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Evaluating the benefit development process utilized in implementing social insurance coverage for COVID-19 Community & Home Isolation

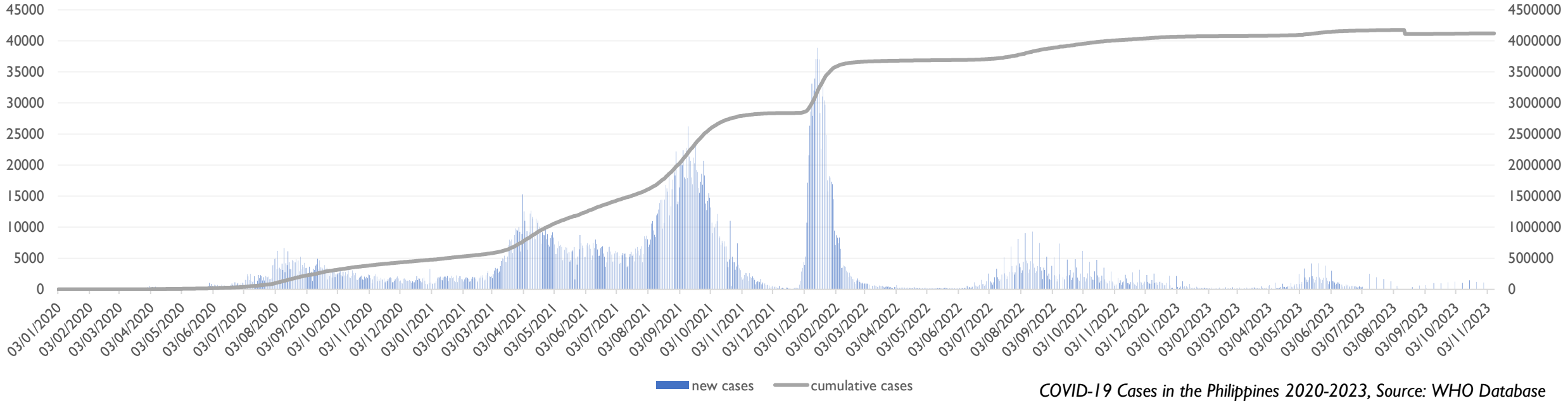
ReachHealth

Improved Health for Underserved Filipinos:
Family Planning and Maternal and Neonatal Health
Innovations and Capacity Building Platforms (FP/MNH ICP)

COVID-19 in the Philippines

The COVID-19 pandemic has been a pervasive threat to public health in the Philippines for the past 3 years.

From 2020, there have been approx. 4.1M reported cases and 66.736 deaths.
Currently there are 0 reported active cases and COVID-19 has since entered endemicity.



COVID-19 Cases in the Philippines 2020-2023, Source: WHO Database

Government Response:

Resource Allocation and Programming Public Funds

National Legislation

Rechannelling funds and resources to deploy top-level strategies in managing the pandemic

Vaccination

Mobilizing local resourcing and authorizing loans to support the purchase, import, and distribution of vaccines

Vaccine Indemnification

Encourage uptake by providing added coverage for adverse effects due to immunization

Cash Transfers

Deployment of cash transfers as income supplement for affected populations following the economic effects of adopting of Non-Pharmaceutical Interventions (NPIs)

Supply-side Incentives

Reduced barriers to import of goods to support commodity supply requirements and creation of incentives and insurance cover for HCWs

Social Health Insurance (SHI) Coverage

Required the national insurer to develop social insurance benefits for COVID-19

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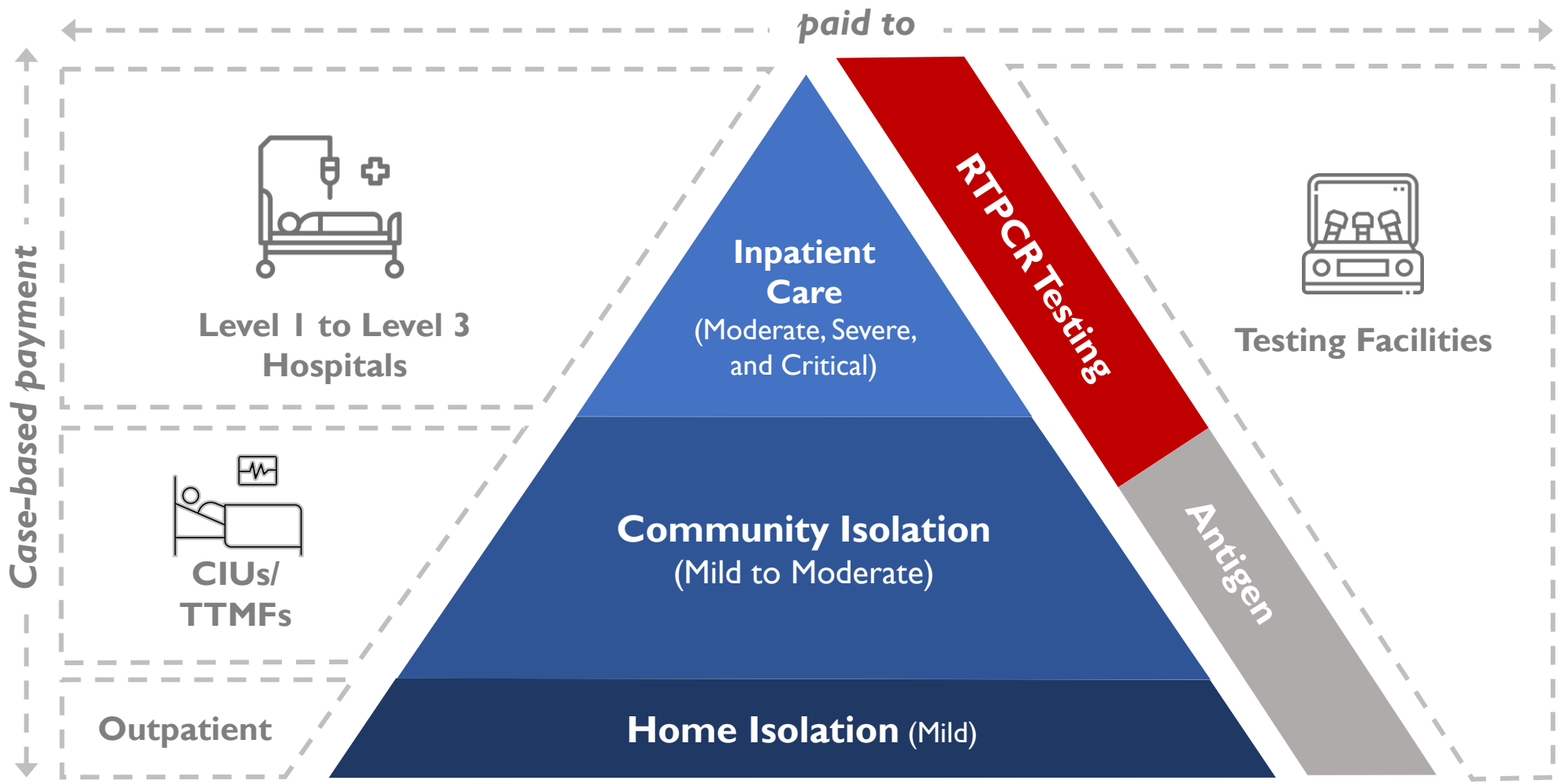
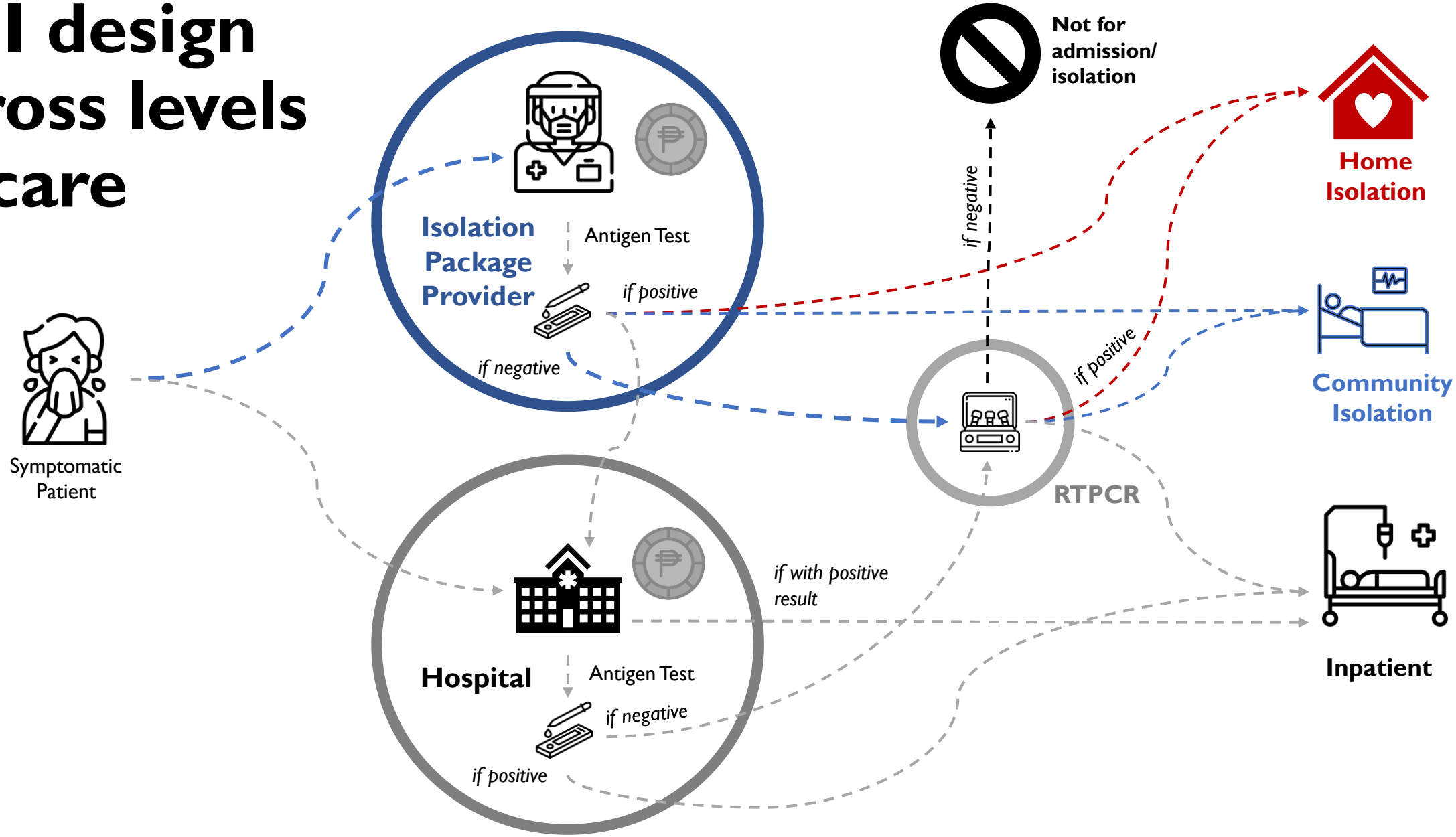
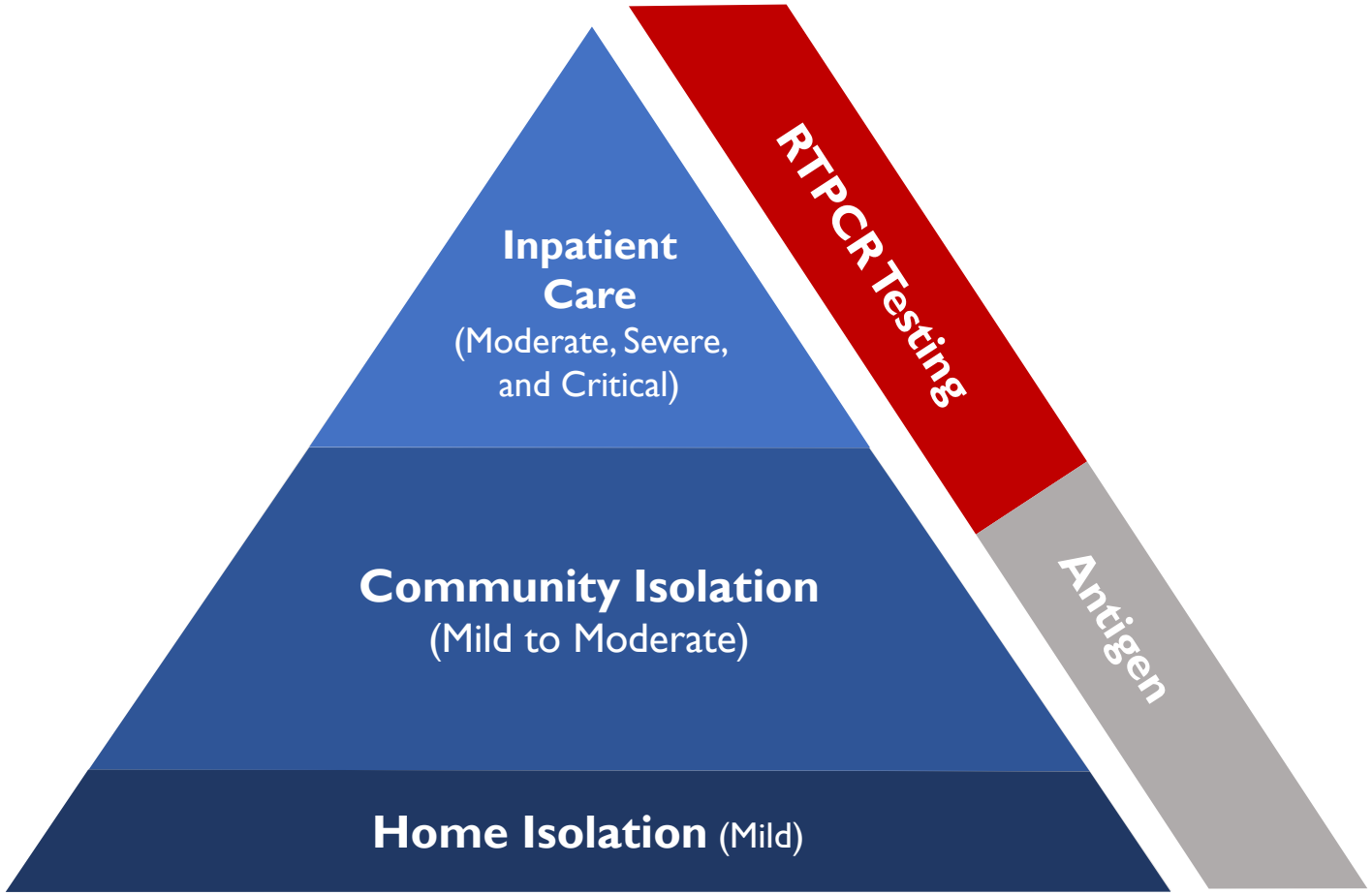
SHI design for COVID-19 across levels of care



