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

TWENTIETH CONGRESS
First Regular Session

House Bill No. 2464

Introduced by **Representative GIRLIE E. VELOSO**

EXPLANATORY NOTE

The right to health is a fundamental human right that is both internationally recognized and constitutionally protected. Yet, despite significant strides in healthcare reform, particularly with the enactment of the Universal Health Care Act, millions of Filipinos continue to experience immense financial distress when confronted with illness or medical emergencies. For many, health problems escalate quickly into an economic crisis. Catastrophic health expenditures translate into financial ruin, pushing families into poverty, trapping them in debt, liquidating essential assets, exacerbating existing vulnerabilities, and even forgoing critical medical interventions altogether. These out-of-pocket expenses for healthcare remain a substantial burden, often forcing impossible choices between necessary medical treatment and basic necessities. The consequence is a distressing pattern wherein survival is frequently determined not by clinical prognosis, but by socioeconomic status, access to financial networks, or sheer luck.

In numerous cases, death results not from the intractability of the illness, but from the inaccessibility of treatment due to prohibitive costs. Patients walk away or withdraw from necessary life-saving care, if only to spare their families from sinking deeper into poverty, even at the cost of their own lives. These supposedly preventable tragedies expose a painful truth that the cost of urgent or catastrophic illness continues to erode economic security and human dignity of countless Filipino families. There is therefore a clear and compelling need for a unified, institutionalized, and nationally coordinated system that guarantees timely, accessible, and financially protective medical assistance to all qualified Filipinos, regardless of their socio-economic status or the severity of their medical condition.

This Bill seeks to institutionalize a permanent, fully funded, and operationally integrated National Medical Assistance Program (NMAP) that consolidates and rationalizes all government-funded medical aid initiatives. It establishes statutory mandates, uniform standards, and streamlined

protocols for the delivery of medical assistance at the point of care. The Program guarantees that no Filipino, regardless of income, location, or social status, is denied access to urgent, life-saving, or catastrophic medical treatment due to financial barriers. To this end, this Bill mandates in-hospital access points, enables inter-agency coordination, and inclusive eligibility mechanisms that allow both walk-in patients and proactively referred cases to access assistance. It bridges the gap between public insurance and actual out-of-pocket affordability at the point of care, particularly for marginalized sectors and those who fall outside or between coverage systems.

As medical expenses are among the top triggers of intergenerational poverty, illness often drags families back into hardship, undoing the gains of billions in state investments in poverty alleviation. This Bill serves as a form of preventive poverty intervention, sparing the State from future burdens in social protection, education dropout, and lost economic productivity. Beyond household level, this Bill supports national development objectives towards enduring workforce. A nation's productivity is only as strong as the health of its people. Hence, untreated illness results in lost working hours, dropped livelihoods, caregiver burdens, and higher long-term system costs. A robust medical assistance system allows individuals to return to work sooner and remain productive. Furthermore, the institutionalization of the Program ensures smarter public spending. The fragmented nature of the provision of medical aid is prone to aid duplication, access inefficiencies, and leakage of public resources. By introducing a unified disbursement systems and safeguards for eligibility and billing, the Bill ensures that every peso reaches those in genuine need at the point of care. It also serves as State readiness for public health emergency by embedding within the DOH a scalable and non-improvised capacity to respond to surges in health care demand. Ultimately, by establishing the right of Filipinos to catastrophic and urgent medical aid as a pillar of public health financing, this measure lays the essential groundwork for future integration with digital health systems, improved health financing modeling, more accurate population-level health analytics, and the eventual creation of a dedicated national health aid trust supported by public-private partnerships or earmarked revenues. More than a relief measure, this Bill is a forward-looking investment in human capital, fiscal discipline, and system modernization.

By institutionalizing medical assistance, the State fulfills its duty to protect human life, uphold the dignity of every Filipino, and place public welfare at the core of governance. It bridges state compassion towards a healthy and productive citizenry with institutional rigor and discipline, all to promote the right to timely, adequate, and life-saving care in times of catastrophic or urgent medical need.

