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Feasibility of Supplemental Funds from the Private Sector for Catastrophic Illness Financing

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Philippine Institute for Development Studies
Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas

Feasibility of Supplemental Funds from the Private Sector for Catastrophic Illness Financing

*Noel R. Juban, Benito R. Reverente, Jr.
and Maria Socorro S.D. Santos*

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FINAL REPORT

Feasibility of Supplemental Funds from the Private Sector for Catastrophic Illness Financing

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AHA	Aquino Health Agenda
AHMC	Asian Hospital and Medical Center
CCU	Critical care unit
COA	Commission on Audit
DOH	Department of Health (Philippines)
EENT	Eye, ear, nose, throat
HMO	Health Maintenance Organization
ICU	Intensive Care Unit
KP	Kalusugan Pangkalahatan
NBB	No Balance Billing
NHIP	National Health Insurance Program
NHS	National Health Service (British)
NSHIF	National Social Health Insurance Fund
OOP	Out-of-pocket expenses
PHIC/PhilHealth	Philippine Health Insurance Corporation
PNHA	Philippine National Health Accounts
PhP	Philippine Peso
RA	Republic Act
SEC	Securities and Exchange Commission
SLMC	St. Luke's Medical Center
STDs	Sexually transmitted diseases
THC	Total Household Consumption
THE	Total Health Expenditures
WHO	World Health Organization

ABSTRACT

Background

Catastrophic illnesses can push a household into poverty by causing unmanageable, or catastrophic, expenditures for their treatment or management. *Kalusugan Pangkalahatan* aims to provide financial risk protection for the poor. Hence, insurance coverage for catastrophic illnesses, need to be strengthened. However, the scope of the PhilHealth Z benefits, which was developed to protect Filipinos affected with certain medical conditions from financial catastrophe, are limited. Supplemental insurance can provide services beyond the basic benefit package of the national insurance (complementary insurance) or provide upgrades for services that are already covered by the national insurance (supplementary insurance). This report provides an analysis of the feasibility of supplemental funds from the private sector, specifically from HMOs and self-insured companies, for the Z benefits program.

Methodology

Key informant interviews were conducted with representatives of PhilHealth, HMOs, and self-insured companies to determine the constraints, prospects and requirements to implement a supplemental fund. Results were analyzed by thematically.

Results

The Z benefits currently include nine packages which can be availed in selected government hospitals and are paid through package rates. The conditions currently covered are breast cancer, prostate cancer, cervical cancer, acute lymphocytic leukemia, kidney transplant, limb prosthesis, coronary artery bypass graft surgery, surgery for Tetralogy of Fallot, and surgery for ventricular septal defect.

HMOs and self-insured companies also cover catastrophic illnesses through HMO packages and employee benefits, respectively. In the present arrangement, the private sector is basically supplementing the PhilHealth Z benefits already, although not in coordination with PhilHealth.

Only one out of five interviewees from HMOs and self-insured companies is open to contributing to a supplemental fund. Since Z benefits is only provided by government hospitals, the participation of the private sector is limited because they are often affiliated with private hospitals only.

The revised National Health Insurance Act of 2013 has provisions for setting-up a supplemental fund to provide additional services for those who can pay. If this fund needs to be established, there may be a need for PhilHealth to hire additional staff, develop new infrastructure, and develop new information systems to manage the supplemental fund. The HMO industry should also be better regulated by the national government to ensure quality services.

Conclusion

Establishing a supplemental fund from the private sector for catastrophic illness financing is currently not feasible. The supplemental fund can be lodged in PhilHealth or outsourced to HMOs. However, managing a supplemental fund would require operational, institutional, and legal changes to be made by PhilHealth. On the other hand, better regulation of the HMO industry is also required. Regardless of how the supplemental fund will be managed and implemented, it is imperative to conduct studies on the incidence and costing of catastrophic illnesses first to make the supplemental fund viable.

Keywords: Catastrophic illness financing, supplemental insurance, HMO, private health insurance

INTRODUCTION

Catastrophic illnesses are defined by the World Health Organization as those that cost a family 40% or more of the non-sustenance income, which is the income left after the basic needs have been met. Health expenditures in catastrophic illnesses may also cause the family to compromise their spending on food, clothing, and even education for their children. On the other hand, many poor patients often decide not to avail of medical services because they cannot afford it. However, most of these patients still end up being pushed further into poverty because of the negative effects of the illness on their earning capability, or because of the greater expenses when they decide to get treatment at a worse stage of the illness.

Kalusugan Pangkalahatan (KP), launched in 2010 as part of the Aquino Health Agenda (AHA), aims to achieve universal health care for all Filipinos by ensuring equitable access to health services, particularly for the lowest income quintiles. KP has three goals: first is financial risk protection, especially for the poor, against catastrophic expenditures; second is a responsive health system and client satisfaction through improved health facilities and services; and third is better health outcomes through achievement of the Millennium Development Goals.

The Philippine Health Insurance Corporation (PhilHealth) is the national health insurance of the Philippines since 1995. It “shall provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines” (Republic Act (RA) 7875).

The minimum services available for all PhilHealth members are inpatient medical care (room and board, professional fees, laboratory fees, drugs, and inpatient education package), outpatient care (professional fees, laboratory fees, preventive services, and prescription drugs), and emergency care. Annual review and expansion of these services shall be done to assess financial sustainability and adapt to changes in medical technology. But the ultimate goals of these assessments are “quality assurance, increased benefits and reduced out-of-pocket expenditure” (RA 10606). Moreover, expansion of PhilHealth enrollment and benefit delivery is the strategy of the AHA to achieve the KP goal of financial risk protection.

In June 2012, PhilHealth launched the benefit package for type Z cases, which are conditions that can be medically and financially catastrophic. Case type Z is defined by PhilHealth as “any illness as a primary condition that is life or limb-threatening and requires prolonged hospitalization, extremely expensive therapies, or other care that would deplete one’s financial resources, unless covered by special health insurance policies”. Through this program, a member will be assured of continuous medical care and protection from sudden, excessive medical expenses.

However, the cases included in the type Z case benefit packages are few and members have to meet eligibility criteria to avail of these benefits. There are currently only nine type Z cases and the Z benefits can only be availed in a limited number of government hospitals. A possible hypothesis to augment the Z benefit package is through a supplemental fund coming from other major players in health financing in the Philippines, like the Health Maintenance Organizations (HMOs) and self-insured companies. This balance of private and public funding may be beneficial for the private sector, PhilHealth, and especially to the population by increasing the breadth and depth

of catastrophic illness coverage in the Philippines. Addressing the limitations of the current Z benefits will enable the government to provide financial protection to more Filipinos and come closer to providing quality health care for all Filipinos.

Based on the literature review, there are no studies that explore the feasibility of the use of supplemental funds from the private sector for catastrophic illness financing in the Philippines.

This paper will involve a review of policies and studies on catastrophic illnesses. The results of key-informant interviews, which probe the Z benefits program and explore the possibility of supplemental funds from the private sector, in particular, HMOs and self-insured companies, will then be presented and discussed.

OBJECTIVES

The study aims to:

- Undertake an analysis of the role of the PhilHealth (through Z Benefits Program), the Health Maintenance Organizations (HMO) and self-insured companies in financing catastrophic illnesses
- Assess the current constraints and prospects of the funds from these institutions as source of supplemental health insurance financing in the future
- Determine the legal, institutional, regulatory, and operational and management factors that should be in place to improve the Philippine environment for private supplemental health insurance.

REVIEW OF RELATED LITERATURE

The Burden of Catastrophic Illnesses

Currently, there is no consensus on the definition of catastrophic illnesses. PhilHealth defines catastrophic illnesses as those that push households into poverty (PhilHealth, 2012). The World Health Organization (WHO) defines it as health expenditures that account for 40% or more of the non-sustenance household income, which is the income left after the basic needs have been met (WHO, 2000). Some studies define catastrophic payments as exceeding a certain fraction of the total household budget, which may be set at different threshold levels. The incidence of catastrophic payments decreases as the threshold is increased. On the contrary, the incidence increases when catastrophic payments are computed based on the non-food budget. (Chuma and Maina, 2012; Somkotra and Lagrada, 2008; van Doorslaer et al, 2007).

Catastrophic payments can have short-term effects, when the family compromises their spending on food, clothing, or long-term when families sell assets, are put into debt, or compromise education for their children. In India, a study showed that households with higher total household consumption (THC) also have higher OOP (Peters et al, 2001). Many poor patients often decide not to spend on medical services because they cannot afford it; thus, compromising their health. Most of these poor patients still end up being pushed further into poverty because of the negative effects of the illness on their earning capability, or because of the greater expenses when they decide to get delayed treatment at a more advanced stage of the illness.

KP stressed that quality health services should be affordable, available and accessible to all members of our society. The basic benefit packages of PhilHealth cover professional fees, medicines, supplies and laboratory examinations but have a maximum allowance for coverage. The case rate is the maximum amount PhilHealth will cover for individually paying and employed members; the actual expense in excess of it will be OOP for the member. Also, there is a maximum limit of 45 hospitalization days per year, and a “single period of confinement rule” such that an admission and readmission within 90 days for the same condition will only be compensated with one case rate benefit (PhilHealth, 2013). Hence, in the case of illnesses that require prolonged, frequent hospitalization and very expensive treatments, paying for health needs would cause high OOP and surely deplete the financial resources of a household, especially the poor.

Up to 11% of the population in some countries suffers severe financial hardship each year due to health expenses, with up to 5% forced into poverty (WHO, 2010). In Asia, the Philippines has one of the lowest percentage and intensity of catastrophic payments. It is estimated that 4.6% of Philippine households incur catastrophic payments at threshold OOP of 10% of the total expenditures on health care. However, this may underestimate the incidence of catastrophic illnesses because using OOP to estimate catastrophic payments does not reflect the households exposed to catastrophic illnesses but opt not to spend for health care (van Doorslaer et al, 2007).

