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PHILHEALTH CIRCULAR
No. 2024 - 0010

TO : **HEALTHCARE PROVIDER NETWORKS, HEALTHCARE PROVIDERS, PHILHEALTH REGIONAL OFFICES, LOCAL HEALTH INSURANCE OFFICES, LOCAL GOVERNMENT UNITS, AND ALL OTHERS CONCERNED**

SUBJECT : **Framework for the Implementation of Cost Sharing Schemes**

I. RATIONALE

Financing of health care services in the country has long been largely dependent on household out-of-pocket (OOP) spending, with the burden rising in absolute terms to 195 billion pesos from 2014 to 2021[1]. PhilHealth support in covering expenses for health services also continues to be challenged, with payments only averaging around 17% of the country's total health expenditure in the country. This leaves patients with very limited protection from financial risk. In fact, as many as 6.49 million Filipino households are subject to catastrophic spending at the global benchmark of 10% threshold.

Section 9.10 of the Universal Health Care (UHC) Act Implementing Rules and Regulations (IRR) aims to address these issues by mandating the DOH and PhilHealth to prescribe guidelines for co-payment or co-insurance in determining the additional services that are not included in the minimum standards of care in the management of the conditions and charges for amenities outside the basic or ward accommodation. Cost sharing mechanisms are recognized as an effective means to limit financial risk to patients and reduce out-of-pocket payments. Additionally, these payment schemes can curtail overutilization and overprovision of certain services, leading to a more effective and efficient health system.

II. OBJECTIVES

This PhilHealth Circular aims to establish rules on how PhilHealth implements cost sharing schemes, in line with the Universal Health Care Act (Republic Act No. 11223) and the National Health Insurance Act of 2013 (RA No. 10606).

[1] Philippine Statistics Authority. (2022). Philippine National Health Accounts. https://psa.gov.ph/statistics/pnha

III. SCOPE

This PhilHealth Circular encompasses the policy on cost sharing schemes which details:

A. Cost sharing mechanisms

B. Development, utilization, and recording of cost sharing payments

IV. DEFINITION OF TERMS

A. Affiliate Primary Care Provider – any non-PhilHealth Konsulta facility engaged by the Network to provide the content of the prevailing primary care benefit package.

B. Amenities[2] – features of the health services that provide comfort or convenience, such as private accommodation, air conditioning, telephone, television, and choice of meals, among others.

C. Apex Hospital[3] – a hospital, offering specialized services as determined by DOH, which is engaged as a stand-alone facility by PhilHealth.

D. Basic or Ward Accommodation – the provision of regular meal, bed in shared room, fan ventilation, and shared toilet and bath, to a patient receiving the essential health services needed during confinement.

E. Bed Days – the number of calendar days in which a patient is confined in an inpatient health facility.

F. Co-insurance – a percentage of a medical charge that is paid by the insured person when receiving health services.

G. Contracting[4] – a process where providers and networks are engaged to commit and deliver quality health services at agreed cost, cost sharing and quantity in compliance with prescribed standards.

H. Co-payment – a flat fee or predetermined rate paid at point-of-service.

I. Cost Sharing – the direct payment of a portion of health care costs by an insured person when receiving health services.

J. Essential Health Services – the health services delivered needed to manage a given patient as based on existing clinical practice guidelines.

[2] UHC Act Implementing Rules and Regulations, Rule 4.2
[3] DOH Administrative Order No. 2020-0019 (Guidelines on the Service Delivery Design of Health Care Provider Networks), IV.A
[4] UHC Act Implementing Rules and Regulations, Rule 4.7

K. Health Care Provider Network (HPCN)[5] – a group of primary to tertiary care providers, whether public or private, offering people-centered and comprehensive care in an integrated and coordinated manner with the primary care provider acting as the navigator and coordinator of health care within the network.

1. **Mixed Network** – a network of providers, which may be composed of health service providers from both the public and private sector, represented by a self-assembled entity of both public and private sector as the managing board.

2. **Private Network** – a network of providers, which may be composed of health service providers from both the public and private sector, represented by a private entity as the managing board.

3. **Public Network** – a network of providers, which may be composed of health care providers from both the public and private sector, represented by the provincial or city health board as the managing board.

L. Individual-Based Health Services[6] – services which can be accessed within a health facility or remotely that can be definitively traced back to one (1) recipient, has limited effect at a population level and does not alter the underlying cause of illness such as ambulatory and inpatient care, medicines, laboratory tests and procedures, among others.