SHI design across levels of care



Isolation Packages



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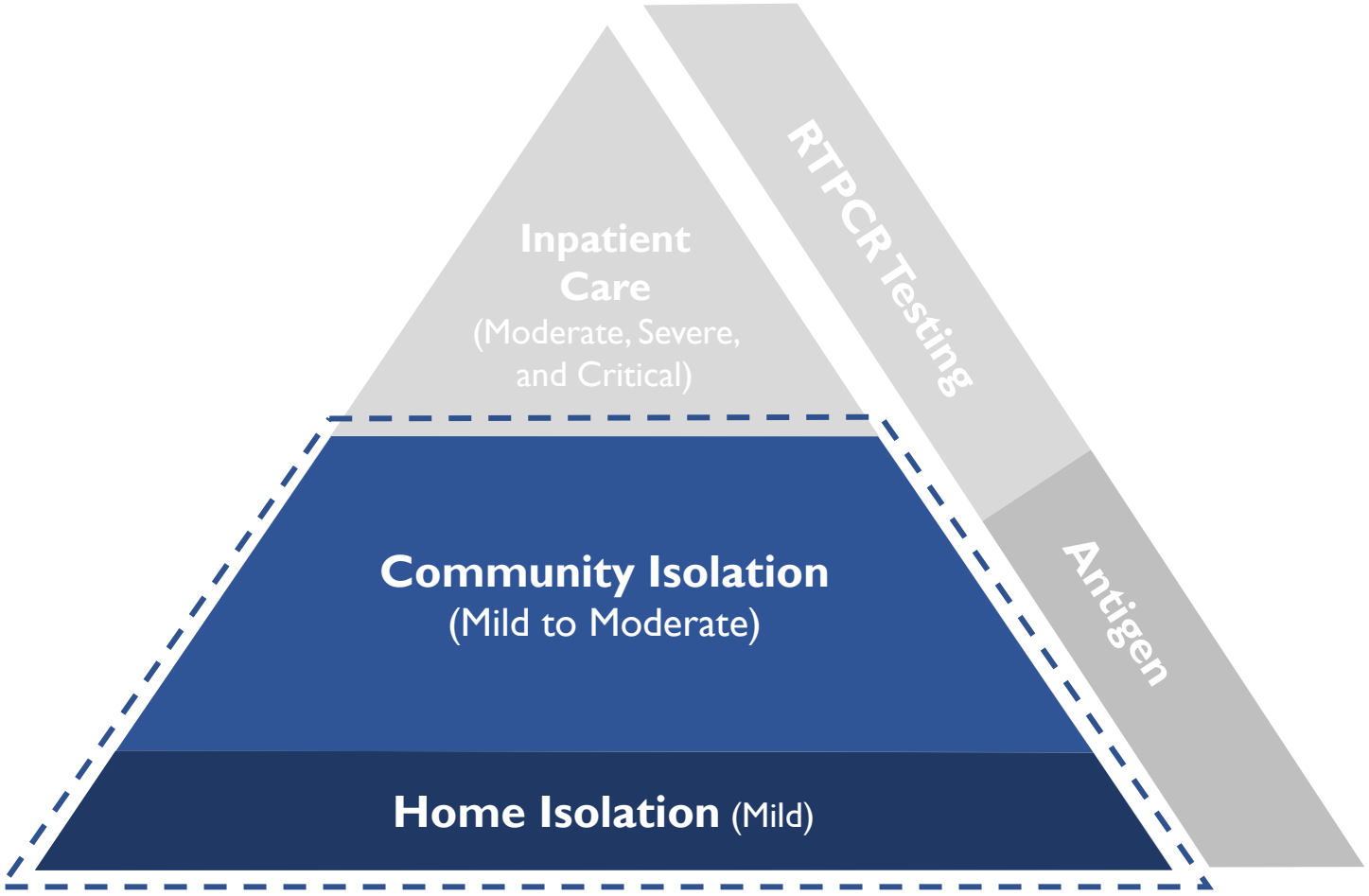


Research Questions:

1. How was the COVID-19 Community and Home Isolation Benefit Packages developed and revised between 2020-2021?
2. How did policymakers respond to the complex policy environment brought about by the pandemic?
3. What have we learned in how financing mechanisms could be designed to better address health disasters in the future?

