Republic of the Philippines
Congress of the Philippines
Metro Manila

Third Regular Session

Begun and held in Metro Manila, on Monday the twenty-fifth day of July nineteen hundred and ninety-four.

[REPUBLIC ACT NO. 7875]

AN ACT INSTITUTING A NATIONAL HEALTH INSURANCE PROGRAM FOR ALL FILIPINOS AND ESTABLISHING THE PHILIPPINE HEALTH INSURANCE CORPORATION FOR THE PURPOSE

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled:

SECTION 1. *Short Title.* — This Act shall be known as the "National Health Insurance Act of 1995"

Article I. GUIDING PRINCIPLES

SEC. 2. *Declaration of Principles and Policies.*— Section 11, Article XIII of the 1987 Constitution of the Republic of the Philippines declares that the State shall not adopt an integrated and comprehensive approach to health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.

In the pursuit of a National Health Insurance Program, this Act shall adopt the following guiding principles:

a) *Allocation of National Resources for Health* — The Program shall underscore the importance for government to give priority to health as a strategy for bringing about faster, economic, development and improving quality of life.

b) *Universality* — The Program shall provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs. The National Health Insurance Program shall give the highest priority to

achieving coverage of the entire population with at least a basic minimum package of health insurance benefits;

c) *Equity* — The Program shall provide for uniform basic benefits. Access to care must be a function of a person's health needs rather than his ability to pay;

d) *Responsiveness* — The Program shall adequately meet the needs for personal health services at various stages of a member's life;

e) *Social Solidarity* — The Program shall be guided by community spirit. It must enhance risk sharing among income groups, age groups, and persons of differing health status, and residing in different geographic areas;

f) *Effectiveness* — The Program shall balance economical use of resources with quality of care;

g) Innovation — The Program shall adapt to changes in medical technology, health service organizations, health care provider payment systems, scopes of professional practice, and other trends in the health sector. It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations;

h) *Devolution* — The Program shall be implemented in consultation with local government units (LGUs), subject to the overall policy directions set by the National Government;

i) *Fiduciary Responsibility* — The Program shall provide effective stewardship, funds management, and maintenance of reserves;

j) *Informal Choice* — The Program shall encourage members to choose from among accredited health care providers. The Corporation's local offices shall objectively apprise its members of the full range of providers involved in the Program and of the services and privileges to which they are entitled as members. This explanation, which the members may use as a guide in selecting the appropriate and most suitable provider, shall be given in clear and simple Filipino and in the local languages that is comprehensible to the member;

k) *Maximum Community Participation* — The Program shall build on existing community initiatives for its organization and human resource requirements;

l) *Compulsory Coverage* — All citizens of the Philippines shall be required to enroll in the National Health Insurance Program in order to avoid adverse selection and social inequity;

m) *Cost Sharing* — The Program shall continuously evaluate its cost sharing schedule to ensure that costs borne by the members are fair and equitable and that the charges, by health care providers are reasonable;

n) Pr*ofessional Responsibility of Health Care Providers — The* program shall assure that all participating health care providers are responsible and accountable in all their dealings with the Corporation and its members;

o) *Public Health Services* — The Government shall be responsible providing public health 'services for all groups such as women, children, indigenous' people,' displaced communities and communities in environmentally endangered areas, while the Program shall focus on the provision of personal health services. Preventive and promotive public health services are essential' for reducing the need and spending for personal health services;

p) *Quality of Services* — The Program shall promote the improvement in the quality of health services provided through the institutionalization of programs of quality assurance at all levels of the health service delivery system. The satisfaction of the community, as well as individual beneficiaries, shall be a determinant of the quality of service delivery;

q) *Cost Containment* — The program shall incorporate features of cost containment in its design and operations and provide a viable means of helping the people pay for health care services; and

r) *Care for the Indigent* — The Government shall be responsible providing a basic package of needed personal health services to indigents through premium subsidy, or through direct service provision until such time that the program is fully implemented.

SEC.3. *General Objectives.* — This Act seeks to:

a) provide all citizens of the Philippines with the mechanism to gain financial access to health services;

b) create the National Health Insurance Program, hereinafter referred to as the Program, to serve as the means to help the people pay for health care services;

c) prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford such services; and

d) establish the Philippine Health Insurance Corporation, hereinafter referred to as the Corporation, that will administer the Program at central and local levels.

Article II. DEFINITION OF TERMS

SEC. *4. Definition of Terms.* — For the purpose of this Act, the following terms shall be defined as follows:

a) *Beneficiary* - Any person entitled to health care benefits under this Act.

b) *Benefit Package* - Services that the Program offers to its members.

c) *Capitation* - *A* payment mechanism where a faxed rate, whether per person, family, household, or group, is negotiated with a health care provider who shall be responsible for delivering or arranging for the delivery of health services required, by the covered person under the conditions of a health care provider contract.

d) *Contribution* - The amount paid by or in behalf of a member to the Program for coverage, based on salaries or wages in the case of formal sector employees, and on household earnings and assets, in the case of the self-employed, or on other criteria as may be defined by the Corporation in accordance with the guiding principles set forth in Article I of this Act.

e) *Coverage* - The entitlement of an individual, as a member or as a dependent, to the benefits of the Program.

f) *Dependent* - *The* legal dependents of a member are: 1) the legitimate spouse who is not a member; 2) the unmarried and unemployed legitimate, legitimated, illegitimate, acknowledged children as appearing in the birth certificate; legally adopted or stepchildren below twenty-one (21) years of age; 3) children who are twenty-one (21) years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support; 4) the parents who are sixty (60) years old or above whose monthly income is below an amount to be determined by the Corporation in accordance with the guiding principles set forth in Article I of this Act.

g) *Diagnostic Procedure* - *Any* procedure to identify a disease or condition through analysis and examination.

h) *Emergency* - An unforeseen combination of circumstances which calls for immediate action to preserve the life of a person or to preserve the sight of one or both eyes; the hearing of one or both ears; or one or two limbs at or above the ankle or wrist.

i) *Employee* - Any person who performs services for an employer in which either or both mental and physical efforts are used and who receives compensation for such services, where there is an employer-employee relationship.

j) *Employer* - A natural or juridical person who employs the services of an employee.

k) *Enrollment* - The process to be determined by the Corporation in order to enlist individuals as members or dependents covered b$_l$the Program.

l) *Fee for Service* - A reasonable and equitable health care payment system under which physicians and other health care providers receive a payment that does not exceed their billed charge for each unit of service provided.

m) *Global Budget* - *An* approach to the purchase of medical services by which health care provider negotiations concerning the costs of providing a specific package of medical benefits is based solely on a predetermined and fixed budget.

n) *Government Service Insurance System* - The Government Service Insurance System created under Commonwealth Act No. 186, as amended.

o) *Health Care Provider* - Refers to;

1) a health care institution, which is duly licensed and accredited devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment, and care of individuals suffering from illness, disease, injury, disability, or deformity, or in need of obstetrical other medical and nursing care. It shall also be construed as any institution, building, or place where there are installed beds, cribs, or bassinets for twenty-four hour use or longer by patients in the treatment of diseases, injuries, deformities, or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries, and such other similar names by which they may be designated; or

2) a health care professional, who is any doctor of medicine. nurse, midwife, dentist, or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation; or

3) a health maintenance organization, which is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium; or

4) a community-based health care organization, which is an association of indigenous members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services.

p) *Health Insurance Identification (ID) Card* - The document issued by the Corporation to members and dependents upon their enrollment to serve as the instrument for proper identification, eligibility verification, and utilization recording;

q) *Indigent* - A person who has no visible means of income, or whose income is insufficient for the subsistence of his family, as identified by the Local Health Insurance Office and based on specific criteria set by the Corporation in accordance with the guiding principles set forth in Article I of this Act;

r) *Inpatient Education Package* - A set of informational services made available to an individual who is confined in a hospital to afford him with knowledge about his illness and its treatment, and of the means available, particularly lifestyle changes, to prevent the recurrence or aggravation of such illness and to promote his health in general.

s) *Member*- Any person whose premiums have been regularly paid to the National Health Insurance Program. He may be a paying member, an indigent member, or a pensioner/retiree member.

t) *Means Test* - A protocol administered at the barangay level to determine the ability of individuals or households to pay varying levels of contributions to the Program, ranging from the indigent in the community whose contributions should be totally subsidized by government, to those who can afford to subsidize part but not all the required contributions for the Program.

u) *Medicare* - The health insurance program currently being implemented by the Philippine Medical Care Commission. It consists of:

