第 161 条．他の違法行為—共和国法 7875 条とこの規定に違反する行為で、NHIP の目的を脅かし、弱めるような、医療提供者の故意による行為あるいは過失による行為あるいは怠慢は、法令第 44 条に従って取り扱われる。

規則 30
加入者の違反

第 162 条．不正行為—NHIP 給付あるいは受給資格を請求するいかなる加入者で、第 147 条、第 156 条、159 条、161 条に規定されるいかなる違反を、単独あるいは医療提供者と共謀して犯した者は、5000 ペソの罰金が科され、3 ヶ月以上 6 ヶ月以内の NHIP 給付利用停止期間が科される。

第 163 条．重過失—重罪により、前節で参照されるいかなる行為を行う加入者は 500 ペソ以上 5000 ペソ以下の罰金が科され、3 ヶ月以上 6 ヶ月以内の NHIP 給付利用停止期間が科される。

規則 31
コーポレーションの役員・職員の違反

第 164 条．財産権違反—コーポレーションの役員あるいは職員の以下の行為を財産権違反とする：

a. コーポレーションに支払われるべき、提供されるべき資金あるいは財産の受領あるいは保持

b. 当該財産あるいは資金をすべて、あるいは部分的に横領するか、あるいは悪用する

c. 他人に対し、当該財産あるいは資金をすべて、あるいは部分的に横領することを許可し、同意する

資金あるいは財産の横領が判明した役員あるいは職員は 6 年以上 12 年以内の懲役刑が科され、10,000 ペソ以上 20,000 ペソ以下の罰金が科される。

第 165 条．資金が関与する他の違反—コーポレーションの資金が関与する他のすべての違反は、改正刑法あるいは他の法律のしかるべき条項によって規定され、資金徴収、送金、投資についての法律の規定が考慮される。

第 166 条．共謀—コーポレーションの役員あるいは職員で、重罪によって、医療提供者あ

るいはいかなる加入者と共謀、同意、企み、陰謀、もくろみを行い、またこの規定で列挙される違反行為を促し、あるいは同意した者はしかるべき刑法、規則、規定によって起訴される。

規則 32
雇用側の違反

第 167 条．保険料を控除しないときあるいは支払わないとき—被用者の給与から保険料を控除しない、あるいは控除を拒否する場合、あるいはコーポレーションへの雇用側・被用側の保険料の送金をしない場合、あるいは拒否するいかなる役員・職員は、6ヶ月以上 1 年以下の懲役刑が科され、企業の合計職員数で乗じた金額である 500 ペソ以上 1000 ペソ以下の罰金が科される。

第 168 条．保険料の横領—保険料徴収権限を持つ役員あるいは職員で、被用者の給与からすでに徴収・控除された毎月の保険料を送金しない者は、当該保険料を横領したと推測され、詐欺についての改正刑法の条項 315、par 1(b)に規定される刑罰が科される。

第 169 条．不法な控除—補償されている被用者の保険料から直接的・非直接的に控除する役員・職員で、あるいは当該被用者に代わって保険料を得る者は 1 年以下の懲役刑あるいは企業の合計職員数で乗じた金額 1000 ペソ以下の罰金が科されるか、あるいは裁判所の裁量により懲役刑と罰金刑の両方が科される。

第 170 条．違反者としての施設—前節で規定されるいかなる行為あるいは怠慢が、協会、協同経営会社、株式会社、他の施設、代表取締役、共同経営者、代表、総支配人、あるいは上記の行為に責任を持つ他の者によってなされる場合は、この規定と他の法律で定められる刑罰が下される。

規則 33
最終規定

第 171 条．違法行為の起訴—規則 31 と規則 32 の下で規定される違法行為は合法な司法権の下に通常裁判所で起訴される。その際、現存する法律の下でコーポレーションが制定する行政行為の権利を侵害することはない。

第 172 条．苦情の申し立て—コーポレーションの面前での苦情申し立ては、違反を行った医療提供者あるいは加入者に対する委員会、事務局、裁判所、法廷の面前での、別個の独

立した刑事訴訟を禁じることはない。またこの逆もしかりである。

第 173 条．刑罰の執行—差し止めに服する前に施設内医療提供者が業務を中止する場合、あるいは独立した医療専門家が診療を停止した場合、同じ所有者あるいは医長が名前と場所に関わりなく新たな施設を開始し、運営する際、あるいは医療提供者が再び診療を開始するときは、執行される刑罰は延期される。条件として、罰金の支払いを要求する解決の権利変動原因たる部分と、支払いが済んでいる請求金額の払い戻しあるいは支払いの拒否は未履行となる。

