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BY REPRESENTATIVES MACIAS, DADIVAS, CASTELO-DAZA, CODILLA, CHATTO, YAPHA, ROQUERO, JALOSJOS-CARREON, BADELLES, MANGUDADATU, BIRON, NICOLAS, CARMONA, AMIN, UMALI (A.V.), FIGUEROA AND ZAMORA (M.), PER COMMITTEE REPORT NO. 1408

AN ACT REGULATING THE ESTABLISHMENT AND OPERATIONS OF HEALTH MAINTENANCE ORGANIZATIONS (HMOS), PROVIDING THEM INCENTIVES AND FOR OTHER PURPOSES

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

1 SECTION 1. *Short Title.* – This Act shall be known as the "Health
2 Maintenance Organizations Act of 2006".
3 SEC. 2. *Statement of Policy.* – It is hereby declared the policy of the
4 State to protect and promote the right to health of the people and instill health
5 consciousness among them. Pursuant to this policy, the government shall
6 encourage the establishment and favorable operation of Health Maintenance
7 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; and

(c) Recognize and protect the rights of HMOs, health care providers and their members.

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

(a) "Actuary" refers to a person with the necessary training, qualification and experience and a fellow of the Actuarial Society of the Philippines and accredited by the Insurance Commission. He shall, among others, compute rates 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" refers to a contract entered into by an HMO with a member or group of members or a corporation on behalf of its employees and their dependents, for the former to provide or arrange to provide pre-agreed or

1 designated health care services to the latter, for a fixed period of time and for a
2 specified fee.

3 (c) "Association" refers to the Association of Health Maintenance
4 Organizations, *the existing* Association of HMOs, recognized by the
5 Department of Health as the industry association and representing a large
6 number of HMOs as well as a greater majority of enrolled members.

7 (d) "Co-payment" refers to a charge which may be collected directly by
8 a health care provider from a member in accordance with the member's health
9 care policy.

10 (e) "Corporation" refers to a juridical person as defined by law, duly
11 registered with the Securities and Exchange Commission (SEC).

12 (f) "Department" refers to the Department of Health (DOH).

13 (g) "Health Maintenance Organization" refers to an insurance company
14 organized in accordance with the provisions of the Corporation Code of the
15 Philippines that sells fixed prepaid health insurance policies as defined in
16 paragraph (q) of this section to the public. It coordinates the delivery of pre-
17 agreed or designated health care services to its members through a network of
18 health care providers for a fixed periodic fee and for a specified period of time.
19 Through managed care, it influences the utilization and costs of health services
20 with the end to make quality health care affordable to the public. The HMO
21 shall possess the following functional characteristics:

1 (1) It uses an organized system called managed care to coordinate the
2 delivery of health services to its members through health care providers in a
3 defined geographical area;
4 (2) It contracts the services of health care providers to deliver health
5 care services to its enrollees and/or their dependents as their agreement may
6 stipulate; and
7 (3) It has an enrolled group of individuals paying a fixed periodic fee.
8 (h) "Managed care" refers to a complex system that involves the active
9 coordination of, and the arrangement for, the provision of health services and
10 coverage of health benefits.
11 (i) "Member" refers to an insured individual or a part of a group, or an
12 employee of a corporation and his dependents, who entered into a contract of
13 health insurance with an HMO.
14 (j) "Person" refers to a natural or juridical person as defined by law.
15 (k) "Provider" refers to a health professional such as physician, dentist,
16 nurse or midwife, or health care professionals' group, or a health facility such
17 as a hospital, diagnostic clinic, medical clinic, pharmacy or HMO licensed by
18 the proper government agency to provide health care services.
19 (l) "Participating provider" refers to a health care provider, who, under
20 a health care provider contract, has agreed to provide health care services to

1 HMO members; has the right to payment, other than co-payment, which may
2 be deductible, directly or indirectly, from the HMO.

3 (m) "Enrollment fee" refers to the amount of money paid to an HMO by
4 an individual member, group or corporation on behalf of its employees and the
5 latter's dependents, in payment for a pre-agreed set of health services, for a
6 specific period of time.

7 (n) "Claim" refers to a statement of services submitted to an HMO by a
8 health care provider following the provision of covered services to a member
9 that shall include diagnosis or diagnoses and itemization of services and
10 treatment provided to the member.

11 (o) "Covered services/coverage" refers to health care services to be
12 delivered by a health care provider to a member as provided for in a health
13 care policy.

14 (p) "Health care provider contract" refers to a contract between an
15 HMO and a health care provider for the latter to deliver or provide health care
16 services to members of the former. It includes a schedule of covered services
17 and compensations and specifies all other terms, conditions, limitations,
18 exclusions, benefits, rights and obligations thereof to which the HMO and
19 health care provider are subject.

