Sustainability of the National Government Premium Subsidy for Indigents

Ida Marie T. Pantig

ABSTRACT
The national subsidy for indigent PhilHealth members identified under the National Household Targeting System for Poverty Reduction (NHTS-PR) began in 2011, in line with the government’s call for universal health coverage. The subsidy involved making all individuals identified under the NHTS-PR automatically eligible for PhilHealth benefits. In 2014, the subsidy reached PHP 35 billion, which was sourced from the sin tax revenue. According to literature, health service use is anticipated to improve along with health insurance coverage. This paper explores how this change will affect the funds coming from the sin tax revenue for premium subsidy and PhilHealth’s resources for benefit payment by examining administrative data and estimating loss ratios. The study finds that resources will be available for the premium subsidies but PhilHealth’s collection from premiums will be much lower than the benefit payments.

INTRODUCTION
The Aquino administration’s commitment to universal health coverage (UHC) as embodied in the Aquino Health Agenda (AHA) led to the enactment of measures such as the premium subsidy program. This program is for the poorest segments of the population—those who belong to the lowest two-fifths of the population based on income. This means automatic Sponsored Program membership for

1 Supervising Research Specialist, Philippine Institute for Development Studies. Email for correspondence: ipantig@mail.pids.gov.ph.
those identified as poor under the National Household Targeting System (NHTS) of the Department of Social Welfare and Development (DSWD).

The government’s provision of health insurance coverage addresses the financial risk protection thrust under the Universal Health Coverage-\textit{Kalusugang Pangkalahatan} agenda of the administration. This action slowly freed up the local government units (LGUs) from the responsibility of sponsoring the premiums of their poor constituents. With the new policy, the poor are either sponsored by the Department of Health (DOH) or the DSWD, depending on their type of membership.

New benefit packages and policies were also crafted by the Philippine Health Insurance Corporation (PhilHealth) with specific preference given to Sponsored Program members. Some of these are the “No Balance Billing (NBB)” policy, primary care benefit packages, and the zero-peso counterpart for Z Benefit packages, among others. This means that although the pool of premium contribution has increased, on the overall, along with guaranteed subsidy from the national government, the benefit payout will also expand because of the added membership, particularly among the poor, as well as of the new benefit packages ranging from the most basic outpatient care to extreme health expenditures for catastrophic illnesses.

The guaranteed premium sponsorship from the national government will be sourced from excise tax collections from tobacco. Republic Act (RA) 10351, or the restructured excise tax on alcohol and tobacco law, earmarks a share of incremental revenues to universal health care, including the National Health Insurance Program (NHIP). As of 2013, around PHP 60 billion has been collected and allotted for UHC, while premium subsidies stand at PHP 12 billion based on the estimated number of members.

With these facts, it will be imperative to look into the fiscal health of PhilHealth as well as the sustainability of the national government’s premium subsidy for the poor.

**OBJECTIVES**

This study’s overall objective is to look at the sustainability of the national government and PhilHealth’s premium subsidy program. It will delve into two aspects of financing: national government finances through sin tax collection and PhilHealth finances. Specifically, the study aims:

1) to compare the Indigent and Sponsored Programs with the other types of membership in PhilHealth;

2) to determine if the national government’s sources for subsidies will sufficiently cover the health spending in the medium term; and
3) to estimate whether the national government’s premium subsidy program will impact PhilHealth’s finances using loss ratios until 2023.

SIGNIFICANCE, SCOPE, AND LIMITATION OF THE STUDY
The share of the national government’s subsidy for premium payments has been growing year on year since 2012. This study will augment the currently limited literature on the impact of the national government’s move to subsidize the premiums of the poorest segment of the population according to the NHTS. It will be looking into the operational side of the impact, focusing on PhilHealth finances and the sin tax collection and allocation for health.

This study, however, will not involve any actuarial projections for PhilHealth and the national government. The projections made here are for purposes of identifying the general direction of the undertaking. In addition, this study will not look into any impact evaluation of the aforementioned. Currently, collecting accurate data appropriate for such analysis is already a challenge—a research gap that will have to be looked into and addressed separate from this study.

The initial intent of this study was to conduct separate studies on the impact of the national subsidy on Quintile 1 (Q1) and Quintile 2 (Q2) households based on the NHTS. However, interviews with PhilHealth revealed that both Q1 and Q2 households are provided with the same membership category, and Q2 households are also accorded membership under the Sponsored Program. This study, therefore, is a joint analysis on the impact of Q1 and Q2 premium subsidy on PhilHealth and the national government.

METHODOLOGY
Desk reviews, descriptive data analyses, and loss ratio estimation will be done. There will also be reviews done on related policies, annual reports, and administrative data and national surveys as well as literature on UHC and impact on health insurance.

Loss ratios will be used to assess whether PhilHealth will have sufficient finances to support the massive enrollment driven by the national government. This will be done using values from the PhilHealth Actuarial Valuation Report 2013 and various administrative and national survey data. Based on US regulations, a loss ratio of 85 percent is instituted so as to ensure that care is accorded and that administrative, overhead, and marketing expenses are also kept at bay (www.healthcare.gov).

LITERATURE REVIEW
The attainment of UHC was one of the factors that pushed the national government to subsidize the premiums of the poorest population. This was
first noted in the 2011 General Appropriations Act (GAA), at around the same
time the AHA was rolled out. The agenda had three thrusts: (1) financial risk
protection; (2) delivery of quality health service through improved health
facilities; and (3) the attainment of the Millennium Development Goals
(MDGs) (DOH Administrative Order 2010-0036). The focus of this study is
on the first thrust.

