

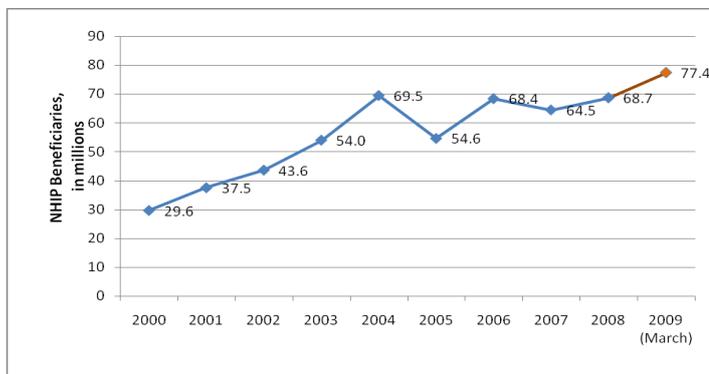


NHIP Membership and Contribution: Braving the Challenges of Universal Coverage

Membership at a Glance

The race is on for the fulfillment of universal health insurance coverage in the country. The Philippine Health Insurance Corporation or PhilHealth, as the administrator of the National Health Insurance Program (NHIP), is directed to achieve this mandate with a given timeline of 15 years since the passage of the National Health Insurance (NHI) Act in 1995. Also referred to as Republic Act (R.A.) No. 7875, the NHI Act is a landmark social legislation that espouses and champions the 4 A's on quality health care services: *affordability, acceptability, availability and accessibility*. Several provisions of the law were amended in 2004 under Republic Act No. 9241.

Figure 1, Growth of NHIP Membership, 2000-2008 (in millions)



Source: PhilHealth Stats and Charts, 2000-2008, 2009 1st Quarter Report, Corporate Planning Department

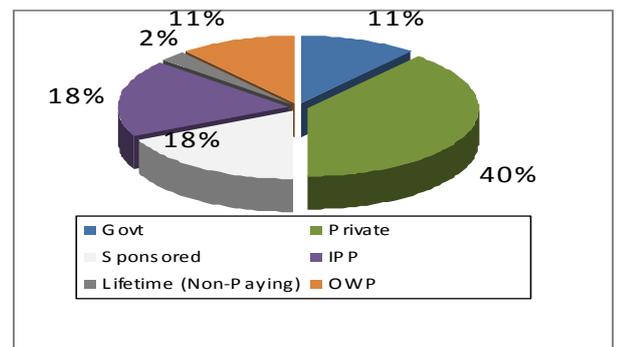
Based on PhilHealth statistical reports between 2000 and 2008, the trend on NHIP membership coverage is steadily increasing, with its peak gained in 2004 (see Figure 1). The growth momentum, however, had a dramatic drop in 2005 owing to the drastic reduction in the Sponsored Program membership base. The cause could be attributed to the inability of the Local Government Units (LGUs) to shore up the required financing in enrolling the target indigent constituents to the Program. Membership growth, nevertheless, recovered in 2006 and though the climb did not continue, membership continued to rise in 2008 and appears to be going up further in the first quarter of 2009 (PhilHealth Stats and Charts, 1st quarter).

To date, NHIP coverage is pegged at 77 Million which is around 82% of the 2009 projected population. It is expected

that universal coverage of 85% is achieved by end of the 3rd quarter of 2009.

On the distribution of NHIP membership by sector, Figure 2 shows that the largest chunk goes to the Private-Employed Sector at 40% (or about 6.6 Million members) while both the Sponsored Program and the Individually Paying Program (IPP) exhibit 18% (around 3.1 Million respectively). The Government-Employed Sector and the Overseas Workers Program (OWP), meantime, demonstrate similar figures at 11% (with 1.9 Million each) while the Lifetime Member Program (formerly Non-Paying Program) posts 3% (0.4 Million) of estimated enrolled members in PhilHealth.

Figure 2. NHIP Membership, By Sector, 2009 (1st Quarter)



Source: PhilHealth 1st Quarter Report, CorPlan

Current Initiatives: The Highs and Lows of Membership Expansion



Over the years, PhilHealth has shown its competence in bringing its mission to fruition insofar as membership expansion is concerned. Current initiatives are gaining grounds. PhilHealth is able to establish new partnerships and fortified existing ones. It employs aggressive marketing and selling strategies performed by its 19 regional offices and 97 service offices nationwide. These facilitated the enrollment of more members in the various membership programs.

