Philippine Institute for Development Studies
Surian sa mga Pag-aaral Pangkaunlarang ng Pilipinas

HEALTH ECONOMICS AND FINANCE PROGRAM

Provider-Level Response to Reimbursement Reform: Charging Practices and Out-of-Pocket Expenditures after Benefit Expansion

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Increasing benefit payouts is a common strategy used by many health systems to reduce patient out-of-pocket (OOP) expenses

2013-2024 — *Case Rate Packages did not increase for 11 years*

Feb 2024 — *30% increase*

Dec 2024 — *Additional 50% increase on select case rates*

Increasing benefit payouts may not necessarily translate into significant patient financial risk protection (FRP)

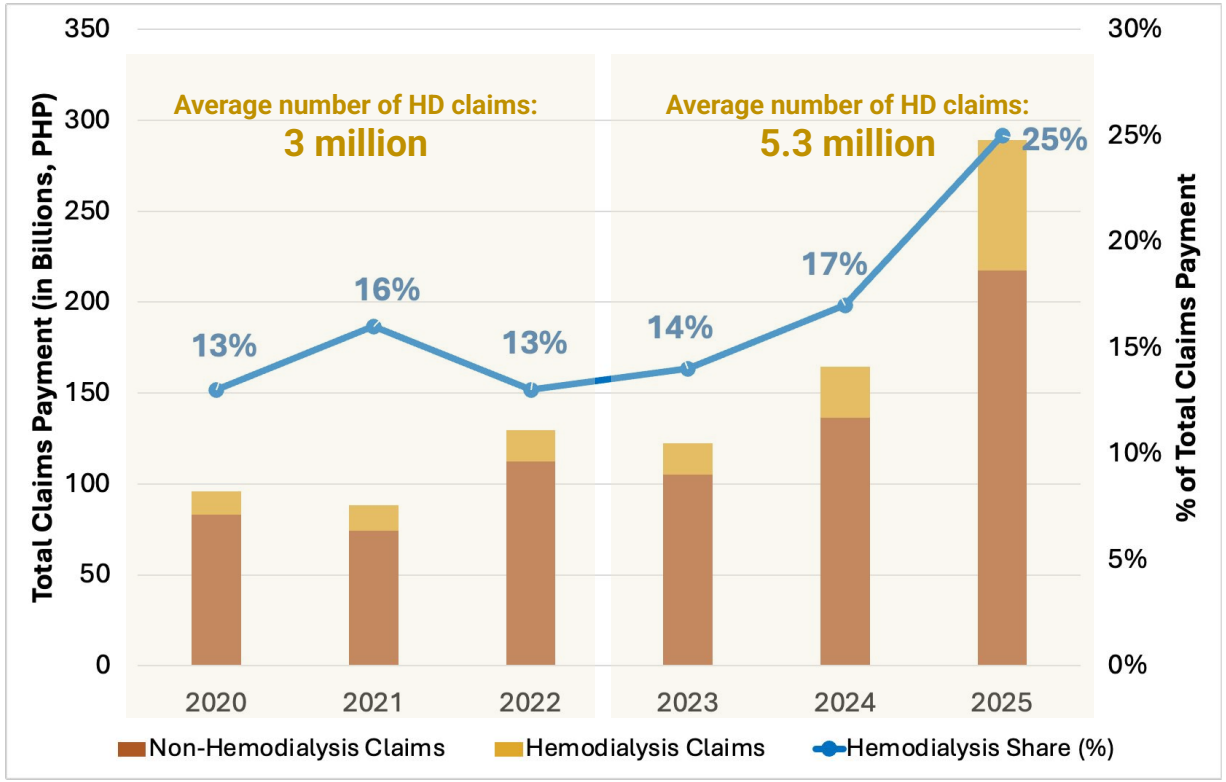
Modest returns to improvements in FRP

Patient welfare and Provider returns

Adjustments in declared prices and volume of service provision

Sources: Arrow (1964); Farley (1996); Ellis and Mcguire (1986); McGuire and Pauly (1991); Wagstaff and Lindelow (2008); Dai and Tang (2015); Gaspar and Koolman (2022), Delvin and McCormack (2023)

Case Study: Hemodialysis is PhilHealth's largest and fastest-growing benefit package in total spending and volume from 2020 to 2025



Discrete, standard, & low-variation procedure for comparison across providers

Source: PhilHealth Stats and Charts 2020-2025, as of June 2026

We examined variation in charges and OOP following the benefit payout expansion for hemodialysis

