

Health, Education and Welfare Specialists, Inc.

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Evaluation of the Potentials of Private Insurance Industry as a Source of Health Care Finance in the Philippines

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Evaluation of the Potentials of Private
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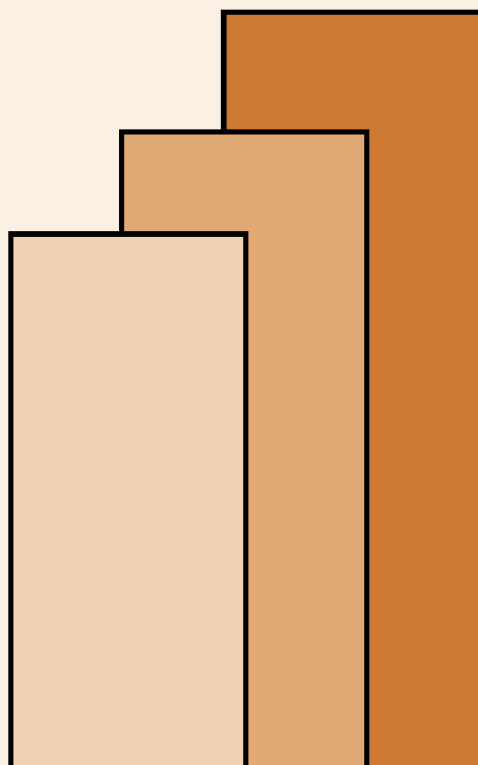
Health, Education and Welfare Specialists, Inc.

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June 30, 1994

**EVALUATION OF THE POTENTIALS OF
PRIVATE INSURANCE INDUSTRY
AS A SOURCE OF
HEALTH CARE FINANCE IN THE PHILIPPINES**

Part I: Main Report

Part II: Case Reports

Prepared by :

**Health, Education and Welfare Specialists
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EXECUTIVE SUMMARY

EVALUATION OF THE POTENTIALS OF PRIVATE HEALTH INSURANCE INDUSTRY AS A SOURCE OF HEALTH CARE FINANCE IN THE PHILIPPINES

Key Policy Questions Investigated and Why They are Important

1. The study was designed firstly, to investigate whether and how private health insurance can be a significant source of health care finance in the Philippines; and secondly, to determine how private health insurance can be regulated and promoted as an industry.
2. The study is important in view of the projected need to raise more resources for health care in order to cope with rising costs and increased demand for services. Health care costs are expected to rise because of: (i) the pursuit of the global goal of health for all by 2000; and (ii) the changing epidemiologic/demographic patterns characterized by rapid population growth and rising incidence of chronic, degenerative diseases and traumatic injuries which generally require more costly care. On the other hand, traditional sources of health care funds, namely tax revenues and family health spending, are not expected to grow as much as needed to finance the cost of providing the required levels and quality of health care.

Previous Works Related to Policy Questions Investigated

3. Earlier, health programs had focused on extending health service outreach to peripheral areas through the community-based health programs initiated by private sector, and the restructured public health service delivery system introduced in the mid-1970s.
4. In the early 1980s, it became evident that the expansion of health services to peripheral areas required the mobilization of additional resources for the sector. This led to more serious efforts to develop alternative modes of health care financing and to investigate the major sources of health care funds and their levels of contribution to the overall health care expenditures in the country.
5. Attempts to estimate health care expenditures from various sources revealed that private health insurance made very little contribution to the overall health care funds, but has experienced rather dramatic growth in the past few years.
6. A background investigation made by Rhais M. Gamboa attempted to define and classify the various forms of health insurance in the country. Mr. Gamboa's classification was used as take-off point for this study.

How the Research was Carried Out

The Philippine Institute for Development Studies (PIDS) pre-selected the sample regions and provinces to be covered by the study based on a 2-staged socio-economic stratification of regions and of provinces within selected regions. In all, the study covered 4 regions and 6 provinces within 3 of the selected regions. Each region/province represented various levels of socio-economic development.

A masterlisting of firms engaged in some form of health insurance per

Mr. Gamboa's classification was attempted in all sample regions and provinces. For each firm masterlisted, a set of secondary data was collected from available sources, mainly reports and/or registration documents. From the masterlist, a purposive sample of firms representing the largest and the smallest in each category was selected for an in-depth case study. Both primary and secondary data were collected. However, because of time and data constraints, not all desired information could be gathered.

Principal Findings, Conclusions and Recommendations

9. The masterlist of firms showed that private health insurance tended to be urban-based and to favor the more economically developed areas. Commercial indemnity insurance firms and health maintenance organizations (HMOs) were all based in Metro Manila although they had branch offices in some provinces and cities. Branch offices were generally merely marketing arms as most management decisions were made in the Metro Manila headquarters.
10. Plans and benefits offered tended to be curative, physician-focused and hospital-oriented for the commercial indemnity insurance and HMOs. Employer-provided benefits and community-based insurance tended to focus on primary care, often using para-professionals as primary providers, but some large firms also provided a wide range of medical and hospitalization benefits. Community-based insurance schemes provided the least benefits, and were often unable to provide adequate coverage for the cost of hospitalization.
11. Benefits were generally provided on a cash-reimbursement basis for commercial indemnity insurance and on a direct service provision basis for HMOs, some employer-provided benefits, and some community-based insurance scheme. Some employer-provided benefits and community-based insurance schemes provided medical loans to members as needed.
12. Targeted beneficiaries for commercial indemnity insurance and HMOs generally belong to the corporate sector, the employed and the high/middle income bracket. They also tended to have longer years of schooling. Most were enrolled through corporate accounts or group insurance. Targeted beneficiaries for employer-provided health care also covered the corporate sector, but generally included a wider range of income groups, with low and middle-income rank and file employees as the dominant groups. Community-based insurance schemes generally covered the low-income families in organized communities.
13. Premiums charged for health plans offered varied widely. For commercial indemnity insurance, it ranged from a low of P25 per annum to a high of P48,000, with the mean computed at P4,049. HMOs offered plans with premiums ranging from a low of P600 per annum to a high of P34,800, with the mean computed at P5,858. Employer provided benefits had a premium range from P240 to P1,500 per annum, with a computed mean of P698. Community-based insurance schemes had premiums ranging from P8 to P1,200 per annum, with a computed mean of P201. In general, higher benefit ceilings went hand in hand with higher premiums.
14. Available data on number of enrollees was incomplete as some private insurance firms could not, or would not, provide information on actual membership at specified reference periods. In all, 9 commercial indemnity insurance reported having 8,669 enrollees in 1991. The same number of HMOs reported having 133,900 enrollees in the same year, while another 9 firms with employer-provided benefits reported coverage for 7,467 members. Seven community-based insurance schemes reported a membership of 21,254.

15. The sample of members who responded to the structured interviews had the following characteristics:
 - a. Monthly incomes ranging from P800 to P70,000, with an outlier response of P200,000;
 - b. Mean income per month estimated at P7,115, median income at P4,000, and modal income at P6,000;
 - c. Incomes below P5,000 per month for 47% of respondents;
 - d. Mean household size of 5;
 - e. Majority (55%) were enrolled through their employers, 23% were persuaded by friends/agents, and 21% voluntarily enrolled;
16. Very little organized data were available from the insurance firms on the service utilization patterns. The survey of members, however, showed that 70% of members had availed of offered benefits at least once since they enrolled, with 58% reporting to have availed of benefits more than once. Of those who availed of service benefits, 40% reportedly were fairly satisfied, 30% were very satisfied, 9% were not satisfied, and 21% did not make any comment.
17. The operations of most commercial indemnity insurance and HMOs were highly centralized, with field/branch offices only processing the application for membership or enrollment and the filing of claims. In the case of employer-provided benefits, the health insurance operations were often integrated with the overall operating budget of the firm, hence financial data could not be segregated for analysis. Community-based health insurance schemes often had crude records of financial transactions, but keep no records on the types of health services used, or the causes of consultation or hospitalization.
18. Premiums and benefits were often determined through actuarial computations in commercial indemnity insurance firms and HMOs. In employer-provided benefits and community-based insurance schemes, consultative processes were often the basis for determining premium contributions and benefits to be provided.
19. Commercial indemnity insurance plans do not usually restrict enrollees' choice of service providers as long as those chosen are licensed physicians or health facilities. HMOs, employer-provided benefits, and community-based insurance schemes often provided primary care through in-house providers, with referral support provided by a network of accredited or retained providers. HMOs generally had a wider selection of accredited providers, while employer-provided benefits and community-based schemes often had a relatively smaller network of accredited providers.
20. Commercial indemnity insurance firms and HMOs often followed rigid standards of financial control and cost-containment. These include: (i) screening of applicants for adverse selection; (ii) setting limits and exclusions on benefits provided; and (iii) assessment of claims to detect frauds and misrepresentation by enrollees or providers. HMOs, employers, and community organizations, on the other hand, often employed primary health care providers to extend first level care and to systematically refer cases to higher level or specialist care and

hospitalization based on assessed medical need. Most community-based health insurance schemes provided preventive or promotive care as means of averting the need for more costly curative care.

21. The health insurance industry is seen by insiders as a growing enterprise because rising medical care costs exert pressures on the population to seek financial relief through health insurance. The pace of growth, however, will reportedly depend largely on economic progress and consumer education on the value of health insurance. Many industry leaders felt that the health insurance industry would also be promoted by general improvement in the business environment as well as by direct government incentives to support the industry, or to remove existing obstacles to the growth of the industry. Premium taxes, value added tax, and high tariff on imported medical facilities and supplies were cited as obstructive of growth because they make health insurance unaffordable to many.
 22. Presently, it is estimated that at most, only 10 per cent of the population could afford to enroll in health insurance plans offered by commercial indemnity firms and HMOs. Employer-provided benefits have the largest prospects for coverage because they have the potential to reach all the formally-employed and their dependents or an estimated maximum potential coverage of 60 to 70 per cent of the population. They also have the least probable organizational and overhead costs because their operations could be integrated with those of the principal business of the firm, they could use payroll deduction as a collection scheme, and they could exert better controls over employees to discourage fraudulent practices. Community-based insurance schemes, on the other hand, seem to be best suited for those in the informal sector who are unemployed or self-employed in small business ventures, and are fairly well organized. Community-based insurance schemes, however, require intensive technical and organizational development inputs which, presently, only a small group of NGOs are committed to. They could, therefore, not be expected to expand coverage very rapidly. At best, they could be expected to cover no more than 10 per cent of the population.
 23. If each category of health insurance could reach its projected maximum outreach potential, an estimated 20 per cent of the population will probably still not be covered by any health insurance scheme. These could be targeted for government subsidy, either through direct health care provisions or through premium subsidy.
 24. At optimum coverage, commercial indemnity insurance and HMOs could probably raise an estimated P2.4 to P3 billion a year for health care financing, assuming a minimum premium contribution of P1,000 per month per member, and assuming further that 40 to 50 per cent of premium costs could be directly allocated for health care provisions.
 25. Employer-provided benefits, on the other hand, could probably raise an estimated P5.5 billion per year for health care financing, assuming that a minimum premium contribution of P240 per employee per year could be set aside as health care fund for employees and their dependents. Community-based insurance schemes may be able to raise an estimated P106 million to P530 million per year for health care financing, assuming that each targeted family could contribute from P20 to P100 per family per year.
- 26.** The realization of the above potentials for raising health care funds, however, hinges on the full development of the health insurance industry

in the Philippines. At present, the industry faces many problems and constraints that hinder its full development. The major problems identified are: (i) lack of adequate economic base because of the high prevalence of poverty among Filipinos; (ii) lack of appreciation of the value of health insurance, or of risk-sharing among the population at large; (iii) stiff competition for a very small market; and (iv) lack of a coherent government policy on health insurance. The absence of suitable hospitals also serve as a deterrent to the development of health insurance in rural areas. Industry leaders feel that government support and incentives may be needed to assist the industry expand its current coverage.

27. Government could assume a significant role in realizing the potentials of private health insurance as a source of health care financing in 2 ways: (i) by creating a supportive environment for business development, or (ii) by directly providing incentives/ support for health insurance development.
28. The following incentives for business development are recommended: (i) instituting improvements in the infrastructure for telecommunications to minimize delays in processing of documents/ papers and facilitate field level decision making without having to forego with essential control measures from the head offices of commercial indemnity firms and HMOs; (ii) expanding use of information technology and communication facilities to facilitate the retrieval and management of data that serve as critical basis for planning and policy formulation; and (iii) promotion of low-cost technologies that would minimize occupational hazards so that more workers could qualify for health insurance coverage and premium costs could be kept low and affordable.
29. Recommended incentives for the development of the health insurance industry are as follows: (i) intensification of public education, advocacy, or information dissemination on the value of health insurance; (ii) exemption of health insurance from premium taxes, or offering tax credits for family expenditures in buying or enrolling in health insurance schemes; (iii) provision of technical assistance in training a corps of prospective health insurance professional, managerial and technical staff who can promote effective health insurance management and ensure a balance between the efforts to contain cost and the need to provide appropriate health and medical care for all insured members; (iv) exploring the possibility of a tie-up between public tertiary hospitals and private health insurance firms in areas without qualified private hospitals; (v) encouraging employers to engage in some form of health insurance schemes for employees and their dependents; (vi) dissemination of information and technology on innovative community-based insurance schemes, particularly in areas where there are already well-organized groups; (vii) promotion of income-generating projects designed to improve the financial viability of community-based insurance schemes; (viii) provision of adequate referral services through public hospitals to support the service delivery provisions by community-based health insurance scheme; and (ix) developing a suitable regulatory scheme to protect the public from undesirable practices and promote the image of the health insurance industry as a legitimate business.

**Evaluation of the Potentials of Private Insurance Industry
as a Source of Health Care Finance in the Philippines**

Table of Contents

**Executive Summary
Table of Contents**

Part I: Main Report

I.	BACKGROUND	1
II.	RESEARCH OBJECTIVES/PROBLEM STATEMENT	1
III.	POLICY RELEVANCE OF THE STUDY	2
IV.	REVIEW OF LITERATURE	3
	A. Trends in Health Service Delivery and Financing	3
	B. Sources of Health Care Financing	6
	C. Health Insurance as Means of Health Care Financing	7
V.	ANALYTIC FRAMEWORK	13
VI.	EMPIRICAL FRAMEWORK	14
	A. Sampling Design	15
	B. Data Collection	17
VII.	FINDINGS	18
	A. Masterlist	18
	B. In-Depth Study	20
	1. Health Plans	21
	2. Profile of Insured Members/Enrollees	26
	3. Service Utilization	36
	4. Organizational Set-Up	37
	5. Perceptions on Industry Prospects	43
VIII.	CONCLUSIONS AND RECOMMENDATIONS	46
	A. Market Potentials of Various Types of Health Insurance	46
	1. Commercial Indemnity Insurance and HMOs	46
	2. Employer-Provided Health Benefits	47
	3. Community-Based Health Care Financing Schemes	47
	B. Potentials for Generating Fund for Health Care	47
	1. Commercial Indemnity Insurance and HMOs	47
	2. Employer-Provided Health Benefits	48
	3. Community-Based Health Care Financing Schemes	48
	C. Potentials for Providing Adequate/Appropriate Health Care	48
	1. Commercial Indemnity Insurance and HMOs	48
	2. Employer-Provided Health Benefits	48
	3. Community-Based Health Care Financing Schemes	49
	D. Potentials for Containing Costs of Medical Care	49
	1. Commercial Indemnity and HMOs	49

2.	Employer-Provided Health Benefits	50
3.	Community-Based Health Financing Schemes	50
E.	Constraining Factors to Expansion of Services	50
1.	Commercial Indemnity and HMOs	50
2.	Employer-Provided Health Benefits	50
3.	Community-Based Health Financing Schemes	50
F.	Required Support to Expand Market Coverage	51
1.	Commercial Indemnity and HMOs	51
2.	Employer-Provided Health Benefits	51
3.	Community-Based Health Financing Schemes	51
G.	Recommendations/Options for Government Interventions	51
References	53
Part II:	Case Reports	57

ACRONYMS

ACP	Annual Contingent Profit
AIDS	Acquired Immune Deficiency Syndrome
BHW	Barangay Health Worker
CARE	Cooperative for American Relief Everywhere
CBA	Collective Bargaining Agreement
CBC	Complete Blood Count
CBHP	Community-Based Health Program
CT	Computerized Tomography
CV	Contract Value
DMP	Dependents Medical Plan
DOH	Department of Health
DOLE	Department of Labor and Employment
ECG	Electro Cardiogram
ER	Emergency Room
GAP	Group Association Plan
GSPA	Group Student Personal Accident Insurance Plan
HAMIS	Health and Management Information System
HEWSPECS	Health, Education and Welfare Specialists
HMO	Health Maintenance Organization
HRD	Human Resource Division
IBRA	Institution Building and Resource Accessing Program for Women
ICU	Intensive Care Unit
IGP	Income Generating Project
LOA	Letter of Authorization
LOI	Letter of Instruction
LOS	Length of Stay
NCR	National Capital Region
NGO	Non-Government Organization
OPC	Out-Patient Consultation
PA	Personal Accident
PCHRD	Philippine Council for Health Research and Development
PDMP	Philippine Airlines Dependents Medical Plan
PE	Physical Examination
PHC	Primary Health Care
PHCFP	Primary Health Care Financing Project
PHILDHRRRA	Philippine Partnership for the Development of Human Resources in Rural Areas
PIDS	Philippine Institute for Development Studies
PMSU	Primary Medical Services Unit
RUV	Relative Unit Value
SA	Statement of Account
SAHMO	San Antonio Health Maintenance Organization
SEC	Securities and Exchange Commission
STD	Sexually-Transmitted Disease
TFAP	Targetted Food Assistance Program
TIN	Tax Identification Number
TPL	Third Party Liability
UNICEF	United Nations Children's Fund
UPHMO	University of the Philippines-Diliman Employees' Health Maintenance Organization
UPHS	University of the Philippines Health Service
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
VAT	Value Added Tax
WHO	World Health Organization

PART I

MAIN REPORT

I. BACKGROUND

Health care in the Philippines has traditionally been financed by tax revenues in the case of public services, and by market generated fees-for-service in the case of privately provided care. As shown in Table 1 below, health insurance contributed only 7 per cent to the overall financing of health care in 1985 and 1988.

Table 1
Share of Health Insurance in Health Care
Financing in the Philippines, 1985 & 1988

	1985	1988
Total Health Exp.	(P)9.831 B	13.645 B
Public Sources (%)	38	50
Family Exp. (%)	55	43
Private Ins. (%)	1	2
Compulsory Ins. (%)	6	5

Source: Health Sector Financing in the Phil.; Solon, et. al.

Current trends suggest that the traditional sources of health care financing may not grow as much as needed to cope with rising health care costs in the country. The depressed economy limits the possibility of increasing tax revenues, while prevalent poverty constrains the growth of family spending for health care. Compulsory insurance, has likewise been constricted by its inability to expand coverage to the non-formal sectors. Private insurance, on the other hand, while contributing a fairly small share of total health care expenditures in 1985 and 1988, has experienced rather dramatic growth between 1985 and 1988. For this reason, private insurance has stimulated interest among policy makers and industry watchers. For one thing, the fairly small present coverage of health insurance indicate that there is a lot of room for growth and expansion of the industry. Secondly, numerous initiatives have been made in the recent past to develop the middle and low-income market for health insurance. This study, therefore, took a closer look at the operations of the private insurance industry and investigated the range of operational approaches as well as the challenges facing the industry.

II. RESEARCH OBJECTIVES/PROBLEM STATEMENT

The study assessed the potentials of the private insurance industry as a means of generating funds for health care, and as a tool for making health care affordable and economical to a wider segment of the Philippine population.

Specifically, the study attempted to answer the following questions:

1. What types of health insurance benefits were available in the Philippines?
2. Who were the intended and actual beneficiaries of available health insurance?
3. What factors influenced the decision of individuals to enroll or

participate in health insurance?

4. What were the characteristics of individuals who enrolled in health insurance?
5. What types of health insurance were dominant or popular? Why were these types popular? What types were unpopular? Why were these types unpopular?
6. What factors contributed to the financial and managerial viability of a health insurance firm or company? Conversely, what factors threatened the viability of the same?
7. What benefits offered by health insurance were fully utilized and why?
8. What factors were considered in determining premium costs and benefit packages?
9. What insurance options were available for the poor and the low income? What were the prospects for developing an insurance scheme for the poor and the low income?
10. What measures had been tested to contain health care costs through health insurance? What specific measures worked and what did not work?

The answers to the above questions were expected to shed light on the policy options that may be adopted to stimulate and/or regulate the growth of private health insurance as an industry in the Philippines.

III. POLICY RELEVANCE OF THE STUDY

The need to develop innovative means of financing health care in the Philippines has been recognized as early as the late 1970s when the Philippine Government embarked on a "Primary Health Care Financing Project" in collaboration with the United States Agency for International Development (USAID). The project was conceived principally as a way of testing alternative means of generating health care funds from sources other than the traditional tax allocation and fees-for-service. Even in those early years, it had already been foreseen that the global goal of health for all would require the mobilization of more resources than what has been available from traditional sources.

The national aspiration to achieve health for all has not diminished despite the relatively poor economic performance in the 1980s and early 1990s. The Department of Health has continued its search for alternative means of raising health care funds and promoting efficient use of available resources for health. Recently, a project agreement was signed between DOH and USAID to implement the Health Finance Development Project which, among others, seeks to promote effective policy on health care financing and to support experimentation and demonstration projects to develop alternative schemes of health care financing.

This study is expected to contribute to the national policy formulation effort of the DOH by generating information on private health insurance operations in the country and identifying the factors and conditions that may promote or constrain their growth and development as health care financing institutions. The findings of the study could guide the DOH in adopting appropriate policies to regulate or support the development of the health insurance industry. The development of the health insurance industry, on the other hand, could generate additional resources for health care and allow the DOH

to re-allocate available public resources to more cost-effective health interventions.

IV. REVIEW OF LITERATURE

A. Trends in Health Service Delivery and Financing

Health care in the 1960s and the 1970s focused principally on the provision of health service facilities, through public or private institutions, in order to improve physical access to health care. The thrust was to set up health facilities in strategic areas, which in the case of private sector, tended to be urban-based because market conditions were supportive, while government was expected to take care of remote, rural areas where privately provided services were inadequate or inexistent.

Trends in external assistance to health during these periods reflected this philosophy. Both bilateral and multilateral donor agencies provided technical and financial assistance to improve facilities and services in the rural areas, leading in 1975, to the restructuring of the Philippine health system, which was supported through a project funded by the World Bank, and included provisions for the construction of main health centers and barangay health stations throughout the country. The re-structured health system resulted in the deployment of midwives as multi-purpose health service providers at the village level. This was intended to bring health services closer to the people.

Another local initiative designed to address the inadequacies in village health services was the experimentation by non-government organizations to implement Community-Based Health Programs (CBHP) in the early 1970s. The CBHPs mobilized the community to take an active role in decisions regarding their health problems. Their main objective was to educate communities to identify their own health problems and needs and to determine the most affordable and indigenous means of addressing their health concerns. CBHPs encouraged community participation through collective problem identification and action planning, and may have been patterned after the Chinese model of health delivery utilizing "barefoot doctors" (Maayo, 1983).

Despite their laudable objectives and the dedication by which they were implemented, the CBHP did not make a significant impact on the nation's health status because of its limited coverage, even though the Rural Missionaries of the Philippines adopted it as a national approach in 1975.

Towards the end of 1970, it became evident that many people, particularly in third world countries like the Philippines, were still not getting adequate and appropriate health services, and that in many cases, the obstacles were not just the absence of facilities or providers of services, but the increasingly prohibitive cost of health and medical care. This was largely brought about by the following:

1. the undue preference, by both the providers and users of services, for secondary and tertiary levels of health care which were costly and often, not the most cost-effective means of addressing the prevailing health problems;
2. the failure to provide adequate preventive and health promotive services, often because scarce public and private resources were tied up in the provision of secondary and tertiary care, coupled

with the users' general lack of appreciation and low demand for the more cost-effective public health interventions, such as immunization, sanitation, etc.;

3. the declining economic growths, particularly in third world countries, which when coupled with increasing debt burdens and rising population, severely constrained the amount of resources available for health care, both at household and national levels;
4. the increasing dependence on health professionals and health technology which were not always attuned to the real needs and economic capacities of the poor and the less educated members of society; and
5. the rising proportion of chronic, degenerative conditions, even as infectious and parasitic diseases remain significant public health problems, giving rise to higher cost medical care at a time when resources available were severely constricted.

Partly in response to the above problems, several community-based health projects similar to the CBHP were also initiated in other countries. These were probably the forerunners of the primary health care movement which culminated in the International Conference on Primary Health Care held from September 6-12, 1978 in Alma Ata, USSR. The conference participants, observing that the state of health in the third world was deteriorating, thought it necessary to define an innovative strategy to close the gap between those who could afford high standard health care and the poor who were often underserved and unserved. The Conference proclaimed the primary health care strategy as the essential approach to improve the health situation around the world. (WHO and UNICEF, 1978)

The Alma Ata Declaration defined primary health care as : "essential health care ...made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford ... It forms an integral part of both the country's health system, of which it is the central function and main focus of the overall social and economic development of the community". (Fry and Hasler, 1986)

The Philippines adopted the Primary Health Care Program (popularly known as PHC) through Letter of Instructions No. 949 issued on October 19, 1979. (LOI No. 949, 1979).

The PHC approach called for the organization of PHC committees at all levels, i.e., national, regional, provincial, municipal, and barangay or village level. It also entailed the deployment of barangay health workers (BHWs) throughout the country. The BHWs were essentially community volunteers who were trained to provide basic health care and to facilitate the delivery of basic health services. In addition to technical training, BHWs were provided with service kits which enabled them to provide first aid measures for primary cases. Their primary role, however, was to provide health education and to serve as link between the health service delivery system and the community.

Despite the adoption of low-cost and cost-effective technologies, the PHC strategy still required the mobilization of enormous amounts of manpower, material and financial resources if the goal of health for all by year 2000 were to be attained. In addition, the emerging demographic and epidemiologic transition was expected to bring about increased and rising health care costs due to the following:

1. increased life expectancies and corresponding aging of the population which could increase the demand for more costly secondary

- and tertiary care;
2. the epidemiologic transition which could change the character of prevailing ailments towards more costly chronic and degenerative diseases;
 3. technological advances in medicine which could require added investments in research and development, acquisition of new equipment, training of skilled manpower, and discarding of old technology/equipment;
 4. increasing probability of provider-induced demand as technology and skills required for diagnosis and treatment become more sophisticated; and
 5. rising consumer demand brought about by expected improvements in educational and socio-economic status.

A clear need to search for methods/ways of financing health care services emerged and became a popular subject for discussion. (Fry & Hasler, 1986). Cognizant of this need, the Philippine government entered into a project agreement with the USAID for the latter to provide financial and technical assistance to the former in undertaking researches and experiments on alternative health care financing schemes. The project, which became known as the Primary Health Care Financing Project (PHCF), supported selected primary health care services and provided grants for research and experimentation to improve the financial viability of the health care system. Implemented in July 1983, it became a major force in building interest in health care financing in the country. (Alfiler, 1986).

Subsequent studies (Intercare, 1987 & RTI/UPSE, 1991) also generated estimates of the health care expenditure and identified the major sources of funds for health care in the Philippines. Public discussions and fora were organized to look into the policy and program implications of the prevailing trends in health care delivery and their financing.

Viewing health care as a commodity subject to market forces tempered by societal values, Dr. Dieter K. Zschock, in his book *Health Care Financing in Developing Countries*, compared it to other goods and services which individual households and many public and private organizations are willing to pay for out of their incomes or revenues. (Zschock, 1979).

Being a market commodity, the cost (or price) of health care is determined by supply and demand factors. The supply of health care is determined by the proportion of national income devoted to health care. This includes the cost incurred by the government and private sector when they engage in health care services provision.

Health expenditures vary from country to country depending on how much they value health care. A large proportion of private health expenditure has been devoted to the provision and/or consumption of curative services. Preventive care has, however, been preferred in the public sector by virtue of its being more cost-effective. Nevertheless, because of the large cost of maintaining public hospitals, curative care also used up a large proportion of public expenditure for health.

Health care demand, on the other hand, is determined by the following: (1) health status, income and education; (2) consumer and provider perspective; (3) cost and accessibility of health care; and (4) quality and quantity of health care.

The health status, income and education of an individual influence his demand for health care services. The current state of one's health determines demand to seek medical care. A person's educational attainment and knowledge about health care also increases demand for specific health services such as immunization and consultation, among others. However, income and lack of education place certain limits on the level of health care an individual will be looking for. Thus, poor people who are quite often ill may not buy the type of health care needed but will have to settle for what they can afford, or forego buying needed health services to purchase other basic necessities.

The provider or practitioner of medical care prescribes the type and level of health care an individual must receive, thus exerting great influence over the level and composition of demand. (Zschock, 1979) A consumer, however, also exercises some degree of influence on health care demand when he decides on whom he will consult and whether he will follow the medical advice given to him by a health provider.

Physical and financial access to the providers of health care affects the level of demand by an individual. A person's perception of how much he will pay as well as how far in terms of physical distance he will travel influences the frequency by which he will seek medical care.

Quality and quantity of services available also influence the demand for medical care. New demands are expected with the introduction of new types of health care services, e.g. ultrasonography, magnetic resonance imaging, etc. One indirect measure of quality is the degree by which a service is being accepted or utilized by both providers and users of health services. Another indicator is its impact on the overall health status of the community.

The supply of, and demand for, health care exert a strong influence on the methods of health care financing. Increased demand creates a simultaneous need for the most suitable means of its financing.

B. Sources of Health Care Financing

The sources of health care financing are conventionally divided into two broad categories: *public and private sources*. Public sources are those generated through the government system while private sources are those coming from the private sector.

Public sources include the following:

1. Tax revenues that support health care, which generally are of three types: (a) duties on imports and exports; (b) taxes on domestic business transactions; and (c) income taxes.
2. Domestic and international borrowings that augment tax revenues in supporting health care. This is usually referred to as "deficit financing" because this scheme spends funds that will, over some future time, have to be repaid.
3. Sales tax, which is an important source of health care funds for the local government. These include taxes imposed on items such as liquor, cigarette or other luxury items.
4. Social insurance, which is a mandatory means of supporting health care. Certain amount of payments or contributions expressed in percentage of wages are required from either the employees or

employers to augment the financial support for health care. Many countries have adopted this type of health care financing. Besides health benefits, social insurance includes pension for disability and old age.

5. Lotteries and betting, which are taxed to contribute to the funds earmarked for health care. In the Philippines, the Philippine Amusement and Gaming Corporation and the Philippine Charity Sweepstakes Office appropriate a certain portion of their income for health projects.

Private sources consist of the following:

1. Direct household expenditures, which are direct out-of-pocket payments of individuals for services rendered by medical practitioners. This comprises the fees-for-service which the consumers of health care pay as a price for goods purchased.
2. Charitable contributions, which consist of cash or in-kind donations made by philanthropic individuals, groups, or institutions such as UNICEF or other grant-providing organizations.
3. Direct employer financing, which are medical benefits given to employees. Private businesses sometimes provide for their employees' medical needs either by contracting private health organizations and practitioners or by establishing in-house health facilities and hiring medical professionals to render health care.
4. Private health insurance, which may be operated either for profit or non-profit and for individual or groups, and are financed through regular premium collections from members/enrollees.
5. Communal self-help, which are community efforts or schemes of providing low-cost health services. Several schemes are currently being tested throughout the world. These schemes are primarily directed at helping the poor segment of a country's population such as the urban poor, low-income farmers and fishermen, etc. Community organization is adopted as an approach in empowering the community to take actions regarding their health needs.

As shown earlier, tax revenues and household spending constitute the major sources of health care financing in the Philippines. Tax revenues are generally used to finance publicly provided services, while proceeds from household spending (or user charges) are used to finance the operation of private service institutions. Health insurance, on the other hand, is a minor, though growing source of health care finance.

The current interest in private health insurance as a source of health care finance in the Philippines reflects the realization that the traditional sources, i.e., taxes and user fees, are already approaching their maximum limits, and therefore may no longer be a reliable source of additional funds to support future health care needs/demands.

C. Health Insurance as Means of Health Care Financing

Generally, insurance is defined as a "social device to reduce risk by combining independent exposures". (Dickerson, 1968) Insurance decreases individual risk by spreading the risk among groups of individuals or

organization. The sharing of the risks is the essence of insurance.

Health insurance is defined in Mr. Rhais Gamboa's *Background Paper on Health Insurance in the Philippines* as "a means of prepaying for health care and spreading the risk of substantial medical care costs across a pool of potential patients". Two essential elements of health insurance are described in this definition, namely: (a) prepayment; and (b) risk-sharing. Health insurance is a mechanism by which individuals agree to regularly pay a certain amount (called premium) in order to be able to pool funds for payment of cost of sickness in some future time. It is a scheme by which those fortunate enough to be healthy at a given time pay for those who are sick, with a clear understanding that should those who are well now fall sick later on, their costs will in turn be covered. (Abel-Smith, 1986.) The reduction of risk by means of combination becomes more important and effective among groups of population who could not afford and immediately pay the cost of getting sick.

For the purpose of this study, private health insurance refers, in a generic sense, to all privately organized mechanisms wherein payment for specified health services are assured through a mechanism of prepaid, risk sharing among the groups covered by the service. This includes the following types and categories described by Mr. Gamboa in the above-cited paper:

1. Commercial indemnity health insurance
 - a. domestic nonlife insurance companies
 - b. foreign nonlife insurance companies
 - c. life insurance companies

2. Health maintenance Organizations (HMOs)
 - a. investor and insurance-based
 - b. investor and hospital/clinic-based
 - c. community based
 - d. employer-initiated

3. Employer-provided health benefits
 - a. health benefits as a result of CBA
 - b. health benefits voluntarily provided

N.B. a third type, i.e. legally mandated health benefits, is covered separately in another study.

4. Community level insurance/financing by socio-economic population groups
 - a. urban poor
 - b. internal refugees
 - c. indigent
 - d. farmers

- e. fishermen
- f. hinterland communities

Commercial indemnity health insurance firms refer to those providing health and accident insurance. Their present coverage is limited to the upper income bracket. The economically disadvantaged majority remain uninsured (Herrin, 1989). In 1985, the total benefit payments made by commercial indemnity health insurance was only about 1 per cent of the country's health care expenditures. (INTERCARE, 1987).

The health maintenance organization, or HMO, is a scheme combining the provision of services with its financing. Gamboa (1991) identified 3 types of HMOs in the country, i.e., investor-based, community-based and employer-initiated.

Investor-based HMOs are profit oriented, generally located in urban centers and generate most of its income from corporate accounts (Manila Chronicle, 1992). A recent estimate pegs the membership size of all profit-oriented HMOs in the country at less than 1% (Picazo, 1990).

The only community-based HMOs recorded in the Philippines are the experimental HMOs developed with support from USAID through PCHRD. Two such HMOs are presently operating - UPHMO and SAHMO. The UPHMO operates in a corporate community while the SAHMO operates in a regular household community. Both are non-profit organizations operated in the same manner as the investor-type of HMOs. Unlike commercial indemnity insurance, HMOs have more cost-effective means of controlling provider abuses, without curtailing the provision of necessary health services. A comparison of the service utilization rates among UPHMO and SAHMO members with the norms prior to HMO operations showed: (1) a marked increase in service utilization rate; (2) shorter length of stay in hospitals; and (3) lower cost of overall consultation and hospitalization. These are positive indicators of the HMO's potential as a mechanism for making health care available and affordable. An important insight gained from the experience is the limited replicability of the scheme. The HMO is appropriate only for those population groups who have some capacity to pay the regular contributions. Poor people cannot benefit fully from such a scheme unless there are added provisions such as livelihood projects and sponsorship to help them defray their membership costs. One other lesson learned is that the HMO cannot spontaneously develop in a community setting. Its organization and growth requires nurturing. Technical assistance is needed in drawing up implementation guidelines. Marketing support is necessary to draw members while information and education are needed to promote an appreciation of the benefits offered and the managed care approach to doing it. Vigilance is crucial to ensure that it is guarded against adverse selection and inappropriate and costly utilization patterns.

Employer-initiated HMOs are those organized by companies for the benefit of their employees and dependents. This is exemplified by the Philippine Airlines Dependents Medical Plan (PDMP) established in early 1988. The PDMP is the only one of its kind in the country. The employer-initiated HMO is similar to the community-based HMO in the sense that it is established in a corporate community, is non-profit, and offers lower fees for membership. The difference lies in the fact that members of PDMP enjoy subsidy from the company. The PDMP serves the dependents of regular employees of Philippine Airlines.

Employer provided health benefits refer to those provided by employers to employees either as legally mandated, or as part of labor-management collective bargaining agreements (CBA), or as a voluntary decision of the management. CBAs may include employer obligations to provide medical benefits to employees and their dependents. There is no current estimate of the relative contribution of

employer provided health financing schemes to total health expenditures in the country. However, the INTERCARE study (1987) found indications that companies make significant contributions to health care financing in the country.

Community-level health insurance refers to a variety of community-managed health financing schemes with elements of risk-sharing and pre-payment. Under such schemes community participation may come in the form of cash or in kind contributions as in the donation of labor or materials. In return the participating community members may receive benefits in the form of discounted medicines, interest-free or low-interest medical or hospitalization loans. Some community-level health insurance schemes serve very poor families. Under such conditions, a livelihood component is usually part of the scheme as a means of enabling the poor to pay membership fees. Loans for livelihood projects are also used as come-ons. A recent contest sponsored by DOH and the German Agency for Technical Cooperation uncovered at least 21 community-level initiatives with health insurance components. Unfortunately, these entries did not provide adequate information on their collective contribution to the country's total health care expenditures. There is also insufficient information to assess their viability. Nonetheless, experiences here and abroad illustrate that community resources can be harnessed to pay for the health care of its members. In Metro Manila, for instance, a drugstore cooperative is operating in Smokey Mountain which provides contributing members with medicines at 50% less cost than those bought from commercial stores. In various parts of the country there are other community initiatives which provide medical loans to its members. Monthly membership contributions are varied, ranging from P1.00 to P10.00. Some also provide loans for livelihood projects.

The private health insurance industry renders needed services to individuals who, singly, may not be able to afford the full cost of a catastrophic disease. It also serves the health sector by harnessing individual or family savings and mobilizing these as earmarked resources for the direct provision of health and medical services for a given population, i.e., insured members.

Experiences in Korea and other developed countries, however, have demonstrated that health insurance may be abused by both supplier and consumer of services, creating an "induced demand" which result in escalation of health care costs. Thus, while health insurance may be an effective means of raising total health care funds, it may also contribute to cost escalation in health care, thereby negating the impact of gains in resources. Happily, the industry has also developed cost-containment measures to control or minimize "induced demand" in order to protect its financial viability and, as an externality, also contribute to improving the efficiency and effectiveness of health care provision.

In many instances, the availability of third party payment schemes such as health insurance contributes to cost escalation by affecting the behavior of consumers and providers alike. With insurance coverage, the behavior of consumers and providers of service have been known to undergo a change prompted by the guarantee of payment which insurance provides to all parties. This altered behavior manifests itself in the form of overutilization of services and inappropriate use of facilities by consumers as well as overprescription by physicians.

Measures to minimize cost escalation come in different forms from different regions of the world. Controlling cost escalation may depend on the particular health care system operating in a particular society. In Canada, where a socialized system of health care delivery is in operation, cost escalation is stemmed by a national regulatory system which discourages exorbitant doctors' fees and controls technology and facility acquisition of hospitals. Japan has

a uniform fee schedule which pays fixed fees for services regardless of the specialization of provider, how and where the service is performed and quality of care. The Japanese system has been identified as the most significant factor in driving costs down. In both countries, public policy is the main force influencing health expenditures.

Procedural mechanisms may also contribute to cost containment. Utilization of services beyond what is medically necessary can be checked with the institution of a "gate-keeper" physician or facility. An individual, if given free choice, would patronize the nearest facility with more sophisticated equipment resulting in more expensive cost of care. The "gate-keeper" can prevent this by differentiation of levels of care, i.e. primary, secondary and tertiary or general and specialty care. Access to higher level care would require referral. The institution of a system of referral has been shown to lessen utilization rates in Korea. "Gate-keeper" physicians are basic safety caps employed by HMOs. Studies from the US have shown that utilization rates of HMO members are significantly lower than non-HMO members with insurance coverage.

The tendency of physicians to engage in "procedural multiplication" or the overprescription for services, return visits and the like can also be controlled through the mechanism described above. Overprescription is more common where the system of compensation is on a fee-for-service basis operating in a free market. A popular alternative is the adoption of payment on capitation basis.

Private sector investments in new buildings and sophisticated technologies can be checked more effectively by a regulatory body. The government plays a major role in ensuring that new acquisitions, whether of buildings or technologies, will not worsen the uneven distribution of health facilities.

Sophisticated technologies also contribute to price escalation in health care, because more often than not, they are initially priced high to recover the cost of the research. The problem is more acute in the US where sophisticated equipment proliferate. But the larger issue is how to determine the "appropriateness" and the "effectiveness" of new interventions. Many interventions such as lithotripsy may actually lower the cost of a procedure. The problem arises when new interventions are employed indiscriminately even if there is no clear evidence that it can improve a patient's health. As a counter-measure, voluntary health insurance schemes generally set limits for benefit payments to protect itself from the catastrophic cost of advanced technologies.

Adverse selection is another factor that contributes to health care costs paid by insurance. To protect itself from adverse selection, most insurance firms exercise selectivity in accepting members. This practice is usually criticized by public health care systems, arguing that private health insurance firms often spend more time, effort and money on deciding who is not to be insured. Consequently, private insurance firms often operate at lower loss ratios than public systems.

In some cases, administrative and other personnel costs which do not generally and directly contribute to the welfare of the insured patient may use up a sizeable portion of health insurance premium costs, thus raising costs over those already charged for direct service provision.

The private health insurance industry must strike a reasonable balance between containing costs and maintaining acceptable standards of quality care. The elimination of ineffective, excessive and unnecessary medical procedures is a prime consideration. Some sources of inefficiency that could be avoided by the industry are:

1. excessive use of hospital services for conditions which could be

efficiently managed at lower health facilities at lower cost;

2. use of marginally effective medical regimen such as physician recommended repeated visits; excessive prescribing of expensive drugs; excessive use of laboratory or x-ray services; and unnecessary surgical operations;
3. excessive provision of physicians' services when other qualified medical professional can do the job; and
4. uncalled for utilization of sophisticated and specialized equipment and facilities when simple medical procedures are sufficient.

The viability of the insurance industry as a source of health care financing is determined by many factors. First, the industry needs a strong economic and industrial base to ensure itself of adequate institutional, financial, and administrative infrastructure needed for efficient operation. Second, it needs to have a sizeable market, i.e., people with adequate savings to make regular small payments and who have a good appreciation of the financial risks involved in non-coverage. Third, it needs to have a reliable and widely dispersed network of health and medical service providers capable of delivering the benefits and services assured. It is no surprise, therefore, that the development of the insurance industry almost runs parallel to the socio-economic development of the country.

One of the nagging issues confronting the health insurance industry is its tendency to favor the urban dwellers, the employed sector, and the economically better-off population, thereby raising questions of equity in service provisions. The urban bias of private health insurance companies could be attributed to the relative access in urban centers of the necessary administrative support to manage the industry, e.g. banks, communication, transportation, etc. Likewise, the health provider network needed to deliver the health services are also more accessible in the urban areas.

As regards the target population of the industry, it has been biased towards regular income earners mainly because of the need for regularity in payment of premiums. Individuals belonging to the higher income group are also relatively low-risk, hence, a desirable client for private health insurance. How the industry could provide services to those individuals with fairly low income and high risk is a continuing challenge. For instance, the elderly, the disabled, and other high risk professionals are often disqualified from available health insurance coverage.

In order to be a politically feasible means of health care financing, the operations of the health insurance industry as whole should take into account the following considerations:

1. efficiency, which refers to the capacity of the industry to provide cost-effective health care and contribute to the goal of making health care affordable;
2. equity, which refers to the capacity of the industry to provide services and benefits to a wide range of clients, particularly the low-income and the underprivileged members of society;
3. accessibility, which refers to the capacity to reach a wide segment of the population by virtue of its physical proximity;
4. affordability, which refers to the cost of coverage being within the reach of a wide segment of the population; and

5. financial viability, which refers to the capacity to recover operating costs without sacrificing benefits to members.

At the level of the firm, the viability of health insurance as a business enterprise is affected by the following factors:

1. the investment environment, which is a function of capital formation, market potentials, government restrictions or incentives, and competition provided by free health services offered in the public sector;
2. the organizational and managerial efficiency of the firm, which may be a function of the production process, the pricing mechanisms, the service delivery protocol, and the adopted cost-containment measures;
3. the socio-economic environment which is a function of the prevailing income/employment levels of the primary target beneficiaries, the levels of consumer education, and the level of industrialization;
4. the product quality and its distribution which may be determined by quality assurance programs, consumer education programs, existing infrastructure for the delivery of services.

An essential requirement for the success of any health insurance firm is a fairly well developed organizational and management machinery to handle the marketing, collection of premiums, accreditation of service providers, provision of prompt and effective medical care to members, processing and payment of claims and containing cost.

Also, the viability of health insurance depends on the size of its plan holders, sound cost and benefit packaging, prudent medical practice and careful screening of member application and claims. In principle, the basic nature of health insurance as a risk-sharing scheme is that small amounts of revenues are collected regularly from each member, so that from the pooled funds, the larger cost of illness or injury of any one member at a given time can be paid. Because there are administrative costs of operating insurance systems, low cost services and care of predictable non-catastrophic services should normally not be covered. Thus, careful screening of application and claims is of vital consideration. (J. Akin, 1987).

V. ANALYTIC FRAMEWORK

This study investigated the potentials of various types of health insurance to firstly, generate added resources for health care financing; and secondly, to promote efficient, cost-effective, and equitable health care. The analysis attempted to validate claims:

1. that health insurance is a significant, but not a sufficient means of health care financing;
2. that health insurance is oriented to curative, hospital-based health care;
3. that health insurance is an appropriate scheme of health care financing only for particular population groups, but not for others; i.e., it tends to have an urban bias, prefers the employed and

economically productive population;

4. that health insurance, as a source of health care financing, should be developed to complement, not replace, other forms of financing;
5. that health insurance is most viable in an industrial setting, and is generally a losing proposition in a predominantly agricultural economy like the Philippines.

Being essentially a baseline study, the research initially determined the scope of operation of the various types of health insurance operating in the country; the eligibility criteria for membership; the range of benefits that were made available to and utilized by insured members; the cost in terms of premium per member; and, the geographic spread of health insurance operation. The assessment focused on equity by looking into the segment of the population who were covered by health insurance given the prevailing cost; effect of the insurance on health care provision in terms of the proportion of preventive services and curative services, type of manpower/facilities being utilized, level of demand for health care, and the proportion of total health insurance premium cost that went to the actual provision of health services.

The dynamics of operating a health insurance scheme were also investigated in depth by looking into the organizational, financial, managerial, and technical factors that make for viable health insurance operation at the level of the firm. The assessment focused on efficiency which referred to the relationship between output and input, i.e. maximizing outputs with minimal amount of inputs. This would also refer to cost-containment as a result of minimizing waste. The analysis validated the extent to which health insurance viability is affected by specific measures to provide quality services, contain costs, enhance organizational and managerial efficiency, screen membership application, screen benefit utilization, and improve marketing.

Time series analysis of membership growth and financial growth were attempted to assess the general industry trends. Supplemented by informed judgment of key informants from the industry, the future growth prospects of the health insurance industry was calculated, using both quantitative and qualitative analysis.

To the extent feasible, variations in performance and growth prospects among various types of health care financing were attempted. Limits to growth were identified for each category of health insurance. Factors that contributed to growth were also identified. Similarly, factors constraining the growth and development of health insurance were identified.

