Health Policy Notes

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The Role of Private and Local Government Health Insurance Schemes in Achieving Universal Coverage: Opportunities and Risks

Although they cover a much smaller population, and mostly those in the higher end of the socio-economic scale, private health insurance (HI) plans and self-insuring (SI) private organizations' spent almost as much for health services as PhilHealth did in 2005, and spent even more than PhilHealth from 2000 to 2004. For those in the lower end of the socio-economic scale, provincial and municipal health insurance schemes initiated by local government units (LGUs) are also mushrooming. Both voluntary HI and LGU health plans provide short-term opportunities for widening HI coverage and deepening benefits. On the other hand, the increasing multiplicity of these health financing schemes, many of which are operating outside of PhilHealth, could be a setback for achieving solidarity and equitable universal coverage under the national social health insurance (SHI) system. The existing legal and regulatory instruments to manage the proliferation of private HI and LGU schemes are weak, and eventually unifying these schemes under one SHI program would be a nightmare: the instruments are quite complex and entail high regulatory costs. Thus, given the opportunities and risks inherent in the operation of private HI and LGU health plans, policy makers need to ruminate on what should be their role in the overall evolution of social health insurance in the Philippines, in the context of the larger long-term vision for social health insurance.

Health expenditures of private health insurance plans and self-insuring private organizations' is almost as large as that of PhilHealth, but their population coverage is so much smaller

Three broad types of private HI and self-insured health programs are operative in the Philippines:

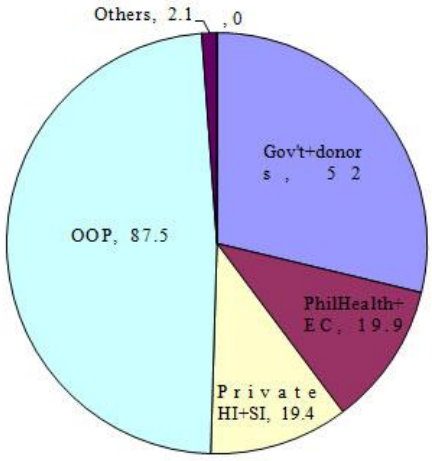
1. Indemnity health insurance underwritten by life and nonlife insurance companies.

2. Health maintenance organizations (HMOs) which are patterned after their American counterparts and, indeed, were established starting in the 1980s and evolved in the 1990s in the wake of the emergence of managed care as a practice in the U.S. There are 25 HMOs which cover around 3 million Filipinos, most belonging to the formally employed sector (Llanto, Portula, and Wipf, 2008). HMOs act as both insurer and arranger or provider of comprehensive but specified medical services for their members. They are registered with the Securities and Exchange Commission but are regulated by the Department of Health (DOH).

3. Self-insured plans, including employer-based health schemes and private schools' health programs.

National health accounts data for 2005 show that private HI expenditures - defined broadly in this note as private HI expenditures + expenditures of SI private organizations for health services - is as large as the expenditures of social health insurance (SHI), i.e., PhilHealth + Employees Compensation (EC) (See Figure 1). Private HI expenditures, including those of HMOs (PHP7.1 billion), life and non-life insurance companies (PHP4.3 billion), and the Health Insurance Program (HIP) program of GSIS employees (PHP2.3 million), totaled PHP11.4 billion in 2005. In the same year, SI private organizations spent PHP8.0 billion on health care: PHP5.8 billion under employer-based plans and PHP2.2 billion by private schools. Thus, in 2005 together these two types of private health expenditure sources spent PHP19.4 billion, compared to PhilHealth's PHP19.9 billion.

Figure 1. Health Expenditures in the Philippines by Major Sources, in Billion Pesos, 2005

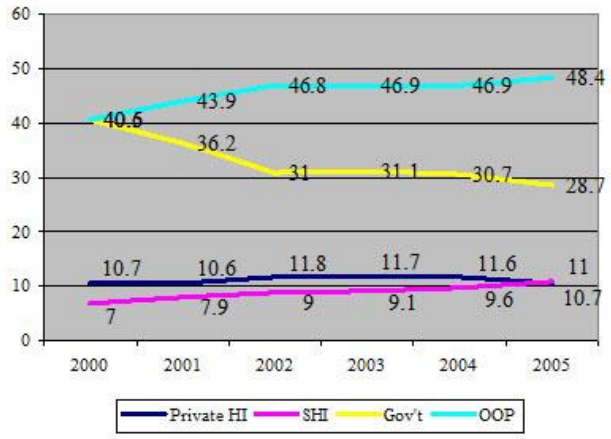


Private HI+SI is still small (at 10.7 percent) relative to total health expenditures (THE), just as PhilHealth+EC[1] spending is also small at 11.0 percent of THE. Indeed, social health insurance appears to have grown faster than private HI in this decade (Figure 2). The slow growth of private health insurance in the Philippines merely reflects the problems encountered by the insurance industry in general. Overall insurance penetration in the country is slightly greater than 1