1) Program I, which covers members of the SSS and GSIS including their legal dependents; and

2) Program II, which is intended for those not covered under Program I.

v) *National Health Insurance Program* - The compulsory health insurance program of the government as established in this Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.

w) *Pensioner* - An SSS or GSIS member who receives pensions therefrom.

x) *Personal Health Services*- Health services in which benefits accrue to the individual person. These are categorized into inpatient and outpatient

y) *Philippine Medical Care Commission* - The Philippine Medicare Commission created under Republic Act No. 6111, as amended.

z) *Philippine National Drug Formulary* - The essential drugs list for the Philippines which is prepared by the National Drug Committee of the Department of health in consultation with experts and specialists from organized professional medical societies, medical academe and the pharmaceutical industry, and which is updated every year.

aa) *Portability* - The enablement of a member to avail of Program benefits in an area outside the jurisdiction of his Local Health Insurance Office

bb) *Prescription* Drug-A drug which has been approved by the Bureau of Food and Drug and which can be dispensed only pursuant to a prescription order from a physician who is duly licensed to do so.

cc) *Public Health Services* - Services that strengthen preventive and promotive health care through improving conditions in partnership with community at large. These include control of communicable and non-communicable diseases, health promotion, public information and education, water and sanitation, environmental protection and health-related data collection, surveillance, and outcome monitoring.

dd) *Quality Assurance* - A formal set of activities to review and ensure the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

ee) *Residence* - The place where the member actually lives.

ff) *Retiree* - A member of the Program who has reached the age of retirement or who was retired on account of disability.

gg) *Self-employed* - a person who works for himself and is therefore both employee and employer at the same time.

hh) *Social Security System* - The Social Security System created under Republic Act No. 1161, as amended.

ii) *Treatment Procedure* - Any method used to remove the symptoms and cause of a disease.

jj) *Utilization Review* - A formal review of patient utilization or of the appropriateness of health care services, on a prospective, concurrent or retrospective basis.

Article III.
THE NATIONAL HEALTH INSURANCE PROGRAM

SEC. 5. *Establishment and Purpose.* — There is hereby created the National Health Insurance Program which shall provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines, in accordance with the policies and specific provisions of this Act. This social insurance programs shall serve as the means for the healthy to help pay for the care of the sick and for those who can afford medical care to subsidize those who cannot. It shall initially consist of Programs I and II of Medicare and be expanded progressively to

constitute one universal health insurance program for the entire population. The Program shall include a sustainable system of funds constitution, collection, management and disbursement for financing the availment of a basic minimum package and other supplementary packages of health insurance benefits by a progressively expanding proportion of the population. The Program shall be limited to paying for the utilization of health services by covered beneficiaries or to purchasing health services in behalf of such beneficiaries. It shall be prohibited from providing health care directly, from buying and dispensing drugs and pharmaceuticals, from employing physicians and other professionals for the purpose of directly rendering care, and from owning or investing in health care facilities.

SEC. 6. *Coverage* — All citizens of the Philippines shall be covered by the National Health Insurance Program. In accordance with the principles of universality and compulsory coverage enunciated in Section 2 (b) and 2 (1) hereof, implementation of the Program shall, furthermore, be gradual and phased in over a period of not more than fifteen (15) years: *Provided,* That the Program shall not be made compulsory in certain provinces and cities until the Corporation shall be able to ensure that members in such localities shall have reasonable access to adequate and acceptable health care services.

SEC. 7. *Enrollment.* — The Program shall enroll beneficiaries in order for them to be placed under coverage that entitles them to avail of benefits with the assistance of the financial arrangements provided by the Program. The process of enrollment shall include the identification of beneficiaries, issuance of appropriate documentation specifying eligibility to benefits, and indicating how membership was obtained or is being maintained. The enrollment shall proceed in accordance with these specific policies:

a) all persons currently eligible for benefits under Medicare Program I, including 558 and GSLS members, retirees, pensioners and their dependents, shall immediately and automatically be made members of the National Health Insurance Program;

b) all persons eligible for benefits through health insurance plans established by local governments as part of Program II of Medicare or in accordance with the provisions of this Act, including indigent members, shall also be enrolled in the Program.

c) all persons eligible for benefits as members of local health insurance plans established by the Corporation in accordance with the implementing rules and regulations of this Act shall also be deemed to have enrolled in the Program. Enrollment of persons who have no current health insurance coverage shall be given priority by the corporation; and

d) all persons eligible for benefits as members of other government initiated health insurance programs, community-based health care organizations, cooperatives, or private non-profit health insurance plans shall be enrolled in the Program upon accreditation by the Corporation which shall devise and provide incentives to ensure that such accredited organizations will benefit from their participation in the program.

All indigents not enrolled in the Program shall have priority in the use and availment of the services and facilities of government hospitals, health care personnel, and other health organizations: *Provided, however,* That such government health care providers shall ensure that said indigents shall subsequently be enrolled in the Program.

SEC. 8. *Health lnsurance lD Card* — In conjunction with the enrollment provided above, the Corporation through its local office shall issue a health insurance ID which shall be used for purposes of identification, eligibility verification, and utilization recording. The issuance of this ID card shall be accompanied by a dear explanation to the enrollee of his rights, privileges and obligations as a member. A list of health care providers accredited by the Local Health Insurance Office shall likewise be attached thereto.

SEC. 9. *Change of Residence* — A citizen can be under only one Local Health Insurance Office which shall be located in the province or city of his place of residence. A person who changes residence, becomes temporarily employed, or for other justifiable reasons, is transferred to another locality should inform said Office of such transfer and subsequently transfer his Program membership.

SEC. 10. *Benefit Package.* — Subject to the limitations specified in this Act and as may be determined by the Corporation, the following categories of personal health services granted to the member or his dependents as medically necessary or appropriate shall include:

a) Inpatient hospital care:

1) room and board;.
2) services of health care professionals,
3) diagnostic, laboratory, and other medical examination. services;
4) use of surgical or medical equipment and facilities;
5) prescription drugs and biologicals, subject to the limitations stated in Section 37 of this Act;
6) inpatient education packages;

b) Outpatient care:

1) services of health care professionals;
2) diagnostic, laboratory, and other medical examination services;
3) personal preventive services; and
4) prescription drugs and biologicals, subject to the limitations described in Section 37 of this Act,

c) Emergency and transfer services; and

d) Such other health care services that the Corporation shall determine to be appropriate and cost-effective: *Provided,* That the Program, during its initial phase of implementation, which shall not be more than five (5) years, shall provide a basic minimum package of benefits which shall be defined according to the following guidelines:

1) the cost of providing said package is such that the available national and local government subsidies for premium payments of indigents are sufficient to extend coverage to the widest possible population.

2) the initial set of services shall not be less than half of those provided under the current Medicare Program I in terms of overall average cost of claims paid, per, beneficiary household per year.

3) the services included are prioritized, first according to its cost-effectiveness and, second, according to its potential of providing maximum relief from the financial' burden on the beneficiary: *Provided;* That in addition to the basic minimum package, the Program shall provide supplemental health benefit coverage to beneficiaries of contributory funds, taking into consideration the availability of funds for the purpose from said contributory funds: *Provided further,* That the Program shall progressively expand the basic minimum benefit package as the proportion of the population covered reaches targetted milestones so that the same benefits are extended to all members of the Program within five (5) years after implementation of this Act. Such expansion will provide for the gradual incorporation of supplementary health benefits previously extended only to some beneficiaries into the basic minimum package extended to all beneficiaries: and *Provided; finally,* that in the phased implementation of this Act, there 'should be no reduction or interruption in the benefits currently enjoyed by present members of Medicare.

SEC. 11. *Excluded Personal Health Services.* — The benefits granted under this Act shall not cover expenses for the services enumerated hereunder except when the' Corporation, after actuarial studies, recommend their inclusion subject to the approval of the Board:

a) non-prescription drugs and devices;
b) outpatient psychotherapy and counselling for mental disorders;
c) drug and alcohol abuse or dependency treatment;
d) cosmetic surgery;
e) home and rehabilitation services;
f) optometric services; and
g) normal obstetrical delivery;
h) cost-ineffective procedures which shall be defined by the Corporation.

SEC. 12. *Entitlement to Benefits* — A member whose premium contributions for at least three (3) months have been paid within the six (6) months prior to the first day of his or his dependents' availment, shall be entitled to the benefits of' the Program:

Provided, That such member can show that he contributes thereto with sufficient regularity, as evidenced in their health insurance ID card: and *Provided further,* That he is not currently subject to legal penalties as provided for in Section 44 of this Act.