The final analysis focused on the various conditions that may propel or inhibit the growth of health insurance in the country. Suggested action by government and by the health insurance industry to promote growth were presented.

VI. EMPIRICAL FRAMEWORK

Four (4) types of research instruments were developed and tested for the study. The first one, a masterlist of firms/ organizations with some form of health insurance, was used to generate macro data on the profile of each firm/organization. Aside from the background information about the firm/organization, the profile included data on facilities and assets; financial status; income; expenditures; members/ enrollees in health insurance; and affiliated companies.

The other three (3) instruments were designed to generate qualitative information and quantitative data on the operations of purposively sampled firms/organizations with some form of health insurance. The 3 instruments corresponded to the 3 levels of respondents, namely: (1) firm or company; (2) accredited/ company physician; and, (3) insured or enrolled member.

The firm-level instrument covered the following aspects of private insurance operations: (1) Health plans and benefit packages offered and their respective premium costs as well as mechanisms for delivery; (2) Profile of enrolled members (3) Health service utilization; (4) Cost-containment measures; (5) administrative, management and information systems; (6) Performance indicators and financial status; and, (7) Perceptions on the growth potential and requisites of growth of the firm/organization.

Interviews with accredited/company physicians generated supplemental information on the service providers' arrangements with the sample firms/organization regarding patient care protocols and controls as well as on payment procedures; advantages and disadvantages of being accredited; and, recommendations to improve their relationship with the company as well as with the enrollees.

On the other hand, interviews with insured members provided background information on the users of health insurance, availment of services and perceived benefits derived from the health insurance.

A. Sampling Design

The masterlisting of health insurance firms/organizations attempted a 100 percent coverage of existing firms/organizations in the sample areas. The Philippine Institute for Development Studies (PIDS) pre-selected the sample regions, representing various levels of socio-economic development, namely:

1. Metro Manila or National Capital Region, representing a highly urbanized region with unique characteristics relative to the other regions;
2. Cagayan Valley or Region 2, representing a low-income region;
3. Central Visayas or Region 7, representing a high-income region; and,
4. Northern Mindanao or Region 10, representing a medium-income region.

In each region, except in NCR, two (2) sample provinces were again pre-selected, one representing a low, and the other a high, level of socio-economic development. The sample provinces were as follows:

1. Quirino (low-income) and Cagayan (high-income) for Region 2;
2. Bohol (low-income) and Cebu (high-income) for Region 7;
3. Surigao del Norte (low-income) and Misamis Oriental (high-income) for Region 10.

Using the masterlist, sample firms/organizations for in-depth study were selected. In some sample provinces, some health insurance categories were not present. Also, those companies with employer-provided benefits and community financing schemes may not have been fully covered because of difficulties in

identifying and locating them for this study.

Purposive random sampling was used in the selection of firms. The sample was limited to two (2) sample firms per health insurance category per province. The sample represented the smallest and the largest firms in each category based on the number of members/enrollees. If the number of members/enrollees was not available, the reported annual income and/or assets were used as proxy indicators.

The sample commercial indemnity firms were selected using nationwide income data as indicator of company size since financial and membership data were available only at the head office and were not disaggregated by region nor province. Thus, six commercial indemnity firms were selected as sample in more than one sample area. At most, two of the sample firms were selected in five of the sample areas. This provided insights as to the differences or similarities in operations of the different branch offices of the same commercial indemnity firms.

Simple random sampling was used in the selection of accredited physicians and insured/enrolled members. For each sample-firm/organization, two accredited physicians and three members/enrollees were selected, if applicable. In cases where there were several types of account (i.e., individual, family and group), samples were drawn from each type. For the group insurance, the sample-group was first selected from which, in turn, the sample-respondents were selected. In one case (in Misamis Oriental) where the health benefit is a rider of only one insurance plan, sample-members were drawn only from among the enrollees in that particular insurance plan. For two of the sample firms, no member was interviewed. One of these firms (in NCR) fully cooperated in the company-level interview but refused to give a list of their enrollees, invoking the policy of confidentiality of client's data. In the second case (in Bohol), there were no enrollees of the health plan which was offered as an optional benefit or a rider to a life plan.

While the research diligently used random sampling methods in selecting respondents/interviewees, the sample derived made generous allowances for replacement in case of respondent refusal to be interviewed or failure to reach/locate respondent after 2-3 attempts. For example, to interview one sample firm, 4-5 sample firms were drawn. The first sample firm drawn was the primary sample, while the subsequent ones were replacements in case of failure to interview the primary sample. Replacement samples made up 16 per cent of final respondents interviewed. All of the replacement samples were in NCR. There was, in fact, a series of replacements in NCR with one sample being the eighth replacement. A lot of these firms/organizations refused to participate in the survey because, according to them, this will mean laying open their trade secrets which resulted from long years of studies. One manager outrightly refused to give data since, by her account, she had participated in a similar study before but was not given a copy of the results despite several requests for such.

Because research based on interviews can be expensive and time-consuming, a number of compromises had to be made. The first compromise was that the sample size was small and the measures were often qualitative, thus the data lent themselves more to cross-tabulation than to rigorous tests of hypotheses. The second was that the interviews were conducted only in sample firms willing to be interviewed and only for data/information that they were willing to spend time retrieving from their records or share with the researchers. The third was that the survey could cover only those firms and related respondents who were readily accessible, i.e., within one hour travel time from the provincial capital and where public transport was available.

B. Data Collection

The data collection consisted of two phases: the first one to masterlist firms/organizations with some form of health insurance and the second to undertake an in-depth study of sample firms/organizations selected from the masterlist. In both phases, a combination of records analysis and collection of primary data was undertaken.

The initial masterlist was drawn up using secondary data/information supplemented by ocular survey of business establishments in the sample areas. Specifically, the masterlist of commercial indemnity firms and health maintenance organizations (HMOs) in the National Capital Region was culled out from the: (1) annual report of the Insurance Commission; (2) registry of the Securities and Exchange Commission; (3) list of top 1,000 corporations in the Philippines; and (4) telephone directory. The masterlist of institutions in Cagayan, Quirino, Cebu, Bohol, Misamis Oriental and Surigao del Norte were obtained through actual verification visits of each firm/organization listed as branch offices of NCR-based companies; search of other institutions listed in local telephone directories and ocular survey of business establishments in sample areas.

The masterlist of companies with employer-provided health benefits was prepared after a review of the Collective Bargaining Agreements (CBAs) filed at the Bureau of Workers' Welfare and regional offices of the Department of Labor and Employment (DOLE). This was supplemented by a random on-site search of firms/ institutions known to have voluntarily provided health benefits for employees beyond those required by law.

Lastly, the masterlist of community-based organizations with health insurance scheme was drawn up through consultation with central and field offices of the Department of Health, coalition or federation of non-government organizations (NGOs) and review of various directories of NGOs.

Actual data collection for the in-depth study were done through direct interview, review of records (mostly annual reports); and, self-administered response to the questionnaire. During the initial visit, the questionnaires were discussed briefly with the head of the firm/organization or a designated staff.

In all sample firms/organizations, at least one week was required to cull out the necessary data from existing records which were off-limits to outsiders. The HMOs took almost two months to process the data on members' service utilization. After the statistical data had been prepared, only then were the researchers able to interview the officials and staff regarding the qualitative data.

Similarly, most of the physicians asked that the questionnaires be left for self-administration. An appointment for a second-visit is immediately set with the respondent. During the second visit, the researcher edited the accomplished questionnaire so that any lacking/inconsistent/ unclear data were outrightly corrected or verified. In many cases, direct interviews were done during the second visit for those unable to accomplish the questionnaire in the interval between visits.

Members/enrollees were interviewed either in the first visit, or in the second visit by appointment.

For the in-depth study, financial data such as the total amount of contributions or premium paid, claims paid, income and expenditures were readily available, but were usually nationwide rather than disaggregated data. Very few

sample firms/ organizations had a breakdown of statistical data by geographic area. Also, there were no processed data on the profile of the members or enrollees. Likewise, only the number of claims are usually recorded but the details on the utilization such as the causes of sickness or type or benefits availed of (e.g., hospitalization or consultation) were not specified in reports. To get these details would entail tedious review of the individual policies or the members' records which, in any case, was not permitted because of the alleged confidentiality of member records.

VII. FINDINGS

A. Masterlist

A total of 1,045 firms/organizations with health plans were listed in all sample areas. Their distribution among the sample provinces is shown in Table 2.

Expectedly, NCR had the largest number of health insurance firms/ organizations for all categories, with 794 firms representing 76 per cent of the total. Not all types of health insurance firms were found in each sample province. Quirino which represented a low-income province in a low-income region did not have a single branch office. In Bohol, there were only 2 branch offices.

In the other sample regions, there were more insurance firms/organizations in high-income provinces (i.e., Cagayan, Cebu and Misamis Oriental) which were also the regional centers, hence, more urbanized.

Specific to commercial indemnity firms, more than three-fourths were non-life insurance category. There were also more domestic non-life insurance firms than the foreign non-life firms. Only NCR and Cebu had foreign non-life insurance firms.

Outside of NCR, all listed commercial indemnity firms and HMOs were actually branch offices of NCR-based establishments. In the course of the masterlisting, it was only in Cebu where an insurance firm not based in NCR was found, but said firm did not offer any health plan even as a rider, thus, was not included in the masterlist. The Securities and Exchange Commission (SEC) had earlier noted that little, or almost no, insurance firms originated outside NCR hence, all were registered in the SEC-NCR office.

Outside of NCR, HMOs were listed only in Cebu and Misamis Oriental both of which represented high-income provinces in their respective regions. It was further noted that only insurance-based HMOs operated in Cebu and Misamis Oriental. No HMOs were registered in Cagayan which represented a high-income province in a low-income region. Inquiries with key informants of sample HMOs revealed that no branch offices were opened in Cagayan, Quirino, Bohol and Surigao del Norte because there were no hospitals qualified for accreditation.

The absence of a commercial indemnity insurance or HMO did not mean, however, that there were no HMO members/enrollees in those areas since accounts may be acquired through agents or brokers. Agents or brokers may deal directly with the head office. Enrollees in areas where there were no branch offices of an HMO had to seek care in the other provinces where there were accredited service providers.

Table 2:
Number of Health Insurance Firms/Organizations
By Category and Sample Areas

Category	Reg. 2		Reg. 7		Reg. 10		TOTAL
	Cagayan	NCR	Cebu	Bohol	Mis Or.	Sur. N.	
A. Com Indem.							
Dom. non-life	4	85	36	1	20	3	149
For. non-life	-	7	2	-	1	-	10
Life	6	23	9	1	3	2	44
B. HMO							
Insurance-based	-	9	3	-	2	1	15
Hospital-based	-	4	-	-	-	-	4
Employer-Initiated	-	1	-	-	-	-	1
Community-based	-	1	-	-	-	-	1
C. Employer-Provided							
CBA	1	659	121	-	23	-	804
Voluntary	-	1	-	-	-	1	2
D. Community-Based							
	1	4	1	-	8	1	15
TOTAL	12	794	172	2	57	8	1,045

Companies with employer-provided health benefits and community based insurance schemes were found in NCR, the high-income sample provinces and Surigao del Norte. Though not representative of a high-income province, Surigao del Norte had one company which voluntarily offered health benefits beyond those legally mandated.

Most of the health insurance data required for the masterlist were not available from secondary sources particularly in the case of those companies with employer-provided health benefits. The company identification data on commercial indemnity insurance firms and HMOs were readily available from the SEC and those on employer-provided health insurance from the DOLE. Data on capital stocks, assets and income of commercial indemnities and HMOs were likewise readily available from the SEC. But these information applied to their nationwide operations since the financial data were generally not disaggregated by geographic area. The health insurance data for companies with employer-provided health benefits were neither available from DOLE nor SEC records. The number of members/enrollees of the commercial indemnities/HMOs were not available from SEC while those of the employer-provided health benefits were available in the CBAs.

Although the masterlisting of health insurance firms in the other sample provinces were done through actual visits of the companies, most of the data were not available in the branch offices but were alleged to be available only in their respective head offices in NCR. However, as previously mentioned, data at the head offices were not disaggregated by region or province. To get the required information by province, the individual records of the policyholders would have had to be reviewed.

In terms of the length of operations, majority of the commercial indemnity firms had been in operation for more than 20 years. This did not mean, however, that the health plans/s had been offered for the same length of time. A lot of firms offered health plans at a much later date.

Most HMOs and community-based insurance schemes had been in operation for only about ten years. The longest in operation among the community-based insurance started in 1971.

With regard to the area of coverage, the commercial indemnity insurance and HMOs, expectedly, had a wider reach. Majority of them covered several regions or the whole country.

In terms of ownership, all commercial indemnity insurance firms, HMOs and companies with employer-provided health benefits were registered in the SEC as corporations, with majority of them having an authorized capital stock ranging from P1 million to P20 million. The community-based health schemes were offered by non-profit organizations or foundations.

In 1990, majority of the insurance firms/HMOs registered a gross revenue ranging from P21 million to P100 million. Net income for the same year was, however, less than P1 million for most of the insurance firms/HMOs. Financial data on the other companies and community-based organizations were not available.

In terms of medical facilities, most commercial indemnity insurance firms/HMOs owned a clinic. A lot of companies with employer-provided health benefits also had their own clinics since the provision of some basic health services for employees is legally mandated. Notably, most of the sample community-based organizations also had their own clinic, which may be attributed to the fact that most of them were initiated by physicians.

Most of the commercial indemnity insurance firms/HMOs did not keep a summary record of their members/enrollees. At best they processed financial data particularly the annual total collection and total claims. In a lot of companies, only the number of policyholders were listed and, in the case of most group accounts, the total number of members/enrollees could not be readily determined.

B. In-Depth Study

A total of 50 sample firms/organizations were covered for the in-depth study. Table 3 shows the distribution of this 50 sample firms/organizations by area and category of health insurance firm. It was only in NCR where a sample of all types of health insurance was covered.

Although 50 sample commercial indemnity firms/HMOs were interviewed, only 35 companies were actually covered by the study since the branch offices of 6 insurance firm and one life insurance firm were covered by the study in all sample areas except in Bohol and Quirino. Two investor-based HMOs were covered in NCR, Cebu and Misamis Oriental. As will be presented in the succeeding sections, this gave some information and insights about the variations in the operations of different branch offices.

Table 3
Number of Sample Firms/Organizations
By Category and Sample Area

Category	Reg. 2	NCR	Reg. 7		Reg. 10	
	Cag		Cebu	Bohol	Mis Or.	Sur.
A. Com Indem.						
Dom. non-life	2	2	2	1	2	2
For. non-life	-	2	1	-	-	-
Life	2	2	2	1	1	2
B. HMO						
Insurance-based	-	2	2	-	2	-
Hospital-based	-	1	-	-	-	-
Employer-Initiated	-	1	-	-	-	-
Community-based	-	1	-	-	-	-
C. Employer-Provided						
CBA	1	2	2	-	2	-
Voluntary	-	1	-	-	-	1
D. Community-Based						
	1	2	1	-	3	1
TOTAL	6	16	10	2	10	6

Among the 50 sample firms/organizations, the oldest in operation was a foreign non-life insurance firm which was established in 1904 while a community-based organization in Misamis Oriental was the most recently opened in 1992. Half of the sample firms were in operation for 10 years. As to their nationality, only 7 of the sample firms were foreign-owned companies, all of which were commercial indemnity firms.

As designed, the in-depth study focused on the following elements of the health insurance: (i) health plans and benefit packages offered as well as their respective target members and premium; (ii) profile of members; (iii) service utilization patterns; (iv) financial management; (v) administrative, management and information systems; and, (vi) perceptions on the growth potential and requisites of growth of the industry.

1. Health Plans

Majority of the sample firms or community-based organizations offered more than one type of health plan. Health plans varied by type of benefits offered and the form by which they were availed of. Variations in benefit package consequently resulted in varying range of premium. Premium for the same type of benefit package may further differ depending on the age of the enrollee or the perceived risks by commercial indemnity firms/HMOs.

The 50 sample firms and organizations offered a total of 363 health plans. However, some plans are counted more than once because companies covered in more

than 1 sample area may offer similar plans in different branches. The same companies, however, may offer different combination of plans in each area.

Majority, or 26 out of the 50 sample firms/organizations, offered multiple or more than 2 types of health plans. The highest number of health plan offered by one company was 48 as offered by an HMO, followed by 30 health plans offered by a life insurance firm. For the commercial indemnity firms, the number of health plans may differ from one branch to another. For example, one domestic non-life firm offered six (6) health plans in NCR and Cebu but offered seven (7) health plans in Surigao del Norte and five (5) in Cagayan and Misamis Oriental. The NCR head office did not always offer more health plans than the other branch offices. In the case of a life insurance firm, the NCR office had only one (1) health plan as a principal product while its Misamis Oriental branch office offered two (2) health plans but only as riders to personal accident insurance plans. On the other hand, the investor-based HMOs offered a uniform set of health plans in all their branches.

Of the 26 firms with multiple health plans, 20 were commercial indemnity firms or HMOs which provided a wider choice of health packages designed according to an applicants' age, desired benefits and the acceptable amount of premium. The other six (6) sample firms which offered multiple health plans were companies with employer-provided health benefits. Their health plans varied on the basis of either status of employment or position in office. Employees in managerial position enjoyed better or higher-cost benefits than the rank and file employees. In some cases, the plans also varied depending on the status of employment with the regular employees receiving more benefits than casual employees.

Eighteen sample firms offered only one type of health plan. Of this, 9 were commercial indemnity firms and HMOs, 6 were community-based; and, 3 were employer-provided. The rest of the sample firms (6) offered 2 health plans each.

Of the 24 sample commercial indemnity firms, 18 carried health plans as riders to personal accident/motor vehicle accident or life insurance. The other six (6) sample companies offered their health plans as principal products. Of these, five (5) were life insurance firm and one was a domestic, non-life insurance firm. The latter offered the health plan as principal product in Surigao del Norte. The same company offered health plans only as a rider to personal accident insurance in the other sample areas.

Of the 363 health plans, 181 were offered as principal products. Expectedly, all HMOs except the employer-initiated HMO, accounted for almost all of the health plans (170) offered as principal products.

Eligible beneficiaries

Eligibility standards for membership in a health insurance plan are usually based on the calculated health and financial risks, as indicated by any one or all of the following: (i) work conditions as applicable to employees, (ii) age, (iii) medical history and, (iv) the affordability or potential of applicant to pay the premium/contribution.

The commercial indemnity insurance firms and HMOs were generally available to any individual or group who could afford to pay the set premium. A group may further mean a family, association or company-employees. Some commercial indemnity firms, however, specified an age range of eligible members, usually 18 to 65 years old. Other firms also classified the employees by occupational class in accordance with the potential risks to which the member is

Target groups of employer-provided health benefits were usually classified by their position and status of employment as previously mentioned. Also, beneficiaries of employer-provided health benefits would either include or exclude the dependents.

As to the community-based health schemes, beneficiaries were confined to the members of the community organization, but in all cases, benefits were also extended to all the relatives of the members.

Premium

There was a wide range of premium among the sample firms/organizations. Expectedly, the premium of commercial indemnity/HMO, which were mainly profit-oriented, were generally higher than those of employer-provided and community-based insurance which were welfare-oriented. Higher premium generally meant more, although not necessarily better quality, benefits.

The commercial indemnity firms and HMOs had a schedule of fees which defined the range of premiums computed according to the preferred type of benefits, desired number of units of services subject to a maximum limit and, in some cases, based on the age of the applicant. Premium costs are usually based on actuarial computations and industry comparison. Since the health plans differed across branch offices, their corresponding premiums also varied.

On the other hand, the premium for employer-provided health benefits came in the form of company appropriation. Seven companies appropriated a fixed budget which was estimated based on benefit ceilings and total number of employees. One company appropriated a fixed annual budget, the amount of which was based on a study of a similarly-designed health benefit package. Two companies did not appropriate a specific amount for health care but could draw from the overall administrative funds whenever claims were made. Some companies established a formula for cost-sharing with employees, either in the cost of the premium or in the cost of actual services used.

Contributions made for community-based health plans were often based on the member's perceived affordability level which, in most cases, was agreed upon during community consultations. One community organization was able to establish the affordability level after a survey of household income and expenditures. Another organization conveniently scheduled the collection of members' contributions after harvest time. Two community organizations linked their respective health plans to income-generating projects (IGP). One of them allocated 50 per cent of the IGP interest earnings for the health plan while the other one set aside 10 per cent of the IGP net income as members' contribution.

Benefit Package

Health insurance generally covered any one or both in-patient and out-patient services. For each of these services, the benefit package may be further itemized by the type of procedures (e.g., diagnostics, ambulance services) or by expenditure item (e.g., medicines, professional fees).

All types of insurance firms/organizations set ceilings or maximum cost of allowable benefits. Ceilings may be applied either to a specific item- or service (inner limit); to the whole benefit package (outer limit); or both.

Out of the 14 sample non-life insurance firms covered only

hospitalization services. Moreover, these hospitalization benefits were limited only to the treatment of injuries due to personal and/or motor vehicle accidents. Three non-life insurance firms offered a comprehensive package which included out-patient consultation, diagnostic services and hospitalization services. Said services were likewise limited only to those needed for the treatment of injuries caused by personal/motor vehicle accidents. One non-life insurance firm only reimbursed the cost of drugs and medicines for the treatment of injuries due to personal accident.

The non-life insurance firms generally provided the benefits to their members in the form of cash reimbursement, hence they often did not see the need to accredit service providers. Neither did they impose restrictions as to where or from whom the members could consult or avail of medical services. There were, however, defined ceilings for service cost per accident which usually consisted only of an outer limit. The ceilings depended on the units of insurance enrolled in, subject to a maximum amount. For other non-life insurance firms, the ceilings were proportionate to the principal or total value of the insurance, but also with provision for a maximum amount. Still other non-life insurance firms had a set lump sum per accident regardless of the type of services availed of.

All life insurance firms also provided hospitalization services but with additional benefits that may be any one or combination of the following: (i) surgical; (ii) nursing; and (iii) maternity services. Life insurance firms likewise provided benefits in the form of cash reimbursement, and did not impose restrictions with regard to the service provider. However, one life insurance firm in Surigao del Norte provided direct services through its company physicians but nevertheless imposed no restrictions on the choice of service providers.

Benefit ceilings consisted of both outer and inner limits. The inner limits were usually applied to each type of surgery for which most life insurance firms have a pre-set schedule of fees. The outer limits, just like the non-life insurance firms, were set either as proportionate to the principal but not to exceed a maximum amount; per number of unit with maximum number of unit; or, a lump sum per type of illness. The last type of ceiling was usually applied to the so-called daily hospital income benefit which is unique to life insurance firms. Through this benefit scheme, a fixed allowance was provided to the member for each day of hospitalization depending on the type of illness, either ordinary or dreaded, with the latter having a higher equivalent daily allowance.

Expectedly, the HMOs provided comprehensive services covering all out-patient consultation, diagnostic services and hospitalization. Though comprehensive in benefit coverage, services could be availed only from accredited and/or company service providers, except when it involved an emergency situation, in which case, cash reimbursement was allowed. If a member availed of services from non-accredited service providers for a non-emergency case, claims were subjected to a penalty either in the form of lower reimbursable amount or even disallowance. Even in emergency situation, procedural controls had been set which usually entailed notification of the HMO coordinator within a specified time. In non-emergency situations, procedural controls, such as issuance of referral slips or letters of authorization, were imposed. Just like those of life insurance firms, HMO benefit ceilings had both outer and inner limits. Inner limits are usually set on room and board daily costs, professional fees, and number of allowable procedures.

As a policy, the commercial indemnity firms and HMOs had a common set of conditions which were excluded from benefit-coverage. These exclusions were imposed largely because the required services were considered expensive and actuarial studies had shown that coverage of such would raise premium costs or cause financial losses for the company. Some of the exclusions were imposed by

virtue of provisions in the Insurance Code. The usually excluded conditions are as follows:

- a. pre-existing illnesses except in the case of some HMOs which allow their coverage after a certain period of time from date of insurance;
- b. not work-related illnesses/injuries for employees who were enrolled under personal accident insurance by their employers;
- c. conditions not sanctioned by society such as STDs, suicide, substance abuse and those arising from war or riots;
- d. New procedures like lithotripsy or ultrasound. Some firms/HMO did not explicitly exclude this but their cost were beyond set benefit ceilings thus were automatically excluded;
- e. mental or nervous disorders;
- f. maternity and abortion;
- g. conditions which require the use of ICU and/or requiring isolation;
- h. congenital deformities
- i. rest cures;
- j. routine physical check up for commercial indemnities whose benefits were only for hospitalization or other services for injuries owing only due to accidents;
- k. conditions with no known cure;
- l. catastrophic diseases

Both employer-provided and community-based health benefits were often decided based on negotiations or consultations with the beneficiaries, hence were likely to be more diverse in scope. Most employer-provided health benefits were operated like HMOs where services were provided by accredited/ company service providers. One sample company reinsured its employees in an HMO. Employers were, however, generally more lenient and tolerant about the use of non-accredited service providers. Furthermore, ceilings, which were negotiated between the union and the management, were usually only of outer limit, allowing the employee to make use of the benefit for any form of service. In two of the sample firms (one in Cebu and the other in Surigao del Norte), benefit was in the form of cash loan. There was no limit on the amount of loan as well as the type of service availed of. Although the employees did not make any prepaid contribution, the total loan was paid back at no interest with liberal amortization period which was negotiable depending on the income level of the employee.

The community-based insurance schemes were even more varied. For one community-based organization, benefits came in the form of a 50%-discount on the price of drugs. However, not all types of drugs were available in the community drugstore. In Cagayan, each member of a cooperative paid an annual contribution of P100.00 for which he may be reimbursed of any health expenses up to P1,000.00 per year. Similarly, in Misamis Oriental, a fixed contribution of P20.00 per month was paid by each member of a cooperative for which hospitalization expenses up to P1,250.00 per year may be reimbursed. In Cebu, 50% of the IGP interest earnings were set aside as contribution to a health fund from which the member

could avail of cash loan up to P1,000.00 per illness. Similarly, in Surigao del Norte, 10% percent of the net income from IGP was set aside as health fund contribution for which cash loans ranging from P200 - P300 per illness may be availed of. In Misamis Oriental, members of a mothers' association and a diocesan organization paid a monthly contribution of P5 and P10.00, respectively in exchange for which their children below 5 years of age may be given supplemental food if they became malnourished. They were also provided with preventive health services such as out-patient consultation. In another community-based scheme, the employer agreed to pay P5.00 per month per factory worker while the employees paid P5.00 per month through salary deduction to cover their dependents. The premium is remitted monthly to the affiliated non-government organization which rendered preventive health services plus limited outpatient medical and dental care. Should any enrollee avail of outpatient medical/dental services, a corresponding cost is deducted from the employer's premium dues for the month. The deductions were treated as penalties for the failure of the preventive health measures which was the main program of the NGO.

Most companies with employer-provided health plans and community-based organizations with health insurance did not have explicit policies regarding the conditions that were excluded from benefit-coverage. Most of them, however, mentioned that conditions arising from substance abuse and suicide were definitely not covered by their health plans. One community-based organization excluded suicide since such condition implied that the person was not willing to help himself.

2. Profile of Insured Members/Enrollees

All of the sample companies/organizations had no ready data on the profile of their members and had to process them for this study. Thirty-four (34) sample firms/organizations were able to give data on the total number of their members/enrollees by the end of 1991. The details are shown in Table 4. Fifteen firms or organizations could not give any data on the total number of their members. One commercial indemnity firm in Bohol offered health plans but no one availed of them to date.

By the end of 1991, nine commercial indemnity firms altogether had 8,669 enrollees, 70 per cent of whom were enrollees of two foreign non-life firms. It should be pointed out, however, that not all of the said enrollees were necessarily covered by a health plan since most commercial indemnity firms offered this only as an optional rider. It was difficult for several firms to determine the enrollees who opted for the rider health plan since it entailed reviewing the individual policies.

Nine sample HMOs had a total of 133,900 enrollees in the fourth quarter of 1991. Of the said total, about 43 per cent were members of the three branches of two investor-based HMOs in NCR, Cebu and Misamis Oriental. Among their respective branch offices, the NCR branches of both investor-based HMOs registered the most number of enrollees, followed by the Cebu branch office. Meanwhile, the hospital-based and employer-initiated HMOs had 26,000 and 11,000 enrollees, respectively, all over the country. The company did not have a breakdown of their enrollees by region or province. Being an area-based initiative, the community-based HMO had the least number of coverage with 865 enrollees in the fourth quarter of 1991.

Table 4
Number of Enrollees
By Category and Type of Account: 4th Q, 1991

Category	Type of Enrollee										
	Corp. Group.		Voluntary Individual		Voluntary Family		Reinsured		Total		
	C	E	C	E	C	E	C	E	C	E	
A. Com. Indem.											
Dom. Non-Life	-	-	-	-	4	127	-	-	4	127	
For. Non-Life	2	2020	2	4223	-	-	1	57	2	6300	
Life	3	2242	-	-	-	-	-	-	3	2242	
B. HMO											
Ins.-Based	4	62741	5	33294	-	-	-	-	6	96035	
Hosp.-Based	1	11000	-	-	-	-	-	-	1	11000	
Empl.-Initiated	1	26000	-	-	-	-	-	-	1	26000	
Com.-Based	1	865	-	-	-	-	-	-	1	865	
C. Emp.-Prov.											
CBA	7	3944	-	-	-	-	-	-	7	3944	
Voluntary	2	919	-	-	1	2604	-	-	2	3523	
D. Com.-Based	1	62	4	10267	3	10925	-	-	7	21254	
Total	22	109793	11	47784	8	13656	1	57	34	171290	

C - company E - enrollee

Nine sample companies with employer-provided health benefits reported a total of 7,467 enrollees for the same period. The highest number of enrolled employees per company was 2,710 while the least was 23 employees.

Lastly, seven (7) community-based organizations had a total of 21,254 enrollees in their health plans. These include 10,925 dependents.

The study also intended to analyze the trend in membership from the first quarter to the fourth quarter of 1991. However, only 19 sample firms/organizations were able to provide data for both periods under review. Of the 19 firms, 5 had the same number of enrollees from the first to the fourth quarter. The other 14 firms showed changes over the said period with 8 firms gaining additional members and 5 firms posting a decrease in membership. The highest percentage increase (576 % or from 37 members during the first quarter to 250 members in the fourth quarter) was achieved by a community-based organization whose geographical outreach expanded from 3 pilot areas to 15 communities. In terms of absolute value, however, an investor-based HMO in Cebu

had the biggest growth in membership with 6,697 additional enrollees. The NCR branch of the same investor-based HMO posted the second highest increase in membership at 2,273 new enrollees.

Meanwhile, the highest and lowest percentage decrease was 48 per cent and 0.3 percent, respectively. Three of the sample companies whose membership decreased were commercial indemnity firms. Two community-based organizations registered the highest depletion in membership from the start to the end of the year. The membership of these community organizations decreased by 2,000 and 280 members, respectively. In the case of the latter organization, 280 members were unable to continue payment of their contributions after their houses were gutted down by fire. Fortunately, the organization was able to generate donations to pay-off the contributions of the fire victims.

Out of the 15 sample firms/organizations who could not give any data on their membership, 14 were branch offices of commercial indemnity firms and one was a community-based organization which had a total of 2,604 members in March 1993. Most of the branch offices of the commercial indemnity firms did not have a complete list of their members/enrollees because some of the accounts were contracted by agents or brokers who dealt directly with the head office. Data about the members were even more difficult to retrieve in the case of the non-life insurance firms which provided health plans as rider to personal accident or motor vehicle accident plans. In the case of personal accidents, the insured members were usually students or employees such that the insurance was contracted with the head of the school or company and the insurance firm get only the total number of insured. As to those enrolled under the motor vehicle plan, the policy usually stated in general terms that the insurance covered any licensed driver and/or the passenger of a particular vehicle making it even more difficult to have the names or even the number of the beneficiaries. There were also cases where group accounts were acquired by the head office but the insurance covered all employees of the client-company in various parts of the country. In cases like this, the head office forwarded a copy of the policy to the concerned branch offices. But the branch office did not automatically get the names or number of the employees until such time that claims were made and the policies were reviewed. Sometimes, the branch offices need not even review the policy as processing of claims were also done at the head office.

The head offices on the other hand, had only the nationwide total number of members and did not have sub-totals by branch office or area. Most, if not all, commercial indemnity firms did not keep a summary record of their members/enrollees. Instead, they kept individual records of the members or only copies of the policy. The HMOs did have a complete list of their members but, just like the commercial indemnity firms, did not have a summary record that could give an overall profile of the enrollees.

Information on members of employer-provided and community-based insurance schemes were easier to generate because they were fewer in number and could be outrightly processed even if one had to go through the individual records. Since the companies or organizations did not regularly or deliberately process the employees' personal data, those of past years' were difficult to retrieve for purposes of trend analysis. Of the 39 firms/organizations which had data on its members, only six were able to give pertinent additional information such as the members' occupation, age and other pertinent demographic data.

To supplement the company-level profile of members, the study also interviewed sample-members. Although the sample size was small, the results of the interviews provided an idea of the characteristics of the population presently covered by private insurance and their perceptions of the health plan they are enrolled in.

Table 5
Number of Sample-Members
By Category and Sample Areas

Category	Reg. 2	NCR	Reg. 7		Reg. 10		Total
	Cagayan		Cebu	Bohol	Mis Or.	Sur.	
Com. Indemnity	10	11	13	-	14	-	48
HMO	-	12	7	-	6	-	25
Emp.-Provided	4	15	6	-	6	3	34
Community-Based	3	6	3	-	6	3	21
Total	17	44	29	0	32	6	128

As designed, 3 principal enrollees/members in each sample firm/organization would have been interviewed; i.e., 150 sample-members for all 50 sample companies. However, only 128 enrollees were covered. As previously mentioned, one sample life insurance firm had only one enrollee in its health plan. A sample non-life insurance firm refused to give a list of its members in keeping with its policy of confidentiality. Three non-life insurance firms, which offered health plans as riders to their respective personal/motor vehicle insurance, could not give a list of its enrollees for reasons cited earlier. Thus, the biggest shortfall in target number of sample-members were among the commercial indemnity firms.

In the case of the HMOs and employer-provided health benefits, the number of respondents were more than the target because they were more accessible. As in the case of the beneficiaries of the employer-provided health benefits, the sample-members were interviewed in the work place during break time.

Since almost half (48 per cent or 24 out of the 50 companies) of the sample companies were commercial indemnity firms, the biggest group of sample-members belonged to this insurance category. In terms of their distribution by area, a significant proportion of the sample-members were from the NCR.

Of the 73 sample-members of commercial indemnity firms and HMOs, there was an almost equal number of enrollees under individual and company accounts. There were only 6 enrollees under family account. The members of employer-provided and community-based health services were all considered as company or group enrollees since their respective health plans were designed for all the members in general.

Table 6 presents the profile of sample principal members according to type of account, age, sex, educational attainment and monthly individual income. These are cross tabulated with the categories of health insurance covered by the study.

Table 6
Profile of Sample Principal Members

	C a t e g o r y			
	Com. Indem. (n=48)	HMO (n=25)	Emp.-Prov. (n=34)	Com.-Based (n=21)
A. Type of Enrollee				
Individual	25	7	-	-
Company	21	14	34	21
Family	2	4	-	-
B. Age				
5-14 yrs. old	1	-	-	-
15-45 yrs. old	35	19	28	16
46-65 yrs. old	11	4	2	4
Not stated	1	2	4	1
C. Sex				
Female	26	7	14	17
Male	22	18	20	4
D. Educ. Attainment				
Elementary	2	-	1	9
High School	6	1	12	5
Vocational	-	1	2	-
College	35	20	16	7
Post Grad.	4	2	-	-
Not Stated	1	1	3	-
E. Monthly Income				
< P5000	19	3	24	14
5000- 9999	11	11	3	1
10000-19999	5	6	2	-
20000-29999	3	-	-	-
> 29999	3	1	-	-
Not Stated	7	4	5	6

There was a wide range between the ages of the youngest principal member who was 7 years old and the oldest principal member who was 63 years old. However, more than three-fourths (3/4) of the sample-members belonged to the 15-45 age bracket. In terms of sex, equal number of male sample-members (64) and the female sample-members (64) were interviewed. More female sample-members belonged to commercial indemnity firms and community-based organizations while more male sample-members were from HMOs and employer-provided groups.

With reference to the educational attainment of the principal members, variance was noted across the four major categories of health insurance. Among the 48 sample-members of the commercial indemnity firms, 40 or 83 per cent were at least college graduate with 4 of them having reached post-graduate education. A higher percentage (88%) of the HMO enrollees also reached, at least, college level. Among the 34 members of employer-provided health plans, 16 reached college level and an almost equal number of 15 had educational attainment below college level including two members who finished vocational courses. As to the members of community-based health plans, three-fourths were not able to proceed to college level with 9 of them having reached only elementary level.

The monthly income of 106 members with income data ranged from P800.00 to P70,000 with an outlier response of P200,000.00. Excluding the outlier monthly income of P200,000.00, the mean was at P7,115, the median at P4,000 and a mode at P6,000. Many of the members (60 or 47 percent) had monthly income less than P5,000.00. Across insurance categories, almost all of the members of community-based and employer-provided health plans had monthly incomes below P5,000.00. Conversely, majority of the enrollees in commercial indemnity firms and HMOs had incomes above P5,000.00 per month.

Table 7
Range of Principal's Monthly Income

	Com. Indem. n=40	HMOs n=21	Emp.-Prov. n=29	Com.-Based n=15	All Cases n = 105
Minimum	P 1,000	2,406	2,310	800	800
Maximum	70,000	40,000	17,000	5,201	70,000
Mean	9,581	9,534	4,402	2,347	7,115
Median	5,500	7,000	3,540	1,700	4,000
Mode	2,000	10,000	2,700	1,600	6,000
Std. Dev.	13,258	8,152	3,069	1,419	9,502

Note: Excluding an outlier response of P200,000 monthly income

Table 8 shows the profile of insured household members. The survey showed an average household size of 5 persons with the maximum being 12 persons. All 128 households had a total of 492 members.

Notably, the members of community-based and employer-provided health plans belonged to bigger households. In terms of the distribution of household members by sex, the female (255) slightly outnumbered the males (237). However, specific to the households of the sample-members of community-based health plans, the males outnumbered the females.

As to the household members' age distribution, 45 per cent belonged to the 15-45 age bracket. This trend holds true for all categories of health insurance except for the HMOs in which most of the household members were below 15 years old.

Fixed salary was most frequently mentioned as the major source of household income followed by business. Specifically, twenty-five (25) members, most of whom were enrollees of commercial indemnity firms, were engaged in business. Their businesses include printing press; airconditioning sales/service; hardware store. Some enrollees of community-based health plans were engaged in small-scale enterprise such as vending, sari-sari store.

The distribution of household income follows the same pattern as the distribution of the principal members' income since the enrollees were usually the household head and its principal earner. Almost one-fifth of households (18 per cent) had an annual income within the range of P30,000.00 to P50,000.00; i.e., monthly income ranging from P2,500.00 to P4,000.00. Across insurance categories, however, it was noted that the annual household income of almost three-fourths (3/4) of the enrollees in commercial indemnity firms, HMOs and employer-provided health plans were above P50,000.00. Conversely, the annual household income of more than half (67 per cent) of the members of community-based health plans were P50,000 or less.

Table 8
Household Profile of Sample Members

	C a t e g o r y			
	Com. Indem.	HMO	Emp.-Prov.	Com.-Based
A. No. of Members				
Solo	6	-	2	-
2- 4	20	10	9	3
5- 7	17	15	20	12
8-10	5	-	3	4
> 10	-	-	-	2
B. Age				
< 5 yrs old	8	15	11	15
5-14 yrs. old	29	40	25	35
15-45 yrs. old	75	47	47	52
46-65 yrs. old	22	4	13	10
> 65 yrs. old	5	3	1	3
Not stated	11	-	10	1
C. Sex				
Female	84	55	64	52
Male	76	54	43	64
D. Educ. Attainment				
None yet	3	1	3	7
Pre-elem.	3	8	7	4
Elementary	39	29	27	44
High School	22	14	31	25
College	76	34	42	19
Post Grad.	-	1	-	-
Not Stated	11	2	2	4
E. Annual Income				
Not fixed	1	-	2	2
< P30000	1	1	4	4
30000- 50000	5	1	9	8
51000-100000	16	6	11	5
101000-150000	6	4	8	2
> 150000	12	11	3	-

The economic status of the enrollees' households was further measured by determining their ownership of valuable properties such as their house and lot, other real estate, car and other machineries. The pertinent data are shown in Table 9. Twenty-two (22) respondents did not own any valuable property, not even their house and lot. The biggest percentage of enrollees whose family did not have any of the said properties were those of the community-based health plans.

Table 9
Ownership of Property
By Category of Health Insurance

Property Owned	C a t e g o r y			
	Com. Indem.	HMO	Emp.-Prov.	Com.-Based
House and Lot	34	19	17	16
Farm/Comm'l. Lot	14	8	7	6
Other Real Estate	3	4	2	1
Business Estab.	17	3	1	5
Machinery	3	-	1	-
Business vehicle	9	3	4	1
Family vehicle	12	11	4	-
None	7	3	3	9
No Response	1	-	-	-

Of the 105 sample-households who owned one or more valuable property, more than three-fourths (3/4) owned their house and lot. About 33 per cent owned a farm or a commercial lot; 26 per cent owned a family vehicle; and, 25 per cent had business establishments.

Of the 86 enrollees who owned a house and lot, 77 were able to indicate the size of their lot. More than half of them owned a residential lot of less than 300 square meters. Most of those who owned more than 300 square meters of residential lot were enrollees of commercial indemnity firms.

Table 10 shows the expenditure pattern which revealed that 40 per cent of the households spent less than P50,000.00 per year. Again, the community-based health plans registered the highest percentage of members whose annual expenditure were less than P50,000.00. Among the members of the other categories, majority have an annual expenditure which exceeded P50,000.00 .

The payment of amortization registered the highest average amount spent at P73,601.85 per year. This was followed by food for which an annual average of P54,381.00 was spent; entertainment for which the average expenditure amounted to P43,504.00; and, alcohol and cigarette with an annual expenditure of P32,050.00. Health and medical expenses ranked seventh highest expenditure item.

More than half (65 per cent) of the sample-households were able to incur savings. It was noted, however, that among the members of the community-based health plans the pattern was reversed with more than half (57 per cent) not being able to make any savings.

Sixty per cent (60%) of those who had savings did so on a regular basis. Overall, emergency expenses ranked first as the intended use of their savings, followed by child's education and medical expenses as second and third priority, respectively. Among the members of the HMO and community-based enrollees, however, child's education ranked as first priority for use of savings.

Table 10
Annual Gross Expenditure
By Category of Health Insurance

Income Bracket	C a t e g o r y			
	Com. Indem.	HMO	Emp.-Prov.	Com.-Based
< P10,000	-	-	2	1
10000-29999	7	-	6	6
30000-49999	7	4	8	10
50000-69999	10	3	4	1
70000-89999	6	2	2	1
90999 & more	16	14	13	2
Can't Estimate	1	1	-	-

Regarding the health status of the household members, about 73 per cent of respondents indicated that none of their family members suffers from a chronic, recurring or congenital ailments. The most common recurring ailments among the members of 44 respondents were as follows: (i) asthma; (ii) respiratory infection; and, (iii) hypertension. Only one member per family was usually afflicted by any recurring/chronic ailment.

About 43 respondents indicated that at least one of their family members suffered from an illness/injury in the preceding 3 months. The most common illness/ injury were: (i) respiratory infection; (ii) fever; (iii) viral/bacterial infection; (iv) renal problem; and (v) hypertension. These illnesses were a combination of infectious and degenerative diseases with infectious cases more dominant. Generally, the illness lasted between 2 to 7 days. This was particularly true with infectious diseases, e.g. respiratory infection and other viral/bacterial infections, except TB which required much longer period of treatment. Most of the respondents who required longer duration of treatment were enrollees of HMOs and commercial indemnity firms.

A large percentage of those who got ill (42 per cent) were hospitalized; 30 per cent sought out-patient consultation; and 13 per cent resorted only to self-medication.

In table 11, it is interesting to note that 50 per cent of respondents had been enrolled in their current health plan for 1 - 3 years and another 27.3 per cent for 4 - 6 years. The concentration of responses within these years somehow indicated how recent various companies/organizations have been engaged in the provision of some form of health insurance. This pattern was true for all types of health insurance covered in the study.

Majority of respondents or 55 per cent obtained their health plans through their employers, 23 per cent were convinced by friends/agents, and 21 per cent voluntarily enrolled. The large proportion of those who acquired their health plans through their employer was consistent with the fact that most of the

respondents are under the group/corporate account.

Table 11
Insurance of Principal Members

	Category of Health Insurance			
	Com. Indem.	HMO	Emp-Prov.	Com. Based
A. Year Enrolled				
< 1 year	4	-	2	-
1 - 3 years	29	14	9	12
4 - 6 years	8	10	11	6
7 - 9 years	1	-	7	2
> 9 years	6	1	5	1
B. Manner Obtained				
By Employer	20	14	32	4
Voluntary	13	4	1	9
By Family	1	-	-	-
Persuaded	13	7	1	8
No response	1	-	-	-
C. Form of Payment				
Self-paid	29	14	4	14
By Employer				
Fully Paid	18	7	27	-
Subsidized	1	4	3	7

Health insurance premiums were either self-paid (48 per cent) or paid through employers (52 per cent). The most common manner of paying premiums was through salary deduction. Next to salary deduction was direct payment particularly among the enrollees who paid their own insurance. The third major means of paying the premium was through the use of collector or agent.

As to the mode of payment, 39 per cent paid on a monthly basis, 29 per cent paid on an annual basis and 12 per cent on a quarterly basis. This was the pattern for both the self-paid group and those paying through their employer.

Annual premium paid by respondents ranged from a minimum of P8.00 to a maximum of P48,000.00, with a mean of P7,225.97. About 28 per cent of the total respondents paid an annual premium of less than P500, while 14 per cent paid within the range of P3,500.00 to P4,000.00. About 34 per cent did not know how much premium was paid by their employer for their health plan.

Among the self-paid enrollees, annual premiums ranged from P8.00 to P48,000.00, with a mean of P3,855.67. The average and maximum were higher than those paid by employers for which the annual premium ranged from a minimum of P15.00 to a maximum of P16,500, with a mean of P2,141.54.

More than half of total respondents or 56 per cent indicated that none of

their family members were also enrolled in the same health plan.

3. Service Utilization

Out of the 50 sample firms/organizations, only 20 had available data on service utilization. Of these 20 firms/organizations, eight (8) were HMOs; five (5) were companies with CBA-obtained health benefits; three (3) were domestic non-life insurance firms; 2 were community-based organizations; and one each of life insurance firm and company with voluntarily-provided health benefits. No trend analysis could be made about the membership since only single-year data were made available in the form required by the study.

It was further noted that nine of the aforementioned firms/organizations were NCR samples, understandably so because, as previously mentioned, statistical data were available only in the head offices. Related to this, the data of the NCR-based sample commercial indemnity firms and HMOs were actually nationwide figures since they had not disaggregated their data by sub-national areas.

Table 12
Number of Members Who Availed of Benefits
By Type of Service and By Category of Health Insurance

Category	Type of Service					
	Out-Patient Consultation		Diagnostic Procedures		Hospitalization	
	C	E	C	E	C	E
A. Com. Indemnity						
Domestic Non-life	1	10	-	-	1	4
Life	-	-	-	-	1	1
B. HMO						
Insurance-based ¹	2	140,485	2	151,305	2	4,991
Hospital-based ¹	1	8,304	-	-	1	393
Community-based	1	1,219	1	515	1	79
Employer-initiated	1	33,556	1	1,566	-	-
B. Employer-Provided						
CBA	3	214	1	700	3	49
Voluntary	1	45	-	-	1	19
C. Community-Based						
	2	243	-	-	-	-
Total	12	185,976	5	154,086	11	5,567

¹ Nationwide data

Five sample HMOs in NCR reported that a total of 183,564 and 151,305 of their members made use of out-patient consultation services and diagnostic services, respectively, in 1991. In addition, 5,494 of their members were

hospitalized.

