

## HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

### Authors:

Gwyneth S. Ong, Anna Loraine M. Mendoza and Jaime S. Fernandez, Martinez Vergara & Gonzalez Sociedad

[gwyneth.ong@mvgslaw.com](mailto:gwyneth.ong@mvgslaw.com) and [jaime.fernandez@mvgslaw.com](mailto:jaime.fernandez@mvgslaw.com)

## LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

- 1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).**

The public sector and the private sector have different roles, albeit ones which sometimes overlap, in the Philippine healthcare economy. The national government is responsible for formulating and implementing healthcare initiatives, regulating the healthcare system, and, together with local government units (LGUs), providing financing for population-based health services, which pertain to interventions such as health promotion, disease surveillance and vector control. Individual-based health services, on the other hand, such as ambulatory and inpatient care, medicines, laboratory tests and procedures, among others, are financed primarily through prepayment mechanisms such as social health insurance, private health insurance, and Health Maintenance Organisation (HMO) plans.

By law, all Filipino citizens are automatically included in the National Health Insurance Program (NHIP), the social health insurance programme, and are immediately eligible for a basic health benefit package under the NHIP.

Nevertheless, Filipinos shoulder a significant portion of health expenditures through out-of-pocket financing. In 2023, household out-of-pocket payments had the highest contribution among healthcare financing schemes at 44.4 per cent, followed by government and compulsory contributory healthcare financing schemes at 42.6 per cent, and then voluntary healthcare payment schemes at 13.0 per cent.

- 2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.**

The regulatory framework for financing and reimbursement is mainly governed by the Republic Act No 7875, as amended, or the National Health Insurance Act (NHIA). The NHIA provides for the creation of the NHIP and mandates the inclusion of a sustainable system of funds constitution, collection, management and disbursement for financing the availment of basic minimum and supplementary packages of health insurance benefits by the covered population. The NHIA also provides for the creation of a National Health Insurance Fund (Fund) consisting of contributions from NHIP members, appropriations of the national government and LGUs, donations and grants-in-aid, and the accruals thereof, as well as the establishment of the Philippine Health Insurance Corporation (PhilHealth), which exercises

the power to collect, deposit, invest, administer, and disburse the Fund in accordance with the provisions of the NHIA.

In 2019, Republic Act No 11223 or the Universal Health Care Act (UHCA) took effect. It provides for the population, service, and financial coverage of the NHIP, specifying that the national government and LGUs shall primarily finance capital investments and the provision of population-based healthcare interventions, while individual-based health services shall be financed primarily through social health insurance, private health insurance and HMO plans. It also sets out the framework for membership in the NHIP, ie, enrolment into the NHIP and categorisation as direct or indirect contributors, as well as the benefits which such members shall be entitled to.

There is also Presidential Decree (PD) No 612, as amended, or the Insurance Code, which mandates the Insurance Commission (IC) to regulate private insurers, ensuring, among others, that they present important information about their level of risk and solvency situation.

### **3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?**

The primary agency tasked to regulate healthcare in the Philippines is the Department of Health (DOH). Particularly, the DOH is tasked with the implementation of the NHIA by providing administrative and technical leadership in healthcare financing. It is tasked with overseeing the financing of the health sector and ensuring equity and accessibility to modernised health services.

Another important body, and one most Filipinos are familiar with, is PhilHealth, which is a tax-exempt government-owned and/or controlled corporation (GOCC) attached to the DOH. PhilHealth administers the NHIP and the Fund, formulates and implements guidelines on contributions and benefits, portability of benefits, cost containment and quality assurance, healthcare provider arrangements, payment methods and referral systems. It also contracts with healthcare institutions and providers regarding the pricing, payment mechanisms, design, and implementation of the procedures, financing, and delivery of health services, among others.

With regard to private health insurance and HMO plans, the same are supervised and regulated by the government through the IC as the business of insurance is a highly regulated commercial activity in the Philippines and is imbued with public interest. The IC thus requires insurers to register and submit statutory statements presenting important information about their level of risk and solvency situation. The Insurance Code also prohibits private health insurers from refusing, without just cause, to pay or settle claims arising under coverages provided by its policies, and from engaging in unfair claims settlement practices.

### **4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?**

The Covid-19 pandemic greatly impacted healthcare financing and reimbursement in the country. The Total Health Expenditure in the country grew over 10 per cent at the time of the pandemic to around PHP1tn in 2020 and PHP1.16tn in 2021 (inclusive of spending for

hospitals, pharmacies and other healthcare providers). Moreover, it is worth noting that the UHCA was passed into law in 2019, and its implementation was expedited in 2020 due to the pandemic.