Methods

Documentary Review

- Laws and Policies

Utilization Review

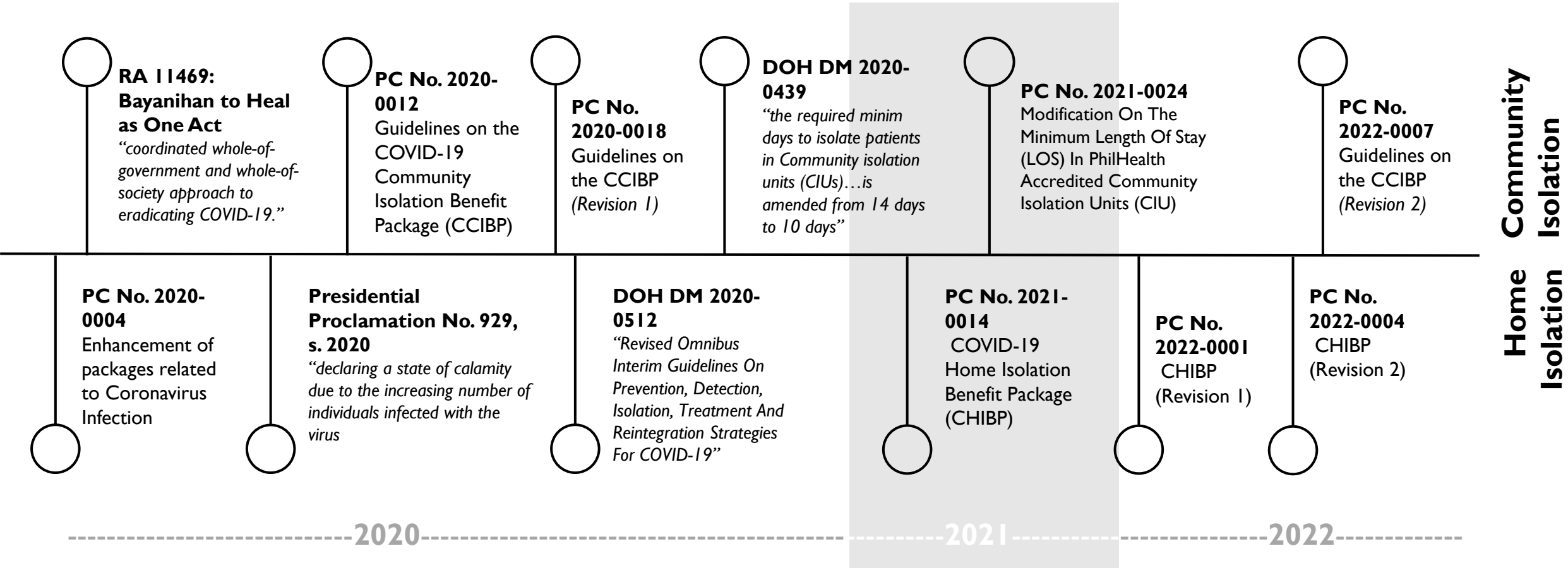
- Claims Data (2020-2021)
- AOM Analysis

Iterative Costing

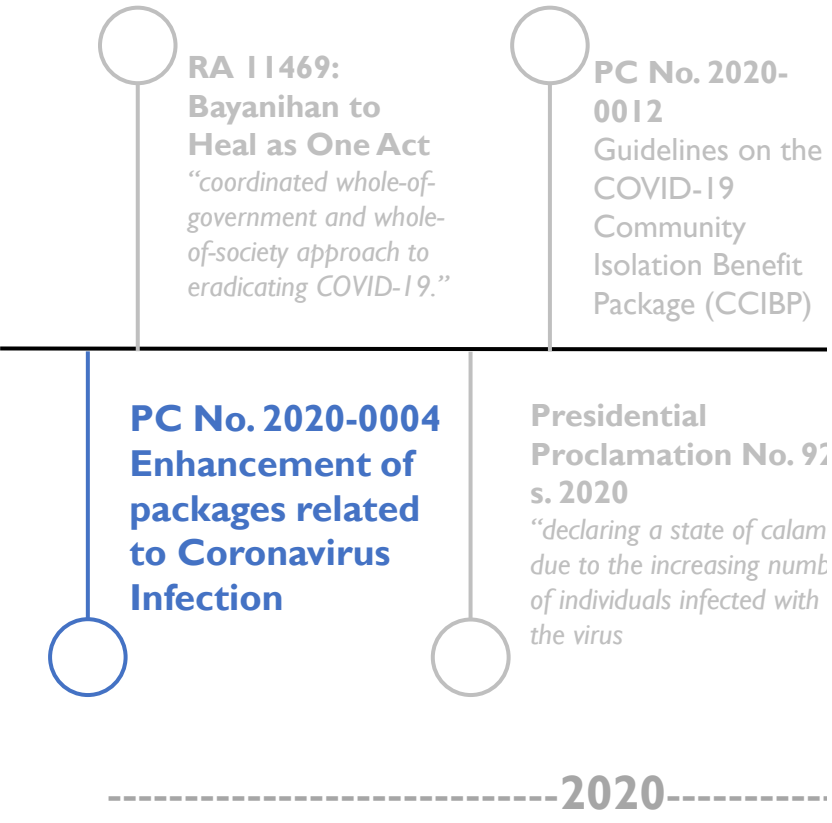
- Facility Expenditure Data (2020-2021)

As part of the technical assistance provided to PhilHealth in the development of PhilHealth Benefits for COVID-19, USAID ReachHealth (RTI International) conducted analysis in aid of policy, reviewing the utilization of COVID-19 isolation benefits between 2020-2021.

Multiple policies contributed in defining isolation packages



A benefit package was developed prior national legislation to support quarantine services

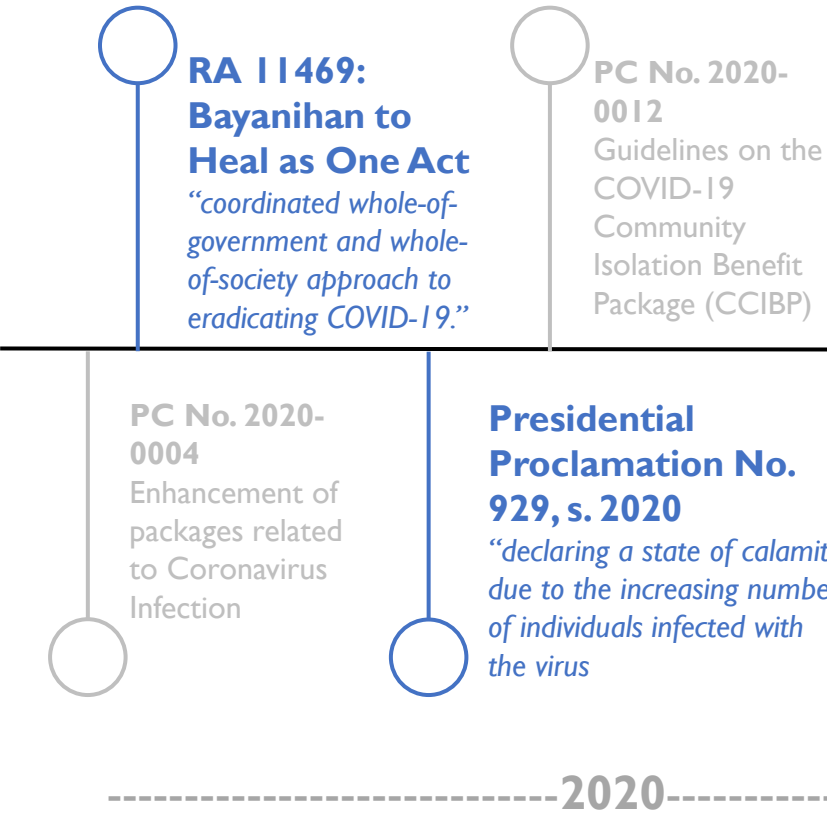


PC No. 2020-0004:

- *Package code: Z29.0*
- *Deployed a package for quarantine services for **mild cases** equivalent to Php 14,000.00 per case.*
- *Permitted payment for referrals equivalent to Php 4,000.00 per referral (package code P0001).*

Hospital-based Isolation:
Transmission rate was unknown and quarantine services were expected to be provided by hospitals.