With reference to the sample-companies in the other sample areas, seven (7) companies reported that 2,412 members made use of out-patient consultation services in 1991. One company with employer-provided health benefits recorded that 700 of its employees availed of various diagnostic procedures and six (6) sample firms reported that 73 of their members were hospitalized.

Only eight (8) sample firms were able to give an indication of the causes of hospitalization of their members. Four (4) of these sample firms cited pneumonia as the leading cause of hospitalization. The other four firms respectively cited hypertension, accident, ulcer and infection as the leading causes of hospitalization of their members.

The lack of available data constrained further analysis on service utilization, which in itself could be a significant finding, since it indicated that health insurance plans were mainly viewed in terms of their economic benefit and hardly in terms of health welfare. Even the welfare-oriented community organizations only kept records on amount of claims and had not found it necessary to monitor service utilization to get an indication of the health problems of the beneficiaries. Not surprisingly, most members/enrollees only articulated the economic benefits of health insurance.

The survey of enrollees showed that 90 members (or 70 per cent of the 128 sample enrollees) had availed of their health benefits at least once since their enrolment. More than half or 58 per cent had even used their health plan more than once.

The level of satisfaction expressed by respondents ranged from fairly satisfied (40 per cent) to very satisfied (30 per cent). About 9 per cent indicated dissatisfaction while 21 per cent did not want to comment. There were more enrollees under the commercial indemnity and employer provided plans who were not satisfied with their current health insurance plans. Conversely, there were more enrollees of the HMOs and community-based plan who expressed satisfaction.

Only 7 of the 11 dissatisfied members respondents gave reasons for such. These reasons were as follows: (i) limited coverage; (ii) poor/inconvenient schedule of service providers; (iii) claims not fully reimbursed; (iv) dissatisfaction over services of physician; and, (v) too long processing of claims.

4. Organizational Set-Up

The study also investigated the organizational set up of the sample companies particularly with reference to three functional areas, to wit: a) marketing; b) provision of services or benefits; and, c) financial management and control.

The study results indicated that the operations of the commercial indemnity firms and HMOs were highly centralized. On the other hand, the operations of the employer-provided and community-based health insurance schemes were integrated with the general operations of the company or the organization. Both the employer-provided and community-based health insurance schemes had simple operating systems and covered a limited number of members.

Marketing

Strictly speaking, only the commercial indemnity firms and HMOs have organized marketing strategies for their insurance plans, including their health plans, both as riders or as principal products. The commercial indemnity firms and HMOs adopted a free marketing scheme which involves various combinations of in-house sales staff, free agents and/or brokers. Twenty sample commercial indemnity firms and eight (8) HMOs had a sales force of 12,356 agents, brokers and in-house staff. Fifteen of these companies had a combination of two types of sales force; ten had only one type and three had all types of sales staff. It was also noted that 11 of the companies do not have an in-house staff and relied solely on agents to market their various plans. There were much more agents/brokers (98 per cent) than in-house sales staff. This might be a way of minimizing the administrative expenditures as agents/brokers were paid on commission basis.

Table 13
Composition of Sales Force
By Category of Health Insurance

Category	Individual Agents		Brokers		In-house Staff	
	C	SF	C	SF	C	SF
A. Comm. Indemnity						
Dom. Non-Life	1	169	3	10	5	23
For. Non-Life	2	180	2	60	1	3
Life	7	4,447	2	20	4	15
B. HMO						
Insurance-Based	6	7,361	1	18	5	29
Hospital-Based	-	-	1	15	1	5
Community-Based	-	-	-	-	1	1
Total	16	12,157	9	123	12	76

C - Company SF - Sales Force

Free marketing scheme also meant that agents and brokers were not confined to a specific area of coverage since processing of application was centralized. The branch offices assumed mainly marketing functions. Applications and claims were received and reviewed for completeness at the branch office but processing for approval were usually done at the head office. In major cities like Cebu, an insurance company could have both a branch office and several agencies/brokers. The latter could deal directly with the head office thus the branch office might not have a complete account of the enrollees in that area.

The individual agents and brokers were compensated on a commission basis which ranged from 15-30 per cent of the total premium. Once their sales reached a certain quota, the agents or brokers were also given bonuses, the amount of which was also a percentage of the premium.

Since the sales force was composed in bulk by individual agents, most commercial indemnity firms and HMOs marketed their insurance plans through direct sales including sales presentation. This was supplemented by advertisements. A unique marketing strategy done by a domestic non-life firm was the advertisement

through major credit cards. On the other hand, commercial indemnity firms which offered motor vehicle insurance with health plan rider set-up sales offices near the Land Transportation Office since vehicle registration requires owners to get said insurance.

In terms of procedures for acceptance of members, the commercial indemnity firms and HMOs had their respective standard application forms which the prospective members had to fill-up. The application form usually asked the prospective member to declare his medical history particularly pre-existing illnesses. The other important aspect of the application form covered the economic status as basis for determining the capability of the applicant to pay the estimated premium.

The company relied basically on the information given in the application form to determine qualifications of a prospective member. In any case, the non-declaration of certain information served as sufficient basis for non-approval of claims later on. Based on the initial review of data in the application form, the company may find it necessary for the applicant to undergo a medical examination. The review of the application is further guided by the lay-underwriting and medical indemnity guidelines in the case of the commercial indemnity firms. Applicants who were determined to be high-risk were either rejected, required to pay higher premium, or given limited benefits.

In the case of the sample companies with employer-provided health benefits, the health plans did not have to be marketed since these resulted from a negotiation between management and the employees' union whose members automatically qualify for coverage. However, all concerned sample companies conducted an in-house orientation about the health plans for their employees. After the initial company-wide orientation, new employees were individually briefed about their health plans until the next CBA negotiation.

As to the community-based organizations, the target beneficiaries were motivated to enroll in the health plans through a process of community organization. In all cases, the communities had already attained a certain level of organization before the health plans were conceived based on the needs of the communities. All members of the community organization or cooperative were automatically eligible for membership. During the conceptual stage, dissemination of information about the health plan usually involved general assemblies and house visits. Like the commercial indemnity firms and HMOs, the community-based organizations also had application forms which need to be filled-up by interested community members. Two community organizations required their applicants to attend an orientation seminar on primary health care before they could be fully accepted for coverage.

Provision of services or benefits

Benefits were in the form of cash reimbursement, direct services or both. But even companies involved in direct services had a system of reimbursing the claims filed by the service providers.

Direct services were provided by in-house or accredited service providers or both. Ten (10) sample companies have both in-house and accredited service providers. One-half of these companies were HMOs while the other half were employers who provided health benefits for their employees. In addition, 4 HMOs and 1 company with employer-provided health benefits had only in-house service providers.

All in all, 13 sample companies had a total of 35 in-house/company

hospitals or clinics and 141 in-house/company physicians and other medical staff. On the other hand, 15 sample companies had a total of 1,004 accredited hospitals or clinics and 3,397 accredited physicians and other medical staff. A single provider, or clinic, and hospital and physician, may be accredited by more than one insurance firms, hence the total member of insurance-affiliated providers may be less than what the figures indicate. In Surigao there was an alleged demand for HMOs but this was not offered by any company because no hospital in the area could qualify for accreditation.

Related to this, the HMOs, which offer direct services, had standard procedures and requirements for accrediting service providers, both hospital/clinics and physicians. All sample HMOs had a common set of criteria for accrediting service providers which were as follows:

a. For Hospitals/Clinics:

- i. must be strategically located such that it is accessible to majority of the target beneficiaries;
- ii. must accept standard rates set by the HMO;
- iii. facilities must be complete or sufficient to provide a broad range of services; and,
- iv. has good reputation or influence in the area and has proper attitude towards HMOs.

b. For Physicians and Other Medical Staff:

- i. must be a licensed medical practitioner. In the case of specialist physicians, must be a fellow or diplomate;
- ii. must hold clinic in accredited hospital/clinic;
- iii. is well known and has right amount of influence in the area; and,
- iv. must accept standard rates offered by the HMO.

Whenever available, the members usually go first to the company service providers for out-patient consultation (OPC). If found necessary, the company physicians may refer the member to another accredited service provider for further treatment.

For HMOs and those companies which did not have company physicians, a member would have to go first to the Primary Medical Services Unit (PMSU) where treatment would be given or, if necessary, a letter of authorization is issued for a member to consult other accredited physicians.

There were also set procedures and requirements for filing claims for cash reimbursements either by the members themselves or the service providers. The members of the commercial indemnity firms and HMOs have to fill-up an official claim form. The duly accomplished forms were submitted along with the required supporting papers which include the medical certificate duly signed by the attending physicians, any proof of services, and official receipts.

In the case of claims filed by service providers, a statement of account was additionally required. For motor vehicle insurance, police reports were also required. As to work-related accident insurance, a certification from the employer regarding the circumstances of the accident had to be attached as well.

In processing the claims filed, the company usually first determined the completeness of the required documents. Once the required documents were found to be complete, the company did a financial review to determine whether the amount being requested for reimbursement was within set ceilings and/or standard rates. Validity checks were also done to determine authenticity of the receipts. And, whenever the company had an in-house physician, a medical review was also done to determine appropriateness of treatment and of the corresponding costs.

For the community-based and employer-provided health benefits which were given through cash reimbursement, the procedures were simpler with the members having only to bring their official receipts to the concerned administrative units where their medical expenses were outrightly reimbursed.

For community-based organizations which provided medical loan assistance, the members were also required to fill up a form and present a proof of need for medical service, usually the physician's prescriptions or diagnostic report. Once the loan was approved, the members were asked to sign an agreement or promissory note stating the repayment terms which was mutually agreed upon by the company/organization and the member.

Eight (8) sample companies reported to have spent a total of P13,056,177.00 for services in 1991. Sixty-five per cent (65 %) of the said amount was spent for in-patient services, 34 per cent for outpatient care (OPC) and only 1 per cent for rehabilitation services.

Of the total amount spent for OPC, 48 per cent was for diagnostic procedures; 42 per cent was for professional fees; 4 per cent for drugs and medicines; and, 6 per cent for other services. The same pattern was observed with regard to the expenditure for in-patient services, with diagnostic procedures also having the biggest percentage share.

The study team also interviewed 31 accredited and company physicians. As previously mentioned, only one commercial indemnity firm had a company physician since the rest of the firms provided their health benefits in the form of cash reimbursement. Twelve (12) of the sample physicians were accredited by HMOs.

Majority of the sample physicians were aged below 41 years, female, married, have been in practice for at most, 20 years, and were already specialists. More than half (20) had been accredited by an insurance company for less than 5 years. Fifteen of them were accredited by more than one insurance company, with two (2) of them providing services to 5 other companies.

When queried about their arrangements with their respective insurance companies, only three of the physicians said that there was no form of control as to service availment. Sixteen of them mentioned that they were required to obtain prior authorization or referral before they provided services to members. This was the most common form of control. The second most mentioned form of control was the imposition of limits on procedures, although this was mentioned only by 6 physicians.

Fifteen of the physicians said that the terms of payment were negotiated with the accrediting company. But a significant number (10 physicians) also said that the rate of professional fees were fixed by the accrediting company.

The insured patients comprised about 25-50 per cent of clients served by

20 accredited/affiliated physicians. Most of the sample-physicians whose insured patients comprised more than 50 per cent of their total clients were company doctors. When asked whether they treat their insured patients differently from those who were uninsured, almost all physicians said no. In any case, the two physicians who claimed they treated their insured patients differently, only do so by way of referring them to other specialists for further treatment.

Having a captive market/client given first rank as the primary advantage of being an accredited physician. Relatedly, the assurance of payment ranked as the second most important benefit of an accredited doctor, followed by the recognition and prestige/honor as third and fourth advantages, respectively.

Interestingly, the disadvantages of being an accredited physician appeared to have negated the aforementioned advantages, as the disadvantages got higher weighted scores. Low fees or rates were considered the primary disadvantage. This was aggravated by the delayed payment of claims which ranked as second most serious disadvantage. The third and fourth disadvantages both relate to the clients who were either more demanding or more problematic.

Notwithstanding these disadvantages, majority of the sample physicians reported no negative experiences with the insurance company. As to the five (5) physicians who reported a negative experience, 4 had to do with the delayed payment of claims or non-payment of claims for services rendered to problematic clients.

Consistently, majority of the respondents expressed satisfaction with their respective arrangements with the insurance companies. Only 4 of them directly stated dissatisfaction over the arrangements.

Despite the general satisfaction, a lot of the respondents presented some recommendations on how to improve their relationship with the insurance company. Expectedly, most of the recommendations were related to the rates of the professional fees. In general, it was recommended that professional fees be updated regularly, with one respondent specifying that this be done annually. Others were more specific by recommending that fees should be increased commensurate to the specialty or may be determined on the basis of the severity of the illness and the extent of the care provided.

The other physicians recommended some improvements in the operational aspects to include: (i) ensuring prompt payment of claims, (ii) regular meetings between accredited physicians and company representatives to thresh out problems on health care; (iii) continuous orientation of physicians and, (iv) regular feedback regarding the services.

The company physicians also had specific recommendations which included: (i) the improvement of the work conditions (e.g., better ventilation); (ii) strict enforcement of the requirement for pre-employment physical examination; (iii) not to use enrolment in private health insurance as basis for withdrawing retainerhip; and (iv) giving physicians more opportunity to work/deal with the head of the company and not only with the personnel manager.

Financial management and control

The major sources of operating funds for commercial indemnity firms and HMOs were the members' pre-payment and stockholders'/owners' equity. The NCR- based sample commercial indemnity firms and HMOs also stated that they invested excess premiums as a way of generating more funds. The usual form of

investment was the purchase of security bonds and money market placements.

In the case of the branch offices, a financial budget proposal is submitted at the start of the year from which fund releases from the head offices were based. Other branch offices were provided with revolving funds, the amount of which were set by the head office. Some excess expenditures were even drawn from the commission earnings of the staff. Some administrative requirements were also directly handled by the head office, e.g. procurement of supplies which were then forwarded to the branch offices upon request. In some cases, even the payroll of the staff were prepared at the head office and disbursed through bank-to-bank transactions.

Most of the companies with employer-provided health benefits had a specific annual appropriation for the operations of their health plans. As to the community-based health benefits, the funds were drawn from the members' contributions although this might not necessarily be out-of-pocket cash as in the case where the funds were deducted from IGP interest or earnings. The community-based organizations also solicited support from the government, notably the Department of Health, and even from external donors.

An important aspect of financial management was cost-containment. The most common form of cost-containment was the imposition of benefit ceilings. Among the commercial indemnity firms and HMOs, other cost-containment measures were well-defined, the major ones being that of screening for adverse selection as well as the imposition of exclusions and limits. The HMOs and some companies with employer-provided health benefits also required their members to go first to the PMSU or in-house medical staff for screening before proceeding to any accredited service provider. Some of the commercial indemnity firms and HMOs also reinsured some of their members as a safety net. The selection of members to be reinsured was usually dependent on the contract/policy value.

In the case of the companies with employer-provided health benefits, the members had undergone a pre-employment health examination which, in itself, was also considered as cost-containment measure. Among the community-based organizations, the provision of preventive health services was considered as a critical input that would minimize availment of health benefits.

5. Perceptions on Industry Prospects

Key informants in the sample companies were asked to give their opinion regarding the prospects for growth and development of their respective health insurance operations.

Firstly, the respondents were requested to give an estimate of the minimum capital requirement to run a health insurance plan. In this regard, no generalization could be drawn as responses varied greatly since they were based on their experiences in operating their respective health plans.

Some trends could be drawn, however, with regard to the factors or conditions which the respondents believed to have affected the growth of a health plan. Among the commercial indemnity firms and HMOs, economic progress ranked as the most important factor that affect the growth and development of health plans, mainly because it could redound to increased household income which, in turn, will enable more Filipinos to afford insurance. Several respondents admitted that insurance, in general, is still a luxury. One respondent cited a different reason for ranking economic progress as number 1 factor. He said it result in more pollution which affects the health conditions of the people and them seek financial protection in the form of health insurance.

Household income, education and government incentives ranked second, and third, respectively, as the most important conditions to ensure growth of the insurance industry. It was opined that when more people are able to afford an insurance coverage, educating them on the importance of enrolling in a health plan becomes a major condition for success.

Other important positive factors cited by the respondents of the commercial indemnity firms and HMOs were: (i) the good relationship with brokers since they take charge of marketing; (ii) the effectiveness of the marketing strategies themselves; (iii) regulation of premium such that they are affordable to more people; (iv) fast settlement of claims; and, (v) good track record of the company.

Specific to HMOs, other factors mentioned were: (i) the quality of services; (ii) adequacy of the facilities; and (iii) the cooperation between the hospitals and physicians.

The respondents of the sample companies with employer-provided health benefits cited a different set of factors that promote the development of their health plans. This includes: (i) the worker's pressure or demand for more health benefits; (ii) the owner's enlightened view of health benefits; (iii) the relationship between the employee and employer; (iv) good controls; (v) more information on the preventive aspects of health; and (vi) the vices of the employees without which they will not get sick and will have no need for health plans.

Some of the companies with employer-provided health benefits refused to venture an opinion with regard the prospects for growth of their health plans since this was not their principal product.

Among the community-based organizations, a different set of factors were mentioned as affecting the development of their health plans. Though these factors were also ranked by order of importance, it was not possible to give an overall ranking due to the variety of responses. It was noted that most of the responses were related to the overall development and not just to the health conditions of the community. These include the following responses: (i) security of land tenure with which the community members will be able to afford the required contribution for the health plan; (ii) availability of water since this will mean better health conditions for the community members hence there is no need for health plans; (iii) peace and order situation; and (iv) adequacy of transportation which means accessibility to health services and facilities.

Other factors cited focused on the characteristics of the community organization itself such as: (i) level of organization of the community since team work and community cohesiveness are important conditions to sustain community projects such as health cooperatives; (ii) quality of training or orientation of community members on health plans; (iii) close follow-up by organizers or community health workers or skills of persons-in charge; and (iv) women's development since they tend to be more effective and committed leaders.

Of course, there were also factors which were attributable to the health sector characteristics in particular, such as: (i) value on health; (ii) effectiveness of preventive measures; (iii) coordination among health agencies; and (iv) demonstrated effectiveness of health plans.

Most of the identified needs and/or problems confronting the commercial community firms and HMOs were conditions attributable to the industry. These problems include: (i) the cut-throat competition among the companies such that agents do not anymore comply with the guidelines of the Philippine Insurance Code; (ii) stringent government restrictions on health plans; (iii) need to

strengthen the association of HMOs; and (iv) need for unified pricing and other standards among the HMOs.

Other problems were internal to the company such as: (i) delayed payment of claims; (ii) need for more vigorous marketing strategies; (iii) high fees of fixers; (iv) lack of computers that hamper data management and analysis of trends that are basis for initiating improvements; (v) lack of personnel; and (vi) lack of qualified hospitals outside of Metro Manila.

The rest of the identified problems were attributed to the people's characteristics, such as: (i) lack of appreciation of the importance of health plans; (ii) inadequate income; and (iii) fraudulent claims.

From the side of the members, majority of 128 sample-enrollees (68 per cent) encountered some problems with their health plan. Of those who cited some problems, the most frequently mentioned were as follows: (i) benefits were deemed too low or too little considering the current high cost of medical services; (ii) clinic hours of doctors coincide with working hours thus, making it difficult for members to go for non-emergency consultation; and, (iii) long period of, and unclear procedures for, processing of claims/reimbursement of payments; (iv) inadequate facilities; and (v) negative attitudes of insurance personnel/service providers.

Notwithstanding these problems, the sample HMOs plan to expand their health plans in terms of more target members; wider geographical coverage and additional health benefits. In the case of the commercial indemnity health insurance, the expansion of the health plans is contingent on the expansion of their principal insurance plan. Several respondents also expressed reservations about expanding their health plans because they did not want to compete with the HMOs and they considered health plans to be of greater risk than life and/or non-life insurance plans.

Most of the commercial indemnity firms and HMOs recognize the important role of the government as a regulatory body particularly responsible for licensing of firms, monitoring of financial status, and ensuring the enforcement of the Insurance Code. They also believed that the government should regulate the premiums, professional fees and capitalization of health insurance firms.

Aside from assuming regulatory functions, the respondents see the government's role as that of arbiter in the settlement of complaints filed by the members against the companies. Furthermore, it was recognized that the government plays a major role in providing incentives to boost the development of the industry through such measures as: (i) allowing duty-free importation of essential medical equipment; (ii) exempting the service providers from payment of contractors' fee and VAT; (iii) issuance of a legislation that will allow payment of health plans/insurance as tax deductible; (iv) requiring the government and private employees to enroll in HMOs; and (v) conducting educational campaign on the importance of health insurance.

In the case of the community-based organizations, they cited the lack of health facilities as their most serious problem. One community-based organization which provides low-cost drugs and medicines faced problems owing to the conflicting program orientation where other non-government organizations operating in the area give health services on dole-out basis thereby making it difficult to convince the members to make a financial contribution. The same community-based organization experienced problems related to the some members' preference for drugs with brand names rather than generic names.

There were no concrete plans for the expansion of community-based and employer-provided health benefits since these are subject to negotiation with

the community members and employees. In some cases, NGOs are deferring decision until the plans have been evaluated for financial viability.

Nevertheless, the following were the recommended support that may be given by the government: (i) establishment of hospital-based drug cooperative where low-income groups can avail of low-cost medicines that are not available in community-based drug cooperative; (ii) technical assistance or training on health; (iii) grants; (iv) increased assistance for income-generating projects to sustain the health plans; and (v) continuing support for preventive health measures.

From the point of view of the members, future plans meant one or more of the following: (i) continuing with the present health plan; (ii) upgrading health plan; (iii) changing insurance company; or (iv) discontinuing their health plan. Majority (73 %) of respondents expressed desire to continue with their current health plan. A major reason given for keeping with the current health plan was affordability. They believed that it may be financially difficult for them to get another plan.

About 2 per cent indicated a desire to upgrade their coverage in the same insurance institution. Meanwhile 10 per cent also expressed a desire to upgrade their health plan but with other health insurance organization/company. Another 3 per cent indicated a desire to get another plan with other insurance company but did not state whether it would be with the same level of coverage or higher package.

VIII. CONCLUSIONS AND RECOMMENDATIONS

Notwithstanding the inadequacy or unavailability of some critical data/information, preliminary conclusions can be drawn on the potentials of the private insurance as a source of health care financing. Since each category of health insurance has unique features and characteristics which determine their broader potentials as sources of health care financing, they will be assessed separately.

A. Market Potentials of Various Types of Health Insurance

1. Commercial Indemnity Insurance and HMOs

The results of the study confirmed an earlier hypothesis that commercial indemnity firms and HMOs tend to cater to the urban employed as indicated by the firms' preference for group accounts. This is understandable since these types of insurance require regularity of income. Also, because of their fairly high premium, they tend to cover the high-income population. In addition, they also seem to be preferred by those with higher education.

On the premise that commercial indemnity insurance and HMOs are more appropriate for those regularly employed in the formal sector, and further considering that they may be affordable and marketable mainly among those earning about P60,000.00 and above per annum and those with fairly high levels of education, then it is reasonable to conclude that these types of health insurance are a fairly constricted market. Using 1988 data on family income and expenditures as indicative figures, probably only about 10% of the population can really afford to voluntarily enroll in commercial indemnity insurance and

HMOs. This means that a maximum of little over 6 million Filipinos could potentially enroll in commercial indemnity insurance and HMOs.

2. Employer-Provided Health Benefits

Although the employer-provided health benefits are likewise restricted to those who are regularly employed, their potential market includes the low-income employees and, in most cases, the dependents of these employees. Using 1991 employment data, about 22.9 million employed Filipinos could potentially benefit from employer-provided health benefits. Assuming further that, on average, one dependent per employee may be covered by the health plan, about 45.8 million Filipinos could be potentially reached through employer-based financing schemes. Within the employed population, the over 864,000 members of labor unions have better chances of obtaining employer-provided health plans through collective bargaining agreements.

3. Community-Based Health Care Financing Schemes

Community-based health care financing are the most likely form of health insurance available for organized low-income families. As shown by the study, most community-based health care financing plans were initiated by community organizations side by side with income generating projects (IGP). The IGP component is essential as a means of ensuring an income source for community members so that they can afford to pay modest premium costs. It is, however, difficult to estimate the probable size of the population representing organized communities as there are no data on the number of existing community organizations. As regards cooperatives, the Cooperatives Development Authority records show that there were 24,193 cooperatives as of June 30, 1993, but no data are available on the number of members.

The present administration promotes the organization of low-income groups in line with its thrust of people empowerment. Using the 1988 data on income and expenditure as an indicative figure, there are 5.3 million families whose income fell below the poverty threshold. Assuming that these families could be organized, community-based health care financing scheme in accordance with their local conditions could be anchored on such organization. The intensive community organization inputs for such an endeavor, however, makes the expansion of community-based financing schemes a slow and painstaking process.

B. Potentials for Generating Fund for Health Care

1. Commercial Indemnity Insurance and HMOs

Commercial indemnity firms and HMOs generate funds from the premiums paid by the policy holders. Given their current expenditure patterns, it can be reasonably assumed that only 40% - 50% of the premiums collected are actually available for health services. If the maximum potential clients of 6 million Filipinos opt to enroll in a health plan offered as principal product whose annual premium is at least P1,000, then these health insurance firms could generate funds for health care ranging from P2.4 billion to P3 billion per annum. Other health plans offered as riders to other forms of insurance could generate additional resources, even if they charge only at least P6.00 per annum per unit of insurance.

2. Employer-Provided Health Benefits

Financing for employer-provided health benefits are usually sourced from company appropriations and, in some companies, employees' counterpart contribution. Of the 9 sample companies providing health benefits to their employees, the lowest-cost allocation per year per member amounted to P240.00. If the same amount is applied to each of the 22.9 million employed Filipinos, the total health care funds that could be generated would amount to P5.496 billion.

3. Community-Based Health Care Financing Schemes

Financing for community-based health insurance schemes usually comes from the members' contribution or from a fixed percentage share of the profit from income generating projects set aside as health funds. Members' contributions for community health funds covered by the study ranged from P20.00 to P100.00 per year per family. Assuming that all of the estimated 5.3 million low-income families could be organized and would agree to contribute or set aside the same amounts, an estimated P106 million to P530 million could be generated as community-based health care funds.

If each category of health insurance could reach its projected maximum outreach potential, an estimated 20 percent of the population will still not be covered by any health insurance scheme. These could be targeted for government subsidy, either through direct health care premium or through premium subsidy.

C. Potentials for Providing Adequate/Appropriate Health Care

1. Commercial Indemnity Insurance and HMOs

Commercial indemnity firms and HMOs often have a uniform set of policies that define not only the amount and types of services offered but also the specific conditions covered for health benefits. The findings of the study supported another earlier hypothesis that the policies set by commercial indemnity firms excludes from coverage a sizeable segment of the population, namely: (i) the disabled; (ii) the senior citizens; (iii) those who are irregularly employed and/or employed in high-risk occupations; and, (iv) those who have pre-existing illnesses. Health plans offered by the commercial indemnity firms and HMOs often put more emphasis on high-cost, technologically-advanced care which, ironically, also makes the health plan more attractive to its potential clients. Benefits offered tend to be anchored on the use of modern medical technology, with physicians as the main provider of care.

On the other hand, the study also showed that HMOs do promote preventive health care by offering coverage for annual check-up, while some already go into limited health information.

2. Employer-Provided Health Benefits

Most of the employer-provided health plans are offered in the form of both ~~cash~~ services and cash reimbursement for medical expenses. The employees are ~~generally~~ not required to avail of services only from accredited providers.

Moreover, the employer-provided health benefits are more flexible in service coverage with most of the sample companies offering a comprehensive set of medical services that include in-patient and out-patient services, dental, rehabilitation and maternity services. They are also often less stringent, particularly in providing coverage for pre-existing illnesses or other conditions normally excluded by HMOs and commercial indemnity health insurance.

The employer-provided health benefits emphasizes primary clinical care through its in-house medical staff and clinic. In providing in-house health care, the companies are more likely to maximize the use of health paraprofessionals such as midwives and nurses as primary care providers.

3. Community-Based Health Care Financing Schemes

With lower-cost premium contributions, the community-based health plans also offer lower-cost benefits. As a supplementary measure, the community-based health schemes often promote the use of alternative health procedures and traditional medicines. Moreover, the community organizations often maximize the use of health paraprofessionals such as midwives and trained barangay health workers as primary care provider. All these are consistent with the operationalization of the primary health care approach which emphasizes preventive and promotive health care through organized effort. Many community-based health insurance schemes are, however, unable to provide coverage for expensive hospitalization.

D. Potentials for Containing Costs of Medical Care

1. Commercial Indemnity and HMOs

By all indications, the commercial indemnity firms have very well-defined system of cost-containment which consist of benefit ceilings and guidelines on who and what are excluded from coverage. As previously mentioned, the same exclusions and limits often inhibit a significant segment of the population particularly the high-risk groups from enrolling since most of them suffer from the illnesses or conditions that are not covered. Again, these findings, support the earlier hypothesis that the commercial indemnity firms have to strike a balance between ensuring cost-containment and providing quality health care services.

The HMOs have similarly prescribed ceilings and exclusions as their primary form of cost containment. Moreover, the HMOs have standard requirements and procedures for accrediting service providers from whom the members are, in turn, required to avail of services. Availment of services is itself subject to the review of the primary medical service unit such that unnecessary health care is avoided or minimized. The HMOs have also effectively imposed standard rates of services including the professional fees, though this is a major cause of physician dissatisfaction. Should such dissatisfaction pervade, the quality of services may suffer. Some members have, in fact, already related bad experiences with how they were treated by HMO physicians.

2. Employer-Provided Health Benefits

As previously mentioned, the employer-provided health benefits were found to be generally less restrictive. Notwithstanding the minimal limits or exclusions, the employees seemed less likely to abuse or misuse the health benefits. This may be partly attributed to the fact that the health plans were based on mutual agreement between management and the employees. Moreover, the more intimate relationship between company management or personnel administration and their employees serve as a check against abuses thus, mitigating the need to be very strict about coverage or benefits. Besides, most employees went through rigid health screening procedures prior to employment, hence, there is less likelihood for adverse selection.

3. Community-Based Health Financing Schemes

Expectedly, the process of organizing community-based health schemes imbues a sense of cooperation among its members which prevent abuse or misuse of benefits. The mutual cooperation and trust among the members serve as a self-imposed cost-containment measure.

E. Constraining Factors to Expansion of Services

1. Commercial Indemnity and HMOs

The expansion of commercial indemnity firm and HMO coverage is restricted by the cost of the premiums, which is often prohibitive for the low-income groups. Furthermore, the highly centralized system of operations often results in prolonged processing of applications and claims which could discourage enrollment in the outlying areas. The required minimum capitalization of P1 million to start-up a similar health insurance appear to be prohibitive as well. In terms of geographical coverage, the expansion of commercial indemnity firms and HMOs are restricted by the absence of suitable hospitals in suburban and rural areas.

2. Employer-Provided Health Benefits

The expansion of employer-provided health benefits is greatly dependent on the employer's magnanimity, on one hand, and the employees' insistent demand for benefits; on the other. Corollary to this, the expansion or sustainability of the health benefits may be constrained by management-union conflicts and tensions. The expansion of health benefits is also dependent on the overall profitability of the business. Increased company profits would create a more positive environment for expansion of health benefits while low revenues may result in reduction or stoppage of such health benefits.

3. Community-Based Health Financing Schemes

The development of community-based health care financing requires intensive community-organizing inputs. Among others, the organizing process would set in place a very flexible organizational/management operating systems that are

responsive to the local conditions. In other words, there can be no single formula for the organization of community-based health care financing that may facilitate expansion of coverage to other areas. As in other area-based initiatives, community-based health care financing have limited potentials for achieving economies of scale.

F. Required Support to Expand Market Coverage

1. Commercial Indemnity and HMOs

Admittedly, the expansion of coverage of commercial indemnity firms and HMOs is dependent on the improvements in the national economy that would translate into higher family income thereby increasing the potential demand for health insurance. Improvements in the management infrastructure for collection, especially the transportation and communication systems could enhance the development of HMOs and commercial indemnity health insurance. Electronic data management would greatly facilitate the processing of applications and of claims. A more critical support to enhance the expansion of coverage of commercial indemnity and HMOs is the setting-up of quality hospitals in outlying areas.

2. Employer-Provided Health Benefits

Support for expansion of employer-provided health benefits may be provided through clear policy directions as well as information on various options for employers to initiate their respective health insurance schemes. At the same time, the employers who provide health insurance to their employees could be given incentives either in the form of direct assistance or tax incentives. More importantly, there is a need to create a supportive business environment that will ensure increased revenues that would go into provision of health insurance.

3. Community-Based Health Financing Schemes

On their part, the low-income groups need organizational development support and, eventually, technical assistance to start up a community-based health care financing. Since community-based health schemes are closely tied-up with income-generating projects, the community organizations may also need funding and technical support for this purpose.

G. Recommendations/Options for Government Interventions

The government could assume a significant role in maximizing the potentials of the private health insurance as a source of health care financing either by creating a supportive environment for business development or by directly providing incentives/support for health insurance development.

The incentives for business development include instituting improvements in the infrastructure for telecommunications. This will minimize delays in processing of documents/papers and facilitate field-level decision-making without having to forego with essential control measures from the head offices of commercial indemnity firms and HMOs. At the same time, improved communication facilities would enhance the retrieval and management of data that serve as

critical basis for planning or policy formulation. Secondly, there is a need to promote low-cost technologies that would minimize occupational hazards so that more workers qualify for health insurance. Ultimately, economic progress would enable a larger segment of the population to enroll in health insurance.

Incentives or support for the health insurance development could include intensification of the government's public education, advocacy, or information dissemination on the importance of health insurance. Similarly, the government could play an important role in disseminating information on various innovative community-based schemes particularly in areas where there are already well-organized groups.

In addition, the government could exempt health insurance from premium taxes or offer tax credits for family expenditure in buying or enrolling in health insurance. The government may also provide technical assistance in training managerial and technical support staff to promote efficient/ effective health insurance management. This will ensure a balance between the efforts for cost-containment and ensuring adequate/appropriate health care particularly among the insurance firms with no medical staff.

In areas where there is lack of qualified private hospitals, the government may explore the possibility of a tie-up between the public tertiary hospitals and private insurance firm for some form of health maintenance plan. The public hospital would gain added revenues from the pre-payment of the employers. Government support may also be needed to promote income-generating projects along with community-health schemes to improve the financial viability of community health insurance. Public hospitals can also support community-based health schemes in their respective areas by providing referral services that are affordable to the community insurance organizations.

The government may also encourage private employers to administer health insurance programs for their employees and their dependents as alternatives to Medicare I or II. Employers offering better health care program benefits than Medicare may be asked to manage their own Medicare programs and asked to extend benefits to employees' dependents or other relatives through a companion health plan with its own premium-benefits structure.

Lastly, the government may develop a suitable regulatory scheme to protect the public from undesirable practices of profit-oriented companies and promote the image of the health insurance industry as a legitimate business offering essential public services. The preferred government regulatory body by most insurance firms is the Department of Health. Quite a number of firms, however, expressed preference for self-regulation by a professional association of health insurance-related institutions.

References

Abel-Smith, Brian. Funding Health for All - Is Insurance the Answer? In World Health Forum, 1986, Vol. 7.

Abel-Smith, Brian. Paying for Health for All. In World Health Journal, May 1986.

Abel-Smith, Brian. World Trends in Health Care Financing and Delivery. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

Akin, John S. Health Insurance in the Developing Countries: Prospects for Risk-sharing. Resource paper for the Regional Seminar on Health Care Financing held in Manila from 27 July - 3 August 1987, under the sponsorship of the Asian Development Bank, Economic Development Institute of the World Bank and the East-West Population Institute of the East-West Center.

Alfiler, Ma. Concepcion. 1982. Comparative Case Studies of Community-Based Projects in Health and Family Planning: An Integrating Report. Paper prepared for the Population Center Foundation.

Alfiler, Ma. Concepcion. 1989. HMO as an Alternative Mode of Financing and Delivering Care in the Philippines: Some Preliminary Findings. Paper prepared for the Philippine Institute for Development Studies.

Alfiler, Ma. Concepcion. 1986. Partnership and Responsibility in Financing Health Activities: Non-Government and Private Voluntary Organizations in the Philippines. Paper prepared for the World Health Organization as background document for the Technical Discussions, Fortieth World Assembly, 30 September 1986.

Alfiler, Ma. Concepcion. 1986. Prepaid, Managed Health Care: The Emergence of HMOs as Alternative Financing Schemes in the Philippines. Paper prepared for the Philippine Institute for Development Studies.

Alternative Health Delivery Systems: Can They Serve The Public Interest in Third World Settings? Occasional papers sponsored by the National Council for International Health, the Cooperative League of the U.S.A. and the Group Health Association of America, Inc. Washington, D.C., August 1984.

Asian Development Bank (ADB). Health Care Financing: Summary of Proceedings of the Regional Seminar on Health Care Financing held in Manila, July 27-August 3, 1987.

Bautista, Victoria. 1988. How Effective is the Primary Health Care Strategy. College of Public Administration.

Burns, Guy. Community Financing of Health Care. In World Health Forum, 1988, (14) 30-31.

Chavez, L., et.al. Integration, Participation and Effectiveness: An Analysis of the Operations and Effects of Five Rural Health Delivery Mechanisms. Manila: [Redacted] Printing Company, Inc., 1985.

[Redacted], et.al. Policy Directions for Health in the 1980's. In Philippine Journal of Public Administration, April 1981, 25(2).

[Redacted], et.al. Primary Health Care: A Continuing Challenge. Thailand: [Redacted] Training Center for Primary Health Care Development, 1987.

Chiang, Tung-Liang. A Critical Assessment of Health Care Financing in the Republic of China. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

Cost and Cure. In Manila Chronicle, 11-17 January 1992.

De Ferranti, D. 1985. Paying for Health Services in Developing Countries.

Department of Finance and Insurance Commission, R.P. Key Data: Insurance Industry, 1985-1989.

Department of Health, R.P. and German Agency for Technical Cooperation. 1991. An Information System on Innovations in Health Care Management: Introduction and Documentation.

Dorros, S. Initiating Popular Participation at the Barangay Level: A Case Study of the Community Health Project at Carigara. In Philippine Journal of Public Administration, January 1980, 24(1).

Djukanovic, V. and E.P. Mach. Alternative Approaches to Meeting Basic Health Needs in Developing Countries. Geneva: World Health Organization, 1975.

Evans, Robert G. The Canadian Health Care System: The Other Part of North America is Rather Different. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

Executive Summaries of Life Insurance Researches. In Insurance Institute for Asia and the Pacific Journal, 1st. Quarter 1990, 7(1).

Fry, J and J. Hasler. Primary Health Care 2000. New York: Churchill Livingstone, 1986.

Gamboa, Rhais M. 1991. Background Paper on Health Insurance in the Philippines. Report prepared for the United States Agency for International Development.

Graf, J. Matthias. The West German Health Care Financing and Delivery System: Its Experiences and Lessons for Other Nations. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

Health Care Program. An unpublished masteral thesis. University of the Philippines.

Health Care - Who Pays. Reprinted from World Health Forum in support of the Technical Discussions, Fortieth World Health Assembly, May 1987.

Health Education and Welfare Specialists, Inc. (HEWSPECS) and Intercare Research Foundation, Inc. (INTERCARE). 1990. Final Report on the Pilot HMO Project. Report prepared for the Philippine Council for Health Research and Development and the United States Agency for International Development.

Johnson, Gail E. and M.S. Cohen. Health Care in the People's Republic of China: A View from Inside the System. In American Journal of Public Health, September 1982, 72(11).

Ortiz, Alejandro N. Assessment of Population, Health and Education Policies in the Philippines, 1986-1988. PIDS Working Paper Series # 90-10.

Robinson, James and E. Sussman. Medicaid Prepayment: Concept and Implementation. Milbank Memorial Fund Quarterly, Health and Society, Fall 1974, 52(4).

Huebner, S.S. and K. Black, Jr. Life Insurance, 8th. edition. New Jersey: Prentice-Hall, Inc., 1976.

Ikegami, Naoki. The Japanese Health Care Financing and Delivery System: Its Experiences and Lessons for Other Nations. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

INTERCARE, Inc. 1987. Health Care Financing in the Philippines: A Country study. Report prepared for the Asian Development Bank.

Joves, L. and L. Cariño. 1980. A Compendium of Existing Mechanisms for Meeting Health Needs in the Philippines.

Kark, Sidney. The Practice of Community-Oriented Primary Health Care. New York: Appleton-Century-Crofts, 1981.

Kloman, H. Felix. Current Comment. In Insurance Institute for Asia and the Pacific, 4th. Quarter, 1987. 4(4).

Laaser, U., et.al.. Primary Health Care in the Making. Germany: Springer-Verlag, 1985.

Lin, Che. International Trends in Health Insurance. In Insurance Institute for Asia and the Pacific Journal, 4th. Quarter, 1989, 6(4).

Lingap Para Sa Kalusugan ng Sambayanan (LIKAS). 1990. Terminal Report on the Cooperative Rice Mill Stores for Community-Based People's Health Programs. Paper prepared for the Seminar on Health Care Financing Schemes held in Manila, 23 November 1990, under the sponsorship of the Philippine Council for Health Research and Development.

Maayo, Geraldine. 1983. Citizen Participation and the Delivery of Health Services. An unpublished masteral thesis. University of the Philippines.

Mehr, Robert. Principles of Insurance. Illinois: Richard D. Irwin, Inc., 1978.

Ministry of Health, R.P. Primer on Primary Health Care. Manila: Ministry of Health, 1980.

Outreville, J. Francois. Insurance Development, Economic Development and the Negotiations on Trade in Insurance Services. In Insurance Institute for Asia and the Pacific Journal, 3rd. Quarter 1990, 7(3).

Preffer, Irving and D.R. Klock. 1974. Perspectives on Insurance.

Risazo, Oscar F. Issues and Initiatives in Health Care. In PIDS Development Research News, March-April 1990, 8(2).

Schhardt, Uwe E. The U.S. Health Care Financing and Delivery System: Its Experience and Lessons for Other Nations. Paper prepared for the International Symposium on Health Care Systems held in Taipei, 18-19 December 1989.

Sriviveda, C. and N. Mehta. Community and Health: An Inquiry into Primary Health Care in Asia. Bangkok: United Nations Asian and Pacific Development Institute, 1980.

Wright, Amaryllis. 1985. Documentation of Specific Area Experiences in Primary Health Care. Report prepared for the Population Center Foundation.

[The] Trend of Mortality Rates of Insured Lives in the Philippines. In Insurance Institute for Asia and the Pacific Journal, 4th. Quarter, 1989, 6(4).

United States Agency for International Development. Primary Health Care Financing Project. A project agreement document.

Wilson, Ronald. International Workshop Towards More Effective Use of Primary Health Care Technologies at the Family and Community Levels. Geneva: Aga Khan Foundation, 1986.

World Bank. Korea: Health Insurance and the Health Sector. Report No. 7412-KO.

World Health Organization. 1978. Financing of Health Services.

WHO and UNICEF. 1978. Primary Health Care: Report of the International Conference on Primary Health Care. Geneva and New York: WHO and UNICEF.

WHO and UNICEF. 1978. Final Report of the International Conference on Primary Health Care. Geneva and New York: WHO and UNICEF.

PART II

CASE REPORTS

Case Report No. 1: Domestic Non-life Insurance Firm
Reference Company No. 1
Area(s) Studied: NCR

A. IDENTIFICATION

The company was established in 1965, assumed a new corporate name in 1975, and adopted its present corporate name in 1985. Though it assumed 3 different corporate names in less than 3 decades, its principal product remains to be non-life insurance. Of Filipino nationality, its operations are limited to the NCR.

B. HEALTH PLANS AND BENEFITS

The company currently offers two basic health plans, namely ID-A and ID-B. Both plans offer similar benefits, but differ in premium cost and benefit ceilings. The general features of both plans are briefly described below:

- a. Death, Dismemberment or Loss of Sight. Pays full amount of principal sum, for accidental death or loss of both hands, both feet, sight of both eyes or any two members, hearing or speech. Pays one-half of the principal sum for accidental loss of one hand, one foot or sight of one eye. Pays ten per cent (10%) of the principal sum for loss of thumb and index finger of one hand. (losses must occur within 180 days from the date of accident).
- b. Permanent Total Disability Indemnity. If, because of injury commencing within 180 days from the date of the accident, the insured is totally and permanently disabled and prevented from engaging in any occupation for wage or profit for which he is reasonably qualified, the company will pay the principal sum less any amount already paid or payable under the principal sum as a result of the same accident at a rate of 1% per month for 100 months, provided the disability has continued for 12 consecutive months and is total, continuous and permanent at the end of the period.
- c. Weekly Indemnity (optional). Pays the amount selected up to 52 weeks in the event of total disability commencing within 90 days from date of accident.
- d. Medical Reimbursement (optional). Pays the actual cost up to the amount selected for medical or surgical treatment including trained nurses and hospitalization incurred within 52 weeks from the date of accident resulting from injuries sustained.

For both plans, the required age limit is 16-60 years old. They cover against losses resulting directly, and independently of all other causes, from accidental bodily injuries including drowning, dog bites, snake bites and traffic accidents.

The insured policy holders are categorized as follows:

1. **Class A:** Non-hazardous office and executive personnel whose duties are confined only to office work and travelling;
2. **Class B:** Occupation involving limited manual labor not using machinery;
3. **Class C:** Industrial workers most of whom are skilled or semi-skilled workers, using machinery; and
4. **Class D:** Industrial workers using heavy machinery.

The annual premium per person for medical Plan ID-A is P11.80 for class A; P15.30 for B; P25.80 for C; P32.80 for D. The annual premium per person for Plan ID-B are slightly lower at P9.20 for Class A; P12.70 for B; P23.70 for C; and P30.20 for D.

As a general policy, the stipulated amount of benefits applicable to both plans are guided by the following:

- a. Principal sum benefit: Minimum - P10,000; maximum - 10 times annual income.
- b. Weekly indemnity - limited to a maximum of P5.00 for each P1,000 principal sum or 75% of the proposers weekly income whichever is lesser but not to exceed P1,000 for a maximum period of 52 weeks.
- c. Medical Reimbursement - The reimbursable amount for medical treatment vary according to the premium with the minimum being P500.00 and the maximum being 10% of the principal sum but not to exceed P100,000.00.

The amount of premium payment per plan and benefits were determined based on actuarial computations. Conditions which are excluded from coverage are as follows:

- a. Conditions existing prior to membership/enrollment;
- b. Conditions which are not work-related;
- c. Conditions arising from acts which are not sanctioned by society like STDs including AIDS, suicide, substance abuse, conditions arising from acts of war/riots, etc.;
- d. Mental or nervous disorders;
- e. Pregnancy, childbirth, miscarriage, abortion and their complications;
- f. Congenital deformities and defects, cosmetic and plastic surgery;
- g. Routine physical check-up and rest cures;
- h. Conditions which are recurrent in nature or require prolonged treatment;
- i. Conditions/diseases requiring isolation as per DOH policy like leprosy, cholera, etc.;
- j. Conditions without known cure;
- k. Conditions resulting from hunting, mountaineering, any form of racing, landslide or cave-in of mines, operating/learning to operate or serving as a crew member of aircraft or vessel, operating or riding in a motorized two-wheeled vehicle with or without side-car, earthquake, tidal waves, volcanic eruptions, and mosquito bites.