The incidence of catastrophic illness among enrollees of the leading HMOs in the Philippines from 1995-2000 was 3-3.5% of all confinements, according to a study done in 2008. Catastrophic illness was defined with respect to the maximum limit per confinement of HMOs: any illness that needed hospitalization with costs beyond PhP

100,000-200,000 was considered catastrophic. During that same period, the total number of HMO enrollees ranged from 400,000 to 500,000 persons. The average hospitalization rate was 6-7%, and the average length of hospital stay was three days. (Reverente, B. unpublished)

Out of pocket payments and Financial Catastrophe

Health systems which require out-of-pocket payments are the most inefficient and inequitable. Under such health systems, a household with a low capacity to pay and a lack of a prepayment mechanism for risk pooling, financial catastrophe may occur. (WHO, 2000)

The amount of OOP has a positive relation to the proportion of households with catastrophic health expenditures. Moreover, a triad of poverty, moderate to high utilization of health services, and the lack of prepayment or health insurance contribute to catastrophic health expenditures. (Xu et al, 2003)

WHO reports that the incidence of financial catastrophe only becomes negligible in a country once the OOP are decreased to 15-20% of the THE. In order to achieve this, prepayment mechanisms may be developed through a social health insurance, taxed-based health financing, private insurance or a combination of the three. Exploring other sources of funds to provide more services and increase coverage benefits may help decrease the out-of pocket expenses of individuals. Especially for illnesses which demand high costs, it may help decrease the incidence of financial catastrophe. (WHO, 2000)

Health Financing in the Philippines

The Philippines Health Systems Review states that there are four main sources of health financing (Romualdez et al, 2010). These are the national and local government, government and private insurance, out-of-pocket payments and donors. An additional source of income overlooked by this study is the self-insured companies, which contribute a significant amount to Philippine health financing.

The Philippine National Health Accounts (PNHA) in 2011 indicates that among financing sources, out-of-pocket expenses has the largest share, comprising 52.7% of the total health expenditure. During that period, the share of national government is 12.3%; local government, 14.7%; social health insurance, 9.1%, HMOs 5.7%, and private insurance 1.7%. (PSA, 2011)

PHIC. PhilHealth was established in 1995 to implement the National Health Insurance Program (NHIP), which will provide quality, accessible, affordable, equitable, and universal healthcare to all Filipino citizens (Republic Act 7875). Run by the government, PhilHealth pools and distributes the citizens' resources through premiums, ensuring that health services will be available to everyone. Through the principle of solidarity, those who are able to pay subsidize the poor, and healthy individuals subsidize those who are sick. The membership type is dependent on a person's capability to pay and employment. Every member can avail of benefit packages in accredited institutions, applicable for both in- and outpatient services.

The PhilHealth basic benefit package is available to all members. It covers part of the total hospital bill of a patient, the extent of which depends on a variety of factors such as the severity of the case, type of health facility, and maximum benefit package.

Unfortunately, in the case of catastrophic illnesses, the basic benefit package was not enough to cover the medical expenses, so members who are not sponsored will have high OOP.

The PhilHealth No Balance Billing Policy (NBB) is available only for sponsored members. Under NBB, PhilHealth will shoulder the full hospital bill of the patient, so there will be zero OOP (PhilHealth, 2011). According to the 2013 PhilHealth Statistics, 31% of the registered members are under the Sponsored Program, 17% in the Individually Paying Program, 33% Private Employed, 7% Government Employed, 10% Overseas Workers, and 2% Lifetime Members. At that same period, only 34% of sponsored member claims were NBB (PhilHealth, 2013).

The PhilHealth Z Benefits was launched in 2012 to provide support for illnesses that may be financially catastrophic to Filipinos. There are currently 9 conditions that have Z benefit packages (breast cancer, prostate cancer, cervical cancer, acute lymphocytic leukemia, kidney transplant, limb prosthesis, coronary artery bypass graft surgery, surgery for Tetralogy of Fallot, and surgery for ventricular septal defect). These packages cover all diagnosis and treatment expenses. No Balance Billing applies for indigents while other members have co-payments.

HMO. An HMO is an organization that provides pre-agreed health services to a group of voluntary members on the basis of a prepaid contract (Encyclopedia Britannica). HMOs started in the United States in 1929 as a group practice of physicians that provided health services for company employees for a prepaid monthly fee. It was a means to address the increasing cost of healthcare during that period.

The HMO industry in the Philippines had a slow start. The first HMOs in the Philippines were established in the 1970s but were mostly unsuccessful. It was not until the 1980s when they were able to get a good hold in the market and experienced a rapid growth in the 1990s. Until now, the HMO industry is steadily growing not only in number of companies, clients, and revenues, but also in its share in national health expenditures. The share of HMOs in THE increased from 1.3% in 1992 to 5.7% in 2011. As of 2012, 22 HMOs have a license to operate from the Department of Health (DOH) (BHFS, 2012).

DOH has regulatory power over the health services aspect and grants HMOs the license to operate, while the Securities and Exchange Commission (SEC), the government agency that regulates the corporate and capital market infrastructure, covers HMO operations as a corporation. The requirements for license renewal include a statement of financial reserves in liquid securities, audited financial reports, and operational reports (BHFS, 2012).

Although HMOs are required to register with the SEC, SEC does not have regulatory power because HMOs do not sell securities. Moreover, there is no regulation in terms of the financial aspect of HMOs. Financial regulation is primarily through the actuaries of the HMOs. The government is currently planning to transfer the authority of HMO regulation to the Insurance Commission in order to focus more on the financial stability of HMOs (Palabrica, 2014).

In 1987, the six existing HMOs at that time established the Association of HMOs of the Philippines (AHMOPI). It is the “recognized trade association of HMOs in the

country” (www.ahmopi.org.ph). Currently, there are 14 HMOs that are AHMOPI members. These are Blue Cross Health Care Inc., Caritas Health Shield, Inc, Cocolife Health Care, Fortune Medicare Inc., Health Maintenance, Inc., Insular, Health Care, Inc., Intellicare, Maxicare Healthcare Corp., Medicard Philippines, Inc., Medocare Health Systems, Inc., Philhealth Care. Inc., Star Healthcare System, Inc., and Value Care Health Systems, Inc.

Part of AHMOPI’s tasks is self-regulation, primarily of marketing and financial standards, for its member HMOs. These standards include commissions for brokers, standard procedures that can be covered, and premium discounts, discipline and a code of ethics (Chua, 2006).

HMOs have standard packages which include catastrophic illnesses but the coverage is limited by the premiums. These packages will be presented as part of the desk review results.

Self-insured companies. Self-insured companies set aside a calculated amount of money to compensate for a future risk, in this case, health expenses, of their employees. The coverage for catastrophic illnesses depends on the company. Instead of buying from a commercial insurance company, the company pays for the health care of employees directly. However, there are only a limited number of self-insured companies in the country. The three biggest self-insured companies in the Philippines are PLDT, San Miguel, and Meralco.

Private and public health financing

Contracting or purchasing health care is a strategic method of purchasing health services that considers the target population and desired services. In contrast, traditional passive, input-based funding is based on historical budget allocations. Purchasing services from the private sector does not reduce the involvement of the government in providing health services. It actually results to a “greater engagement (of the government) by securing sustainable financing”. Competition within the private sector can also increase the efficiency of the system. (Preker, 2005)

However, contracting requires the government to increase its capacity in competitive bidding, regulation, and coordination of the private providers. Issues that should also be considered are the capacity of the private sector to provide services at a national scale and their willingness to cover the very poor, which may result in inequities. (Loevinsohn and Harding, 2005)

Supplemental insurance has two types: complementary and supplementary. Complementary insurance allows citizens to avail of services beyond the basic benefit package of the national insurance while supplementary insurance can provide upgrades for services that are already covered by the national insurance. Both the government and the private sector can provide supplemental insurance. In Croatia, a new supplemental insurance law has been implemented. This supplemental insurance can only be purchased from the national health insurance. The law re-classified some services that were previously part of the basic benefit package into categories requiring higher co-pays and then introduced a supplemental health insurance to cover these higher co-pays and the use of high-end services in private facilities. However, issues have arisen from this new law such as decline in quality of care for those who cannot pay for the supplemental insurance and generating debts in the local governments which

will subsidize children, pensioners, those who are disabled, and other members of the population who do not pay contributions (Langerbrunner, 2002).

In the European Union, private supplemental insurance is being utilized by many member countries. The supplemental insurance commonly provides upgrades of national health insurance services, such as facilities and private care. (Mossialos and Thomson, 2002). A well-designed private supplemental insurance can reduce the burden of public insurance by covering certain conditions or population groups. Moreover, the more advanced information and management technologies used by private insurance companies can spill-over to and improve the national health insurance system. However, a possible unfavorable scenario is private insurers selecting beneficiaries who are healthier or illnesses with predictable costs of treatment in order to maximize profits. The more difficult and expensive conditions will then be left to the national insurance. This can be avoided by carefully designing the insurance system (Langerbrunner, 2002).

Private insurance is an option for citizens who prefer services that are not provided by the national insurance. These citizens may be allowed to opt out of contributing to the national insurance, but this can reduce the total collections, and consequently the revenues and coverage, of the national insurance. Complementary and supplementary insurance can provide private services without citizens opting out of national insurance contributions (Anderson and Hussey, 2005).

