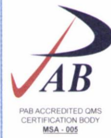
Republic of the Philippines
Department of Finance
INSURANCE COMMISSION
1071 United Nations Avenue
Manila



Circular Letter No.	2024-01
Date	03 January 2024
Amends/Supersedes:	N/A

CIRCULAR LETTER

TO : **ALL HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AUTHORIZED TO DO BUSINESS IN THE PHILIPPINES**

SUBJECT : **GUIDELINES DEFINING UNSOUND BUSINESS ACTS AND PROVIDING ADMINISTRATIVE FINES FOR VIOLATION THEREOF**

WHEREAS, Executive Order (EO) No. 192, s. 2015 transferred the jurisdiction over the HMOs from Department of Health to the Insurance Commission (IC);

WHEREAS, Section 1 of EO No. 192, s. 2015 mandates the IC to regulate and supervise the establishment, operations, and financial activities of the HMOs;

WHEREAS, in the exercise of its authority under EO No. 192, s. 2015, the IC is empowered, among others, to: (a) regulate, supervise, and monitor the operations and management of HMOs to ensure compliance with this Order, existing laws, rules, and regulations, and such other directives and circulars issued by the IC; (b) issue orders to prevent fraud and injury to the HMO plan holders and industry stakeholders; (c) pursuant to existing laws, rules, and regulations, impose sanctions and/or appropriate penalties;

WHEREAS, Republic Act No. 11765 or the "*Financial Products and Services Consumer Protection Act*," mandates the IC, as a financial regulator, to protect the rights of the financial consumers, namely: (a) right to equitable and fair treatment, (b) right to disclosure and transparency of financial products and services; (c) right to protection of consumer assets against fraud and misuse; (d) right to data privacy and protection; and (e) right to timely handling and redress of complaints;

NOW, THEREFORE, pursuant to the powers vested in me by EO No. 192, s. 2015, the following guidelines are hereby promulgated:

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Section 1. Applicability

This Circular shall govern the unsound business acts of HMOs and HMO intermediaries.

This Circular does not cover acts that affect compliance with requirement on capital adequacy, product approval, corporate governance, or other internal matters not directly dealing the public and are covered by other rules or regulations of the Commission.

Section 2. Definition of Terms

For purposes of this Circular, the following definitions shall apply:

A. *Advertisement* – any communication, notice, or presentation designed to motivate and/or inform the public with respect to any HMO product or related services.

B. *Annual Benefit Limit (ABL)* – the maximum liability that the HMO shall assume for all covered services rendered to a member within the one-year term of the HMO product. ABL is replenished upon renewal of the HMO product but not during extension.

C. *Authorized Representative* – a person duly authorized by the HMO to approve the provision of medical services or claims reimbursements to a member.

D. *Commission* – refers to the Insurance Commission of the Philippines.

E. *Commissioner* – refers to the Insurance Commissioner.

F. *Claims* – a request or a demand for payment of benefits under an HMO product, such as, but not limited to, refund or reimbursement. It may also refer to the request for availment of healthcare benefits under the HMO product.

   As used in this Circular, the terms "claims" and "availments" may be used interchangeably.

G. *Documentation* – all pertinent communications, receipts, bills, records, reports, and all other papers relative to an HMO claim.

H. *HMO* – a juridical entity legally organized to provide or arrange for the provision of pre-agreed or designated health care services to its enrolled members for a fixed pre-paid fee for a specified period of time.

I. *HMO Card* – the identification card (ID) issued by the HMO to a member containing the latter's name and signature, ID reference number, and other matters pertaining to his or her membership.

J. *HMO Product* – refers to a pre-agreed or designated health care services to the enrolled members for a fixed pre-paid fee for a specified period of time through the use of selected network of health care providers.

   This term also refers to the agreement, whether individual or corporate, entered into by the HMO and the member pursuant to Circular Letter No. 2017-19.[1]

K. *HMO Intermediaries* – include HMO agents, brokers, and soliciting official under Circular Letter No. 2022-09.[2]

L. *Investigation* – all activities of an HMO related to the determination of liabilities under coverage of an HMO product.

M. *Letter of Authorization (LOA)* – a written document issued by the HMO or its authorized representative to, and signed by, the member which shall serve as the authority of the latter to avail of the medical services.

N. *Material Information* – an information is deemed material if its disclosure would have resulted in (a) declining the application for membership of the applicant, (b) higher assessment of membership fee or (c) inclusion of additional exclusions or limitations to the benefits of the member under the HMO product.

O. *Maximum Benefit Limit (MBL)* – refers to the maximum liability that the HMO assumed per covered illness or injury, and its complications, of a member within the terms and conditions of the HMO product. MBL is replenished upon renewal of the HMO product by the member but not during any extension thereof.

