



Republic of the Philippines
House of Representatives
Quezon City

NINETEENTH CONGRESS

First Regular Session

House Bill No. 1614



Introduced by Representative Albert Raymond S. Garcia

EXPLANATORY NOTE

In a country registering the highest Coronavirus Disease 2019 (COVID-19) infection in Southeast Asia,^[1] nothing could probably be more revolting than to uncover that the officials tasked with the administration and management of the National Health Insurance Program and the National Health Insurance Fund are themselves allegedly robbing the coffers they were sworn to protect. In a pandemic that has caused thousands of deaths in our country, bleeding billions of pesos away from state resources intended for this purpose is a brazen violation of the Filipinos' right to health and right to life.^[2]

Allegations of corruption in the state-run Philippine Health Insurance Corporation (PhilHealth) is not new. It dates back several years and has taken many forms: diverted premium payments of up to P114 million in 2012, sham cataract removals worth P2 billion in 2014, fraudulent dialysis claims, "upcasing" of mild respiratory infections to pneumonia, maintenance in the membership rosters of some 50,000 "supercentenarians" aged from 100 to 121,^[3] and procurement of overpriced and obsolete information technology equipment.^[4] The allegations recently turned to their worst when the pandemic that is devastating our country's people and economy appeared to open more opportunities for corruption with the reported purchase of overpriced COVID-19 test kits, and the implementation of an interim reimbursement mechanism that expedited COVID-19 related advances to hospitals in regions with low infections rates, while hospitals in high infection areas, including government facilities, still await reimbursement.^[5]

While the reported acts of corruption still remain to be established beyond reasonable doubt, the persistent allegations of abuse against the agency's resources suggest a systemic flaw that begs to be addressed. At the heart of the problem is the persistent resistance of the Agency to upgrade its information technology backbone. It is of critical importance that reforms and modernization of the National Health Insurance Program begins with a state-of-the-art information system that provides real-time information on claims, expenditures, and health conditions of the country.

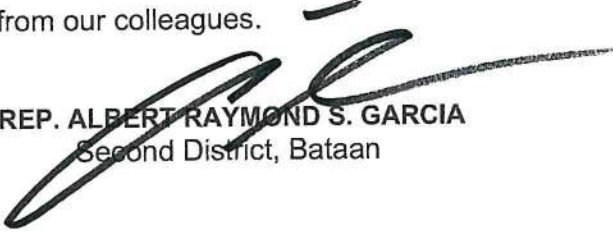
PhilHealth is the principal implementer of the Universal Health Care Act. With limited resources to finance the implementation of the universal coverage of all Filipinos, it is imperative that its funds are prudently utilized and safeguarded against loss or wastage.

This bill seeks to institute reforms in the administration of the National Health Insurance Program to strengthen institutional checks by separating the financing and purchasing functions of the Program and delegating the relevant responsibilities to two (2) distinct corporate entities working independently but in coordinated fashion towards a common objective of efficiently administering the country's health insurance program.

The financing function embracing membership eligibility, premium, collection, formulation of rules and standards for program benefits, reimbursement of medical claims, investment of program and reserve funds, and actuarial studies shall be retained by PhilHealth. On the other hand, the purchasing function involving, mainly, the analysis of the trends and impacts of financing on population health outcomes through review and approval of benefit claims, and assessment of promotive, preventive, curative and rehabilitative services shall be assumed by the Health Insurance Review and Assessment Corporation, a juridical entity created under the proposed measure. Modernization and upgrading of information technology systems will be under the HIRAC.

In bifurcating the aforementioned functions, and in strengthening the ability to analyze trends, shape policy directions toward prevention and improvements in population health outcomes, regulate medical benefits and review of medical claims, the measure hopes to enhance controls, plug perceived weaknesses in the system and eliminate the opportunity for corruption. More importantly, this measure seeks to ensure that health inequity from structural and systemic biases against the poor that have evolved through the years, are continuously addressed. The proposed reform in the system likewise provides an occasion to inject fresh blood of highly qualified, competent, young, idealistic, and service-driven personnel that shall form the core of the new corporation's workforce.

Support for this bill is earnestly requested from our colleagues.


REP. ALBERT RAYMOND S. GARCIA
Second District, Bataan

[1] <https://www.aseanbriefing.com/news/coronavirus-asia-asean-live-updates-by-country/>; last accessed on 9 September 2020.

[2] <https://opinion.inquirer.net/133193/philhealth-corruption-violates-the-right-to-health-and-life>; last accessed on 9 September 2020.

[3] *Id.*; see also <https://www.scmp.com/week-asia/economics/article/3097861/philippines-coronavirus-crisis-led-massive-philhealth>; last accessed on 9 September 2020.

