PhilHealth
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OFFICIAL STATEMENT

On Claims Payments

August 5, 2021

The Philippine Health Insurance Corporation (PhilHealth) acknowledges the complaints of hospitals in claims processing delays. Upon the directive of its President and CEO Atty. Dante A. Gierran, these issues are being closely addressed by no less than the Chief Operating Officer and the Regional Vice Presidents through constant dialogues and reconciliation of figures with hospital representatives at the regional level. The allegations of huge payables of the Corporation were dispelled after these reconciliation meetings.

Based on records, PhilHealth has paid a total of Php166 B for some 13.6 million claims, or 76.4% of the almost 18 million claims received from its accredited government and private hospitals in the country from CY 2020 to June 30, 2021. The Corporation is working double time to process the remaining 12% amounting to Php25.6 B which are in varying levels of processing in its offices.

Some 8% of total claims received were returned to hospitals (RTH) for compliance with identified deficiencies while 3% were denied due to non-compliance and various violations of existing rules and regulations.

Of the total claims received during the same period, almost 10 million claims were from accredited private hospitals, of which, 8.2 million (82%) amounting to almost Php 96 B has been paid while 892K+ claims amounting to Php14.4 B is still under process.

The Corporation would like to clarify that the Php 6.3 billion paid to 206 hospitals as claimed by the PHAPi in recent news reports refer to the partial payments made by PhilHealth under the Debit-Credit Payment Method (DCPM) for hospitals with COVID cases in IATF identified critical areas during the initial phase of implementation.

The seeming discrepancy in figures between PhilHealth and the hospitals may be due in large part to differences in accounting treatments. During the claims data reconciliation meetings with a number of hospitals, it was noted that hospitals have been including denied and returned-to-hospital claims in their accounts receivables while PhilHealth recognizes only good claims as its payables pursuant to prevailing government accounting rules and regulations. This accounting practice was earlier validated during the House Committee on North Luzon Growth Quadrangle hearing with hospitals and PhilHealth in June of this year.

The Corporation has employed several strategies to fast track the remaining claims being processed in its offices. PhilHealth is in constant dialogues with hospitals in the regions, even as it intensify its efforts in the NCR where COVID-19 cases are high.

Pandemic response

In support of the Government's response to the COVID-19 pandemic, PhilHealth has paid almost Php12 billion for benefit claims against its COVID-19 portfolio consisting of testing packages (inclusive of tests conducted by the Philippine Red Cross), community isolation benefit package and hospitalization cases. This comprises 56% of total received COVID claims from affected areas.

For in-patient claims, relevant policies have been issued to clarify claims concerns in processing. With the voluminous claims received in the regions, arrangements to augment existing human resource for claims processing are currently being implemented in regional offices.

As to the payment of testing benefits, non-compliance to required documents like the DOH-required Claims Investigation Form (CIF) and eClaims submissions caused delays in claims payment. This is being addressed by intensive information and education campaign by PhilHealth's regional offices, and review of policies to address the identified issues. The Corporation allowed for the manual submission of testing claims while accredited COVID-19 laboratories transition to the use of eClaims for more efficient claims transmittal.

PhilHealth with all its Regional Offices is committed to assist hospitals in the reconciliation of claims records, and to guide them in the effective compliance of returned-to-hospital claims. The Corporation rolled out the Reconciliation Summary Module (RSM), an IT solution provided for free where hospitals can monitor the status of processing of individual claims and encourages accredited hospitals to maximize its use. In addition, reconciliation officers are at hand in regional offices to assist in identifying claims that have passed adjudication, needing compliance, under investigation, and denied.

The Agency remains steadfast in its commitment to pay hospital claims that are in order and compliant to rules and regulations.

Insurance fraud is a reality in most insurance systems. As steward of public funds, the Corporation is accountable to its members and duty bound to protect the funds from fraudulent claims. Hence, the Corporation has intensified its efforts in fraud identification, control and prosecution. ###

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