EIGHTEENTH CONGRESS)
REPUBLIC OF THE PHILIPPINES)
First Regular Session)

HOUSE OF REPRESENTATIVES

Introduced by Representative Rufus B. Rodriguez

House Bill No. 2770

EXPLANATORY NOTE

This bill was originally introduced as House Bill No. 2403 during the 14th Congress where it was approved and transmitted to the Senate where it was not acted upon. It was re-filed during the 16th Congress and the 17th Congress.

This bill seeks to encourage the establishment and growth of the Health Maintenance Organizations (HMOs) in the Philippine to promote participation of the private sector in providing health care to Filipinos.

Section 15, Article II of the 1987 Constitution provides that the Senate shall protect and promote the right to health of the people and instill health consciousness among them. Section 11, Article XIII of the same Constitution provides that the State shall endeavor to provide free medical care to paupers.

Over the years, the growing population of the country, which is expected to reach 94 million in 2010 and the minimal government spending for public health, have not been able to address the health needs of Filipinos. Of the top ten causes of death and sickness, only four are not poverty-related. More than 30 percent of Filipino children suffer from various stages of malnutrition. The costs of locally-available drugs and medicines are at least 30 to 50 percent higher than retail costs in countries such as India. Worse, more than 60 percent of Filipinos have not heard of health insurance coverage, much less possess of the capacity to pay for such basic protection. Clearly, the State cannot do it alone. There is therefore a need to encourage private sector participation in addressing the health need of our country. Such private participation can be initiated thru establishment and regulation of health maintenance organizations.

Under this bill, a health maintenance organization is an insurance company that sells fixed pre-paid health insurance policies to the public. It coordinates the delivery of pre-agreed or designated health care services to its members through a network of health care providers for a fixed periodic fee and for a specified period of time. Through managed care, it influences the utilization and cost of health services with the end to make beneficial, effective, and//or necessary quality health care affordable to the public. The importance of State's intervention in this endeavor is crucial because it is only thru such intervention will the imposition of harsh unconscionable terms be avoided. That is why this proposed measure enumerates the operating guidelines for HMOs to address the alleged gross inequality of bargaining power that currently characterizes the HMO relationship with its members and health care providers. Moreover, for the protection of HMO members and health care providers, the establishment and operations of the Health Maintenance Organizations (HMOs) shall be regulated and shall be under the supervision of the Insurance Commission.

In view of the foregoing, the immediate approval of this bill is earnestly urged.

RUFUS B. RODRIGUEZ

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AN ACT
REGULATING THE ESTABLISHMENT AND OPERATIONS OF HEALTH MAINTENANCE ORGANIZATIONS (HMOs), FOR OTHER PURPOSES

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

SECTION 1. *Short Title* – This Act Shall be known as the "Health Maintenance Organization Act".

SEC. 2. ***Statement of Policy*** – It is hereby declared the policy of the State to protect and promote the right to health of the people and instill health consciousness among them. Pursuant to this policy, the government shall encourage the establishment and favorable operation of Health Maintenance Organizations (HMOs) by granting reasonable incentives to enhance accessibility to quality health care services through affordable health insurance policies.

SEC. 3. ***Objectives*** – In line with the above policy, this Act seeks to:

a) Recognize HMOs as unique health care insurance entities that combine the financing, management and coordination of health services and to encourage their growth by granting them reasonable incentives.
b) Establish the regulatory framework for HMOs.
c) Recognize and protect the rights of HMOs, health care providers and members.
d) Advance health consciousness among our people by promoting greater accessibility to quality health care through affordable health insurance policies.

