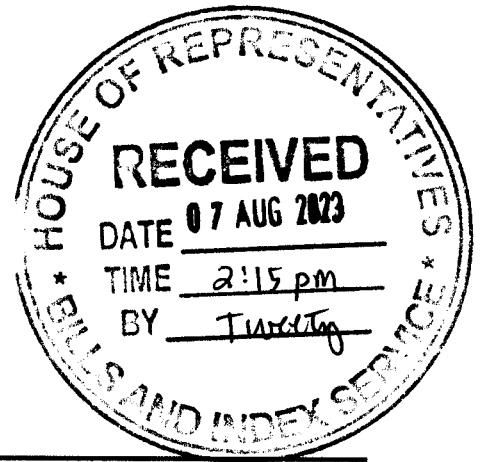


**Republic of the Philippines
House of Representatives
Quezon City, Metro Manila
Nineteenth Congress
Second Regular Session
HOUSE BILL NO. 8787**



Introduced by Rep. Anthony R.T. Golez Jr. MD, MBAH

EXPLANATORY NOTE

The Health Maintenance Organizations (HMO) Bill of 2023, herein referred to as the "Bill," is an essential piece of legislation aimed at ensuring the access of all Filipinos to the highest attainable standard of health while enhancing the financial security and quality of healthcare services provided by HMOs. The Bill recognizes healthcare as a fundamental right of every Filipino citizen and endeavors to create a comprehensive regulatory framework for HMOs to meet the growing healthcare demands of the population.

The Philippines, like many countries, faces significant challenges in providing accessible and affordable healthcare services to its citizens. The current healthcare system requires strengthening to cater to the evolving needs of the population. HMOs play a pivotal role in contributing to the improvement of the nation's health and well-being by providing accessible healthcare services to individuals and families. Therefore, it becomes crucial to establish comprehensive and transparent regulations for HMOs to ensure their financial stability, sound management, and compliance with ethical standards in delivering healthcare services.

The Bill is firmly grounded in the principles enshrined in the Philippine Constitution, particularly Article II Sections 15 and 16, which guarantee the right to health and promote the welfare of the people. Additionally, the Bill aligns with Article XIII Section 11, which recognizes the duty of the state to adopt an integrated and comprehensive approach to health development. Thus, the Bill seeks to create an enabling environment for the private sector's active participation in providing, funding, and managing healthcare services while ensuring alignment with constitutional rights and the National Agenda of the Philippines.

The objectives of the Bill are multi-faceted. It aims to recognize HMOs as unique medical service providers combining financial management and direct/indirect healthcare provision. By establishing a national framework for HMO regulation, the Bill seeks to uphold the rights of the people, ensure the delivery of quality and timely health services, and protect patients' rights during the delivery of healthcare products and services. The creation of the Center for Managed Care Services, an attached agency of the Department of Health, further supports the objective of effective coordination, oversight, and regulation of HMOs in the country.

In promoting competition, efficiency, and innovation, the Bill fosters growth in the healthcare industry while safeguarding the interests and rights of healthcare consumers. By improving the interoperability between PhilHealth and HMOs, the Bill aims to decrease or eliminate out-of-pocket expenditures for health in the country, thus reducing financial barriers to access.

The Bill outlines key definitions, ensuring clarity and consistency in its application. It sets forth the qualifications and responsibilities of an Actuary, ensuring the actuarial soundness of HMO operations. The Bill also defines the terms "Agreement," "HMO," "Managed Care," and others, providing a comprehensive foundation for the regulation and understanding of HMO operations.

Under the Bill, the Center for Managed Care Services is tasked with critical responsibilities, such as registration and licensing of HMOs, regulation and supervision of HMO activities, consumer protection, establishment of quality standards, dispute resolution mechanisms, data collection, and collaboration with relevant stakeholders. The Administrator of the Center plays a central role in executing the objectives and powers conferred upon the Center.

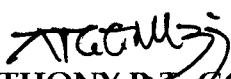
The Bill emphasizes the importance of transparency and consumer protection. It establishes provisions for secrecy to protect sensitive personal information derived from healthcare services. Additionally, the Bill includes a conflict of interest clause, ensuring the Collegiate Board's impartiality and integrity in its decision-making processes.

The Bill lays down clear provisions regarding the registration and licensing of HMOs. The minimum required paid-up capital is set to ensure the financial stability and sustainability of HMOs. The grandfather rule allows existing HMOs to continue their operations while complying with the new requirements within a given timeframe.