National Policies defined the broad strategies for social insurance coverage



Republic Act No. 11469:

- *Adopting and implementing measures, which are based on World Health Organization guidelines and best practices, to prevent or suppress further transmission and spread of COVID-19 through education, detection, protection and treatment*
- *"coordinated whole-of-government and whole-of-society approach to eradicating COVID-19."*

Presidential Proclamation No. 929 s.2020:

- *"declaring a state of calamity due to the increasing number of individuals infected with the virus"*

Community Isolation:
Led to the establishment of non-hospital quarantine facilities (TTMFs) to provide quarantine services to reduce cases managed by hospitals

State of Calamity:
Need to reduce administrative burden in claims filing

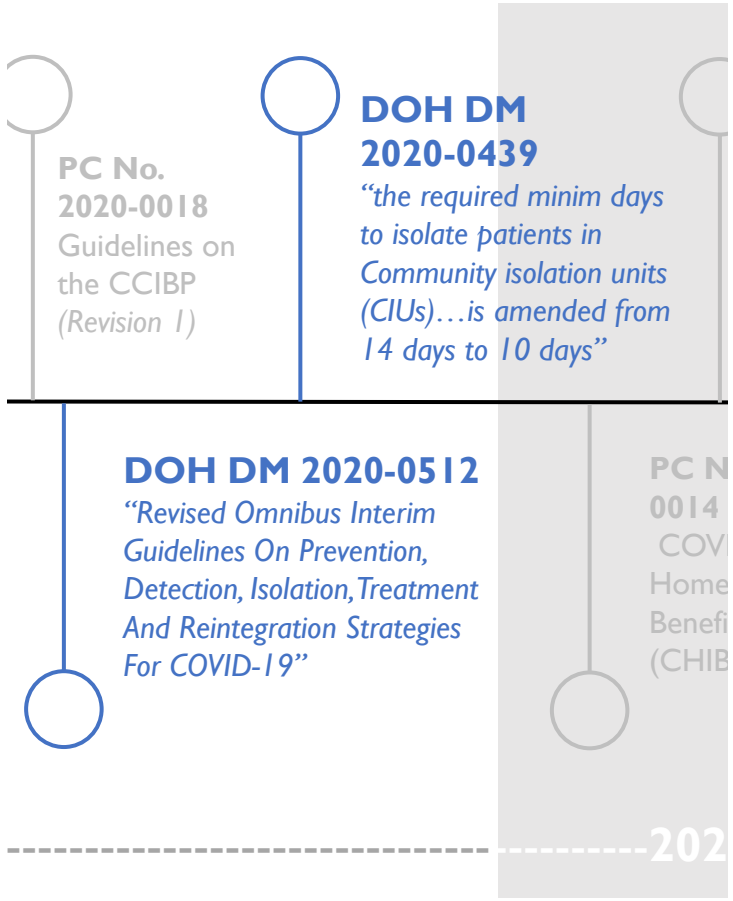
Pandemics cause volatile policy environments

which required strategies and protocols to change over time

DOH DM 2020-0512:

- *Included Home-based care in the treatment strategies*

Home Isolation was added as a treatment pathway as there was a *need to further rationalize hospital beds allocation.*



DOH DM 2020-0439:

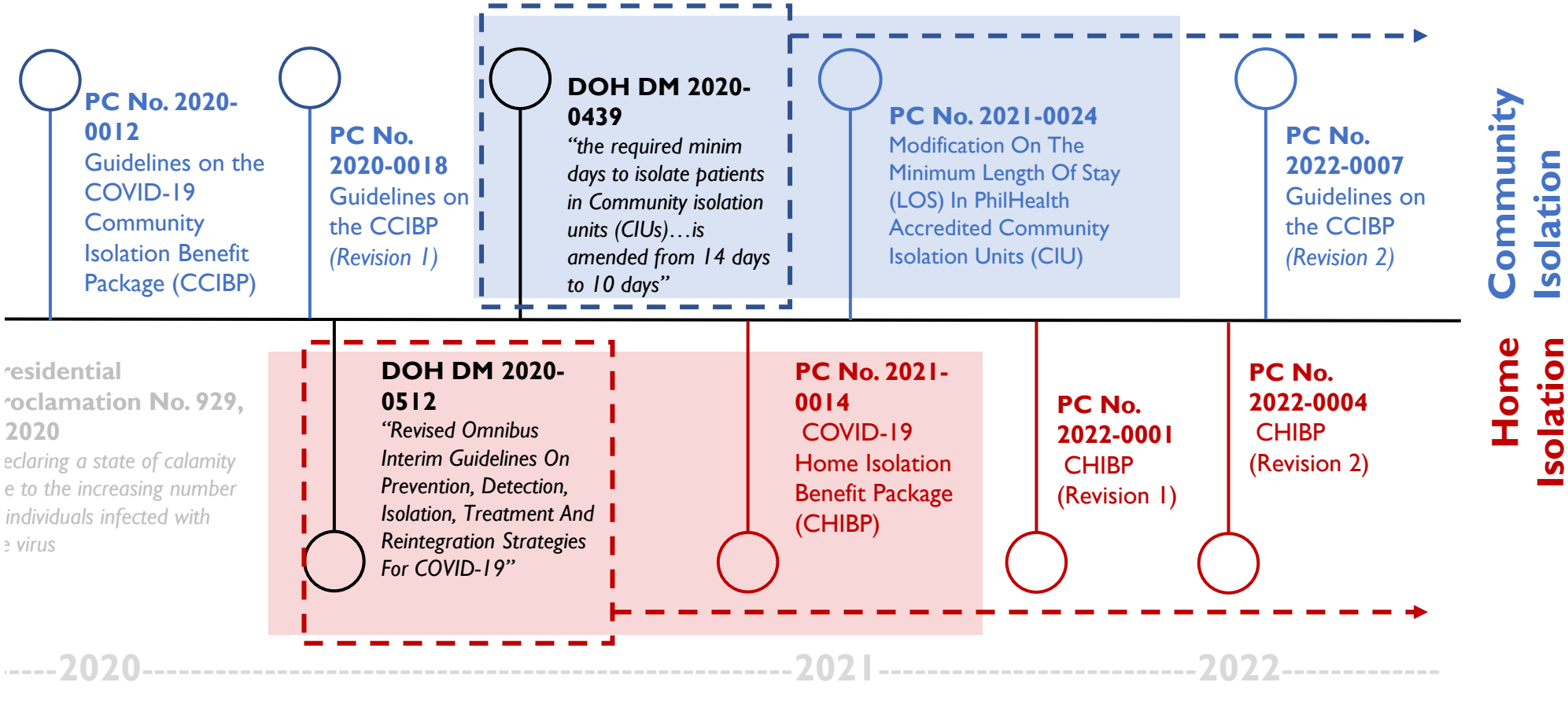
- *Adjusted isolation period from 14 to 10 days*

**isolation period was further reduced to 5 days by virtue of DM2022-0013*

Isolation period changed over time *the more we know about the disease..*

Isolation packages were developed and were regularly updated (with observed policy and implementation lag) between 2021-2022 to accommodate changes in **treatment protocols** and **strategies**

Through the technical assistance provided by USAID ReachHealth, isolation packages were created and the policies were revised regularly to **accommodate changes in protocols and in response to market signals with some policy & implementation lag.**



Following regulatory changes, these were some of the policy questions PhilHealth needed to answer:

Rate setting & strategic purchasing

Following a reduction in the isolation period (from 14 to 10 days), is there a need to adjust rates?

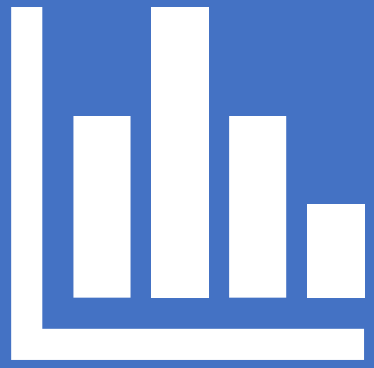
Home Isolation Package

In introducing home isolation as a treatment strategy, how can these services be paid by the national health insurer?

Financing Health Systems

What is the uptake of social insurance benefits for COVID-19 and how can strategic purchasing be leveraged in addressing the pandemic?

USAID ReachHealth (RTI International) supported PhilHealth in answering these questions through a comprehensive policy review, evaluating the current implementation of existing policies and setting and reviewing rates and payment mechanisms.