The following need not pay the monthly contributions to be entitled to the Program's benefits:

a) Retirees and pensioners of the 555 and GSIS prior to the effectivity of this Act,

b) Members who reach the age of retirement as provided for by law and have paid at least one hundred twenty (120) monthly contributions; and

c*)* Enrolled indigents.

SEC. 13. *Portability of Benefits.* — The Corporation shall develop and enforce mechanisms and procedures to assure that benefits are portable across Offices.

Article IV.
THE PHILIPPINE HEALTH INSURANCE CORPORATION

SEC. 14. *Creation and Nature of the Corporation.* — There is hereby created a Philippine Health Insurance Corporation, which shall have the status of a tax-exempt government corporation attached to the Department of Health for policy coordination and guidance.

SEC. 15. *Exemptions from Taxes and Duties.* — The Corporation shall be exempt from the payment of taxes on all contributions thereto and all accruals on its income or investment earnings.

Any donation, contribution, bequest, subsidy or financial aid which may be made to the Corporation shall constitute as allowable deduction from the income of the donor for income tax purposes and shall be exempt from donor's tax, subject to such conditions as provided in the National Internal Revenue Code, as amended.

SEC. 16. *Powers and Functions.* — The Corporation shall have the following powers and functions:

a) to administer the National Health Insurance Program;

b) to formulate and promulgate policies for the sound administration of the Program;

c) to set standards, rules, and regulations necessary to ensure quality of care, appropriate utilization of services, fund viability, member satisfaction, and overall accomplishment of Program objectives;

d) to formulate and implement guidelines on contributions and benefits; portability of benefits, cost containment and quality assurance, and health care provider arrangements, payment methods, and referral systems;

e) to establish branch offices as mandated in Article V of this Act,

f) to receive and manage grants, donations, and other forms of assistance;

g) to sue and be sued in court,

h) to acquire property; real and personal, which may be necessary or expedient for the attainment of he purposes of this Act,

i) to collect, deposit, invest, administer, and disburse the National Health Insurance Fund in accordance with the provisions of this Act,

j) to negotiate and enter into contracts with health care institution professionals, and other persons, juridical or natural, regarding the price payment mechanisms, design and implementation of administrative and operating systems and procedures, financing, and delivery of health services;

k) to authorize Local Health Insurance Offices to negotiate and enter into contracts in the name and on behalf of the Corporation with any accredited government or private sector health provider organization, including but not limited to health maintenance organizations, cooperatives and medical foundations, for the provision of at least the minimum package of personal health services prescribed by the Corporation;

l) to determine requirements and issue guidelines for the accreditation of health care providers for the Program in accordance with this Act,

m) to supervise the provision of health benefits with the power to inspect medical and financial records of health care providers and patients who are participants in or members of the Program, and the power to enter and inspect accredited health care institutions, subject to the rules ~ regulations to be promulgated by the Corporation;

n) to organize its office, fix the compensation of and appoint person' nd as may be deemed necessary and upon the recommendation of the president of the Corporation;

o) to submit to the President of the Philippines and to both Houses of Congress its Annual Report which shall contain the status of the National Health Insurance Fund, its total disbursements, reserves, average costings to beneficiaries, any request for additional appropriation, and other data pertinent to the implementation of the Program and publish a synopsis of such report in two (2) newspapers of general circulation;

p) to keep records of the operations of the Corporation and investments of the National Health Insurance Fund; and

q) to perform such other acts as it may deem appropriate for the attainment of the objectives of the Corporation and for the proper enforcement of the provisions of this Act.

SEC. 17. *Quasi-Judicial Powers.* — The Corporation, to carry out its tasks more effectively, shall be vested with the following powers:

a) to conduct investigations for the determination of a question, controversy, complaint, or unresolved grievance brought to its attention, and render decisions, orders, or resolutions thereon. It shall proceed to hear and determine the case even in the absence of any party who has been properly served with notice to appear. It shall conduct its proceedings or any part thereof in public or in executive session; adjourn its hearings to any time and place; refer technical matters or accounts to an expert and to accept his reports as evidence; direct parties to be joined in or excluded from the proceedings; and give all such directions as it may deem necessary or expedient in the determination of the dispute before it,

b) to summon the parties to a controversy, issue *subpoenas* requiring the attendance and testimony of witnesses or the production of documents and other materials necessary to a just determination of the case under investigation;

c) to suspend temporarily, revoke permanently, or restore the accreditation of a health care provider or the right to benefits of a member and/or impose fines after due notice and hearing. The decision shall immediately be executory, even pending appeal, when the public interest so requires and as may be provided for in the implementing rules and regulations. Suspension of accreditation shall not exceed twenty-four (24) months. Suspension of the rights of members shall not exceed six (6) months.

The revocation of a health care provider's accreditation shall operate to disqualify him from obtaining another accreditation in his own name, under a different name, or through another person, whether natural or juridical.

The Corporation shall not be bound by the technical rules of evidence.

SEC. 18. *The Board of Directors.* —

a) *Composition* - The Corporation shall be governed by a Board of Directors hereinafter referred to as the Board, composed of eleven members as follows:

The Secretary of Health;

The Secretary of Labor and Employment or his representative;

The Secretary of the Interior and Local Government or his representative;

The Secretary of Social Welfare and Development or his representative;

The President of the Corporation;

A representative of the labor sector;

A representative of employers;

The SSS Administrator or his representative;

The GSIS General Manager or his representative;

A representative of the self-employed sector; and

A representative of health care providers.

The Secretary of Health shall be the ex *officio* Chairperson while the President of the Corporation shall be the Vice Chairperson of the Board.

b) *Appointment and Tenure* - The President of the Philippines shall appoint the Members of the Board upon the recommendation of the Chairman of the Board and in consultation with the sectors concerned. Members of the Board shall have a term of four (4) years each, renewable for a maximum of two (2) years, except for members whose terms shall be co-terminous with their respective positions in government. Any vacancy in the Board shall be filled in the manner in which thc original appointment was made and the appointee shall serve only the unexpired term of his predecessor.

c) *Meetings and Quorum* - The Board shall hold regular meetings least once a month. Special meetings may be convened at the call of the Chairperson or by a majority of the members of the Board. The presence of six (6) voting members shall constitute a quorum. In the absence of the Chairperson and Vice Chairperson, a temporary presiding officer shall be designated by the majority of the quorum.

d) *Allowances and Per Diems* - The members of the Board shall receive a *per diem,* for every meeting actually attended subject to the pertinent budgetary laws, rules and regulations on compensation, honoraria and allowance.

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SEC. 19. *The President of the Corporation. —*

a) *Appointment and Tenure* - The President of the Philippines shall appoint for a non-renewable term of six (6) years the President of the Corporation, hereinafter referred to as the President, upon the recommendation of the Board. The President shall not be removed from office except in accordance with existing laws.

b) *Duties and Functions* - The President shall have the duty of advising the Board and carrying into effect its policies and decisions. His functions are as follows:

1) to act as the chief executive officer of the Corporation; and

3) to be responsible for the general conduct of the operations and management functions of the Corporation and for other duties assigned to him by the Board.

c) *Qualifications* - The President must be a Filipino citizen and must possess adequate and appropriate training and at least (5) years experience in the field of health care financing and corporate management.

d) Salary - The President shall receive a salary to be fixed by the Board, with the approval of the President of the Philippines, payable from the funds of the Corporation.

e) *Prohibition-To* avoid conflict of interest, the President must not be involved in any health care institution as owner or member of its board.

SEC. 20. *Health Finance Policy Research.* — Among the staff departments that will be established by the Corporation shall be the Health Finance Policy Research Department, which shall have the following duties and functions:

a) development of broad conceptual framework for implementation of the Program through a national health finance master plan to ensure sustained investments in health care, and to provide guidance for additional appropriations from the National Government,

b) conduct of researches and studies toward the development of policies necessary to ensure the viability, adequacy and responsiveness of the Program;

c) review, evaluation, and assessment of the Program's impact on the access to, as well as the quality and cost of, health care in the country;

d) periodic review of fees, charges, compensation rates, capitation rates, medical standards, health outcomes and satisfaction of members, benefits, and other matters pertinent to the operations of the Program;

e) comparison in the delivery, quality, use, and cost of health care services of the different Offices;

f) submission for consideration of program of quality assurance, utilization review, and technology assessment, and

g) submission of recommendations on policy and operational issues that will help the Corporation meet the objectives of this Act.