Financial risk protection, or the access to quality health services without
financial hardship (Saksena et al. 2014), pushed the government to provide
premium subsidies for the poor. Out-of-pocket payment for health has been
consistently on an uptrend: from PHP 2,267 in 2000 to PHP 7,035 in 2012 in nominal
terms on average (Ulep and Dela Cruz 2014), and health insurance coverage is
seen as one of the options to address this concern. In addition, the Healthcare
Financing Strategy 2010–2020 is firm on achieving universal membership,
which will eventually result to compelling advantages: more available resources
for the single-payer PhilHealth, which will strengthen its purchasing power in
price negotiations with private providers; cross-subsidization becomes a reality,
allowing PhilHealth to become a social safety net for risk of illness; and more
homogenous implementation arrangements are favored, which will reduce the
fragmentation among providers of basically the same services (DOH 2010).

PhilHealth adopted the National Household Targeting System for Poverty
Reduction (NHTS-PR) in 2012. The NHTS-PR is “an information management
system that identifies who and where the poor are nationwide.” It is a database
on poor families that is provided to national government agencies and other
social protection stakeholders and can be used as “reference in identifying
potential beneficiaries of social protection programs and services” (DSWD
2013). In 2013, the first year of adopting the NHTS-PR, 5.255 million poor
households were identified in the NHTS-PR. In 2014, there were 5.477 million
poor households recorded. However, according to PhilHealth, the number of
households in the NHTS-PR does not necessarily correspond to the number of
individuals eligible for PhilHealth membership. For example, one household
may have two to three eligible members (i.e., children of household heads aged
21 years and above). Because of this, the number of PhilHealth-sponsored
members provided with national government premium subsidy jumped from
4.9 million in 2011 to 14.7 million in 2014. For those identified as eligible
members, identification cards are provided so that they can avail of benefits in
various accredited health service providers.

The impact of health insurance provision on health-care use has had varying
results. Taiwan’s experience with their National Health Insurance on the provision
of new insurance has shown increased utilization in outpatient visits and hospital
admissions than before the universal health insurance was implemented (Shou-
Hsia and Tung-Liang 1997). This study further adds that the universal health insurance removed some barriers to health care for the newly insured.

The same impact was observed in Colombia, where the subsidized National Health Insurance Program increased the likelihood of health service use by nearly 5 percent. This trend was observed particularly among women, elderly, and urban residents (Trujillo et al. 2005). Improvement in skilled birth attendance and child immunization were also noted with Colombia’s insurance subsidy program (Giedion et al. 2007), and that financial burden for the poorest has dipped as compared to the non-insured (Ruiz et al. 2007). Meanwhile in Mexico, health insurance coverage reduced catastrophic expenses (Galarraga et al. 2008).

Adverse impacts were also noted. In its literature review, the International Initiative for Impact Evaluation learned that the use of health care improves when people are insured, although poor people do not always benefit (3ie 2009). Despite the success in Colombia, Wagstaff et al. (2007) noted that under China’s New Cooperative Medical Scheme, better access to tertiary health care was achieved and outpatient visits increased by 5 percent but this finding is not for the poorest fifth of the people. Similar results were observed by Gnaawali et al. (2008) and Jütting (2004), where health-care utilization has indeed increased, but the benefits were concentrated among the better off. Sood et al. (2014) observed similar results for India, where out-of-pocket health expenditure may have been reduced, but there was no significant increase in the use of covered services.

Any discussion of health insurance is always accompanied by the concepts of moral hazard and adverse selection. Moral hazard is the change in behavior that results from obtaining insurance against an adverse outcome which increases the likelihood of the outcome, while adverse selection is a phenomenon under which the uninformed side of a deal gets exactly the wrong people trading with it (Mankiw 2012). In addition, health insurance coverage has a “direct effect”, which lowers the effective price of medical care, hence inducing participants to use more care, all things remaining equal (Dong 2010).

PHILHEALTH AND ITS FINANCES

This section will cover the three objectives defined for this study. It will begin with a detailed description of how PhilHealth is operationalized, followed by a description of the sin tax collection and anticipated expenses for the premium subsidy, and the impact of coverage and benefit expansion on PhilHealth’s finances.

PhilHealth and its continuing pursuit for universal health coverage
The National Health Insurance Act, amended and implemented in 2013, highlights major changes in policies on universal coverage, financing, and membership. The
new law is explicitly for universal coverage—i.e., that “the [National Health Insurance Program] shall be compulsory in all provinces, cities and municipalities nationwide, notwithstanding the existence of LGU-based health insurance programs.” This is in contrast to the coverage provision in the old law, which states that PhilHealth “shall 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 healthcare services.”

Considerable leeway was accorded to LGUs with poor fiscal standing based on their income classification at that time. Fourth-, fifth- and sixth-class municipalities, according to the old law, were to be subsidized up to 90 percent for not over five years. There was an expectation that these poor LGUs will have improved fiscal performance, and that they will be able to pay 50 percent of the premium counterpart for their poor constituents. The law, therefore, implied a gradual shift of responsibility from the national government to the local government as the program went on.

**PhilHealth membership**

In the NHIP Act of 2013 (RA 10606), the detailed eligibility criteria, particularly for the poor and the vulnerable, cannot be left unnoticed. The old law had very general definition of the poor and membership categories, which made enrollment in a specific category a challenge. Particularly problematic was the case of informal sector members as they could be classified as either employed or indigent, depending on income. Such concerns, however, were addressed in the new law. The following section lists the membership categories and the sources of premium payment in the new act:

1) **Members in the formal economy** - workers with formal contracts and fixed terms of employment, including workers in the government and private sector. The premium contributions are equally shared by the employee and employer, rates of which are based on a prescribed salary bracket system instituted by PhilHealth.

2) **Members in the informal economy** - workers who are not covered by formal contracts or agreements and whose premium contributions are self-paid or subsidized by another individual. This category includes migrant workers, informal sector workers including street hawkers, market vendors, pedicab and tricycle drivers, small construction workers, and home-based industries and services, among others.

Self-earning individuals are also under this category. These are individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, including doctors, lawyers, engineers, artists, architects, businessmen, entrepreneurs, actors, actresses
and other performers, news correspondents, professional athletes, coaches, trainers, and other such individuals.

