

Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City, Metro Manila

Fifteenth Congress
First Regular Session

House Bill No. 2174

Introduced by **Hon. Lorenzo R. Tañada III** and **Hon. Daisy Avance-Fuentes**

EXPLANATORY NOTE

In his first State of the Nation Address (SONA) barely a week ago, **President Benigno S. Aquino III** announced that the government vision of pushing Philhealth coverage to the maximum is at hand. He highlighted the impending completion of DSWD's National Household Targeting System (NHTS) as the appropriate jumping board to truly extend the Philhealth coverage of the country's poorest of the poor.

The emphasis on the universal coverage of Philhealth is well-placed. After all, this is just in keeping with Sec. 11, Article XIII of the 1987 Constitution, which mandates that "*the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable cost.*" The same provision of the Constitution also provides that "*there shall be priority for the needs of the underprivileged sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers.*"

In spite of the constitutional policy, however, the cracks in the foundations upon which we have built our nation's development are revealed by our health indicators. Nowhere else do we find the yawning socio-economic disparities displayed so glaringly. Those sectors of our population with higher incomes, who are in better health and hence have less need for health care services, are the only ones that have access to them; while the poor suffer their sickness in silence. There is therefore a strong impetus to direct public health expenditure to levels that truly reflect our commitment to provide all Filipinos with basic health care.

As of 2008, ADB notes that government expenditures on health in the country comprised a paltry 0.4% of our GDP – well below Malaysia's 1.8% and Thailand's 1.7%. Even Cambodia came ahead of us in this respect, devoting 0.8% of its GDP for health services.

In the 2009 and 2010 appropriations, the government allocated a total of P10 billion for Philhealth's sponsored program for indigent Filipinos. The figure is misleading, though, as over-all government spending in health has experienced a steadily decline over the last years. Local government spending failed miserably to compensate for the huge slashes in health expenditure made by the national government. Furthermore, out of the total amount allocated for public health expenditure, the portion spent on social health insurance is at a dismal 11%. The result is that our health care system has become heavily indebted to out-of-pocket spending, which effectively marginalizes the vast majority who do not have the sort of disposable income to spend on health insurance.

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1 Indeed, there is no better time than now to extend coverage of health insurance to the millions of
2 poor Filipinos who do not have access to health facilities otherwise. This is not just a matter of sound
3 governance but one of social solidarity. With 70% of our population considered as living in dire poverty,
4 there is all the more reason for the state to step in and effect a more equitable distribution of access to
5 health care. Numerous studies show that a significant number of Filipinos do not have the kind of access
6 they need to meet the standard of adequate well-being. This translates directly to health indicators. For
7 instance, low-income rural communities like Bicol, Samar and ARMM have indicators mirroring those of
8 the least developed countries, with life expectancy at birth under 60 years, infant and child mortality
9 hover around 90, and maternal mortality at an alarming 150. When compared to the more affluent urban
10 centers such as Metro Manila, Cebu and Davao, the disparity is cause for dismay: richer areas with the
11 most equalized access to health care facilities evince numbers closely approaching those in developed
12 countries: the average life expectancy at birth is over 80 years, infant and child mortality is at less than
13 10, while maternal mortality is at less than 15.

14 Extending Philhealth coverage to the country's lowest income earners is but one goal of this bill.
15 This measure intends to rework the Charter of the Philippine Health Insurance Corporation in order to
16 tailor both its internal organization and its health care delivery system to the changing demands of our
17 nation's development. By doing so, it is hoped that we will bring the corporation away from a
18 commercially-dominated mindset with a concern only for profit, and a step closer to the fulfillment of its
19 real mandate, that of giving all Filipinos access to their right to health and a quality life.

20 Urgent consideration and approval of this measure is in order. As representatives of our people,
21 we owe all of our constituents this much. Indeed, they deserve nothing less than universal health care.
22 We, therefore, urge all of our colleagues to transform this bill into one of the early cornerstones of the 15th
23 Congress.


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**AN ACT AMENDING REPUBLIC ACT NO. 7875 OTHERWISE KNOWN AS THE
NATIONAL HEALTH INSURANCE ACT OF 1995 AS AMENDED, AND FOR OTHER
PURPOSES**

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

SECTION 1. Section 4, Article II of Republic Act No. 7875, is hereby further amended by adding the following definitions accordingly.

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

x x x

C) *BIOLOGICALS OR BIOLOGICAL PRODUCTS* - REFERS TO ANY PRODUCT OF BIOLOGICAL ORIGIN, PREPARED BY BIOLOGICAL PROCESSES, DERIVED FROM HUMAN BLOOD AND PLASMA, OR MANUFACTURED BY BIOTECHNOLOGY, CONSISTING OF SUBSTANCES OF HIGHER MOLECULAR WEIGHT WHOSE PURITY, POTENCY AND COMPOSITION CANNOT READILY AND RELIABLY BE DETERMINED BY CHEMICAL OR PHYSICOCHEMICAL ANALYSIS.

x x x

M) *FAIR PRICE* – REFERS TO THE RESULT OF THE CORPORATION’S NEGOTIATION IN BEHALF OF ITS MEMBERS AND ADEQUATELY FUNDED HEALTH PROVISIONS, WHICH PRICE SHALL BE DETERMINED BY THE CORPORATION TOGETHER WITH THE DEPARTMENT OF HEALTH’S NATIONAL CENTER FOR PHARMACEUTICAL ACCESS AND MANAGEMENT (NCPAM), IN ACCORDANCE WITH THE MECHANISM PROVIDED FOR UNDER SECTION 38 OF THIS ACT.

x x x

s) *Indigent* – A person who has no visible means of income, or whose income is insufficient for the subsistence of his/ HER family[,] as identified by THE DEPARTMENT OF SOCIAL WELFARE AND DEVELOPMENT (DSWD) BASED ON IT’S NATIONAL HOUSEHOLD TARGETTING SYSTEM (NHTS) FOR POVERTY REDUCTION OR ANY OTHER TOOL THAT THE DEPARTMENT MAY LATER DETERMINE TO BE THE MOST EFFICIENT MEANS OF TARGETTING THE POOR FOR DIRECT GOVERNMENT ASSISTANCE.

T) *INFORMAL SECTOR* – REFERS TO HOUSEHOLD UNINCORPORATED ENTERPRISES WHICH CONSIST OF BOTH INFORMAL OWN-ACCOUNT ENTERPRISES AND ENTERPRISES OF INFORMAL EMPLOYERS.

INFORMAL OWN-ACCOUNT ENTERPRISES ARE HOUSEHOLD UNINCORPORATED ENTERPRISES OWNED AND OPERATED BY OWN-ACCOUNT WORKERS, EITHER ALONE OR IN PARTNERSHIP WITH MEMBERS OF THE SAME OR OTHER HOUSEHOLDS WHICH MAY EMPLOY UNPAID FAMILY WORKERS AS WELL AS OCCASIONALLY/SEASONALLY HIRED WORKERS BUT DO NOT EMPLOY EMPLOYEES ON A CONTINUOUS BASIS.

