to streamline the enrollment process, including policies for data protection, ensure data privacy and facilitate data sharing across agencies.

Public agencies have implemented real-time eligibility determination to confirm eligibility for subsidized coverage. Individuals can apply for public benefits online through a registration portal that enables real-time eligibility determinations and enrollment (i.e., within 24 hours). Applicants provide self-attestation of their citizen ID number, income, address, and other relevant information, which will be verified by agency staff.[17] Agencies utilize an electronic portal to automatically verify the information provided by applicants and determine eligibility through electronic data accessed via a national data service hub and other public and private data sources.

Governments have established national eligibility verification standards for online applications. Countries use national unique identification numbers as the foundation for individual identification and verification. In Turkiye, individuals' national ID number allows for the connection of personal records across various economic and social databases. This digital integration enhances the social registry by providing additional information to identify potential beneficiaries based on multiple criteria.[18] Similarly,

[13] Fossett and Thompson 2005.
[14] Gelb and Mukherjee 2020.
[15] Fossett and Thompson 2005.
[16] http://www.coveringkidsandfamilies.org/
[17] Fox et al. 2020.
[18] Gelb and Mukherjee 2020.

people in Thailand use their national ID number to enroll in public benefits and health insurance programs. Using a unique identifier to enroll also eliminates duplicate beneficiaries across different program registries.[19]

Express Lane Eligibility (ELE) options were introduced to streamline the sharing of eligibility information across agencies. ELE allows insurers to receive data and eligibility findings from other public benefit programs and government databases. The insurer can use these findings to ascertain if an applicant qualifies for subsidized insurance coverage. By automatically transferring data from a public program to the insurer the need for face-to-face interviews for enrollment is eliminated. This coordination among agencies has had a tremendous impact on enrollment and has reduced administrative costs for all.[20]

ELE simplifies the insurance enrollment process for applicants. Instead of requiring families to complete multiple application forms for different public programs, ELE enables insurance agencies to receive data that is already on file from other government programs and databases. If a family is already receiving benefits from a public agency, the insurer automatically receives that data to confirm eligibility for free health coverage. ELE expedites the enrollment process, reduces paperwork, and ensures that vulnerable individuals receive health coverage without administrative complications.

Digital enrollment may still require in-person assistance for applicants unfamiliar with the process. Measures of digital access that include online and smartphone capabilities are crucial to facilitate enrollment for vulnerable groups who are increasingly using online applications and smartphones. Online enrollment features are now widely available in many countries. In Thailand, for example, individuals can enroll in the Universal Coverage Scheme through the publicly accessible registration system on the Office's website.[21] Applicants who are unfamiliar with the process may still need in-person assistance.

Removing an enrollment barrier caused by incomplete data can have an immediate effect on the insurance coverage of eligible individuals. The government of Massachusetts implemented an auto-enrollment system for its poorest individuals who qualified for fully subsidized insurance coverage but failed to choose a health plan during enrollment. Instead of leaving them without coverage, the auto-enrollment policy placed them into a plan by default. They had the option to opt out or switch plans later, ensuring they had insurance coverage. In 2010, the suspension of this auto-enrollment process led to an immediate drop in enrollment by 33 percent. Re-introducing the process led to a 48 percent increase in enrollment, demonstrating a tremendous impact.[22]

Fiscal constraints limit the number of beneficiaries for subsidize enrollment

Subsidized health insurance coverage is particularly important in countries with high poverty rates and large informal sector economies. In 2015, the government of Ghana subsidized the enrollment of 6 percent of all insurance enrollees, who only constituted 2 percent of the eligible poor population. In contrast, the government of Viet Nam subsidized the enrollment of 45 percent of the insured population, mainly the poor. The Philippines took a different approach by providing a 50 percent premium subsidy for informal groups resulting in a modest 3 percentage point enrollment increase, showing that partial contribution subsidies may not be enough to make enrollment truly affordable.[23]

[19] World Bank 2018.
[20] Blavin et al. 2014.
[21] Kantamaturapoj et al 2020.
[22] Sheperd and Wagner 2023.
[23] Global Financing Facility and World Bank 2019.