RESEARCH OBJECTIVES

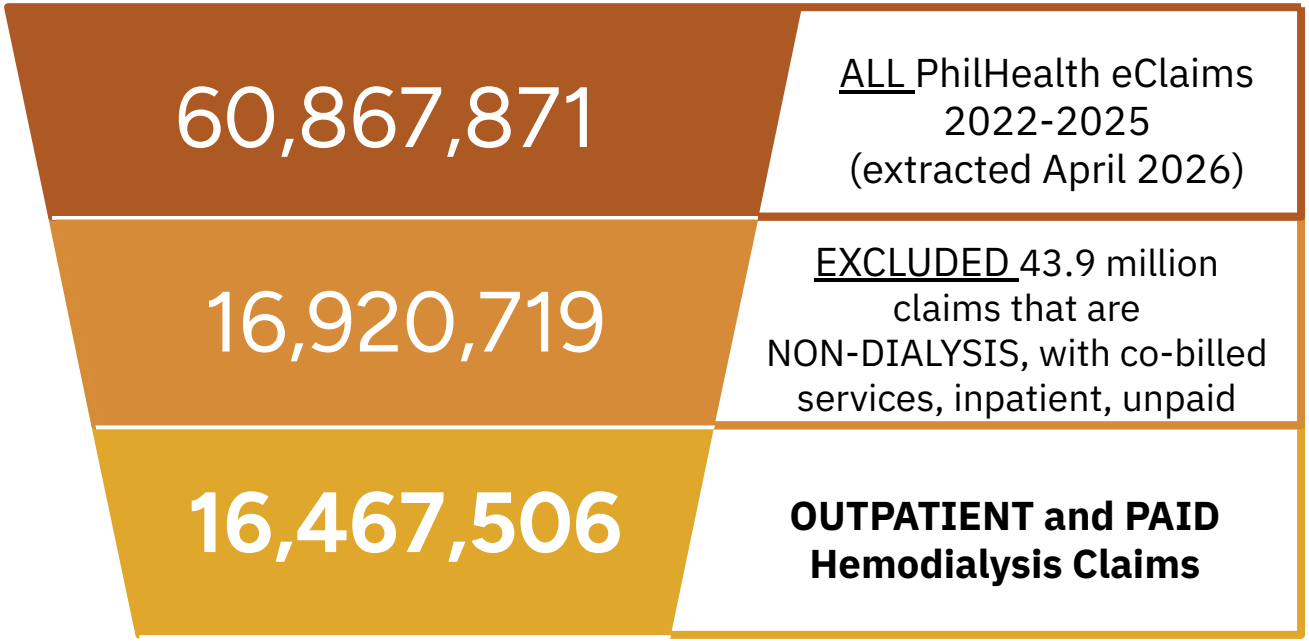
1) Document variation in outpatient dialysis charges across provinces and highly urbanized cities before and after the increase
2) Evaluate the effect of PhilHealth's benefit expansion

OUTCOMES

1) Provider-declared Claim Charges
   (Total = HCI Fee + Professional Fee)
2) Out-of-Pocket expenditures
   (OOP = claim charge - PhilHealth benefits)

*Note: All values are in real terms, deflated to **2018 prices (PHP)***

We analyzed a large scale dataset with 16.4 million hemodialysis claims from 2022 to 2025



The study covers three periods: before the increase, after the first increase (July 2024) and after the second increase (October 2024)

Note: Rates apply to Level 1,2,3 Hospitals, Ambulatory Surgical Clinics (ASCs), and Primary Care Facilities (PCFs), and Free-Standing Dialysis Clinics (FSDCs).
Source: Authors' consolidation of relevant policies on the hemodialysis benefit package from PhilHealth.

Data Analysis

Objective 1:
Variation in Outpatient Hemodialysis Charges

Generalized Linear Model (GLM)

$$ln[Y_{ipt}|X_{ipt}] = a + \partial_t + \delta_o + \partial_t * \delta_o + \mu_p + X_{ipt} + \epsilon_{ipt}$$

- **Goal**: ***age- & sex-adjusted hemodialysis prices*** across provinces/HUCs by intervention period
- **Unit of analysis:** claim or episode of care

Objective 2:
Changes in Charges and OOP following the Benefit Expansion

Interrupted Time Series Analysis (ITS) without Control

$$Y_t = \beta_0 + \beta_1 T_t + \beta_2 X1_t + \beta_3 X1_t T_t + \beta_4 X2_t + \beta_5 X2_t T_t + S_t + \epsilon_t$$

- **Outcome:** average charge or OOP for a given month
- Strong **quasi-experimental** design, **Counterfactual**: baseline trend correctly reflects what would have happened without intervention
- Note: Analysis was restricted to 315 facilities with complete submissions for all months during the study period