SEC. 4. ***Definitions*** – When used in this Act, the following terms shall mean:

a) Health Maintenance Organization – an insurance company organized in accordance with the provisions of the Corporation Code of the Philippines that sells fixed pre-paid health insurance policies as defined in paragraph (j) of this section to the public. It coordinates the delivery of pre-agreed or designated health care services to its members through a network of health care providers for a fixed periodic fee and for a specified period of time. Through managed care, it influences the utilization and cost of health services with the end to make beneficial, effective, and/or necessary quality health care affordable to the public;

The HMO shall possess the following functional characteristics:

1) It uses an organized system called managed care to coordinate the delivery of health services to its members through health care providers in a defined geographical area;
2) It contracts the services of health care providers to deliver health care services to its enrollees and/or their dependents as their agreement may stipulate;
3) It has an enrolled group of individuals paying a fixed periodic fee.

b) Actuary – a business professional who analyzes the financial consequences of risks with the necessary training, qualification and experience and a fellow of the Actuarial Society of the Philippines or in any internationally recognized association or society of actuaries (SOA). He shall, among others, determine the financial soundness of health care agreements , evaluate the likelihood of events, design creative ways to reduce the likelihood and decrease the impact of adverse events that may actually occur in the operation of HMOs;
c) Co-Payment – a charge which may be collected directly by a health care provider from a member in accordance with the member's health care policy;
d) Claim – a statement of services submitted to an HMO by a health care provider following the provision of Covered Services to a member that shall include diagnosis or diagnoses and itemization of services and treatment provided to the member;
e) Covered Services/Coverage – health care services to be delivered by a health care provider to a member as provided for in a health care policy;
f) Deductible – the amount a member pays out-of-pocket before the HMO begins to pay the cost associated with treatment;
g) Health-Care Provider – a health professional such as physician, dentist, nurse, midwife, health care professional group and hospital, duly licensed by the proper government agency to provide active health care services;
h) Health Care Provider Contract – a contract between an HMO and a health care provider for the latter to deliver or provide health care services to members of the former. It includes a schedule of Covered Services and compensations and specifies all other terms, conditions, limitations, exclusions, benefits, rights and obligations thereof to which the HMO and health care provider are subject.
i) Health Care Policy – an insurance policy comprising an individual set of health service delivery and compensation procedure offered as a Managed Care product of an HMO to its members. It specifies Covered Services and all other terms, conditions, limitations, exclusions, benefits, rights and obligations thereof to which the HMO and members are subject. It may be in the form of a Comprehensive HMO Policy, Preferred Provider Policy, Managed Indemnity, Self-Insured Policy or Third Party Administration Policy.
j) Managed Care – A complex system that involves the active coordination of, and the arrangement for, the provision of health services and coverage of health benefits. It involves relationships and organization of the providers giving care, and the covered benefits tied to managed care rules;
k) Medically Necessary Services – refer to health care services that a reasonably prudent physician would deem necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part of a member;
l) Member – an insured individual, a part of a group or an employee of a corporation and his dependents, who entered into a contract of health insurance with an HMO;
m) Enrollment Fee – the amount of money paid to an HMO by an individual member, group or corporation on behalf of its employees and the latter's dependents, in payment for a pre-agreed set of health services, for a specific period of time;
n) Participating Provider – a health care provider, who, under a Health Care Provider Contract, has agreed to provide health care services to the HMO members, with the right to payment, other than co-payment or deductible directly or indirectly from the HMO;
o) Specialist - a diplomate and/or Fellow of a Specialty Society recognized by the Philippine Medical Association (PMA).

SEC. 5. ***Health Care Incentives*** – To tap and encourage private sector participation in the government's thrust to make health services accessible to the low income sectors of the population through affordable enrollment fee. Domestic corporations, individuals and resident corporations shall be allowed to deduct the cost of HMO membership fees from the taxable income of said employers.

SEC. 6. ***Registration*** – An HMO shall be legally organized as a juridical person and shall be registered with the Securities and Exchange Commission, hereinafter referred to as the SEC.

SEC. 7. ***Licensure*** – The Insurance Commission, hereinafter referred to as the Commission, shall supervise and regulate the operations of all HMOs and all other entities that possess the functional characteristics of HMOs, except the Philippine Health Insurance Corporation (PHIC). After registering with the SEC, said entities shall secure a license to operate as an HMO from the Commission. All HMOs existing at the time of effectivity of this Act shall likewise secure a license to operate from the Commission.

The Commission shall, upon receipt of a completed application for a license to operate, provide a sixty (60) day period for public comment. As soon as the period has lapsed and after thorough review, it shall either approve or deny the application, the reasons thereof shall immediately be known to the applicant. The license to operate granted under this Act shall be effective for one (1) year, subject to renewal by the Commission.