One Hundred Percent Coverage of the Poor - To institutionalize the implementation of the Sponsored Program and ensure that universal coverage of the

poor is achieved in all Local Government Units (LGUs), PhilHealth strongly advocates the Program among Local Chief Executives (LCEs) at the provincial, city and municipal levels.

To date, 9 out of 10 LGUs carry out the Program and it is expected that before the end of 2009, LGUs in several parts of the country particularly in the ARMM (Autonomous Region of Muslim Mindanao) which never participated in the NHIP would likewise enroll their indigent constituents to the Sponsored Program.



While the Sponsored Program already gained headway, enrollment of the target 4.7 Million indigent families remains an enormous task for PhilHealth. Despite the guaranteed provision in the General Appropriations



Act (GAA) on the National Government (NG) counterpart subsidy for the Program, accessing the entire amount is a challenge particularly in recent years. The NG counterpart premium share is not released if the

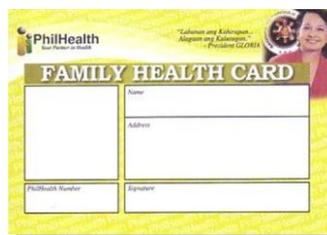
corresponding LGU share has not been remitted to PhilHealth. LGUs do not have adequate financial backing to subsidize and sustain the Program. Although there are other sponsors that can be tapped such as the legislators using their Priority Development Assistance Fund (PDAF), private companies via their corporate social responsibility (CSR) programs, other government agencies (e.g. PCSO, DSWD), as well as non-government/ civic/religious organizations, among others, funding remains insufficient to augment the LGU budget for this purpose.

In terms of additional fund sources, PhilHealth as NHI fund steward has lobbied to Congress and other concerned agencies in seeking entitlements to a number of legislated measures, as the Philippine Government is mainly responsible for "guaranteeing the financial viability of the NHIP" as clearly stipulated in Section 28 of R.A 7875 as amended. Said measures are identified as the excise tax-related laws (R.A Nos. 7654 and 9334), the documentary stamp tax law (R.A. 7660), the Bases Conversion and Development Act (R.A. 7917) and the reformed value-added tax law (R.A 9337). PhilHealth has initiated talks with several line agencies that take charge of the Philippine treasuries namely the Department of Budget and Management (DBM), the Department of Finance (DOF), the Bureau of Treasury (BTr) and the Bureau of Internal Revenues (BIR) on how PhilHealth can access these funds. According to them, the funds from these sources are pooled into the general fund to finance the programs, projects and activities of the Philippine government that are included in the approved GAA. PhilHealth position sees these funds from revenue-generating laws as trust fund and should be treated over and above the yearly appropriations for the Sponsored

Program. Being in trust, the funds are segregated only for carrying out a specific purpose which, in this case, is to be utilized as premium counterpart subsidy of the LGUs for the enrollment of their target indigents. PhilHealth likewise regards these funds as not being part of the Internal Revenue Allocation (IRA), thus, should not be considered as IRA intercept. Therefore, fund releases of such to PhilHealth are in order.



Furthermore, there is a need to address the issue on establishing at the national level an indisputable means of identifying indigents for the Program to avoid massive leakage and allow the 'rightful poor' full access to Program benefits. At the moment, PhilHealth accepts the reliability and accuracy of the data generated by the



National Household Targeting System for Poverty Reduction (NHTS-PR) of the Department of Social Welfare and Development (DSWD) as well as the Community-Based Monitoring System (CBMS) developed by the National Anti-Poverty Commission (NAPC). These are some of the tools that help identify the legitimate indigents in the community.

So far, DSWD has identified around 300,000 indigents nationwide and targeted around 700,000 more this year. Similarly, around 625 LGUs utilize the CBMS around the country according to NAPC data (November 2008). The key to ensuring only the legitimately qualified ones are included in the Sponsored Program is to mandate DSWD as lead agency in the identification of the poor. PhilHealth, in turn, would acknowledge and endorse these DSWD-enlisted indigents and seek for endorsement of DBM and Congress to finance the corresponding premium requirements and treat this as full subsidy of the National Government. The LGUs, on the other hand, should ensure the availability, accessibility and the quality of health care facilities for the indigent families at their level.