ENTERPRISES OF INFORMAL EMPLOYERS ARE HOUSEHOLD UNINCORPORATED ENTERPRISES OWNED AND OPERATED BY OWN-ACCOUNT WORKERS, EITHER ALONE OR IN PARTNERSHIP WITH MEMBERS OF THE SAME OR OTHER HOUSEHOLDS WHICH EMPLOY ONE OR MORE EMPLOYEES ON A CONTINUOUS BASIS.

x x x

V) *LOW-INCOME INFORMAL SECTOR* - REFERS TO INDIVIDUALS ENGAGED IN HOUSEHOLD UNINCORPORATED ENTERPRISES THAT THE DSWD, IN COORDINATION WITH THE NSCB MAY DEFINE, CLASSIFY, OR ALSO CONSIDER AS INDIGENT OR LOW-INCOME UNITS OR INDIVIDUALS; PROVIDED: THAT THE DSWD, IN COORDINATION WITH THE NSCB, SHALL ESTABLISH THE LIST OF INFORMAL BUSINESSES, ENTERPRISES OR UNDERTAKINGS THAT WILL COMPRISE THE SECTOR BEING DEFINED HEREIN; AND, PROVIDED FURTHER: THAT THE DSWD, IN COORDINATION WITH THE NSCB, MAY, FROM TIME TO TIME, REVISE OR UPDATE SAID LIST IN CONSULTATION WITH THE CONGRESSIONAL OVERSIGHT COMMITTEE ESTABLISHED FOR THE PURPOSES OF THIS ACT.

W) *MEDIAN PRICE* - REFERS TO THE RATIO OF LOCAL PRICE TO THE INTERNATIONAL REFERENCE PRICE (IRP) CONVERTED INTO THE SAME CURRENCY. THE INTERNATIONAL REFERENCE PRICE SHALL PRETAIN TO THE MEDIAN OF RECENT PROCUREMENT SUPPLY PRICES OR TENDER PRICES OFFERED BY SUPPLIERS TO DEVELOPING COUNTRIES FOR MULTI-SOURCE PRODUCTS, AS RECOMMENDED BY THE WORLD HEALTH ORGANIZATION.

x x x

DD) *PHARMACEUTICALS OR PHARMACEUTICAL PRODUCTS* - REFERS TO ANY PREPARATION FOR HUMAN USE THAT IS INTENDED TO MODIFY OR EXPLOREPHYSIOLOGICAL SYSTEMS OR PATHOLOGICAL STATES FOR THE BENEFIT OF THE RECIPIENT.

II) *PROGRESSIVE PREMIUM CONTRIBUTION* - REFERS TO A SLIDING SCALE OF PREMIUM CONTRIBUTION DIRECTLY PROPORTIONAL TO ONE'S INCOME AND/OR EARNINGS.

The other terms are re-lettered accordingly."

x x x"

SEC. 2. Section 6 of the same Act is hereby further amended to read as follows:

"Sec. 6. Coverage. - All citizens of the Philippines shall be AUTOMATICALLY ENROLLED AND covered by the National Health Insurance Program. [In accordance with the principles of universality and compulsory coverage enunciated in Section 2(b) and 2(1) hereof, implementation of the Program shall, furthermore, be gradual and phased in over a period of not more than fifteen (1 5) years: Provided, That the Program shall not be made compulsory in certain provinces and cities until the Corporation shall be able to ensure that the members in such localities shall have reasonable access to adequate and acceptable health care services. "]

SEC. 3. Section 7 of the same Act is hereby further amended to read as follows:

“Sec. 7. Enrollment. -The Program shall AUTOMATICALLY enroll ALL CITIZENS OF THE PHILIPPINES AS beneficiaries in order for them to be placed under coverage that entitles them to avail of benefits with the assistance of the financial arrangements provided by the Program. [The process of enrollment shall include the identification of beneficiaries, issuance of appropriate documentation specifying eligibility to benefits, and indicating how membership was obtained or is being maintained. The enrollment shall proceed in accordance with these specific policies:

- a) all persons currently eligible for benefits under Medicare Program I, including SSS and GSIS members, retirees, pensioners and their dependents, shall immediately and automatically be made members of the National Health Insurance Program;
- b) all persons eligible for benefits through health insurance plans established by local governments as part of Program II of Medicare or in accordance with the provisions of this Act, including indigent members, shall also be enrolled in the Program;
- c) all persons eligible for benefits through health insurance plans established by local governments as part of Program II of Medicare or in accordance with the provisions of this Act, including indigent members, shall also be enrolled in the Program; and
- d) all persons eligible for benefits as members of other government-initiated health insurance programs, community-based health care organizations, cooperatives, or private non-profit health insurance plans shall be enrolled in the Program upon accreditation by the Corporation which shall devise and provide incentives to ensure that such accredited organizations will benefit from their participation in the program.

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

SEC. 4. Section 8 of the same Act is hereby further amended to read as follows:

“SEC. 8. *Health Insurance ID Card* – [In conjunction with the enrollment provided above, t] The Corporation SHALL ENLIST ALL FILIPINOS AS MEMBERS OF THE PROGRAM AND through its local office [shall], issue a health insurance ID which shall be used for purposes of identification, eligibility verification, and utilization recording. The issuance of this ID card shall be accompanied by a 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 attached thereto.

THE ID CARD SHOULD BE IN A FORM PRESCRIBED BY THE CORPORATION AND IN NO CASE SHALL IT BEAR ANY PICTURE, SEAL, OR EMBLEM THAT IDENTIFIES A GOVERNMENT OFFICIAL OR POLITICAL PARTY.

SEC. 5. Section 10 of the same Act is hereby further amended to read as follows:

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

x x x

B) Outpatient care:

1. services of health care professionals;
2. diagnostics, laboratory, and other medical examination services;
3. personal preventive services; and
4. prescription drugs and biological, subject to the limitations described in SECTION 38

of this Act;

x x x

SEC. 6. Section 16 of the same Act is hereby further amended to read as follows:

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

x x x

(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;

x x x

j) to negotiate and enter into contracts with health care institutions, professionals, and other persons, juridical or natural, regarding pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing, and delivery of health services IN BEHALF OF ITS MEMBERS;

x x x

(m) [to supervise the provision of health benefits with the power] to VISIT, ENTER AND inspect FACILITIES OF HEALTH CARE PROVIDERS AND EMPLOYERS AND TO SECURE COPIES OF THEIR medical and financial records AS WELL AS THAT of THEIR PATIENTS OR EMPLOYEES, WHERE APPLICABLE, [health care providers and patients] who are [participants in] BENEFICIARIES or members of the Program. [, and the power to enter and inspect accredited health care institutions, subject to the rules and regulations to be promulgated by the Corporation];

x x x"

(q) TO CONDUCT REGULAR PRICE MONITORING, IN COORDINATION WITH THE DEPARTMENT OF HEALTH'S NATIONAL CENTER FOR PHARMACEUTICAL ACCESS AND MANAGEMENT, OF ALL DRUGS AND BIOLOGICALS LISTED IN THE PHILIPPINE NATIONAL DRUG FORMULARY OR COVERED BY ANY EXISTING BENEFIT PACKAGE OR REIMBURSABLE LIST OF THE NATIONAL HEALTH INSURANCE PROGRAM;

(R) TO DETERMINE AND ESTABLISH TOGETHER WITH THE DEPARTMENT OF HEALTH'S NATIONAL CENTER FOR PHARMACEUTICAL ACCESS AND MANAGEMENT THE FAIR PRICE FOR THE LISTED DRUGS AND BIOLOGICALS BEING MONITORED;

(S) TO DISSEMINATE THE DETERMINED FAIR PRICE OF DRUGS AND BIOLOGICALS TO THE GENERAL PUBLIC, NATIONAL AND LOCAL GOVERNMENT AGENCIES, HEALTH INSTITUTIONS AND THE HEALTH INDUSTRY;

