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Legislating regulation for the Philippine HMO industry

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Abstract

This paper examines the process of legislating regulation for the Philippine health maintenance organization (HMO) industry. It particularly looks at how interest groups compete with each other and attempt to influence legislation of the regulation law. We find that a substantial number of government agencies and private organizations, principally the Association of Health Maintenance Organizations of the Philippines Inc. (AHMOPI), lobbied for or influenced legislation. The result of lobbying, "The HMO Act of 2003", appears to be a compromise settlement among the interest groups, with the association taking the biggest slice of the pie.

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1. Introduction

The health maintenance organization (HMO) industry is the fastest-growing component of the national health account. In 1989, total enrollment was 375,000. Ten years later, total enrollment exceeded 2.5 million, equivalent to an average growth rate of 19 percent annually[1] (Table 1). Moreover, the industry's health expenditure grew from Php 4.4 billion in 2000 to Php 6.8 billion in 2001, equivalent to a 56 percent growth rate, the highest jump in the national health account (Table 2). At the same time, its main substitutes, private health insurance and employer-based plans, fell by 32 percent and grew slightly by 6 percent, respectively. Clearly, HMOs are taking a strong lead in private health expenditures outside out-of-pockets, surpassing both its substitutes—the traditional means of providing medical benefits.

The rising market for HMOs, which subsequently saw an increase in the number of HMOs, some fly-by-nights,[2] and the increasing concern for patients' and providers' rights

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[1] This and the following figures on the HMO industry were sourced from the Association of Health Maintenance Organizations of the Philippines Inc. (AHMOPI) and the national health account in the Philippine Statistical Yearbook.

[2] Fly-by-nights are defined as HMOs that are not accredited or have spurious capitalization. A number of fly-by-nights have closed shop recently and have left problems for the industry as a whole.

given rising medical costs have led interest groups to push for state regulation of the industry, of which the AHMOPI [henceforth called the association], is the principal proponent. On 21 October 2002, the lower house version of the bill, HB 4666, "The HMO Act of 2003", was approved on third reading by unanimous vote and is currently on second reading in the upper house. With sessions on recess since 6 February 2004 to give way to the electoral campaign, it is unlikely that the bill, classified as national but not urgent, would be signed into law by the 12th Congress before it adjourns. If left unsigned, the bill needs to be refiled in the 13th Congress. For the meantime, while legislation of the regulation law is still being deliberated and delayed in Congress, the association has taken onto itself the task of self-regulation.

Table 1. Share of HMO in total health expenditure

Year	*Share*	*Growth in share*
1992	1.3%	8%
1993	1.4%	14%
1994	1.6%	25%
1995	2.0%	15%
1996	2.3%	9%
1997	2.5%	16%
1998	2.9%	38%
1999	4.0%	-3%
2000	3.9%	46%
2001	5.7%	

Source: *Philippine statistical yearbook 2003.*

Table 2. Sources of health expenditures

Sources of funds	*Amount (In billions of pesos)*		*Growth rate*
	2000	*2001*	
GOVERNMENT	46.6	44.7	(4.1)
National	24.4	19.8	(19.0)
Local	22.2	24.9	12.3
SOCIAL INSURANCE	8.1	9.3	14.9
Medicare	7.8	9.0	15.3
Employees'	0.3	0.3	2.6
Compensation	58.8	65.4	11.3
PRIVATE SOURCES	46.5	51.1	9.9
Out-of-pocket	2.3	1.6	(32.2)
Private insurance	4.4	6.8	56.1
HMOs	4.3	4.5	6
Employer-based plans	1.3	1.4	5
Private schools	113.5	119.4	5.2
TOTAL			

Given the issues, this paper proposes to examine the process of legislating regulation of the industry, beginning with the association's current role in self-regulation followed by a closer look at how interest groups compete in influencing legislation that led to the passage of the HMO bill.

This paper uses information gathered from interviews of key people in the industry—including association officers and members, HMO brokers and actuaries, and human resource managers of corporate clients—House bills, minutes of the meeting of the Subcommittee on Health Financing, and few published papers on the Philippine HMO industry.