[4] *Id.*

[5] *Id.*



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AN ACT
INSTITUTING REFORMS IN THE NATIONAL HEALTH INSURANCE
PROGRAM, AMENDING FOR THE PURPOSE CERTAIN LAWS AND FOR
OTHER PURPOSES

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

SECTION 1. *Short Title.* – This Act shall be known as the “*National Health Insurance Reform Act.*”

SEC. 2. *Declaration of Policy* – It is the policy of the State to provide all Filipinos access to a comprehensive set of quality and cost-effective, promotive, preventive, curative, rehabilitative and palliative health services without causing financial hardship, and prioritizes the needs of the populations who cannot afford such services. Towards this end, the State shall institute reforms in the administration of the National Health Insurance Program by restructuring the financing and purchasing functions to strengthen institutional checks and balances and ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risk.

SEC. 3. *Scope.* – This Act shall provide for the restructuring of the National Health Insurance Program by placing the administration and management of the same under different government entities separately performing the management of program funds and formulation of rules and standards for program benefits, and the analysis of trends and impacts of financing on population health outcomes, review, and approval of benefit claims, assessment of promotive, preventive, curative and rehabilitative services, and defining the roles and responsibilities of the government entities vested with the powers and functions relative thereto.

SEC. 4. Definition of Terms. – As used in this Act, the following terms shall mean:

- (a) *Beneficiary* refers to any person entitled to health care benefits under the National Health Insurance Program;
- (b) *Case-based payment* refers to a payment method that reimburses to hospitals a predetermined fixed rate for each treated case or disease;
- (c) *Entitlement* refers to any singular or package of health services provided to Filipinos for the purpose of improving health; (d) *Dependent* refers to:
 - (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 and 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 Commission in accordance with the guiding principles set forth in Republic Act No. 7875, otherwise known as the "National Health Insurance Act of 1995", as amended;
 - (5) parents with permanent disability that render them totally dependent on the member for subsistence.
- (e) *Direct contributors* refer to those who have the capacity to pay premiums, are gainfully employed and are bound by employer-employee relationship, or are self-earning professional practitioners, migrant workers, including their qualified dependents, and lifetime members.
- (f) *Fee-for-service* refers to a fee predetermined by the Commission 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 Commission;
- (g) *Global budget* refers to an approach in 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

- (h) *Health benefit package* refers to a set of individual-based entitlements covered by the NHIP which includes primary care; medicines, diagnostics and laboratory; and preventive, curative, and rehabilitative services; (i) *Health care provider* refers to any of the following:
- (1) *A health facility*, which may be public or private, devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation and palliation of individuals suffering from illness, disease, injury, disability, or deformity, or in need of obstetrical or other medical and nursing care;
 - (2) *A health care professional*, who may be a doctor of medicine, nurse, midwife, or other allied professional or practitioner duly licensed to practice in the Philippines;
 - (3) *A community-based health care organization*, which is an association of members of the community organized for the purpose of improving the health status of that community;
 - (4) Pharmacies or drug outlets, laboratories and diagnostic clinics.
- (j) *Health Technology Assessment (HTA)* refers to the systematic evaluation of properties, effects, or impact of health-related technologies, devices, medicines, vaccines, procedures and all other health-related systems developed to solve a health problem and improve quality of lives and health outcomes, utilizing a multidisciplinary process to evaluate the social, economic, organizational, and ethical issue of a health intervention or health technology;
- (k) *Indirect contributors* refer to all others not included as direct contributors, as well as their qualified dependents, whose premium shall be subsidized by the national government including those who are subsidized as a result of special laws;
- (l) *Member* refers to a person whose premiums have been regularly paid to the National Health Insurance Program either as a direct or indirect contributor;
- (m) *Migrant workers* refer to documented or undocumented Filipinos who are engaged in remunerated activity in another country of which they are not citizens;
- (n) *National Health Insurance Program* refers to the compulsory health insurance program of the government established under Republic Act No. 7875, as amended, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all Filipinos;

- (o) *Philippine National Drug Formulary* refers to the essential drugs list of the Philippines 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 updated every year;
- (p) *Portability* refers to the feature that enables a member to avail of program benefits in an area outside the jurisdiction of his local health insurance office;
- (q) *Professional practitioners* include doctors, lawyers, certified public accountants, and other practitioners required to pass government licensure examinations in order to practice their professions;
- (r) *Public health services* refer to 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;
- (s) *Quality assurance* refers to a formal set of activities to review and ensure the quality of services provided. It includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services;
- (t) *Self-earning individuals* refer to those 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,
- (u) *Utilization review* refers to a formal review of a patient utilization or of the appropriateness of health care services, on a prospective, concurrent or retrospective basis;

CHAPTER II

THE NATIONAL HEALTH INSURANCE PROGRAM

SEC. 5. Administration and Management. – The National Health Insurance Program (NHIP) shall be administered and managed by the Philippine Health Insurance Corporation (PhilHealth) and the Health Insurance Review and Assessment Corporation (HIRAC) created under Section 28 of this Act. Except as otherwise provided in this Act, the administration and management of the NHIP, including membership coverage and entitlement to benefits shall continue to be governed by the provisions of Republic Act No. 7875, as amended by Republic Act No. 9241, Republic Act No. 10606, and Republic Act No. 11223, otherwise known as the “Universal Health Care Act.”