(T) TO CONDUCT POST-AUDIT ON QUALITY OF SERVICES RENDERED BY HEALTH CARE PROVIDERS;

(U) TO MONITOR AND CHECK COMPLIANCE OF REGULATORY AGENCIES TO THE REQUIREMENTS OF SUBPARAGRAPH (B) OF SECTION 11 AS PROVIDED HEREIN AND CARRY OUT NECESSARY ACTIONS TO RESOLVE NON-COMPLIANCE;

(V) TO ENLIST AT LEAST NINETY PERCENT (90%) OF THE TOTAL POPULATION ONE YEAR AFTER THE IMPLEMENTATION OF THIS ACT;

(W) TO ORGANIZE AWARENESS PROGRAM AND/OR DISCUSSION ON PHIC BENEFITS IN PUBLIC AND PRIVATE SCHOOLS, COLLEGES AND UNIVERSITIES IN SUPPORT OF SUB-PARAGRAPH (V) AND DETERMINE IN SAID OCCASIONS WHO ARE NOT YET COVERED IN THE PROGRAM;

(X) TO ISSUE PROVISIONAL PHILHEALTH MEMBERSHIP CARDS FOR THOSE IDENTIFIED IN SUB-PARAGRAPH (W) AS NOT YET COVERED;

(Y) TO REQUIRE HOSPITALS TO ENLIST AND ISSUE PROVISIONAL PHILHEALTH CARDS TO PATIENTS IDENTIFIED AS NOT YET COVERED BY THE PROGRAM UPON DISCHARGE, IN COORDINATION WITH THE CORPORATION;

(Z) TO MANDATE HEALTH CARE SERVICE PROVIDERS TO REPORT PER PATIENT DISCHARGED A MINIMUM SET OF INFORMATION AS MAY BE DETERMINED BY THE CORPORATION; AND

(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.

x x x

SEC. 7. Section 18 of the same act, is hereby further amended to read as follows:

"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 his representative;

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

The Secretary of Social Welfare and Development or his representative;

The President of the Corporation;

A representative of the [labor] FORMAL sector;

A representative of employers;

[The SSS Administrator or his representative];

[The GSIS General Manager or his representative];

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

A representative of Filipino overseas workers;

A representative of the [self-employed] INFORMAL SECTOR; and

A representative of health care providers [to be endorsed by the national associations of health care institutions and medical health professionals].

SECTORAL REPRESENTATIVES SHALL BE ENDORSED BY THEIR RESPECTIVE DULY ACCREDITED NATIONAL ASSOCIATIONS.

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

THE CHAIRPERSON OF THE BOARD SHALL BE SUPPORTED BY THE OFFICE OF THE CHAIR WHICH SHALL BE COMPOSED OF A MAXIMUM OF THREE STAFFS, AMONG WHICH IS AN OFFICIAL OF THE HEALTH POLICY DEVELOPMENT AND PLANNING BUREAU (HPDPB) OF THE DEPARTMENT OF HEALTH.

THE CHAIRPERSON SHALL ESTABLISH COMMITTEES UNDER HIS OFFICE, WHENEVER NECESSARY, TO ENSURE THE IMPLEMENTATION OF PUBLIC HEALTH POLICIES.

x x x"

SEC. 8. Subsection (a) of Section 19 of the same Act, is amended to read as follows:

“Sec. 19. *The President of the Corporation.*

(a) *Appointment and Tenure* – The President of the Philippines shall appoint for a non-renewable term of six (6) years, the President of the Corporation, hereinafter referred to as the President, upon recommendation of the Board. The President [shall not be removed from office except in accordance with existing laws] MAY BE REMOVED FOR CAUSE BY THE PRESIDENT OF THE PHILIPPINES, UPON RECOMMENDATION OF THE BOARD.

x x x”

SEC. 9. Section 23 of the same Act, is hereby amended BY ADDING TWO (2) SUBSECTIONS, NAMELY (S) AND (T) to read as follows:

“SEC. 23. Functions. - Each Office shall have the following powers and functions:

x x x

(S) TO CONDUCT AN INFORMATION CAMPAIGN ON THE BENEFITS PACKAGES PROVIDED BY THE CORPORATION AND ON THE MECHANISMS TO AVAIL OF THE SAME; AND

(T) TO MAINTAIN AND SECURE AN ELECTRONIC DATABASE OF ALL ITS MEMBERS.

SEC. 10. Section 26 of the same Act, is hereby amended to read as follows:

“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 resolution of the Board of Directors of the Corporation, subject to the following limitations:

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

b.) The Corporation is authorized to charge FROM the various funds under its control [for] the costs of administering the Program. Such costs may include administration, monitoring, marketing and promotion, research and development, audit and evaluation, information services, and other necessary activities for the effective management of the Program. The total annual costs for these shall not exceed [twelve] EIGHT percent [(12%)] (8%) of the total [contributions] REIMBURSEMENTS MADE BY THE CORPORATION FOR THE CURRENT YEAR [, including government contributions to the Program and not more than three percent (3%) of the investment earnings collected during the immediately preceding year.]

SEC. 11. Section 28 of the same Act, is hereby amended to read as follows:

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

a) Formal sector employees [and current Medicare members] and their employers shall [continue paying the same monthly contributions as provided for by law until such time that the Corporation shall have determined the contribution schedule mentioned herein: Provided, That their monthly contribution shall not exceed three percent of their respective monthly salaries.] PAY A PROGRESSIVE PREMIUM CONTRIBUTION IN ACCORDANCE WITH A SCHEDULE OF RATES TO BE DETERMINED BY THE CORPORATION, IN CONSULTATION WITH A

CONGRESSIONAL OVERSIGHT COMMITTEE CREATED FOR THE PURPOSES OF THIS ACT. PROVIDED THAT THE RATE OF PREMIUM CONTRIBUTION SHALL NOT BE MORE THAN FIVE PERCENT (5%) OF THE EMPLOYEE'S MONTHLY SALARY. PROVIDED FURTHER THAT THE IMPLEMENTATION OF THIS SECTION SHALL BE GRADUAL FOR A PERIOD OF THREE (3) YEARS AND SHALL ONLY BEGIN UPON CERTIFICATION BY THE CHAIRPERSON OF THE BOARD THAT THERE HAS BEEN SUBSTANTIAL IMPROVEMENT OF PHIC BENEFITS FROM THE IMPLEMENTATION OF THIS ACT;

b) Contributions from [self-employed members] THE INFORMAL SECTOR shall be based primarily on household earnings and assets; [their total contributions for one year shall not, however, exceed three percent (3%) of their estimated actual net income for the-preceding year.] PROVIDED THAT FOR PURPOSES OF COMPUTING THE PREMIUM CONTRIBUTION OF THE INFORMAL SECTOR MEMBER WHOSE PRACTICE OF PROFESSION REQUIRES REGULATORY LICENSES AND/ OR PERMITS, HE/SHE SHALL BE ASSESSED AS A MIDDLE INCOME EARNER UNLESS PROVEN OTHERWISE. PROVIDED FURTHER THAT THE REGULATORY AGENCIES CONCERNED WILL ONLY ISSUE THE SAID LICENSES AND/OR PERMITS, OR RENEW THE SAME, UPON SUBMISSION OF PROOF THAT THE CURRENT YEAR'S PREMIUM PAYMENTS TO PHIC HAVE BEEN MADE. THE REGULATORY AGENCIES' FAILURE TO MAKE PHIC PAYMENTS A PRE-REQUISITE TO THE ISSUANCE OR RENEWAL OF THE NECESSARY LICENSES AND/OR PERMITS SHALL BE CONSIDERED A VIOLATION OF THIS ACT AND SHALL SUBJECT OFFICIALS OF SAID REGULATORY AGENCIES TO APPROPRIATE ADMINISTRATIVE LIABILITY. PROVIDED FINALLY THAT MEMBERS FROM THE LOW-INCOME INFORMAL SECTOR AS DEFINED IN SUBPARAGRAPH (V) OF SEC. 4 OF THIS ACT, WHAT SHOULD HAVE BEEN CONTRIBUTED BY THE EMPLOYER IF THEY WERE ENROLLED UNDER PARAGRAPH (a) OF THIS SECTION SHALL BE SUBSIDIZED BY THE NATIONAL GOVERNMENT.

c) [Contributions made in behalf of indigent members shall not exceed the minimum contributions set for employed members.]

