Senate
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SIXTEENTH CONGRESS OF THE REPUBLIC )
OF THE PHILIPPINES )
Second Regular Session )

SENATE

P.S. Res. No. 1368

Introduced by **Senator Teofisto "TG" Guingona III**

**RESOLUTION**
**DIRECTING THE SENATE COMMITTEE ON ACCOUNTABILITY OF PUBLIC OFFICERS AND INVESTIGATIONS (BLUE RIBBON) AND THE SENATE COMMITTEE ON HEALTH AND DEMOGRAPHY TO CONDUCT AN INQUIRY, IN AID OF LEGISLATION, INTO THE REPORTED SUSPICIOUS CLAIMS OF HOSPITALS AND CLINICS WITH THE PHILIPPINE HEALTH INSURANCE CORPORATION (PHILHEALTH) AMOUNTING TO TWO BILLION PESOS AND OTHER SIMILAR FRAUDULENT TRANSACTIONS.**

***WHEREAS,*** the Section 11, Article XIII of the 1987 Philippine Constitution 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. There shall be priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers."

***WHEREAS,*** the mandate of the Philippine Health Insurance Corporation (Philhealth) is to provide health insurance coverage and to ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines[1];

***WHEREAS,*** it has been reported that Two Billion Pesos (Php 2,000,000,000.00) worth of claims filed by affiliated hospitals and clinics to Philhealth are now under investigation for suspicion of fraud;

***WHEREAS,*** according to Philhealth, there are "highly suspicious" benefit payments to accredited hospitals and clinics over questionable claims for procedure;

***WHEREAS,*** there were reports of a "hakot" mechanism being employed by these accredited hospitals and clinics wherein Philhealth members were being operated on or made to undergo a procedure, even if said treatment is not necessary and which may even be dangerous;

[1] SEC. 5, R.A. 7875.

***WHEREAS,*** some reports say that certain accredited hospitals and clinics have filed claims with Philhealth based on procedures or treatments that were never, in fact, performed;

***WHEREAS,*** Section 38[2] of R.A. 7875 (National Health Insurance Act of 1995), mandates Philhealth to set up a monitoring mechanism to ensure safeguards against over and under utilization of services;

***WHEREAS,*** these questionable actions of health care service providers is detrimental to the health and safety of the patient and lead to a misappropriation of funds actually needed by other patients;

***WHEREAS,*** there are reports that such fraud is being perpetrated with the connivance of some insiders of the Philhealth;

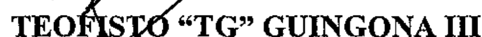
***WHEREAS,*** there is a need to see and determine whether this huge problem has become such because of the nonfeasance, misfeasance, and malfeasance of public officers within and without Philhealth;

***WHEREAS,*** these "highly suspicous" and fraudulent claims are detrimental to the integrity and sustainability of the operations of Philhealth in ensuring that Filipinos will be given not only greater access to health care, but also increasing the benefits of the members of Philhealth;

***WHEREAS,*** it is incumbent upon PhilHealth, as the country's premiere health insurance provider, to set up a *policing mechanism* that will promote transparency and accountability among health care providers, with respect to how they charge PhilHealth;

***NOW, THEREFORE, BE IT RESOLVED,*** as it is hereby resolved, that the Philippine Senate directs the Senate Committee on Accountability of Public Officers and Investigations (Blue Ribbon) and the Senate Committee on Health and Demography to conduct an inquiry, in aid of legislation, into the reported suspicious claims of hospitals and clinics with the Philippine Health Insurance Corporation (Philhealth) amounting to two billion pesos and other similar fraudulent transactions.

Adopted,



**TEOFISTO "TG" GUINGONA III**

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[2] SEC. 38. **Safeguards Against Over and Under Utilization.** – It is incumbent upon the Corporation to set up a monitoring mechanism to be operationalized through a contract with health care providers to ensure that there are safeguards against: a) over-utilization of services; b) unnecessary diagnostic and therapeutic procedures and intervention; c) irrational medication and prescriptions; d) under-utilization of services; and e) inappropriate referral practices. The Corporation may deny or reduce the payment for claims when such claims are attended by false or incorrect information and when the claimants fails without justifiable cause to comply with the pertinent rules and regulations of this Act.