SEC. 6. Roles and Responsibilities of PhilHealth and HIRAC. – The provision of any existing law to the contrary notwithstanding, the responsibility of PhilHealth in the implementation of the NHIP shall embrace the program coverage, membership eligibility, premium collection, formulation of rules and standards for program benefits, claims reimbursement, management of program funds, actuarial studies, and other related responsibilities specified in this Act.

The HIRAC shall assume the responsibility of conducting analysis of trends and impacts of health financing on population health outcomes, review and approval of benefit claims, assessment of promotive, preventive, curative and rehabilitative services, and such other related functions defined in this Act.

CHAPTER III

THE PHILIPPINE HEALTH INSURANCE CORPORATION

SEC. 7. Powers and Functions of PhilHealth. – The Philippine Health Insurance Corporation created under Republic Act No. 7875, as amended, shall exercise the following powers and functions:

- (a) Formulate and promulgate policies on benefit packages under the Program and for the sound administration of the National Health Insurance Fund;
- (b) Set standards, rules, and regulations necessary to ensure the provision of health benefits, quality of care, appropriate utilization of services, member satisfaction, fund viability, and overall accomplishment of the Program objectives;
- (c) Formulate and implement guidelines on contributions and payments;
- (d) Pay the claims for reimbursement of health care providers duly reviewed and approved by HIRAC;
- (e) Receive and manage grants, donations, and other forms of assistance;
- (f) Sue and be sued in court;
- (g) Acquire property, real and personal, which may be necessary or expedient for the attainment of the purposes of this Act;
- (h) Collect, deposit, invest, administer, and disburse the National Health Insurance Fund in accordance with the provisions of this Act;
- (i) Keep records of its operations and the investments of the National Health Insurance Fund;
- (j) Establish and maintain an electronic database of all its members and ensure its security to facilitate efficient and effective services;

- (k) Invest in the acceleration of PhilHealth's information technology systems;
- (l) Establish an office, or where it is not feasible, designate a focal person in every 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 overseas Filipino workers (OFWs);
- (m) Visit, enter and inspect facilities of 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 financial, and other records and data pertinent to the premium contributions, and that of their employees;
- (n) Impose interest and/or surcharges of not exceeding three per cent (3%) per month, for employers and not exceeding one and one-half per cent (1.5%) for self-earning, professional practitioners, and migrant workers. Notwithstanding the provisions of any law to the contrary, the PhilHealth may also compromise, waive or release, in whole or in part, such interest or surcharges imposed regardless of the amount involved under such valid terms and conditions as it may prescribe;
- (o) Accredite independent pharmacies and retail drug outlets;
- (p) Monitor compliance by the regulatory agencies with the requirements of this Act and to carry out necessary actions to enforce compliance;
- (q) Fix the reasonable compensation, allowances and other benefits of all positions, including its President and Chief Executive Officer (CEO), based on a comprehensive job analysis and audit of actual duties and responsibilities, subject to the approval of the President of the Philippines. The compensation plan shall be comparable with government social security institutions and shall be subject to periodic review by the Board no more than once every four (4) years without prejudice to merit reviews or increases based on productivity and efficiency;
- (r) Establish the organizational structure and staffing pattern of PhilHealth's central and regional offices to cover as many provinces, cities and legislative districts, including foreign countries, whenever and wherever it may be expedient, necessary and feasible and to inspect or cause to be inspected periodically such offices, subject to the approval of the Board;
- (s) Maintain a Provident Fund which consists of contributions made by both PhilHealth and its officials and employees and earnings thereon, for the payment of benefits to such officials and employees or their dependents or heirs under such terms and conditions as may be prescribed by the Board, subject to the approval of the President of the Philippines;

- (t) Adopt or approve the annual and supplemental budget of receipts and expenditures including, salaries, allowances and early retirement of PhilHealth personnel and to authorize such capital and operating expenditures and disbursements as may be necessary and proper for the effective management and operation of PhilHealth: *Provided*, That this shall be subject to the budgetary limitations stated under Section 21 of this Act: *Provided, further*, That the submission of the corporate budget to the Department of Budget and Management (DBM) shall be for information purposes only;
- (u) 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, any request for additional appropriations, and other data pertinent to the administration, management, and financing of the fund and publish a synopsis of such report in PhilHealth's website and in two (2) newspapers of general circulation; and
- (v) Perform such other acts as it may deem appropriate for the attainment of the objectives of PhilHealth and for the proper enforcement of the provisions of this Act.

SEC. 8. Quasi-Judicial Powers. – To carry out its tasks more effectively, PhilHealth 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. 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.

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 PhilHealth shall not be bound by the technical rules of evidence.