The rest of the paper is organized as follows. Section 2 gives a brief picture of the Philippine HMO industry. Section 3 summarizes self-regulation by the association. Section 4 walks through the process of legislating regulation for the industry. Section 5 gives an overview of the HMO bill. Some concluding remarks are presented in section 6.

2. The Philippine HMO industry

HMOs in the Philippines began in the late 1970s[3] as a spillover from a successful run in the United States. The US Congress passed the HMO Act of 1973, which paved the way for a federal grant and loan program to encourage and stimulate the growth of US HMOs. In the late 1980s, Philippine HMOs began to grow at accelerated rates as corporations found HMOs cheaper and more accessible in terms of network of health services. In the last decade, the health card has become a norm in corporate benefits package.

The growth of the industry did not go undisturbed. The rising market demand saw a jump in the number of HMOs. In 2001, the Department of Health (DOH) accredited 40 HMOs, but admitted that there existed HMOs or pseudo-HMOs that were not on the official list. The emergence of fly-by-night HMOs, which offer lower premiums but with a higher probability of default, is the industry's biggest headache. Recent years have seen a number of them close shop, adversely affecting the industry.

Another headache is medical inflation. Medical costs have risen rapidly over the years. HMO brokers revealed that premium rates of their clients grew by an average of 20-30 percent in 2003.[4] Despite medical inflation, premium rates and quality of services remain at competitive and acceptable levels partly due to credible threat from the one-year contract between clients and HMOs.[5] The rising cost of medical services has led to a preference for corporate clients as opposed to individual clients, who are perceived to be more prone to moral hazard. At present, the industry's clientele mix is about 85 percent corporate and 15 percent individual, family, or small businesses. Medical inflation has led some companies to shift into self-administered plans.[6]

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[3] The pioneers were Philam Care, Medicard, Fortune Care, and Health Maintenance Inc.

[4] Rising premium rates have resulted in faster client turnovers. For instance, a major university in Metro Manila transferred to a new HMO provider in 2002 due to a 40 percent increase in premium.

[5] Contracts used to be for three years, but due to rising medical cost and variability of actuarial estimation, it has been reduced to a year.

[6] Self-administered plan is a variant of the standard HMO in which the company, instead of the HMO firm, shoulders financial risk while outsourcing the management of the benefit to an HMO.

Rising medical cost has led to either shutdowns or consolidation in the industry. Of the 40 accredited HMOs in 2001, a number of them have been bought or have closed down. Empirically, economies of scale have provided a strong justification for mergers and acquisitions only in the case of relatively small HMOs [Given 1996]. Wholey et al. [1996] also found that HMOs benefit from scale economies.

Despite the problems, the association's president, Carlos da Silva, believes that that the market will continue to grow as HMOs maintain their efficiency and cost advantage over traditional means of providing medical benefit and over the public health care system, which remains underfunded and inadequate. Furthermore, given the proper motivation such as tax incentives, the HMO industry is expected to thrive.

3. Self-regulation by AHMOPI

Currently, government intervention in the industry requires HMOs to register with the Securities and Exchange Commission (SEC) and to secure clearances from the Bureau of Health Facilities and Services of the DOH. Securing a clearance from DOH is mandated by Executive Order 102, which directs DOH to supervise all health care services and facilities.[7] Beyond this, no government body has regulatory power over HMOs. The SEC has no regulatory power over HMOs since these do not sell securities. DOH only issues clearances to operate, but in-between issuances do not have direct regulatory power over HMOs. Finally, the Insurance Commission (IC) does not consider HMOs insurance companies. Given no formal government policy toward the HMO industry, the association has taken unto itself the task of self-regulation.

AHMOPI,[8] as the official trade association of Philippine HMOs, is mandated by its mission to protect the interest of the industry and individual member firms as well as to improve means of providing appropriate health care at affordable cost. Among the goals of the association are to attain proper recognition for itself and the industry, to establish minimum industry standards, and to represent the industry in transactions with the government [AHMOPI yearbook]. It has every incentive to self-regulate since one firm's failure translates into industry-wide problems such as higher prices charged by health care providers. For instance, hospitals facing unpaid bills from bankrupt HMOs tend to increase their rates, demand shorter turnaround time of payment of contractual obligations, or demand cash bonds from some HMOs. On the other hand, individual firm's successes generate positive externalities to the entire industry.