The company does not require accreditation of health providers. Policy holders can go to any licensed hospital, clinic, or doctor of their choice.

PROFILE OF MEMBERS/ENROLLEES

In the first quarter of 1991, a total of 36 policy holders were listed as insured for personal accident benefits. Of these, 23 were classified as

corporate/group and 13 as individuals. No data were, however, available on the characteristics of beneficiaries, hence no profile could be made.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Neither were there data available on the benefit utilization patterns by members.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment of Members

The company's main marketing strategy is through direct sales. Sales force is composed of 6 individual agents and 2 insurance brokers. Both types of sales force are compensated by commission amounting to 30% of total premium per policy.

Aside from the previously mentioned age limit and conditions of exclusions, status of employment of the insured is also considered as a criteria for accepting applicants for insurance. If the insured comes within the standard range, he is accepted as policy holder. If not, then his application is rejected.

2. Premium Collection

Premiums are paid regularly to the company through individual agents who also act as collectors.

3. Payment of Claims

Benefits are extended to the insured or policy holder after all claims requirements have been completed or satisfied. Claims requirements include notice of claims, accident report, doctors certificate, official receipts of drugs/medicines prescribed, hospitalization and laboratory diagnosis, and statement of accounts.

The review/assessment of the claims focuses on the following:

- a. Medical review to determine the appropriateness of service provided or amount of benefits availed.
- b. Financial review to determine the application of benefit ceilings or standard cost.
- c. Accounting review to determine veracity of receipts.
- d. Validity checks to safeguard against possible abuses like submission of false receipts or statement of accounts.

All the above documents are forwarded to the company for processing and eventual payment of claims to the claimant. On average, claims are processed and paid within 21 days. The shortest claims processing time is 14 days while the longest is more than 30 days.

COST CONTAINMENT MEASURES AND MECHANISMS

As with most health insurance operations, cost-containment measures include: (i) pre-membership screening to weed out high risk clients; and (ii)

controls on utilization through careful review/assessment of claims and exclusion of high risk/high cost services from benefit coverage.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Policy holders with premium amounting to P500,000 and above are qualified for reinsurance. At the time of this study only 1 policyholder is recorded as having been reinsured.

No information was given on the nature and proceeds from reinsurance. Likewise, there were no data on marketing and administration costs, premium collections, total claims filed and paid. In the absence of data, it is difficult to assess the performance and financial status of the company.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Respondents estimated that the start-up capital needed to set up a health insurance business is around P2,000,000. As a minimum, an insurance firm should hire at least 3 office personnel including 1 Manager, 1 Cashier and 1 typist. Tables and chairs, and at least 1 typewriter, 1 telephone and 1 calculator are also needed as initial equipment.

Economic progress, household income and employment, education and government incentives were identified as factors and conditions that affect the growth and development of health insurance operations.

Economic progress was considered the most important factor because this brings about industrialization which generally leads to improved income and increased environmental health hazards which often compel people to seek protection for themselves. HMOs are considered the most appropriate means of obtaining health services and financial protection from the adverse cost of illness.

Competition and government controls on the plans offered were considered to be the most serious problems facing health insurance operations. These problems were considered most unmanageable and possibly could be addressed through the following:

- a. Having plans cover all types of diseases including AIDS;
- b. Standardization of benefits, coverage and premium contribution.

As a means of promoting equity, the respondents suggested that government regulate the premium-benefit ratio so as to allow higher benefits but lower premiums for members from low income group.

Case Report No. 2: (Domestic Non-Life Insurance)

Reference Companies No. 2, 18, 24, 36 & 46

Area(s) Studied: NCR, Cagayan, Cebu, Misamis Oriental, Surigao del Norte

A. IDENTIFICATION

The Reference Company, which was established in 1930 with a start-up capital of P147,000, is now at the forefront of non-life insurance business in the Philippines. Filipino in nationality, it serves almost all key provinces, cities and municipalities in the country. The study covered the National Capital Region head office, and the branch offices at (i) Tuguegarao, Cagayan which covers Cagayan Valley and Kalinga Apayao; (ii) Cebu City which covers the whole Visayas and some provinces in Mindanao; (iii) Cagayan de Oro City which covers Mindanao; and (iv) Surigao City which covers Surigao del Norte.

B. HEALTH PLANS AND BENEFITS

The Reference Company, offers 6 principal plans covering personal accidents resulting in loss of life, death, permanent disablement or dismemberment.

The first four plans which give full medical and surgical benefits to the insured are Master Plan, Exeplan, Econoplan and Budget Plan. Premiums are based on: (i) the age of the insured, which ranges from 20 to 64 years old; (ii) amount of daily cash benefits selected among those offered by plans; and (iii) the type of enrollee, which is categorized as individual, spouse or family. The daily cash benefit options range from a minimum of P100.00 to a maximum of P1000.

The term of coverage is one year, starting at noon of the inception date, with benefits as follows:

- a. When, as a result of accidental injury or sickness, the insured is hospitalized and put under the continuous care of a currently licensed physician or surgeon, the Reference Company will pay the daily cash benefit as stated in their schedule up to a maximum of 365 days. The insured and spouse are entitled to 100% of above benefits, while children are entitled to 50%.
- b. When, as a result of accidental injury or sickness, the insured is confined in an Intensive Care Unit (ICU) and put under the continuous care of a currently licensed physician or surgeon, the Reference Company will pay double the daily cash benefit amount stated in their schedule up to a maximum of 30 days.

If the total number of days confined in ICU exceeds thirty (30) days, the insured will be paid the Daily Cash Benefit for the additional days of confinement. For instance, if Gerry was confined in ICU for 12 days in January, 14 days in April and 5 days in July, he will be paid the ICU benefit for 30 days of the 33 days he was confined, and the Daily Cash Benefit for the remaining 3 days.

The insured and his spouse are entitled to 100% of the above benefit, while the children are entitled to 50%.

Surgical benefit - If, as a result of the disease, the insured needs to be operated on by a duly licensed surgeon, the Reference Company will pay for the expenses incurred. However, the amount paid shall not exceed the maximum surgical benefit as stated in the schedule. In the schedule, different parts or organs of the body affected by sickness or accident are

assigned different percentage of maximum benefits. For instance, amputation of thigh, breast, removal of kidney and other vital parts get 100% surgical benefit; cutting of thoracic cavity, amputation of leg, entire foot, arm, etc. get 25% and puncture of antrum, cutting operation of eye on eyelid, etc. gets only 5%.

The fifth plan is called the "The Rajah", a personal accident insurance plan which covers employees of four occupational classifications as follows:

- a. Class I- non-hazardous office and executive personnel whose duties are office and travelling only.
- b. Class II- occupation involving limited manual labor (not using machinery).
- c. Class III- skilled or semi-skilled worker using light machinery.
- d. Class IV - industrial workers using heavy machinery or unskilled workers.

Annual premiums vary according to the class where the insured belongs. The term of coverage is one year with the following benefits:

- a. Accidental death - pays the whole sum for loss of life occurring within 12 months after the date of the accident.
- b. Permanent disablement or dismemberment - pays the principal sum in the case of permanent or total disability defined as being prevented permanently and totally from engaging in a reasonable occupation based on education, training or experience (monthly payment commences with the 13th month); percentages thereof for loss of feet, hands, fingers, thumbs, arms, leg(s), sight, hearing, and other injuries.
- c. Weekly indemnity - pays the weekly indemnity as stated in the schedule not to exceed 52 consecutive weeks when, by reason of injury, the insured is continuously disabled and prevented from performing each and every duty pertaining to his occupation and one third of the weekly indemnity if he can't perform at least one important duty.
- d. Medical reimbursement - pays the actual expenses incurred, but not to exceed the amount stated in the schedule when injury results in treatment by licensed qualified physician or surgeon, confinement in a hospital or employment of a licensed or private nurse.

The sixth plan is the Motor Vehicle Personal Accident Plan - This is intended primarily to insure against accidental death, dismemberment and loss of sight of all unnamed passengers of the insured vehicle including the driver, such that anyone, regardless of age and sex is covered.

Most vehicles used for private and commercial purposes are eligible for coverage except public utility vehicles. The benefits of the plan are as follows:

1. Death. Pays the capital sum insured, which ranges from a minimum of P10,000.00 to a maximum of P50,000.00.
2. Permanent disablement or dismemberment. Pays a pre-determined percentage of the capital sum insured. For instance, the loss of two limbs, both hands, or all fingers, and both thumbs, etc. are paid up to 100% of sum insured, while loss of other body parts or organs are paid from 10% to 70% of sum insured.

The first 4 plans do not cover those conditions normally excluded in other health plans and insurance. For "The Rajah" plan, exclusions include suicide, bacterial infection, certain murder and assault, war or organized hostilities, mountaineering, scuba diving, aerial sports, racing, mini cave-ins, etc. For plan six, excluded are vehicles classified as public utility vehicles, military vehicles, other law enforcement vehicles, those utilized for testing, racing, race-making, vehicles used in pursuance of felonious acts punishable by laws of the Philippines. This also includes some of the exclusions of the other 5 plans. It does not cover vehicles being operated in some areas of Mindanao, the Visayas and Luzon.

Exclusions are defined very clearly and, in most cases, followed very strictly because some conditions, even if efforts are done, could not be altered anymore. Other acts or situations are considered as too high-risk hence, including them for coverage will be extremely prejudicial to the insurance business. In essence, exclusions of whatever form is the most common cost-containment measure applied in the insurance industry.

The Reference Company has no facilities for direct health services. Neither does it accredit health providers like hospitals, clinics and doctors. Basically, the company requires appropriate licensing and credible track record of medical institutions, facilities and practitioners. The insured can, on his own free-will, go to any of these providers in case of sickness or accident. There are specific standard rates and ceilings for each plan as previously mentioned in the stipulated benefits. However, Medicare benefits, like in other insurance, are deducted first from the total reimbursement cost of hospitalization, including drugs and medicines, due the insured. This is in addition to the daily cash benefits corresponding to the number of days the insured was treated and confined at the hospital.

C. PROFILE OF MEMBERS/ENROLLEES

In all the areas/regions covered by this study, no data was given on total numbers of insured, except in NCR which had 157 policy holders during the fourth quarter of 1991. There were no breakdown of data by age, sex, marital status, residence and educational status. The NCR respondent said there were no data at the time of the survey.

D. SERVICE UTILIZATION PATTERN

Only NCR gave some data on hospital admissions in 1991. It recorded 31 cases, 21 of which were medical in nature; 9 were surgical and 1 was confined at intensive care unit. The 5 leading causes of hospitalization were: pneumonia, fever (typhoid/dengue), urinary tract infection, amoebiasis and gastro-enteritis. This comprised about 55% of the total hospital admitted cases. The average length of stay (LOS) was about 7 days. The shortest LOS was 1 day and the longest was 13 days. The total amount spent for hospitalization services was P98,390.00. The Company also paid a total of P56,400.00 for daily cash benefits.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

Looking back to its history, the company started with only 8 agents who slowly moved the Reference Company into the competitive world of insurance business. Today marketing is done primarily through 112 individual agents in 5 areas. Other marketing efforts are being done by 16 in-house staff and 8

insurance brokers.

The sales force is compensated either through commission of 20% per policy or through fixed salaries and other incentives. In some cases, those who reached the sales quota of P100,000.00 or above, are given a share of the profit of the company.

Members or insured clients are screened basically through the accomplished application forms. The applicant, if deemed necessary, may be required to undergo a physical examination before approval of his policy. If the applicant passed these basic requirements, then his application is accepted. The screening is intended to detect adverse selection and determine whether there are pre-existing illnesses which could be a basis for the rejection of the applicant.

2. Collection of Premium

Premiums are usually paid on an annual basis. Payments are generally done through salary deduction, or are collected by agents and collectors. Others may opt to voluntarily pay their dues at the office.

3. Claims Processing

Benefits are extended to the insured after the claims requirements have been fully satisfied. This involves filling up a claims reimbursement form and submitting all official receipts and hospital statements of accounts. In some cases, certifications from attending physicians and police reports are required.

All claims are routinely reviewed and assessed by a process which involves thorough medical review to determine appropriateness of service provided and the amount of benefits availed. Validity checks are also done to determine possible abuses like submission of false receipts or statement of accounts. The amount of time to process claims and effect payment to members is usually 3-4 days. The shortest processing time is 2 days and the longest is about 7 days.

F. COST CONTAINMENT MEASURES

Cost-containment measures usually undertaken by the company include the following:

- a. Screening for adverse selection through the use of application form;
- b. Application of exclusions and limits as stipulated in each plan; and
- c. Referral controls through agents and brokers.

Frauds and abuses are considered an industry hazard. The forms and ways of committing fraud are:

- a. Connivance between the insured and hospital/doctor for fictitious claims;
- b. Non-declaration of pre-existing illness;
- c. Alteration of receipts and falsification of other claim documents; and
- d. Fake accidents and suspicious death claims.

As a safeguard against the above abuses, the following measures have been instituted:

- a. Stringent review and assessment of claims;
- b. Conducting physical examination with necessary laboratory diagnosis;
- c. Reviewing medical certification of doctors, their prescriptions (specifying amount and type of medicines used);
- d. Verifying claims through proper interview of witnesses in case of

- accidents;
- e. Disallowing a portion of the claim which is considered anomalous; and
- f. Making surprise visits to hospitals.

The respondents feel that fraud may be completely eliminated if medical practitioners would uphold their integrity and honesty.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

The company does not re-insure its policy holders. Membership and premium trends are not defined as there are no time-series data available. There were 157 insured members in the beginning and end of 1991. In 1992, 138 were insured. The least cost premium was P498.96 per annum. The highest cost premium was P8,899.24 and the most popular premium ranged from P2,000 to P3,000.

In NCR, premium collected for 1990 was P279,196 with 6 claims filed, 100% of which were paid; in 1991, total collection was P490,433 with 37 claims filed and 31 claims fully paid representing a claims payment rate of 80.11%. As of June 1992, total collection was P204,166 with 11 claims filed, 100% of which were paid. No data were given on the amount of claims paid for the said three years.

Excess premiums are either added to profits, or added to reserve or invested as time deposits for securities/bonds, money market and stock.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Based on the respondents own experiences, the estimated minimum capitalization required to initiate health insurance operations is about P10 M to cover expenses needed to recruit and hire a complement of 60 personnel to perform marketing and management functions as well as meet the administrative and operating expenses of the company. Five sets each of computers, adding machines and typewriters are identified as necessary for the operation.

Considered to affect the growth and development of the industry are the following factors:

- a. Household income and employment;
- b. Economic progress;
- c. Education; and
- d. Government incentives.

Household income and employment were ranked as the leading factors affecting the growth of the insurance industry. To most of the country's population who comprise the lower income group, insurance is deemed a luxury rather than a necessity. Paying for an insurance means less money for food, clothing and other basic needs. Hence, if the income is improved, there will be corresponding increase in funds which might go to availment of insurance.

The most serious problems facing the industry today are fraudulent claims. They are solvable through educational campaign and value orientations to be conducted or implemented by both government and industry itself.

Additional government intervention is not considered necessary in establishing the industry. Instead, government should be more liberal and allow more parties to offer health benefits to the public to encourage healthy competition among industry peers.

Case Report No. 3: (Domestic Non-Life Insurance)
 Reference Company No. 17
 Area(s) Studied: Cagayan

A. IDENTIFICATION

The Reference Company started as a small non-life insurance company established on March 23, 1960. Today, it is a conglomerate which ranks among the top ten insurance groups in the country and is one of the fastest growing and biggest Filipino-owned insurance groups with a total combined resources of P300 million.

The original company was the first granted a composite license by the Insurance Commission to engage in both life and non-life insurance business. In view of this, its original name was changed to reflect its composite nature.

In 1987, the Reference Company became a conglomerate of three life and non-life insurance when it bought in two non-life insurance firms. The acquisition of these companies strengthened the operation of the Reference Company.

At present, the Reference Company is composed of 5 groups of companies engaged in various types of insurance operation.

The Reference Company's branch office in Tuguegarao, Cagayan was established in 1974. Its principal product was non-life insurance and bonds. The branch office covered all areas in Cagayan Valley.

B. HEALTH PLANS AND BENEFITS

The Company offers 4 types of personal accident insurance plans which include medical benefit provisions. These 4 plans are briefly described below:

1. The Group Student Personal Accident Insurance Plan (GSPA) is a comprehensive student plan that provides protection to students while travelling from home to school and back; while in regular attendance on school premises; while taking part in school sponsored activity or travelling to and from such activity as member of a group which is under school supervision. The following benefits are provided:

- a. Cash indemnity for accidental loss of life, dismemberment and loss of sight.
- b. Accidental medical expense benefit. The company will pay actual expenses incurred for treatment of accident related injuries, whether outpatient or in-patient, provided such expenses were incurred within 52 weeks from the date of the accident. Reimbursement is up to a maximum of P2,000.
- c. Burial assistance of P1,000 if the insured dies as a result of the accident, provided that the group's number of enrollees in the master policy is 500 or more.

Exclusions

The plan does not cover death or injuries resulting from bacterial infections, disease, suicide or self destruction, act of war or rebellion, murder and/or provoked or unprovoked assault or any attempt thereof.

2. The Keyman Personal Accident Insurance Plan is a personal accident

protection plan that covers a person while riding in any kind of conveyance used for land and sea travel or while riding as a passenger in any commercial airline.

Keyman offers two plans. Plan A covers accidental death and dismemberment and provoked or unprovoked murder. Plan B covers accidental death and dismemberment, provoked or unprovoked murder, and medical indemnity. The plan also offers optional coverage for the spouse and children.

Medical indemnity depends on amount of coverage. For Plan B, the amount of medical indemnity ranges from P20,000 to P50,000. For the optional coverage (wife only), medical indemnity ranges from P10,000 to P20,000.

3. The Motor Vehicle Passenger Accident Insurance Policy provides coverage for accidental death and dismemberment and medical expense benefit to all vehicle occupants (including the driver) of insured vehicles. Insurance coverage is extended on an unnamed driver/passenger seat basis. Only vehicles used for private or commercial purposes are qualified to insure under this policy. Benefits include the following:

- a. Accidental death and dismemberment benefits; and
- b. Accidental medical expense benefits. The company pays actual cost, up to the maximum benefit amount, for medical/hospital treatment provided such expenses are incurred within 52 weeks from the date of the accident. Amount of medical benefit depends upon coverage per plan. Plan I extends benefits up to P1,000 per occupant or seat; Plan II, P2,000 per occupant or seat; Plan III, P5,000 per occupant or seat.

Exclusions

The policy does not cover medical expenses incurred arising from bacterial infections and other diseases, suicide, and injuries arising out of war or rebellion. Only accident related injuries are covered.

4. Unlimited Personal Accident. Only males are eligible to enroll under this plan. The amount of medical benefits depends on the classification of occupation, and include the following:

- a. Death benefits;
- b. Permanent disability benefits;
- c. Temporary/partial disability benefit; and
- d. Medical expense benefit. Medical expenses can only be covered if sold with death and permanent disability benefits jointly. Medical reimbursement ranges from P100 to P1,000.

Exclusions

Only accident related injuries are covered.

Reference Company does not require accreditation of service providers. Insured members who need medical attention due to accident related injuries could go to any licensed hospital/doctor for treatment.

PROFILE OF MEMBERS

Like other insurance companies under this category, Reference Company did not have processed data on profile of members.

D. SERVICE UTILIZATION PATTERNS, BY MEMBERS

Since, the company covers only accident related injuries in all its plans; the leading cause of consultation/confinement were those resulting from accidents.

D. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing & Recruitment

The company engages in advertising in broadcast and print media. It also provides posters and brochures to agents for direct marketing purposes.

A total of five agents (3 individual agents and 2 in-house sales staff) were employed to carry out marketing activities in the branch office covered by the study. These agents receive 30% commission. Individual agents could qualify for the 10% annual contingent profit (ACP) if they reach the P30,000 sales quota per year.

All insurance plans of the company do not require applicants to undergo medical check-up as a screening procedure. The only requirement is for them to fill up the application form that contains the personal data and medical history of the applicant. The company accepts whatever the applicant declares in the medical history form.

Application for renewal of policy of clients who have previously committed fraudulent claims are rejected outright.

2. Premium Collection

Being a term insurance, annual premiums are paid upon signing of the policy. Premium payments may be remitted to company collector, to the agent or directly to the office. The company could not say how many members availed of particular modes of payment or how much of total collections were paid from which mode.

3. Claims Processing

Claims for reimbursement are subject to submission to the office of all specified requirements. For medical reimbursement, the requirements are:

- a. police report;
- b. medical/hospital bills;
- c. medical certificate duly signed by the attending physician; and
- d. official receipts of drugs purchased outside the hospital.

The branch office sees to it that all the requirements are complied with before claims are sent to the head office for processing. Claims are subjected to medical, financial, accounting, and other validity checks. The usual time spent to process claims ranges from one to four months.

F. COST CONTAINMENT MEASURES

To contain the cost of member services, each plan has specified benefit limits and exclusions. Reimbursements are subject to all these conditions.

Submission of fraudulent receipts is a common form of fraud experienced by the company. Cost of services and medicines are sometimes overpriced by

tampering with the amount on the receipts or through connivance with unscrupulous sales clerks. To avoid or minimize this, the company conducts routine checks/investigation with establishments that issue the receipts. Fraudulent claims, if proven, will not be paid.

G. PERFORMANCE INDICATOR

Information on this section was provided by the Head Office.

Reinsurance of members is done on a case to case basis. As a general rule, policies over P200,000 are automatically reinsured. However, there are exceptional cases when policies below P200,000 are also reinsured.

Excess premiums are generally invested or added to reserve funds. No data were, however, provided on the type of investment and investment income levels. Investment incomes were usually added to profits.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Company has a standard operating policy governing the setting up of a branch office in a given area. A branch office is required by the Head Office to put up a P50,000 bond. The branch office is expected to operate with the following as minimum personnel requirements: 1 branch manager, 1 cashier, 1 policy issue clerk, and 1 janitor. All office equipment and supplies are provided by the head office. Even the salaries and allowances of the branch personnel come from the Head Office.

Respondent gave economic progress as the most important factor affecting the growth and development of the insurance industry. Economic progress means employment and income opportunities to a greater number of people. The people will then have the money to spend for an insurance coverage.

Respondent cited stiff competition as the most serious problem facing the insurance industry. In the 1990 annual report of the Insurance Commission, there were 101 non-life insurance authorized to do business in the Philippines.

There were also problems on insurance company and client relationship usually caused by delays in claims payment. This is often the result of any of the following:

- a. Failure of claimants to submit all the necessary papers needed for processing. The branch office does not forward claims with incomplete requirements to the Head Office for processing; and
- b. Delays in the processing of claims by the Head Office.

Case Report No. 4: (Domestic Non-Life Insurance Firm)
Reference Company No. 23
Area(s) Studied: Cebu

A. IDENTIFICATION

The Reference Company is a domestic non-life insurance corporation whose branch office in Cebu City was established in 1978. Its principal product or main business is fire insurance. Its market area covers the provinces of Cebu and Bohol as well as the cities of Zamboanga and Dipolog.

B. HEALTH PLAN AND BENEFITS

The company's pre-paid health service is a rider to the Personal Accident policy targeted for persons between the ages 16 and 60 years. Policy issued prior to age 60 for males are renewable up to 65 years old. The annual premium which are actuarially computed ranges from P200 to P2,500 depending on the policy subscribed and the occupation of the insured which are classified as follows:

- a. Class I - persons whose work are strictly for office duties only, e.g. accountant, advertising manager, architect, auditor, clergyman etc.;
- b. Class II - persons with no manual work but whose duties include travel by land, sea and air on commercial scheduled flight, e.g. agent, appraisers, automobile dealer, commercial traveler, lawyer, physician, and similar professions and occupations;
- c. Class III - persons involved in supervisory manual work, e.g. bakery managers, chemist, dentist, engineer, grocery manager, painting contractor, master tradesmen; and
- d. Class IV - persons with duties involving light manual work e.g. baker, barber, private driver, gardener, messenger, veterinary surgeon, etc.

Considered as prohibited risks and not insurable in the plan are acrobats, army personnel, asylum attendant, auto racing driver, boilermen, carpenters, drivers of public hire vehicles, electricians, explosives handlers and people with chronic diseases, totally blind, deaf, etc.

The Plan covers reimbursement of expenses for drugs and medicines provided such expenses resulted from injuries caused by accident. Reimbursable amount is subject to ceilings ranging from P1,000 to P5,000 depending on the policy.

The company does not accredit medical service providers. In case of accident, a policyholder can go to any hospital/physician for treatment and then file a claim for reimbursement for drugs used.

C. PROFILE OF MEMBERS

Most data needed by the study were said to be available only from the head office in Manila. A high-ranking official in Manila was approached regarding data and information but was not available during several visits to his office. Unfortunately, only said official can authorize any personnel to release the data which were considered classified information. In any case, extra time and effort would have been needed to sort and retrieve the required data from voluminous files. The study was, therefore, unable to obtain the needed data on members.

D. SERVICE UTILIZATION PATTERNS, BY MEMBERS

In 1991 the office received drug/medicine claims from 10 clients, all of whom were involved in work related accidents. Unfortunately, the Reference Company does not keep records on the specifics of the availment or utilization of services, hence the patterns and causes of accidents, much less, the type of services used could not be determined.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The Cebu branch office employed 25 individual agents and 7 in-house sales staff. Agents are paid by commission and have no quota. In-house sales staff are salaried employees and get added commission upon recruitment of new members.

The acceptance or rejection of application is based on risk assessment. persons doing high risk jobs are not insurable.

2. Premiums Collection

Premiums are paid or collected on regular basis by collectors or agents. For 1991, the branch office collected an estimated P300,000 from 200 members.

3. Claims Processing

Filing claims for reimbursement requires the submission of application together with adjuster's report, medical certificate, official receipts for drugs purchased and certification from employer. The review and assessment of claims involves: a) financial review, e.g. application of benefit ceilings or standard costs; and b) validity checks, e.g. safeguards against possible abuses like submission of false receipts.

The usual time to process and effect payment of claims is 2 days, with the shortest at 1 day and the longest at one month.

F. COST CONTAINMENT MEASURES AND MECHANISM

Aside from exclusions and limits, no other cost containment measures have been adopted. No abuses or fraud relative to filing of claims have reportedly been made. Respondent claims that fraud and abuse can be totally eliminated through close screening of documents submitted to substantiate claims.

G. PERFORMANCE INDICATORS AND FINANCIAL STATUS

Data on financial status were reportedly available only at home office.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECT

The Respondent estimated that the minimum capitalization required for start-up operation is P200,000 with an office staff of 3. The basic office equipment/furniture should include typewriter, adding machines/calculators, telephone lines, tables and chairs.

Economic progress was ranked as the number 1 factor/condition affecting the growth and development of a health insurance operation. Government incentives

and education were ranked second and third, respectively. Economic growth was ranked first place because it provides employment and higher wages thus enabling people to pay insurance premium.

The most serious problem facing health insurance operation is the people's lack of appreciation of the importance of health insurance. Also, slow payment of claims by some companies gives a negative mark on the whole industry.

This reference company does not have firm plans for expansion of their health plans since their principal concern is fire insurance.

Case Report No. 5: (Domestic Non-Life Insurance)
 Reference Company No. 33
 Area(s) Studied: Bohol

A. IDENTIFICATION

The Reference Company branch office in Bohol is highlighted, because branch offices in the other sample areas were either non-existent or refused to give information on their operations.

Established only in June 24, 1991, the Bohol branch office is a commercial indemnity firm whose main business is motor vehicle insurance, fire and bonds.

B. HEALTH PLANS AND BENEFITS

The health plans are offered merely as riders on Personal Accident and Third Party Liability (TPL) for motor vehicle insurance. Personal accident benefits apply only to authorized driver and motor vehicle helper. Cash reimbursement up to P500.00 per person per accident covers hospitalization, and cost of drugs and medicines. Annual premium cost is P108.00.

Third Party Liability (TPL) insurance covers unnamed riders or passengers of insured vehicles. Annual premium rates are P70.75 for light motor vehicles and P1,171.05 for buses and big trucks.

Cash reimbursement of P500.00 per person per accident are provided to cover costs of hospitalization, drugs and medicines.

Like other insurance plans, the company excludes the following conditions from coverage:

- a. Conditions existing prior to membership;
- b. Conditions which are not work-related;
- c. Conditions arising from acts which are not sanctioned by society like STDs including AIDS, suicide, substance abuse, conditions arising from acts of war/riots, etc.;
- d. New procedures like lithotripsy, ultrasound;
- e. Mental or nervous disorders;
- f. Pregnancy, childbirth, miscarriage, abortion and their complications;
- g. Conditions requiring use of ICU;
- h. Congenital deformities and defects, cosmetic and plastic surgery;
- i. Routine physical check-up and rest cures;
- j. Conditions which are recurrent in nature or require prolonged treatment;
- k. Conditions/Diseases requiring isolation as per DOH policy like leprosy, cholera, etc.;
- l. Conditions without known cure; and
- m. Conditions which are not accident-related.

These exclusions limit payment of benefits to those types of accident which are identified and specified in the policy. Payments to the claimants are made through cash reimbursements. The Company has no facilities for direct health services nor does it accredit different health providers.

Except for owners and operators who directly insured the vehicles, other beneficiaries of the insurance like drivers, helpers and passengers are not identified and virtually not known to the insurance until claims are filed. Company records showed that the number of insured vehicle owners in the last quarter of 1991 was 65, ten of which were females and fifty-five were males.

C. PROFILE OF INSURED MEMBERS

No data available.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Data were either not available or were not applicable for particular item.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

Acceptance or rejection of vehicle insurance is primarily based on risk assessment. Vehicles that are considered high-risk in nature are not insurable.

2. Premium Collection

Premiums are paid or collected on a regular basis by direct remittance to the branch office. As of 1991, P6,900.00 was said to have been collected. No claims were filed or paid that year.

3. Claims Processing

Claims for reimbursement normally need submission of claims documents from the claimant to the company's office. Claims documents consist of claims application, police report, driver's license, pictures, official receipts, medical certificate, or death certificate, in case of death.

As a matter of procedure, the Company reviews and assesses claims based on the following considerations:

- a. medical review to determine appropriateness of service provided;
- b. accounting review to evaluate veracity of receipts; and
- c. validity checks, e.g. to put safeguards against possible abuses like submission of false receipts or statement of accounts and validate adjuster's report.

The usual or average time to process claims and effect payment to claimant is about two months. The shortest is one month, and the longest is six months.

Even though health service providers are not accredited, provider's bills are required in statement of accounts and are processed. Included in these are the official receipt of medical expenses and driver's license.

F. COST CONTAINMENT MEASURES AND MECHANISMS

No information was given on cost-containment measures but one instance of fraud and abuse was experienced when one claimant filed medical expenses not related to the accident. Claimant was not penalized but was merely reminded of the policy on what items are reimbursable and what items are not.

PERFORMANCE INDICATOR AND FINANCIAL STATUS

The Bohol branch office started in 1991 and serves mainly as a marketing office of the head office in Manila. The branch manager interviewed was new and not very familiar with the Company's region-wide operations. Consequently, data

on performance and financial status were not available or virtually non-existent.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Company branch manager thinks that a minimum of P500,000.00 start-up capital is needed to operate a health insurance business (Tagbilaran operation only) with a staff of 4, 2 computers and sets of tables and chairs.

The main factor perceived to affect the growth and development of health insurance is the availability of company funds at the local level. This is needed to build credibility for the new office. This will also serve as assurance to policy holders that their claims could be reimbursed or paid immediately upon proper presentation of claims document. Processing in Manila which unnecessary delays reimbursement could be avoided by decentralizing funds.

She thinks that the most serious problem that affect the growth and development of the industry, including the one she runs now, is the high commission rates being charged by fixers and some LTO personnel. This is solvable through closer and more honest supervisor and supervision.

Case Report No. 6: (Domestic Non-Life Insurance)
Reference Company No. 35
Area(s) Studied: Misamis Oriental

A. IDENTIFICATION

Reference Company is a non-life insurance company primarily engaged in bonds, fire, marine, motor vehicle, and personal accident business.

The company started its Cagayan de Oro operation in March 1991 while NCR operation started in 1959. Filipino in nationality, the company operates nationwide offering the same types of product in its branches.

B. HEALTH PLANS AND BENEFITS

The company offers health benefits as riders to their personal accident insurance plan which have the following coverage:

- a. Accidental Death. Pays the beneficiaries the principal sum assured;
- b. Permanent Disablement. Provides compensation depending on the extent of disability following the schedule of percentage reflected in the table of benefits;
- c. Temporary Disablement (Optional);
 - c.1 Temporary Total. Pays the insured the sum agreed upon;
 - c.2 Temporary Partial. Pays the insured 1/3 of the benefits in c.1
- d. Medical and Surgical Expenses. Reimburses the actual medical/surgical expenses up to the limits stated in the policy;
- e. Murder and Assault. Pays the insured 25% of benefits A and B (as per schedule of percentage) should the bodily injury/death be caused by unprovoked murder and assault or any attempt thereat.

Target members/beneficiaries for the health plans are classified according to the following occupational class:

- a. Class A - persons whose duties do not entail manual work, e.g. accountants, managers, teachers, students and other similar occupation;
- b. Class B - persons whose duties do not entail manual work, but include travelling, e.g. inspecting or surveying agent, automobile dealers and other similar occupation;
- c. Class C - persons involved in supervising manual work, including occasional work in superintending workmen, e.g. Bakery Manager, Chemist, Engineer, etc.; and
- d. Class D - persons whose duties involve light manual work, e.g. baker, barber, janitor, messenger, generally who do light manual work.

Premium rates vary depending on the type of occupation and are summarized below:

<u>Occupational Class</u>	<u>Annual Premium</u>
Class A	P12.30
Class B	14.55
Class C	16.80
Class D	22.00

The amount of prepaid contribution per class is based on actuarial computation. The company offers the personal accident plan as principal product in addition to other products offered by the company

Minimum benefit ceiling for medical reimbursement is P500 or 10% of principal sum but not to exceed P8,000 per accident per year.

Services and conditions usually excluded in the plan coverage are:

- a. Bacterial infections/diseases;
- b. Medical or surgical treatment not resulting from accident;
- c. Hernia;
- d. Suicide;
- e. War or service in the armed forces;
- f. Earthquake, volcanic eruption, tidal waves; and
- g. Any injury consequent upon the insured engaging purely for sports, hunting, racing of all kinds, polo playing, etc.

The above services and conditions are excluded from the plan because of the risks involved. Health benefits are extended to members in the form of cash reimbursement for accident related cases only.

Sources of capital and operating funds for health plans are members' pre-payments and stockholders equity.

C. PROFILE OF MEMBERS/ENROLLEES

As of the 4th quarter of 1991, the company had 58 corporate/ group accounts and 10 individual enrollees. Statistics on the occupation, age, sex and marital status of members were not available.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The company had no information on the services extended to members because they do not accredit any service providers. Neither do they compile statistical data on these events, although records may be available and filed.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The branch office employs 3 individual agents and 1 insurance broker to market their product. Marketing of health plans is done through direct selling, any visit and group product presentation. Individual agents are compensated on commission basis while in-house sales staff are paid on salary basis.

Standard procedures adopted by the company in screening applicants are:

- a. Applicants are required to fill up the company's application form;
- b. Accomplished forms are forwarded to agents concerned for examination of pre-existing illness; and
- c. If accepted, applicants and agents sign the application form to be forwarded to the main office for processing.

Application for membership is accepted if applicants meet the company criteria for accepting applicants. Rejection of applicants is done if applicant is found to have pre-existing conditions.

2. Premium Collection

Collection of premium is usually done either through agents or direct payment to office.

3. Claims Processing

The company does not accredit its own health service facilities and providers. Insured members can go directly to any licensed hospital and service providers. Upon discharge, members can file claims for reimbursement upon presentation of hospital statement of account, police report, medical certificate and official receipts.

On average, claims filed are processed and paid within 10 days, or a minimum of 5 days and a maximum of 15 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

To contain the cost of member services, the company has adopted the following measures:

- a. Screening for adverse selection; and
- b. Exclusions and limits.

G. RESPONDENT'S VIEWS ON INDUSTRY PROSPECT

Based on company experiences on the insurance business, the perceived minimum capitalization required for a start up operation is P10 M. The office must have 1 manager, 1 clerk, and 1 accountant/ cashier. Office equipment needed for the operation are telephone, typewriter, calculator, airconditioner.

Factors and conditions that will affect the growth and development of health insurance operations are:

1. Household income and employment;
2. Economic progress;
3. Education; and
4. Information drive

Household income was considered as number 1 factor because if family income is not enough for their basic needs, then getting an insurance coverage will be a last priority.

Stiff competition was cited as the most serious problem faced by health insurance at present. This problem is being addressed by the industry by reviewing the plans and benefits offered by other companies and upgrading their

plans by incorporating benefits offered by other companies.

Suggested regulatory measures that should be enforced by government include: (i) a uniform application of tariff taxes; and (ii) immediate settling of claims to members.

Looking at the industry as a whole, the company suggested that the regulatory body for the industry should be the industry peers.

The company projects a 70% increase in coverage of population in the next 5 years and 30% expansion of benefit packages.

Case Report No. 7: (Domestic Non-Life Insurance)
Reference Company No. 45
Area(s) Studied: Surigao del Norte

A. IDENTIFICATION

Reference Company is a non-life insurance branch office established in Surigao in 1972. Market area covers Surigao City, Maasin Leyte, and Dapa Surigao Norte.

B. HEALTH PLANS AND BENEFITS

The company's principal product is motorcar insurance. In this type of insurance, enrollees have the option to include personal accident in their coverage. As part of the benefits of a personal accident coverage, an insured person could get cash reimbursement for medical expenses incurred in an accident.

Target beneficiaries are any persons or passengers of an insured vehicle at the time of accident. The seating capacity of a vehicle determines the maximum number of persons that could be insured. However, there are vehicle owners who insure only the driver. Premium per seat is P108.50/year.

The plan reimburses medical costs of hospitalization, outpatient care and other related services provided to treat injuries caused by accident. Reimbursement is subject to a maximum limit of P750.00 per person/accident.

The company does not have any standards for accreditation of service providers. In case of accident, an insured person could go to any hospital/physician for treatment of injuries and file a claim for medical reimbursement.

C. PROFILE OF INSURED MEMBERS

The company issued a total of 21 policies of motorcar insurance with personal accident (with health rider) in the first quarter of 1991. This comprises the voluntary clients. In the 4th quarter of 1991, there were a total of 24 policies issued.

No statistical data regarding occupation, age, sex, marital status, etc. of insured persons could be derived because there are no specific names of insured persons spelled out in the policies issued. Policies call for unnamed persons.

D. SERVICE UTILIZATION PATTERN BY MEMBERS

As expected, availment of hospital/medical and other services were all due to accidental injuries. But the company had no available data on the total number of availments per type of service. Neither could they give the total amount spent for such services.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The company need not engage in intensive marketing strategies because motor

car insurance is compulsory upon registration of vehicles. Sales force is composed of 20 individual agents who are paid on commission basis. They are given 20% for TPL policies and 30% for PA policies.

The plan insures unnamed persons/passengers and covers only accident related injuries. Therefore, screening is not applicable. The company does not have standard procedures/criteria for accepting or rejecting enrollees.

2. Premium Collection

Premium payments are on a yearly basis and paid on a one-time payment scheme. Some, however, opt for a longer period of coverage e.g. 3 years. Premiums are paid directly to the agents. The total amount collected by agents in 1991 (or any other year) could not be determined, or were deliberately concealed from the researchers.

3. Claims Processing

Like other insurance companies, Reference Company operations were highly centralized. Processing and claims payments were done at the head office. The branch office merely saw to it that claimants submitted the complete claims requirements. Review and assessment of claims were done at the head office. The review/assessment include: (1) medical review - e.g. appropriateness of service provided on amount of benefits availed. (2) accounting review, receipts (3) validity checks, e.g. safeguards against possible abuses like submission of false receipts.

The usual amount of time to process claims and effect payment was 3 months, but some claims were paid in a month.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The company does not employ any cost-containment measure and did not consider the questions asked as relevant to their operations.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Responses to questions on performance and financial status were referred to the head office in Manila. However, the head office was unwilling to share confidential data which needed the approval of top management. In some cases, no processed data were available.

Excess premiums are invested in securities/bonds and stocks. No range of investment income is given. Investment income are said to be added to reserve and profits and some are reinvested to other ventures like real estate.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Respondent in the branch office refused to speculate on the industry prospects and referred us to the head office for responses to the set of questions on this subject. The estimated minimum administrative requirements for starting a health insurance business in the country are as follows:

Capitalization - P10,000,000;

Personnel Category;

(1) President

(11) Executive VP

- iii) VP Comptroller
- iv) VP Administration
- v) Staff - 20 persons
- c. Type of Equipment;
 - i) Typewriters - 3 units
 - ii) Validating Machine - 1 unit

The factors and conditions perceived to affect the growth and development of health insurance are:

- a. Economic progress;
- b. Household income;
- c. Education;
- d. Government incentives;
- e. Competitions;

The respondent views regulation of health insurance operations as a function and responsibility of the industry itself and one that should focus on the following:

- a. Improvement of services;
- b. Improvement of facilities;

Case Report No. 8: (Foreign Non-Life Insurance)
 Reference Company No. 3
 Area(s) Studied: NCR

A. IDENTIFICATION

The Reference Company was created through a merger of several subsidiary insurance companies. In December 11, 1991, when the Reference Company formally started its operation, it was basically an American business concern engaged in fire, marine, motor vehicle and personal accident insurance.

B. HEALTH PLANS AND BENEFITS

As part of a wider insurance plan the company offers the following health plans:

a. Payroll Deduction Plan - This personal accident insurance is designed for employees and their family. Premium per annum is P300.00 for individual and P540.00 for employee and family. The benefits are as follows:

i.	Accidental Death and Dismemberment/Permanent Total Disability: (Per unit of coverage)		
	Principal insured	-	P100,000.00
	Spouse	-	50,000.00
	Each child	-	10,000.00
ii.	Accident Medical Expenses (Per accident)		
	Principal insured	-	P 2,500.00
	Spouse	-	1,250.00
	Each child	-	250.00
iii.	Accident Burial Expense		
	Principal insured	-	P 5,000.00
	Spouse	-	2,500.00
	Each child	-	500.00

b. Group Accident Plan - This is an accident insurance designed for private or government employees who wish to enroll as a group. There is no standard annual premium rate for group because these are individually computed based on the number of employees per group, nature of occupation of employees and type of premium the group may desire. Employees are classified by size into 7 groups, the smallest group of which is composed of 2-4 employees and the biggest is a group of more than 200 employees. Employees are further classified into 4 occupational classes such as Class I - office duties only; Class II - limited manual work; Class III - skilled or semi-skilled worker; and, Class IV - heavy machinery or unskilled worker.

Health benefits are in the form of medical expense reimbursement, weekly indemnity (for principal insured only), weekly hospital income and surgical professional fees. Coverage varies according to annual premiums selected. The schedule of coverage for each type of benefit is as follows:

1.	Accident Medical Reimbursement:		
	Principal insured	-	P10,000.00
	Spouse	-	5,000.00
	Each child	-	1,000.00
	Each brother/sister	-	1,000.00

ii.	Weekly Indemnity	-	P500.00/unit
iii.	Weekly Hospital Income:		
	Principal insured	-	P500.00/unit
	Spouse	-	250.00/unit
	Each child/sibling	-	50.00/unit
iv.	Surgical Professional Fees:		
	Principal insured	-	P500.00/unit
	Spouse	-	250.00/unit
	Each child/sibling	-	50.00/unit

The amount of premium payment as well as benefits are based on actuarial computations and industry comparisons.

Covered for medical reimbursement are: (i) cost of drugs and medicines and hospitalization up to P2,500 for principal, P1,250.00 for spouse and P250.00 per child; (ii) room and board at P700.00/day; and (iii) laboratory examinations of not more than P1,400.00 per accident.

The conditions listed below are generally excluded from coverage by most insurance but are covered under the company's policy:

- a. Conditions which are not work-related;
- b. New procedures like lithotripsy, ultrasound;
- c. Conditions/diseases requiring isolation as per DOH policy, e.g., leprosy, cholera, etc.;
- d. Conditions which are recurrent in nature or require prolonged treatment.

For pre-existing illnesses, coverage takes effect after six months of membership as per insurance policy. Members or enrollees are not restricted to a limited set of accredited health providers such as hospitals, laboratories and doctors, because the company accepts all licensed providers.

C. PROFILE OF MEMBERS/ENROLLEES

During the last quarter of 1991, there were 2,000 group policy holders, 3,984 individual policy holders and 50 policies on voluntary payroll deduction scheme. Data on the characteristics of these policy holders were not available at the time of the survey.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The company does not have processed data on medical benefits utilization by members.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The company sells insurance through its network of 150 individual agents and 50 insurance brokers. Agents and brokers are compensated by commissions, cash incentives and profit-sharing schemes on a case to case basis.

The insured, in case of group insurance, must meet minimum number of employees per group e.g. 2-4. In terms of age requirement, the principal insured spouse should not be more than 65 years old while the child/sibling should

be aged 19-23 years old.

The following limits are observed by the company in accepting or rejecting policy holders:

- a. High benefit limit. Benefits should not exceed ten times the annual salary;
- b. Politicians. They are usually high risks due to ambush cases and are therefore not readily accepted; and
- c. Those with existing policies with many claims are usually not accepted.

2. Premium Collection

The Reference Company collects regular premiums from policy holders through salary deduction, collector (agent/broker), bank and credit card.

3. Claims Processing

As previously discussed, benefits are extended to members through the following procedures:

- a. Presentation of reimbursement claims forms with attached official receipt, hospital statement of account, certification of attending physician;
- b. For accident claim - police report must be accomplished; and
- c. For death claim - accomplished autopsy report and marriage contract if necessary are required documents.

Procedures for processing claims for reimbursement filed by the insured are as follows:

- a. Submit reimbursement claims to the Claims Department;
- b. Forward documents to Underwriting Department for verification; and
- c. Return documents after verification to Claims Department for payment.

The company reviews/assesses these claims based on the following considerations:

- a. Medical review to determine the appropriateness of service provided or amount of benefits availed;
- b. Financial review to determine proper application of benefit ceilings or standard cost; and
- c. Accounting review to determine veracity of receipts.

The usual amount of time to process claims and effect payment to the claimant is 3-4 days. The shortest is 2 days and the longest is 14 days.

7. COST CONTAINMENT MEASURES AND MECHANISMS

Screening for adverse selection through use of application form and application of exclusions and limits are the main cost-containment measures employed.

Fraud and abuses were occasionally experienced by the company in the form of ghost confinement and connivance between the claimant and hospital and/or doctor. There are, however, safeguards adopted to minimize or avoid said fraud and abuses. Concerned brokers/agents are called to discuss the problem which, if verified to be true and correct, could result in the suspension of the employees and non-renewal of coverage.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Company has provisions for reinsurance with American International Group. However, data on the number of reinsured members was not available.

Salaries of personnel, supplies and communication expenses are the main items of administrative expenditures. Most of these come from Reference Company's accounts, the excess of which is added to reserve fund. Again, the amount spent for administrative purposes was not available.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECTS

The company respondent did not cite any administrative and capitalization requirement for operating a health insurance. However, factors and conditions that affect the growth and development of health insurance operation were cited as follows:

- a. Household incomes and employment;
- b. Education;
- c. Economic progress; and
- d. Government incentives.

Household incomes and employment were considered the most important factors affecting the growth and development of health insurance because a person will buy insurance only after he has met his other basic needs.

The most serious problem perceived as affecting insurance is the lack of knowledge about the business. In this regard, agents must explain very well the insurance and scope of its coverage.

Case Report No. 9: (Foreign Non-Life Insurance)
 Reference Company No. 4
 Area(s) Studied: NCR

A. IDENTIFICATION

The Reference Company started doing business in the Philippines through its agent in 1839. The Reference Company still has in its possession a marine policy issued at that time which is displayed at the branch office lobby.