所有者あるいは医長の配偶者あるいは二親等内の親戚あるいは類縁者は、上記の目的により、当該所有者あるいは医長の代理としてみなされる。

原告が審問を受けている間は、業務の停止あるいは医療提供者の診療の停止にもかかわらず、コーポレーションと不正な提供者間での今後の関係性を決定するため、手続きは判決言い渡しまで続行する。

第 174 条．この規則の適用性—この規則が効力を生じる際、コーポレーションの適切な団体にすでに申し立てられた告訴あるいは審議中の告訴は、以前の規則に従って刑罰が下される。

表題 8
行政的救済

規則 34
一般規定

第 175 条．司法権—コーポレーション、LHIO、Grievance and Appeals Review Committee (GARC)と委員会は、認定を受けた医療提供者あるいは加入者がプログラム開発者に対して申し立てたすべての苦情を聞き入れ、決定を下す。コーポレーションは同じようにして、料金や手数料の支払い、請求に関する行政決定に対するすべての抗議に対して処置を取る。

第 176 条．補償されていない苦情と抗議—オンブズマン事務局、sandiganbayan、国家公務員任用委員会、通常裁判所の管轄の下での行政的苦情あるいは刑事告発あるいは課徴金の基となるプログラム開発者の行為についての不平と抗議はこの規定で補償されず、しかるべき法律に従って処理される。

規則 35
プログラム開発者への苦情

第 177 条．苦情の原因—以下の行為は苦情の正当な原因となる：

a. 患者の権利の侵害

b. 加入者あるいはその扶養家族の給付の失効あるいは無所有を生じさせるような、義務を故意に無視すること

c. 請求行為の不当な遅延

d. 同意した期間を超える、請求手続きの遅延

e. 法令とこの規定の目的を脅かし、傷つける傾向のある他の行為あるいは怠慢

第 178 条．申し立てる者—不当に扱われたいかなる医療提供者あるいは加入者が、苦情について実証された苦情を申し立てる。

第 179 条．場所—この法律で規定された苦情は LHIO 本部に申し立てられるか、あるいは不平を持つ医療提供者のいる地域の LHIO に申し立てられるか、あるいは加入者が居住する場所の LHIO に申し立てられる。

第 180 条．苦情の内容—苦情の内容は以下である：

a. 原告の氏名と住所

b. 被告であるプログラム開発者の氏名と住所

c. 苦情申し立ての原因を明確に、簡潔に記した文書

d. 求められた救済

苦情は、原告の宣誓と承認、他の追加書類によって立証され、これらが添付される。書類は被告人の人数分のコピーと、公文書ファイル用にコピーの 2 部が添付される。当該宣誓は、宣誓管理人の前で宣誓をし、宣誓管理人は宣誓供述人が個人的に調査を受けていることを立証し、宣誓供述人が自発的に宣誓を執行し、また宣誓を理解することをもって満たす。

第 181 条．調査—苦情を申し立てる際、コーポレーションは事実に基ずく意見を生じさせるのに十分な理由があるかを決定するために、調査を実施する調査員を指名する。GARC はその調査を認め、プログラム開発者が調査を管理し、GARC による申し立ての起訴と判決が苦情の救済をもたらす。

第 182 条．調査員の義務—調査員が GARC に申し立てを起訴する苦情の原因を見つけた際、

証人は個人的に調査員によって申し立てが審問されたことを立証し、また調査員は、苦情の正当な原因があると信じる、しかるべき理由があり、被告である開発者が苦情について知らされ、論議の証拠を提出する機会が与えられていることを立証する。さもなければ、調査員は苦情の取り消しを提案する。

前者の場合、調査員はGARCに対し、委員会を通じて、ケースの記録、正当な苦情と返答、宣誓、対抗宣誓、当事者が提出した追加証拠を提出することで解決を促す。

規則 36
苦情請求調査委員会

第 183 条．苦情請求調査委員会—委員会は苦情請求調査委員会(GARC)を発起し、委員会は代表と投票場監督官としての最高責任者と他の 4 名のメンバーで構成され、委員会による立証を投票場監督官が提案した際、委員会は苦情に対するすべての行為を審問し、決定する。委員会はGARCを通じて同じように、苦情を訴える提供者あるいは加入者の証明請求におけるプログラム開発者に対する苦情を取り下げるため、コーポレーションの行為を調査する司法権を行使する。GARC は調査員による認定あるいは保証、請求申し立てを召還し、判決が下されるまで委員会は組織として集合を続ける。