In OECD countries, health insurance agencies receive an average of about 25 percent of their annual revenues from government subsidies.[24] In Turkiye, government subsidies accounted for 30 percent of public health insurance expenditure in 2019.[25] Hungary is partially subsidizing the enrollment of all insurance members to reduce labor cost, resulting in 65 percent of public health insurance revenues coming from government transfers in 2019.[26] In Thailand, the Universal Coverage Scheme is fully government-funded to cover all the uninsured who are not covered under any other insurance scheme.[27]

Fiscal constraints also limit the comprehensiveness of health benefits covered. When government health spending is low, the benefits package covered will be reduced, patients will have to pay higher copayments for care, and they will face longer wait times for treatment as fewer services are available. For example, the Latvian government finances a limited health benefits package for the entire population. In 2020, the government allocated 4.7 percent of GDP to the program, which was not enough to reduce high out-of-pocket payments by patients (2.4 percent of GDP) and long waiting lists to access healthcare.[28]

Development partners, private foundations and advocacy groups have supported subsidized enrollment. In the United States, groups such as the Children's Defense Fund and National Governors Association endorsed measures to facilitate subsidized enrollment across states.[29] In some countries with fiscal constraints, development partners co-finance subsidized enrollment. For example, in Rwanda, the Global Fund for Aids, Tuberculosis and Malaria (GFATM) allocated funding directly to the government budget to help subsidize health insurance coverage for low-income groups.

Expanding subsidized insurance coverage through automatic enrollment will have fiscal implications. This underscores the importance of conducting financial and performance analysis by enrollment category to estimate the financing needs of subsidized insurance coverage over time.

Key factors affecting subsidized UHIS enrollment in Egypt

The UHIS currently provides subsidized enrollment to around 56 percent of eligible individuals. A review of the current UHIS enrollment process for vulnerable groups reveals several hurdles related to administrative responsiveness and data transfers. This review was conducted based on information collected during interviews with UHIA staff and development partners as well as a review of UHIA policies and procedures on the enrollment process.

Administrative responsiveness is impacting subsidized UHIS enrollment for eligible groups

Limited information campaigns about subsidized UHIS enrollment

Few efforts exist to inform vulnerable individuals about their right to enroll in subsidized UHIS. While some information campaigns have been carried out, the overall UHIS communication strategy has yet to be finalized and implemented**.** Other public agencies that serve the needs of the poor, such as health facilities, MOSS and NOSI, offer limited information or assistance to help vulnerable individuals access subsidized UHIS coverage. Eligible children, including those enrolled in the child pension program (category 1), adopted children in alternative families (category 3), and children from families in any underprivileged

[24] OECD 2023.
[25] OECD Health Statistics 2023.
[26] Szigeti 2019.
[27] Tangcharoensathien et al 2020.
[28] European Observatory on Health Systems and Policies 2022.
[29] Fossett and Thompson 2005.

category (Figure 2), are not being targeted for UHIS enrollment through public schools. Information campaigns could help inform eligible individuals about their right to free insurance coverage.

UHIS enrollment and renewal process is cumbersome

Enrollment in subsidized UHIS involves face-to-face interviews with a UHIA staff. Enrollment points are available at UHIA customer management office (CMO) in governorates, as well as at registration points in post offices or health facilities. Applicants must submit the required documents and proof eligibility for subsidized enrollment during the interview.

The amount of information required to verify eligibility for UHIS enrollment can be overwhelming. A video and publication on the UHIA website explain the necessary documents needed for enrollment. Individuals can also visit one of the registration offices to inquire about the documents required. To enroll with UHIS, individuals must provide photo IDs for each family member over the age of 16, birth certificates for children under 16, and marriage certificates for each spouse. Applicants are also required to submit documentation from other agencies, such as NOSI to prove that they are not processing their UHIS enrollment through the contribution-paying categories (Figure 1). To proof eligibility for subsidized UHIS coverage, applicants must present their MOSS beneficiary card to UHIA and other identification documents from MOSS to confirm their eligibility status for MOSS programs, and from NOSI to verify their eligibility as unemployed without unemployment benefits under category 2 (Figure 2).