In view of the foregoing, support for the enactment of this measure is earnestly sought.

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AN ACT ESTABLISHING THE RIGHT OF FILIPINOS TO CATASTROPHIC AND URGENT MEDICAL AID THROUGH A NATIONAL MEDICAL ASSISTANCE PROGRAM UNDER THE DEPARTMENT OF HEALTH, 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 "Medical Assistance for Filipinos Act".

SECTION 2. Declaration of Policy. — It is the policy of the State to protect all Filipinos from the financial hardship caused by illness and medical emergencies. The State recognizes that access to urgent and life-saving medical care is a fundamental component of the right to health and the preservation of human dignity. In pursuit of this, the State shall uphold the right of every Filipino, especially the poor, vulnerable, and those facing catastrophic health situations, to receive timely medical assistance regardless of their financial capacity. The government shall institutionalize a responsive and nationally coordinated system of medical aid anchored on the principles of equity, compassion, and social justice.

SECTION 3. Definition of Terms. — As used in this Act:

(a) National Medical Assistance Program refers to the government's permanent, nationwide initiative, administered by the Department of Health (DOH), to provide financial assistance for urgent, life-saving, or catastrophic medical care to eligible Filipino patients. The Program operates exclusively through eligibility-based access and covers only public

health facilities, in accordance with this Act and its Implementing Rules and Regulations (IRR).

(b) Indigent refers to a Filipino who is classified as poor or near-poor under official government social protection systems, and whose income or circumstances render them unable to afford even subsidized healthcare services.

(c) Financially incapacitated refers to a Filipino who is not classified as indigent but lacks the disposable income or liquid resources to afford the cost of necessary medical care without experiencing undue financial hardship.

(d) At Risk of Catastrophic Health Expenditure refers to a Filipino whose anticipated out-of-pocket medical expenses, due to illness or injury, are likely to exceed a significant portion of their income or savings, placing them at risk of financial ruin, asset depletion, or foregone essential needs. This includes patients facing urgent or high-cost medical interventions without sufficient financial buffer or coverage.

(e) Qualified Patient refers to any Filipino who, based on the provisions of this Act and guidelines issued by the DOH, is eligible to receive medical assistance through eligibility-based access.

SECTION 4. Establishment of National Medical Assistance Program. — There is hereby established a National Medical Assistance Program, hereinafter referred to as the Program, which shall be administered by the DOH as the lead agency. The Program shall serve as the central mechanism of the State to guarantee access to urgent, life-saving, and financially protective medical assistance to qualified Filipinos who are indigent, financially incapacitated, and at risk of catastrophic health expenditure.

SECTION 5. Eligibility Parameters. — To ensure fairness, clarity, and ease of access, the Program shall operate under the following eligibility parameters for determining qualified beneficiaries:

(a) Indigent. A person shall be presumed indigent if their monthly household income falls below the regional poverty threshold set by the Philippine Statistics Authority (PSA), as regularly updated. In addition, a person shall be considered indigent if they are included in national poverty and official social protection databases, such as:
   1. The DSWD Listahanan;
   2. Beneficiaries of the Pantawid Pamilyang Pilipino Program (4Ps);
   3. Those classified as indigent by the Philippine Health Insurance Corporation (PhilHealth); or
   4. Any other official indicators identified in the IRR.

(b) Financially Incapacitated. A person shall be considered financially incapacitated if, while not officially indigent, they are unable to afford necessary medical treatment without experiencing undue financial hardship. This may be determined through:
   1. Household income that exceeds the poverty line but remains below a threshold for subsistence-level medical emergencies, as set in the IRR;

2. Documented inability to pay for urgent treatment without incurring debt, selling essential assets, or foregoing other basic needs;
3. Certification by a medical social worker using standardized assessment tools issued by DOH; and/or
4. Verified lack of financial support from an insurance other than PhilHealth, sufficient to cover the total cost of care.