第 184 条．票決に必要な定足数—GARC のメンバー3 名は審議の定足数を満たし、持ち出される申し立てについての決定を下す。すべての申し立てには、GARC の少なくとも 3 名のメンバーで、投票場監督官としての代表を含むメンバーの同意が判決、解決、指令、規定に達するのに必要である。

第 185 条．予備判決—苦情の証明の際、GARC は証拠不十分、あるいは訴訟原因を明記しないこと、あるいは委員会との協議の後の苦情の取り消しにより申し立てを取り下げる。あるいは申し立てを進め、審問し、決定を下す。

被告であるプログラム開発者が、証明された返答や、コーポレーションの面前での手続きにおける対抗宣誓と他の追加書類を提出しない際、被告開発者は送達から5日以内にGARCに同じ内容を申し立てることを要求する。送達はこの規定の条項に従うものとする。

第 186 条．不正な判決—前節において規定された 5 日間の期間内に被告開発者が返答しない場合は、GARC は自発的に、記録に記された真実によって立証される判決を下す。

第 187 条．ポジションペーパー—返答が申し立てられ意見が対決した後、GARC は当事者

に対し、命令を受けた日から 10 日以内に簡潔な文書を提出することを要求する。コーポレーションの面前で手続きの記録を GARC が見つけた際、また当事者が提出したポジション文書を見つけた際、公式の審問を開く必要がなく判決が与えられ、当事者がポジションペーパーを提出した日から 10 日以内に判決を与えるよう進める。

第 188 条. CLARIFACTORY HEARING—GARC が判決を与える前に特定の問題について明確にするため、審問を行う必要があると見なした場合、審問は設定される。審問において、以前に宣誓が提出された証人は弁護者と GARC から質問を受け、相手方から反対尋問を受ける。ケースについての審問を設定した命令は、立証するために召還される証人を特定し、審議で取り扱われる案件について特定する。審問は 15 日間で終結し、ケースは GARC によって終結から 15 日間以内に決定される。

第 189 条. 判決の内容—GARC の判決は明確で簡潔で、ケースの事実について、関わった問題、適用される法律、結論と理由、特別救済を含む、簡潔な文書が出される。

第 190 条. 判決の最終性—GARC の判決は、その知らせが当事者に渡されてから 15 日後に最終で、行政的なものとなる。その期間に委員会に何の請求も出されなければ、この規定での手続きに従って規定される。

第 191 条. 行政的処理—有罪になった際、GARC は違反の程度に従い、被告である開発者を告発、懲戒、停職できる。条件として、停職は 30 日を超えてはならない。

第 192 条. 証明の範囲—すべての手続きにおいて、委員会は技術的な証拠法則によって拘束を受けない。条件として、RULE OF COURT は補充の効果を申請する。

第 193 条. GARC の権力—GARC は宣誓を行い、公務上の行為を証明し、証人召喚令状を発行し、承認の出席と立証を強要することができ、証拠文書提出命令に対し、ケースに関連する本、書類、他の記録を作成するよう要求できる。命令に従わない場合は改定行政法の第 7 巻、第 3 章、第 14 条に従って取り扱われる。

規則 37
GARC 決定の調査

第 194 条. 司法権—委員会は大法廷において、独占的な上訴管轄権を持ち、この法律と規定の下に申し立てられた苦情において、GARC の下した決定を調査する。

第 195 条. 調査請求申し立て期間—調査申し立ては GARC の決定の受領から 15 日以内の期間に申し立てられる。

第 196 条. 調査請求を申し立てる者—GARC の決定した、苦情請求における当事者は調査請求を申し立てられる。

第 197 条. 委員会の決定—委員会は、調査請求の受領から 30 日以内に請求を解決する。

規則 38
行政的な抗議

第 198 条. 司法権—LHIO が完全に運営できるようになるまで、請求書調査ユニット(CRU)の代表と最高責任者は、請求書の手続きと支払いに関する CRU の決定に対して、医療提供者と加入者の申し立てた行政的抗議を取り扱う。