However, transfer of benefits from mandatory social to supplemental private insurance can reduce solidarity because of the shift from community-rated to risk-rated premiums. In community-rated premiums, all members of the population are given equal chances of being sick and pay the same premiums. Through this mechanism, low-risk individuals subsidize the high-risk individuals. On the other hand, risk-rating uses the estimated risk for an individual to determine the premium or the coverage. Without interventions from the government, the competitive private insurance market will use risk-rating to maintain profits. This can lead to a predominance of low-risk individuals getting supplemental insurance because the premiums are cheaper, while the high-risk and poor are unable to pay for the supplemental insurance. (Paolucci, 2006)

Based on a study on the suitability of private financing (i.e. individual responsibility) on a publicly funded health-care system, six attributes that should be present when exploring private financing were identified. These are: (1) it should enable individuals to value the need and quality both before and after utilization, (2) it targets individuals that have a reasonable level of autonomy, (3) should be associated with low levels of positive externalities, or external benefits associated with the consumption of health-care services (4) demand should be sufficient to generate a private market, (5) should have affordable payments, (6) should be associated with lifestyle enhancements rather than medical necessities (Tinghog et al, 2010).

Experiences of other nations in financing catastrophic illnesses

Studies on the impact of health financing schemes of different countries on catastrophic health expenditures show different outcomes. China's national health insurance program, launched in 2002, is a new health financing policy aimed to reduce catastrophic health expenditures. However, there is still no clear evidence that the program has achieved its goal. The scheme is similar to PhilHealth, which is also jointly funded by governments and individual households. A possible reason for the failure of

the program is that factors contributed by the program may be counter-acting each other. Even though the insurance program decreased the average OOP, the availability and utilization of health services or higher-level health services increases. In the end, there was no significant difference in the proportion of households affected by catastrophic health expenditures (Liang et al, 2012).

In Thailand, the implementation of the Universal Coverage policy decreased catastrophic payments for health care, particularly among the poor. After the implementation of universal coverage, the proportion of OOP as a share of THC, the incidence and intensity of catastrophic payments decreased, with the lowest socioeconomic quintiles having the least intensity and incidence of catastrophic payments. Moreover, universal coverage also prevents impoverishment by decreasing the poverty headcount and poverty gap. (Somkotra and Lagrada, 2008)

The British, through its National Health Service (NHS), attempted to address the problem of OOP, by providing healthcare that is "free at the point of service". Instead of having insurance-based financing, funds were derived from taxes, enabling a more equitable distribution of resources for health care (Light, 2003). However, even if the British NHS provided free service, access to facilities was compromised because tight restrictions are being applied to control costs. Even for medically sound indications, services cannot be availed of because of high demand and long waiting times. People were then forced to get private insurance to meet their healthcare needs. Hospitals have also introduced a new category, the "self-funded" patient. The rates are based on estimates of what NHS will spend to treat these patients and are lower than the usual rates for private patients. Although it is seen as a way devised by hospitals to increase their income, it is also an option for patients to gain access to health care in a system with many restrictions to availing services. However, it can also negatively affect equity in the system because people who can pay will be able to circumvent the rationing by the NHS (Iacobucci, 2013).

The health system of Singapore is an example where individuals take responsibility for their own health through co-payments while a targeted portion of the population is subsidized by the government. Although the Singaporean government provides health subsidies, citizens are required to save a significant amount for health insurance and a medical savings account. Hence, the government was able to decrease government expenditures on health care by increasing private expenditures. Despite this, they are able to achieve good health outcomes such as a 78.4 year life expectancy and an infant mortality rate of 2.2 per 1000. Improvements in health outcomes cannot be solely attributed to the modifications in the health system because they may also be due to other factors such as socioeconomic progress and demographic characteristics. In a high-income country like Singapore, there are less poor people and most citizens can afford and access health care. The population is also relatively young, and therefore, healthier. Hence, the success of the health financing system of Singapore should be viewed in the context of Singapore's situation and that all these factors contributed to the improvements in health outcomes. (Taylor and Blair, 2003; Lim, 2004)

In Kenya, utilization of outpatient services decreased when cost-sharing was introduced to a national health system that was primarily financed by tax revenue due to severe government budget constraints. A proposed health reform to establish a National Social Health Insurance Fund (NSHIF) that will provide universal coverage explores the possible sources of financing. These include government tax revenues,

employee and employer contributions, OOP, and private top-up insurance. An issue raised by HMO's regarding the proposed NSHIF is the decline in business due to universal health coverage. Contrary to this, the proposed NSHIF can increase the current market of HMOs because they can sell supplementary packages to those who are willing to pay. (Whitaker et al, 2006).

While it is reasonable to learn from the experiences in other countries regarding health policies that worked and did not, we should always keep in mind that formulating our own national policies should be based on the local context: what programs and methods are applicable and implementable. These programs should be backed up by an in-depth analysis of our current situation, needs, and capacities. (Reverente, 2001)

METHODOLOGY

General Approach

The objective of this study to explore the feasibility of other methods for catastrophic illness financing in the Philippines in conjunction to that provided by PhilHealth is part of finding ways to improve the breadth and depth of coverage for catastrophic illnesses, primarily through the private sector, to achieve universal health care.

Key informants interviewed were those involved in the development and implementation of the Z Benefits and stakeholders from the private sector. Secondary data contributed in providing a better picture of HMO health financing and the Z benefits program.

Desk Review

A desk review was conducted regarding PhilHealth policies and programs for catastrophic illnesses, literature on private sector financing for catastrophic illnesses, and catastrophic illness financing schemes in other countries. The literature search was done through PubMed, Herdin, WHO database, and Oxford journals using the following keywords: catastrophic illness, supplemental fund and private financing.

Interviews

Two semi-structured interview guides were developed based on the desk review and the personal experience of the investigators on health financing and policy. One interview guide was for the informants from PhilHealth, while the other was for the informants from HMOs and self-insured companies. The interviews guides tackled the Philhealth Z benefits, catastrophic illness coverage of private companies, and the related company policies, regulations, and protocols (See Appendix 1)

Informants associated with HMOs, self-insured companies, and PhilHealth were invited to participate in the study. All three PhilHealth representatives, who were selected based on their current position and involvement in the Z benefits program, agreed to participate. HMOs were selected based on the size and years of operation of the HMO. Three out of the six invited HMO informants agreed to be interviewed. Among the three identified self-insured companies, two agreed to participate in the study. The list of key informants is provided in Appendix B.

The interviews were recorded upon consent of the interviewee. Otherwise, interview notes were taken.

Analysis

The interview recordings were transcribed and integrated with the interview notes. These transcriptions were organized based on the corresponding questions in the interview guide and further arranged into common themes. These were then compared between and across interviewee groups: PhilHealth, HMOs, and self-insured companies, to determine the points of agreement, difference, or those that complement each other.

RESULTS

The desk review will focus on the Z benefit packages and HMO standard packages. Key informant interviews with PhilHealth officers, HMOs, and self-insured companies will cover catastrophic illness coverage provided by their respective offices and its relation to the Z benefits. A total of eight interviews were conducted. Three interviews were with PhilHealth informants from the Office of the Actuary and two from the Quality Assurance Group. Two were from HMOs, one represented a group of HMOs and two are from self-insured companies. The interview guide is Annex 1.

This section will be discussed as follows:

1. Summary of the desk review: Z benefits and HMOs
2. Summary of interviews
3. Scope and limitations of the PhilHealth Z benefits
4. Private Sector Catastrophic Illness/Dread Diseases Financing
5. Feasibility of Supplemental Funds from the Private Sector
6. PhilHealth Supplemental Fund Policies

Desk Review

Z Benefits

There are currently nine conditions that are classified as case type Z. These are breast cancer, prostate cancer, cervical cancer, acute lymphocytic leukemia, kidney transplant, limb prosthesis, coronary artery bypass graft surgery, surgery for Tetralogy of Fallot, and surgery for ventricular septal defect. The criteria for identifying type Z cases are presented in Table 1.

Table 1. Criteria for Selecting Type Z Cases

The management of the case is expensive and may result into depletion of one's resources and subsequent impoverishment
The support value offered by Philhealth is relatively low compared to actual expenses for quality care
The financial support from the benefit package will improve the health outcomes of the patient, based on good survival rates and acceptable success rate of the treatment for the condition.
Other indicators (mortality and morbidity data, claims, incidence and prevalence, expert opinion, value judgement)

Source: (PhilHealth, 2012)

Each case Type Z has a defined set of criteria for eligibility, and PhilHealth members must undergo a pre-authorization clearance before they can avail of the Z benefits (Table 2).

Services for nine case types Z are paid through package rates which cover all mandatory and other services necessary to achieve high survival rates and the best outcomes for the member. Hospital fees, professional fees, medicines, and mandatory laboratory examinations are all covered by the Z package (Table 2). All complications arising from the primary Z condition covered, other conditions with causes will be paid separately.

The package rates are computed based on average value per claim (computed from PhilHealth data), current costs given by reference hospitals, expert opinion, and fair market prices. For sponsored members, the No Balance Billing shall apply, and they

would not pay for anything during the course of their treatment. No additional premium is required to avail of the Z benefits, but for non-sponsored members, a fixed co-pay not exceeding the amount of the package rate shall be applied. The Z benefits are aimed to provide 100% support value for sponsored members and at least 50% support value for non-sponsored members.