SEC. 21. *Actuary of the Corporation.* — An Office of Actuary shall be created within the Corporation to conduct the necessary actuarial studies and present recommendations on insurance premium, investments and other related matters.

Article V. LOCAL HEALTH INSURANCE OFFICE

SEC. 22. *Establishment.* — The Corporation shall establish a Local Health Insurance Office, hereinafter referred to as the Office, in every province or chartered city, or wherever it is deemed practicable to bring its services closer to members of the Program. However, one office may serve the needs of more than one province or city when the merged operations will result in lower administrative cost and greater cross-subsidy between rich and poor localities.

Provinces and cities where prospective members are organized shall receive priority in the establishment of local health insurance offices.

SEC. 23. *Functions.* — Each Office shall have the following powers and functions:

a) to consult and coordinate, as needed, with the local government units within its jurisdiction in the implementation of the Program;

b) to recruit and register members of the Program from all areas within its jurisdiction;

c) to collect and receive premiums and other payment contributions to the Program;

d) to maintain and update the membership eligibility list at community levels;

e) to supervise the conduct of means testing which shall be based on the criteria set by the Corporation and undertaken by the Barangay Captain in coordination with the social welfare officer and community-based health care organizations to determine the economic status of all households and individuals, including those who are indigent,

f) to issue health insurance ID cards to persons whose premiums have been paid according to the requirements of the Office and the guidelines issued by the Board;

g) to recommend to the Board premium schedules that provide for lower rates to be paid by members whose dependents include those with reduced probability of utilization, as in fully immunized children;

h) to recommend to the Board a contribution schedule which specifies contribution levels by individuals and households, and a corresponding uniform package of personal health service benefits which is at least equal to the minimum package of such benefits prescribed by the Board as applying to the nation;

i) to grant or deny accreditation to health care providers in their area of jurisdiction, subject to the rules and regulations to be issued by the Board;

j) to process, review and pay the claims of providers, within a period not exceeding sixty (60) days whenever applicable in accordance with the rules and guidelines of the Corporation;

k) to pay fees, as necessary, for claims review and processing when such are conducted by the central office of the Corporation or by any of its contractors;

1) to establish referral systems and network arrangements with other Offices, as maybe necessary and following the guidelines set by the Corporation;

m) to establish mechanisms by which private and public sector health facilities and human resources may be shared in the interest of optimizing the use of health resources;

n) to support the management information system requirements of the Corporation;

o) to serve as the first level for appeals and grievance cases;

p) to tap community-based volunteer health workers and barangay officials, if necessary, for member recruitment, premium collection and similar activities, and to grant such workers incentives according to the guidelines set by the Corporation and in accordance with applicable laws. However, the incentives for the barangay officials shall accrue to the barangay and not to the said officials.

q) to participate in information and education activities that are consistent with the government's priority programs on disease prevention and health promotion; and

r) to prepare an annual report according to guidelines set by the Board and to submit the same to the central office of the Corporation.

Article VI. THE NATIONAL HEALTH INSURANCE FUND

SEC. 24. *Creation of the National Health Insurance Fund.* — There is hereby created a National Health Insurance Fund, hereinafter referred to as the Fund, that shall consist of:

a) Contribution from Program members;

b) Current balances of the Health Insurance Funds of the 555 and GSIS collected under the Philippine Medical Care Act of 1969, as amended, including arrearages of the Government of the Philippines with the GSIS for the said Fund;

c) other appropriations earmarked by the national and local governments purposely for the implementation of the Program;

d) Subsequent appropriations provided for under Sections 46 and 47 of this Act,

e) Donations and grants-in-aid; and

f) All accruals thereof.

SEC. 25. *Components of the National Health Insurance Fund.* — The National Health Insurance Fund shall have the following components:

a) *The Basic Benefit Fund.* This Fund shall finance the availment of the basic minimum benefit package by eligible beneficiaries. All liabilities associated with the extension of entitlement to the basic minimum benefit package to the enrolled population shall be borne by the basic benefit fund. It shall be constituted and maintained through the following process:

1) upon the determination of the amount of government subsidies and donations available for paying fully or partially the premium of indigenes beneficiaries, a bask minimum benefit package affordable for enrolling as. many of the indigent beneficiaries as possible shall be defined. The government subsidies will then be constituted as premium payments for enrolled indigents and contributed into the basic benefit fund.

2) for extending coverage of this same minimum benefit package to non-indigents who are not members of Medicare, premium prices for specific population shall be actuarially determined based on variations in risk, capacity to pay, and projected costs of services utilized. The amounts corresponding to the premium required, including costs of direct benefit payments, all costs of administration, and provision of adequate reserves, for extending the coverage of the basic minimum benefit package for such population groups shall be contributed into the basic benefit fund.

3) for the population enrolled through Medicare Program I under SSS, the corresponding premium for the basic minimum benefit package, including costs of direct benefit payments, all costs of administration, and provision of adequate reserves, shall be charged to the health insurance fund of the SSS and paid into the basic benefit fund.

4) for the population enrolled through Medicare Program I under GSIS, the corresponding premium for the basic minimum benefit package, including costs of direct benefit payments, all costs of administration, and provision of adequate reserves, shall be charged to the health insurance fund of the GSIS and paid into the basic benefit fund.

5) for groups enrolled through any of the existing or future health insurance schemes and plans, including those created under Medicare Program II and those organized by local government units, national agencies, cooperatives, and other similar organizations, the corresponding premium, including costs of direct benefit payments, all costs of administration, and provision of adequate reserves, for extending the basic minimum benefit package to their respective enrollees will be charged to their respective funds and paid into the basic benefit fund.

b) *Supplementary Benefit Fund.* These are separate and distinct supplementary benefit funds created by the Corporation as eligible for use to provide supplementary coverage to various groups of the population enjoying the basic benefit coverage as are affordable by their respective funding sources. Each supplementary benefit fund shall finance the extension and availment of additional benefits not included in the basic minimum benefit package but approved by the Board. Such supplementary benefits shall be financed by whatever amounts are available after deducting the costs of providing the basic minimum benefit package, including costs of direct benefit payments, all costs of administration, and provision of adequate reserves. All liabilities associated with the extension of supplementary benefits to the defined group of enrollees shall be borne exclusively by the respective supplementary benefit fund. Upon the implementation of this Act, the following supplementary benefit funds shall be established:

1) supplementary benefit fund for SSS-Medicare members and beneficiaries. After deducting the amount corresponding to the premium of the basic minimum benefit package, the balance of the SSS-Health Insurance Fund (HIF) shall be constituted into a supplementary benefit fund to finance the extension of benefits in addition to the minimum basic package to SSS members and beneficiaries; and

2) supplementary benefit fund for GSIS-Medicare members" and beneficiaries. After deducting the amount corresponding to the premium for the basic minimum benefit package, the balance of the GSIS-HIF plus the arrearages of the Government of the Philippines with the GSIS for the *said* HIF shall be constituted into a supplementary benefit fund to finance the extension of benefits in addition to the minimum basic package to GSIS members and beneficiaries.

In accordance with the principles of equity and social solidarity, as enunciated in Section 2 of this Act, the above supplementary benefit funds shall be maintained for not more than five (5) years, after which, such funds shall be merged into the basic benefit fund.

SEC. 26. *Financial Management.* — The use, disposition, investment, disbursement, administration and management of the National Health Insurance Fund, including any subsidy, grant or donation received program operations shall be governed by resolution of the Board of Directors of the Corporation, subject to the following limitations:

a) All funds under the management and control of the Corporation shall be subject to all rules and regulations applicable to public funds.

b) The Corporation is authorized to charge the various funds under its control for the costs of administering the Program. Such costs may include administration, monitoring, marketing and promotion, research and development, audit and evaluation, information services, and other necessary activities for the effective management of the Program. The total annual costs for these shall not exceed twelve percent (12%) of the total contributions, including government contributions to the Program and not more than three percent (3%) of the investment earnings collected during the immediately preceding year.