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[7] Executive Order 102 seems to contradict the implementing rules and regulations of Republic Act 7875, National Health Insurance Act, which mandates the PHIC to set guidelines for general and specific requirements for the accreditation of HMOs.

[8] AHMOPI was formed in 1987 by the first six HMOs: Health Maintenance, Philam Care, Medicard, Fortune Medicare, Health Plan Philippines, and Integrated Health Care Services. In 2003, it has 15 member firms out of about 40 duly accredited HMOs, not counting the non-accredited. Given this, it is obvious that while it controls about 85 percent of the market share (AHMOPI's estimate) in 2003, it does not have majority of the HMO firms. The top ten HMOs in the country in terms of market share are members of AHMOPI. In 2003, total revenue (premiums plus investment) of members stood at Php 4.95 billion.

The association primarily regulates marketing and financial standards. With regard to marketing standards, the association puts a cap of 20 percent of revenue for commissions paid to brokers. Premium discounts offered are also checked for their sustainability. It also determines standard procedures that can be covered in hospitals, clinics, and by doctors. All in all, the goal is to prevent destructive price wars and maintain sustainability of premiums corresponding to an agreed-upon quality of service.[9] With regard to financial regulation, all association members are required to have actuaries. The association also sets standards for accounting, financial, and utilization reports.

Besides self-regulation, the association hears all complaints filed by or against member firms. Complaints vary and may come from health care providers who do not get paid on time, or from member HMOs, which may complain about ex post opportunistic behavior by hospitals that require cash bonds, or from clients regarding substandard health care service. Unresolved complaints at the association level are elevated to government bodies, such as DOH or the courts.

The power of the association in disciplining its members includes sanctions and expulsion. HMOs wishing to join or rejoin the association cannot do so freely since membership is by invitation only (per the association's by-laws). Clearly, any form of self-regulation is limited to its members only. Fly-by-nights are not solved by self-regulation. Any serious regulation must be provided for by the State.

4. The road to regulation

As early as the 8th Congress, HMOs were already a national issue. In the Senate, Senate Resolution 425 directed the Senate Committee on Health to look into the practices, program, policies, procedures, and government supervision of HMOs since these were not subject to the requirements of minimum capitalization, margin of solvency, inspection, audit, and annual reporting. Also, House Bill 16185 sought to revise the Philippine Medicare Act and establish a national nonprofit HMO.

Seminal papers on Philippine HMOs (Alfiler [1989]; Gamboa, Bautista, and Beringuela [1993]) revealed that the industry did not oppose regulation so long as it was not restrictive and no unilateral decisions were imposed on the industry without consultation. As early as 1993, the association has already suggested that both the IC and the DOH jointly regulate the industry. An interview with Dr. Benito Reverente, founding president of the association, confirmed that the association has actively supported legislation for regulation. Industry leaders have been actively attending committee hearings and suggesting some provisions for the bill, such as minimum capitalization, tax incentives, and official recognition of the association.

[9] It was an indirect price war among firms in recent years that overcame a major HMO provider. Instead of adhering to industry standard of maximum benefit limit of Php 100,000 per person per illness per year, it chose to give a maximum benefit limit of Php 1 million per person per year regardless of the number of illness.

In the 12th Congress, four house bills were filed, each proposing the regulation of HMOs. House Bills (HB) 588, 826, and 2436 had varying provisions that were subsequently consolidated into HB 4666 (see Appendix A for bill-by-bill comparison). House Bill 4666 was passed by the lower house as the "HMO Act of 2003" on 21 October 2002. The bill, however, has not passed the Senate floor as of March 2004.