To ensure ease of doing business, the Bill mandates timely processing of applications by the Center. It also imposes penalties for violations, including fines, suspension, and revocation of licenses, as well as asset freezing in cases of suspension or revocation.

Lastly, the Bill highlights the importance of data dissemination, publication of licensed HMOs, and reporting of the Center's activities to the Congress of the Philippines.

In conclusion, the HMO Bill of 2023 is a critical step towards achieving the government's vision of providing accessible, affordable, and quality healthcare to all Filipinos. By establishing a robust regulatory framework and promoting collaboration among stakeholders, the Bill seeks to create a more inclusive and efficient healthcare system for the nation.


HON. ANTHONY R. GOLEZ JR. MD, MBAH
Malasakit at Bayanihan Party List

Republic of the Philippines
House of Representatives
Quezon City, Metro Manila
Nineteenth Congress
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HOUSE BILL NO. 8787

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AN ACT
ENSURING THE ACCESS OF ALL FILIPINOS TO THE HIGHEST
ATTAINABLE STANDARD OF HEALTH AND IMPROVING HEALTH
FINANCING SECURITY OF ALL FILIPINOS THROUGH HEALTH
MAINTENANCE ORGANIZATIONS, REGULATING THEIR OPERATIONS BY
ESTABLISHING A CENTER FOR MANAGED CARE SERVICES,
APPROPRIATING FUNDS THERETO 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 "Health Maintenance Organizations (HMOs) act of 2023."

SECTION 2. Statement of Policy. - Pursuant to Article II Sections 15 and 16 and Article XIII Section 11 of the Philippine Constitution, it is hereby declared a policy of the State to:

- a. Enhance the accessibility to affordable health care services through the participation of the private sector in providing, funding, managing health care services to the people.
- b. Ensure that all managed care services managed by the private sector are aligned with the constitutional rights of all people to the highest attainable standard of health and with the National Agenda of the Philippines
- c. Encourage the growth of Health Maintenance Organizations (HMOs) in the country by providing government support, incentives, technical assistance, and ease of doing business.

SECTION 3. Objectives. - In line with the above policy, this Act seeks to:

- a. Recognize HMOs as unique medical service providers combining financial management and the direct and indirect provision of health services
- b. Establish a national framework for the regulation of HMOs that shall uphold the rights of the people, ensure the delivery of quality and timely health services, and upholds the rights of patients in the delivery of their product and services.

- c. Establish the Center of Managed Care Services which shall be an attached agency of the Department of Health that shall be responsible for the coordination with, oversight of, and regulation of HMOs in the country.
- d. Improve the inter-operability between PhilHealth and HMOs to further decrease or otherwise eliminate out-of-pocket expenditures for health in the country.

SECTION 4. Definition of Terms. – When used in this Code, the following terms shall mean:

- a. **Actuary**- a person with necessary training, qualification and experience and a fellow of the Actuarial Society of the Philippines. He shall, among others, compute rates and reserves for health care plans on the basis of experience tables and determine the financial soundness of health care agreements and operations of HMOs.
- b. **Agreement**- a contract entered into by an HMO with a member or group of members or a corporation on behalf of its employees and/or their dependents, for the former to provide or arrange to provide pre-agreed or designated health care services to the latter, for a fixed period of time and for a specified fee.
- c. **Corporation**- a juridical person as defined by law, duly registered with Securities and Exchange Commission.
- d. **Department**- the Department of Health (DOH)
- e. **Center**- the Center for Managed Care Services (CMCS)
- f. **Health Maintenance Organization (HMO)**- a type of managed care organized in accordance with law to provide pre-agreed or designated health care services to its enrolled members for a fixed periodic fee and for a specified period of time. It uses a system of health care delivery called managed care that influences utilization and costs of services and measures performance resulting in quality cost-effective care. It integrates financing and delivery of health care services through managed health plans which may be in the form of a comprehensive HMO plan, preferred provider plan, managed indemnity or self-insured plans, third party administration plan and such other that fall under the definition of a managed health plan under paragraph (k) of this section.
- g. **Managed Care**- a system of health care delivery that influence utilization and cost of services and measures performance with a goal to deliver quality and cost-effective health care.
- h. **Member or Enrollee**- an individual or a person who is part of a group or an employee and/or dependents or a corporation, who entered into a contract with an HMO;
- i. **Person**- a natural or juridical person as defined by law.

