



# POOLING HEALTH RISKS TO PROTECT PEOPLE

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An assessment of health insurance coverage  
in the Philippines

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## Abbreviations

4Ps	<i>Pantawid Pamilyang Pilipino Program</i>
APIS	Annual Poverty Indicators Survey
ASEAN	Association of Southeast Asian Nations
CARES	Customer Assistance, Relations and Empowerment
CI	Concentration Index
COA	Commission on Audit
DBM	Department of Budget and Management
DOH	Department of Health
DOLE	Department of Labor and Employment
DSWD	Department of Social Welfare and Development
FHS	Family Health Survey
FIES	Family Income and Expenditure Survey
GCG	Governance Commission for GOCCs
GOCC	Government-owned and Controlled Corporation
GSIS	Government Service Insurance System
HFS	Health Financing Strategy
HMO	Health Maintenance Organization
IRRs	Implementing Rules and Regulations
LGU	Local Government Unit
MDR	Member Data Record
NBB	No Balance Billing
NGO	Nongovernmental Organization
NHTS-PR/ <i>Listahanan</i>	National Household Targeting System for Poverty Reduction
OECD	Organization for Economic Co-operation and Development
OFW	Overseas Filipino Worker
OOP	Out-of-pocket
OSCA	Office for Senior Citizens Affairs
PCB	Primary Care Benefit
PCSO	Philippines Charity Sweepstakes Office
PHIC	Philippines Health Insurance Corporation
PNHA	Philippine National Health Accounts
SWS	Social Weather Stations
TB DOTS	Tuberculosis Directly Observed Treatment
UHC	Universal Health Coverage

## Overview

Taking the Philippines Health Financing Strategy (HFS) 2010–2020 objective of “sustaining membership in PhilHealth for all Filipinos” as its point of departure, this report assesses the expansion of health insurance coverage in the Philippines and the extent to which it provides protection from out-of-pocket (OOP) health spending. The report commences with a description of the organization of social health insurance through PhilHealth, the different PhilHealth membership groups, their eligibility criteria, contribution structure, and benefits. Using both administrative data and household surveys, the report then analyzes the patterns and trends in PhilHealth membership over time and discusses the drivers of membership expansion among different membership groups. Because the HFS and the country’s health insurance laws stress the link between the objective of sustaining membership in PhilHealth and the attainment of equity and financial protection goals, the equity dimension of PhilHealth membership gets special attention. In this regard, the report looks at equity in coverage, contributions, benefit design, and benefit payments, as well as performance on financial protection measures. It concludes by proposing some future directions, together with associated specific recommendations.

### Organization of social health insurance

Social health insurance in the Philippines is organized through the Philippines Health Insurance Corporation (PHIC), or PhilHealth, which is a government-owned and controlled corporation (GOCC). PhilHealth was established in 1995 to manage an existing program of contributory health insurance for the formal sector, as well as a new subsidized health insurance program for the poor and a new voluntary program for the informal sector. Today there are seven different membership groups, with each group facing different contribution rates and copayment structures. However, there is risk-pooling and cross-subsidization across member groups, offering a good opportunity to achieve efficiency and equity goals. As a GOCC, PhilHealth has considerable autonomy to make decisions on a broad range of policy areas relevant to these goals—including benefits package design, provider payment arrangements, contribution/premium rates, collection mechanisms, and the allocation of PhilHealth revenues—subject to the approval of its Board.

Enrollment in PhilHealth is legally mandated for all Filipino citizens. However, this is only enforced in the formal sector where members contribute through payroll reduction. Enrollment among the informal sector has been difficult to increase and sustain, and adverse selection is a problem. One may not opt out of PhilHealth membership by obtaining private insurance as a substitute; rather, private insurance is complementary and supplementary to PhilHealth. The basis of membership is the ‘principal member’ and premiums automatically include coverage of both the principal member and the principal member’s ‘eligible’ dependents.

Currently, there are seven categories of membership and the categories are determined by the member’s employment and socioeconomic status. The contributing categories are the formal sector program, the informal sector (otherwise known as the ‘individually paying program’), and the overseas Filipino workers (OFWs) program. The non-contributory categories are the indigent program whose members are identified by a national household targeting instrument (*‘listahanan’*) and fully subsidized by national government, the sponsored group whose membership is subsidized by local governments, lifetime members who no longer contribute because of their age (60+) and sufficient contribution history, and the senior citizens’ group (60+) whose members are subsidized by national government. In 2016, the indigent program and formal sector categories were the largest membership categories with 14.6 million families

each. The senior citizens' program was the third-largest member category (6.2 million families). The informal sector category consists of 2.6 million families. In addition, there were 1.2 million sponsored families, 1.2 million lifetime member families, and 0.7 million OFW families.

Premiums vary by member type and are related to the member's income. Premiums do not vary by family size. Formal sector members pay premiums that are proportional to their income (subject to a floor and a cap) and shared equally between employer (1.25 percent) and employee (1.25 percent). The informal sector pays an annual premium of either PHP 2,400 or PHP 3,600, depending on reported income level; de facto, most members pay the lower rate regardless of income. OFW members pay PHP 2,400 per family. The remaining four member types do not pay any premiums. Their membership may be subsidized by the national government (in the case of the indigent and senior citizen members); or by a third-party sponsor, which could include local government units (LGUs), churches, nongovernmental organizations (NGOs) or individuals (in the case of sponsored members); or their premium may be waived due to a long record of contributions (in the case of lifetime members). Premium subsidies are PHP 2,400 per family.

While PhilHealth benefits are not completely harmonized across member types, there is a core set of inpatient, catastrophic, and outpatient benefits for which all are eligible. First, there is inpatient care of up to 90 days per family. Second, there are the 'Z-benefits' for a set of 12 'catastrophic' conditions. Outpatient benefits include the outpatient malaria package, outpatient HIV/AIDS package, outpatient tuberculosis directly observed treatment (TB DOTS) package, voluntary surgical contraception, an animal bite treatment package, a maternity package (for use at non-hospital facilities), and a few others (including select day surgeries, radiotherapy, hemodialysis, and blood transfusion). In addition, there is an outpatient primary care package, but only the subsidized groups (namely indigent members, sponsored members, and senior citizens) are eligible.

Indigent, sponsored, senior citizen, and lifetime member groups benefit from a 'no balance billing' policy, which is effectively a zero-copayment policy. Compliance by providers with no balance billing has improved steadily since the policy's introduction in 2011, reaching 63 percent in 2016. However, there are no formal copayment arrangements in place for formal and informal sector members which, coupled with the lack of a national official/regulated user fee schedule, means that most PhilHealth members still face unpredictable (and potentially high) OOP payments even when seeking care for conditions that are in the PhilHealth benefit package. The exception is the catastrophic Z-benefits package where a clear copayment policy is also in place for non-indigent members: copayments are capped at a certain percentage of the reimbursement (with the percentage varying by condition).

### Expansion of health insurance coverage

Administrative data from PhilHealth show that the number of Filipinos with health insurance more than tripled between 2000 and 2016, growing from 7.9 million families (29.6 million people) to 41.2 million families (93.4 million people). In 2016, 90.9 percent of Filipinos had PhilHealth coverage.

The major expansions in PhilHealth membership have been driven by decisions of the national government to subsidize the premiums of certain categories of members, especially the poor. While the payment of health insurance premiums for the poor was initially the responsibility of LGUs, from the late 1990s the national government started to provide direct subsidies to complement (or replace) LGU contributions. There were also presidential initiatives that provided free health insurance to segments of the poor in the mid-2000s, but these political initiatives were not sustained. The most significant expansions of coverage were the introduction of the indigent program in 2011 through which the national

government completely subsidized the health insurance coverage of 5.2 million people who appeared on the national list of the poor (*listahanan*); the 2014 expansion of subsidized coverage to the near-poor (also identified using the *listahanan*) paid for by earmarked revenues from the ‘Sin Tax Law’ reform which increased and restructured tobacco and alcohol excises; and, then, in 2015, the expansion of subsidized health insurance coverage to senior citizens, also funded by Sin Tax revenues.

Household surveys, while confirming the strong upward trend in health insurance coverage data, reveal a large and persistent gap—of around 20 percentage points—between the health insurance coverage rates obtained from PhilHealth administrative data and the health insurance coverage rates reported by households. This implies that many of those who are listed in the PhilHealth database as being entitled to free health insurance do not know of this entitlement. The main reason for this gap appears to be the policy of ‘automatically’ enrolling those who are listed as poor in the DSWD’s *listahanan*, as well as the elderly, into the PhilHealth database. While a similar “automatic enrollment” approach is used in some other countries, in order to be successful it needs to be accompanied by intensive outreach effort to inform people that, first, they have been assessed as poor, and, second, that those who have been assessed as poor are eligible for health insurance. The persistent gap between administrative and household survey estimates of coverage in the Philippines suggests that, to date, efforts in this regard have been insufficient.

### Equity in coverage, contributions, benefits, copayments, and benefit payments

The expansion in health insurance coverage has been pro-poor, in line with policy intentions, with an increase in the membership share of the poor. Administrative data show that the indigent and sponsored programs grew from 32 percent of total PhilHealth beneficiaries in 2010 to 50 percent in 2016. Also important is the fact that, since 2011, the process of identifying the poor who are eligible for national government-subsidized health insurance has become much more credible and transparent; the poor are identified using the national targeting system (*listahanan*) rather than by local governments. Most, but not all, of the household surveys analyzed in this report also support the finding that PhilHealth coverage has become more pro-poor.

Premium contributions are structured quite equitably. Most importantly, PhilHealth premiums are not adjusted according to individual health risk. Also, premium contributions are related to income: poor members (in the indigent and sponsored categories) are exempt from premium payments, informal sector members face two income-related tiers, and formal sector members contribute proportional to salary. However, the salary ceiling at which the maximum premium contribution is reached is set fairly low, after which premium payments become regressive.

The benefit package offered by PhilHealth can also be considered quite equitable in that most benefits (such as the inpatient benefit package, Z-benefits package, and disease-specific outpatient packages) are harmonized across all membership groups. The glaring exception is the primary care benefit which is currently only available to indigent and sponsored members (and, in principle, but not yet in practice, also to senior citizens). Intrahousehold equity is something of an issue in that while the principal member enjoys a 45-day inpatient benefit, the dependents must share an additional 45-day benefit. This may be a cost containment measure implemented in light of the fact that premiums do not increase with family size, but it effectively penalizes large families (who are also more likely to be poor).

The copayment policy varies substantially by member group with importance implications for financial protection. Through the ‘no balance billing policy’, the poor and elderly are exempt from any copayments

at the point of care for all inpatient and other services. For other members, though, there is no formal copayment policy in place; while PhilHealth limits what it will reimburse health care providers, it does not limit what providers can charge patients. This erodes the most fundamental benefit of health insurance which is to provide financial protection by replacing unpredictable and potentially high health spending with a predictable premium payment. The exception is the Z-benefit package where copayments for all members are capped at a percentage of the fixed amount (case rate) of the PhilHealth reimbursement.

Despite the equitable benefit structure, benefit payments are currently regressive, with the poor receiving much less than their membership share. While in absolute terms most of the PhilHealth benefit payments accrue to the poor, their share in benefit payments (at around 30 percent of all payments) is much less than their membership share (50 percent). This could reflect lack of knowledge of their health insurance entitlement (which, in turn, could be due to automatic enrollment of the poor in PhilHealth); lack of knowledge of benefits; and/or poor access to hospitals. Interestingly, the formal sector's benefit payments share (25 percent) is also now less than its membership share (31 percent) and this is a shift that only occurred within the last couple of years. By contrast, senior citizens receive a disproportionately large share of benefits (25 percent) compared to their membership share (10 percent), likely due to age-related illness. The informal sector also receives a greater share of benefit payments (20 percent) than its population share (9 percent), possibly due to adverse selection.

## Financial protection

While the share of the population that is covered by PhilHealth is 90.9 percent (in 2016), the share of total health care expenditure that is pooled through PhilHealth is only 14.2 percent (according to the latest Philippine National Health Accounts [PNHA] of 2014). Put differently, while almost all Filipinos are now members of PhilHealth, they are not having a substantial share of their health expenditure pooled through PhilHealth. OOP spending, at 55.8 percent in 2014, remains the major source of health financing.

The poverty impact of the reliance on OOP spending is captured by household-level estimates of financial protection which have shown no improvement, and in fact some deterioration, despite the increase in health insurance coverage, there has. Analyses of six rounds of the Family Income and Expenditure Surveys (FIES), conducted from 2000 to 2015, show that the share of household spending that goes to health has almost doubled (to 2.7 percent). The incidence of catastrophic spending (measured as the percentage of households whose health spending exceeds 10 percent of consumption) has more than doubled (to 6.3 percent). The percentage of people impoverished by health spending also increased such that, by 2015, OOP spending on health added 1.4 percentage points to the incidence of poverty in the Philippines (when measured using the US\$3.10 per day poverty line), thus plunging more than 1.4 million people into poverty in that year. These findings underscore the fact that the expansion of health insurance coverage is not sufficient to guarantee progress on financial protection goals. A broader array of complementary health financing and service delivery reforms, some of which are elaborated upon in the report and in the policy recommendations in the following section, are also needed.

## Directions for reform and policy recommendations

We recommend some general directions for reform, together with associated specific recommendations.

*Ensure that all those who are eligible for PhilHealth benefits, especially under the indigent program, know of their coverage and their benefits.* This needs to be done to eliminate the large gap between administrative estimates of coverage and the number of people who know of their insurance entitlement

(as measured through household surveys). This gap likely arises due to the practice of ‘automatic’ enrollment of the *listahanan* poor. One way to do this would be to issue health insurance cards to all indigent members. Complementary or supplementary measures include intensified outreach through LGUs, through the 4Ps program, and through television, radio, and other mass media. Additional communications efforts will be needed to ensure that all members also know of their full range of benefits.

*Reduce fragmentation and move toward a more equitable PhilHealth benefit structure, with formal copayments or ‘no balance billing’, as well as free primary care for all.* Most important is to make OOP payments for non-indigent members more predictable by introducing a formal fixed copayment policy for this group. To ensure that providers are still adequately compensated, this will also require a revision of the case rates, based on a costing exercise. Indigent and senior citizen members already benefit from the no balance billing policy, and PhilHealth should continue its efforts to enforce this policy and ensure that members know about it. Equally as important is to extend the primary care package to all Filipinos. Together these measures will ensure that PhilHealth benefits are largely harmonized across members. Everyone will have access to free primary care and, when it comes to inpatient care, face predictable OOP health payments that are either zero (in the case of the indigent and elderly) or limited by formal copayments (in the case of other members).

*Decide whether to move boldly toward attaining universal health insurance coverage by using tax financing to cover the remaining 9 percent of the population.* This is ultimately a societal value judgment, but if guaranteeing PhilHealth coverage to all Filipinos regardless of socioeconomic status or occupation is a desirable social goal, resources could potentially be found—such as from Sin Tax revenues, other health earmarks (for example, Philippines Charity Sweepstakes Office) or non-earmarked general revenues. If the remaining 9 percent of the population is covered by tax financing, PhilHealth will then need to consider whether to continue the informal sector program—which, at 2 percent of membership, is small but entails substantial premium collection costs—or also use tax financing to cover this group. Another recommended membership change, but with smaller fiscal implications, is to merge the lifetime member program into the subsidized senior citizens’ program. This would simultaneously simplify administration, provide current lifetime members with essential primary care, and give PhilHealth additional income (through subsidies) to offset the larger health care expenses of this elderly group. There would then be only two groups of members: contributory members in the formal sector and subsidized members (consisting of the current indigent, sponsored, senior citizens, lifetime, and informal sector members).

*Improve equity in the structure of the formal sector contribution rates while also considering a formal sector premium increase and a shift in the employer/employee premium share.* The salary level at which the premium ceiling is reached could easily be increased from its current level of PHP 35,000 to make the formal sector contribution structure less regressive. A reasonable ceiling would be around PHP 42,000, which is close to the top income bracket used for income tax calculation purposes. With formal sector premiums low by international standards and only half of the 5 percent maximum currently allowable by law, a modest increase in formal sector premiums could also be considered. If increasing formal sector contributions rates is politically difficult, it could be implemented simultaneously with a shift in the employer-employee contribution ratio so that a greater share of the tax increase falls on the employer (as it does in most other countries in the region).

*Further improve the measurement and monitoring of health insurance coverage.* First would be to invest in PhilHealth information systems. As one of the world’s largest health insurance agencies (in terms of

membership), PhilHealth needs a health information system to match. Second would be to improve membership data. In this regard, one action could be to update the PhilHealth beneficiary database using the latest *listahanan* which would enable PhilHealth to better count the number of eligible beneficiaries, improve actuarial estimates, and potentially even adjust the premium subsidy for family size. A final simple action would be to include a question on health insurance coverage in the triennial FIES. This would not only ensure regular collection of this information in one of the government's most prominent surveys but mean that (for the first time) information on health insurance coverage would be collected in the same survey as health expenditure and consumption data, allowing a statistical assessment of the impact of health insurance coverage on financial protection to be made.