Another group under this category are Filipinos with dual citizenship, naturalized Filipino citizens, and citizens of other countries working and/or residing in the Philippines.

4) **Indigent members** - PhilHealth uses the NHTS-PR of the DSWD as the official list of indigents in the Philippines. An indigent is a person who has no visible means of income, or whose income is insufficient for the subsistence of his family. Premium contribution payments are sponsored by the national government through PhilHealth.

5) **Lifetime members** - To be qualified as lifetime member, a paid contribution of 12 months with PhilHealth and former Medicare programs of the Social Security System (SSS) and Government Service Insurance System (GSIS) should have been made. Uniformed personnel who have also contributed the same are considered in this category. The GSIS and SSS pensioners prior to March 4, 1995 are also under this category.

6) **Sponsored members** - Members are classified as sponsored if their premium payment contributions are being sponsored partly or fully by others. Specifically, those included in this segment are: (1) members of the informal economy from the lower income segment who do not qualify for full subsidy as identified by DSWD through NHTS but whose premium contribution is subsidized by the LGUs or through cost-sharing mechanisms between/among LGUs, and/or legislative sponsors, and/or other sponsors, and/or the member, including the national government; (2) orphans, abandoned, abused minors, out-of-school youths, street children, persons with disability, senior citizens, and battered women under the care of DSWD, premium contributions of which are paid by the DSWD; (3) barangay health workers, nutrition scholars, *barangay tanod*, and other barangay workers and volunteers, with their premiums sponsored by the LGUs concerned; and (4) women who are about to give birth but are not yet part of PhilHealth, premiums of which shall be borne by the national government or LGU, or LGUs or legislative sponsors.

As a general rule, beneficiaries of the principal members include:
- legitimate spouse who is not a member;
- children below the age of 21 years and are unmarried and unemployed;
- children over 21 years but suffering from disability that renders them totally dependent on the principal member for support;
- foster child;
- parents who are aged 60 years and above but are not members;
- Parents with permanent disability.
In the old law, the following classification are used: Private, Government, Individually Paying, Sponsored/Indigent, Lifetime, and Overseas Filipino Worker (OFW). In the new law, the Individually Paying and OFW members were reclassified under the Members in the Informal Economy category—the same category where household help/kasambahay, enterprise owners, family drivers, and organized groups fall under. These classifications can be broadly classified as “Nonpaying” and “Paying”:

- Nonpaying members: Indigent, Sponsored, and Lifetime members
- Paying members: Members in the formal and informal economy

Table 1 summarizes the changes in membership categories in PhilHealth based on the NHIP Act of 2013.

As observed in Figures 1 and 2, the growth in PhilHealth membership has been remarkable since 2000 until the first semester of 2014. The total number of PhilHealth members in 2000 was roughly at 8 million, which then ballooned to 32 million as of first half of 2014. PhilHealth claims a 79-percent coverage rate based on actual number of members and dependents and the 2013 projected population, or 76.9 million people (PhilHealth 2013). Spikes in PhilHealth membership were observed in 2004, 2009, 2011, and 2013. As to distribution (Figure 2), fluctuations in the number of sponsored and indigent members, decreasing trend in the share of members in the formal economy, and increasing trend in the share of Lifetime and Overseas Workers Program members are all observed.

As mentioned, premium payments are derived from different sources based on membership. Premium payment from paying members come from salary deductions and employer share of employees in government and private sectors, and out of pocket from the self-employed; Lifetime members are automatic members without having to pay for premium; Sponsored members get their premium sponsorship from the national or local government, national agencies, or other sponsoring

<table>
<thead>
<tr>
<th>“National Health Insurance Act of 1995” RA 7875</th>
<th>“National Health Insurance Act of 2013” RA 10606</th>
<th>Broad Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>Members in the Formal Economy</td>
<td>Paying</td>
</tr>
<tr>
<td>Government</td>
<td>Members in the Informal Economy</td>
<td></td>
</tr>
<tr>
<td>Individually Paying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overseas Filipino Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsored/Indigent</td>
<td>Indigent</td>
<td>Nonpaying</td>
</tr>
<tr>
<td>Lifetime</td>
<td>Sponsored</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime</td>
<td></td>
</tr>
</tbody>
</table>

Source: RA 7875 and RA 10606
Figure 1. Number of principal members in PhilHealth, 2000–2014

Note: Categories identified in 2014.
Source: PhilHealth data. Data for 2014 is for first semester, which excludes the number for individually paying members as membership categories were redefined.

Figure 2. Distribution of PhilHealth members by type of membership, 2000–2014

Note: Categories identified in 2014.
Source: PhilHealth data. Data for 2014 is for the first semester, which excludes the number for individually paying members as membership categories were redefined.

PhilHealth premium is at PHP 2,400 (previously at PHP 1,800) per member from July 2012. Figure 3 shows the total premium collection and benefit payout from 1997 to 2013. Notice the sudden increase in 2012, which can be attributed to the rise in the rate of premium payments implemented in that same year.
Expanding coverage: Providing health insurance to the poor

In a massive move to provide the poor with access to medical services, the national government included the premium subsidy of the population’s poorest segment in the 2012 GAA. This entails that all those identified as “poor” in the DSWD’s NHTS are provided with automatic membership to the NHIP. The poor are eligible to receive PhilHealth benefits as long as their names are in PhilHealth’s database. PhilHealth took the extra step by digging through the NHTS list and therefore expanding its coverage from 5.6 million in 2013 to 14 million in 2014. The basic household unit in the NHTS sample may consist of several families, members of which may be eligible for separate principal membership in PhilHealth.

In addition to the NHTS-PR list, PhilHealth also came up with measures to provide health insurance coverage to other vulnerable sectors, particularly the near poor and the elderly.