Table 2. Z Benefit Packages. Rates, services, and criteria

Z Benefit Package	Package Rate (PhP)	Included services	Inclusion and Exclusion Criteria
Acute Lymphocytic Leukemia	210,000	Chemotherapy, antimicrobials and antifungals, emergency medication, pain medication, laboratory and diagnostics, blood transfusion.	<ul style="list-style-type: none"> • New cases only • Age 1-10 years old • No CNS leukemia • No testicular involvement • WBC < 50,000/ml • B or T lymphoblastic leukemia immunophenotype
Breast cancer	100,000	Surgery, laboratory and diagnostics, chemotherapy, radiotherapy, hormonal therapy, and anti-emetics Reconstructive surgery not included	<ul style="list-style-type: none"> • New cases only • Stage I-III A
Prostate cancer	100,000	Surgery, laboratory and diagnostics, radical or laparoscopic surgery, radiation therapy, anti-androgen drugs	<ul style="list-style-type: none"> • New cases only • Low to moderate risk localized cancer • 70 years old or below • Controlled co-morbid conditions
Cervical Cancer	120,000 (stage IA1) 175,000 (stage 1A2 - IIA1)	Histopathology, chemotherapy, radiotherapy, brachytherapy, surgery blood transfusion, antibiotics, and other medications	<ul style="list-style-type: none"> • New cases only • Stage IA1-IIA2 only • No previous chemotherapy or radiotherapy • Controlled co-morbid conditions
Kidney transplant	600,000	Surgery, laboratory and diagnostics, immunosuppression induction therapy, blood transfusion, post-transplant monitoring of donor and recipient. Maintenance anti-rejection meds not included	<ul style="list-style-type: none"> • 11-69 years old • On chronic dialysis because of ESRD* • Single organ transplant • Low immunologic risk • No severe illnesses
Coronary artery bypass graft surgery	550,000	Pre-operative labs, antibiotics, medications, open heart surgery, blood transfusions cardiac post-operative care, cardiac rehabilitation	<ul style="list-style-type: none"> • 19-70 years old • Stable coronary artery disease • Elective isolated CABG • Not in severe decompensated heart failure • No severe angina • No previous cardiac surgery
Tetralogy of Fallot Total Correction	320,000	Pre-operative labs and medications, open heart surgery, blood transfusion, post-operative support and medications, cardiac rehabilitation	<ul style="list-style-type: none"> • 1-10 years old • Functional class I-II • No co-morbidities
Closure of Ventricular Septal Defect	250,000	Pre-operative laboratories and medications, VSD patch closure, post-op laboratories, cardiac rehabilitation	<ul style="list-style-type: none"> • 1-5 years old • No other congenital heart disease • No co-morbidities
Limb prosthesis	15,000 (one limb) 30,000 (both limbs)	Pre-prosthetic assessment, fitting, fabrication, and rehabilitation program	<ul style="list-style-type: none"> • Can be congenital or acquired • For below the knee amputations

*ESRD (End-stage renal disease); CABG (Coronary artery bypass graft) Source: PhilHealth, 2012; PhilHealth, 2013

Standard Packages of Health Maintenance Organizations

HMOs are commonly being utilized by companies to provide benefit packages for employees, but private groups or individuals can also avail of HMO packages (Chua, 2006). A membership card enables members to avail of health services, including consultations with health professionals and use of facilities, in hospitals or clinics accredited by the HMO without co-payment. HMOs have standard benefit packages for individuals, groups or families. For larger groups or companies, packages can be customized. We will present in this section a description of standard packages offered by the HMOs that were interviewed for this study and other HMOs in the Philippines.

PhilCare. PhilCare has four major types of plans, namely: the classic/classic elite, classic executive/classic executive elite, premier global and the IPER Care Programs. These plans vary in terms of the premiums, the annual benefit limit, the type of eligible hospitals where claims can be made, the spectrum of management procedures allowed, and whether claims can be made internationally. The most basic plan, the classic pearl, has an annual benefit limit (one limit for all illnesses per year) of Php 55,000. Coverage include annual physical examinations at PhilCare or designated clinics, preventive health care, out-patient services, Php 100,000 term life insurance, Php 100,000 accidental death and dismemberment and hospitalization (which includes physician services, room and board, general nursing service, use of operating room and recovery room, anesthesia, medications, confinement to the intensive care unit (ICU), and other services deemed medically necessary like dialysis and chemotherapy. (www.philcare.com.ph, Accessed 5 February 2014)

Intellicare. Intellicare currently only caters to corporate accounts and not to individuals or families. Single proprietors/partnerships/corporations duly registered with DTI or SEC to conduct business with the Philippines who have a minimum of 10 regular employees are eligible to apply. Employees determined by the enrolling company along with their dependents are entitled to the benefits.

The benefits include an annual physical exam, routine laboratories, preventive care, outpatient care and treatment, in-patient confinement (room and board specified in contract, operating room and facilities, standard admission kit, professional services, anesthesia and medications, blood transfusions and intravenous fluids, diagnostics, medicines, dressings, plaster casts, sutures, ICU confinement, dialysis, CT scan and ultrasound except for maternity cases, ambulance service and other hospital charges deemed necessary by the Intellicare affiliated physician), and emergency care. Financial assistance for death and dismemberment for principal members are also available with claims up to Php 20,000 (for accidental death).

Intellicare lists general exclusions and limitations on their website. Some of the notable ones are: recuperation, professional fees in medico-legal cases, treatment by non-affiliated doctors, blood screening, vaccines, organ transplant, prosthetics, pacemakers, infertility treatment, reconstructive surgery except for treatment of a functional defect directly caused by an accident or illness, conditions derived from external forces (related to violence, hazardous activities, or epidemics), congenital anomalies, developmental delay, STDs including AIDS, substance abuse, GBS, pregnancy and pre-existing conditions. Pre-existing conditions, as defined by Intellicare, are illnesses diagnosed before enrollment or during the first year of coverage and includes hypertension, thyroid disease, cataracts, glaucoma, pterygium, EENT (eye, ear, nose, throat) conditions requiring surgery, asthma, tuberculosis, chronic cholecystitis/cholelithiasis, hernia, prostate disorders, hemorrhoids and anal fistulae,

tumors, uterine myoma, ovarian cyst and endometriosis, Buerger's disease, varicose veins, scoliosis, arthritis, chronic allergies, gastric and duodenal ulcers, and dreaded diseases (chronic and irreversible conditions requiring frequent and/or prolonged hospitalization, including those requiring continuous confinement for 15 days or more). (www.intellicare.com.ph, Accessed 5 February 2014)

Maxicare. Maxicare's specialized plan for individuals and families is called MyMaxicare. This plan is offered in different variants tailored depending on the client's budget. Generally, it consists of extensive benefit coverage for in-patient, out-patient, emergency, preventive care, optional dental and other added features to address the common recurring demands and needs of most people pertaining to their health security such as accidental death, dismemberment, and motor vehicular accidents. The coverage, however, vary in terms of maximum benefit limit depending on the plan types and the premium vary depending on the Plan type mode of payment (annual, semi-annual, quarterly), age, type of coverage (family or individual), and dental coverage option. These plans are only for people 65 years and below (Table 3). (www.maxicare.com.ph, Accessed 5 February 2014)

Table 3. Maxicare standard benefit packages

Plan Type	Room and Board	Maximum Benefit Limit
Platinum Plus	Large Private	Php 200,000
Platinum	Regular private	Php 150,000
Gold	Regular Private	Php 100,000
Silver	Semi-private	Php 60,000

Source: www.maxicare.com.ph

Medicard. Medicard has three general types of programs: 1) individual and family program, 2) group and corporate program and 3) VIP program. The individual and family program has 4 different packages with premiums being paid annually (Table 4). (www.medicardphils.com, Accessed 5 February 2014)

Table 4. Medicard standard benefit packages

	PLAN 550	PLAN 800	PLAN 1,500 w/o AHMC*	PLAN 2,500
Limit for Dreaded Diseases	Php 50,000	Php 60,000	Php 100,000	Php 120,000
Principal Member only	7,782	8,731	13,659	15,876
Principal + 1 dependents	14,107	15,817	24,734	28,714
Principal + 2 dependents	20,794	22,819	36,460	41,615
Principal + 3 dependents	27,485	29,821	48,182	54,515
Principal + 4 or MORE dependents	34,175	36,826	59,901	67,414

*AHMC- Asian Hospital and Medical Center; Source: www.medicardphils.com

Plans 500 and 800 do not cover for hospitalizations at Asian Hospital and Medical Center, Makati Medical Center, St. Luke's Medical Center (SLMC)-Quezon City, SLMC-Global City, The Medical City and Cardinal Santos Medical Center. Plan 1500 covers all except for Asian Hospital and Medical Center and SMLC-Global City. Plan 2,500 covers all except for SMLC-Global City. Non-PhilHealth members are required to pay the corresponding portion during confinements.

Confinement benefits include room and board according to type of enrollment, use of operating theater and recovery room, services of Medicard specialist, blood transfusions, x-ray and laboratory examinations, administered medicines, dressings, plaster casts, sutures, ICU confinements, chemotherapy, radiotherapy, dialysis, modern therapeutic modalities and interventional surgical procedures, up to Php20,000 each per year, CT scan, MRI and ultrasound up to Php 50,000 each per member per year, and additional diagnostic procedures like angiography and treadmill stress test limited to Php 5,000 each per member per year. Out-patient benefits include referral to specialists, regular consultations and treatment (except prescribed medicines), EENT treatment, treatment of minor injuries and surgeries not requiring confinement, and x-ray and laboratory examinations prescribed by MediCard physician. Members are also eligible for preventive health care benefits including an annual physical examination, management of health, routine immunization, counseling, family planning, and record keeping of medical history. In emergency cases, members are provided with doctor's services, medicines, oxygen and intravenous fluids, dressings, casts and sutures, laboratory, x-ray and other diagnostic examinations directly related to the emergency management of the patient free of charge. Finally, aside from healthcare benefits, the principal member is entitled to a life indemnity program providing his heirs with financial assistance in the event of death or injuries through natural causes or accidental means ranging from Php 5,000 for the loss of sight of one eye to Php 20,000 for death through accidental means. (www.medicardphils.com)

FortuneCare. FortuneCare offers individual (people 21 to 64 yrs of age) and family packages similar in design to Medicard with premiums ranging from Php500 to Php1500. The plan covers dread diseases (from up to PhP 50,000 to up to 150,000), hospital access (hospital choice depending on the plan), surgical expenses (PhP 25,000 to 75,000), ambulance fee, coverage of special procedures, annual physical examination, dental services and financial assistance. (www.fortunecare.com.ph, [Accessed 5 February 2014](#))