The budget allocation for Health (DOH and PhilHealth) likewise reflected this urgency to meet the healthcare needs during the pandemic as the allocation increased from PHP175.9bn in 2020, PHP210.2bn in 2021, PHP268.4bn in 2022 and PHP314.7bn in 2023. This was sustained post-pandemic, thereby highlighting greater support public health initiatives and the aim of providing a quality and reliable healthcare system under the UHCA.

**5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?**

The law mandates that every Filipino, without limitation and whether they directly contribute to the Fund, shall be granted immediate eligibility and access to preventive, promotive, curative, rehabilitative and palliative care for medical, dental, mental and emergency health services, to the extent provided by law and relevant regulations. However, while such healthcare services are covered by the NHIP and most services will be eligible for public funding/reimbursement, in actuality, patients are constrained to shoulder significant out-of-pocket payments.

Notably, while the UHCA covers all Filipino citizens, the NHIP allows foreign nationals who are either (1) foreign retirees or former Filipino nationals and their qualified dependents who hold a Special Resident Retiree's Visa and are granted a permanent residency status; and (2) citizens of other countries working and/or residing in the Philippines and holders of a valid alien certificate of registration identity card, to enrol as members under the Informal Economy Program.

Medical service providers/suppliers of medical goods, including individual healthcare professionals, providing such goods and services to the public may be reimbursed by PhilHealth, provided that they are duly accredited by PhilHealth. Accreditation requires, apart from the submission of the applicable documents required by PhilHealth, eg, License to Operate issued by the DOH, certificates of good standing issued by the Philippine Medical Association and by medical specialty societies for physicians, and evidence of training and competency for nurses and midwives, that said applicants must also accept the payment mechanisms provided in the NHIA.

**HEALTH INSURANCE FINANCING AND COVERAGE**

**6. How are health insurance carriers financed? How are premiums determined?**

All members of the NHIP are mandated to contribute to the Fund, in accordance with a reasonable, equitable and progressive contribution schedule determined by PhilHealth on the basis of applicable actuarial studies and in accordance with guidelines provided under the NHIA. There are direct contributors, ie, those who are employed in both the public and private sectors (where the costs for contributions are divided between the employer and the employee), as well as those working in informal economies who may opt to make voluntary premium

contributions to the Fund. The rates for premium contributions of direct contributors are determined by the monthly basic salary of formal sector employees and on the household earnings and assets of the self-employed. There are also indirect contributors to the Fund, ie, indigents, senior citizens, and those whose contributions are sponsored by special government programmes. From 1 January to 31 December 2023, premium contributions from direct contributors amounted to approximately PHP158bn, while those from indirect contributors amounted to approximately PHP78bn. The Fund is also supplemented by appropriations from the national government and LGUs, donations and grants-in-aid, and the accruals thereof.

Individuals may also supplement their medical insurance coverage with private health insurance options and HMO plans, whether on their own or with the assistance of their employers who offer to subsidise such options as part of their employment benefits.

For private health insurance, the rates of premiums are determined taking into consideration the character of the risks assumed. Risks may be grouped into classifications for the establishment by insurers of rates and minimum premiums. Notably, insurers or the rating organisations which they subscribe to are generally required to file with the IC the rate manual, schedule of rates, classification of risks, and rating plan and rules and modifications thereto which they propose to use. Insurers and their agents are, as a general rule, prohibited from charging rates or premiums which deviate from the rates, rating plans, classifications, schedules, rules and standards which they filed with the IC.

The IC may, after notice and hearing, order the rates charged by insurers for any class of risks to be appropriately adjusted upon a determination that they are excessive, discriminatory, inadequate, or unreasonable.

**7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?**

The NHIA provides for the categories of personal health services covered by the benefits package of the members of the NHIP and their dependents, which include inpatient hospital care, outpatient care, emergency and transfer services, and such other healthcare services that PhilHealth shall determine to be appropriate and cost effective.

As for private insurers, they are mandated to indicate the character and extent of the coverage corresponding to the manual or schedule of rates and rating plans (or any modification thereof) which they have filed with the IC. The IC shall review such filings and, if it determines that they provide rates or rules which are inadequate, excessive, unfairly discriminatory or otherwise unreasonable, may order that the same be withdrawn. However, before issuing any such order, the IC shall give notice of not less than ten days in advance and allow the filing insurer or rating organisation to be heard.

Claims for reimbursement for both telemedicine and personal appointments may be filed for transactions and services falling under PhilHealth coverage. As to the coverage of telemedicine appointments, PhilHealth, in coordination with the DOH, is mandated to implement a telemedicine benefit package and reimbursement mechanism for healthcare providers. The consultation rates for telemedicine services shall, at minimum, reference and be based on the

standardised claims rate of PhilHealth and the recommended rates from medical associations, among others.

## HOSPITAL SECTOR

### 8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

The services provided by hospitals are primarily financed through out-of-pocket payments, claims from private health insurance plans, private health maintenance organisation insurance plans, or social health insurance offered by PhilHealth.

