

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

**EIGHTEENTH CONGRESS**  
**Second Regular Session**

House Bill No. 7578



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**Introduced by REP. JOEY SARTE SALCEDA**

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**AN ACT**  
**INTRODUCING REFORMS TO THE NATIONAL HEALTH INSURANCE**  
**SYSTEM, AMENDING FOR THE PURPOSE REPUBLIC ACT NO. 11223 OR THE**  
**UNIVERSAL HEALTH CARE ACT, AND FOR OTHER PURPOSES**

**EXPLANATORY NOTE**

Our health insurance system is sick. The national health insurer is ill with mismanagement and corruption. In a report this representation submitted to Congressional leadership, we have outlined how mismanagement and corruption were exacerbated by design flaws in the health insurance system, and how these flaws can be remedied by structural reforms. This bill proposes systemic reforms in the management of the reserve fund, the collection system, the distribution and verification of claims and benefits, and the governance of the agency.

This bill mainly

- Makes the contribution scheme more progressive, potentially saving working minimum-wage families thousands of pesos annually, and effectively exempting OFWs from paying premiums;
- Reforms the PhilHealth governance structure and makes the Secretary of Finance Chair of the Board;
- Reforms reserve fund management, making the Bureau of Treasury the fund manager of the investment reserve fund, accumulating net income into the reserve fund, and removing the two-year ceiling in fund life, to ensure that the health insurance system can withstand demand shocks such as pandemics;
- Mandates the creation of the national health database of all claims and benefits requested from and granted by the PhilHealth. This will also follow the one-patient, one-record principle; and
- Requires independent audit of the PhilHealth, apart from those conducted by the Commission on Audit, and mandates the PhilHealth President to report to the President of the Philippines and to Congress measures taken to address adverse audit findings.

These provisions respond to the following findings:

**Much of PhilHealth's financial troubles arise out of its design.** While claims that it will face a shortfall of P90 billion in 2020 are largely unfounded, there are legitimate threats to the solvency of the national health insurance, arising out of flaws in the insurer's design. PhilHealth is not a medical institution. It is not an administrative agency. It is an insurance company, with government subsidy, a collection aspect, a claims and benefits distribution operation, and a reserve fund to administer. These are specialties that all ought to be optimized, or they will systemically affect each other negatively.

**Because PhilHealth's diverse functions are all currently administered together, they do not benefit from the gifts of specialization.** Another problem is that the company is perceived as a "health institution," when most of its operations have very little to do with medical science.

**To clean PhilHealth up, we will have to set up systems where PhilHealth's general operations, its reserve fund, its claims and benefits distribution, and its collection activities are optimized.** Where administration is tainted, faultily commingled operations can yield to diseconomies of scope.

## **RESERVE FUND MANAGEMENT**

**The reserve fund was put in place to ensure that shortfalls during bad years can be covered. Part of the issue with PhilHealth's reserve fund mismanagement, however, stems from design.** While most corporations would fill their "reserves" with accumulated equity, PhilHealth's reserve fund comes from funds set aside from current-year revenues.

**Taking current-year revenues to set aside as reserves places operations in the financially awkward position of drawing from reserves (part of which has probably already been invested) if current-year claims are actuarially underestimated.** This exposes operations to actuarial miscalculation, and, given the inaccuracies of PhilHealth's actuarial projections, such miscalculations are very probable risks.

**This is why this bill proposes amendments to the reserve fund provisions of the UHC law.** Under current provisions, PhilHealth sets aside "a portion of its accumulated revenues not needed to meet the cost of the current year's expenditures as reserve funds." This is prone to several layers of risks: actuarial miscalculation for current-year expenses, the moral hazards of having a fund that can be used for expenditures, the risks of unfavorably influencing market prices, downward, when PhilHealth sells its equity holdings (which should be the most liquid among the investment reserve fund), among others.

**A simpler, more rational approach, to ensure that profits during good years are used to cover losses in bad years is to simply accumulate all net income in the investment reserve fund,** to be managed by the Bureau of Treasury, to ensure that the best macroprudential standards are upheld. This would also ensure that regular operations and reserve fund operations are not unduly commingled.

## QUESTIONS OF FAIRNESS IN PAYMENTS

Current payment contributions reflect a probably necessarily discriminatory regime, where the poor do not pay any direct premiums, and are instead covered by government subsidy, there are self-employed voluntary contributors, and there are formal sector contributors, who pay the bulk of PhilHealth's non-subsidy revenue.