- j. **Provider-** a health professional such as physician, dentist, nurse, midwife, physical therapist or health care professional's group, or a health facility such as hospital, diagnostic clinic, pharmacy licensed or authorized by the proper government agency to provide health care services.
- k. **Membership Fee-** the amount of money paid by an individual member, group corporation on behalf of its employees and the latter's dependents, in payment for pre-agreed set of health services, for a specific period of time.

CHAPTER ONE - HEALTH MAINTENANCE CONTRACT

SECTION 5. Health Maintenance Contract. A Health Maintenance Contract is a contract entered into between a health maintenance organization with a subscriber or group of subscribers to provide coverage for comprehensive health care services in exchange for a prepaid per capita or prepaid aggregate fixed sum. It may cover individuals, families, or group of people with an established and fixed affinity of association. A Health Maintenance Contract shall also include Third-Party Administration contracts or Administrative Services Only contracts.

SECTION 6. Exclusivity. Only majority-owned Filipino corporations licensed to do business as Health Maintenance Organization may issue Health Maintenance Contracts. Foreign HMOs, Insurance Companies, Surety Providers, Pre-Need Companies, Third-Party Administrators and other corporations are prohibited from issuing Health Maintenance Contracts. Any other companies offering a product akin to a Health Maintenance Contract such as Third Party Administrators must be registered as an HMO under this Act.

SECTION 7. Exemption from Value Added Tax. All Health Maintenance Contracts issued by registered HMOs shall be exempt from Value Added Tax but the same shall be subject to Documentary Stamp Tax at the same rate applied to Insurance Contracts.

SECTION 8. Exemption from Income Tax. All benefits received or receivable by any person arising from a Health Maintenance Contract is exempt from income tax. Premiums paid by the employer on behalf of their employees and their dependents shall not accrue as income on the employee for the purpose of the latter's taxation.

SECTION 9. Secrecy. The details and contents of a Health Maintenance Contract including the availments arising from contracts and all sensitive personal information generated and derived from the negotiations, consummation, and delivery of health care services up to the period of five (5) years from the date of its termination shall not be disclosed to any third party including government investigations without prior written consent of the data subject. In case of corporations, such prior written consent must be exercised by its President with the consent of its Board and its consent shall only extend to its collective data and to the individual data of all members under its plan which shall be exercised by each respective member prior its disclosure. In case of families, such prior written consent must be exercised by the father or mother, or if

absent by the oldest member of the family, and such consent may be voidable by any of its family members.

CHAPTER TWO - THE CENTER FOR MANAGED CARE SERVICES

SECTION 10. Creation and Nature — There is hereby created a Center for Managed Care Services, which shall be an attached agency of the Department of Health. The Center shall be headed by an Administrator and guided by a collegiate body or the Board. The CMCS shall serve as the primary regulatory body responsible for overseeing the operation and performance of HMOs in the Philippines.

SECTION 11: Powers and Functions of the CMCS. The CMCS shall have the following powers and functions:

- a) **Registration and Licensing:** The CMCS shall be responsible for the registration and licensing of Health Maintenance Organizations that comply with the requirements and standards set forth in this law.
- b) **Regulation and Supervision:** The CMCS shall regulate and supervise the activities of HMOs to ensure compliance with the provisions of this law and other relevant regulations. It shall have the authority to inspect and investigate HMOs, issue guidelines, and impose sanctions for violations.
- c) **Consumer Protection:** The CMCS shall protect the interests of HMO subscribers by ensuring that HMOs adhere to fair and transparent policies in their service offerings, billing, and claims processing.
- d) **Quality Standards:** The CMCS shall establish and enforce minimum quality standards for healthcare services provided by HMOs to guarantee the delivery of safe and effective medical care to subscribers.
- e) **Dispute Resolution:** The CMCS shall establish a mechanism for the fair and timely resolution of disputes between HMOs and their subscribers, including appeals for denied claims.
- f) **Data Collection and Reporting:** The CMCS shall collect and maintain data on HMO performance, subscriber satisfaction, and overall healthcare trends to inform policy and decision-making.
- g) **Collaboration:** The CMCS shall collaborate with other relevant government agencies, healthcare providers, and stakeholders to promote a unified and integrated healthcare system in the Philippines.

SECTION 12. Administrator. The Administrator shall be appointed by the President of the Republic of the Philippines for a term of six (6) years without reappointment and who shall serve as such until the successor shall have been appointed and qualified. If the Administrator is removed before the expiration of his term of office, the reason for the removal must be published.

