

The Revised Implementing
Rules and Regulations of the
**NATIONAL HEALTH
INSURANCE ACT** of **2013**
(RA 7875 as amended by RA 9241 and 10606)

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Regulations of the National Health
Insurance Act of 2013**
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2013 Edition

MESSAGE

from the Secretary of Health and Chairperson of the Board



The Aquino government has consistently demonstrated its commitment to Universal Health Care or Kalusugan Pangkalahatan (KP). This priority reform is supported by increasing budget for health as well as the passage of the Sin Tax Reform Law, which will ensure the sustainability of resources for health. Under KP, all Filipinos must be accorded financial risk protection, especially the poor and marginalized. Thus, effective implementation of the National Health Insurance Program is imperative to make universal care a reality in our country.

The timely amendment of the National Health Insurance Act of 1995 (RA 7875) with the National Health Insurance Act of 2013 (RA 10606), and its Implementing Rules and Regulations ensures that the aspirations of Kalusugan Pangkalahatan will become a reality.

The new implementing rules streamlines the PhilHealth membership experience, from assurance of full premium payment for the poor families identified by the Department of Social Welfare and Development to simplify the requirements when availing their benefits. Moreover, the new rules also established simpler procedures in accrediting health care providers to promote greater access to health services across the country without sacrificing the quality of care. This IRR also highlights the new role of the Local Government Units in implementing the National Health Insurance Program as well as the enhanced powers of PhilHealth in implementing the Program.

The new IRR will serve as a guidepost in ensuring viability, adequacy and continued responsiveness of PhilHealth towards the achievement of Universal Health Coverage and enhancing the country's performance in achieving the targets for health-related Millennium Development Goals.

Through the support of all partners in the health sector, both in government and private sectors, the vision of "Bawat Pilipino, Miyembro. Bawat Miyembro, Protektado. Kalusugan Natin Segurado." will soon become a reality.


ENRIQUE T. ONA

MESSAGE

from the President and CEO



Only recently, President Benigno S. Aquino III, approved and signed into law, Republic Act No. 10606, otherwise referred to as the “National Health Insurance Act of 2013”, and thus marked an unprecedented milestone in the annals of the nation’s social health insurance program. The new PhilHealth law is the embodiment of government’s unwavering commitment to the attainment of Universal Health Care or “Kalusugan Pangkalahatan”.

Some of the law’s salient features includes the dramatic shift from premium sharing between the national and local governments to that of full national subsidy of the indigent sector as defined and listed by the DSWD’s ‘Listahanan’. Having enrolled over 14.7 million families or more than half of the population in 2014, the government has exhibited its steadfast commitment to the poorest of the poor who shall now be able to avail of quality health care at no or very little cost. Coupled with primary care benefit packages initially intended for them as well, PhilHealth is now investing in the future by providing for preventive health care services so as to lessen the costs of more expensive curative treatments.

Priority is also given to the health care needs of the underprivileged, the elderly, persons with disability, abandoned and neglected children including those who are not regularly employed in the informal sector. Coverage being made compulsory, social health protection is now extended to the project based or contractual employees who were previously not considered part of the workforce. Documentary requirements have been reduced to a minimum thus facilitating membership as well as benefit availment procedures.

PhilHealth has likewise been periodically upgrading and expanding its benefits to include catastrophic benefit packages. With the ‘all case rate’ regime and the ‘no balance billing’, we not only increase the Corporation’s support value to its members but hopefully ascertain that indeed the benefits are impacting on the members themselves, now the focus of our attention.

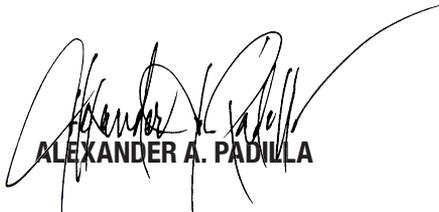
PhilHealth believes that every Filipino should have the opportunity to access quality health care because health is a matter of entitlement and right and not merely a privilege bestowed upon or removed at the whim of others.

Thus, with the timely publication and dissemination of the law’s Implementing Rules and Regulations (IRR), one that was forged through years of experience and upon valued consultations from concerned stakeholders, the circle is now complete for the full attainment of the promise of Universal Health Care.

As PhilHealth moves steadily forward with Kalusugan Pangkalahatan, we are again reminded of our mission statement which succinctly describes what financial risk protection is all about;

Bawa’t PILIPINO, MIYEMBRO;
Bawa’t MIYEMBRO, PROTEKTADO;
KALUSUGAN Natin, SEGURADO.

Mabuhay po ang PhilHealth, Mabuhay po ang bansang Pilipinas.



ALEXANDER A. PADILLA

HISTORY

The National Health Insurance Program (NHIP) administered by the Philippine Health Insurance Corporation (PhilHealth) was established in 1995 with the passage of Republic Act (RA) 7875. PhilHealth took over the Medicare functions previously administered by the Philippine Medical Care Commission (PMCC) since 1972.

PhilHealth's mandate is to provide health insurance coverage to all Filipinos. In 1997, it assumed Medicare functions for government workers from the Government Service Insurance System (GSIS) and a year later, for the private sector workers, which was previously administered by the Social Security System (SSS). In the same year, PhilHealth started the Indigent Program. In partnership with Local Government Units (LGUs), PhilHealth has enrolled millions of families who otherwise have no access to health services. Since then, this program has been at the heart of PhilHealth's program and now forms the bulk of membership. To date, all families in the DSWD's National Household Targeting System for Poverty Reduction (NHTS-PR) are covered by PhilHealth. For 2014, 14.7 million families are being enrolled through full National Government subsidy. The provision of full National Government subsidy was made possible by an amendment introduced in RA 10606 enacted into law in 2013.

In 1999, PhilHealth started covering self-employed and the informal sector and in 2005, PhilHealth assumed Medicare functions from the Overseas Workers Welfare Administration (OWWA) for Overseas Filipino Workers.

Now on its 19th year, PhilHealth has improved the way health services are delivered, financed and regulated. It has introduced a primary and catastrophic benefit package as it had shifted to an all case rates system from the previous inflationary and ineffective fee for service which has been in place since Medicare. PhilHealth endeavors to cover the financing of every Filipino's health needs, from preventive primary to hospital care including catastrophic conditions.

With Kalusugan Pangkalahatan as the overall sectoral agenda, PhilHealth is committed to ensure a coordinated and intensified effort towards its end goal of "Bawat Pilipino, Miyembro, Bawat Miyembro, Protektado, Kalusugan Natin Segurado".

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IMPLEMENTING RULES AND REGULATIONS
of Republic Act 7875 As Amended
Otherwise Known As
the National Health Insurance Act of 2013

Title I
GUIDING PRINCIPLES AND OBJECTIVES

SECTION 1. Declaration of Principles

It is hereby declared the policy of the State to 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 to provide free medical care to paupers. Towards this end, the State shall provide comprehensive health care services to all Filipinos through a socialized health insurance program that will prioritize the health care needs of the underprivileged, sick, elderly, persons with disabilities (PWDS), women and children and provide free health care services to indigents.

In pursuit of this principle, the Implementing Rules and Regulations (IRR) of the National Health Insurance Program (NHIP) herein referred to as the Program, 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 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 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, 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. **Informed 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 are 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** – The Program shall enroll all citizens of the Philippines 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. **Professional 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 Program shall focus on the provision of benefit packages for personal health services while the Government shall provide 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 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 viable means of helping the people pay for health care services; and,
- r. **Care for the Indigent** – The Program shall provide a basic package of needed personal health services to indigents through premium subsidy or through direct supervision from the Government.

SECTION 2. General Objectives

This IRR seeks to attain the objectives of the Act which are to:

- a. Provide all citizens of the Philippines with the mechanism to gain financial access to health services;
- b. Establish the Program to serve as the means to help the people pay for health care services;

and,

- c. Prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford these services.

Title II DEFINITION OF TERMS

SECTION 3. Definition of Terms

For the purposes of this Rules, the terms below shall be defined as follows:

- a. **Abandoned Children** – children who have no known family willing and capable to take care of them and are under the care of the Department of Social Welfare and Development (DSWD), orphanages, churches and other institutions.
- b. **Accreditation of Health Care Providers** – a process whereby the qualifications and capabilities of health care providers are verified in accordance with the guidelines, standards and procedures set by the Corporation for the purpose of conferring upon them the privilege of participating in the Program and assuring that health care services rendered by them are of the desired and expected quality. Accreditation encompasses licensing or certification, or pre-accreditation survey, as applicable, and their participation in the Program.
- c. **Accredited Collecting Agent** – any person, natural or juridical, accredited by the Corporation to receive, account and remit premium contributions of members.
- d. **Act** – refers to Republic Act No. 7875 as amended, otherwise known as the National Health Insurance Act of 2013.
- e. **Automatic Accreditation** – is the accreditation route of health care institutions that are licensed or certified by Department of Health (DOH) or other certifying body duly recognized by the Philippine Health Insurance Corporation (PhilHealth) and has the opportunity to be accredited through basic participation with the Program. These institutions do not require Pre-Accreditation Survey (PAS). Automatic accreditation is likewise applicable to professional health care providers subject to compliance of requirements as determined by the Corporation.
- f. **Benefit Package** – services that the Program offers to members, subject to the classification and qualifications provided for in this Rules.
- g. **Board** – the Board of Directors of the Philippine Health Insurance Corporation.
- h. **Capitation** – a payment mechanism where a fixed 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.
- i. **Case Rate Payment** – a payment method, also known as Case-Based Payment, that reimburses health care institutions a predetermined fixed rate for each treated case or disease.
- j. **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 members in the formal economy and on household earnings and assets, in the case of the informal economy, or on other criteria as may be defined

by the Corporation in accordance with the guiding principles set forth in Article I of the Act.

- k. **Clinical Practice Guidelines (CPG)** – systematically developed statements based on best evidence, intended to assist practitioners in making decisions about appropriate management of specific clinical conditions or diseases.
- l. **Corporation** – refers to the Philippine Health Insurance Corporation (PHIC or PhilHealth), which is mandated by law to administer the Program.
- m. **Coverage** – the entitlement of an individual, as a member or as dependent, to the benefits of the Program.
- n. **Dependent** – the legal dependents of a member who are the:
 - 1. Legitimate spouse who is not a member;
 - 2. Unmarried and unemployed legitimate, legitimated, acknowledged, illegitimate children and 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, as determined by the Corporation;
 - 4. Foster child as defined in Republic Act 10165 otherwise known as the Foster Care Act of 2012 ;
 - 5. Parents who are sixty (60) years old or above, not otherwise an enrolled member, whose monthly income is below an amount to be determined by the Corporation in accordance with the guiding principles set forth in the Act; and,
 - 6. Parents with permanent disability regardless of age as determined by the Corporation, that renders them totally dependent on the member for subsistence.
- o. **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, the performance of which is under an employer-employee relationship.
- p. **Employer** – a natural or juridical person who pays or compensates for services rendered by one or more individuals.
- q. **Enrollment** – the process determined by the Corporation to enlist individuals as members or dependents covered by the Program.
- r. **Fee-for-Service** – a fee pre-determined by the Corporation for each service delivered by a health care provider based on the bill. The payment system shall be based on a pre-negotiated schedule promulgated by the Corporation.
- s. **Global Budget** – an approach in the purchase of medical services by which health care providers negotiate the cost of providing a specific package of medical benefits based solely on a pre-determined and fixed budget as determined by the Corporation.
- t. **Grievance** – is a remedy as provided for in this Rules where anyone aggrieved by any decision of the implementors of the Program can avail of redress.
- u. **Gross Negligence** – the utter lack of care and diligence expected of a reasonable person as evidenced by the respondent's indifference or being oblivious to the danger of the injury to the person or property of others.
- v. **Group Health Care Institutions** - refer to institutions that have been accredited by PhilHealth

as a group/corporation under one management (e.g. hospitals or other health care institutions with branches, extensions).

- w. **Health Care Institution** - refers to health facilities that are accredited with PhilHealth which includes, among others, hospitals, ambulatory surgical clinics, TB-DOTS, freestanding dialysis clinics, primary care benefits facilities, and maternity care package providers.
- x. **Health Care Institution Extension or Branches** – a licensed facility of any category situated in another location that is owned and operated by a health care institution that has been accredited for at least two (2) years.
- y. **Health Care Provider** – refers to any of the following:
 - 1. A health care institution, which is duly licensed and/or 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, drug addiction or in need of obstetrical or 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 (24) hour use or longer by patients in the treatment of disease, injuries, deformities or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries, rehabilitation centers 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, pharmacist 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 (HMO), which is an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed pre-paid premium; or,
 - 4. A community-based health care organization (CBHCO), which is an association of members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services.
- z. **Health Education Package** – a set of informational services such as training and instruction on disease prevention, health promotion, rehabilitation and other health education packages that may be determined by the Corporation. These shall be made available by health care providers to provide members and their family with knowledge about an illness and its treatment, the means available to prevent the recurrence or aggravation of such illness and to promote health in general.
- aa. **Health System Providers (HSP)** – the organization of people, institutions, and resources that deliver health care services to meet the health needs of target population that may be accredited subject to the guidelines set by the Corporation. These include, among others, Inter-local Health Zones (ILHZ), health care facility network owned and managed by provincial, city and/or municipal governments.
- bb. **Health Technology Assessment** – a field of science that investigates the value of a health technology such as procedure, process, products, or devices, specifically on their quality, relative cost-effectiveness and safety. It is usually related to the science of epidemiology and economics and has implications on policy, decision to adopt and invest in these technologies, or in health benefit coverage.
- cc. **Home Care and Medical Rehabilitation Services** – skilled nursing care, which members

get in their homes/clinics for the treatment of an illness or injury that severely affects their activities or daily living. Home care and rehabilitation services include hospice or palliative care for people who are terminally ill but does not include custodial and non-skilled personal care.

- dd. **Indigent** – a person who has no visible means of income, or whose income is insufficient for family subsistence, as identified by the DSWD based on specific criteria set for this purpose in accordance with the guiding principles set forth in Article I of the Act.
- ee. **Late Remittance** – PhilHealth premium contribution remitted after the prescribed period as determined by the Corporation.
- ff. **Local Government Units (LGUs)** – provinces, cities, municipalities, and barangays where an enrolled member resides.
- gg. **Mechanism for Feedback** – the process devised to inform both the Corporation and health care providers of the data and results of the performance monitoring and outcomes assessment processes.
- hh. **Member** – any person whose premium contributions have been regularly paid to the Program who may be a paying member, an indigent member, a sponsored member or a lifetime member or otherwise known as covered member.
- ii. **National Health Insurance Program (NHIP)** – the compulsory health insurance program of the government as established in the Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.
- jj. **Outcomes Assessment** – the process of monitoring and reviewing of outcomes resulting from the health care services rendered by accredited providers. Information that can result from an outcome assessment includes knowledge and attitude changes, short-term or intermediate behavior shifts, reduction of morbidity and mortality, satisfaction of patients with care and cost, among others.
- kk. **Out-Patient Clinic** – an institution or facility with a basic team providing health services such as diagnostic consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.
- ll. **Out-patient Services** – Health services such as diagnostic, consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.
- mm. **Participation to the Program** – a process whereby a health care provider commits to provide quality health care services to Program members and dependents as stipulated in a performance commitment. All services provided shall receive reimbursement from PhilHealth.
- nn. **Peer Review** – a process by which the quality of health care provided to Program members or the performance of a health care professional is reviewed by professional colleagues of comparable training and experience either within the professional organization or hospital or within the Corporation itself when commissioned by the Corporation to undertake the same. The results of the said review can be utilized as basis for quality interventions and/or payment or non-payment of claims.
- oo. **Performance Commitment** – a document signed by health care institutions who intend to participate in the Program, which stipulate their undertakings to provide complete and quality health services to PhilHealth members and their dependents, and their willingness to comply

with PhilHealth policies on benefits payment, information technology, data management and reporting and referral, among others.

- pp. **Performance Monitoring** – an ongoing measurement of a variety of indicators of health care quality in the health field to identify opportunities for improvement in health care delivery.
- qq. **PhilHealth Employer Number (PEN)** – the permanent and unique number issued by the Corporation to registered employers, who may either be juridical or natural persons.
- rr. **PhilHealth Identification Number (PIN)** - the permanent and unique number issued by the Corporation to individual members and to each and every dependent.
- ss. **PhilHealth Identification Card** – is the health insurance identification card issued by the Corporation to members and their dependents.
- tt. **PhilHealth Office** – the head office and other offices established by the Corporation in every province and chartered city, or wherever it is deemed practicable.
- uu. **Philippine National Formulary (PNF)** – the essential drugs list of the Philippines which is prepared by the Department of Health (DOH) in consultation with experts and specialists from organized professional medical societies, the academe and the pharmaceutical industry and which is updated regularly.
- vv. **Policy Review and Formulation** – the process of continuous research, development and evaluation of program policies that address health needs and ensure delivery of quality and cost-effective health services.
- ww. **Portability** – the enablement of a member and their dependents to avail of program benefits in an area outside the jurisdiction of the member’s PhilHealth office.
- xx. **Pre-Accreditation Survey (PAS)** - is a process of assessing health care institutions that are not automatically accredited as defined by the Corporation as well as those applying for advanced participation. This includes among others, on-site observation, evaluation of pertinent documents and interview of personnel and patients.
- yy. **Preferred Health Care Institution** - is a recognition conferred to a health facility that has been granted advanced participation for beyond compliance with PhilHealth policies, demonstrated higher financial risk protection, excellent quality of care and better service satisfaction to its clients/patients.
- zz. **Prescription Drug** – a drug which has been approved by the Food and Drug Administration (FDA) and which can only be dispensed pursuant to a prescription order from a provider who is duly licensed to do so.
- aaa. **Professional Practitioners** – include doctors, lawyers, certified public accountants, and other practitioners required to pass government licensure examinations in order to practice their professions.
- bbb. **Program Implementor** – any official and/or employee of the Corporation who, in the general conduct of the operations and management functions of the Corporation, is charged with the implementation of the Program and the enforcement of the provisions of the NHI Act of 1995 as amended, this Rules, and other administrative issuances related thereto, including officials and employees of other institutions who are duly authorized by virtue of a Memorandum of Agreement (MOA) to exercise any of the powers vested in the Corporation to implement the Program.
- ccc. **Quality Assurance** – a formal set of activities to review and ensure the quality of services

provided. It includes quality assessment and corrective actions to remedy any deficiency identified in the quality of patient care, administrative and support services.

- ddd. **Residence** – the place where a member actually resides.
- eee. **Retiree** – refers to a member of the Program who has reached the age of retirement as provided by law or who was retired on account of permanent disability as certified by the employer and the Corporation.
- fff. **Salary** – the basic monthly compensation paid regularly for services rendered.
- ggg. **Sufficient Regularity of Premium Contribution** – is a pattern characterized by consistent remittance of premium contributions.
- hhh. **Third Party Accreditation** – is the accreditation of health care institutions by a third party duly recognized and authorized by PhilHealth exclusive of the decision-making function to grant or deny accreditation to Program.
- iii. **Traditional and Alternative Health Care** – the application of traditional knowledge, skills and practice of alternative health care or healing methods which include reflexology, acupuncture, massage, acupressure, chiropractics, nutritional therapy and other similar methods in accordance with the accreditation guidelines set forth by the Corporation and the Food and Drug Administration (FDA).
- jjj. **Treatment Procedure** – any method used to remove or alleviate the signs and symptoms and/or causes of a disease.
- kkk. **Utilization Review** - a formal review of health resource utilization or of the appropriateness of health care services on a prospective, concurrent, or retrospective basis.

Title III MEMBERSHIP AND CONTRIBUTIONS

Rule I COVERAGE

SECTION 4. Objective

All Filipinos shall be mandatorily covered under the Program. In accordance with the principles of universality and compulsory coverage enunciated in Section 2(b) and 2(l) of the Act, implementation of the Program shall ensure sustainability of coverage and continuous enhancement of the quality of service. The Program shall be compulsory in all provinces, cities and municipalities nationwide, notwithstanding the existence of LGU-based health insurance programs. The Corporation, DOH, LGUs, and other agencies including Non-Governmental Organizations (NGOs) and other National Government Agencies (NGAs) shall ensure that members in such localities shall have access to quality and cost-effective health care services.