Blue Cross Healthcare, Inc. Blue Cross has two basic plans and a variety of add-ons and specialized plans. The two basic plans are the Blue Royale and the Standard Select Plans. Both of these have certain conditions that are permanently excluded: congenital conditions, birth defects, anomalies, cosmetic surgery or related complications, contact lenses, hearing aids (except those required for reconstructive surgery), suicide, attempted suicide or intentional self-inflicted injury, Acquired immunodeficiency syndrome (AIDS), AIDS Related Complex, STDs, contraceptive methods of birth control, screening and treatment pertaining to infertility, pregnancy related expense and screening, weight treatment, management and its complications, and routine medical examinations. Coverage for pre-existing conditions is done on a case-to-case basis. (www.bluecross.com.ph, [Accessed 5 February 2014](#))

Blue Royale is the dollar plan of Blue Cross Health Care, Inc. It is applicable to people of all ages. Premiums depend on the age and the plan ranging from \$861 to

\$4,780. Maximum coverage per year vary on the plan type with \$500,000 for Plan A, \$1,000,000 for Plan B and \$2,000,000 for Plan C. Core benefits include: room and board, miscellaneous in-patient charges, professional fee, intensive care unit, coronary care unit, telemetry, operating theater and recovery room, surgeon's fee, anaesthetist's fee, organ transplant, mental and nervous disorders, private duty nurse, procedures done on an out-patient basis, alternative treatments (plan B and C), executive checkup Package (plan B and C), maternity benefit (plan B and C), emergency out-patient treatment, emergency dental services, emergency local ambulance service, emergency overseas coverage, and worldwide emergency assistance (emergency medical evacuation, medical repatriation, return of mortal remains, compassionate visit by a relative, and care of minor children).

Select Standard, on the other hand, is the peso plan. Unlike the Blue Royale, this plan is limited only people aged 65 and below. Annual premiums vary depending on age and type of plan (ward/semi-private/private/suite) ranging from an annual premium of Php 3,843 to Php 52,059. Maximum coverage limits are Php500,000 (ward), Php 750,000 (Semi-private), Php 1,500,000 (private) and Php 3,000,000 (suite). For each claim, Blue Cross pays 80% and the subscriber 20% as co-payment. The plan covers room and board, miscellaneous hospital expenses (laboratory tests, prescribed medicines, physiotherapies, blood and components, anesthesia, and surgical appliances), physician's visit, specialist's fee, private duty nurse, procedures done on an outpatient basis, ICU, critical care unit (CCU) and telemetry, operating room theater and recovery room, surgeon's fee, anaesthetist's fee, artificial limb, emergency outpatient, emergency dental services, emergency local ambulance service, emergency overseas confinement coverage, and worldwide emergency assistance service (emergency medical evacuation, medical repatriation, return of mortal remains, compassionate visit by a relative, care of minor children), and personal accident benefit. (www.bluecross.com.ph, Accessed 5 February 2014)

In summary, PhilHealth, HMOs, and self-insured companies provide coverage for catastrophic illnesses. Nine PhilHealth Z benefits can be availed only in government hospitals, while the private sector usually provides services in private hospitals. A major difference between HMOs and self-insured companies is HMOs provide packages depending on the premium paid by their clients, while self-insured companies have benefits which they are obliged to provide their employees.

Interviews

PhilHealth Z Benefits Scope and Limitations

All the necessary procedures necessary for the complete treatment of the respective conditions are included in the Z benefit packages: from preparations prior to starting the treatment or admission, until post-operative care and rehabilitation. However, only nine conditions are currently covered. Increasing the number of condition covered by the Z benefits is planned by PhilHealth but in order to maintain fund viability, the conditions covered are limited, and the criteria for patients who can avail of the packages (e.g. newly diagnosed cancer cases only and advanced stages of cancer excluded) are strictly followed. Moreover, the Z packages cover inpatient services only, and excludes the complications not related to the primary illness during hospitalization such as hospital acquired infections.

PhilHealth officials agreed that PhilHealth Z benefits are currently limited by funding to cover only certain types of diseases. They believe that a supplemental fund

may increase the scope of PhilHealth Z benefits. However, they have different views regarding the possible source of a supplemental fund. Suggested sources of supplemental funds are PAGCOR, PCSO, microinsurance and non-government organizations (NGOs). Two respondents believe that a PhilHealth should not establish a supplemental fund because it will be similar to a private insurance. For them, PhilHealth should avoid getting into the market of private insurance through the supplemental fund. The other respondent from PhilHealth believes it is not necessary to involve private insurance or HMOs because they are not involved with government hospitals, which the Z benefits program is currently prioritizing in order to empower them. (Table 5)

Table 5. Responses of PhilHealth informants

Question	Response
<i>Briefly describe the PHIC program for catastrophic (type Z) illness.</i>	Informant 1: Benefit package for selected catastrophic illnesses Informant 2: Benefit package for selected catastrophic illnesses Informant 3: Benefit package for selected catastrophic illnesses
<i>Limitations of Z benefits</i>	Informant 1: Covers selected illnesses only; can be availed in government hospitals only Informant 2: Covers selected illnesses only; can be availed in government hospitals only; Budget allocation Informant 3: Can be availed in government hospitals only
<i>Need for additional funding for Z benefits</i>	Informant 1: Yes, to increase the number of covered conditions. Informant 2: No, funds viable.
<i>Possible sources of additional funds</i>	Informant 1: More funds, but not from private sector Informant 2: PCSO, PAGCOR, microinsurance, NGOs
<i>Role of private sector in additional (supplemental) funds</i>	Informant 1: None. Government hospitals priority, no plan to involve private sector
<i>How can supplemental funds be accessed?</i>	Informant 2: By establishing supplemental fund
<i>Are there current regulations or policies that may hinder supplemental funding from private sector for catastrophic illnesses?</i>	Informant 2: COA ruling that government funds to be used for public purposes only Informant 3: Regulation of HMOs should be by Insurance commission
<i>Are there regulations or policies that may facilitate supplemental funding from private insurance for catastrophic illnesses?</i>	Informant 2: Through National Health Insurance Act amendment on supplemental fund
<i>What changes or additions in the current system of PHIC would be needed to implement supplemental funding?</i>	Informant 3: A separate office for managing supplemental funds: more personnel, infrastructure, data systems
<i>What will be the impact of supplemental funding for catastrophic illnesses to PhilHealth financing?</i>	Informant 1: Will increase the scope and benefits of the program Informant 2: Will increase the scope and benefits of the program
<i>Others</i>	Informant 2: Avoid overlap of PhilHealth with private market; May accredit HMOs Informant 3: The development of plans for catastrophic illness to supplement the Z benefits will be up to the private

	insurance and HMOs.
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Financing the current Z benefits program is still feasible with its existing budget allotment for the coming few years based on PhilHealth’s assessment of its fund viability. This was done by considering: how many Filipinos will have illness; how many will enroll in Philhealth; and what it will cost Philhealth. Eligibility criteria were developed for each condition in the Z benefits to be compatible with the fund viability. According to one of the informants from PhilHealth, PhilHealth is currently paying more than it previously did for benefits and reimbursements. PhilHealth plans to add other type Z cases, but feasibility studies still need to be done using the criteria stated above.

Another limitation of Z benefits is that only a few government hospitals have agreed to the present rate and to provide the Z benefits. Moreover, specific protocols for management are to be followed for the patients under the Z packages, and any deviation from this protocol will not be covered by the package. At present, a patient who wants treatment that deviates from the management offered by the Z package will receive regular case rates for hospital admissions. According to an interviewee from PhilHealth, the principle in engaging the private sector is to provide choices for patients who can afford to pay; when a patient’s choice of hospital or management deviates from that indicated in the Z package, the HMO or insurance can cover the patient instead of PhilHealth. However, providing more choices does not mean that the services of the Z benefits are poor or inferior to standard management because the packages are based on clinical practice guidelines.

According to a PhilHealth informant, they are prioritizing government hospitals as providers of the Z benefits because they aim to improve these hospitals through the program. Another respondent from PhilHealth sees the possibility that if the contracted government hospitals are not sufficient to provide for the services and accommodate the patient load for the Z benefits, they may explore the possibility of negotiating with private hospitals to provide the Z benefits.

Private Sector Catastrophic Illness Financing: HMO

The interviewed HMOs do not use the term “catastrophic illnesses”. However, based on the definition from PhilHealth, they have a similar category for such conditions which they call “dreaded diseases”. These are a vast list of conditions that include but are not limited to cancers, stroke, chronic illnesses, and other conditions that may require intensive care. In essence, the HMOs and self-insured companies are supplementing the Z benefits already by providing services and coverage for some Filipinos with catastrophic illnesses who do not avail of Z benefits. Out of the three HMO respondents, only one stated that they are open to the prospect of a supplemental fund. (Table 6)

HMOs provide standard benefit packages that can cover illnesses to a certain extent based on the premium. However, there is no separate package for catastrophic illnesses. Benefits included vary from inpatient expenses only, to both inpatient and outpatient drugs. The target market of HMOs is anyone willing to pay for the premiums. They can be individuals, small groups, or companies. The premiums increase as the scope of the benefits increase.

HMOs can also customize packages for large companies depending on the number of employees covered, the premiums the company is willing to pay, and the services

the HMO can offer. For large groups (more than 100 persons), pre-existing illnesses can be covered unlike individual packages that usually exclude pre-existing illnesses and their complications.