It is worth noting that in relation to stationary (inpatient) services, the UHCA requires hospitals to maintain a certain percentage of their capacity for basic or ward accommodation which pertains to the basic provision of a regular meal, bed in a shared room, fan ventilation, and a shared toilet and bath. Different kinds of hospitals must maintain a different percentage for such basic or ward accommodation. Government general hospitals, specialty government hospitals, and private hospitals must maintain 90 per cent, 70 per cent, and 10 per cent respectively of their authorised capacity for basic or ward accommodation. The provision of these basic or ward accommodation is fully subsidised by the government and no other fees or expenses shall be charged to such patients, including fees for professional services, drugs, medical devices, diagnostic imaging and laboratory tests. In case patients are admitted to non-basic or non-ward accommodations, the same would incur out-of-pocket expenses but subject to co-payment with PhilHealth.

In 2020, PhilHealth also launched the ‘Konsultang Sulit at Tama’ programme (Konsulta+) which primarily provides for an outpatient benefits package which encompasses primary care services. The programme is intended to provide patients with access to whole healthcare provider networks through a primary care provider which may include hospitals duly licensed by the DOH.

PhilHealth frontloads the payments and finances such services through a prospective payment scheme. Prospective payment refers to a method of reimbursement wherein payment is based on a predetermined and fixed amount relating to a defined bundle or package of goods/services for each enrolled individual for a fixed period of time, regardless of whether or not such goods/services are provided. It is only upon the actual utilisation of the prospective payments paid to hospitals to provide services that the hospital can record the same as its income. Prospective payments to hospitals, in turn, are funded depending on whether the hospital is government or private. If the hospital is a government hospital and part of a public network of healthcare providers, then the prospective payment is coursed through the Special Health Fund administered by LGUs. On the other hand, if the hospital is private and part of a private or mixed network of healthcare providers, then the prospective payment will be coursed through the pooled fund for health administered by various healthcare provider networks.

### 9. How are the prices of such services determined? How is economic efficiency controlled?

The prices for services provided by private hospitals in the Philippines are generally unregulated, and these hospitals have the freedom to set their own prices for various healthcare services. However, Section 28(c) of the UHCA imposes transparency requirements on all healthcare providers and facilities, including private hospitals wherein hospitals must make information about their service prices, as well as details on all goods and services they offer, readily accessible to the public. These transparency requirements are governed by DOH Administrative Order No. 2021-0008, which outlines the specific guidelines and procedures for providing such information.

While private hospitals have the freedom to set their own prices, PhilHealth uses a ‘case rates’ system, where the amounts paid out to claimants for specific medical conditions or episodes of care are pre-determined. This system helps to control spending by establishing fixed rates for various procedures, treatments and conditions, which are based on historical data and healthcare guidelines.

## **HEALTHCARE PROVIDERS IN PRIVATE PRACTICE**

### **10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?**

The services of healthcare professionals (inclusive of physicians and therapists), laboratories, and diagnostic centres in private practice are financed in a similar manner as hospitals. Private healthcare professionals accredited by PhilHealth directly receive payments from PhilHealth for professional services as co-payments for services rendered to insured patients.

Laboratories and diagnostic centres, on the other hand, may be covered by the Konsulta+ programme which was discussed above in relation to outpatient care. Notably, diagnostic laboratories, among others, may be engaged by the Konsulta+ programme service provider.

### **11. How are the prices of such services determined? How is economic efficiency controlled?**

The prices of the services of healthcare professionals (inclusive of physicians and therapists), laboratories and diagnostic centres in private practice are not fixed by law or administrative issuance. Thus, as a rule, the pricing for the same is dependent on the service provider.

Notably, in case of social health insurance, where PhilHealth shares in the burden of the patient for the cost of professional fees, PhilHealth payments to healthcare professionals for their professional fees, particularly physicians for surgical procedures, are based on the Relative Value Unit (RVU) which is a computation that takes into account the following:

- physician’s time spent;
- technical difficulty of the procedure; and
- potential risks to the patient.

Furthermore, the Code of Ethics of the Medical Profession which was jointly adopted in September 2019 provides that the physician shall ensure that professional fees are reasonable

and commensurate to the services rendered, nature of the case, time consumed, risk involved, professional standing of the physician, and the financial status of the patient.

Laboratories and diagnostic centres, while regulated by the DOH insofar as they require a license to operate a clinical laboratory, may freely price the services they provide, provided that they provide public access to their pricelist.