SECTION 5. Nature and Scope

The Program shall cover the following members and their dependent/s:

- a. **Members in the Formal Economy** – those with formal contracts and fixed terms of employment including workers in the government and private sector, whose premium contribution payments are equally shared by the employee and the employer.
 1. **Government Employee** - an employee of the government, whether regular, casual or contractual, who renders services in any of the government branches, military or police force, political subdivisions, agencies or instrumentalities, including government-owned and-controlled corporations, financial institutions with original charter, Constitutional Commissions, and is occupying either an elective or appointive position, regardless of status of appointment.
 2. **Private Employee** - an employee who renders services in any of the following:
 - i. Corporations, partnerships, or single proprietorships, NGOs, cooperatives, non-profit organizations, social, civic, or professional or charitable institutions, organized and based in the Philippines including those foreign owned;
 - ii. Foreign governments or international organizations with quasi-state status based in the Philippines which entered into an agreement with the Corporation to cover their Filipino employees in PhilHealth;
 - iii. Foreign business organizations based abroad with agreement with the Corporation to cover their Filipino employees in PhilHealth.
 3. **All other workers rendering services, whether in government or private offices, such as job order contractors, project-based contractors, and the like**
 4. **Owners of Micro Entreprises**
 5. **Owners of Small, Medium and Large Enterprises**
 6. **Household Help** – as defined in the Republic Act 10361 or “Kasambahay Law”
 7. **Family Drivers**
- b. **Members in the Informal Economy** – this sector would include but are not limited to the following:
 1. **Migrant Workers** – documented or undocumented Filipinos who are engaged in a remunerated activity in another country of which they are not citizens.
 2. **Informal Sector** - to this sector belong, among others, street hawkers, market vendors, pedicab and tricycle drivers, small construction workers, and home-based industries and services.
 3. **Self-Earning Individuals** – individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship or as a career. These include professional practitioners including but not limited to doctors, lawyers, engineers, artists, architects and the like, businessmen, entrepreneurs, actors, actresses and other performers, news correspondents, professional athletes, coaches, trainers, and such other individuals.
 4. **Filipinos With Dual Citizenship** – Filipinos who are also citizens of other countries.
 5. **Naturalized Filipino Citizens** – those who have become Filipino citizens through naturalization as governed by Commonwealth Act No. 473 or the Revised Naturalization Law.
 6. **Citizens of other countries working and/or residing in the Philippines** – foreign citizens with valid working permits and/or Aliens Certificate of Registrations (ACRs)

working and/or residing in the Philippines.

- c. **Indigent** – a person who has no visible means of income, or whose income is insufficient for family subsistence, as identified by the DSWD based on specific criteria set for this purpose in accordance with the guiding principles set forth in Article I of the Act.
- d. **Sponsored Member** – a member whose contribution is being paid by another individual, government agency, or private entity according to the rules as may be prescribed by the Corporation.
- e. **Lifetime Member** – a member who has reached the age of retirement under the law and has paid at least one hundred twenty (120) monthly premium contributions. Lifetime members shall include but not limited to the following:
 - 1. Retirees/ Pensioners from the Government Sector
 - i. Old-age retirees and pensioners of the GSIS, including non-uniformed personnel of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408.
 - ii. GSIS Disability Pensioners prior to March 4, 1995.
 - iii. GSIS Retirees who have reached the age of retirement on or after March 4, 1995 and have at least 120 months PhilHealth premium contributions.
 - iv. Retirees and Pensioners who are members of the Judiciary who have reached the age of retirement and have at least 120 months PhilHealth contributions.
 - v. Retirees who are members of Constitutional Commissions and other Constitutional Offices who have reached the age of retirement and have at least 120 months PhilHealth contributions.
 - 2. Retirees/ Pensioners from the Private Sector
 - i. SSS Pensioners prior to March 4, 1995.
 - ii. SSS Permanent Total Disability Pensioners prior to March 4, 1995.
 - iii. SSS Death/ Survivorship Pensioners prior to March 4, 1995.
 - iv. SSS Old-age Retirees who have reached the age of retirement on or after March 4, 1995 and have at least 120 months PhilHealth premium contributions.
 - 3. Uniformed Members of the AFP, PNP, BJMP and BFP
 - i. Uniformed personnel of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement before June 24, 1997, and retirees under Presidential Decree 408.
 - ii. Uniformed members of the AFP, PNP, BJMP and BFP who have reached the compulsory age of retirement on or after June 24, 1997, being the effectivity date of RA 8291 which excluded them in the compulsory membership of the GSIS and have at least 120 months PhilHealth premium contributions.
 - 4. Members of PhilHealth who have reached the age of retirement as provided by law and have met the required premium contributions of at least 120 months, regardless of their employer/s' or sponsor's arrears in contributions and is not included in the Sponsored program nor declared as dependent by their spouse or children.

SECTION 6. Functions

To achieve its objectives, the Corporation shall undertake the following:

- a. Require the enrollment and coverage of all citizens of the Philippines under the Program;
- b. Coordinate with the DSWD, DILG, DOH, LGUs and other stakeholders for the enrollment and coverage of identified indigents, sponsored members and those members in the informal

economy from the lower segment who do not qualify for full subsidy under the means test rule of the DSWD;

- c. Ensure that all government entities including LGUs issuing professional or business license or permit shall require all applicants to submit certificate or proof of payment of PhilHealth premium contributions, prior to the issuance of renewal of such license or permit;
- d. Encourage associations, charitable institutions, cooperatives, private non-profit health insurance organizations/associations or individuals to mobilize funds for the enrollment of as many persons who cannot afford to pay premium contribution;
- e. Establish an efficient premium collection mechanism;
- f. Establish and maintain an updated membership and contribution database;
- g. Conduct information campaigns on the principles of the Program to the public and private accredited health care providers. This campaign must include the current benefit packages provided by the Corporation, the mechanisms to avail of the current benefit packages, the list of accredited and dis-accredited health care providers, and the list of offices/branches where members can pay or check the status of paid health premiums; and,
- h. To establish an office, or where it is not feasible, designate a focal person in every Philippine Consular Office in all countries where there are Filipino citizens. The office or the focal person shall, among others, process, review and pay the claims of the migrant workers.

Rule II GENERAL PROVISIONS CONCERNING ALL MEMBERS

SECTION 7. PhilHealth Identification Number and Health Insurance ID Card

Consistent with the mandate of enrolling Filipinos into the Program, the Corporation shall assign a permanent and unique PhilHealth Identification Number (PIN) to every member including each and every dependent of theirs. It shall facilitate the issuance of a Health Insurance ID Card containing the PIN for purposes of identification, eligibility verification and utilization recording. The issuance of this ID card shall be accompanied by a clear explanation on the rights, privileges and responsibilities of a PhilHealth member and the list of PhilHealth-accredited healthcare providers.

The absence of the ID card shall not prejudice the right of any member to avail of benefits or medical services under the Program.

This health insurance ID card with a corresponding ID number shall be recognized as a valid government identification and shall be presented and honored in transactions requiring the verification of a person's identity.

SECTION 8. Replacement of Health Insurance ID Card

A member may request for replacement of the Health Insurance ID Card due to loss or wear and tear upon payment of fees for the issuance of a new card.

SECTION 9. Requirements for Registration of Members and Dependents

A person intending to register with the Program regardless of membership category, shall submit to the Corporation a properly accomplished prescribed Membership Registration Form, whereby the member shall certify the truthfulness and accuracy of the information provided including the list of declared qualified legal dependents. If warranted, the Corporation may require submission of supporting documents. The same process shall be maintained for amendments/revision to any submitted data of the member and/or dependents.

SECTION 10. Emancipated Individual or Single Parent

Any person below 21 years of age, married or unmarried but with a child, shall be enrolled as a member.

SECTION 11. Remittance of Premium Contribution

Remittance of contribution shall be mandatory for all members. It shall be made to PhilHealth offices or to any of the accredited collecting agents. Failure to timely remit the appropriate premium contribution shall be subject to interest and penalties as prescribed by the Corporation without prejudice to other applicable penalties herein provided.

SECTION 12. Effectivity

Membership shall take effect upon enrollment and payment of the required premium contribution.

Rule III SPECIFIC PROVISIONS CONCERNING MEMBERS IN THE FORMAL ECONOMY

SECTION 13. Registration of Employers

All government and private sector employers are required to register with the Corporation and each shall be issued a permanent and unique PhilHealth Employer Number (PEN).

Employers may register with the Philippine Business Registry (PBR). If registered through the PBR, the Corporation shall no longer require submission of documents from employers. Should the employer be unable to register through the PBR, the Corporation shall require the following documentary requirements, whichever is applicable:

- a. For single proprietorships – Department of Trade and Industry (DTI) registration;
- b. For partnerships and corporations – Securities and Exchange Commission (SEC) registration;
- c. For foundations and other non-profit organizations – SEC registration;
- d. For cooperatives – Cooperative Development Authority (CDA) registration;
- e. For backyard industries/ventures and micro-business enterprises – Barangay Certification and/or Mayor's Permit.

SECTION 14. Employer Data Amendment and Revision

An employer shall update the Corporation on the revision/amendment in the data previously furnished the Corporation by accomplishing an amendment form and submitting documents to substantiate the same. The request may be due to any of the following:

- a. Correction/change of business name/legal personality – submit certificate of filing of business name with the DTI or Articles of Partnership/Incorporation;
- b. Temporary suspension of operation – if due to:
 1. Bankruptcy – submit Financial Statement, or Income Tax Return, or Board Resolution;
 2. Separation of employee/s – submit Separation paper of last employee;
 3. Fire/Demolition – submit Certification from the Fire Department of the municipality or city or Certification from the concerned municipality or city government; or
 4. Earthquake, declared calamities, and such other analogous circumstances.
- c. Termination/dissolution
 1. For single proprietorship – submit approved application for business retirement by the Municipal Treasurer’s Office
 2. For partnership or corporation – submit Deed of Dissolution approved by SEC or Minutes of the Meeting certified by the corporate secretary
 3. For cooperatives – Certificate/Order of Dissolution/ Cancellation issued by the CDA
 4. Under fortuitous events as defined by law – submit applicable supporting documents as may be determined by the Corporation.
- d. Change of ownership – submit Deed of Sale/Transfer/ Assignment;
- e. Resumption of operation – submit prescribed PhilHealth form reporting newly-hired or re-hired employees. In case of closure due to fortuitous events, submit supporting documents as determined by the Corporation.

SECTION 15. Obligations of the Employer

All government and private employers are required to:

- a. Register their employees and their qualified dependents by submitting a list of their employees complete with their salary base and other documents as may be required.
- b. Report to the Corporation its newly-hired employees within thirty (30) calendar days from assumption to office.
- c. Give notice to the Corporation of an employee’s separation within thirty (30) calendar days from separation.
- d. Keep true and accurate work records for such period and containing such information as the Corporation may prescribe.
- e. Allow the inspection of its premises including its books and other pertinent records.

SECTION 16. Rates of Premium Contributions

Members in the formal economy shall continue paying the monthly contributions to be shared equally by the employer and employee at a prescribed rate set by the Corporation not exceeding

five percent (5%) of their respective basic monthly salaries.

SECTION 17. Mandatory Appropriation of Premium Contribution for Government Agencies

It shall be mandatory for all government agencies to include the payment of premium contribution in their respective annual appropriations. Any increase in the premium contribution of the national government as employer shall only become effective upon inclusion of said amount in the annual General Appropriation Act (GAA).

SECTION 18. Payment of Premium Contributions

- a. The member's monthly contribution shall be deducted and withheld automatically by the employer from the former's salary, wage or earnings. The premium contributed shall be divided equally between the employer and the employed. The employer's counterpart shall not, in any manner be charged to the employee.
- b. The monthly premium contribution of employed members shall be remitted by the employer on or before the date prescribed by the Corporation.
- c. The remittance of premium contribution by the employer shall be supported by a Remittance List to be submitted regularly to the Corporation.
- d. The failure of the employer to remit the required contribution and to submit the required remittance list shall make the employer liable for reimbursement of payment of a properly filed claim in case the concerned employee or dependent/s avails of Program benefits, without prejudice to the imposition of other penalties as provided for in this Rules.
- e. For government agencies, it shall be mandatory and compulsory for the employers to include the payment of contributions in their annual appropriations. The use of said funds withheld by government agencies other than for the purpose of remitting Program contributions will hold the erring government employers liable under the pertinent provisions of the Revised Penal Code.
- f. Failure and/or refusal of the employer to deduct or remit the complete employees' and employer's premium contribution shall not be a basis for denial of a properly filed claim. In such a case, the Corporation shall be entitled to reimbursement of claims paid from the erring or negligent employer, without prejudice to the latter's prosecution and other liabilities, as may hereafter be provided by this Rules.
- g. The last complete record of monthly contributions paid by the employer or the average of the monthly contributions paid during the past three (3) years as of the date of filing of the action for collection shall be presumed to be the monthly contributions payable by and due from the employer to the Corporation for each of the unpaid month, unless contradicted and overcome by other evidence: Provided, that the Corporation shall neither be barred from determining and collecting the true and correct contributions due it even after full payment pursuant to this provision, nor shall the employer be relieved of his/her liability.

SECTION 19. Remittance of Premiums for Employees with Income Gaps

Employees with no income for particular month/s due to non-rendition of service or for such other reasons such as those who are on leave without pay or on extended leave, including members

engaged in seasonal employment, shall continue to pay premiums to the Program to ensure continuous entitlement to benefits.

SECTION 20. Premium Payment of the Government and Private Employee Members with Multiple Employment

Members engaged in multiple employment in the government and private sectors whose aggregate monthly premium contribution exceeds the maximum rate in the prescribed premium contribution schedule may request for adjustment of personal share subject to the guidelines to be issued by the Corporation.

Rule IV SPECIFIC PROVISIONS CONCERNING THE KASAMBAHAYS

SECTION 21. Obligations of the Employer of Household Help or Kasambahay

To ensure that PhilHealth membership of the household help or kasambahay is sustained, employers are required to:

- a. Register their kasambahay with the Corporation and the kasambahay's qualified dependents under their PIN;
- b. Report to the Corporation their kasambahay within thirty (30) calendar days upon employment; and,
- c. Give notice to the Corporation upon separation of the kasambahay and pay the corresponding PhilHealth Premium contributions for the rendered services until the date of separation.

Employers of household-help who have registered with the SSS prior to July 1, 1999, are considered automatically registered. They shall be required to update their records with the Corporation.

SECTION 22. Premium Payment of Household Help

The annual premium contributions of household helps shall be fully paid in accordance with the provisions of Republic Act No. 10361 or the 'Kasambahay Law'.

Rule V SPECIFIC PROVISIONS CONCERNING MEMBERS IN THE INFORMAL ECONOMY

SECTION 23. Payment of Premium Contributions

Contributions of members in the informal economy shall be based primarily on household earnings and assets.

SECTION 24. Cessation from Formal Employment or Coverage as Indigent, Sponsored Member or as Migrant Workers

A member separated from formal employment or whose coverage as a Sponsored member or as an Indigent or as a migrant worker has ceased should pay the required premium as self-earning individuals to ensure continuous entitlement to benefits.

SECTION 25. Retroactive Payment of Premium Contribution

A member who has missed/unpaid premium contribution shall be allowed to pay retroactively as prescribed by the Corporation.

SECTION 26. Enrollment of Citizens of Other Countries Working in the Philippines

Citizens of other countries working in the Philippines may be allowed coverage in the Program provided that their countries have existing reciprocity agreements with the Philippines, subject to additional guidelines as may be prescribed by the Corporation.

Rule VI SPECIFIC PROVISIONS CONCERNING INDIGENTS

SECTION 27. Identification and Enrollment of Indigents

All indigents identified by the DSWD under the NHTS and other such acceptable methods, shall automatically be enrolled and covered under the Program.

SECTION 28. Payment for Premium Contributions

Premium contributions for indigent members shall be fully subsidized by the National Government. The amount necessary shall be included in the appropriations for the DOH under the annual GAA.

SECTION 29. Women as Primary Members

The female spouse of the families identified by DSWD may be designated as the primary member of the Program.

SECTION 30. Data Sharing on the List of Indigents and their Dependents

The DSWD shall regularly provide the Corporation with the list of indigent families and their dependents including their personal data and other pertinent information required for their enrollment to the Program. Likewise, the Corporation shall provide DSWD any updates on the personal data and information of the indigent families. This data sharing arrangement shall be at no cost to DSWD and PhilHealth.

Rule VII
SPECIFIC PROVISIONS CONCERNING SPONSORED MEMBERS

SECTION 31. Payment for Sponsored Members' Contributions

The premium payment for Sponsored Members shall be as follows:

- a. Members of the informal economy from the lower income segment who do not qualify for full subsidy under the means test rule of the DSWD shall be subsidized by the LGUs or through cost sharing mechanisms between/among LGUs, and/or legislative sponsors, and/or other sponsors and/or the member, including the National Government.
- b. The premium contributions of orphans, abandoned and abused minors, out-of-school youths, street children, persons with disability (PWD), senior citizens and battered women under the care of the DSWD, or any of its accredited institutions run by NGOs or any nonprofit private organizations, shall be paid by the DSWD and the funds necessary for their inclusion in the Program shall be included in the annual budget of the DSWD;
- c. The needed premium contributions of all barangay health workers, nutrition scholars, barangay tanods, and other barangay workers and volunteers shall be fully borne by the LGUs concerned;
- d. The annual required premium for the coverage of un-enrolled women who are about to give birth shall be fully borne by the National Government and/or LGUs and/or legislative sponsors or the DSWD if such woman is an indigent as determined by it through the means test.

Rule VIII
SPECIFIC PROVISIONS CONCERNING LIFETIME MEMBERS

SECTION 32. Required Number of Monthly Premium Contributions to Qualify as Lifetime Member

Any person who has reached the age of retirement and has paid at least 120 monthly contributions shall be qualified as a Lifetime Member. The number of monthly contributions required as a Lifetime Member may be increased in accordance with an actuarial study to sustain the financial viability of the Program.

SECTION 33. Lifetime Member with Current Source of Income

A Lifetime Member who obtains a regular source of income from employment, practice of profession and other means shall resume paying the required monthly premium contribution until finally ceasing to earn, provided that said income is above the poverty threshold.

Rule IX
PROVISION ON MAKING PHILHEALTH A REQUISITE FOR
ISSUANCE / RENEWAL OF LICENSE / PERMITS

SECTION 34. Requisite for Issuance or Renewal of License / Permits

Among the powers and functions of the Corporation and notwithstanding any law to the contrary, all government entities including LGUs issuing professional or business license or permits, shall require all applicants to submit a certificate or proof of payment of PhilHealth premium contributions as a pre-requisite to the issuance or renewal of such license or permit.

Title IV
BENEFIT ENTITLEMENTS

Rule I
BENEFITS

SECTION 35. Objective

The Program aims to provide its members with responsive benefit packages. In view of this, the Corporation shall continuously endeavor to improve its benefit package to meet the needs of its members.

SECTION 36. Functions

To achieve the above objective, the Corporation shall undertake the following:

- a. Introduce additional benefit items and improve those already being provided;
- b. Develop the appropriate provider payment mechanisms;
- c. Continuously improve the system for benefit availment; and,
- d. Strictly monitor the implementation of benefit availment.

SECTION 37. Benefit Package

Members and their dependents are entitled to the following minimum services, subject to the limitations specified in the Act and as may be determined by the Corporation:

- a. In-patient 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 of the Act; and,
 6. Health Education.

- b. Out-patient medical and surgical care:
 - 1. Services of health care professionals;
 - 2. Diagnostic, laboratory and other medical services;
 - 3. Personal preventive services;
 - 4. Prescription drugs and biologicals, subject to the limitations of the Act; and,
 - 5. Health Education.
- c. Emergency and transfer services;
- d. Health Education Packages; and,
- e. Such other health care services that the Corporation and the DOH shall determine to be appropriate and cost-effective.