Table 6. Responses of informants from HMOs

Question	Response
<i>Position</i>	Informant 1: HMO assistant medical director Informant 2: HMO medical director Informant 3: HMO association official
<i>Definition of catastrophic illness.</i>	Informant 1: Called “dread diseases” but same definition as PHIC Informant 2: Complex or life-threatening conditions that meet certain criteria in terms of hospital days or cost. Informant 3: Called “dread diseases” but same definition as PHIC
<i>Coverage for catastrophic illnesses</i>	Informant 1: Yes, but not for all clients; Depends on package availed by client; Almost all conditions except STDs and transplant can be covered Informant 2: Yes, but not for all clients; Depends on package availed by client Informant 3: Yes, but not for all clients; Depends on package availed by client; All conditions except STDs can be covered
<i>Scope of benefits or services in catastrophic illness package</i>	Informant 1: Inpatient and outpatient services Informant 2: Inpatient and outpatient services except most outpatient drugs; oral chemotherapy Informant 3: Inpatient and outpatient services; limited involvement with government hospitals
<i>Are there current regulations or policies that may hinder supplemental funding from private sector for catastrophic illnesses?</i>	Informant 1: Z benefits available in government hospitals only Informant 2: Z benefits available in limited number of hospitals; strict criteria for eligibility Informant 3: Z benefits available in government hospitals only; tedious process for application
<i>What changes or additions in the current system of company to implement supplemental funding?</i>	Informant 3: None, just needs approval by board of directors and money can be given to PHIC Tap foreign funding
<i>What will be the impact of supplemental funding for catastrophic illnesses to PhilHealth financing?</i>	Informant 1: Better for clients because HMO benefits can be used on top of Philhealth benefits Informant 2: Better for clients because HMO benefits can be used on top of Philhealth benefits Informant 3: Better for clients because HMO benefits can be used on top of Philhealth benefits
<i>Others</i>	Informant 3: Open to idea. Need to know first what they can get in contributing to PhilHealth supplemental fund.

HMOs that participated in this study prefer their clients to also enroll in PhilHealth. When HMO members avail of health services, PhilHealth benefits are first deducted and the HMO covers the rest of the medical expenses. If the expenses exceed the coverage benefits from the HMO, then, the patient will have to pay out-of-pocket.

Private Sector Catastrophic Illness Financing: Self-insured Companies

Self-insured companies have comprehensive medical benefits for their employees, including coverage for catastrophic illnesses. Although they do not specifically use the term “catastrophic illnesses”, the self-insured companies have a classification for conditions that incur huge expenses and are severe health conditions. The medical benefits are considerable amounts and allow an employee to choose a hospital to get treatment from and the kind of treatment to receive. However, these companies have agreements with certain private hospitals only, and some also have a “medical package” for treatment, so the range of choices for the employee is limited by these. (Table 7)

One of the two self-insured companies interviewed covers all the medical needs of its employees with no maximum limit. The only exceptions for coverage are sexually transmitted diseases and those related to violations of the law. The company has a list of hospitals that have an agreement with them where employees can go for treatment without having to pay anything. The company shoulders all hospitalization expenses, but since all its employees are PhilHealth members, PhilHealth benefits are also deducted, as applicable, from the medical expenses.

The other self-insured company provides benefits with a maximum coverage of PhP 1 Million per illness per year to cover for certain diseases such as cancers and a limited number of conditions which require a large medical expense. This amount can be availed in the succeeding years for such conditions, and covers the outpatient drugs and diagnostics needed for continued treatment. For other illnesses aside from those mentioned earlier, employees have hospitalization benefits and coverage of outpatient drugs. An optional health card is also available for employees, where they share the payment of premiums with the company. This health card has a maximum benefit per illness per year, and can be used for the extended family of the employee such as children, parents, and in-laws. This can be used for illnesses such as those part of the Z benefits. The advantage for the employees of the said company is that if they exceed the medical benefits offered, the rest of the expenses can be loaned from the company and deducted from their future salary or they can loan from the company cooperative.

Table 7. Responses of informants from self-insured companies

Question	Response
<i>Company type</i>	Informant 1: Self-insured company Informant 2: Self-insured company
<i>Definition of catastrophic illness.</i>	Informant 1: Called “dread diseases” but same definition as PHIC Informant 2: None, but covers conditions classified under PHIC catastrophic illnesses
<i>Coverage for catastrophic illnesses</i>	Informant 1: Covers all illnesses except STDs, violation of laws Informant 2: Cancers, bypass, others with large medical expense
<i>Scope of benefits or services in catastrophic illness package</i>	Informant 1: All expenses covered; can be availed in different private hospitals. Informant 2: Up to PhP 1M coverage per illness per year. Hospitalization and outpatient; in selected private hospitals
<i>Are there current regulations or policies that may hinder supplemental funding from private sector for catastrophic illnesses?</i>	Informant 1: Z benefits available in government hospitals only Informant 2: Z benefits available in government hospitals only
<i>What changes or additions in the current system of company to implement supplemental funding?</i>	Informant 1: None, can be through charity foundation of company
<i>What will be the impact of supplemental funding for catastrophic illnesses to PhilHealth financing?</i>	Informant 1: Better for employees because company benefits can be used on top of Philhealth benefits
<i>Others</i>	Informant 1: Highly taxed company whose employees all pay PhilHealth premiums does not need to contribute more to PhilHealth supplemental fund

PhilHealth Supplemental Fund Policies

According to a PhilHealth respondent, a recent amendment in the National Health Insurance Act stipulates that PhilHealth shall set-up “A fund for any optional supplemental benefits that are subject to additional contributions” (RA 10606). However, Section 4 of the State Audit Code of the Philippines states that “Government funds or property shall be spent or used solely for public purposes.” This ruling is applicable to health financing because it prohibits PhilHealth from purchasing services from HMOs and private insurance. For an agency which needs supplemental benefits, insurance and HMO riders can be tapped for funding of catastrophic illness for patients who can pay.

Feasibility of Private Supplemental Funding for Catastrophic Illness

Out of the five non-Philhealth respondents, only the representative of an HMO association expressed openness to the possibility of HMOs contributing to a supplemental fund since it is “for the benefit of the Filipino people”. However, all the HMO respondents believe that the benefits of PhilHealth are helpful because they are an add-on for the health insurance for their clients. If the HMO member can use both Z benefits and HMO benefits, the HMO can cover expenses in excess of the Z benefits, increasing the total financial support for their clients.

The primary concern for one respondent before considering the supplemental fund is to first be given the complete picture. This means identifying “what it is for them (HMOs)” if they contribute to a supplemental fund for the Z benefits. Some HMOs had an initial concern that if the Z benefits is only for sponsored members, they would have no role in that. But since the Z benefits is not only for sponsored members, the HMOs would like to explore the possibility of a supplemental fund because it is “an avenue the HMO planholder can go to”, especially if the Z benefits can be provided by private hospitals.

The involvement of HMOs with government hospitals is limited because of a Commission on Audit directive that requires a large cash bond, PhP 1 Million, to be affiliated with a government hospital. As such, HMOs clients can avail of HMO benefits in only a few government hospitals. However, since the employed sector and HMO clients can also avail of the Z benefits as non-sponsored PhilHealth members, HMOs may find an incentive in contributing to a supplemental fund managed by PhilHealth. For HMOs, giving these supplemental funds, if ever, would be very simple because the transfer of funds to PhilHealth would only need the approval of the HMOs board of directors.

An interviewee from a self-insured company questions why private sector should contribute to a supplemental fund when they are already contributing to the PhilHealth funds through the PhilHealth premiums of their employees. Moreover, the taxes these companies pay are the sources of the funds used by the government for subsidizing the sponsored members. The company can contribute funds for PhilHealth through its Foundation, but this should not be expected to be given regularly.

On the other hand, instead of the private sector contributing to a supplemental fund, a respondent from PhilHealth suggested giving HMOs PhilHealth accreditation to provide coverage for PhilHealth members. In this scenario, PhilHealth will pay for the HMO premiums and the HMO packages will supplement the PhilHealth benefits.

DISCUSSION

Coverage of catastrophic illnesses in the Philippines is provided by different institutions: Philhealth through the Z benefits, HMOs through packages, self-insured companies through their employee benefits, and out-of-pocket payments.

Catastrophic illnesses have been covered by hospital reimbursement insurance and HMOs years before PhilHealth started its Z benefits coverage. In addition, some large corporations have covered it on a self-insured basis. The problem however, is that the coverage is limited by a peso depending on the health plan and premium paid. HMOs on one hand limit coverage on a yearly cap ranging from P100,000 to P1 Million. A few large corporations cover catastrophic illness with practically no limits.

The Z benefits are not supplemental benefits because no additional premium is required to avail them. Although the Z benefits presently include or will include conditions that would cause catastrophic expenditures to almost all affected households, it does not cover all conditions that may cause catastrophic expenditures. Any health condition may cause catastrophic expenditures and impoverishment, depending on the income of the affected household and the cost of the management for the condition. While breast cancer will cause catastrophic expenditures to most households, a simple case of pneumonia will similarly do so to a very poor household. In a worse scenario, the patient may not even seek medical care because they cannot afford it. The Z benefits can only cover selected catastrophic conditions due to the limitation in PhilHealth funds. However, in order to more effectively reduce financial catastrophe, the current health system should be improved such that out-of-pocket payments are reduced or eliminated.

Studies have shown that OOP increases with Total Household Consumption (THC), which can be used as a surrogate for living standards (Peters et al, 2001; van Doorslaer et al, 2007). Richer households are able to allocate more of their total consumption on health care by cutting back on luxury spending, while the poor are not able to do so because this means cutting back on their basic necessities. For a health system with high OOP, such as that of the Philippines, poor patients may not be able to pay for their health needs because they do not have enough to spend for OOP. In order to more effectively reduce financial catastrophe, the current health system should be improved such that out-of-pocket payments are reduced or eliminated. This can be achieved through better insurance benefits, such that health expenses are mostly covered by insurance, and by providing health services free at the point-of-service, such that patients do not have to think about any payment at all.

Another limitation of the Z benefits is the lack of data on catastrophic health expenditures. Both the incidence and cost of catastrophic expenditures are needed to design appropriate PhilHealth Z benefits. Moreover, the costing method used by PhilHealth should also include actuarial validation.