Point-of-care enrollment

The NHTS-PR list does not capture all members who are unable to pay for their medical expenses. PhilHealth implemented the Point-of-Care (POC) Enrollment Program in October 2013 to expand coverage to those identified by medical social workers as nonmembers and belonging to socioeconomic class C3 and D. According to PhilHealth Circular 0032 Series 2013, the premium is paid for by the government hospital, entitling such members to PhilHealth inpatient benefits as well as other types of benefits upon hospital admission and is valid for a year. As

---

2 Interview with Ms. Jenny Escueta, PhilHealth.
of August 2014, 73,107 beneficiaries have been enrolled nationwide through this system (PhilHealth 2014a). Under the same circular, upon DSWD’s validation, members enrolled through POC will be included in the NHTS list, and are thus covered and eligible to avail of PhilHealth benefits in the succeeding years.

**Automatic enrollment for senior citizens**

RA 10645 (or the Expanded Senior Citizens Act) was signed last November 2014. This law ensures that all individuals above the age of 60 years are automatically enrolled under the NHIP’s Sponsored Program. The previous Senior Citizens Act only provided for the automatic enrollment of the indigent elderly. With this scheme, local health insurance officers enroll those in the list of the Office of Senior Citizens Affairs of cities and municipalities. Premium payment will be sourced from the sin tax collection. According to PhilHealth Circular 33 of 2014, PhilHealth is tasked to post a billing statement to the Department of Budget and Management through the DOH on an annual basis for this purpose (PhilHealth 2014b). Reports indicate that in 2014, there were 6.1 million senior citizens eligible for membership, which translates to PHP 14.64 billion in premium contribution from senior citizen members.

** Preferential treatment for the poor and the vulnerable**

As enshrined in the Philippine Healthcare Financing Strategy, the protection of the most vulnerable groups is suggested. Further, according to the strategy, “equity must be ensured and financial risk protection guaranteed especially for the poor and marginalized Filipinos” (DOH 2010). Adopting this principle, PhilHealth crafted benefit packages with preferential treatment for the poor. Under the Sponsored Program, members can avail of the Z Benefit Package with zero-peso counterpart; the Sponsored Program, Organized Groups and Overseas Workers Program members are entitled to primary care benefit packages; and the NBB policy was instituted for sponsored members only. In addition, the POC enrollment and automatic enrollment for senior citizens support the government’s thrust to provide protection to the most vulnerable sectors of the population (Reyes 2014).

**PhilHealth finances: Premium collection and benefit payment**

With sudden preferential benefits and policies now given to the Sponsored Program, it will be worth looking at the perceived impact on PhilHealth’s major income source (premium collection) and major expenses item (benefit payment).

The primary source of income for PhilHealth are the premiums paid by members. Lifetime members, or the pensioners, are eligible for PhilHealth entitlements without having to pay for premiums. Other sources of income
include interest income, income from fees, fines and penalties, grants, rent, and dividend. On average, the share of premium collection to PhilHealth’s total income is 85 percent (PhilHealth Annual Reports, various years).

PhilHealth’s premium collection can be classified as either from private sources (regular paying members: members of the formal and informal economy), or from government sources (sponsored members: indigents identified under the NHTS-PR and other members sponsored by either national or local government units). Lifetime members, as earlier mentioned, do not pay for premium. The amount of premium collection from sponsored members has ballooned to PHP 36 billion in 2014—11 times its value in 2004 at PHP 3 billion (Figure 4). This constitutes 48 percent share in premium collection in 2014, compared to 17 percent a decade ago (Figure 5). This trend shows the increasing support from the government, both local and national, for the premium payment to PhilHealth for social health insurance.

Benefit payments have continued to increase as well, with the paying members getting majority of the share. In 2013, PHP 33.4 billion worth of benefits were provided to paying members, a two-fold increase from the PHP 14.2 billion worth of benefits in 2008 (Figure 6). Sponsored members are getting an increasing amount of benefit payment as well. The growth seemed stagnant up to 2008 but has rapidly grown since then. Benefit payment for sponsored members jumped from PHP 2 billion in 2008 to PHP 17.9 billion in 2013.

During the initial rollout of PhilHealth in 1998–2001, majority of PhilHealth’s benefit payment went to paying members, and less than 1 percent of the total went to the sponsored members (Figure 7). In 2013, 60 percent went to the paying members; 32 percent, to sponsored members; and 7 percent, to nonpaying lifetime members.

The natural rising trend in premium contributions is attributed to the increasing PhilHealth coverage rate, which was at 84 percent of the total population as of the first semester of 2014 (PhilHealth Stats and Charts 2014). The growth of benefit payment, on the other hand, is explained by the various benefit packages developed and being developed by PhilHealth for its members. These are briefly explained below.

**Benefit packages and enhancements:** Before the advent of case rates, benefit packages were continuously enhanced; the benefit ceiling was increased and made uniform across sectors; and benefit packages such as Outpatient Benefit Package for Sponsored Program and OFW Program, Maternity Care Package and Newborn Care Package, TB DOTS Package, Dialysis Package, Malaria and Cataract Packages, among others, were crafted. Special packages in response to health emergencies were also developed, such as SARS and AH1N1. The latest
Figure 4. Premium collection from paying and sponsored members, in PHP million, 1998–2014H1

Source: PhilHealth Stats and Charts

Figure 5. Share of premium collection from paying and sponsored members, 1998–2014H1

Source: PhilHealth Stats and Charts
Figure 6. Benefit payment for paying, sponsored, and lifetime members, in PHP million, 1998–2014H1

Source: PhilHealth Stats and Charts

Figure 7. Distribution of benefit payment among paying, sponsored, and lifetime members, 1998–2014H1

Source: PhilHealth Stats and Charts
addition to the list of packages from PhilHealth include the Primary Care Benefit 1 for sponsored members and Department of Education (DepED) personnel, and the Z Benefit package for select catastrophic cases.

