Republic of the Philippines
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PHILHEALTH CIRCULAR
NO. 2024 - 0018

TO : PHILHEALTH REGIONAL OFFICES, NATIONAL GOVERNMENT AGENCIES, GOVERNMENT OWNED AND CONTROLLED CORPORATIONS, ACCREDITED HEALTHCARE PROVIDERS AND FACILITIES, HEALTH MAINTENANCE ORGANIZATIONS, DIRECT CONTRIBUTORS, AND ALL OTHERS CONCERNED

SUBJECT : Guiding Principles on Supplemental Health Insurance Coverage (PhilHealth Plus)

I. RATIONALE

Philippine Health Insurance Corporation (PhilHealth) by virtue of Section 11 of Republic Act No. 11223 entitled the "Universal Health Care Act" is mandated to provide supplemental benefits on top of the basic health package managed through a supplemental benefit fund financed through additional premiums.

In setting up a supplemental benefit package, PhilHealth issued PhilHealth Board Resolution No. 2398 s.2018 creating PhilHealth Plus for this purpose.

II. OBJECTIVES

This PhilHealth Circular establishes PhilHealth Plus as a voluntary health insurance product offered by PhilHealth providing supplemental and complementary health insurance coverage.

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III. SCOPE AND COVERAGE

This policy outlines the core principles that will guide the implementation of PhilHealth Plus as stipulated in any and all succeeding policy issuances concerning the program. Provisions in the policy do not extend to any policies and benefits covered through standard PhilHealth insurance to which payments are derived from different premiums operating under a different benefit fund and different core principles and policy interests.

IV. DEFINITION OF TERMS

A. **Benefit Rider** – an optional insurance policy that adds benefits to or amends the terms of a basic insurance policy.

B. **Co-payment** - a predetermined fee or rate paid at point-of-service before accessing insurance, as may be determined by PhilHealth Plus.

C. **Complementary Health Insurance** – health insurance designed to provide coverage for the cost share for health services accessed by the insured within the period of coverage.

D. **Complementation** – an approach to health financing whereby multiple payors within a set jurisdiction design payments efficiently in the interest of lowering out-of-pocket expenditure and increasing health service utilization.

E. **Cost share** – the portion of the total cost of care that is not paid by the insurer. This constitutes the total amount subject to co-insurance, co-pay, or out-of-pocket payment.

F. **Health Maintenance Organization** - an entity that provides, offers, or covers designated health services for its plan holders or members for a fixed prepaid premium.

G. **Maximum Benefit Limit (MBL)** – the annual maximum payable amount per disease per admission.

H. **PhilHealth Plus** – a program providing supplemental benefits and complementary coverage provided by the Corporation on top of basic PhilHealth benefits.

I. **PhilHealth Plus Premium** -- the premium amount per beneficiary set by the Corporation to be paid by the individual, agency, or institution for any given period of coverage.

J. **PhilHealth Plus Provider** – are providers engaged by PhilHealth Plus to provide supplemental coverage.

K. **Reinsurance** - a contract between a reinsurer and an insurer whereby the insurer transfers some of the risk to the reinsurer who assumes all or in part of the risks from insurance policies issued by the insurer.

L. **Supplementary Health Insurance** - health insurance designed to provide coverage for services not covered through universal health coverage.

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V. POLICY STATEMENTS

A. PhilHealth Plus shall be constituted as a health insurance program by PhilHealth in complementation with universal health coverage in alignment with a complementarity framework.

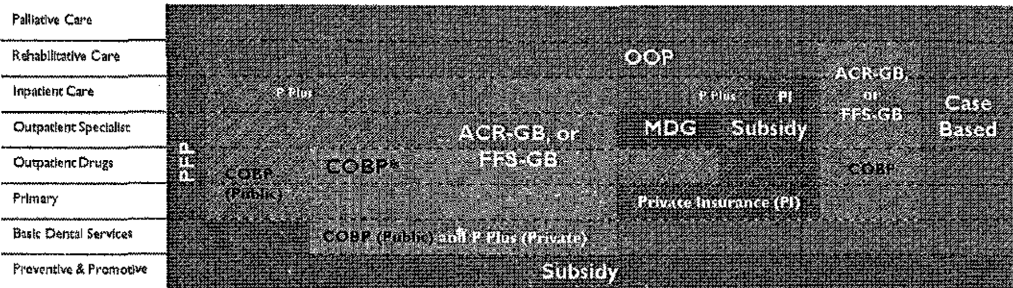

Figure 1: Social Health Insurance Complementarity Framework.