第 199 条. 抗議に関連する請求—請求書処理部門が拒否あるいは減額した請求書は CRU の抗議に従属する。

第 200 条. 書式—抗議は文書で、抗議を訴える者の署名が入り、代表と最高責任者宛に送られる。補助書類が添付されなければならず、請求書処理部門の決定についての知らせの受領から 60 日以内に申し立てられる。

第 201 条. CRU の手続き—抗議の受領において、抗議を申し立てる期間が失効した場合は CRU は抗議を返却し、あるいは支払い予定を与える。CRU は補助書類の提出を要求し、抗議の解決に関する宣誓を要求する。その後、関連当事者に抗議を知らせ、申し立てについての彼らのコメントを要求する。

第 202 条. 請求書における行為—完全な協議の後、CRU は以下の行為について代表と最高責任者に提案を与える：

a. 現存の法律、コーポレーションの規定に照らした場合に、請求書が無効あるいは価値がない場合の抗議の拒否
b. 請求書が有効で価値があり、支払いを請求していることが分かった場合の抗議の許可
c. しかるべき行政団体あるいは、法律・規則違反を認める法廷の前で、責任の所在する当事者の起訴
d. 状況において公平な他の行為

代表と最高責任者はCRUの提案を、すべてあるいは一部導入し、修正し、拒否する。直ちに、代表と最高責任者は抗議を解決する指令を出し、基になっている事実と法律を明示する。代表と最高責任者の決定は、上記の手続きに従った調査請求について、委員会に請求しない限り、最終で行政的なものとなる。

表題 9
一時的な規定

第 203 条．フィルヘルスナンバーカード—NHIP の加入者は一時的にフィルヘルスナンバーカードを使用できる。そのカードはフィルヘルス ID カードが発行される時までサービスの利用を裏付ける。OWWA メディケア受給者は給付の受給において、受給資格証明(EC)を使用できる。

第 204 条．GSIS/SSS/OWWA 番号—GSIS、SSS、OWWA の加入者で NHIP に記録を更新していない者は、永久的なフィルヘルス ID カードが発行される際まで一時的に GSIS、SSS、OWWA 番号を利用できる。

第 205 条．SSS 雇用者 ID 番号—世帯雇用者を含む民間セクターの雇用者で 1999 年 7 月 1 日前に SSS に登録した者は永久的なフィルヘルス雇用者番号(PEN)が発行される際まで一時的に SSS の雇用者 ID 番号を利用できる。

第 206 条．LGU の所得分類—財務省(DOF)が市のバランガイにおける所得の分類を規定する時まで、市の所得分類は地方政府補助金額の決定を用いて使われる。

表題 10
その他の規定

第 207 条．無効条項—この規定に一致しないすべてのフィルヘルスサーキュラー、規定、覚書は取り消し、あるいは改定が考慮される。

第 208 条．分離条項—いかなる者がいかなる状況において、この規定あるいは法律の条項あるいはそのような条項の適用が無効だと申告する場合、この規定あるいは他人あるいは他の状況への当該条項の適用は、そのような申告による影響を受けない。

第 209 条．公表と有効性—委員会はこの規定を、少なくとも 2 つの全国紙に公表する。それは 2000 年 7 月 1 日に施行される。

REPUBLIC ACT NO. 7875
February 14, 1995

AN ACT INSTITUTING A NATIONAL HEALTH INSURANCE PROGRAM FOR ALL FILIPINOS AND ESTABLISHING THE PHILIPPINE HEALTH INSURANCE CORPORATION FOR THE PURPOSE

Sec. 1. Short Title. - This Act shall be known as the "National Health Insurance Act of 1995."

Article I. GUIDING PRINCIPLES

Sec. 2. Declaration of Principles and Policies. - Section 11, Article XIII of the 1987 Constitution of the Republic of the Philippines declares that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.