**Case rate system:** To streamline the hospital reimbursement process and improve turnaround time in claims processing, PhilHealth shifted from the fee-for-service system to the case rate system in 2012. The first round of case rates included 11 medical and 12 surgical cases. In 2013, the All Case Rates policy was implemented for all claims. These rates will be the sole basis for reimbursement to health service providers and are identified based on fair rates for the cases (PhilHealth Circular 11 s. 2011). An initial study by the Philippine Institute for Development Studies (forthcoming) revealed that the average cost of claims has dropped with the case rates system compared to the older fee-for-service system.

**No Balance Billing policy:** Part of the benefits under the Sponsored Program is the NBB policy, which means that “no other fees should be charged to indigent patients and that all necessary services and complete quality care to attain the best possible health outcomes shall be provided to them” (RA 10606, or the National Health Insurance Act of 2013). The basis for this policy would be the case rates previously identified. Government hospitals, therefore, are responsible for ensuring that all the needed medicines and supplies are readily available in their facility to ensure the provision of “free” medical service. In instances where medicines and/or supplies are not available, the law mandates hospitals to reimburse the patient of their out-of-pocket expenditures. The Z Benefit package also applies the NBB policy to the sponsored members.

*Comparing premium collection and benefit payment*
Social health insurance works in such a way that the benefits of the less privileged are subsidized by paying members. An ideal scenario is when the premium collected from the paying members is used for the benefit payment of the sponsored members, and not the other way around. Figure 8 compares the premium collection and benefit payment for sponsored and paying members.

Also, the ideal situation is when the premium collection from sponsored members are expended for their benefit payment, or when premium collection is less than or equal to benefit payment. This trend is observed for all years except for 2012 and first semester of 2014. During these two years, the premium collection was greater than the benefit payment, which implied that there could have been more resources for sponsored members that were not spent for target beneficiaries, or were spent somewhere else or put into savings.
Thus, premium collection from paying members should be greater than or equal to the benefit payment. This ensures that there will be available resources in the event that additional funding will be required for the sponsored members as well as the lifetime members. For all years, the premium payment from paying members has exceeded the benefit payment, but it should be noted that the yearly increase in benefit payment is faster than the rise in premium collection.

**PhilHealth claims and utilization**

As a result of increasing coverage, the number of claims paid by PhilHealth has increased as well. From 1.8 million in 2003, the number of claims processed and paid ballooned to 5.8 million in 2013 (Figure 9). The increasing trend is consistent across membership types, with the fastest rate of increase from 2003 to 2013 seen among lifetime members at 56 percent, followed by individually paying members at 34 percent. Figure 10 shows the annual average growth rate of claims for each membership type. The distinctly higher rate of increase in nonpaying members compared to paying members should be noted. It shows that the uptake of benefit packages from sectors that should ideally utilize social health insurance has been improving.

Based on the share of number of claims paid to members, it can be seen that a shift to the nonpaying members has occurred in a span of 10 years. The larger growth rate indicates a shift toward the nonpaying members. When PhilHealth started in 1995, the initial years were dedicated to members in the employed sector. This was around the period when the GSIS and SSS were starting to
transitions to the NHIP. The Sponsored Program only commenced in 1997, and its rollout was gradual based on the membership in 2011, which stood at 9.5 million while national poverty estimates were at 19.7 percent of families in 2012, or roughly 19 million families (NSCB 2012).

It can be noticed that even if paying members take up 60 percent of the total number of claims paid, they would account for 62 percent of the total benefit payment for 2013. This can be explained by the average value of claims paid per sector.

Figure 11 presents the average value of paid claims (AVPC) by membership category. Note that the All Case Rates policy was implemented in 2012, and this
resulted in the comparable AVPC for all sectors. Despite this, the AVPC for the Sponsored Program was the lowest, next only to the OFW members.

**National government's premium sponsorship**

In 2011, the Philippine government committed to subsidize the premium of the poorest segment of the population through a line item allocation in the budget. With the use of the NHTS list of poor households, automatic eligibility was accorded to those identified in the list as poor. The national government guaranteed the premium subsidy with annual renewal, with funds coming from the sin taxes from alcohol and tobacco.

The list was first used in 2011. The national government agreed to a 100-percent subsidy in 2013. It is also important to note that the number of poor households eligible for membership has been growing since 2011. Table 2 summarizes the number of NHTS-identified poor eligible for PhilHealth benefits and the corresponding allocation from the national government.

The sudden increase in the number of members in 2014 was due to the data mining exercise that PhilHealth conducted. In previous years, the head of

---

**Table 2. Number of PhilHealth indigent members, dependents, and beneficiaries under the NHTS, and GAA allocation for premium payment subsidy, 2011–2014**

<table>
<thead>
<tr>
<th>Members</th>
<th>Dependents and Beneficiaries</th>
<th>General Appropriations Act Allocation (in PHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>4,910,022</td>
<td>21,355,378</td>
</tr>
<tr>
<td>2012</td>
<td>4,606,334</td>
<td>20,429,293</td>
</tr>
<tr>
<td>2013</td>
<td>5,157,389</td>
<td>21,011,928</td>
</tr>
<tr>
<td>2014</td>
<td>14,706,520</td>
<td>30,442,497</td>
</tr>
</tbody>
</table>

Source: PhilHealth Stats and Charts, various years; General Appropriations Act (GAA), various years
the basic sampling unit in the NHTS was considered as the principal member. However, PhilHealth noted that a single sampling unit in the NHTS may have more than one PhilHealth-eligible member. An example of this is the encoding (enrollment) of children of household heads who are over 21 years of age and employed. The list is reviewed every year, taking note of dependents who are eligible for principal membership, and vice versa. This leads to the fluctuating numbers in Indigent membership.

As committed by the national government, proceeds from the amended excise tax law are earmarked for health. Article 8, Subsection C of the law states that “after deducting the allocations under RA numbers 7171 and 8240, eighty percent (80%) of the remaining balance of the incremental revenue derived from this Act shall be allocated for the universal healthcare under the National Health Insurance Program, the attainment of MDGs and health awareness programs, and twenty percent (20%) shall be allocated nationwide, based on political and district subdivisions, for medical assistance and health enhancement facilities program, the annual requirements of which shall be determined by DOH.”

