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Who benefits from the government health insurance subsidy for the poor?

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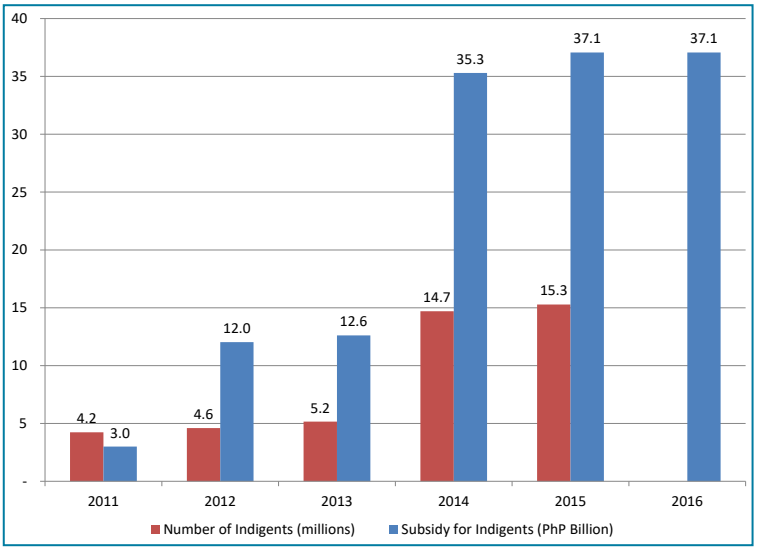
In 1995, the Philippine government instituted the National Health Insurance Program to ensure universal health coverage for Filipinos. Guided by the principles of equity and solidarity, it aims to give priority and facilitate the delivery of health care to the poor.

To identify the program's beneficiaries, the government adopted the National Household Targeting System for Poverty Reduction (NHTS-PR) in 2010. The Philippine Health Insurance Corporation (PhilHealth) also utilized the said system for the enrollment of indigents to the Sponsored Program, pursuant to PhilHealth Board Resolution No. 1417, series of 2010. NHTS-PR identified close to 5.3 million poor families out of 10.9 million assessed in 2011. Of this figure, PhilHealth enrolled 4.2 million or 80 percent in its Indigent Program. In 2015, indigent membership had risen to 15.3 million, with its share in the total membership increasing from 15 percent in 2011 to 38 percent within five years (Figures 1 and 2).

A national government subsidy financed by incremental revenues from the revised excise taxes on cigarettes, alcohol, and tobacco funds the indigent enrollment/premium contribution. The general appropriation for the health insurance premium subsidy had risen from PHP 3 billion in 2011 to PHP 37.1 billion in 2015 as reflected in the General Appropriations Act (Figure 1). It now comprises over a third of the national health insurance fund surpassing the share of payroll contributions from private employees.

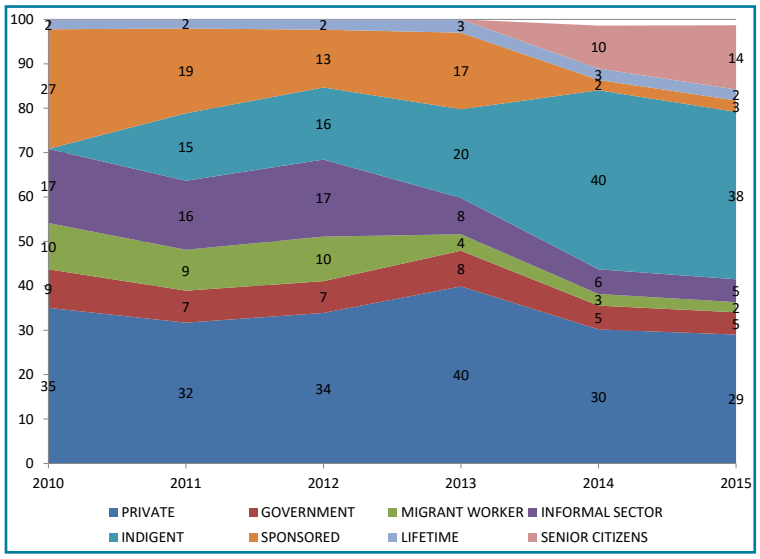
This *Policy Note* explains how the said government subsidy benefits not only the poor who are its target beneficiaries but also other groups and institutions, such as the informal sector, senior citizens, the nonpoor, and the near-poor sponsored members, hospitals, and even PhilHealth itself.