These services and packages shall be reviewed annually to determine its financial sustainability and relevance to health innovations, with the end in view of quality assurance, increased benefits and reduced out-of-pocket expenditure. Such review shall include actuarial studies.

SECTION 38. Excluded Personal Health Services

The Corporation shall not cover expenses for health services, which the Corporation and the DOH consider cost-ineffective through health technology assessment. The Corporation may institute additional exclusions and limitations as it may deem reasonable in keeping with its protection objectives and financial sustainability.

SECTION 39. Entitlement to Benefits

Members and/or their dependents are entitled to avail of the benefits if either of the following is met:

- a. Paid premium contribution for at least three (3) months within the six (6) months prior to the first day of availment; or,
- b. Paid in full the required premium for the calendar year.

In addition, the member is not currently subject to legal penalty of suspension as provided for in Section 44 of the Act and has paid the premium with sufficient regularity. The Corporation may issue other requirements for entitlement to benefits as it deems appropriate.

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

- a. Retirees and pensioners of the SSS and GSIS prior to March 4, 1995; and,
- b. Members of PhilHealth who have reached the age of retirement as provided for by law, not gainfully employed or continuing their practice as professional and have met the required premium contributions of at least 120 months.

SECTION 40. Continuation of Entitlement to Benefits in Case of Death of Member

In case of death of the member, the dependents of the deceased member shall continue to avail of the benefits for the unexpired portion of the coverage or until the end of the calendar year, whichever comes first.

SECTION 41. Benefits of Members and their Dependents Confined Abroad

Members and/or their dependents shall be eligible to avail of benefits for confinement/s outside the country: Provided, that the conditions for entitlement under this Rules are met and the following requirements are submitted within one hundred eighty (180) calendar days from the date of discharge:

- a. Official receipt or any proof of payment and/or statement of account from the health care institution where the member/dependent was confined; and,
- b. Certification of the attending physician as to the final diagnosis, period of confinement and services rendered.

The benefits to be granted shall be paid to the member in the equivalent local rate based on the Level Three (3) hospital category with the applicable case-rate payment.

Rule II PAYMENT OF CLAIMS

SECTION 42. Provider Payment Mechanisms

The following provider payment mechanisms shall be allowed in the Program:

- a. Fee-for-Service payments;
- b. Case Rate payments;
- c. Capitation of health care professionals and institutions, or networks of the same including HMOs, medical cooperatives, and other legally formed health service groups;
- d. Global budget; and,
- e. Such other provider payment mechanisms that may be determined and adopted by the Corporation.

SECTION 43. No Balance Billing for Indigents in Government Health Care Institutions

No other fee or expense shall be charged to indigent in government health care institutions, subject to the guidelines issued by the Corporation. All necessary services and complete quality care to attain the best possible health outcomes shall be provided to them.

Health care institutions must give indigent members preferential access to their social welfare funds, which may be used to augment the benefit package provided, in case of insufficiency to fully cover all confinement charges.

Health care professionals must not charge over and above the professional fees provided by the Program for members admitted to a service bed.

The No Balance Billing may also be extended to other member categories as defined by the Corporation.

SECTION 44. Payment for Health Care Professionals in Health Care Institutions

All payments for professional services rendered by salaried public providers shall 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 retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to primarily 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.

SECTION 45. Income Retention by Government Health Care Institutions

Reimbursements paid to public facilities shall be retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to primarily 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.

SECTION 46. Reimbursement and Period to File Claims

All claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider. The period to file the claim may be extended for such reasonable causes as may be determined by the Corporation.

SECTION 47. Guidelines on Claims Payment

The following are the guidelines for the claims payment:

- a. The health care provider shall submit the prescribed and completely filled up PhilHealth claim forms and other documents required for processing.
 1. The claim sent through mail or courier, the date of mailing as stamped by the post office of origin or date received by the courier service shall be considered as the date of filing.
 2. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.
 3. If the delay in the filing of claim is caused by the health care provider and the benefits had already been deducted, the claim will not be paid. If the benefits are not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider.
 4. For any other means of filing of claims, such as but not limited to electronic submission, the Corporation shall issue specific guidelines for the purpose.
- b. The health care provider shall deduct from the total charges all expenses reimbursable by the Corporation upon discharge of the patient. The payment of benefits shall be made directly to the health care provider.
- c. Health care providers are not allowed to charge for PhilHealth forms and processing fees from the member when claiming reimbursement from the Corporation.
- d. Direct filing of claims and payment to the member shall be allowed only for confinements abroad, claims for adjustment of reimbursement, emergency in non-accredited facilities or such other conditions as may be determined by the Corporation.

- e. The Corporation shall penalize health care providers for claims attended by any but not limited to the following circumstances:
 - 1. Over-utilization of services;
 - 2. Unnecessary diagnostic and therapeutic procedures and intervention;
 - 3. Irrational medication and prescriptions;
 - 4. Fraudulent, false or incorrect information as determined by the appropriate office;
 - 5. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;
 - 6. Inappropriate referral practices;
 - 7. Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs;
 - 8. Use of drugs other than those recognized in the latest PNF and those for which exemptions were granted by the Board; and,
 - 9. Failure to comply without justifiable cause with the pertinent provisions of the law, IRR and any issuances of the Corporation.
- f. When the claim is denied, the amount of claim shall not be recovered from the member.
- g. All claim applications for drugs and medicines shall be in generic terminology in conformity with DOH regulations and the law.
- h. When the claims filed by a private health care institution indicate that its bed occupancy rate exceeds its accredited bed capacity, such claims must be justified in a notarized document, the contents of which shall be prescribed by the Corporation. Otherwise, the same shall not be processed.
- i. Any operation performed beyond the accredited capability shall be considered a violation and a claim for such shall be denied by the Corporation, except when the same is done in an emergency case or when referral to a higher category health care institution is physically impossible.
- j. Primary care facilities shall be compensated only for certain medical and simple surgical operations as determined by the Corporation.
- k. All claims for services filed by a health care institution after its category is downgraded/upgraded pursuant to this Rules shall be paid based on rates for such downgraded/upgraded category.
- l. All completed claims, except those under investigation, shall be paid within sixty (60) calendar days from receipt of the Corporation.
- m. Confinements of less than twenty-four (24) hours shall only be compensated under the following instances:
 - 1. If the patient is transferred to another health care institution;
 - 2. In emergency cases as defined by the Corporation;
 - 3. If the patient expired; or,
 - 4. Other cases as may be determined by the Corporation.
- n. Claims of members confined in a non-participating health care institution shall be compensated; Provided, that all of the following conditions are met:
 - 1. The health care institution is licensed by DOH;
 - 2. The case is emergency as determined by the Corporation; and,
 - 3. When physical transfer/referral to an accredited health care institution is impossible as determined by the Corporation.

SECTION 48. Capitation Arrangement

All capitation arrangement shall be covered by a performance commitment by and between the Corporation and the concerned accredited health care provider.

SECTION 49. Disposition of Capitation Payments

Consistent with the mandates for each political subdivision under Republic Act No. 7160 or "The Local Government Code of 1991", LGUs shall provide basic health care services. To augment their funds, LGUs shall invest the capitation payments given to them by the Corporation on health infrastructures or equipment, professional fees, drugs and supplies, or health information technology and database: Provided, that basic health care services, as defined by the DOH and the Corporation, shall be ensured especially with the end in view of improving maternal, infant and child health. Provided, further, that the capitation payments shall be segregated and placed into a special trust fund created by LGUs and be accessed for the use of such mandated purpose.

Title V QUALITY ASSURANCE AND ACCREDITATION

Rule I QUALITY ASSURANCE

SECTION 50. Objective

The Corporation shall implement a Quality Assurance Program applicable to all health care providers for the delivery of health services nationwide. This program shall ensure that the health services rendered to the members by accredited health care providers are of the quality necessary to achieve the desired health outcomes and member satisfaction.

Thus, the Corporation is specifically mandated to ensure that:

- a. The personal health services delivered, measured in terms of inputs, processes, and outcomes, are of desired and expected quality;
- b. The health care standards are uniform throughout the nation;
- c. Acquisition and use of scarce and expensive medical technologies and equipment are consistent with actual needs and standards of medical practice and that the performance of medical procedures and the administration of drugs are appropriate, necessary and consistent with accepted standards of medical practice and ethics and respectful of the local culture. Drugs for which payments will be made shall be those included in the PNF, unless explicit exception is granted by the Corporation; and,
- d. Health care professionals of the accredited health care institutions possess the proper training and credentials to render quality health care services to members of the Program.

SECTION 51. Functions

To achieve the above objectives and ensure the quality of health care services provided to its members the Corporation shall undertake the following:

- a. Verify, through the accreditation process, the qualifications and capabilities of health care providers for the purpose of conferring upon them the privilege of participating in the Program and assuring that the health care services they render meet the desired and expected quality;
- b. Monitor on a periodic basis, the services rendered to members by health care providers through surveys, utilization review, peer review and patient satisfaction review or index;
- c. Monitor and review, through outcomes assessment, the outcomes resulting from the health care services rendered by health care providers both from the standpoint of effects on health and member satisfaction;
- d. Initiate and impose changes and corrective actions based on the results of performance monitoring and outcomes assessment to ensure quality health service by using mechanisms for feedback;
- e. Formulate and review program policies on health insurance based on data gathered from the conduct of the above activities;
- f. Translate and implement quality assurance standards in the medical evaluation of claim applications for reimbursement of services rendered to members; and,
- g. Undertake studies/researches that would gauge the effectiveness of the program

In the same manner, the program shall include, among others, the following functions that will ascertain quality standards of its providers:

- a. Review the credentials of individual health care professionals working in the health care institution;
- b. Provide referral and practice guidelines for the health care providers;
- c. Establish utilization review and monitoring scheme for the performance of health care providers;
- d. Institutionalize a mechanism to measure health outcomes and patient satisfaction including mortality, morbidity, infection rates and other related activities;
- e. Set-up a data gathering and retrieval system from the health and financial records to support performance monitoring and outcomes measurement activities;
- f. Establish a system for peer review and feedback to the health care professionals and mechanism for change in practice patterns as needed;
- g. The appointment of a specific person responsible for quality assurance in the institution;
- h. Implement remedial measures to correct deficiencies in the quality of the health services that have been identified through utilization review, peer review, performance assessment of health care institutions; and,
- i. Document meetings of quality circles or Quality Assurance Committee

SECTION 52. Health Finance Policy Research

The Corporation shall establish the Health Finance Policy Research Department, which shall have the following duties and functions:

- a. Develop 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 researches and studies toward the development of policies necessary to ensure the viability, adequacy and responsiveness of the Program;
- c. Review, evaluate, and assess the Program's impact on the access as well as to the quality and cost of health care in the country;
- d. Conduct 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. Analyze the delivery, quality, use and cost of health care services of the different offices;
- f. Submit for consideration a program of quality assurance, utilization review, and technology assessment;
- g. Submission of recommendations on policy and operational issues that will help the Corporation meet the objectives of the Act; and,
- h. Conduct client-satisfaction surveys and research in order to assess outcomes of service rendered by health care providers.

Rule II ACCREDITATION

SECTION 53. Types of Accreditation

Accreditation shall be of the following types:

- a. Initial Accreditation – This shall be given to qualified health care providers that are applying for the first time. The accreditation shall take effect upon compliance of the requirements. If the facilities of a revoked institutional health care provider are transferred either by sale or lease or such other modes of transfer, such will be treated as an application for initial accreditation.
- b. Continuous Accreditation – This shall be given to accredited health care providers that applied through basic participation and who complied with the requirements prescribed by the Corporation that qualify them for uninterrupted participation to the Program, until their accreditation is withdrawn based on rules set by the Corporation.
- c. Re-accreditation – the accreditation that shall be given to health care providers under any of the following conditions, or any other conditions as determined by the Corporation:
 1. Health care institutions whose previous accreditation has lapsed or whose subsequent application was denied;
 2. Health care institutions that failed to submit the requirements for continuous participation within the prescribed period;

3. Acquisition of additional service capability that would require change in license/certificate, as applicable, issued by the relevant authority;
4. Transfer of location. The health care institution must first secure a license to operate from the DOH for the new facility prior to the date of transfer and apply for re-accreditation within ninety (90) calendar days from the date of transfer. Beyond this period, the accreditation shall automatically lapse and all claims filed with the Corporation shall not be paid. The health care institution must inform the Corporation of the planned transfer indicating the exact date of transfer and address of the new site. The ninety (90) day grace period shall not apply to the new site if it is not licensed;
5. Upgrading of facility level or category;
6. Change in the classification of health care institution;
7. Change in ownership. The health care institution in good standing must apply within the ninety (90) calendar days from actual change of ownership;
8. Resumption of operation after closure/cessation of operation.

Professionals whose previous accreditation has lapsed or whose subsequent application was denied shall be re-accredited.

When the accreditation of a health care institution lapsed due to the voluntary act of a health care provider to evade the consequences of a previous violation or adverse findings indicating fraud, as determined by the Corporation, the application for re-accreditation shall be denied.

- d. Reinstatement of Accreditation – the restoration of accreditation after compliance to conditions following a suspension imposed by the Corporation.

SECTION 54. Participation to the Program

A process whereby a health care provider commits to provide quality health care services to the Program members and their dependents as articulated in its performance commitment. In return, it shall receive reimbursement from PhilHealth for services provided.

There are two levels of participation for Health Care Institutions (HCI):

- a. Basic Participation – is the minimum level of participation granted by PhilHealth to all HCIs that comply with all the requirements including the performance commitment (e.g. license or certificate, as applicable) and pass the accreditation survey, when applicable. Health care institutions shall be granted continuous basic participation with PhilHealth until withdrawn based on the rules set by the Corporation.
- b. Advanced Participation – a higher level of participation granted by PhilHealth to HCIs already engaged for basic participation that are able to comply with all the requirements set by PhilHealth and pass the mandatory survey for Advanced Participation.

SECTION 55. Health Care Providers

The following health care providers shall be accredited before they can participate in the Program:

- a. Health Care Institutions
 1. Hospitals
 2. Out-patient clinics
 - iv. Rural health units/health centers
 - v. Dispensaries/infirmaries
 - vi. Birthing homes/facilities

- vii. Medical Out-patient Clinics
 - viii. Other Primary Care Facilities licensed by the DOH
 - 3. Free-Standing Dialysis Clinics
 - 4. Ambulatory Surgical Clinics
 - 5. Health Maintenance Organizations (HMOs)
 - 6. Community-Based Health Care Organizations (CBHCOs)
 - 7. Pharmacies
 - 8. Other health care institutions licensed by the DOH
- b. Health Care Professionals
- 1. Physicians
 - 2. Dentists
 - 3. Nurses
 - 4. Midwives
 - 5. Pharmacists
 - 6. Other duly licensed health care professionals

SECTION 56. Accreditation Requirements for Health Care Institutions

The following requirements shall apply to Health Care Institutions in appropriate cases:

- a. They must have been operating for at least three (3) years prior to initial application for accreditation, with a good track record in the provision of health care services. The date of reckoning of the three-year operation requirement shall be the effectivity date of either the initial license, clearance to operate, certificate, or other proof of operation issued by the DOH or other pertinent government agencies if applicable. HCI that have temporarily stopped operation due to upgrading, expansion, change of ownership or any other causes shall have their length of operation computed on a cumulative basis from the date of the initial operation of the former institution;
- b. They must be licensed / certified by the DOH, as applicable;
- c. They must comply with the provisions of the performance commitment. They must have their own ongoing formal program of quality assurance that satisfy the Corporation's standards;
- d. Any other requirements that may be determined by the Corporation.

SECTION 57. Exemptions from the Three-Year Operation Requirement

A HCI that does not qualify for the provision of the three- year operation requirement may still apply and qualify for initial accreditation if it meets any of the following conditions:

- a. Its managing health care professional has a working experience in another accredited health care institution for at least three (3) years or a graduate of hospital administration or any related degree. If the managing health care professional leaves the accredited health care institution within the initial year of accreditation the accreditation shall be withdrawn effective on the date of vacancy;
- b. It operates as a tertiary facility or its equivalent;
- c. It operates in an LGU where the accredited HCI cannot adequately or fully service its population;
- d. Its service capability is not currently available in the LGU;

- e. It is an extension or branch of a health care institution that has been accredited for at least two (2) years; and,
- f. Other conditions as may be determined by the Corporation.

The following health care institutions shall be exempted from the three (3) year operation requirement:

- a. Primary Care Benefit Providers with or without out-patient malaria package;
- b. TB DOTS providers;
- c. Non-hospital maternity care package providers;
- d. Animal bite treatment providers; and,
- e. Such other health facilities as may be determined by the Corporation

SECTION 58. Accreditation Requirements for Group Health Care Institutions, Health System Providers, Pharmacies and Retail Drug Outlets, Health Maintenance Organizations, and Community-Based Health Care Organizations

The Corporation shall prescribe the requirements for the accreditation of group health care institutions, health system providers, pharmacies and retail drug outlets, health maintenance organizations, and community-based health care organizations.

SECTION 59. Guidelines on the Accreditation of Health Care Institutions

The accreditation of HCIs shall be guided by the following:

- a. The Corporation shall prescribe the requirements for the accreditation of HCIs applying for basic and advanced participation.
- b. The HCI shall apply for accreditation through basic participation and advanced participation by submitting the duly accomplished forms and documents and upon payment of the required fees as prescribed by the Corporation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.
- c. The HCI shall submit the requirements for accreditation to its respective PhilHealth Regional Offices (PRO) for evaluation and processing.
- d. The accreditation of HCIs through the basic participation shall be continuous unless withdrawn, suspended or revoked based on the rules set by the Corporation.
- e. HCIs shall be visited and inspected as often and as necessary to determine compliance with the requirements and conditions for accreditation.
- f. The Corporation shall determine the period of accreditation within a reasonable period of time from receipt of application and reserves the right to issue, deny or withdraw the accreditation after an evaluation of the capability and integrity of the health care institution.
- g. All matters pertaining to accreditation shall be decided by the Accreditation Committee whose decision shall become effective upon approval by the President and CEO. Only decisions on application for basic participation may be the subject of a motion for reconsideration to be filed with the Accreditation Committee. Only one motion for reconsideration shall be entertained.

- h. Accreditation shall take effect prospectively. Claims for services before the effectivity of accreditation and after the withdrawal of accreditation shall be denied.

SECTION 60. Third Party Accreditation through the Hospital Accreditation Commission

The Corporation shall develop a policy for the implementation of third party accreditation through the Hospital Accreditation Commission.

SECTION 61. Accreditation Requirements for Physicians, Dentists, Nurses, Midwives, Pharmacists and other Licensed Health Care Professionals

Physicians, dentists, nurses, midwives, pharmacists and other licensed health care professionals shall comply with the following requirements to be accredited:

- a. They must be duly licensed to practice in the Philippines by the PRC;
- b. They must be members of the Program with qualifying premium contributions;
- c. They must comply with the provisions set forth in the performance commitment for professionals; and
- d. They must comply with any other requirements that may be determined by the Corporation.

No accreditation fees shall be imposed by the Corporation for health care professionals and shall not require a certificate of good standing or such other analogous certification for them to be accredited.

Findings on ethical issues by disciplinary bodies of accredited professional organizations of the Professional Regulation Commission (PRC) or specialty societies recognized by the Philippine Medical Association (PMA) in the case of medical specialists, shall be considered in assessing the performance of health care professionals. Suspension of membership in such professional organizations shall be given due consideration in assessing the continued accreditation of such professionals.

SECTION 62. Process of Accreditation for Health Care Professionals

The following is the process for all health care professionals for them to be accredited:

- a. The health care professional shall apply for accreditation by submitting duly accomplished forms and documents as required by the Corporation. Such documents shall be subject to verification and authentication at the discretion of the Corporation.
- b. The health care professional shall submit all requirements for accreditation for evaluation and processing.
- c. The Corporation shall determine the period of accreditation and reserves the right to issue or deny accreditation after an evaluation of the capability and integrity of the health care professional.
- d. Accreditation shall take effect prospectively.
- e. All matters pertaining to accreditation shall be decided by the Accreditation Committee whose decision shall become effective upon approval by the President and CEO. Such decision may be

the subject of a motion for reconsideration to be filed with the Accreditation Committee. Only one motion for reconsideration shall be entertained.