Individuals with missing documents must return to submit the requested information. Families with missing non-essential documents are given temporary one-month enrollment until they submit all required documents. However, temporary enrollment does not grant access to health care.

To qualify for category 6 benefits, individuals must provide substantial documentation to UHIA and evidence of their vulnerability to demonstrate their eligibility. These individuals had previously applied for TKP benefits but were rejected. Their applications are then reviewed by a high-level committee that includes representatives from UHIA, MOSS and MOHP. The policies, procedures, and criteria for confirming eligibility under category 6 are not publicly available. The review process is time-consuming and has resulted in low enrollment rates (Table 1).

Empanelment with a health provider poses an additional barrier. The UHIS enrollment process is only considered complete once individuals have visited a health facility to become empaneled. There are UHIA registration points at health facilities that allow individuals to register with UHIA and become empaneled with a provider when seeking care. However, if public program beneficiaries enroll at a UHIA office, they still need to visit a health facility to get empaneled with a provider, regardless of their health status. This creates an added burden as each visit to a health facility results in informal registration fees, transportation costs, healthcare costs, and requires substantial time and effort to prepare additional paperwork.

Renewal in UHIS enrollment is not automatic. UHIA uses standardized applications and renewal forms for enrollment and re-enrollment. In the absence of electronic data to renew UHIS coverage individuals are still required to visit a UHIA office and fill out a renewal form.

Performance management to change organizational behavior in agencies

Government entities do not use enrollment rates as a performance indicator. Staff working in agencies are not rewarded for higher enrollment in the categories they are responsible for. To implement this change, UHIA, NOSI and MOSS would need to monitor enrollment by category and reward employees based on UHIS enrollment results.

Digital integration to facilitate data transfers across public programs

Egypt launched a strategy to invest in government-wide digital reforms.[30] The Unified National Registry (UNR) registers Egyptian citizens based on their national ID number and identification card. These improved data efforts have supported coordination across ministries to facilitate the joint targeting of social protection programs towards vulnerable groups.

Data-sharing primarily occurs through Excel files. Currently, the MOSS sends monthly aggregated data for individuals in categories 1 and 3 to UHIA in an Excel file. However, data for people living with disabilities who are registered in category 4 has yet to be transferred. Additionally, NOSI still needs to share data with UHIA for unemployed individuals and their family members who do not receive unemployment benefits (category 2 in Figure 2).

Although online enrollment is available, it is not widely used. Online registration still requires applicants to visit the UHIA office to present the necessary documentation, calculate and pay contributions if enrollment is not subsidized, and receive a membership card. Online enrollment through the Digital Egypt platform at the post office is not being utilized. There is no platform for individuals to determine their eligibility for subsidized UHIS coverage in real time.

The empanelment process with health providers is not digitally integrated with the UHIS. Applicants are still required to visit their health facility in person to complete the empanelment process. Digital integration is necessary to facilitate data transfer between UHIA and health providers for enrollment, empanelment, and updates related to individual life changes.

The fiscal impact of increasing subsidized UHIS enrollment would be relatively small

The fiscal impact of a subsidized UHIS enrollment expansion is estimated in three scenarios based on current enrollment (Table 3). In all three scenarios, the fiscal impact of subsidized UHIS enrollment is lower than the 0.8 percent of GDP the government spent on fuel subsidies in 2021 (Figure 4).

