PhilHealth
Your Partner in Health

BAGONG PILIPINAS

PHILHEALTH CIRCULAR
No. ___7o飞5 - 0007___

TO : **ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHER CONCERNED**

SUBJECT : **Lifting the 45-Day Benefit Limit Rule**

I. RATIONALE

Under Republic Act No. 11223 or the Universal Health Care Act, all Filipinos are guaranteed equitable access to quality and affordable health care goods and services, and protected against financial risk (Section 3.b).

In fulfillment of this mandate, PhilHealth has deemed it necessary to revisit the 45-day Benefit Limit Rule (herein used interchangeably with "Rule"), a cost-containment strategy of the Philippine Medical Care Commission (Medicare Program) established by Republic Act No. 6111 otherwise known as the Philippine Medical Care Act of 1969[1], the precursor of the National Health Insurance Program under PhilHealth.

The Rule limits the utilization of PhilHealth benefits to 45 days for the members, and another 45 days to be shared by their qualified dependents. This was originally designed to prevent overutilization of health services. However, with the expanded mandates of PhilHealth as prescribed in Republic Act No. 7875, as amended by R.A. Nos. 9241, 10606 and 11223, cost-containment strategies must not hamper access to critical services.

Aligned with existing laws, PhilHealth is continuously instituting new ways of engaging and paying providers in a manner that drives efficiency, while preserving both access and quality outcomes. Hence, the PhilHealth Board of Directors through PhilHealth Board Resolution No. 2999, s. 2025, approved the discontinuance of the 45-Day Benefit Limit Rule.

II. OBJECTIVES

This PhilHealth Circular aims to lift the 45-day Benefit Limit Rule in claims payment policy.

---

[1] Philippine Medical Care Act of 1969, Republic Act 6111 (1969). Philippine Medical Care Act of 1969.
https://lawphil.net/statutes/repacts/ra1969/ra_6111_1969.html#:~:text=R.A.%206111&text=AN%20ACT%20ESTABLISHING%20THE%20PHILIPPINE,FUNCTIONS%2C%20AND%20APPROPRIATING%20FUNDS%20THEREFOR.

SOCOTEC
ISO 9001
√AB

III. SCOPE

This policy shall be applicable to medical conditions and surgical procedures under the All Case Rates (ACR), and special packages that are subject to the 45-day Benefit Limit Rule.

IV. DEFINITION OF TERMS

A. All Case Rates (ACR) – a fixed rate or amount that PhilHealth will reimburse for a specific illness/case, which shall cover for the fees of health care professionals, and all facility charges including, but not limited to, room and board, diagnostics and laboratories, drugs, medicines, and supplies, operating room fees and procedures, regardless of member category, that are admitted in accredited health care institutions.

B. 45-day Benefit Limit – a member is entitled to a maximum of 45 days confinement per calendar year. All qualified dependents of the member share another 45 days benefit per calendar year.
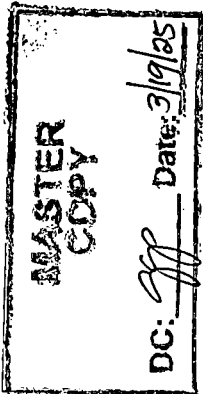
V. POLICY STATEMENTS

A. General Provisions

1. The 45-day Benefit Limit Rule is lifted for all PhilHealth members and qualified dependents.

2. Availment of services must have proper indication that is appropriate, necessary, and aligned with the patient's treatment plan, adhering to widely-accepted standards of care, DOH-approved Clinical Practice Guidelines (CPGs) and/or PhilHealth Circulars on quality standards.

3. For patients with prolonged confinements or series of confinements that exceed 45 days, Health Facilities (HF) are enjoined to conduct review or audit of the patient case for quality assurance purposes. Report on such reviews or audits should be available upon request of any PhilHealth office or during PhilHealth facility monitoring.

4. The Corporation reserves the right to impose additional rules and limitations to address and/or avert the potential abuse of the lifting of this Rule.

5. This policy shall not cover hemodialysis benefit and other benefits which are not subject to the 45-day Benefit Limit Rule.

B. Monitoring and Evaluation

1. PhilHealth shall closely monitor admissions/readmissions, utilization of benefits and services of patients that exceed 45 days.

2. Compliance of HFs to clinical standards and reimbursement rules shall be monitored closely through the Health Care Providers Performance Assessment System (HCPPAS).

3. HFs are enjoined to implement a comprehensive organization-wide policy focused on quality and performance improvement.

4. Health Care Providers (HCPs) shall provide, upon request, certified true copies of complete clinical charts and patient records during medical post-audit and validation activities. HCPs who fail to comply shall be dealt with in accordance with the UHC Law, and other pertinent and applicable rules.

C. This PhilHealth Circular shall be regularly reviewed and enhanced, as necessary.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 7875 as amended by R.A. Nos. 9241, 10606, and 11223 and their respective Implementing Rules and Regulations.
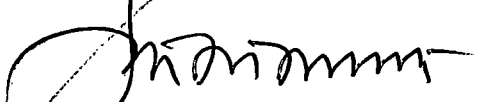
VII. SEPARABILITY CLAUSE

In the event that any part or provision of this PhilHealth Circular is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

VIII. REPEALING CLAUSE

All provisions of previous issuances that are inconsistent with any provisions of this PhilHealth Circular are hereby amended/modified/or repealed accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen(15) days after its publication in the Official Gazette or in any newspaper of general circulation. Three (3) certified copies shall be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EDWIN M. MERCADO, MD, MHA, MMSc
Acting President and Chief Executive Officer

Date signed: 3|19|2025

Lifting the 45-Day Benefit Limit Rule