B. PhilHealth Plus shall be designed to provide both supplemental & complementary health insurance.

1. PhilHealth shall implement PhilHealth Plus as a supplemental health insurance product, to which:
    a. Coverage under PhilHealth Plus shall include benefits and services not included in Standard PhilHealth Packages (SPPs); and,
    b. PhilHealth Plus may engage with healthcare providers not currently accredited and/or contracted with PhilHealth. This includes outpatient clinics, medical arts centers, diagnostic centers, dental clinics, and pharmacies, among others as may be deemed necessary to provide inclusive benefit packages.

2. PhilHealth shall endeavor to ensure that coverage under PhilHealth Plus acts in complementarity to universal health coverage and to other means and avenues for health financing which includes: Coverage provided through Private Health Insurance (PHI) and Health Maintenance Organizations (HMOs), health subsidies, corporate insurances, health saving accounts (HSAs), health loans, among others.

3. PhilHealth Plus shall be programmed to, in part or in full, cover for the cost share of their beneficiaries on top of SPPs in the interest of lowering out-of-pocket expenditure.

4. PhilHealth shall operate PhilHealth Plus under a principle of parity whereby it aims to provide equitable and fair access to supplemental and complementary health coverage to all interested persons temporarily or permanently residing in the Philippines, to which PhilHealth Plus shall incrementally expand coverage for.

5. PhilHealth Plus shall be provided on a voluntary basis, to which:

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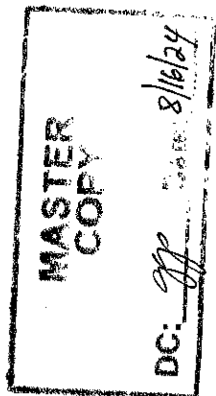
a. All domestically visiting or residing persons shall have the right to purchase PhilHealth Plus coverage, provided that there is an available insurance plan designed for them;
b. All interested institutions shall have the right to sponsor PhilHealth Plus coverage for identified populations, provided the creation of subsequent rules on subsidization;
c. Persons who secured PhilHealth Plus coverage through their employers or affiliate organizations shall have been assumed to have provided implied consent through association unless they explicitly withdraw from the program;
d. All persons shall reserve the right to opt-out from participating in the program. No person shall be coerced into purchasing PhilHealth Plus; and,
e. Persons who have opted out from the program shall not have to pay applicable premiums, but shall likewise not be entitled to coverage.

C. PhilHealth shall define the appropriate provider payment mechanism for PhilHealth Plus, in which:

1. a blended payment method shall be used for PhilHealth Plus, where:
    a. Payment methods shall be rationalized based on the services covered, anticipated behavior of service providers, assumed dispersion of risks, and consumer behavior;
    b. PhilHealth may use a mix of prospective & retrospective payment methods in purchasing health services under PhilHealth Plus. This can include Fee-For-Service (FFS), Capitation, including Global Budgets, Per-Diem Payments, Case-based payments, and Diagnosis Related Groups (DRGs).;
    c. Adopted payment methods shall be rationalized based on market practice with the intention, at the minimum, of matching private sector coverage and with due consideration of social health insurance (SHI) and tax-based subsidies, to ensure parity across all persons seeking financial coverage within the country;
    d. Provider Payment Methods shall be aligned with national health financing strategies; and,
    e. PhilHealth shall aspire to transition towards predominantly close-ended, prospective payments in alignment with SPP payment methods, where practicable and appropriate.



2. PhilHealth shall, in implementing PhilHealth Plus, avoid double payments for benefits and services already covered through SPPs. Likewise, PhilHealth shall avoid providing duplicate benefits already covered in SPPs.

3. Denied payments for SPPs shall not immediately constitute a denial of PhilHealth Plus payment. A separate claims adjudication process and claim submission requirements shall be set for PhilHealth Plus.

4. PhilHealth shall endeavor to manage supply induced demand (SID) and overutilization under PhilHealth Plus, in which:
    a. Co-payment shall be set for cases with high moral hazard;
    b. Co-payment shall be determined outside of the cost of the service;
    c. Co-payment shall be set high enough to deter irrational utilization but low enough to not act as a barrier to access. It shall be calibrated regularly, factoring in macro and microeconomic factors influencing buying behaviours; and,
    d. PhilHealth Plus shall likewise endeavor to apply network regulation strategies by working with regulatory agencies and the private sector in monitoring and regulating provider behaviour in order to deter tendencies for SID, when undesired.