**Increase in PhilHealth contributions.** Republic Act No. 11223, or the Universal Health Care Act, increased PhilHealth contributions. Section 10 of the law states that *Premium Contributions*. - For direct contributors, premium rates shall be in accordance with the following schedule, and monthly income floor and ceiling:

**Schedule of formal sector monthly contribution scheme**

| Year | Premium Rate | Income Floor | Income Ceiling |
|------|--------------|--------------|----------------|
| 2019 | 2.75%        | P10,000      | P50,000        |
| 2020 | 3.00%        | P10,000      | P60,000        |
| 2021 | 3.50%        | P10,000      | P70,000        |
| 2022 | 4.00%        | P10,000      | P80,000        |
| 2023 | 4.50%        | P10,000      | P90,000        |
| 2024 | 5.00%        | P10,000      | P100,000       |
| 2025 | 5.00%        | P10,000      | P100,000       |

*Source: Universal Health Care Act*

The law defines "Direct contributors" as "those who have the capacity to pay premiums, are gainfully employed and are bound by an employer-employee relationship, or are self-earning, professional practitioners, migrant workers, including their qualified dependents, and lifetime members."

This income scheme effectively means that, those earning an annual income of P120,000 a year will, by 2025, already be paying 5% of their income for PhilHealth benefits, when the same income segment is exempt from personal income taxes (PIT) for the simple reason that the country considers them too poor to pay these taxes.

**This premium scheme is extremely unfavorable to working families.** The capped contribution scheme means that those earning more than P1,200,000 a year are effectively paying less and less premiums as a share of their income. This makes for a bizarre health premium regime where the very poor pay effectively no direct premiums (but pay indirectly through their consumption of excised products), the poor and middle working class pay the same percentage on premiums, and the rich and very rich pay less and less as a share of their income, the richer they get.

**A simpler fix would have been to just tie the premium contributions to the PIT. In 2018, the formal sector paid P65.9 billion in premiums, implying around P32.95 billion in employee share.** A simpler collection scheme that matches the progressivity of the recently reformed personal income tax scheme, and would have yielded the same revenues would simply have been a 3% levy on individual tax dues and a minimum P100/month employee share. This would have saved the minimum wage earner at least P4,800 a year in premiums, and would also have made the premium structure more attuned to changes in income.

A 5% levy on individual taxes, which this bill proposes, plus the minimum premium would have yielded around P46 billion in employee share, or around P92 billion in formal sector premiums. Considering the same expenses in 2018, this scheme would have also made enough surpluses to cover almost 60% of the government subsidy to PhilHealth.

Premiums more closely tied to income are also more sustainable than the floor-and-ceiling approach in the UHC, as health expenditures tend to rise with national income<sup>1</sup>. **Tying premiums with income taxes withheld also means that PhilHealth can significantly outsource its collection function to the Bureau of Internal Revenue**, which can simply charge a collection fee from PhilHealth, instead of PhilHealth having to maintain full collection operations.

Finally, as this bill requires only residents to pay the premium, Overseas Filipino Workers, who do not benefit from PhilHealth services, will not have to pay premiums.

## ISSUES ON CLAIMS AND BENEFITS

**The most glaring cases of fraud in PhilHealth appear to be in the management of claims and benefits.** As with any insurance operation, the risk of insurance fraud is real and must be proactively managed by designing transparent and accountable systems. According to the Presidential Anti-Corruption Commission Commissioner Greco Belgica, around P153 billion, or almost a third of PhilHealth claims, since 2013, have been lost due to fraud.

**If this is true, PhilHealth's losses due to fraud are around 5 to 6 times the global average.** According to a 2015 study by PKF Littlejohn LLP and the University of Portsmouth, the global average loss rate due to fraud is around 6.19% as a proportion of global healthcare expenditure.

**According to the same study, the sources of fraud are as follows:**

| Patients                                                                                                                                                              | Medical professionals                                                                                                                                                                        | Contractors                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Fraudulent provision of sickness certificates</li> <li>• Prescription fraud</li> <li>• Evasion of medical charges</li> </ul> | <ul style="list-style-type: none"> <li>• Prescription fraud by pharmacists</li> <li>• Fraud and error concerning payments for medical tests, facility services, and consultations</li> </ul> | <ul style="list-style-type: none"> <li>• Fraud and error related to long-term care, home, and community-based services, foster and childcare</li> <li>• Insurance fraud</li> </ul> |

To address these issues, our office has begun consultations and studies. The immediate rollout of the National Identification System, coupled with a national health database, with a one-patient, one-record system, would make it easier to spot cases of false identity, and fraudulent sickness declarations. Linking this with a national prescription database would also help identify and prevent over-prescription.