In the pursuit of a National Health Insurance Program, this Act shall adopt the following guiding principles:

a) Allocation of National Resources for Health - The Program shall underscore the importance for government to give priority to health as a strategy for bringing about faster economic development and improving quality of life.

b) Universality - The Program shall provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs. The National Health Insurance Program shall give the highest priority to achieving coverage of the entire population with at least a basic minimum package of health insurance benefits;

c) Equity - The Program shall provide for uniform basic benefits. Access to care must be a function of a person's health needs rather than his ability to pay;

d) Responsiveness - The Program shall adequately meet the needs for personal health services at various stages of a member's life;

e) Social Solidarity - The Program shall be guided by community spirit. It must enhance risk sharing among income groups, age groups, and persons of differing health status, and residing in different geographic areas;

f) Effectiveness - The Program shall balance economical use of resources with quality of care;

g) Innovation - The Program shall adapt to changes in medical technology, health service organizations, health care provider payment systems, scopes of professional practice, and other

trends in the health sector. It must be cognizant of the appropriate roles and respective strengths of the public and private sectors in health care, including people's organizations and community-based health care organizations;

h) Devolution - The Program shall be implemented in consultation with local government units (LGUs), subject to the overall policy directions set by the National Government;

i) Fiduciary Responsibility - The Program shall provide effective stewardship, funds management, and maintenance of reserves;

j) Informed Choice - The Program shall encourage members to choose from among accredited health care providers. The Corporation's local offices shall objectively apprise its members of the full range of providers involved in the Program and of the services and privileges to which they are entitled as members. This explanation, which the members may use as a guide in selecting the appropriate and most suitable provider, shall be given in clear and simple Filipino and in the local languages that is comprehensible to the member;

k) Maximum Community Participation - The Program shall build on existing community initiatives for its organization and human resource requirements;

l) Compulsory Coverage - All citizens of the Philippines shall be required to enroll in the National Health Insurance Program in order to avoid adverse selection and social inequity;

m) Cost Sharing - The Program shall continuously evaluate its cost sharing schedule to ensure that costs borne by the members are fair and equitable and that the charges by health care providers are reasonable;

n) Professional Responsibility of Health Care Providers - The Program shall assure that all participating health care providers are responsible and accountable in all their dealings with the Corporation and its members;

o) Public Health Services - The Government shall be responsible for providing public health services for all groups such as women, children, indigenous people, displaced communities and communities in environmentally endangered areas, while the Program shall focus on the provision of personal health services. Preventive and promotive public health services are essential for reducing the need and spending for personal health services;

p) Quality of Services - The Program shall promote the improvement in the quality of health services provided through the institutionalization of programs of quality assurance at all levels of the health service delivery system. The satisfaction of the community, as well as individual beneficiaries, shall be a determinant of the quality of service delivery;

q) Cost Containment - The program shall incorporate features of cost containment in its design and operations and provide a viable means of helping the people pay for health care services; and

r) Care for the Indigent - The Government shall be responsible for providing a basic package of needed personal health services to indigents through premium subsidy, or through direct service provision until such time that the program is fully implemented.

Sec. 3. General Objectives. - This Act seeks to:

a) provide all citizens of the Philippines with the mechanism to gain financial access to health services;

b) create the National Health Insurance Program, hereinafter referred to as the Program, to serve as the means to help the people pay for health care services;

c) prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford such services; and

d) establish the Philippine Health Insurance Corporation, hereinafter referred to as the Corporation, that will administer the Program at central and local levels.

Article II. DEFINITIONS OF TERMS

Sec. 4. Definitions of Terms. - For the purpose of this Act, the following terms shall be defined as follows:

a) Beneficiary - Any person entitled to health care benefits under this Act.

b) Benefit Package - Services that the Program offers to its members.

c) Capitation - A payment mechanism where a fixed rate, whether per person, family, household, or group, is negotiated with a health care provider who shall be responsible for delivering or arranging for the delivery of health services required by the covered person under the conditions of a health care provider contract.

d) Contribution - The amount paid by or in behalf of a member to the Program for coverage, based on salaries or wages in the case of formal sector employees, and on household earnings and assets, in the case of the self-employed, or on other criteria as may be defined by the Corporation in accordance with the guiding principles set forth in Article I of this Act.

e) Coverage - The entitlement of an individual, as a member or as a dependent, to the benefits of the Program.

f) Dependent - The legal dependents of a member are: 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 or 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 Corporation in accordance with the guiding principles set forth in Article I of this Act.

g) Diagnostic Procedure - Any procedure to identify a disease or condition through analysis and examination.

h) Emergency - An unforeseen combination of circumstances which calls for immediate action to preserve the life of a person or to preserve the sight of one or both eyes; the hearing of one or both ears; or one or two limbs at or above the ankle or wrist.