Supplemental services are already offered by HMOs because they are providing added services for those who can afford to pay. However, HMOs, as well as self-insured companies, do not coordinate with PhilHealth on catastrophic illness coverage. There are gaps and overlaps in the breadth of benefits, depth of benefits, and membership coverage.

First is the actual membership to any insurance, whether PhilHealth or private. An

overlap is that members of the employed sector are required to be PhilHealth members, and they are also the ones who are covered by HMOs and self-insured companies. On the other hand, the gap is in the unemployed and informally employed sectors, who are not covered by company insurance and may not choose to be members of PhilHealth.

Second is on the breadth of coverage. The eligibility criteria for malignant type Z cases are only for the lower stages of cancer, and HMOs prefer to cover healthier individuals to maintain profits. This leaves out higher risk and more severe cases without catastrophic illness coverage.

Third is the depth of coverage. For the Z benefits, all necessary treatment and management procedures are covered, but can only be availed in selected government hospitals. HMOs and self-insured companies provide different ranges of services that can be from inpatient procedures only, up to all medical needs including outpatient drugs. They are separate entities that cannot be used together to provide more options for a patient. This is also the constraint noted by most interviewees. A very few private insurance and HMOs in the country are affiliated with government hospitals, so the possible direct involvement of HMOs with the Z benefits program is currently limited. PhilHealth can overcome this by giving incentives for private hospitals to agree with Z benefit rates and implement Z packages in their facility. On the other hand, there is also a positive effect of the current system of private supplemental funding in the Philippines for catastrophic illnesses. Compared to the private or “self-funding” in the British NHS that caused inequities in the health system, the employed and middle class Filipinos have access to health care in private hospitals without using up the resources in government hospitals for the PhilHealth members availing the Z benefits. Despite both positive and negative effects, coordination of PhilHealth and the private insurance sector in the coverage of catastrophic illness is necessary to ensure all Filipinos across all income and risk levels are protected from the financial risk of catastrophic illnesses.

Catastrophic illness coverage should be mandatory for all Filipinos because the lack of foresight of individuals (i.e. not being able to prepare for being ill in the distant future) across all income groups has a strong impact on their future health expenditures. Even with mandatory coverage, moral hazard is not likely because the nature of these illnesses will not encourage overuse of the insurance services (Paolucci, 2006). This could have been achieved through the PhilHealth Z benefits if it had broader and deeper coverage.

In exploring the feasibility of private sector to provide supplemental catastrophic illness coverage, the significance of protecting all Filipinos from catastrophic health expenditures should always be kept in mind. PhilHealth uses community rating and cross-subsidies in the different income groups while HMOs use risk-rating. With risk-rating, the poor and high-risk may be unable to purchase insurance from the HMOs. There should be interventions by the government (PhilHealth), if the competitive private insurance market will be involved in order to maintain solidarity.

Constraints and Prospects of Private Supplemental Funds

The supplemental fund for catastrophic illness will provide benefits that are outside the scope of the Z benefits. These can be in the form of coverage for additional illnesses or upgrades in services (e.g. ward bed to suite room; government to private hospital). PhilHealth will be the first payer since it is the provider of social health insurance. The second payer will be the HMOs and self-insured companies because they are providing

supplemental insurance, which is by definition, additional services that are beyond those provided by the national/social insurance. The individual will then be the last to pay through OOP. Given that the private sector is already providing coverage for catastrophic illness to a certain extent, the prospect of generation of additional funds for financing catastrophic illness from the private sector will be difficult and limited to premiums from individuals not covered by any insurance or HMO. Individuals with limited coverage from their employers may also be willing to pay additional premiums to supplement their limited coverage, but it will depend on the affordability of the additional premiums.

Possible scenarios for catastrophic illness supplemental funding are public and private supplemental funds, but the discussion will focus on private supplemental funds.

1. PhilHealth can provide supplemental Z benefits by charging additional premiums

A supplemental fund will be managed by PhilHealth, where additional premiums are contributed by individuals who are willing to pay. The supplemental fund that can be set-up by PhilHealth, as stipulated in the amended National Health Insurance Act, would be similar to a private insurance and potentially compete in the private insurance and HMO market. However, PhilHealth currently lacks resources such as manpower, capacity, and technology to manage it. Supplemental benefits will entail additional membership categories and different benefits that will be availed by each member instead of the usual package rates of the Z benefits. Development of the supplemental packages, monitoring availment and utilization and reimbursing to the providers are some of the aspects that will require additional capacity and expertise.

2. The private sector provides supplemental insurance through HMOs, insurance companies, and self-insured companies.

Instead of providing supplemental packages themselves, PhilHealth can contract it to HMOs. Compared to PhilHealth, private sector has the capacity to manage a supplemental fund because it is part of their business. However, the inadequately regulated HMO industry may pose a risk of fraudulent practices to consumers. Also, there is a risk of decreasing solidarity if the profit-driven private sector is left unchecked, so PhilHealth should still be able to control the provision of benefits. The resources mentioned in the first scenario will still be required for PhilHealth to manage the fund and monitor the HMOs, but the bulk of the work will be handled by the HMOs. The HMOs can bid for either the premiums or the coverage and benefits. If HMOs will bid for premiums, PhilHealth will provide the scope of the benefits and the population to be covered and the HMOs will compete with the cost. If HMOs will bid for the scope of packages, PhilHealth can set what premium it is willing to pay and the HMOs will stipulate what benefits it can provide and who can be covered. In contracting HMOs, PhilHealth can concentrate on the sponsored and high-risk members. The employed sector and those who can pay will pay additional premiums to HMOs, through PhilHealth, for catastrophic illness coverage.

A distinct advantage of HMOs and self-insured companies is their negotiating power since they represent a large group of individuals. Similar to PhilHealth that negotiates rates with hospitals to provide the Z benefits, HMOs can have agreements with hospitals and providers of health care for lower costs of services for their members.

Particularly for catastrophic illnesses, the financial burden can be much less compared to the regular costs for individual patients because these companies can negotiate for lowering the hospital rates.

Improving the Philippine Environment for Private Supplemental Insurance

Setting-up a supplemental fund from the private sector would require changes to be made in current laws, organization of PhilHealth, the implementation of the Z benefits program, and the accredited hospitals for the private sector. In order to engage the private sector, the benefits for them in contributing to a supplemental fund for catastrophic illness would have to be determined. Most of the clients of HMOs and health insurance are the employed sector, and HMO accredited hospitals are private institutions. It is given that the poor are not capable of paying for their own insurance premiums, which is why the government is subsidizing them as PhilHealth sponsored members. Hence, if the private sector participates in a supplemental fund, they would prefer that only their clients would use this fund, and there will be a different set of benefits available for them.

Regulatory. The HMO industry is currently inadequately regulated. There is no single body responsible or appropriate for the regulation of HMOs. DOH can partially regulate the health aspect of HMOs through licensing and SEC registers, but does not regulate, HMOs. Neither the DOH nor the SEC are able to assess the financial sustainability of HMOs. AHMOPI serves as a self-regulating body, but its jurisdiction is limited only to its members. Better regulation of the HMO industry will not only improve the environment for supplemental financing for catastrophic illnesses but will protect Filipinos from fly-by-night HMOs that may not provide the proper services.

The Insurance Commission, the government agency that regulates and supervises the insurance and pre-need industries, may be the best agency to regulate HMOs since HMOs are primarily providers of prepaid health services which are similar to insurance. The IC will be able to review the premiums of HMOs and examine their financial viability (Insurance Commission, 2006). Pricing is the most important aspect of HMOs to be regulated. If placed under the IC for monitoring, premiums can be actuarially estimated and underpricing of premiums, to obtain more market share, will be prevented.

DOH does not need to regulate HMOs anymore because the medical directors of the respective HMOs can ensure that the quality of the medical services is maintained. DOH can still have control over the health services provided by HMOs indirectly because HMO clients avail of the services in hospitals and other health facilities, which, are regulated by DOH.

Institutional. The recent National Health Insurance Act amendment stipulates that a supplemental fund shall be set-up for optional benefits. If additional premiums in order to receive more or different benefits is to be offered by PhilHealth for those who can pay, the supplemental fund should be separate from the pool of funds of Philhealth because the middle and upper classes cannot subsidize the poor in this matter. Thus, management of this fund should be different and separate from that of the national pool of funds. On the other hand, if supplemental packages will be contracted out to HMOs, the capacity of PhilHealth to manage transactions with HMOs and contract services out should also be developed.

PhilHealth would need to increase its capacity to optimally manage a supplemental fund or contract out supplemental packages, which may require setting-up another unit

or office. In preparation for this, additional personnel, training, infrastructure, and information systems will be needed. Information systems, particularly an efficient database system, are necessary in monitoring the utilization and implementation of the supplemental fund. It can also be the source of data for future costing and program evaluation studies.

Legal. Despite having a provision for a supplemental fund in current Philippine law, the fact that only government hospitals are providing the Z benefits limit the participation of the private sector. The State Audit Code, which states that “Government funds or property shall be spent or used solely for public purposes” also prohibits PhilHealth from paying private companies, such as HMOs.

In order to engage the private sector in financing the PhilHealth Z benefits, the major constraint of Z benefits being exclusively provided in selected government hospitals should be addressed. One solution, is to include private hospitals in the facilities that provide the Z packages. On the other hand, the COA bond requirement of PHP 1 million for an HMO to be affiliated with a government hospital, can also be relaxed so that HMOs and their clients will not be limited to private hospitals only. Through these changes, the private sector can have options to provide supplemental catastrophic illness coverage to their clients or employees along with the Z benefits.

If PhilHealth will explore the possibility of purchasing benefit packages that are provided by HMOs, the State Audit Code that states “Government funds or property shall be spent or used solely for public purposes”, will be a major limitation. On the other hand, these packages should be considered as purchased for “public purposes”, as part of the PhilHealth benefits, even if HMOs are private companies. This ruling may be more difficult to overcome compared to the other legal limitations because it is not within the jurisdiction of DOH or PhilHealth and it affects all other government institutions. But the rationale for purchasing HMO packages can be logically presented to still be in accordance to this ruling.