- **Baseline: In June 2024, Egypt subsidized UHIS enrollment for 542,973 UHIS enrollees** by transferring EGP 3,600 per subsidized person per year to the UHIS, resulting in a total government transfer of EGP 1.95 billion, or 0.014 percent of GDP in 2024 (Table 3).
- **Scenario 1: If the government were to provide subsidized enrollment to all 970,964 beneficiaries** registered with public programs in the four Phase 1 governorates (Table 1), this would require an annual government transfer of EGP 3.5 billion to the UHIS or 0.025 percent of GDP in 2024.
- **Scenario 2: If subsidized UHIS enrollment increased to 30 percent of the population in the four governorates**, or 1.15 million people, the annual government transfer to the UHIS would increase to EGP 4.16 billion or 0.03 percent of GDP in 2024.
- **Scenario 3: Assuming the UHIS is rolled out nationwide by 2028/29 and 30 percent of the population will benefit from subsidized enrollment**, this would provide subsidized UHIS coverage to about 35.7 million Egyptians. The annual government transfer to the UHIS would increase to EGP 128.52 billion. The fiscal impact is estimated at 0.4 percent of projected nominal GDP for 2028/29 (Figure 4), which is about 2 percent of projected government expenditures.

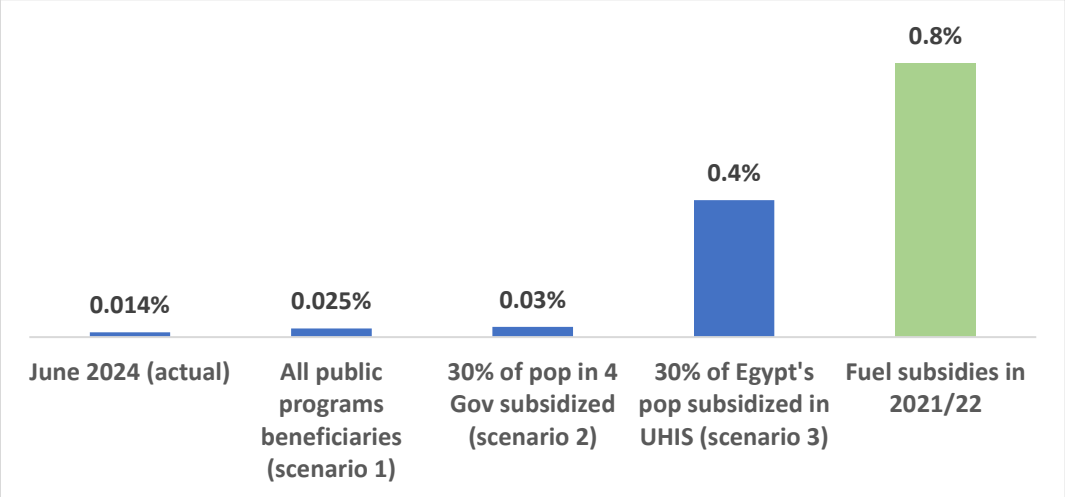
[30] https://mcit.gov.eg/en/ICT_Strategy

Table 3: Estimated fiscal impact of expanding subsidized UHIS enrollment, scenarios 1, 2, and 3

UHIS Enrollment	Phase 1 Governorates Port Said, Ismailia, Luxor, and South Sinai			Nationwide
	Baseline: June 2024 enrollment	**Scenario 1: Public programs beneficiaries in 2024 (cat. 1-6)**	**Scenario 2: 30% of pop in 4 governorates with subsidized UHIS coverage**	**Scenario 3: 30% of Egypt's pop with subsidized UHIS coverage (2028/29)**
Subsidized UHIS enrollees	542,973	970,964	1,154,327	35,700,000
% of individuals with subsidized enrollment	17.3% of UHIS enrollees	25% of pop. in 4 governorates	30% of pop. in 4 governorates	30% of Egypt's population
Government transfers for subsidized UHIS enrollment				
Subsidies for vulnerable UHIS enrollees, in billions	EGP 1.95	EGP 3.50	EGP 4.16	EGP 128.52
UHIS subsidies, % of GDP	**0.014%**	**0.025%**	**0.030%**	**0.399%**
UHIS subsidies, % of government expenditures	0.065%	0.116%	0.138%	1.976%
Memorandum items				
Total UHIS enrollment	3,134,342			
Population		3,847,758	3,847,758	119,000,000
UHIS subsidy per person per year	EGP 3,600	EGP 3,600	EGP 3,600	EGP 3,600
Nominal GDP, in billions	EGP 13,859	EGP 13,859	EGP 13,859	EGP 32,199
Government expenditures in billions	EGP 3,007.40	EGP 3,007.40	EGP 3,007.40	EGP 6,504.20