SEC. 9. PhilHealth Board of Directors. – The PhilHealth Board of Directors, hereinafter referred to as the Board, shall have a maximum of thirteen (13) members, consisting of the following:

- (a) The Secretary of Health as *ex officio* non-voting Chairperson;
- (b) The Secretary of Finance;
- (c) The Secretary of Social Welfare and Development;
- (d) The Secretary of Budget and Management;
- (e) The Secretary of Labor and Employment;
- (f) Three (3) expert panel members with expertise in public health, management, finance, or health economics; and
- (g) 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 a 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.

At least one (1) of the expert panel members and at least two (2) of the sectoral panel members shall be women.

The expert and sectoral panel members must: (i) be Filipino citizens; (ii) be of good moral character; (iii) be of recognized probity and independence and must have distinguished themselves professionally in public, civic or academic service; (iv) be in the active practice of their professions for at least seven (7) years; and (v) not be appointed within one (1) year after losing in the immediately preceding elections, whether regular or special. They shall be appointed by the President of the Philippines and shall serve a term of office in accordance with Republic Act No. 10149.

All appointive members of the Board must undergo training in health care financing and health systems, costing, health services, and HTA prior to the start of their term. Noncompliance shall be a ground for termination of membership.

The incumbent appointive members of the PhilHealth Board shall continue to serve as such upon the effectivity of this Act unless sooner replaced for just and valid cause. Subsequent appointments to the Board shall be governed by the nomination and selection process promulgated by the Governance Commission for Government-Owned or Controlled Corporations (GCG) in accordance with the provisions of Republic Act No. 10149.

SEC. 10. 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 the Vice Chairperson, a temporary presiding officer shall be designated by the majority of the quorum.

SEC. 11. Allowances and Per Diems. – The members of the Board shall receive a per diem for every meeting attended and such other allowances as may be allowed by the regulations issued by the GCG and other pertinent budgetary laws, rules and regulations on compensation, honoraria and allowances.

SEC. 12. President and Chief Executive Officer (CEO). – Upon the recommendation of the Board, the President of the Philippines shall appoint the President and CEO of PhilHealth from the Board's non-ex *officio* members: *Provided*, That the Board shall not recommend a President and CEO of PhilHealth unless the member is a Filipino citizen and must have at least seven (7) years of experience in the field of public health, management, finance, and health economics or a combination of any of these expertise.

The President and CEO shall have a tenure of one (1) year in accordance with the provisions of Republic Act No. 10149. He shall also be the Vice Chairperson of the Board.

SEC. 13. PhilHealth Personnel as Public Health Workers. – All PhilHealth personnel shall be classified as public health workers in accordance with the pertinent provisions under Republic Act No. 7305, otherwise known as the Magna Carta of Public Health Workers.

SEC. 14. PhilHealth Actuary. – The PhilHealth shall maintain an Office of the Actuary within the corporation to conduct the necessary actuarial studies and present recommendations on insurance premiums, investments and other related matters.

CHAPTER IV

LOCAL HEALTH INSURANCE OFFICE

SEC. 15. Establishment. – The PhilHealth 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 16. 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 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 recommend to the Board a 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;
- (f) 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;
- (g) To establish referral systems and network arrangements with other Offices as may be necessary in accordance with the guidelines prescribed by the Board;
- (h) To serve as the first level for appeals and grievance cases;
- (i) 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;
- (j) To support the management information system requirements of PhilHealth;
- (k) To tap community-based volunteer health workers and barangay officials, if necessary, for premium collection and similar activities, and to grant such workers incentives according to the guidelines set by the PhilHealth and in accordance with applicable laws. However, the incentives for the barangay officials shall accrue to the barangay and not to the said officials.

- (l) To participate in information and education activities that are consistent with the government's comprehensive and coordinated approach to health development with emphasis on scaling up health promotion and preventive care; and
- (m) To prepare an annual report according to guidelines promulgated by the Board and to submit the same to the PhilHealth central office.

CHAPTER V

HEALTH CARE PROVIDERS

SEC. 17. Authority to Grant Accreditation. - The PhilHealth shall have the authority to grant accreditation to health care providers based on the set of rules, standards and minimum criteria prescribed by the Board. The accreditation confers the privilege to participate in the Program.

SEC. 18. Accreditation Eligibility. - All health care providers, as enumerated in Section 4(i) 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 local government unit where the accredited health care provider cannot adequately or fully service its population; and
- (d) Other conditions as may be determined by PhilHealth.

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

SEC. 19. 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 PhilHealth 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;
- (b) Case-based payment;
- (c) Global budget; and

- (d) Such other provider payment mechanism that may be determined and adopted by PhilHealth.

Subject to the approval of the Board, PhilHealth may adopt other payment mechanism that are most beneficial to the members and PhilHealth.

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

CHAPTER VI

THE NATIONAL HEALTH INSURANCE FUND AND RESERVE FUND

SEC. 20. *Administration and Management of the National Health Insurance Fund and Reserve Fund.* – The National Health Insurance Fund and the Reserve Fund, hereinafter referred to as “Funds”, shall be administered and managed by PhilHealth in accordance with the provisions of Republic Act No. 7875, as amended, and by the provisions of this Act.