Table 3 presents the allocations for universal health care under the NHIP, attainment of MDGs, health awareness programs and health enhancement facilities program, and allocations according to RA 7171 and RA 8240, which provide guidelines on the allocation of incremental revenue to provinces producing Virginia tobacco and burley and native tobacco, respectively. These are compared with the actual excise tax collection from alcohol and tobacco.

The table proves that there is enough financing for health from the sin tax. Allocations based on the GAA for health are lower than the actual income from the sin tax. In 2014, even with the 180-percent increase in premium subsidy requirement for NHTS from 2013, an excess of PHP 57 billion is still expected from the earmarked taxes from alcohol and tobacco. As for the succeeding years, the enhanced methodology for the identification of NHTS poor, which should minimize inclusions and exclusions, and the recently passed law mandating the automatic entitlement for senior citizens would have an impact on the allocation for PhilHealth. The more people identified as eligible for subsidy, the better the finances of PhilHealth as these will translate to premium contribution for their coffers. Figure 12 presents these numbers graphically.

The amended sin tax law, on the other hand, includes provisions on increasing levies until 2017 for alcohol and tobacco products. However, the effect of this increase—i.e., whether the collections from alcohol and tobacco will rise or fall—is still undetermined. Despite this, the excesses posted from
<table>
<thead>
<tr>
<th>Year</th>
<th>NHTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>2009</td>
<td>2,073.2</td>
</tr>
<tr>
<td>2010</td>
<td>3,251.7</td>
</tr>
<tr>
<td>2011</td>
<td>3,000.0</td>
</tr>
<tr>
<td>2012</td>
<td>3,733.0</td>
</tr>
<tr>
<td>2013</td>
<td>12,612.3</td>
</tr>
<tr>
<td>2014</td>
<td>35,295.7</td>
</tr>
</tbody>
</table>

* Estimate based on growth rates from previous years.
Source: GAA, Budget of Expenditures and Sources of Financing, Bureau of Internal Revenue (BIR) Annual Reports, various years
latest years 2009–2014 reveal that the earmarked funds should be made available for the sector.

**MEDICAL COST ESTIMATION: IS PHILHEALTH FINANCIALLY READY?**

The spike in membership under the Sponsored Program has pushed PhilHealth to further improve its service provision to the targeted members. In recent years, various benefit packages have been crafted—and both breadth and depth of these benefit packages have been expanded—to address the varying needs of the poor. Can PhilHealth afford such developments both in terms of membership and service delivery?

Based on PhilHealth’s Actuarial Valuation Report done in 2013, under a status quo scenario, PhilHealth’s “projected expense would consistently be higher than the projected income for the next ten (10) years. Hence, the net effect on the fund resulted to projected fund life of seven (7) years or until year 2020.” Such status quo scenario, based on the report, has the following assumptions:

- Philippine population projection as of May 2010 is at an annual growth rate of 1.9 percent;
- Annual salary increase for the employed sector is at 4 percent;
- Contribution rate would remain at 2.5 percent under the status quo scenario and in another scenario, at 3.0 percent;
- Salary floor is at PHP 8,000 beginning calendar year (CY) 2014 onward for all scenarios;
• Salary cap/ceiling is pegged at PHP 35,000 under the status quo scenario and other variations for other scenarios;
• The employer’s share for the government sector would still be lower than the required premium share per salary base;
• The annual premium for the members under Individually Paying Program, OFW Program, and Sponsored Program would be the same at PHP 2,400 beginning CY 2014 onward;
• Annual utilization rate for inpatient claims increases at 0.5 percent;
• Allowance for benefit increases at 10 percent for CYs 2014, 2017, and 2020;
• Full implementation of the following benefits:
  o All Case Rates beginning January 2014 onward for all sectors
  o Initial 15 catastrophic packages or Z Benefits for all sectors
  o Initial seven Z packages in 2013 then additional eight Z packages in 2014
  o Primary Care Benefit 1 (PCB1) at PHP 500 per family payment rate for Sponsored Program
  o PCB1 at PHP 500 per family payment rate for DepED (teachers)
• Pilot implementation of PCB2 at PHP 400 per family payment rate by CY 2014 and nationwide implementation beginning CY 2015 for the Sponsored Program
• No capital expenditures were considered in the calculation of interest income;
• Operating expense is based on 5 percent each of previous year’s collection, benefit payment, and interest income for CYs 2014–2018. Rates will decrease to 4 percent of previous year’s collection and benefit from CY 2019 onward.

Projected fund balances for PhilHealth for years 2012–2023 are presented in Table 4.

Using these actuarial numbers, PhilHealth’s loss ratio will be estimated using different scenarios. Loss ratios, also called medical cost ratio, indicate the portion of the premium income that is paid out in claims (losses). According to Margus (2007), loss ratios are based on aggregates and are easy to calculate. He further qualified that the medical cost ratio is a good tool for analysis based on the following criteria: ease of use (i.e., easy to calculate using premiums, claims, and reserves), drill-down capability (i.e., it should be possible to get loss ratios for various underwriting and occupation classes, geographical regions, and markets), and consistency (i.e., keeping experience exactly assumed, the loss ratio should remain constant throughout the life of the business).