## 1. Introduction

**The strategic directions for health financing reforms in the Philippines are defined by the Health Financing Strategy (HFS) 2010–2020 of the Department of Health (DOH).** The HFS is built on five strategic pillars which have important interdependencies: creating more fiscal space for health (pillar 1), sustaining membership in PhilHealth-pooling (pillar 2), who pays for what (pillar 3), provider payments (pillar 4), and fiscal autonomy of health facilities (pillar 5) (Republic of the Philippines, Department of Health 2010). The directions described in the HFS are carefully justified and aligned with overall sector goals of enhancing financial protection, achieving efficiency gains, and ensuring access to quality care.

**With the HFS just past the midpoint of implementation, this report examines progress on the second strategic objective of the Philippines HFS 2010–2020, namely “sustaining membership in social health insurance of all Filipinos.”** The specific overarching goal of this pillar is to ensure that by 2020, every household should have at least one member enrolled in PhilHealth, such that total PhilHealth membership reaches 28.5 million families, approximately 10 million families more than in 2010. It also lays out steps to be taken to expand membership within each membership group, guiding principles, and monitoring indicators (see Annex 1). Seen together with the overarching HFS goal of reducing out-of-pocket (OOP) spending for all Filipinos, this pillar positions the expansion of health insurance coverage as a critical policy instrument to pool financial risk, reduce OOP health spending, and enhance the financial protection of the population.

**Because the HFS and the country’s health insurance laws stress the link between sustaining membership in PhilHealth and the attainment of health system equity and financial protection goals, this report focuses especially on the equity dimension of PhilHealth membership.** The HFS has the overarching objective of ensuring financial protection from OOP spending for all Filipinos. Pillar 2 of the HFS on sustaining membership in PhilHealth mentions ‘social solidarity’ as one of its key guiding principles. The 1995 and 2013 National Health Insurance Acts list ‘equity’, ‘social solidarity’, and ‘universality’ among their guiding principles.<sup>1</sup> In doing so, the Philippines has put equity and financial protection goals at the heart of its health financing reforms. This echoes the emphasis on equity in the global universal health coverage (UHC) agenda: one widely used definition of UHC is “a situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative care) receive them without undue financial hardship.” (WHO 2010)

**This report is structured as follows.** It commences with a description of the organization of social health insurance through PhilHealth (section 2) and then describes the different PhilHealth membership groups, their eligibility criteria, contribution structure, and benefits (section 3). Using both administrative data and household surveys, the report analyzes the patterns and trends in PhilHealth membership over time and discusses the policy drivers of membership expansion among different groups (section 4). It also takes a cross-cutting look at health insurance expansion through an equity lens by analyzing equity in coverage, contributions, benefit design, and benefit payments, as well as the health system’s performance on financial protection indicators (section 5). It concludes with a set of recommendations (section 6).

## 2. Organization of social health insurance through PhilHealth

**Risk-pooling through health insurance institutions, whether public or private, reduces the unpredictability of health expenditure for the individual and distributes the burden of financing more evenly across the population.** While the risk of an adverse health event and the magnitude of the

associated OOP spending may be unpredictable at the individual level, it can be estimated—through actuarial models—at the societal or group level. This gives rise to a market for health insurance. Not knowing their individual health risk, people are willing to pay predictable premiums rather than face unpredictable (and potentially large) OOP health spending. In this way, financial contributions from individuals/households are combined (pooled) to protect each contributor from having to pay the full cost of care in the event of illness. Insurance, thus, redistributes from those at low risk of OOP spending on health care to those at high risk of OOP spending on health care.<sup>2</sup> Because health risks tend to be concentrated among the elderly, insurance also typically redistributes from the young to the old. Risk-pooling is, thus, largely about reducing OOP spending and, therefore, enhancing financial risk protection.

**Social health insurance institutions, like PhilHealth, address the market failure that private health insurance is often unaffordable to people—especially high-risk people—by mandating coverage, avoiding the risk-rating of premiums, and subsidizing the poor.** In private health insurance, premiums usually bear a relationship to individual risk (that is, risk-rated premiums) which may make premiums unaffordable to those who are chronically sick, poor, or old. Also, in private health insurance markets, participation is usually voluntary, which means that low-risk people may opt out, effectively increasing the average risk of those who do join and necessitating even higher premiums. Social health insurance institutions address this market failure by making contributions mandatory for all (or, at least, for a subset of the population, like the formally employed and civil servants), avoiding the risk-rating of premiums, and subsidizing the health insurance contributions of those who cannot afford to pay. Thus, in social health insurance, one typically finds three types of redistribution of financial risk: from the healthy to the sick; from the productive (for example, young and/or employed) to the non-productive members (for example, old and/or unemployed) of society; and from the rich to the poor. The arguments in favor of risk-pooling reflect equity and efficiency considerations. The equity argument reflects the view that society does not think it is fair that individuals should assume all of the financial risk associated with their health needs. The efficiency argument arises because pooling can reduce uncertainty associated with health care expenditure, leading to improvements in population health and productivity.

**PhilHealth was established in 1995 to manage an existing program of contributory health insurance for the formal sector, as well as a new subsidized health insurance program for the poor and a new voluntary program for the informal sector.** With the passage of the 1995 National Health Insurance Act (R.A. 7875), the Philippines created one public health insurance scheme, called the National Health Insurance Program, implemented by the Philippines Health Insurance Corporation (PHIC or PhilHealth). PhilHealth took on the social health insurance functions of Medicare, which was previously implemented by Social Security System (SSS) for private sector employees and by the Government Service Insurance System (GSIS) for government employees. The Act also simultaneously introduced coverage of the poor, to be financed by contributions from national and local governments, and voluntary contributory social insurance for informal sector workers. The scheme has different membership categories (reflecting the employment and income status of the members) with each group facing different contribution rates and copayment structures, but there is redistribution and cross-subsidization across groups. According to the law, a guiding principle is ‘compulsory coverage’, whereby “all citizens of the Philippines shall be required to enroll in the National Health Insurance Program.”

**In PhilHealth, then, there is effectively a single pool (that is, where all members are grouped into one insurance scheme or tax-financed program) which offers a good opportunity to achieve efficiency and equity goals.** Even though entitlements differ somewhat by member group (as will be discussed later), there is no limit to the funds available to cover individuals in each member group; funds contributed by formal sector members can be used to cover the health costs of indigent (subsidized) members, and vice

versa. This approach is preferable to the multiple pools that exist in many countries. Multiple pools limit the potential for cross-subsidy and, through unequal resource availability across pools, tend to create unequal benefits, inequitable access and quality, and unnecessarily increase administrative costs.<sup>3</sup> Multiple pools can also reduce the purchasing power of the insurer. Pooling the contributions of all members into one risk pool, as PhilHealth has done since inception, is also the practice in the Republic of Korea, Taiwan (China), Mongolia, and Indonesia (which in 2014 consolidated separate insurance schemes into one pool). In Thailand and Vietnam, fragmented pools persist.<sup>4</sup>

**PhilHealth has considerable decision-making power and quite some autonomy from the rest of the government, but internal and external accountability mechanisms create checks and balances.** PhilHealth is a government-owned and controlled corporation (GOCC), headed by a Chief Executive Officer/President who is appointed by the President of the country. The degree of autonomy that PhilHealth has to make decisions on a broad range of policy areas—including benefit package design, provider payment arrangements, contribution/premium rates, collection mechanisms, and the allocation of PhilHealth revenues—is high compared to social health insurance funds in other countries. This authority and discretion is checked by internal and external accountability arrangements, though. PhilHealth is governed by a Board, with Board members representing various government agencies as well as providers and members.<sup>5</sup> The Secretary of Health is the chairperson of the Board. PhilHealth is required to report to the Governance Commission for GOCCs (GCG) on a set of agreed performance indicators on a quarterly basis and an annual performance report is published on the GCG website.<sup>6</sup> PhilHealth also shares information on membership and benefit utilization with the public on a semiannual basis through its online ‘Stats and Charts’.<sup>7</sup> Like other GOCCs, PhilHealth is audited by the Commission on Audit (COA) and is required to release an annual report and audited financial statements.

### 3. PhilHealth membership categories, eligibility criteria, contributions, and benefits

**While enrollment in PhilHealth is legally mandated for all Filipino citizens, this is not enforced outside of the formal sector and adverse selection is likely among those working in the informal sector.** By the 1995 Health Insurance Act, “all citizens of the Philippines shall be required to enroll in the National Health Insurance Program.” The law’s Implementing Rules and Regulations (IRRs) describe coverage as being ‘mandatory’ for all Filipinos, in accordance with the principles of universality and compulsory coverage (Sections 2[b] and 2[l] of the Act). In practice, though, not all Filipinos enroll. For those working in the formal sector, contributions to PhilHealth can be enforced by payroll deduction, making membership for private formal sector employees and government employees (who together constitute the PhilHealth ‘formal sector’ membership group) de facto compulsory. Formal sector employers who fail to enroll their employees are subject to fines. Indigent members, who are subsidized by the national government, are automatically enrolled by PhilHealth based on a means test (as will be discussed later). For people who are neither employed in the formal sector nor indigent, it is incumbent on the individual to actively enroll. Those who fail to enroll face no sanctions, thereby contributing to an adverse selection problem.

**One may not opt out of PhilHealth membership by obtaining private insurance as a substitute; rather private insurance is complementary and supplementary to PhilHealth.** Benefit packages offered by private insurers tend to be structured around the PhilHealth package, with most insurers either requiring or assuming prior PhilHealth membership. If a person enrolls in private insurance without being enrolled in PhilHealth, he or she will be responsible for paying the portion of the bill that would have otherwise been paid by PhilHealth. Some private insurers also pay for additional services that are not included in the

PhilHealth benefit package. In that sense, private insurance in the Philippines is both complementary and supplementary to PhilHealth,<sup>8</sup> explaining why PhilHealth is commonly referred to as the ‘first peso payer’.<sup>9</sup>

**The basis of membership is the ‘principal member’ and premiums automatically include coverage of both the principal member and the principal member’s ‘eligible’ dependents.** Eligible dependents include the spouse, unmarried children (birth, adopted, foster, or stepchildren) below 21 years old, parents 60 years old and above, and disabled family members (children and parents) regardless of age.<sup>10</sup> The list of dependents can be updated anytime and there can be as many dependents as qualify in terms of the eligibility criteria. It is possible for nuclear families to have two principal members; this can arise, for example, when both spouses are employed in the formal sector or when both spouses are senior citizens.

**Larger families do not pay higher premiums; however, they are obliged to split the same (inpatient) benefit across more dependents.** At first glance, the fact that premiums do not vary by family size seems to imply cross-subsidization of larger families by smaller families. To some extent that is true. However, while the principal member enjoys his/her own 45-day limit on hospitalization, all dependents share a combined 45-day limit. This limits the extent of cross-subsidization. In fact, this feature could actually be considered a penalty for family size since it is not possible for large families to obtain similar coverage to smaller families by paying a higher premium.

**Currently, there are seven categories of membership and the categories are determined by the member’s employment and socioeconomic status.** The seven categories are the formal sector program, the informal sector or individually paying program, the overseas Filipino workers (OFW) program, the indigent program, the sponsored group, lifetime members, and the senior citizens’ program. It is possible that an individual’s characteristics may make him or her eligible for two types of categories and, so, there are rules about which membership category takes precedence. The (government-subsidized) senior citizens’ program, for example, is a residual scheme in the sense that only the elderly who not covered by other membership types (for example, as lifetime members or as dependents on a family member’s formal or informal sector membership) are included. In 2016, the indigent program and formal sector categories were the largest membership categories with 14.6 million families each. The senior citizens’ program has recently expanded, making it the third-largest member category (6.2 million families). The informal sector category consists of 2.6 million families. In addition, there are 1.2 million sponsored member families, 1.2 million lifetime member families, and 0.7 million OFW families.

### 3.1 Premiums /contributions

**Premiums vary by member type and are related to income, and many member types (including indigent members, senior citizens, third-party sponsored, and lifetime members) are exempt from premium payment.** Formal sector members pay premiums that are proportional to their income (subject to a floor and a cap); the informal sector pays an annual premium of either PHP 2,400 or PHP 3,600, depending on income level; and OFW members pay a PHP 2,400 premium per family. The remaining four member types do not pay any premiums. Their membership is subsidized by the national government (in the case of the indigent and senior citizen members) or by a third-party sponsor which could include local governments, churches, nongovernmental organizations (NGOs) or individuals (in the case of sponsored members), or membership is waived due to a sufficient contributions record (in the case of lifetime members). The annual subsidy paid by the national government (for indigent and senior members) and by the respective sponsors, such as local government units (LGUs) or NGOs, is PHP 2,400 per family. The benefit package and degree of cost-sharing also differs somewhat across member categories; this will be taken up later.

**For contributing members, a contribution record that is at least somewhat, but not necessarily completely, up-to-date is required to claim benefits.** According to sections 39–40 of the Act’s IRRs, members and/or their dependents are entitled to claim benefits if they have paid premium contributions for at least three months within the previous six months or, alternatively, if they have paid the full premium for the current calendar year. In case of the death of the member, the dependents of the deceased member remain covered until the end of the current coverage period or the end of the calendar year, whichever comes first.

**Formal sector members contribute through payroll deduction with contribution rates set proportional to earnings (subject to a floor and a cap) and shared equally between employer and employee.** Members of the formal economy (henceforth referred to as ‘formal sector’ members) are those with formal contracts and fixed terms in either the private or government sector. Specifically, it includes government employees;<sup>11</sup> private sector employees;<sup>12</sup> owners of microenterprises; owners of small, medium, and large enterprises; household help and family drivers; and “all other workers rendering services, whether in government or private offices, such as job order contractors, project-based contractors, and the like”.<sup>13</sup> The formal sector premium is currently set at 2.5 percent of salary,<sup>14</sup> split equally between employer and employee (that is, 1.25 percent each). The premium is currently well below the maximum 5 percent of salary permitted by law. The floor is set at PHP 200 (or PHP 2,400 per year), for those earning less than PHP 8,999 per year. The cap is set at PHP 875 per month (or PHP 10,500 per year) for those earning PHP 35,000 per month or more.<sup>15</sup> Employers are responsible for submitting their share, together with the employee’s share (deducted from payroll), to one of PhilHealth’s accredited collecting agents by the due date or are subject to penalties.<sup>16</sup>

**Informal sector members face a two-tiered contribution structure, but, in reality, almost all pay at the lowest tier.** Members of the informal economy (henceforth referred to as ‘informal sector’ members) are those who are self-employed or lack a fixed-term contract.<sup>17</sup> This definition means that this group encompasses a wide range of job classes and economic groups, from informal vendors and tricycle drivers to doctors, lawyers, and other self-employed professionals. In 2014, premiums were raised to PHP 2,400 per year for those earning PHP 25,000 per month or less and PHP 3,600 per year for those earning more than PHP 25,000 per month.<sup>18</sup> These new premium rates at least doubled the previous premium rate of PHP 1,200 per year for all informal sector member types (who were then referred to as individually paying members). According to the IRRs, contributions of members in the informal economy should be based primarily on household earnings and assets, but there is no clearly defined procedure for assessing these; also, declaration of earnings and assets is voluntary. A PhilHealth circular specifies a list of professions assumed to be earning more than PHP 25,000, unless it can be proven otherwise. However, de facto, unless an informal member declares that he or she earns more than PHP 25,000 per month, he or she will have to pay only PHP 2,400 and no verification is undertaken.<sup>19</sup> For all informal sector members, the premium may be paid annually, semi-annually, or quarterly, and submitted to any of PhilHealth’s accredited collecting agents.

**OFWs may also enroll in PhilHealth to ensure that they and their dependents in the Philippines will be entitled to PhilHealth benefits even while the member is working abroad.** Land-based overseas Filipinos pay a premium of PHP 2,400 per year, while seafarers<sup>20</sup> have the same premium schedule as the formal sector. Enrollment of OFWs is less strongly enforced than before. Up until early 2015, PhilHealth enrollment was required before the Philippines Overseas Employment Administration would issue the Overseas Employment Certificate to the OFW, but this is no longer the case.

**Indigent members are those who have been identified as ‘poor’ by the Department of Social Welfare and Development (DSWD) and are fully subsidized by the national government, that is, they pay no premiums.** To qualify as an indigent member, one has to have been assessed as indigent according to the National Household Targeting System for Poverty Reduction (NHTS-PR/*Listahanan*) of the DSWD. This is the same targeting mechanism that is also used for other government programs (such as the conditional cash transfer scheme, *Pantawid Pamilyang Pilipino Program*). Indigent members are exempt from premium payments. To cover the costs of insuring the indigent members and their dependents, PhilHealth receives a transfer of PHP 2,400 per indigent member—an amount that does not vary by family size—from the Department of Budget and Management (DBM), financed from earmarked revenues from excise taxes on tobacco and alcohol, upon the submission of the list of names of these principal members.

