

## **The 3P Study: A randomized experiment to assess the impact of premium subsidies and insurance information on the enrollment of the informal sector in PhilHealth\***

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### Abstract

A key strategic thrust of the government's *Kalusugang Pangkalahatan* (KP) program is the rapid expansion of enrollment of the poor and the near poor in the National Health Insurance Program. This paper presents the design and preliminary results of an on-going randomized evaluation study undertaken to inform policy on expanding the insurance coverage of the near-poor, self-employed and employed and the rest of the those in the informal sector. The 3P Study involves both randomly-chosen treatment households and control households. Unlike the control households, the treatment households are offered pre-paid premium certificates, information about PhilHealth programs and processes, and also sent text messages to remind them to use their certificates to enroll in PhilHealth's Individually Paying Program. Based on the baseline survey, majority of the treatment and control households are found willing to pay a monthly premium contribution of 50 pesos or more to become PhilHealth members. So far, only 67 of 906 certificate holders enrolled. Based on the feedback from the certificate holders, the potentials reasons for the low take up are briefly discussed.

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\* Prepared for the 1st M&E Forum organized by the National Economic and Development Authority, this paper reports the preliminary results of an on-going policy experiment of the Health Equity and Financial Protection in Asia (HEFPA) Project of the UPecon Foundation, Inc. and undertaken in partnership with the Philippine Health Insurance Corporation (PhilHealth). Comprising the UPecon-HEFPA Team, the authors claim sole responsibility for the contents of the study.

## 1. INTRODUCTION

In pursuit of the Aquino Health Agenda, the Department of Health through its *Kalusugan Pangkalahatan* strategy strives to enroll about five million poorest families. This strategy will help achieve universal health insurance coverage by 2015, as originally envisaged when the National Health Insurance Program (NHIP) was started in 1995. The current thrust sustains the effort made in the previous administration through its own *Medicare Para sa Masa* Program that enrolled in the Sponsored Program (SP) of PhilHealth<sup>1</sup> also around five million indigent families in 2004 and about half of this number in succeeding years. As a consequence, the SP's share in the total PhilHealth members shoot up from less than 5% in 2001 to about 25 percent by March 2010.

The wide and sustained PhilHealth coverage of the poor is both laudable and necessary. For one, the poorest families had lower health status or access to health services when compared to richest families in 1998 and 2003 (Gwatkin et al. 2007). Despite government's effort, the families in the lowest three income deciles consistently have lower PhilHealth coverage or health service utilization than those in the highest two income deciles in 2002, 2004 and 2007 (Capuno and Kraft 2010). Moreover, the poor population remains large. According to the National Statistical Coordination Board, there were 4.7 million poor families in 2006, up from 4.02 million three years earlier. Also, their number could easily swell due to health shocks. Using 1999 data, van Doorslaer et al. (2006) estimate 446,000 and 790,000 Filipinos that fall below the \$1.08-a-day and \$2.15-a-day poverty lines, respectively, due to health care payments. These estimate suggest a large number of near-poor people who are just as vulnerable to health shocks as the poor, and therefore may need health insurance coverage as well.

A large number of the near poor families are in the informal sector, which also includes the self-employed and unemployed individuals. Thus, the families in this group has wide income range and very mobile groups. Unlike the poor families or those formally employed (in the public or private sector), those in the informal sector are not easily tagged by local officials or through their employers. Hence, they are expected to enroll voluntarily in PhilHealth's Individually Paying Program (IPP). However, the number of IP Program members has not

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<sup>1</sup> The PhilHealth is the Philippine Health Insurance Corporation, the corporate entity created by law to administer the National Health Insurance Program.

grown as fast as the SP during the last ten years. From 1.77 million in 2003 to 3.42 million in early 2010, the number of IPP members account for around 17% of the total PhilHealth members. Arguably, extending PhilHealth coverage to the near-poor, the self-employed and unemployed, and the rest of those in the informal sector will be a major policy challenge.<sup>2</sup>

To entice the potential IPP members to enroll, the Department of Health is considering several options, including the offer of a partial premium subsidy. Previous and on-going attempts of PhilHealth are geared towards reducing the transaction costs of enrolling and paying regular premium contributions, and information and advocacy campaigns. These include the POGI-KASAPI, a group-enrollment scheme, and the Remittance-By-Air Payment Scheme, which allows existing IPP members to remit their premium contributions using cellular phones. However, the evidence so far concerning the effectiveness of these attempts are partial and inconclusive.