20 (q) "Health care policy" refers to an insurance policy comprising an
21 individual set of health service delivery and compensation procedures offered

1 as a managed care product of an HMO to its members. It specifies covered
2 services and all other terms, conditions, limitations, exclusions, benefits, rights
3 and obligations thereof to which the HMO and members are subject. It may be
4 in the form of a Comprehensive HMO Policy, Preferred Provider Policy,
5 Managed Indemnity, Self-insured Policy or Third Party Administration Policy.
6 (r) "Medically necessary services" refers to health care services that a
7 reasonably prudent physician would deem necessary for the diagnosis or
8 treatment of illness or injury or to improve the functioning of a malformed
9 body of a member.
10 (s) "Specialist" refers to a diplomate and/or fellow of a specialty
11 society recognized by the Philippine Medical Association (PMA).
12 SEC. 5. *Registration.* – An HMO shall be legally organized as a
13 juridical person and shall be registered with the SEC.
14 SEC. 6. *Licensure.* – The Insurance Commission, hereinafter referred to
15 as the Commission, shall supervise and regulate the operations of all HMOs
16 and all other entities that possess the functional characteristics of HMOs,
17 except the Philippine Health Insurance Corporation (PHIC). After registering
18 with the SEC, said entities shall secure a license to operate as an HMO from
19 the Commission: *Provided,* That an HMO intending to operate a medical
20 clinic or a hospital shall secure a license from the DOH: *Provided, further,*
21 That all HMOs existing at the time of the effectivity of this Act shall secure a

1 new license to operate from the Commission within one year from the
2 effectivity of this Act.

3 The Commission shall, upon receipt of a completed application for a
4 license to operate, provide a 60-day period for public comment. As soon as
5 the period has lapsed and after thorough review, it shall approve or disapprove
6 the application. In case the application is not approved, the reasons therefor
7 shall immediately be known to the applicant. The license to operate granted
8 under this Act shall be effective for three years, subject to renewal by the
9 Commission.

10 SEC. 7. *Licensure Requirements.* – The Commission shall prescribe the
11 requirements for licensure and renewal of license of HMOs. The requirements
12 shall include, but are not limited to, the following:

13 (a) The minimum authorized and paid-up capitalization;
14 (b) Financial statement/projections for new HMOs;
15 (c) Annual Reports for existing HMOs;
16 (d) Data on membership enrollment;
17 (e) Geographical area operation;
18 (f) Health policies being offered;
19 (g) Arrangements for ensuring the payment of the cost of health care
20 services or the provision for automatic applicability of an alternative coverage
21 in the event of discontinuance of the HMO;

1 (h) Any deposit of cash, or guaranty or minimum restricted reserves
2 which the Commission, by regulation, may adopt to assure that the obligations
3 to subscribers will be performed; and

4 (i) Presence of the following guaranties.

5 (A) Guarantees its members fundamental patients' rights, to include
6 among others:

7 (1) Patient's right to choose physician/specialist or health facility – All
8 members of HMOs shall be offered an out-of-network option that will enable
9 them to obtain, even at the member's additional expense, care from a health
10 care provider outside the HMO's network of participating providers. Such out-
11 of-network health care providers shall have the right to HMO compensation,
12 other than co-payment or deductible directly or indirectly from the HMO. All
13 health policies must guarantee direct access to an obstetrician/gynecologist for
14 women and access to a pediatrician for children as their primary physician.

15 (2) Patient's right to emergency care – A member who reasonably
16 believes that he is suffering from an emergency condition has the right to seek
17 emergency care from the nearest emergency department without first pre-
18 authorizing or pre-certifying the care with their HMO.

19 (3) Patient's right to grievance and external review program –
20 Members of HMOs shall be granted the right to dispute coverage denials on

1 the basis of "medically necessary" decisions before an independent Medical
2 *Review Committee as provided for in Section 10 hereof.*

3 (B) Guarantees to health care providers:

4 (1) Physicians'/Dentists' full freedom to manage and treat patients in
5 accordance with the prevailing standard of care – "Medically necessary"
6 decisions shall be made by physicians/dentists in accordance with generally
7 accepted standards of medical/dental practice that a prudent physician/dentist
8 will make.

9 (2) Prompt and just compensation – Health care providers shall be paid
10 their just professional/facility fees within thirty (30) days from receipt of the
11 HMOs' written or electronic claim. In the event that such claim is not
12 approved, the reasons therefor shall be made known to the provider within
13 seven days after receipt of such written or electronic claim. Disputes may then
14 be addressed to the Commission for arbitration as provided for in Section 10
15 hereof. HMOs that do not pay clean claims within the 30-day window may be
16 liable for suspension of license to operate and will be required to pay interest
17 at a rate to be determined by the Commission. Professional fees must be in
18 accordance with the PMA or the Philippine Dental Association's latest
19 schedule of fees and latest Relative Unit Value and Factor (RUVF) prevailing
20 upon the effectivity date of the contract.

