Health Affairs Scholar, 2024, **2**(2), 1–4
https://doi.org/10.1093/haschl/qxae004
Advance access publication: January 22, 2024
Commentary

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Effect of a case-capped, fee-for-service payment mechanism on accessibility and affordability of health care

Bernardo Cielo II[1,2], Melanie Santillan[3], Vergil de Claro[1,*]

[1]RTI International Philippines, Pasig City 1600, Philippines
[2]School of Economics, De La Salle University, Manila 1004, Philippines
[3]Benefits Development and Research Department, Philippine Health Insurance Corporation, Pasig City 1600, Philippines
*Corresponding author: RTI International Philippines, Pasig City 1600, Philippines. Email: vdeclaro@rti.org

Abstract

In response to a government audit report in 2021, the Philippine health insurance system transitioned its case-based payment system back into a fee-for-service model capped at individual case rates. This commentary discusses the adverse effects of this policy on health care accessibility and affordability in the country. A rapid review of data shows that it may have resulted in delayed insurance payments, increased denial rates, and reduced coverage, and weakened the strategic purchasing capacity of public health insurance, hugely affecting vulnerable populations and public health care facilities. The commentary calls for a reconsideration of the policy and emphasizes the importance of aligning financial auditing procedures with the needs of health-financing institutions. It advocates for a transformation of audits, moving beyond their traditional role as compliance checks, to become valuable tools supporting a nation's health care purchasing strategies, ultimately benefiting both health care providers and the broader public.

Key words: provider payment; case-based payment; health insurance; PhilHealth; Philippines.

Health insurance plays a vital role in ensuring people's access to care and protecting them from significant financial burdens and the risk of being pushed into poverty due to illness. In the Philippines, health financing is characterized by a mix of public and private funding sources, with the social health insurance program (PhilHealth) as the main payor of health services.[1] The program was established in 1995 to provide universal health coverage at an affordable price. However, the level of financial protection provided remains limited, with the dominance of private spending consisting mostly of out-of-pocket (OOP) expenses.[2]

Since 2014, PhilHealth transitioned from fee-for-service (FFS) to case-based payment, known as All Case Rates (ACR), to incentivize efficient and high-quality care, enhance predictability in reimbursements for health care providers, and streamline claims processing.[3] Through ACR, PhilHealth sets a fixed rate for bundled services provided for each identified case, prompting health care providers to adhere to stringent standards and reduce acquisition costs, with the intent of reducing overall health care expenditure in the long run. While the case rate reflects the average cost of treating an episode of care, actual hospitalization costs vary across each patient. With sufficient scale, however, the sum of claim payments for each case should approach the total actual cost of care, granting a reasonable level of efficiency.

In March 2021, the Philippine Commission on Audit (COA) released its audit report of PhilHealth indicating an "existence of overpayments or efficiency gains in ACR due to the policy of payment in fixed-rate despite lower actual hospitalization charges amounting to Php41.75 billion from CY 2011 to June 30, 2020," equating efficiency gains to overpayment.[4] A congressional inquiry led the national health insurer to modify its case-based payment approach to pay the lesser amount between the actual hospital charges and the published case rates, in what is known as the "pay-whichever-is-lower" policy.[5] This resulted in a fundamental shift in the country's health-financing strategy where case-based payments were transitioned back into an FFS model, capped at individual case rates.

Adverse effects of the policy on accessibility and affordability of health care

One year and a half after its implementation, we conducted a rapid policy review examining the various aspects and the anticipated impact of the policy. We analyzed relevant policy documents and processes, cross-referencing them with PhilHealth claims data between 2020 and 2022. The overall shift in case-based payouts and the average change in payment per case were reviewed to understand the potential effect of the policy on provider income. Our analysis identified the following effects on the accessibility and affordability of health care in the country:

1. **Delayed insurance payments, increased denial rates, and over-discounting of claims.** Transitioning to an FFS model increases the administrative workload for processing claims driving inefficiencies in the adjudication process. The sudden shift in payment mechanisms relied heavily on human intervention to satisfy the policy requirements

Received: November 20, 2023; Revised: January 10, 2024; Accepted: January 19, 2024

since PhilHealth's electronic claims system was not designed for FFS. Additionally, PhilHealth's current organizational structure and standard procedures were not built to support the rigor required. This resulted in significant delays in payment and greater discretion and variability in determining the amounts paid to accredited providers. The situation was further exacerbated by PhilHealth offices becoming increasingly risk averse in processing payments due to concerns for COA disallowances and risks for potential legal action. This resulted in higher rates of denial and over-discounting of claim payments. Taken together, these factors led to a 20.7% reduction in total paid claims from 2020 to 2021, with 28% of total paid claims reimbursed at rates lower than the case rate. While multiple factors can inform this change, drastic shifts in payment trends over a short period are typically uncommon. This suggests that the policy may have contributed to a reduction in coverage by approximately US$54 million from 2019 for similar claim volumes. Further study is needed to establish causal inference.