This bill requires the creation of the National Health Database that will follow the one-patient, one-record principle.

<sup>1</sup> Moore, W. J., Newman, R. J., & Fheili, M. (1992). Measuring the relationship between income and NHEs (national health expenditures). Health care financing review, 14(1), 133–139.

**To develop the infrastructure necessary for these databases, and to strengthen our primary care system, we also have proposed House Bill No. 7422 or the Philippine E-Health and Telemedicine Development Act of 2020.** This would extend primary care to the remotest regions (preventing the higher costs of overspecialized care), and, if used to develop a national health database, would help prevent cases of fraud. Those who would organize fraud, whether inside or outside PhilHealth, need to connive with more people, in an easily verifiable system, where anomalies can be identified with data analytics. If ever fraud happens in the telehealth system, we can more easily catch them

## **GOVERNANCE REFORM FOR PHILHEALTH**

Considering that PhilHealth has significant fiscal implications and is more an insurance agency with a massive investment operation than a health agency, we propose a greater role for and oversight by the Secretary of Finance. The board structure of the Centers for Medicare and Medicaid Services, the US counterpart of PhilHealth, is simpler: Four members serve by virtue of their positions in the Federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. Two other members are public representatives whom the President appoints, and the Senate confirms.

The managing trustee is essentially the Chair of the Board. Considering the size of its insurance and investment operations, and considering the potential convergences with the Secretary of Finance's oversight of the Insurance Commission for the insurance operations, and the Bureau of Treasury and the Securities and Exchange Commission for the investment operations, we propose that the Secretary of Finance also be designated as Chair of PhilHealth under a reformed governance model.

As for transparency and audit, this bill requires independent external audits be mandates for PhilHealth, on top of audits by Commission on Audit. PhilHealth has a history of being flagged by the COA (we have annexed audit findings from 2008 to 2017 herewith), but many of these issues remain unresolved. This bill also requires the PhilHealth President to report to Congress and the President of the Republic on measures taken to address audit findings.

In summary, this bill mainly

- Makes the contribution scheme more progressive, potentially saving working minimum-wage families thousands of pesos annually, and effectively exempting OFWs from paying premiums;
- Reforms the PhilHealth governance structure and makes the Secretary of Finance Chair of the Board;
- Reforms reserve fund management, making the Bureau of Treasury the fund manager of the investment reserve fund, accumulating net income into the reserve fund, and removing the two-year ceiling in fund life, to ensure that the health insurance system can withstand demand shocks such as pandemics;
- Mandates the creation of the national health database of all claims and benefits requested from and granted by the PhilHealth. This will also follow the one-patient, one-record principle; and

- Requires independent audit of the PhilHealth, apart from those conducted by the Commission on Audit, and mandates the PhilHealth President to report to the President of the Philippines and to Congress measures taken to address adverse audit findings.

In view of the foregoing, the approval of this bill is urgently sought.



JOEY SARTE SALCEDA

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*Be it enacted by the Senate and the House of Representatives of the Congress of the Philippines in session assembled,*

**CHAPTER I**  
**GENERAL PROVISIONS**

SECTION 1. *Short Title.* – This Act shall be known as the “PhilHealth Reform Act of 2020.”

Sec. 2. *Declaration of Policy.* – The State shall protect and promote the universal and inalienable right to quality and accessible health services of the people. Towards this end, the State shall ensure that public resources devoted to the provision of access to universal health care shall be optimally managed and utilized for the benefit of all Filipinos.

Sec. 3. *Objectives.* – The PhilHealth Reform Act of 2020 aims to make fundamental improvements to the four main areas of the national health insurance system, namely, collection of premiums, reserve fund management, claims and benefits verification and payment, and governance as a state agency. The objectives of these improvements are:

- a) Ensure the continued financial sustainability of the national health insurance program;
- b) Make the incidence of costs of premiums fairer and more aligned with the financial capability of contributors to pay;
- c) Make the premium contribution scheme more progressive;
- d) Prolong the fund life of the national health insurance program and prepare it for demand shocks such as pandemics;
- e) Prevent fraud in claims and benefits;
- f) Improve records management and detection of fraud; and
- g) Improve governance and accountability mechanisms in the health insurance system.