i) Employee - Any person who performs services for an employer in which either or both mental and physical efforts are used and who receives compensation for such services, where there is an employer-employee relationship.

j) Employer - A natural or juridical person who employs the services of an employee.

k) Enrollment - The process to be determined by the Corporation in order to enlist individuals as members or dependents covered by the Program.

l) Fee for Service - A reasonable and equitable health care payment system under which physicians and other health care providers receive a payment that does not exceed their billed charge for each unit of service provided.

m) Global Budget - An approach to 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.

n) Government Service Insurance System - The Government Service Insurance System created under Commonwealth Act No. 186, as amended.

o) Health Care Provider - Refers to:

1) a health care institution, which is duly licensed and accredited devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment, and care of individuals suffering from illness, disease, injury, disability or deformity, or in need of obstetrical or other medical and nursing care. It shall also be construed as any institution, building, or place where there are installed beds, cribs, or bassinets for twenty-four hour use or longer by

patients in the treatment of diseases, injuries, deformities, or abnormal physical and mental states, maternity cases or sanitarial care; or infirmaries, nurseries, dispensaries, and such other similar names by which they may be designated; or

2) a health care professional, who is any doctor of medicine, nurse, midwife, dentist, or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation; or

3) a health maintenance organization, which is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium; or

4) a community-based health care organization, which is an association of indigenous members of the community organized for the purpose of improving the health status of that community through preventive, promotive and curative health services.

p) Health Insurance Identification (ID) Card - The document issued by the Corporation to members and dependents upon their enrollment to serve as the instrument for proper identification, eligibility verification, and utilization recording.

q) Indigent - A person who has no visible means of income, or whose income is insufficient for the subsistence of his family, as identified by the Local Health Insurance Office and based on specific criteria set by the Corporation in accordance with the guiding principles set forth in Article 1 of this Act;

r) Inpatient Education Package - A set of informational services made available to an individual who is confined in a hospital to afford him with knowledge about his illness and its treatment, and of the means available, particularly lifestyle changes, to prevent the recurrence or aggravation of such illness and to promote his health in general.

s) Member - Any person whose premiums have been regularly paid to the National Health Program. He may be a paying member, an indigent member, or a pensioner/retiree member.

t) Means Test - A protocol administered at the barangay level to determine the ability of individuals or households to pay varying levels of contributions to the Program, ranging from the indigent in the community whose contributions should be totally subsidized by government, to those who can afford to subsidize part but not all the required contributions for the Program.

u) Medicare - The health insurance program currently being implemented by the Philippine Medical Care Commission. It consists of:

1) Program I, which covers members of the SSS and GSIS including their legal dependents; and

2) Program II, which is intended for those not covered under Program I.

v) National Health Insurance Program - The compulsory health insurance program of the government as established in this Act, which shall provide universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.

w) Pensioner - An SSS or GSIS member who receives pensions there from.

x) Personal Health Services - Health services in which benefits accrue to the individual person. These are categorized into inpatient and outpatient services.

y) Philippine Medical Care Commission - The Philippine Medical Care Commission created under Republic Act No. 6111, as amended.

z) Philippine National Drug Formulary - The essential drugs list for the Philippines which is 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 which is updated every year.

aa) Portability - The enablement of a member to avail of Program benefits in an area outside the jurisdiction of his Local Health Insurance Office.

bb) Prescription Drug - A drug which has been approved by the Bureau of Food and Drug and which can be dispensed only pursuant to a prescription order from a physician who is duly licensed to do so.

cc) Public Health Services - 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.

dd) Quality Assurance - A formal set of activities to review and ensure the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

ee) Residence - The place where the member actually lives.

ff) Retiree - A member of the Program who has reached the age of retirement or who was retired on account of disability.

gg) Self-employed - A person who works for himself and is therefore both employee and employer at the same time.

hh) Social Security System - The Social Security System created under Republic Act No. 1161, as amended.

ii) Treatment Procedure - Any method used to remove the symptoms and cause of a disease.

jj) Utilization Review - A formal review of patient utilization or of the appropriateness of health care services, on a prospective, concurrent or retrospective basis.