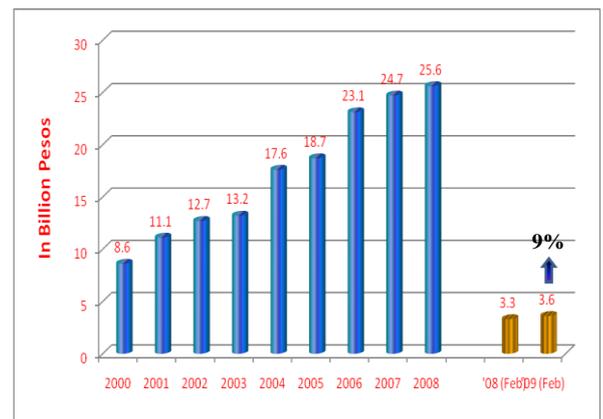
Health Protection for a Bigger Chunk of the Informal Sector - Massive information campaigns are undertaken to cover a larger part of the Informal Sector (IS) either through the Individually Paying Program (IPP) or the KASAPI (Kalusugang Sigurado at Abot Kaya sa PhilHealth Insurance). The KASAPI taps organized groups such as microfinance institutions, cooperatives, non-government and civic organizations, various associations, among others, as PhilHealth partners in the implementation of the Program to encourage bulk or group membership enrollment.

Likewise, the KASAPI partners with organized groups in the administration of the Program, facilitating a more flexible and affordable payment mechanism. The informal sector, however, is a highly diverse and fragmented segment of the population yet with an immense market potential estimated between 16 and 19 Million. This is a tough mission for PhilHealth as it only covers around 19% of the IS to date. Collective efforts are imperative and new initiatives are needed to conquer this vast market. Seen fundamental in addressing this concern is implementation of the partial subsidy scheme where sponsors can be tapped to partially take care of the premiums of the IS. The LGUs, in this case, can come into the picture. Should the National Government shoulder the full premium subsidy for poor families, LGUs can redirect their counterpart towards the Informal Sector. The IS, however, needs to undergo further segmentation. Those that can be identified at the lowest stratum can be prioritized to qualify either for full or partial premium subsidy by the LGU, depending on the LGUs' capacity to pay. Studies should be made to explore providing incentives such as allowing them to continue receiving the PhilHealth Capitation Fund.

Continuous Coverage of Filipinos Overseas - PhilHealth likewise recognizes the importance of guaranteeing the health insurance coverage of individual Filipinos in other countries, primarily the land-based workers. According to the report of the Commission on Filipinos Overseas, there is an estimated 3.14 Million Filipinos overseas whether temporary contract workers, irregular migrants and even undocumented migrants. PhilHealth so far covered about 1.9 Million or roughly 32% of the estimated figure. As PhilHealth intensifies membership expansion of this sector, instituting off-shore service offices in strategic areas around the globe is a welcome move so that the growing concerns of members under this Program would be immediately responded to such as visible payment venues to ensure up-to-date premium remittances of OWP members or their family as well as address members' concerns on their benefit entitlement/availlment.

PhilHealth is up to the challenge of meeting universal coverage by 2010, the year NHIP is supposed to deliver according to the law. The PhilHealth Board and articulations in the Medium Term Plans define universal coverage as health insurance coverage of 85% of the projected population in 2010. This definition however is confined only to quantity or numbers that must be covered by PhilHealth and not necessarily pertaining to "satisfying all the healthcare needs of all the population". The World Health Organization (WHO) defines universal coverage as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". PhilHealth does not take these definitions separately - current initiatives make sure both quantity and quality, breadth and depth of coverage are considered.

Figure 3. Growth of NHIP Premium Collection Performance, 2000-2008; Comparative Collection Performance, February 2008 and 2009

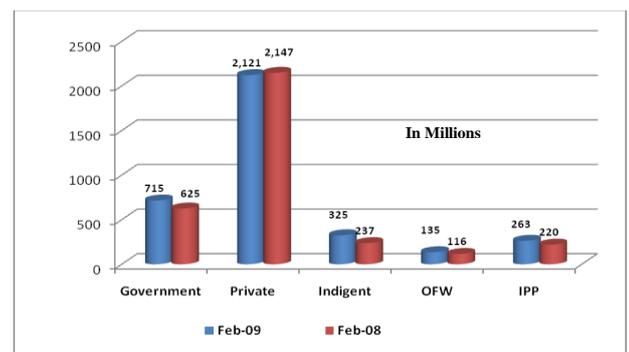


Premium Contributions and Collection

Premium contributions are the lifeblood of the NHIP. Ensuring timely payments and remittances of premiums is extremely crucial in the NHIP implementation so that payments of members' benefit claims are up-to-date as well.