The Administrator shall have the duty to see that all laws relating HMOs are faithfully executed and to perform the duties imposed upon him by this Act.

The Administrator may issue such rulings, instructions, circulars, orders and decisions as may be deemed necessary to secure the enforcement of the provisions of this Act, to ensure the efficient regulation of the insurance industry in accordance with global best practices and to protect the public. Except as otherwise specified, decisions made by the Administrator shall be appealable to the Office of the President.

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

SECTION 13. The Collegiate Board of Directors. —

- a) **Composition** — The Corporation shall be governed by a Collegiate Board of Directors, composed of five members as follows:
 - i. The Secretary of Health - Chairman
 - ii. The Administrator of the Center for Managed Care Services (CMCS) - Vice-Chairman
 - iii. One representative from the Department of Trade and Industry (DTI)
 - iv. One representative from the Department of Finance - Treasury (DOF-Treasury)
 - v. One representative from the Health Maintenance Organization (HMO) industry.
- b) **Appointment and Tenure** — The President of the Philippines shall appoint the Members of the Board upon the recommendation of the Chairman of the Board and in consultation with the sectors concerned. Members of the Collegiate Board shall have a term of four (4) years each, renewable for a maximum of two (2) years, except for members whose terms shall be co-terminous with their respective positions in government. Any vacancy in the Collegiate Board shall be filled in the manner in which the original appointment was made and the appointee shall serve only the unexpired term of his predecessor.
- c) **Meetings and Quorum** — The Collegiate 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 three (3) voting members shall constitute a quorum. In the absence of the Chairperson and Vice Chairperson, a temporary presiding officer shall be designated by the majority of the quorum. In the event of a tie in voting, the Chairman, who is the Secretary of Health, shall cast the deciding vote.
- d) **Allowances and Per Diems** — The members of the Board shall receive a per diem for every meeting actually attended subject to the pertinent budgetary laws, rules and regulations on compensation, honoraria and allowances.

SECTION 14: Industry Representative. The HMO industry representative shall be an individual with significant knowledge and experience in the HMO sector. The

industry representative shall be selected based on their expertise, integrity, and commitment to promoting the welfare of HMO subscribers and the industry.

SECTION 15: Conflict of Interest. Members of the Collegiate Board shall avoid any conflict of interest that may arise from their official duties. They shall refrain from participating in any decision-making process that may directly or indirectly benefit their personal or financial interests. Any member of the Collegiate Board found to have a conflict of interest shall be subject to appropriate sanctions, as determined by the CMCS.

SECTION 16: Reporting and Accountability The CMCS shall regularly report its activities, accomplishments, and financial status to the Collegiate Board for review and assessment. The Collegiate Board shall submit an annual report to the Congress of the Philippines, which shall include an evaluation of the HMO industry's performance and recommendations for further improvements.

Section 17. Powers of the Administrator. The Administrator, with the concurrence and upon consultation with the Board, shall have the following powers and functions:

- a) Formulate policies and recommendations on issues concerning the HMO industry, advise Congress and other government agencies on all aspects of the HMO industry and propose legislation and amendments thereto;
- b) Approve, reject, suspend or revoke licenses or certificates of registration provided for by this Act;
- c) Impose sanctions for the violation of laws and the rules, regulations and orders issued pursuant thereto;
- d) Prepare, approve, amend or repeal rules, regulations and orders, and issue opinions and provide guidance on and supervise compliance with such rules, regulations and orders;
- e) Enlist the aid and support of, and/or deputize any and all enforcement agencies of the government in the implementation of its powers and functions under this Act;
- f) Issue cease and desist orders to prevent fraud or injury to the public;
- g) Punish for contempt of the Administrator, both direct and indirect, in accordance with the pertinent provisions of and penalties prescribed by the Rules of Court;
- h) Compel the officers of any registered HMOs to call meetings of stockholders or members thereof under its supervision;
- i) Issue subpoena duces tecum and summon witnesses to appear in any proceeding of the Center and, in appropriate cases, order the examination, search and seizure of all documents, papers, files and records, tax returns, and books of accounts of any entity or person under investigation as may be necessary for the proper disposition of the cases before it, subject to the provisions of existing laws;