5. PhilHealth in coordination with the private health insurance sector shall endeavor to standardize all fees and/or rates, including those for PhilHealth Plus, with its accredited healthcare providers in order to control for the out-of-pocket spending of its beneficiaries.

6. PhilHealth shall have the ability to employ co-insurance rules or determine cost-share limits for PhilHealth Plus in accordance with the standardized fees and rates, subject to provider payment design, the limits of the supplemental benefit fund, its risk pool, and market dynamics.

D. Coverage

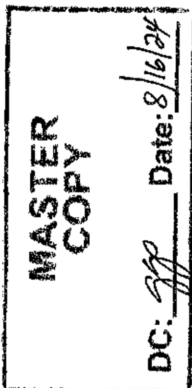
1. PhilHealth shall provide individual coverage for PhilHealth Plus with corresponding individual-based premiums.

2. PhilHealth shall have the ability to extend coverage for PhilHealth Plus to dependents subject to additional premium payments.

3. PhilHealth shall have the ability to extend coverage for PhilHealth Plus to non-Filipinos, subject to existing laws and regulations.

E. Insurance Designs

1. Various insurance designs may be employed in PhilHealth Plus as deemed necessary. It can include group insurance, individual insurance, and any other insurance products that fit the appropriate modality for the benefit it intends to provide. Specifically:
    a. PhilHealth Plus can utilize group insurance schemes to capture organized groups, employers, and sponsored populations, among others;
    b. PhilHealth Plus can utilize individual insurance schemes to provide coverage for individuals interested in purchasing health insurance. This includes but is not limited to short-term health insurance, term insurance, among others; and,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c. PhilHealth Plus can utilize other insurance schemes including single use insurance, managed care plans, among others as deemed necessary.

2. PhilHealth shall determine applicable premiums for PhilHealth Plus based on the assumed risks of the pool of beneficiaries. Premiums can be stratified based on market segments defined either through or a combination of demographic variables.

3. PhilHealth shall have the ability to adjust premiums for PhilHealth Plus on an annual basis, as may be deemed necessary, in order to properly align premium collection with anticipated benefit payout. Adjustment to premiums shall be defined through actuarial estimates in the interest of achieving actuarial fairness.

4. PhilHealth shall have the ability to set up benefit riders under PhilHealth Plus. This shall allow for flexibility in insurance design whereby beneficiaries can determine the extent of coverage relative to their willingness to pay.

5. PhilHealth Plus may be implemented together with the primary care benefit package and other SPPs to ensure adequate financial risk protection.

F. Benefit Coverage

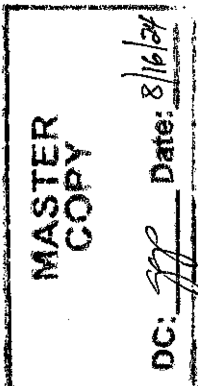
1. PhilHealth shall develop a benefit plan for PhilHealth Plus to outline service and benefit inclusions.

2. The benefit plan shall be aligned with the PhilHealth Benefit Plan whereby as coverage expands for SPPs, PhilHealth Plus benefit inclusions shall be adjusted accordingly.

3. The benefit plan shall outline supplementation and complementation arrangements. It shall endeavor to inform other health payors, including PHIs and HMOs, health subsidies, corporate insurances, HSAs, and banks providing health loans, among others, on the minimum service inclusions to achieve complementarity.

4. PhilHealth Plus shall endeavor to coordinate with other health payors to enable parity in coverage and efficient allocation of resources.

5. PhilHealth Plus shall have the ability to cover a wide array of health services provided that the inclusive costs have been appropriately costed and included in the premium. This can include:
   a. Annual Physical Examination (APE) for employed personnel;
   b. Pre-employment physical examinations;
   c. outpatient services, commodities, and diagnostics;
   d. healthcare amenities; and,
   e. any other health service or commodity determined to be suitable for supplementation or complementation.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G. Fund Management

1. PhilHealth shall set up a Supplemental Benefit Fund (SBF). The SBF shall be managed separately from the PhilHealth Benefit Fund and it shall be constituted by additional premium payments through PhilHealth Plus.

2. In setting up the SBF, PhilHealth shall coordinate with appropriate regulating agencies, including the Commission on Audit, to ensure the appropriate management of insurance funds.