SEC. 12. Section 29 of the same Act, is hereby amended to read as follows:

"SEC. 29. *Payment for Indigent Contributions.* - Contributions for indigent members shall be subsidized ENTIRELY BY THE NATIONAL GOVERNMENT. PROVIDED THAT THE LOCAL GOVERNMENT UNIT WHERE THE INDIGENT MEMBER RESIDES SHALL PAY FOR A SUPPLEMENTARY BENEFIT PACKAGE FOR THE SAID MEMBER. ALLOCATION FOR THE ENROLLMENT OF INDIGENTS SHALL BE APPROPRIATED IN THE GENERAL APPROPRIATIONS ACT AS A SEPARATE LINE ITEM IN THE DEPARTMENT OF HEALTH BUDGET.[partially by the local government unit where the member resides. The Corporation shall provide counterpart financing equal to the LGU's subsidy for indigents: Provided, That in the case of fourth, fifth and sixth class municipalities, the National Government shall provide up to ninety percent (90%) of the subsidy for indigents until such time that they shall have been upgraded to first, second or third class municipalities. The share of the LGU's shall be progressively increased until such time that its share becomes equal to that of the National Government.]

SEC. 13. Section 31 of the same Act, is hereby amended to read as follows:

"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; PROVIDED, HOWEVER, THAT IN NO CASE SHALL THE CORPORATION

ACCREDIT ANY HEALTH CARE PROVIDER WITH PENDING ADMINISTRATIVE OR CRIMINAL CASES OR THOSE METED WITH FINAL JUDGMENTS FOR ANY VIOLATION OF THIS ACT."

SEC. 14. Section 34 of the same Act, is hereby amended to read as follows:

"Sec. 34. Provider Payment Mechanisms. - The following mechanisms for public and private providers shall be allowed in the Program:

- a) Fee for service based on mechanisms established by the Corporation PROVIDED THE CORPORATION NEGOTIATES FEES IN BEHALF OF ITS MEMBERS ;
- B) CASE BASED PAYMENTS WITH MECHANISMS DETERMINED BY THE CORPORATION;
- C) Capitation of health care professionals and facilities, or network of the same, including HMOs, medical cooperatives, and other legally formed health service groups;
- D) A combination of both; and
- E) Any or all of the above, subject to global budget.

IN ANY OF THE FOREGOING, BALANCE BILLING SHOULD ONLY BE ALLOWED FOR AMENITIES AND FOR SERVICES VOLUNTARILY CHOSEN BY THE MEMBER.

THE CORPORATION MAY ADOPT ANOTHER MECHANISM NOT PROVIDED ABOVE AS LONG AS IT WILL BE THE MOST BENEFICIAL TO PROVIDE MAXIMUM SERVICES TO ALL, SUBJECT TO THE APPROVAL OF THE BOARD.

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

SEC. 15. Section 38 of the same Act, is hereby amended to read as follows:

"Sec. 38. Safeguards Against Over and Under Utilization AND OVERPRICING OF DRUGS AND BIOLOGICALS - It is incumbent upon the Corporation to set up a monitoring mechanism to be operationalized through a contract with health care providers AND IN CONSULTATION WITH THE PATIENTS' GROUPS, CIVIL SOCIETY ORGANIZATIONS, AND OTHER STAKEHOLDERS 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; AND
- f) OVERPRICING OF DRUGS AND BIOLOGICALS

The corporation may deny or reduce the payment for claims when such claims are attended by false or incorrect information and when the claimants fail, without justifiable cause, to comply with the rules and regulations of this act.

THE CORPORATION IN COMPLIANCE WITH THE PRINCIPLES OF RESPONSIVENESS, EFFECTIVENESS, AND FIDUCIARY RESPONSIBILITY AS STATED IN SEC. 2 OF REPUBLIC ACT NO. 7875 AND THIS ACT, IS HEREBY MANDATED TO DESIGN AND IMPLEMENT POLICIES, PROCEDURES AND OTHER MEASURES TO ENSURE THAT ONLY FAIR-PRICES DRUGS AND BIOLOGICALS ARE QUALIFIED AS PART OF ANY BENEFIT PACKAGE UNDER THIS ACT. THE CORPORATION SHALL

ALSO ENSURE THAT NO DISRUPTIONS IN SUPPLY FOR BENEFICIARIES SHALL OCCUR AS A RESULT OF THESE MEASURES, INCLUDING A POLICY OF COVERING ALL DRUGS AND BIOLOGICALS DEFINED IN SECTION 37 WITHIN AN EXTENDED PERIOD OF TIME NOT EXCEEDING SEVEN (7) YEARS.

THE CORPORATION SHALL DETERMINE THE FAIR PRICE OF DRUGS AND BIOLOGICALS COVERED BY THE PHIC BENEFIT PACKAGE, PERIODICALLY USING ONE OR MORE OF THE FOLLOWING MECHANISMS:

1. PRICE COMPARISON WITH THREE OR MORE COUNTRIES IN THE ASEAN REGION THAT ARE RELATIVELY AT PAR WITH THE PHILIPPINES IN TERMS OF SOCIO-ECONOMIC DEVELOPMENT;
2. PRICE COMPARISONS WITH TRANSACTIONS DONE BY INTERNATIONAL BODIES, DONOR AGENCIES, AND OTHER SIMILAR INTERNATIONAL DEVELOPMENT AGENCIES;
3. PRICE-VOLUME NEGOTIATIONS WITH MANUFACTURERS FOR SINGLE-SUPPLIER PRODUCTS;
4. USE OF MEDIAN PRICE RATIOS AS RECOMMENDED BY THE WORLD HEALTH ORGANIZATION; AND
5. OTHER CRITERIA AS MAY BE SET BY THE BOARD IN CLOSE COORDINATION WITH THE DEPARTMENT OF HEALTH'S NATIONAL CENTER FOR PHARMACEUTICAL ACCESS AND MANAGEMENT.

THE CORPORATION SHALL ENSURE THE PUBLICATION OF UP-TO-DATE PRICE LISTINGS OF FAIR PRICES OF DRUGS AND BIOLOGICALS IN VARIOUS NEWSPAPERS OF NATIONAL CIRCULATION, ON THE CORPORATION'S WEBSITE, AND POSTERS PROMINENTLY DISPLAYED IN PHARMACIES AND HOSPITALS ON A REGULAR BASIS. THE CORPORATION SHALL LIKEWISE ENSURE THAT PRINTED COPIES OF FAIR PRICE LIST ARE DISTRIBUTED TO ALL ACCREDITED HEALTH CARE INSTITUTIONS AT LEAST ONCE A YEAR.

