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[REPUBLIC ACT NO. 7875, January 21, 1995]

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

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 "National Health Insurance Act of 1995."

Article 1. 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. DEFINITION OF TERMS

SEC. 4. *Definition 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 (2 1) years of age; 3) children who are twenty-one (2 1) 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 presense 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 sense 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 I 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 Insurance 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 therefrom.
x. Personal Health Services - Health services in which benefits accrue to the individual person. These are categorized into impatient 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.