**The shift to using the NHTS-PR/*Listahanan* to identify the poor and to using national government subsidies to finance their premiums helped to end the previous politicized, discretionary, and unpredictable practice of identification and enrollment of the poor by LGUs.** Not all LGUs were able or willing to sponsor the poor, while many of those who did were motivated by political considerations. LGUs had complete discretion to decide who was poor and who was not. Health insurance cards for the poor often featured the faces of sponsoring mayors and presidents on them and were typically distributed with great fanfare at community events with sponsoring politicians present. On the upside, the political motivations of the sponsoring politicians meant that mayors and LGUs made sure that those who were entitled to free health insurance knew about it.

**Sponsored members include various type of people whose premiums are paid by third parties.** Sponsors can include other individuals, other government agencies (such as the DSWD), LGUs, or private entities (such as churches, NGOs, or others).<sup>21</sup> The premium of the sponsored member is PHP 2,400 regardless of the socioeconomic status of the person being sponsored.

**Lifetime members are those who no longer have to pay premiums because they have reached the age of 60 and have a sufficient contribution history.** One becomes eligible for this membership category and is exempt from premiums if one is at least 60 years of age<sup>22</sup> and has paid at least 120 monthly contributions to PhilHealth (or the former Medicare programs of SSS and GSIS). PhilHealth does not receive premium subsidies from the state to cover these members; rather, they are completely cross-subsidized by other members.

**Under the newest PhilHealth membership program, senior citizens automatically become PhilHealth members at the age of 60 and do not need to pay premiums.** The senior citizens’ program was introduced in 2014 by Republic Act 10351<sup>23</sup> and covers all Filipino citizens who are residents of the Philippines, aged 60 years or above and are not currently covered by any membership category of PhilHealth.<sup>24</sup> As with the indigent program, PhilHealth receives a transfer of PHP 2,400 per indigent principal member from the DBM—sourced from tobacco and alcohol excise tax revenues—upon the annual submission of the list of names to the DBM. One way in which this program differs from the others is that if there are two family members who are both age-eligible, they both become principal members and PhilHealth receives two premium subsidies from the DBM. Presumably, this is intended to compensate for the higher healthcare costs of the elderly.

**Table 1. PhilHealth membership categories and contribution rates**

Membership Group	Eligibility Criteria	Premium
1. Members in the formal economy	Those with formal contracts and fixed terms of employment, including workers in the government and private sector	Split equally between employer and employee: 2.5% of salary (1.25% employer and 1.25% employee), with minimum of PHP 2,400 and maximum of PHP 10,500 per year
2. Members in the informal economy	Those who are self-employed or lack a fixed-term contract	Paid fully by member. PHP 2,400 per year for those earning PHP 25,000 per month or less, and PHP 3,600 per year for those earning more than PHP 25,000 per month.
3. OFWs	(a) Sea-based Filipino workers or (b) land-based OFW	For sea-based Filipino workers, the premium contribution schedule of the formal economy group applies. For land-based OFWs, PHP 2,400 per year.
4. Indigents	The poor, identified through the DSWD's NHTS-PR/ <i>Listahanan</i> targeting mechanism	Paid by national government: PHP 2,400 per principal member per year
5. Sponsored members	Those sponsored by local governments, individuals, other government agency, or private entities	Paid by sponsor: PHP 2,400 per principal member per year
6. Lifetime members	Those who have reached 60 years of age and have made at least 120 monthly contributions	No premiums to be paid
7. Senior citizens	Those who have reached 60 years of age and are not covered by any of the above membership types	Paid by national government: PHP 2,400 per principal member per year

### 3.2 Benefit package and cost-sharing

**While PhilHealth benefits are not completely standardized across member types, especially when it comes to outpatient care and cost-sharing arrangements, there is a core set of inpatient, catastrophic, and outpatient benefits for which all are eligible.** First, there is inpatient care of up to 45 days per member per calendar year; the dependents of a member share another 45 days. Second, there are the 'Z-benefits' for a set of 12 'catastrophic' case types at low to intermediate disease stages;<sup>25</sup> the Z-benefits have been included in the PhilHealth benefit package since 2012. Another set of benefit packages were developed to help the Philippines attain the Millennium Development Goals for health and include the outpatient malaria package, outpatient HIV/AIDS package, outpatient tuberculosis directly observed treatment (TB DOTS) package, voluntary surgical contraception, an animal bite treatment package, and a maternity package that can be used at non-hospital facilities. There are also a few other specific outpatient packages for day surgeries, radiotherapy, hemodialysis, and blood transfusion.

**There is also an outpatient primary care benefit (PCB) package, but only the indigent, sponsored members, and senior citizens are eligible for it.** Formal sector, informal sector, and lifetime members are not eligible. Also, while senior citizens are entitled to the PCB (on paper), they are not yet able to use this benefit since the assignment of senior citizens to primary care providers has not yet taken place. A few other groups—such as employees of the Department of Education and families of OFW members—are also eligible for the PCB package.

**With the exception of the Z-benefits package, there are no formal copayment arrangements in place for formal and informal sector members, which means that patients still bear considerable financial risk.** Not only is there no formal copayment policy, but there is also no official/regulated (national) user fee schedule.<sup>26</sup> This means that, while PhilHealth limits what it will reimburse health care providers, there is no limit on what health care providers can charge patients. The consequence is that most members still face unpredictable (and potentially high) OOP payments even when seeking care for conditions that are in the PhilHealth benefit package. As will be discussed later, this (lack of) copayment policy is likely an important factor explaining the persistence of high OOP spending and the high incidence of impoverishing and catastrophic spending in the Philippines. For the catastrophic Z-benefits package, there is a fixed copayment policy in place in the sense that copayments are capped at a certain percentage of the official reimbursement rate for each condition. Depending on which catastrophic condition the patient suffers from, the copayment can range from 0 percent to 100 percent.<sup>27</sup> The copayment percentage for the conditions in the Z-benefits package are supposed to be reflected in the accredited provider's contract with PhilHealth and made available on the PhilHealth website.<sup>28</sup>

**For indigent, sponsored, senior citizen, and lifetime member groups, though, a 'no balance billing' (NBB) policy has been in place since 2011 and compliance by providers is improving steadily.** Since 2011, providers cannot charge indigent and sponsored members (and their dependents) anything beyond the case rate paid by PhilHealth, effectively creating a zero copayment for this group. It has not been easy for PhilHealth to enforce compliance with this policy, but compliance rates have improved over time. According to PhilHealth, compliance with the NBB policy increased from 13 percent in 2012 to 41 percent in 2014 to 51 percent in 2015 and to 63 percent in 2016.<sup>29</sup> The NBB policy has also been applied to the senior citizens' program since the latter's introduction in 2015<sup>30</sup> and, in January 2017, the NBB policy was also extended to lifetime members.<sup>31</sup>

#### 4. Expansion of health insurance coverage

**The major expansions in PhilHealth membership have been driven by legal decisions by the national government to subsidize the premiums of certain categories of members, especially the poor.** When PhilHealth was founded in 1995, the law envisaged a gradual expansion of health insurance coverage over a period of 15 years. The idea was that membership would not be compulsory immediately in all areas of the country; health insurance coverage would expand in line with the geographic availability of health care services.<sup>32</sup> Starting in the late 1990s, the national government and PhilHealth started to implement policy measures to ensure that all poor and vulnerable people have health insurance, including through providing direct subsidies to complement (or replace) LGU contributions to the health insurance of the poor. From the late 1990s, LGUs and the national government split the premiums of the poor 50/50;<sup>33</sup> around this time, PhilHealth also started to pay the LGUs a small capitation payment of PHP 300 to subsidize the primary care of each family enrolled and marketed it as a 'return of investment' to the LGU's share (PHP 900) of the premium (PHP 1,800). Half a decade later, major presidential initiatives in the form of Oplan 5M (in 2004) and Oplan 2.5M (in 2006) provided nationally subsidized PhilHealth coverage to 5 million and 2.5 million poor families, respectively. Funds for the subsidies were sourced from the Philippines Charity Sweepstakes Office (PCSO),<sup>34</sup> but these initiatives were not sustained.

**The most significant legislative expansions of coverage took place during the last six years, and they were focused on the poor and the elderly.** From 2011, with the introduction of the indigent program, the national government has provided full health insurance subsidies to 5.2 million poor people (identified through the NHTS-PR/*Listahanan*). From 2014, subsidized coverage was also expanded to the near-poor (also identified through the NHTS-PR/*Listahanan*). Then, in 2015, coverage was also extended to the

elderly under the senior citizens' program. The 2014 and 2015 expansions were financed by the "Sin Tax Law" reform which increased and restructured tobacco and alcohol excises and then earmarked a large share of the revenues to cover health insurance subsidies and other health programs (Kaiser, Bredenkamp, and Iglesias 2016).

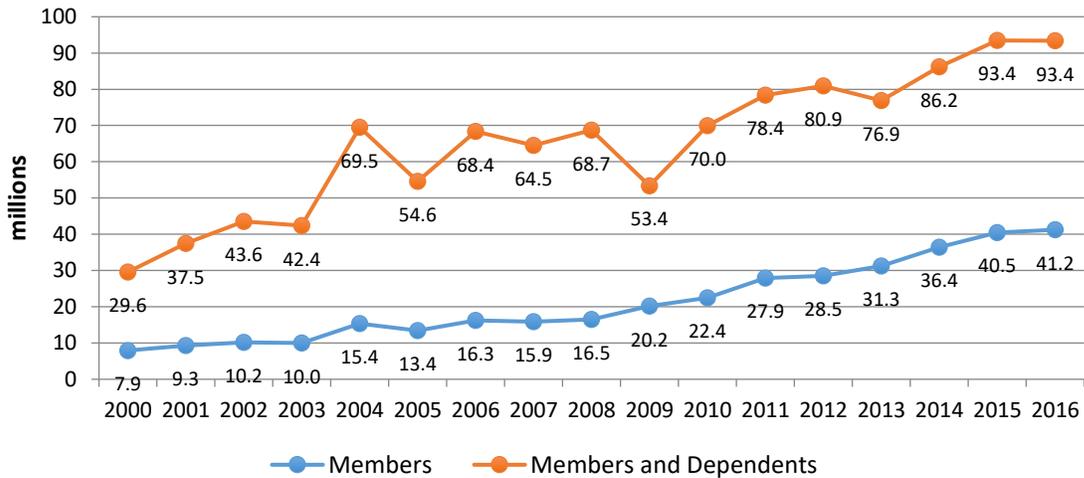
**Beyond these prominent policy decisions of the national government to guarantee health insurance to the poor and vulnerable, PhilHealth has also employed a variety of innovative approaches to encourage and sustain enrollment among those who are not yet members, including (but not only) in the informal sector.** One approach was to use 'premium lock-ins'. Ahead of the mid-2012 premium increase to PHP 2,400/year, informal sector members were offered the opportunity to 'lock in' their current lower premium of PHP 1,200/year by paying the full annual premium in advance (instead of in quarterly installments). Another innovation was 'group enrollment' whereby PhilHealth offered group discounts to informal sector groups who could 'organize' themselves together to enroll in large numbers. The larger the group, the lower the premium. Examples of organized groups included cooperatives, microfinance institutions, associations of tricycle drivers, and professional organizations, but it is not known how many people enrolled this way. The most recent innovation was point-of-care enrollment. Essentially, if a patient lacks PhilHealth coverage, but the hospital's social worker assesses that they seem poor enough to qualify for the PhilHealth indigent program, then the hospital may pay the patient's health insurance premium and receive reimbursement from PhilHealth (which typically exceeds the premium) for their care. If the person is later confirmed to be indigent, PhilHealth will also add them to the database of the indigent.<sup>35</sup> If not, then he/she either has to enroll as an individually paying/informal sector member or lose coverage the following year.

**PhilHealth has also eagerly collaborated with researchers to experiment with and assess new approaches to encouraging enrollment.** In 2011, for example, PhilHealth collaborated with the University of the Philippines and the World Bank on a randomized study to test the effectiveness of additional premium subsidies, information campaigns, and facilitating of the enrollment process (through visiting households to fill out and collect enrollment forms) on increasing informal sector enrollment (Capuno et al. 2016). Universities and individual researchers are also frequently asked to provide advice on the design of PhilHealth policies, assess their implementation, and develop methods to assess their impact.<sup>36</sup>

#### 4.1 Estimates from administrative data

**Administrative data show that the number of Filipinos with health insurance more than tripled between 2000 and 2016.** Measured in terms of the number of families covered (that is, the number of principal members), coverage almost tripled from 7.9 million families in 2000 to 22.4 million families in 2010 and then near-doubled again to 41.2 million families by the end of 2016 (see Figure 1). Measured in terms of total coverage (that is, members and dependents), coverage increased from 70 million to 93.4 million people between 2010 and 2016 (see Figure 1). In 2011, the introduction of full national government subsidies to cover the health insurance of the poor (see next section) contributed to a jump in total health insurance coverage of around 8.4 million individuals between 2010 and 2011.<sup>37</sup> Then, in 2012, the Sin Tax Law (which earmarked tobacco and alcohol revenues for the health insurance of the poor and near-poor) facilitated the further expansion of subsidized health insurance to the near-poor from 2014 onwards, as well as free health insurance for the elderly (from 2015), bringing the total number of families/people with PhilHealth coverage to 93.4 million individuals (or 41.2 million families) by the end of 2016.

**Figure 1. Expansion of membership in PhilHealth, 2000–2016**



Source: 2000 to 2006 - PhilHealth Corporate Planning Department; 2007 to 2016 - PhilHealth Stats and Charts.

**It has not been easy for PhilHealth to generate consistent estimates of the number of individuals covered and, in particular, to translate estimates of the number of principal members into numbers of covered individuals.** The total number of individuals covered by PhilHealth consists of the sum of the principal members (who pay premiums, or on whose behalf premiums are paid, and whose names are clearly listed in the PhilHealth database) and their dependents. The challenge in generating numbers of covered individuals stems from two (related) sources. One is that, for many years, the PhilHealth database only recorded the actual number of members (based on contributions received) while using assumptions about dependency ratios to estimate the total number of individuals (members and dependents) covered. Another is that while the NHTS-PR/*Listahanan* instrument that is used to target the poor for health insurance coverage is a household-based targeting mechanism, PhilHealth enrolls families, requiring decisions to be made as to what constitutes a legal ‘PhilHealth family’ and how it relates to household composition. These challenges are described in a little more detail in Annex 2, but suffice to say that some of the unusual patterns observed in the trend of total members and dependents in Figure 1, and also in the figures on trends in specific member categories in Annex 3, reflect challenges in defining and measuring dependents, as well as changes in how PhilHealth deals with them in its reporting, rather than changes in the actual coverage of individuals by PhilHealth.

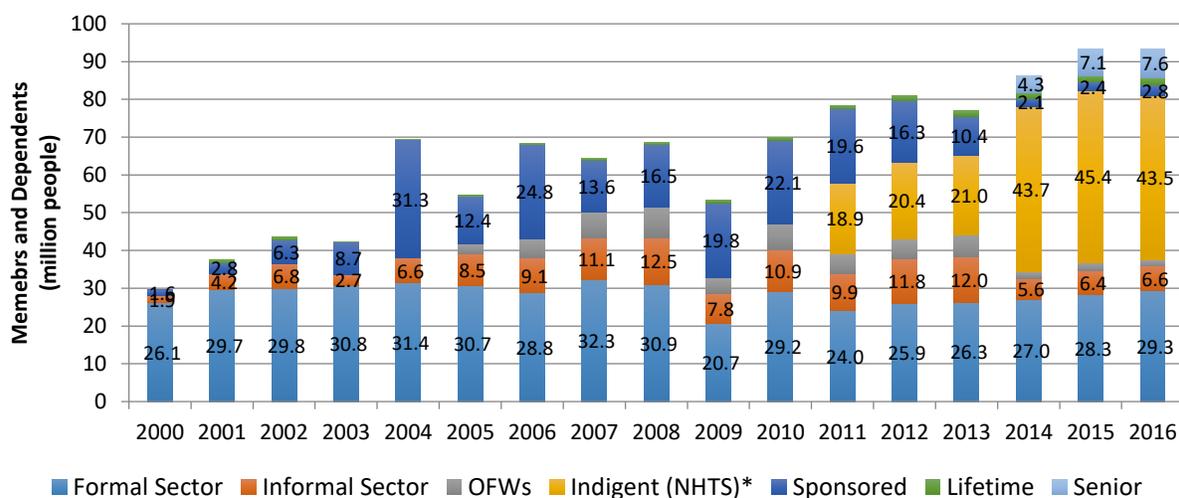
**In recent years, there have been major shifts in the composition of PhilHealth membership, with indigent/sponsored members growing to form the majority of PhilHealth members, sharp increases in the membership share of those older than 60 years, and an absolute decline in the membership of the informal sector program.** Between 2010 and 2016, the indigent and sponsored programs grew from being almost a third (32 percent) to half (50 percent) of PhilHealth’s total membership. The number of principal members increased from 6.0 million in 2010 to 15.9 million in 2016, while the total number of beneficiaries in this group (principal members plus dependents) increased from 22.1 million to 46.3 million. The number of people over the age of 60 with PhilHealth coverage has skyrocketed since 2014 when the senior citizen category (whose membership is also fully subsidized) was created. The combined membership of the lifetime and senior citizens’ programs increased from only 0.5 million (0.9 million) members (members and dependents) in 2010 to 4.5 million (5.9 million) in 2014 when the senior citizens’ membership category was introduced and climbed still further to 7.5 million (9.7 million) by 2016—a tenfold (sevenfold) increase in just three years. By contrast, membership of the informal sector group fell

from over 5 million in 2013 to 2.4 million in 2014—the year that the national government expanded insurance subsidies to the near-poor—suggesting that many of those who were formerly in the informal sector group became covered under the indigent program. Throughout this period, formal sector membership continued to grow steadily: from 9.8 million principal members in 2010 to 14.6 million principal members in 2016 for a total of 29.3 million members and dependents.