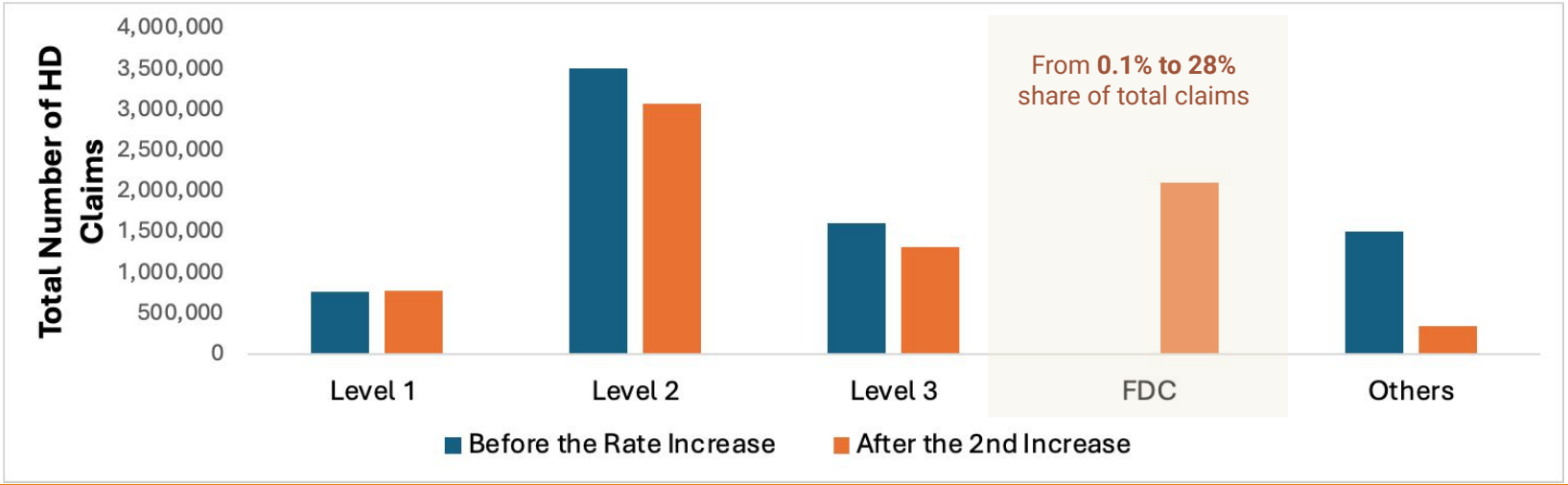
Private providers submitted the majority of the HD claims, and the number of claims from FDCs significantly increased

Number and Share (%) of Hemodialysis Claims

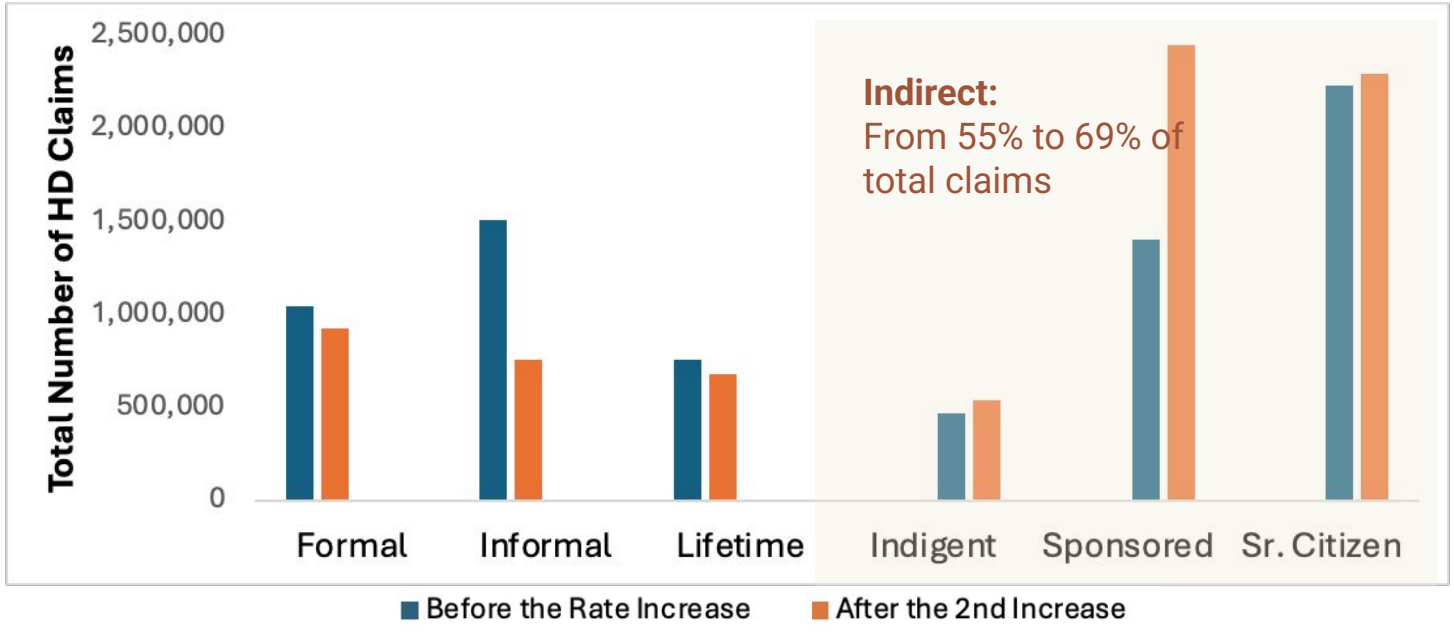
	Before the Increase *(Jan 2022 to Jun 2024)*	After the Second Increase *(Oct 2024 to Dec 2025)*
Public	1.1 million (15%)	1 million (13%)
Private	**6.2 million (85%)**	**6.6 million (87%)**