This paper presents the preliminary results of an on-going study that attempts to provide more concrete evidence to guide policy. In particular, it shows the number of potential IPP members who were enticed to enroll after they were given premium subsidy, relevant information about PhilHealth, and sent text reminders to enroll. Further, the enrollees are compared to those who did not based on willingness or ability to participate in the country's social health insurance program.

## 2. THE 3P STUDY

In October 2010, the Philippine Health Insurance Corporation (PhilHealth) and the UPecon Foundation, Inc. signed a memorandum of agreement to conduct two studies to identify policies that will help improve the coverage, sustainability, and financial protection aspects of PhilHealth's Individually Paying Program (IPP). The two studies are:

1. 3P Study - an analysis of the effect of the PhilHealth prepaid premium (3P) certificate on the enrollment, health care utilization and health care payments of eligible IPP members who are randomly selected to receive the certificates.

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<sup>2</sup> Wagstaff (2007) finds that extending coverage to the informal sector is major challenge in many countries that have social health insurance programs.

2. RBA Evaluation - an evaluation of the Remittance By Air (RBA) payment facility, with focus on its impact on collection efficiency and claims, and on use patterns, and Under the terms of the agreement, which covers the period October 2010-June 2012, PhilHealth will provide institutional support, including relevant data and documents and inputs in the design of the said studies, and issue necessary operational guidelines to facilitate the study implementation. For its part, the UPecon is primarily responsible for the development of the overall design, implementation, and dissemination of the results of two studies.

The UPecon undertakes the said studies as part of its commitments under the Health Equity and Financial Protection in Asia Project, a four-year, EU-funded research project of a consortium of ten research institutions in East Asia and Europe. The objectives of the overall HEFPA Project are to find evidence on the effect of health insurance on service utilization and financial protection of the poor and the informal sector, and to inform policy.

### 3. EVALUATION DESIGN

#### *Evaluation questions*

The main evaluation question is: Will a reduction in the financial and informational barriers increase the voluntary enrollment of the informal sector in the IPP? If so, by how much? If not, why?

As subsidiary questions concerning those who are encouraged to enroll: Will they have improved service utilization<sup>3</sup>, health status or capacity to cope with catastrophic events? At the program level, will the increase in enrollment improve the risk profile of the IPP members?

#### *The intervention - 3P certificate*

The main intervention under the 3P study is called the *PhilHealth pre-paid premium certificate* (3P certificate) that consists of a premium subsidy voucher and an information packet. Intended to reduce the financial cost of participation, the voucher is pre-paid, non-transferable and worth PhP600.<sup>4</sup> The amount covers 50% or 25% of the annual insurance premium of those whose monthly family income is below PhP25,000 or above it, respectively.

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<sup>3</sup> This seems important in the light of an earlier finding that most poor do not avail their PhilHealth insurance benefits (Quimbo et al. 2008).

<sup>4</sup>The UPecon-HEFPA paid the 600 pesos directly to PhilHealth for each voucher issued. No cash is give to the 3P certificate holders.

The recipient is also advised that he/she will still pay the balance of the required annual premium contribution. Each voucher is valid for enrollment from 1 January 2011 to 31 December 2011 (see Annex 1).

Intended to increase awareness, the information packet comprises PhilHealth brochures on membership requirements, benefit entitlements, application forms and , sample copies of member's data records and other pertinent facts (see Annex2 for the FAQ brochure). In addition, the certificate recipients are sent text messages via cellular phones to remind them to enroll and to respond to their queries or complaints.

A 3P certificate is offered to each randomly selected potential IPP member based on three requirements. First, the household resides in a treatment site (i.e., randomly selected area where the 3P certificates are distributed). Second, the household head or the spouse (if household head is not eligible) or the respondent (if neither the household head nor the spouse is eligible) is not an active member or dependent of a member of PhilHealth, where active membership means having paid at least one month premium during the period June-December 2010. Last, the respondent has expressed willingness to participate in the 3P Study (informed consent). The certificate is named to the eligible household head, spouse or respondent. The list of names of the certificate recipients with the corresponding certificate numbers are then sent to PhilHealth-Marketing and Collections Department (in the head office) to be sent in turn to their service offices. The PhilHealth service offices will use the list to verify the names of the applicants who surrender the voucher upon enrollment. Only when the names and voucher numbers are matched will the applicant be considered for membership.