The Philippine branch of the Reference Company was opened for business in 1904 and has become a distinguished member of the local insurance community. The Reference Company is directly linked by modern technology to its head office in Hongkong. In 1960, it became a wholly owned subsidiary of one of Britain's leading insurance companies.

The company is a commercial indemnity (foreign non-life insurance) type and offers a full range of insurance services in (a) fire/lightning, full earthquake, typhoon/flood; (b) marine cargo, (c) motor car, (d) personal accident, (e) liability cover and (f) burglary.

B. HEALTH PLANS AND BENEFITS

The health plan is an add-on to the Personal Accident (PA) policy with optional benefits for medical expenses. The liability of the company is for actual expenses incurred up to the maximum specified in the policy. Maximum limit for this benefit is 10% of the principal sum insured but not to exceed P50,000. The target members/beneficiaries of this plan are classified as follows: Class I - professionals, i.e. architects, clerks, doctors, lawyers, etc.; Class II - those whose occupations involve occasional light manual work, i.e. bankers, surveyors, tradesmen or those not using tools or machinery, and Class III - those whose occupation involve light manual work or the use of tools of light machinery. The annual premium paid for the insurance of the above occupational class per P1,000 medical benefit are P20, P23.50 and P29.00 respectively. The amount of prepaid contribution was determined through actuarial computations and paid upon issuance of policy. Benefits are extended through cash reimbursement and on accident basis.

C. PROFILE OF INSURED MEMBERS

In the last quarter of 1991, there were 262 policies issued consisting of 100 policies for corporate/group, 189 voluntary or individual policies and 53 others. The insured clients can be broken down into 189 self-employed (both sexes); 447 in the ages 15-45, these are the student and group P.A.; 342 high school graduates and 40 college graduates.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

There are no attempts to accredit doctors, hospitals or clinics. PA policy holders can go to any hospital or clinic for treatment of injuries resulting from an accident. In 1991 there were only 2 hospitalization cases reported due to accidental bodily injury. The average length of confinement by a single member in 1991 was 4 days, with one month as the longest and 2 days the shortest confinement period. There were no records/data on the amount spent for services and the company generally pays all medical expenses relative to the accident up to 10% of the principal sum insured and not to exceed P50,000.

E. MANAGEMENT AND OPERATING SYSTEMS**1. Marketing and Recruitment**

The Company uses the direct approach to attract new members. It has a sales/marketing force of 30 individual agents, 10 insurance brokers and 3 in-house sales staff. Individual agents and brokers are paid on commission basis while the in-house sales staff are salaried employees. There are no stringent procedures for screening and approval of applications. All that is needed is the accomplishment of application forms although there are criteria used to accept or reject an applicant for membership. These criteria are (a) between ages 18 to 60, and (b) occupations falling under class I to III as mentioned previously. Persons engaged in dangerous sports such as mountaineering, skin diving, car racing, etc., are not accepted.

2. Premium Collection

One time annual premiums are paid directly to the office and are collected upon issuance of policy. In 1991, the amount of premium collected was about P500,000.

3. Claims Processing

Benefits are extended to members through cash reimbursement. The insured is required to submit supporting documents which consist of accident report, invoices, hospital official receipts and others. The Company conducts a medical review and validity check as safeguards against possible abuses. The average time to process claims is one week. The shortest time is 5 days and the longest 15 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

Outside of the exclusions and limits stated earlier, the Company does not implement other measures to contain cost of member services. They claim not to have experienced any abuse and/or fraud in claims submitted for reimbursement.

G. PERFORMANCE INDICATORS AND FINANCIAL STATUS

The Company selectively reinsures its members depending on the amount insured, up to P500,000 per member. In 1991 only one policy holder was reinsured with a professional reinsurance company. Proceeds received from one reinsurance claim in 1991 was P30,000 out of a total claim of P75,000. The balance of P45,000 was absorbed by the Company.

In 1991, total premium collected was P416,016.96, while total claims paid was P60,000 for 2 claims filed. Excess premiums were invested in money market placements with an estimated P50,000 highest investment income for the year. The income was added to the reserve fund of the Company.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Based on the Company's experience, the perceived requirements for running a health insurance business is a minimum start-up capitalization of P5 million and the hiring of 30 personnel of all categories, 50% of which comprise the marketing/sales staff, 5 personnel for administrative and support staff and 10 claims processing and accounting staff.

Economic progress was ranked no. 1 factor affecting the growth and development of health insurance and the whole insurance industry as a whole. Other influential factors and conditions were cited in the following order: (i) household income and employment, (ii) government incentives, and (iii) education. Improved economic condition creates an atmosphere more conducive to business thus creating more employment for the people and increase family income. At present, only people in the upper strata of society can afford to buy health insurance. Premiums are not within the reach of daily wage earners and ordinary employees.

There should be a legislation that would put all health insurance operations under the control and supervision of a Health Insurance Commission. As an added incentive, premiums paid for health insurance should be allowed as income tax deductions.

Although the Reference Company carries only Personal Accident Insurance with optional medical benefits, they like the health insurance business, particularly the HMOs, to prosper so that they can serve the health needs of a wider segment of the population.

Case Report No. 10: (Foreign Non-Life Insurance)
Reference Company No. 25
Area(s) Studied: Cebu

A. IDENTIFICATION

Reference Company was founded in London in 1861. As one of the world's largest insurance group, it underwrites insurance risks of all types in nearly one hundred countries. The company has a widespread network of branches or associated companies in Singapore, Malaysia, Thailand, Hongkong, the Philippines, Taiwan and Macau. It is also represented in Japan, Brunei, Indonesia, Sri Lanka, and the Maldives. To provide technical assistance in the Far East, a Regional Head office was established in Singapore.

Reference Company was established in the Philippines on July 14, 1945 as a foreign non-life insurance. It has branches in 17 key cities in the Philippines namely: Cebu, Davao, Cagayan de Oro, General Santos, Bacolod, Iloilo, Naga, Legaspi, Pampanga, Dagupan, Dau, Tarlac, Bataan, Isabela, Bulacan, Manila and Makati.

The Reference Company's Cebu Branch was established in May 1991. Market area covered are Cebu, Bohol, Dumaguete and Tacloban.

B. HEALTH PLANS AND BENEFITS

Plans with health benefits offered by the company are:

1. Motor Vehicle Insurance with Personal Accident, which extends benefits in the event of accidental death or bodily injury to the insured person to include reimbursement of medical expenses incurred as a direct consequence of an accident.
2. Keyman Golden Protector, which offers the following benefits:
 - a. Pays the sum insured benefit in case of accidental death and permanent total disablement;
 - b. Pays sum insured or fixed percentage in case of accidental loss of limbs by permanent paralysis or dismemberment, loss of sight, hearing or speech;
 - c. Pays back medical expenses incurred for treatment of accidental bodily injuries in or out of hospital;
 - d. Replaces 75% of income in case of total disability arising out of an injury and 50% of total disability benefits in case of partial disability; and
 - e. Sickness in-hospital benefits - pays cash benefit for every day of hospital confinement that arises out of sickness up to a maximum of 6 months per sickness.

Health benefits are extended to members through cash reimbursement of medical expenses as stated in the benefit package chosen. For instance, 3 benefit program packages are offered for Keyman Golden Protector. Each program has 4 plans. Program 1 and 2 extend accidental medical reimbursement only. Reimbursement ranges from P50,000 to P150,000. Program 3 extends both accidental medical reimbursement and sickness in-hospital income. Medical reimbursement is

the same as programs 1 and 2, while sickness in-hospital income ranges from P9,000 to P30,000.

C. PROFILE OF INSURED MEMBERS

There were no readily available data on profile of members. Raw data were available from records but would require tedious and lengthy retrieval.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The company could not give data on benefit availment. They are not very particular about keeping records of the inpatient, outpatient or diagnostic services availed of and the amount spent by the company for such services. All hospitalization and outpatient consultation were presumably due to accident-related injuries, requiring medical care.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The branch office employs 20 individual agents who earn 30% commission plus incentives if they reach the quota set by the Head Office.

Like other insurance companies, they are not very strict in accepting applicants. Questions on health status are asked in the proposal form. Whatever the clients declare in the application forms are accepted as true and complete. However, clients who had previously committed fraud are rejected.

2. Premium Collection

Premium payments are collected by agents. All clients are required to pay the annual premiums in full.

3. Claims Processing

In claiming cash reimbursement, a claim form has to be accomplished. Such questions as time and place where the accident occurred, injuries sustained, are asked. Accomplished forms must be submitted to the office together with the medical certificate duly signed by the attending physician, the hospital bills, official receipts of drugs purchased outside the hospital together with the doctor's prescription.

All claims are reviewed and assessed for validity. Review and assessment covers medical and financial review, accounting review and other validity checks. Receipts submitted are validated, determine if items in the hospital bills are accident related or related to sickness etc. Legitimate claims take 1 to 3 weeks to process.

COST CONTAINMENT MEASURES AND MECHANISMS

Cost containment is not much of a problem because each plan has its own set limits or ceiling. All cash reimbursements are paid up to the limit specified in the policy.

Respondent refused to answer questions on fraud and abuse committed by agents. However, he said, fraudulent claims could never be eliminated.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Answers to this block were provided by the Head Office.

The Company reinsures its policy holders on a case to case basis depending on amount of insurance (e.g. P1.5 M coverage and up are automatically reinsured with regional office, Singapore). The cost of reinsurance was not given. No claims have yet been filed on reinsured clients.

The head office refused to give any financial data as these were deemed confidential. Besides, no processed data were available during the survey.

Excess premiums are invested in securities and bonds but the Company respondents refused to give data on their investment income. Decisions on what to do with investment income are made by the head office in London. The Company gave us a copy of their audited financial statements for 2 reference years namely, 1989 and 1990.

As reflected in the financial statements, the Reference Company, Philippine branch incurred a net loss of P7,446,213.00 in 1989 and P32,068,052 in 1990. Assets amounted to P152,881,706.00 in 1989 and P135,079,166.00 in 1992 and liabilities P112,682,880.00 and P106,693,437 respectively. Equity is P40,198,826.00 in 1989 and P30,385,729.00 in 1990.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Cebu Branch Manager had no idea on the capitalization needed to start a health insurance operation. However, he cited that a branch office like theirs needs a branch manager, 2 marketing staff, 2 effective claims staff, and a collection staff to be able to function effectively. Basic office equipment like typewriters, calculators etc. are also necessary.

Factors cited as affecting the growth and development of a health insurance operation are: 1) economic progress, household incomes and employment (respondent said these factors usually go together); 2) government incentives; and 3) education.

Respondent thinks that the most serious problems facing health insurance operations in the country are: (i) the lack of insurance consciousness among people; and (ii) the large proportion of low income people who could not afford the high premium cost of health insurance. He believes, however, that there are no unmanageable problems as long as there are people who are willing to solve it. Both the government and the insurance industry should join hands to solve this problem. Government should try to improve the economic conditions. The health insurance industry should regulate premiums to make it affordable to a greater number of people (if not all).

To promote growth and development of health insurance in the Philippines, respondent feels that government must do something to trim down hospital/medical costs so that premium costs of health insurance could be lowered.

Case Report No. 11: (Life Insurance)
 Reference Companies No. 5 & 26
 Area(s) Studied: NCR and Cebu

A. IDENTIFICATION

The Company's NCR office was established on February 13, 1979 as its head office with its designated market covering not just the Metro Manila but that of the whole country. The Cebu City branch, which was opened in 1983, covers the Visayas and part of Mindanao. The Reference Company is of Filipino nationality and looks to a Fraternal Association as its mother company. Categorized as commercial indemnity, its main business is life insurance with supplementary benefits for medical expenses due to accident and illnesses.

The Company head office at NCR has given more detailed and extensive data than the branch office in Cebu. Hence, the views and information noted herein mainly reflects those of NCR operation unless otherwise specified.

B. HEALTH PLANS AND BENEFITS

The Reference Company offers one basic plan termed as Group Insurance Program with major health benefits component. The Plan is classified into four classes with the following corresponding rates of premiums per unit per quarter: Class I - P164.20; Class II - P120.68; Class III - P82.38; and Class IV - P45.45.

In addition, the Reference Company offers tailored options of insurance package for client groups or corporations, with their corresponding premiums and benefits suited to the priorities and preferences of the clients.

Medical benefits for the above plans are categorized as either Basic Medical Benefit or Major Medical Benefit.

Items included in Basic Medical Benefits are:

- a. Hospital room and board and general nursing services. This benefit is payable in an amount equal to the actual charge for room and board and general nursing services (except special nursing services) made by the hospital in connection with hospital confinement but not to exceed the maximum daily rate benefit and maximum number of 31 days for any one continuous period of disability as stated in the Schedule of Benefits. The maximum daily rate for each insurance class are as follows: Class I - P200.00; Class II - P150.00; Class III - P150.00; and Class IV - P50.00.
- b. Special hospital services. This benefit is payable in the amount equal to actual charges made by the hospital for any services rendered in connection with the confinement provided that aggregate benefits shall not exceed the special hospital services maximum stated in the Schedule of Benefits. The special hospital services covers the following:
 - i. use of operating and treatment room
 - ii. anesthesia and oxygen and their administration
 - iii. transfusions of blood and blood plasma
 - iv. medicines and curative materials
 - v. films and x-rays and their interpretation and special diagnostic procedures, such as electrocardiogram and basal metabolism.
 - vi. ambulance service (for accident and sickness not to exceed the amount stated in the Policy).

Special hospital services are also available to reimburse actual expenses incurred for outpatient treatment of an injury sustained in an accident or for outpatient surgical operation within 24 hours from the date of such injury or operation. Reimbursable amount is P100% of the actual expenses but not to exceed P2,400 for Class I; P1,800 for Class II; P1,200 for Class III; and, P600 for Class IV.

- c. Surgical expense benefits are also payable even if no hospital confinement is involved, provided that the surgery is performed by a legally qualified physician/surgeon and/or for treatment of an injury sustained in an accident within 24 hours from the date of such injury. Maximum reimbursable amount are P4,800 for Class I; P3,600 for Class II; P2,400 for Class III; and, P1,200 for Class IV.
- d. In-house hospital physician's visit benefit. This benefit is payable in an amount equal to the actual expenses incurred for necessary professional medical treatment received from a qualified doctor during hospital confinement up to the maximum daily benefit limit and maximum number of 31 days for any one continuous period of disability. The maximum daily rates are as follows: P100 for Class I; P75 for Class II; P50 for Class III; and P25 for Class IV. The word "visit or call" shall mean a personal attendance of the doctor to the interned patient and such visit shall not include telephone or other calls during which doctor does not see or examine the patient in person.

The number of days that insured individual is confined in the hospital shall be construed to be number of days from which the hospital charges for room and board and shall correspond to one treatment only in any calendar day.

Major Medical Benefits are payable only after the Basic Medical Benefits and Medicare Benefits have been deducted. A Corridor Deductible, or an amount that has to be paid by member, is applied before any Major Medical Benefits are payable. The Corridor Deductible for all insurance Classes is P100. The maximum benefit are as follows: P50,000 for Class I; P30,000 for Class II; P20,000 for Class III; and, P10,000 for Class IV.

All items under the Basic Medical Benefits are also covered with the addition of the following:

- a. Radiologist's and pathologist's or physiotherapist's fees for diagnosis or treatment;
- b. Emergency transportation by a professional ambulance from the place of disablement to nearest hospital;
- c. Rental of wheelchair, hospital type of bed, iron lung used solely for medical treatment;
- d. Prosthetic appliances such as artificial limbs, eyes, etc.
- e. Professional services performed by a registered nurse other than one who ordinarily resides in the insured home or who is an immediate member of the family;
- f. Medical services and supplies performed or prescribed during confinement on account of toxemia of pregnancy, eclampsia of pregnancy, extra-uterine pregnancy, hyperemesis gravidarum of hydatidiform mole; and,
- g. Non-surgical care of tuberculosis or psychiatric treatment while the

insured individual is confined in a hospital as a registered in-patient.

Under the Basic Medical Benefits, the following services, products, or conditions shall not be paid:

- a. Hospitalization services, or treatment in a hospital or in any institution, operated by any authorized civic organization or agency where such confinement care, services or supplies are provided free of charge;
- b. Room and board, general nursing care or special hospital services which are not related or in accordance with the diagnosis and treatment of the condition for which hospital confinement is required by the attending physician or surgeon;
- c. Epidemics or communicable diseases such as smallpox, cholera, bubonic plague, etc. declared by any governmental agency or entity, or an executive order as causing a state of emergency in any area and necessitating the setting-up of appropriate quarantine or isolation measures;
- d. Treatment of any mental and nervous disorders such as psychosis, schizophrenia and others;
- e. Hospitalization priority for x-ray examinations, electrocardiograms, blood examinations, etc. as physical check-up or for diagnostic purposes or purely for recuperative purposes such as confinement in the sanitarium or convalescent homes;
- f. Any treatment for tuberculosis except surgical operations for removal of diseased portions of organs afflicted with tuberculosis, e.g. lung, caecum, etc;
- g. Venereal disease/AIDS, rest cures and care of the aged and infirmed, or treatment arising from alcoholism or drug addiction;
- h. Any treatment or surgical operations for congenital abnormalities or deformities such as harelip, heart defect, cleft palate, clubfoot, cerebral palsy, birthmark, abnormal bone or muscular growth and others;
- i. Cosmetic surgery for purposes of beautification or plastic surgery for any conditions present on the date of effectivity of the coverage as bone or flesh transplanting, except to the extent that any of them are necessary for the repair and alleviation of damage caused solely by accidental bodily injuries covered by the Certificate;
- j. Sickness due to birth control preparation or conditions which result from any of them;
- k. Sterilization of either sex such as castration, vasectomy, tubectomy and tubal ligation;
- l. Hospital confinement due to pregnancy or resulting childbirth, abortion or miscarriage or caesarian section, prenatal or postnatal care;
- m. Use or acquisition of special braces or prosthetic appliances such as artificial limbs, hearing aids, etc.;
- n. Dental examination, extractions, fillings and general dental attention surgery, except dental operation to repair injury sustained in an accident;

- o. Any process in determining the refractive errors of the eyes and correction of glasses on contact lenses;
- p. X-ray therapy, radium therapy, radium and isotopes or cobalt;
- q. Charges for private nursing duty of a registered nurse, special food orders, accommodations and food for companions, vitamins, minerals and other supplemental food preparations and medicines which are personally requested and/or bought without the physician's prescriptions and non-medical personal services as radio, telephone, refrigerator and the likes;
- r. Any other hospitalization expenses which have not been previously recommended by a legally licensed physician or surgeon or not provided under the plan;
- s. Any accidental bodily injury, or disease incurred by an insured individual as a result of the employment or in the course of performance of such employment and for which the insured individual is entitled to benefits under the Employee Compensation Commission or similar laws;
- t. Hospital confinement or for charges of surgical fees incurred which result from:
 - i. Any bodily injury sustained by the insured individual while he is in or on or about any airplane or aerial device except while travelling as a fare paying passenger in a passenger airplane which is operated by a commercial airline or any regular and scheduled passenger trip over its established passenger route;
 - ii. Any form of disability, injury or sickness, sustained or contracted in riot, civil commotion, insurrection or war or any act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization; and
 - iii. Any bodily injury self-inflicted intentionally whether the insured is sane or insane at the time of commission.

u. This insurance is not payable for hospital confinement services, supplies, treatment or any other medical care which are furnished or for which benefits are payable under any other in force policy or plan, or under any extension of benefits provision of any other such policy or plan which has been canceled; provided, however, that if the benefits payable from such policy or plan are less than the total expenses incurred by the insured individual, the Company shall reimburse the remaining amount equal to benefits provided under this plan. In no instance however, shall the total payments from this plan and such other policy or plan exceed the total incurred expenses.

The limitations under the Basic Medical Benefits shall also apply to the Major Medical Expense Benefits. In addition to these, the Major Medical Expense Benefits is not payable for the following expenses:

Not included in the definition of eligible medical expenses;

Not connected with treatment of a disability as defined in the Schedule;

Not recommended or approved and certified by a physician as necessary and reasonable;

- d. Rendered or received in any facility where care is provided without charge;
- e. In connection with pregnancy, resulting childbirth (normal or caesarean), miscarriage, or abortion, prenatal or postnatal care;
- f. Incurred for medical services for a newborn child during hospital confinement immediately following birth;
- g. Incurred within 3 months after the commencing date of insured individual's insurance hereunder or account of any disability commencing prior to the effective date of the insured individual's insurance hereunder;
- h. Incurred for hospital confinement, services supplies, treatment or any other medical care which are furnished or for which benefits are payable under any other in force policy or plan or under any extension of benefits provisions of any such policy or plan which has been canceled, provided, however, that if the benefits payable under such other policy or plan are less than the total expenses incurred by the insured individual, the Company shall reimburse in an amount equal to the benefits provided under the plan. In no event, however, shall the total payments from the plan and such other policy or plan exceed the total incurred expenses.

C. PROFILE OF INSURED MEMBERS

At the end of 1991, 32 corporations were recorded as insurers of the Reference Company. No head count of individual policy holders or members were, however, given. In Cebu City, the Company had 575 enrolled members the same year but there were no insurer corporations.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Since the Reference Company has no accredited health facilities, information on the availment of services by members such as, consultation, diagnostic procedure and hospital admission are not considered significant to its operations. Nevertheless, the Company cited four leading causes of consultation by insured individuals, namely: hypertension, urinary tract infection (URI), cancer and diabetes. Diagnostic procedures availed of by members, on the other hand, were: chest x-ray, ECG, ultrasound, treadmill test, CT scan, biopsy and ECG. The leading causes of confinement or hospital admissions were hypertension, URI, cancer, diabetes, cholecystitis, PTB, maternity cases. The average length of confinement cited per member or patient is 3-5 days, with the shortest at 1 day and the longest at 100 days.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The Reference Company markets its plans mainly through sales presentation to respective companies. This is usually done by a sales force composed of individual agents, insurance brokers and in-house sales staff. Commissions and bonuses are provided as compensation to the first two types of sales force. Salary, allowance, bonus, car plan and profit-sharing opportunity are given to in-house staff who are involved in marketing activities.

Applications for membership is approved if the applicants qualify as individuals. These refer to full-time active employees aged 18 to 64.

Future members shall become eligible upon permanent appointment as regular full-time active employees. Individuals not actively at work on the effective date of the policy shall be eligible only upon return to active full-time work.

An individual eligible on the date the Policy took effect shall accomplish the enrollment card furnished by the Reference Company to insurer (contracting company). Future members must be enrolled within 31 days from the date he becomes eligible, otherwise, he shall be required to furnish, at his own expense, evidence of insurability satisfactory to the company in addition to his properly accomplished enrollment card. His insurance shall become effective only upon approval of such application and evidence of insurability.

Individuals may benefit from the plan during any one period of disability which, upon the recommendation and approval of a legally qualified physician, requires confinement of at least six (6) consecutive hours in a hospital licensed by the Department of Health.

Benefits are in the form of reimbursement or payment of actual, necessary, reasonable and customary expenses incurred but not to exceed the applicable maximum benefits.

The term "any one period of disability" as used refers to all periods of disability arising from the same cause or causes or closely interrelated causes separated by an interval of not more than two (2) weeks of active full-time work. The interval is counted from the date of discharge in one confinement to the date of admission in the subsequent confinement. Once the confinement is so separated, they shall be considered as if they were caused by disability wholly different from each other then shall be individually and separately compensable in accordance with the maximum benefits in the Schedule of Benefits. With respect to pregnancy (if maternity is provided under the plan), all hospital confinement related to the same pregnancy shall be regarded as one disability.

2. Claims Processing

The Company adopts the following standard procedures for processing claims for reimbursement filed by members:

- A. Obtain Claim Form from Personnel Department and have Parts I and III accomplished by claimant and attending physician.
- B. Return the form to Personnel Department properly accomplished together with hospital's and doctor's statement of accounts, charge slips and all official receipts.
- C. Claims Committee assesses and approves claim.
- D. Accounting Department prepares check and payment.

The Claims Committee reviews and assesses claims based on the following:

Medical review;
Financial review;
Accounting review; and
Validity check.

The Company urges claimants to file their claims immediately after leaving hospital to facilitate processing. The usual or average amount of time to process claims and effect payment to claimants is 7 working days. The longest period experienced was 20 days while the shortest was 2 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The Company adopts the following measures to contain the cost of services to members at reasonable levels and generate savings and profit for the business:

- a. Enforcement of exclusions and limits;
- b. Careful calculation of risks on the basis of age and type of occupation;
- c. Calculation of costs through volumes of employees; and
- d. Use of company's claim experience in determining renegotiation or repackaging of premium.

The last 2 measures stated above have been used effectively to retain or increase cost of premiums. However, if estimates were found too high for the client-corporations, renegotiation and repacking are undertaken.

The usual forms and methods of abuse and fraud experienced by the company were tampering of documents and client's tendency to go to expensive facilities even if it was not necessary.

To protect the Company from such abuses, investigation of records in concerned facilities were conducted. This safeguard has been found effective as demonstrated by a case where one member claimed for 10 days confinement but, upon investigation, was discovered to have been confined only for 2 days. The claim was declared anomalous and therefore, was denied.

However, respondent said that safeguards do not always work satisfactorily. If the claim originates from the provinces, verifying the authenticity of documents becomes difficult. Sometimes, it is more costly to verify than to just pay the claim. The Company-respondent opined that safeguards, however air-tight, cannot totally eliminate frauds and abuse.

G. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Company-respondent believes that the prospect of expanding target market among employees/members of big corporations or organizations is very promising as indicated by the increasing number of corporate accounts. This is attributed to the following factors:

1. Good relation of the Company with their brokers;
2. Fast settlement of claims;
3. Being affiliated with big fraternal organizations; and
4. Being known in the field of insurance business.

Case Report No. 12: (Life Insurance)

Reference Companies No. 6, 20, 27, 37 & 48

Area(s) Studied: NCR, Cagayan, Cebu, Misamis Or. & Surigao del Norte

A. IDENTIFICATION

The reference company is represented in this study by its head office and four regional or branch offices. These are: (i) the National Capital Region (NCR) head office established in 1932 with Metro Manila towns and cities as its market area; (ii) Tuguegarao, Cagayan branch office in Region II established in 1980, serving Cagayan and Kalinga-Apayao areas; (iii) Cebu City branch office in Region VII established in 1947, serving Cebu province and nearby areas; (iv) Surigao City, Surigao del Norte branch office in Region X, serving the province of Surigao del Norte; and, (v) Cagayan de Oro City, Misamis Oriental branch office also in Region X, serving the whole of Northern Mindanao.

The above offices are affiliated with a well-known American firm whom they recognize as their mother company. Although managed and staffed by Filipinos, the company is listed as American.

In general, the survey respondents, who were mostly Regional or Branch Managers, gave full support to the study and were courteous and accommodating. However, many vital data and information on the health insurance operations in their respective service areas could not be obtained at the branch offices. Instead, the research teams were referred to the Home office for data and information on many items indicated in the questionnaire. The branch offices claimed that said data which are routinely sent to home office may be available in Manila.

The branch offices in NCR, Surigao City and Cagayan de Oro City were able to give some information, although these were not complete and/or left many questions unanswered. The Cebu City and Tuguegarao branch offices, on the other hand, gave practically no information on their local operations and plans.

As a consequence, the study relied mainly on data retrieved from available documents, brochures, reports and other information materials describing the operations and product offerings of the company. In general, the information and data presented in this report describes the general features of the company. There are, however, some unique features applicable only to a particular branch office and are, therefore, so specified in the report.

B. HEALTH PLANS AND BENEFITS

The Company offers standard health plans, either as automatic features of its main product(s) or as optional riders to other insurance plans. Each branch office, however, may introduce new features, or remove some features of the standard plans based on their perception of local demand and supply of services. Branch offices also differ in their marketing focus and approaches.

In Cagayan and NCR, the company focused on their Group Hospital Insurance as their main offering for business companies and industrial firms whose end beneficiaries are the employees and the workers. Premium rates are not listed nor reflected in usual tabulated schedules, but are custom-made for each group based on assessment of risk, occupation and location of employees, etc.:

Cities of Cebu, Cagayan de Oro and Surigao offer the regular and basic plans with reimbursable medical cost benefits. As "special offer" they

are promoting a plan called "Excelife" for the general public. The premium rates are based on age of policy holder and corresponding benefit package, ranging from a minimum of P1,551.06 per year to a maximum of P23,797.93 per year.

Premium rates are determined by actuarial computation for the standard plans. In the case of Group Hospitalization plan, premium rates are determined by both actuarial computation and negotiation with corporate clients.

Group medical insurance provides for the reimbursement of hospitalization expenses incurred as a result of accidental bodily injury or disease. This covers the following items as reimbursable expense benefits.

- a. Hospitalization
 - Room and Board
 - Professional Fee
 - Laboratory, x-ray, diagnostics
 - Drugs and medicines.
- b. Others
 - Surgical
 - Ambulance

All medical insurance benefits are applicable without geographical limitations.

The following are excluded from coverage in the Group Medical Insurance:

- a. Functional disorders of the mind;
- b. Rest cures;
- c. Non-surgical care for tuberculosis;
- d. Congenital anomalies existing prior to the insured person's effective date of insurance;
- e. Voluntary sterilization of either sex;
- f. Hospitalization primarily for diagnosis, x-ray examinations, or physical therapy;
- g. Dental examinations, extractions, fillings and general dental attention or eye refraction or fitting of glasses except to the extent that any of them are necessary for the repair and alleviation of damage to the insured person caused solely by accidental bodily injuries;
- h. Drug addiction or alcoholism;
- i. Any communicable disease declared by any government agency or entity as causing a state of emergency in the area and necessitating the setting up of quarantine measures therein;
- j. Injuries due to insanity or self-infliction;
- k. Special nursing care on non-surgical services rendered by physicians;
- l. Diseases or injuries whose basic care is provided for by law;
- m. Facilities care and hospital services not in congruence with the diagnosis;
- n. Blood and blood plasma;
- o. X-ray, radium therapy, radium and isotopes;
- p. Procurement and use of special braces, appliances or equipments; and
- q. Cosmetic surgery for purposes of beautification;

In addition to the above exclusions, the following limitations are also on hospitalization benefits:

- Number of days that the insured person is confined in a hospital shall be construed to be equivalent to the number of days for which the hospital charges for room and board;

- b. Successive periods of hospital confinement shall be construed as having occurred during one continuous period of disability;
- c. No benefit is payable as a result of confinement in a hospital where care is provided without charge;
- d. No benefits shall be payable to any period of confinement on special hospital services unless these had been recommended and/or approved by a Physician;
- e. No benefits shall be paid if confinement is due to pregnancy, childbirth, abortion or miscarriage;
- f. No benefits are payable for non-medical services such as radio, telephone and the like;
- g. No benefits shall be payable for confinement, services, supplies, treatment on any other medical care which are furnished or are payable under any other plan or policy in force; and
- h. No benefits shall be payable with respect to any period of disability which commenced prior to the insured person's date of eligibility to participate.

Group major medical insurance, on the other hand, provides reimbursement health benefits for the following:

- a. Charges for room and board made by a hospital in connection with hospital confinement;
- b. Charges made by a physician for diagnosis on treatment;
- c. Charges made by a physician or professional anesthetist for the cost and administration of anesthetics;
- d. Charges made by registered nurse for nursing care;
- e. Charges made by radiologist or physiotherapist, on laboratory for diagnosis of treatment;
- f. Charges made by physician for the performance of surgical procedures;
- g. Charges made for professional ambulance to and from the hospital; and
- h. Charges made by any person or institutions for supplying any of the following, to the extent that they do not duplicate any charges included under items (a) to (g): (i) drugs or medicines prescribed by physician; (ii) blood or blood plasma; (iii) artificial limbs or eyes; (iv) casts, splints, trusses, braces or crutches; (v) oxygen and rental of equipment for the administration thereof; (vi) rental of an iron lung or other mechanical equipment required for the treatment of respiratory paralysis.

The general exclusions applicable to group medical insurance also apply to Major Insurance.

For the life plan (Excelife) which the reference company promotes as "action par excellence" and referred to as a plan that provides almost everything, the following benefits are highlighted:

Death benefit - pay the face amount of the policy to the beneficiary upon

the death of the insured within 20 years. Thereafter, the face amount of the policy payable to the beneficiary will be increased annually. The value of the benefit ranges from P50,000 to P300,000;

- b. Hospital income benefit (for 20 years) - whether the insured is alive or not, the beneficiary will be paid the daily hospital income specified in the schedule of benefits and premiums if the injury or sickness results in hospital confinement. Daily hospital benefit ranges from P100 to P700;
- c. Double benefit for dreaded disease (for 20 years) - Daily hospitalization benefits will be doubled if the sickness which results in confinement is classified as dread disease. These are cancer, polio-myelitis, muscular dystrophy, multiple sclerosis, cerebral palsy, or cirrhosis of the liver. Daily hospital benefit ranges from P200 to P1,400; and
- d. Personal Accident Insurance Benefit - the principal amount or a portion thereof of Personal Accident Insurance coverage are paid to beneficiaries in case of accidental death disability or dismemberment. The value of the personal accident insurance benefit ranges from P50,000 to P300,000.

The exclusions and limitations previously mentioned are also applicable to "Excelife". No benefits shall be provided for hospital confinement resulting from injury sustained or sickness for which the insured received medical advice or treatment within 12 months prior to the effective date.

Additionally, the following limits on Excelife benefits are applied:

- a. Room and Board - daily limit for a maximum of 31 days from P30 to P40;
- b. Hospital services - 80% of actual charges with a maximum of P600 to P900;
- c. Surgical benefits - as per schedule with a maximum of P1,000 to P1,500; and
- d. Ambulance - fixed at P100 to P150.

Exclusions are observed and enforced as a cost-saving measure because some of the conditions are already covered by workmen's compensation law.

Health plan benefits are extended to members through cash reimbursement and direct services.

There are no set limitations on the service providers. Policy holders or enrollees are free to avail of services rendered by any licensed health provider. In Surigao City where direct health facilities are inadequate, members may avail of services outside the city, such as: St. Luke Medical Center, Capitol Medical Center, Manila Doctors Hospital and Cebu Doctors Hospital.

Except for Tuguegarao, all branch offices process claims for reimbursement. Members or insured persons are expected to share 20% of the cost of services after Medicare and health benefits from other plans are deducted from the total hospitalization expenses.

PROFILE OF MEMBERS/ENROLLEES

During the last quarter of 1991, the head office had an estimated 500,000 policy holders from client groups and corporations all over the country. Surigao on the other hand listed 3 corporations as its policy holders for the same quarter but could not give estimates of the number of covered individuals.

Statistical data were obtained on the occupation, age, sex, marital status and residence of enrollees because these would require tedious records

review which would not have been possible within the timetable of the survey. Also, the survey team was referred to the home office where computerized data were presumably kept. When followed up, however, the home office was also unable to give disaggregated data by region on the profile of members.

D. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

In marketing their plans, the branch offices make use of the company sales force composed of individual agents, insurance brokers and in-house sales staff. NCR was reported to have 4,000 individual agents, 10 insurance brokers and 6 in-house staff as active members of its sales force. Cebu City comes next with 350 individual agents; Tuguegarao with 45 individual agents and 3 in-house staff; Surigao City with 32 individual agents and 2 in-house staff; and Cagayan de Oro city with no individual agents but with 2 insurance brokers or agencies. Individual agents and brokers are compensated by commissions. In-house staff are paid regular salaries. Incentives, whether cash or in-kind, are sometimes given on sporadic and seasonal basis.

Policy holders and enrollees are the lifeblood of the insurance business, thus extra effort is usually exerted to promote productive marketing. Nevertheless, the company does not indiscriminately accept new enrollees. Standard procedures for screening enrollees and approval of applications are enforced. The following guidelines are used in accepting applicants for enrolment:

- a. Applicant should not be more than 55 or 60 years old depending on the plan he wants to enroll in;
- b. Applicant must be healthy and actively at work; and
- c. Applicant must accomplish and submit application form.

If prospective enrollees pass these criteria, their applications will be approved and subsequently accepted. Those who fail to meet the criteria are rejected.

2. Premium Collection

Premiums are collected from enrollees in various ways. The NCR branch office directly collects from client groups or corporations. Others do their collection through salary deduction, sales agents doubling as collectors, and direct payments to collecting offices.

3. Claims Processing

The standard procedures for extending benefits to members or policy holders in processing of claims are as follows:

Notice of any hospital confinement, operation or other disablement on which a claim may be based must be submitted to the company on a prescribed form by, or on behalf of, an insured person within 20 days from the commencement of such confinement or disablement, or on the date in which operation is performed;

All official receipts must be attached to the prescribed form. Such request of benefits must be presented within 6 months from the expiration of the allowed period for notifying the Company about the events for which claim for benefits is filed;

- c. The company will process the payment of all claims for benefits in accordance with the terms of the policy. All benefits that pertain to a member will be paid to the order of the said member. In case of death of member, any benefit due but remaining unpaid shall be paid to the person or persons designated as beneficiary by said member;
- d. Statements of account, medical certificates, and official receipts should be attached and submitted with the claim form;
- e. Claim forms and supporting documents are submitted to regional office for processing then to home office for approval; and
- f. Upon approval, check will be released to claimant via the regional office concerned.

Claims are reviewed and assessed based on the following considerations:

- a. Medical review to determine the appropriateness of service provided and amount of benefits availed;
- b. Accounting review to check on the receipts; and
- c. Validity checks to safeguard against possible abuses like submission of false receipts or statement of accounts.

The time required to process claims and effect payment is affected by the relative distance from the home office. For NCR, the average is 14 days; shortest 5 days; and longest 60 days. Cebu City took 30 days on average, with 7 days as the shortest and 60 days as the longest. Cagayan de Oro City meanwhile reported 30 days as average and shortest; and 60 days as the longest. Surigao City and Tuguegarao did not indicate the average, shortest and longest claims processing time.

To process provider bills for services directly provided as in pre-membership physical examination, official receipt of expenses, medical certificate and attending physician's certificate are submitted.

3. COST CONTAINMENT MEASURES AND MECHANISMS

The primary cost-containment measure is the screening for adverse selection through the use of prescribed application forms and application of exclusions and limits. Determination of authenticity of claims and use of co-insurers are also used as cost containment measures.

These measures were proven effective in some instances, the examples of which are cited below:

- Attempts to claim benefit items not within the coverage were detected and eliminated;
- Insuring of high risk groups were prevented;
- 80% share of expenses of co-insurer was assured; and
- Isolated cases of adverse selection.

However, there were also instances when these measures have failed. A case was when the hospitalization occurred in a far-flung area where collection of documents was difficult to implement. Another was an ex-gratia

case where payment was made on a claim which did not merit coverage, but was converted into a financial assistance by the claims committee.

Various forms of abuse and frauds were experienced by the company. The following are some of the more common:

- a. Submission of fraudulent documents;
- b. Misrepresentation- concealment of pre-existing illness;
- c. Ghost confinement; and
- d. Collusion of patient and doctor - misrepresentation of hospital charges.

As safeguard, agents caught concealing medical history of members had their license revoked. Surprise visits were made to hospitals and those found guilty of anomalous practice were penalized by termination of their policy.

F. PERFORMANCE INDICATOR AND FINANCIAL STATUS

No data/information were given on the financial status and service performance of the reference company. The company has invested in securities and bonds, lending and real estate, presumably using savings from excess premiums.

G. RESPONDENTS' VIEWS ON INDUSTRY PROSPECTS

The company respondents suggested that a health insurance operation like theirs would require at least P20M as start-up capital. The minimum requirements for personnel are: 12 for marketing, 25 for administration, 5 for actuaries, and 3 for analysts and programmers. The minimum equipment needed are IBM 400-15 work station, 1 telephone, 1 fax machine and telex.

The following factors and conditions are deemed to affect the growth and development of the industry (health insurance):

- a. Current cost of medical care;
- b. Capacity of group/employer to provide health insurance;
- c. Economic progress; and
- d. Reduced taxes on insurance plan.

The cost of medical care was considered the most important factor affecting the growth and development of health insurance because it determines the price of the plan, and is the primary motivation for buying insurance.

The most serious problems considered to affect the business are:

- a. Escalation of health care cost; and
- b. Absence of standard health care cost.

These problems could be addressed by preventive health care and education to make people health conscious. High health care cost is deemed a formidable problem which is not totally within the control of the insurance industry.

Advertising should be regulated both by government and industry peers so they are truthful, factual and not misleading. Tax incentives should be used to encourage the growth of health insurance. Current tax rates could be used to ease the financial burden of running a health insurance operation.

Case Report No. 13: (Life Insurance Firm)
 Reference Companies No. 19, 34 & 47
 Area(s) Studied: Cagayan, Bohol, Surigao del Norte

A. IDENTIFICATION

The Reference company operates in all sample provinces except Quirino. However, only three branch offices of the company were included in the in-depth study; i.e., branch offices in Tuguegarao, Cagayan (Region 2); in Tagbilaran City, Bohol (Region 7); and, in Surigao City, Surigao del Norte (Region 10). For most part, the operations in each of the three branches did not differ much from each other.

The Reference Company is a Filipino corporation principally engaged in life insurance. The branch office in Cagayan was established in 1969, or 20 years ahead of that in Tagbilaran City, Bohol which was established in 1989. The respondents from the Surigao del Norte branch office were not aware of the date it was established.

Of the three, the Cagayan branch office had a wider area of coverage, its market being that of the whole Region 2. The other two subject branch offices cover only the provinces of Surigao del Norte and Bohol, respectively.

B. HEALTH PLANS AND BENEFITS

All three branch offices offer health plans as optional rider to personal accident insurance. Though each branch office call their respective health plans by different names, the benefits offered are basically the same. For one, all three subject branch offices only offer group health plans.

In Region 2, the Reference Company offers the Teachers Protection Plan and Student Group Plan. The premium is P102.00/unit/year for teachers and P15.00/unit/year for students. Similar Plans are offered in Surigao del Norte but at different premium costs as follows: (a) Teachers Family Protection Plan with premium of P8.50/unit/month, (b) Student Group Plan with a premium of P15 per unit per year, and (c) Employees' Protection Plan with a premium of P187 per unit per year.

For all the above Plans, an insured member may reimburse expenses for hospitalization or surgery due to accident, subject to certain ceilings and other limits. Specific benefits and corresponding limits are as follows:

1. Room, Board and General Nursing Services - actual charges up to P12 per day, for a maximum of 31 days during any disability in any benefit year;
2. Special Hospital Services - 80% of the actual charges incurred during any disability (except pregnancy) in any benefit year for each one of the services specified below, provided that the net amount payable pertaining to each service shall not exceed the amount indicated therein, and provided further that the total net amount payable for all these services shall not exceed P150;
3. Surgical Benefits - surgical fees incurred in any operation enumerated in "Schedule of Surgical Operation", including post-operative care, subject to the maximum payment indicated in the said schedule. Maximum fee is set for each type of surgery, the lowest being P15 for simple surgeries such as the treatment of fractured toe or finger and the highest being P300 for more complicated surgery such as removal of portions of the lungs; and

- d. Maternity and Obstetrical Benefits - female life assured will be reimbursed for maternity expenses as indicated up to a maximum of P150, obstetrical procedures included.

The plan offered in Bohol is called Group Association Plan (GAP) which is specially designed for open groups (associations duly registered) with at least fifty (50) members. GAP is a level term insurance coverage packaged by units of one(1) up to a maximum of ten (10). The premium is determined on the basis of number of units and type of group. The groups are classified in consideration of the potential risks that members are exposed to. In this manner, groups under Class A are considered exposed to less risks, therefore are charged lower rate; Class B, more risky, with higher rates; and Class C, most risky, with highest premium rates. This Plan classifies associations as:

- a. Class A - Associations like religious and civic association, homeowners associations, florist and gardeners association, consumers associations, professional organizations, health and sports clubs, mass media and entertainment industry association, association of bell boys, waiters, cooks and bakers;
- b. Class B - Associations like association of jeepney, tricycle, bus, taxi drivers, association of farmers, credit cooperatives, market vendors associations, employees of refineries, paint varnish and fertilizer manufacturing firms; are
- c. Class C - Associations like association of security guards, pilots, metro aide, labor unions, political groups, association of stevedores and warehousemen, association of miners (no underground miners) and cement manufacturing employees.

Benefits covered are as follows:

	<u>Coverage</u>	<u>Benefits per Unit</u>
a.	Life Insurance with Burial	P10,000
b.	Accidental Death	10,000
c.	Dismemberment Indemnities	
	- loss of both hand or both feet or sight of both eyes	10,000
	- loss of one hand or one foot or loss of one hand or foot or sight of one eye	10,000
	- Loss of one hand or one foot or sight of one eye	5,000
d.	Hospitalization and surgical expense benefit	
	- Rooms and board, per day, maximum of 31 days	75
	- Special hospital services, maximum of	2,000
	- Surgical, per schedule, maximum of	5,000
	- Physician's visit per day, maximum of 31 days	40

It may be noted, that the maternity and obstetrics benefits are not offered in Bohol. On the other hand, the Bohol Plan has provisions for physicians visits which are not included in Cagayan and Surigao.

For GAP of Bohol, limitations on coverage are on the type of occupations and their corresponding risks. For instance, stuntmen, sports, like mountain climbing and underground miners are excluded. Likewise Associations with less than fifty (50) members are excluded.

The Health Plans in Cagayan and Surigao, are subject to the following exclusions which are enforced by the Insurance Commission as standard procedures to restrict the commercial indemnity insurance firms from competing with HMOs:

- a. Dental service of any kind;
- b. Eye refraction;
- c. Functional disorders of mind;
- d. Rest cures;
- e. Non-surgical care for tuberculosis;
- f. Congenital anomalies;
- g. Sterilization of either sex;
- h. Hospitalization, primarily for diagnosis, x-ray, physical therapy;
- i. Drug addiction or alcoholism;
- j. Communicable diseases requiring isolation or quarantine;
- k. Injuries due to insanity or self-infliction;
- l. Special nursing care on non-surgical services rendered by a physician;
- m. Hospital or medical services for which no charge is made to the individual;
- n. Confinement of which charges for hospital and medical services are payable from the benefits of any workmen's compensation law;
- o. Room, board, general nursing on special hospital services not in accordance with the diagnosis and treatment of the condition for which hospital confinement is required;
- p. Blood and blood plasma;
- q. X-ray therapy, radium therapy, radium and isotopes;
- r. Procurement and use of special braces, appliances or equipment;
- s. Cosmetic surgery for purposes of beautification;
- t. Plastic surgery for any condition existing on the effective date of the insurance;

The Reference Company does not have accredited health service providers. Members could avail of services from any hospital, diagnostic clinic, or doctor of their choice.

C. PROFILE OF MEMBERS/ENROLLEES

The branch office in Cagayan did not have data on their enrollees. In Bohol, not one of their enrollees opted to avail of the hospital and surgical benefits as rider.

The branch office in Surigao registered a total of 1,632 enrollees as of the last quarter of 1991. Of the 1,632 enrollees in Surigao, 1,600 are students and 32 are employees. All 1,600 students are below 15 years old and single; 600 are in elementary and 1,000 are in high school. As to the employees, 27 are teachers and 5 are employees of other offices; 5 are male and 27 are female; 28 are married and 4 are single; all of them are college graduates; 31 belong to the 15-45 years old bracket and 1 within 45-65 bracket; all are city residents and principal policy holders.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Data on availment of hospital services by members are not available in all three branches. In Surigao, 3 cases of confinement were recorded; i.e., one student due to accident; one employee due to infection and one teacher due to renal case. Estimated average length of confinement was 7 days; with the shortest at 3 days and the longest at 21 days.

E. MANAGEMENT AND OPERATING SYSTEMS**1. Marketing and Recruitment**

The three branches market their insurance plans primarily through direct selling. In Bohol, marketing is reinforced by the use of "padrinos".