## CHAPTER II NATIONAL HEALTH INSURANCE PROGRAM

Sec. 4. *PhilHealth premiums reform.* – Section 10 of Republic Act No. 11223 is hereby amended to read as follows:

Section 10. *Premium Contributions.* – [For direct contributors, premium rates shall be in accordance with the following schedule, and monthly income floor and ceiling:

| Year | Premium Rate | Income Floor | Income Ceiling |
|------|--------------|--------------|----------------|
| 2019 | 2.75%        | ₱10,000.00   | ₱50,000.00     |
| 2020 | 3.00 %       | ₱10,000.00   | ₱60,000.00     |
| 2021 | 3.50%        | ₱10,000.00   | ₱70,000.00     |
| 2022 | 4.00 %       | ₱10,000.00   | ₱80,000.00     |
| 2023 | 4.50 %       | ₱10,000.00   | ₱90,000.00     |
| 2024 | 5.00 %       | ₱10,000.00   | ₱100,000.00    |
| 2025 | 5.00 %       | ₱10,000.00   | ₱100,000.00]   |

**(A) FOR DIRECT CONTRIBUTORS WHO ARE RESIDENTS OF THE PHILIPPINES, THE PREMIUM RATES SHALL BE A MINIMUM MONTHLY CONTRIBUTION OF ONE HUNDRED PESOS (P100.00) AND AN ADDITIONAL PREMIUM EQUIVALENT TO FIVE (5) PERCENT OF THEIR INDIVIDUAL INCOME TAX DUE UNDER SECTION 24 (A) OF THE NATIONAL INTERNAL REVENUE CODE (NIRC), AS AMENDED.**

***PROVIDED,* THAT FOR DIRECT CONTRIBUTORS WHO ARE EXEMPT FROM FILING OR PAYING INCOME TAXES UNDER SECTION 24(A) OF THE NIRC, THE PREMIUM RATE SHALL BE THE MINIMUM MONTHLY CONTRIBUTION, AS REQUIRED UNDER THIS SECTION.**

***PROVIDED FURTHER,* THAT THE MINIMUM MONTHLY CONTRIBUTION UNDER THIS SECTION SHALL BE INCREASED BY THREE (3) PERCENT AT THE START OF EVERY YEAR, TO ACCOUNT FOR INFLATION.**

**THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF FINANCE, PHILHEALTH, AND THE BUREAU OF INTERNAL REVENUE SHALL ISSUE THE RULES AND REGULATIONS NECESSARY FOR THE IMPLEMENTATION OF THIS PARAGRAPH, IN CONSULTATION WITH RELEVANT AGENCIES AND STAKEHOLDERS.**

**(B) NOTWITHSTANDING THE PROVISIONS IN SECTION 4, PARAGRAPH (A) OF THIS ACT,** [*Provided, That*] for indirect contributors, premium subsidy shall be gradually adjusted and included annually in the General Appropriations Act (GAA): *Provided, further,* That the funds shall be released to PhilHealth: *Provided, furthermore;* That the DOH, in coordination with PhilHealth, may request Congress to appropriate supplemental funding to meet targeted milestones of this Act: *Provided, finally,* That for every increase in the rate of contribution of direct contributors and premium subsidy of indirect contributors, PhilHealth shall provide for a corresponding increase in benefits.

Sec. 5. *Reserve funds management reform.* – Section 11 of Republic Act No. 11223 is hereby amended to read as follows:

Section 11. Program Reserve Funds. – **ASIDE FROM EXISTING FUNDS SET ASIDE AS RESERVE FUNDS, PHILHEALTH SHALL ACCUMULATE ALL NET INCOME AS RESERVE FUNDS. ADDITIONALLY,** PhilHealth 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 fiscal year, the excess of the PhilHealth reserve fund shall be used to increase the Program's benefits and to decrease the amount of members' contributions.]

Any unused portion of the reserve fund that is not needed to meet the current expenditure obligations [or support the abovementioned programs] shall be placed in investments to earn an average annual income at prevailing rates of interest and shall be referred to as the Investment Reserve Fund. The Investment Reserve Fund 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: *Provided, That* such investment shall be at least fifty percent (50%) of the reserve fund;

(b) In debt securities and corporate bonds of prime or solvent corporations created or existing under the laws of the Philippines: *Provided, That* the issuing or its predecessor entity shall not have defaulted in the payment of interest on any of its securities: *Provided, further,* That the securities are issued by companies with high growth opportunities and earnings potentials: *Provided, finally,* That such investment shall not exceed thirty percent (30%) of the 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 the bank shall 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 listed in the stock exchange with proven track record or profitability over the last three (3) years and payment

of dividends for a period of at least three (3) years immediately preceding the date of investment in such preferred stocks;

(e) In common stocks of any solvent corporation or institution created or existing under the laws of the Philippines listed in the stock exchange with high growth opportunities and earnings potentials;

(f) 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 shall be guaranteed by the Republic of the Philippines or the issuing medical institution and the issued securities 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 reserve fund; and

(g) In debt instruments and other securities traded in the secondary markets with the same intrinsic quality as those enumerated in paragraphs (a) to (e) hereof, subject to the approval of the PhilHealth Board.