A number of private organizations and government agencies have expressed their support for HMO regulation. These include AHMOPI, Philippine Hospital Association (PHA), Philippine Medical Association (PMA), Philippine Dental Association (PDA), Association of Insurance Brokers (AIB), Bureau of Internal Revenue (BIR), Department of Finance (DOF), Philippine Health Insurance Corporation (PHIC), IC, DOH, and SEC. At first glance, this might seem favorable due to a convergence of stands. Convergence of stands helps minimize delays and strategic manipulation in regulatory proceedings. However, upon examination of the underlying reasons for advocating regulation, we find evidence of vested interests for doing so.[10]

According to one form of the capture theory, regulation is supplied in response to the industry's demand for regulation. The key to a successful capture lies in how well the industry organizes itself and, owing to its small size, results in higher marginal per capita benefit and less free riding. A successful capture results in welfare gains for the industry. With more than one interest group, Becker's [1983] version of the capture theory, in which interest groups compete with one another in influencing the result of legislation, is more applicable in our case. What will determine the outcome of legislation is the relative influence of interest groups and the relative efficiency in applying pressure on legislators.

Vested interests vary according to the agency or organization. The association's interests primarily lie in protecting industry reputation, acquiring incentives for industry growth, and official recognition for the association. The interests of PHA, PMA, and PDA lie primarily in consumer and health service providers' protection and preventing HMOs from acquiring unnecessary tax incentives. DOF and BIR are interested in increasing tax revenues while IC and DOH may want solo regulation to increase agency power, prestige, and revenue-earning capability.

Vested interests can be seen immediately from how the different groups define HMOs since the choice of definition significantly affects support for regulation, the choice of regulatory body, and the weight of argument for tax incentives. HB 4666 defines an HMO as an insurance company. The National Health Insurance Act defines it as a health care provider. AHMOPI defines it as a firm that arranges coverage for designated health services. Most other groups define HMOs as insurance companies.[11]

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[10] The following discussion on vested interests in advocating regulation is based on investigative research of house bills, committee meeting minutes, and interviews. As it is not incentive compatible to publicly reveal vested interests, we cannot say with utmost certainty that the analysis is error-free. We can only surmise the possible meanings of each statement written or uttered in light of reason and economic theory.

[11] The differences in definition can be attributed to different origins of HMOs. Some are sister companies of life insurance companies (e.g., Philam Care, Icare, and Fortune Care). Others are associated with doctor groups (e.g., Maxicare and Medicard), while others have tie-ups neither with life insurances nor with doctor groups (e.g., Health Maintenance Inc. and Price Care). Still other HMOs are community-based, nonstock, and nonprofit.

The definition effectively narrows down the choice of regulatory body to IC and/or DOH. No agency or organization had suggested a new regulatory body. Almost all groups were in favor of joint regulation except for AIB. AIB considered HMOs insurance companies, which buy health care services, as opposed to hospitals and doctors who sell health care services. Hence, AIB reasoned that it was not necessary for DOH to regulate HMOs since hospitals and doctors were already being regulated by DOH. Giving regulatory power to DOH, AIB continued, was not only unnecessary but would also water down the regulatory hold of IC over the industry.[12]

The definition has also been used to support or deny tax incentives. All three original bills had explicit provisions for tax incentives to encourage growth of the industry. These include (a) 50 percent reduction in custom duties for medical equipment; (b) exemptions from value-added, documentary, and percentage taxes on all health care agreements; and (c) deductibility of premium from personal and corporation income taxes. Aside from the above tax incentives, the association had also requested the following additional incentives: legislation compelling employers to grant their employees mandatory dual choice between health insurance or HMO, soft loans to new HMOs, and incentives for HMOs operating in the provinces. All these incentives, the association claims, would reduce premium charges and spur industry growth.

Most groups, however, were not in favor of granting HMOs tax incentives for practical and equity reasons. On the practical side, since HMOs are defined as insurance companies, they have no need to import medical equipment and thus need not request for reduction in custom duties. Some groups believed that granting tax exemptions could actually be detrimental to the rest of the medical industry. Furthermore, both DOF and BIR explained why tax incentives are not necessary[13] and maintained that it was not the right time to ask for tax exemptions for non-urgent matters, given huge national government budget deficits.

On equity grounds, one member of the committee disagreed with tax incentives for HMOs on the basis that its four million members should not get priority over the rest of the population in health care. Moreover, PMA considered it grossly unfair to grant tax incentives to HMOs since as insurance companies, their main concerns were business gains and the benefit of their enrollees, and not the general welfare of the populace. PHA opined that if HMOs get tax incentives, then they should be granted to hospitals as well. Also, since PHIC existed anyway as a public HMO, there was no need to grant any incentives to private HMOs. Instead, incentives and support should be directed to PHIC.