For the purpose of this study, the loss ratios will be used as indicators of PhilHealth’s financial status. Ratios above 100 percent mean that premium
Table 4. Ten-year projection, in PHP billion (status quo scenario)

<table>
<thead>
<tr>
<th>Year</th>
<th>Membership</th>
<th>Income</th>
<th>Expense</th>
<th>Fund Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Covered Principal Members (millions)</td>
<td>Covered Beneficiaries (millions)</td>
<td>Collection</td>
<td>Other Income</td>
</tr>
<tr>
<td>2012*</td>
<td>22.80</td>
<td>63.57</td>
<td>47.34</td>
<td>6.78</td>
</tr>
<tr>
<td>2013*</td>
<td>25.83</td>
<td>65.47</td>
<td>55.36</td>
<td>6.70</td>
</tr>
<tr>
<td>2014</td>
<td>31.23</td>
<td>79.89</td>
<td>76.47</td>
<td>6.58</td>
</tr>
<tr>
<td>2015</td>
<td>31.83</td>
<td>81.41</td>
<td>78.41</td>
<td>5.78</td>
</tr>
<tr>
<td>2016</td>
<td>32.43</td>
<td>82.96</td>
<td>80.36</td>
<td>4.93</td>
</tr>
<tr>
<td>2017</td>
<td>33.05</td>
<td>84.53</td>
<td>82.43</td>
<td>4.05</td>
</tr>
<tr>
<td>2018</td>
<td>33.67</td>
<td>86.14</td>
<td>84.65</td>
<td>2.73</td>
</tr>
<tr>
<td>2019</td>
<td>34.31</td>
<td>87.78</td>
<td>85.90</td>
<td>1.44</td>
</tr>
<tr>
<td>2020</td>
<td>34.97</td>
<td>89.44</td>
<td>89.30</td>
<td>0.11</td>
</tr>
<tr>
<td>2021</td>
<td>35.63</td>
<td>91.14</td>
<td>91.86</td>
<td>0.00</td>
</tr>
<tr>
<td>2022</td>
<td>36.31</td>
<td>92.87</td>
<td>94.26</td>
<td>0.00</td>
</tr>
<tr>
<td>2023</td>
<td>37.00</td>
<td>94.64</td>
<td>96.85</td>
<td>0.00</td>
</tr>
</tbody>
</table>

* Actual figures
Source: PhilHealth Actuarial Valuation Report 2013
collection (or total income) is not enough to cover for the benefit payment (or total expenses). Based on the results of PhilHealth’s actuarial valuation report for 2013, Figure 13 presents the loss ratio for three different scenarios:

1 – At status quo, the Benefit-Premium loss ratio
2 – At status quo, the Total Expenses-Total Income loss ratio
3 – Best scenario projection (highest collection at full implementation of benefit packages)

Salary floor for basis of premium contribution is at PHP 8,000 from CY 2017, while collection efficiency values in Table 5 are used as reference.

The loss ratios at status quo (scenarios 1 and 2) indicate that with the expansion in coverage due to the massive enrollment under the Sponsored Program and the full implementation of pipeline projects such as PCB1 and PCB2, Z Benefits, and shift to All Case Rates, PhilHealth will not have resources to fund its benefit provisions (scenario 1) and operations (scenario 2). However,

Figure 13. Estimates of loss ratios using PhilHealth projections

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>64</td>
<td>70</td>
<td>80</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>81</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2013: Actual figures
Source of data: PhilHealth Valuation Report 2013

Table 5. Improved collection efficiency (in percent)

* with PCB1 and PCB2 for all sectors beginning CY 2015
Source: PhilHealth Actuarial Valuation Report 2013
if reforms in the employed sector collection and salary caps were implemented, PhilHealth will be able to recover its losses after 2016 (scenario 3).

Based on scenario 3, it can be observed from Figure 13 that the collection efficiency by 2017 has significantly brought down the loss ratio to 86 percent in 2017, the same year when collection efficiency for employees from both government and private sectors reaches 100 percent. This is possible even with the full implementation of PCB1 and PCB2.

To expand on PhilHealth’s projections, four scenarios are simulated for this study. These projections take into consideration the government’s objective of providing financial protection to the population, particularly the poor and the vulnerable. The four scenarios will be focused on the expansion of benefit payments due to an increase in utilization and improvement in the support value.

“Benefit Blast” scenarios A-D

Scenario A: Increase in utilization of inpatient benefits
According to the Annual Poverty Indicators Survey (APIS), of those reported to be ill in 2011, only 2.4 percent received any form of payment from PhilHealth. In 2012–2013, the share of inpatient, ambulatory, and MDG claims was at 93 percent of total claims; the rest were outpatient benefit claims. Given these details, the loss ratio with an increase in inpatient benefit utilization from 2.4 percent to 3.0 percent will be estimated.

Scenario B: Improvement in premium collection with enrollment of senior citizens
The enrollment of 6.1 million elderly members under PhilHealth translates to an additional PHP 14.6 million worth of premium contributions. The impact of this cash flow on benefit delivery will be estimated in this scenario. Due to the limited utilization data on the elderly, this will not be included in this particular simulation. Similar to Scenario A, projections on any increase in inpatient benefit utilization will be estimated.

Scenario C: Improvement in support value for sponsored members
The support value for Quintiles 1 and 2 households in the APIS 2011 stands at 51.88 percent. In 2013, PhilHealth reported a support value of 54 percent based on the average value of paid claims and average cost of confinement. As a social health insurance, the maximum support value is expected from the corporation. This scenario estimates the loss ratios if the support value increases from 52 percent to 70 percent.

Scenario D: Improvement in support value for all members
A full support value for all members is the ultimate goal of any social health
insurance. For this scenario, the loss ratio if the support value is improved from 41.1 percent of the 2011 APIS to 50 percent for all PhilHealth members will be estimated.

Figure 14 presents the loss ratios for the “Benefit Blast” scenarios A-D.

Based on Figure 14, both the status quo and benefit blast scenarios are consistent with a spike in the loss ratio for 2015, but has gone down in 2017.

This simulation exercise shows the impact of the aggressive expansion of PhilHealth both in terms of coverage and benefit delivery. Note that this is also the result of PhilHealth’s actuarial valuation report. The loss ratio estimates, however, focused on the policies directly affecting the sponsored members.

SUMMARY OF FINDINGS

1) Through the years of PhilHealth’s operations, there has been a shift in the composition of members. During its first year of implementation, only 5 percent of the members were indigents. This improved to 12 percent in 2000, and was roughly at 30 percent in 2013. Despite this, the actual number of employed members has been on an increasing trend as well. One of the observations is that a rising share of premium contribution going into PhilHealth’s funds comes from the government sector, both local and national.