#### *Randomized experiment*

To properly measure the impact of the intervention, the 3P certificates are distributed using a randomized evaluation design, i.e., with randomly selected treatment and control units (households) and both tracked before and after the intervention.<sup>5</sup> To avoid contamination between treatment and control groups, all treatment households and control households come from randomly designated treatment and control sites, respectively. Moreover, it was decided to adopt a multi-stage cluster sampling scheme to save on costs. An added consideration is that the

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<sup>5</sup> The PhilHealth has been involved in an earlier policy experiment, called the Quality Improvement Demonstration Study (Shimkada, Peabody, Quimbo and Solon 2008) that a randomized evaluation design.

baseline survey for the 3P Study is also taken as opportunity to collect additional information to make a national-level assessment of households' vulnerability to and coping with shocks (e.g., natural calamities, illness/injury, deaths, crime, unemployment, etc.).

In determining the required sample sizes for the treatment and control units in both the baseline and follow-on surveys, the parameters shown in Table 1 are used. Under simple random sampling, the base sample for the control group and the treatment group is set to 389. The base sample is adjusted further. To allow for the potential loss of information associated with the use of cluster sampling, an incremental sample is computed by multiplying the base sample at SRS by a factor of  $1 + \text{design effect}$ . The design effect (DE) is calculated using the formula  $DE = (n-1) * ICC$ , where  $n$  is the cluster size and ICC is the intra-cluster correlation coefficient<sup>6</sup>. The ICC is estimated from the 2008 NDHS by comparing the variation of families with at least one member covered by PhilHealth<sup>7</sup>. Using the estimated ICC of 1.64 and a cluster size of 5, the required sample of 638 is then estimated for each group. This estimate is increased further to 702, or by 10 percent, to allow for attrition, say, due to refusals in the follow-up survey or migration of the sample respondent.

**Table 1. Parameters for sample size calculation**

Parameter	Value
PhilHealth coverage	0.53
IPP coverage rate	0.33
Minimum detectable effect size	0.10
alpha	0.05
power	0.80
Intra-cluster correlation coefficient	0.16
Cluster size	5
Estimated design effect	1.64
Attrition rate due to non-availability of respondent for the follow-up survey	0.10
Take up rate of 3P certificates	0.50

Then, an additional 792 sample households are included in the treatment sites, to meet the sample size requirements both for the 3P experiment and national-level assessment of households' exposure to shocks. The increment is based on the national estimate that 53 percent of the households have PhilHealth coverage. The treatment samples are further adjusted to allow

<sup>6</sup> The ICC is defined as the ratio of between variation relative to the sum of the between and within variation

<sup>7</sup> The 2008 NDHS however employs a cluster size of 16.

for the possibility that some eligible households will not accept the offer of 3P certificate or fail to use it to enroll with PhilHealth. Assuming a take-up rate of 50 percent, the additional sample requirement is 747 households, giving a total required sample of around 2,242 households in the treatment sites. Note that of 2,242 households, only 1,053 of them will be considered for treatment. The rest (1,187) will be households with PhilHealth coverage residing in the treatment sites.

In sum, the target total sample households is 2,942, of which 702 will be in the control sites and 2,240 will be in the treatment sites. All these households were to be interviewed in the baseline survey in early 2011. Of those in the treatment sites, 1,053 samples were expected to be eligible to receive the 3P certificates and will be offered the certificates during the baseline survey. All 1053 3P certificate holders in the treatment sites, whether or not they have enrolled using their premium subsidy vouchers, and the 702 households in the control sites will be interviewed again in early 2012. Table 2 summarizes the sample size computations.

**Table 2. Sample size computations**

	Control	Treatment
Base sample (using SRS)	389	389
Base sample (using cluster sampling)	638	638
Required sample after adjusting for attrition (A)	702	702
Additional samples to obtain the number of households without PhilHealth coverage (B)	0	791
Additional samples to account for non-acceptance of the 3P certificate (C= $\frac{1}{2}(A+B)$ )	0	747
Total samples for baseline survey (A + B + C)	702	2,240
Total samples for follow-up survey (A $\times$ 1.5 for treatment)	702	1,053

*Baseline survey and text blasts*

The baseline survey for the 3P study was conducted in February -April 2011 together the Philippine Survey and Research Center, Inc. Using a multi-stage cluster sampling schemes, 63 provinces from 15 regions (excluding ARMM) were initially selected. From these provinces, 165 municipalities and cities were designated as treatment sites and 65 as control sites. Then from each of these sample municipalities or cities, at least two spots were randomly selected. The

spots are either barangays (in rural areas) or election precincts (in urban areas). Then from each spot, 5 samples of households are drawn randomly.