Free-standing Dialysis Clinics

- 13-15% average annual growth rate of accredited FDCs *(PhilHealth Stats and Charts, 2021-2025)*



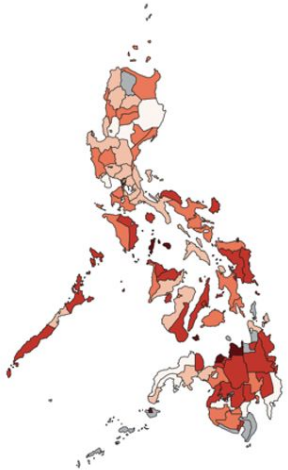
After the second increase, the share of claims from indirect members increased



Overall, the number of unique hemodialysis patients submitting claims changed from 104,585 before the rate increase to 117,522 from October 2024 to December 2025.

Before the rate increases, hemodialysis prices across provinces and HUCs ranged from under PHP 3,000 to over PHP 5,000

ALL FACILITIES



Before the Rate Increase (Jan 2022 to Jun 2024)

Adjusted National Average Price: **PHP 3,645**

LEGEND:

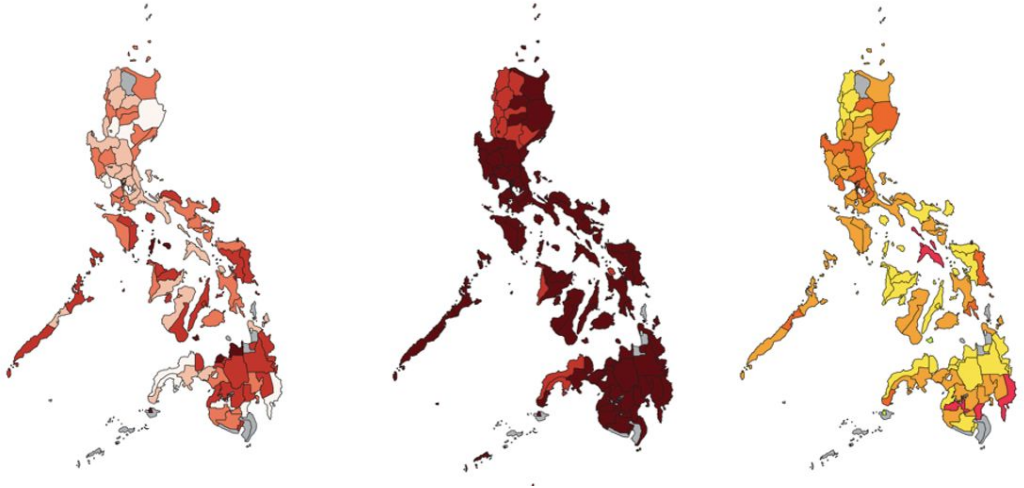
Price of dialysis session

- 3,000 PhP and below
- 3,000 PhP - 3,500 PhP
- 3,500 PhP - 4,000 PhP
- 4,000 PhP - 5,000 PhP
- 5,000 PhP and above
- No available data

Note: Values are in 2018 PHP

After the second rate increase, most hemodialysis prices were above PHP 5,000, with changes ranging from 5% to 164%

ALL FACILITIES



Before the Rate Increase (Jan 2022 to Jun 2024)

Adjusted National Average Price: **PHP 3,645**

Second Rate Increase (9 Oct 2024 to Dec 2025)

Adjusted National Average Price: **PHP 5,879**

% Change

LEGEND:

Price of dialysis session

- 3,000 PhP and below
- 3,000 PhP - 3,500 PhP
- 3,500 PhP - 4,000 PhP
- 4,000 PhP - 5,000 PhP
- 5,000 PhP and above
- No available data

Change in price of dialysis session, (%)

- 0% and below
- 0 - 50%
- 50% - 75%
- 75% - 100%
- 100% and above
- No available data

After the second rate increase, private facilities consistently had higher hemodialysis prices. Public prices showed some variation.