IN THE DETERMINATION OF FAIR PRICES ABOVE SPECIFIED, THE CORPORATION SHOULD AT ALL TIMES CONSULT AND HARMONIZE THEIR PRICING POLICIES AND MEASURES TO THAT OF THE DEPARTMENT OF HEALTH, THROUGH THE NATIONAL CENTER FOR PHARMACEUTICAL ACCESS AND MANAGEMENT (NCPAM).

SEC. 16. Section 40 of the same Act is hereby amended by adding subsection (e) to read as follows:

"Sec. 40. *Grounds for Grievances.* – The following acts shall constitute valid grounds for grievance action:

X X X

E) ANY ACT OR OFFENSE ENUMERATED IN ARTICLE X OF THIS ACT; AND

F) Any other neglect that tends to undermine or defeat the purposes of this Act.

SEC. 17. Subsections a and b of Section 41 of the same Act is hereby amended to read as follows:

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

a) A complaint for grievance must be filed with the [Office] CORPORATION which shall rule on the complaint within [ninety (90)] SIXTY (60) calendar days from receipt thereof;

b) Appeals from [Office] THE CORPORATION's decisions must be filed with the Board within [thirty (30)] FIFTEEN (15) CALENDAR days from receipt of notice of dismissal by the office.

x x x"

SEC. 18. Article X of the same Act is also amended to read as follows:

Article X. OFFENSES AND Penalties

"SEC. 44. *OFFENSES OF INSTITUTIONAL HEALTH CARE PROVIDERS.* - AN INSTITUTIONAL HEALTH PROVIDER, after due notice and hearing, shall [suffer the following penalties] BE PUNISHED WITH A PENALTY OF A FINE OF NOT LESS THAN FIFTY THOUSAND PESOS (P50,000.00) BUT NOT MORE THAN ONE HUNDRED THOUSAND PESOS (P100,000.00), SUSPENSION OF ACCREDITATION FROM THREE (3) MONTHS TO THE WHOLE TERM OF ACCREDITATION OR REVOCATION OF ACCREDITATION, OR BOTH, AT THE DISCRETION OF THE CORPORATION, UPON A FINDING THAT IT IS ENGAGED IN ANY OF THE FOLLOWING ACTS OR OMISSIONS:

A. *PADDING OF CLAIMS* - BY FILING A CLAIM FOR PAYMENT FROM THE NHIP FOR DRUGS, MEDICINES, SUPPLIES, PROCEDURES, SERVICES AND OTHER BENEFITS WHICH ARE IN EXCESS OF THE BENEFITS ACTUALLY PROVIDED TO A BENEFICIARY.

B. *CLAIMS FOR SERVICES NOT RENDERED AND / OR CONFINEMENTS OF NON-ADMITTED PATIENTS* - BY MAKING IT APPEAR THAT THE PATIENT IS ACTUALLY CONFINED AND /OR PROVIDED PHILHEALTH-COVERED SERVICES IN THE HEALTH CARE INSTITUTION / FACILITY OR USES SUCH OTHER MACHINATIONS THAT WOULD RESULT IN CLAIMS FOR SERVICES NOT RENDERED/GIVEN.

C. *EXTENDING PERIOD OF CONFINEMENT* - BY:

1. INCREASING THE PERIOD OF ACTUAL CONFINEMENT OF ANY PATIENT;
2. CONTINUOUSLY CHARTING ENTRIES IN THE DOCTOR'S ORDER, NURSES NOTES AND OBSERVATION DESPITE ACTUAL DISCHARGE OR ABSENCE OF THE PATIENTS;
3. SUCH OTHER MACHINATIONS THAT WOULD RESULT IN THE UNNECESSARY EXTENSION OF CONFINEMENT.

D. *ANTE-DATING OF CLAIMS* - BY ALTERATION, DELETION OR INTERCALATION OF DATES, IN A CLAIM THAT WOULD OTHERWISE BE DEEMED PRESCRIBED FOR HAVING BEEN MADE BEYOND SIXTY (60) CALENDAR DAYS FROM THE DATE OF DISCHARGE OF THE BENEFICIARY.

ANY CLAIM FILED BEYOND THE SIXTY (60) DAY PERIOD SHALL BE DENIED, EXCEPT UPON GOOD REASONS AS MAY BE DETERMINED SUFFICIENT BY THE CORPORATION.

E. *MISREPRESENTATION BY FURNISHING FALSE OR INCORRECT INFORMATION* -ANY HEALTH CARE PROVIDER SHALL BE LIABLE FOR FRAUDULENT PRACTICE WHEN, FOR THE PURPOSE OF PARTICIPATION IN THE NHIP OR CLAIMING PAYMENT THEREFROM, IT FURNISHES FALSE OR INCORRECT INFORMATION CONCERNING ANY MATTER REQUIRED BY THIS ACT.

WHERE SUCH MISREPRESENTATION LEADS TO DAMAGE TO THE CORPORATION, THE PENALTY SHALL BE THE MAXIMUM FINE AND REVOCATION OF ACCREDITATION.

1 *F. FILING OF MULTIPLE CLAIMS* – BY FILING TWO OR MORE CLAIMS FOR A
2 PATIENT FOR THE SAME CONFINEMENT OR ILLNESS, OR MAKES IT APPEAR THAT
3 THE PATIENT HAD BEEN CONFINED FOR TWO OR MORE TIMES AND/OR FOR TWO
4 OR MORE DIFFERENT ILLNESSES.

5 *G. UNJUSTIFIED ADMISSION BEYOND ACCREDITED BED CAPACITY* – BY
6 FILING CLAIMS FOR PATIENTS CONFINED IN EXCESS OF THE ACCREDITED BED
7 CAPACITY AT ANY GIVEN TIME WITHOUT JUSTIFICATION IN THE FORM AND
8 MANNER PRESCRIBED BY THE CORPORATION.

9 *H. CLAIMS FOR UNAUTHORIZED SERVICES/PROCEDURES PERFORMED*
10 *BEYOND ACCREDITATION CAPABILITY OF THE HEALTH CARE INSTITUTION/ FACILITY*
11 – BY PERFORMING ANY HEALTH CARE SERVICES/ PROCEDURES BEYOND ITS
12 AUTHORIZED CAPABILITY EXCEPT WHEN SUCH SERVICES WERE DONE IN AN
13 EMERGENCY SITUATION / CONDITION TO SAVE LIFE AND REFERRAL TO A
14 HIGHER CATEGORY PROVIDER IS PHYSICALLY IMPOSSIBLE.

15 *I. FABRICATION OR POSSESSION OF FABRICATED FORMS AND SUPPORTING*
16 *DOCUMENTS* – BY ANY HEALTH CARE PROVIDER WHO IS FOUND PREPARING
17 CLAIMS WITH MISREPRESENTATIONS OR FALSE ENTRIES, OR TO BE IN
18 POSSESSION OF CLAIM FORMS AND OTHER DOCUMENTS WITH FALSE ENTRIES.