A structured interview questionnaire is used during the baseline survey to elicit both household-level and individual-level information. The survey instruments includes modules on socioeconomic and demographic characteristics, income and expenditures, assets and housing amenities, self-assessed health status, health service utilization and health insurance, vulnerability to shocks, and participation in government programs. The last part of the survey instrument contains eligibility questions to determine which households in the treatment sites that will be offered the 3P certificates (by the same specially trained survey enumerators) .

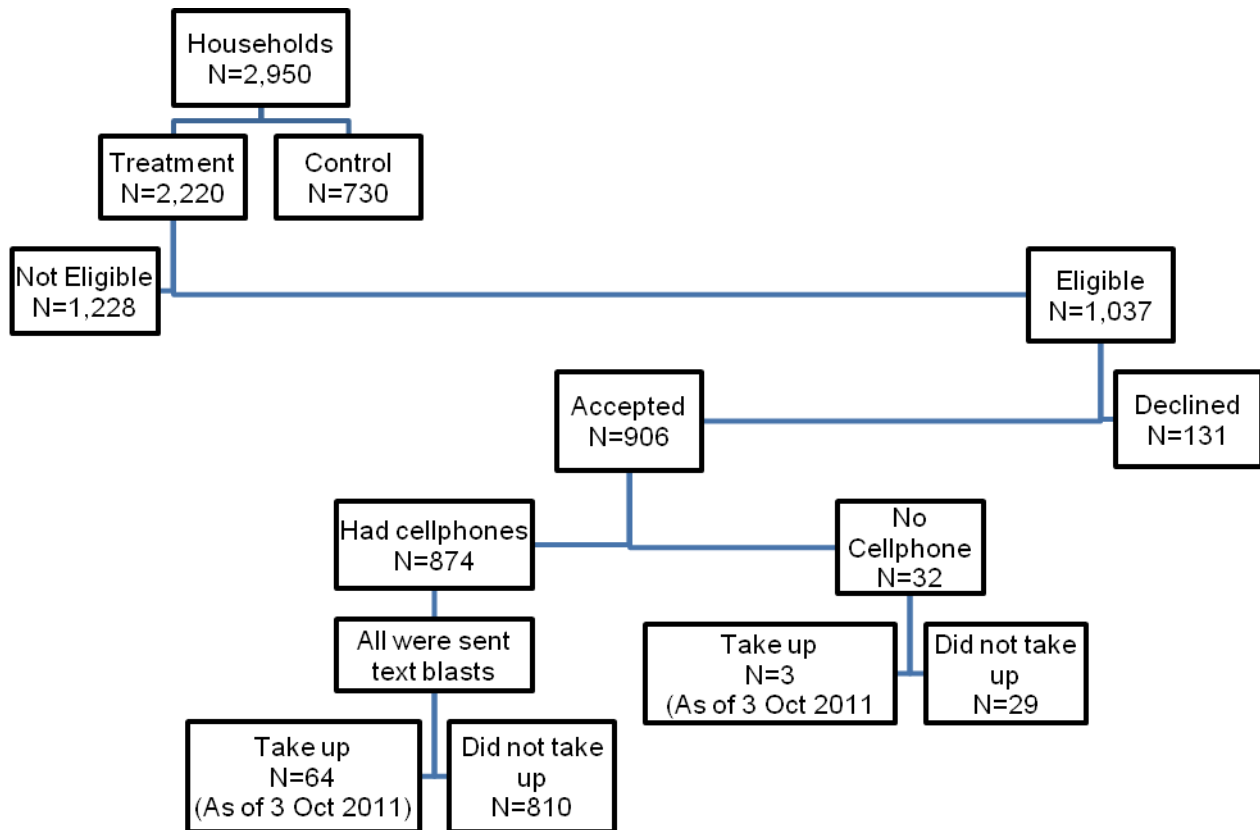
A total of 2,950 households were interviewed in the baseline survey. As shown in Figure 1, 2,220 of them are in the treatment sites and 730 in the control sites. Of those in the treatment sites, 1,228 were found not eligible to received the 3P certificate (because most already have PhilHealth coverage). Of the 1,037 households found eligible, 906 accepted the offer, and 131 declined.<sup>8</sup> Of the 906 that have 3P certificates, 874 have cellular phones and the rest only have landlines or neither.