Private companies may not be amenable to contributing to a supplemental fund because they are already paying for the PhilHealth premiums of their employees and paying large taxes. Tax incentives can be given to companies that provide catastrophic illness coverage for employees, either through HMOs or self-insurance. Companies that currently do not provide catastrophic illness coverage can purchase catastrophic illness coverage from HMOs or expand the benefits for their employees. Tax incentives can potentially increase health coverage because it encourages employers to provide health insurance and employees to avail them. It also promotes risk-pooling since use of healthcare is not usually related to a person’s choice of employment (Kim, 2007).

Operational. As mentioned above, the capacity of PhilHealth to manage a supplemental fund should be increased through additional personnel, training, infrastructure, and information systems. The details of these requirements will have to be determined based on an assessment of the current capacity of PhilHealth and the objectives of the supplemental fund management; whether it is an actual supplemental fund that will be set-up by PhilHealth, or supplemental benefits contracted out to HMOs.

If the servicing of Z benefits is expanded from government to private hospitals, appropriate measures to control possible balance billing violations for the indigents and excessive co-payments should be established. Appropriate reimbursement rates for participating private hospitals should be determined thorough actuarial studies. Continuous actuarial monitoring of claims, costs, and utilization rates to ensure

viability is also necessary.

A detailed actuarial study is imperative to determine the proper premiums that will be charged to cover costs, projected utilization and additional administrative expenses. Without accurate actuarial studies, PhilHealth over- or under spending for the catastrophic illness packages can easily occur among the health service providers. Incidence data from other countries should not be used because risk factors and baseline characteristics vary in different populations. Data in the Philippines on catastrophic illnesses is limited, but data from various sources can be used and aggregated to give fair estimates and guide identification of catastrophic illnesses. For example, the National Kidney and Transplant Institute has counts of end stage renal disease and HMOs have data on health expenditures of their clients during admissions. Collection and analysis of these data will require cost, time, and actuarial expertise. Cost-effectiveness analyses can also be conducted to guide selection of interventions that will be covered by the Z benefits.

However, HMO data is for the employed sector only, majority of which is from the employed sector and higher socioeconomic quintiles. Also, using expenditures to estimate the incidence of catastrophic illnesses only takes into account those who spend for health care and does not include those who forego spending, who are usually the poor.

The limitation of using expenditures to estimate the incidence of catastrophic payments is that the impact of catastrophic illnesses may be greater for those who do not spend for health: those from the poorest quintiles. An alternative method is by determining incidence of exposure to catastrophic illnesses instead of the incidence of catastrophic spending (van Doorslaer, 2007).

Catastrophic illnesses cause major expenses for patients and their families. Similarly, for an insurance company to cover catastrophic illnesses, a large fund pool is necessary as well. Hence, in order to increase the scope for the Z benefits, more funds are needed. However, the sustainability of the PhilHealth budget for Z benefits should first be reviewed by using accurate data from costing and incidence studies.

CONCLUSIONS

A supplemental fund from the private sector for catastrophic illness financing is currently not feasible due to financial, legal, operational, and regulatory constraints. In the current system of coverage for catastrophic illness in the Philippines, the private sector is already supplementing the Z benefits by providing catastrophic illness coverage for its clients and employees. The PhilHealth Z benefits, HMOs and self-insured companies provide financial support for eligible members, clients, or employees, respectively, who have catastrophic illnesses. Self-insured companies provide the most extensive support for catastrophic illnesses, while HMOs benefits are limited by the package availed by the client, and the Z benefits have specific requirements to be eligible. However, each source of health financing covers a distinct subgroup of patients: PhilHealth for those who prefer government hospitals, the indigents and sponsored members; HMOs for most of the employed sector; and self-insured companies for a small fraction of the employed sector.

The following are the major constraints to establishing a supplemental fund:

1. The current configuration of PhilHealth and the private sector in financing catastrophic illnesses gives little incentive, if any, for the private sector to contribute to a supplemental fund. First, a major constraint is that government hospitals are the providers of the Z packages, while the private sector is mostly limited to private hospitals. Second, private companies may not agree to contribute to a supplemental fund because they are already paying PhilHealth premiums and taxes.
2. The HMO industry is inadequately regulated, posing a risk of fraud to the consumers if HMOs are involved in the planned supplemental fund.
3. Although the amended National Health Insurance Act, has a provision for establishing a supplemental fund, PhilHealth lacks the additional administrative, structural, and operational requirements to manage it.

Affordability of premiums and willingness to allocate more resources for health are the prime factors affecting generation of funds from the private sector. Since the utility of Z benefits for the private sector is low, there is no incentive for them to supplement it. Further discussions between PhilHealth and the private sector are still needed to determine what each party may benefit from this arrangement. Involving the competitive private insurance market will also require measures in the formulation of supplemental benefits such that solidarity is maintained. Whether through PhilHealth or outsourced to the private sector, further actuarial studies are needed to make the supplemental fund viable.

RECOMMENDATIONS

The following recommendations are presented based on the findings of this study.

First, the supplemental fund needs to be well-planned and formulated. It should include: plans on management of the fund, either through a new office in PhilHealth or outsourcing to HMOs; incentives for the private sector to contribute to catastrophic illness financing, for example, tax incentives; and coordination of PhilHealth and the private sector in terms of catastrophic illness coverage.

Second, private hospitals should be allowed to provide the Z benefit packages. This is an important step to involve the private sector in the Z benefits because it will provide a common ground for PhilHealth, HMOs and self-insured companies to serve their clients or employees who incur catastrophic illnesses.

Third, HMOs should be regulated appropriately to ensure their financial sustainability, protect the Filipino market from fraud, and maintain a healthy competition beneficial for both the clients and the HMO industry. The private sector, particularly HMOs, is a growing contributor to health financing in the Philippines. Acknowledging this potential and involving them as a means to achieve universal health care would require measures to control and maintain quality of the HMO industry through national policies.

Lastly, in order to determine the budget needed for the Z benefits, actuarial studies are necessary to provide accurate costing and incidence data for catastrophic illness in the Philippines. It is recommended for PhilHealth to conduct continuous review and revision of the Z packages so that they will reflect the current fair market prices, and reduce risks of over- or undercosting. More accurate incidence data of catastrophic illnesses in Filipinos are also needed to estimate the number of individuals who will be covered by the Z benefits.

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Appendix 1. Interview Guides

QUESTIONNAIRE FOR INTERVIEWEES

Questions for PhilHealth Program Manager
<ol style="list-style-type: none">1. Briefly describe the PHIC program for catastrophic (type Z) illness.2. What are the policies of the PHIC Benefit Package for Type Z?3. What are its limitations?
<ol style="list-style-type: none">4. Is there a need for additional funding for this program?5. How much additional funding is needed for this program?6. What possible sources is PHIC considering for supplemental funding?7. Are there any plans to expand the coverage for other illnesses in the PhilHealth Benefit Package for Type Z?
<ol style="list-style-type: none">8. How does the PHIC perceive the role of the private sector in supplemental funding for catastrophic illnesses?9. What organizations can provide supplemental funds for PHIC?10. How can these funds be accessed?
<ol style="list-style-type: none">11. Are there current regulations or policies that may hinder supplemental funding from private insurance for catastrophic illnesses?12. Are there regulations or policies that may facilitate supplemental funding from private insurance for catastrophic illnesses?13. What changes or additions in the current system of PHIC would be needed to implement supplemental funding in terms of:<ol style="list-style-type: none">a. infrastructure,b. personnel,c. regulations,d. operations,e. management?
<ol style="list-style-type: none">14. What will be the impact of supplemental funding for catastrophic illnesses to PhilHealth financing?

Questions for HMO manager/ Medical Director of Self-insured Companies

1. How does your company define catastrophic illness?
2. Is your definition the same as that of PHIC?

3. Does your company cover catastrophic illnesses?
 - 3.a.1. if yes, what catastrophic illnesses are covered by your company?
 - 3.a.2. What are the inclusion criteria for your clients/employees covered for the benefit package for catastrophic illnesses?
 - 3.a.3. What are the exclusion criteria for your client/employee for coverage?
 - 3.a.4. What are the benefits or services being covered by your company?
 - 3.b.1. If no, does your company have plans to include catastrophic illnesses in any of your product lines in the future?
 - 3.b.2. How much will the company cover for each illness?
 - 3.b.3. How much will the additional costs for premiums?

4. How will the supplemental fund be accessed by PHIC?

5. Are there policies or regulations that hinder the creation of supplemental funding for catastrophic illness for private companies?
6. Are there policies or regulations that facilitate the creation of supplemental funding for catastrophic illness for private companies?
7. What changes or additions in the current system of your company would be needed to implement supplemental funding in terms of:
 - a. infrastructure,
 - b. personnel,
 - c. regulations,
 - d. operations,
 - e. management

8. What do you think will be the impact of supplemental funding for catastrophic illnesses to PHIC funding?

Appendix 2. List of Key Informants

Philippine Health Insurance Corporation

1. Ms. Nerissa Santiago Vice President, Office of the Actuary
2. Dr. Leizel Lagrada OIC, Vice President, Quality Assurance Group
3. Dr. Melanie Santillan Special Benefits Team

Philippine Long Distance Telephone Co.

Dr. Rafael Bejar Vice President and Head of Medical Services

Meralco

1. Ms. Nina Pablo Corporate Wellness Center
2. Mr. Ferdinand Victoria Benefits and Employee Services

Intellicare

Dr. Ramon Agregado AVP & Assistant Medical Director

PhilCare

Dr. Irene Limpo Medical Director

Association of Health Maintenance Organizations of the Philippines, Inc

Mr. Carlos Da Silva Executive Director