The Cagayan branch office is the biggest in terms of sales force which consists of 30 agents and 3 in-house staff. The Bohol and Surigao offices had 3 and 14 individual agents, respectively. The agents are compensated through commissions, and other incentives, either in cash or in kind. The in-house staff receive regular salaries as well as commissions and incentives for every sales made.

There are standard procedures for screening of enrollees and approval of application of membership for all the three branches. Members are accepted or rejected depending on their age, health status and type of occupation.

2. Premium Collection

Premiums are regularly collected from members through salary deduction, bank payment, agent/collector, and direct payment to the office. There are no statistical data on the distribution of members by manner of payment.

3. Claims Processing

Procedures for availment of benefits are standardized across the three branches.

There being no accredited service provider, members may go directly to hospitals of their choice. The company must be informed of member's confinement. The claims form is accomplished and submitted to the company together with the proof of hospital confinement within ninety (90) days from the termination of the confinement. Failure to do so shall invalidate the claim except if it can be proven that it was not possible to furnish such proof within 90 days and such proof was furnished as soon as reasonably possible. The company may require, submission of patient charts and/or certification of hospital confinement. The company also reserves the right to examine the patient-claimant while the claim is being processed and held pending.

All claims document are processed and approved in the Manila head office. Once approved, payments are made to members only after benefits from Medicare and Employees Compensation Commission have been deducted. The average or usual time to process claims and effect payment to members is about 7 days; with the shortest at 30 days and the longest at 60 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The Reference Company considers the exclusions imposed by the Insurance Commission as its primary form of cost containment.

Cases of abuse or fraud were experienced. In one case, one claimant was found to have a pre-existing condition. The claim was subsequently denied. Abuses and frauds were also committed by agent. For instance, one agent insured a non-existing individual for regular life insurance. To further avoid abuses, agents are usually screened to ensure that they are of good moral character. They are also required to attend a seminar and pass an examination before they are accepted as insurance agents.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

About 25% of premium are spent on marketing costs which consist mainly of commissions and overrides. Administrative costs on the other hand, consist of salaries, rental and expenses for light, water and telephone bills. The specific amounts spent were, however, not available, or were not given to the researchers.

H. RESPONDENTS' VIEWS ON INDUSTRY PROSPECTS

Respondents from both the Bohol and Surigao branch offices ranked household income and employment; and, economic progress as most important factors affecting the growth of the industry. The Bohol respondent also cited the competition posed by HMOs as an important factor. Household income was ranked first because it determines the capacity of people to purchase and maintain a hospitalization plan.

On the other hand, the respondents mentioned that the prohibitive cost of insurance which is beyond the reach of the average Filipino families hampers the industry's growth. It was opined that this problem should be addressed through equitable distribution of wealth which is now under the control of just 10% of the total population. One respondent also cited the pirating of agents as a serious problem. No solution was mentioned except to recruit and train new agents.

It was recommended that the government impose tariff rates on premiums to avoid cut-throat competitions. It was also recommended that the government regulate charging of professional fees by imposing uniform rates for each kind of service rendered.

The expansion of coverage of health plans was also viewed in relation to the HMOs. One respondent believed that if the premium of HMO-hospitalization continues to go up and yet fail in the delivery of its committed benefits, then the traditional reimbursement type of hospital insurance under the commercial indemnity firms may double its current enrollees.

Case Report No. 14: (Investor-Based Health Maintenance Org.)
 Reference Companies No. 7, 28 & 38
 Area(s) Studied: NCR, Cebu and Misamis Oriental

A. IDENTIFICATION

Reference company is an investor and insurance type of HMO organized in September 1, 1990. It was created through a merger of a prominent pre-need company and a group health service-based health maintenance organization, two companies noted as pioneers in their respective fields.

One partner was the recognized leader in the pre-need education plan industry, having introduced the concept of pre-need education plan in the Philippines in 1980; while the other partner introduced the HMO industry in the country in 1974.

This study covers operations at NCR, Region 7 and Region 10.

B. HEALTH PLANS AND BENEFITS

The company offers 6 types of health plans for individual and family membership. These are:

<u>Basic Plan</u>	<u>Annual Premium</u>
Plan 200	P 2,989.00
Plan 300	3,829.00
Plan 400	5,519.00
Plan 600	8,715.00
Plan 800	11,133.00
Plan 1000	15,243.00

The amount of premium varies depending on the type of enrollee, whether individual or family, Medicare or non-Medicare member. There are no standard rates for group or corporate accounts. The amount of prepaid contributions are individually determined through actuarial computations and negotiation with clients. The company offers comprehensive health care benefits. Out-patients benefits include the following:

- a. Any number of consultation with primary medical service unit (PMSU) or clinic;
- b. Laboratory, X-ray, diagnostic examinations;
- c. Annual physical examination, which includes taking of medical history, chest x-ray, urinalysis, stool examination and CBC; and
- d. Emergency treatment of minor injuries.

In-patient benefits include the following:

- a. Room and board;
- b. Professional fees of attending doctor; and
- c. Laboratory, X-ray, diagnostics

Confinements due to ordinary sickness is unlimited, but confinement for dreaded sickness has a ceiling of P30,000 for the lowest cost plan and P159,999.99 for the highest cost plan.

Other benefits with limits are dental services wherein a member can avail of one oral prophylaxis per year and rehabilitation services, which is limited

to a maximum of 7 sessions.

Services and conditions usually excluded from the Plan are as follows:

- a. Conditions existing prior to membership;
- b. Conditions arising from acts which are not sanctioned by society like STD, AIDS, suicide, etc.;
- c. New procedures like lithotripsy and ultrasound;
- d. Mental and nervous disorders;
- e. Pregnancy, childbirth, miscarriage, abortion;
- f. Conditions requiring use of ICU;
- g. Congenital deformities and defects, cosmetic and plastic surgery; and
- h. Conditions which are recurrent in nature.

Pre-existing conditions are generally excluded during the first year of membership, but can be covered in the second and subsequent years of membership.

The above benefits are extended to members in a form of direct services through accredited service providers and cash reimbursement for emergency case obtained in non-accredited facilities.

In NCR, the company has 10 accredited out-patient clinics and one company owned, 17 dental clinics, 4 laboratory and diagnostic clinics, 13 private and public hospitals and 221 physicians with various specialization.

To be accredited, hospitals must meet the following company requirements:

- a. It must be accessible to client;
- b. It must provide a broad range of services; and
- c. It must have complete hospital facilities.

For physicians to be accredited, they must have the necessary Board Certification and must concur with the procedures and rates offered by the HMO.

Members are required to consult only with accredited health care providers. In emergency cases where members are served by a non-accredited physician or hospital, members must first pay for the total hospitalization cost and file a claim for reimbursement of 80% of approved expenses up to a specified ceiling.

Medicare benefits are deductible and standard rates for services are observed. Operating funds for the health care provision are sourced from member pre-payments and stockholders equity.

C. PROFILE OF MEMBERS/ENROLLEES

As of the 4th quarter of 1991, the company had 88 group/ corporate accounts consisting of 13,751 members and 1,352 voluntary individual enrollees, nationwide.

Data on the occupation, age, sex, marital status and educational status of enrollees were not available.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

From January - December 1991, the company had provided its members a total of 7,612 MD consultations, 1,313 diagnostic procedures and 410 hospital admissions. Primary consultations done in accredited facilities totalled 4,348 while specialists' consultation totalled 3,257. There were 4 primary

consultations and 3 specialists' consultations in non-accredited facilities.

Cursory analysis of primary consultations by month showed that October had the highest number of consultations (591) while January had the lowest with 220 consultations. For specialist consultations, the month of July had the highest number (374) and the month of February the lowest with 164 consultations.

The ten leading causes of MD consultation were fever (1,903), headache (1,142), cough and colds (990), diarrhea (761), chest pain (685), difficulty in breathing (609), allergy (533), vomiting (457), dizziness (305), and sore throat (227).

Of the total MD consultations done in 1991, 817 availed of laboratory examinations, 490 availed of radiology examinations and 6 had other related examinations performed.

The ten leading diagnostic procedures performed were chest X-ray with 410 cases, ECG with 75 cases, cholesterol (57), Fasting Blood Sugar (353), High Density Lipoprotein (75), ultrasound (25), and stress test (30).

Hospital admissions in accredited facilities, recorded a total of 353 medical cases and 57 surgical cases. There were 24 medical cases recorded in non-accredited facilities.

The ten leading causes of hospitalization were broncho-pneumonia (33), acute gastro-enteritis (21), hypertension (18), dengue/H-fever (17), urinary tract infection (17), systemic viral infection (12), amoebiasis (10), measles (10), and hepatitis (3).

Average length of confinement was 3 days, with the shortest at 1 day and the longest at 5 days.

E. MANAGEMENT AND OPERATING SYSTEM

1. Marketing and Recruitment

To increase its membership, the company utilizes the following marketing strategies:

- a. Advertisement through newspaper ads;
- b. Product presentation to corporate accounts;
- c. Proposal letters to company; and
- d. Cold canvass and account visit

The company has a sales force consisting of 300 individual agents and 17 in-house sales staff. Individual agents get a commission of 17% for group account of 100 members and above, 20% for family account and a prize in the form of health coverage given as incentive when a sales quota is met.

In-house sales staff are compensated on a salary basis and health coverage as incentive.

All applicants undergo medical underwriting evaluation. Enrollees must meet age requirement which a minimum of 16 days and maximum of 65 years, must pass the physical health examination required and must meet the criteria required for dependents enrollment.

2. Premium Collection

Regular contribution is collected from members in a form of salary deduction, collector and company appropriations.

3. Benefits Availment and Claims Processing

As a general rule, members are extended health and medical services directly in company clinics and accredited providers.

The following procedures are usually followed:

- a. Patient must first consult the PMSU;
- b. If PMSU service is adequate, patient is given prescription;
- c. If the PMSU service is inadequate, the doctor will issue a Letter of Authorization (LOA) for referrals to a specialist, diagnostic procedure, and hospitalization.

Members do not normally make out of pocket payments for authorized and covered medical services. Only expenses in excess of ceilings and unauthorized services are paid directly by members.

If members are confined in a non-accredited hospital, the member must inform the office within 24 hours so that they can be reimbursed up to 80% of total hospital bill or the specified ceiling in the plan for emergency care, whichever is lower.

To process claims for reimbursement filed by members, the following should be submitted: medical certificate, official receipts, reimbursement form and original charge slips from the hospital.

Claims filed are subject to medical review to determine appropriateness of service provided; financial review to check application of benefit ceiling; accounting review; and validity checks.

The usual amount of time to process claims and effect payment to members is 8 days on the average with the shortest at 7 days and the longest at 10 days.

Services rendered by accredited providers are billed directly to the HMO following standard procedures, to wit:

For Accredited Hospitals

- a. Charge slip from statement of account are examined; and
- b. Procedures done are examined to determine coverage or charged at the expense of the company.

For Accredited Physicians

- a. Service reports submitted by doctors are examined to determine completeness of report; and
- b. If report is complete, the company will prepare a professional fee summary as a basis for payment

Requirement for processing of bills to service providers are official receipts, statements of account, proof of service use and validation of statements of account. Bills from hospital, clinic and MD's are subjected to medical review, financial review and accounting review. The average amount of time to process bills and effect payment to service providers is 8 days. Shortest is 7 days and longest is 10 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The company adopted the following measures to contain the cost of member services: (i) screening for adverse selection; (ii) exclusions and limits; (iii) PMSU screening; and (iv) referral controls.

Specific example wherein PMSU screening was found to be effective was the low utilization in areas where PMSU is strict and high utilization in areas where PMSU is liberal.

There were also various abuses and fraud that the company have experienced. These include non-declaration of pre-existing conditions in application forms, requests for unnecessary examination/confinements and overstaying in hospitals.

To minimize or avoid these abuses the company has adopted the following safeguards:

- a. Conduct physical examination of patients with high blood pressure, high blood sugar, and patients with asthma;
- b. Monitoring of PMSU; and
- c. Charging patients for excess hospital expenses not covered by the contract

The company opined that fraud and abuses cannot be totally eliminated because of inadequate monitoring system.

G. FINANCIAL STATUS

The company's assets more than doubled from P2,668,441 in 1989 to P5,589,839 in 1990. The increase was mainly due to additional paid-up capital when the company's increase in authorized capital stock was approved by SEC in 1990. The additional assets represented investment in marketable securities, additional acquisition of properties and equipment, and increase in miscellaneous deposits. However, the assets slightly decreased to P5,558,102 in 1991.

On the other hand, the company's liabilities continually increased from P1,592,164 in 1989, to P2,443,327 in 1990 and to P5,348,323 in 1991. The increases were attributed mainly to additional payables and increase in deferred income which represented membership fees collected in advance by the company from clients whose payments are made on staggered basis.

Though the revenues also continually increased from P4,969,488 in 1989 to P8,638,235 in 1990 and P11,037,449 in 1991, the expenses were higher at P5,494,528 in 1989, P9,685,997 in 1990 and P13,967,501 in 1991. Thus, the company incurred net losses of P525,040 in 1989, P1,047,762 in 1990; and, P2,930,052 in 1991. Claims payment represented 45%, 47% and 48% of the total expenditures in 1989, 1990 and 1991, respectively.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECT

To run a health maintenance organization business in the country, the company must have a minimum capitalization of P5,000,000. Personnel staff should consist of 30 marketing staff, 20 administrative staff, 10 health care staff, 20 accounting staff and 5 actuarial staff.

The company should have the following equipment: (i) computer system; (ii) calculator; (iii) telephone, Easy Call/Pocketbell, and (iv) FAX machine.

The growth and development of a health insurance operation is affected by the following factors: (i) economic progress; (ii) company's ability to pay providers and sales force; (iii) government incentives; (iv) household income and employment; (v) education; and (vi) service effectiveness.

Economic progress was mentioned as the most important factor along with the company's ability to pay its service providers and sales force. If company's payment for MD's, hospital and marketing or sales people is on time, then members will benefit from prompt and quality service.

The most serious but solvable problems facing health insurance operations at present are inflation, lack of primary hospitals outside Metro Manila and pricing.

These problems can be addressed by the government by improving the economic condition of the people and providing incentives to encourage private sectors to engage in health insurance. The industry can also help by strengthening the association of HMO's.

The company considers the very low health consciousness of Filipinos as an unmanageable problem attributed to the culture and low economic condition of the people.

Operational aspects that must be regulated by both the government and industry are insurance pricing and standardization of benefits and services.

Looking at the industry as a whole, the company suggested that the regulatory body should be jointly the government and industry peers.

Government support needed to promote the growth and development of health insurance in the Philippines are:

- a. Legislation of a bill requiring health coverage for government and private employees; and
- b. Legislation of a bill mandating hospitals and doctors to recognize HMOs and establish tie-up arrangements.

In the next 5 years, the company estimated a 70% wider coverage of population, 50% expansion of benefit packages and 80% wider geographic scope, because most people are getting more conscious of health care maintenance due to the rising cost of medical services.

**Case Report No. 15: Insurance-Based Health Maintenance Org.
Reference Companies No. 8, 29 & 39
Area(s) Studied: NCR, Cebu, Misamis Oriental**

A. IDENTIFICATION

Reference Company was created to help people cope with the rapidly increasing cost of medical care in the country. Its objective is to manage public health care needs at an affordable cost without sacrificing the quality of service. To accomplish this, Reference Company tapped the expertise of prominent physicians who were originally grouped under a Philippine pioneer group in health care delivery systems.

Reference Company is an affiliate of the largest life insurance company in the country. This study covers its operations at NCR, serviced by the head office located in Manila; as well as its operations in Region 7 with branch office in Cebu City and in Region 10 through its office in Cagayan de Oro City. The Reference Company started its HMO operations in 1985.

B. HEALTH PLANS AND BENEFITS

The company offers three types of health plans to suit the needs of the consumers. These are the Diamond Plan with an annual premium cost of P2,586.00; the Emerald Plan with an annual premium cost of P2,039.00; and, Pearl Plan with an annual premium cost of P1,704.00.

Payment of premiums can be made through salary deduction, collector, company appropriations and direct payment to the head office.

All plans provide comprehensive health care benefits to its members. For the outpatient benefits, members are entitled to the following:

- a. Any number of consultations with designated Primary Service Units (PMSU) doctors;
- b. Necessary diagnostic services;
- c. Annual Physical examination;
- d. Preventive health care coverage for immunization, (excluding the cost of vaccines); and
- e. Emergency treatment of minor injuries.

For the In-Patient benefits, members can avail of the following:

- a. Free Room and Board up to ceilings specified in the Plan;
- b. Professional fees of Physicians and Specialist;
- c. Drugs and medicines used while in confinement;
- d. X-ray, lab test and other diagnostic procedures;
- e. Use of operating and recovery room.

A member is entitled to an unlimited number of out-patient consultation, covering the aforementioned services. However, there are ceilings for room and board during hospitalization. Maximum daily room and board is P400.00 (private) under the Diamond Plan; P275.00 (semi-private) under the Emerald Plan; and P175.00 (ward) under the Pearl Plan. The maximum sum per dreaded disability is P100,000.00 under the Diamond Plan; P50,000.00 under the Emerald Plan; and, P40,000.00 under the Pearl Plan.

To keep membership fees low, a few items are not covered under the health care plan, namely: consultation and treatment for pregnancy related conditions,

rest cures, cosmetic surgery, dental treatments and other diseases listed as exclusions.

Pre-existing illnesses are excluded from coverage during the first year of membership. Upon the renewal of the policy, such pre-existing conditions will already be covered.

C. PROFILE OF MEMBERS/ENROLLEES

As of the fourth quarter of 1991, Reference Company had a total of 39,851 members for corporate or group account and 30,474 voluntary individual enrollees. No data on the distribution of members by socio-economic and demographic characteristics could be obtained by the researchers.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

From January to December 1991, a total of 132,873 outpatient consultation were rendered at accredited facilities. Consultations with primary physicians totalled 118,274, while consultation with specialists totalled 14,599. No information was given on consultations done at non-accredited facilities and on the major causes of consultation.

During the same period, there were 14,992 diagnostic procedures performed at accredited facilities. No information was given on the breakdown of consultations made by month and the type of procedures performed.

Medical cases accounted for a total of 3,275 confinements. There were a total of 1,188 surgical cases and 130 obstetric cases hospitalized. No account of the ten leading causes of hospitalization were made available to the researchers.

Average length of confinement was 4 days. The shortest recorded length of stay was 1 day while the longest was 54 days.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The Reference Company had a sales force consisting of 4,000 individual agents; 18 insurance brokers; and, 4 In-house sales staff. Individual agents and brokers are compensated on commission basis, while in-house sales staff receive regular salaries.

Marketing of health plans are being undertaken by advertising through print media; motivating agents to sell more through raffle promotion; and, by giving incentives to agents who meet the company quota.

To contain the cost of services, the company performs individual screening of applicants. Screening is done by requiring an applicant to fill-up an application form and choose the plan preferred. Application forms are submitted to Lay-Writing Dept. for evaluation of the age, height, weight and occupational requirement. Application are then forwarded to the medical underwriter for medical evaluation. Further medical test will be recommended if necessary. Clearance on all points should be obtained from both medical and lay-underwriting. Any point against lay writing guidelines and or medical underwriting guidelines as prescribed by the management is a ground for rejection.

2. Premium Collection

Premiums are collected through salary deduction, collectors or are paid directly to the office. The NCR office reported that in 1990, the total premium collection amounted to P126,902 representing a 40.6 per cent increase over the 1989 premium collection which amounted to P90,231. However, the 1991 premium collection which totalled P111,284 represented a decrease of 12 per cent over that of 1990.

Excess premium are added to profit or to the reserve fund and invested in the money market.

3. Benefits Availment and Claims Processing

Members can avail of the above services by visiting the designated clinic for consultation. If specialists care or hospitalization is necessary, a letter of authorization will be issued by the doctor for presentation to any of the accredited specialist or hospital.

Benefits are in the form of direct services by accredited service providers and cash reimbursement for emergency services rendered in non-accredited facilities.

Members can go to any of the accredited clinics and hospitals located all over the country. The company has 14 fully owned outpatient clinics; 39 accredited clinics; 10 diagnostic clinics; 68 affiliated hospitals; and over 900 accredited specialist that provide immediate diagnosis and treatment.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The company adopted the following measures to contain the cost of member services:

- a. Screening for adverse selection;
- b. Exclusions and limits;
- c. Preventive health service.

Specific indications which showed the effectiveness of the cost containment measures are as follows:

- a. Expenditures for dreaded diseases were kept within limits;
- b. Limited use of costly procedures;
- c. A patient who was previously diagnosed to be suffering from hypertension did not unnecessarily incur cost for ICU;
- d. Confinements were minimized as a result of vaccination against immunizable diseases.

G. PERFORMANCE AND FINANCIAL STATUS

The assets of the company totalled P50,783,205 in 1991. Major account from receivables represented hospital bills for collection and retainer enrollees' fees amounting to P2,374,739 and P4,277,178, respectively.

Liabilities amounted to P34,236,933 of which 27 per cent or P9,285,854 were for claims payable. Administrative and selling expenses amounted to P119,620,884 of which 45 per cent were for enrollees' claims; 17 per cent for payment of commissions of agents/brokers; 3 per cent for marketing and advertisement; and, 2 per cent for medical and laboratory supplies.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Based on the company's experience in running a health insurance business in the Philippines, the minimum capitalization deemed required to start-up a similar health insurance operation is P10 million. The company must have at least two (2) actuarial services staff, ten (10) health professionals, sales and marketing staff. There should also be at least 1 each of the following: personnel and administration staff, underwriter, utilization review and quality assurance staff.

Basic equipment required to run the operation efficiently are; computer systems, x-ray/diagnostic equipment and one outpatient clinic complete with basic medical facilities.

The growth and development of a health insurance operation could be affected by the following factors:

- a. Household incomes and employment;
- b. Economic progress;
- c. Government incentives;
- d. Education;
- e. Marketing efforts; and
- f. Cooperation of hospitals and physicians

Household income and employment was considered the most important factor that affects the growth and development of this type of insurance because having more people with disposable incomes expands the market potentials of health insurance. Large numbers of poor or low income people means that only very few can afford to buy health insurance.

Among the cited important problems faced by the insurance sector were: (i) low cost, cut-throat pricing; (ii) lack of standards in the industry; and (iii) stringent government regulation and taxation.

The above-cited problems could be partly addressed by setting a standard pricing rate for all health insurance industry. The industry would perform best under self-regulation. Government could encourage the growth of the industry by limiting taxation to a minimal corporate income tax.

Other Government support cited that could promote the growth and development of health insurance industry in the Philippines were:

- a. Removal of sales percentage, contractor's taxes and VAT;
- b. Allowing duty-free importation of essential medical equipment; and
- c. Preventing Medicare from competing unfairly with private HMO's.

The respondent considered the Department of Health as the appropriate government agency to regulate HMOs. Side by side with the DOH would be the AHMOPI as industry peers to self-regulate the member organizations.

Case Report No. 16: (Hospital-based Health Maintenance Org.)
Reference Company No. 9
Area(s) Studied: NCR

A. IDENTIFICATION

The reference company is a hospital-based health maintenance organization (HMO) established in 1988, and fully backed by one of the most excellent hospital facilities and the best medical practitioners in the NCR.

With a network of 65 hospitals and 1,200 doctors nationwide, availments and servicing are now expanded into various cities and municipalities throughout the Philippines.

B. HEALTH PLANS AND BENEFITS

Four basic health plans are offered for various target markets. The general features of each plan are briefly summarized below:

1. Platinum Plan/Platinum Family Plan (FP)

- a. Unlimited out-patient consultation, laboratory, x-ray and diagnostic services;
- b. Hospitalization benefits;
 - i) Room & Board - regular private room P300/day
 - ii) Professional fees, lab, x-ray, diagnostic services
 - iii) Drugs and medicines
 - iv) Use of recovery room and ICU
 - v) nursing services
- c. Preventive health care, annual executive check-up and annual routine check-up; and
- d. Maximum benefit is up to P150,000 per injury/illness per year for services availed in accredited health care providers and a maximum limit of P10,000 in non-accredited health care providers (for emergency care only).

2. Gold Plan/Gold Family Plan

- a. Unlimited out-patient consultation, laboratory, x-ray and diagnostic services;
- b. Hospitalization benefits;
 - i) Room & Board - regular private room P300/day
 - ii) Professional fees, laboratory, x-ray, diagnostic examinations
 - iii) Drugs and medicines
 - iv) Use of recovery room and ICU
 - v) Nursing services
- c. Dental services (optional);
- d. Preventive health care, annual executive check-up, and annual routine check-up; and
- e. Maximum benefit up to P75,000 per injury/illness per year in accredited

service provider, and a maximum limit of P5,000 in non-accredited service providers.

3. Silver Plan

- a. Unlimited out-patient consultation, laboratory, x-ray and diagnostic services;
- b. Hospitalization benefits;
 - i) Room & board - semi private room P300/day
 - ii) Professional fees, laboratory, x-ray, diagnostic examinations
 - iii) Drugs and medicines
 - iv) Use of recovery room and ICU
 - v) Nursing services
- c. Preventive health care, annual executive check-up, and annual routine check-up; and
- d. Maximum benefit of P50,000 per injury/illness per year in accredited providers.

4. Bronze Plan

- a. Unlimited out-patient consultation, laboratory, x-ray and diagnostic services;
- b. Hospitalization benefits;
 - i) Room & board - ward P300/day
 - ii) Professional fees, laboratory, x-ray, diagnostic examinations
 - iii) Drugs & medicines
 - iv) Use of recovery room & ICU
- c. Nursing services;
- d. Preventive health care, annual executive check-up, and annual routine check-up; and
- e. Maximum benefit of P40,000 per injury/illness per year.

Targeted enrollees for Platinum and Gold Plans are from the upper income group; Silver Plan, middle income group; and Bronze Plan, low income group. Silver and Bronze Plans are for corporate accounts only.

Annual membership fees are as follows:

- | | | |
|----|-------------|----------|
| a. | Platinum | - P8,350 |
| | Platinum FP | - P6,350 |
| b. | Gold | - P5,650 |
| | Gold FP | - P4,350 |
| c. | Silver | - P2,750 |
| d. | Bronze | - P2,150 |

Health plan contributions are determined through actuarial computations.

Exclusions:

- a. In all 4 plans, pre-existing conditions are not covered within the first

year of membership, are covered during the second year but only up to of 50% of the amount of benefits. After the second year of membership, pre-existing conditions are covered and payable up to 100% of the amount of benefits;

- b. Conditions arising from acts which are not sanctioned by society like STD, Aids, Suicide, substance abuse, etc. are not covered in all plans;
- c. Mental and nervous disorders are excluded;
- d. Maternity, miscarriage and abortion are not covered;
- e. Congenital deformities and defects, cosmetic and plastic surgery are excluded;
- f. Recurrent illnesses are not covered;
- g. Conditions/diseases requiring isolation are not covered; and
- h. Conditions without known cure are not covered.

C. PROFILE OF MEMBERS

The company had a total of 14,068 enrollees in the fourth quarter of 1991. Of these, 11,100 belong to corporate/ group accounts and 2,968 enrollees belong to voluntary accounts.

The general demographic characteristics of members/enrollees are summarized below:

- a. Sex (all Plans)

Males	-	7,035
Females	-	7,118
- b. Age bracket (all Plans)

below 15 years old	-	3,476
15-45 years old	-	8,683
45-65 years old	-	1,798
over 65 years old	-	24
- c. Marital status (all Plans)

Married	-	4,385
Single	-	6,464
Widow/Widower	-	59
- d. Type of enrollee (all Plans)

Principal	-	6,690
Dependents	-	7,633

D. BENEFIT UTILIZATION PATTERNS, BY MEMBERS

A total of 8,304 enrollees availed of out-patient consultations in 1991. Breakdown of availments per health plan are as follows:

Platinum Plan	-	1,489
Gold Plan	-	4,815
Silver Plan	-	1,702
Bronze Plan	-	296

Highest number of utilization was in August, where a total of 971 members availed of out-patient consultations. The least was in October with only 346 availments. Availments for the remaining months range from 509 to 785.

All out-patient medical consultations were made in accredited facilities. The ten leading causes of MD consultation in 1991 and their percentages to total are:

a.	Upper respiratory tract infection	-	3%
b.	Tonsillitis	-	2%
c.	Hypertension	-	2%
d.	Pharyngitis	-	1.8%
e.	Rhinitis	-	1.6%
f.	Bronchitis	-	1.6%
g.	Bronchial asthma	-	1%
h.	Gastritis	-	1%
i.	Systemic viral infection	-	0.9%
j.	Sinusitis	-	0.5%

There were 393 hospital admissions in 1991. Of this, 67 were Platinum enrollees, 210 Gold enrollees, 99 Silver enrollees, and 16 Bronze enrollees.

All hospital admissions were done in accredited facilities. About 375 of these admissions were medical cases and 18 were surgical cases.

The ten leading causes of hospitalization in 1991 and their percentages to total were:

a.	Acute gastroenteritis	-	6%
b.	H-fever	-	5%
c.	Systemic viral infection	-	4%
d.	Upper respiratory tract infection	-	4%
e.	Bronchitis	-	4%
f.	Tonsillitis/Tonsilo-pharyngitis	-	4%
g.	Typhoid fever	-	3%
h.	Pneumonia	-	3%
i.	Urinary tract infection	-	2%
j.	Acute gastritis	-	2%

The average length of confinement per member was 7 days. Length of confinement ranged from 1 to 14 days.

The six leading diagnostic procedures performed in 1991 were:

- a. Laboratory;
- b. X-ray (including CTscan/Magnetic Resonance Imaging);
- c. ECG;
- d. Nuclear Medicine;
- e. Physical Therapy; and
- f. Gastroscopy.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

Since early 1992, the company implemented publicity and advertising programs, paving the way for a sustained corporate image building campaign for the next three years. Reference company forged ties with popular health-oriented corporations to attract new members. To carry out marketing activities, they

hired individual account executives (no data on total number); 15 insurance brokers; and 5 in-house sales staff. Individual account executives and brokers receive 2.5% to 10% commission based on contract value (CV) for corporate group accounts and 15% for industry, family/group account. In-house sales staff are given basic monthly salary, transportation allowance plus 2.5% to 10% commission.

The standard procedures for screening enrollees and approval of applications for membership are summarized below:

- a. Accomplishment of medical questionnaire.
- b. Evaluation of accomplished medical questionnaire to determine pre-existing illness and exclusions.
- c. Applicants who are 40 years old and above are subject to a medical evaluation. They are asked to submit themselves for an interview and undergo laboratory examinations.
- d. Approval is based on results of medical assessment.

All applicants for membership are accepted, but each one is subjected to limits and exclusions appropriate to their specific health conditions.

Reference company adopts an "open door" policy wherein members can go directly to chosen accredited doctor/hospital. Customer Relations Assistants are tasked to provide personalized and direct client servicing during and after availments.

2. Claims/Bills Processing

The company's Claims Group is the unit tasked with the processing of all bills (in-patient, out-patient, annual check-up dental availments, and reimbursement) and claims for payment received from accredited service providers and members. The extent of medical coverage of each confinement is also assessed by the Medical Directors prior to approval of payments.

In response to the clamor for faster payments of bills/claims, the company's claims group had developed a work system which allows easy recording and processing of claims/bills to facilitate payments at a specified timetable and avoid complaints over delayed payments.

Standard procedures for processing of claims for reimbursement are:

- a. Reimbursement forms must be accomplished properly and submitted to the office together with the original receipts and statement of accounts;
- b. Reimbursement is subject to approval after which claims are reviewed and assessed. Review and assessment covers medical, accounting, financial and other validity checks (e.g., receipts are authenticated with indications of the TIN and VAT. Processing of claims takes from 5 days to 8 days.

Services provided by accredited providers are billed directly to the HMO. Standard procedures for processing statement of accounts from accredited service providers are:

For Hospitals

- a. Accomplishment of hospital bill analysis sheet for a clear breakdown of all ancillary services availed.

- b. Determination of coverage or non-coverage of availment with corresponding LOA.
- c. Seeking recommendation for payment by Medical Director.
- d. Forwarding claims documents to the Accounting Department for voucher preparation and cheque payment.

For Physicians

- a. Submission of consultation slips.
- b. Accomplishment of Patient Utilization Summary Sheet.
- c. Accomplishment of Doctor's Bill Analysis Sheet and a summary of computation done for recommendation or approval by the Medical Director.
- d. Transmittal of documents to the Accounting Department for preparation of voucher and cheque payment.

Requirements for processing of bills of accredited service providers are: a) official receipts of expenses b) statement of account c) proof of service use d) validation of statement of account. All requirements submitted are reviewed and assessed. The review/assessment covers medical, financial, and accounting concerns. Amount of time to process bills and effect payment to hospitals is from 5 to 12 days, with an average of 8 days. Doctors bills would take 8 to 15 days, with average of 10 days.

The company extends benefits through direct services by accredited providers and cash reimbursement for services rendered by non-accredited providers. In Metro Manila, there are 75 accredited hospitals and 1,650 accredited doctors. Of the 75 accredited hospitals, 20 are secondary private hospitals and 55 are tertiary private hospitals.

As a requirement for accreditation, a hospital must be in the tertiary level with complete Emergency Room facilities. The company utilizes hospital laboratory and diagnostic facilities.

Requirements for accreditation of physicians are:

- a. Must be diplomates or fellows.
- b. Doctors must be hospital based with clinics within hospital premises.
- c. Must be willing to accept company rates for professional fees.

All members are required to consult only with accredited health care providers. In cases where members need the attention of physician and where no accredited physician could provide such service, referrals or endorsements made by accredited doctors are honored. In this case, members can file claims for reimbursement. Levels of claims paid are less than those allowed for using the services of accredited providers. The company reimburses 50% to 80% of hospital bills from non-accredited providers.

All plans have provisions for ceilings or limits of benefit that can be availed by members. Bills and expenses over that ceiling are shouldered by members.

Capital and operating funds come from member pre-payments and stockholders equity.

F. COST CONTAINMENT MEASURES

The following measures are taken to minimize cost and improve efficiency:

- a. Screening for adverse selection. This is done through accomplishment of medical questionnaire. Those over 40 years old are required to submit to an interview and laboratory examinations.
- b. Application of exclusions and limits.
- c. Referral controls in cases where no accredited specialists/physicians are available.
- d. Adoption of preventive health care as part of all package.

The most common forms of abuse/fraud experienced by the company are:

- a. pre-existing conditions which are not declared but were discovered in the course of consultations and clinical examinations with accredited physicians
- b. inclusion of laboratory tests that are not required in the treatment but were requested by members.

As a safeguard, reference company adopts the Hospital Bill and Physician Bill analysis. If conditions and services availed are not covered, bills or expenses from these availments are charged to the members/doctors concerned.

G. PERFORMANCE AND FINANCIAL STATUS

The total amount spent by the company for services by category of service in 1991 and the out-of-pocket amount shared by members are summarized below:

<u>Expenditure Item</u>	<u>Amount Spent by Co.</u>	<u>Amount Shared by Member</u>
a. OP Consultation		
PF	P1,112,656.00	P65,492.28
Lab, x-ray, diagnostics	P1,166,796.19	P22,130.00
Drugs & medicines	-	-
Others	-	-
b. In-patient care		
R & B	no data given	no data given
PF	560,802.66	156,344.96
Lab, x-ray, diagnostics	2,927,687.07	551,671.33
Drugs & medicines	no data given	no data given
Others	no data given	no data given

The operations of the Company in the past 3 years show an expanding trend as shown in the levels of expenses below:

	Early (1988)	Middle (1990)	Latest (1991)
Marketing Cost	69,602	777,143	1,595,706
Increased(P)		707,541	818,563
Growth Rate%		1,016.55	105.33
Utilization	119.055	3,580,785	6,818,079
Increased(P)		3,561,730	3,237,294
Growth Rate%		186.92	90.40
Administrative	1,157,316	4,611,734	8,059,520
Increased(P)		3,454,418	3,447,786
Growth Rate%		298.48	74.76
Total Expenses	P1,245,973	8,969,662	16,473,305

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Factors and conditions affecting the growth and development of a health insurance operation are: government incentives, economic progress, household income, employment, and education. Respondent did not give a ranking of these factors. Moreover, she stressed that entering the market requires extensive information and awareness campaign. Being a service industry, market will respond favorably to the following factors:

- a. the number and quality of clinics and hospitals affiliated into the program
- b. the number and expertise of doctors accredited by the HMO
- c. the availment system required
- d. the price of the program package
- e. the quality of service rendered by the medical providers under the system.

Respondent said that no incentives so far had been given by the government to HMO's.

Industry prospect is very encouraging as demonstrated by the rate of program expansion in terms of wider geographic and population coverage and expansion of benefit packages.

Respondents indicated that based on their own analysis, there is increased awareness and interest of target market sectors in the HMO concept. Target markets are inclined to shift from the traditional reimbursement system towards the no-cash-out or use of card system in availing health benefits. The market is estimated to be anywhere between P1B to P2B per annum in aggregate premium.

Case Report No. 17: (Community-Based Health Maintenance Organization)
 Reference Company No. 10
 Area(s) Studied: NCR

A. IDENTIFICATION

The Reference Company is a Filipino community-based health maintenance organization that offers health service as its principal product. It was established on December 6, 1988 with technical and managerial assistance from HEWSPECS, Inc. INTERCARE Research Foundation, Inc. and support fund from USAID and PCHRD.

At present self-supporting, its operating funds come from the pre-payments enrollees/clients. The covered area, at present, is the whole community of UP Diliman Quezon City where the Reference Company holds office.

B. HEALTH PLANS AND BENEFITS

The Reference Company has been engaged in pre-paid health services for its members since 1989. It has four (4) plans namely: Plan A, Plan B, Plan C and Plan D.

The target enrollees of these plans are groups, families and individuals with minimum annual premium of P480/member and a maximum of P1,200/ member. The annual premium is determined by actuarial computation. The Reference Company covers the following as its principal plan offering:

Outpatient

- a. Unlimited outpatient consultation with the Primary Medical Service Unit (PMSU) and authorized consultation with accredited medical specialists.
- b. Unlimited authorized outpatient laboratory and other diagnostic examinations.
- c. Drugs and medicines used during treatment of illnesses and injuries not requiring confinement.

Inpatient

- a. Professional Fees of physicians:

Ordinary case	: P 100/day
ICU confinement	: 150/day
Surgical Case	: 250/RUV
Anesthesiologist fee:	30% of Surgeon's Fee
- b. Room & Board accommodation up to the specified limit

Plan A	: P 100/day
Plan B	: 200/day
Plan C	: 300/day
Plan D	: 400/day
- c. Laboratory, x-ray and other diagnostic examinations
- d. Drugs, medicines and medical supplies used during confinement.
- e. Ceilings are applied per illness lifetime:

Non-Catastrophic:	Plan A - P 7,500
	Plan B - 8,500
	Plan C - 10,000
	Plan D - 12,000
Catastrophic	: Plan A - P 20,000
	Plan B - 30,000
	Plan C - 40,000
	Plan D - 50,000

To make pre-paid health care costs affordable to its members, the Reference Company hospitalization benefits exclude the following conditions:

- a. Conditions existing prior to membership or employment with company.
- b. Conditions arising from acts which are not sanctioned by society like STD including AIDS, suicide, substance abuse, conditions arising from acts of war/riots, etc.
- c. Mental or nervous disorders.
- d. Pregnancy, childbirth, miscarriage, abortion and their complications.
- e. Congenital deformities and defects, cosmetic and plastic surgery.
- f. Conditions/Diseases requiring isolation per DOH policy, e.g. leprosy, cholera, etc.
- g. Conditions without known cure.

The Reference Company covers lithotripsy procedure and dreaded diseases that require Intensive Care Unit (ICU) confinement or need prolonged hospitalization subject to ceilings of chosen plan.

Health plan benefits are extended to members in the form of direct services for non-emergency care in accredited facilities and cash reimbursement for emergency care provided in non-accredited hospitals. For its direct services, Reference Company has a number of accredited service providers and affiliated institutions namely:

- 1 - HMO outpatient clinic
- 1 - Primary public hospital
- 3 - Tertiary public hospitals
- 1 - Tertiary private hospital
- 56 - Accredited physicians with varying specializations

Cash reimbursements, on the other hand, are allowed in cases of emergency medical services obtained from non-accredited providers. Emergency medical services obtained from non-accredited providers are reimbursed up to 80% of assessed expenses, but not exceeding specified ceilings depending on the plan enrolled in, and whether emergency care was rendered as an outpatient or inpatient.

The accreditation of health care providers is based on standards and requirements set by the Reference Company, to wit:

For Medical Specialists

- a. He/She must have passed the specialty board exam with good reputation.
- b. Amenable to UPHMO standard rates.

For Medical Clinics/Hospitals

- a. Medical Doctor/Specialist complement
- b. Provide broad range of services such as ECG, laboratory, x-ray and others.
- c. Reasonable rates
- d. Accessible to the majority of members.

All enrolled members are required to consult only with accredited or company health care providers. In case a member avails the service of non-accredited health providers with valid reason(s), the member can still file claims for reimbursement but must follow the specific penalties imposed by the Reference Company. The member is

asked to share the cost of services availed of through deductible, percent sharing ceilings and standard rates/services. Coverage of hospitalization charges are net of Medicare reimbursements which are considered deductible. Percent sharing up to defined ceiling based on plan, is imposed on emergency service availment in non-accredited hospitals. In these cases, the HMO assumes 80% of charges up to a pre-determined ceiling. Standard fees are also adopted for particular services. Charges beyond the standard rates per plan are shouldered by the enrollee.

C. PROFILE OF MEMBERS/ENROLLEES

As of the first quarter of 1991, the Reference Company had a total of 729 enrollees/clients. This increased to 865 in the last quarter of the same year. Sex, age, and classification characteristics of members are as follows:

a.	Male	:	442
	Female	:	423
b.	Below 15 years	:	180
	15 - 44	:	431
	45 - 65	:	233
	No data	:	21
c.	Employees	:	316
	Dependents	:	496
	Outsiders	:	53 (principal + dependent)

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

There were 1,212 outpatient consultations rendered in 1991 at a cost of P79,909 for professional fees alone. The primary causes of consultation are infections and inflammatory conditions which accounted for 38.06% of the total outpatient consultations.

The total amount spent for diagnostic services/procedures was P33,914.40. Urinalysis was the leading diagnostic procedure which accounted for 21.75% of the total of 515.

There were 79 hospitalizations in 1991. Most of these confinements were medical cases. 53% of the total hospitalization was caused by infection and inflammatory condition but there were also 7 surgical cases covered. The average length of confinement was 2 days; the shortest was 1 day; and the longest was 20 days. The organization spent P13,468.26 for Room and Board charges; P47,958.02 for professional fees; P35,939.97 for drugs and medicines administered during confinement; and P40,196.49 for diagnostic procedures and other hospital charges in 1991.

For the other health services offered, namely, outpatient emergency consultation (including drugs and medicines used during treatment), Reference Company spent P1,902.72 and P300, respectively.

The respondent did not have any data on the out-of-pocket expenditure or per cent share of members who obtained services in non-accredited service providers, or who exceeded allowable ceilings, or consumed services not covered by the insurance.

As mentioned earlier, enrollees may claim a cash reimbursement for valid reasons only. (Valid reasons include life-threatening emergencies and other reasons acceptable to the Reference Company Medical Officer.) In this regard, Reference Company has set standard procedures and requirements for processing claims for reimbursements filed by enrollees.

An enrollee claiming reimbursement must:

- a. Accomplish the reimbursement form from the Reference Company office.
- b. Attach all the necessary requirements such as:
 - medical certificate from the attending physician
 - original official receipts

As soon as the member meets the requirements, Reference Company will review/assess these claims to validate or confirm the medical procedures and management protocol; assess financial liability of the HMO; review the validity of receipts and supporting documents; and determine the amount of claims to be paid. Processing of claims takes an average of seven (7) working days. Those with incomplete documentation requirements may be delayed to about ten (10) working days. The shortest period for processing is three (3) days.

Services rendered in accredited facilities by accredited providers are billed directly to the HMO following agreed procedures and requirements. Statements of account are reviewed by the Reference Company to:

- a. Verify whether charges are within allowed ceilings, especially for Room and Board accommodation, and if the enrollee paid for the excess charges upon discharge.
- b. Verify if the confined enrollee filed Medicare form. If not, the enrollee pays for the medicare portion.
- c. See to it that hospital bills are paid within 15 days from receipt of Statement of Account (S/A).
- d. Verify that the S/A includes the following:
 - i. original official receipts of expenses
 - ii. proof of service use
 - iii. validation of S/A
 - iv. corresponding Letter of Authorization (LOA 2 & 3)

For accredited physicians, Reference Company pays for all authorized consultations on the month following the availment.

Physicians fees are computed based on agreed 1991 standard rates of P90/initial consultation, P80/follow-up, PMSU P50/consultation and for UP Health Service (UPHS) staff, P70/initial consultation and P60/follow-up.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The Reference Company has one sales staff who, together with the health service coordinator, conducts regular information dissemination and social marketing through the following:

- a. Present plans to potential members and groups within UP Diliman
- b. Follow-up referrals from enrollees/members
- c. Give briefings to walk-in applicants and callers

In accepting new enrollees, standard procedures are followed to assess the risks and qualifications of applicants. These include the following:

- a. Fill-up the application form, not leaving any blanks.
- b. Submit to a Physical Examination (PE) with in-house Medical Officer including:
 - i. taking of medical history;
 - ii. assessing results of CBC, urinalysis, fecalysis, chest x-ray. Enrollees who are 40 years old and above must submit to ECG and papsmear.
- c. Application forms are approved on the same date submitted.

- d. Enrollee must be at least six (6) months old and not more than fifty-five (55) years old on his/her last birthday.

If one of the above mentioned criteria/procedures is not satisfied/ followed, application will not be processed. As soon as the applicant is accepted as member he/she must observe the following availment procedures:

a. Outpatient Benefits: Elective

- i. Go to Reference Company clinic for consultation or treatment;
- ii. As a result of the consultation, Reference Company physician may recommend any of the following:
 - laboratory, x-ray and other diagnostic examination
 - consultation with medical specialist
- iii. A corresponding LOA will be issued to the enrollee. Without proper LOA the enrollee will pay for his/her sole account and will not be covered by the health plan.

b. Emergency consultation (Accredited)

- i. Proceed directly to the Emergency Room (ER) and present HMO ID card to the ER physician or nurse on duty.
- ii. ER physician will provide the necessary treatment and services.
- iii. Sign all bills incurred during the ER treatment.

c. Emergency consultation (Non-Accredited)

- i. Proceed directly to the Emergency Room (ER) of the nearest hospital.
- ii. ER physician shall provide the necessary treatment and services.
- iii. Notify Reference Company within 24-hours or the next working day from time of treatment to facilitate transfer to accredited facility and/or claims processing.
- iv. Pay for the treatment and the corresponding professional fees.
- v. Go to Reference Company office and accomplish reimbursement form supported by original official receipts and doctor's medical certificate within seven (7) days from the date of treatment, otherwise this will not be honored anymore.
- vi. Reference Company shall reimburse 80% of hospital expenses including professional fees at standard rates up to the specified ceiling of chosen plan.

d. Inpatient Benefits: Elective

- i. Go to Reference Company clinic. If confinement is necessary, a Letter of Authorization (LOA) will be issued.
- ii. Go to the hospital named in the LOA. Present UPHMO ID card and LOA to the admitting officer. Enrollee will be admitted as a HMO patient and put under the care of an accredited doctor.
- iii. Before discharge, submit Medicare form to the Billing Section of the hospital.
- iv. Upon discharge, affix signature and ID number on the Statement of Account. The hospital will bill Reference Company for covered expenses. Expenses not covered by the Health Plan will be billed to enrollee.

e. Inpatient Benefits: Emergency (Accredited)

- i. Proceed to the ER of the accredited hospital.
- ii. Present UPHMO ID card.
- iii. The ER physician shall place enrollee under the care of the accredited Medical Officer.