First during February 21-March 29, 3P certificate holders were sent text messages to remind them to use their vouchers to enroll, to answer to their queries (about the nearest PhilHealth service office, additional payments, transferability of the certificates, etc.) and help them with their complaints (by referring their case to the PhilHealth-Marketing and Collections Department). Subsequent text messages were sent during April 24-30, May 1-7, May 8-14 and August 8-22, 2011. Text blasts were also done during PhilHealth's special enrollment campaigns in May 15-June 16 (PhilHealth Sabado) and September 29-October 3 (launching of the PhilHealth ID discount card for IPP members).

Out of the 906 3P certificate holders, 67 have enrolled as of 3 October 2011 according to PhilHealth reports from their services offices. Of the 67, all but three had cellular phones and presumably received several reminders through text messages. Possibly, more will enroll while the vouchers remain valid until 31 December 2011.

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<sup>8</sup> Of those who declined the offer, 37% percent said they were not interested, 32% said they did not have the money to pay the balance of the premium, and 17% were hesitant to sign the consent form.

**Figure 1. 3P Study Cohort Diagram**

#### 4. PRELIMINARY RESULTS

Since the main purpose of the 3P Study is to assess whether or not a premium subsidy plus information can increase enrollment in the IPP, what then can be said of the results of the experiment so far? As of 3 October 2011, the take up rate (or the proportion of 3P certificate recipients who enrolled) is 7.4%, while positive is low. While we have yet to test whether this is statistically significant to warrant a claim that the intervention works, some preliminary assessments can be made concerning its validity and low magnitude.

First, it may be asked if the take up rate is due to initial differences in the willingness or ability to participate in the IP program of the households in the treatment and control sites. To verify this, we use as proxy variables the reported amount that the households are willing to pay<sup>9</sup> per month to become PhilHealth members and their annual household income per capita. Then

<sup>9</sup> We assume that the household head's willingness to pay is the same as the expressed willingness to pay of the survey respondent, who may not be the household head himself/herself.

we grouped the households into those whose willingness to pay (WTP) is below 50 pesos and 50 pesos and above. The threshold WTP is 50 pesos per month, which sums up to 600 pesos per year and therefore enough for those 3P certificate holders with monthly family income of PhP25,000 to become PhilHealth members.

We also classified them according to income quintile, based on their annual household income per capita. Then for each classification, say, WTP below 50, we test if the proportions of households in the control sites and treatment sites are different. Table 3 shows the relevant household proportions and the  $p$ -values of the test of equality of proportions. The  $p$ -values consistently indicate the null of no differences in the proportions of households in the two sites cannot be rejected. This implies, for example, that proportion of households in the treatment sites that were willing to pay 50 pesos or below in monthly insurance premium was not higher or greater than those in the control sites.

**Table 3. Proportion of all sample households by amount of willingness to pay, annual household income per capita quintile, and by site\***

	Control sites		Treatment sites		Test of proportions ( $p$ -value)
	Freq.	Percent	Freq.	Percent	
Willingness to pay (PhP)					
Below 50	40	6.00	148	7.00	0.203
50 and above	654	94.00	1,889	93.00	0.203
TOTAL	685	100.00	2,037	100.00	
Average household income per capita quintile					
First quintile	134	18.53	378	17.24	0.430
Second quintile	141	19.50	404	18.43	0.522
Third quintile	149	20.61	429	19.57	0.544
Fourth quintile	149	20.61	465	21.21	0.730
Fifth quintile	150	20.75	516	23.54	0.121
TOTAL	723	100.00	2,192	100.00	

\*Based on unweighted samples.

Limiting the comparison between the two sites to the sample of households that would qualify to be offered the 3P certificates, Table 4 shows the relevant proportions in the treatment and control sites. As in Table 3, the  $p$ -values again indicate no statistically significant differences in the proportions of eligible households in the treatment and control sites. The results so far

suggest no systematic differences in the willingness or ability to participate in the IPP between the households in the treatment sites and those in the control sites.