19 *J. ABUSES AND UNETHICAL PRACTICES* - ANY HEALTH CARE PROVIDER
20 SHALL BE LIABLE FOR THE FOLLOWING ABUSES AND UNETHICAL PRACTICES:

- 21 1. UNSAFE OR DANGEROUS PRACTICES AS MAY BE DETERMINED BY
22 THE CORPORATION;
- 23 2. IRRATIONAL OR UNNECESSARY DRUG USE;
- 24 3. UNNECESSARY PERFORMANCE OF DIAGNOSTIC OR THERAPEUTIC
25 PROCEDURES;
- 26 4. CHARGING OR COLLECTING FROM A MEMBER AN AMOUNT IN
27 EXCESS OF THE BENEFITS INCLUDING THOSE COVERED BY
28 CAPITATION OR GLOBAL BUDGETS FOR PHILHEALTH-COVERED
29 SERVICES AND SUPPLIES WHICH PROHIBITS CHARGING OF OUT-OF-
30 POCKET PAYMENT INCLUDING OUTSIDE PURCHASES OF MEDICINES,
31 SUPPLIES AND HEALTH CARE SERVICES THAT ARE INCLUDED IN
32 THE BENEFIT;
- 33 5. ENROLLMENT AND / OR RECRUITMENT OF A PERSON FOR THE SOLE
34 PURPOSE OF CLAIMING BENEFITS AND / OR PAYMENT OF PREMIUM
35 OF A MEMBER BEFORE PROVIDING HEALTH CARE SERVICES TO HIM/
36 HER, EXCEPT WHEN THE PATIENT OR MEMBER IS ITS EMPLOYEE OR
37 THE OWNERS RELATIVE WITHIN THE FOURTH CIVIL DEGREE OF
38 CONSANGUINITY OR AFFINITY; AND,
- 39 6. ALL SUCH OTHER ABUSES AND UNETHICAL PRACTICES AS MAY BE
40 DETERMINED BY THE CORPORATION.

41 *K. OTHER FRAUDULENT ACTS* - ANY HEALTH CARE PROVIDER SHALL ALSO
42 BE LIABLE FOR THE FOLLOWING FRAUDULENT ACTS:

- 43 1. MAKING IT APPEAR THAT THE PATIENT SUFFERED FROM
44 COMPENSABLE ILLNESS OR UNDERWENT A COMPENSABLE
45 PROCEDURE;

2. FAILURE OR REFUSAL TO GIVE THE BENEFITS DUE TO QUALIFIED MEMBERS/ DEPENDENTS;
3. CHARGING QUALIFIED PATIENTS FOR MEDICINES AND/OR SERVICES WHICH ARE LEGALLY CHARGEABLE TO AND COVERED BY THE NHIP;
4. FAILURE OR REFUSAL TO REFUND TO THE MEMBER THE PAYMENT RECEIVED FROM THE NHIP WHEN THE HOSPITAL CHARGES AND PROFESSIONAL FEES ARE FULLY PAID IN ADVANCE BY THE MEMBER WITHIN A PERIOD OF THIRTY (30) DAYS FROM THE DATE OF RECEIPT OF REFUND CHECK FROM THE CORPORATION;
5. FAILURE OR REFUSAL TO ACCOMPLISH AND SUBMIT THE REQUIRED FORMS IN CONNECTION WITH NUMBER 4;
6. 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
7. DELIBERATE FAILURE OR REFUSAL TO COMPLY WITH THE REQUIREMENTS UNDER THIS ACT.

L. BREACH OF THE WARRANTIES OF ACCREDITATION – BY COMMITTING ANY OTHER WILLFUL OR NEGLIGENT ACT OR OMISSION WHICH TENDS TO UNDERMINE OR DEFEAT THE OBJECTIVES OF THE NHIP.

M. OTHER VIOLATIONS - ANY OTHER ACT OF ANALOGOUS NATURE AS ABOVE ENUMERATED.

N. CRIMINAL LIABILITY - IN ADDITION, A CRIMINAL COMPLAINT SHALL BE FILED AGAINST THE OFFICIALS OF THE ERRING INSTITUTIONAL HEALTH CARE PROVIDER BEFORE THE APPROPRIATE OFFICE OF THE PROSECUTOR FOR VIOLATIONS OF THIS ACT AND/OR THE REVISED PENAL CODE

SEC. 45. OFFENSES OF HEALTH CARE PROFESSIONALS – SUB PARARAPHS (E), (L), (M) AND (N) OF SEC. 44 OF THIS ACT SHALL EQUALLY APPLY TO A HEALTH CARE PROFESSIONAL WITH THE SAME PENALTIES AS THAT IMPOSED IN SAID SEC. 44.

IN ADDITION, A HEALTH CARE PROFESSIONAL SHALL ALSO BE HELD LIABLE FOR THE FOLLOWING ABUSES AND UNETHICAL PRACTICES:

1. PERFORMANCE OF PROCEDURES BEYOND THOSE ALLOWED BY THE HEALTH CARE PROFESSIONAL'S QUALIFICATIONS AND TRAINING EXCEPT WHEN UNDER THE DIRECT SUPERVISION OF A QUALIFIED HEALTH CARE PROFESSIONAL;
2. UNSAFE OR DANGEROUS PRACTICES AS MAY BE DETERMINED BY THE CORPORATION;
3. IRRATIONAL OR UNNECESSARY DRUG USE;
4. UNNECESSARY PERFORMANCE OF DIAGNOSTIC OR THERAPEUTIC PROCEDURE;
5. CHARGING OR COLLECTING FROM A MEMBER AN AMOUNT IN EXCESS OF THE BENEFITS INCLUDING THOSE COVERED BY CAPITATION OR

GLOBAL BUDGETS FOR PHILHEALTH-COVERED SERVICES AND SUPPLIES WHICH PROHIBITS CHARGING OF OUT-OF-POCKET PAYMENT INCLUDING OUTSIDE PURCHASES OF MEDICINES, SUPPLIES AND HEALTH CARE SERVICES THAT ARE INCLUDED IN THE BENEFIT;

6. ENROLLMENT AND/OR RECRUITMENT OF A PERSON FOR THE SOLE PURPOSE OF CLAIMING BENEFITS AND/OR PAYMENT OF PREMIUM OF A MEMBER BEFORE PROVIDING HEALTH CARE SERVICES TO HIM/HER, EXCEPT WHEN THE PATIENT OR MEMBER IS HIS/HER EMPLOYEE OR RELATIVE WITHIN THE FOURTH CIVIL DEGREE OF CONSANGUINITY OR AFFINITY;

7. ANY OTHER WILLFUL OR NEGLIGENT ACT OR OMISSION OF THE HEALTH CARE PROFESSIONAL IN VIOLATION OF THIS ACT WHICH TENDS TO UNDERMINE OR DEFEAT THE OBJECTIVES OF THE NHIP; AND

8. ALL SUCH OTHER ABUSES AND UNETHICAL PRACTICES AS MAY BE DETERMINED BY THE CORPORATION.

SEC. 46. OFFENSES OF MEMBERS - ANY MEMBER WHO, FOR PURPOSES OF CLAIMING NHIP BENEFITS OR ENTITLEMENT THERETO, SHALL COMMIT ANY OF THE OFFENSES DEFINED UNDER THIS ACT, INDEPENDENTLY OR IN CONNIVANCE WITH A HEALTH CARE PROVIDER, SHALL SUFFER A FINE OF FIVE THOUSAND PESOS (P5,000.00) AND SUSPENSION FROM AVAILMENT OF NHIP BENEFITS FOR NOT LESS THAN THREE (3) MONTHS BUT NOT MORE THAN SIX (6) MONTHS.