SECTION 63. Grounds for Denial/Non-Reinstatement of Accreditation

Any of the following shall be grounds for the denial/non-reinstatement of accreditation:

- a. Non-compliance with any or all of the requirements of accreditation;
- b. Revocation, non-renewal or non-issuance of license/ accreditation/ clearance to operate or practice of the health care provider by the DOH, PRC or government regulatory office or institution;
- c. Conviction due to fraudulent acts as determined by the Corporation until such time that the decision is reversed by the Appellate Court or the penalty has been fully served;
- d. Change in the ownership, management or any form of transfer either by lease, mortgage or any other transfer of a health care institution without prior notice to the Corporation; or,
- e. Such other grounds as the Corporation may determine.

Rule III PERFORMANCE MONITORING OF HEALTH CARE PROVIDERS

SECTION 64. Performance Monitoring System for Health Care Providers

The Corporation shall develop and implement a performance monitoring system for all health care providers. The monitoring system shall provide for, among others:

- a. Periodic actual inspection of facilities and offices when necessary and appropriate;
- b. Analysis of mandatory monthly hospital reports and other reportorial requirements as determined by the Corporation;
- c. Periodic review of health facility data and patient's chart review for purposes of determining quality and cost-effectiveness as well as adherence to practice guidelines by health care providers;
- d. Conduct of utilization review;
- e. Peer review, adverse reports and other pertinent information;
- f. Conduct of patient satisfaction surveys;
- g. Periodic assessment of the performance of all health care providers based on performance commitment and standards;
- h. Inspection and audit of books, records, billing statements, medical charts, doctor's notes, and other documents and processes deemed important by the Corporation to complete a thorough review;
- i. Inspection of books of accounts, ledgers, invoices, receipts and other accountable forms deemed relevant by the Corporation; and,

- j. Other mechanism or analogous process, as may be determined by the Corporation that would be necessary to conduct a complete audit and investigation.

Rule IV OUTCOMES ASSESSMENT

SECTION 65. System of Outcomes Assessment

The Corporation shall implement a system of assessing outcomes of services rendered by health care providers to include the following:

- a. Review of mortality and morbidity rates, post-surgical infection rates and other health outcome indicators;
- b. Conduct of outcomes research projects; and,
- c. Conduct of client satisfaction surveys.

A periodic report of outcomes assessment shall be submitted to the President/CEO and to the Board.

Rule V MECHANISM FOR FEEDBACK

SECTION 66. Mechanism for Feedback

The Corporation shall establish a mechanism aimed at improving quality of service and to periodically inform health care providers, program administrators and the public of the performance of accredited health care providers. The Corporation shall make known to the general public information on the performance of accredited health care providers-as well as those whose accreditation has been suspended or revoked by the Corporation.

Rule VI HEALTH TECHNOLOGY ASSESSMENT

SECTION 67. Health Technology Assessment

The Corporation shall use Health Technology Assessment (HTA) to examine the medical, economic, social and ethical implications of use of health technology in order to support its benefit and quality assurance policies within the context of actual needs, current standards of medical practice and national health objectives. The Corporation shall do this in partnership with the DOH, academe, government, medical professional organizations and other stakeholders. The outputs of HTA shall be one of the bases for inclusion or non-inclusion of health technologies in the benefit package.

Rule VII
POLICY FORMULATION AND REVIEW

SECTION 68. Policy Formulation

In formulating and designing policies to pursue the principles and objectives of the Program, the Corporation shall utilize and incorporate data, research results, reports and other information derived from the conduct of the preceding formal set of activities to ensure quality health care.

SECTION 69. Policy Review

The Corporation shall continuously evaluate and validate the relevance, efficacy and acceptability of existing policies in the light of the outcomes and results derived from the conduct of the Quality Assurance Program.

SECTION 70. Remedial Measures

As the need arises and based on data obtained from performance monitoring, remedial measures shall be imposed by the Corporation on particular health care providers found to be deficient in the delivery of cost-efficient and quality services.

Title VI
CREATION OF THE NATIONAL HEALTH INSURANCE FUND

Rule I
NATIONAL HEALTH INSURANCE FUND

SECTION 71. 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. Other appropriations earmarked by the national and local governments purposely for the implementation of the Program;
- c. Subsequent appropriations provided for under Sections 46 and 47 of the Act;
- d. Donations and grants-in-aid; and,
- e. All accruals thereof.

SECTION 72. Financial Management

The use, disposition, investment, disbursement, administration and management of the Fund, including any subsidy, grant or donation received for program operations shall be governed by applicable laws and in the absence thereof, existing resolutions 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 to the various funds under its control 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.

For the first five (5) years from the effectivity of the Act, the total annual cost shall not exceed the sum total of the following:

- a. Five percent (5%) of the total contributions;
- b. Five percent (5%) of the total reimbursements; and,
- c. Five percent (5%) of the investment earnings generated during the immediately preceding year.

Subsequently, the total annual costs for these shall not exceed the sum total of the following:

- a. Four percent (4%) of the total premium contributions collected during the immediately preceding year;
- b. Four percent (4%) of the total reimbursements or total cost of health services paid by the Corporation in the immediately preceding year; and,
- c. Five percent (5%) of the investment earnings generated during the immediately preceding year.

Rule II RESERVE FUNDS

SECTION 73. Reserve Funds

The Corporation shall set aside a portion of its accumulated revenues not needed to meet the cost of the current year's expenditures as reserve funds: Provided, That the total amount of reserves shall not exceed a ceiling equivalent to the amount actuarially estimated for two (2) years' projected Program expenditures: Provided further, that whenever actual reserves exceed the required ceiling at the end of the Corporation's fiscal year, the excess of the Corporation's reserve fund shall be used to increase the Program's benefits, decrease the members contributions, and augment the health facilities enhancement program of the DOH. Specific guidelines will be formulated in consultation with the Department of Finance.

The remaining portion of the reserve fund that are not needed to meet the current expenditure obligations or used for the above-mentioned programs shall be placed in 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 debt, securities and corporate bonds issuances: Provided, That such securities and bonds are rated triple “A” by authorized accredited domestic rating agencies: Provided, further, That the issuing or assuming entity or its predecessor shall not have defaulted in the payment of interest on any of its securities and that during each of any three (3) including last two (2) of the five (5) fiscal years next preceding the date of acquisition by the Corporation of such bonds, securities or other evidences of indebtedness, the net earnings of the issuing or assuming institution available for its recurring expenses, such as amortization of debt discount and rentals for leased properties, including interest on funded and unfunded debt, shall have been not less that one and one quarter (1 ¼) times the total of the recurring expenses for such year: Provided, further, That such investment shall not exceed fifteen percent (15%) of the investment reserve fund;
- c. 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;
- d. 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 corporation: 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 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; and,
- e. In bonds, securities, promissory notes or other evidence of indebtedness of accredited and financially sound medical institutions exclusively to finance the construction, improvement and maintenance of hospitals and other medical facilities: Provided, That such securities and instruments are backed up by the guarantee of the Republic of the Philippines or the issuing medical institution and the issued securities and bonds are both rated triple ‘A’ by authorized accredited domestic rating agencies: Provided, further, That said investments shall not exceed ten percent (10%) of the total investment reserve fund.

The Corporation shall formulate specific investment guidelines in consultation with the Department of Finance.

As part of its investments operations, the Corporation may hire institutions with valid trust licenses as its external local fund managers to manage the investment reserve fund, as it may deem appropriate, through public bidding. The fund managers shall submit annual reports on investment performance to the Corporation.

SECTION 74. Funds for Lifetime Members and Supplemental Benefits

The Corporation shall set up, at the appropriate time, the following funds:

- a. A fund to secure benefit payouts to members prior to their becoming lifetime members;

- b. A fund to secure payouts to lifetime members; and,
- c. A fund for any optional supplemental benefits that are subject to additional contributions.

A portion of each of the above funds shall be identified as current and kept in liquid instruments. In no case shall said portion be considered part of invested assets.

Another portion of the said funds shall be allocated for Lifetime Members within six (6) months after the effectivity of the Act. Said amount shall be determined by an actuary or pre-calculated based on the most recent valuation of liabilities.

The Corporation shall allocate a portion of all contributions to the fund for Lifetime Members based on an allocation to be determined by the PhilHealth actuary based on a pre-determined percentage using the current average age of members and the current life expectancy and morbidity curve of Filipinos.

The Corporation shall manage the supplemental benefits and the lifetime members' fund in an actuarially sound manner.

The Corporation shall manage the supplemental benefits fund to the minimum required to ensure that the supplemental benefit payments are secure.

Title VII

QUASI-JUDICIAL POWERS OF THE CORPORATION

Rule I

QUASI-JUDICIAL POWERS

SECTION 75. Quasi-Judicial Powers

The Corporation, to carry out its tasks more effectively, shall be vested with the following powers:

- a. Subject to the respondent's right to due process, 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. Subject to the respondent's right to due process, 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 this Rules. Suspension of accreditation shall not exceed six (6) months. Suspension of the rights of

members shall not exceed six (6) months.

- d. 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.

Rule II

THE BOARD AS A QUASI-JUDICIAL BODY

SECTION 76. The Board as Quasi-Judicial Body

The Board, as a quasi-judicial body, may sit en banc or in divisions in all cases brought before it for review.

The Corporation shall be governed by the Board, which shall be composed of the following members:

- The Secretary of Health;
- The Secretary of Labor and Employment or a permanent representative;
- The Secretary of the Interior and Local Government or a permanent representative;
- The Secretary of Social Welfare and Development or a permanent representative;
- The Secretary of Finance (DOF) or a permanent representative;
- The President and Chief Executive Officer (CEO) of the Corporation;
- The SSS Administrator (President & Chief Executive Officer) or a permanent representative;
- The GSIS General Manager (President and General Manager) or a permanent representative;
- The Vice-Chairperson for the basic sector of the National Anti-Poverty Commission or a permanent representative;
- The Chairperson of the Civil Service Commission (CSC) or a permanent representative;
- A permanent representative of Filipino Migrant Workers;
- A permanent representative of the members in the Informal Economy;
- A permanent representative of the members in the Formal Economy;
- A representative of employers;
- A representative of health care providers to be endorsed by their national associations of health care institutions and medical health professionals;
- A permanent representative of the elected Local Chief Executives to be endorsed by the League of Provinces, League of Cities and League of Municipalities; and,
- An independent Director to be appointed by the Monetary Board.

The Secretary of Health shall be the ex-officio Chairperson of the Board while the President and CEO shall be the Vice-Chairperson.

SECTION 77. Quorum and Votes Required

When sitting en banc or in divisions, the concurrence of the majority of all the members thereof shall be required to render a decision in all cases.

Rule III
The Prosecutors, Arbiters and Investigating Officers of the Corporation

SECTION 78. Jurisdiction and Qualifications of the Prosecutors and Arbiters of the Corporation

Prosecutors of the Corporation shall have the power and authority to conduct fact-finding investigation on complaints filed by any person or by the Corporation against health care providers and/or members, and if a prima facie case exists, to file and prosecute the complaint before the Arbiter. The Prosecutor may also administer oath in accordance with Chapter X, Section 41, paragraph 2 of Executive Order No. 292. A Prosecutor must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

Arbiters shall exercise original and exclusive jurisdiction over all complaints filed with the Corporation in accordance with R.A. 7875 as amended and this Rules. They shall have the power to administer oaths, issue subpoenas, (ad testificandum and duces tecum) and such other powers vested in them by R.A. 7875 and this Rules. An Arbiter must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three (3) years prior to appointment.

SECTION 79. Authority of the Investigating Officers of the Corporation

Investigating Officers shall exercise, among others, the powers and functions enumerated under Section 10 (m) of R.A. 7875 as amended and to administer oath in the performance of their official functions and duties.

Title VIII
RULES OF PROCEDURE ON ADMINISTRATIVE CASES AGAINST
HEALTH CARE PROVIDERS AND MEMBERS

Rule I
Complaints, Grounds, Venue and Parties

SECTION 80. Who May File

Any person, natural or juridical, may file a complaint against health care providers and/or members. The Corporation shall however have the authority to motu proprio direct the conduct of a fact-finding investigation and the filing of a case against HCPs and/or members.

SECTION 81. Grounds for a Complaint Against a Health Care Provider

A written complaint against a health care provider may be filed for the commission of any of the offenses enumerated in Rules I and II, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 82. Grounds for a Complaint Against a Member

A written complaint against a member may be filed for the commission of any of the offenses enumerated in Rule III, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 83. Where To File

The written complaint against a health care provider and/or member may be filed with any PhilHealth Regional Office (PRO) - Legal Office or directly with the Fact-Finding Investigation and Enforcement Department (FFIED) – Central Office .

Rule II FACT-FINDING INVESTIGATION

SECTION 84. Complaints Filed Before the Fact-Finding Investigation and Enforcement Department

For complaints filed before the FFIED, the following procedure shall be observed. Upon receipt of the complaint, the FFIED shall:

- a. Immediately docket the complaint;
- b. Conduct the necessary fact-finding investigation and issue the Fact-Finding Investigation Report (FFIR) within sixty (60) days;
- c. File the affidavit -complaint with the Prosecution Department within ten (10) days from the issuance of the FFIR if warranted by the same.

SECTION 85. Complaints Filed Before the Legal Office of the PRO

For complaints filed before the PRO Legal Office the following procedure shall be observed. Upon receipt of the complaint, the PRO Legal Office shall:

- a. Conduct the necessary fact-finding investigation, issue the FFIR along with its recommendation on whether to dismiss the complaint or file a case, and transmit the same to the FFIED within a period of sixty (60) days;
- b. Upon receipt of the FFIR, the FFIED shall immediately docket the same and, within ten (10) days, file the affidavit-complaint with the Prosecution Department, if warranted by the FFIR.

Rule III PRELIMINARY INVESTIGATION BEFORE THE PROSECUTION DEPARTMENT

SECTION 86. Duty of the Prosecutor

After receipt of an affidavit-complaint, the investigating prosecutor shall immediately conduct

the preliminary investigation. The investigating prosecutor may, from an examination of the allegations in the affidavit-complaint and such evidence as may be attached thereto, dismiss the same outright on any of the following grounds:

- a. Lack of jurisdiction over the subject matter;
- b. Failure to state a cause of action; or,
- c. Insufficiency of evidence.

SECTION 87. Directive to Answer

If no ground for dismissal is found, the investigating prosecutor shall issue the corresponding directive to the respondent health care provider and/or member directing the respondent/s to file their verified answer in three (3) copies to the affidavit-complaint within five (5) calendar days from receipt of the directive.

SECTION 88. Finding of a Prima Facie Case

If from an evaluation of the affidavit-complaint, answer and other evidence attached thereto, the investigating prosecutor finds a prima facie case against the respondent health care provider/member, the investigating prosecutor shall submit the resolution together with the formal complaint for the approval of the Senior Vice-President for Legal Sector (SVP-LS) within thirty (30) days from receipt of the answer or from the expiration of the period to file the same.

SECTION 89. Period for Approval of the Senior Vice-President for Legal Sector

The SVP-LS shall have five (5) days from receipt of the formal complaint and resolution to act on the same. If no action is taken within the given period, the formal complaint and resolution shall be deemed approved.

SECTION 90. Finality of Resolutions

The resolution of the prosecutor duly approved by the SVP-LS shall be final. No motion for reconsideration (MR) or similar pleadings shall be allowed and entertained.

Rule IV
CONTENTS OF THE FORMAL COMPLAINT

SECTION 91. Caption and Title

The formal complaint shall be filed in accordance with the following caption:

REPUBLIC OF THE PHILIPPINES
PHILIPPINE HEALTH INSURANCE CORPORATION
(PLACE)
Arbitration Office

PHIC Case No. _____

(I.S. No. _____)

Philippine Health Insurance Corporation,
Complainant,
-versus-

Respondent/s.

x- ----- x

SECTION 92. Contents of Formal Complaint

A formal complaint shall contain, among others, the following:

- a. The name and address of the complainant;
- b. The name/s and address/es of the respondent/s health care provider/s and/or member/s;
- c. A clear and concise statement of the cause/s of action; and,
- d. The relief/s sought.

Rule V
PROCEDURE BEFORE THE ARBITRATION OFFICE

SECTION 93. Docket Number

A formal complaint shall be filed by the Prosecution Department with the docket clerk of the Arbitration Office in three (3) copies with annexes. The docket clerk shall then assign a docket

number to the formal complaint in the order of the date and time of filing and shall immediately endorse the complaint to the Arbiter for appropriate action.

SECTION 94. Service of Summons

Upon receipt of the docketed formal complaint, the Arbiter shall then issue the summons to the respondent/s, directing them to file their verified answers in three (3) copies, furnishing the Prosecution Department with another copy, with a notice that unless the respondent/s so answers, the complainant will take judgment by default and demand from the Arbiter the relief/s applied for. A copy of the complaint with the supporting documents shall be attached to the original copy of the summons. Service of summons shall be made either personally or by registered mail.

SECTION 95. Proof of Service

The proof of personal service of the summons shall be made in the form of an affidavit of service executed by the server who shall state the manner, place, and date of service and shall specify any papers which have been served with the process and the name of the person who received the same.

Service of summons by registered mail may be proved by a certificate of the server attesting that a copy of the summons and papers attached thereto, enclosed in an envelope and addressed to the respondent, with postage prepaid, has been mailed to which certificate the registry receipt and return card shall be attached to the certificate.

SECTION 96. Verified Answer

Within fifteen (15) calendar days from service of the summons and a copy of the complaint with supporting documents, respondent shall file a verified answer and serve a copy thereof to the complainant. Affirmative and negative defenses not pleaded therein shall be deemed waived except lack of jurisdiction over the subject matter. Failure to specifically deny any of the material allegations in the complaint shall be deemed an admission thereof.

No motion to dismiss shall be entertained, except one filed on the ground of lack of jurisdiction over the subject matter or failure to state a cause of action.

SECTION 97. Default

Should the respondent/s fails to file a verified answer to the complaint within the prescribed period, the Arbiter may, motu proprio or on motion of the complainant, render judgment as may be warranted by the facts and evidence alleged in the complaint.

SECTION 98. Pre-Hearing and Formal Hearing

Should the Arbiter find it necessary to conduct a formal hearing, an order setting the pre-hearing shall be issued. Such order shall further set the date or dates of the hearings and specify the witnesses who will be called to testify therein. All formal hearings shall be terminated as soon as possible.

SECTION 99. Affidavits and Position Papers

After a verified answer is filed and the issues are joined, the Arbiter shall issue an order requiring the parties to simultaneously submit their respective position paper within fifteen (15) calendar days from receipt of the order. The position paper shall contain a brief statement of the positions of the parties, setting forth the law and the facts relied upon them, including the affidavits of the witnesses and other evidence on the factual issues defined therein.

SECTION 100. Rendition of Judgment

The Arbiter shall have a period of one hundred twenty (120) days, upon receipt from the Prosecution Department of the formal complaint with complete supporting documents in three (3) copies, within which to render judgment.

SECTION 101. Procedure of Trial

Whenever the conduct of a hearing is deemed necessary by the Arbiter, the affidavits submitted by the parties shall constitute the testimonies of the witnesses who executed the same. Witnesses who testify may be subjected to clarificatory questions by the Arbiter. No witness shall be allowed to testify unless a corresponding affidavit was previously submitted to the Arbiter.

SECTION 102. Role of Arbiter in Proceedings

The Arbiter shall:

- a. Personally conduct the hearings and determine the order of presentation of evidence by the parties;
- b. Take full control of the proceedings and as becomes necessary, ask clarificatory questions to the parties and their witnesses with respect to the matters at issue; and,
- c. Limit the presentation of evidence to matters relevant to the issue/s.

SECTION 103. Powers of the Arbiter

The Arbiter shall:

- a. Conduct proceedings or any part thereof in public or in executive session;
- b. Adjourn hearings to any time and place;
- c. Refer technical matters or accounts to an expert and to accept the report as evidence;
- d. Direct parties to be joined or excluded from the proceedings;
- e. Give such directions as may be deemed necessary or expedient in the resolution of the dispute at hand;
- f. Summon the parties to a controversy;
- g. Issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other necessary material/s;

- h. Administer oaths; and,
- i. Certify official acts.