Source: UHIA data and IMF Egypt Country Report April 2024. IMF projections for 2023/24 and 2028/29.

Figure 4: Government subsidies for UHIS enrollment and for fuel, in % of GDP



Source: based on Table 3

Egypt has yet to develop a financing strategy to determine how much the government could feasibly afford to subsidize the provision of a basic health benefits package under the UHIS. Insurance revenues are used to reimburse health providers for care delivered to the insured within the benefits package. However, Egypt has not defined a standard health benefits package offered by the UHIS. The current UHIS subsidy amount is set at 5 percent of the monthly minimum wage, not based on the cost of providing a health benefits package, as is done in other countries. In Thailand, the Universal Coverage budget is determined based on the unit cost of services and the quantity of services provided in the basic package.

To ensure sustainable financing, the Egyptian government would need to define a basic health package that can be financed within the available UHIS budget. If it is decided that the basic package covered by the UHIS should include more services, then the budget for financing it would need to be increased. This will have fiscal implications for the government, which subsidizes the UHIS enrollment of vulnerable groups and thus their access to a basic benefits package.

Conclusion and Recommendations

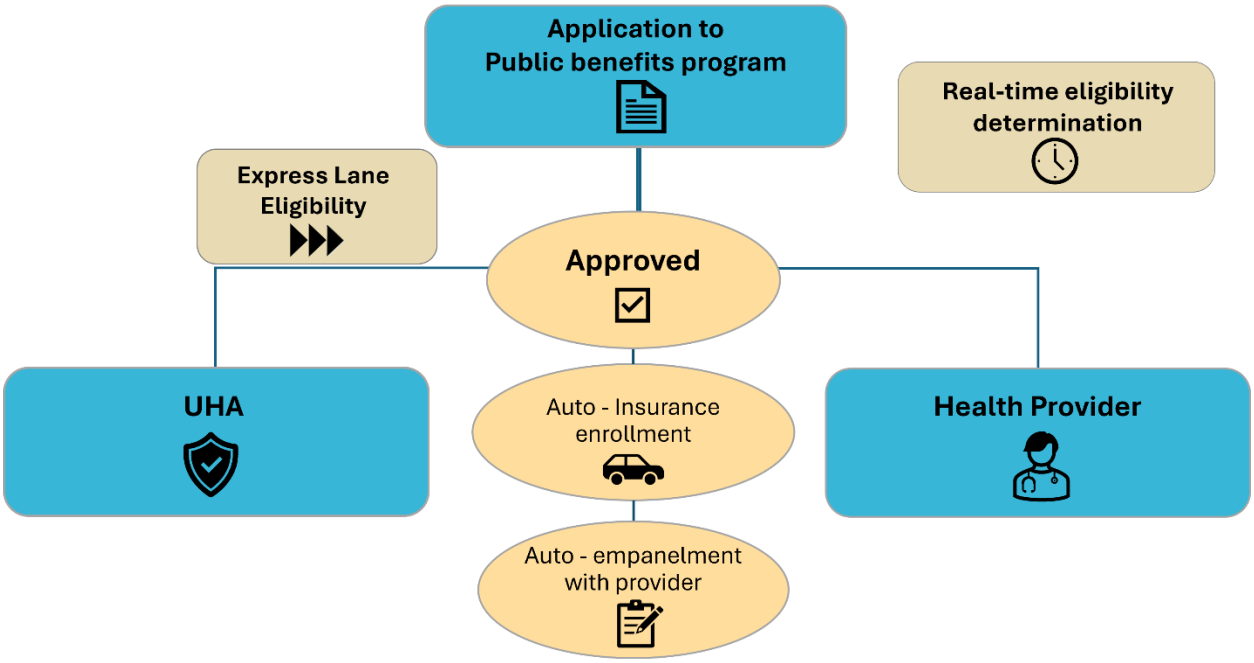
This review shows that administrative processes and digital integration have an impact on subsidized UHIS enrollment. It also suggests that administrative simplification could greatly boost UHIS enrollment. Real-time eligibility determination for public programs and the UHIS could speed up the enrollment process. An express lane eligibility option would enable UHIA, MOSS, NOSI and health providers to share data and eligibility findings for subsidized UHIS enrollment. The fiscal impact of subsidizing UHIS coverage for all eligible individuals in the four governorates is estimated to be minimal. These efforts could have a significant impact on the poor. They can be bolstered by the governor's leadership who is a key catalyst for reforms within a governorate.