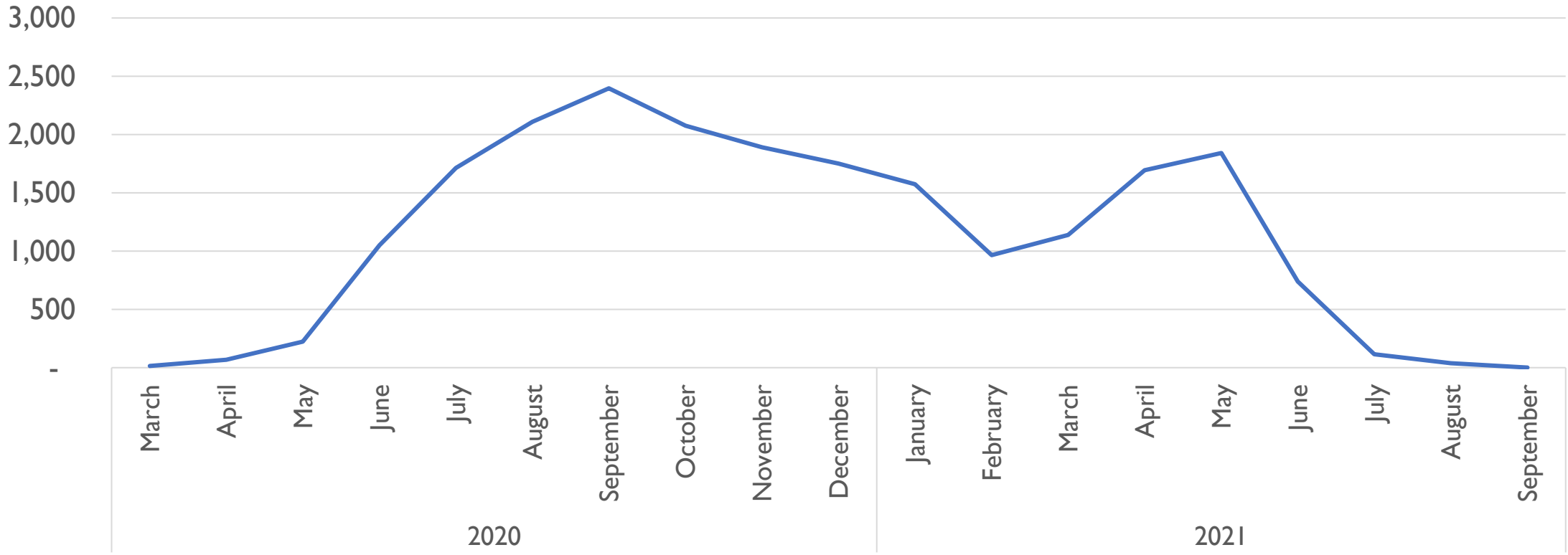
Utilization Review Findings

Community Isolation claims

(Mar 2020 to Sept 2021)

Isolation Claims Data showed low utilization between 2020(Q2)-2021(Q3)

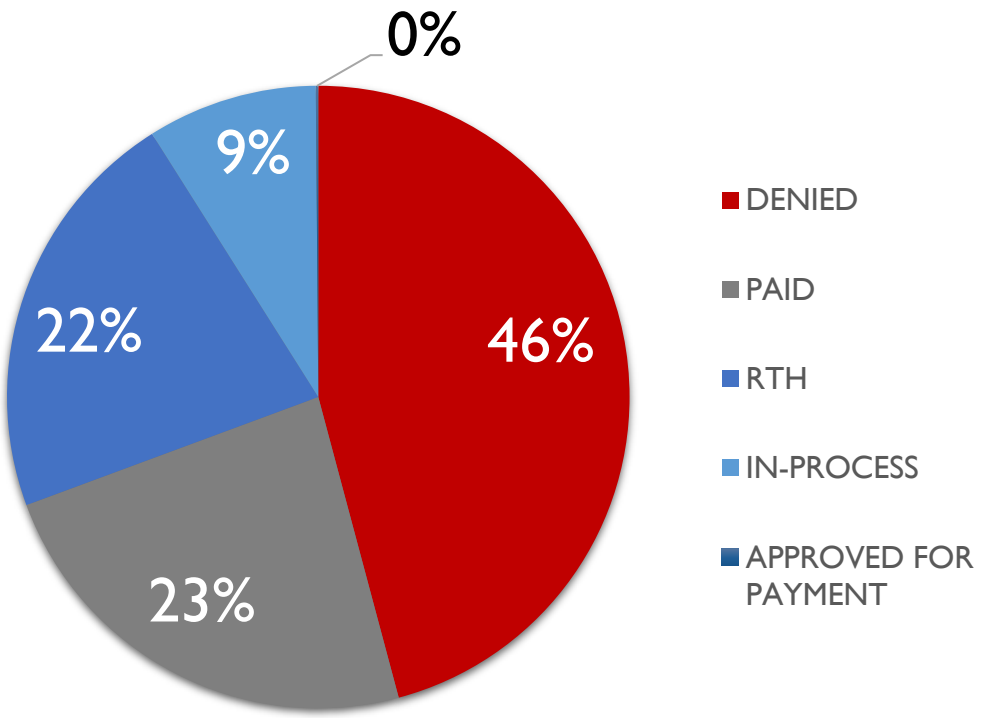
Monthly claims for CCIBP has not breeched 2,500 claims/month despite high volume of reported cases between March 2020 to September 2021



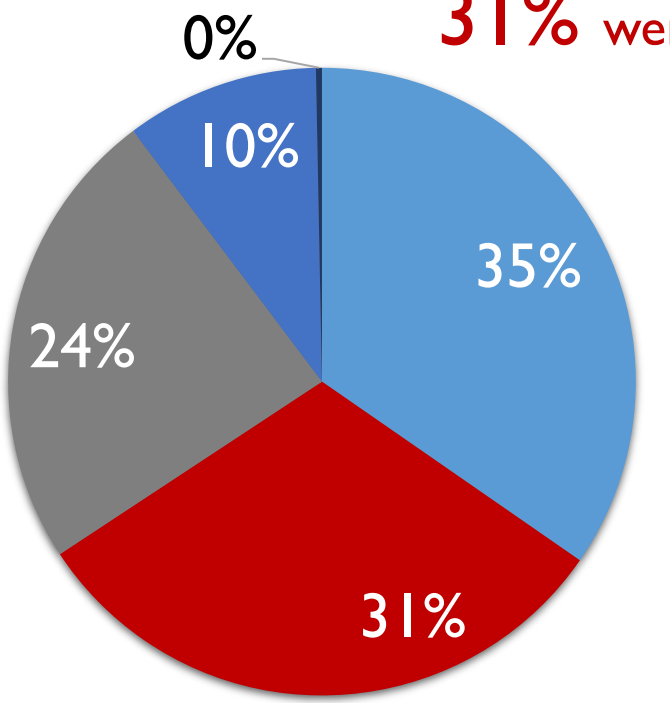
*Source: eClaims as of October 13. Includes all claims regardless of claim status

With high processing rates, but also high denial rates due to non-compliance to LOS.