- j) Suspend or revoke, after proper notice and hearing, the license or certificate of authority of any entity or person under its regulation, upon any of the grounds provided by law;
- k) Conduct an examination to determine compliance with laws and regulations if the circumstances so warrant as determined by appropriate rules and regulations;
- l) Investigate not oftener than once a year from the last date of examination to determine whether an institution is conducting its business on a safe and sound basis: Provided, That, the deficiencies/irregularities found by or discovered by an audit shall be immediately addressed;
- m) Inquire into the solvency and liquidity of the institutions under its supervision and enforce prompt corrective action;
- n) To retain and utilize, in addition to its annual budget, all fees, charges and other income derived from the regulation of HMOs
- o) To fix and assess fees, charges and penalties as the Administrator may find reasonable in the exercise of regulation; and
- p) Exercise such other powers as may be provided by law as well as those which may be implied from, or which are necessary or incidental to the express powers granted the CMCS to achieve the objectives and purposes of this Act.

SECTION 18. Exclusive Powers of the Administrator. In addition to the administrative sanctions provided elsewhere in this Act, the Administrator is hereby authorized, at his discretion, to impose upon HMOs companies, their directors and/or officers and/or agents, for any willful failure or refusal to comply with, or violation of any provision of this Act, or any order, instruction, regulation, or ruling of the Administrator, or any commission or irregularities, and/or conducting business in an unsafe or unsound manner as may be determined by the Administrator, the following:

- (a) Fines not less than Five thousand pesos (P5,000.00) and not more than Two hundred thousand pesos (P200,000.00); and
- (b) Suspension, or after due hearing, removal of directors and/or officers and/or agents.

The Administrator shall have the power to adjudicate claims and complaints arising from Health Maintenance Contracts issued, where the amount of any such loss, damage or liability, excluding interest, cost and attorney's fees, being claimed or sued does not exceed in any single claim Five million pesos (P5,000,000.00).

The Administrator may authorize any officer or group of officers under him to conduct investigation, inquiry and/or hearing and decide claims and he may issue rules governing the conduct of adjudication and resolution of cases. The Rules of Court shall have supplementary application.

The party filing an action pursuant to the provisions of this section thereby submits his person to the jurisdiction of the Administrator. The Administrator shall acquire

jurisdiction over the person of the impleaded party or parties in accordance with and pursuant to the provisions of the Rules of Court.

CHAPTER THREE – REGISTRATION AND LICENSING

SECTION 19. Registration. – No entity, natural or juridical, shall operate in the Philippines without first obtaining registration and a license from the CMCS. Any Filipino corporation, duly formed and organized under the Revised Corporation Code, may register and apply for a license to conduct business as an HMO with the Center provided that it has a minimum paid-up capitalization of not less than TWO HUNDRED MILLION PESOS (PHP 200,000,000.00).

HMOs shall comply with the minimum capital requirements set by the CMCS to ensure their financial stability and ability to provide healthcare services. HMOs must demonstrate compliance with the quality standards set by the CMCS and submit periodic reports as required by the CMCS.

SECTION 20: Minimum Required Paid-up Capital

- a) All Health Maintenance Organizations (HMOs) seeking registration and licensing from the CMCS must have a minimum required paid-up capital of Two Hundred Million Pesos (PHP 200,000,000.00) upon application.
- b) The paid-up capital requirement shall be subject to periodic review by the CMCS to ensure its adequacy in supporting the financial stability and sustainability of HMOs.
- c) HMOs shall submit proof of the required paid-up capital as part of their application for registration and licensing. Failure to meet the minimum capital requirement shall result in the denial of their application until such requirement is satisfied.
- d) The CMCS shall issue guidelines and regulations detailing the procedures for verifying and validating the paid-up capital of HMOs during the registration process.

SECTION 21: Adjustment of Minimum Paid-up Capital

- a) The CMCS, in consultation with relevant stakeholders and based on prevailing economic conditions, may adjust the minimum required paid-up capital to keep pace with inflation and market demands.
- b) Any adjustment to the minimum required paid-up capital shall be done with due notice to all existing HMOs, giving them a reasonable period to comply with the new requirement.

SECTION 22. Grandfather Rule. All HMOs duly licensed by the Insurance Commission upon approval of this Act shall be deemed registered and licensed to conduct business as an HMO provided that all HMOs are given five (5) years to comply with any requirements imposed by this Act or may be imposed by the CMCS.

SECTION 23. Term. All licenses issued by the CMCS shall be effective for not more than five (5) years and renewable thirty (30) days from the date of its expiry.