**The effect of the moving to the use of a common targeting mechanism in the form of the NHTS-PR/*Listahanan* is clearly reflected in the change in the share of the sponsored and indigent member categories in overall PhilHealth membership.** In Figure 2, one can clearly see how the system has switched from one that relies on LGU targeting of the poor to national targeting of the poor. In 2011, the number of sponsored principal members (5.3 million) exceeded the number of indigent members (4.2 million), but this had reversed in 2012, and by 2016, there were 14.6 million principal indigent members and only 1.2 million sponsored principal members.<sup>38</sup>

Annex 3 discusses the trends in the expansion of membership across the different PhilHealth membership categories in detail, illustrated by graphs for each member category.

**Figure 2. PhilHealth beneficiaries (members and dependents) by membership type, 2000 to 2016**



Sources: 2000 to 2006 - PhilHealth Corporate Planning Department; 2007 to 2016 - PhilHealth Stats and Charts.

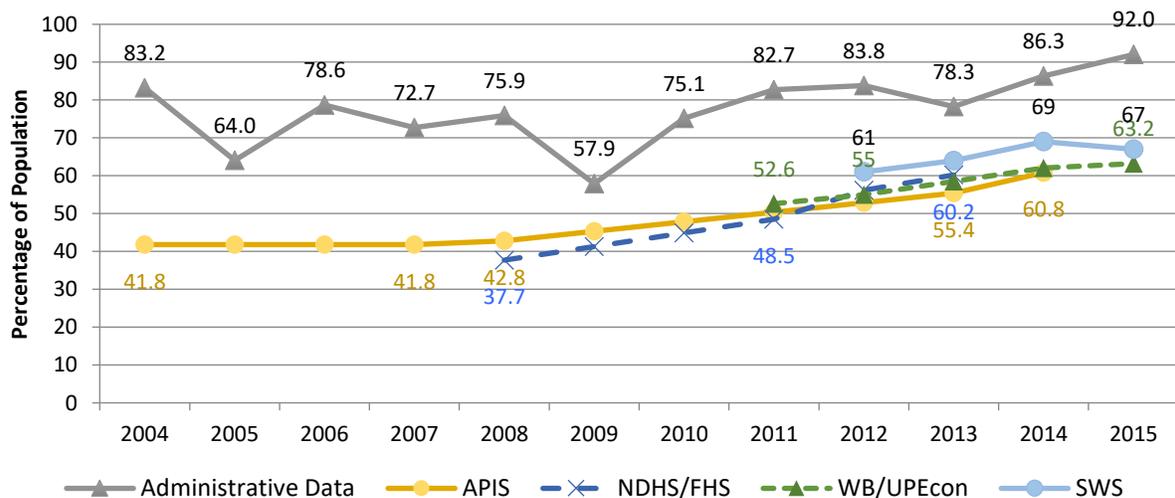
#### 4.2 Estimates from household surveys

**Household surveys—which are used to ask people directly whether they are covered by PhilHealth—confirm the strong upward trend in health insurance coverage that is observed in administrative data.** Self-reported coverage rates that are nationally representative can be obtained from the National Demographic and Health Surveys (NDHSs) (2008, 2013); the Family Health Survey (FHS) (2011);<sup>39</sup> the regular Annual Poverty Indicators Survey (APIS) managed by the Philippine Statistics Authority; surveys commissioned by the DOH (2012, 2014, and 2015) from the Social Weather Stations (SWS) research firm; and surveys financed by universities and donors (such as the World Bank-University of the Philippines surveys in 2011 and 2015). Estimates from these surveys show a clear upward trend in health insurance

coverage (see Figure 3Error! Reference source not found.).<sup>40</sup> While the point estimates obtained from the different surveys differ, by and large these different sources tell the same story in terms of the overall trend in health insurance coverage.

**However, there is a persistent gap between the health insurance coverage rates obtained from national administrative databases and the health insurance coverage rates reported in household surveys.** Household surveys produce self-reported coverage rates that are around 20 percentage points lower than what the PhilHealth administrative data show. In 2013, when the PhilHealth Stats and Charts reported coverage equivalent to 78.3 percent of the population, the NDHS showed coverage rates of only 60.2 percent of the population (Bredenkamp and Buisman 2016). In mid-2015, when the PhilHealth Stats and Charts mid-year estimates (not the end-year estimates shown in the graph below) reported national coverage rates of 89 percent, a household survey fielded at the same time by the World Bank and the University of the Philippines found coverage rates of 63.2 percent (Bredenkamp et al. 2017a) while an SWS survey commissioned by the DOH found coverage rates of 67 percent.<sup>41</sup>

**Figure 3. PhilHealth coverage estimates from various household surveys, 2004–2015**



*Sources:* Administrative data from PhilHealth Stats and Charts; authors' calculations for APIS, NDHS/FHS, and World Bank/UPEcon Foundation data; SWS estimates obtained from reports.

**The gap in coverage between administrative estimates and household survey estimates suggest that many of those who are listed in the PhilHealth database as being entitled to free health insurance do not know of this entitlement.** This may, in part, reflect measurement issues associated with dependency ratios (as already discussed) but is also largely due to the policy of 'automatic enrollment' of those who are subsidized by the national government. By 'automatic enrollment', we mean the policy that all of those who are identified as being poor by the NHTS-PR/*Listahanan* automatically have their names entered in the PhilHealth database. Consequently, the PhilHealth administrative data only capture the number of people entitled to free health insurance (that is, de jure coverage) and on whose behalf PhilHealth is allocated premium subsidies by the DBM, and not the number of people who know that they have subsidized coverage (that is, de facto coverage).

**PhilHealth and other government entities—at both national and local levels—have implemented a number of measures to inform households who are automatically enrolled of their entitlement (coverage), but these measures have not been altogether successful.** For those subsidized households

who are also beneficiaries of the DSWD's 4Ps program, there are the 'family development sessions' where health, education, and other topics are discussed. In addition, 4Ps beneficiaries can use their 4Ps cards to access health services without any additional documentation. The PhilHealth Customer Assistance, Relations and Empowerment (CARES) program, initiated in 2012, deploys PhilHealth staff in PhilHealth-accredited hospitals to provide information and assist members with determining their eligibility, understanding their benefits, and claims inquiries. In 2014, PhilHealth launched the '*Alamin at Gamitin para sa Maayos na Buhay*' (or *Alaga Ka*) roadshows, in partnership with the DOH and LGUs, to inform indigent members of their entitlement (through the distribution of the MDR) and to explain to indigent members how to use the primary care package. PhilHealth also uses mass media, in particular television, to reach a wider audience with information on its programs and benefits.

**However, it is not clear that all of these measures have been effective as they could be in informing people of their coverage and generating awareness of the PhilHealth benefits.** A recent household survey conducted by the World Bank and the University of the Philippines found that among those who are aware of their entitlement to subsidized insurance, most learned of it from their barangay officials or through officials of the DSWD (especially the 'municipal links' employees), emphasizing the role played by local governments and other non-health national programs in informing people of their health insurance coverage (Bredenkamp et al. 2017b).<sup>42</sup> At the same time, the same study revealed that there is considerable room to improve people's knowledge of the PhilHealth benefit package. While awareness of coverage of various types of hospital care was found to be high and around 75 percent of the poor know about the no-balance billing policy, only a minority of poor people know that their PhilHealth coverage includes a free primary care consultation.

## 5. An equity lens

**Given the emphasis in the Philippines HFS on equity and financial protection, it is important to consider how PhilHealth coverage performs on the equity dimension and the extent to which the country is achieving financial protection goals.** This section looks at equity in health insurance coverage, that is, how health insurance coverage is distributed across different income groups; equity in contributions, that is, whether health insurance contributions are regressive or progressive—in general, and within specific programs; equity in benefit structure, that is, whether benefit design includes pro-poor elements such as additional benefits for the poor or a pro-poor copayment policy; and equity in benefit payments, that is, whether the poorest member groups receive a share of benefit payments that is smaller or greater than their membership share. The section also examines the extent to which financial protection goals, that is, a reduction in the incidence of catastrophic and impoverishing health expenditures, are being achieved.

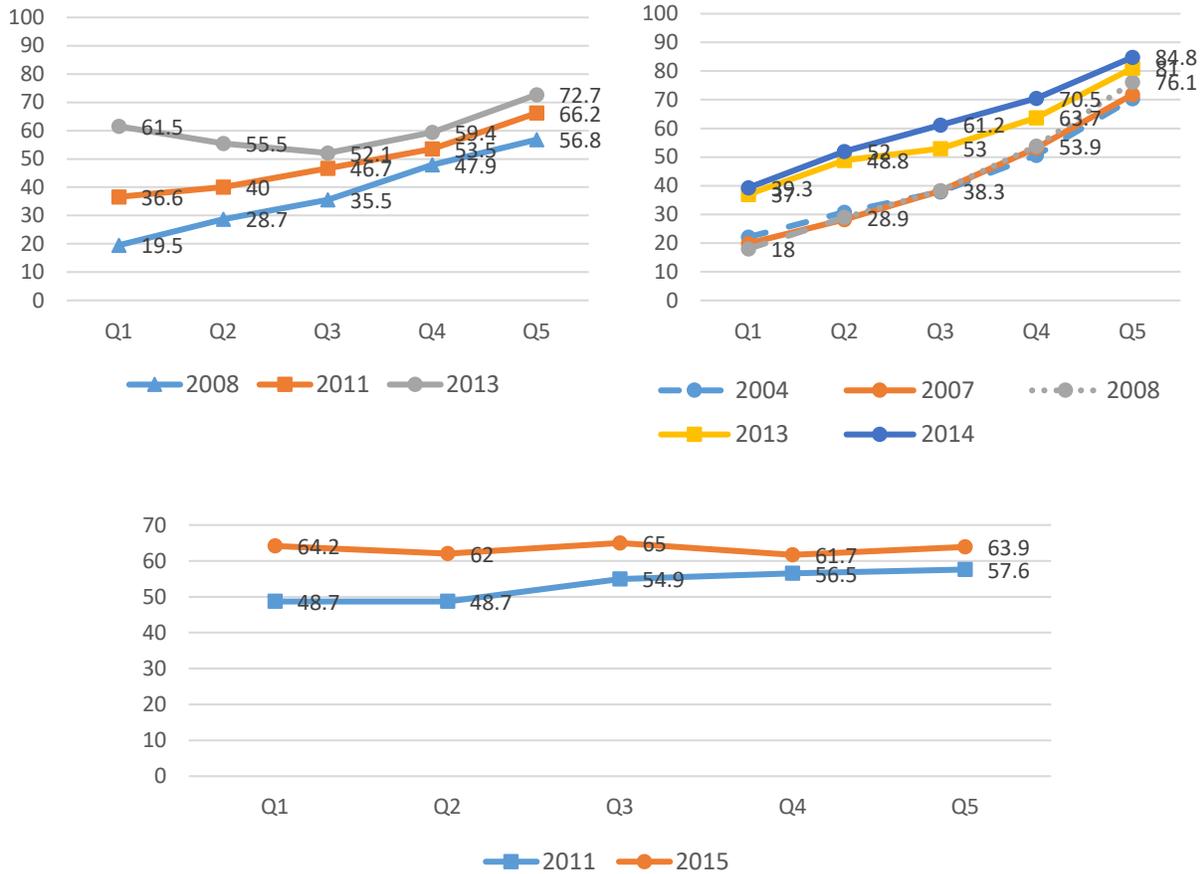
### 5.1 Equity in coverage

**Administrative data show that the expansion in PhilHealth insurance coverage has been pro-poor, in line with policy intentions, with an increase in both the absolute number and the membership share of the poor.** The driving factor behind the rapid increase in membership among the poor was the expansion of the indigent program, first in 2011 to the poor, and then again in 2014 to the near-poor. As PhilHealth administrative data in section 4 revealed, the number of Filipinos (both members and dependents) in the indigent/sponsored programs for the poor increased from 22.1 million (just more than a fifth of the population) in 2010 to 46.3 million (just under half of the population) by the end of 2016. The share of these two groups in overall PhilHealth membership has also increased—from 32 percent of total program members/dependents in 2010 to 50 percent of the program members/dependents in 2016—thus making the overall membership composition of PhilHealth membership more pro-poor.<sup>43</sup>

**Also important is the fact that over the last five years the process of identifying the poor who are eligible for free government-subsidized health insurance has become much more credible and transparent.** As previously discussed, with the introduction of the use of the NHTS-PR/*Listahanan* in 2011, there is greater certainty that those families receiving subsidies are objectively poor rather than the beneficiaries of (potentially politically motivated) local government allocation decisions.

**Most household surveys (although not all) support the finding that PhilHealth coverage has become more pro-poor.** First, analysis of the Philippines DHS and FHS shows that between 2008 and 2013, the steep socioeconomic gradient in insurance coverage in 2008 had been replaced by a U-shaped pattern of coverage (that is, where the poorest and wealthiest quintiles have the highest coverage rates). The concentration index (CI) for health insurance coverage changed from being pro-rich (CI = 0.21\*\*\*) in 2008 to neither pro-rich nor pro-poor (CI = 0.04) in 2013 (Bredenkamp and Buisman 2016). However, the APIS presents a less rosy picture in that, despite confirming that for every quintile, health insurance coverage increased between 2008 and 2014, there has been very little change in the distribution of health insurance (by quintile). On a more positive note, recent data from two household surveys conducted by the University of the Philippines and the World Bank in 2011 and 2015 confirm the improvement in the equity of health insurance coverage; it was found that health insurance coverage has increased by more in the poorer quintiles than in other quintiles and the distribution of health insurance has shifted from being clearly pro-rich (CI = 0.08\*\*\*) in 2011 to neither pro-rich nor pro-poor (CI = -0.00) in 2015 (Bredenkamp et al. 2017a). This finding implies a transition from a U-shaped distribution to a fairly flat distribution by 2015 as a result of the increases in subsidized coverage of the poor which occurred in 2011 and 2014. Results are shown in Figure 4.

**Figure 4. Inequalities in health insurance coverage from NDHS (left), APIS (right), and World Bank/UPecon (bottom) surveys, 2004–2015**



Source: Authors' calculations based on the DHS, APIS, and World Bank/UPecon surveys.

Note: Data points show the percentage of households covered by health insurance in each consumption (income) quintile 1 through 5.

## 5.2 Equity in contributions

**Important from an equity perspective is that PhilHealth premiums are not risk rated.** In other words, premiums are not adjusted according to individual health risk. This protects people who are unhealthier or older from facing high, or even unaffordable, premiums. It is also in line with the HFS's principle of 'social solidarity' which holds that health financing arrangements should cross-subsidize from richer to poorer households, from healthier to sicker members, and from younger to older individuals.

**Also, contributions vary across membership groups in a way that is pro-poor, with those who can least afford it being exempt from premium payments while those who can better afford it pay higher premiums.** Those in the indigent and sponsored groups, who together account for half of members/dependents, do not pay any premiums at all; those in the informal sector, which includes many people whose income stream—and, thus, ability to finance health care costs—is unpredictable, typically contribute PHP 2,400; and those in the formal sector contribute a premium that is proportional to their income.

**While formal sector premiums (in absolute peso terms) increase proportional to salary, this is only up to a fairly low salary ceiling after which premium payments become regressive.** The PhilHealth premium structure has a premium floor at PHP9,000 (that is, the premium is the same for those earning anywhere up to PHP 9,000) and a premium ceiling at PHP35,000 (that is, the premium is the same for all those earning more than PHP 35,000, no matter how high their incomes). This means that while the premium is proportional to salary for those whose salaries fall between PHP 9,000 and PHP 35,000 per month, above and below these thresholds, contributions are regressive, that is, as salary rises, people pay a smaller share of their salary as a premium. Premium floors and ceiling are normal features in most health insurance systems, but can have inequitable implications, depending on the salary levels at which the floor and ceiling is set. The logic behind the salary level at which the premium floor is set in the Philippines is that it is the salary level at which the annual premium would be equivalent to the PHP 2,400 indigent subsidy and informal sector premium. Having a minimum threshold also simplifies collections. However, the salary ceiling at which the maximum contribution kicks in is fairly low.