Whenever a person, without lawful excuse, fails or refuses to take an oath or to produce documents for examination or to testify, in disobedience to a lawful subpoena issued by the Arbiter, the latter may invoke the aid of the Regional Trial Court within whose territorial jurisdiction the case is being heard to cite such person in contempt, pursuant to Section 14, Chapter 3, Book VII of the Revised Administrative Code.

SECTION 104. Non-Appearance of Parties at Hearings

When the complainant or respondent fails to appear at the trial on two (2) successive occasions, despite due notice thereof, the Arbiter may *motu proprio* or upon motion of the opposing party, dismiss the case or deem the case submitted for resolution based on the records on hand, respectively. The complainant may, by proper motion with proper justification and within ten (10) calendar days after the resolution is received, ask for the reopening of the case.

The withdrawal or desistance of the complainant shall not bar the Arbiter from proceeding with the hearing of the complaint against the respondent. The Arbiter shall act on the complaint as may be merited by the complaint and evidence on record and impose such penalties on the erring respondent as may be deemed appropriate.

SECTION 105. Postponement of Hearing

The parties and their counsel or representative appearing before an Arbiter shall be prepared for continuous hearing. Postponements or continuances of hearing shall not be allowed by the Arbiter except upon meritorious grounds and subject always to the requirement of expeditious disposition of cases.

SECTION 106. Records of Proceedings

Except when any or both of the parties request that the proceedings be duly transcribed, the proceedings before an Arbiter need not be recorded by stenographers. The Arbiter shall make a written summary of the proceedings, including the substance of the evidence presented, in consultation with the parties. The written summary shall be signed by the parties and shall form part of the records.

SECTION 107. Contents of Decisions

The decision of the Arbiter shall be clear and concise and shall include a brief statement of the following:

- a. Facts of the case;
- b. Issue/s involved;
- c. Applicable laws or rules;
- d. Conclusions and the reasons therefor; and,
- e. Specific remedy or relief granted.

SECTION 108. Motion For Reconsideration

No motion for reconsideration (MR) or similar pleadings shall be allowed and entertained on the decision of the Arbitration Office. The filing of such pleading shall not toll or interrupt the period for filing an appeal to the Board.

Rule VI APPEAL TO THE BOARD

SECTION 109. Grounds

The decision of the Arbitration Office may be appealed to the Board on any of the following grounds:

- a. The existence of a prima facie evidence of abuse of discretion on the part of the Arbiter, due to a misappreciation of facts or misapplication of law, or both;
- b. The decision was secured through fraud or coercion, including graft and corruption;
- c. The appeal is grounded on questions of law;
- d. Serious errors in the finding of facts which, if not corrected, would cause grave or irreparable damage or injury to the appellant.

SECTION 110. Filing of Appeal (Notice and Memorandum of Appeal)

A notice of appeal accompanied by a memorandum of appeal shall be filed through the Arbitration Office in at least three (3) copies.

SECTION 111. Who May File An Appeal

Any party to the case may appeal from a decision of the Arbitration Office.

SECTION 112. Appeal Fee and Appeal Bond

Except when the appellant is the Corporation or a member of the sponsored program, the appellant shall pay an appeal fee in an amount of ten percent (10%) of the imposed fine but not exceeding ten thousand pesos (P10,000.00) and shall post an appeal bond in the form of cash or surety bond in the amount equivalent to the fine imposed in the decision appealed from. Proof of such payment and posting shall be attached to the notice of appeal.

SECTION 113. Period of Appeal

The decision of the Arbitration Office shall be final and executory unless validly appealed to the Board within fifteen (15) calendar days from receipt of such decision in accordance with this Rules. If the last day falls on a Saturday, Sunday, holiday, or declared a non- working day due to force majeure, the last day to file and perfect the appeal shall be the next working day.

SECTION 114. No Extension of Appeal Period

No motion or request for extension of the period within which to file an appeal shall be allowed and entertained.

SECTION 115. Perfection of Appeal

An appeal shall be perfected and valid only upon the filing with the Arbitration Office of the following within the prescribed fifteen (15)-day period:

- a. Notice of appeal;
- b. Memorandum of appeal;
- c. Proof of payment of the appeal fee; and,
- d. Proof of posting of appeal bond.

Non-perfection of the appeal as provided in this Rules shall be a valid ground for the immediate dismissal by the Arbitration Office of the appeal and renders the decision final and executory.

SECTION 116. Memorandum of Appeal of Appellant

A memorandum of appeal shall state the date when the appellant received the appealed decision, the grounds relied upon, the arguments in support thereof, the relief prayed for, and shall be accompanied by an affidavit of service on the other party of such memorandum.

SECTION 117. Transmittal of the Records of the Case on Appeal

The Arbitration Office shall transmit the entire records of the case to the Board within five (5) calendar days from receipt of a perfected appeal.

Rule VII REVIEW OF APPEALED ADMINISTRATIVE CASES

SECTION 118. Jurisdiction

The Board en banc shall have exclusive appellate jurisdiction to act, determine, review and decide all perfected appeals of health care providers and members involving decisions on administrative cases promulgated by the Arbitration Office.

SECTION 119. Delegation of Review

The Board en banc shall delegate to a division thereof the study and review of the decisions on administrative cases brought before it on appeal and the division shall submit its report and recommendation to the Board en banc. Such division shall be named as the Committee on Appealed Administrative Cases (CAAC) against health care providers and members.

SECTION 120. Composition of CAAC

The CAAC shall be composed of five (5) Board Members designated as such by the Board en banc. The members of the CAAC shall elect among themselves its Chairperson and Vice-Chairperson. The Chairperson, or in his/her absence, the Vice-Chairperson, shall preside over all meetings of CAAC.

SECTION 121. Review and Recommendation by CAAC

The CAAC shall study and review the decisions on administrative cases brought before the Board on appeal. It shall have the power to study and report the appellant's compliance with all the requirements of appeal, review the grounds of appeal, and provide reports and recommendations to the Board en banc. With the concurrence and approval of the majority of all its members, the CAAC shall elevate its written report and draft decision to the Board en banc for the latter's consideration and approval.

SECTION 122. Decision En Banc

The concurrence of the majority of the members of the Board constituting a quorum during the en banc session shall be required to approve the written reports, recommendations and draft decisions of the CAAC and to promulgate the decisions on the appealed administrative cases.

If the report and recommendation of the CAAC is not approved by the Board en banc, then the Chairperson of the Board will designate one of its members, who was part of the majority who voted not to approve such report and recommendation, to draft the decision for the consideration and approval of the Board en banc.

SECTION 123. Inhibition

Any Board Member may inhibit himself/herself from the consideration and resolution of any case/matter before the Board and shall so state in writing the grounds therefor.

Rule VIII PROCEDURE BEFORE THE BOARD ON APPEALED CASES

SECTION 124. Functions of the Clerk of the Board

The Corporate Secretary shall act as the Clerk of the Board and the CAAC and shall assign one of its personnel to perform the following functions:

- a. Receive all pleadings, motions, and other papers required to be filed with the Board and CAAC in connection with any appeal pending therewith and to legibly stamp the date and hour of the filing thereof duly signed by the receiving personnel. If the filing is by registered mail, the Office of the Corporate Secretary shall legibly stamp or indicate on the first page of the pleading, motion or other paper the date of receipt thereof, the fact that the same was received by registered mail and the date of posting thereof, duly signed by the receiving personnel. The corresponding envelope or portion thereof showing the date of posting and registry stamp shall be attached to the rollo;

- b. Keep such books as may be necessary for recording all the proceedings of the Board and the CAAC;
- c. Send notices to the appellant as regards the filing of the verified memorandum of appeal and the submission of the appeal bond;
- d. Require the parties to submit the necessary pleadings, required number of copies of their pleadings, and/or legible copies of the assailed decision or order; and,
- e. Enter judgment upon finality of a decision or final resolution.

SECTION 125. Comment/Answer or Reply of Appellee

The appellee may file its comment/answer or reply to appellant's memorandum of appeal with the Clerk of the Board within a period of fifteen (15) calendar days from receipt of the memorandum of appeal. Failure to file such comment/answer within the said period shall be construed as a waiver to file the same.

SECTION 126. Rejoinder

The appellant may file its rejoinder to the comment/answer filed by the appellee within a period of ten (10) calendar days from receipt of such comment/answer. Failure to file such rejoinder within the said period shall be construed as a waiver to file the same.

Rule IX DECISION PROCESS

SECTION 127. Reply/Deliberation of Appealed Case

The CAAC shall deliberate and make a study and written report on the appealed case within sixty (60) calendar days from the time of the submission of the appellant's rejoinder or upon the expiration of the period to file the same.

SECTION 128. Substantial Evidence

The CAAC shall determine whether or not there exists substantial evidence in deliberating on and studying the appealed case. Substantial evidence is that amount of relevant evidence which a reasonable mind might accept as adequate to justify a conclusion.

In determining whether or not to affirm the decision of the Arbitration Office, the CAAC shall take into account the presence or absence of mitigating, aggravating circumstances and prior violations, if any, of the respondent health care provider or member, and the possible impact to the community/members of imposing administrative penalties against the appealing respondent.

SECTION 129. Assignment of the Appealed Case

The CAAC Chairperson shall assign to its member to write the report and recommendation and

draft decision based on the deliberations conducted by the CAAC. Thereafter, the Clerk of the Board shall present the report and draft decision for the consideration and approval of the Board en banc.

SECTION 130. Decision or Resolution on Appeal

The Board en banc shall resolve the appeal within sixty (60) calendar days from receipt of the entire records of the case.

SECTION 131. Form of Decision or Resolution

The decision or resolution of the Board en banc shall state clearly and distinctly the findings of facts, issues and conclusions of law on which it is based and the relief/s granted, if any.

SECTION 132. Promulgation of Decisions and Resolutions

Promulgation of decisions or resolutions shall be the direct responsibility of the Clerk of the Board.

- a. Promulgation is made by filing the decision or resolution with the Clerk of the Board, who shall forthwith annotate the date and time thereof and attest to it by his/her signature thereon.
- b. The Clerk of the Board shall record in the promulgation book the docket number, title of the case, nature of the document (whether decision or resolution), and the action taken by the Board en banc. The promulgation book shall be under his/her care and custody.
- c. Immediately after promulgation of a decision or resolution, the Clerk of the Board shall forward the original and two (2) copies thereof to the Arbitration Office for proper action.
- d. Within seven (7) working days from the promulgation of a decision or resolution, the Clerk of the Board shall send notices and copies thereof in sealed envelopes to the parties through their counsel, either personally or by registered mail.

Rule X ENTRY OF JUDGMENT

SECTION 133. Entry of Judgment and Final Resolution

If no appeal or motion for reconsideration is filed within the time provided in this Rules, the decision or final resolution shall forthwith be entered by the Clerk of the Board in the book of entries of judgments. The date when the judgment or final resolution becomes executory shall be deemed as the date of its entry. The record shall contain the dispositive part of the decision or final resolution and shall be signed by the Clerk of the Board, with a certificate that such decision or final resolution has become final and executory.

SECTION 134. Form

Entry of judgment shall be made in the prescribed form, signed by the Clerk of the Board, who shall certify the date when the decision or resolution was promulgated and the date it became final and executory.

Rule XI
EXECUTION OF A DECISION

SECTION 135. Execution of a Decision

Any decision of an Arbiter or of the Board in a complaint filed against a health care provider or member shall be executed after the same shall have become final and executory; Provided that, the penalty of fine shall first be satisfied or paid from the forfeiture of the appeal bond if applicable. The decision may be enforced and executed in the same manner as decisions of the Regional Trial Court. The Board shall have the power to issue to the City or Provincial Sheriff or the Sheriff whom it may appoint such needed writs of execution. Any person who shall fail or refuse to comply with such decision or writ after being required to do so shall, upon application by the Board, be punished by the proper court for contempt. The decision of the Board shall immediately be executory even pending appeal when the public interest so requires and unless such decision expressly states otherwise.

Rule XII
WRIT OF EXECUTION ON HEALTH CARE INSTITUTIONS

SECTION 136. Writ of Execution on Health Care Institutions

After the lapse of the fifteen (15) day period to appeal decisions of the Arbiter wherein the penalty imposed is suspension or revocation of accreditation, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension or revocation has become final and executory and upon motion of the prosecution, an order granting the issuance of a writ of execution ("writ" for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension or revocation, as the case may be, which in no case shall be earlier than sixty (60) days from the date of issuance of the writ. no motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

SECTION 137. Directive to Execute Writ

Attached to the order granting the issuance of the writ is the directive to the Legal Office under whose regional jurisdiction the respondent health care institution is situated to execute and implement it. Copies of the said directive shall likewise be furnished to the Office of the Regional Vice-President or Head of the receiving PRO, the Accreditation and Prosecution Departments of the Central Office.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent health care institution within seven (7) days. The Legal Office shall also coordinate and inform the Accreditation Unit and Benefit Administration Section of the PRO upon its receipt of the writ.
- b. In the event that the authorized officials or representatives of the respondent health care institution refuse to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof at the premises of the health care institution.

Tender of the writ is tantamount to an effective service of the same.

- c. After personal service of the writ, the Legal Office shall submit within seven (7) days a report or certification of compliance to the directive, attaching thereto satisfactory evidence or proof of service, to the Arbiter and the Manager of the Accreditation Department. The Legal Office shall keep a record of the writs received and personally served for verification purposes.
- d. After receipt of the compliance report or certification, the Accreditation Department shall then commence appropriate revisions in the database of the accreditation status of the respondent health care institution. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO wherein the respondent health care institution is situated once the revision has been effected.

SECTION 138. Notice of Suspension/Revocation

Within ten (10) days prior to the commencement of the suspension or revocation as stated in the writ, the Legal Office together with representatives from the Accreditation Unit of the PRO, shall post notices of suspension/revocation ("notice" for brevity) in three (3) conspicuous areas of the facility, namely (1) near the signage which says "PhilHealth Accredited"; (2) the main entrance; and (3) the billing or accounting office where settlement of hospital bills are transacted.

- a. The notice must be made of white tarpaulin and in the same size as that of the required signage and in bold black letters must state clearly and visibly as follows: "the PhilHealth Accreditation of (name of hospital) is suspended from (date of start) until (date of conclusion). No claims for confinements at this hospital during this period shall be received, processed and paid by PhilHealth" or "the PhilHealth Accreditation of (name of hospital) is revoked effective on (date). No claims for confinements on such date and onwards shall be paid by PhilHealth", as the case may be. If possible, a translation in the vernacular may likewise be inserted in the notice. With due consent of the convicted health care provider, the signage of "PhilHealth Accredited" or any other sign or marker informing the public of its PhilHealth accreditation should be removed if possible.
- b. The Legal Office and Accreditation Unit representatives shall exhaust all efforts to monitor faithful compliance on the posting of the notice and to the writ by the respondent health care institution. In case there shall be a violation of the same, such acts shall constitute a ground for the filing of a new case for the administrative offense of breach of Warranties of Accreditation/Performance Commitment.
- c. The PRO through its public relations/information office shall exert efforts to inform PhilHealth members of the suspension or revocation of accreditation of the respondent health care institution in their region after the writ has been served.

SECTION 139. Report

After satisfaction of the writ and within fifteen (15) days from the expiration of the period of suspension, the Legal Office shall make a report stating therein that the provider faithfully complied with the same. The report shall be addressed to the Executive Arbiter and Manager of the Accreditation Department.

SECTION 140. Deduction of Fines from Benefit Claims

Where the respondent health care institution refuses or fails to timely satisfy or pay the penalty of fine despite having been duly served with a writ of execution, the said fine shall be deducted by the Corporation from the proceeds of the pending or future benefit claims with the Corporation of the respondent health care institution.

Rule XIII WRIT OF EXECUTION ON HEALTH CARE PROFESSIONALS

SECTION 141. Writ of Execution on Health Care Professionals

After the lapse of the fifteen (15) day period to appeal decisions of the Arbiter wherein the penalty imposed is suspension or revocation of accreditation, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension or revocation has become final and executory and upon motion of the prosecution, an order granting the issuance of a Writ of Execution (“writ” for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension or revocation, as the case may be, which in no case shall be earlier than sixty (60) days from the date of issuance of the writ. no motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

SECTION 142. Directive to Execute Writ

Attached to the order granting the issuance of the writ is the directive to the Legal Office under whose regional jurisdiction the respondent health care professional is situated, to execute and implement it. Copies of the said directive shall likewise be furnished to the Office of the Regional Vice-President or Head of the receiving PRO, the Accreditation and Prosecution Departments of the Central Office.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent health care professional within seven (7) days. The Legal Office shall also coordinate with and inform the Accreditation Unit and Benefits Administration Section of the PRO upon its receipt of the writ. Personal service of the writ shall be made on the last known residential address of the professional or in the institution wherein the professional regularly or is otherwise known to practice, as supplied by the professional to the Accreditation Department.
- b. In the event that the respondent health care professional refuses to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof. Tender of the writ is equivalent to an effective service of the same.
- c. In the event that personal service of the writ is no longer feasible due to valid and justified reasons, service by registered mail at the last known address of the professional shall be resorted to.
- d. After service of the writ under the modes above-mentioned, the Legal Office shall submit within fifteen (15) days a report or certification of compliance to the directive, attaching thereto

satisfactory evidence or proof of service, to the Arbiter and the Manager of the Accreditation Department. In case the service shall be via registered mail, an explanation on the failure to personally serve the writ must be stated along with the verification of relevant dates to confirm completeness of service under this mode. The Legal Office shall keep a record of the writs received and personally served for verification purposes.

- e. After receipt of the compliance report or certification, the Accreditation Department shall then commence appropriate revisions in the database on the accreditation status of the respondent health care professional. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO wherein the respondent health care professional is situated once the revision has been effected.

SECTION 143. Claims Filed with Suspended Professional

All claims for reimbursement filed with PhilHealth involving the suspended professional shall be denied payment with respect to the claim for the professional fees only but may still be subject to appeal following the regular procedures for appealed claims. Health care institutions are hereby enjoined to refrain from endorsing or referring PhilHealth members to suspended professionals who regularly render service or practice in their institution so as to avoid undue delay in the processing of their claims.

SECTION 144. Report

After satisfaction of the writ and within fifteen (15) days from the expiration of the period of suspension, the Legal Office shall make a report, stating therein that the respondent faithfully complied with the same. The report shall be addressed to the Executive Arbiter and Manager of the Accreditation Department of the Central Office.

SECTION 145. Deductions of Fines from Benefit Claims

Where the respondent health care professional refuses or fails to timely satisfy or pay the penalty of fine despite having been duly served with a writ of execution, the said fine shall be deducted by the Corporation from the proceeds of the pending or future benefit claims with the Corporation of the respondent health care professional.

Rule XIV WRIT OF EXECUTION ON MEMBERS

SECTION 146. Writ of Execution on Members

After the lapse of the fifteen (15) day period to appeal the decisions of the Arbiter wherein the penalty imposed is payment of fine and/or suspension of availment of PhilHealth benefits, or after the decision of the Board on appealed cases affirming the imposition of the penalty of suspension has become final and executory and upon motion of the prosecution, an order granting the issuance of a Writ of Execution (“writ” for brevity) shall be issued by the Arbiter. The writ shall state therein the exact date of implementation and effectivity of the suspension which in no case shall be earlier

than sixty (60) days from the date of issuance of the writ. No motion for reconsideration, opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the decision is not yet final and executory or that the penalties imposed therein have already been fully satisfied.