**Table 4. Proportion of eligible households by amount of willingness to pay, annual household income per capita, and by site\***

	Eligible households in control sites		Eligible households in treatment sites		Test of proportions ( <i>p</i> -value)
	Freq.	Percent	Freq.	Percent	
Willingness to pay (PhP)					
Below 50	18	6.00	31	3.00	0.122
50 and above	298	94.00	865	97.00	0.122
TOTAL	316	100.00	896	100.00	
Annual household income per capita quintile					
First quintile	57	18.21	210	20.61	0.354
Second quintile	60	19.17	206	20.22	0.685
Third quintile	71	22.68	212	20.80	0.477
Fourth quintile	66	21.09	195	19.14	0.447
Fifth quintile	59	18.85	196	19.23	0.880
TOTAL	313	100.00	1,019	100.00	

\*Baseline survey, unweighted samples.

If the low take up is not related to differences in financial capacity, might it then be due to differences in the expected value of insurance coverage? To answer this question, two variables are used here as proxy, albeit imperfect ones, for the expected value of PhilHealth coverage. The first measure is the self-assessed health status. The hypothesis is that those with relatively poor assessment of their health are more likely to use health services and therefore benefit from their insurance entitlements. The second measure relies on the observation that those who are nearer health facilities are likelier to visit them when sick or injured and therefore will benefit more from their insurance coverage. In addition, since some of these facilities are located near PhilHealth service offices, their distance also partly reflect the incidental costs of enrolling with PhilHealth.

In Table 5, shows the proportions of 3P certificate holders by enrollment status and the associated *p*-values for the relevant comparison of proportions. In the top row, the *p*-values this time indicate that statistically significant differences between the two groups of 3P certificate holders. Specifically, there is a greater proportion among those who did not enroll with a WTP below 50 pesos. As expected, there is a greater proportion among those who enrolled with a higher WTP (50 pesos and above). However, the *p*-values in the last two rows indicate that the differences in enrollment status among 3P certificate holders is not due to systematic differences

in self-assessed health status or proximity to the nearest health facility. Therefore, there are as yet undetermined factors that hold back the 3P certificate holders to enroll.

**Table 5. Proportion of 3P certificate holders by amount of willingness to pay, self-assessed health status and average distance from nearest health facility, by enrollment status\***

	Enrolled with PhilHealth		Not enrolled in PhilHealth		Test of proportions ( <i>p</i> -value)
	Freq.	Percent	Freq.	Percent	
<b>Willingness to pay (PhP)</b>					
Below 50	0	0.00	23	3.19	0.00
50 and above	62	100.00	699	96.81	0.00
TOTAL	62	100.00	722	100.00	
<b>Self-Assessed Health Status</b>					
Poor	2	2.99	14	1.67	0.431
Fair	6	8.96	90	10.73	0.650
Good	24	35.82	370	44.10	0.188
Very Good	18	26.87	202	24.08	0.608
Excellent	17	25.37	163	19.43	0.241
TOTAL	67	100.00	839	100.00	
<b>Average distance form nearest facility</b>					
Less than 15 minutes	16	23.88	188	22.43	0.785
15 to 30 minutes	16	23.88	275	32.82	0.132
31 to 60 minutes	18	26.87	226	26.97	0.985
Above 1 hour	17	25.37	149	17.78	0.122
TOTAL	67	100.00	838	100.00	

\*Baseline survey, unweighted samples.

Some of these factors can be inferred from the feedback we gathered during the text blasts. Several 3P certificate holders failed to enroll due to cash flow problems, the toil and trouble of travelling to and fro the local PhilHealth service office, lingering doubts about the validity of the 3P certificates and lack of readiness of PhilHealth offices to accept vouchers. Others were also later enrolled in the Sponsored Program (for the indigents) by their local governments. We shall continue to encourage the 3P recipients in the remaining months of the intervention period to send more "stories" to complement the "hard" evidence from the survey and administrative data we're collecting.