Figure 1. PhilHealth indigent members and subsidy for health insurance premium, 2011–2016



Sources: Department of Budget and Management (various years); Philippine Health Insurance Corporation (PhilHealth), various years

Figure 2. Distribution of Philhealth membership by category, 2010–2015



Source: PhilHealth (various years)

The indigents and sponsored members

Premium contributions for indigents had risen from over PHP 2.2 billion in 2011 to close to PHP 36.3 billion in 2015. In proportion to total contributions, premium contributions for indigents had risen from 6 percent in 2011 to 36 percent in 2015. Meanwhile, PhilHealth benefit payments for indigents had risen from PHP 6.1 billion in 2011 to over PHP 25 billion in 2015. In proportion to their premium contributions, the benefit payments had decreased from 280 percent in 2011 to 70 percent in 2015. In proportion to the total subsidy, the payments fluctuated but dwindled from 200 percent in 2011 to 68 percent in 2015.

The number of combined PhilHealth benefit claims for indigents and sponsored members had increased from over 758,000 in 2011 to over 2.7 million in 2015. Their share in total claims had likewise increased from 19 percent to 33 percent during the same period. However, in terms of membership, they had been among the lowest, increasing only from 8 percent in 2011 to 17 percent in 2015 (Table 1).

Meanwhile, benefit payments for indigents and sponsored members had increased from PHP 7.3 billion in 2011 to almost PHP 32.6 billion in 2015. Their share in total benefit payments had risen from 21 percent in 2011 to 34 percent in 2015. However, in proportion to their contributions, their benefits had decreased from 141 percent in 2011 to 83 percent in 2015 (Table 2).

The nonpoor

The NHTS-PR identified close to 5.3 million poor households in 2011 (DSWD n.d). This is

Table 1. Claims-membership ratio, 2010–2015

Membership Category	2010	2011	2012	2013	2014	2015
Government	31	33	37	36	38	33
Private	15	14	15	15	15	13
Informal sector	18	19	24	60	86	84
Migrant workers	5	5	5	18	20	19
Indigent and sponsored	12	8	11	17	12	17
Lifetime and senior citizen	44	52	57	56	10	21

Source: PhilHealth (n.d.)

Table 2. Benefit-contribution ratio by member, 2010–2015

Membership Category	2010	2011	2012	2013	2014	2015
Government	0.73	0.74	0.79	0.74	0.81	0.74
Private	0.58	0.59	0.60	0.55	0.63	0.57
Informal sector	2.66	2.83	3.90	3.32	3.81	3.64
Migrant workers	1.13	1.47	1.44	1.33	0.49	1.02
Indigent and sponsored	1.33	1.41	0.94	1.05	0.68	0.83
Lifetime and senior citizen					2.65	1.48

Source: Philhealth (n.d.)

26 percent more than the closest poverty data from the Philippine Statistics Authority (PSA 2015a) that indicated close to 4.2 million poor families in 2012. PhilHealth enrolled 4.2 million indigent members in 2011 using the NHTS-PR list, but this may be subject to both the exclusion of some poor and the inclusion of some nonpoor families. Assuming a 26 percent overcoverage rate, premium contributions of the PhilHealth leaked to 1.1 million nonpoor households over an estimated 3.3 million actual poor families. With an average premium contribution of PHP 500 in 2011, the leakage translates to PHP 550 million or 15 percent of the premium subsidy intended for indigents.

In 2015, the NHTS-PR identified 5.1 million poor households out of 15.1 million households assessed while the PSA (2015b) only identified 3.7 million poor families. Therefore, the number of NHTS-PR poor households was almost 38 percent more than the actual number of poor families. PhilHealth also identified several poor families in the same households and registered close to 15.3 million indigent members. This means more than one PhilHealth member may be from the same household. The relevant reference then becomes the poverty incidence among the population. The PSA (2015b) estimated the poverty incidence for the population at 21.6 percent in 2015.[1] Applying this proportion to the labor force of 41.2 million yields 8.9 million poor in the labor force. This makes the indigent PhilHealth members 72 percent more than the poor labor force, which means 6.4 million nonpoor are being subsidized by PhilHealth. With a PHP 2,400 subsidy per member since 2014, this translates to PHP 15.36 billion in leakages or 41 percent of the government subsidy. Clearly, leakages of the PhilHealth premium subsidy for the poor to the nonpoor had increased from PHP 550 million in 2011 to over PHP 15 billion in 2015.

While there were already leakages in benefits intended for the poor, underprovision of

[1] Poverty incidence is the "proportion of families/individuals with per capita income/expenditure less than the per capita poverty threshold to the total number of families/individuals" (NSCB 2007).

benefits to the poor can also be noted. In 2011, PhilHealth adopted the No Balance Billing (NBB) policy which frees indigents from fees in excess of the prescribed case rates for common medical and surgical services. In 2012, there were almost 932,000 indigent and sponsored member claims, 55 percent of which were case-based payments while the remaining were fee-for-service payments. Of the case-based payments, 62 percent were NBB. This translates to only 34 percent of indigent and sponsored member claims billed without balance, leaving almost two-thirds of them entailing out-of-pocket spending. With PhilHealth providing a support value of 55 percent to the poor, 45 percent of the cost of health services that the poor avail of are still incurred as out-of-pocket spending. In 2015, 51 percent of over 2.7 million indigent and sponsored member claims were NBB. However, it is not clear what the support value was.