No portion of the reserve fund or income thereof shall accrue to the general fund of the National Government or to any of its agencies or instrumentalities, including government-owned or -controlled corporations.

**THE BUREAU OF TREASURY SHALL MANAGE THE INVESTMENT RESERVE FUND. THE BUREAU OF TREASURY MAY DESIGNATE INSTITUTIONS WITH VALID TRUST LICENSES AS ITS EXTERNAL LOCAL FUND MANAGERS TO MANAGE THE RESERVE FUND, AS IT MAY DEEM APPROPRIATE. *PROVIDED*, THAT IN CASE THE PHILHEALTH NEEDS TO UTILIZE ANY PART OF THE INVESTMENT RESERVE FUND FOR ITS OPERATIONS, IT MAY ONLY DO SO WITH THE APPROVAL OF THE PHILHEALTH BOARD.**

***PROVIDED FURTHER*, THAT AT THE END OF EVERY YEAR, THE PHILHEALTH BOARD SHALL DETERMINE WHETHER ACCUMULATED INCOME FROM THE INVESTMENT RESERVE FUND SHALL BE REINVESTED.**

***PROVIDED FINALLY*, THE COMMISSION ON AUDIT SHALL UNDERTAKE A SEPARATE AUDIT OF THE MANAGEMENT OF PHILHEALTH RESERVE FUNDS.**

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

The PhilHealth shall set up the following funds:

- (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 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.

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

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

Sec. 6. Section 13 of Republic Act No. 11223 is hereby amended to read as follows:

**Section 13. *PhilHealth Board of Directors.* -**

(a) The PhilHealth Board of Directors, hereinafter referred to as the Board, is hereby reconstituted to have a maximum of thirteen (13) members, consisting of the following: (1) five (5) ex officio members, namely: the Secretary of Health, Secretary of Social Welfare and Development, Secretary of Budget and Management, Secretary of Finance, Secretary of Labor and Employment; (2) three (3) expert panel members with expertise in public health, management, finance, and health economics; and (3) five (5) sectoral panel members, representing the direct contributors, indirect contributors, employers group, health care providers to be endorsed by their national associations of health care institutions and health care professionals, and representative of the elected local chief executives to be endorsed by the League of Provinces of the Philippines, League of Cities of the Philippines and League of Municipalities of the Philippines: *Provided*, That at least one (1) of the expert panel members and at least two (2) of the sectoral panel members are women.

The sectoral and expert panel members must be Filipino citizens and of good moral character.

The expert panel members must: (i) be of recognized probity and independence and must have distinguished themselves professionally in public, civic or academic service; (ii) be in the active practice of their professions for at least seven (7) years; and (iii) not be appointed within one (1) year after losing in the immediately preceding elections, whether regular or special.

**(b) THE SECRETARY OF FINANCE SHALL BE THE CHAIRPERSON OF THE BOARD, AND The Secretary of Health shall be CO-CHAIRPERSON OF THE BOARD.** [an ex officio nonvoting Chairperson of the Board.]

**AS CHAIRPERSON OF THE BOARD, THE SECRETARY OF FINANCE SHALL ENSURE THAT THE FINANCIAL OPERATIONS OF PHILHEALTH ARE MANAGED EFFICIENTLY AT ALL TIMES.**

(c) All appointive members of the Board shall be required to undergo training in health care financing, health systems, costing health services and HTA prior to the start of their term. Noncompliance shall be a ground for dismissal.

Within thirty (30) days following the effectivity of this Act, the Governance Commission for Government-Owned or -Controlled Corporations (GCG) shall, in accordance with the provisions of Republic Act No. 10149, promulgate the

nomination and selection process for appointive members of the Board with a clear set of qualifications, credentials, and recommendation from the concerned sectors.