1 EC health expenditures are small (PHP646 million in 2005) relative to PhilHealth (PHP19.3 billion).

percent and compares poorly with Thailand, Malaysia and India but is slightly better than Vietnam and Indonesia. Industry analysts describe it as fragmented, subject to high taxation (including VAT), and weak in terms of capital, reserves, and professional expertise (Llanto, Portula, and Wipf, 2008). The regulatory environment is weak – neither the SEC nor DOH have been particularly strong in regulating HMOs, for instance – and industry growth has not kept pace with economic growth.

Figure 2. Percent Share of Spending of Private Health Insurance Relative to Social Health Insurance, Government, and Out-of-Pocket Expenditures, 2000-2005



What health services do these private HI schemes finance? Table 1 shows that in 2005, private HI concentrated exclusively on the provision of personal health care, much like PhilHealth.

In theory, private HI serves as "wrap-around" insurance to the first-peso coverage provided by PhilHealth. Indeed most, if not all, HMOs require their members to be members of PhilHealth first, and seek reimbursements from PhilHealth on behalf of their members for covered illnesses. (Such doesn't seem to be the case for indemnity-type health insurance plans.) Little analysis has been done on the extent to which private HI indeed acts as wrap-around insurer, and whether overall support value (financial protection) improves with a household's purchase of secondary, private HI.

Table 1. Uses of Health Expenditures by Source and by Type of Service, in Billions of Pesos, 2005

Type of Service	Govt+ Donors	Phil Health +EC	Private HI		OOP	Others	Total
			Priv HI plans	Priv SI orgs			
Personal health	21.4	17.9	6.9	8.0	87.5	0.2	141.8
Public health	20.2	0.0	0.0	0.0	0.0	1.0	0.8
Others	10.4	2.0	4.5	0.0	0.0	1.0	18.1
Total	52.0	19.9	11.4	8.0	87.5	2.1	180.8

Source of basic data: Philippine NHA, NSCB

While PhilHealth health expenditures are almost of the same magnitude as private HI, its population coverage is far broader than the narrow, usually upper-middle-class coverage of private HI. Table 2 attempts to compare PhilHealth and HMO data on THE, total population covered, and THE per person covered. While HMOs only account for 5 percent of the population covered (PhilHealth+HMO), they account for more than a quarter (about 27 percent) of total health expenditures. Thus, HMOs have higher health expenditures per population covered relative to that of PhilHealth.

Table 2. THE and Population Coverage of PhilHealth Versus HMOs, 2005

	PhilHealth	HMOs	SI + HMOs
Total Health Expenditures (in PhP)	19.3 B (73.1%)	7.1 B (26.9%)	26.4B 100.0%)
Total Population Coverage	54.0 M (94.7%)	3.0 M (5.3%)	N.A.2
THE/Total Pop. Coverage (in PhP)	357.40	2,366.66	

LGU health insurance initiatives are also mushrooming, although their long-term viability remains in doubt

A number of local government units (LGUs) ventured into health insurance in recent years, including those from the provinces of Negros Oriental, North Cotabato, Palawan and Bukidnon as well as a few municipalities (e.g., Calapan, Mindoro). No comprehensive inquiry has been made on the reasons for their emergence. They may just be coping mechanisms in response to the current weaknesses of PhilHealth, or they may be motivated by the LGUs' desire for alternative means of mobilizing additional resources for health. In any case, experiences in other countries indicate that while these local initiatives have the potential for expanding insurance coverage of the population because of their proximity to households, their operations are fraught with problems. Often too small to become viable, most local health insurance ventures also lack management and operating systems, and their service coverage is often limited and irregular. If they do succeed to become viable as independent risk pools, integrating them later into the larger SHI program becomes a major challenge. Two examples illustrate some of these difficulties.