SEC. 27. *Reserve Fund.* — The Corporation shall set aside a portion of its accumulated revenues not needed to meet the cost of the current year expenditures as reserve funds: *Provided* That the total amount of reserves shall not exceed equivalent to the amount actuarially estimated for two years' projected Program expenditures: *Provided, ,further,* That whenever actual reserves exceed the required ceiling at the end of the Corporation's fiscal year, the Program's benefits shall be increased or member contributions decreased prospectively in order to adjust expenditures or revenues to meet the required ceiling for reserve funds. Such portions of the reserve fund as are not needed to meet the current expenditure obligations shall be invested in short-term investments to earn an average annual income at prevailing rates of interest and shall be known as the "Investment Reserve Fund" which shall be invested in any or all of the following.

a) In interest-bearing bonds, securities or other evidences of indebtedness of the Government of the Philippines, or in bonds, securities, promissory notes and other evidences of indebtedness to which full faith and credit and unconditional guarantee of the Republic of the Philippines is pledged;

b) In interest-bearing deposits and loans to or securities in any domestic bank doing business in the Philippines: *Provided,* That in the case of such deposits, this shall not exceed at any time the unimpaired capital and surplus or total private deposits of the depository bank, whichever is smaller: *Provided further,* That said bank shall first have been designated as a depository for this purpose by the Monetary Board of the *Bangko Sentral ng Pilipinas;* and

c) In preferred stocks of any solvent corporation or institution created or existing under the laws of the Philippines: *Provided,* That the issuing, assuming, or guaranteeing entity or its predecessor has paid regular dividends upon its preferred or guaranteed stocks for a period of at least three (3) years immediately preceding the date of investment in such preferred or guaranteed stocks: *Provided, further,* That if the stocks are guaranteed the amount of stocks so guaranteed is not in excess of fifty percent (50%) of the amount of the preferred common stocks as the case may be of the issuing corporations: *Provided, furthermore,* That if the corporation or institution has not paid dividends upon its preferred stocks, the corporation or institution has sufficient retained earnings to declare dividends for at least two (2) years on such preferred stocks and in

common stocks option or warrants to common stocks of any solvent corporation or institution created or existing under the laws of the Philippines in the stock exchange with proven track record of profitability and payment of dividends over the last three (3) years or in common stocks of a newly organized corporation about to be listed in the stock exchange: *Provided, finally,* That such duly organized corporations shall have been rated 'A', double 'A's or triple 'A's by authorized accredited domestic rating agencies or by the Corporation or in mutual funds including allied investments.

Article VII. FINANCING

SEC. 28. *Contributions.* — All members of the Program shall contribute to the Fund, in accordance with a reasonable, equitable and progressive contribution schedule to be determined by the Corporation on the basis of applicable actuarial studies and in accordance with the following guidelines.

a) Formal sector employees and current medicare members and their employers shall continue paying the same monthly contributions as provided for by law until such time that the Corporation shall have determined the contributions schedule mentioned herein: *Provided,* That their monthly contributions shall not exceed three percent (3%) of their respective monthly salaries.

b) Contributions from self-employed members shall be based primarily on household earnings and assets; their total contributions for one year shall not, however, exceed three percent (3%) of their estimated actual net income for the preceding year.

c) Contributions made in behalf of indigent members shall exceed the minimum contributions set for employed members.

SEC. 29. *Payment for lndigent Contributions.* — Contributions for indigent members shall be subsidized partially by the local government unit where the member resides. The Corporation shall provide counterpart financing equal to the LGU's subsidy for indigents: *Provided,* That in the case of fourth, fifth and sixth class LGU's, the National Government shall provide up to ninety percent (90%) of the subsidy for indigents for a period not exceeding five (5) years. The share of the LGUs shall be progressively increased until such time that its share becomes equal to that of the National Government.

Article VIII. HEALTH CARE PROVIDERS

SEC. 30. *Free Choice of Health Facility, Medical or Dental Practitioner.* — Beneficiaries requiring treatment or confinement shall be free to choose from accredited health care providers. Such choice shall, however, be subject to limitations based on the area of jurisdiction of the concerned Office and on the appropriateness of treatment in the facility chosen or the desired provider.,

SEC. 31. *Authority to Grant Accreditation.* — The Corporation shall have the authority to grant to health care providers accreditation which confers the privilege of participating in the Program.

SEC. 32. *Accreditation Eligibility.* — All health care providers, as enumerated in Sec. 4(o)hereof and operating for at least three (3) years may apply for accreditation.

SEC. 33. *Minimum Requirements for Accreditation.* — The minimum accreditation requirements for health care providers are as follows:

a) human resource, equipment and physical structure in conformity with the standards of the relevant facility, as determined by the Department of Health;

b) acceptance of formal program of quality assurance and utilization review.

c) acceptance of the payment mechanisms specified in the following section;

d) adoption of referral protocols and health resources sharing arrangements;

e) recognition of the rights of patients; and

f) acceptance of information system requirements and regular transfer of information.

SEC. 34. *Provider Payment Mechanisms.* — The following mechanisms for public and private providers shall be allowed in the Program:

a) Fee-for-service based on mechanisms established by the Corporation;

b) Capitation of health care professionals and facilities, or networks of the same including HMOs, medical cooperatives, and other legally formed health service groups;

c) A combination of both; and

d) Any or all of the above, subject to a global budget.

Each Office shall recommend the appropriate payment mechanism within its jurisdiction for approval by the Corporation. Special consideration shall be given to payment for services rendered by public and private health care providers serving remote or medically under served areas.

SEC. 35. *Fee-for-service Payments and Payments in General.* — Fee-for-service payments may be made separately for professional fees and hospital charges, or both, based on arrangements with health care providers. This fee shall be based on a schedule to be established by the Board which shall be reviewed every three (3) years. Fees paid for professional services rendered by salaried public providers shall be allowed to be

retained by the health facility in which services are rendered and be pooled and distributed among health personnel. Charges paid to public facilities shall be allowed to be retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to defray operating costs other than salaries, to maintain or upgrade equipment, plant or facility, and to maintain or improve the quality of service in the public sector.

SEC. 36. *Capitation Payments.* — Capitation payments may be paid to public or private providers according to rates of capitation payments based on annual capitation rate guidelines to be issued by the Corporation.

SEC. 37. *Quality Assurance.* — Under the guidelines approved by the Corporation and in collaboration with their respective Offices, health care providers shall take part in programs of quality assurance, utilization review, and technology assessment that have the following objectives.

a) to ensure that the quality of personal health services delivered, measured in terms of inputs, process, and outcomes, are of reasonable quality in the context of the Philippines over time;

b) to ensure that the health care standards are uniform within the Office's jurisdiction and eventually throughout the nation; and

c) to see to it that the acquisition and use of scarce and expensive medical technologies and equipment are consistent with actual needs and standards of medical practice, and that:

1) the performance of medical procedures and the administration of drugs are appropriate, necessary and unquestionably consistent with accepted standards of medical practice and ethics. Drugs for which payments will be made shall be those included in the Philippine National Drug Formulary, unless explicit exception is granted by the Corporation.

2) the performance of medical procedures and the administration of drugs are appropriate, consistent with accepted standards of medical practice and ethics, and respectful of the local culture.

SEC. 38. *Safeguards Against Over and Under Utilization.* — It is incumbent upon the Corporation to set up a monitoring mechanism to be operationalized through a contract with health care providers to ensure that there are safeguards against:

a) over-utilization of services;

b) unnecessary diagnostic and therapeutic procedures and intervention;

c) irrational medication and prescriptions;

d) under-utilization of services; and

e) inappropriate referral practices.

The Corporation may deny or reduce the payment for claims when such claims are attended by false or incorrect information and when the claimant fails without justifiable cause to comply with the pertinent rules and regulations of this Act.

Article IX. GRIEVANCE AND APPEAL

SEC. 39. *Grievance System.* — A system of grievance is hereby established, wherein members, dependents, or health care providers of the Program who believe they have been aggrieved by any decision of the implementors of the Program, may seek, redress of the grievance in accordance with the provisions of this Article.

SEC. 40. *Grounds for Grievances.* —The following acts shall constitute valid grounds for grievance action:

a) any violation of the rights of patients;

b) a will full neglect of duties of Program implementers that results in the loss or non-enjoyment of benefits by members of their dependents;

c) unjustifiable delay in actions on claims;

d) delay in the processing of claims That extends beyond the period greed upon; and

e) any other act or neglect that tends to undermine or defeat the purposes of this Act.

SEC. 41. *Grievance and Appeal Procedures.* — A member, his dependent, or a health care provider may file a complaint for grievance based on any of the above grounds, in accordance with the following procedures;

a) A complaint for grievance must be filed with the Office which shall rule on the complaint within ninety (90) calendar days from receipt thereof.

b) Appeals from Office decisions must be filed with the Board within thirty (30) days from receipt of notice of dismissal or disallowance by the Office.

c) The Offices shall have no jurisdiction over any issue involving the suspension or revocation of accreditation, the imposition of fines, or the imposition of charges on members or their dependents in case of revocation of their entitlement.

d) All decisions by the Board as to entitlement to benefits of members or to payments of health care providers shall be considered final and executory.