SEC. 21. *Financial Management.* – The use, disposition, investment, disbursement, administration and management of the Funds including any subsidy, grant, or donation received for program operations shall be governed by resolution of the PhilHealth Board, subject to the following limitations:

- (a) All funds under the management and control of PhilHealth shall be subject to all rules and regulations applicable to public funds; and
- (b) The cost of administering the Program shall not be more than seven and one-half per cent (7.5%) of the actual total premium collected from direct and indirect contributory members during the immediately preceding year, to be divided equally between PhilHealth and HIRAC. The PhilHealth shall remit the share of HIRAC within ten (10) days following the end of every quarter.

CHAPTER VII

FINANCING

SEC. 22. *Premium Contributions.* – For direct contributors, premium rates shall be in accordance with the following schedule, and monthly floor and ceiling:

Year	Premium Rate	Floor	Ceiling
2019	2.75%	P10,000.00	P50,000.00

2020	3.00%	P10,000.00	P60,000.00
2021	3.50%	P10,000.00	P70,000.00
2022	4.00%	P10,000.00	P80,000.00
2023	4.50%	P10,000.00	P90,000.00
2024	5.00%	P10,000.00	P100,000.00
2025	5.00%	P10,000.00	P100,000.00

For indirect contributors, premium subsidy shall be gradually adjusted and included annually in the General Appropriations Act (GAA): *Provided*, That the funds shall be released to PhilHealth: *Provided, further*, That the Department of Finance (DOF), in coordination with PhilHealth, may request Congress to appropriate supplemental funding to meet targeted milestones of the Universal Health Care Act: *Provided, finally*, That for every increase in the rate of contribution of direct contributors and premium subsidy of indirect contributors, PhilHealth shall, upon the recommendation of the Health Technology Assessment Committee created under Republic Act No. 11223, provide for a corresponding increase in benefits.

CHAPTER VIII

GRIEVANCE AND APPEAL

SEC. 23. *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 implementers of the Program, may seek redress of the grievance in accordance with the provisions of this Chapter.

SEC. 24. *Grounds for Grievances.* – The following acts shall constitute valid grounds for grievance action:

- (a) any violation of the rights of patients;
- (b) willful neglect of duties of Program implementers that results in the loss or non-enjoyment 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 period provided for in this Act; and
- (e) any other act or neglect that tends to undermine or defeat the purposes of this Act.

SEC. 25. *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 PhilHealth 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 forty-five (45) calendar days from receipt thereof.
- (b) Appeals from Office decisions must be filed with the Board within thirty (30) calendar days from receipt of notice of resolution.
- (c) The Offices shall have no jurisdiction over any issue involving the suspension or revocation of accreditation, or the imposition of fines.
- (d) All decisions of the Board as to entitlement to benefits of members or to payments of health care providers shall be considered final and executory.

SEC. 26. *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 decide on complaints from members and health care providers relative to this Act and its implementing rules and regulations.

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

SEC. 27. *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 a cause of action, or any other valid ground for dismissal of the complaint; 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 reglementary 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*, That the decision may be appealed 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 appellee 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 become final and executory fifteen (15) days after notice thereof: *Provided*, That the decision may be subject to judicial review 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 8 of this Act, 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 Committee or the Board, 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, when warranted.

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

CHAPTER IX

THE HEALTH INSURANCE REVIEW AND ASSESSMENT CORPORATION

SEC. 28. Creation of the Health Insurance Review and Assessment Corporation. – There is hereby created a Health Insurance Review and Assessment Corporation, which shall assume the authority and responsibility of

PhilHealth on the analysis of trends and impacts of health financing on population health outcomes, review and approval of benefit claims, and assessment of promotive, preventive, curative and rehabilitative services.

The HIRAC shall be a tax-exempt government corporation attached to the Department of Health for policy coordination and guidance.

SEC. 29. *Exemption from Taxes and Duties.* – The HIRAC shall be exempt from the payment of taxes on all income or investment earnings.

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

SEC. 30. *Powers and Functions.* – The HIRAC shall exercise the following powers and functions:

- (a) Establish the roadmap for implementation of universal health care (UHC) through strategic purchasing of services addressing leading causes of morbidity and mortality in the country;
- (b) Develop and maintain an information technology system to establish realtime monitoring of claims by health care providers, availment of benefits, quality of care and services, and overall accomplishment of Program objectives;
- (c) Build capacity of LGUs to implement UHC through the Social Health Insurance Academy that will be expanded to link up with the Local Government Development Academy and other relevant institutions involved with Local Government development.
- (d) Develop strategic communication campaigns to inform members and the general public about the health insurance program, where they can access information and how to verify claims and benefits on-line.
- (e) Support the use of technology in the delivery of health care services especially in far flung areas such as, but not limited to, telemedicine, electronic health record, and the establishment of a comprehensive health database;
- (f) Implement the guidelines on benefits, portability of benefits, cost containment and quality assurance; and health care provider arrangements, methods, and referral systems;
- (g) Establish local branch offices;
- (h) Sue and be sued in court;