In 2020, almost 46% of claims have been denied while 23% were paid

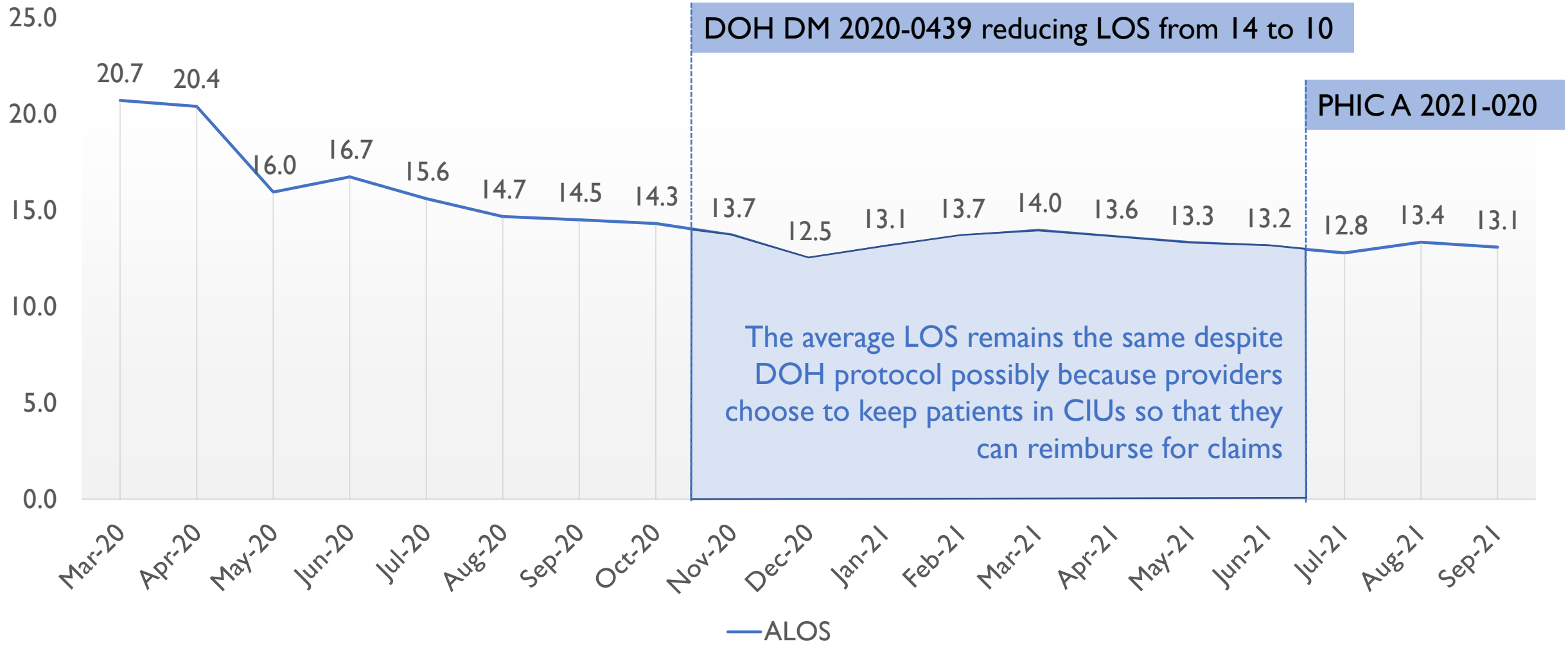


In 2021, 10% have been paid while 35% are still in-process and 31% were denied



*Source: eClaims as of October 13

LOS has remained relatively constant since 2020



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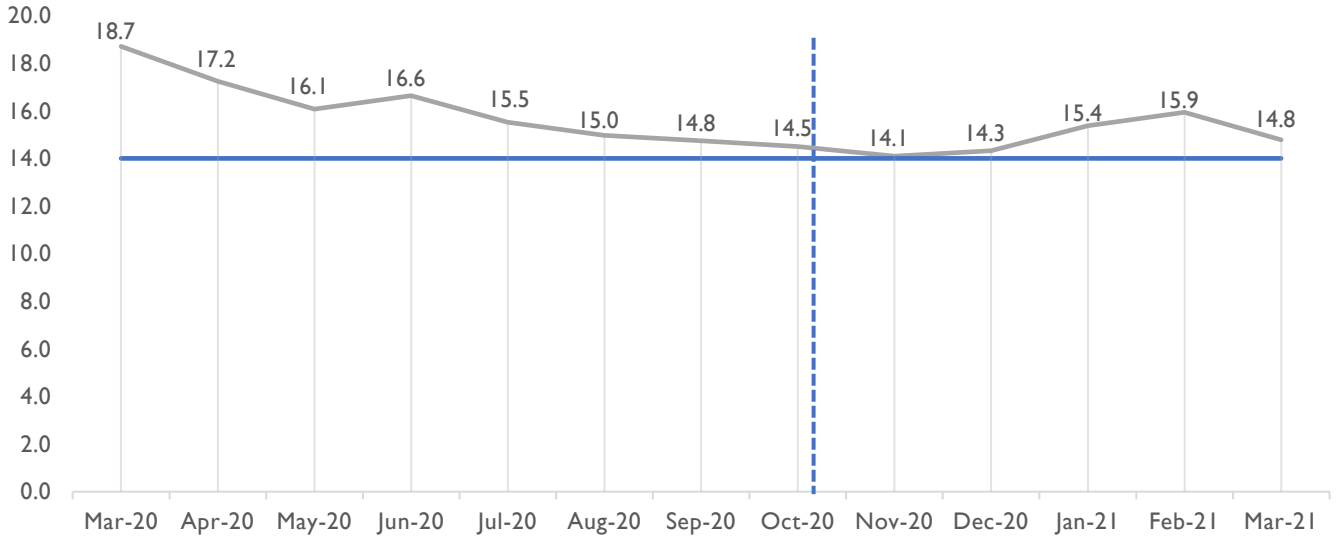


No Change in ALOS trend

eClaims data shows that despite the release of DM 2020-0439 adjusting discharge protocols for COVID-19 from 14 to 10 days, average **LOS per month remained unchanged.**

Average LOS per claim:

15 days

What does this tell us?

- Cases on the average require 15 days isolation despite protocols allowing for shorter isolation period
- This could be explained by different reasons:
  1. The average LOS is 15 days despite DOH protocol
  2. Providers choose to keep patients in CIUs despite changes in the protocol to ensure that they can reimburse for claims

Audit Observation Memorandum (AOM) Review

COA AOM 2021-0015

COA AOM Findings suggested that there were over/underpayments

AOM 2021-0015

- Of the 1,349 CCIBP claims filed in 2021, 78% of claims were alleged to have been "underpaid" while 22% of claims were supposedly "overpayments".
- There was a reported "overpayment" of Php1.06M
- "Underpayment" was supposedly at Php6.4M

	Month	Total No. of Claims	Total Amount	Overpayment		Underpayment	
				No. of Claims	Amount	No. if Claims	Amount
1	January 2021	8	179,592.00	2	2,256.93	6	50,524.32
2	February 2021	0	0.00	0	0.00	0	0
3	March 2021	3	67,347.00	1	13,719.20	2	8,102.85
4	April 2021	6	134,694.00	1	708.06	5	67,059.50
5	May 2021	6	134,694.00	2	947.00	4	22,763.23
6	June 2021	8	179,592.00	1	837.85	7	95,222.45
7	July 2021	5	112,245.00	5	11,764.72	0	0
8	August 2021	59	1,324,491.00	23	35,502.86	36	686,928.65
9	Sept. 2021	98	2,200,002.00	25	86,149.17	73	639,295.47
10	October 2021	359	8,059,191.00	66	116,925.90	293	2,167,896.86
11	Nov. 2021	470	10,551,030.00	64	129,324.31	406	1,895,686.73
12	Dec. 2021	327	7,340,823.00	104	666,055.26	223	832,307.93
	Total	**1,349**	**30,283,701.00**	**294**	**1,064,191.26**	**1,055**	**6,465,787.99**
		100%	**100%**	**22%**		**78%**	

Was there over/underpayment?

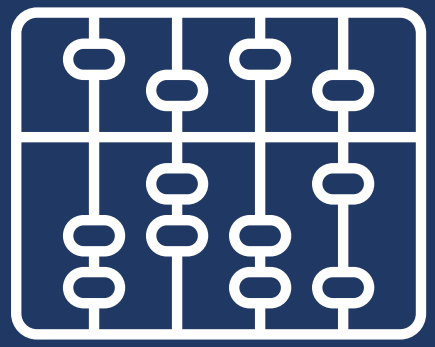
CLAIMS	CLAIMS AMT	CASE RATE
1,349	30,283,701	22,449.00

		claims paid	over/under amount	tot exp.	ideal CR
over	294	6,600,006.00	1,064,191.26	5,535,814.74	
under	1055	23,683,695.00	6,465,787.99	30,149,482.99	
				35,685,297.73	26,453

Working through the tables provided in the AOM. The average cost per patient is at Php 26,453.

This suggests that **there was no "overpayment".**
More so, **PhilHealth rates are set below the average cost per case*.**

**while PhilHealth pays less than the average case, this does not mean that the insurer underpaid. Insurers are not required to cover for the full cost of care. Underpayment entails that the insurer pays below the declared rate.*



Iterative Costing

Top-down Costing (Price surveys) &
Bottom-up costing results
(Utilization and Expenditure Reports 2020-2021)

Applicable rate following Top-Down Costing

CCIBP

Php 22,499

COVID-19 Community Isolation Benefit Package

Bottom-up costing results

	Cost per admission	Cost per Discharge	Admissions	Discharge
Mean	28,050.29	29,369.54	149.46	140.92
Median	**20,282.67**	**27,354.41**	42.00	29.00
Min	2,142.86	2,142.86	7.00	7.00
Max	83,863.60	83,863.60	659.00	659.00

*Source: CIU Expenditure and Utilization Report 2020-2021

Payments are apt following a comparison of rates & costs.

+9.8%
Efficiency Gains

Php 20,282.67
ave. cost per admission

CCIBP

Php 22,499

COVID-19 Community Isolation Benefit Package

Current case rate covers at least 78.4% of average health costs

-21.6%
For cross subsidization or OOP

Php 27,354.41
ave. cost per discharge

However, the range in costs across individual cases is wide*

**case-based payment is poor in accounting for variations in payment across individual cases, especially in pandemic settings where protocols are subject to change as the disease matures.*

1050%
of current case rate

Php 2,142.86
Min. cost per admission/discharge

CCIBP

Php 22,499

COVID-19 Community Isolation Benefit Package

27%
of current case rate

Php 83,863.60
max. cost per admission/discharge

Applicable rate following Top-Down Costing

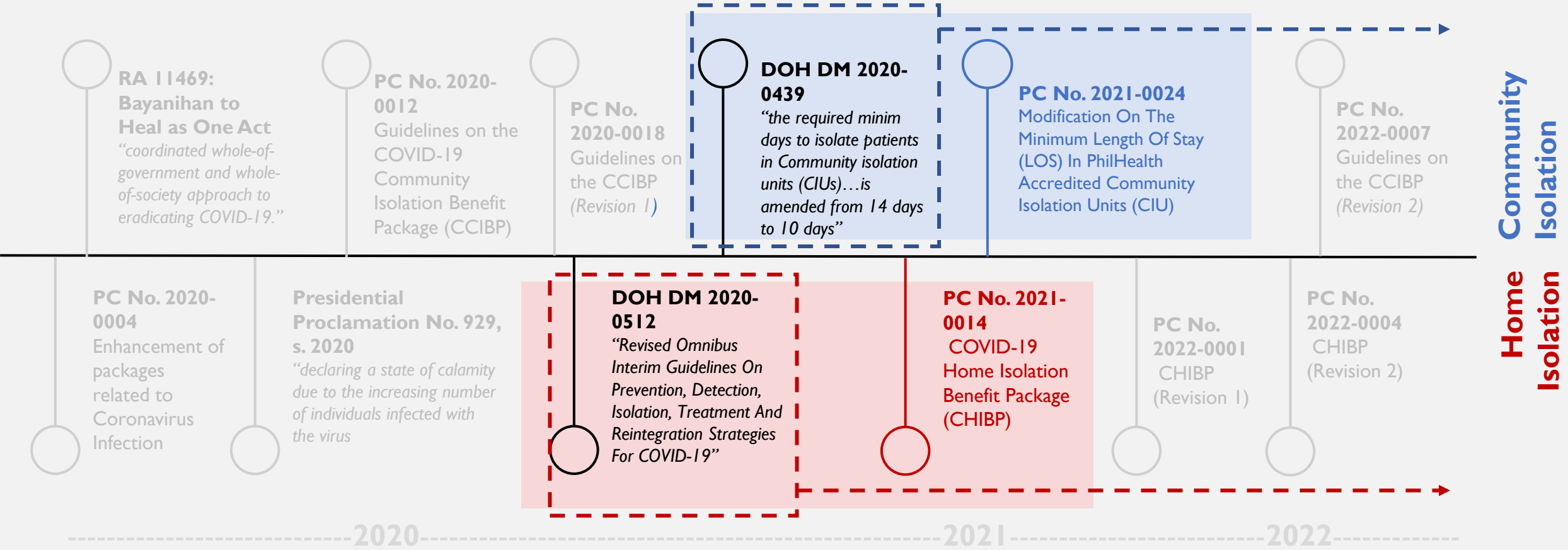
CHIBP

Php 5,917

COVID-19 Home Isolation Benefit Package

Translating evidence into policy

Were the evidence generated during the policy review used in designing future policies?