SEC. 42. *Grievance and Appeal Review Committee.* — The Board shall create a Grievance and Appeal Review Committee, composed of three (3) to five (5) members, hereinafter referred to as the Committee, which, subject to the procedures enumerated above, shall receive and recommend appropriate action on complaints from members and health care providers relative to this Act and its implementing rules and regulations.

SEC. 43. *Hearing Procedures of the Committee.* — Upon the filing of the complaint, the Grievance and Appeal Review Committee, from a consideration of the allegations thereof, may dismiss the case outright due to lack of verification, failure to state the cause of action, or any other valid group for the dismissal of the complaint after consultation with the Board; or require the respondent to file a verified answer within five (5) days from service of summons.

Should the defendant fail to answer the complaint within the reglamentary five-day period herein provided, the Committee, *motu proprio* or upon motion of the complainant, shall render judgment as may be warranted by the facts alleged in the complaint and limited to what is prayed for therein. -

After an answers filed and the issues are joined, the Committee shall require the parties to submit, within ten (10) days from receipt of the order, the affidavits of witnesses and other evidence on the factual issues defined therein, together with a brief statement of their positions setting forth the law and the facts relied upon by them. In the event the Committee finds, upon consideration of the pleadings, the affidavits and other evidence, and position statements submitted by the parties, that a judgment may be rendered thereon without need of a formal hearing, it may proceed render judgment not later than ten (10) days from the submission of the position statements' of the parties.

In cases where the Committee deems it necessary to hold a hearing to clarifying specific factual matters before rendering judgment, it shall set the case for hearing for the purpose. At such hearing, witnesses whose affidavits were previously submitted may be asked clarificatory questions by the proponent and by the Committee and may be cross-examined by the adverse party. The order setting the case for hearing shall specify the witnesses who will be called to testify, and the matters on which their examination will deal. The hearing shall be terminated within fifteen (15) days, and the case decided by the Committee within fifteen (15) days from such termination.

The decision of the Committee shall become final and executory fifteen (15) days after notice thereof: *Provided, however* That it is appealable to the Board by filing the appellant's memorandum of appeal within fifteen (15) days from receipt of the copy of the judgment appealed from. The appellees shall be given fifteen (15) days from notice to file the appellee's memorandum after which the Board shall decide the appeal within thirty (30) days from the submittal of the said pleadings.

The decision of the Board shall also become final and executory fifteen (15) days after notice thereof: *Provided, however,* That it is reviewable by the Supreme Court on purely questions of law in accordance with the Rules of Court.

The Committee and the Board, in the exercise of their quasi-judicial function, as specified in Section 17 hereof, can administer oaths, certify to official acts and issue *subpoena* to compel the attendance and testimony of witnesses, and *subpoena duces tecum ad testificandum* to enjoin the production of books, papers and other records and to testify therein on any question arising out of this Act. Any case of contumacy shall be dealt with in accordance with the provisions of the Revised Administrative Code and the Rules of Court. The Board or the Committee, as the case may be, shall prescribe the necessary administrative sanctions such as fines, warnings, suspension or revocation of the right to participate in the Program.

In all its proceedings, the Committee and the Board shall not be bound by the technical rules of evidence: *Provided, however,* That the Rules of Court shall apply with suppletory effect.

Article X. PENALTIES

SEC. 44. *Penal Provisions.* — Any violation of the provisions of this Act, after due notice and hearing, shall suffer the following penalties:

A fine of not less than Ten thousand pesos (P10,000) nor more than Fifty thousand pesos (P50,000) in case the violation is committed by the hospital management or provider. In addition, its accreditation shall be suspended or revoked from three (3) months to the whole term of accreditation: *Provided, however;* That recidivists may not anymore be accredited as a participant of the Program;

A fine of not less than Five hundred pesos (P500) nor more than Five thousand pesos (P5,000) and imprisonment of not less than six (6) months nor more than one (1) year in case the violation is committed by the member.

Where the violations consist of failure or refusal to deduct contributions from the employee's compensation or to remit the same to the Corporation, the penalty shall be a fine of not less than Five hundred pesos (P500) but not more than One thousand pesos (P 1,000) multiplied by the total number of employees employed by the firm and imprisonment of not less than six (6) months but not more than one (1) year: *Provided further* That in the case of self-employed members, failure to remit one's own contribution shall be penalized with a fine of not less than five hundred pesos (P500) but not more than One thousand pesos (P1000).

Any employer or any officer authorized to collect contributions under this Act who, after collecting or deducting the monthly contributions from his employees' compensation, fails to remit the said contributions to the Corporation within thirty (30) days from the date they become due shall be presumed to have misappropriated such

contributions and shall suffer the penalties provided for in Article 315 of the Revised Penal Code.

Any employer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them his own contribution. on behalf of such employees shall be punished by a fine not exceeding One thousand pesos (P1,000) multiplied by the total number of employees employed by the firm, or imprisonment not exceeding one (1) year, or both fine and imprisonment, at the discretion of the Court.

If the act or omission penalized by this Act be committed by an association, partnership, corporation or any other institution, its managing directors or partners or president or general manager, or other persons responsible for the commission of the said act shall be liable for the penalties provided for in this Act and other laws for the offense.

Any employee of the Corporation who receives or keeps funds or property belonging, payable or deliverable to the Corporation, and who shall appropriate the same, or shall take or misappropriate or shall consent or through abandonment or negligence shall permit any other person take such property or funds wholly or partially, shall likewise be liable for misappropriation of funds or property and shall suffer imprisonment of not less than six (6) years and not more than twelve (12) years and a fine of not less than Ten thousand pesos (P10,000.00) nor more than Twenty thousand pesos (P20,000). Any shortage of the funds or loss of the property upon audit shall be deemed *prima facie* evidence of the offense.

All other violations involving funds of the Corporation shall be governed by the applicable provisions of the Revised Penal Code or other laws, taking into consideration the rules on collection, remittances, and investment of funds as may be promulgated by the Corporation.

Article XI. APPROPRIATIONS

SEC. 45. *Initial Appropriation.* — The unexpended portion of the budget of the Philippine Medical Care Commission (PMCC) for the year during which this Act was approved shall be utilized for establishing the Corporation and initiating its operations, including the formulation of the rules and regulations necessary for the implementation of this Act. In addition, initial funding shall come from any unappropriated but available fund of the Government.

SEC. 46. *Subsequent Appropriations.* — Starting 1995 and thereafter, twenty-five percent (25%) of the increment in total revenue collected under Republic Act No. 7654 shall be appropriated in the General Appropriations Act solely for the National Health Insurance Fund.

In addition, starting 1996 and thereafter, twenty-five percent (25%) of the incremental revenue from the increase in the documentary stamp taxes under Republic Act No. 7660 shall likewise be appropriated solely for the said fund.

SEC. 47. *Additional Appropriations.* — The Corporation may Request Congress to appropriate supplemental funding to meet targetted milestones of the Program in accordance with Section 10(d) of this Act.

Article XII. TRANSITORY PROVISIONS

SEC. 48. *Appointment of Board Members.* — Within thirty (30) days from the date of effectivity of this Act, the President of the Philippines shall appoint the members of the Board and the President of the Corporation.

SEC. 49. *Implementing Rules and Regulations.* — Within thirty (30) days from the completion of such appointments, the Board shall convene to formulate the rules and regulations necessary for the implementation of this Act.

SEC. 50. *Promulgation.* — Within one (1) year from its initial meeting, the Board shall promulgate the aforementioned rules and regulations in at least two (2) national newspapers of general circulation. But until such time that the Corporation shall have promulgated said rules and regulations the existing rules and regulations of the PMCC shall be followed. The present Medicare Program shall continue to be so administered, until the Corporation's Board deems the new system as ready for implementation in accordance with the provisions of this Act.

SEC. 51. *Merger.* — Within sixty (60) days from the promulgation of the implementing rules and regulations, all functions and assets of the Philippine Medical Care Commission shall be merged with those of the Corporation without need of conveyance, transfer or assignment. The PMCC shall thereafter cease to exist.

The liabilities of the PMCC shall be treated in accordance with existing laws and pertinent rules and regulations.

To the greatest extent possible and in accordance with existing laws, all employees of the PMCC shall be absorbed by the Corporation.