PUBLIC

Adjusted National Average Price: **PHP 4,660**

PRIVATE

Adjusted National Average Price: **PHP 6,082**

LEGEND:

Price of dialysis session

- 3,000 PhP and below
- 3,000 PhP - 3,500 PhP
- 3,500 PhP - 4,000 PhP
- 4,000 PhP - 5,000 PhP
- 5,000 PhP and above
- No available data

Overall share of Zero OOP claims increased from 9% before the benefit expansion to 32% after the second increase

By Sector Ownership

PUBLIC:

21% → **68%**

Out of 1.1 million claims → *Out of 1 million claims*

PRIVATE:

7% → **26%**

Out of 6.3 million claims → *Out of 6.6 million claims*

By Service Level Capability

HOSPITALS:

5% → **31%**

Out of 5.8 million claims → *Out of 5.2 million claims*

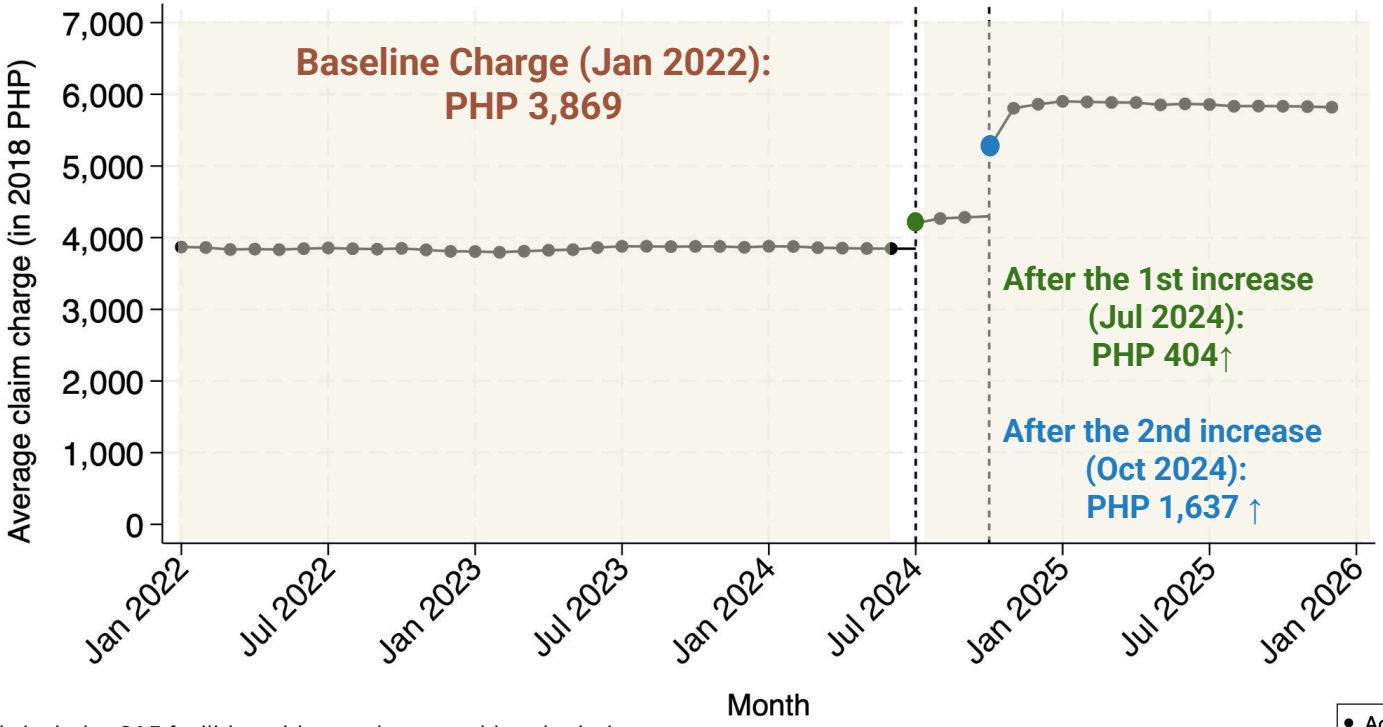
NON-HOSPITALS

22% → **33%**

Out of 1.5 million claims → *Out of 2.5 million claims*

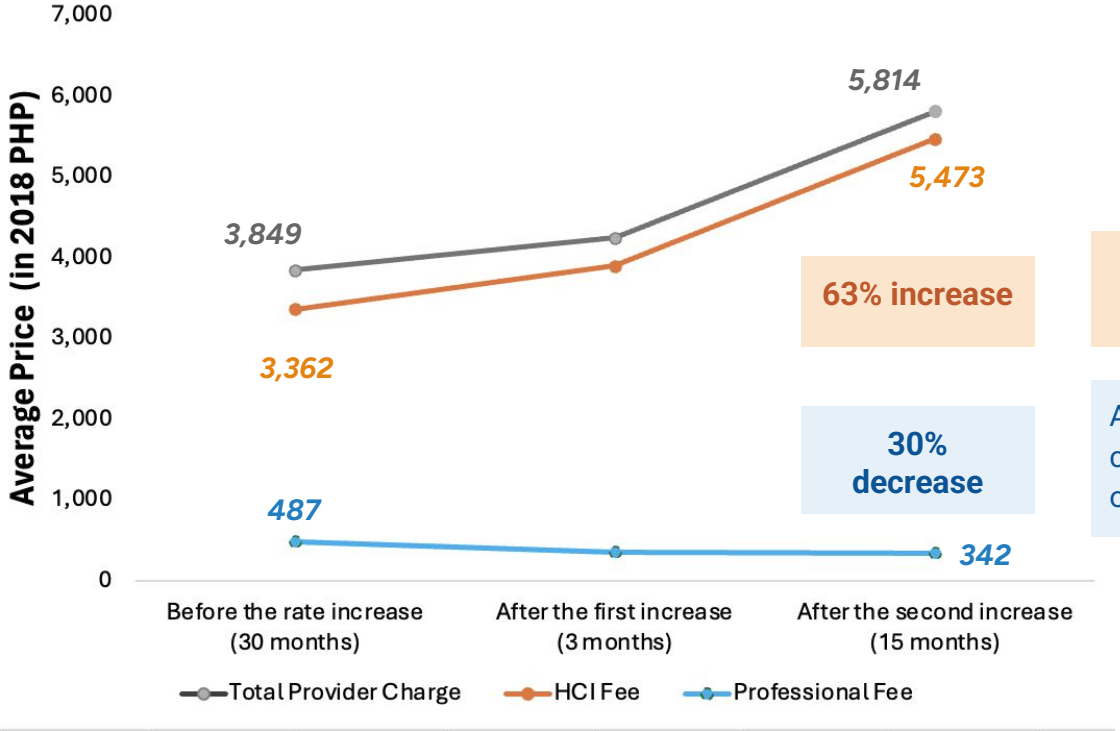
Based on preliminary analysis, as of September 16, 2026

Average charges were stable before the benefit expansion, while the period after the increases was associated with higher declared charges



Note: ITS Analysis only includes 315 facilities with complete monthly submissions

The observed increase in declared charges was driven by healthcare institution (HCI) fees