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[12]It is strange for AIB, who brokers for both HMOs and life insurance companies, to insist that HMOs are insurance companies when both the HMO and life insurance industries agree that while HMOs share many similarities with insurance companies, they are not strictly insurance companies and thus should not be regulated as such.

[13] BIR and DOF clarified that all contracts are subjected to the documentary stamp tax, while under the tax code, premiums paid by an individual for hospitalization benefit are already exempted from gross taxable income so there is no need to explicitly write it in the bill. Moreover, BIR clarified that percentage and value-added taxes are paid by HMOs only on realized income and not the gross receipt.

From the minutes of the committee meeting, it was evident that a lot of time had been spent on tax incentives.[14] Surprisingly, the association was relatively silent during the deliberations on tax incentives while most other groups were very vocal in denying tax incentives for the industry. We can only speculate that tax incentives, perhaps, were not the major concern of the association, but rather a smoke screen for their real intent, and since minimum capitalization to deter fly-by-nights was generally supported by all groups, could it be that the association's true intent in lobbying for legislation was to increase its hold over the entire industry? In other words, did the association purposely leave crumbs for other interest groups to chew on while it silently ran away with its prize?

A second look at the minutes revealed that the issue on official recognition of the association escaped deliberations. The association had proposed to Congress that it be named the official industry association in the bill. Such a move effectively required all HMOs to be members of the association as prerequisite for it to operate. Again, we can only speculate the possible underlying reasons for such a move. For one, since bigger firms have held the leadership in the association, the move for formal recognition might actually be a front to maintain their dominance and effectively bar entry of new firms, some indiscriminately labeled as fly-by-nights even if they would have been viable alternatives. Effectively, regulation of the industry would actually favor larger HMOs. Moreover, regulation might even be a facade for legalizing or formalizing a cartel-like behavior.

Having said all these, we find that not only was there competition per se among interest groups, there was also a successful capture of legislation by the association. This capture, however, would only be complete if it could do the same in the Senate floor.

5. The HMO Act of 2003

How had lobbying, competition among interest groups, and strategic moves by the association affected the outcome of the legislated bill? Was there a successful regulatory capture? Going through the bill, we find on surface that it appears to be a compromise among interest groups. However, we also cannot reject evidence that the association took the biggest slice of the pie.

The compromise bill is visible in the following sections. Section 4 defines an HMO as an insurance company, and thus effectively removes provisions for tax incentives. This section alone satisfies most groups. Section 6 provides joint regulation of HMOs by assigning IC to regulate financial operations and DOH to regulate health care services.[15] Moreover, section 6 adds another step to the current procedure by requiring HMOs to secure a license from IC, which is valid for two years. This section is clearly a compromise. Section 9 outlines the rights of consumers and providers, which are desired by medical associations. Section 10 requires the use of actuaries and financial consultants, a plus for deterring fly-by-nights

[14] In fact, PHA expressed concern that giving tax incentives would delay passage of the bill.

[15] Looking at the original bills, both HB 826 and 2436 define HMOs as health care providers and thus place it under DOH regulation while HB 588 defines it as an insurance company, effectively placing it under IC.

and protecting consumers' and providers' rights. Section 11, possibly the most important for the association, requires all HMOs to be members of the existing trade organization.[16] This provision has a big impact. Given that the association's current by-laws state that membership shall be by invitation, this provision may effectively give the association huge powers to restrict entry of new players to the market.[17]

Section 12 calls for both IC and DOH to act as arbitration bodies. It also states that HMOs shall provide an internal mechanism for hearing disputes. This may be a compromise to balance the powers of stakeholders. Section 13 provides for the suspension of license, which is in line with keeping quality in check and maintaining a sound financial balance. Moreover, IC can order a freeze of the assets and funds of the HMO suspended or revoked for the protection of investors, providers, and members.