- (i) Acquire property, real and personal, which may be necessary or expedient for the attainment of the purposes of this Act;
- (j) 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 members;
- (k) Authorize local branch offices to negotiate and enter into contracts in the name and on behalf of HIRAC with any accredit 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 PhilHealth.
- (l) Review, process, approve, and endorse for payment by PhilHealth the claims for reimbursement of health care providers;
- (m) Supervise the provision of health benefits and visit, enter and inspect facilities of health care providers 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, and that of their patients who are members of the Program;
- (n) Establish and maintain an electronic data base of all members, invest in information technology systems, and ensure its security to facilitate the delivery of efficient and effective services;
- (o) Conduct information campaign on the principles of the NHIP to the public and to accredited health care providers. The campaign shall include the current benefit packages provided by the HIRAC, the mechanisms to avail of the current benefit packages, and the list of accredited and disaccredited health care providers;
- (p) Conduct pre-audit and post-audit on the quality of services rendered by health care providers;
- (q) 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 and review claims of the overseas Filipino workers;
- (r) Charge fees, as necessary, for claims review and processing performed by its central and local branch offices;

- (s) Fix the reasonable compensation, allowances and other benefits of all positions, including its President and Chief Executive Officer (CEO), based on a comprehensive job analysis and audit of actual duties and responsibilities, subject to the approval of the President of the Philippines. The compensation plan shall be comparable with government social security institutions and shall be subject to periodic review by the Board no more than once every four (4) years without prejudice to merit reviews or increases based on productivity and efficiency;
- (t) Establish the organizational structure and staffing pattern of HIRAC's central and regional offices to cover as many provinces, cities and legislative districts, including foreign countries, whenever and wherever it may be expedient, necessary and feasible and to inspect or cause to be inspected periodically such offices, subject to the approval of the Board;
- (u) Maintain a Provident Fund which consists of contributions made by both HIRAC and its officials and employees and earnings thereon, for the payment of benefits to such officials and employees or their dependents or heirs under such terms and conditions as may be prescribed by the Board, subject to the approval of the President of the Philippines;
- (v) Adopt or approve the annual and supplemental budget of receipts and expenditures including, salaries, allowances and early retirement of HIRAC personnel and to authorize such capital and operating expenditures and disbursements as may be necessary and proper for the effective management and operation of HIRAC: *Provided*, That this shall be subject to the budgetary limitations stated under Section 21 of this Act: *Provided, further*, That the submission of the corporate budget to the DBM shall be for information purposes only;
- (w) Submit to the President of the Philippines and to both Houses of Congress its Annual Report which shall contain significant highlights of the implementation of the Program, such as total purchases, average costing to beneficiaries, and other pertinent data, and publish a synopsis of such report in its website and in two (2) newspapers of general circulation;
- (x) Perform such other acts as the HIRAC may deem appropriate for the attainment of its objectives and for the proper enforcement of the provisions of this Act.

SEC. 31. Board of Directors. – The HIRAC Board of Directors, hereinafter referred to as the Board, shall be composed of the following:

- (a) The Secretary of Health as *ex officio* non-voting Chairperson;
- (b) The Secretary of Budget and Management;

- (c) The Secretary of Finance;
- (d) The Commissioner of the Insurance Commission;
- (e) Two (2) expert panel members with expertise in public health, finance, or health economics;
- (f) Three (3) sectoral panel members, representing the direct contributors, indirect contributors, and health care providers to be endorsed by their national association of health care institutions and health care professionals.

At least one (1) of the expert panel members and at least one (1) of the sectoral panel members shall be women.

The expert and sectoral panel members must: (i) be Filipino citizens; (ii) be of good moral character; (iii) be of recognized probity and independence and must have distinguished themselves professionally in public, civic or academic service; (iv) be in the active practice of their professions for at least seven (7) years; (v) not be holding appointment of similar capacity in another government agency or instrumentality; and (vi) not be appointed within one (1) year after losing in the immediately preceding elections, whether regular or special. They shall be appointed by the President of the Philippines and shall serve a term of office in accordance with Republic Act No. 10149.

All appointive members of the Board must 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 termination of membership.

Within thirty (30) days following the effectivity of this Act, the GCG shall, in accordance with the provisions of Republic Act No. 10149, promulgate the nomination and selection process for appointive members in the Board with a clear set of qualifications, credentials, and recommendation from the concerned sectors.

SEC. 32. 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.

SEC. 33. Allowances and Per Diems. – The members of the Board shall receive a per diem for every meeting attended and such other allowances as may be allowed by the regulations issued by the GCG and other pertinent budgetary laws, rules and regulations on compensation, honoraria and allowances.

SEC. 34. *President and Chief Executive Officer (CEO).* – Upon the recommendation of the Board, the President of the Philippines shall appoint the President and CEO of HIRAC from the Board's non-*ex officio* members: *Provided*, That the Board shall not recommend a President and CEO unless the member is a Filipino citizen and must have at least seven (7) years of experience in the field of public health, management, finance, and health economics or a combination of any of the aforementioned expertise.