The PhilHealth Financial Reports from 2000 to 2008 provided the information on the annual premium collection performance of the NHIP. Collective efforts paid off as the trend continues to demonstrate an upward streak (see Figure 3). The growth in collection dramatically accelerates in 2004 which posted a 33% increase over 2003 performance. Large sponsorship started to pour in to the Sponsored Program by government agencies such as the DBM and the Philippine Charity Sweepstakes Office (PSCO) especially that the Arroyo administration put the Program among her top priorities in mitigating poverty condition in the country. Premium remittances further demonstrated an increment in 2006 and this is sustained until 2008, in spite of the reported global economic crisis in the last quarter of that year. It is also remarkable to note that PhilHealth posted a 9% increase during the first two months of 2009 compared to collection achievement during same period of the previous year.

Figure 4. Comparative NHIP Collection Performance, By Sector, February, 2008 and 2009



Source: PhilHealth Financial Report (First Quarter)

On collection performance by sector, the biggest bulk is exhibited by the private and government employed sector. PhilHealth relies heavily on the contributions of the employed sector, considered a captured market of the NHIP, owing to compulsory and automatic membership. All the sectors performed fairly in premium remittances except the private sector which posted a slight decrease of over one percent.

The favorable performance on collection of PhilHealth was facilitated by around 45 accredited collecting banks/agencies which have 4,510 branches around the country and actively providing services to all PhilHealth members.

Identifying Collection Efforts and Some Policy Concerns

The collection performance of PhilHealth can be ascribed to past and present initiatives. The mapping and profiling of employers (particularly the private sector) is seen as a very useful tool in helping put in place effective account management techniques and mechanisms within PhilHealth. Mapping of employers likewise aims to update the database system of PhilHealth and help beef up premium collection in the process through increased compliance of employers.

PhilHealth is authorized to collect three (3) percent, at the maximum, of the monthly salary of the members in the employed sector and similar three percent, at the maximum, of the estimated actual net income of the self-employed for the preceding year as per Section 28 of R.A 7875 as amended. The self-employed members are categorized under the IPP. Currently, premium rate for the employed is nailed at 2.5 percent. PhilHealth would have to exhaust the 3% level as sanctioned by law, depending on the actuarial viability of the Funds with the recent benefit increases. The big question is if the employed sector can still accommodate premium increases under tight economic conditions. Although, the government as employer remains the number one remitter of premiums, it has also incurred arrearages when premium rates were adjusted since 2000. PhilHealth continues its lobbying efforts to DBM for the appropriation of the amount of Php7 Billion to settle the payment of its arrearages accumulated through the years.

A bill is pending in Congress which proposes for amendments of the PhilHealth law in order to safeguard the NHI funds from fraud and abuse. This includes stiffer penalties for employers who fail to remit the required premium. The amendment provides more teeth to the charter by strengthening PhilHealth's police and visitorial powers.

Meanwhile, the IPP collection performance has a lot of catching up to do. From the currently enrolled members of 3.1 Million, less than half or only 1.2 Million are actively-paying. Among the actively paying, only 40% are paying the full premium of P1,200 and around 30% have paid at least one quarter in 12 months. The members of the IPP also exhibit high benefit utilization rate (Stats and Charts 2008 data). It is only deemed necessary that all collection efforts under this sector be geared towards having more accessible payment centers (such as Bayad Centers in malls). There is also a need to explore what the technology can offer, that premium payments can also be remitted by air and this can be done

via Short Message Service (SMS) since every adult Filipino practically owns a cellular/mobile phone nowadays.

PhilHealth endeavors to further improve and sustain collection performance especially that Program benefit ceiling has increased by 35 percent effective April 2009. It is expected that by the third quarter of the current year, claims reimbursements will start to soar and additional benefit payout may reach 7 Billion pesos by end of 2009. It is critical therefore for PhilHealth, as steward of the fund, to exhaust all efforts in ensuring the Program is here to stay and that more Filipinos from the generations to come will likewise enjoy the fruit of today's hard work.

Moving Forward

PhilHealth should pursue the on-going amendments of RA 7875 as amended especially the provision on premium contribution for the indigents to be fully subsidized by the National Government, with DSWD mandated as lead agency in the identification of the poor;

To reform the IPP, PhilHealth should include the provision that LGUs can be tapped to sponsor the Informal Sector, especially those belonging to the lowest stratum, partial or full subsidy depending on the LGU's capacity to pay. Further segmentation is a requisite and one way of doing so is to explore the data/information reflected in the community tax certificates (CTCs) filed at the LGUs.

When universally covered, the voluminous data from PhilHealth's databases will be a rich source of information for planning, policy development and decision-making not only for PhilHealth but for the health sector. Investments in health analytics and informatics in terms of enhancement of systems, processes and capabilities should be prioritized and new and emerging technologies explored.

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