Beyond compromise and capture, the state must make the bill appear fair and socially beneficial. One way to do so is to show how certain regulatory instruments appear to increase welfare. By controlling the number of firms through stringent entry criteria, including investment decision restrictions (sections 8 and 11), the bill is made to appear to protect consumers' right to uninterrupted access to health care and providers' right to just compensation without fear of default by HMOs. Likewise, quality control[18] (section 9) appears to improve welfare. Needless to say, appearances can sometimes be deceiving. A successful capture and compromise necessarily improve interest groups' welfare, sometimes to the detriment of others.

6. Concluding remarks

Medical care is a right and its protection is necessary, but it does not automatically follow that state regulation of HMOs can improve total welfare. A World Bank [2003] study on regulation warned that the number of state regulations is positively correlated with inefficiency, corruption, and higher unemployment.[19] Furthermore, enforcement problems may arise and defeat the purpose of regulation. Second, total welfare is not necessarily increased in a regulated environment. The association believes that improperly considered regulation could raise membership fees excessively. In the literature, it has been shown that premiums may either decrease or increase under regulation [Encinosa 2001]. Third, industry standards may actually decrease in a regulated environment. Encinosa argued that a minimum

[16] This provision in HB 4666 is already milder compared to HB 826, which explicitly gave the association the authority to issue certificates of membership in good standing, which is necessary for application of a license to operate.

[17] It is also possible that nonmembers, the smaller players but the majority in terms of number of firms, form a new association to challenge the leadership of AHMOPI.

[18] Regulation quality includes protecting consumers' right to choose any physician of choice, access to specialists, emergency care, and medically necessary services and procedures without prior approval from the HMO but at an additional cost. In the health care provider side, quality can translate into prompt and just compensation for health care providers and their right to full freedom to manage and treat patients in accordance with the prevailing standard of care.

[19] In the World Bank study, Philippine firms are among the most regulated. The Philippines joins nine other developing countries out of 130 with the most number of rules for doing business.

standard that is set too low, perhaps due to political bargaining, could result in a floor-to-ceiling effect wherein the quality would have been above the standard in an unregulated market. He is supported by Leland [1979], who found that quality standards that are set by the state regulator is likely to be too low compared with that set by the profession or industry itself.

Other problems that may have been overlooked in the legislation stage can surface in the implementation stage. First, inefficiencies can arise from joint regulation. Second, the bill may overrule existing contracts between HMOs and health care providers. For example, according to section 9.A.1, patients have the right to see any physician of his or her choice but this may violate contracts already signed with physicians who agreed to charge lower fees in exchange for more volume. Allowing for unlimited choice of physicians could technically breach this contract.[20] Third, the relationship between HMOs and PHIC needs to be studied more carefully. Since PHIC and HMOs have a common objective of providing quality health care at low cost, then the law creating and regulating them must necessarily explore possible areas of collaboration, which may need some amendments to the NHIA and the HMO bill to achieve smoother functions. Finally, since IC would be regulating, changing its mandate is necessary, as well as modifying the insurance code to include HMOs or writing a separate HMO code.

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[20] The only exemption is that patients can see any obstetrician-gynecologist and pediatrics of his or her choice, given that they provide personalized and private care to patients.

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Appendices

Appendix A. Bill-by-bill summary comparison

Provision	*HB 588*	*HB 826*	*HB 2436*	*HB 4666*
1. Defines HMO as insurance companies	Y	N	N	Y
2. Regulator	IC	DOH	DOH	Both
3. Rights of consumers and providers	Y	N	N	Y
4. Mechanism for arbitration and review	Y	Y	N	Y
5. Provides sanctions for erring HMOs	Y	Y	Y	Y
6. Tax incentives	Y	Y	Y	N
7. Requires actuary	Y	Y	Y	Y
8. Recognition of AHMOPI	N	Y	N	Y

Appendix B. List of acronyms

AHMOPI	Association of Health Maintenance Organizations of the Philippines
AIB	Association of Insurance Brokers
BIR	Bureau of Internal Revenue
DOF	Department of Finance
DOH	Department of Health
IC	Insurance Commission
HB	House Bill
HMO	Health Maintenance Organization
PHIC	Philippine Health Insurance Corporation
PDA	Philippine Dental Association
PHA	Philippine Hospital Association
PMA	Philippine Medical Association
SEC	Securities and Exchange Commission