**Selected text feedback from 3P certificate holders**

“Bkit ngayon po lang kyo sumagot nkadaan na bangka, wla na me masasakyan.” - Sender from Rizal

“hindi kopa na file. ang philhealth. form kc gepit pa sd pera. sa ngaun. baka sa june na po!” - Sender from Leyte

“K po tapusin lng namin un pag aani ng palay eh registered qu n po tnks po s paalala.” - Sender from Quezon

“si (Name Concealed) ay nakapag enrol na kahapon sa philhealth CAINTA BRANCH april 28 gmit ang inyong UPECON HEFPA PROJECT salamat po sa inyong ibinigay n pabor sa akin upang maging member ng phl health.” -Sender from Rizal

“Pan0 p0 yan kng pilyd0 ng baTA sa pngalan ng papa nya,PEr0 hndi p0 kmi kasal, madala q0 paRin ba cla sa pilhlth q0?? “ - Sender from South Cotabato

“Gd am regarding sa promo philhealth nyo pinakta na namin sa dumaguete philhealth ofc chek pa nila kc d nila alam upecon hefpa team ng survey d2..gs2 q muna chek office if tutoo ba.” - Sender from Negros Oriental

## 5. NEXT STEPS

So far, we have only begun to process and analyze the baseline survey data of the 3P Study. The results shown here - that premium subsidies and information packet has only modest impact on PhilHealth enrollment - remains preliminary and has to be validated further. First, the intervention period has to be completed to allow for more 3P certificate holders to enroll. Towards this, we shall continue with our text blasts and, in addition, phone calls to those with landlines. Second, we will apply multivariate analysis with the appropriate sampling weights tease out the partial effects of the interventions, controlling for possible confounding factors.

In future studies, for example, we should be able to control for membership in private health insurance schemes or HMOs among the sample households, validate their WTP against their income or wealth status, cross-checked their self-assessed health status against their illness/injury incidence or hospitalization in previous months. Also, we should be able to explore more fully the reasons for the failure of the many 3P certificate holders to enroll. We could classify them, for example, according to distance from city or municipal centers, educational status, participation in other social protection programs of the government, etc. With these all refinements, we hope to provide more concrete and potent policy inputs in the future.

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Annex 1. PhilHealth Prepaid Premium Certificate

**Congratulations! Meron ka nang** **P600**

**PhilHealth Prepaid Premium** **PhilHealth Prepaid Premium**

**PhilHealth** UPecon Foundation  
*Your Partner in Health*

This premium is paid for by UPecon Foundation, Inc. under its HEFPA project, in partnership with PhilHealth, to support the government's objective of providing health insurance to all Filipinos.

**This entitles**

Head of the family/spouse  
**to avail of the P600 worth of premium contributions to PhilHealth.**

Redeemable from January 1, 2011 to December 31, 2011.  
For enrollment in PhilHealth's Individually Paying Program only.

**Recipient:**  
Head of the family/spouse

**Control Number:**

*Rey B. Aquino, M.D.*  
President  
Philippine Health Insurance Corporation

*Arsenio Balisacan, Ph.D.*  
Chair, UPecon Foundation, Inc.

THIS CARD IS NON-TRANSFERABLE AND NON-CONVERTIBLE TO CASH.

UPECON HEFPA'S COPY

(Front)

**RESPONDENT'S CONSENT**

My signature indicates that:

- I am informed of the purpose, terms & conditions of the PhilHealth Prepaid Premium, and of my rights and responsibilities as a recipient.
- I consent to participate in the UPecon-HEFPA study.
- I allow the HEFPA Project to submit my name/name of the family head or spouse to PhilHealth in order to facilitate the processing of my enrollment and premium payment.

Name & signature of respondent \_\_\_\_\_ Date \_\_\_\_\_

Verified by: \_\_\_\_\_

Enumerator \_\_\_\_\_ Date \_\_\_\_\_

*Joseph J. Capuno*  
HEFPA Study Team Leader

To complete enrollment, the recipient should bring:

- Duly accomplished PhilHealth Member Registration Form (PMRF)
- Own and dependents' birth certificates
- Marriage certificate
- Valid ID
- PhilHealth Prepaid Premium

**Nearest PhilHealth Service Office**

ADDRESS: \_\_\_\_\_

CONTACT NO.: \_\_\_\_\_

**Pag member ka na, bawas gastos sa gamot, doktor at ospital para sa iyo at sa pamilya mo!**

As a recipient, you are eligible for a prepaid premium contribution worth P600 when you use this card to enroll in PhilHealth's Individually Paying Program (IPP) in 2011.