- iv. Notify Reference Company of confinement within 24-hours. Get an L from the Reference Company office and submit it to the Billing Section of hospital.
 - v. Before discharge submit Medicare form to the Billing Section of hospital. Failure to accomplish the Medicare forms would mean that member will have to pay the Medicare portion of the expenses.
 - vi. Pay for any excess charges not covered by the Health Services Agreement.
- f. Inpatient Benefits: Emergency (Non-Accredited)
- i. Proceed to the ER.
 - ii. Enrollee will be admitted by the ER physician.
 - iii. Notify Reference Company of the confinement within 24-hours or within next working day if patient is admitted on Saturday or Sunday, otherwise the benefits will not apply. Reference Company will decide what patient can be transferred to affiliated hospital.
 - iv. Pay all hospital bills.
 - v. Submit to Reference Company duly accomplished reimbursement form support by Office Receipts, Statement of Account of the hospital (breakdown expenses) and doctor's medical certificate.
 - vi. Reference Company shall reimburse 80% of the hospital expenses including professional fees at standard rates and up to the specified ceiling chosen plan.

Should the member be subsequently transferred to an affiliated hospital, then the rule on the treatment of a member confined as an emergency case in an affiliate hospital shall apply. However, if the nature of the illness or condition of the patient is such that in the opinion of the affiliated doctor, the patient cannot be moved or transferred to an affiliated hospital, the Reference Company shall pay the member up to the specified ceiling.

F. COST CONTAINMENT MEASURES AND MECHANISM

There are three (3) measures adopted to contain the cost of member services, namely: (a) exclusions and limits; (b) PMSU screening; and (c) referral controls. Reference Company adopted these measures because it has been proven effective especially in cases of recurrent acute episodes of asthmatic bronchitis. This kind of illness needs frequent utilization of manpower services (medical specialist) and diagnostic examination or even hospitalization. If not properly screened and referred to accredited medical specialists/hospitals, this kind of illness could incur high costs.

Sometimes the above measures fail because some patients go directly to physicians or hospitals of their choice without clearance from the Medical Officer.

Reference Company has not yet experienced any abuse or fraud, although it has encountered a few clear cases of adverse selection, i.e. enrollees who had pre-existing conditions who demanded coverage for those conditions.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

The Reference Company, being a community-based non-profit organization, does not have any excess premium. All membership fees collected are allocated for service utilization, marketing and administrative expenses. Enrolled members and even the company itself are not covered by any reinsurance scheme.

The Reference Company had a total asset of P316,590 in 1990, representing an 151%

from the 1989 asset which totalled P125,955. This was attributed to the following factors:

- a. increase in cash collection and short-term investment.
- b. increase in accounts receivables
- c. increase in property and equipment

On the other hand, the total liabilities of the company was P30,802 as of December 31, 1991.

The company's 1991 revenue recorded an increase of 300% or P161,737 over 1990. This was due to growth in the number of enrollees/members of the company. Collection of health plan membership fees was the major source of revenue.

The company's expenses increased from P72,328 in 1989 to P241,589 in 1990. Expenses continued to rise to P503,884 in 1991. For the past three (3) years, expenses were relatively higher than the company's gross revenue. Members' services utilization was the major expenditure of the company. Utilization ranged from 32% to 53% of the total membership fees collected. Losses for the 3 consecutive years, 1989, 1990 & 1991 were P18,382, P25,906 and P13,411 respectively.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

When starting-up an operation on health insurance business, a minimum of P300,000.00 capitalization is needed, in addition to office and medical equipment and supplies. Personnel/staff consisting of an accountant/ administrator, medical officer, service coordinator and marketing personnel are also required.

The factors that affect the growth and development of a health insurance operation include: (a) education; (b) household incomes and employment; and (c) health. Reference Company considers education as the most important factor positively affecting the growth and development of a health insurance because it enhances people's awareness of the importance of good health and well-being and makes them appreciate the value of risk-sharing through health insurance.

The general economic situation in the country, the low level of household income, unemployment, and the lack of information and education are some of the problems facing health insurance operations. The respondent feels that the general economic situation in the country is unmanageable because it requires long-term solutions.

The respondent considers self-regulation and open communication among members and the organization as appropriate for community-based HMOs.

Government support in terms of the provision of material, financial and professional assistance and other services are needed for the growth and development of health insurance in the Philippines.

In the next five (5) years, the respondent believes that its population coverage could expand to about 1,000 to 2,000. In terms of benefit packages and geographic scope, the respondent also envisions an expansion.

Case Report No. 18: Employer-Initiated Health Maintenance Organization
 Reference Company No. 11
 Area(s) Studied: NCR

A. IDENTIFICATION

The Reference Company was established in February 26, 1941 but stopped operation shortly thereafter because of WWII. It resumed operation in February 14, 1946. The Company has more or less 12,000 regular employees nationwide including foreign based personnel.

The Reference Company and its employees are contributing their share in funding and administering a medical plan that assures the best health care benefits and medical services for employees and their dependents.

B. HEALTH PLANS AND BENEFITS

The Company has 2 health plans, one for its employees and another for their dependents.

Plan 1 is the Dependents Medical Plan which started in March 1988. The target beneficiaries are the dependents of employees, including the first 2 dependents and parents aged below 60 years old. Starting February 1993, the annual contribution per dependent was P160.00. The premium cost for the first 2 dependents is shared 50-50 by the employee and the company. Premium costs of additional dependents, are paid fully by the employee.

Under the plan, unlimited outpatient consultations, x-ray, laboratory and diagnostics are offered. Drugs and medicines are provided for emergency treatment only. The company, however, maintains a pharmacy where members can buy medicines at discounted prices. Hospitalizations are subject to limits or ceilings. Room and board is at P400/day, dreaded and pre-existing diseases are covered after one year at P50,000/case/member. Rehab services, maternity and dental services, prosthetic devices are not covered.

The amount of prepaid contribution was determined through an in-house (HRD) survey of health expenses of employees, study of existing HMOs and actuarial computations.

Plan 2 is the company initiated medical plan for all regular employees who have completed at least 6 months of continuous service and are automatically entitled to lifetime unlimited benefits. In case of direct conversion from contract (full time) to regular status, the employees' period of continuous service rendered immediately prior to his regular appointment shall be considered.

No premium is charged from employees and the total cost of outpatient and inpatient services is wholly shouldered by the company. Hospitalization costs include the cost of physician's services, medicines, laboratory and other charges under the following arrangements:

	<u>100% Company Expense</u>	<u>50-50% Sharing</u>	<u>100% Employee</u>
<u>Non-Surgery</u>			
Less than 10 yrs of regular employment	60 days within a 12 mo. period	61st to 120th day	in excess of 120 days
10 yrs or more	120 days within a 12 mo. period	121st to 140th day	in excess of 240 days

<u>Surgery</u>			
Less than 10 yrs of regular employment	120 days within a 12 mo. period	121st to 140th day	in excess of 240 days
10 yrs or more	180 days within a 12 mo. period	181st to 360th day	in excess of 360 days

All services usually excluded in other health plans are covered by the plan except for the following: AIDS, suicide, drug abuse, conditions arising from wars, riots etc., and cosmetic/plastic surgery.

In both plans, health benefits are extended to members through direct services provided by accredited MDs, affiliated institutions and by company regular physicians. The Company owns and manages 6 clinics which serves members of both plans. It has accredited 56 private hospitals and 84 physicians of various specialties all throughout the country. In addition there are 28 company or in-house physicians that are based mostly at the company clinic at Nichols, Pasay City and at the Makati office clinic.

In the accreditation of hospitals, laboratory, x-ray and diagnostic clinics, the DMP Manager together with one of the company doctors, conduct ocular inspection of the "candidate hospital". While they don't have standards and requirements for accreditation, they give importance to the hospital's cleanliness and adequacy of equipment in the emergency room and laboratory. Accreditation of physicians is often based on the preferences of management or the recommendation or endorsement of their regular company doctors. Employees and their dependents are required to consult only with accredited or company health care providers. If treatment is done in a non-accredited clinic or hospital, DMP will reimburse 80% of the member's total bills inclusive of professional fees up to a maximum of P5,000.00. DMP clinic should be informed of emergency cases within 24 hours.

C. PROFILE OF INSURED MEMBERS

Employee dependents enrolled with DMP totalled 26,000 in the 4th quarter of 1991. No data on membership is available for previous years. All the 12,000 regular employees, including foreign based, are covered. There are no available statistics about occupation, age, sex, marital status, etc. of enrollees.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

In 1991, the total consultation services availed of by members was 33,556 for DMP and 185,815 for employees; diagnostic procedures performed was 26,908 for employees, no data for DMP; number of hospital admissions was 1,566 for DMP and 759 for employees. There are no available data on the breakdown of MD consultations, by month, nor the leading causes of MD consultations, and breakdown of hospital admissions by month in accredited and non-accredited hospitals. The average length of confinement of employees is one week. The shortest is 1 night (executive check-up) and the longest is up to 120 days. No data is available on the confinement period for DMP members.

The overall amount spent for services by all category of services and expenditure items in 1991 was P36,937,820 for both plans. Of this amount, P3,992,664 was spent by DMP and P32,945,156 by its personnel. The amount spent covered all services, both outpatient and inpatient care, and include professional fees, medicines, laboratory, room and board, etc. It is not clear, however, whether these payments included services rendered at non-accredited/non-company providers.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

For the DMP, applicants are required to submit birth certificates, marriage certificate and ID picture. These documents are verified in the 201 file of the employee, after which they fill-up an application form and then undergo a medical examination. The medical exam covers routine medical examination, ECG and x-ray, the costs of which are paid by the employee/applicant. After the results of the medical exam are submitted, the application is processed. This involves ascertaining completeness of documents and determining veracity of health information. The latter is done by the company doctor. If everything is in order, the applicant/employee is made to sign a notice of deduction, the ID card is issued to the member which need only to be presented to clinics or hospital to avail services.

In Plan 2, all applicants for employment undergo a rigid medical examination. Only the medically/physically fit are hired and enjoy automatic coverage of Plan 2 after 6 months of employment.

2. Benefit Availment/Claims Processing

The standard procedures for extending benefits include the presentation of ID card to the nurse who does routine physical examination and recording, then refers the patient to the doctor on duty. If findings indicate need for further diagnosis/exam, the member is referred to an accredited specialist in any of the accredited hospitals.

In Plan 2, the employee goes to any of the company doctors on duty in any of the company clinics. After initial exam, the company doctors may either prescribe outpatient treatment or hospital confinement. In the latter, the employee is given the authority to be admitted in any of the accredited hospitals which is usually at the Makati Medical Center, Manila Doctors Hospital or Cebu Medical Center.

Certain procedures are followed in the processing of claims.

In Plan 1, request is submitted to accounting clerk with attached statement of account, discharge invoice, medical certificate and official receipt. The accounting clerk first determines the completeness of required documents, then forwards to the company doctor for review in terms of appropriateness of services rendered as well as cost. After approval by the doctor, the documents are returned to accounting which prepares the voucher which is in turn forwarded to DMP Director for signature. The Director does the standard financial and accounting review to ascertain whether the claims are within set ceilings and receipts are valid.

In Plan 2, the procedure is much simpler. In claiming reimbursement of cost of prescription medicine, the employee presents the prescription and receipts to the accounting office and payment is effected.

The processing of the hospital bill follows the same procedure. In Plan 1, it takes an average of 3 days to process claims and effect payment of claims, with a minimum of 1 day and maximum of 10 days. In Plan 2, 5 days is the minimum, 6 days average and 2 weeks, the maximum.

F. COST CONTAINMENT MEASURES AND MECHANISMS

Cost containment measures include screening for adverse selection, exclusions and limits, PMSU screening, referral controls and preventive health services. These measures were adopted to preserve the viability of the program. Although no evaluation

has been conducted to determine impact of these measures, the claimed reduction in medical expenses is considered an indication of their positive result.

The usual form of abuse or fraud that have been detected are (a) unnecessary medical check-up demanded by members and employees, (b) use of fake receipts or inclusion of unnecessary or unrelated expenses.

To minimize such frauds/abuse, memo has been issued to doctors and hospitals for stricter implementation of company rules and policies, and at the same time ensure strict auditing and review of demand bills. So far, there are no concrete examples indicating the success or failure of those safeguards, but, again reduced medical expense indicate some degree of success. It is believed that fraud and abuse can be totally eliminated if the doctors, particularly the hospital coordinator, are given better pay or benefits. This also depends on the honesty of both the employee and service provider.

3. PERFORMANCE INDICATOR AND FINANCIAL STATUS

No financial data were made available because these are treated as confidential information by the company. However, we were informed that in Plan 2, the total medical expenses for all employees including foreign based personnel amounted to P31 million. As a company policy, the amount of past year's expenses is the amount allocated for the following year's budget for this purpose.

The excess premiums or contribution in Plan 1 is invested in securities and bonds out investment income per year is not available. In Plan 2, excess amount is reverted to the general fund of the company.

4. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Per experience, it is estimated that a start-up fund of P5 M is needed to operate a similar health plan. At least 3 clerks and 5 nurses are needed to man the operation. As to equipment, basic requirement includes tables and chairs, computer, xerox machine, typewriters and medical equipment to include x-ray machine, ECG and basic medical kit.

Economic progress was ranked as the most important factor that contributes to progress of the health insurance operation such as DMP. This is so because economic progress means increased income for the company which, in turn, means more or better benefits for employees. The viability or profitability of the company will determine continued viability of the medical plan. Household income, education and government incentives were ranked second, third and fourth respectively.

The most serious problem in their perception that affects or is confronting their health plan operation is the lack of computers. This hampers the analysis of trends which should be basic for instituting improvements. This is aggravated by lack of personnel, particularly nurses.

As to regulatory measures, it is believed that the government should assume the role particularly in the aspect of drug pricing, professional fees, enforcement of provision of the Labor Code on industrial injury policy/rules, conversely, incentives and supports from the Government can be provided in the form of drug cooperatives, subsidies and tax incentive measures.

The Reference Company has plans for expansion. For one, there are serious plans to expand coverage within the next 2 years to include illegitimate children. The inclusion of parents up to 65 years old is also being studied. Expansion of health benefit package will mean the inclusion of dental services.

Case Report No. 19: Employer-Provided Health Benefits: CBA
Reference Company No. 14
Area(s) Studied: NCR

A. IDENTIFICATION

The reference company is a Filipino owned corporation established on September 25, 1987. It runs branch stores in Recto Avenue and Rizal Avenue both in the city of Manila. It is principally engaged in the retail business and caters to the C & S market.

B. HEALTH PLANS AND BENEFITS

The health plan of the company is in the form of employee benefits which include (a) free medical services (out-patient) provided by the company physician, (b) hospitalization benefits in case of work related accidents and (c) free medicines for common illnesses. Only the company's regular employees are entitled to the above benefits. These benefits were given to employees as a result of negotiations between the company and employees' union. The employees are not asked to pay a premium for participating in the plan.

The company does not have any standard mechanisms and procedures in accrediting service providers. The decision to accredit clinics and doctors are left to the discretion of management. Presently, there are 2 direct health service providers, one primary, private and one company owned clinic. There are also 2 accredited physicians. All health benefits are subject to prior evaluation of the company physician.

Employees share some of the cost of services utilized. Outpatient consultations and medicines for common illness, i.e. colds, fever, stomach ache, etc. are provided free at the company clinic. Cost of prescribed medicines are shouldered by employees. Hospitalization benefits are limited to only P500.00 per illness/injury resulting from work related accident. The amount due is reimbursed to employee after presentation of necessary supporting papers, and after Medicare benefits are deducted.

C. PROFILE OF MEMBERS/ENROLLEES

As of end of 1991, there were 30 employees covered by the plan. No data are available on the occupation, age, sex, marital status and educational status of covered members.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

No data are available on the services used by members, nor the breakdown of MD consultations, nor the leading causes of MD consultation; etc.

E. MANAGEMENT AND OPERATING SYSTEM

1. Marketing and Recruitment

No sales force is engaged by the company because the health benefits cover only regular employees. All applicants for employment in the company undergo complete physical examination. Regular employees are automatically covered by the Company's health care plan.

2. Benefits Availment/Claims Processing

Employees are required to go to the company physician or the accredited MD consultation. If illness/injury requires in-patient treatment and diagnosed to be work related accidents, a referral or authorization letter is issued to accredited clinic or hospital to render needed services.

The only procedure for processing claims for cash reimbursement is the presentation of necessary supporting papers to support claims, i.e. MD's authorization and official receipts. The total amount of reimbursement is limited to P500.00 per illness after Medicare deduction. This is only for work-related accidents.

All claims go through 2 levels of review, namely: (a) medical review determine appropriateness of the service provided, and (b) validity checks to safeguard against abuses like submission of false or altered receipts. The average time to process claims and effect payment is 1 week, or a minimum of 4 days and a maximum of 2 weeks.

F. FINANCIAL STATUS

No data were given on the financial costs of extending services to members.

G. COST CONTAINMENT MEASURES AND MECHANISMS

To contain the cost of health services to its employees, the company undertakes a pre-employment physical examination to all applicants so that only the medically fit are employed.

The company has not yet experienced any abuse and fraud in claiming health benefits.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Respondent did not give any views on industry prospects.

Case Report No. 20: Employer-Provided Health Benefits: CBA
 Reference Company No. 15
 Area(s) Studied: NCR

A. IDENTIFICATION

In 1949, just a few years after the devastating and catastrophic event of World War II, the Reference Company was put up in the municipality of Paranaque, Rizal where the town was not yet incorporated to Metro Manila now known as National Capital Region.

The Company did not indicate its nationality but simply stated that it was organized under the laws of the Philippines. It is not an insurance nor a health organization per se. As its name suggests, it is engaged primarily in the manufacture and marketing of cigars and cigarettes throughout the country. It provided health benefits to its employees initially on a voluntary basis, and later incorporated its Collective Bargaining Agreement (CBA) with labor unions.

B. HEALTH PLANS AND BENEFITS

The Company already extended health benefits to its employees when it was established in 1949. No CBA was yet formalized during that period. With the organization of labor unions and institutionalization of CBA as a negotiating instrument between labor and management, the Company set up its own clinic where employees go for consultation and emergency treatment. A full-time nurse and 2 doctors man the clinic 24 hours a day.

To meet the in-patient needs of employees, the Company has a contract/agreement for Comprehensive Group Hospitalization and Health Maintenance Program under Medicare Phils. Inc. with maximum coverage of P50,000 per employee/annum.

The Company shoulders 100% of hospitalization costs incurred by employees. Hospitalization expenses in excess of the maximum ceiling of P50,000.00, are paid by the employer after deducting applicable Medicare and SSS benefits.

The Company also sets aside a hospital contingency fund of P300,000.00 per year for its employees. In addition, each employee is allocated P1,800.00 for consultation and laboratory diagnostic tests outside the HMO.

C. PROFILE OF INSURED MEMBERS

As of 1992, the Company had a total of 2,023 employees broken down as follows:

a.	Rank and file	-	223
b.	Supervisory	-	71
c.	Manager	-	32
d.	Factory worker	-	1,697

Of the total, 1,346 are female and 677 are male employees. Female employees outnumber the male work force by 67%.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The ten leading causes of outpatient consultation are as follows:

a.	URTI	f.	UTI
b.	LBM	g.	Hyper-acidity

- | | |
|--------------|---------------------|
| c. Arthritis | h. Asthma |
| d. HPN | i. Allergy |
| e. Dizziness | j. Headache/tension |

On the other hand, the 10 leading causes of hospitalization are as follow:

- | | |
|---------------------------|---------------------|
| a. Hypercholesterolemia | f. Hypertension |
| b. Orthopedic cases | g. Emphysema |
| c. Stroke | h. Bronchitis |
| d. Lupus | i. Pneumonia |
| e. Ischemic heart disease | j. Pleural effusion |

The average days of confinement is 7 days, with a minimum of 4 days, and maximum of 15 days. No data was available on the number of cases seen.

E. MANAGEMENT AND OPERATING SYSTEMS

Availability of services and benefits for employees is not stringent. Outpatients, employees can go directly and freely to company's clinic at the prescribed clinic hours. For inpatient services, employee gets letter of authorization from PMSU for confinement. If PMSU is not present, the employee can go directly to the emergency rooms of any accredited hospital, present his Medicaid ID and avail of treatment hospital confinement as the case may be.

Medicaid Phils, Inc. has accredited health care providers for company employees. If employees, by any chance, go to non-accredited health providers, 20% of his/her expenses are deducted from his/her P1,800.00 employee's medical allowance. Reimbursement of medical expenditures is done provided the following procedure requirements are satisfied:

- a. Submission of all official receipts and prescription forms to the company doctor for verification and screening.
- b. After the doctor's verification, submission of documents to Sales Audit department for processing of payment.
- c. Submission of claims document to Accounting department for payment.

During the review and assessment of claims, the Company performs the following:

- a. Medical review, to determine appropriateness of service provided or amount of benefits availed.
- b. Financial review, to determine application of benefit ceilings or standard costs.
- c. Accounting review, receipts.
- d. Validity checks to safeguard against possible abuses like submission of false receipts or statement of accounts.

Processing of claims and effecting payment to members usually takes 7 days, with a minimum of 1 day and maximum of 90 days.

F. COST CONTAINMENT MEASURES AND MECHANISMS

Measures adopted by the Company to contain cost of health services for covered employees are as follows:

- a. pre-employment health screening
- b. application of exclusion and limits
- c. PMSU screening
- d. referral control
- e. preventive measures - yearly physical examination

Instances of abuses and frauds in claiming health benefits were noted as follows:

- a. forging of doctor's signature on prescription slip
- b. reimbursement of pedia medicines, which were not allowed nor covered by the medical allowance
- c. submission of receipts for medicines not used by the employee-claimant.

However, there are safeguards adopted to protect the Company from those abuses and frauds. One is to require that request for medicine reimbursement show original copies of official receipts, and that prescriptions are endorsed by company doctor. Second, guidelines for claims processing are strictly followed. These safeguards usually worked as flow of document is clear and without delay, and responsible persons are easily identified.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

No data was provided on the financial transactions related with the employee health benefits scheme.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Company suggested that Government could focus on more information dissemination on the preventive aspect of diseases and increase Medicare benefits to promote the growth and development of health insurance in the Philippines.

Case Report No. 21: Employer-Provided Health Benefits: CBA
Reference Company No. 22
Area(s) Studied: Cagayan Province

A. IDENTIFICATION

The Reference Company is a filipino-owned corporation operating in Tuguegara City. Established in 1991, the company is principally engaged in the manufacture processing and nationwide distribution of sugar.

B. HEALTH PLANS AND BENEFITS

The company offers the following benefits to its employees:

- a. Free medical/dental consultation at the company clinic;
- b. Free first aid medicines for common colds, fever and flu; and
- c. Hospital reimbursement benefit up to a maximum of P1,000.

Regular employees and their dependents can avail of the above benefits by visiting the company clinic for outpatient consultation. Hospitalization benefits are extended to members in a form of cash reimbursement up to a maximum amount of P1,000.00/employee/year.

The company maintains within its premises a completely furnished clinic with basic medical equipment and first-aid medicines. It is manned by one full-time nurse and one part-time doctor. The clinic is open daily from Monday to Saturday to serve the health needs of its workers. The company does not accredit exclusive hospitals and doctors to serve its employees. Employees can go to any hospital for confinement. Reimbursement claims will be paid upon presentation of official receipts, statement of account and proof of service.

C. PROFILE OF MEMBERS/EMPLOYEES

As of survey date, the company had 154 employees covered by the health plan. This included 32 supervisory employees and 125 rank and file employees. No data was given on the occupation, age, sex, marital status and educational attainment of employees.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The company has recorded a total of (74) outpatient consultation made by employees and dependents. Usual causes of consultation were lacerated wound due to manual harvesting of sugarcane, influenza, upper respiratory infection, arthritis and peptic ulcer. No data was given on the breakdown of consultation by month. There were 5 cases of hospital admission. Causes of confinement were peptic ulcer (2 cases), acute gastro-enteritis (1), choledithiasis (1) and hepatitis (1).

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

To be considered for coverage in health plan, employees are usually screened by the company. Criteria and considerations used in deciding which employees are to be covered are: a) applicant must be a CBA member, b) must be physically fit for employment and c) must be a regular employee of the company.

2. Premium Collection

The company does not collect any pre-paid contribution from employees. The only contribution asked of members are SSS premiums and Medicare contribution.

3. Claims Processing

Standard requirements for processing of claims for cash reimbursement are: a) statement of account; b) official receipts on medicines purchased; and c) certification by attending physician. The total reimbursable amount is P1,000.00/employee/year. After Medicare deduction, the excess shall be shouldered by the employee.

Scope of review and assessment of claims done by the company includes:

- a. medical review - to determine appropriateness of service provided or amount of benefits availed;
- b. financial review - to check application of benefit ceiling; and
- c. accounting review - to check veracity of receipts presented

G. FINANCIAL STATUS

For the health provision of covered employees and dependents, the company maintains a yearly allocation of P50,000 as negotiated by the company and the labor union. Said amount should be used solely for the health needs of covered employees. The company spent a total of P44,204 in 1991. This covered salaries of company doctor and nurse, drugs and medicines and other employee benefits. No breakdown of costs were, however, provided.

F. COST-CONTAINMENT MEASURES

Cost-containment is effected by screening of employees who are medically fit, and ensuring that claims are proper and accurately filed.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECTS

Respondent did not express any views on this topic.

Case Report No. 22: Employer-Provided Health Benefits: CBA
Reference Company No. 31
Area(s) Studied: Cebu

A. IDENTIFICATION

The Reference Company was established in Cebu City in 1981. Its main business is the printing of labels.

B. HEALTH PLANS AND BENEFITS

Aside from the health benefits which employers are legally-mandated to provide, the Reference Company advances payment of medical expenses incurred by the employees and/or their dependents.

The employee pays back the advances made by Company through salary deduction at no interest and at a monthly rate affordable to him. These arrangements resulted from the negotiation between the management and the union as documented in their Collective Bargaining Agreement.

There is no set limit on the health cash loan. The Reference Company does not impose any ceiling, nor does it limit the type of services for which the advance payment may be made. There are no documented policy on exclusions although the respondent enumerated the following conditions for which the management may not approve a cash loan:

1. Conditions arising from acts which are not covered by insurance, e.g. STDs, including AIDS; suicide; substance abuse; and, conditions arising from acts of war/riots;
2. Mental or nervous disorders;
3. Congenital deformities and defects, cosmetic and plastic surgery;
4. Conditions with no known cure; and,
5. Conditions requiring isolation.

C. PROFILE OF MEMBERS/EMPLOYEES

The Company had 23 employees, all of whom were eligible for availment of the health cash loan. Only two of the employees were female; all belonged to the 15-45 age bracket; 22 were married and only one was single; 21 were high school graduates and 2 were able to finish college; 21 employees resided within the city and two lived outside the city.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The Company does not keep a record of the health services utilized by their employees, much less the causes of their illnesses. The respondent recalled, however, that 5 employees were hospitalized in 1991. It was further estimated that the average period of confinement was 3 days, the shortest was 2 days and the longest was 5 days.

E. MANAGEMENT AND OPERATING SYSTEM**1. Marketing and Recruitment**

All employees may avail of the health cash loan.

2. Premium Collection

The company does not collect any pre-paid contribution since the health benefit is in the form of cash loan. Neither does it allocate a specific amount for their health plan.

3. Benefit Availment

The Reference Company prefers that their employees and/or their dependents go to the Cebu-Velez Hospital, a private tertiary hospital, since a daughter of the manager used to work there thus, facilitating the service arrangements. Nevertheless, the Company does not compel the employees and/or their dependents to go to the said hospital particularly in times of emergency. However, they do require the employee or any relative to inform the Company of any confinement upon admission or before the discharge of the patient. The Company then calls up the hospital to make arrangements for billing and payment of bills. The Reference Company does not have a formal contract with the hospitals regarding these arrangements for settlement of service fees. But the owner happens to be a prominent figure in the City thus, several big hospitals in the area trust that the Company will assume payment of the services used by the latter's employees and their dependents. To claim payment, the hospitals or clinics send a financial statement together with the official receipts and proof of service rendered. Upon receipt of the hospital/clinic bills, the Company does an accounting review and validity check. If the required documents are complete and found in order, it takes only a week to effect payment. On the other hand, it may take as long as one month to process the bills if any problem arises as a result of the review. On the average, it takes 2 weeks to process the hospital/clinic bills and effect payment.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The Company requires all job applicants to undergo a pre-employment medical examination to ensure that they are physically fit for work. The Company has not instituted any other cost containment measure.

So far, the Company had not encountered any problem in the operation of its health cash loan. The Reference Company had not experienced any form of abuse or fraud. The respondent did not think that employees would resort to abuse or fraud since she believed that employees were treated well by management.

G. FINANCIAL STATUS

No specific amount was allocated for the health cash loan. Payments made to the hospitals/clinics are drawn from the general funds. The Company does not keep a record of the details of the expenses for which advance payment has been made. Thus, there are no information on the particular health services availed of and the types of illnesses or health problems encountered. It was estimated, however, that the Company issued loans amounting to P15,000.00 in 1991.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECTS

Given the Company's experiences, it was estimated that a start-up capitalization

of P100,000 - P200,000 is required. No additional personnel is needed since the task involved in processing the bills is very minimal and can be performed by the administrative officer.

The respondent mentioned that vices of the employees was the factor that affect the viability of the health plan. If the employees did not have vices, then their salary would be enough for their daily living and they would not get sick. For the Company, this would mean low rate of the cash loan. The respondent did not think there was need for additional regulatory measures nor other support from the government. She believed that the Company was doing well with its present health scheme.

Case Report No. 23: Employer-Provided Health Benefits: CBA
 Reference Company No. 32
 Area(s) Studied: Cebu

A. IDENTIFICATION

The reference company is engaged principally in the worldwide export of office and house furniture made mostly of rattan and wood. It was established in 1974 and has its offices and shops in Mandaue City, Cebu.

B. HEALTH PLANS AND BENEFIT

Starting in 1985, a health benefit plan for employees was supported by the Company. All regular employees are automatically covered under the plan. The Company shoulders the full cost of the health benefit plan with a yearly allocation of approximately P3 M. The amount was decided upon by management after some consultation with employees, taking into account the Company's financial position. The current health plan provides the following benefits:

- a. 17 days sick leave, which if unused, can be converted to cash at a minimum of P113 per day;
- b. Outpatient consultation with the company doctor in the company clinic;
- c. X-ray once a year;
- d. Drugs and medicines up to P1,125.00 per employee per year;
- e. Hospitalization up to P4,000 per year, this includes expenses for room and board, professional fees, labs and x-ray and diagnostics, drugs and medicines; and
- f. Dental services except dentures.

The following services or conditions which are usually excluded from commercial insurance coverage are included in the company's health plan benefits up to the ceiling prescribed above.

- a. Conditions existing prior to employment with company.
- b. Conditions which are not work related.
- c. Mental or nervous disorder.
- d. Pregnancy, childbirth, miscarriage, abortion and their complications.
- e. Conditions requiring use of ICU.
- f. Conditions requiring prolonged treatment or recurring in nature.
- g. Conditions/diseases requiring isolation per DOH policy like leprosy, cholera, etc.

The following are not covered under the plan:

- a. Conditions arising from acts not normally sanctioned by society like, STDs/AIDs, suicide, substance abuse and conditions arising from acts of war/riots, etc.;
- b. New procedures like lithotripsy, ultrasound;
- c. Congenital deformities and defects, cosmetic and plastic surgery;
- d. Conditions without known cure.

Screening of employees is done through pre-employment physical check-up. Once accepted for employment they have to be regular employees to avail of the health benefits.

Health benefits are extended to employees in the form of direct service through company facilities and accredited service providers and also through cash reimbursement. The company maintains 2 clinics in its factory premises and has 1 accredited private clinic. There are no accredited hospitals.

As a standard procedure for extending benefits in non-emergency cases, a employee simply goes to the company doctor for consultation and is given necessary prescription. If patient needs hospital confinement or needs to be referred to specialized physician, the company doctor issues a referral slip.

For emergency treatment, employees could go to any doctor or hospital but should notify the company within 24 hours from admission.

C. PROFILE OF MEMBERS

The Company has a workforce of 850 employees, all of which are covered by the health plan. No data are available on the demographic and socio-economic profile of the employees.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

In 1991, there were 600 outpatient consultations; 700 diagnostic procedures and 10 hospitalized cases. Upper respiratory infection was the leading cause of MD consultation, while x-ray was the leading diagnostic procedure performed. No other reasons for consultation and diagnostic procedures was cited by the respondent. No data is available on the leading causes of hospitalization nor the breakdown of admissions by month.

The usual length of confinement per member is 4 days. The minimum is 3 days and the maximum is 12 days. In 1991, the company spent a total of P30,000 for all category of services rendered. This included expenses for hospitalization, room and board, professional fees, lab, x-ray, drugs and medicines, etc.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Recruitment and Marketing

Not applicable.

2. Premium Collection

No pre-paid contributions are collected from employees. Company makes a pre-allocation of P3 M per year to cover cost of health care.

3. Claims Processing

As a company policy, cash reimbursement claims require that employees and service providers submit official receipts, prescriptions, medical certificate and certificate of services rendered. Outright reimbursement is effected only upon presentation of these papers.

The review and assessment of claims is guided by the following:

- a. Medical review to ensure that services provided and amount of benefits is appropriate for such claim;
- b. Accounting review; and
- c. Validity checks to authenticate receipts and statements of accounts.

The average time to process and effect payment for claims is 15 minutes, with 5 minutes as the shortest and 1 day as the longest probable time. As regards retained or accredited providers who extend direct services to employees, the processing of bills is done after the submission of statement of accounts and proof of service

utilization such as medical certificate. These documents are usually submitted on monthly basis. The hospital claims and MD's bills are reviewed to determine appropriateness of service and amount of benefits availed while receipts are reviewed for authenticity. A guarantee letter stating entitled amount is then sent to the provider. The usual time to process provider bills is 2 weeks, with 1 week as the shortest and 1 month as the longest.

F. COST CONTAINMENT MEASURES

The following measures have been instituted to contain the cost of health services:

- a. Pre-employment health screening. Applicants with pre-existing diseases are not generally accepted for employment;
- b. Exclusions and limits - the company pays only up to set ceilings; and
- c. Preventive measures through health seminars and medical bulletins posted to increase employee health awareness.

The most common form of abuse and fraud is the submission of tampered receipts. As a safeguard against this practice, the Company introduced the use of official medicine requisition form. As a result, financial outlay for drugs and medicine has remained steady or even declined despite the significant increase in their costs over the years.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

No financial and performance data were made available to the research team, hence the financial status of the health insurance operation cannot be assessed.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECTS

The respondent is of the opinion that starting a company health benefit plan like theirs would require a minimum outlay of P1.5M. This amount covers the hiring of a full time company doctor and one nurse, the setting up of a company clinic equipped with at least 1 set of first aid facilities and supplied with all kinds of emergency medicines.

Four factors and conditions contributing to the growth and development of the company's health plan were cited. These are:

- a. The workers demand for more benefits to offset the effects of inflation while wages were frozen;
- b. The receptiveness of management to the workers demand for benefits;
- c. The effectiveness of control measures to minimize abuses and frauds; and
- d. The congenial and personalized relationship between employer and employees.

The most serious problem foreseen by the company in sustaining the health plan is the limited availability of funds. To correct this problem, the company needs to increase production and improve or expand its foreign market so that it can generate enough funds to maintain or expand their employee benefits.

Case Report No. 24: Employer-Provided Health Benefits: CBA
 Reference Company No. 43
 Area(s) Studied: Misamis Oriental

A. IDENTIFICATION

The reference company is principally engaged in hotel and restaurant business operating solely in Cagayan de Oro City. Established in 1982, the company is categorized as employer providing health benefits to employees.

B. HEALTH PLANS AND BENEFITS

The company provides free medical and dental consultation, including drugs and medicines (only those available at the company clinic) and laboratory tests through its company clinic. In addition, the company has a health fund for in-patient services.

Employees can request for cash advance or file claims for reimbursement of expenses incurred in hospitalization. The health fund is drawn from the company allocation of P7,980.00/year/employee and monthly contribution of P35/employee which is deducted from his salary. The amount of contribution and company allocation were agreed upon as a result of negotiation between employees' union and management.

Services/conditions excluded in health plan are as follows:

- a. Conditions arising from acts which are not sanctioned by society, like STD/AIDS, suicide, etc.;
- b. New procedures like lithotripsy and ultrasound;
- c. Mental and nervous disorders;
- d. Conditions requiring use of ICU;
- e. Congenital deformities and defects; and
- f. Conditions without known cure

C. PROFILE OF MEMBERS/EMPLOYEES

The company had 29 employees, 19 of whom are covered by CBA and 10 are not. There are no data available on age, sex, marital status, residence of employees and dependent with health plan coverage.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The company kept no record of the total number of consultations, diagnostic procedures and hospital admissions. The company doctor is hired by the company on a retainer basis and the company has no way of knowing how many consultations were done in his clinic and how many were hospitalized. The only record of expenditure for health services were the claims payment from SSS which amounted to P24,850.00 in 1991. Data on the claims paid from the health fund was not available.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The company sets certain criteria/considerations in deciding which employees are to be covered by health plan. Criteria used are:

1. The applicant must be a CBA member;

- b. Physically fit for employment; and
- c. Must be a regular employee of the company.

2. Premium Collection

Regular contribution of P35/month is being collected from covered employee through salary deduction. This amount represents employee's contribution to the health fund.

3. Benefit Availment/Claims Processing

For out-patient consultation, the employees go directly to the company clinic or an accredited out-patient clinic located within 5 km. radius from the company office. The company does not have any accredited hospital.

In case of confinement, members can avail of cash advance, the amount of which is decided by management based on estimated expenses in excess of Medicare and SSS coverage or they may claim for cash reimbursement for hospitalization expenses.

Employees are required to submit official receipts and statements of account from the hospital to claim cash reimbursement for hospitalization.

Claims filed by employees are subject to the following review:

- a. Medical review to determine appropriateness of service provided; and
- b. Accounting review to verify authenticity of documents submitted.

F. COST CONTAINMENT MEASURES AND MECHANISMS

To contain the cost of health services for covered employees, the company adopted the following measures:

- a. Pre-employment health screening;
- b. Primary MD screening prior to confinement; and
- c. Preventive measures;

G. FINANCIAL STATUS

The company was not able to provide financial data.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECT

No response was given since company is not engaged in health insurance.

Case Report No. 25: Employer-Provided Health Benefits: CBA
 Reference Company No. 44
 Area(s) Studied: Misamis Oriental

A. IDENTIFICATION

This reference company is in the transportation business with franchise routes in Cagayan de Oro City, Misamis Occidental and Bukidnon. Its head office is in Bacolod City. Since 1976, it has been providing health care benefits to its employees.

B. HEALTH PLANS AND BENEFITS

The company provides 3 types of health plans, a) accident insurance with health benefits, b) clinic consultation and c) hospitalization. The accident insurance with health benefits plan is part of the health benefits defined in the Collective Bargaining Agreement, while clinic consultation and hospitalization were voluntarily developed and administered by the company. All employees who are members of the Union are covered by the health benefits.

Costs are shared 50%-50% between the employee and company. Each member contributes P120.00 a year, and the company puts up the same amount for the health fund. The cost sharing scheme is the result of negotiations between the company and the employees/union.

Under Plan A, out-patient consultation, lab, x-ray, diagnostics, drugs and medicines are not covered. Hospital confinement costs, e.g., room and board, professional fees, lab, x-ray, diagnostics, drugs and medicines are covered subject to ceiling, and should be accident related. Plan B offers unlimited outpatient consultation within the company clinic. Drugs and medicines are limited to those needed to treat minor ailments like fever, stomach ache, headache, etc. Laboratory, x-rays and diagnostics are not covered. In Plan C, hospitalization confinement benefits are limited according to the number of days confined as shown in the following table:

1 - 5 days confinement	P300/employee per illness
6 - 10 days confinement	P700/employee per illness
> 10 days confinement	maximum of P1,000/employee/illness

Conditions which are usually excluded in health plan/insurance coverage are likewise excluded from coverage. These include conditions existing prior to employment, conditions which are not work related, acts not sanctioned by society like STDs, including AIDS, suicide, drug abuse, procedures like ultrasound or lithotripsy, mental or nervous disorders, congenital deformities, cosmetic and plastic surgery and conditions without known cure.

The company maintains 1 outpatient clinic within the company premises and has 2 accredited private hospitals. The company does not have any standard procedure and requirement for accrediting physicians and hospitals. Top management in the Bacolod head office decides which hospitals and doctors are to be accredited.

Health plan benefits are extended to members either through cash reimbursement or direct service by accredited service providers. The benefits can be availed through:

- a. Consultation with accredited physician who visit the company clinic daily for one hour;

- b. Hospitalization in accredited private hospital; and
- c. Reimbursement of hospitalization expenses subject to limits based on number of days confined.

C. PROFILE OF MEMBERS

There are no available data on covered employees in 1991, nor data about occupation, age, sex, marital status, etc. The number of covered employees in 1992 was 764.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

No data were available on the services used by members. However, information on the leading causes of hospitalization listed the following: 1) Pharyngitis, 2) Bronchitis, 3) Upper respiratory tract infection, 4) Urinary tract infection, and 5) T.B. The average length of confinement per member is 3-5 days. The shortest is 2 days and the longest is 8 days.

E. MANAGEMENT AND OPERATING SYSTEM

1. Marketing and Recruitment

Employees covered by the health benefits are all union members who have worked for at least a year with the company, have passed the physical and medical examination and have undergone drug test, all of which are pre-employment requirements.

2. Benefits/Availment/Claims Processing

Procedures for extending health benefits to employees include:

- a. claiming reimbursement of accident/hospitalization expenses from the insurance company on behalf of the employees;
- b. direct services from company clinic and accredited health providers;
- c. reimbursement of medical expenses corresponding to cash equivalent of days confined up to maximum of P1,000 per employee per illness; and
- d. salary deduction of expenses shouldered by employer.

Processing of claims include the following procedures:

- a. submission of required documents;
- b. review and approval of claims; and,
- c. release of payment

Processing of claims requires the submission of :

- a. clearance or endorsement from respective department head;
- b. hospital bill/statement of account;
- c. medical certificate if not hospitalized; and,
- d. insurance processing form, if claiming from insurance company.

All claims submitted are subjected to a medical review for appropriateness of service provided done by the doctor or nurse; financial review for application of benefit ceilings; and, an accounting review of receipts, bills, vouchers, etc. The average time to process claims and effect payment is from 2 weeks to 1 month.

The standard procedure for processing statement of accounts submitted . accredited service providers who extend direct services to covered employees are enumerated below:

- a. hospital forwards bills to reference company;
- b. the Personnel Manager reviews the bill; and.
- c. Accounting division releases and effects payment.

Physicians are paid a monthly retainers fee. Before payment of the above is effected, a medical, financial and accounting review is done. The usual/shortest time to process bills from service providers is one week. The longest time to process claims is one month.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The two measures adopted by the company to contain the cost of health services for covered employees are: (i) the pre-employment health screening , that is, to employ only the physically and mentally fit; and (ii) the adoption of exclusions and limits on what the company can afford. This was arrived at through consultation with the employees union.

The company experienced only one case of abuse or fraudulent claim of health benefit, through submission of tampered and altered receipts. The employee was suspended. The penalty was deemed effective in discouraging others from doing the same.

G. PERFORMANCE INDICATORS AND FINANCIAL STATUS

No information was given on financial status of the Company.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The respondent had no idea about the minimum administrative requirements for running a health insurance in terms of capitalization and personnel. However, he stated that the most important factor that affect the development of a health plan like theirs is the agreement between the management and employees through CBA. Both sides should arrive at a common point. The problem facing the provision of health plan is the attitude of employees to take as much as they can from the company, the tendency to use sick leave even when not needed and the uncontrolled movement of people going to the office clinic. All these problems, however, are solvable through an educational program. Respondent thinks that government should regulate health cost e.g. hospitalization, drugs and medicines in order to promote the growth of health insurance.

Case Report No. 26: Employer-Provided Health Benefits: Voluntary
 Reference Company No. 16
 Area(s) Studied: National Capital Region

A. IDENTIFICATION

The reference company is a Filipino owned corporation established on December 17, 1981 with office and factory located in Mandaluyong, Metro Manila. Its main business is the manufacture and export of children's wear to USA, Canada, Australia and EEC.

B. HEALTH PLANS AND BENEFITS

The Company started providing health care benefits to its employees in 1981. The health plan was voluntarily developed and administered by the Company. No charges or contributions from its employees are collected. Instead, the Company allocated P350,000 per year to finance its health plan. Given the number of covered employees in 1991, the allocation is equivalent to about P35 per month per employee.

Management decided to set aside the above amount based on the premium estimate of a similar plan proposed by a health insurance firm. The Company had originally wanted to enroll its employees in a health insurance plan but opted instead to administer and manage its own health benefit plan.

Three (3) types of health plans are offered. These are: Plan A for its managerial personnel, Plan B for supervisory personnel and Plan C for rank and file employees. Benefits provided under these plans are subject to limits and conditions except for preventive health services which are unlimited. Benefit ceilings for medical care are as follows:

Plan A - Managerial	- P35,000 per person per year
Plan B - Supervisory	- P25,000 per person per year
Plan C - Rank and File	- P15,000 per person per year

The above amounts cover outpatient consultation and hospital confinement including room & board, professional fees, lab, x-ray, diagnostics and drugs and medicines. ICU coverage is limited to 14 days, Surgery coverage is limited to 80% of cost and dialysis or blood transfusion coverage is limited to 10 treatments. Room and board rates are computed according to existing rates of accredited hospitals. Diagnostic test is provided when deemed necessary by accredited physician.

The following services or conditions which are usually excluded in other health insurance plan are covered under the company's health plan.

- a. Conditions existing prior to employment (Plan A only);
- b. Conditions which are not work related (Plan A only);
- c. Mental or nervous disorders (All Plans);
- d. Routine physical check up once a year (all Plans);
- e. Conditions which are recurrent in nature or require prolonged treatment (Plan A);
- f. Conditions/diseases requiring isolation per DOH policy (All Plans); and
- g. Conditions without known cure (Plan A).

Conditions or services not covered under all plans are:

- New procedures like lithotripsy, ultrasound;
- Pregnancy, childbirth, miscarriage, abortion and their complication; and
- Congenital deformities and defects, cosmetic and plastic surgery.

The company also provides preventive health care for its employees. The services include administration of vaccine, advice on diet, exercise and other healthful habits, family planning counselling and wellness program.

Health plan benefits are extended to employees through cash reimbursement or direct services rendered by accredited service providers and company facilities. The Company pays for 100% of covered expenses for services rendered by accredited hospitals and accredited MDs. It assumes 90% of covered expenses for services rendered by non-accredited hospitals and 80% for those rendered by non-accredited MDs. Direct services include free annual physical examination and medical and dental consultation.

The company operates one outpatient clinic at its office/factory site, and has accredited 7 private tertiary hospitals and 3 family/general physicians. The company had no standards or requirements in accrediting health care providers, but relied solely on management's decision. Employees are required to consult only with accredited or company health care providers. If they seek the services of non-accredited providers, 10% of claims are deducted as penalty.

Only cases certified by the company physician as needing hospital care and attention will be covered for in-patient care. In cases when the company physician is not available and the employee needs immediate attention or in cases of emergency, he may go to any of the accredited hospitals even without referral provided he brings with him the ID card issued to him by the company. Notice of confinement in a hospital should be given to the company physician or the personnel department within 24 hours from admission.