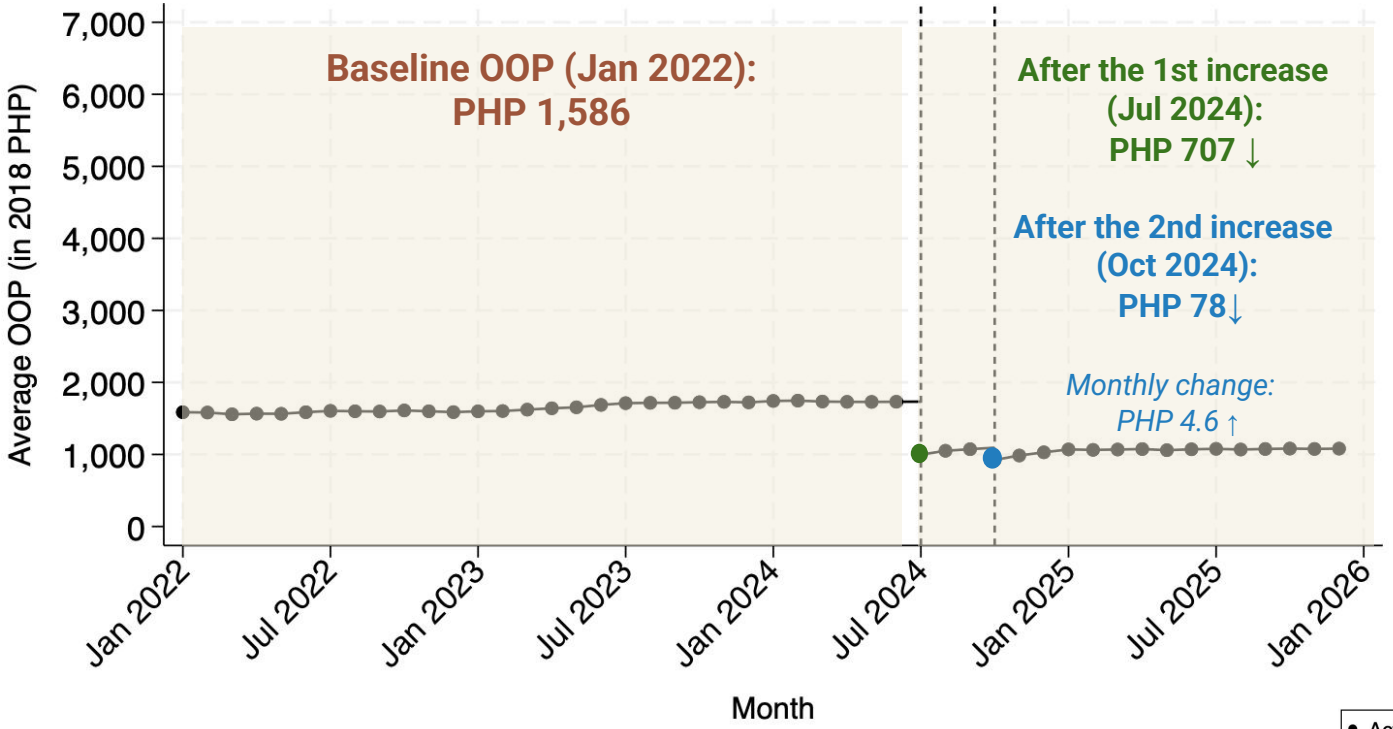


In real terms, average facility fees increased by 63%

Average PF decline is consistent with the cap on maximum allowable co-payment of PHP 450 (October 2024 issuance)

Note: ITS Analysis only includes 315 facilities with complete monthly submissions

Average OOP fell significantly during the period of the first increase, with a smaller, non-significant reduction following the second increase in benefit payouts



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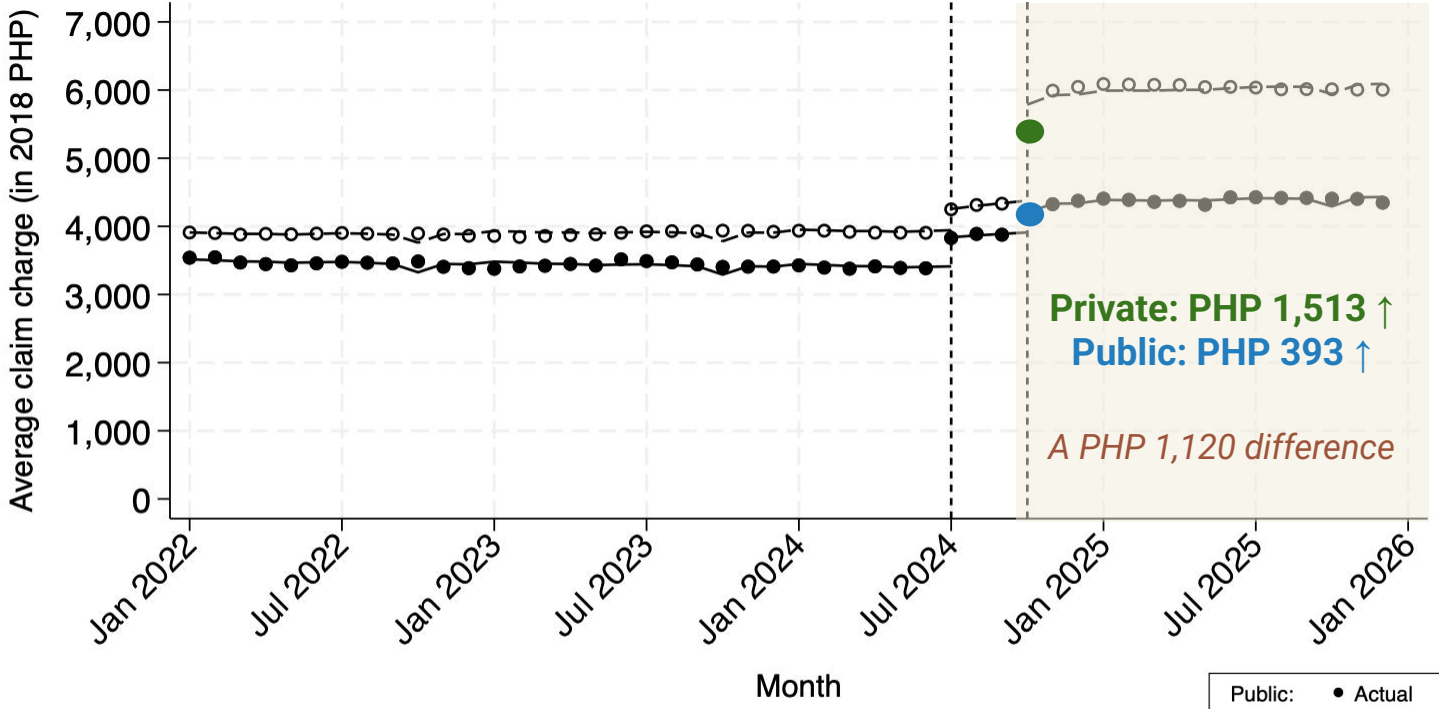
By provider ownership, the trends were similar but private providers recorded a larger increase in average charges after October 2024