The near-poor sponsored members

Pursuant to PhilHealth Circular No. 32, series of 2013, PhilHealth established the Point-of-Care Enrollment Program to provide health insurance coverage to supposedly poor nonmember or uncovered patients, those with special circumstances, or members of particular sectors upon admission to a government health facility in 2013. Among the beneficiaries of the program are patients who are by definition not poor but may be considered near-poor, whose household monthly income per capita is not more than 40 percent higher than the regional per capita poverty threshold. In one hospital studied, the near-poor, point-of-care enrollees are 270 percent higher than the poor enrollees. Moreover, the sponsored members are only assessed through interviews, without evidence of their economic status. While the hospital shoulders the premium contributions of these hospital-sponsored PhilHealth members, the actual benefit payment comes from cross-subsidies from the indigents, government sector, and private sector employees.

With its huge share, the premium subsidy for indigents is effectively subsidizing health-care service for other members particularly the informal sector and senior citizens.

The informal sector

The share of benefit claims of the informal sector had generally increased from 2010 to 2015. While this share has been lower than that for indigents and sponsored members in recent years, in proportion to membership, the benefit claims of the informal sector tended to be higher. They had increased from 18 percent of sector membership in 2010 to 86 percent in 2014.

Premium contributions from the informal sector had risen from only PHP 2 billion in 2011 to PHP 5 billion in 2015. Meanwhile, benefit payments for the sector had risen from PHP 5.8 billion in 2011 to PHP 18.5 billion in 2015, with its share having increased from 14 percent in 2010 to 25 percent in 2014. Although this share is lower than that of

indigents and sponsored members, benefit payments as a proportion of contributions are much higher for the informal sector, with the benefit-to-contribution ratio rising from 2.7 to 3.6 times. Specifically, benefit payments to the informal sector were 270 percent its premium contributions in 2010. This figure went up to 390 percent before it declined to 360 percent in 2015. The larger benefits of the informal sector relative to its contributions considering the voluntary nature of its participation indicate adverse selection, where the sick tend to join more than the healthy.

Consequently, cross-subsidies to the informal sector had increased from PHP 3.8 billion in 2011 to PHP 13.5 billion in 2015. They constituted 49 percent of total cross-subsidies in 2011 and up to 80 percent in 2014. Meanwhile, cross-subsidies from indigents comprised 7 percent of total in 2012, increasing to 69 percent in 2014 but decreasing to 33 percent in 2015. Cross-subsidies from indigents to the informal sector were estimated at PHP 533 million in 2012, PHP 9.7 billion in 2014, and PHP 4.5 billion in 2015. These comprised 4 percent of the subsidy for the poor in 2012, 28 percent in 2014, and 12 percent in 2015.

The informal sector may be considered as the near-poor vulnerable sector of society. While they may not be eligible for indigent subsidy, their economic activity renders them vulnerable to health risks while their unstable income may not allow them to pay for hospital services. These compel them to voluntarily enroll in PhilHealth to finance the likely occurrence of illness. This suggests that the Indigent and Sponsored Programs may have to consider members of the informal sector.

Senior citizens

Premium contributions of lifetime members and senior citizens had increased from only PHP 686 million to PHP 13 billion in 2015. Likewise, benefit payments had increased from PHP 2.3 billion in 2011 to PHP 19.3 billion in 2015. However, benefit claims to membership ratios for lifetime members were much larger than those for indigents and sponsored members except in 2014 with the mandatory coverage of senior citizens. Notwithstanding the increase in membership, the benefit-contribution ratios for lifetime members and senior citizens were higher than those for indigent and sponsored members. Although benefit-to-contribution ratio had decreased from 3.3 in 2011 to 1.5 in 2015, lifetime members and senior citizens continue to be cross-subsidized by government and private employees and indigents. These cross-subsidies amounted to almost PHP 1.4 billion in 2011 and increased to almost PHP 6.3 billion in 2015. Estimated cross-subsidies from indigents amounted to PHP 157 million in 2012, almost PHP 2.4 billion in 2014, and almost PHP 2.1 billion in 2015. These constitute 1 percent of the subsidy for the poor in 2012, 7 percent in 2014, and 6 percent in 2015.