### 5.3 Equity in benefit structure

**Overall, the structure of the PhilHealth benefit package is quite equitable with the inpatient benefit package, Z-benefits package, and disease-specific outpatient packages harmonized across all membership groups; however, only the poor and senior citizens are eligible for the primary care package, though.** In this regard, social health insurance in the Philippines is much more equitable than in many other countries where different membership groups are often entitled to very different benefits and levels of coverage. The fact that the PCB package is implemented only for the poor and senior citizens could be considered a pro-poor policy action. However, restricting this benefit to the poor may be short-sighted: access for all to quality primary care is important from a health outcomes and efficiency perspective. It prevents future illness and reduces health system costs in the long run.

**When it comes to cost-sharing, the PhilHealth benefit package favors the poor and the elderly who benefit from the NBB policy.** The fact that indigent members are exempt from copayments at the point of care under the NBB policy means that they, de facto, have a more generous benefit structure than other members. The NBB policy is also applied to senior citizens (since the inception of the senior citizens' program) and to lifetime members (since 2017). The decision to extend the NBB policy to the elderly will have large financial implications for PhilHealth, but it is in line with other social policies in the Philippines that provide special benefits and discounts to the elderly, even if the individual senior citizen in question is not necessarily financially vulnerable.

**However, the lack of predictable copayments for non-poor and non-elderly members erodes the financial risk protection that should be provided by health insurance membership.** Because PhilHealth limits what it will reimburse health care providers without limiting what health care providers can charge patients (through fixed copayments or coinsurance), most members still face unpredictable and high OOP payments. This risk is faced by all non-indigent and non-elderly members for all packages, except for the Z-benefits packages where formal copayments are in place. The absence of any limit to patient OOP spending erodes the most fundamental benefit of health insurance which is to provide financial protection by replacing unpredictable and potentially high health spending with a predictable premium payment.

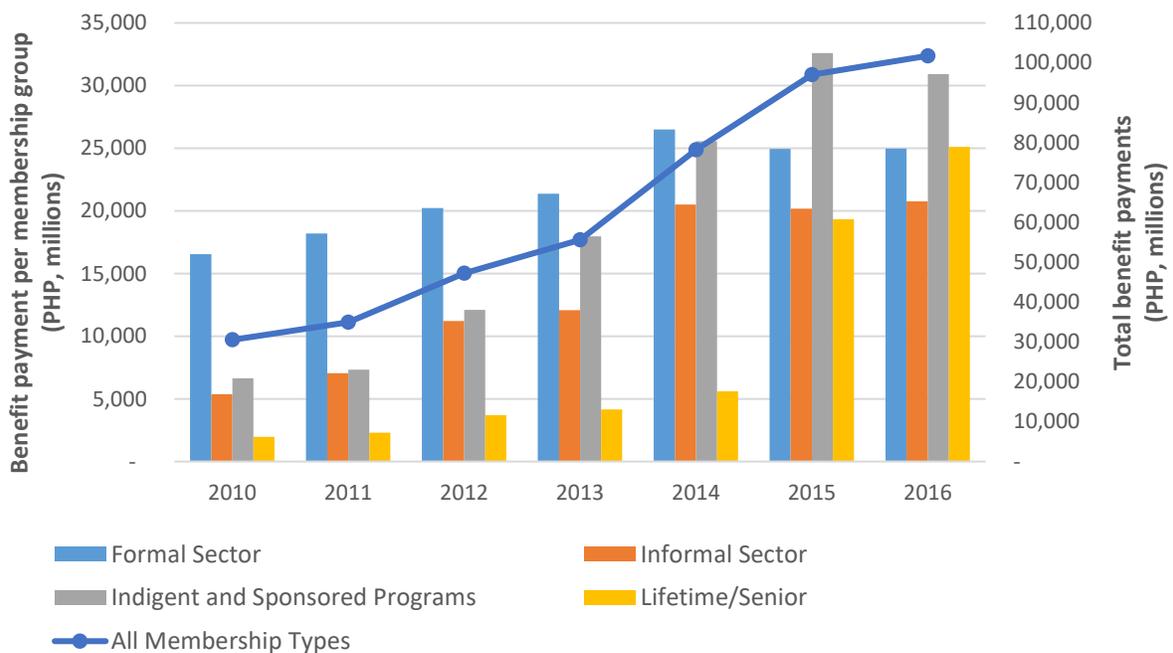
**Intrahousehold equity is also an issue, with the insurance benefit package redistributing toward the principal family member and away from other household members.** While the principal member enjoys a separate 45-day limit for hospitalization, the dependents share a combined 45-day limit. This also

effectively penalizes larger families (households) which, to the extent that family size is correlated with poverty, is a pro-rich redistribution.

#### 5.4 Equity in benefit payments

**The indigent/sponsored and senior citizens’ groups receive the largest and second-largest shares of PhilHealth benefit payments.** Total PhilHealth benefit payments tripled between 2010 and 2016, from around PHP 31 billion to PHP 102 billion. Between 2010 and 2014, benefit payments to each of the membership groups also increased, with additional increases seen in subsequent years for the indigent program (in 2015) and for the senior citizens’ program (2015 and 2016). For indigent and sponsored membership groups (that is, the poor and near-poor), the value of claims increased from PHP 6.6 billion in 2010 to PHP 32.6 billion in 2015 when, for the first time, the value of the claims of this group exceeded the claims of any other member group (see Figure 5). The benefit payments to the indigent and sponsored groups decreased to PHP 30.9 billion in 2016, but was still bigger than payments made to any other groups. The other group whose benefit payments have increased considerably in recent years is the senior citizens’/lifetime members group (from PHP 4.1 billion in 2013 to PHP 25.1 billion in 2016), following the extension of coverage to senior citizens in late 2014. In fact, this group received the second-largest amount of PhilHealth benefit payments in 2016 – and a huge leap from being the group with the smallest benefit payments the previous year.

Figure 5. PhilHealth benefit payments, by membership type, 2010–2016

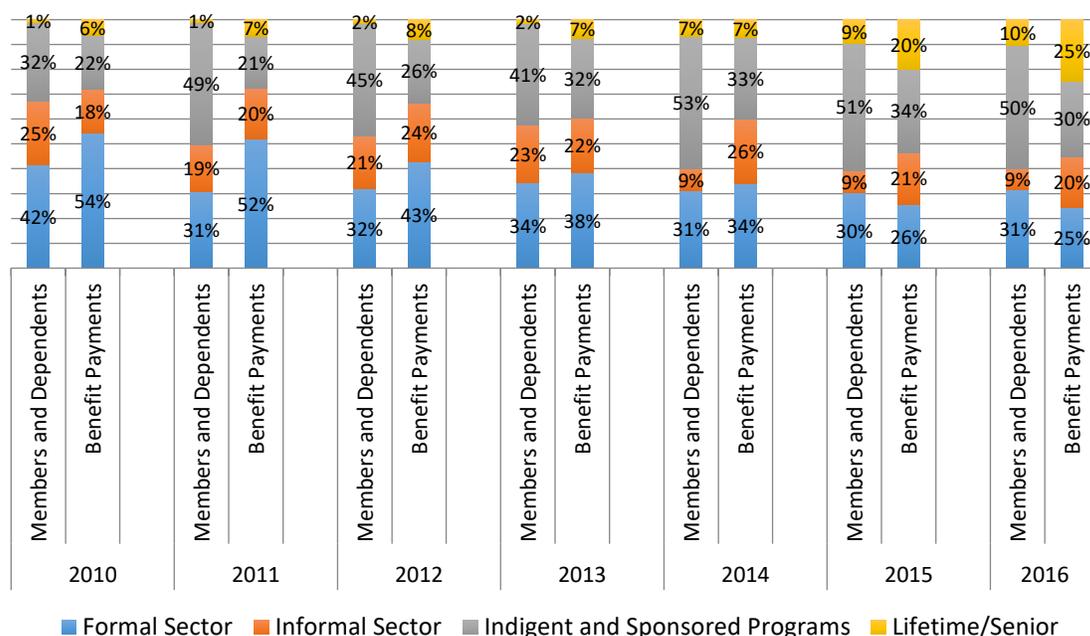


Source: PhilHealth Annual Reports.

**However, the share of total benefit payments going to the indigent/sponsored groups is much less than their membership share.** In 2016, while the indigent/sponsored program accounted for 50 percent of PhilHealth members/dependents, it accounted for only 30 percent of the value of payments/claims. It is only two years since the near-poor were included in this program and it is possible that this ratio will improve over time. For example, if we look back to 2011 when government-subsidized health insurance was first expanded to the poor, we see a similar disproportionality, but this diminished over time.

Elsewhere, it has been noted that in its early stages of development, it is quite typical for social health insurance to divert resources from the poorer segment of the population to the richer segment (Gottret and Schieber 2006, 74). The formal sector’s membership share (31 percent) is also much larger than its benefit payments share (25 percent) (see Figure 6), but it was not always like that. Two years previously, in 2014, the formal sector’s membership share and benefit payments share were relatively similar, and at the start of the decade its benefit payments share substantially exceeded its member share. By contrast, the informal sector receives more than its proportional benefit share; in 2016, the informal sector program accounted for only 9 percent of members/dependents but as much as 20 percent of payments. Senior citizens/members also receive a disproportionately large share of benefits; in 2016, at 25 percent, their benefit payment share was more than double their membership share of 10 percent, and it appears to be growing.

**Figure 6. PhilHealth membership and benefit payment share, by membership category, 2010–2016**



Sources: PhilHealth annual reports 2010–2015 and PhilHealth Stats and Charts 2016.

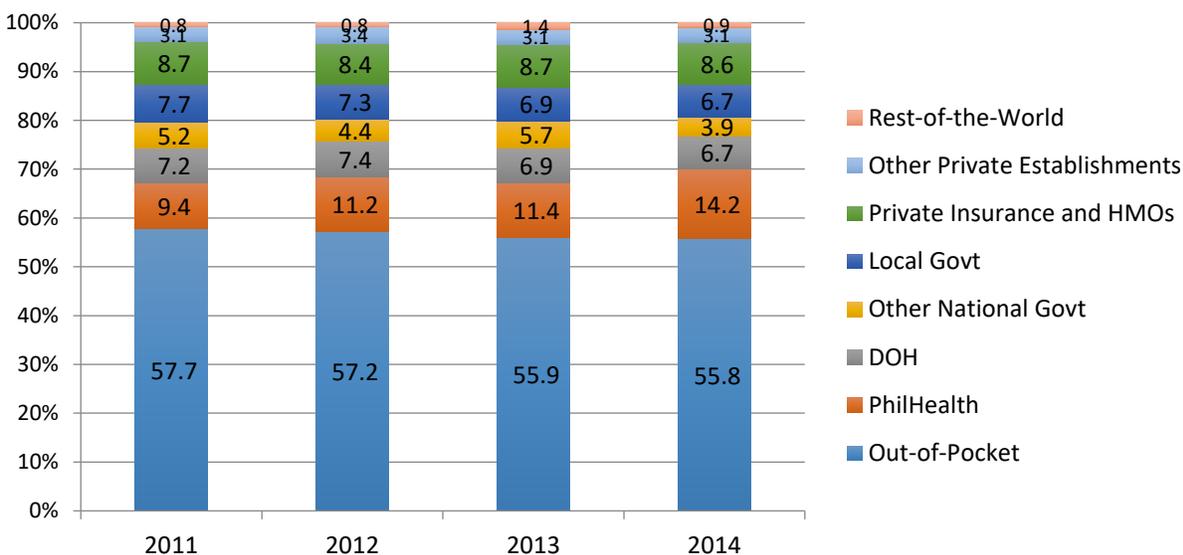
**Factors which contribute to different groups receiving more or less than their membership share in payments suggest that the observed inequities in benefit payments are both justifiable and unjustifiable.** Justified inequities are those that stem from differences in case mix (as a result of variation in age distribution or disease burden, for example) across member groups. Claims by senior citizens in excess of their population share owing to this group’s age and higher illness incidence is an example of this. Claims by the informal sector in excess of their population share may also potentially be justified by a higher disease burden if it stems from adverse selection whereby those who are ill are more likely to sign up for PhilHealth. However, other explanations are not justifiable from an equity standpoint. One is that subsidized indigent members may not be aware of their health insurance entitlement (due to automatic enrollment). Another is that they may not know their full range of benefits. Or their use of healthcare may be constrained by poor geographic access to health facilities (especially facilities that deliver the expensive and catastrophic care that would drive up benefit payments). The formal sector program’s transition from receiving more than its membership share for many years to a point where it now receives less than its membership share represents a more typical pattern of redistribution seen in

social health insurance systems (from those who are formally employed and relatively well-off to the rest of the population).

## 5.5 Financial protection

**While the share of the population whose health expenditure risk is pooled through PhilHealth is large (90.9 percent), the share of total health care expenditure that is pooled through PhilHealth is not (14.2 percent).** According to the Philippine National Health Accounts (PNHA) data, PhilHealth accounted for 9.4 percent of the country’s health expenditures in 2011, 11.2 percent in 2012, 11.4 percent in 2013, and 14.2 percent in 2014. This is the largest share since PhilHealth was established, but the share is quite small for a country where around 90.9 percent of citizens are PhilHealth members (according to the PhilHealth database end-2016 estimates). Rather, the health system continues to rely on OOP spending for most of its health financing, with OOP spending estimates in the range of 56 percent to 58 percent between 2011 and 2014 (according to PNHA data). Put differently, while almost all Filipinos are now members of PhilHealth, they are not having a substantial share of their financial risk pooled through PhilHealth.

**Figure 7. Share of PhilHealth and other financing agents in total health expenditure, 2011 to 2014**

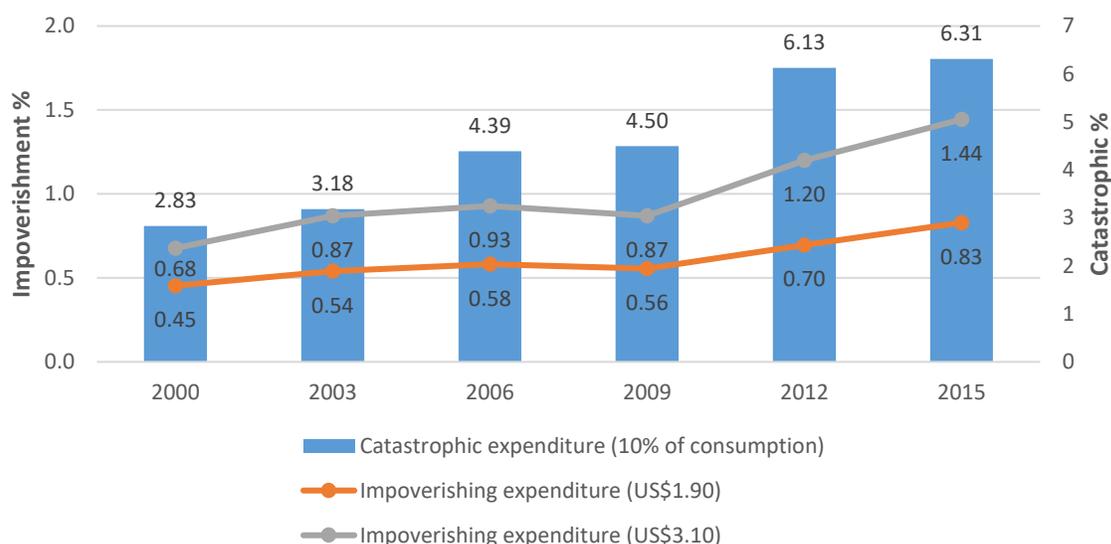


Source: PNHA, Philippine Statistics Authority.

Note: HMO = Health maintenance organization.

**Despite the increase in health insurance coverage, there has been no improvement, and in fact some deterioration, on financial protection goals.** Data from six Family Income and Expenditure Surveys (FIES), conducted from 2000 to 2015, show that the share of household spending that goes to health has almost doubled, the incidence of impoverishing expenditure has doubled, and the incidence of catastrophic spending has more than doubled. As a share of total health spending, OOP health spending grew from 1.4 percent to 2.7 percent between 2000 and 2015—an increase of 86 percent. In addition, the incidence of catastrophic payments (that is, the percentage of households whose health spending exceeds 10 percent of consumption) grew from 2.8 percent to 6.3 percent. The percentage of people impoverished by health spending also increased such that by 2015, OOP spending on health added 1.4 percentage points to the incidence of poverty in the Philippines (when measured using the US\$3.10 per day poverty line), thus plunging more than 1.4 million people into poverty in that year. Spending on medicines is a major driver of health spending and possibly even of catastrophic and impoverishing health spending.