## PHARMACEUTICALS AND MEDICAL DEVICES

### 12. How are pharmaceuticals and medical devices financed and reimbursed?

Pharmaceuticals and medical devices dispensed by healthcare facilities are financed in a similar manner as hospitals and other healthcare providers. PhilHealth issued a circular providing the implementing guidelines for outpatient drug benefit packages and PhilHealth Guaranteed and Accessible Medications for Outpatient Treatment or PhilHealth (GAMOT). The circular provides for PhilHealth GAMOT Facilities, which are retail drug outlet/pharmacies with valid LTO from the FDA that is contracted by PhilHealth to provide the contents of the outpatient drug benefit package. As of date, medications dispensed under the PhilHealth GAMOT are fully covered for the first PHP9,000 consumed by each individual per calendar year. Anything in excess of PHP9,000 shall be purchased through out-of-pocket, but the pricing thereof shall be based on the fixed fee schedule. Medical devices are often packaged with other services and are subsidised by social health insurance depending on the circumstances of the case.

On a national government level, the DOH, under Administrative Order No. 2021-0038, provided for the framework for the Philippine Essential Medical Devices List and Price Reference Index. Under the framework, reference is made to the Philippine Essential Medical Devices List (PEMDL) which refers to the list of medical devices considered as important or necessary for preventive, diagnostic, therapeutic or rehabilitative procedures carried out in government health facilities. Moreover, the framework provides that only PEMDL medical devices are to be procured by the national government. However, the price of medical devices is generally unregulated.

### 13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

For certain pharmaceuticals, Republic Act No. 9502 or the Universally Accessible Cheaper and Quality Medicines Act of 2008 grants the President of the Philippines, with the recommendation of the DOH, the power to impose maximum retail prices (MRP) or maximum wholesale price (MWP) over any or all drugs and medicines which the DOH determines to be in need of price regulation. For this purpose, the President issued Executive Order No 104, series of 2020, which provided for the MRP and MWP for an updated list of drugs. For drugs that are not indicated in the list, MRP and MWP will not apply and may be freely priced. The law further punishes any manufacturer, importer, trader, distributor, wholesaler, retailer or any person engaged in any method of disposition of drugs and medicines who engages in acts of price manipulation.

For medical device procurement by the national government, DOH Administrative Order No. 2021-0038 provides that PEMDL are to be procured at prices based on the Medical Devices

and Supplies Price Reference Index (MDSPRI) which provides a mandated ceiling price of essential medical devices for government bidding by the DOH for all its facilities. The MDSPRI is based on the median of the range of prices collected from suppliers. This is in order to have a transparent and unified pricing scheme in medical device procurement. Notably, the same issuance provides that PhilHealth shall consider the MDSPRI when costing and developing benefit packages.

## LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

### 14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

In 2017, Republic Act No 10932 (RA 10932) was signed into law. RA 10932 prohibits hospitals, clinics and medical practitioners from requesting, soliciting, demanding or accepting any deposit or any other form of advance payment as a prerequisite for a confinement or medical treatment of a patient, or for administering basic emergency care. RA 10932 then mandates PhilHealth to reimburse the cost of the basic emergency care, as well as transportation services, rendered by the hospital or clinic to poor and indigent patients. Expenses incurred in giving basic emergency care to poor and indigent patients not reimbursed by PhilHealth are allowed to be treated as tax deductions.

The said law is intended to curb the practice of refusing to provide initial medical treatment and support in emergency or serious cases without the corresponding deposit or advance payment, a prevalent issue faced by poor and indigent patients in the Philippines.

The Philippine Hospitals Association of the Philippines (PHAP) sought to have certain provisions of the law declared unconstitutional, including the provision regarding PhilHealth reimbursement and tax deductibility, on the ground that it excluded from PhilHealth reimbursement and tax deductibility the costs of basic emergency care of patients not classified as poor, indigent, or marginalized in violation of the equal protection clause.

The Supreme Court *En Banc* declined to take cognisance of the petition filed by PHAP and did not rule on the constitutionality of the assailed law. Thus, at present, RA 10932 is in force. However, to date, there are still reports of hospitals and clinics refusing to administer appropriate initial medical treatment in emergency or serious cases in the absence of deposit or advance payment. Thus, the DOH is called upon to ensure stricter and more efficient implementation of RA 10932 as well as the guidelines it issued for the handling of complaints against hospitals or clinics which violate said law.

## RECENT DEVELOPMENTS AND TRENDS

### 15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

In 2025 the Philippines Government made a significant cut to the health budget with a drop in the allocation to PHP297.6bn, along with removal of all government subsidies to PhilHealth which previously covered the premiums of indirect members.

According to the DOH Secretary, PhilHealth's surplus funds from the 2024 budget are sufficient to cover indirect members' subsidy. He further stated that PhilHealth only utilised 63 per cent of its budget representing government subsidy in 2024. PhilHealth has likewise confirmed that it has enough funds to finance its benefits packages.

Nevertheless, the removal of government subsidy to PhilHealth in the 2025 budget may potentially undermine the quality and accessibility of healthcare services and impact the financial viability of the Fund.