The President and CEO shall have a tenure of one (1) year in accordance with the provisions of Republic Act No. 10149. He shall also be the Vice Chairperson of the Board.

SEC. 35. *HIRAC Personnel as Public Health Workers.* – All HIRAC personnel shall be classified as public health workers in accordance with the pertinent provisions under Republic Act No. 7305, otherwise known as the Magna Carta of Public Health Workers.

SEC. 36. *Health Policy Research.* - The HIRAC shall establish, among others, a Health Policy Research Department, which shall perform the following duties and functions:

- (a) Develop a broad conceptual framework for implementation of the UHC Program through a to ensure improvement in population outcomes through strategic procurement of promotive, preventive, curative and rehabilitative services that address concerns of public health magnitude;
- (b) Conduct researches and studies to analyze trends and demonstrate the impact of health financing policies on population health outcomes - toward the development of policies to ensure the adequacy and responsiveness of the Program to evolving needs of various population subsets, as well as new problems;
- (c) Review, evaluate, and assess the Program's impact on equity, access as well as on the quality and cost of health care in the country;
- (d) Review fees, charges, compensation rates, medical practice standards, health outcomes and satisfaction of members, benefits, and other matters pertinent to the operation of the Program;
- (e) Submit for consideration of program of quality assurance, utilization review, and technology assessment;
- (f) Submit recommendations on policy and operational issues that will help HIRAC meet the objectives of this Act; and
- (g) Conduct client-satisfaction surveys and research in order to assess outcomes of service rendered by health care providers.

CHAPTER X

REVIEW OF BENEFIT CLAIMS

SEC. 37. *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 the appropriateness of treatment in the facility chosen or by the desired provider.

SEC. 38. *Reimbursement and Period to File Claims.* – All claims for reimbursement or payment for services rendered shall be filed immediately after the 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 HIRAC.

SEC. 39. *Quality Assurance.* – Under the guidelines approved by the HIRAC, 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 local jurisdictions 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 PhilHealth.

(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. 40. *Safeguards Against Over and Under Utilization.* – It is incumbent upon the HIRAC 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 HIRAC 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 pertinent rules and regulations issued pursuant to this Act.

CHAPTER XI

PENAL PROVISIONS

SEC. 41. Penalties. – Any violation of the provisions of this Act, after due notice and hearing, shall suffer the corresponding penalties as herein provided:

(a) A health care provider contracted for the provision of individual-based health services who commits an unethical act, abuses the authority vested upon the health care provider, or performs a fraudulent act shall be punished by a fine of Two hundred thousand pesos (P200,000.00) for each count or suspension of contract up to three (3) months or the remaining period of its contract or accreditation whichever is shorter or both, at the discretion of PhilHealth, taking into consideration the gravity of the offense.

The same shall also constitute a criminal violation punishable by imprisonment of six (6) months and one (1) day up to six (6) years, upon the discretion of the court, without prejudice to criminal liability defined under the Revised Penal Code.

If the health care provider is a juridical person, its officers or employees or other representatives found to be directly responsible, who acted negligently or with intent, or have directly or indirectly caused the commission of the violation, shall be liable. Recidivists may no longer be contracted as participants of the Program.

(b) A member who commits any violation of this Act or knowingly and deliberately cooperates or agree, whether explicitly or implicitly, to the commission of the violation by a contracted health care provider or employer as defined in this section, including the filing of a fraudulent claim for benefits or entitlement under this Act, shall be punished by a fine of Fifty thousand pesos (P50,000.00) for each count or suspension from availment of the benefits of the Program for not less than three (3) months but not more than six (6) months, or both, at the discretion of PhilHealth.

(c) An employer who:

- (1) Deliberately or through inexcusable negligence, fails or refuses to register employees regardless of their employment status, accurately and timely deduct contributions from the employee's compensation or to accurately and timely remit or submit the report of the same to PhilHealth shall be punished with a fine of Fifty thousand pesos (P50,000.00) for every violation per affected employee, or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

Any employer or any officer authorized to collect contribution under this Act, after collecting or deducting the monthly contributions from the employee's compensation, fails or refuses for whatever reason to accurately and timely remit the contributions to PhilHealth within thirty (30) days from due date shall be presumed *prima facie*, to have misappropriated the same and is obligated to hold the same in trust for and in behalf of the employee and PhilHealth, and is immediately obligated to return or remit the amount.

If the employer is a juridical person, its officers and employees or other representatives found to be responsible, whether they acted negligently or with intent, or have directly or indirectly caused the commission of the violation, shall be liable.

- (2) Deducts, directly or indirectly, from the compensation of the covered employees or otherwise recover from them the employer's 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 or imprisonment of not less than six (6) months but not more than one (1) year, or both such fine and imprisonment, at the discretion of the court.

If the unlawful deduction is 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 act shall be liable for the penalties provided for in this Act.