P. *Member* – refers to the principal client, whether individual or corporate, that has been accepted for membership by the HMO after complying with the eligibility provision and is currently enrolled in any of the HMO's products. In case of individual client, the term 'member' also refers to his or her dependents designated in the HMO product; while, in case of corporate client, the term 'member' covers its employees, officers, directors, and other persons enrolled by the juridical entity in its HMO product.

Q. *Membership* – refers to membership in an HMO product.

R. *Membership Fees* – refers to the fees for the enrollment of a member or members, specified in the HMO product.

S. *Surface Bargaining* – an act or series of acts in the guise of negotiating the HMO claims but made without any intent to reach an agreement or a settlement.

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[1] Entitled, "*Guidelines on the Approval of HMO Products and Forms.*"

[2] Entitled, "*Guidelines on the Licensing Requirements of Insurance and/or Reinsurance Brokers Engaged in Health Maintenance Organization (HMO) Business.*"

Section 3. Unsound Business Acts. The following are considered unsound business acts by an HMO or an HMO intermediary, whenever applicable:

A. **Misrepresentation to the Public** –

1. **On HMO product provisions**

   Misrepresenting to prospective client or member the true nature or the terms or conditions of the HMO product, such as, but not limited to:

   (a) Making, issuing, circulating, or permitting to be made, issued and/or circulated any literature, illustration, circular or statement of any sort which misrepresents the terms or conditions of an HMO product;

   (b) Misrepresenting or making false misrepresentation or misleading statements as to the benefits; exclusions or limitations; affiliated hospital, medical clinic or physician; covered injuries or illnesses; membership fees; MBL; ABL; application of the pre-existing conditions; or, other benefits or perks, without which the member would not have availed the HMO product;

   (c) Making any false or misleading statement regarding the financial position of any person with respect to HMO business or with respect to any person in the conduct of the HMO business;

   (d) Using any name or title of any HMO product or class of HMO products misrepresenting the true nature thereof;

   (e) Failing to disclose all applicable charges.

2. **On payment of claims**

   (a) Indicating on a payment draft, check, or in an accompanying letter for payment of benefits of the HMO product made to a member that said payment is a final release of any claims under the HMO product, except:

      i. the member already consumed the MBL or ABL of the HMO product; or

      ii. the member and the HMO amicably settled regarding the amount payable and coverage under the HMO product.

   (b) Making partial settlement of a claim, which contains a statement which directly or indirectly releases the HMO from total liability under the HMO product.

3. **On advertisement**

   (a) Advertising an HMO product which has not been approved by the Commission; or

   (b) Mispresenting an HMO product to have been approved by the Commission

B. **Unfair Discrimination**. -The following are considered unfair discrimination:

   1. Making any discrimination against any Filipino, or any other race, in the sense that he or she is given less advantageous rates or other HMO product conditions or privileges than are accorded to other nationals solely because of his or her race; or

   2. Making or permitting to make any unfair discrimination in any person similarly situated with respect to fees or rates charged, conditions or privileges of an HMO product, or in any other manner or means constituting the same.

C. **Unfair Claims/Availments Management**. - The following acts are considered unfair claims/availments management:

   1. Failure to acknowledge with reasonable promptness pertinent communications with respect to claims/availments of healthcare benefits stipulated in the HMO product;

   2. Failure to adopt and implement reasonable standards for the prompt investigation of disputes arising from claims/availments of healthcare benefits in the HMO product;

   3. Failure to provide the services to the members in accordance with terms and conditions set forth in the HMO product without justifiable cause;

   4. Denying to pay claims without conducting reasonable investigation based on all available documentation, proof, or any other information relative to a claim. The different findings by the doctor who initially checked the member and by the doctor whose diagnosis is relied upon by the HMO shall not be considered material information. The HMO has the duty to prove, by substantial evidence, that the denial be based on any valid grounds, such as, but not limited to, concealment of material information or the claim is an exclusion or limitation under the HMO product.

   5. Failure to affirm or deny claims/availments within a reasonable time after all relevant and required documentation had been submitted by the member;

6. Failure to issue or deny issuance of LOA within a reasonable time after all relevant and required documentation had been submitted by the member;

7. Failure to provide within a reasonable time a reasonable explanation, based on facts and/or applicable laws, for the offer of compromise settlement or for the denial of a claim;

8. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

9. Failure to promptly effectuate settlement of claims, where liability has become reasonably clear under one portion of the HMO product coverage in order to affect the settlement under other portions of the HMO product coverage;

10. Compelling members to institute suits to recover amounts due under its HMO product by offering without justifiable reason substantially less than the amounts ultimately recovered in suits brought by them;

11. Attempting to settle a claim for less than the amount to which a reasonable person would have believed to be due to him or her by reference to written or printed advertising material accompanying or made part of an HMO product, which could have misled or misrepresented certain material information about the HMO product, or doing an inequitable settlement which includes offering a proposal without any legal or factual basis;