SEC. 8. ***Licensure Requirements*** – The Insurance Commission and the Department of Health shall prescribe the requirements for licensure and renewal of license of HMOs based on the provisions of Section 7 of this Act. The requirements shall include but not be limited to:

a) The minimum authorized and paid up capitalization;
b) Financial Statement/projections for new HMOs;
c) Annual Reports for existing HMOs;
d) Data on membership enrollment;
e) Geographical area operation;
f) Health policies being offered;
g) Arrangements for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the Health Maintenance Organization;
h) Any deposit of cash, or guaranty or minimum restricted reserves which the Commissioner, by regulation may adopt to assure that the obligations to subscribers and providers will be performed;
i) Philippine Health Insurance Corporation (PHIC) Accreditation;
j) Department of Health HMO Accreditation – The Department of Health shall accredit HMOs after the Secretary has determined that the applicant:

   A. Guarantees its members fundamental patient's rights, to include among others:

      1) *Patient's right to choose physician or health facility* - The freedom of patients to choose their physician or health facility shall not be negotiated by any contract arrangement or procedure of a health maintenance organization. All members in HMOs shall be offered an out-of-network option that will enable them to obtain, even at the member's additional expense care from a health provider. Such out-of-network health providers shall have the right to HMO compensation, other than co-payment or deductible directly or indirectly from the HMO;
      2) *To see a specialist of choice* – An HMO patient may seek the services of a specialist who may not necessarily be affiliated with the HMO.
      3) *Patient's right to emergency care* – A member who reasonably believes that he is suffering from an emergency condition has the right to seek

emergency care from the nearest emergency department without first pre-authorizing or pre-certifying the care with their HMO;

4) *Patient's right to Grievance and external review program* – Members of an HMO shall be granted the right to dispute coverage denials on the basis of "medically necessary" decisions before an independent Review Committee as provided for in Section 10 hereof.

B. Guarantees in Health Care Providers:

1) *Physician's/Dentist's full freedom to manage and treat patients in accordance with the prevailing standard of care* – Permitting arbitrary health policy definitions of "medically necessary" to control all coverage determinations and allowing HMO bureaucrats, rather than properly qualified licensed physician/dentists to make "medically necessary" decisions shall be made by physicians/dentists in accordance with generally accepted standards of medical/dental practice that a prudent physician/dentist will make;

2) *Prompt and just compensation* – health care providers shall be paid their just professional/facility fees within thirty (30) days from receipt of the latter's written or electronic claim. In the event that such claim is not approved, the reasons therefor shall be made known to the provider within seven (7) days after receipt of such written or electronic plan. Disputes may then be addressed to the Insurance Commission for arbitration as provided for in Section 10 hereof. HMOs that do not pay clean claims within the thirty (30) day window may be liable for suspension of its license to operate and , additionally, will be required to pay interest at a rate to be determined by the Insurance Commission. Professional fees must be in accordance with the Philippine Medical Association's/Philippine Dental Association's latest schedule of fees and latest Relative Unit Values and multiplying factors (RUV) prevailing upon the effectivity date of the contract.

C. Has a network of qualified and duty licensed health providers.

SEC. 9. ***Actuaries/Financial Consultants*** – To protect the potential and enrolled members of the HMOs, the Commission shall ensure that HMOs adhere to actuarially sound practices and possess financial capabilities to render the services stipulated in their agreements.

To achieve these objectives, the Commission shall engage the services of actuaries and/or financial consultants to analyze the financial status and the actuarial soundness of the HMO practices prior to issuance or renewal of licenses. For this purpose, the Commission shall require from HMOs such additional data and reports it deems necessary: *Provided,* That, such data and reports are certified by either an actuary, financial consultant or external auditor.