**Figure 8. Incidence of catastrophic and impoverishing expenditure**



Source: FIES 1997–2015.

**These findings highlight that providing financial protection requires more than the expansion of health insurance coverage; other health financing and service delivery policies need to be designed and implemented in a way that enhances financial protection.** Provider payment mechanisms do not function effectively to constrain what patients pay out-of-pocket. Case rates are implemented with neither regulated user fees nor formal copayments in place with the consequence that providers are free to charge patients whatever they want beyond what PhilHealth reimburses.<sup>44</sup> Also, the high share of medicines in OOP payments – 62 percent of total household spending on average and as much as three-quarters among the poor according to the 2012 FIES (Bredenkamp and Buisman 2016) – suggests that regulatory action on medicines procurement and prescribing practices is needed to reduce the price and quantity, respectively, of medicines dispensed. In addition, as already pointed out, not all insurance beneficiaries are aware of their entitlements and benefits. On the service delivery side, the low density of public health care providers relative to the population and great distance that most rural residents must travel to seek care means that delaying of treatment until conditions are more severe, and thus more expensive to treat, is likely to commonly occur. Also, not all facilities have been accredited by PhilHealth which means that members living in the catchment areas of those facilities cannot use their benefits. Reaching the goal of financial protection cannot be achieved by expanding health insurance alone; it will also require action in other areas of health financing and service delivery – not only by PhilHealth but also by the DOH and LGUs. Finally, if the stagnant household income growth that has characterized the Philippines over the last 15 years continues, even the best policies will struggle to make a substantial dent in the incidence of impoverishing and catastrophic spending. Policy needs to be directed not only at reducing OOP spending (that is, containing the numerator) but also at raising incomes (that is, growing the denominator)—and that requires action well beyond the health sector.

## 6. Moving forward: directions for reform and specific recommendations

### 6.1 General directions for reform

- (a) Ensure that all those who are eligible for PhilHealth benefits, especially under the indigent program, know of their coverage and their benefits.

- (b) Reduce fragmentation and move toward a more equitable PhilHealth benefit structure, with formal copayments or ‘no balance billing’ and free primary care for all.
- (c) Decide whether to move boldly to attaining universal health insurance coverage by using tax financing to cover the remaining 9 percent of the population.
- (d) Improve equity in the structure of the formal sector contribution rates while also considering a formal sector premium increase.
- (e) Further improve measurement and monitoring of health insurance coverage.

## 6.2 Specific recommendations

Within each of the general directions for reform, we recommend a set of specific recommendations.

(a) [Ensure that all those who are eligible for PhilHealth benefits, especially under the indigent program, know of their coverage and their benefits.](#)

- **Issue health insurance cards to all (subsidized) indigent members to ensure that they know of their entitlement to free health insurance.** This can help to address the fact that many of those covered by PhilHealth do not know it—as evidenced by the persistent 20 percentage point gap between administrative estimates and household survey estimates of health insurance coverage. The lack of awareness likely arises due to the practice of ‘automatic enrollment’ of the poor (see section 4.2). Issuing health insurance cards to all indigent members will ensure that people are aware of their eligibility for health insurance; awareness is the first step toward utilization. From a practical standpoint, the size of the eligible population should be no obstacle. Indonesia, which is also a large archipelagic country, recently approved the issuance of health insurance cards to all its 91 million subsidized members, proving that this can be done at large scale. From a legal standpoint, the 2013 Health Insurance Law describes the issuance of cards for all members as an obligation of PhilHealth.<sup>45</sup> While there will be technical issues to be resolved regarding the technology of the card (for example, chip, magnetic strip, or just number); its appearance; and how it will be distributed (for example, through municipalities, or through PhilPost, or other channel), these decisions should not get in the way of achieving the outcome of informing people of their coverage. At the same time, it will be important to avoid the past practice of politicizing card distribution and, instead, communicate that the card (and the coverage that it symbolizes) is a citizen entitlement.
- **Take (similar) measures to ensure that senior citizens know of their entitlement to free coverage.** Like the indigent program, the senior citizens’ program is one in which people are largely ‘automatically enrolled’. The Office for Senior Citizens Affairs (OSCA) of each municipality provides the names of those 60 years and older living in the community to PhilHealth, while the DSWD provides the names of institutionalized senior citizens<sup>46</sup> to PhilHealth. PhilHealth assesses whether or not they are already members but does not inform new members of their coverage. Consequently, it is possible that there will be a number of people who are enrolled in the PhilHealth database as senior citizens but are not knowledgeable of the fact that they have free health insurance. PhilHealth should work with OSCA and other government bodies to ensure that all senior citizens know of their full range of benefits. Health insurance cards could also be considered for this group, but since

entitlement is age-related, cards would mainly serve the purpose of informing this group of their new entitlement; for purposes of service utilization any form of personal identification should suffice.

- **Additional effort needs to be made to ensure that all PhilHealth members (and especially the poor and near-poor) know of their full range of benefits.** While there have been considerable PhilHealth, DSWD, and LGU initiatives to ensure that PhilHealth members know of their benefits, surveys still find low levels of benefit awareness among the enrolled population (see section 4.2). In line with the findings of those surveys, we would recommend making better use of the 4Ps of the DSWD to provide relevant information to the poor on PhilHealth benefits, especially the monthly ‘family development sessions’ which beneficiaries attend; continuing the deployment of PhilHealth staff at hospital level to inform patients of benefits (through the PhilHealth CARES program); reassessing the design, content, and implementation of the *Alaga Ka* campaign to see whether it can become a better source of information of PhilHealth benefits or should be disbanded; and sustaining and even scaling up mass media campaigns, particularly TV adverts which appear to be an important source of information on PhilHealth benefits.
- **Ensure that internal and external accountability mechanisms incentivize not only membership expansion but also utilization of benefits (especially by the poor).** To address this, PhilHealth—as well as the institutions and actors which should hold PhilHealth accountable for results (such as DOH, COA, GCG, Congress, and the President)—should ask whether existing accountability arrangement and financial incentives need to be modified to better align the institution with overall health financing goals. For the first time in 2015, the PhilHealth Scorecard (on which PhilHealth reports to the CGC) started to report on indicators like awareness of benefits and introduction of new benefits, going beyond its historic focus on increasing enrollment, collection efficiency, and claims turnaround time. The indicators on the PhilHealth scorecard should continue to shift toward results areas that are aligned with overall health financing goals (including the utilization of benefits by members and financial protection) rather than focus so much on income generation and administrative efficiency. Oversight agencies could also consider adding a PhilHealth board member to represent the interests of indigent members who constitute around half of the members.

(b) Reduce fragmentation and move toward a more equitable PhilHealth benefit structure, with formal copayments or ‘no balance billing’ and free primary care for all.

- **Make OOP payments more predictable by introducing a formal fixed copayment policy for non-indigent members.** Indigent and senior citizen members benefit from a NBB billing policy which is intended to ensure that accredited health care providers do not charge them anything beyond what is reimbursed (to the provider) by PhilHealth. Other members, however, continue to face potentially unlimited OOP payments because while PhilHealth limits what they pay providers under case rates, they do not limit what providers can bill patients. This may (at least partly) explain why catastrophic spending and OOP spending (as a share of total health expenditure) has not declined in the Philippines. To enhance the financial protection provided to members, PhilHealth could consider complementing its NBB policy for the poor with the introduction of fixed copayments for other members. To ensure

that providers are still adequately compensated, this will also require a revision of the case rates, based on a costing exercise.

- **Ensure effective implementation of the NBB policy.** As shown in this analysis, the implementation of the NBB policy has improved substantially since its introduction, with better compliance by providers with every year that goes by. We encourage PhilHealth to continue its efforts to conduct regular surveys of the implementation of the NBB policy, impose fines—and even stiffer fines than is currently the case if need be—on providers who violate the NBB policy, and redouble efforts to inform indigent and sponsored members that NBB is part of their benefit package. The introduction of a formal, fixed copayment policy for non-indigent members would further strengthen the implementation of the NBB policy because under such a system no Filipino would be required to pay accredited providers more than what PhilHealth reimburses—unless clearly stated in the copayments policy.
  - **Expand free primary care to all Filipinos.** The intention of the 2013 Health Insurance Act is “to give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits.” This implies that the primary care package should be expanded beyond the poor and senior citizens to include all PhilHealth members. Making the primary care package a universal entitlement would also bring longer-term benefits to overall population health status and potentially also efficiency gains (such as reduced use of inpatient care because diseases will be caught early and managed). A primary package may also incentivize enrollment among people in the informal sector who have not yet signed up with PhilHealth. However, the expansion of the PCB to all PhilHealth members would also entail a substantial cost to PhilHealth and may require policy actions to ensure adequate additional revenues. These revenues could potentially be sourced from increased premiums (see section [d] below) and/or some fixed copayment for primary care from (non-indigent) households.
  - **Equalize benefits within families.** The fact that the principal member enjoys a separate 45-day hospitalization limit, while all dependents share a combined 45-day limit, sends the message that the member’s health is more valued than the dependents’ health and also penalizes larger families. We recommend that the inpatient benefit be restructured such that families are not penalized for their size or demographic composition. A simple step would be to pool the hospital benefits into one 90-day benefit that can be used by any family member, but this would still discriminate against larger families. Alternatively, every individual could have his/her own hospitalization limit, or the hospitalization limit could eventually be removed. If this is not financially sustainable, the solution could be to adjust the premium (including the subsidy that the government pays on behalf of indigent families) to account for family size and composition.
- (c) **Decide whether to move boldly to attaining universal health insurance coverage by using tax financing to cover the remaining 9 percent of the population.**
- **This is ultimately a societal value judgment, but if guaranteeing PhilHealth coverage to all Filipinos regardless of socioeconomic status or occupation is a desirable social goal, resources could be found to expand health insurance coverage to all people.** With government health spending in the Philippines fairly low by regional and global standards, using general revenues is one option. Another options is to use additional resources from

the Sin Tax revenues. Alternatively, one could explore the use of the PCSO funds whose purpose is to subsidize the health care of the indigent and other needy individuals at hospitals. Instead of financing care on the supply side (through payments to the hospitals), the PCSO resources could be shifted to the demand side (through providing subsidies to health insurance).

- **If tax financing is used to cover the remaining 9 percent, the question will also arise as to whether the dwindling informal sector group is worth continuing – or if it should also be tax-financed.** The size of the informal sector program has fallen substantially. In 2016, it had 2.6 million principal members, down from 5.4 million principal members in 2013. If government subsidies are used to cover the remaining uncovered PhilHealth members, members of this group may choose not to contribute, hoping to qualify for subsidies. There is also the question of administrative cost: is it worth maintaining a separate program for only 2.2 million members, given the administrative effort involved in collecting their premiums? PhilHealth may want to consider using tax-financing to cover all non-formal sector members, including the informal sector. Regardless of whether the Philippines would like to push for 100 percent coverage through further subsidies (through the Sin Tax revenues, PCSO, or non-earmarked general revenues), the many innovative, but ultimately only incrementally effective, schemes that PhilHealth has implemented to expand coverage to the informal sector in the past—such as the financial incentives, enrollment discounts, and premium lock-in—will not make much of a dent in closing the remaining coverage gap. It may be better to use the resources spent devising and implementing such schemes elsewhere, including perhaps on subsidies for those who are not yet covered.
- **Simplify the membership of the elderly by merging the lifetime members’ program into the senior citizens’ program.** Right now, those in the 60+ age group fall into two member groups: lifetime members and senior citizens. Neither lifetime members nor senior citizens pay premiums; the former are exempt from premiums because of their long contribution history, while the latter are exempt from premiums because a subsidy is paid on their behalf by the government. While lifetime members recently became eligible for no balance billing (in 2017), they are not eligible for the primary care benefit. With the lifetime member group now quite a small share of PhilHealth members, merging the lifetime member program into the senior citizens’ program would simultaneously simplify administration, provide the current lifetime members with access to essential primary care (like senior citizens are eligible for), and ensure PhilHealth of some additional income (through subsidies) to offset the larger health care costs of the elderly.

(d) [Improve equity in the structure of the formal sector contribution rates while also considering a formal sector premium increase.](#)

- **The salary level at which the premium ceiling is set could be increased from its current level of PHP 35,000 to make the formal sector contribution structure less regressive.** Earlier attempts to increase the ceiling failed,<sup>47</sup> but now that six years have gone by, another attempt could be made. For one, nominal wages in the Philippines have shifted upwards (Rutkowski et al. 2016), suggesting that the salary ceiling should too. Moreover, as argued in this paper, the ceiling creates inequities in the contribution structure: the ceiling kicks in fairly low down the income or wage distribution,<sup>48</sup> and contributions after the ceiling are regressive. At the minimum, one would want to increase this from the current PHP 35,000

(or PHP 420,000 per year) to around PHP 42,000, which would be close to the top income bracket used for income tax calculation purposes, that is, PHP 500,000.

- **An alternative to consider would be to change the contribution structure from a proportional one to a tiered progressive one, but this may come with added administrative complexity.** A tiered progressive structure would mean that, as salaries rise, members would pay a larger percentage of their salary as health insurance contributions. For example, while contribution rates could be set at 3 percent for some contributors, those in the higher earning brackets/tiers could contribute 4 percent or even 5 percent. This is the same principle that is applied in income tax. It is also similar to the health insurance contributions structure in Mongolia, where contribution rates vary from 3 percent to 6 percent, according to income. The advantage of this approach would be a less regressive contribution structure. The disadvantage would be greater administrative complexity and (possibly, depending on the rates set) lower overall income for PhilHealth.
- **With formal sector premiums low by international standards and only half of the maximum currently allowable by law, a modest increase in formal sector premiums could also be considered.** At 2.5 percent, current formal sector contributions are currently set well below the 5 percent maximum allowed by the 2013 Law.<sup>49</sup> Failed attempts to increase the contribution rates<sup>50</sup> mean that the rate of the formal sector premium has not changed since 2010. A modest increase in formal sector contributions rates—for example, from 2.5 percent to 4 percent—would also bring the Philippines in line with other countries in the region; for example, 3.7 percent in the Republic of Korea, 4.5 percent of salary in Vietnam, 5 percent in Indonesia, 4 percent to 6 percent (depending on income) in Mongolia, and 6 percent in China’s urban employees scheme. The impact on labor markets, including labor demand and the Philippines’ international competitiveness, is not expected to be detrimental. The main reason is that the tax wedge in the Philippines, and also the share of social security contributions in the overall tax wedge, is low enough by regional standards (see World Bank 2014) that increasing the PhilHealth contributions from 2.5 percent to 4 percent would not change the Philippines’ regional ranking in this regard. Also, the dominance of income tax in the overall tax wedge in the Philippines suggests that any effect on labor demand would be more influenced by, and also more easily addressed by, income tax policy rather than health insurance policy. However, it would be important to be cognizant of the possible impact on labor demand, and therefore employment, especially since the Philippines employment rate, while average for middle-income countries, is low compared to other Association of Southeast Asian Nations (ASEAN) countries.<sup>51</sup>
- **If increasing formal sector contribution rates is politically difficult, it could be implemented simultaneously with a shift in the employer-employee contribution ratio so that most of the tax increase falls on the employer.** For example, if contribution rates were increased from 2.5 percent to 4 percent, instead of being split in a 2 percent/2 percent ratio between employer and employee, the ratio could be 2.5 percent/1.5 percent (or even 2.75 percent/1.25 percent); the employer contribution would double, but the employee contribution would only increase very slightly. A number of other countries in the region require higher contributions from the employer than the employee; in Vietnam, the employer pays 3 percent and the employee pays 1.5 percent, in Indonesia the employer pays 4 percent and the employee pays 0.5 percent, and in China’s urban employees schemes, the

employers pays 6 percent of an average local workers' salary while the employee pays 2 percent of his or her own salary.

(e) Further improve the measuring and monitoring of health insurance coverage.

- **Invest a lot more in PhilHealth information systems.** Identifying specific areas of improvement for PhilHealth information systems is beyond the scope of this report. Suffice to say that with membership approaching 100 million, PhilHealth is one of the largest health insurance agencies in the world and needs a state-of-the-art information system to manage its large number of members and the increasing number of transactions/claims. Beyond managing enrollment, collections, and claims processing, the information system also needs to produce the data that is needed for decision making and policy formulation. Integration with other government information systems and health facility systems is also key.
- **Improve membership data and enhance the credibility of the PhilHealth membership database, including through updating PhilHealth beneficiary data using the new NHTS-PR/*Listahanan*.** The repeated revisions to PhilHealth coverage figures undermine the credibility of PhilHealth, DOH, and DSWD data and institutions. One immediate opportunity for a large-scale update and cleaning of the beneficiary database is the release of the new NHTS-PR/*Listahanan* list—the first update since the original NHTS-PR/*Listahanan*. Inevitably, some of those people currently on the list will have moved out of poverty, while others not previously on the list will have fallen into poverty. An updated NHTS-PR/*Listahanan* list can form the basis of a new and more accurate list of PhilHealth indigent members. Also, since the new NHTS-PR/*Listahanan* list will also contain updated information on family composition, PhilHealth will be able to work with actual data (rather than assumptions) on family composition and the number of dependents when counting the number of beneficiaries. This would also help improve the quality of actuarial analysis and also open up the possibility of adjusting the premium subsidy for family size.
- **Include a question on health insurance coverage in the triennial FIES.** It is commendable that the Philippines has included questions on health insurance coverage in major government-financed and donor-financed household surveys, such as the APIS and the DHS. The government might also consider including a question on PhilHealth coverage in the triennial FIES. This would not only ensure regular collection of this information in one of the government's most prominent surveys but would mean that (for the first time) information on health insurance coverage would be collected in the same survey as health expenditure data and consumption, allowing the impact of health insurance coverage on financial protection to be directly examined.