SEC. 52. *Transfer of Health Insurance Funds of the SSS and GSIS.* — The Health Insurance Funds being administered by the SSS and GSIS shall be transferred to the Corporation within sixty (60) days from the promulgation of the implementing rules and regulations. The SSS and GSIS shall, however, continue to perform Medicare functions under contract with Corporation until such time that such functions are assumed by the Corporation, in accordance with the following Section.

SEC. 53. *Transfer of the Medicare Functions of the SSS and* GSIS. — Within five (5) years from the promulgation of the implementing rules and regulations, the functions, assets, equipment, records, operating systems, and liabilities, if any, of the Medicare operations of the SSS and GSIS shall be transferred to the Corporation: *Provided, however;* That the SSS and GSIS shall continue performing its Medicare functions

beyond the stipulated five-year period if such extension will benefit Program members, as determined by the Corporation.

Personnel of the Medicare departments of the SSS and GSIS shall be given priority in the hiring of the Corporation's employees.

Article XIII. MISCELLANEOUS PROVISIONS

SEC. 54. *Oversight Provision.* — Congress shall conduct a regular review of the National Health Insurance Program which shall entail a systematic evaluation of the Program's performance, impact or accomplishments with respect to its objectives or goals. Such review shall be undertaken by the Committees of the Senate and the House of Representatives which have legislative jurisdiction over the Program.

SEC. 55. *Information Campaign.* — There shall be provided a substantial period of time to undertake an intensive public information campaign prior to the implementation of the rules and regulations of this Act.

SEC. 56. *Separability Clause.* — In the event any provision of this Act or the application of such provision to any person or circumstances is declared invalid, the remainder of this Act or the application of said provisions to other persons or circumstances shall not be affected by such declaration.

SEC. 57. *Repealing Clause.* — Executive Order 119, Presidential Decree 1519 and other laws currently applying to the administration of Medicare are hereby repealed. All other laws, executive orders, administrative rules and regulations or parts thereof which are inconsistent with the provisions of this Act are also hereby amended, modified, or repealed accordingly.

SEC. 58. *Government Guarantee.* — The Government of the Philippines guarantees the financial viability of the Program.

SEC. 59. *Effectivity.* — This Act shall take effect fifteen (15) days after its publication in at least three (3) national newspapers of general circulation.

Approved,

(Sgd.) JOSE DE VENECIA, JR.
Speaker of the House of Representatives

(Sgd.) EDUARDO J. ANGARA
President of the Senate

This Act, which is a consolidation of Senate Bill No. 1738 and House Bill No. 14225, was finally passed by the Senate and the House of Representatives on February 7, 1995.

(Sgd.) CAMILO L. SABIO
Secretary General
House of the Representatives

(Sgd.) EDGARDO E. TUMANGAN
Secretary of the Senate

Approved: Feb. 14, 1995

(Sgd.) FIDEL V. RAMOS
President of the Philippines

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

8/F Philippine Heart Center Medical Arts Building
East Avenue, Diliman, Quezon City

EXECUTIVE SUMMARY

FOR : HONORABLE MEMBERS OF THE CABINET CLUSTER C

FROM : PHILIPPINE HEALTH INSURANCE CORPORATION

RE : IMPLEMENTING RULES AND REGULATIONS OF THE NATIONAL HEALTH INSURANCE ACT OF 1995

DATE : 30 APRIL 1996

ACTION REQUESTED: ENDORSEMENT TO PRESIDENT FIDEL V. RAMOS FOR EXECUTIVE AND LEGISLATIVE ACTION

I. Backgrounder on the National Health Insurance Law

On February 14, 1995, President Fidel V. Ramos signed into law RA 7875, otherwise known as the National Health Insurance Act (NHI) of 1995. A major piece of social legislation, the NHI Law promises to provide financial access to quality health care services though a social health insurance program.

The NHI law was enacted as an answer to the growing imperative to make more available and accessible quality, appropriate and adequate health care services at affordable and reasonable cost. Prior to the enactment of the NHI law, health care financing schemes in the country has proved wanting. The government's sole health care financing scheme, the Medicare Program catered only to the working population and has covered only 25M of the 69M Filipino population. In short, 44M Filipinos are not covered by social health insurance. Moreover, the indigent population, the most needy, financially and healthwise, were left to their own devises and lay most vulnerable.

The current health care financing profile of the country paints a picture of misallocation and misallocation of public and private funds: over the years, health expenditures has not substantially increased. Current health care financing schemes both in the public and the private sector likewise reveal a Filipino population growing more vulnerable to health contingencies.

As mandated by law, the PHIC has completed the drafting of the IRR of RA 7875 within the prescribed time frame. The PHIC now presents the attached IRR for endorsement to His Excellency Fidel V. Ramos for executive and legislative action.

II. Process of IRR Consultation

The IRR of the NHIP was drafted in constant consultation with the different sectors, stakeholders, government and private agencies and experts to ensure that it is faithful to the mandate of the law and reflects the concerns and interests of all involved sectors.

The TWGs

The 10 Technical Working Groups (TWGs) that drafted the IRR were composed of experts/resource persons from the DOH, the academe, professional associations, non-government organizations, the social security organizations and experts, and personnel from the Philippine Medical Care Commission. The draft IRR were subjected to a Nationwide Public Consultations. The consultations were held in Metro Manila, Dagupan City, Baguio City, Cebu City, Iloilo City, Davao City and Cagayan de Oro City. A total of 2,100 representative from the different sectors participated in the activity.

III. Highlights of the IRR of the NHIP

- No increase in Premium Contribution

The IRR adopts the existing premium contribution levels and contribution sharing schemes for all member groups.

For the indigency program, the National Government through the PHIC and the local government unit where the qualified indigent resides shall shoulder the premium contribution. The LGU share shall be determined by their capability to pay as determined by their classification.

- Improved Basic Benefit Package and Provisions for a Supplementary Benefit Package

a.) Basic Benefit Package – The Basic Benefit Package (BBP) for all member groups shall be equivalent to the current SSS Benefit Package levels. This means a 20% qualitative improvement in benefits for GSIS members.

b.) Supplemental Benefit Package – In addition to the BBP, the SSS and OWWA members shall enjoy a Supplemental Benefit Package equivalent to 50% of the BBP levels. The GSIS's availment of the SBP shall be subject to the availability of the Equalization Fund.

- Provisions for ensuring Universality

  Membership and contribution to the program is mandatory and compulsory.

  a.) Indigency Program and LGU partnership

The program shall target the poorest *25%* of the population, or an equivalent to 3.6 M indigent families over a period of five years. To this end, Local Health Insurance Offices shall be established in the areas where the indigency program shall be implemented.

b.) Expansion of coverage of Employed Sector

The NHIP shall expand the coverage of the employed sector, with special focus on the Overseas Contract Workers and the self -employed. The NHIP shall expand OCW enrollment from the current 200,000 to 2M members.

- Ensuring Quality of Health Care Delivery

  As a condition for accreditation under the program, health care providers are required to abide by the Quality Assurance Program and standards set by the PHIC. Accreditation may be denied or revoked and payment for claims may be denied payment upon violation of or failure to conform with the Quality Assurance program.

- Containing Cost of Health Services and Goods

  The IRR grants the PHIC Board the authority to institute Cost Containment Measures that will rationalize health care delivery and their cost, deter fraud against the Health Insurance Fund as well as drive down the incidence and recurrence of diseases through preventive and promotive measures. Initially, the IRR provides for the

  a.) Institution of In-patient Education Program, and

  b.) Price limits on medicines as a condition for reimbursement

- Improved Fraud Control and Quasi-Judicial Powers of the PHIC

  The IRR enhances the Quasi-Judicial powers of the PHIC to allow it to curb fraud against the system/program. The Rules of Procedure abbreviates the administrative procedures to allow expeditious disposition of cases. The IRR likewise provides for eventual centralization of administration of the current Medicare program now under the SSS, GSIS and the OWWA — under one administrative agency: PHIC. This shall make efficient the handling of the Health Insurance Fund due to economies of scale as well as do away the problems attendant to fragmented administration.

IV. STATUS OF PREPARATIONS FOR EARLY IMPLEMENTATION

To immediately implement the NHIP, the PHIC has undertaken the following:

- Finalized the Organizational Design and Staffing Pattern Plan that will allow the PHiC to undertake the early and effective implementation

- Finalized the Program Manual of Operations

- Finalized the Information System Plan to allow efficient and effective management of data and information between the Corporation and the LHIOs as well as with the SSS and the GSIS

- Analyzed and identified priority areas for implementation of the Indigent Program. 7 SRA areas will be prioritized for 1996. In 1997, there will be an additional 25 Areas.