2. **Reduced social health insurance coverage following the introduction of the policy.** When claims from 2020 to 2022 were analyzed for specific cases, the data revealed consistently lower payment trends across the board (Figure 1). For instance, coverage for chemotherapy showed an 8.64% reduction in 2022, while coverage for HIV/AIDS treatment saw an 8.29% decrease in the same year. Considering that PhilHealth does not establish a fixed cost share for health services it covers, patients, on average, receive reduced insurance coverage since the difference is covered directly from their own pockets. This issue becomes increasingly problematic, especially with the planned incremental increase of premiums by 0.5% each year until 2025.
3. **Diminished PhilHealth's strategic purchasing capacity for health services.** Case rates are fixed payments to health care providers, set based on actuarial viability, service priority, and desired provider and patient behavior. Conversely, FFS involves negotiated fees for each case, allowing for payment flexibility. However, when PhilHealth shifted to a case-capped, FFS model, it lost the advantages of both payment mechanisms. Case rates distribute the risks across the patients under the provider's care, ensuring regular and predictable payments. By setting these case rates as payment caps, providers are required to bear the cost of their efficiency and lose the ability to predict their income from the national insurer. On the other hand, FFS offers adaptability as patients' health care needs evolve during their hospital stay. Capping payments under this system creates adverse incentives to drive up inefficiencies to capture a larger share of the capped rates, which, in turn, makes patients shoulder a greater portion of the cost. In this context, what PhilHealth does not cover should not be considered "savings" for the government[6] as it essentially passed these costs to providers or patients depending on demand elasticity and applicable subsidies. This approach, while resulting in reduced government expenditures, did not contribute to lowering the overall cost of admissions. While acknowledging the potential impact of the new scheme in diminishing PhilHealth's ability to strategically purchase health services, the policy itself is indicative of PhilHealth's general weaknesses in leveraging its purchasing power. Despite being the single largest health purchaser in the country, accounting for 13.6% of total current health expenditure in 2022, PhilHealth has not effectively leveraged its market influence to curb health care costs, as evidenced by high OOP over the years.[2]
4. **Disenfranchised the poor and other vulnerable groups.** The shift in payment mechanism has disproportionately affected public facilities that serve low-income populations. PhilHealth payments constitute a significant share of public hospital income, with some providers reporting that as much as 90% of their total revenue comes from the national insurer.[7] These facilities primarily serve financially disadvantaged communities who lack the financial means to seek medical care at privately owned institutions. Reducing the total payments to public facilities can lead to increased financial pressure for the poor to bear a larger portion of the costs, such as having to purchase medications at retail prices while hospitalized, paying hospital deposits, or covering professional fees. This practice further diminishes their overall revenue and narrows the fiscal space for cross-subsidization within the health care system. Additionally, hospitals have been reported to have stopped honoring legally mandated discounts for the elderly and people with disabilities to secure larger claims from PhilHealth. This raises a significant concern, particularly in light of the already poor regulation and monitoring, amplifying the adverse impact of these illicit actions on the well-being of the poor and vulnerable.

Overall findings and recommendations

Shifting from case-based payment to a case-capped, FFS model does not seem to offer clear advantages for the patient, the provider, or the government. Initial data suggest that setting case caps for FFS payments, while moderately successful in reducing total government expenditures, did not contribute significantly to improving the efficiency of claims payment. Instead, the policy has likely shifted the financial burden of seeking care from the national insurer to patients and providers, potentially resulting in lower support value and higher OOP expenses. While reducing total government spending is a commendable goal when it drives efficiencies in health care delivery, artificially limiting government payments by imposing coverage caps per case only weakens PhilHealth's role as a strategic purchaser. Facilities may become more inclined to bill patients for their balances due to reduced efficiency gains from social insurance payments.[8] This disproportionately disenfranchises disadvantaged populations who rely more on public insurance to cover their health care costs. For these reasons, it would be prudent for the state insurer to consider a transition back towards case-based payments and conduct a thorough review of the current case rates to assess its adequacy to provide financial protection.