M. Inpatient Payments – PhilHealth benefit payouts for services provided in an inpatient setting as defined by the guidelines of the specific benefit, including, but not limited to, payments through All Case Rates (ACR) and Diagnosis-Related Groups (DRG).

N. Non-Basic Accommodation – the provision of minimum standards of care for patients, and includes amenities provided by the facility at the option of the patient.

O. Outpatient Payments – PhilHealth benefit payouts for services provided in an outpatient setting as defined by the guidelines of the specific benefit, including, but not limited to, payments for the PhilHealth Outpatient Drug Benefit (ODB) Package.

P. Pooled Fund for Health – pool of financial resources used by private or mixed networks to finance individual-based health services, health system operating costs, capital investments, and maintenance and other operating expenses.

Q. Primary Care Facilities (PCF) – health facilities that primarily deliver primary care services and are licensed or registered by the DOH.

[5] UHC Act Implementing Rules and Regulations, Rule 4.16
[6] UHC Act Implementing Rules and Regulations, Rule 4.20

R. Primary Care Payments – PhilHealth benefit payouts for services provided in a primary care setting as defined by the guidelines of the specific benefit, including, but not limited to, payments for the PhilHealth Konsulta Package, Konsulta+, and Konsulta+SDG benefits.

S. Primary Care Provider Network (PCPN)[7] – a coordinated group of public, private or mixed primary care providers providing a range of primary care services, as the foundation of the health care provider network.

T. Prospective Payments[8] – a provider payment mechanism that pays providers a predetermined, fixed amount ahead of the actual delivery of the anticipated health goods and services.

U. Provider Payment Mechanisms – methods of payment of PhilHealth to providers for the provision of healthcare services as stipulated within the benefit packages of the Corporation.

V. Provincial- and City-Wide Health Systems (P/CWHS)[9] – integrated local health system in which health care providers deliver continuous and integrated health services to individuals and/or communities in a well-defined catchment area.

W. Special Health Fund (SHF) – a pool of financial resources at the P/CWHS intended to finance population-based and individual-based health services, health system operating costs, capital investments, and remuneration of additional health workers and incentives for all health workers.[10]

V. POLICY STATEMENTS

A. Cost Sharing General Standards

1. Cost sharing mechanisms shall ensure that all patients are protected from financial risk by ensuring predictability and facilitating informed choice for patients when accessing health services.

2. Cost sharing mechanisms shall be instituted to protect patients from any additional costs incurred beyond the prevailing PhilHealth payment rates, provided that the additional costs are not incurred through elective requests by the patient or beyond the relevant benefits applicable to the patient.

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[7] UHC Act Implementing Rules and Regulations, Rule 17.3.a
[8] PhilHealth Circular No. 2022-0032 (Governing Policies Of The Konsulta+), IV.N
[9] DOH Administrative Order No. 2020-0021 (Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)), VI.B
[10] DOH-DBM-DOF-DILG-PHIC Joint Memorandum Circular No. 2021-0001 (Guidelines on the Allocation, Utilization, and Monitoring of and Accountability for the Special Health Fund), III.R

3. Cost sharing mechanism may be implemented either through fixed co-payments or pre-determined co-insurance rates, depending on strategic appropriateness with the benefit package.

4. PhilHealth shall cover the full cost necessary to deliver minimum standards of care to patients.

5. Cost-sharing rate shall cover the additional services and/or amenities beyond the scope of PhilHealth benefits.

6. Certain services shall be subject to cost sharing mechanisms in order to disincentivize unnecessary utilization.

    a. The prevailing national average epidemiological measures shall be used in determining overutilization of health services, except for health services aligned with national targets.

    b. Future benefit packages shall itemize health services subject to cost-sharing mechanisms.

7. PhilHealth shall use cost data based on or aligned with the standard costing framework and methodology (PhilHealth Circular No. 2023-0015 entitled, "Implementing Guidelines On The PhilHealth Framework And Methodology For Costing Of Health Services (Revision 1)" and its succeeding revisions) for estimating the cost-sharing rates of future benefit packages.

    a. The nature of covered individual-based health services shall be considered in the estimation of the cost-sharing rate.

    b. The estimation of cost sharing payments shall be defined and detailed within the different benefit packages.
    b.1 Estimation shall be designed appropriate to the nature of their covered individual-based health services and desired incentives.
    b.2 Adjustment of rates using relevant factors, such as but not limited to: age of demographic served, gender of demographic served, geographic location, facility ownership, inflation.