Egypt could make tremendous strides in UHIS coverage with automatic UHIS enrollment for vulnerable groups. The UHIS enrollment and provider empanelment would be automatically processed during the application and eligibility determination for the public benefits programs. Once approved for public benefits, individuals would be automatically enrolled in UHIS, assigned to their chosen provider, and notified of their free UHIS coverage. Their information would be transferred to UHIA and providers through ELE (Figure 5). If applicants do not select a provider or if their chosen provider is at full capacity, the UHIS system would assign them to the nearest provider automatically. UHIA would communicate the empanelment decision to individuals and share the relevant data with the assigned provider.

Implementing automatic enrollment through a streamlined process would quickly eliminate barriers to UHIS coverage. It would eliminate long queues for applicants, decrease the administrative burden on agency staff and applicants during enrollment, and reduce the time and effort required to prepare necessary documents for individuals. People who are not eligible for subsidized coverage would still have to actively enroll with the UHIS in one of the four contribution-paying categories. Implementing automatic enrollment would require updating administrative processes, enhancing digital integration across agencies and health facilities, and medium-term budget planning.

A capacity assessment of administration and information technology within relevant agencies and the UNR could be conducted. This would allow the identification of possible investment scenarios for administration, information technology, and financing needs across agencies. Once agreed upon by the government, implementation plans can be developed and put in action. Based on the current assessment, this note proposes selected recommendations towards achieving this vision.

Figure 5: A vision for UHIS automatic enrollment for eligible groups



1. *Administrative simplification to streamline the enrollment process*

The UHIS communication strategy would outline the information process about automatic UHIS enrollment. MOSS, NOSI and health providers could assist UHIA by informing their beneficiaries about their eligibility for subsidized UHIS coverage. Mobile phone features could be used to invite people to apply for subsidized UHIS coverage. Agency staff would assist applicants with during the enrollment process.

Consolidating the six public benefits categories (Figure 2) into fewer programs along with streamlined eligibility determination would simplify the enrollment process.

Eligibility determination would occur when individuals apply for a public program category at MOSS or NOSI, or at UHIA. This would eliminate another face-to-face interview with UHIA. Individuals in Category 6 could be enrolled during their MOSS application, if they are poor but did not qualify for TKP but qualify for Category 6 enrollment based on specific criteria (such as being poor and suffering from a chronic condition).

Agencies would need to establish policies and procedures for the simplified administrative processes, including how to handle incomplete information and how to obtain data from other databases such as the UNR. Application and renewal forms should be standardized across agencies to facilitate data transfers.

An auto-empanelment policy would automatically assign applicants to the nearest health provider if they do not specify a preferred provider during the enrollment process. Once empaneled, individuals could then have the option to switch providers if desired.

Egypt could also consider providing enrollees with a single benefits card that identifies them as beneficiaries of public programs (such as the TKP) and UHIS. This would eliminate the need for multiple benefits cards.