Article III. THE NATIONAL HEALTH INSURANCE

PROGRAM

Sec. 5. Establishment and Purposes. - There is hereby created the National Health Insurance Program which shall provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines, in accordance with the policies and specific provisions of this Act. This social insurance program shall serve as the means for the healthy to help pay for the care of the sick and for those who can afford medical care to subsidize those who cannot. It shall initially consist of programs I and II of Medicare and be expanded progressively to constitute one universal health insurance program for the entire population. The Program shall include a sustainable system of funds constitution, collection, management and disbursement for financing the availment of a basic minimum package and other supplementary packages of health insurance benefits by a progressively expanding proportion of the population. The Program shall be limited to paying for the utilization of health services by covered beneficiaries or to purchasing health services in behalf of such beneficiaries. It shall be prohibited from providing health care directly, from buying and dispensing drugs and pharmaceuticals, from employing physicians and other professionals for the purpose of directly rendering care, and from owning or investing in health care facilities.

Sec. 6. Coverage. - All citizens of the Philippines shall be covered by the National Health Insurance Program. In accordance with the principles of universality and compulsory coverage enunciated in Section 2 (b) and 2 (l) hereof, implementation of the Program shall, furthermore, be gradual and phased in over a period of not more than fifteen (15) years: Provided, That the Program shall not be made compulsory in certain provinces and cities until the Corporation shall be able to ensure that members in such localities shall have reasonable access to adequate and acceptable health care services.

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

a) all persons currently eligible for benefits under Medicare Program I, including SSS and GSIS members, retirees, pensioners and their dependents, shall immediately and automatically be made members of the National Health Insurance Program;

b) all persons eligible through health insurance plans established by local governments as part of Program II of Medicare or in accordance with the provisions of this Act, including indigent members, shall also be enrolled in the Program;

c) all persons eligible for benefits as member of local health insurance plans established by the Corporation in accordance with the implementing rules and regulations of this Act shall also be deemed to have enrolled in the Program. Enrollment of persons who have no current health insurance coverage shall be given priority by the corporation; and

d) all persons eligible for benefits as members of other government initiated health insurance programs, community-based health care organizations, cooperatives, or private non-profit health insurance plans shall be enrolled in the Program upon accreditation by the Corporation which shall devise and provide incentives to ensure that such accredited organizations will benefit from their participation in the program.

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

Sec. 8. Health Insurance ID Card. - In conjunction with the enrollment provided above, the Corporation through its local office shall issue a health insurance ID which shall be used for purposes of identification, eligibility verification, and utilization recording. The issuance of this ID card shall be accompanied by a clear explanation to the enrollee of his rights, privileges and obligations as a member. A list of health care providers accredited by the Local Health Insurance Office shall likewise be attached thereto.

Sec. 9. Change of Residence. - A citizen can be under only one Local Health Insurance Office which shall be located in the province or city of his place of residence. A person who changes residence, becomes temporarily employed, or for other justifiable reasons, is transferred to another locality should inform said Office of such transfer and subsequently transfer his Program membership.

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

a) Inpatient hospital care:

1) room and board;

2) services of health care professionals;

3) diagnostic, laboratory, and other medical

examination services;

4) use of surgical or medical equipment and facilities;

5) prescription drugs and biologicals; subject to the

limitations stated in Section 37 of this Act;

6) inpatient education packages;

b) Outpatient care:

1) services of health care professionals;

2) diagnostic, laboratory, and other medical examination services;

3) personal preventive services; and

4) prescription drugs and biologicals, subject to the

limitations described in Section 37 of this Act;

c) Emergency and transfer services; and

d) Such other health care services that the Corporation shall determine to be appropriate and cost-effective: Provided, That the Program, during its initial phase of implementation, which shall not be more than five (5) years, shall provide a basic minimum package of benefits which shall be defined according to the following guidelines:

1) the cost of providing said package is such that the available national and local government subsidies for premium payments of indigents are sufficient to extend coverage to the widest possible population.

2) the initial set of services shall not be less than half of those provided under the current Medicare Program I in terms of overall average cost of claims paid per beneficiary household per year.

3) the services included are prioritized, first, according to its effectiveness and, second, according to its potential of providing maximum relief from the financial burden on the beneficiary: Provided, That in addition to the basic minimum package, the Program shall provide supplemental health

benefit coverage to beneficiaries of contributory funds, taking into consideration the availability of funds for the purpose from said contributory funds: Provided, further, That the Program shall progressively expand the basic minimum benefit package as the proportion of the population covered reaches targetted milestones so that the same benefits are extended to all members of the Program within five (5) years after implementation of this Act. Such expansion will provide for the gradual incorporation of supplementary health benefits previously extended only to some beneficiaries into the basic minimum package extended to all beneficiaries: and Provided, finally, That in the phased implementation of this Act, there should be no reduction or interruption in the benefits currently enjoyed by present members of Medicare.