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<sup>1</sup> Guiding principles are “equity,” which means that “the program shall provide for uniform basic benefits” and that “access to care must be a function of a person’s health needs rather than his ability to pay;” “social solidarity,” which means that the program should be guided by “community spirit” and “enhance risk sharing among income groups, age groups, and persons of differing health status, and residing in different geographic areas;” and “universality,” which means that the program should “provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs” and “give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits.”

<sup>2</sup> The actual extent of this redistribution will depend on the structure of the insurance, for example, the extent to which premiums are risk-adjusted, whether people can be excluded because of pre-existing conditions, copayment/deductibles/ceilings, depth of the benefit package, and so on.

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<sup>3</sup> Note that while efficiency goals may be best served by a single pool, including with subsidization across membership groups, equity goals could also be served by multiple pools with equalization of benefits across pools.

<sup>4</sup> Thailand has three insurance schemes for different types of members, with differentiated benefits across the schemes. Vietnam has 63 separate provincial funds, and although funds are redistributed via central reserves, the net effect is that subsidies effectively flow from poor to rich regions.

<sup>5</sup> The following government agencies are represented in the Board: Department of Interior and Local Government, DSWD, Department of Labor and Employment (DOLE), Social Security System (SSS), GSIS, Department of Finance, Civil Service Commission, and the National Anti-Poverty Commission. There are also Board members representing formal sector, informal economy sector, migrant workers, employers, elected local chief executives, health care providers, and the Monetary Board. There are no Board members to directly represent the interests of the indigent and sponsored member categories who together constitute around half of PhilHealth members, although the representative of the DSWD is presumed to speak on behalf of the indigent.

<sup>6</sup> For example, see [http://gcg.gov.ph/site/public\\_files/gcg1405585878.pdf](http://gcg.gov.ph/site/public_files/gcg1405585878.pdf).

<sup>7</sup> See [https://www.philhealth.gov.ph/about\\_us/statsncharts/](https://www.philhealth.gov.ph/about_us/statsncharts/).

<sup>8</sup> Following Organization for Economic Co-operation and Development (OECD) practice, we define additional coverage purchased through private insurance as ‘complementary’ when it covers any cost sharing left after basic coverage, ‘supplementary’ when it covers additional services, and ‘duplicate’ when it provides faster access or a larger choice to providers (OECD 2012, 118). In the Philippines, private health insurance can be complementary (by covering cost of service beyond what PhilHealth pays), supplementary (when it includes coverage outside the PhilHealth benefit package), and duplicate (when it permits access to providers that are not PhilHealth-accredited), but it typically does not pay the share that PhilHealth would cover.

<sup>9</sup> The phrase ‘first peso payer’ refers to the fact that when patients seek care, PhilHealth benefits are drawn down before other insurance benefits kick in.

<sup>10</sup> Qualified dependents include legitimate spouse who is not a member; child or children—legitimate, legitimated, acknowledged, and illegitimate (as appearing in birth certificate), adopted or stepchild or stepchildren below 21 years of age, unmarried, and unemployed; child or children who are 21 years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support, as determined by the Corporation; foster child as defined in Republic Act 10165, otherwise known as the Foster Care Act of 2012; parents who are 60 years old or above, not otherwise an enrolled member, whose monthly income is below an amount to be determined by PhilHealth in accordance with the guiding principles set forth in the National Health Insurance Act of 2013; and parents with permanent disability regardless of age as determined by PhilHealth, that renders them totally dependent on the member for subsistence. Qualified dependents must be declared by the principal member. Their names must be listed under the principal member’s Member Data Record (MDR).

<sup>11</sup> For the purposes of PhilHealth, this category of member includes all employees of the government, whether regular, casual, or contractual, who render services in any of the government branches, military or police force, political subdivisions, agencies or instrumentalities, including government-owned and -controlled corporations, financial institutions with original charter, Constitutional Commissions, and occupy either an elective or appointive position.

<sup>12</sup> For PhilHealth purposes, this membership category includes all employees who renders services in any of the following: (a) corporations, partnerships, or single proprietorships, NGOs, cooperatives, nonprofit organizations, social, civic, or professional or charitable institutions, organized and based in the Philippines including those foreign owned; (b) foreign governments or international organizations with quasi-state status based in the Philippines which entered into an agreement with the corporation to cover their Filipino employees in PhilHealth; and (c) foreign business organizations based abroad with agreement with the corporation to cover their Filipino employees in PhilHealth.

<sup>13</sup> National Health Insurance Act. 2013. IRRs (Implementing Rules and Regulations). p9. Contributions for contractual employees became mandatory in 2012, following a DOLE order in 2011.

<sup>14</sup> Technically, the contributions are not exactly equal to 2.5 percent of salary. Rather, there are 28 salary brackets, increasing by PHP 1,000 increments, and each bracket has a corresponding premium, equivalent to 2.5 percent of the lowest salary in that bracket.

<sup>15</sup> For household help (that is, ‘kasambahay helper’) receiving a wage of less than PHP 5,000 per month, the employer will shoulder both the employee and employer share, based on the premium schedule, according to Republic Act 10361, otherwise known as the Domestic Workers Act.

<sup>16</sup> According to Circular 03-2015, for delinquent, under-remitting, and non-remitting employers, PhilHealth will recover all unpaid premiums and, in addition, the employer will be penalized with fines in the range of PHP 5,000 to PHP 10,000 per employee. If the erring employer still fails to comply, PhilHealth can pursue legal action.

<sup>17</sup> Members of the informal economy include the informal sector (for example, market vendors, tricycle drivers, small construction workers, and home-based industries and services); self-earning individuals (for example, doctors, lawyers, professional athletes, artists, businessmen); Filipinos with dual citizenship; naturalized Filipino citizens; and citizens of other countries working and/or residing in the Philippines.

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<sup>18</sup> The new premium rate was approved in 2011, planned for implementation in July 2012, but was deferred and a transition period was implemented in calendar year 2013 with a premium rate of PHP 1,800 per year.

<sup>19</sup> Thus far, only PhilHealth-accredited physicians—for whom PhilHealth membership is a requirement for PhilHealth accreditation—are consistently charged the PHP 3,600 annual premium.

<sup>20</sup> Seafarers, who are also referred to as sea-based Filipino workers, include fishermen, cruise ship personnel, and those serving foreign maritime and mobile offshore drilling units.

<sup>21</sup> Prominent categories of sponsored members include, among others, (a) members of the informal economy from the lower income segment who do not qualify for full subsidy under the means test rule of the DSWD, whose premium contribution is subsidized by the LGUs, legislative sponsors (for example, congressmen), and/or other sponsors and/or the member, including the national government; (b) orphans and abandoned children under the care of the DSWD, orphanages, churches and other institutions, and abused minors, out-of-school youths, street children, persons with disability, senior citizens and battered women under the care of the DSWD, or any of its accredited institutions run by NGOs or any nonprofit private organizations, whose premium contributions shall be paid for by the DSWD; (c) *barangay* health workers, nutrition scholars, *barangay tanods*, and other *barangay* workers and volunteers whose premiums are fully borne by the LGUs concerned; and (d) unenrolled women who are about to give birth, whose premium contributions shall be fully borne by the national government and/or LGUs and/or legislative sponsors or the DSWD if such woman is an indigent, as determined by the means test (IRR, Section 31).

<sup>22</sup> The age is reduced to 56 years in the case of uniformed personnel and 55 years in the case of SSS underground miner retirees; the category also includes anyone who was an SSS or a GSIS pensioner before March 4, 1995.

<sup>23</sup> While the senior citizens' program started in 2014, no national government transfers were received by PhilHealth for this program in 2014; transfers were only received starting in 2015. Therefore, any claims by senior citizens in 2014 were subsidized by other members.

<sup>24</sup> Currently, those who retire with a sufficient contribution history continue to be added to the lifetime membership program rather than the senior citizens' program.

<sup>25</sup> These include acute lymphocytic/lymphoblastic leukemia, breast cancer, cervical cancer, prostate cancer, colon and rectal cancer, end-stage renal disease eligible for requiring kidney transplantation, coronary artery bypass graft surgery standard risk, surgery for tetralogy of fallot in children, surgery for ventricular septal defect in children, Z MORPH (mobility, orthosis, rehabilitation, prosthesis help), selected orthopedic implants, and end-stage renal disease requiring peritoneal dialysis.

<sup>26</sup> Sometimes, provincial authorities may standardize user fees within the province.

<sup>27</sup> Circular 014-2015, Guidelines for Contracting Healthcare Institution as Z Benefit Packages Provider (issued June 2015).

<sup>28</sup> At the time of writing, however, the copayments/coinsurance rates were not available on the PhilHealth website.

<sup>29</sup> Estimates are based on facility exit interviews conducted by PhilHealth. Since 2015, NBB estimates have been formally reported and made available online as part of the PhilHealth Stats and Charts.

<sup>30</sup> Circular 006-2015, Implementing Guidelines for Mandatory Coverage of Senior Citizens.

<sup>31</sup> PhilHealth Circular 006-2017.

<sup>32</sup> According to section 6 of the National Health Insurance Act of 1995, implementation of the program would be "gradual and phased in over a period of not more than fifteen (15) years." Further, it would "not be made compulsory in certain provinces and cities until the Corporation shall be able to ensure that members in such localities shall have reasonable access to adequate and acceptable health care services."

<sup>33</sup> Actually, lower-income LGUs (that is, fourth to sixth class) need to only contribute 10 percent of the premium in the first year, but every year their share increased by an additional 10 percent points until it reached the regular 50 percent LGU share.

<sup>34</sup> However, take-up by LGUs was lower than expected, the national government did not contribute its total promised share, and sustainability presented a challenge.

<sup>35</sup> Subject to having the hospital's medical social worker administer a means test to the patient, hospitals can choose to pay the premium (PHP 2,400) of a confined (that is, admitted) poor patient who is not on the PhilHealth indigent list, giving him/her PhilHealth coverage from confinement until the end of that calendar year. This makes financial sense for the hospital, which will receive reimbursements from PhilHealth well in excess of the PHP 2,400 that it pays in premium, and it is beneficial for the patient in that it provides financial protection. While this can be described as adverse selection, PhilHealth sees it as a strategy to find all financial vulnerable people who are not included in the PhilHealth indigent program database but should be (for example, because they have fallen into poverty since the last NHTS-PR/*Listahanan* enumeration). For continuity of coverage in subsequent years, the hospital is supposed to forward the list of members sponsored by the hospital to the DSWD for further formal assessment and inclusion in the following year's list of government-subsidized indigent program members. More details on point-of-care enrollment can be found in Circular 0032-s2013.

<sup>36</sup> For example, PhilHealth assesses the financial protection that it provides to its members through a measure called 'support value' which was developed in collaboration with the University of the Philippines.

<sup>37</sup> In terms of the number of individuals, there was a 12 percent increase from 70.0 million to 78.4 million individuals; in terms of families, there was a 24 percent increase from 22.4 million to 27.9 million families.

<sup>38</sup> Earlier spikes in the share of sponsored and indigent members (as a share of total members) in 2004 and 2006 reflect the implementation Oplan 5M and Oplan 2.5M policies (discussed earlier), respectively.

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<sup>39</sup> The FHS was financed by the U.S. Agency for International Development and has a similar questionnaire structure to the NDHSs but a larger sample size.

<sup>40</sup> With the exception of the SWS estimates, all estimates were generated from the actual household survey data by the authors and contributors to this paper.

<sup>41</sup> In general, the SWS estimates (which we obtained from the SWS reports) tend to be a little higher than those obtained from the other surveys (which we calculated from the underlying data).

<sup>42</sup> When it comes to knowing the details of particular PhilHealth benefits, as opposed to whether or not one has health insurance coverage, the most important source of information was social networks (that is, friends, neighbors, families, and relatives), then PhilHealth staff deployed in health facilities, and then the mass media. By contrast, outreach programs, such as the *Alaga Ka* and even the 4Ps' 'family development sessions', do not appear to be an important source of information on PhilHealth benefits, even among the poor and 4Ps members.

<sup>43</sup> However, part of this increased membership share is an artifact of changes in the definition of who is poor, specifically by raising the upper income (via proxy means test) threshold for membership of the indigent program.

<sup>44</sup> See companion piece on Provider Payments for detailed treatment of this topic.

<sup>45</sup> According to Rule II of the 2013 Health Insurance Law: "Consistent with the mandate of enrolling Filipinos into the Program, the Corporation shall assign a permanent and unique PhilHealth Identification Number (PIN) to every member including each and every dependent of theirs. It shall facilitate the issuance of a Health Insurance ID Card containing the PIN for purposes of identification, eligibility verification and utilization recording." According to Section 222, "Members can temporarily use their PhilHealth Number Card which shall serve as the basis for availment of services until such time that they are issued a PhilHealth Identification Card."

<sup>46</sup> That said, senior citizens' organizations can also submit names for enrollment, as can individual senior citizens themselves, provided that they can produce a senior citizen's identification card issued by the OSCA.

<sup>47</sup> A PhilHealth circular in early 2011 provided for an increase in the ceiling of the base salary to PHP 50,000 from the then base salary PHP 30,000, which was reiterated by another circular in February 2012, but then another circular (No. 57) reduced the salary ceiling to PHP 35,000 (while also simultaneously eliminating a proposed premium increase).

<sup>48</sup> This conclusion is based on the income distribution as generated using the latest Labor Force Survey.

<sup>49</sup> According to Section 16 of the 2013 Law, "Members in the formal economy shall continue paying the monthly contributions to be shared equally by the employer and employee at a prescribed rate set by the Corporation not exceeding five percent of their respective basic monthly salaries." This is a 2 percentage point increase over the limit set in the 1994 Health Insurance Law.

<sup>50</sup> For example, a 2011 PhilHealth Circular (Circular 22, s. 2011), which sought to implement a 2011 Board resolution on premium increases for various member types intended to take effect in 2012 and 2013, was deferred by subsequent circulars in 2012 and 2013 citing public outcry as the reason.

<sup>51</sup> The recent Philippines labor market study (World Bank 2016, 32–33) points out that employment rates in the Philippines are around 15 percentage points and 11 percentage points lower than in Vietnam and Thailand, respectively, although more or less on par with Indonesia. Because of the phenomena of underemployment and discouraged workers, the employment rate (that is, employment to working age population ratio) is a better measure of the utilization of labor resources than the unemployment rate.

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## Annex 1: Goal 2 of the Health Financing Strategy Goal: “Sustain membership in social health insurance of all Filipinos”

**Goal:** By 2020, every household should have at least one member enrolled in PhilHealth, such that total PhilHealth membership should reach 28.5 million families, approximately 10 million more than in 2010.

### Steps to take:

- **Formal sector:** Enrollment drive to include casual and contractual employees (2010–2020).
- **Informal sector:** Starting with voluntary coverage in 2010, introduce a system of partial subsidies from LGUs for the poorer informal sector members by 2016 with contributions linked to administrative licenses/permits/documentation, so that by 2020 some of the informal sector members are on partial subsidy from the LGUs while others are fully paying members.
- **Indigents:** Subsidy of the members of the sponsored program would be shared between LGUs and national government between 2010 and 2016, and by 2020, the sponsored program would be fully subsidized by the national government.
- **OFWs:** Expanded membership among OFWs to be achieved by requiring premium payment before migration by 2016 and then continuous premium payment by 2020.

### Principles:

- Social solidarity with cross-subsidies from richer to poorer households, from healthier to sicker members, and from younger to older individuals.
- Pooling across all Filipinos will be achieved through a combination of public subsidies and premiums.
- Competition in the insurance markets with PhilHealth membership remaining mandatory but other insurance schemes able to compete for services that complement the PhilHealth benefit package (for example, private health insurance, HMOs, and provincial health insurance initiatives).