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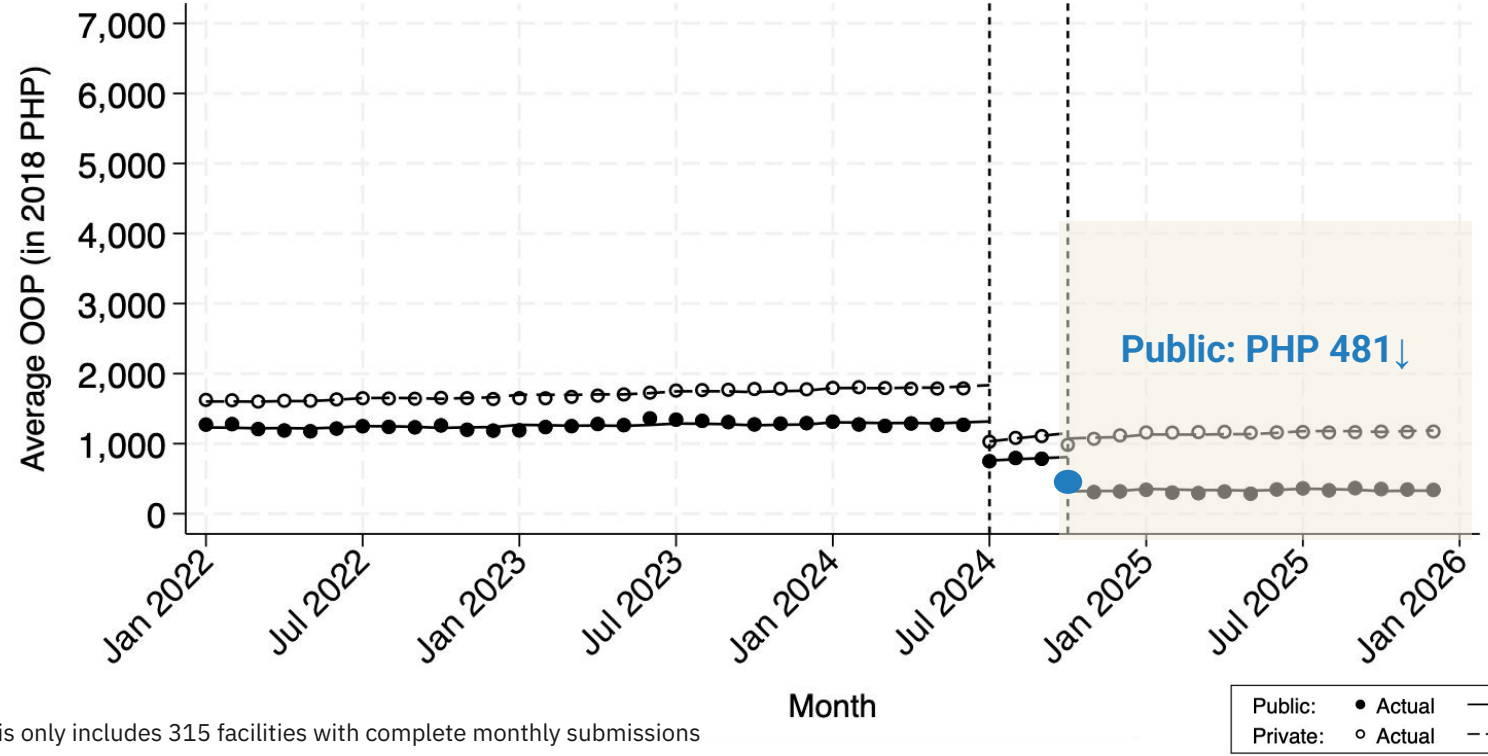
Average OOP among private providers did not significantly decline after the second increase (October 2024)



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What are the observed changes in provider declared charges and OOP before and after the expansion of hemodialysis benefit payout?

1. HD charges before and after the benefit expansion varied, despite being considered a low-variation treatment
2. The increases in benefit payout for HD were accompanied by rapid expansion of FDCs from 2022 to 2025
3. Reform periods were associated with financial risk protection gains (e.g., increase in zero-OOP and reductions in OOP spending)
4. The increase in declared charges coincided with the reimbursement rate reforms, driven largely by healthcare institution fees
5. FRP gains gradually declined over time after the second increase

How can we sustain gains in financial protection?

Negotiate with and monitor provider response

PhilHealth can negotiate prices, monitor provider behavior, and strengthen compliance with FRP efforts

Institutionalize evidence generation

Analysis can be replicated for other benefit expansions to gain inputs for benefit design

Integrate strategic purchasing

Reimbursement increases alone are unlikely to sustain gains without policies that contain prices

Future studies can explore influence of other factors (e.g., provider concentration) and how reimbursement reforms can be linked to incentives that can improve quality of care

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Maraming Salamat!

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