- a. After receipt of the directive to execute, the respective Legal Office shall personally serve the writ to the respondent member within seven (7) days. The Legal Office shall also coordinate with and inform the concerned offices of the PRO upon its receipt of the writ. Personal Service of the writ shall be made on the last known residential address of the member.
- b. In the event that the respondent member refuses to expressly receive the writ, the Legal Office shall take note of such refusal and tender the writ by leaving a copy thereof. Tender of the writ is equivalent to an effective service of the same.
- c. In the event that personal service of the writ is no longer feasible due to valid and justified reasons, service by registered mail at the last known address of the member shall be resorted to.
- d. After service of the writ under the modes above-mentioned, the Legal Office shall within fifteen (15) days submit a report or certification of compliance to the directive, attaching thereto satisfactory evidence or proof of service, to the Executive Arbiter and Heads of the concerned offices. In case the service shall be via registered mail, an explanation on the failure to personally serve the writ must be stated along with the verification of relevant dates to confirm completeness of service under this mode. The Legal Office shall keep a record of the writs received and personally served for verification purposes.
- e. After receipt of the compliance report or certification, the concerned offices shall then commence appropriate action in the database and shall inform the Arbiter of the action taken.

SECTION 147. Claims Filed by Suspended Member

All benefit claims for reimbursement filed with PhilHealth involving the suspended member shall be denied payment but may still be subject to appeal following the regular procedures for appealed claims.

SECTION 148. Report

After satisfaction of the writ, the Legal Office shall make a report, stating therein that the respondent member faithfully complied with the same, within fifteen (15) days from the expiration of the period of suspension. The report shall be addressed to the Executive Arbiter and Head of concerned office of the Central Office.

Rule XV APPEAL TO THE COURT OF APPEALS

SECTION 149. Appeal to Court of Appeals of Board Decisions

Final orders and decisions of the Board may be reviewed by the Court of Appeals through an appeal in accordance with the provisions of Revised Administrative Circular No. 1-95 issued by the

Supreme Court on May 16, 1995, pursuant to Republic Act No. 7902, approved on February 23, 1995, expanding the jurisdiction of the Court of Appeals.

Title IX

DEFINITION OF ADMINISTRATIVE OFFENSES AND PENALTIES

Rule I

OFFENSES OF HEALTH CARE INSTITUTIONS

SECTION 150. Padding of Claims

Any health care institution who, for the purpose of claiming payment from the Program, files a claim for benefits which are in excess of the benefits actually provided by adding drugs, medicines, supplies, procedures and services.

SECTION 151. Claims for Non-Admitted or Non-Treated Patients

This is committed by any health care institution who, for the purpose of claiming payment from the Program, files a claim for a non-admitted or non-treated patient by:

- a. Making it appear that the patient was actually confined or treated in the health care institution; or,
- b. Using such other machinations that would result in claims for non-admitted or non-treated patient.

SECTION 152. Extending Period of Confinement

This is committed by any health care institution who, for the purpose of claiming payment from the Program, files a claim with extended period of confinement by:

- a. Increasing the period of actual confinement of any patient;
- b. Continuously charting entries in the Doctor's Order, Nurse's Notes and Observation despite actual discharge or absence of the patient; or,
- c. Using such other machinations that would result in the unnecessary extension of confinement.

SECTION 153. Post-Dating of Claims

Any health care institution who, for purposes of claiming payment from the Program, files a claim for payment of services rendered not within sixty (60) calendar days from the date of discharge of the patient or such other prescriptive periods as the Corporation may issue but makes it appear so by changing, erasing, adding to the period of confinement or in any manner altering dates so as to conform with the adopted prescriptive period.

SECTION 154. Misrepresentation by Furnishing False or Incorrect Information

Any health care institution shall be liable for fraudulent practice when, for the purpose of participation in the Program or claiming payment therefrom, it furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules. This offense covers or includes, but is not limited to, the following acts involving benefit claims for case-rate payment:

- a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure;
- b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment; or,
- c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

SECTION 155. Filing of Multiple Claims

Any health care institution who files two or more claims for a patient for the same confinement or out-patient treatment or illness.

SECTION 156. Unjustified Admission Beyond Accredited Bed Capacity

Any private health care institution who, for the purpose of claiming payment from the Program, files claims for patients confined in excess of its accredited bed capacity at any given time without justification in the form and manner prescribed by the Corporation.

SECTION 157. Unauthorized Operations Beyond Service Capability

Any primary care facility which performs a surgical operation beyond its authorized capability except when the operation is done in an emergency to save life and referral to a higher category provider is physically impossible.

SECTION 158. Fabrication or Possession of Fabricated Forms and Supporting Documents

Any health care institution who is found preparing claims with misrepresentations or false entries, or to be in possession of claim forms and other documents with false entries.

SECTION 159. Other Fraudulent Acts

Any health care institution shall also be liable for the following fraudulent acts:

- a. Making it appear that the patient suffered from a compensable illness or underwent a compensable procedure;
- b. Failure or refusal to give benefits due to qualified members/dependents;
- c. Charging qualified patients for medicines and/or services which are legally chargeable to and covered by the Program;

- d. Failure or refusal to refund to the member the payment received from the Program within a period of thirty (30) days from the date of receipt of the refund check from the Corporation when the hospital charges and professional fees are fully paid in advance by the member;
- e. Failure or refusal to accomplish and submit the required forms in connection with letter d.;
- f. Failure or refusal to provide the members with the required forms for direct filing of claims, billing statements, official receipts and other documents required/necessary for filing of claims; or,
- g. Deliberate failure or refusal to comply with the requirements of RA 7875 as amended and this Rules.

SECTION 160. Breach of the Warranties of Accreditation/Performance Commitment

Any health care institution who commits any breach of the Warranties of Accreditation/Performance Commitment.

SECTION 161. Criminal Liability

In addition, a criminal complaint shall be filed against the officials of the erring institutional health care providers before the appropriate Office of the Prosecutor for violations of this Rules and/or the Revised Penal Code.

**Rule II
OFFENSES OF HEALTH CARE PROFESSIONALS**

SECTION 162. Misrepresentation by False or Incorrect Information

Any health care professional shall be liable for fraudulent practice when, for purposes of participation in the Program or claiming payment from the Corporation, furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules. This offense covers or includes but is not limited to the following acts involving benefit claims for case-rate payment:

- a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure;
- b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment;
- c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

SECTION 163. Breach of the Warranties of Accreditation/Performance Commitment

Any health care professional found to have committed any breach of the Warranties of Accreditation /Performance Commitment .

SECTION 164. Other Violations

Any other willful or negligent act or omission of the health care professional in violation of RA 7875 as amended and this Rules which tends to undermine or defeat the objectives of the Program shall be dealt with in accordance with Section 44 of RA 7875 as amended.

SECTION 165. Criminal Liability

In addition, a criminal complaint shall be filed against erring health care professionals before the appropriate Office of the Prosecutor for violations of this Rules and/or the Revised Penal Code.

Rule III OFFENSES OF MEMBERS

SECTION 166. Fraudulent Acts

Any member who, for purposes of claiming PhilHealth benefits or entitlement thereto, shall commit any of the offenses provided for in Sections 150 to 159 and Sections 162 and 164 hereof, independently or in connivance with the health care provider.

SECTION 167. Criminal Liability

In addition, a criminal complaint shall be filed against the member before the Office of the Prosecutor for the appropriate offenses under the Revised Penal Code.

Rule IV CLASSIFICATION OF ADMINISTRATIVE OFFENSES

SECTION 168. Non-Fraudulent Offenses

The following are considered as non-fraudulent offenses:

- a. Breach of the Warranties of Accreditation/Performance Commitment;
- b. Filing of multiple claims;
- c. Unjustified admission beyond accredited bed capacity; and
- d. Unauthorized operations beyond service capability.

SECTION 169. Fraudulent Offenses

The following are considered as fraudulent offenses:

- a. Padding of claims;

- b. Claims for non-admitted or non-treated patients;
- c. Extending period of confinement;
- d. Post-dating of claims;
- e. Misrepresentation by false or incorrect information;
- f. Misrepresentation by furnishing false or incorrect information;
- g. Fabrication or possession of fabricated forms and supporting documents; and
- h. Other fraudulent acts

SECTION 170. Scale of Administrative Penalties

The following administrative penalties shall be respectively imposed on cases involving non-fraudulent and fraudulent offenses:

a. Non-Fraudulent Offenses

First Offense	Suspension of 3 months and/or Fine of not less than P50,000.00 but not more than P70,000.00
Second Offense	Suspension of 4 months and/or Fine of not less than P70,000.00 but not more than P90,000.00
Third Offense	Suspension of 6 months and/or Fine of not less than P90,000.00 but not more than P100,000.00
Fourth Offense	Revocation of accreditation and Fine of P100,000.00

b. Fraudulent Offenses

First Offense	Suspension of 3 months to 4 months and/or Fine of not less than P50,000.00 but not more than P70,000.00
Second Offense	Suspension of 4 months and 1 day to 6 months and/or Fine of not less than P70,000.00 but not more than P90,000.00
Third Offense	Revocation of accreditation and Fine of P100,000

Any member who, for purposes of claiming PhilHealth benefits or entitlement thereto, shall commit any of the above-mentioned offenses, independently or in connivance with the health care provider, shall suffer the penalties of a fine of not less than Five Thousand Pesos (5,000.00) but not more than Ten Thousand Pesos (10,000.00) and/or suspension from availment of PhilHealth benefits for not less than three (3) months but not more than six (6) months.

SECTION 171. Cumulative Application of Penalties/Recidivists

The determination of the degree of imposable administrative penalties shall be based cumulatively on the number of the offense or offense(s) of the same classification (non-fraudulent/fraudulent) that the appealing health care provider or member has been found guilty of in a prior case and/or decision. Guilt on two or more counts of the same offense in a decision shall be considered as one

offense.

Recidivists are health care providers who have been found guilty of the maximum number of offenses and meted the penalty of revocation of accreditation in accordance with the herein Scale of Administrative Penalties. Recidivists may no longer be accredited by the Corporation.

Rule V GENERAL PROVISIONS

SECTION 172. Mitigating and Aggravating Circumstances

The following circumstances shall affect the gravity of the violation and the liability of the erring health care provider:

- a. Mitigating Circumstances – The following circumstances shall mitigate the liability: voluntary admission of guilt; good track record; or first offense.
- b. Aggravating Circumstances – The following circumstances shall aggravate the liability: Previous conviction of an offense, as provided for in this Rules; connivance and/or conspiracy to facilitate the commission of the violation; or gross negligence.
- c. Such other similar circumstances that may mitigate or aggravate the violation and liability of the health care provider as may be determined by the Arbitration Office or Board, as the case may be.

SECTION 173. Application of Circumstances in the Imposition of Penalties

- a. The presence of a mitigating circumstance without any aggravating circumstance shall limit the imposable penalty to its minimum.
- b. When there is neither a mitigating nor an aggravating circumstance, the imposable penalty shall be between the minimum and the maximum of the applicable penalty for the offense committed, at the discretion of the Corporation. The same shall apply when both mitigating and aggravating circumstances are present.
- c. The presence of any aggravating circumstance without any mitigating circumstance shall increase the penalty for the offense to its maximum.

SECTION 174. Application of Suspension and Revocation of Accreditation

If the penalty of suspension imposed upon the health care provider exceeds the validity of the current accreditation, the application for renewal or re-accreditation of the health care provider shall not be acted upon until the full term of the suspension imposed has lapsed. Suspension shall be carried out by the temporary cessation of the benefits or privileges of the health care provider under the Program. Revocation shall be carried out by the permanent cessation of the benefits or privileges of the health care provider under the Program.

Title X
PENAL OFFENSES AND PENALTIES

Rule I
OFFENSES OF OFFICERS AND EMPLOYEES OF THE CORPORATION

SECTION 175. Infidelity in the Custody of Property

This offense is committed by any officer or employee of the Corporation who:

- a. Receives or keeps funds or property belonging, payable or deliverable to the Corporation, or who shall appropriate the same; or
- b. Shall take or misappropriate such property or fund wholly or partially; or
- c. Shall consent, or through abandonment or negligence, shall permit any other persons to take such property or funds wholly or partially.

The officer or employee found liable for misappropriation of funds or property shall suffer imprisonment of not less than six (6) years but not more than twelve (12) years and a fine of not less than Ten Thousand Pesos (P10,000.00) but not more than Twenty Thousand Pesos (P20,000.00).

Any shortage of funds or loss of the property upon audit shall be deemed prima facie evidence of the offense.

SECTION 176. Other Violations Involving Funds

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 provisions under this Rules on collection, remittances, and investment of funds.

SECTION 177. Connivance

Any officer or employee of the Corporation who shall connive, conspire, agree, plot, scheme, contrive or collude with any health care provider or any member, or through gross negligence or imprudence shall facilitate or consent to the commission of the same offenses enumerated in this Rules shall be prosecuted under applicable penal laws, rules and regulations, without prejudice to the filing of appropriate administrative action with the appropriate agency.

Rule II
OFFENSES OF EMPLOYERS

SECTION 178. Failure or Refusal to Register/Deduct Contributions

Any employer or officer who fails or refuses to register/deduct contributions from the employee's compensation shall be penalized with a fine of not less than Five Thousand Pesos (P5,000.00) but not more than Ten Thousand Pesos (p10,000.00) multiplied by the total number of employees of the firm.

SECTION 179. Failure or Refusal to Remit Contributions

Any employer or officer authorized to collect contributions who, after collecting or deducting the monthly contributions due from the employees, fails or refuses to remit said contributions to the Corporation within thirty (30) days from the date they become due shall be punished with a fine of not less than Five Thousand Pesos (P5,000.00) but not more than Ten Thousand Pesos (p10,000.00) multiplied by the total number of employees of the firm.

SECTION 180. Unlawful Deductions

Any employer or officer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them their own contribution on behalf of such employees shall be punished with a fine of Five Thousand Pesos (P5,000.00) multiplied by the total number of affected employees.

SECTION 181. Institution as Offender

If any of the acts or omissions provided in the preceding Sections of this Rules be committed by an association, partnership, corporation or any other institution, its managing directors or partners or president or general manager and/or any other persons responsible for the commission of the said acts or omissions shall be liable for the penalties provided for in this Rules and other laws for the offense.

SECTION 182. Reports on Violations by Employers

The PRO shall submit to the Chief Operating Officer a quarterly report on all violations by employers within the area of jurisdiction of the PRO for deduction of their counterpart contributions from their employees' compensation, under remittance and/or non-remittance of their employees' contributions to the Corporation. Such report shall simultaneously be copy furnished by the PRO to the SVP-LS and to its Legal Office and Collection Unit of the PRO for their appropriate action.

SECTION 183. Affidavit-Complaint and Complainant in Actions

The Head or Officer-In-Charge (OIC) of the Collections Unit of the PRO shall, within five (5) days upon receipt from its Legal Office of the final draft affidavit-complaint for actions against employers, execute or sign the same as the complainant and nominal witness in behalf of the Corporation against employers within their area of jurisdiction for any of the aforementioned offenses. In the absence, failure or inability of the Head or OIC of the Collection Unit of the PRO to do so, the Regional Vice-President or OIC of the PRO shall timely perform the same duty.

SECTION 184. Preparation and Filing of Affidavit-Complaint

The affidavit-complaint shall be prepared and filed with the appropriate Office of the Prosecutor/ Court or administrative body by the Legal Office of the PRO within thirty (30) days from its receipt of the quarterly report; provided that, the SVP-LS may likewise direct the Legal Office to prepare and file an affidavit-complaint based on considerations other than such report.

Rule III FINAL PROVISIONS

SECTION 185. Prosecution of Offenses

Offenses defined under Rules I and II, Title X hereof, shall be prosecuted in the regular courts of justice of competent jurisdiction without prejudice to administrative action that may be instituted by the Corporation under existing laws.

SECTION 186. Filing of Complaint

The filing of a complaint before the Corporation shall not bar a separate independent criminal action before any board, office, tribunal or court against the erring health care provider or member, and vice versa.

SECTION 187. Execution of Penalty

When a health care institution ceases operation or an independent health care professional stops practicing before serving the suspension, execution of penalty shall be deferred, to be implemented when the same owner or medical director opens or operates a new institution irrespective of the name or location, or when the health care provider practices again; Provided, that the dispositive part of the resolution or decision requiring payment of fines, reimbursement of paid claim or denial of payment shall be immediately executory.

A spouse or relative within the fourth (4th) degree of consanguinity or affinity of the owner or medical director shall be presumed to be the alter ego of such owner or medical director for the above purposes.

Despite the cessation of operation or practice of a health care provider while the complaint is being heard, the proceedings may continue until rendition of judgment for the purpose of determining future relationships between the Corporation and the erring provider.

SECTION 188. Applicability of this Rules

Complaints already filed with and under deliberation by appropriate bodies of the Corporation prior to the effectivity of this Rules shall be governed in accordance with the previous rules.

Title XI
ADMINISTRATIVE REMEDIES OF HEALTH CARE PROVIDERS
AND MEMBERS

Rule I
COMMON PROVISIONS

SECTION 189. Jurisdiction

The Corporation, through the Grievance and Appeals Review Committee (GARC) and the Board, shall hear and decide all grievances filed by any accredited health care provider or by any member against any program implementor. The Corporation shall likewise act on all protests against administrative decisions involving payments of charges, fees or claims, subject to the procedures hereafter provided.

SECTION 190. Grievance and Protests Not Covered

Any action of a program implementor which can be the basis of an administrative or criminal complaint or charge under the jurisdiction of the Office of the Ombudsman, Sandiganbayan, Civil Service Commission, or the regular courts of justice is neither a grievance nor a protest covered by this Rules and shall be dealt with in accordance with applicable laws.

Rule II
GRIEVANCE AGAINST PROGRAM IMPLEMENTORS

SECTION 191. Grounds for Grievances

The following acts shall constitute valid grounds for grievance:

- a. Any violation of the rights of patients;
- b. Willful neglect of duty resulting in the loss or non-availment of benefits by members or their dependents;
- c. Unjustifiable delay in actions on claims;
- d. Delay in the processing of claims that extends beyond the prescribed period; and,
- e. Any other act or omission that tends to undermine or defeat the purposes of the Act and this Rules.

SECTION 192. Who May File

Any aggrieved health care provider or member may file a verified complaint for a grievance.

SECTION 193. Venue

A grievance covered by this Rules may be filed with the PhilHealth Office where the aggrieved health care provider is located or where the member resides.

SECTION 194. Contents of Grievance

All complaints for grievance shall contain, among others, the following:

- a. Name/s and address/es of the aggrieved party/ies;
- b. Name/s and address/es of respondent program implementor/s;
- c. A clear and concise statement of the aggrieved party's cause/s of action, citing the specific ground relied upon and the acts or omissions complained of which constitute the same; and,
- d. The relief/s sought.

The complaint shall be verified and accompanied by affidavits of the complainant and the witnesses as well as other supporting documents, in such number of copies as there are respondents, plus two (2) copies for the official file.

SECTION 195. Referral of Grievance Complaint to the GARC

Upon receipt by the PhilHealth Office of a grievance complaint, it shall refer the same to the GARC within five (5) calendar days.

Rule III THE GRIEVANCE AND APPEALS REVIEW COMMITTEE

SECTION 196. Grievance and Appeals Review Committee (GARC)

The GARC shall be composed of a Chairperson, Vice-Chairperson and three (3) members, to be designated by the Board, through which it shall hear and decide all actions for grievance; provided, that one of its members shall be a representative of any health care providers as endorsed by the dOH. The Board, through the GARC, shall likewise exercise jurisdiction to review the action of the Corporation dismissing the grievance against the program implementor upon a verified petition of the aggrieved party. The GARC shall be convened upon the filing of the petition and shall continue to meet as a body until a decision thereon is rendered.

SECTION 197. Quorum and Votes Required

Three (3) members of the GARC shall constitute a quorum to deliberate on and decide any grievance brought before it. In all cases, the concurrence of at least three (3) members of the GARC which shall include the President as the Presiding Officer shall be necessary to reach a decision, resolution, order or ruling.

SECTION 198. Preliminary Determination

Upon the endorsement of the grievance, the GARC, after consideration of the allegation thereof, may dismiss a case outright due to lack of verification, failure to state a cause of action, or any valid ground for the dismissal of the grievance, or proceed to hear and determine the case.

If the GARC decides to proceed to hear and determine the case, the respondent implementor shall be required to file a verified answer or counter-affidavit with supporting documents within five (5) calendar days from the service of summons. Summons may be served in accordance with the provisions of this Rules.