2) The analysis of the distribution of benefit payment based on source also shows a shift. Prior to 2011, majority of premium contribution was collected from the paying members (i.e., those employed in government

![Figure 14. Loss ratio estimates for various scenarios](source_of_basic_data)
and private sectors as well as the individually paying/self-employed). With the entry of the government subsidy program, the premiums collected for the sponsored members rose to almost the same level as the paying members—at 48 percent and 52 percent, respectively. As for PhilHealth’s benefits payments in terms of actual amounts, paying members account for 60 percent of the total in 2013. There is also a need to monitor the benefit payments for lifetime members as it has been increasing at higher growth rates compared to those of other sectors.

3) The utilization of PhilHealth benefits as attested by the number of claims has been increasing for both paying and nonpaying members. In particular, claims under the Sponsored Program rose from 0.93 million in 2012 to 1.5 million by 2013. This may indicate an improvement in the poor’s health-seeking behavior due to their health insurance coverage. The increase in the number of claims from paying members, on the other hand, is not as stark—3.4 million in 2012 to 3.5 million in 2013. Numbers indicate that the paying members, who took up 62 percent of the total number of claims in 2013, consumed 60 percent of the total benefit payments for the same year.

4) Funds for the subsidies vis-à-vis premium subsidy requirement will be made available based on Department of Finance estimates of sin tax collection and allocation for earmarked funds. The law is explicit on the earmarking of funds, which will ensure its availability. The excesses, however, are also noted, including the fact that a certain portion of the sin tax collections is not reallocated elsewhere due to the rigidity of the law.

5) With the host of programs and packages for indigents, the rising cost of health service provision should be a cause for alarm in terms of the sustainability of PhilHealth programs. In-house actuarial reports have already noted this, given the different scenarios they identified (i.e., impact of collection efficiency improvement on their income; impact of new benefit packages on their expenditures). In PhilHealth’s report, losses were projected even at their “best case” scenario.

6) The loss ratios estimated also reveal financial strain on PhilHealth. These scenarios considered in studies were based on improvements in premium collection with the continuous effort to enroll the most number of poor and vulnerable, as well as a “benefit blast” to the sponsored members and improved support value to all members. Clearly, an increase in inpatient utilization rate will lead to loss ratios of not less than 109 percent, even with additional premiums from the enrollment of senior citizens. Improving support value, one of the main indicators for financial risk protection, to 70 percent even just for the Sponsored Program will result in loss ratios
of at least 99 percent. Based on the scenarios, the additional premiums collected through improved collection efficiency and readjusted salary bases will have a positive impact on PhilHealth’s finances, but the near-100 percent loss ratio is still not a safe state to be at.

CONCLUSION AND RECOMMENDATIONS
PhilHealth has done a great job in expanding health insurance coverage since the institution of the AHA in 2010. Although various programs have been instituted by the previous administration, membership and application for eligibility have become more accessible to the most vulnerable sectors in recent years. Programs such as Point-of-Care Enrollment, NHTS-PR list, and senior citizens’ automatic eligibility opened PhilHealth benefits to each corresponding target population.

Demand for health care has likewise risen. The number of claims recorded under the Sponsored Program has increased from year 2011, which was the start of the premium subsidy from the national government. PhilHealth reimbursements have reached an all-time high of PHP 322 billion in 2013, 27 percent of which is for the Sponsored Program. Caution, however, should be used when interpreting the higher number of claims as this number does not represent the actual number of patients who availed of the benefit packages.

The Bureau of Internal Revenue’s (BIR) sin tax collection has been consistently greater than what was projected in 2011, when the law was still being deliberated. In 2014, the national government needed to raise PHP 35 billion for the premium subsidy; BIR, on the other hand, collected PHP 105 billion in 2013. Unlike the huge spike in subsidy requirement from PHP 12 billion in 2013 to PHP 35 billion in 2014, the requirement in the next years is not expected to increase substantially, except for the additional PHP 14.6 billion requirement for the automatic enrollment of senior citizens. This means that despite expanding coverage, the collection from sin taxes will still be enough to provide for this earmarked fund.

The massive expansion of PhilHealth coverage using the most convenient and practical ways will eventually result to higher utilization and will mean higher reimbursement costs to PhilHealth. As illustrated above, such expansion in benefit package use will lead to loss ratios above 100 percent, implying deficits for the corporation. Although measures to increase their income such as collection efficiency improvement and expanded enrollment of the poor and vulnerable sectors, deficits will still be inevitable.

Given the foregoing, this study proposes the following:
Ensure ready access to sin tax collection for additional benefit package requirements through legislation. PhilHealth will eventually require additional financing due to the increase in coverage and benefit utilization. To ensure the
continuous flow of resources to the corporation, provisions in the sin tax law should ensure that PhilHealth has emergency access to these funds during instances of deficit.

**Adjust premium contribution based on benefit packages to be crafted.** It seems that PhilHealth is supporting its benefits delivery through additional sources of premium collection. The automatic enrollment of the poor and senior citizens was considered as additional revenue to fund the newly developed Primary Care Benefit packages. That is, additional sponsored members would entail automatic budget appropriation for PhilHealth as the government is mandated to fund their premiums. Sources of funding should be developed first before new benefit packages are developed.

**Lay out a medium-term plan for the national subsidy program.** The national government subsidy program started in 2011 and has been ongoing without definite plans. Even if the source of funds might be sustainable, the changing health-seeking behavior of the population must first be understood so as to be able to apply the suitable changes in the benefit packages that PhilHealth is crafting. This, in turn, will have an impact on the finances of PhilHealth. Studies on the utilization patterns of members of the Sponsored Program can be conducted to determine if they are indeed utilizing the benefits and if they are, if these are being utilized appropriately.

**REFERENCES**