SEC. [44] 47. [Penal Provisions Any violation of the provisions of this Act, after due notice and hearing, shall suffer the following penalties:]-*OFFENSES OF EMPLOYERS-*

[A fine of not less than Ten thousand pesos (P 10,000) nor more than Fifty thousand pesos (P50,000) in case the violation is committed by the hospital management or provider. In addition, its accreditation shall be suspended or revoked from three (3) months to the whole term of accreditation: *Provided, however;* That recidivists may not anymore be accredited as a participant of the program;

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

Where the violations consist of failure or refusal to [deduct contributions from the employee's compensation or to remit the same to the Corporation, the penalty shall be a fine of not less than Five hundred pesos (P500) but not more than One thousand pesos (P1,000) multiplied by the total number of employees employed by the firm and imprisonment of not less than six (6) months but not more than one (1) year: *Provided, further,* That in the case of self-employed members, failure to remit one's own contribution shall be penalized with a fine of not less than five hundred pesos (P500) but not more than One thousand pesos (P1,000.00).] REGISTER EMPLOYEES, OR TO DEDUCT CONTRIBUTIONS FROM THE EMPLOYEES COMPENSATION AND/OR REMIT THE SAME TO THE CORPORATION, THE PENALTY SHALL BE A FINE OF FIVE THOUSAND PESOS (P5, 000. 00) MULTIPLIED BY THE TOTAL NUMBER OF EMPLOYEES OF THE FIRM AND IMPRISONMENT OF NOT LESS THAN SIX (6) YEARS AND ONE (1) DAY BUT NOT TO EXCEED TWELVE (12) YEARS.

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

Any employer who shall deduct directly or indirectly from the compensation of the covered employees or otherwise recover from them his own contribution on behalf of such

employees shall be punished by a fine [not exceeding] OF [One] FIVE thousand pesos (P[1] 5,000.00) multiplied by the total number of employees employed by the firm[or] AND imprisonment FOR not [exceeding one (1)] LESS THAN SIX (6) YEARS AND ONE DAY BUT NOT TO EXCEED TWELVE (12) years.[or both fine and imprisonment, at the discretion of the Court.]

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

Any employee of the Corporation who receives or keeps funds or property belonging, payable or deliverable to the Corporation, and who shall appropriate the same, or shall take or misappropriate or shall consent, or through abandonment or negligence shall permit any other person to take such property or funds wholly or partially, shall likewise be liable for misappropriation of funds or property and shall suffer imprisonment of not less than six (6) years and not more than twelve (12) years and a fine of not less than Ten thousand pesos (P10,000. 00) nor more than Twenty thousand pesos (P20,000. 00). Any shortage of the funds or loss of the property upon audit shall be deemed *prima facie* evidence of the offense.

CRIMINAL ACTION ARISING FROM A VIOLATION OF THE PROVISIONS OF THIS ACT MAY BE COMMENCED BY THE CORPORATION OR THE EMPLOYEE CONCERNED EITHER UNDER THIS ACT OR IN APPROPRIATE CASES UNDER THE REVISED PENAL CODE: PROVIDED, THAT SUCH CRIMINAL ACTION MAY BE FILED BY THE CORPORATION IN THE CITY OR MUNICIPALITY WHERE: THE VIOLATION WAS COMMITTED OR IN PROPER COURTS IN METRO MANILA, AT THE OPTION OF THE CORPORATION.

“SEC. 48. *GENERAL PROVISIONS.*

SEC. 48-A. *MITIGATING AND AGGRAVATING CIRCUMSTANCES* - THE FOLLOWING CIRCUMSTANCES SHALL AFFECT THE GRAVITY OF THE VIOLATION AND THE LIABILITY OF THE ERRING HEALTH CARE PROVIDER, MEMBER, AND EMPLOYER:

(A) *MITIGATING CIRCUMSTANCES* - THE FOLLOWING CIRCUMSTANCES SHALL MITIGATE THE LIABILITY OF THE RESPONDENT:

1. VOLUNTARY ADMISSION OF GUILT;
2. GOOD TRACK RECORD;
3. FIRST OFFENSE; AND
4. SUCH OTHER CIRCUMSTANCES AND CONSIDERATIONS AS MAY BE DETERMINED BY THE CORPORATION.

(B) *AGGRAVATING CIRCUMSTANCES* - THE FOLLOWING CIRCUMSTANCES SHALL AGGRAVATE THE LIABILITY OF THE RESPONDENT:

1. PREVIOUS CONVICTION OF AN OFFENSE, AS PROVIDED FOR IN THIS ACT; OR
2. CONNIVANCE AND/OR CONSPIRACY WITH AN OFFICER OR EMPLOYEE OF THE CORPORATION TO FACILITATE OR CONCEAL THE COMMISSION OF THE VIOLATION; OR
3. GROSS NEGLIGENCE; AND
4. SUCH OTHER CIRCUMSTANCES AND CONSIDERATIONS AS MAY BE DETERMINED BY THE CORPORATION.

SEC 48-B. APPLICATION OF CIRCUMSTANCES IN THE IMPOSITION OF PENALTIES-

- A. THE PRESENCE OF MITIGATING CIRCUMSTANCE WITHOUT ANY AGGRAVATING CIRCUMSTANCE SHALL LIMIT THE IMPOSABLE PENALTY TO ITS MINIMUM.
- B. WHEN THERE IS NEITHER MITIGATING NOR 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 CIRCUMSTANCE ARE PRESENT.
- C. THE PRESENCE OF ANY AGGRAVATING CIRCUMSTANCE WITHOUT THE MITIGATING CIRCUMSTANCE SHALL INCREASE THE PENALTY OF THE OFFENSE TO ITS MAXIMUM.

SEC. 48-C. *COMMON PROVISIONS* - ALL PENALTIES FOR OFFENSES COMMITTED BY HEALTH CARE PROVIDERS AND MEMBERS SHALL CARRY WITH THEM DENIAL OF PAYMENT OF CLAIMS IN QUESTION AND/OR REFUND TO THE CORPORATION, IF ALREADY PAID.

IF THE PENALTY OF SUSPENSION IMPOSED AGAINST A HEALTHCARE PROVIDER EXCEEDS THE VALIDITY OF THE CURRENT ACCREDITATION, THE RENEWAL OR THE REACCREDITATION OF THE LATTER SHALL NOT BE ACTED UPON UNTIL THE FULL TERM OF THE SUSPENSION IMPOSED HAS BEEN SERVED OR LIFTED. FOR THIS PURPOSE, THE PERIOD COVERING THE EXPIRATION OF ACCREDITATION AND THE START OF THE EFFECTIVITY OF THE RENEWAL AND/OR REACCREDITATION SHALL BE CONSIDERED AS PART OR CONTINUATION OF THE SUSPENSION. SUSPENSION SHALL BE CARRIED OUT BY THE TEMPORARY CESSATION OF THE BENEFITS OR PRIVILEGES UNDER THE NHIP.

SHOULD THE AGGREGATE PERIOD OF SUSPENSION TO BE IMPOSED UPON THE PROVIDER ON ACCOUNTS OF TWO OR MORE VIOLATIONS EXCEED TWENTY-FOUR (24) MONTHS, THE MAXIMUM IMPOSABLE PENALTY SHALL BE EXACTED.

IN ALL CASES WHEREIN A DECISION IS RENDERED AGAINST A HEALTH CARE PROVIDER, THE DEPARTMENT OF HEALTH (DOH), PROFESSIONAL REGULATIONS COMMISSION (PRC) AND/OR OTHER CONCERNED AGENCIES SHALL BE FURNISHED WITH A COPY OF THE SAME FOR INFORMATION AND/OR APPROPRIATE ACTION.