The Provincial Health Insurance of Negros Oriental (PHINO) is a program of the provincial government targeting the indigent population. Cities and

2 This figure cannot be established with certainty because HMO members also tend to be PhilHealth members. There are no data on how many HMO members are not PhilHealth members.

municipalities in the province are expected to participate by providing counterpart premium for these indigent families. The feasibility assessment (Asanza, 2008) indicates that: (i) If the premium is set at PHP600 per family per year, the total premium collected would not be enough to cover the projected total benefit payments until year 10. (ii) If the premium is increased to PHP1,200 per family per year, the total premium collected would be enough to cover the projected total benefit payments until year 10 but not after 20 years. (iii) If the premium is increased to PHP1,800 per family per year, this will make the scheme viable. However, because of the higher premium level, would-be members and LGU executives who are expected to sponsor indigent families may find this cost of sponsorship unaffordable. (iv) If the scheme is organized as an add-on or supplementary health insurance to PhilHealth members where PhilHealth provides the first-peso coverage and PHINO covers the rest of the bill, then the scheme becomes locally affordable and viable.

The Cotabato Health Insurance Program (CHIP) was introduced to provide better financial protection to constituents of North Cotabato. The scheme has three types of membership: indigent families with a premium of PHP1,200 who are fully subsidized by the sponsoring LGU; indigent families partly subsidized by the LGU sponsor; and nonpoor families who pay a premium of PHP1,600 on their own. Membership to PhilHealth is a prerequisite to membership to CHIP. A recent assessment of this program (Asanza, 2008) indicates that in spite of the high priority being accorded to recruit poor families, two-thirds (67 percent) of CHIP membership is nonpoor, 32 percent partially subsidized poor, and only 1 percent fully subsidized poor. The renewal rate for fully subsidized poor members is very low at 0.5 percent. Lapses in renewal are also frequent across the board. Nonpoor members have a higher utilization rate and go to private hospital more often. Moral hazard is creeping up with the number of processed claims increasing by 282 percent from 2007-2008, and hospitals observed to be increasing their charges for CHIP patients relative to non-CHIP members. Finally, the combined support value of PhilHealth and CHIP is only 79 percent, with CHIP only contributing to 29 percent of the total medical bill.

Voluntary private HI can provide opportunities for widening coverage and deepening benefits, although these are yet to be demonstrated on a sustainable basis by LGU health initiatives

1. *Widening coverage* – Private voluntary HI can widen overall insurance coverage by adding new members. However, to the extent that HMOs require that a potential member be also a member of PhilHealth, then this positive feature may be muted. Indemnity insurance is different since they do not generally require PhilHealth membership among their clients. However, those covered under indemnity HI is currently small. LGU health schemes recruit new members especially under their sponsorship programs, although high lapsation rates and nonrenewal of many initial members put into question their ability to retain these members over the long haul.
2. *Deepening benefits and improved financial protection* – Operating on the principles of managed care, HMOs are supposed to provide promotive and preventive care that PhilHealth does not provide, so this could deepen the health insurance benefits to their members. (Whether and how adequately HMOs do provide preventive and promotive care is an empirical issue that needs to be studied.) In general, private HI also seems to provide better financial protection, although there is yet no analysis that has been done on the support value of HMO members. Indemnity health insurance plans have higher premiums and offer more liberal benefits, and therefore provide greater financial protection than PhilHealth.

The plethora of private HI plans and LGU health programs poses risks of achieving equitable universal coverage and could be a setback for achieving solidarity under the national social health insurance system

1. *Higher cost of administration* – The higher cost of administration of private HI relative to social health insurance under PhilHealth is a major concern. In 2005, life and non-life insurance companies spent more than half (57.4 percent) while HMOs used 28.6 percent of their respective THEs on general administration (Table 2). In contrast, PhilHealth only spent 9.0 percent of it's THE on administration, indicating the relative cost-effectiveness of social health insurance.

Table 2. Uses of Health Expenditures of PhilHealth, Life and Non-life Insurance Companies, and HMOs, 2005 (in PhP)

Uses of funds	PhilHealth	Life and Nonlife Insurance Companies	HMOs
Health services	17.518 B (91.0%)	1.849 B (42.6%)	5.059 B (71.4%)
General administration	1.735 B (9.0%)	2.492 B (57.4%)	2.023 B (28.6%)
Total	19.253 B (100.0%)	4.341 B (100.0%)	7.082 B (100.0%)

Source of basic data: Philippine NHA, NSCB

2. *Tendency for more intensive technology utilization and medical cost inflation* - Private financing, particularly HI, is also prone to use medical technology more intensively and to incur higher medical care costs, as has been shown in industrial countries (notably the U.S.) and emerging economies with significant private HI financing (e.g., South Africa). In the Philippines, this issue has not been analyzed using empirical data. It certainly warrants closer study given the increasing number of anecdotal accounts especially about large price differences on the same procedure (e.g., CT scan or MRI)

experienced between private and public funders. Quimbo (2007) theorizes that the utilization patterns of medical technology are the result of imperfect information and imperfect market structures, and that the marginal cost pricing (monopoly pricing) can be shown as the outcome of the absence of bargaining power among providers (patients).