(d) Any director, officer or employee of PhilHealth or HIRAC who:

- (1) Without prior authority or contrary to the provisions of this Act or its IRR, wrongfully receives or keep funds or property payable or deliverable to PhilHealth or HIRAC, and who appropriates and applies such fund or property for personal use, or shall willingly or negligently consents either expressly or implicitly to the misappropriation of funds or property without objection to the same and promptly reporting the matter to proper authority, shall be liable for misappropriation of funds under this Act and shall be punished with a fine equivalent to triple the amount misappropriated per count and suspension for three (3) months without pay.

- (2) Commits an unethical act, abuse of authority, or performs a fraudulent act shall be punished by a fine of Two hundred thousand pesos (P200,000.00) or suspension for three (3) months without pay, or both, at the discretion of PhilHealth or HIRAC, as the case may be, taking into consideration the gravity of the offense. The same shall also constitute a criminal violation punishable by imprisonment for six (6) months and one (1) day up to six (6) years, upon discretion of the court without prejudice to the criminal liability defined under the Revised Penal Code.

Other violations of the provisions of this Act or of the rules and regulations promulgated by PhilHealth or HIRAC 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).

All other violations involving the funds of PhilHealth 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 PhilHealth.

The PhilHealth may enumerate circumstances that will mitigate or aggravate the liability of the offender or erring health care provider, member or employer.

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 shall continue until the resolution of the case.

CHAPTER XII

GENERAL PROVISIONS

SEC. 42. Appropriations. – The amount necessary for the organization and continued operation of the HIRAC shall be taken from:

- (a) initial appropriation of Two Billion Pesos (P 2,000,000,000.00) from the funds of PhilHealth, Five Hundred Million Pesos (Php500,000,000.00) of which shall be allocated for the operations of HIRAC and One Billion Five Hundred Million Pesos (Php1,500,000,000.00) for the establishment and continuous upgrading of the information technology for health financing.
- (b) share from the 7.5% cost for administering the Program as provided for in Section 21(b) of this Act;
- (c) Fees charged for the review and processing of claims of health care providers, the amount of which shall be retained and form part of the corporate funds available for inclusion in the corporate operating budget.

The HIRAC may request Congress to appropriate supplemental funding should the abovementioned funds become insufficient to meet operational costs.

SEC. 43. *Transfer of Functions and Responsibilities.* – Within thirty (30) days after the effectivity of this Act, PhilHealth shall commence the turnover of functions and responsibilities transferred to HIRAC. The turnover shall be carried out without any disruption in the delivery of services and benefits under the Program and shall be completed within a period not exceeding six (6) months.

SEC. 44. *Separation Benefits of Officials and Employees Affected.* – PhilHealth officials and employees that may be displaced or separated from the service as a result of the restructuring of the Program pursuant to this Act shall be entitled to either a separation pay and other benefits in accordance with existing laws, rules and regulations or be entitled to avail of the privileges provided under a separation plan which shall be one and one-half month salary for every year of service in the government: *Provided*, That those who avail of the privilege but are subsequently employed in the new corporation or in any government agency or instrumentality, shall start their government service anew.

Separated personnel as a result of the restructuring, if qualified, shall be given preference in the hiring of manpower requirements of the HIRAC.

With respect to employees who are not rehired, the government, through the Department of Labor and Employment, shall endeavor to implement re-training, job counselling, and job placement programs.

CHAPTER XIII

MISCELLANEOUS PROVISIONS

SEC. 45. *Oversight Provision.* – The Joint Congressional Oversight Committee on Universal Health Care created under Section 39 of Republic Act No. 11223 shall conduct a regular review of the implementation of this Act. For this purpose, PhilHealth and HIRAC shall separately furnish the Joint Congressional Oversight Committee, within ten (10) days following the end of every quarter, a report on the significant accomplishments, innovations, changes, and challenges in implementing the Program, among others.

The National Economic and Development Authority, in coordination with the Philippine Statistics Authority, National Institutes of Health, and other academic institutions shall undertake studies to validate and evaluate the accomplishments of this Act. These validation studies and annual reports, on the performance of PhilHealth and HIRAC shall be submitted to the Joint Congressional Oversight Committee.

SEC. 46. *Implementing Rules and Regulations (IRR).* – The DOH, PhilHealth and HIRAC, 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, within one hundred twenty (120) days from its effectivity.

SEC. 47. *Separability Clause.* – If any part of this Act is held invalid or unconstitutional, the remaining parts or provisions not affected shall remain in full force and effect.

SEC. 48. *Repealing Clause.* – The pertinent provisions of the following laws are hereby amended accordingly:

- (a) Sections 16, 17, 20, 21, 22, 23, 31, 32, 34, 35, 37, 38, 39, 41, 42 and 43 of Republic Act No. 7875, otherwise known as the “National Health Insurance Program”, as amended by Republic Act No. 9241 and Republic Act No. 10606; and
- (b) Sections 10, 12, 13, 14 and 38 of Republic Act No. 11223, otherwise known as the “Universal Health Care Act.”

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

Approved