A NOTICE OF SUSPENSION FOR THE INFORMATION OF THE PUBLIC SHALL BE POSTED IN CONSPICUOUS PLACES AND / OR IN THE INSTITUTION CONCERNED INDICATING THE PERIOD OF SUSPENSION IN SUCH FORM AND MANNER TO BE PRESCRIBED BY THE CORPORATION.

A HEALTH CARE PROVIDER WHO AT THE TIME OF TRIAL FOR AN OFFENSE ENTUMERATED HEREIN SHALL HAVE BEEN PREVIOUSLY CONVICTED BY FINAL JUDGMENT FOR ANY OFFENSE UNDER THIS ACT MAY NO LONGER BE ACCREDITED AS PARTICIPANT OF THE NHIP.

SEC. 49. *FINAL PROVISIONS* -

SEC. 49-A. *PROSECUTION OF OFFENSES* - OFFENSES DEFINED UNDER SECTIONS 44s, 45s, 46s and 47s HEREOF, SHALL BE PROSECUTED IN REGULAR COURTS OF JUSTICE OF COMPETENT JURISDICTION WITHOUT PREJUDICE TO ADMINISTRATIVE ACTION THAT MAY BE INSTITUTED BY THE CORPORATION UNDER EXISTING LAWS.

1 SEC. 49-B. *FILING OF COMPLAINT* - THE FILING OF COMPLAINT BEFORE THE
2 CORPORATION SHALL NOT BAR A SEPARATE INDEPENDENT CRIMINAL ACTION
3 BEFORE ANY COURT AGAINST THE ERRING HEALTH CARE PROVIDER OR
4 MEMBER AND VICE VERSA.

5 SEC. 49-C. *EXECUTION OF PENALTY* - WHEN AN INSTITUTIONAL HEALTH
6 CARE PROVIDER CEASES OPERATION OR AN INDEPENDENT HEALTH CARE
7 PROFESSIONAL STOPS HIS/HER PRACTICE BEFORE SERVING THE SUSPENSION,
8 EXECUTION OF PENALTY SHALL BE DEFERRED, TO BE IMPLEMENTED WHEN THE
9 SAME OWNER OR MEDICAL DIRECTOR OPENS OR OPERATES A NEW INSTITUTION
10 IRRESPECTIVE OF THE NAME OR LOCATION, OR WHEN THE HEALTH CARE
11 PROVIDER PRACTICES AGAIN. *PROVIDED*, THAT THE DISPOSITIVE PART OF THE
12 RESOLUTION REQUIRING PAYMENT OF FINES, REIMBURSEMENT OF PAID CLAIM
13 OR DENIAL OF PAYMENT SHALL BE IMMEDIATELY EXECUTORY.

14 A SPOUSE OR RELATIVE WITHIN THE SECOND DEGREE OF
15 CONSANGUINITY OR AFFINITY OF THE OWNER OR MEDICAL DIRECTOR SHALL
16 BE PRESUMED TO BE THE ALTER EGO OF SUCH OWNER OR MEDICAL DIRECTOR
17 FOR THE ABOVE PURPOSES.

18 DESPITE THE CESSATION OF OPERATION OR PRACTICE OF A HEALTH CARE
19 PROVIDER WHILE THE COMPLAINT IS BEING HEARD, THE PROCEEDING SHALL
20 CONTINUE UNTIL RENDITION OF JUDGMENT FOR PURPOSES OF DETERMINING
21 FUTURE RELATIONSHIPS BETWEEN THE CORPORATION AND THE ERRING
22 HEALTH CARE PROVIDER.

23 SEC. 49-D. *APPLICABILITY OF THESE PROVISIONS* - COMPLAINTS ALREADY
24 FILED WITH AND UNDER DELIBERATION BY APPROPRIATE BODIES OF THE
25 CORPORATION PRIOR TO THE EFFECTIVITY OF THIS ACT SHALL BE GOVERNED IN
26 ACCORDANCE WITH THE PREVIOUS ACTS AND THEIR IMPLEMENTING RULES
27 AND REGULATIONS.

28 SEC. 49-E. *IMPOSITION OF INTEREST AND SURCHARGES* - THE CORPORATION
29 MAY IMPOSE INTEREST AND SURCHARGES OF THREE PERCENT (3%) PER MONTH
30 OR AT ANY RATE AS MAY BE FIXED BY THE CORPORATION IN CASE OF ANY
31 DELAY IN THE REMITTANCE OF CONTRIBUTIONS WHICH ARE DUE WITHIN THE
32 PRESCRIBED PERIOD. NOTWITHSTANDING THE PROVISION OF ANY LAW TO THE
33 CONTRARY, THE CORPORATION MAY ALSO COMPROMISE, WAIVE AND / OR
34 RELEASE, IN WHOLE OR IN PART, SUCH INTEREST OR SURCHARGES UNDER SUCH
35 TERMS AND CONDITIONS AS IT MAY PRESCRIBE.

36 SEC. 49-F. *OTHER VIOLATIONS* - All other violations [involving funds] of the
37 PROVISIONS OF THIS ACT OR OF THE RULES AND REGULATIONS PROMULGATED
38 BY THE Corporation shall be PUNISHED BY A FINE OF NOT LESS THAN FIVE
39 THOUSAND PESOS (P5,000.00) NOR MORE THAN TWENTY THOUSAND PESOS
40 (P20,000.00), OR IMPRISONMENT FOR NOT LESS THAN SIX (6) YEARS AND ONE (1)
41 DAY BUT NOT TO EXCEED TWELVE (12) YEARS OR BOTH, AT THE DISCRETION OF
42 THE COURT.[governed by the applicable provisions of the Revised Penal Code or other laws,
43 taking into consideration the rules on collection, remittances, and investment of funds as may be
44 promulgated by the Corporation.]

45 SEC. 19. *CONGRESSIONAL OVERSIGHT COMMITTEE* - A Joint Congressional
46 Oversight Committee is hereby created, composed of the Chairman of the Senate Committee on
47 Health and five (5) other Senators designated by the Senate President, and the Chairman of the
48 House Committee on Health, and five (5) other Members of the House of Representatives
49 designated by the Speaker of the House of Representatives: Provided, That, of the five (5)
50 members to be designated by each House of Congress, three (3) should come from the majority
51 and the remaining two (2) from the minority.

1 The Joint Congressional Oversight Committee shall have the power to monitor and
2 evaluate the implementation of this Act. It shall review and propose amendments to the
3 Implementing Rules and Regulation proposed by the Corporation.

4 SEC. 20. *APPROPRIATIONS* – The necessary funds required for the implementation of
5 this Act shall be included in the annual appropriations of the Department of Health.

6 SEC. 21. *Implementing Rules & Regulations* - The Philippine Health Insurance
7 Corporation (PhilHealth) AND THE DEPARTMENT OF HEALTH shall issue the necessary
8 rules and regulations to implement the provisions of this Act.

9 SEC. 22. *Repealing Clause* - All laws, issuances or any part thereof inconsistent with this
10 Act are hereby repealed or modified accordingly.

11 SEC. 23. *Effectivity*. - This Act shall take effect fifteen (15) days after its complete
12 publication in the Official Gazette or in at least two (2) national newspapers of general
13 circulation.

Approved,