8. Cost sharing mechanisms shall be only applicable to charges that patients are subject to from health care facilities and providers.

    a. Cost-sharing rate shall be charged to the patient at the point of care.

    b. Claim forms shall reflect the type of accommodation used.

    c. Statements of Account (SOA), or equivalent document, shall reflect the cost-sharing payment applied.

9. The implementation of cost sharing mechanisms shall be published in the relevant PhilHealth Circular of the corresponding benefit.

a. For existing benefits, the relevant PhilHealth Circular will be updated to reflect the cost sharing mechanisms as necessary. These shall also be released to the public through PhilHealth advisories.

b. The PhilHealth Circular will include the development of a communication and information dissemination plan to ensure that patients have access to the relevant information.

10. PhilHealth shall set the cost-sharing rate for future benefits, following the aforementioned cost-sharing mechanism per type of service and payment mechanism.

B. **Development of Cost Sharing Mechanisms**

1. Cost sharing schemes and rates shall be designed appropriate to the payment mechanism of the benefit.

   a. For Primary Care benefit paid for through Capitation, a flat fixed fee copayment shall be implemented. Copayment shall be applicable in cases wherein a patient seeks care from private Primary Care Providers.

   b. For case-based and standalone outpatient benefits, a flat fixed fee copayment shall be implemented. This shall be costed as a fixed portion of the PhilHealth predetermined case rate.

   c. For case-based inpatient benefits, a fixed fee per bed day shall be implemented depending on the type of non-basic accommodation and level or type of facility. Co-payment shall be applicable in the following cases:

      c.1. Cases wherein a patient requests non-basic or non-ward accommodation.
      c.2. Cases wherein a patient requests additional amenities.

2. Cost sharing schemes may be modified depending on the implementation of the given schemes and based on the strategic directions of the health sector.

C. **Utilization for Cost Sharing**

1. Payments collected from cost sharing shall be declared as income of the respective health facility for accounting purposes.

2. Applicable taxes shall be applied to cost sharing payments upon utilization in accordance with revenue regulations of Bureau of Internal Revenue.

D. **Accounting of Cost Sharing Payment**

1. The health care facility may use cost sharing payments at their discretion subject to the usual accounting and governing rules and regulations of each facility.

2. Each health facility shall create and maintain appropriate recording mechanisms on the flow and utilization of funds derived from cost sharing payments.

E. **Monitoring and Evaluation of Cost Sharing**

1. The Commision on Audit shall reserve the right to conduct audits based on the guidelines set forth in this PhilHealth Circular.

2. PhilHealth shall establish and monitor performance targets that will ensure accountability toward providing health care services.

3. PhilHealth shall conduct periodic evaluations of facilities and patients through utilization reviews and other methodologies to assess the quality of healthcare services provided.

4. PhilHealth shall conduct facility assessments to evaluate the operationalization of the cost sharing mechanisms.

5. PhilHealth shall monitor and investigate grievance reports filed by beneficiaries and providers following existing guidelines of the Corporation. Reports or complaints may be filed through the Feedback Management Response (FMR) of PhilHealth. These complaints may also be handled following the quasi-judicial process of PhilHealth, as needed.

6. PhilHealth reserves the right to inquire regarding the accounting of cost sharing payments.

7. PhilHealth shall report violations to cost sharing mechanisms to the Department of Health in accordance with Section 9 of the UHC Act (RA No. 11223), as necessary.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular, terms and conditions of the Performance Commitment and/or Contracts, and all existing related PhilHealth Circulars shall be dealt with and penalized in accordance with the pertinent provisions of Republic Act No. 7875, as amended by Republic Act Nos. 9241 and 10606 (National Health Insurance Act of 2013) and Republic Act No. 11223 (Universal Health Care Act) and their respective Implementing Rules and Regulations, and other pertinent laws and rules.

VII. TRANSITORY CLAUSE

The PhilHealth Cost Sharing mechanisms will be applicable for future benefits and should be reflected therein. Otherwise, the adoption and implementation of these for existing PhilHealth benefits shall be done through amendments to the relevant PhilHeath Circular.

VIII. SEPARABILITY CLAUSE

If, for any reason, any part of this PhilHealth Circular is declared invalid or unconstitutional, any part or provision not affected thereby shall remain in full force and effect.

IX. REPEALING CLAUSE

All previous issuances that are inconsistent with any provisions of this PhilHealth Circular are hereby amended, modified, or repealed accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall be published in any newspaper of general circulation and shall take effect fifteen (15) days after its publication. Further, this PhilHealth Circular shall also be deposited thereafter with the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA JR.
President and Chief Executive Officer

Date signed: 4/19/24

MASTER COPY
DC: Date: 5/2/24