If you are a professional, this prepaid premium will pay for one quarter (3 months) worth of premium contributions. You only have to pay the balance for the unpaid 3 quarters.

If your monthly family income is P25,000 or below, this prepaid premium will pay for two quarters (6 months) worth of premium contributions. You only have to pay the balance for the unpaid 2 quarters.

For example, if you use this to enroll in 2011..

	1 2 MONTHS				You only pay for:
	1st 3 months	2nd 3 months	3rd 3 months	4th 3 months	
Professionals	<del>1st</del>	<del>2nd</del>	3rd	4th	3 quarters
Monthly Income P25,000 or below	<del>1st</del>	<del>2nd</del>	3rd	4th	2 quarters

This prepaid premium is non-refundable, non-convertible to cash and non-transferable to another person. It is issued by the UPecon Foundation (www.upecon.org.ph), a non-stock, non-profit research institution duly registered with SEC. For any questions, you may contact...

**UPecon HEFPA PROJECT**  
PCED Building, UP Campus, Diliman, Quezon City  
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Annex 1. 3P brochure on the IPP

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# 5 Frequently Asked Questions

## PhilHealth's Individually Paying Program (IPP)

Mag-enroll na at gamitin ang inyong

### PhilHealth Prepaid Premium

Pag IP member ka na, bawas gastos sa gamot, doktor at ospital para sa iyo at sa pamilya mo!

In partnership with PhilHealth, this is prepared by the UPecon Foundation-HEFPA Project

Website: <http://www.ypecon.org.ph>  
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### 1 What is PhilHealth's Individually Paying Program (IPP)?

- PhilHealth's IP Program is an insurance program for the self-employed individuals, such as self-practicing professionals, single proprietors, farmers and fisher folk, vendors, transport drivers & operators, and for those who are not covered by the other PhilHealth enrollment programs.

### 2 What are my benefits as an IP member?

- You and your declared dependents are covered by the program: your spouse, all children under 21 years old & parents who are 60 years old & above.
- You may avail of the following benefits in any accredited health providers:
  - Inpatient benefits, including room & board, drugs & medicines, laboratories, operating room & professional fees for confinements of more than 24 hours.
  - Outpatient benefits, such as day surgeries, hemodialysis and chemotherapy
  - Special packages, such as newborn care, TB DOTS treatment, malaria treatment, outpatient HIV/AIDS treatment & cataract extraction.

### 3 How do I become an IP member?

- Fill out the PhilHealth Member Registration Form (PMRF)
- Bring a valid ID & a photocopy & original copy of your birth certificate.
- Also bring photocopies & original copies of the birth certificates of your children below 21 yrs old, as well as your marriage contract.
- If you are a professional, attach a photocopy of your Professional Regulation Commission (PRC) license or Business Permit. If your monthly family income is P25,000 or below, bring a photo copy of your latest Income Tax Return (ITR).
- Enroll at any PhilHealth Service Office & pay the premium.
- Secure your PhilHealth Identification Number & Member Data Record (MDR). You will need these to claim your benefits.

### 4 How much is my premium as an IP member?

- For the first half of 2011, the annual premium is P2,400 for professionals and P1,200 for those with a monthly family income of P25,000 or below. The premium may be paid monthly, quarterly, semi-annually or annually.
- If you use your **PhilHealth Prepaid Premium** to enroll between January-June 2011, you only have to pay for 3 quarters if you are a professional or 2 quarters if your monthly family income is P25,000 or below.
- For example:

	12 MONTHS				You only pay for:
	1st 3 Months	2nd 3 Months	3rd 3 Months	4th 3 Months	
Professionals	1st 3 Months	2nd 3 Months	3rd 3 Months	4th 3 Months	3 quarters
Monthly income P25,000 or below	1st 3 Months	2nd 3 Months	3rd 3 Months	4th 3 Months	2 quarters

- You may pay at any accredited collecting agents (ACA), bayad centers, or through text (Remittance-By-Air).

### 5 How can I avail of the benefits?

- To avail of the benefits, you should have paid at least 9 monthly contributions within the last 12-months prior to confinement.
- Benefits can be availed at any PhilHealth accredited health care provider.



For additional information or questions, please ask the PhilHealth Service Officer when you enroll or visit their website at [www.philhealth.gov.ph](http://www.philhealth.gov.ph).

**Kalusugan ng lahat, PhilHealth ang katapat!**