### Monitoring indicators:

- Baseline/2016 Target/2020 Target
- PhilHealth beneficiaries as percentage of total population (86 percent/90 percent/95 percent)
- Formal sector employees enrolled as percentage of total formal sector employees (15 percent/60 percent/60 percent)
- Informal sector workers enrolled as percentage of total informal sector workers (31 percent/65 percent/85 percent)

- Indigent families enrolled as percentage of total poor families (94 percent/100 percent/100 percent)
- OFWs enrolled as percentage of total number of OFWs (49 percent/69 percent/78 percent)
- Consistent persistency rates (that is, active members of current year/active members of previous year - 100 percent/100 percent)

## Annex 2: Challenges in using administrative data to estimate the number of individuals covered by PhilHealth

It is difficult to obtain consistent reports from administrative data on the number of individuals covered by PhilHealth. The challenge stems from two (related) sources.

One difficulty in assessing trends in health insurance coverage using administrative data is that, up until very recently, the PhilHealth databases tracked only the number of principal members and used assumptions about dependency ratios to estimate the number of dependents. For example, in 2011, a dependency ratio of 2.2 was used for formal sector members, while a dependency ratio of 1.7 was used for lifetime members. These assumptions were grounded in hard data, specifically, they were calculated based on actual household composition data from the Family Income and Expenditure Survey (FIES). Moreover, dependency ratios were apparently calculated to reflect the dependency ratios in the province in which the family lived, rather than a national average, and also calculated separately for different employment categories (for example, formal and informal), again based on dependency ratios observed for different family-employment types in the FIES. However, because the exact assumptions used by PhilHealth were changed frequently, estimates of PhilHealth coverage changed from year to year. From 2013, though, the number of members and dependents reported were obtained directly from the membership database, thereby reflecting the actual number of dependents, rather than a dependency ratio derived from surveys.

An additional challenge arises when it comes to counting the number of families covered by the PhilHealth indigent program, namely the fact that while DSWD's NHTS-PR targeting mechanism assesses poor households, PhilHealth enrolls poor families. For most member types, coverage includes both the principal member of the household plus qualified dependents. The definition of qualified dependents means that any person below 21 years of age, married or unmarried but with a child, is enrolled as a separate member, constituting their own separate PhilHealth family. This definition of a PhilHealth 'family' has created a lot of complications in counting the number of individuals covered by the indigent program. For example, given the definition of members and dependents, an NHTS-PR household of two parents, a 20 year old son and an 18 year old daughter would count as one PhilHealth family, with one principal member. On the other hand, an NHTS-PR household with two parents, a 21 year old son and an 18 year old daughter with a baby out of wedlock would count as three PhilHealth families with three separate principal members<sup>1</sup>. The fact that DSWD assesses household eligibility for free health insurance, while PhilHealth enrolls families, has made it very difficult for PhilHealth to count the exact number of individuals covered by the indigent program. This is, of course, further complicated by the use of estimated dependency ratios.

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<sup>1</sup> This is because children 21 years or older become members in their own rights and because children who have their own children need to become members in their own rights because grandchildren cannot be included as dependents.

## Annex 3: Expansion of PhilHealth membership by membership category

This annex discusses recent trends in the expansion of membership across the different PhilHealth membership categories. Membership trends over the 2000–2016 period covered by the HFS are shown in Figure 3.1, with longer-term trends from 2000 to 2016 shown in Figure 3.2

### Formal sector membership

**Membership of the formal sector program grew steadily between 2010 and 2016.** From 9.8 million principal members in 2010, the program grew to 14.6 million principal members in 2016 for a total of 29.3 million members and dependents. The number of principal members increased every year during this period. When one looks at the change in the total number of members and dependents, there appears to have been a decline relative to 2011, but this is fully explained by a drop in the total number of members and dependents (by around 5 million people) between 2010 and 2011. The reason for this dip is statistical rather than actual; it reflects a change in the dependency ratio used to calculate the number of dependents for every principal member (from 2.98 to 2.2) to address possible double-counting (where, for example, the standard dependency ratio had been applied to each spouse in cases where both spouses were formal sector members).<sup>ii</sup> The total number of members and dependents increased every year after 2011.

### Indigent and sponsored program membership

**Expansion of the membership of the indigent and sponsored programs has been very dramatic, and between 2010 and 2015 these groups increased from a third (32 percent) to half (50 percent) of PhilHealth’s total membership.** The number of principal members increased from 6.0 million in 2010 to 15.9 million in 2016, while the total number of beneficiaries in this group (principal members plus dependents) increased from 22.1 million to 46.3 million. While recognizing that the indigent group (which in 2016 are those targeted by the NHTS-PR/*Listahanan* and fully subsidized by the national government) and the sponsored group (which in 2016 are those subsidized at the discretion of local government and other entities for any reason they choose) are currently separate and different groups (see section 3), when looking at trends in coverage, we have to examine them together both because of (a) changes in the definition of the sponsored and indigent programs and, relatedly, (b) how the information on their membership is made available by PhilHealth.

**The trend data on the number of principal members in the indigent/sponsored programs reflects policy changes very clearly, especially the expansion of the government subsidized health insurance to the poor in 2011 and to the near-poor in 2014.** The number of principal members jumped from 6.0 million to 9.6 million in 2011 when the national government fully subsidized the poor (including 4.2 million members and their families) for the first time, and then jumped again in 2014 (to 15.6 million principal members, including 14.7 million fully subsidized members) following the subsidization of an even larger group of members using additional revenues from tobacco and alcohol excise revenues. Coverage under the indigent and sponsored program increased further to 16.3 million in 2015.<sup>iii</sup> Some of this increase may

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<sup>ii</sup> From 2013 onwards, however, the number of members and dependents reported by PhilHealth are actual members and dependents rather than assumptions based on dependency ratios derived from household surveys. See Annex 2.

<sup>iii</sup> It is not clear why the number of principal members fell to 15.9 million in 2016, but we speculate that it could be due to cleaning of the PhilHealth database to remove double-counting.

reflect newly covered people who were not previously covered by health insurance, but a significant share is people who were previously classified as PhilHealth dependents but now became classified as principal members following stricter application of the definition of a PhilHealth family (as previously discussed earlier in this section and in Annex 2).

### **Informal sector ('individually paying') members**

**Enrollment of informal sector group members, who pay their own premiums, has always been difficult to encourage and sustain but then plummeted following the Sin Tax Law when a number of (former) informal sector members became eligible for free health insurance through the indigent program.** Membership in the informal sector group increased from less than 3 million principal members in the mid-2000s to a little more than 5 million in 2013. However, this number then dropped back down to 3.4 million informal sector members in 2014, the year that the national government tripled enrollment in the indigent program. This suggests that many of those who were formerly in the informal sector group were near-poor and, thus, now eligible to receive free health insurance under the indigent program. By 2016, this group was made up of only 2.6 million principal members and 6.6 million members and dependents.

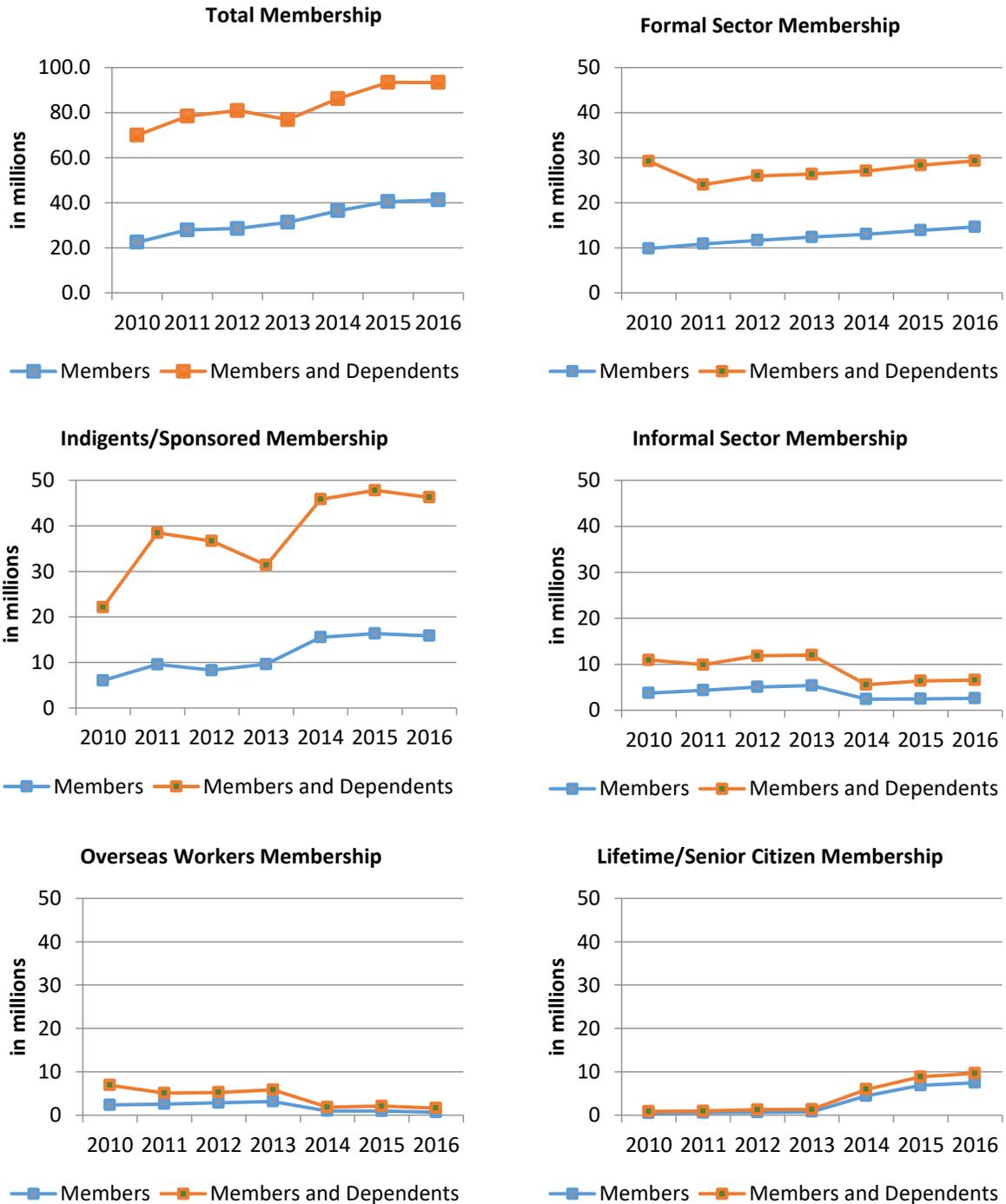
### **Overseas Filipino Workers**

**By 2013, OFW enrollment had reached 3.1 million principal members but fell to only 1.0 million in 2014, from where it continued to decline.** The drop in membership is attributed to the fact that, from 2014, PhilHealth premium payments were no longer required by the POEA before issuing the OECs.

### **Lifetime members and senior citizens**

**The number of people over the age of 60 with PhilHealth coverage has skyrocketed since 2014 when the senior citizen category, with membership subsidized by the Sin Tax Law, was created.** Figure 3.1 shows the change in the combined membership of the lifetime and senior citizens programs, which have in common the fact that the principal member is aged 60 or older. Between 2010 and 2013, when only the lifetime member program existed, the number of members (members and dependents) grew only slightly from 0.5 million (0.9 million) to 0.8 million (1.3 million). It then increased sharply to 4.4 million (5.9 million) in 2014 when the senior citizens' membership category was introduced (accounting for 4.3 million principal members and dependents), and climbed still further to 6.9 million (8.9 million) by 2015—a ninefold (sevenfold) increase in just two years. This category of membership continues to increase through 2016 to 7.5 million (9.7 million). The ratio of members to dependents within this category increased over time, mainly due to the introduction and subsequent growth of the senior citizens' category (with low dependency ratio of 1.2) between 2013 and 2015, while growth of the lifetime members' segment remained at a steady 0.1 principal members each year (with a more or less constant member-dependency ratio of 1.7).

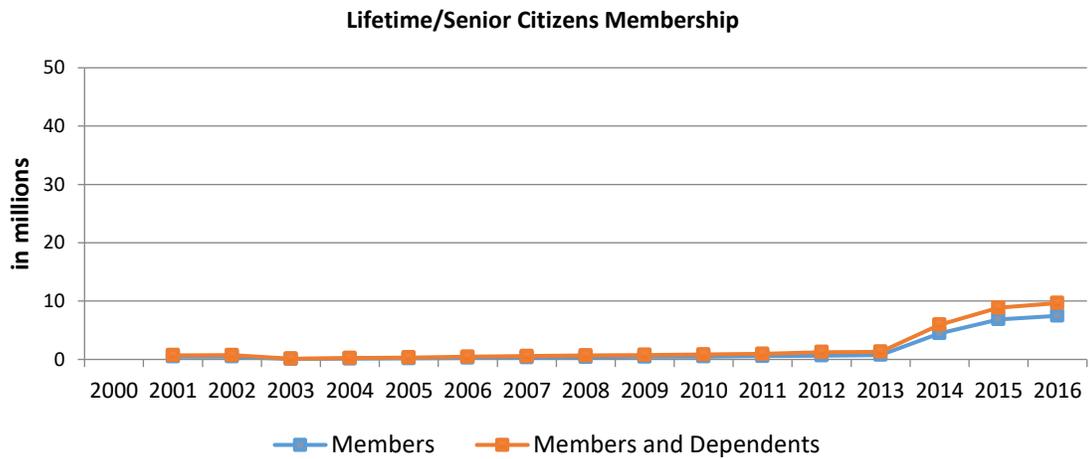
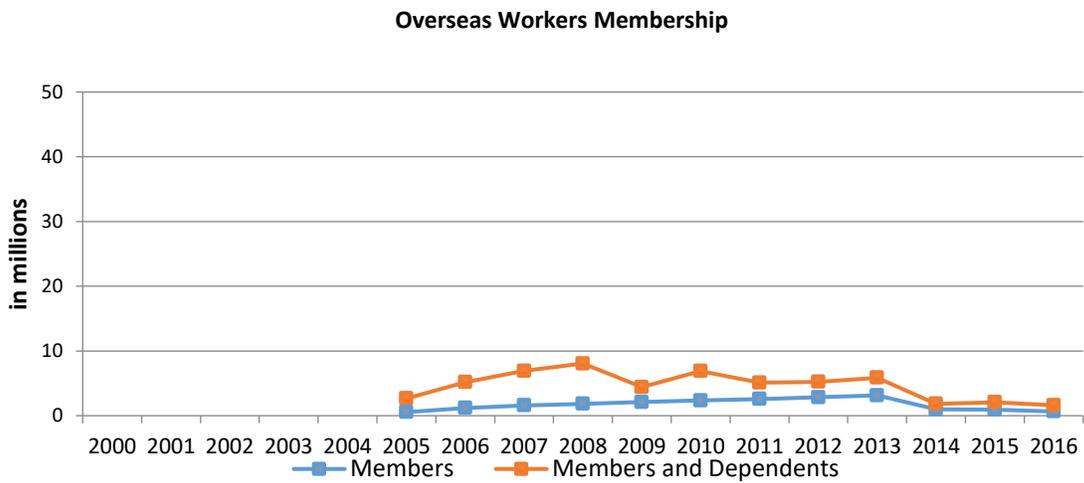
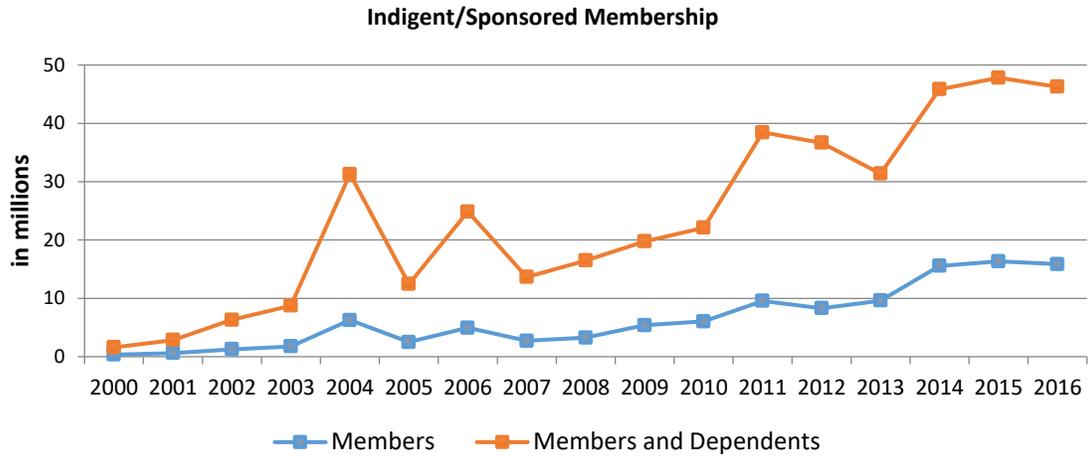
Figure 3.1. Expansion of PhilHealth membership, by member category, 2010–2016



Source: PhilHealth Stats and Charts, 2010 to 2016.

Figure 3.2. Expansion of PhilHealth membership, longer term trends, 2000–2016





Sources: 2000 to 2006 data - PhilHealth Corporate Planning Department; 2007 to 2016 data - PhilHealth Stats and Charts.