3. *Loss of equity and solidarity* – Once established, private HI and LGU schemes tend to entrench themselves. The difficulties arise when the private HI plans begin to market highly variable insurance products oriented to different market segments that suit different tastes, risk profiles, and levels of household affordability. While this is a most welcome development in a purely market-driven system oriented at individual preferences, it wreaks havoc on the national goal of establishing a national health financing system that underscores the principles of solidarity and equity in financing and access. Since private HI plans are voluntary, they also tend to resort to adverse selection, i.e, choosing good risks (e.g., young and healthy) and avoiding bad risks (e.g., elderly and sick). Experience-rating used by private HI plans (i.e., the worse the risk profile in terms of age, sex, health background, etc., the higher the premium) also means that equity gets eroded; in the extreme the elderly and the sick may not be able to get any affordable private HI insurance coverage as premium payments become extremely prohibitive for them. More importantly, since private HI risk pools are independent of each other, cross-subsidization occurs only among the members of each HI scheme, and even cross-subsidization is muted by the differences in premium payments.

4. *Fragmentation of risk pooling and adverse effects on health service delivery* – Unlike a single, national risk pool embodied in an SHI such as PhilHealth which reflects the solidarity principle, a plethora of private HI schemes and LGU programs will evolve into independently run, and therefore fragmented, risk pools of varying sizes, risk profiles, and financial capabilities. Thus, the long-term challenge is how to put these disparate schemes together into a single social health insurance program, hopefully in combination with PhilHealth.

Of more immediate concern, however, is the effect of the co-existence of private voluntary HI schemes (which tend to attract the upper classes) and PhilHealth (which is a mandatory HI program usually catering to the formal sector but increasingly expanding to the informal sector and indigents as well) and the government-funded health service delivery system. Further growth in the private HI sector, especially if PhilHealth and the government health delivery system slacken, can only lead to a two- or three-tiered health care system. Indeed, this is already quite visible in the metropolitan areas in the country where the rich with private supplementary HI coverage get their care from highest-echelon health facilities, the middle class with PhilHealth coverage get their care from second-echelon facilities, and the poor without any HI coverage have no choice but to seek care from government facilities. Critics of the unregulated growth of private medical care, especially private HI, point out that such a situation is untenable, and therefore the focus of policy should be on the expansion and strengthening of the social health insurance program coupled with increasing regulation of private HI.

Legal and regulatory instruments exist in Europe to manage the proliferation of their private HI in the long run and eventually unify them under a social health insurance program, but the instruments are quite complex for the Philippines and they entail high regulatory costs

A variety of legal and regulatory instruments are being used in Europe to deal with the problems and risks engendered by private HI, specifically the loss of solidarity and the erosion of equity. Paolucci, et al. (2004) reviewed these instruments to shape the behavior of private HI schemes and make them support national solidarity goals, and classified the corresponding legal and regulatory strategies as follows:

Strategy 1: Legal restrictions on free competition – (a) Imposition of community rating (i.e., one level of premium payment across a group) and making experience or individual rating illegal; (b) Open enrollment, which mandates private HI schemes to allow anyone to become a member of the scheme during a particular enrolment period; (c) Prescribed minimum benefit package that all private HI schemes have to offer; (d) Premium rate restrictions (which are, in effect, price controls). The consequence of these legal restrictions to free trade and competition is the creation of predictable losses for insurers of high-risk individuals, and predictable profiles on low-risk individuals, despite open enrollment. Thus, they create further incentives for risk selection, including more subtle forms of selection that are not covered by law (Paolucci, et al., 2004). These subtle forms of risk selection are discussed below.

Strategy 2: Risk compensation schemes, including establishment of a risk equalization fund (REF) for insurers or direct or indirect consumer subsidy – Risk equalization operates on the principle that if a number of private HI schemes act as the financing intermediaries for an SHI, contribution revenue is pooled and individual schemes allocated an amount which reflects the expected costs of that scheme given the illness or risk profile of its membership (through a risk adjusted capitation payment). Thus, the expected impacts of risk equalization (as conjectured for the South African REF initiative) are as follows: (a) Risk equalization will equalize the risk profile faced by the schemes, not the outcome of successful risk management or managed care. (b) Private HI that are successful at reducing the cost of delivery of health care retain that benefit for their own members. (c) All HI schemes will effectively face the same risk profile. The most successful ones will benefit those that can best manage that risk and reduce the cost of delivery. (d) Thus, future competition will be on health care delivery, not on risk selection. In principle, post-REF competition will be on the cost of providing care,

not on risk selection (which would be "equalized") and not on premium (which will become uniform under the SHI).