1 (C) Guarantees of a network of qualified and duly licensed health care
2 providers.
3 SEC. 8. *New License.* – The Commission shall grant the HMOs their
4 new licenses in accordance with this Act: *Provided,* That existing agreements,
5 rights and obligations derived therefrom shall be respected: *Provided, further,*
6 That HMOs comply with the licensing requirements within one year from the
7 effectivity of this Act.
8 SEC. 9. *Actuaries/Financial Consultants.* – To protect the potential and
9 enrolled members of the HMOs, the Commission shall ensure that HMOs
10 adhere to actuarially-sound practices and processes, and possess adequate
11 financial capabilities to render the services stipulated in their agreements.
12 To achieve these objectives, the Commission shall engage the services
13 of actuaries and/or financial consultants to analyze the financial status and the
14 actuarial soundness of the HMO practices prior to issuance or renewal of
15 licenses. For this purpose, the Commission shall require from HMOs such
16 additional data and reports it deems necessary: *Provided,* That such data and
17 reports are certified by an actuary, a financial consultant or an external auditor.
18 SEC. 10. *Arbitration and Review.* – HMOs shall provide an internal
19 mechanism where disputes between parties to a health care policy or parties to
20 a health care provider contract may be resolved in an expeditious manner. In
21 the event that the dispute is unresolved, a member, health care provider or an

1 HMO may elevate the case directly to the Commission for binding arbitration.
2 *However, if the Commission determines the conflict to be medical in nature or*
3 requiring a review of medically necessary conditions, the case shall be referred
4 for judgment to an HMO Medical Review Committee to be constituted by the
5 DOH. The HMO Medical Review Committee shall ensure that reviews of
6 medically necessary decisions must be made only by truly independent
7 *licensed physicians* familiar with the medical condition or treatment in question
8 and of the same specialty as the treating physician. Such complaints or
9 disputes shall be decided upon within thirty (30) days and the decision shall be
10 final and executory. All other complaints that remain with the Commission for
11 arbitration shall be decided upon within sixty (60) days. The decision of the
12 Commission shall be final and executory, appealable to the Supreme Court
13 only on a question of law.
14 SEC. 11. *Grounds for Suspension of License.* – The license to operate
15 issued to HMOs may be suspended by the Commission on any of the following
16 grounds:
17 (a) When based on financial reports, continued operation of the HMO
18 business is no longer financially sound;
19 (b) When agreements with members are not honored;

1 (c) When contracts with health care providers, including, but not
2 limited to, prompt and just compensation for health services rendered are
3 violated;
4 (d) When the statements in the application for license or renewal
5 thereof are found to be false, misleading, inadequate or incomplete such that
6 the Commission cannot arrive at an honest appraisal of the true capability of
7 the HMO;
8 (e) When the decision of the Commission on cases for arbitration is not
9 honored by an HMO; and
10 (f) When an HMO continuously violates the rules and regulations
11 issued by the Commission and the Department pursuant to Section 7 of this
12 Act.
13 SEC. 12. *Grounds for Revocation of License.* – The Commission shall
14 revoke the license of an HMO on any of the following grounds:
15 (a) Repeated violations of this Act by an HMO;
16 (b) Impairment of the status of the HMO, as may be determined by the
17 Commission, during suspension based on paragraph (a) of Section 11 hereof,
18 after a fair appraisal by impartial actuaries and financial consultants, such that
19 even if allowed to continue to operate, it can no longer provide the services it
20 assumed under the agreement with its members; and
21 (c) Repeated suspension of HMO license.

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

4 (a) A fine of Ten thousand pesos (P10,000.00) for the first violation of
5 the provision of this Act, Twenty thousand pesos (P20,000.00) for the second,
6 and Thirty thousand pesos (P30,000.00) for the third violation. The provision
7 of Section 12 shall apply for the fourth violation of this Act.

8 (b) A fine of Fifty thousand pesos (P50,000.00) every time the license
9 of the HMO is suspended: *Provided,* That payment of this fine shall not
10 absolve the HMO from its obligations under the agreement.

11 (c) An order to freeze the assets and funds of the suspended HMO or
12 whose license has been revoked for the protection of investors, providers and
13 members.

14 The Commission shall retain the amount that may be collected as fines
15 for its use in the information dissemination provided under Section 15 hereof.

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

18 (a) List of duly licensed HMOs in good standing;

19 (b) List of suspended HMOs or HMOs whose license/s have been
20 revoked, copies of which shall be furnished the associations of the

1 medical/dental profession, hospitals and employers who shall inform their
2 members accordingly.
3 SEC. 15. *Implementing Rules and Regulations* – The Commission and
4 the Department shall promulgate the rules and regulations necessary to
5 implement this Act within ninety (90) days from its approval. Such rules and
6 regulations shall be furnished to HMOs and shall take effect upon publication
7 in a newspaper of general circulation.
8 SEC. 16. *Separability Clause.* – If any provision of this Act is declared
9 unconstitutional or invalid, the other provisions not affected by such
10 declaration shall remain in full force and effect.
11 SEC. 17. *Repealing Clause.* – All laws, decrees, ordinances, rules and
12 regulations, executive or administrative orders or parts thereof inconsistent
13 with this Act are hereby repealed, amended or modified accordingly.
14 SEC. 18. *Effectivity.* – This Act shall take effect fifteen (15) days
15 following its approval.

Approved,

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