(c) At Risk of Catastrophic Health Expenditure. A person shall be considered at risk of catastrophic health expenditure if the cost of medically necessary treatment would result in severe financial distress or economic displacement. This includes cases where:

1. The projected or actual out-of-pocket health spending exceeds 50% of the household's annual income, based on official income documentation or social worker assessment;
2. For middle-income households, treatment costs exceed 100% of monthly income, as may be further defined by the DOH in the IRR using tiered income brackets;
3. The illness involves high-cost intensive care, chronic, rare, or emergency conditions, such as cancer, dialysis, neonatal intensive care, or major trauma, as may be further defined in the IRR; or
4. A DOH-designated panel or licensed medical social worker certifies the case as financially catastrophic under standardized national guidelines.

SECTION 6. Consolidation of DOH Medical Assistance Programs. — The Program shall serve as the central and primary national mechanism for providing medical assistance to indigent, financially incapacitated, and catastrophically burdened Filipinos. It shall consolidate, harmonize, and formalize all medical assistance mechanisms administered or funded by the DOH, including but not limited to:

(a) The Medical Assistance to Indigent Patients (MAIP) program;
(b) Hospital-based subsidy schemes funded through DOH; and
(c) Any other special or regional DOH medical assistance initiatives existing at the time of enactment.

The DOH shall issue guidelines to ensure that these programs are integrated under a unified operational framework, subject to common standards on eligibility, documentation, fund allocation, and reporting.

Nothing in this provision shall be construed to limit or alter the functions of Malasakit Centers as provided under R.A. No. 11463, except that all DOH funds disbursed through such centers shall be aligned with the standards and procedures of the Program established in this Act.

SECTION 7. Service Coverage and Purpose. — The Program shall provide financial assistance to address the medically necessary treatment needs of qualified patients. Covered services shall include, but not be limited to, the following:

(a) Hospital confinement, whether in public or private facilities, and whether emergency or scheduled in nature;
(b) Clinically indicated medical and surgical procedures, including operating room use, anesthesia, obstetrics-gynecological cases considered high-risk, and cases requiring implants, medical devices, or supplies;
(c) Drugs and medicines approved by the Food and Drug Administration (FDA), as prescribed by a licensed physician or health professional;
(d) Laboratory, imaging, radiological, and other diagnostic procedures essential to treatment, including readers' or assessment fees;
(e) Blood and blood products, including necessary screening or processing costs;
(f) Dialysis sessions, chemotherapy, radiation therapy, or other outpatient treatment sessions not sufficiently covered by PhilHealth;
(g) Professional fees of attending physicians and specialists, within reasonable and DOH-prescribed ceilings to be defined in the IRR;
(h) Prescribed post-hospitalization rehabilitation services, aftercare programs, and appropriate mental and psychosocial support;
(i) Clinically indicated dental care, including routine preventive services, subject to guidelines to be issued by the DOH; and/or

Medical assistance under this Program shall be net of PhilHealth benefits and any other applicable health insurance claims. PhilHealth shall remain the primary payer for services within its benefit packages. The Program shall only cover uncovered balances or services not included in PhilHealth coverage, subject to documentation and prioritization rules issued by the DOH

SECTION 8. Eligibility-Based Access. — The Program shall operate through eligibility-based access, wherein medical assistance is granted directly to patients who meet the criteria established under this Act and its IRR. Assistance shall be based on verified need, supporting documentation, and institutional assessment. Funds shall be prepositioned in public hospitals and other designated health facilities, and disbursed in accordance with established protocols.

SECTION 9. Access Points and Implementing Units. — The program shall be accessed through eligibility-based mechanism. Medical assistance shall be granted to patients who apply directly at the following implementing units, which shall also serve as access points for eligibility screening and fund processing:

(a) Malasakit Centers, established pursuant to Republic Act No. 11463, shall serve as the primary access points in all public hospitals and health facilities where they are present; and
(b) In the absence of a Malasakit Center, hospital-based social welfare offices or other equivalent units accredited by the Department of Health (DOH) shall serve as alternative access points and implementing units.