There is also a critical need for a proper alignment in defining financial auditing procedures for health-financing institutions. Financial audits are essential in ensuring that public funds are properly utilized by government institutions. However, the current financial auditing procedures are inadequately equipped to evaluate the effectiveness of health-financing institutions in purchasing health services. This disparity arises because the payment mechanisms for health care services differ significantly from budget execution processes within public

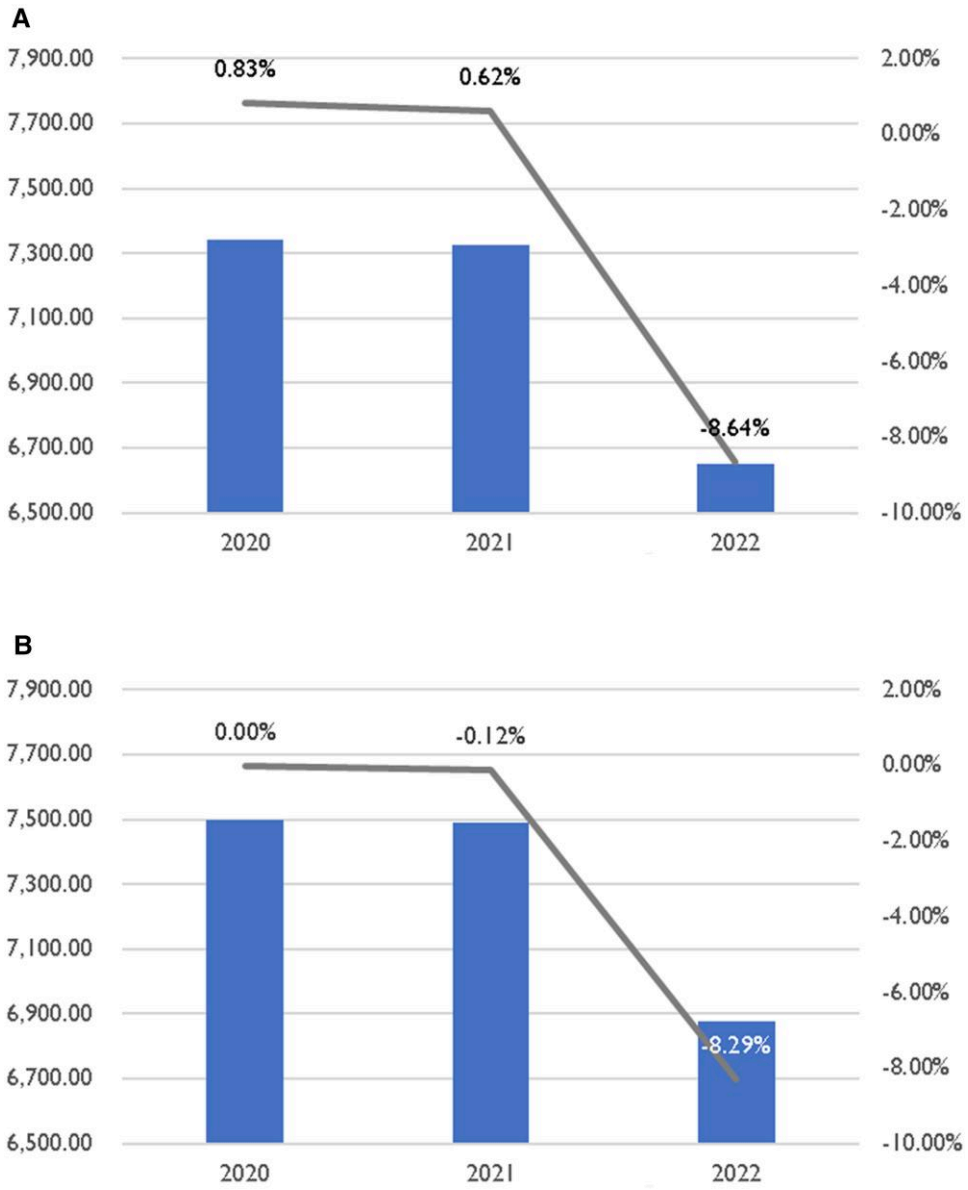

Figure 1. Trend analysis of claims payment on selected case rates: (A) chemotherapy and (B) outpatient HIV/AIDS treatment package. Blue bar (Amount of Insurance Claims) and grey line (% change).