Translating evidence into policy

Positive use of evidence in policy making with a few exceptions

Evidence	Technical Inputs & Recommendation	Policy
Low uptake and utilization of community isolation benefits despite high incidence of mild COVID-19 cases.	• Possibly informed by consumer preference to isolate at home instead of in quarantine facilities Recommendation: **Expand options for coverage to include Home Isolation**	Developed the **Home Isolation Package** *(PC No. 2021-0014)*
High denial rate due to non-compliance to LOS	• Compliance to LOS is a deterrent to securing payment,	LOS was maintained as a requirement for payment* *(PC No. 2021-0024)*
Average LOS is 15 days despite changes in protocol	• Suggests that either on the average, patients still need 15 days for isolation despite changes in protocol or insurance policy is more determinant in setting provider discharging behaviour Recommendation: **Remove LOS requirement to better align with protocols and to encourage rational use of health services**	**PhilHealth was reluctant to remove LOS due to political pressures from COA and NBI.*

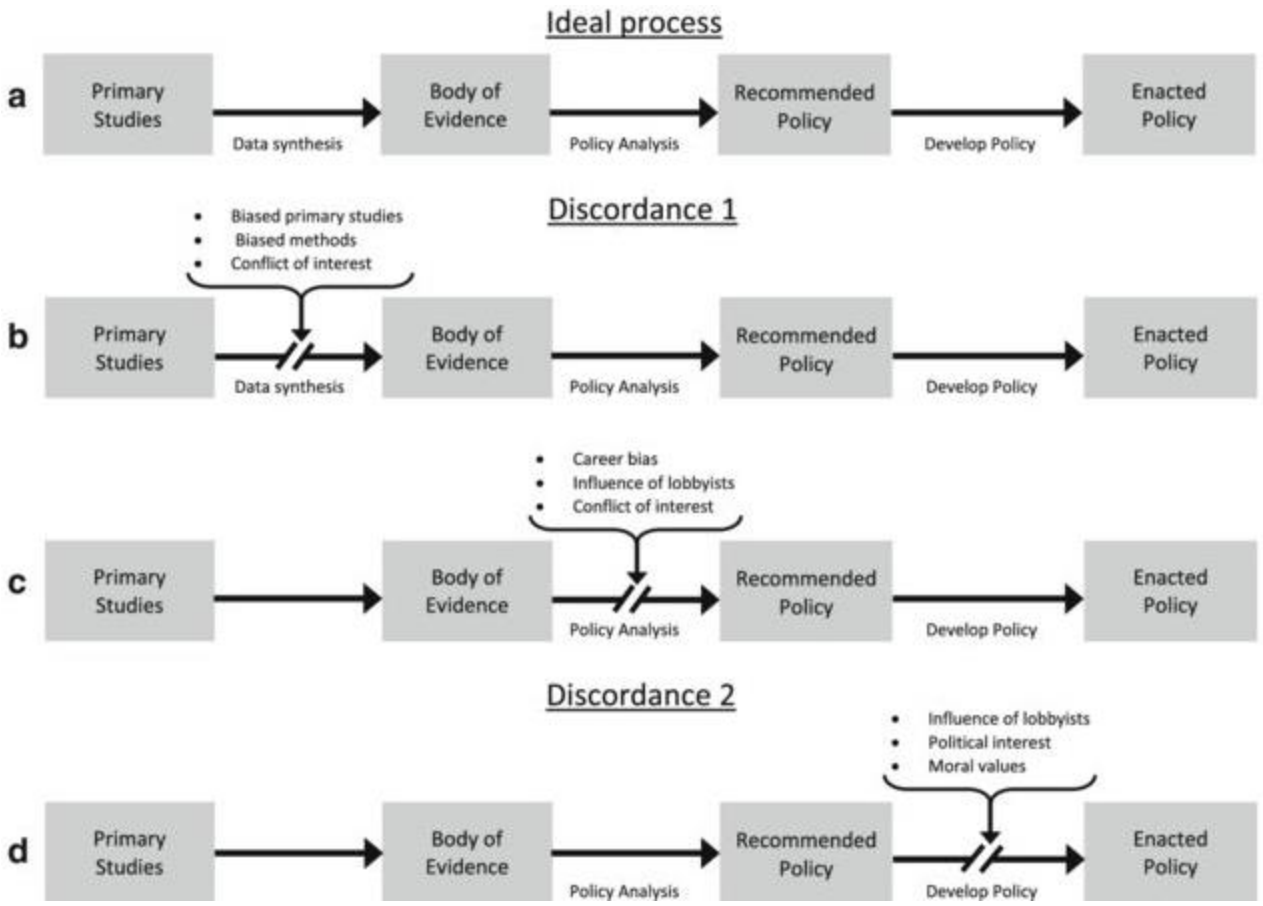
Translating evidence into policy

Evidence	Technical Inputs & Recommendation	Policy
AOM Findings suggest that PhilHealth is paying below current reported costs	• Some variance in actual payments per case is expected • Evidence suggests that PhilHealth does not pay over the total expense of the case • Overpayment is a misnomer since the basis of payment is the case rate and not the actual cost of the service (providers can profit from insurance payment) • Underpayment is a misnomer since providers received the full case amount. Recommendation: **Do not adjust reimbursement**	**Retained Case rate.** *(PC No. 2021-0024)* **Setting capped reimbursement for all case rates** Reducing reimbursements and paying based on the amounts indicated in the SOA up to the case rate *(PC No. 2021-0012)*
Wide range of costs across individual cases	• Case rates require defined protocols and stable prices to work. FFS is better equipped in financing Recommendation: **Shift payment mechanism from case rates to Fee-For-Service (FFS) for COVID-19 benefits**	

Translating evidence into policy

Evidence	Technical Inputs & Recommendation	Policy
Average LOS is 15 days despite changes in protocol (cont.)	• Assumptions used in top-down costing regarding period of isolation still hold.	Retained current Case Rate at **Php 22,499** per case. *(PC No. 2021-0024)*
Expenditure review using AOM findings suggest that rates are below average provider expenditure per patient	• Current case rate falls below the average cost of care for community isolation.	
Case rates fall within median costs in providing community isolation services.	• Difference in cost is attributable to inefficiencies in the market when demand for the service is low. • Costs are likely cross-subsidized by LGUs, this requires further study. Recommendation: **Retain current case rate.**	
Top-down costing suggests that outpatient care cost for COVID-19 is at Php 5,917.	Recommendation: **Provide a home isolation benefit package at Php 5,917 per case.**	Provided the Home Isolation Package at **Php 5,917** per case *(PC No. 2021-0014)*

Discussion



Conceptual framework on evidence-based policy-making process and 'unwanted' factors influencing discordance. a Ideal process, b and c Discordance 1, d Discordance 2 (Malekinejad et al., 2018)

There is an **observed demand and appreciation for evidence in policy making**.

However, there is **weaker evidentiary uptake due to discordance** in the policy process.

- Misalignment between COA auditing rules with health financing processes can result in political and legal risk for PhilHealth causing reluctance in properly structuring responsive payment mechanisms.
- Bias towards case-based payment led to a failure in considering more appropriate payment methods in dealing with pandemics (i.e. FFS)

Recommendations

Institutionalize interface arrangements with regulatory institutions

Working with regulatory institutions in the early stages of the policy development process can help mitigate risks for discordance. Further, requiring auditing and oversight institutions to be capacitated in health financing when setting their own processes can help mitigate political and legal risks.

Managing Uncertainty by defining policy processes

PhilHealth and the National Government should develop policies and processes to better manage health disasters like pandemics. Setting up rules on payment for pandemics/epidemics (pandemic financing) and defining rapid policy processes in managing emerging diseases can help reduce bias in policy making.

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Interventions to reduce discordance:

1. Conduct **capacity building activities** for Auditors, Congressional and Senate Staff, GCG staff and other relevant offices involved in regulating and auditing the National Health Insurance Program

2. **Provide technical inputs in the development of auditing and regulatory processes and policies** to help align auditing practice and performance measures with health financing principles.

3. Improve **legislative liaison support and communication** to mitigate undue political pressure and to manage oversight expectations.