SECTION 10. Fund Deployment to Public Health Facilities. — The DOH shall ensure that Program funds appropriated under the General Appropriations Act (GAA) are deployed and made available for eligibility-based access in the following manner:

(a) Funds shall be directly downloaded to all DOH-retained hospitals and specialty hospitals at the beginning of each fiscal year and replenished as necessary to ensure the continuous availability of medical assistance; and
(b) Funds may also be deployed to public hospitals and health facilities not directly operated by the DOH, including those run by local government units (LGUs), state universities and colleges (SUCs), government-owned or -controlled corporations (GOCCs), or other government entities: Provided, That a Memorandum of Agreement (MOA) is executed between the DOH, through its Centers for Health Development (CHDs), and the recipient facility. The MOA shall prescribe the terms for fund utilization, eligibility screening in accordance with Section 5, documentation requirements, liquidation procedures, and reporting obligations, consistent with DOH guidelines.

The DOH shall establish uniform operational standards, reporting protocols, and audit mechanisms to ensure timely, efficient, and accountable utilization of Program funds by all participating facilities.

SECTION 11. Operational Oversight and Management. — The DOH shall exercise central oversight over the implementation of the Program, particularly due to the designation of Malasakit Centers as the primary access point across hospitals. For this purpose, the DOH may establish a National Eligibility-Based Access Unit to oversee system-wide monitoring, fund tracking, policy harmonization, and coordination among Malasakit Centers, hospital social welfare offices, and other accredited access points.

SECTION 12. Eligibility Validation and Approval. — Eligibility for medical assistance under the Program shall be validated by Malasakit Centers in hospitals where they are established pursuant to R.A. No. 11463. In the absence of Malasakit Centers, validation shall be conducted by hospital-based social welfare offices or other DOH-accredited units.

Assistance shall be approved and processed based on the following criteria:

(a) Verified eligibility in accordance with Section 5 of this Act;
(b) Availability of Program funds at the participating health facility; and
(c) Compliance with documentation requirements, screening protocols, and coverage ceilings as prescribed by the DOH.

To ensure consistency and ease of access, the DOH shall streamline documentation requirements across all access points, and may adopt and utilize the standardized intake process of Malasakit Centers where applicable. The Department shall also issue guidelines on the applicability of assistance for referred cases, including safeguards against fund abuse and mechanisms to ensure continuity of assistance across facilities.

SECTION 13. Settlement and Payment. — Funds utilized under the Program shall be liquidated in accordance with applicable government accounting and auditing rules and regulations. The DOH shall process and release replenishments or reimbursements to participating public health facilities within fifteen (15) calendar days upon receipt of complete and proper documentation, including billing summaries and patient-level utilization reports.

The IRR shall define detailed payment schedules, documentation standards, dispute resolution procedures, and reconciliation mechanisms to ensure timely, accountable, and transparent fund disbursement.

SECTION 14. Monitoring and Reporting. — All public health facilities receiving funds under the Program shall submit Monthly Fund Utilization Reports (FURs) to the DOH. Each report shall include, at a minimum:

(a) The number of patients served;
(b) The medical services provided;
(c) Amounts disbursed and remaining fund balances; and
(d) Noted irregularities or compliance concerns.

These reports shall serve as the basis for fund replenishment, audit, and performance evaluation.

SECTION 15. Complementarity and Prohibition of Double Charging. — The Program shall operate in a complementary and non-exclusive manner alongside other public and private medical assistance mechanisms. It is the policy of the State that no patient shall be denied necessary care or be financially burdened due to fragmented or insufficient funding sources.