Sec. 7. Section 18 of Republic Act No. 11223 is hereby amended to read as follows:

**Section 18. Individual-based Health Services. -**

(a) PhilHealth shall endeavor to contract public, private, or mixed health care provider networks for the delivery of individual-based health services: *Provided*, That member access to services shall not be compromised: *Provided, further*, That these networks agree to service quality, co-payment/co-insurance, and data submission standards: *Provided*, furthermore, That during the transition, PhilHealth and DOH shall incentivize health care providers that form networks: *Provided, finally*, That apex or end-referral hospitals, as determined by the DOH, may be contracted as stand-alone health care providers by PhilHealth.

(b) PhilHealth shall endeavor to shift to paying providers using performance-driven, close-end, prospective payments based on disease or diagnosis related groupings and validated costing methodologies and without differentiating facility and professional fees; develop differential payment schemes that give due consideration to service quality, efficiency and equity; and institute strong surveillance and audit mechanisms to ensure networks' compliance to contractual obligations.

**(C) PHILHEALTH SHALL MAINTAIN AN ELECTRONIC NATIONAL HEALTH RECORDS SYSTEM WHERE PATIENT DATA, INCLUDING ALL REQUESTED AND ACTUALLY GRANTED AND PAID CLAIMS AND BENEFITS SHALL BE STORED, AND MAY BE OBTAINED UPON REQUEST BY THE PATIENT. THE DEPARTMENT OF INFORMATION AND COMMUNICATION TECHNOLOGY (DICT) SHALL PROVIDE SUPPORT IN DESIGNING A SECURE DATABASE WITH MECHANISMS FOR DETECTING PROBABLE FRAUD. PROVIDED, THAT THE DATABASE SHALL ABIDE BY THE 'ONE-PATIENT, ONE-RECORD' PRINCIPLE.**

### **CHAPTER III GOVERNANCE AND ACCOUNTABILITY**

Sec. 8. Section 32 of Republic Act No. 11223 is hereby amended to read as follows:

**Section 32. Monitoring [and,] Evaluation, AND ACCOUNTABILITY. -**

(a) The Philippine Statistics Authority (PSA) shall conduct the relevant modules of household surveys annually during the first ten (10) years of the implementation, and thereafter follow its regular schedule.

(b) The DOH shall publish annual provincial burden of disease estimates using internationally validated estimation methods and biennially using actual public and private sector data from electronic records and disease registries, to support LGUs in tracking progress of health outcomes.

**(C) IN ADDITION TO AUDITS BY THE COMMISSION ON AUDIT AS MANDATE BY LAW AND RELEVANT REGULATIONS,**

**PHILHEALTH SHALL BE SUBJECT TO EXTERNAL AUDIT BY AN ACCREDITED PRIVATE-SECTOR AUDITING FIRM, AT LEAST ONCE EVERY FISCAL YEAR.**

**(D) THE PHILHEALTH PRESIDENT AND CEO SHALL SUBMIT TO THE PHILHEALTH BOARD, THE PRESIDENT OF THE REPUBLIC OF THE PHILIPPINES, AND CONGRESS, A REPORT ON THE MEASURES TAKEN BY THE CORPORATION TO ADDRESS ISSUES RAISED IN AUDIT REPORTS BY THE COMMISSION ON AUDIT AND IN THE THIRD-PARTY AUDIT.**

#### **CHAPTER IV MISCELLANEOUS PROVISIONS**

*Sec. 9. Interpretation.* – All doubts in the implementation and interpretation of this Act, including its IRR, shall be resolved in favor of upholding the rights and interests of every Filipino to quality, accessible and affordable health care.

Nothing in this Act shall be construed to eliminate or in any way diminish Program benefits being enjoyed at the time of promulgation of this Act.

*Sec. 10. Implementing Rules and Regulations (IRR).* – Unless otherwise specified, the DOH, DOF, and the PhilHealth, in consultation and coordination with appropriate national government agencies, civil society organizations, nongovernment organizations, private sector representatives, and other stakeholders, shall promulgate the necessary rules and regulations for the effective implementation of this Act no later than ninety (90) days upon the effectivity of this Act.

*Sec. 11. Separability Clause.* – If any part or provision of this Act is held invalid or unconstitutional, the remaining parts or provisions not affected shall remain in full force and effect.

*Sec. 12. Repealing Clause.* – All other laws, decrees, executive orders and rules and regulations contrary to or inconsistent with the provisions of this Act are hereby repealed or amended accordingly.

*Sec. 13. Effectivity.* – This Act shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation.

Approved,