Hospitals

The National Health Insurance Act allows fee-for-service and capitation as provider

payment mechanisms, subject to the global budget. However, PhilHealth shifted from fee-for-service to case-based payment in 2013, following PhilHealth Circular No. 31. The said circular defines case-based payment as a "payment method that reimburses to health-care providers a predetermined fixed rate for each treated case or disease" covering professional fees and hospital charges (PhilHealth 2013, p. 3). The case-based payment system allowed the implementation of the NBB policy for indigents and sponsored members, including point-of-care enrollees. While the hospital shoulders charges over the case rate, charges less than the case rate yield hospital income. This means that hospitals earn as income fixed case-rate reimbursements over the actual cost of services.

The case-based payment scheme is said to have facilitated hospital reimbursements but shifted administrative burden to hospitals. Given the fixed case rates, the payment scheme is also said to have induced some doctors to upcode tests under cases that pay higher rates (Dalmacion et al. 2014). Evidence also suggests the tendency to increase admission and reduce confinement period with the violation of the single period confinement being the number one reason for denial of claims of the studied hospital. Moreover, the provision for multiple medical conditions in the case rate system may induce unnecessary second cases because while second cases are reimbursable at only half the case rate, the share of professional fee remains intact. Finally, while case-based payments allow for efficiency gains for hospitals, it is said to be questioned by the Commission on Audit. One suggestion to address the issue is payment of the case rate or the actual charge, whichever is smaller.

PhilHealth

Established in 1995, PhilHealth manages the National Health Insurance Fund, including member contributions and earmarked appropriations from the national government particularly from the revised excise taxes on cigarettes, alcohol, and tobacco. The General Appropriations Act provides for the allotment of a portion of the subsidy for the health insurance premium of indigents for administration cost, whose share had decreased from 10 percent in 2012 to 7 percent in 2015. Deducting premium contributions from the subsidy gives an estimate of administration cost that accrues to PhilHealth. This administration cost had decreased from 26 percent (PHP 1.27 billion) in 2011 to 2 percent (PHP 785 billion) of the subsidy in 2015. In 2015, total contributions amounted to PHP 99.6 billion while benefit expenses totaled PHP 97 billion. The share of indigents to the excess of the contributions over the benefit expenses is estimated at PHP 862 million, which contributes to PhilHealth's net margin.

Conclusion

The National Health Insurance Program provides for compulsory coverage of indigents. From a membership of less than 15,000 in 1997, indigents now have a membership

of over 15 million, the largest group of PhilHealth members comprising close to 4 out of 10 members. The nationwide identification of the poor through NHTS-PR of the Department of Social Welfare and Development has driven this growth in membership. However, this massive identification has also led to the enrollment of more members and/or households than the official estimates of poor population/families. This means the government subsidy leaks to the nonpoor. Notwithstanding the guidelines in the identification of the poor, it seems to be prone to subjectivity in the selection of beneficiaries. However, the evidence is anecdotal and the size of the problem cannot be determined in this study. Nevertheless, there is a need to ensure the integrity of the identification of poor.

Government subsidy for the premium contributions of indigents had increased from PHP 3 billion in 2011 to PHP 37.1 billion in 2015. In 2011, indigent benefits exceeded contributions by 80 percent, making indigents recipients of cross-subsidies from the formal sector. In 2015, they were estimated at only 49 percent of the subsidy. Administration cost constituted 26 percent in 2011 but decreased to 2 percent in 2015. An increasing amount of the subsidy leaks to the nonpoor, the informal sector, and senior citizens. With the 26 percent overidentification of poor in the government targeting system, an estimated 1.1 million nonpoor households were enrolled in the Indigent Program in 2011. This translates to leakages to the nonpoor

As stated earlier, the larger benefits of the informal sector relative to its contributions considering the voluntary nature of its participation indicates adverse selection, which can actually destabilize the National Health Insurance Fund.

constituting 15 percent of the subsidy. With 72 percent more indigent enrollment than the poor labor force in 2015, an estimated 6.4 million nonpoor were enrolled in the Indigent Program in 2015, translating to 41 percent leakage in the subsidy.

Cross-subsidies from indigents to the informal sector increased from 4 percent in 2012 to 28 percent in 2014 while cross-subsidies to the senior citizens increased from 1 percent in 2012 to 7 percent in 2014. There were also cross-subsidies to migrant workers, but these constituted less than 1 percent of the subsidy. The share of indigents to the excess of total contributions over benefits had increased from 1 percent of the subsidy in 2012 to 16 percent in 2014, contributing to PhilHealth's net margin.

As stated earlier, the larger benefits of the informal sector relative to its contributions considering the voluntary nature of its participation indicates adverse selection, which can actually destabilize the National Health Insurance Fund (McIntyre and Kutzin 2016). To prevent fund instability, the compulsory enrollment of informal sector members for social health insurance should be implemented. With its current voluntary nature, informal

sector enrollment will be determined more by ability to pay. As a result, the needy who have no ability to pay cannot enroll and avail of the program benefits. To address these issues, the government should expand the sponsored program to include the informal sector, particularly the disadvantaged.

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