SEC. 10. ***Arbitration and Review*** – HMOs shall provide an internal mechanism where disputes between parties to a Health Care Policy or parties to an internal Care Provider Contract may be resolved in an expeditious manner. In the event that the dispute is unresolved, a member, health provider or an HMO may elevate the case directly to the Commission for binding arbitration. However, if the Commission determines the conflict to be medical in nature or requiring a review of medically necessary decisions, the case shall be referred to an HMO Medical Review Committee to be constituted by the DOH for judgment. The HMO Medical Review Committee shall ensure that reviews of medically necessary decisions must be made only by truly independent licensed physicians familiar with the medical condition or treatment in question and of the same specialty as the treating physician. Such complaints or disputes shall be decided upon within thirty (30) days and the decision shall be final and executory. All other complaints that remain with the Insurance Commission for arbitration shall be decided upon within sixty (60) days. The decision of the

Commission shall be final and executory, appealable to the Supreme Court only on question of law.

SEC. 11. ***Grounds for Suspension of License*** – The license to operate issued to an HMO may be suspended by the Commission, after due notice, examination and hearing, on the following grounds:

a) When, based on financial reports, continued operation of the HMO business is no longer financially sound;
b) When agreements with members are not honored;
c) When contracts with health care providers, including but not limited to prompt and just compensation for health services rendered, are violated;
d) When the statements in the application for license or renewal thereof are found to be false, misleading, inadequate or incomplete such that the Commission cannot ascertain the true status from such statement or are not sufficient to arrive at an honest appraisal of the true capability of the HMO;
e) When the decision of the Commission on cases for arbitration is not honored by an HMO;
f) When the decision of the HMO Review Committee is not honored by an HMO;
g) When an HMO continuously violates the rules and regulations issued by the Commission and the Department of Health pursuant to Section 18 of this Act.

SEC. 12. ***Grounds for Revocation of License*** **–** The Commission shall revoke the license of any Health Maintenance Organization on the following grounds:

a) Repeated violations of this Act by an HMO;
b) Repeated suspension of HMO license;
c) Impairment of the status of the HMO, as may be determined by the Insurance Commission during suspension based on paragraph (a) of Section 11 hereof, after a fair appraisal by impartial actuaries and financial consultants, such that even if allowed to continue to operate, it can no longer provide the services it assumed under the agreement with its members.

SEC. 13. ***Administrative Sanctions*** **–** The following administrative sanctions are hereby imposed for violations that do not warrant suspension or revocation of license:

1) A fine of Ten Thousand Pesos (P10,000.00) for the first violation of the provision of this Act, Twenty Thousand Pesos (P20,000.00) for the second, and Thirty Thousand Pesos (P30,000.00) for the third violation. The provision of Section 11 shall apply upon the fourth violation of this Act;
2) A fine of Fifty Thousand Pesos (P50,000.00) every time the license of the HMO is suspended : *Provided*, that, payment of this fine shall not absolve the HMO from its obligations under the agreement;
3) An order to freeze the assets and funds of the HMO suspended or revoked for the protection of investors, providers and members.

The fees and penalties collected pursuant to this section shall be deposited in the National Treasury as income of the general fund.

SEC. 14. ***Publication*** – The Commission shall periodically publish in a newspaper of general circulation the following:

1) List of duly licensed HMOs in good standing;
2) Suspension and/or revocation of the license of HMOs, copies of which shall be furnished to associations of the medical/dental profession, hospitals and employers who shall inform their members accordingly.

SEC. 15. ***Existing HMOs*** – All existing Health Maintenance Organizations duly registered with the Securities and Exchange Commission and have been in operation prior

to the effectivity of this Act shall continue to operate: *Provided,* That, they shall apply for new license with the Commission within one (1) year from the effectivity of this Act.

SEC. 16. ***New License*** – The Commission shall grant the above HMOs their new license in accordance with this Act: *Provided,* however, That existing agreements, rights and obligations derived therefrom shall be respected: *Provided,* further, That the HMOs comply with the licensing requirements within one (1) year.

SEC. 17. ***Implementing Rules and Guidelines*** – The Insurance Commission and the Department of Health 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 shall take effect upon publication in a newspaper of general circulation.

SEC. 18. ***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.

SEC. 19. ***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.

SEC. 20. ***Effectivity*** – This Act shall take effect fifteen (15) days following its publication in at least two (2) newspapers of general circulation.

Approved,