C. PROFILE OF MEMBERS

In 1991, there were 813 employees covered by the health benefit plan. These are broken down according to salary scales as follows:

a.	Executives -		3
b.	P8,000 - P15,000/mo. (Plan A) -		10
c.	P5,000 - P 7,000/mo. (Plan B) -		20
d.	P3,000 - P 4,000/mo. (Plan C) -		778

No data were available on the age, sex, marital status, residence and educational attainment of employees.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

In 1991, there were 45 outpatient MD consultations (A-4;B-10;C-31), and 19 hospital admissions. There were no diagnostic procedures performed during the year. All these services were rendered by accredited facilities and providers, except for one case done in a non-accredited facility.

Headaches accounted for 80% of the MD consultation during the year and was the leading cause of consultation followed by fever, colds, hypertension, stomach-ache, cough, rheumatism, muscle pain, wounds and allergy. Of the 18 hospital admissions in accredited facilities, 12 were for medical treatment and 6 were surgical. There was one surgical operation done in a non-accredited hospital. The leading causes of hospital confinement were hypertension, allergy, (asthma), bronchitis and surgical operation. The average length of confinement per member was 5 days, with 2 to 3 days as the shortest and 8 days as the longest.

The total amount spent by the company for services, by category and expenditure item in 1991 was as follows:

Outpatient Consultation:		
Prof. Fees	-	P30,000
Lab., X-ray	-	none
diagnostics	-	P40,000
Drugs & Medicines	-	P20,000

Inpatient Care:		
Room & Board	-	P33,400
Prof. Fees	-	P67,000
Lab, x-ray, Diag.	-	P23,000
Drugs & Medicine	-	P16,854.76

Of the total amount spent, the following payments were made for services rendered (one case) by non-accredited health facilities: P4,000 for room and board, P5,000 for professional fees, P2,000 for lab., x-ray, diagnostics and P2,906.97 for drugs and medicines.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

All regular/permanent employees of the reference company as of July 1, 1987 are covered under the company's employee health benefit plan. Non-regular or non-permanent employees are entitled to these benefits upon completion of their training or probationary period.

2. Premium Collection

No premium or contribution is collected from employees.

3. Benefits Availment/Claims Processing

To claim cash reimbursements for health expenditures the employees are required to submit official receipts and hospital bill. For those confined in non-accredited hospitals, the employee should notify the Company to make arrangements for payment at least one day before his/her discharge from the hospital. The company shall then arrange payment with the hospital concerned. The company only pays a maximum of 90% of his/her total bill or of the standard fees and charges (based on the rates of accredited hospitals) whichever is lower. The same rule applies for non-accredited doctors.

The company reviews and assesses all claims submitted for payment and reimbursement. The average time to process claims and effect payment is 2 to 3 days. The review/ assessment includes:

- a. Medical review to determine appropriateness of service provided or amount of benefits availed;
- b. Financial review to verify application of benefit ceilings or standard costs;
- c. Accounting review to validate receipts; and
- d. Validity checks to safeguard against possible abuses such as submission of false or altered receipts.

Accredited providers who extend direct services to covered employees are required to submit a hospital report, breakdown of bills, and official receipt of expenses. Provider bills are also subjected to financial and accounting review. The average time to process bills and effect payment to service providers is 2 days, with 1 day as the

shortest and 4 days as the longest.

F. COST CONTAINMENT MEASURES

To contain the cost of health services, the company adopts the following measures:

- a. Pre-employment health screening to ensure hiring of healthy workers only;
- b. Exclusions and limits to prevent large outlays due to prolonged confinement;
- c. Referral controls - to discourage unnecessary hospital confinement.

To minimize or avoid abuses and fraud, the company maintains close coordination with accredited MD's, reminding them of the need to be strict in evaluating cases for confinement. Employees who are sick of minor illnesses would be advised to recuperate at home rather than be hospitalized. The company had not experienced abuses and frauds in claiming health benefits. The respondent, however, claims that fraud and abuse cannot be totally eliminated. At times, an emergency confinement may be made in a small provincial hospital and verification may be too burdensome, or in certain cases, some MD,s in the province may recommend unnecessary confinement.

G. PERFORMANCE INDICATORS AND FINANCIAL STATUS

Unutilized health care allocations are returned to the General fund. The respondent opted not to answer questions related to this section since the provision of health plan is not their principal concern.

H. RESPONDENT'S VIEW ON INDUSTRY PROSPECT

Respondent refused to express views on the subject.

Case Report No. 27: Employer-Provided Health Benefits: Voluntary
Reference Company No. 50
Area(s) Studied: Surigao del Norte

A. IDENTIFICATION

The Reference Company was established in 1978 as an electric power cooperative servicing Surigao del Norte. The company has provided generous health/medical benefits for its employees since its establishment. It had a work force of 140 regular employees as of January 1993.

B. HEALTH PLANS AND BENEFITS

The health benefits offered by Reference Company to its employees may be classified into 3 broad plans.

Plan 1 is in the form of fixed annual cash medical allowance amounting to P2,000 per employee per year. Cash payments are made in 2 installments, i.e. P1,000 in June and P1,000 in December of each year. The medical cash allowance are given to employees regardless of whether he/she is sick or not.

Plan 2 is in the form of hospitalization benefits for all work-related accidents. Under this plan, the Company shoulders the full cost of hospitalization of employees involved in work-related accidents. No ceilings or limits are set. As soon as a work-related accident is reported, Company takes care of taking patient to hospital and pays for all hospital bills.

Plan 3 is in the form of medical emergency loans which are extended to employees whenever they or members of their families get sick (not work-related sickness). The loans cover medical expenses beyond those covered by Medicare. The maximum amount of loans provided is P500/case, but may be raised to P1,500 depending on needs.

The health plans cover both regular and casual employees and are given equally to management and rank and file employees.

Accidents resulting from alcoholism are excluded from benefits.

The Company does not operate its own service clinic or facility, but it hires a physician on retainer basis to look after the outpatient care needs of its employees. There are no formal hospital accreditation programs, but the company has an informal arrangement with a nearby private hospital who is often called upon to render services in cases of work-related accident. Any hospital nearest the accident site, however, could be used for service purposes.

C. PROFILE OF MEMBERS/EMPLOYEES

Of the company's 140 employees, 113 are males, while 27 are females. Majority, or 123, are aged 15-45 years old, while 17 were over 45 years old. The oldest employee was 64 years old, while the youngest was 23 years old at the time of the survey. Almost all employees were married except for 6 who were single and 1 who was a widow at the time of the survey.

No information was available on the educational attainment of the workers and their number of dependents.

D. SERVICE UTILIZATION PATTERNS, BY MEMBERS

No data were provided on the service utilization patterns for all plans. While Plan 1 benefits are automatically given whether sick or not, hence can be assumed to be 100% utilized, the other Plans are utilized based on risk. Unfortunately, the Company was unable to provide the needed information during the survey as they said it would require tedious and time-consuming work to dig up their records to get the information.

E. MANAGEMENT AND OPERATING SYSTEM

Reference Company claimed to be able to provide prompt service to workers involved in work-related accidents. This is so because the Company provides two-way radio communications facilities and vehicles to service their employees who perform field work.

As soon as an accident is reported, the Company immediately assigns someone to take care of making necessary arrangements for hospitalization. All expenses are directly shouldered by the Company, including purchase of medicines. The Company also takes care of making/filing Medicare claims whenever applicable.

F. COST CONTAINMENT MEASURES AND MECHANISMS

Preventive measures are adopted by Company to minimize accidents and reduce cost of services. Regular safety seminars are conducted to acquaint workers with standard safety procedures. In addition, field workers are provided with complete set of protective gears such as helmets, rubberized gloves, rubber boots, etc.

So far, the Company has not experienced attempts to abuse or commit fraud in their health plans. They had, however, encountered cases of fraudulent Medicare claims filed by hospitals. In one case, a hospital filed hospitalization claims from Medicare even if employee only availed of outpatient care. In another case, an employee who had not been confined was claimed by the hospital to have been hospitalized and the hospital filed for Medicare benefits. To avoid such claims in the future, the Company maintains a log book of all Medicare claims filed by employees and compares its records with those filed by hospitals.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Unfortunately, the Company did not keep separate records of their medical/health care budget and expenditures, hence it was difficult to get data and information on their health plan operations. The Company also failed to provide a copy of their financial statement, so it was difficult to assess their financial status.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

No responses were made to these questions.

Case Report No. 28: Community-Based Health Scheme
Reference Company No. 13
Area(s) Studied: NCR

A. IDENTIFICATION

The reference organization/cooperative was established in July 1990. The organization is a duly recognized non-government organization registered with the Bureau of Cooperatives. Market coverage includes the depressed barangay 128 and part of barangay 129 composing the Smokey Mountain area in Balut, Tondo, Manila.

B. HEALTH PLANS

The organization's principal product is a drug cooperative. The target beneficiaries are the families in barangays 128 and 129. Members of the cooperative contribute P10.00 per month. The amount of prepaid contribution per family was computed based on the assumed affordability level estimated at 1% of average family income per month.

The plan is part of a bigger community health program which includes free out-patient consultation, nutrition education, mothers' class, etc.

There are no accredited health providers but the cooperative maintains a health center which combines as a drug store. It is staffed by a physician who is also the cooperative's founder and president. She is assisted by trained Barangay Health Workers and medical students, nurses and midwives on community service or practicum from the nearby Tondo General Hospital and other medical/nursing schools.

Members of the drug cooperative were asked to contribute monthly dues amounting to P10.00 per family. Drugs and medicines sold to them were discounted up to 20% of the purchased price. The balance of 80% was paid for by the member-family.

Operating funds of the cooperative are sourced mainly from members' contribution, donations from DOH (HAMIS) and private donations. The respondent did not state how much were received from outside donors. The money received from HAMIS was used to subsidize payment of dues of fire victims for 8 months and to improve the health/drug center. Another source of fund, although minimal, is the interest earned from bank deposits.

C. PROFILE OF MEMBERS

The main source of income of the majority of members-beneficiaries is scavenging at the garbage dump site near the area. Some are engaged in vending and small business operations such as sari-sari stores, junkshops, etc.

At the start of 1991, there were 680 members-beneficiaries but this dropped to 400 at the end of 1991 due to economic difficulties brought about by a fire that razed the area during the year.

D. SERVICE UTILIZATION PATTERNS, BY MEMBERS

No data.

E. MANAGEMENT AND OPERATING SYSTEMS

At present, 6 Barangay Health Workers are engaged by the organization. These workers serve also as a sales force engaged in marketing activities to attract new

members. House-to-house visits and meetings are conducted to recruit and enroll new members. The barangay health workers work for free, performing their duties primarily as volunteers. When asked what motivated them to volunteer, they mentioned their desire to help their community, particularly the poor families, as their main motivation.

There are no standard procedures in screening and approval of application for membership, although membership is limited to families of Barangays 128 & 129, Balut, Tondo. Monthly contributions are collected monthly by collectors (BHWs).

The only requirement in extending benefits to its members is the presentation of prescription slip and membership card. Members only have to go to the center which is a walking distance from their residences. If the center is closed, they can go to any of the 6 BHWs who will open the center and sell them the needed medicines or drugs, if available. Drugs/medicines not available at the center will have to be bought elsewhere.

F. COST CONTAINMENT MEASURES AND MECHANISMS

The only measure taken to contain cost of members services is the presentation of membership card and prescription slip. One form of abuse employed by members is the lending of membership card to non-members. When detected, concerned members are confronted personally. Members are also advised against this abuse during regular meetings.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

In the initial year of operation, membership increased faster than anticipated. However, when a big fire gutted a big portion of the community in 1991, membership dropped and collection of dues became extremely difficult.

H. RESPONDENTS' VIEWS ON INDUSTRY PROSPECTS

Initiators of the project consider the implementation of this type of scheme in the Smokey Mountain area a success. The drug cooperative concept is currently being tested in some communities in Mountain Province and depressed areas in Metro-Manila. However, the following have to be considered in adopting the scheme since these affect the member's level of satisfaction:

- a. conflicting program orientation/approach with other NGOs, e.g. dole out approach/giving drugs for free;
- b. some members prefer brand names over generics;

To address the above problems, house to house visits were made to educate the families on the concept of the project and on health in general.

As a possible support to this scheme, the government may allow similar community drugs cooperative to link with hospital-based pharmacies to enable them to access a wider range of low-cost drugs.

Case Report No. 29: Community-Based Health Scheme
Reference Company No. 12
Area(s) Studied: NCR

A. IDENTIFICATION

The Reference Company health insurance scheme started only in 1992 as an adjunct to its broader program on occupational health for workers. A special health plan was also drawn up for social development workers of 1 affiliated institution.

The scheme for factory workers was developed in consultation with management and labor groups. Amount of pre-payment was based on negotiations rather than on cost. The agreed amount was P5/mo. per employee to be paid by the company and P5/mo. to cover dependents to be paid by the employee.

The payment scheme is unusual. In the case of dependents, the concerned employees pay P5/mo. through salary deduction. In the case of employees covered, however, the Company agrees to pay a fixed monthly premium computed at P5/mo./employee. If no one avails of the service in a given month, the full premium due is remitted to the Reference Company. However, if any employee used or availed of services, the cost of these services are deducted from the premiums due to the employees. These deductions are treated as penalties for failure of the Reference Company's main program of preventive health measures.

B. HEALTH PLANS AND BENEFITS

Benefits are limited to free medical and dental consultations. Other procedures are offered on a fee-for-service basis at socialized pricing. Dental services are limited to 3 tooth extractions and temporary filling plus free annual oral prophylaxis. A loan advance amounting to P2,000 per confinement is extended to members who are hospitalized. The loan is payable through salary deduction at no interest rates.

Members may be extended referral services to laboratory and hospital facilities forming a network with the Reference Company. Such services, however, are in the nature of incidental benefits rather than part of the health plan benefit package. The referred patients pay for the services rendered. There may be cases of referred patients eligible for free services, if the referral institutions offer such services for free.

Service provision for covered members is rendered directly by the Reference Company which operates 2 outpatient clinic facilities - 1 in its office compound in Quezon City, and another 1 in Pasig. The clinics operate 8 hours-a-day, 5 days a week. There are 6 physicians, 3 dentists, 1 nurse and 1 acupuncturist manning the clinics on rotation basis. Most of the physicians also perform administrative functions. The clinics provide free consultation services to members, but also render services to non-members or walk-in patients on a fee-for-service basis.

C. PROFILE OF MEMBERS

The health plan started only in 1992, with 73 members, i.e., 62 for plan 1 and 11 for plan 2. Of the 62 enrolled in plan 1, 48 had covered dependents. Because the primary targets are factory and social development workers, all members are employed. There were 43 males and 30 females. Other socio-economic information on the members were not available in processed form.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Between January-October 1992, there were 77 medical consultations and 18 dental consultations by members. The number of consultations per month vary widely from a minimum of 1 in March and July, to a maximum of 15 in April. Unfortunately, there is no record of the major causes of consultations. There is likewise no record of the number of laboratory referrals to network facilities.

There were 4 cases of hospitalization which availed of the loan advance benefits. Two of these cases referred to only 1 patient who was confined twice. The major causes of hospitalization were: (a) neonatal sepsis, 2 cases, (b) bronchopneumonia, 1 case and (c) spontaneous abortion, 1 case. The average duration of confinement was 5 days, with a minimum of 2 days and a maximum of 10 days.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

Presently, the Reference Company health insurance scheme only operates in selected factories on a pilot basis. There is no standard procedure for screening and accepting members. All employees of participating companies are accepted automatically as members. Being part of the active labor force, however, it may be presumed that most accepted members passed the physical fitness requirements for employment, and are, therefore, relatively low-risk.

There is no sales force to recruit new enrollees. Instead, CO workers are fielded to implement the occupational safety program which includes training paramedics, conducting lectures on relevant medical/dental issues, and enlisting workers to enroll in the health plan, with the participation of employers. Employers pay a fixed monthly fee for their workers based on agreed scheme. Workers pay a fixed monthly fee to enroll their dependents in the program. Company workers salaries are paid from donor grants.

2. Benefits Availment/Claims Processing

Availment procedures are fairly simple. The employer issues a referral letter to the Reference Company clinic to confirm/validate the membership status of employees/dependents. The member visits the Reference Company clinic nearest him/her for free consultation services and other needed medical/dental services on a fee-for-service basis. The Reference Company clinic issues medical certificate to members who get sick and are entitled to sick leave benefits from the company. Members needing services not provided by the Reference Company clinic may be referred to other network facilities who offer these services on fee-for-service basis. The Reference Company may provide transport to refer members to hospitals for confinement. In addition, the Reference Company provides free annual physical examination for members, and conducts regular health education/training to promote occupational safety at the workplace.

F. FINANCIAL STATUS

The health service operations of the Reference Company are financed from 3 sources, namely: a) member prepayments; b) fee-for-service; and c) donor grants. At the time of the survey, the Institute records showed that the amounts contributed from each source are as follows:

a.	member prepayment	P9,900.00
b.	fee-for-service	P37,991.12

c. foreign donor grant DM 356,000 for 4 years

Of the P37,991.12 earned from fees-for-service, P11,542.95 represent payments by members who availed of services which were not offered as part of the free service benefit package of the plan (e.g. diagnostic services, drugs and medicine, etc.)

Unfortunately, the Reference Company has not kept separate financial and accounting records for its health insurance operations, hence it is difficult to determine whether the operation is financially viable or not. The current membership size is too small to be economical and the cost of premium is probably too low to allow cost-recovery. Much of the present operation is subsidized by reference company through its grant financing and from its own institutional resources (i.e. manpower). As of this survey, the Reference Company still had no clear idea of the actual cost of its health insurance operations because most of its resources were shared with other projects and activities of the institute. There is, however, an on-going effort to assess the financial viability of the health insurance scheme and to formulate a more realistic health care plan based on cost-analysis and client needs.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The factors and conditions deemed to affect the growth and development of health insurance of this type are: (1) attitudes and perceptions of clients re health insurance (not yet fully appreciated at present), (2) income or capacity to pay of population; and (3) willingness of health providers to participate.

The Reference Company Coordinator feels that for health insurance to thrive, people need to change their attitudes and curb the natural tendency to take rather than give or share. Beneficiaries must overcome the temptation to grab whatever services are offered regardless of need. Providers should likewise curb the tendency to over-prescribe simply because there is a third party payor. On the part of employers, they also need to think of giving more benefits to their workers to make them more productive rather than be stingy and avoid costs such as health insurance.

The most serious problems facing the health insurance industry is the lack of facilities to service the industry. Also, there is some form of cartelization of the health care industry, with price determination (professional fees, drugs, etc.) controlled only by a few.

Government should invest in consumer education/ motivation and industry should strive to complement rather than compete with government.

The Reference Company considers licensure as the most likely regulatory measure. The elements that the reference company feels should be regulated are: (i) pricing and (ii) service quality. Both government and industry should take some regulatory responsibility. For instance, the industry can embark on accreditation and citation of firms who are doing well, while government may give tax incentives to firms serving the needy population groups. Industry could also strive to develop plans that match the paying capacities and needs of various categories of beneficiaries.

Case Report No. 30: Community-based Health Scheme
Reference Company No. 21
Area(s) Studied: Cagayan Province

A. IDENTIFICATION

The Reference Organization is a multi-purpose cooperative established in 1986 in the municipality of Baggao, province of Cagayan. The Cooperative is involved in grains trading, provision of loans to farmer members and operation of a cooperative store.

The Cooperative is managed by a Board of Directors headed by a chairman and composed of vice-chairman, secretary, treasurer and 3 Directors as members. Various committees were also created to maximize delivery of services to its members, namely Committee on Election, Supervisory Committee, Credit Committee and Education Committee. The Reference Organization was adjudged as the "Most Outstanding Small Farmers Organization" in Region 2 in 1989 by the Department of Agriculture.

B. HEALTH PLANS AND BENEFITS

The Cooperative offers a health plan called "Saranay", or progress, as one of its services to its members. Said name was adopted since the members believe that good health is a requisite for progress. The members of the cooperative contribute P100.00 per annum, collectible after every harvest. The said amount was determined through consultation with the members. However, the pre-paid contribution is used not only for health benefits but also for burial assistance in case of death among the members and/or their dependents.

The health benefit is in the form of cash reimbursement for expenses incurred in any type of medical service except purchase of dentures and eyeglasses and self-inflicted injuries. The reimbursable amount is subject to a ceiling of P1,000.00 per year per member.

The Cooperative does not accredit any medical service providers. Members can avail of medical service from any hospital/clinic or physicians.

C. PROFILE OF MEMBERS

As of end of 1992, there were 2,006 registered members, all of which were farmers. No breakdown of the total number of members by education, age, sex, educational status was given.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

In 1992, a total of 162 claims for medical expense reimbursement were filed. The Cooperative did not collect information regarding the specific illnesses nor services sought by the members. The respondent mentioned that they might collect these data in the future since they could be an important basis for determining health needs of the members.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The Cooperative, being a community based organization, does not have a sales force. To disseminate information regarding its purpose and services, the parish priest-organizer, conducted house to house visits and barangay assemblies or meetings.

He also talked about the cooperative after his Sunday masses. The acceptance of new members has been temporarily stopped as they still have to assess the feasibility of expanding their membership. Sometime this year (1993), however, they plan to accept application again since a lot of barangay residents clamor for membership.

As a criteria for approval of application, the prospective member must be physically fit to work, has never been engaged in lending operations popularly known as 5-6, and owns less than 6 hectares of land. The cooperative management and members view 5-6 as an exploitative act against the already poor members of the community. The cooperative has in fact been conceived largely as a counter force against the 5-6. The third criteria is meant to ensure that only the needy farmers of Baggao became members and benefit from the cooperative.

An applicant fills up an application form which is like a bio-data sheet. Then, he is required to undergo a one-day orientation seminar on cooperatives.

2. Benefit Availment/Claims Processing

The procedure for extending benefits to members is very simple. The members bring the official receipts of medical expenses incurred and present these to the treasurer. The treasurer does a brief financial review to ascertain validity of receipts and also does an accounting review to determine whether the claims are still within the P1,000/member/year ceiling. The claims are reimbursed outright in a transaction which normally takes only 5 minutes.

F. COST CONTAINMENT MEASURES

No cost containment measure has been initiated so far except the imposition of the annual ceiling. But during the last general assembly held on March 7, 1993, the body agreed that the present medical benefit of P1,000 per year/member is too high and may cause financial loss. It was then agreed that the medical reimbursement will be stopped and only the death indemnity of P10,000 per member will be continued. However, the parish priest, who now sits in the Board as an adviser, intends to discuss this further with the members with the hope that they would opt to continue the medical/health plan with a lower benefit ceiling.

The Cooperative had not experienced any form of abuse or fraud. The respondent opined that the members would not resort to abusive or fraudulent acts since, being a cooperative, such act will adversely affect all of them.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

There is no time-series data on membership and collection. At most, an annual account of financial matters is kept.

Member contribution is the only source of funds for the health plan. Donations in the form of free medicines are sometimes received from DOH and Medical Sales Representatives.

In 1992, a total of P299,600 was collected from 2,006 members. In the same year, the total claims filed amounted to P42,591.00, all of which were paid. Excess collection was added to reserve fund.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

Based on their own experiences, it was estimated that the minimum capitalization of P200,000 to P500,000 is required to start-up operation similar to that of the Reference Organization.

The high value placed on health is considered as the single most important factor that affects the growth and development of the community health financing operation.

In terms of expansion, the Cooperative plans to admit 1,000 to 5,000 new members. Specific to the health plans, the Reference Organization intends to hire a doctor, on a retainership basis, to render out-patient consultation. They have also initiated the setting-up of a drug cooperative but they cannot, as yet, comply with the government's requirement to have a pharmacist. The Cooperative has already offered a college scholarship for a pharmacy student but it will take another four years before completion of the degree. The respondent expressed hope that the government can support their health program by regulating the cost of medicines and professional fees as well as by strengthening the government's preventive services.

Case Report No. 31: Community Based Health Scheme
Reference Company No. 30
Area(s) Studied: Cebu

A. IDENTIFICATION

The reference organization is a community cooperative engaged in income-generating projects (IGP) and primary health care. Established in 1986 as a sister organization of a community-based hospital, it was set up principally to promote PHC and to provide IGP loan assistance to members of organized communities. Barangay health workers were trained and deployed as community organizers, health educators and change agent.

Community members participating in the cooperative are eligible for IGP loans and automatically partake of the health financing benefits. IGP loans charge interest at 2% per month. The interest earnings on the IGP loans are allocated as follows:

- 50% - health fund
- 30% - association fund
- 20% - membership fund

The maximum amount of IGP loan is P25,000. Loan repayment period is 6 months.

B. HEALTH PLANS AND BENEFITS

The health financing scheme is in the form of medical loans from the health fund. Members of the cooperative can borrow up to a maximum of P1,000 per sickness. The loan can be repaid over a 6-month period at 2% interest per month. The actual amount of loan given is determined by the borrowers, based on self-assessed needs and paying capability. The only requirement is that the loan be used for health/medical purposes, as confirmed by the BHW.

Although the organization does not have its own health facility, it has a network of 110 BHWs and is affiliated with a primary level community hospital attached to a tertiary private hospital. The community hospital has 2 in-house physicians. Most of the members patronize the community hospitals which provide free consultation services. The loan is usually used to purchase medicines and other medical supplies.

C. PROFILE OF MEMBERS

The Cooperative started with 37 members in 1987. This rose to 250 as of 1993. The usual source of income of members is vending. Majority are self-employed. No data are available on the demographic and socio-economic characteristics of members.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

To date, a total of 89 medical loans were approved amounting to P41,000, or an average of P460 per loan. No information is available on how the loans were used.

E. MANAGEMENT AND OPERATING SYSTEMS

1. Marketing and Recruitment

The organization utilizes the BHW as community organizer and health educator who is also responsible for recruiting new members to join the cooperative. To join,

applicants have to attend a seminar-training session and pass the screening for credit-worthiness and character investigation.

All approved members of the IGP cooperative are automatically eligible for medical loan assistance.

2. Premium Collection

No premiums are collected and no claims are filed, hence this is not applicable. The health fund, however, appears to be stable.

3. Benefit Availment/Claims Processing

To avail of medical loan, member seeks the assistance of the BHW who first determines who should be the proper health care provider to render services. The BHW then assists the member file an application for medical loan. The coordinator assesses the loan application and prepares the necessary documents, i.e. vouchers and promissory note. Member signs voucher and promissory note and gets cash from cashier. The transaction is usually completed within 1 day.

F. COST CONTAINMENT MEASURES

Aside from the PHC preventive services, the loan mechanism is viewed as a cost-containment measure in itself. Since members have to repay the loan, it is expected that they would exercise prudence in applying for loans. Also, since loans are repaid with interest, there is a natural tendency not to over-extend use of loans.

Also, BHWs validate or countercheck need for medical assistance.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

Association membership grew from 50 in 1987, to 120 in 1988, 150 in 1989, 200 in 1990, and reached its current level of 250 in 1991. A slight decline to 240 was experienced in 1992, but bounced back to 250 in early 1993. As of end of 1991, the health fund reserve was P31,880.76. No real premiums were collected from members. Instead, 50% of interest earnings on IGP loans were allocated as Health Fund, from which medical assistance loans were drawn. To date, 89 loan applications amounting to P41,000 for medical assistance have been filed. The number of loan applicants vary considerably by year, with 20 borrowers in 1989, 32 in 1990, 25 in 1991 and 10 in 1992. Total amount of approved medical assistance loan was P7,900 in 1989, P15,000 in 1990, P12,600 in 1991, and P5,500 in 1992. The average loan per member has been gradually increasing from P395 in 1989, to P469 in 1990, P504 in 1991 and P550 in 1992. The increase probably reflects the increasing cost of medical care.

Only 1991 and 1992 financial statements were obtained. The statement combines the operation of the IGP and Health Fund. The 1992 income statement shows a net savings of P99,335.27. Total operating expenses was reported at P83,977.93 while revenue was recorded at P183,313.20. The largest sources of revenue were interests on loans and on fixed deposits. The largest expenditure accounts were for honorarium, (P32,173.00), premium for doubtful accounts, (P17,709.00) and legal and audit fees (P12,510.00).

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The Association Coordinator feels that starting an operation like theirs would require a minimum capitalization of P300,000. A minimum of 8 personnel, including 1 coordinator, 1 chairman, 1 bookkeeper, 1 secretary and 3 collectors, are required to

run the organization. Minimum set of equipment includes at least 1 computer, typewriter, 1 adding machine and 1 filing cabinet.

The most important factors affecting the growth and development of this type of organization are: (i) organization, (ii) training, and (iii) value formation. Organization is considered the most important factor in sustaining the operation of the cooperative, particularly as it promotes team-work and community cohesiveness.

The organizers feel that accreditation by NGOs would be the appropriate regulatory measure for community-based insurance operations like theirs. The status of operation of this type of health insurance should be regularly assessed and published. The scheme is not very easy to replicate, but it can be expanded to cover more people and more communities; provided there is adequate human and organizational resources that can be tapped to promote its growth and development.

Case Report No. 32: Community-Based Health Financing
Reference Case No. 40
Areas(s) Studied: Misamis Oriental

A. IDENTIFICATION

The reference organization is under the diocesan structure established in June 1971 in Cagayan de Oro City.

The organization provides assistance to poor communities in the depressed areas for purposes of improving their nutritional well-being through the conduct of various nutrition and nutrition-related activities, such as feeding, shelter, social credit and income generating projects, the proceeds of which are used to sustain food supplementation and other nutrition projects.

B. HEALTH PLANS AND BENEFITS

The health plan is part of the nutrition program being offered to urban poor communities within the Archdiocese of Cagayan de Oro. Nutrition centers are set up to facilitate the implementation of the program.

Enrollees are children below five years old. Only about two children per family are accepted as enrollees, with a monthly contribution of P5.00 per child.

Benefits available for these children include the following:

- a. Food assistance;
- b. Growth monitoring services;
- c. Health and nutrition education;
- d. Promotion of immunization; and
- e. Loan for economic and food production undertaking.

C. PROFILE OF MEMBERS

In 1991, there were 10,500 member beneficiaries all of which came from the urban communities in the City and whose source of income came from vending and farming. Other information regarding their profile, such as sex, age, marital status and educational attainment, were not available at the time of field visit.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

The target number of beneficiaries is easily reached within the first month of operation. Membership to the program is for two years, thus no increase in membership was registered in between the periods of registration.

Program operation at the community level is done through the established nutrition centers, with field nutritionists implementing the projects.

Once a month, mothers are asked to attend a nutrition education classes. Daily feeding is done at the community.

E. MANAGEMENT AND OPERATING SYSTEMS

The basic operating unit of the organization at the community level is the nutrition center. This is manned by field nutritionists/parish nutrition workers, who

act as field coordinators of the various community activities and undertakings. The field nutritionists also act as the link between the community and the operation center based at the Archdiocese Nutrition Program Center.

The organization follows some protocol in screening and approval of application of members. This includes: (i) survey of children below five; and (ii) analysis or screening of survey data.

Enrollees are prioritized according to the following:

- a. Newborn children and women in their third trimester of pregnancy;
- b. Malnourished children under 5 years old;
- c. Children up to 12 months regardless of nutritional status; and
- d. Children 13 - 59 months regardless of nutritional status.

Benefits are extended to members through various form of nutrition services, e.g. feeding, health education, immunization, etc.

F. COST CONTAINMENT MEASURES

The Archdiocese sets limits on how much the nutrition centers can request for reimbursement. The parish nutrition workers prepare reimbursement/replenishment report, which are endorsed by field nutritionists. The reports are counter-checked by the bookkeeper and funds are released by the cashier. In processing the requests for replenishment/reimbursement, the following documents are required: (i) duly accomplished vouchers; and (2) official receipts.

Requests for reimbursements/replenishment are processed and paid within 3 days on average. The shortest probable period for processing claims is 1 day, while the longest is 14 days.

Case Report No. 33: Community-Based Health Scheme
Reference Company No. 41
Area(s) Studied: Misamis Oriental

A. IDENTIFICATION

The reference organization is an association composed of urban poor mothers established in July 1992 at Macanhan, Cagayan de Oro city. It was initiated and founded by a Filipino NGO, whose main project concern was called "Institution Building and Resource Accessing (IBRA) Program for Women".

Two prominent NGOs with area offices in Mindanao are jointly supporting the implementation of the IBRA project. These NGOs could be considered as co-parents of the reference organization. Initially, its membership was no more than 25 mothers with malnourished children less than five years old. Organized in Macanhan, it considers Carmen and Cagayan de Oro city as its operating area.

B. HEALTH PLANS AND BENEFITS

Basically, IBRA as implemented by the organization, is designed to enable the family beneficiaries to: (1) have access to resources needed to improve their social and economic well-being; and (2) operate and support an indigenous nutrition program for malnourished children and their families.

Its basic strategies are:

- a. Use CARE'S Targeted Food Assistance Program (TFAP) as an entry-point for organizing women beneficiaries to undertake sustainable social and/or economic activities that improve nutritional status and increase income of the households;
- b. Provide training, guidance and other social preparation for identifying, implementing, and attaining the objective of the project;
- c. Promote savings consciousness and understanding of the uses and costs of credits;
- d. Promote community-based enterprise development.

In essence, the project is envisioned to provide assistance to urban poor families in improving their nutritional well-being through sustainable socio-economic activities, such as (1) the conduct of daily food preparation and wet feeding for malnourished children in the community; (2) the organization of other indigenous nutrition projects; and (3) the operation of livelihood projects whose proceeds are used to sustain their food supplementation and other nutrition projects.

Based on the above objectives and strategies, health-related activities are implemented as adjuncts or off-shoots of the social development programs, especially nutrition, which cannot be carried out successfully without interplay of different health activities. Hence, the wider program includes also non-medical benefits.

Cost-sharing scheme is translated more aptly as sharing of resources, skills, efforts by the different groups involved in the project as stated below:

- a. CARE - provides (i) donated food commodities until these can be supplied by local food sources; (ii) credit funds available to Group, Inc. to re-lend to individual members of the organization; and (iii) assistance in linking up the parent NGO/the association to resource agencies/institutions, including formal financial institutions;

- b. PHILDHARRA - (i) performs the over-all coordinating function to ensure that all parties concerned manage their responsibilities; (ii) provides technical assistance to parent NGO when necessary; and (iii) installs an appropriate credit delivery system through Group, Inc. for loan funds approved by CARE;
- c. Group, Inc. - (i) provides community organizing/community development support to mothers association; (ii) provides technical support to various processes and phases of social preparation of the mother's group. Technical support comes in the form of health education, training and seminars that are needed by the members in undertaking the feeding and other nutrition-related projects; (iii) installs an appropriate credit delivery system for loan funds approved by CARE; (iv) undertakes loan administration, program and financial reporting system; and (v) oversees operation of mother's association vis-a-vis nutrition activities/project, and income generating projects; and
- d. Reference Association - (i) provides supplemental inputs in the preparation of food for wet feeding of children. Usually the inputs are in the form of fuel materials, such as firewood and cooking utensils; (ii) provides labor in the conduct of food preparation, wet feeding, and other nutrition-related activities; (iii) provides cash contribution to nutrition funds of the association. Monthly cash contribution was set at P5.00 per child. Additional cash contribution is taken from proceeds of collection generated from the credit loan.

The association has no accredited health providers, and no claims are filed, processed or paid. Sources of fund for the association are monthly contribution per child, and proceeds, if any, generated from loan and donations from outside. Food commodities (PL-480) are common donations to the association through CARE. Sometimes funds are also generated through fund-raising activities such as beauty contests.

C. PROFILE OF MEMBERS/ENROLLEES

In the third quarter of 1992 there were 20 members. There were 25 at the first quarter of 1993. Vending and small businesses are the usual sources of income of members/beneficiaries.

All members were female. Three were self-employed and 22 unemployed; all were between 15-45 yrs. old; 22 were married, 2 single and 1 widow; 3 were high school graduates, 16 were at one-time or another in high school; 4 were college graduates; and 2 were elementary graduates. All were city residents and principal members of the association.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

There were no data on service utilization that could be provided for the study.

E. MANAGEMENT AND OPERATING SYSTEMS

The association is engaged in marketing activities, in the context of community level organization, information drive to attract or encourage new members to join the association. They (old members) did this through house to house visits.

The association adopts the following qualification standards for accepting new members:

- a. Resident of the target community;
- b. Has a malnourished child; and
- c. Willing to actively participate in all required activities of the project.

Benefits are extended to members through collective food production, weekly wet feeding and loan assistance. The project is experimental, thus the target number of members is limited to 25.

The amount of membership contribution was determined according to what was perceived as affordable. This was essentially a result of meeting of the minds.

Generally, members were able to give the required contribution. Instances of delay, though, could not be avoided.

Cash contributions are pooled to buy supplemental materials needed for wet feeding and other nutrition-related activities. Member mothers are also required to set aside savings that will be deposited into a capital build-up fund aimed to eventually replace the loan.

F. COST CONTAINMENT MEASURES AND MECHANISMS

Standardized member's contribution, interest and loanable amount are used as cost-saving measures. Frauds and abuses were not observed.

G. PERFORMANCE INDICATOR AND FINANCIAL STATUS

The association is a newly formed organization and evidently had no data on financial performance and related items.

H. RESPONDENT'S VIEWS ON INDUSTRY PROSPECTS

The project in Macanhan, Carmen is an extension of the IBRA projects initiated in other urban poor communities in Cagayan de Oro city. To initiate similar project in Macanhan, the inputs required are as follows:

- a. Manpower - 6 field workers
 - 2 specialist
 - 1 supervisor
- b. Capitalization to start -up the project is about P174,000.00 to be used for the following:
 - i. Salaries of personnel
 - ii. Operating expenses
 - iii. Enterprise development research and training.
 - iv. Credit assistance for community sub- projects set at a minimum of P75,000.00 per community.

Major factors and conditions that affect the sustainability and growth of the project are:

- a. Security of land tenure since the area is urban poor;
- b. Sources of safe water;
- c. Member's participation which is constrained by household needs, e.g. caring for younger children; and
- d. Close follow-up.

Case Report No. 34: Community-Based Health Scheme
Reference Company No. 42
Area(s) Studied: Misamis Oriental

A. IDENTIFICATION

The reference organization is a multi-purpose cooperative established in 1954 in Cagayan de Oro City. The cooperative is a Filipino entity and is considered one of the largest community-based non-governmental organization operating in Misamis Oriental. Its main objective is to assist members in credit financing and capitalization for livelihood projects and income generating activities.

B. HEALTH PLANS AND BENEFITS

The health benefits offered by the cooperative to its members, spouses and dependents is part of its "Mutual Aid Fund". Cash reimbursement of hospitalization expenses not exceeding P1,250.00 can be extended to each affected member per year. The ceiling applies also to hospitalization expenses of spouses and eligible dependents.

Hospitalization expenses in excess of ceilings are charged to medicare if member is an employee or paid by the member as out-of-pocket expenses if not employed.

Monthly dues or contribution" is P20.00 per member plus an additional P20.00 for spouse and P10.00 each for identified dependents up to a maximum of four.

Funds to support the health benefits of members came from a fixed budget allocation and from the pre-paid provident fund.

The hospitalization plan covers outpatient services such as consultation, x-ray and diagnostics and inpatient services such as room and board, professional fees, laboratory, x-ray and diagnostics and drugs and medicines.

Following the standards set by established health insurance firms, the cooperative likewise observes and enforces the following exclusions:

- a. Conditions arising from acts which are not sanctioned by society like STDs including AIDS, suicide, substance abuse, acts of war/riot, etc;
- b. Pregnancy, childbirth, miscarriage, abortions and their complications;
- c. Congenital deformities and defects, cosmetic and plastic surgery; and
- d. Routine physical check-up and rest cures.

C. PROFILE OF MEMBERS

In 1991, the estimated membership was around 10,000. It went down to 8,000 in 1993 of which only about 50% were considered active (those who could make regular contribution). About 2,000 were considered drop-outs.

Though members identification data are available in the membership card filed in the office, such had not been processed into usable statistics. The data could be retrieved manually through the card index, but requires tedious records review and tallying.

D. SERVICE UTILIZATION

Utilization pattern by members was not perceived to be a crucial part of the organization's operation. Thus, data regarding in-patient consultations, diagnostic procedures performed, hospital admissions, and length of hospital confinement are not recorded nor processed. However, information on the ten leading causes of hospitalization for that year was provided. These were: amoebiasis, dengue fever, urinary tract infection, bronchitis, asthma, heart/cardio-vascular diseases, influenza, bone fracture, diabetes, dehydration and typhoid fever.

E. MANAGEMENT AND OPERATING SYSTEMS

The cooperative had no direct health service facilities. Neither do they have accredited health providers. Health benefits are availed through cash reimbursement of hospitalization expenses.

Basically, all members are entitled to avail of the hospitalization benefits. However, the actual percentage of expenses reimbursed is subject to the approval of the General Manager based on member's regularity of paying his contribution, the standard procedures and requirements formulated and approved during general assembly meetings.

Application for benefits or claims reimbursement must be submitted not later than one week after hospital confinement. The following are the standard procedures for processing of claims:

- a. submission of required documents;
- b. authentication of documents by Auditor; and
- c. approval of claims by General Manager.

Financial review, accounting review and validity checks are routinely done during the review/assessment of claims. The following documents are required for the review/assessment of claims:

- a. Marriage contract/birth certificate of spouse/dependent;
- b. Official receipts;
- c. Medical certificate; and
- d. Pass Book.

The average or usual time to process claims and effect payment to members is about 3 days; the shortest 1 day; the longest 14 days.

The cooperative has no sales force. Instead it has 2 in-house loan processors who conduct verification of claims and give regular orientation/ education on cooperativism and its benefits to members.

F. COST CONTAINMENT MEASURES AND MECHANISMS

To lessen the financial burden of getting ill or injured, the cooperative allocates a minimum of P1,250 up to a maximum of P7,500 for hospitalization expenses per member per year. Each member contributes a minimum of P240 to a maximum of P960 per year as premium for the covered hospitalization benefits. To minimize cost, the cooperative adopts some of the standard exclusions and limits in health insurance coverage.

The cooperative also regularly conducts investigation to ascertain the authenticity of claims filed. However, even among the cooperative officials, this mechanism cannot totally eliminate fraud and abuse since there are cases where

authenticity of documents is difficult to determine.

G. PERFORMANCE INDICATORS AND FINANCIAL STATUS

Since provision of health plan is not its main line of operation, only a few personnel are assigned to undertake its required activities. Such personnel are simultaneously performing tasks related to its cooperative functions, e.g., credit investigators are doubling as claims processor and educators. With a large number of members, personnel assigned to receive, review/assess and recommend approval of claims may be over-extended.

While the idea of providing health benefits appear to be an added attraction to join the cooperative, in actuality, the inability to meet the demand for health benefits discourages members from continuing their membership.

H. RESPONDENTS' VIEWS ON INDUSTRY PROSPECTS

The cooperative did not want to focus on health insurance as its primary line of service. In its experience, providing health benefits requires a large fund allocation e.g., about P600,000.00 per year. One major concern in its operations is the fact that claims filed had greatly exceeded the pre-paid contributions and allocations set aside by the organization. The officers consider the following as problem areas that need looking into:

- a. negative attitude of members towards health benefits;
- b. inadequate financial analysis and budget allocation;
- c. lack of proper skills; and
- d. weak or inadequate linkage with health facilities, e.g., hospitals.

Case Report No. 35: (Community-Based Health Scheme)
Reference Company No. 49
Area(s) Studied: Surigao del Norte

A. IDENTIFICATION

The Reference Organization is a cooperative established in 1986 as a federation of women's club in a Northern Mindanao City. It originated as a primary health care movement among mothers who banded together to implement community projects that benefit the community and generated resources for health care. Institutional and technical support was provided by the city government through the City Health Office.

Initially, the Reference Organization focused on income-generating projects (IGP) for its members. IGP loans were made available and 10% of profits were to be set aside as a local chapter health fund. Later, the Reference Organization introduced a Mortuary Plan wherein each participating couple paid P20 per year. The plan paid P1,000.00 as death benefits to affected members' family. The excess premium from the mortuary fund were pooled as the federation health fund. Members who get sick or hospitalized may avail of cash loans amounting to P300.00-P500.00 per episode for health care expenses.

B. HEALTH PLANS AND BENEFITS

Two types of health plans are offered. The first plan is administered by local chapters using health funds generated from the 10% share in IGP profits. The second plan is administered by the federation using the health funds generated from the unused portion of mortuary fund collections from members.

The benefit package of both plans comes in the form of medical loans extended to members who get sick or whose dependents get sick or hospitalized. The maximum amount of loan is P200.00-P300.00 per episode for plan 1 and P500.00 per episode for plan 2. Loan proceeds can be used to buy medicine, or pay for treatment and diagnostic services, including hospitalization.

Except for the ceiling on the amount of loan, there are no exclusions or limitations on how the money is used as long as it is used for health care. Cash loans could be used even for pre-existing illnesses.

The amount of loan ceiling per episode was decided by the local chapter officers in case of plan 1 and the federation officers in case of plan 2. The actual amount lent to members is based on the assessed needs of the members. The assessment of needs is generally based on the kind of illness, medications prescribed and expected hospitalization expenses. Cash loans are made available prior to actual expenditures, hence, are not based on receipts of expenditures as in the case of reimbursed expenses.

There are no limits to the number of times a member may avail of medical loans as long as there is a legitimate need for it and all previous accounts have been fully paid.

The Reference Organization does not maintain its own service facilities nor accredit providers of such services. They are, however, affiliated institutionally with the City Health Office. Members are encouraged to fully avail of primary health care services provided by the government and to patronized public health facilities as a means of cost-saving. The medical loans can then be used to purchase commodities and services not offered free by public facilities. In most cases, medical loans are used to purchase drugs and medicines.

The health care funds of the Organization came mainly from the proceeds of IGP

loans (10% of profits) and the excess or unutilized contributions from the mortuary fund. Since the type of benefits provided is in the form of loans which are paid back by the members in installment, the funds are not used up, but operate as a revolving fund.

C. PROFILE OF MEMBERS/ENROLLEES

The health insurance operation of the Reference Organization started only in October 1991. There were 1,754 registered members in both plans (IGP and Mortuary) in 1992 when the plans became effective. In 1993, membership grew to 2,604 in each plan.

It should be noted that all enrolled members in the local chapter-based IGP health plan are also enrolled in the federation-wide Mortuary plan, hence each member is actually enrolled in 2 health plans.

Majority of members derived their income from farming and small business operations. All members are females, since the organization is a women's club of sorts. Benefits, however, are extended to family members of the principal. Likewise, all members had been married, though some are widowed and separated. Exact data on the number of widows or separated are not available. Neither are there data on the age distribution, employment status, or educational attainment of members.

D. SERVICE UTILIZATION PATTERN, BY MEMBERS

Data on benefit utilization were available only on the federation-wide health plan (Plan 2). Information on benefits utilization for Plan 1 was recorded in each local chapter scattered throughout the City.

There were a total of 109 medical loans granted to members in 1992. These were distributed by quarter, as follows:

First quarter	-	4
Second quarter	-	11
Third quarter	-	43
Fourth quarter	-	51

There is a notable increase in loan availment toward the later quarter. It is not clear, however, whether this reflects the pattern of illness or the availability of funds. As mentioned earlier, the plan 2 health funds are derived mainly from the excess or unutilized mortuary fund benefits.

It is quite possible, therefore, that fund use for health loans would be restricted in the earlier part of the year to make ample allowance for its intended primary use as mortuary fund. It is also possible that the limited utilization in the first 2 quarters was a result of operational inertia since the plan operations just started in the year.

The total mortuary fund collections in 1992 was P45,380.00. Of this, P15,000.00 was allocated for the health fund. Total amount of medical loans availed by members was P22,832, or an average of P209.00 per loan. The amount of loan is larger than the allocated funds because loan payments are re-lent to other needy members.

No records are kept on how the medical loans were spent by members. Neither are there records on the types of health care for which the loans were applied. Anecdotal evidence suggests that medical loans were used mainly to buy prescribed drugs and medicines for both out-patient and in-patient care.