12. Attempting to settle claims based on an HMO product which was unilaterally altered or modified without notice, knowledge or consent of the client or member, or its, or his or her authorized representatives;

13. Failure to accompany the claim payments with a formal and written statement, served upon a member, setting forth the coverage under which the payments are being made;

14. Delaying the investigation or payment of claims by requiring a member to submit other set of documents which are deemed superfluous or irrelevant due to the earlier submission of the member of documents that are competent and substantial to establish a claim;

15. Directly advising a member not to obtain the services of an attorney with respect to his or her valid claim;

16. Misleading a member with respect to the application of pre-existing conditions, or applicable statute of limitations pertaining to his or her claim; or

17. Surface bargaining.

D. **Misrepresentation in HMO applications or claims** – Making a false or fraudulent statement or representation in or with reference to any HMO application, including the total cost of claims/availments of the client-HMO or member from its previous HMO vendor, by an agent, broker, or solicitor.

E. **Failure to effectively control and supervise its agent/s**. – Failure to maintain reasonable standards of supervision and control over its agents, and, by such reason, the agents committed or were permitted to commit an act or omission which is prejudicial to its members or the public in general.

F. **Failure to provide a copy of the HMO product.** – Failure to provide a complete copy of the HMO product, including all of its riders and/or endorsements, within fifteen (15) days from receipt of payment of the premium. A member must be provided with a printed copy or an electronic copy, whichever the member may prefer.

G. **Failure to respond to regulatory inquiries**. – Unjustifiable failure to provide substantial and reasonable response to an inquiry, directive, or order by the Commission regarding the denial of claim or issuance of LOA; cancellation; nonrenewal; or, any alleged violation of this Circular or other rules or regulation of the Commission, within fifteen (15) days from receipt of the pertinent communication, or if a period for submission of a response is specifically fixed by the Commission, within such period. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry which must be answered within the same period as above prescribed.

H. **Analogous unsound acts.** – The acts enumerated in this Circular are not an exhaustive list of unsound acts by an HMO or HMO intermediary. In the exercise of his or her discretion, the Commissioner may now and then consider an analogous conduct to the enumerated acts in this Section an unsound act for purposes of preventing fraud or injury and protecting the rights of a member/s.

Section 4. **Penalties**. If, after an administrative hearing before the Regulation, Enforcement and Prosecution Division (REPD), the Commission determines that the person charged has engaged in an unfair business act as defined under this Circular, the Commissioner shall issue a written Order, Resolution or Decision containing said findings and shall include therein an order requiring such person to cease and desist from engaging in such act and shall, in his discretion, impose the following fines:

A. **First Offense**

1. Php 10,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 50,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

2. If the punishable conduct or violation was made deliberately or willfully; or was made with his or its knowledge or should have been reasonably known by him or it, a fine of Php 50,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 100,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

B. **Second Offense**

1. Php 50,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 100,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

2. If the punishable conduct or violation was made deliberately or willfully; or was made with his or its knowledge or should have been reasonably known by him or it, a fine of Php 100,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 150,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

C. **Third and Subsequent Offense**

1. Php 100,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 150,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

2. If the punishable conduct or violation was made deliberately or willfully; or was made with his or its knowledge or should have been reasonably known by him or it, a fine of Php 150,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 200,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

Notwithstanding the foregoing, the Commission may impose either as independent or accessory penalty, the revocation or suspension of the Certificate of Authority or license of the adjudged HMO or HMO intermediary.

Moreover, this Circular is without prejudice to the application of RA No. 11765 or "*The Financial Products and Services Consumer Protection Act,*" its Implementing Rules and Regulations, and Circular Letter No. 2019-28.[3]

Further, the Commissioner may, at his discretion, modify the application of the foregoing prescribed monetary penalties depending upon the severity of the offense, the frequency of its commission, the gravity of the damage caused, the history of the offender, or other circumstances which warrant imposition of a lower or a more severe amount of fines and penalties than that prescribed in this Circular.

In addition, the suspension or removal from office may also be imposed upon directors and/or officers and/or employees of HMO or intermediary found to have violated this Circular as the circumstances would warrant.

Section 5. Separability Clause

Should any provision of this Circular or any part thereof be declared invalid, the other provisions, insofar as they are separable from the invalid ones, shall remain in full force and effect.

Section 6. Repealing and Amending Clause

All orders, rules and regulations, memoranda and other issuances inconsistent with or contrary to the provisions of this Circular are hereby repealed or amended accordingly.

Section 7. Effectivity

This Circular shall take effect immediately.

REYNALDO A. REGALADO
Insurance Commissioner

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[3] Entitled, "Guidelines on the Issuance of Cease and Desist Orders (CDOs) Against Health Maintenance Organizations (HMOs)."