3. PhilHealth shall maintain separate financial reserves for PhilHealth Plus in order to ensure sufficient resourcing to pay for anticipated annual liabilities.

4. In excess of the reserves, PhilHealth may have the ability to maintain a statutory surplus fund.

5. Both the financial reserves and statutory surplus shall be actuarially set and shall be reported in accordance with local and global accounting standards.

6. All funds created in the interest of implementing PhilHealth Plus shall be subject to internal and external audit.

7. PhilHealth may seek reinsurance arrangements for PhilHealth Plus through public or private financing institutions.

H. PhilHealth Plus Providers

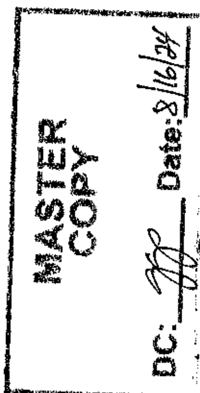
1. PhilHealth may employ a group accreditation or network contracting process in engaging provider networks.

2. PhilHealth Plus shall engage provider networks that meet group accreditation or network contracting standards to provide the benefits identified by PhilHealth Plus. Engaged provider networks shall hence be referred to as PhilHealth Plus Providers.

3. PhilHealth Plus Providers can include HMOs, PHIs, and other relevant organizations.

4. PhilHealth Plus Providers shall be engaged to carry out various functions to ensure the efficiency of operations. This includes but is not limited to client management, facilitating provider payments, and claims processing. Agreements set forth are defined within Third-Party Administration (TPA) agreements within group accreditation or network contracting.

5. PhilHealth Plus Providers shall ensure that all benefits and health services covered are made available and accessible for its assigned beneficiaries.



6. PhilHealth Plus Providers shall ensure that they have access to a fully functional and appropriate electronic health information system to manage day-to-day operations, including but not limited to patient management, claims submission and processing, and financial reporting.

7. A PhilHealth Plus card may be created and distributed by PhilHealth Plus Providers as an identifier of the beneficiaries as needed.

8. Applicable rules on group accreditation and/or network contracting shall be published through a separate circular.

I. Standards and Monitoring

PhilHealth shall employ mechanisms to assure quality healthcare. Performance targets shall be identified to guide all concerned stakeholders in their accountability toward providing quality and efficient services.

PhilHealth shall utilize electronic systems to facilitate the implementation of PhilHealth Plus including building a system to make it interoperable with primary care, other benefit packages, and inpatient availment for monitoring purposes for immediate feedback and documentation of actual patient encounter transactions.

J. Marketing and Promotion

PhilHealth Plus shall have a unique and distinct identifier. Unauthorized reproduction of the PhilHealth Plus logo and other brand elements shall be subject to legal action based on applicable laws.

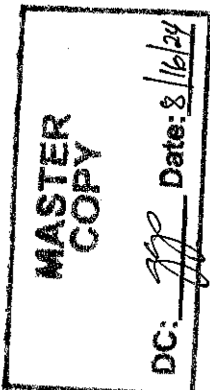
PhilHealth shall conduct communication and social marketing activities to increase awareness of stakeholders on the PhilHealth Plus Package. This can include but is not limited to the following:

1. Marketing and promotion delivered through in-person, social media, radio and television;
2. Production of video clips, pamphlets, and brochures, on the benefits of PhilHealth Plus; and/or,
3. Setting up a dedicated website page for PhilHealth Plus.

VI. MONITORING AND EVALUATION

1. All PhilHealth Plus Providers shall be subject to existing PhilHealth rules on performance monitoring.

2. The program shall be monitored and evaluated using a predefined monitoring tool specific to PhilHealth Plus as approved by the Corporation. Any recommendations in the result of the monitoring shall be utilized to improve PhilHealth Plus program implementation.



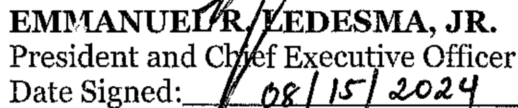
3. This policy issuance shall be reviewed regularly and enhanced as necessary.

VII. SEPARABILITY CLAUSE

Should any of the provisions of this circular be declared invalid, unconstitutional or unenforceable in whole or in part by any competent authority, it shall not affect or invalidate the remaining provisions thereof.

VIII. DATE OF EFFECTIVITY

This circular shall take effect immediately following its publication in a newspaper of general circulation. Three (3) certified true copies shall thereafter be deposited 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: 08/15/2024