Strategy 3: Premium compensation schemes – These correspond to premium-related subsidies granted directly to consumers, such as deductible premiums. Under this strategy, insurers are free to ask risk-rated (experience-rated) premiums and to refuse or accept high-risk individuals. This is appropriate only in a situation of universal or near-universal coverage, otherwise only those with coverage will enjoy tax deductibility.

Strategy 4: Excess loss compensation schemes – Under this strategy, private HI are compensated by the solidarity fund for all expenditures above a certain threshold for each individual insured.

Paolucci, et al. (2004) concluded that Strategy 2 (Risk Compensation or use of REF) is the first-best strategy because it achieves solidarity without compromising effective price competition, and without endangering the financial sustainability of the private HI schemes. While Strategy 1 (Legal Restrictions on Free Competition) is preferred by politicians for its visible direct effects, it actually threatens efficiency as it controls the premium (price) as well as the quantity and quality of care (minimum benefit package).

While theoretically appealing, however, risk equalization is extremely complicated even in developed economies, and there have not been many successes. Indeed, there have been many quite unfortunate experiences. Van de Ven, et. al.'s (2003) review of risk adjustment in five countries (Belgium, Germany, Israel, the Netherlands, and Switzerland) in the mid-1990s show that "all five countries experienced severe implementation problems… Even the simplest risk adjustment mechanisms are complex and that there are many surprise problems."

And even with risk equalization, subtle risk selection could insidiously occur. Anecdotal evidence collected by Van de Ven, et al. (2003) suggests that even in systems with REFs such as Switzerland and Germany, sickness funds find subtle ways to select risks, among others, by selective advertising; selectively terminating business in unprofitable (high-cost) areas; special bonuses for agents who are successful in getting rid of expensive cases; turning away applicants on the phone; and offering supplementary health insurance.

These are clear warnings on the difficulties of establishing social health insurance out of private HI schemes. And even if these legal and regulatory instruments could be applied sensibly on private HI schemes (assuming away, for the moment, the high costs of designing and enforcing these regulations), one is still left with two issues: (a) How will PhilHealth as an independently-run SHI interface with these private HI schemes that will be organized as an SHI? (b) How will these risk pools, in turn, interface with the government-funded system of the national and local governments? In some countries (e.g., Israel), a central resource allocation authority determines overall funding flows for both public and private sectors. Short of having such an authority, the private and the public will never "meet," and true solidarity and funding equity can never be achieved at the national level.

Given the opportunities and risks inherent in promoting private HI and LGU health schemes, what should be their role in the overall evolution of social health insurance in the Philippines?

Getting everybody covered in a national SHI is daunting, and "smaller ships" (private HI, LGU schemes, self-insuring health programs) may be required before everybody eventually gets on board the "mother ship" of national SHI centered around PhilHealth. This is the principal argument for the "launch a hundred ships" approach that favors the promotion of private HI and other health financing schemes. The approach is premised on the notion that these other health financing schemes are transitory or "bridging" mechanisms for the eventual national SHI.

But a less sanguine interpretation of the emergence of private HI, LHU health initiatives, and other alternative financing schemes is the fact that these are just coping mechanisms for the weaknesses of PhilHealth to deliver on its promise of becoming the true national SHI of the Philippines. Although PhilHealth (and its predecessor, the Medicare program) is one of the oldest SHI schemes in the developing world, it remains a minor payer of health care in the country. Its population coverage is even less impressive, certainly less than the coverage of the much younger SHI scheme in Thailand. Least impressive of all is the continuing low support value (financial protection) that PhilHealth provides. One could argue that alternative health financing schemes, such as private HI and LGU health plans, emerge in response to these PhilHealth shortcomings.

Should private HI and LGU schemes be viewed as (transitory) "bridging" or (permanent) "coping" mechanisms? This is the critical question that health policymakers have to wrestle with and, in the end, the answer also boils down to what these policymakers think PhilHealth's role should be in the future. The problem in Philippine health care financing is that the details of the "room" are being designed (e.g., private HI and LGU schemes) but the overall structure of the "house" (i.e., the vision for social health insurance) is yet to be determined and agreed on.

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