SECTION 24. Ease of doing business. All applications submitted to the CMCS shall be disposed of within thirty (30) days from the submission of all the required documentations as may be required by the CMCS. If the said application has not been denied or acted upon by the CMCS it shall be deemed approved.

SECTION 25. Grounds for Revocation of License. – The CMCS shall revoke the license of any Health Maintenance Organization, with strict adherence to due process, on the following grounds:

- a) Repeated violations of this Act.
- b) Unjustified refusal to provide the health care services contracted for by a member as provided for in the agreement;
- c) Impairment of the financial status of HMO, as may be determined by the CMCS during suspension

In all cases of revocation, the CMCS shall have the authority to assign the agreements of the HMO whose license was revoked, to other existing HMOs, or to order such applicable remedies in order to protect the rights derived by members from agreements.

SECTION 26. Grounds/or Suspension of License. – The license to operate issued to HMOs may be suspended by the CMCS, with strict adherence to due process, on the following grounds;

- 1. When based on the financial reports, continued operation of the HMO business is no longer financially sound;
- 2. When without justifiable cause, agreements with members are not honored;
- 3. When the statements in the application for license or renewal thereof are found to be false, misleading, inadequate or incomplete such that the Department cannot ascertain the true status from such statement, sufficient to arrive at an honest appraisal of the true capability of the HMO;
- 4. When the decision of the CMCS or arbitration of complaint is not honored by an HMO: and
- 5. When an HMO continuously violates the rules and regulations issued by the CMCS

SECTION 27. Penal Clause. The following administrative sanctions are hereby imposed for violations of this Act:

- a) A fine of Twenty Thousand Pesos (20,000.00) for the first violation of the provisions of this Act, Thirty Thousand Pesos (30,000.00) for the second; and

- Fifty Thousand Pesos (50,000.00) for the third violation. For the fourth violation of this Act, the provision of Section 25, shall apply;
- b) A fine of One Hundred Thousand Pesos (100,000.00) every time the license of the HMO is suspended. Provided, that the payment of this fine shall not absolve the HMO of its obligations under the agreements it has contracted with members and/or participating or accredited providers.
 - c) An order to freeze the assets of the HMO suspended or revoked for the protection of investors, providers and members.

The amount that may be collected as fines shall be retained by the CMCS for its use in the information dissemination mentioned in the following section. Provided, that a separate account be maintained by the CMCS for such purpose.

Violations committed by HMOs in the direct provisions of health care services, performance of laboratory or diagnostics services, operations of hospitals or clinics shall be subject to applicable rules and regulations of the Department of Health.

SECTION 28. Reinstatement of Suspended or Revoked Licenses. – The CMCS shall order the reinstatement of a suspended or revoked license upon reasonable showing that the ground for which the suspension or revocation was based has ceased to exist and that the HMO has sufficiently complied with the requirements the CMCS may determine for such reinstatement.

SECTION 29. Publication. – The CMCS shall inform the public by publishing periodically:

- a) List of licensed HMOs.
- b) Suspension and/or revocation of the license of HMOs, copies of which shall be furnished to associations of the medical profession, hospitals and employers who shall inform their members accordingly.

SECTION 30. Exemption from Anti-Money Laundering Compliance. Health Maintenance Organizations (HMOs) shall be excluded from the obligations and requirements set forth in the Anti-Money Laundering Act of 2001 (Republic Act No. 9160) and any amendments thereto. However, HMOs shall still be subject to reporting suspicious transactions involving large or unusual financial activities to the appropriate authorities as mandated by relevant laws and regulations.

SECTION 31. Appropriations. - The amount necessary for the implementation of this Act shall be included in the General Appropriations Act of the year following its enactment and every year thereafter.

SECTION 32. Implementing Rules and Regulations. – The CMCS shall be organized and shall promulgate the rules and regulations necessary to implement this Act within Ninety (90) days from its approval. Such rules and regulations shall be furnished to HMOs and concerned sectors and shall take effect upon publication in newspaper of general circulation.

SECTION 33. Separability Clause. – If any provision of this Act is declared unconstitutional or invalid, the other provisions not affected by such declaration shall remain in full force and effect.

SECTION 34. Repealing Clause. – All laws, decrees, ordinances, rules, and regulations, executive or administrative orders or parts thereof inconsistent with this Act are hereby repealed, amended or modified accordingly.

SECTION 35. Effectivity. – This Act shall take effect fifteen (15) days following its publication in newspaper of general circulation.

Approved,