Sec. 11. Excluded Personal Health Services. - The benefits granted under this Act shall not cover expenses for the services enumerated hereunder except when the Corporation, after actuarial studies, recommend their inclusion subject to the approval of the Board:

a) non-prescription drugs and devices;

b) outpatient psychotheraphy and counselling for

mental disorders;

c) drug and alcohol abuse or dependency treatment;

d) cosmetic surgery;

e) home and rehabilitation services;

f) optometric services;

g) normal obstetrical delivery; and

h) cost-ineffective procedures which shall be defined

by the Corporation.

Sec. 12. Entitlement to Benefits. - A member whose premium contributions for at least three (3) months have been paid within the six (6) months prior to the first day of his or his dependents' availment, shall be entitled to the benefits of the Program: Provided, That such member can show that he contributes thereto with sufficient regularity, as evidenced in their health insurance ID card: and Provided, further, That he is not currently subject to legal penalties as provided for in Section 44 of this Act.

The following need not pay the monthly contributions to be entitled to the Program's benefits:

a) Retirees and pensioners of the SSS and GSIS prior to the effectivity of this Act;

b) Members who reach the age of retirement as provided for by law and have paid at least one hundred twenty (120) monthly contributions; and

c) Enrolled indigents.

Sec. 13. Portability of Benefits. - The corporation shall develop and enforce mechanisms and procedures to assure that benefits are portable across Offices.

Article IV. THE PHILIPPINE HEALTH INSURANCE CORPORATION

Sec. 14. Creation and Nature of the Corporation. - There is hereby created a Philippine Health Insurance Corporation, which shall have the status of a tax-exempt government corporation attached to the Department of Health for Policy coordination and guidance.

Sec. 15. Exemption from Taxes and Duties. - The Corporation shall be exempt from the payment of taxes on all contributions thereto and all accruals on its income or investment earnings.

Any donation, contribution, bequest, subsidy or financial aid which may be made to the Corporation 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 Cede, as amended.

Sec. 16. Powers and Functions. - The Corporation shall have the following powers and functions:

a) to administer the National Health Insurance Program;

b) to formulate and promulgate policies for the sound administration of the Program;

c) to set standards, rules, and regulations necessary to ensure quality of care, appropriate utilization of services, fund viability, member satisfaction, and overall accomplishment of Program objectives;

d) to formulate and implement guidelines on contributions and benefits, cost containment and quality assurance; and health care provider arrangements, payment methods; and referral systems;

e) to establish branch offices as mandated in Article V of this Act;

f) to receive and manage grants, donations, and other forms of assistance;

g) to sue and be sued in court;

h) to acquire property, real and personal, which may be necessary or expedient for the attainment of the purposes of this Act;

i) to collect, deposit, invest, administer, and disburse the National Health Insurance Fund in accordance with the provisions of this Act;

j) to 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;

k) to authorize Local Health Insurance Offices to negotiate and enter into contracts in the name and on behalf of the Corporation with any accredited 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 the Corporation;

l) to determine requirements and issue guidelines for the accreditation of health care providers for the Program in accordance with this Act;

m) to supervise the provision of health benefits with the power to inspect medical and financial records of health care providers and patients who are participants in or members of the Program, and the power to enter and inspect accredited health care institutions, subject to the rules and regulations to be promulgated by the Corporation;

n) to organize its office, fix the compensation of and appoint personnel as may be deemed necessary and upon the recommendation of the president of the Corporation;

o) to 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, average costings to beneficiaries, any request for additional appropriation, and other data pertinent to the implementation of the Program and publish a synopsis of such report in two (2) newspapers of general circulation;

p) to keep records of the operations of the Corporation and investments of the National Health Insurance Fund; and

q) to perform such other acts as it may deem appropriate for the attainment of the objectives of the Corporation and for the proper enforcement of the provisions of this Act.

Sec. 17. Quasi-Judicial Powers. - The Corporation, to carry out its tasks more effectively, shall be vested with the following powers:

a) 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