Agencies could consider implementing performance management practices supportive of increased take-up. Performance indicators could include UHIS enrollment rates by category and wait time for enrollment. Staff could be rewarded for achieving higher enrollment rates.

MOSS, NOSI and UHIA should produce and publish quarterly reports, based on timely monitoring and evaluation of enrollment across programs and governorates. This would allow for the identification of areas with low enrollment and addressing any potential barriers to UHIS enrollment. UHIA could conduct focus group discussions to identify issues affecting enrollment.

Additional analysis could focus on pertinent policy questions, such as the efficiency of the enrollment process, and the impact of UHIS coverage on enrollees' health care seeking behavior and out-of-pocket payments. Results will be valuable in raising awareness and informing policy decisions regarding the design, financing, and procedural and organizational aspects of the UHIS. Think tanks could be engaged to regularly analyze the UHIS effectiveness and publish reports to inform policy decisions.

2. Digital integration to enable seamless enrollment across agencies

Digital integration across MOSS, NOSI, and the UHIS is recommended to improve data flow. This may require replacing or upgrading eligibility and enrollment systems at the MOSS, NOSI, UHIA and health facilities, investing in digital integration across agencies, implementing express lane eligibility and real-time eligibility determination, and enhancing consumer-friendly features of online applications. Through digital integration, health providers would be able to report newborns, deaths, and uninsured patients directly to UHIA. An interagency agreement may be needed to allow electronic data transfer of beneficiary data across agencies and to the UHIS.

With express lane eligibility UHIA can rely on MOSS or NOSI's eligibility findings and obtain data from other public databases such as the UNR. ELE processes could be implemented for vulnerable individuals in all categories, eliminating the need for UHIA to reassess eligibility criteria using UHIS rules. Successful data matching between agencies would necessitate standardized forms and electronic file structure to guarantee consistency in data reporting across files.

Real-time eligibility determination is recommended to streamline the application process with results ideally available within 24 hours. MOSS, NOSI and UHIA registration points could establish a real-time eligibility platform to allow applicants to quickly verify their eligibility for public programs (Figure 2). To enroll in any of the public programs, applicants could enter their data into the portal and receive immediate confirmation of their eligibility. Eligibility would be verified through electronic data accessed through the government's data services hub, the UNR, and private data services (e.g. telecom). Real-time eligibility determination would also be beneficial for individuals living in disaster areas (category 5), and for those low-income groups applying for category 6. Applicants unfamiliar with the online process may still require in-person assistance with submitting self-attestation of information.

Automated UHIS renewal would allow UHIA to renew coverage without requiring an individual to fill out a renewal form. Data can be consistently verified through information exchange with other agencies and against the unified national registry. This will minimize paperwork for both individuals and staff.

3. Medium-term expenditure planning to boost subsidized UHIS enrollment

The rollout of UHIS will necessitate an increase in government transfers to subsidize UHIS coverage. Subsidizing UHIS enrollment for all 970,964 beneficiaries currently registered in public benefits programs in the four governorates would require in an annual transfer from the MOF to UHIS of EGP 3.5 billion, equivalent to 0.025 percent of GDP in 2024. Subsidizing UHIS enrollment for 30 percent of the population nationwide by 2028/29 will likely require annual government subsidies equivalent to about 0.4 percent of GDP. Subsidized UHIS enrollment for TKP members would result in high targeting efficiency, considering the low leakage rate in TKP.

The UHIS health benefits package should be designed based on a prioritized list of medical conditions and treatments provided in Egypt's health sector. The financial implications of the package for all payers, including the government and individuals, would need to be analyzed. If the basic package covered by the UHIS should include more services, then the budget for financing it must be increased. This will have fiscal implications for the government who subsidizes the UHIS enrollment of vulnerable groups. The UHIS should aim to maximize the amount of revenue spent on healthcare and minimize its administrative costs. Regular analysis will be needed to assess the impact on population health in return for the UHIS subsidies.

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