Recommendations

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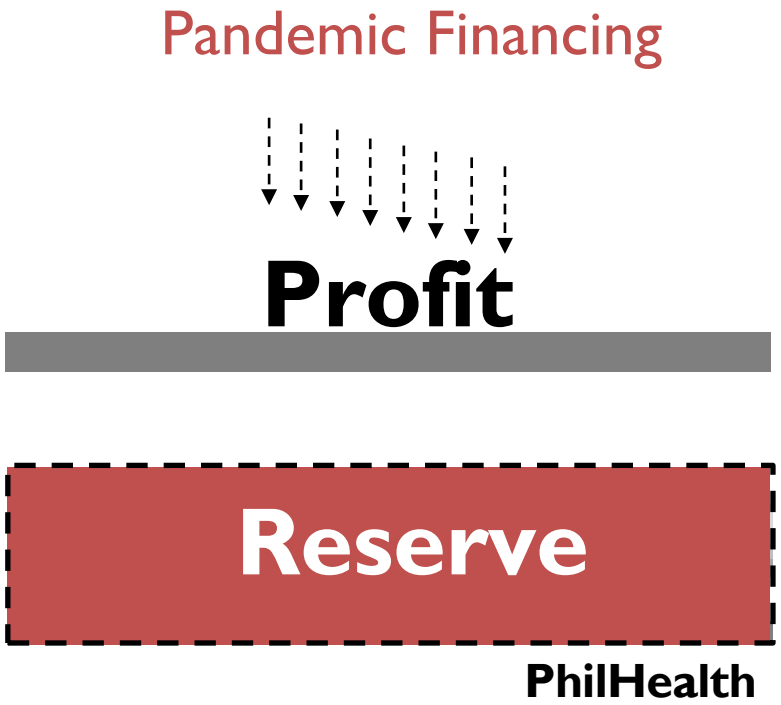
Recommendations

Develop Policies on Pandemic Financing for Social Health Financing Institutions

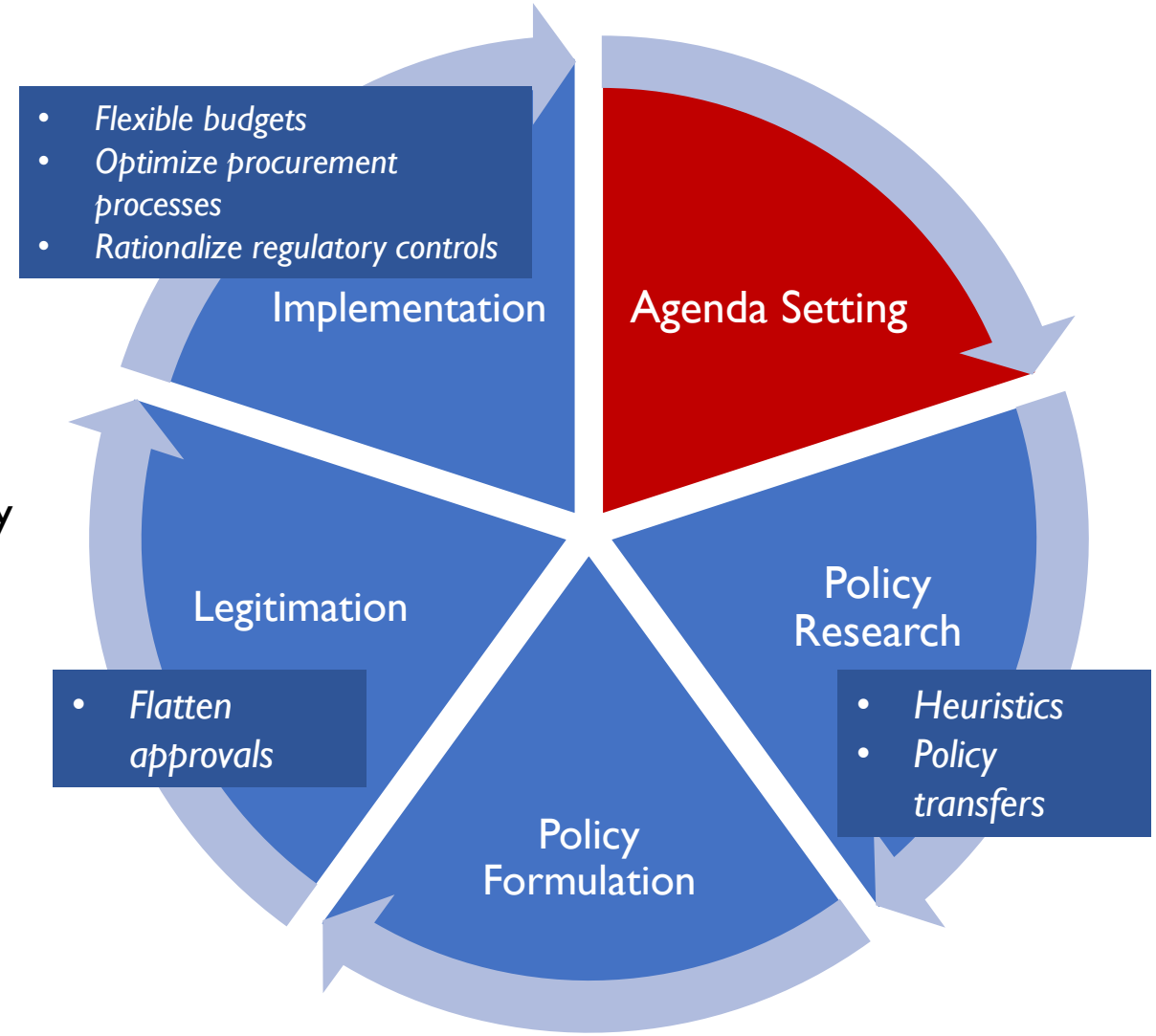
- Prioritize actuarial fairness in setting premiums (**minimal profits**)
- Set a portion of reserves shall be maintained for cases of health emergencies
- In cases where reserves are insufficient, the National Government **reinsures** social insurance.

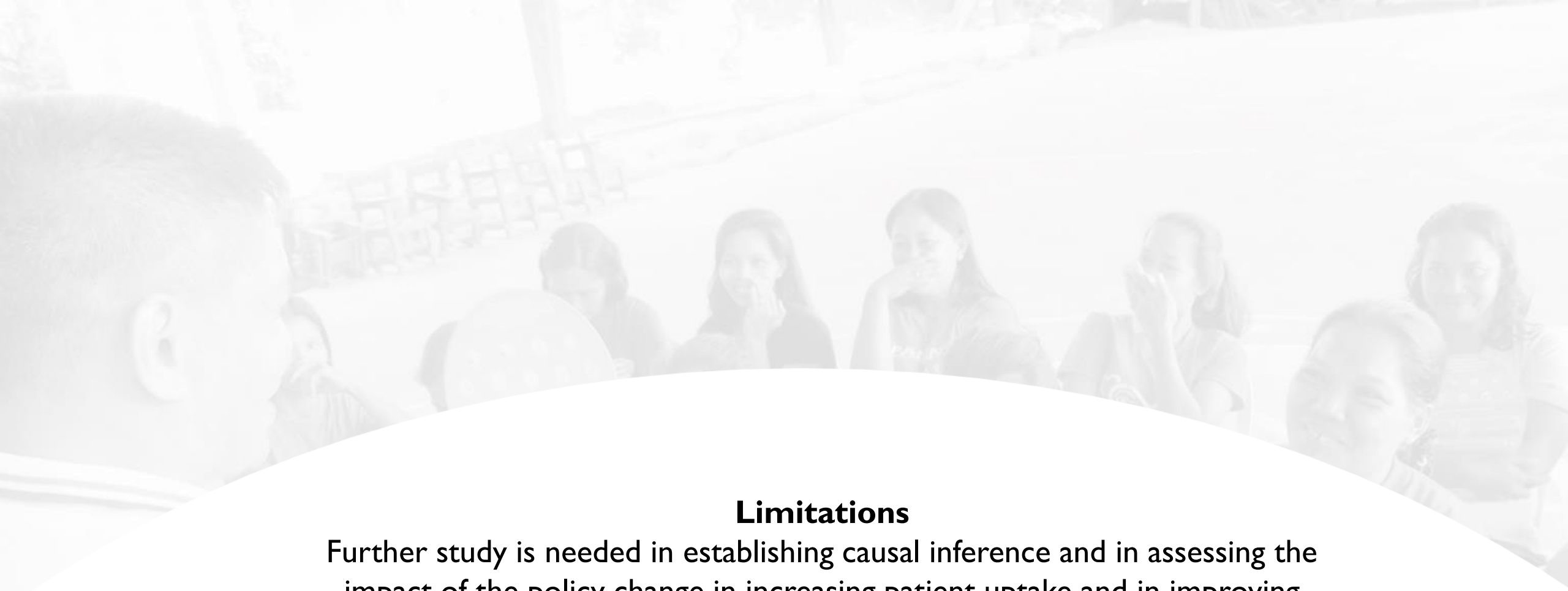


Recommendations

Develop Rapid Policy Development Processes (in periods of crisis)

- Leverage on heuristics in managing uncertainty
- Build flexible policy environments to account for volatility
- Develop a revised policy development process during period of crisis
    - Rationalized legitimation process
    - Utilize rapid reviews for quick evidence generation
    - Utilize iterative policy making to allow micro-improvements as the policy environment changes





Limitations

Further study is needed in establishing causal inference and in assessing the impact of the policy change in increasing patient uptake and in improving payments and health outcomes during the COVID-19 pandemic.

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