V. CHALLENGES AND ACTION REQUESTED

- DBM
  a.) Immediate release of Employers Counterpart Contribution for the Medicare Program to the GSIS to allow the latter to build up the GSIS Health Insurance Fund
  b.) Immediate Action on the PHIC Corporate Budget and the PHIC Organizational Design and Staffing Pattern
  c.) Immediate Release of Funds specifically allocated by the RA 7875 for Indigent premium subsidy.
  d.) Yearly Programming/Allocation of Funds for the Program

- Oversight Committee on Devolution
  For the Oversight Committee on Devolution to address the issue of Devolution Funding difficulties and the LGU counterpart contribution to Indigent premium subsidy

- Congress
  a.) Enactment of a law establishing an Equalization Fund to allow the GSJS to increase Benefit Package levels for GSIS members as provided for in Sec. 25., GENERAL PROVISIONS, GAA 1996 (RA 8174)

  b.) Amendment of Sec. 32 of RA 7875 re 3 year in operation requirement (for Health Care Institutions as a condition for Accreditation under the NHIP. Certification of Amendment requested from His Excellency

- PIA
  a.) Assistance in the Information Dissemination/Campaign on the NHIP

- DECS/CHED
  a.) Inclusion of the NHIP in the curriculum

- National Computer Center
  a.) Approval of the PHIC Information System Plan

- Malacanang

a.) Amendment of Executive Order 195 s. 1994 to effect the transfer of administration of he OWWA Medicare Program to the PHIC

We are looking forward for a closer partnership with your office for the successful implementation of the NHIP. Thank you very much and more power.

(Sgd.) ATTY. JOSE A. FABIA
President, PHIC

MEMORANDUM

TO:	**The Chairman and Honorable Members of the Cabinet Cluster C**
FROM:	**Atty. Jose A. Fabia President and CEO Philippine Health Insurance Corporation**
RE:	**Implementing Rules and Regulations of RA 7875**
DATE:	**30 April 1996**
ACTION REQUESTED:	**Endorsement of IRR to President Fidel V. Ramos**

The *R.A. 7875: National Health Insurance Act of 1995* provides for the institution of a National Health Insurance Program and establishes the Philippine Health Insurance Corporation. It aims to provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.

After a series of nationwide consultations with the affected sectors and round table discussions with health care providers, beneficiaries and local government units, the PHIC Board approved the Implementing Rules and Regulations (IRR) of RA 7875 last 19 April 1996, as per PHIC Board Resolution No. 34, Series of 1996.

The LRR was presented to and provisionally approved by NEDA's Social Development Committee last 25 April 1996 for endorsement to Cabinet Cluster C. In view of this, may we respectfully request the honorable chairman and members of the Cabinet Cluster C to endorse the IRR of RA 7875 to President Fidel V. Ramos for implementation

Thank you.

SOCIAL DEVELOPMENT COMMITTEE
RESOLUTION NO.____
SERIES OF 1996

Approving the Implementing Rules and Regulations of RA 7875: National Health Insurance Act of 1995

WHEREAS, the *Philippine Constitution* declares that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost; and that priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall be recognized; and that it shall be the policy of the State to provide free medical care to paupers;

WHEREAS, *RA 7875* has been enacted in line with the declared policy of the state to provide adequate social services and improved quality of life for all, and for this purpose, the state shall adopt an integrated and comprehensive approach towards health development;

WHEREAS, the *Ten-year Public Investment Plan for the Health Sector (1994-2004)* identifies national health insurance as one of its public investment packages towards a national framework for universal insurance coverage; and

WHEREAS, the draft IRR on RA 7875 was formulated through the efforts of an inter-agency Technical Working Group, Task Force IRR, National Organizing Committee, national consultations of the affected sectors, and round-table discussions with health care providers, beneficiaries, and local government units;

WHEREAS, the IRR has been approved by the Philippine Health Insurance Board last 19 April 1996, as per PHIC Board Resolution No. 34, Series of 1996;

NOW, THEREFORE, BE IT RESOLVED AS IT IS HEREBY RESOLVED, by the Chairman and members of the NEDA Board's Social Development Committee (SDC) Cabinet Cluster C, to endorse the Implementing Rules and Regulations of RA 7875 to President Fidel V. Ramos for implementation.

HON. CIELITO F. HABITO, Jr.
Secretary for Socio-Economic Planning
Chairman, Social Development Committee
Cabinet Cluster C

HON. LINA B. LAIGO
Secretary
Department of Social
Welfare and Development

HON. ROBERT BARBERS
Secretary
Department of Interior and
Local Government

HON. JOSE BRILLANTES
Secretary
Department of Labor
and Employment

HON. CARMENCITA REODICA
Secretary
Department of Health

HON. RICARDO T. GLORIA
Secretary
Department of Education,
Culture and Sports

HON. SALVADOR ESCUDERO
Secretary
Department of Agriculture

HON. WILLIAM PADOLINA
Secretary
Department of Science
and Technology

HON. ERNESTO GARILAO
Secretary
Department of Agrarian Reform

HON. RUBEN TORRES
Secretary
Office of the Executive Secretary

MALACAÑANG

MANILA

BY THE PRESIDENT OF THE PHILIPPINES

ADMINISTRATIVE ORDER NO._____

DIRECTING PARTICIPATING NATIONAL GOVERNMENT AGENCIES AND LOCAL GOVERNMENT UNITS TO ENSURE THE SPEEDY IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE PROGRAM AND FOR OTHER PURPOSES

WHEREAS, the *Philippine Constitution* declares that the State Shall adopt an integrated and comprehensive approach to health development which shall endeavor to make sure essential goods, health and other social services available to all the people at affordable cost; and that priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall recognized; and that it shall be the policy of the State to provide free medical care to paupers;

WHEREAS, *RA 7875: The National Health Insurance Act of 1995* has been enacted in line with the declared policy of the State to provide adequate social services and improved quality of life for all, and for this purpose, the State shall adopt an integrated and comprehensive approach towards health development;

WHEREAS, the *Ten -Year Public Investment Plan for the Health Sector* (1994-2004) identifies national health insurance as one of its priority public investment packages toward a national framework for universal insurance coverage;

WHEREAS, the *Implementing Rules and Regulations of RA 7875* was formulated through the efforts of the inter-agency Technical Working Groups, National Organizing Committee, Task Force IRR, national consultations of the affected sectors, and round table discussions with care providers, beneficiaries, and local government units;

WHEREAS, the IRR has been approved by the Board of Directors of the Philippine Health Insurance Corporation last 19 April 1996, as per PHIC Board Resolution No.34, series of 1996, and has been endorsed by Cabinet Cluster C to the president last 30 April 1996;

NOW, THEREFORE, I, FIDEL V. RAMOS, President of the Republic of the Philippines, by virtue in me by law, do hereby order:

SECTION 1. Five-Year Phased-In Implementation of the Indigent Component of the National Health Insurance Program. The Philippine Health Insurance Corporation is hereby directed to ensure that the NHIP shall have covered at least the poorest twenty five percent of the population within a period of five years.

SEC. 2. Directive to Department of Finance. The DOF is hereby directed to ensure the automatic programming of all funds identified by law for premium subsidy of the Indigent Component of the NHIP.

SEC. 3. Directive to Department of Budget and Management. The DBM is hereby directed to automatically allocate the programmed funds for premium subsidy in the annual Budget of the National Government; and to ensure the immediate and regular release of the Employer's Counterpart Contribution for the Medicare Program.

SEC. 4. Directive to the Oversight Committee on Devolution. The Oversight Committee on Devolution is hereby directed to work with the PHIC in addressing the issue of devolution funding difficulties vis-à-vis the local government units' counterpart contribution to the Indigent premium subsidy.

SEC. 5. Directive to the Philippine Informational Agency. The PIA is hereby directed to assist and support the PHIC in the information dissemination/campaign on the NHIP.

SEC. 6. Directive to Local Government Units. The LGUs are hereby directed to ensure the immediate and effective implementation of the Indigent component of the NHIP in their respective jurisdiction. To this end, the LGUs are directed to prioritize the NHIP in their annual social development plans.

SEC. 7. **Effectivity.** This Administrative Order shall take effect immediately.

DONE, in the City of Manila, this day of in the year of Our Lord, Nineteen Hundred and Ninety-Six.

By the President:

RUBEN D. TORRES
Executive Secretary