financial management systems.[9] Traditional financial audits are primarily designed to assess purchases made through line-item budgets with fixed prices at the point of sale. In contrast, health financing involves risk-based payments intended to achieve actuarial fairness, where the goal is to balance the current level of coverage with the premiums collected.[9] As such, prices may vary at the individual level but should average out adequately with sufficient scale. Given these distinctive conditions, audits of health-financing institutions should shift their focus away from assessing individual claims; rather, they should primarily evaluate the institution's adherence to its purchasing strategies, compliance with its policies, and commitment to maintaining actuarial fairness. Moreover, audits should extend beyond the role of mere compliance checks and evolve into a valuable tool for optimizing the management and allocation of resources within the health care sector, ultimately benefiting both health care providers and the wider public.

The recent declaration to repeal the policy is certainly a positive step forward, indicating a recognition of its limitations and inefficiencies, as well as a determined commitment to rectify these issues.[10] Nevertheless, it remains essential for communication to continue between PhilHealth and regulatory bodies to achieve conceptual clarity and establish a shared understanding of fundamental principles and processes that complement each other's disciplines to prevent similar adverse policy responses in the future.

Acknowledgments

The policy review indicated in this paper was technically supported by the ReachHealth Project funded by the US Agency for International Development (USAID) and implemented by RTI International. The views or information expressed in this article are solely those of the authors and do not necessarily reflect the views or opinions of the US government, USAID, or the authors' institutions.

Contribution statement

B.C., M.S., and V.d.C. contributed equally as joint first authors. All authors reviewed and edited the manuscript and agreed on the final version for submission.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Data availability

The dataset used and/or analyzed in this article is available from the corresponding author upon reasonable request.

Notes

1. Obermann K, Jowett M, Kwon S. The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis. *Glob Health Action*. 2018;11(1):1483638.
2. Philippine Statistics Authority. 2022 Philippine National Health Accounts; 2022. Accessed September 23, 2023. https://psa.gov.ph/system/files/sad/Press%20Release_PNHA_2022.pdf
3. Philippine Health Insurance Corporation. PhilHealth Circular No. 0031s. 2013: governing policies in the shift of provider payment mechanism from fee-for-service to case-based payment; 2013. Accessed September 23, 2023. https://www.philhealth.gov.ph/circulars/2013/circ31_2013.pdf
4. Commission on Audit. National Health Insurance Program (PAO-2021-01) [Performance Audit Report]. In the All Case Rate (ACR) payment scheme sped up the reimbursement process for Health Care Institutions (HCIs) but existing control mechanisms have been deficient and underperforming in the prevention and detection of improper payments. 2021. Accessed September 23, 2023. https://www.coa.gov.ph/reports/performance-audit-reports/2020-2/national_health_insurance_program/
5. Philippine Health Insurance Corporation. PhilHealth circular 2021-0012: modification on the payment rules of benefit packages under All Case Rates policy including COVID-19 benefit packages; 2021. Accessed September 23, 2023. https://www.philhealth.gov.ph/circulars/2021/circ2021-0012.pdf
6. Valverde HA, Anacio DB, Garcia AL, Lam HY. How protected are PhilHealth members and beneficiaries? The 2017 PhilHealth Support Value Survey. *Sci Engg J*. 2022;15:22-28.
7. Salvador D, Ong A, Laquindanum CA, et al. PhilHealth share ratio study: a national survey of PhilHealth share on revenues of government hospitals from 2011-2017. Philippine Health Insurance Corporation; 2019. Accessed September 23, 2023. https://www.philhealth.gov.ph/about_us/studies/abstract/6.2017ShareRatio.pdf
8. Cashin C, ed. Assessing health provider payment systems: a practical guide for countries working toward universal health coverage. Joint Learning Network for Universal Health Coverage; 2015. Accessed September 23, 2023. https://jointlearningnetwork.org/wp-content/uploads/2019/11/JLN_ProviderPayment_MainGuide_InteractivePDF.pdf
9. Cashin C, Bloom D, Sparkes S, et al. *Aligning Public Financial Management and Health Financing: Sustaining Progress Toward Universal Health Coverage*. World Health Organization; 2017.
10. Presidential Communications Office. PBBM directs PhilHealth to ensure expanded coverage for its members; 2023. Accessed September 23, 2023. https://pco.gov.ph/news_releases/pbbm-directs-philhealth-to-ensure-expanded-coverage-for-its-members/