SECTION 199. Judgment by Default

Should the respondent implementor fail to answer within the reglementary five (5) calendar-day period provided in the immediately preceding section, the GARC, motu proprio, or upon motion of the aggrieved party, shall render judgment as may be warranted by the facts on record and limited to what is prayed for in the complaint for grievance.

SECTION 200. Position Papers

After an answer is filed and the issues are joined, the GARC shall require the parties to submit, within ten (10) calendar days from receipt of the order, a brief statement of their respective positions setting forth the law and the facts relied upon by them. In the event the GARC finds, upon consideration of the pleadings, records of the proceeding before the Corporation and position papers submitted by the parties, that a judgment may be rendered thereon without need of a formal hearing, it may proceed to render judgment not later than ten (10) calendar days from submission of the position papers by the parties.

SECTION 201. Clarificatory Hearing

In cases where the GARC deems it necessary to hold a hearing to clarify specific factual matters before rendering judgment, it shall set the case for hearing for the said purpose. At such hearing, witnesses whose affidavits were previously submitted may be asked clarificatory questions by the proponent and by the GARC 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) calendar days, and the case shall be decided by the GARC within fifteen (15) calendar days from such termination.

SECTION 202. Contents of the Decision

Decisions of the GARC shall be clear and concise and shall include brief statements of the facts of the case, the issue/s involved, the applicable law/s or rule/s, conclusions and reasons therefor, and specific reliefs granted.

SECTION 203. Finality of Judgment

The decision of the GARC shall become final and executory fifteen (15) calendar days after notice thereof to the parties, unless an appeal is filed with the Board within the same period, in accordance

with the procedure set forth in this Rules.

SECTION 204. Administrative Sanctions

Upon finding of guilt, the GARC may censure, reprimand, or suspend the respondent implementor from office, depending on the gravity of the offense; provided, that the suspension shall not exceed thirty (30) days.

SECTION 205. Construction and Suppletory Application of the Rules of Court

In all proceedings, the GARC 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.

SECTION 206. Powers of the GARC

The GARC can administer oaths, certify to official acts and issue subpoena ad testificandum to compel the attendance and testimony of witness, and subpoena duces tecum to enjoin the production of books, papers and other records pertinent to the case. Any act of contumacy shall be dealt with in accordance with Section 14, Chapter 3, Book VII of the Revised Administrative Code.

Rule IV REVIEW OF GARC DECISION

SECTION 207. Appellate Jurisdiction of the Board Over Grievance Cases

The Board en banc shall have exclusive appellate jurisdiction to review the decisions of the GARC in grievances filed under RA 7875 as amended and this Rules.

SECTION 208. Period to File Petition for Review

A Petition for Review may be filed with the Board within a non-extendible period of thirty (30) calendar days from receipt of the decision of the GARC.

SECTION 209. Who May File Petition for Review

Any of the parties in a complaint for grievance decided by the GARC may file a Petition for Review.

SECTION 210. Decision of the Board

The Board shall resolve the petition within thirty (30) calendar days from receipt thereof with the records of the case.

Rule V ADMINISTRATIVE PROTESTS

SECTION 211. Original Jurisdiction of the PRO

The respective PRO has original jurisdiction to act on all administrative protests filed by health care providers and members against the written notices of the respective claims processing unit or office which pertain to the denial or reduction of payment of benefit claims.

SECTION 212. Claims Subject to Protest

Benefit claims that were either denied or reduced payment may be the subject of a protest before the PRO.

SECTION 213. Form and Period to File

The protest shall be in writing, duly signed by the protestant and addressed to the concerned PRO. It must be accompanied by supporting documents and filed within sixty (60) calendar days from receipt of the written notice of the denial/reduction of payment of the benefit claim.

SECTION 214. Procedure Before the PRO

Upon receipt of the protest, the PRO may require submission of additional documents or affidavits pertinent to a just resolution of the protest.

SECTION 215. Action on Protests

After thorough deliberation, the PRO shall take the following actions on the protest through a decision or notice, as appropriate:

- a. Deny the protest if the same is without merit in the light of existing laws, pertinent circulars and orders of the Corporation;
- b. Grant the protest if the same is meritorious and to direct the payment of the benefit claim thereof, in whole or in part; or,
- c. Take such other actions as are just or equitable under the circumstances.

SECTION 216. Appeal Before the Protests and Appeals Review Department (PARD)

The decisions or notices of the PROs may be appealed by the aggrieved health care provider or member in writing to the PARD within fifteen (15) days from receipt of such decisions or notices.

The PARD may adopt, modify or reject the decisions or notices of the PRO on protests in whole or in part. Forthwith, the PARD shall issue an order resolving the appeals, as far as practicable, within a period of thirty (30) days from receipt of the appeal, citing the facts and the law or rules on which the same is based. The order of the PARD shall be final and executory.

Rule VI CONSTRUCTION AND APPLICATION

SECTION 217. Title of this Rules

This Rules shall be known as the Rules of Procedure of the Corporation.

SECTION 218. Application of this Rules

This Rules shall apply to all administrative cases brought before the Corporation.

SECTION 219. Construction

This Rules shall be liberally construed to carry out the objectives of RA 7875 as amended and to assist the parties in obtaining an expeditious and inexpensive resolution of any case arising under the Act.

SECTION 220. Suppletory Application of the Rules of Court and Jurisprudence

In the absence of any applicable provisions in this Rules, the pertinent provisions of the Rules of Court of the Philippines and prevailing jurisprudence may be applied in a suppletory manner to all cases brought before the Corporation in the interest of expeditious resolution of these cases; provided that, the Corporation shall not be bound by the technical rules of evidence.

TITLE XII VISITORIAL POWERS OF THE CORPORATION

SECTION 221. Visitorial Powers

Any representative of the Corporation as duly authorized by the President and CEO or by the concerned Regional Vice President shall have the power to visit, enter and inspect facilities of health care providers and employers during office hours, unless there is reason to believe that inspection has to be done beyond office hours, and where applicable, secure copies of their medical, financial, and other records and data pertinent to the claims, accreditation, premium contribution and that of their patients or employees, who are members of the Program.

Title XIII

TRANSITORY PROVISIONS

SECTION 222. PhilHealth Identification Card

Members can temporarily use their PhilHealth Number Card which shall serve as the basis for availment of services until such time that they are issued a PhilHealth Identification Card.

SECTION 223. Excluded Benefits

Until such time that the Corporation and the DOH has determined their cost effectiveness through health technology assessment, all health services not currently compensable shall remain as such.

Title XIV

MISCELLANEOUS PROVISIONS

SECTION 224. Nine (9) Month Contribution within Twelve (12) Months

The previous requirement of payment of nine-(9) month contribution within the last twelve (12) months shall no longer be required in the member's entitlement to benefits.

SECTION 225. Validation Studies

The National Economic and Development Authority, in coordination with the National Statistics Office and the National Institutes of Health of the University of the Philippines shall undertake studies to validate the accomplishments of the Program. Such validation studies shall undertake studies to validate the accomplishments of the Program. Such validation studies shall include an assessment of the enrollees' satisfaction of the benefit package and services provided by the Corporation. These validation studies, as well as an annual report on the performance of the Corporation, shall be submitted to the Congressional Oversight Committee.

The Corporation shall annually transfer 0.001% of its income in the previous year for the purpose of conducting these studies.

SECTION 226. Repealing Clause

All PhilHealth circulars, orders and other issuances which are inconsistent with the provisions of this Rules are hereby considered repealed or amended.

SECTION 227. Separability Clause

In the event any provision of this Rules or the Act or the application of such provision to any person or circumstance is declared invalid, the remainder of this Rules or the application of said provisions to other persons or circumstance shall not be affected by such declaration.

SECTION 228. Promulgation and Effectivity

The Board shall promulgate this Rules in at least one (1) national newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center. It shall take effect fifteen (15) days after its publication.

Done in Pasig City, this 12th of September 2013.

(SGD.) **HON. ENRIQUE T. ONA, M.D.**
DOH Secretary
Chairperson

(SGD.) **HON. ALEXANDER A. PADILLA**
PHIC President and CEO
Employers Sector
Vice-Chairman

ABSENT
HON. FRANCISCO T. DUQUE, III, M.D., M.Sc
CSC Chairman
Member

(SGD.) **HON. MAR A. ROXAS II**
DILG Secretary
Member

(SGD.) **HON. CORAZON J. SOLIMAN**
DSWD Secretary
Member

(SGD.) **HON. CESAR V. PURISIMA**
DOF Secretary
Member

(SGD.) **HON. ROSALINDA D. BALDOZ**
DOLE Secretary
Member

HON. ALFONSO V. UMALI, JR.
Local Chief Executives
Member

(SGD.) **JUAN M. FLAVIER, M.D.**
Health Care Providers' Sector
Member

(SGD.) **HON. ALEXANDER A. AYCO, M.D.**
Labor Sector
Member

(SGD.) **HON. FRANCISCO VICENTE F. LOPEZ, M.D.**
Self-Employed Sector
Member

(SGD.) **HON. JANE M. N. STA ANA, RN.**
Overseas Filipino Workers (OFW) Sector
Member

ABSENT
HON. ROBERT G. VERGARA
GSIS President and General Manager
Member

(SGD.) **HON. EMILIO A. DE QUIROS, JR.**
SSS President and CEO
Member

(SGD.) **HON. MARLON J. MANUEL**
NAPC-BS Vice Chairperson
Member

Attested by:
(SGD.) **ATTY GENESIS M. ADARLO**
Corporate Secretary

This IRR has been approved as per PhilHealth Board Resolution No. 1843 s. 2013.

**Republic of the Philippines
Congress of the Philippines
Metro Manila
Fifteenth Congress
Third Regular Session**

Begun and held in Metro Manila, on Monday, the twenty-third day of July, two thousand thirteen.

**[REPUBLIC ACT NO. 7875]
As Amended by Republic Act no. 9241 and Republic Act 10606**

**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:

SEC. 1. Short Title. – This Act shall be known as “The National Health Insurance Act of 2013”.

Article I. GUIDING PRINCIPLES

SEC. 2. Declaration of Principles and Policies. – It is hereby declared the policy of the State to 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 to provide free medical care to paupers. Towards this end, the State shall provide comprehensive health care services to all Filipinos through a socialized health insurance program that will prioritize the health care needs of the underprivileged, sick, elderly, persons with disabilities (PWDs), women and children and provide free health care services to indigents. (RA 10606)

Pursuant to this policy, the State shall adopt the following 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;

- f. **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;
- g. **Effectiveness** – The Program shall balance economical use of resources with quality of care;
- h. **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;
- i. **Devolution** – The Program shall be implemented in consultation with local government units (LGUs), subject to the overall policy directions set by the National Government;
- j. **Fiduciary Responsibility** – The Program shall provide effective stewardship, funds management, and maintenance of reserves;
- k. **Informed Choice** – The Program shall encourage members to choose from among accredited health care providers. The Corporation’s local offices shall objectively appraise 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;
- l. **Maximum Community Participation** – The Program shall build on existing community initiatives for its organization and human resource requirements;
- m. **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;
- n. **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;
- o. **Professional 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;
- p. **Public Health Services** – The Government shall be responsible for 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;
- q. **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;
- r. **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
- s. **Care for the Indigent** – The Government shall be responsible for 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 fixed 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 care 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; **and**
 5. **parents with permanent disability that render them totally dependent on the member for subsistence. (RA 10606)**
- 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 by the Program.
- l. **Fee-for-service** – **A fee pre-determined by the Corporation for each service delivered by a health care provider based on the bill. The payment system shall be based on a pre-negotiated schedule promulgated by the Corporation.(RA 10606)**
- 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, drug addiction or in need of obstetrical or 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, rehabilitation centers 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 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 Department of Social Welfare and Development (DSWD) based on specific criteria set for this purpose in accordance with the guiding principles set forth in Article I of this Act.(RA 10606)**
- 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 who may be a paying member, a sponsored member, or a lifetime member.(RA 10606)**
- 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 services.
- y. **Philippine Medical Care Commission** – The Philippine Medical Care 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 Drugs 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 the 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 as provided for by law or who was retired on account of permanent disability as certified by the**

employer and the Corporation.(RA 10606)

- 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.
- kk. **Rehabilitation Center** – Refers to a facility, which undertakes rehabilitation of drug dependents. It includes institutions, agencies and the like which have for their purpose, the development of skills, or which provides counselling, or which seeks to inculcate, social and moral values to clientele who have a drug problem with the aim of weaning them from drugs and making them drug free, adapted to their families and peers, and readjusted into the community as law-abiding, useful and productive citizens. (n)
- ll. **Home Care and Medical Rehabilitation Services** – Refer to skilled nursing care, which members get in their homes/clinics for the treatment of an illness or injury that severely affects their activities or daily living. Home care and medical rehabilitation services include hospice or palliative care for people who are terminally ill but does not include custodial and non-skilled personal care. (n)
- mm. **Abandoned Children** – Children who have no known family willing and capable to take care of them and are under the care of the DSWD, orphanages, churches and other institutions.(RA 10606)
- nn. **Case-based Payment** – Hospital payment method that reimburses to hospitals a predetermined fixed rate for each treated case or disease; also called per case payment. (RA 10606)
- oo. **Health Technology Assessment** – A field of science that investigates the value of a health technology such as procedure, process, products, or devices, specifically on their quality, relative cost-effectiveness and safety. It usually involves the science of epidemiology and economics. It has implications on policy, decision to adopt and invest in these technologies, or in health benefit coverage.(RA 10606)
- pp. **Informal Sector** – Units engaged in the production of goods and services with the primary objective of generating employment and income for the persons concerned. It consists of households, unincorporated enterprises that are market and nonmarket producers of goods, as well as market producers of services.
- These enterprises are operated by own-account workers, which may employ unpaid family workers as well as occasional, seasonally hired workers.
- To this sector belong, among others, street hawkers, market vendors, pedicab and tricycle drivers, small construction workers and home-based industries and services. (RA 10606)
- qq. **Other Self-earning Individuals** – Individuals who render services or sell goods as a means of livelihood outside of an employer-employee relationship, or as a career, but do not belong to the informal sector. These include businessmen, entrepreneurs, actors, actresses and other performers, news correspondents, professional athletes, coaches, trainers, and other individuals as recognized by the Department of Labor and

Employment (DOLE) and/or the Bureau of Internal Revenue (BIR). (RA 10606)

- rr. **Out-patient Services – Health services such as diagnostic consultation, examination, treatment, surgery and rehabilitation on an out-patient basis.(RA 10606)**
- ss. **Professional Practitioners – Include doctors, lawyers, certified public accountants, and other practitioners required to pass government licensure examinations in order to practice their professions.(RA 10606)**
- tt. **Traditional and Alternative Health Care – The application of traditional knowledge, skills and practice of alternative health care or healing methods which include reflexology, acupuncture, massage, accupressure, chiropractics, nutritional therapy and other similar methods in accordance with the accreditation guidelines set forth by the Corporation and the Food and Drug Administration (FDA).(RA 10606)**
- uu. **Lifetime Member – A former member who has reached the age of retirement under the law and has paid at least one hundred twenty (120) monthly premium contributions. (RA 10606)**
- vv. **Members in the Formal Economy – Workers with formal contracts and fixed terms of employment including workers in the government and private sector, whose premium contribution payments are equally shared by the employee and the employer.(RA 10606)**
- ww. **Members in the Informal Economy – Workers who are not covered by formal contracts or agreements and whose premium contributions are self-paid or subsidized by another individual through a defined criteria set by the Corporation.(RA 10606)**
- xx. **Migrant Workers – Documented or undocumented Filipinos who are engaged in a remunerated activity in another country of which they are not citizens.(RA 10606)**
- yy. **Sponsored Member – A member whose contribution is being paid by another individual, government agency, or private entity according to the rules as may be prescribed by the Corporation.”(RA 10606)**

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 program 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 or 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. Mandatory 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(l) hereof, **implementation of the Program shall ensure sustainability of coverage and continuous enhancement of the quality of service: Provided, That the Program shall be compulsory in all provinces, cities and municipalities nationwide, notwithstanding the existence of LGU-based health insurance programs: Provided, further, That the Corporation, Department of Health (DOH), local government units (LGUs), and other agencies including nongovernmental organizations (NGOs) and other national government agencies (NGAs) shall ensure that members in such localities shall have access to quality and cost-effective health care services. (RA 10606)**

SEC. 7. Enrollment. – The Corporation shall enroll beneficiaries in order for them to avail of benefits under this Act with the assistance of the financial arrangements provided by the Corporation under the following categories:

- a. Members in the formal economy;
- b. Members in the informal economy;
- c. Indigents;
- d. Sponsored members; and
- e. Lifetime members.

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.” (RA 10606)

SEC. 8. Health Insurance Identification (ID) Card and ID Number. – In conjunction with the enrollment provided above, the Corporation through its local office shall issue a health insurance **ID with a corresponding ID number** which shall be used for purposes of identification, eligibility verification, and utilization recording. The issuance of this ID card shall be accompanied by a clear 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 **provided to the member together with the ID card.**

The absence of the ID card shall not prejudice the right of any member to avail of benefits or medical services under the National Health Insurance Program (NHIP).

This health insurance ID card with a corresponding ID number shall be recognized as a valid government identification and shall be presented and honored in transactions requiring the verification of a person’s identity.”(RA 10606)

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. – Members and their dependents are entitled to the following minimum services, subject to the limitations specified in this Act and as may be determined by the Corporation:

- 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; **and**
 7. 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;
 5. this Act;
- c. Emergency and transfer services; and
- d. Such other health care services that the Corporation **and the DOH shall determine to be appropriate and cost-effective.**

These services and packages shall be reviewed annually to determine their financial sustainability and relevance to health innovations, with the end in view of quality assurance, increased benefits and reduced out-of-pocket expenditure.(RA 10606)

SEC. 11. Excluded Personal Health Services. – The Corporation shall not cover expenses for health services which the Corporation and the DOH consider cost-ineffective through health technology assessment.