In cases where the cost of treatment exceeds the Program's coverage, qualified patients may seek additional aid from lawful sources to complete the necessary amount for care, including but not limited to:

(a) The Department of Social Welfare and Development (DSWD), including the Assistance to Individuals in Crisis Situations (AICS) program;
(b) The Philippine Charity Sweepstakes Office (PCSO);
(c) LGUs;

(d) Hospital-based charitable foundations or independent medical aid programs; and
(e) Any other public or private organization providing direct financial support for medical needs.

Provided, That double charging of the same medical item, service, or professional fee from two or more public or government-affiliated sources shall be strictly prohibited. Participating health facilities shall adhere to the order of charging and coordination protocols to be issued by the DOH.

The DOH, in coordination with PhilHealth and other concerned agencies, shall establish a standardized charging matrix to guide the sequencing of benefits, ensure that PhilHealth is prioritized for covered services, and prevent overlapping reimbursements. The matrix shall include this Program, the DSWD's AICS, the PCSO's medical assistance, PhilHealth benefits, and other applicable national or local programs, to promote transparency, accountability, and fund integrity.

SECTION 16. National Monitoring and Oversight. — The DOH shall monitor the implementation of the Program through a unified reporting system that consolidates all financial and operational data from participating health facilities.

The DOH shall submit an Annual Implementation Report to the Senate Committee on Health and Demography and the House Committee on Health on or before December 31 of each year, or as may be requested. The report shall include, at a minimum:

(a) National and regional utilization data;
(b) Financial statements showing allocations, disbursements, and remaining balances;
(c) Operational performance metrics and implementation challenges; and
(d) Policy recommendations to improve the Program's effectiveness and sustainability.

SECTION 17. Data Privacy and Confidentiality. — The implementation of this Act shall strictly comply with the provisions of Republic Act No. 10173, otherwise known as the Data Privacy Act of 2012, and its IRR.

All personal, medical, and financial information collected or processed under the Program shall be treated with the highest standard of confidentiality and used solely for the purposes of determining eligibility, processing assistance, and monitoring implementation.

The DOH shall ensure that all participating health facilities and authorized officials or staff implement appropriate organizational, technical, and physical security measures to safeguard sensitive personal information in accordance with law.

SECTION 18. Implementing Rules and Regulations. — Within ninety (90) days from the effectivity of this Act, the DOH shall, in consultation with the Department of the Interior and

Local Government (DILG), and other concerned government agencies and stakeholders, promulgate the necessary rules and regulations for the effective implementation of this Act.

SECTION 19. Appropriations. — The amount necessary to carry out the implementation of this Act shall be included in the annual General Appropriations Act (GAA) under the budget of the DOH.

Program funds shall be allocated and utilized in accordance with the eligibility-based access and deployment mechanisms provided in this Act, including arrangements under memoranda of agreement with LGUs and participating health facilities. All funds shall remain under the full control and administration of the DOH.

To respond to public health emergencies, surges in demand, or national disasters, the DOH may augment the Program using available appropriations, subject to the approval of the Department of Budget and Management (DBM) and applicable laws and regulations.

To ensure long-term sustainability and responsiveness to national health financing needs, the DOH, in consultation with the DBM, may explore and recommend supplementary funding mechanisms for future consideration. These may include, but are not limited to, the creation of a dedicated trust fund, contributions from public-private partnerships, or the earmarking of specific taxes or revenues, subject to separate enabling legislation.

SECTION 20. Repealing Clause. — All laws, decrees, executive orders, rules and regulations, or parts thereof inconsistent with the provisions of this Act are hereby repealed or modified accordingly.

SECTION 21. Separability Clause. — If, for any reason, any section of this Act shall be deemed unconstitutional or invalid, the other sections or provisions shall not be affected and shall remain in force and in effect.

SECTION 22. Effectivity Clause. — This Act shall take effect after fifteen (15) days from its publication in the Official Gazette or in at least two (2) national newspapers of general circulation, whichever comes earlier.

Approved.