The Corporation may institute additional exclusions and limitations as it may deem reasonable in keeping with its protection objectives and financial sustainability.”(RA 10606)

SEC. 12. Entitlement to Benefits. – A member whose premium contributions for at least three (3) months have been paid within six (6) months prior to the first day of availment, including those of the dependents, shall be entitled to the benefits of the Program: Provided, That such member can show that contributions have been made with sufficient regularity: Provided, further, That the member 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 SSS and GSIS prior to the effectivity of this Act; and
- b. Lifetime members.(RA 10606)

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 for 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 **supervise the provision of health benefits and** 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;(RA 10606)
- 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 the 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 institutions, professionals, and other persons, juridical or natural, regarding the pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing, and delivery of health services **in behalf of its members; (RA 10606)**
- 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 visit, enter and inspect facilities of health care providers and employers during office hours, unless there is reason to believe that inspection has to be done beyond office hours, and where applicable, secure copies of their medical, financial, and other records and data pertinent to the claims, accreditation, premium contribution, and that of their patients or employees, who are members of the Program; (RA 10606)**
- n. to organize its office, fix the compensation of and appoint personnel 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 costing 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;
- q. **to establish and maintain an electronic database of all its members and ensure its security to facilitate efficient and effective services; (RA 10606)**
- r. **to invest in the acceleration of the Corporation's information technology systems; (RA 10606)**
- s. **to conduct an information campaign on the principles of the NHIP to the public and to accredited health care providers. This campaign must include the current benefit packages provided by the Corporation, the mechanisms to avail of the current benefit packages, the list of accredited and disaccredited health care providers, and the list of offices/branches where members can pay or check the status of paid health premiums; (RA 10606)**
- t. **to conduct post-audit on the quality of services rendered by health care providers; (RA 10606)**
- u. **to establish an office, or where it is not feasible, designate a focal person in every Philippine Consular Office in all countries where there are Filipino citizens. The office or the focal person shall, among others, process, review and pay the claims of the Overseas Filipino Workers (OFWs);(RA 10606)**
- v. **notwithsatnding the provisions of any law to the contrary, to impose interest and/or surcharges of not exceeding three percent (3%) per month, as may be fixed by the Corporation, in case of any delay in the remittance of contributions which are due within the prescribed period by an employer, whether public or private. Notwithstanding the provisions of any law to the contrary, the Corporation may also compromise, waive or release , in whole or in part, such interest or surcharges imposed upon employers regardless of the amount involved under such valid terms and conditions it may prescribe; (RA 10606)**
- w. **to endeavor to support the use of technology in the delivery of health care services especially in farflung areas such as, but not limited to, telemedicine, electronic health record, and the establishment of a comprehensive health database; (RA 10606)**

- x. **to monitor compliance by the regulatory agencies with the requirements of this Act and to carry out necessary actions to enforce compliance; (RA 10606)**
- y. **to mandate the national agencies and LGUs to require proof of PhilHealth membership before doing business with a private individual or group; (RA 10606)**
- z. **to accredit independent pharmacies and retail drug outlets; and (RA 10606)**
- aa. **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.” (RA 10606)**

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

- a. **subject to the respondent’s right to due process**, 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; (RA 10606)
- 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. **subject to the respondent’s right to due process**, 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. 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 six (6) months. Suspension of the rights of members shall not exceed **six (6) months. (RA 10606)**

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 the following members:

The Secretary of Health;

The Secretary of Labor and Employment or **a permanent representative;**

The Secretary of the Interior and Local Government or **a permanent representative;**

The Secretary of Social Welfare and Development or **a permanent representative;**

The Secretary of the Department of Finance (DOF) or a permanent representative;

The President and **Chief Executive Officer (CEO)** of the Corporation;

The SSS Administrator or a **permanent representative;**

The GSIS General Manager or a **permanent representative;**

The Vice Chairperson for the basic sector of the National Anti-Poverty Commission or a **permanent representative;**

The Chairperson of the Civil Service Commission (CSC) or a permanent representative;

A permanent representative of Filipino migrant workers;

A permanent representative of the members in the informal economy;

A permanent representative of the members in the formal economy;

A representative of employers;

A representative of health care providers to be endorsed by their national associations of health care institutions and medical health professionals;

A permanent representative of the elected local chief executives to be endorsed by the League of Provinces, League of Cities and League of Municipalities; and

An independent director to be appointed by the Monetary Board. (RA 10606)

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

- b. **Appointment and Tenure.** – Except for ex officio members, the other members of the Board shall be appointed by the President of the Philippines in accordance with the provisions of Republic Act No. 10149, otherwise known as the ‘GOCC Governance Act of 2011’; Provided, That sectoral board members shall be appointed by the President of the Philippines upon the recommendation of the Chairperson and after due consultations with the sectors concerned.

The term of office of the appointive members of the Board shall be in accordance with Republic Act No. 10149. (RA 10606)

- c. **Meetings and Quorum** – The Board shall hold regular meetings at 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 a majority of all the 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. (a)
- 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 allowances.”

SEC. 19. The President of the Corporation.

- a. **Appointment and Tenure.** – The President of the Philippines shall appoint the President and CEO of the Corporation, hereinafter referred to as the President, upon the recommendation of the Board. The President shall have a tenure of one (1) year in accordance with the provisions of Republic Act No. 10149. (RA 10606)

- 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
 - 2. 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 as well as to 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;
- g. submission of recommendations on policy and operational issues that will help the Corporation meet the objectives of this Act; **and**
- h. **conduct of client-satisfaction surveys and research in order to assess outcomes of service rendered by health care providers. (RA 10606)**

SEC. 21. Actuary of the Corporation. – An Office of the 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;
- l. to establish referral systems and network arrangements with other Offices as may be 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. Other appropriations earmarked by the national and local governments purposely for the implementation of the Program;
- c. Subsequent appropriations provided for under Sections 46 and 47 of this Act;
- d. Donations and grants-in-aid; and
- e. All accruals thereof.

(RA 10606, deleting letter b of RA 9241)

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 indigent beneficiaries, a basic 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; and
 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 Funds** – 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 for program operations shall be governed by **applicable laws and in the absence thereof, existing resolutions of the Board of Directors of the Corporation, subject to the following limitations: (RA 10606)**

- 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 to the various funds under its control 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 the sum total of the following:

1. **Four percent (4%) of the total premium contributions collected during the immediately preceding year;**
2. **Four percent (4%) of the total reimbursements or total cost of health services paid by the Corporation in the immediately preceding year; and**
3. **Five percent (5%) of the investment earnings generated during the immediately preceding year.**

The period for implementation of the cost ceiling provided under this section shall not be later than five (5) years from the effectivity of this Act during which period, the total annual cost shall not exceed the sum total of the following: (RA 10606)

- (i) Five percent (5%) of the total contributions;
- (ii) Five percent (5%) of the total reimbursements; and
- (iii) Five percent (5%) of the investment earnings generated 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’s expenditures as reserve funds: Provided, That the total amount of reserves shall not exceed a ceiling equivalent to the amount actuarially estimated for two (2) years’ projected Program expenditures: **Provided, further, That whenever actual reserves exceed the required ceiling at the end of the Corporation’s fiscal year, the excess of the Corporation’s reserve fund shall be used to increase the Program’s benefits, decrease the member’s contributions, and augment the health facilities enhancement program of the DOH. (RA 10606)**

The remaining portion of the reserve fund that are not needed to meet the current expenditure obligations or used for the abovementioned programs shall be placed in 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 debt securities and corporate bonds issuances: Provided, That such securities and bonds are rated triple ‘A’ by authorized accredited domestic rating agencies: Provided, further, That the issuing or assuming entity or its predecessor shall not have defaulted in the payment of interest on any of its securities and that during each of any three (3) including last two (2) of the five (5) fiscal years next preceding the date of acquisition by the Corporation of such bonds, securities or other evidences of indebtedness, the net earnings of the issuing or assuming institution available for its recurring expenses, such as amortization of debt discount and rentals for leased properties, including interest on funded and unfunded debt, shall have been not less than one and one quarter (1 ¼) times the total of the recurring expenses for such year: Provided, further, That such investment shall not exceed fifteen percent (15%) of the investment reserve fund; (RA 10606)**
- c. 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;

- d. **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 corporation: 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 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; and (RA 10606)**
- e. **In bonds, securities, promissory notes or other evidences of indebtedness of accredited and financially sound medical institutions exclusively to finance the construction, improvement and maintenance of hospitals and other medical facilities: Provided, That such securities and instruments are backed up by the guarantee of the Republic of the Philippines or the issuing medical institution and the issued securities and bonds are both rated triple 'A' by authorized accredited domestic rating agencies: Provided, further, That said investments shall not exceed ten percent (10%) of the total investment reserve fund. (RA 10606)**

As part of its investments operations, the Corporation may hire institutions with valid trust licenses as its external local fund managers to manage the investment reserve fund, as it may deem appropriate, through public bidding. The fund managers shall submit annual reports on investment performance to the Corporation. (RA 10606)

The Corporation shall set up the following funds: (RA 10606)

- (1) A fund to secure benefit payouts to members prior to their becoming lifetime members;**
- (2) A fund to secure payouts to lifetime members; and**
- (3) A fund for any optional supplemental benefits that are subject to additional contributions.**

A portion of each of the above funds shall be identified as current and kept in liquid instruments. In no case shall said portion be considered part of invested assets.(RA 10606)

Another portion of the said funds shall be allocated for lifetime members within six (6) months after the effectivity of this Act. Said amount shall be determined by an actuary or pre-calculated based on the most recent valuation of liabilities.(RA 10606)

The Corporation shall allocate a portion of all contributions to the fund for lifetime members based on an allocation to be determined by the PHIC actuary based on a pre-determined percentage using the current average age of members and the current life expectancy and morbidity curve of Filipinos.(RA 10606)

The Corporation shall manage the supplemental benefits and the lifetime members' fund in

an actuarially sound manner.(RA 10606)

The Corporation shall manage the supplemental benefits fund to the minimum required to ensure that the supplemental benefit payments are secure. (RA 10606)

Article VII. FINANCING

SEC. 28. Contributions. – All members **who can afford to pay** 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: (RA 10606)

- a. **Members in the formal economy and their employers shall continue paying the same monthly contributions as provided for by law until such time that the Corporation shall have determined a new contribution schedule: Provided, That their monthly contributions shall not exceed five percent (5%) of their respective monthly salaries. (RA 10606)**

It shall be mandatory for all government agencies to include the payment of premium contribution in their respective annual appropriations: Provided, further, That any increase in the premium contribution of the national government as employer shall only become effective upon inclusion of said amount in the annual General Appropriations Act. (RA 10606)

- b. **Contributions from members in the informal economy shall be based primarily on household earnings and assets. Those from the lowest income segment who do not qualify for full subsidy under the means test rule of the DSWD shall be entirely subsidized by the LGUs or through cost sharing mechanisms between/among LGUs and/or legislative sponsors and/or other sponsors and/or the member, including the national government: Provided, That the identification of beneficiaries who shall receive subsidy from LGUs shall be based on a list to be provided by the DSWD through the same means test rule or any other appropriate statistical method that may be adopted for said purpose.(RA 10606)**
- c. **Contributions made in behalf of indigent members shall not exceed the minimum contributions for employed members. (RA 10606)**
- d. **The required number of monthly premium contributions to qualify as a lifetime member may be increased by the Corporation to sustain the financial viability of the Program: Provided, That the increase shall be based on actuarial estimate and study. (RA 10606)**

SEC. 29. Payment for Indigent Contributions. – Premium contributions for indigent members as identified by the DSWD through a means test or any other appropriate statistical method shall be fully subsidized by the national government. The amount necessary shall be included in the appropriations for the DOH under the annual General Appropriations Act. (RA 10606)

SEC. 29-A. Payment for Sponsored Members' Contributions. – (RA 10606)

- a. **The premium contributions of orphans, abandoned and abused minors, out-of-school youths, street children, PWDs, senior citizens and battered women under the care of the DSWD, or any**

of its accredited institutions run by NGOs or any nonprofit private organizations, shall be paid by the DSWD and the funds necessary for their inclusion in the Program shall be included in the annual budget of the DSWD.

- b. The needed premium contributions of all barangay health workers, nutrition scholars and other barangay workers and volunteers shall be fully borne by the LGUs concerned.
- c. The annual premium contributions of househelpers shall be fully paid by their employers, in accordance with the provisions of Republic Act No. 10361 or the 'Kasambahay Law'.

SEC. 29-B. Coverage of Women About to Give Birth. – The annual required premium for the coverage of unenrolled women who are about to give birth shall be fully borne by the national government and/or LGUs and/or legislative sponsor which shall be determined through the means testing protocol recognized by the DSWD. (RA 10606)

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 by 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 Section 4(o) hereof and operating for at least three (3) years may apply for accreditation: Provided, That a health care provider which has not operated for at least three (3) years may likewise apply and qualify for accreditation if it complies with all the other accreditation requirements of and further meets any of the following conditions:

- a. Its managing health care professional has had a working experience in another accredited health care institution for at least three (3) years;
- b. It operates as a tertiary facility or its equivalent;
- c. It operates in a LGU where the accredited health care provider cannot adequately or fully service its population; and
- d. Other conditions as may be determined by the Corporation.

A health care provider found guilty of any violation of this Act shall not be eligible to apply for the renewal of accreditation. (RA 10606)

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 payments – payments made by the Corporation for professional fees or 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 periodically but not less than every three (3) years; (RA 10606)**
- 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. **Case-based payment; (RA 10606)**
- d. **Global budget; and (RA 10606)**
- e. **Such other provider payment mechanisms that may be determined and adopted by the Corporation. (RA 10606)**

Subject to the approval of the Board, the Corporation may adopt other payment mechanism that are most beneficial to the members and the Corporation. (RA 10606)

Each **PhilHealth local** 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 underserved areas. (RA 10606)

SEC. 34-A. Other Provider Payment Guidelines. – No other fee or expense shall be charged to the indigent patient, subject to the guidelines issued by the Corporation.

All payments 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 retained by the individual facility in which services were rendered and for which payment was made. Such revenues shall be used to primarily 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. (RA 10606)

SEC. 35. Reimbursement and Period to File Claims. – All claims for reimbursement or payment for services rendered shall be filed within a period of sixty (60) calendar days from the date of discharge of the patient from the health care provider. (RA 10606)

The period to file the claim may be extended for such reasonable causes determined by the Corporation. (RA 10606)

SEC. 36. Role of Local Government Units (LGUs). – Consistent with the mandates for each political subdivision under Republic Act No. 7160 or ‘The Local Government Code of 1991’, LGUs shall provide basic health care services. (RA 10606)

To augment their funds, LGUs shall invest the capitation payments given to them by the Corporation on health infrastructures or equipment, professional fees, drugs and supplies, or information technology and database: Provided, That basic health care services, as defined by the DOH and the Corporation, shall be ensured especially with the end in view of improving maternal, infant and child health: (RA 10606)

Provided, further, That the capitation payments shall be segregated and placed into a special trust fund created by LGUs and be accessed for the use of such mandated purpose. (RA 10606)

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 claimants 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 willful neglect of duties of Program implementors that results in the loss or non-enjoyment of benefits by members or their dependents;
- c. unjustifiable delay in actions or claims;
- d. delay in the processing of claims that extends beyond the period agreed 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, a 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: (RA 10606)

- a. A complaint for grievance must be filed with the **Corporation** which shall **refer such complaint to the Grievance and Appeal Review Committee. The Grievance and Appeal Review Committee shall rule on the complaint through a notice of resolution within sixty (60) calendar days from receipt thereof. (RA 10606)**
- b. Appeals from **the decision of the Grievance and Appeal Review Committee** must be filed with the Board within thirty (30) **calendar** days from receipt of the notice of **resolution. (RA 10606)**
- 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 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. (RA 10606)

The Committee shall have as one of its members a representative of any of the accredited health care providers as endorsed by the DOH. (RA 10606)

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 ground 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 answer is 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 to 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 clarify 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 upon 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 functions, 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. **Violation by an Accredited Health Care Provider** – Any accredited health care provider who commits a violation, abuse, unethical practice or fraudulent act which tends to undermine or defeat the objectives of the Program shall be punished with a fine of not less than Fifty thousand pesos (P50,000.00) but not more than One hundred thousand pesos (P100,000.00) or suspension of accreditation from three (3) months to the whole term of accreditation, or both, at the discretion of the Corporation: Provided, That recidivists may no longer be accredited as a participant of the Program; (RA 10606)
- b. **Violations of a Member** – Any member who commits any violation of this Act independently or in connivance with the health care provider for purposes of wrongfully claiming NHIP benefits or entitlement shall be punished with a fine of not less than Five thousand pesos (P5,000.00) or suspension from availment of NHIP benefits for not less than three (3) months but not more than six (6) months, or both, at the discretion of the Corporation. (RA 10606)
- c. **Violations of an Employer** –
 1. **Failure/Refusal to Register/Deduct/Remit the Contributions** – Any employer who fails or refuses to register employees, regardless of their employment status, or to deduct contributions from the employee's compensation or remit the same to the Corporation shall be punished with a fine of not less than Five thousand pesos (P5,000.00) multiplied by the total number of employees of the firm. (RA 10606)

Any employer or any officer authorized to collect contributions under this Act who, after collecting or deducting the monthly contributions from his employee's 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. (RA 10606)

2. **Unlawful Deductions** – Any employer or officer 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 with a fine of Five thousand pesos (P5,000.00) multiplied by the total number of affected employees. (RA 10606)

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. (RA 10606)

3. **Misappropriation of Funds by Employees of the Corporation** – 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 to take such property or funds wholly or partially, shall likewise be liable for misappropriation of funds or property and shall be punished with a fine not less than Ten thousand pesos (P10,000.00) nor more than Twenty thousand pesos (P20,000.00). Any shortage of the funds or loss of the property upon audit shall be deemed prima facie evidence of the offense. (RA 10606)

- d. **Other Violations** – Other violations of the provisions of this Act or of the rules and regulations promulgated by the Corporation shall be punished with a fine of not less than Five thousand pesos (P5,000.00) but not more than Twenty thousand pesos (P20,000.00). (RA 10606)

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. (RA 10606)

The Corporation may enumerate circumstances that will mitigate or aggravate the liability of the offender or erring health care provider, member or employer. (RA 10606)

Despite the cessation of operation by a health care provider or termination of practice of an independent health care professional while the complaint is being heard, the proceeding against them shall continue until the resolution of the case. (RA 10606)

The dispositive part of the decision requiring payment of fines, reimbursement of paid claim or denial of payment shall be immediately executory. (RA 10606)

Article XI. APPROPRIATIONS

SEC. 45. Initial Appropriations. – The unexpected portion or 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 sixty (60) days from the effectivity of this Act, the Corporation, in coordination with the DOH, shall issue the necessary rules and regulations for its effective implementation. (RA 10606)

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 thereafter ceases 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 the 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. – There is hereby created a Joint Congressional Oversight Committee to conduct a regular review of the NHIP which shall entail a systematic evaluation of the Program’s performance, impact or accomplishments with respect to its objectives or goals. The Oversight Committee shall be composed of five (5) members from the Senate and five (5) members from the House of Representatives to be appointed by the Senate President and the Speaker of the House of

Representatives, respectively. The Oversight Committee shall be jointly chaired by the Chairpersons of the Senate Committee on Health and Demography and the House of Representatives Committee on Health. (RA 10606)

The National Economic and Development Authority, in coordination with the National Statistics Office and the National Institutes of Health of the University of the Philippines shall undertake studies to validate the accomplishments of the Program. **Such validation studies shall include an assessment of the enrollees' satisfaction of the benefit package and services provided by the Corporation. These validation studies, as well as an annual report on the performance of the Corporation shall be submitted to the Congressional Oversight Committee. (RA 10606)**

The Corporation shall annually transfer 0.001% of its income in the previous year for the purpose of conducting these studies. (RA 10606)

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. Requisites for Issuance or Renewal of License or Permits. – Notwithstanding any law to the contrary, all government agencies issuing professional or business license or permit, shall require all applicants to submit certificate or proof of payment of PhilHealth premium contributions, prior to the issuance or renewal of such license or permit. (RA 10606)

SEC. 57. Separability Clause. – If any part or provision of this Act shall be held unconstitutional or invalid, other provisions which are not affected thereby shall continue to be in full force and effect. (RA 10606)

SEC. 58. Repealing Clause. – All laws, issuances or parts thereof inconsistent with this Act are hereby repealed or modified accordingly. (RA 10606)

SEC. 59. Government Guarantee – The Government of the Philippines guarantees the financial viability of the Program.

SEC. 60. Effectivity. – This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in at least two (2) newspapers of general circulation.

Approved,

RA 7875

(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. 1783 and House Bill No. 14225, was finally passed by the Senate and House of Representatives on February 7, 1995.

(SGD.) **CAMILO L. SABIO**
Secretary General
House of Representatives

(SGD.) **EDGARDO E. TUMANGAN**
Secretary of the Senate

Approved: Feb. 14, 1995

(SGD.) **FIDEL V. RAMOS**
President of the Philippines

RA 9241

Approved:

(SGD.) **FRANKLIN M. DRILON**
President of the Senate

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

This Act which is a consolidation of House Bill No. 5547 and Senate Bill No. 2630 was finally passed by the House of Representatives and the Senate on October 15, 2003 and October 14, 2003, respectively.

(SGD.) **OSCAR G. YABES**
Secretary of the Senate

(SGD.) **ROBERTO P. NAZARENO**
Secretary General
House of Representatives

Approved: February 10, 2004

(SGD.) **GLORIA MACAPAGAL-ARROYO**
President of the Philippines

RA 10606

(SGD.) **FELICIANO BELMONTE JR.**
Speaker of the House of Representatives

(SGD.) **JUAN PONCE ENRILE**
President of the Senate

This Act which is a consolidation of Senate Bill No. 2849 and House Bill No. 6048 was finally passed by the Senate and the House of Representatives on February 4, 2013.

(SGD.) **MARILYN B. BARUA-YAP**
Secretary General
House of Representatives

(SGD.) **EDWIN B. BELEN**
Acting Senate Secretary

Approved:

(SGD.) **BENIGNO S. AQUINO III**
President of the Philippines



Bawat Pilipino **MIYEMBRO**
Bawat miyembro **PROTEKTADO**
Kalusugan natin **SEGUARADO**

